An Interpretive Manual for the Multidimensional Inventory of Dissociation (MID)

4th Edition

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4th Edition Revised and Expanded 2022 by:
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Current versions of this and associated MID documents, including MID Analysis v6.0, may be found at:

www.mid-assessment.com

Credits and Notes – An Interpretive Manual for the MID
4th Edition: December 2022

Welcome to the *Interpretive Manual,* a guide to administration, scoring, and interpretation for the Multidimensional Inventory of Dissociation (MID). The MID was developed by Paul F. Dell for the assessment of pathological dissociation to assist in the diagnosis of the dissociative disorders. The original *Mini-Manual* was written by Paul F. Dell in 2013. Starting with the 2nd Edition (2017), the *Interpretive Manual* has been maintained and updated by D. Michael Coy, MA, LICSW, and Jennifer A. Madere, MA, LPC-S.

You must have a copy of the *MID 6.0*, which is the actual 218-item inventory that the test-taker completes. You should also obtain a copy of the *MID Analysis (current iteration is v6.0, dated November 30, 2022)*, which is the MS Excel spreadsheet that scores the MID and produces *The MID Report* and *The Extended MID Report*, as well as illustrative line and bar graphs. These and other documents relevant to the MID may be found, free of charge, at http://www.mid-assessment.com. Training and consultation on use of the MID are available for a fee via the same website.

Please send information regarding typographical and suspected calculation errors/omissions to admin@mid-assessment.com with 'MID CORRECTION/UPDATE' in the Subject Line.

How to reference the MID if you are writing an article:

Dell, P. F. (2006). The Multidimensional Inventory of Dissociation (MID): A comprehensive measure of pathological dissociation. *Journal of Trauma & Dissociation, 7*(2): 77-106.

Major articles on the MID and the model of dissociation on which it is based:

Dell, P. F. (2006). A new model of dissociative identity disorder. *Psychiatric Clinics of North America, 29*(1), 1-26.

Dell, P. F. (2009). The phenomena of pathological dissociation. In P. F. Dell & J. A. O'Neil (Eds.). *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 225-237). New York, NY: Routledge.

Dell, P. F., & Lawson, D. (2009). Empirically delineating the domain of pathological dissociation. In P. F. Dell & J. A. O'Neil (Eds.). *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 667-692). New York: Routledge.

How to cite this Interpretive Manual:

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Additional article/chapter references may be found here: http://www.mid-assessment.com/articles-references/

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Part I: Introduction and Clinical Foundations

How to Use this Manual

This manual is designed to both provide basic instructions for administering and scoring the MID, to address most questions clinicians and researchers may have about what the items, scales, etc., mean, and to provide introductory information to related concepts and differential diagnosis that may assist practitioners in the accurate diagnosis and effective treatment of the persons they serve.

Clinical use of the MID is incomplete and the results are invalid without conducting a follow-up interview after administration and scoring (see Part IV below). New and seasoned professionals will benefit from reading this manual and applying informed interpretation of each person's scores to identify which items and scales to clarify in the follow-up interview. Used in this way, the MID can most fully support clarity in diagnosis and treatment planning. After an initial reading of this manual, Appendix V may be useful when needing to access a summary of symptom descriptions.

Navigation headings have been embedded within this document. If the navigation panel is not currently visible to the left of this text, it may be activated in Adobe *Acrobat* by selecting 'View' → 'Navigation Panels' and clicking to activate a ✓ next to 'Bookmarks.'

> ***Just getting started?***
> *A summary of instructions for administering and scoring the MID can be found under the heading 'MID Basics' starting on page 16 of this manual.*

Basic Information about the MID

The *Multidimensional Inventory of Dissociation* (MID) was developed by Paul F. Dell, PhD, to assess pathological dissociation and the dissociative disorders. Importantly, the MID is not a clinician-administered instrument, such as the Semi-Structured Clinical Interview for Dissociative Symptoms and Disorders (SCID-D; Steinberg, 2023, formerly the *Structured Clinical Interview for DSM-IV Dissociative Disorders* (Steinberg, 1994)) or the *Dissociative Disorders Interview Schedule* (DDIS; Ross, 1989, 2016). 'Clinician administered' means that the clinician reads the questions aloud and gathers information based on the respondent's verbal (and, in the case of the *SCID-D*, nonverbal) responses.

Rather, the MID is to be self-administered, with the test-taker reading items in their own voice (in whatever facets) and answering based on their own perception. Although it is self-

administered, the MID is not a screening instrument, such as the Dissociative Experiences Scale (Carlson & Putnam, 1993). Instead, the MID is a multiscale measure that yields a detailed account of the person's dissociative symptoms and likely diagnoses. The MID's Diagnostic Impression has a predictive power of .89 that distinguishes DID and OSDD from other clinical presentations (Dell, 2011). Despite its assessment and diagnostic power, valid use of the MID requires a clinician-directed, follow-up interview (See Part IV below).

The MID was created in 2004 and first published in 2006. At the time of this writing, the current version of the MID itself is 6.0, and the current version of *MID Analysis* is 6.0 (as of December 2022). MID items are written to a 7th grade reading comprehension level. The MID can be used with persons age 18 years and older. There is also an Adolescent MID that uses the same 218 items (several of which have been revised with teen-appropriate languaging). *Note: The Adolescent MID includes a separate answer sheet at the end of the document.*

MID *Basics at-a-Glance*

- The MID has 218 items, and usually takes about 30-60 minutes to complete
- If a person endorses *ever* having the indicated experience, that item score is 1 or higher
- The MID takes approximately 10 minutes to score
- A clinician-administered follow-up interview is imperative
- For clinicians familiar with the DES, the Mean MID Score is roughly equivalent to an overall mean DES score of the same value, though neither is considered definitive of dissociative symptomology

The MID has been translated into Hebrew, Spanish, European Portuguese, Italian, French, German, Finnish, Norwegian, and Chinese. The Hebrew MID has been independently validated in Israel. All MID translations known to the authors are available at www.mid-assessment.com.

What is required of clinicians to use the MID?

Read this manual! The MID is a robust and detailed instrument with many scales. There is no substitute for learning about the MID by studying this manual alongside practicing the steps of administering, scoring, following up, and interpreting it in your practice.

The MID is available to clinicians, researchers and students of mental health-related fields free of charge. While specialized training is not required, familiarity with dissociative experiences, the Dissociative Experiences Scale (DES), and basic Excel skills will be useful. Familiarity with the assessment and treatment of persons with complex trauma and dissociative disorders will enhance your use and application of information provided by *The MID Report*.

Each of the MID's 218 items measure the frequency of the described experience on a 0 to 10 rating scale, where 0 means "Never" and 10 means "Always." No timeframe of experience is specified. Episodes of amnesia are very important but may be infrequent. Thus, the test-taker will rate an amnesia item that was experienced rarely and occurred years ago with at least a 1.

Most test-takers require 30-60 minutes to complete the MID. It takes about 10 minutes for the clinician to enter item scores into the *MID Analysis* **Questions** tab.

Of the 218 items, 168 tap dissociative experiences; the remaining 50 are "validity" items. The MID measures 23 dissociative symptoms and has 74 Scales which are defined and described below (and in Appendix V).

Reasons to Assess for Pathological Dissociation

To Clarify Diagnosis

The MID assesses dissociative experiences broadly and deeply. The *MID Analysis* differentiates and offers a diagnostic impression regarding the following clinical presentations:

- Dissociative Identity Disorder (DID)
- Other Specified Dissociative Disorder (OSDD), Type 1a (ICD Partial DID)
- Other Specified Dissociative Disorder (OSDD), Type 1b (DSM only)
- Unspecified Dissociative Disorder
- Posttraumatic Stress Disorder (PTSD)
- Posttraumatic Stress Disorder, Dissociative Sub-type
- Functional/Dissociative Neurological Symptom Disorder
- Problematic and Severe Traits Indicating Borderline Personality Disorder

How reliable is it? The MID has correctly diagnosed 87-93% of DID cases (Dell, 2006b).

NOTE: DSM-5-TR criteria for DID explicitly allow evidence of distinct personality states (aka switching) to be observed by others or to be reported by the individual (American Psychiatric Association, 2022).

To Guide Treatment Planning

Symptoms and diagnosis inform treatment-planning. A tool such as the MID provides an objective lens through which to consider such information and determine readiness for trauma accessing and trauma resolution approaches. Additionally, clinicians may benefit from reading the ISSTD guidelines for treating dissociative identity disorder (2011), which identifies three stages of treatment (described below).

Two individuals who meet criteria for Dissociative Identity Disorder (DID) may have very different MID profiles, and very different treatment needs. The 74 scales within *The MID Report* provide a wealth of information regarding the person's internal experience that would otherwise take many sessions to discover. Within the frame of psychotherapy, the identification of symptom features and characterological traits may inform treatment even if the exact diagnostic criteria met is unclear.

Why do we Assess?

The International Society for Traumatic Stress Studies recommends use of assessment tools to facilitate personalized care for those seeking treatment for complex trauma and C-PTSD by identifying symptoms that are clinically significant (ISTSS, 2018).

To Ensure Non-Maleficence ('Do No Harm')

Treating complex trauma and pathological dissociation (also referred to as 'structural' dissociation) can pose risks to both the person seeking treatment and the treating clinician, especially when dissociative symptoms are not accurately assessed. Bethany Brand et al. (2016) noted that inappropriate therapeutic interventions can exacerbate symptoms, while persons experiencing DID generally have a good treatment prognosis when clinicians are well trained and follow treatment guidelines. Richard Kluft found that when DID (then Multiple Personality Disorder) is actively treated by knowledgeable and experienced clinicians the recovery success rate is 91-94%. When treated actively by "neophytes," the success rate is 25%. When dissociation is acknowledged but not addressed directly, success rates are 2-3% (Kluft, 1985). These outcome statistics reflect treatment from a primarily psychodynamic approach facilitated by clinical hypnosis (Kluft, 2017). Clinicians are urged to study and invest in training if they undertake the treatment of a person with a severe dissociative disorder.

Clinicians trained in Eye Movement Desensitization and Reprocessing (EMDR) therapy and other body-oriented psychotherapies will benefit from reading Appendix IV.

"Accurate diagnoses are critical for appropriate treatment planning. If DID is not targeted in treatment, it does not appear to resolve" (Brand et al., 2016, p. 258).

When to Assess for Pathological Dissociation

Assess for pathological dissociation is advised when the person seeking treatment reports or evidences signs that are common in dissociative individuals, such as:

- Extensive trauma and/or substance use history
- Extensive treatment history

- History of early medical trauma/attachment wounding
- Numerous prior diagnoses such as:
    - Bipolar I or II
    - Major Depression
    - Borderline Personality Disorder (traits, prior diagnosis)
    - ADHD (with comorbid trauma history)
- Voices or 'loud thoughts'
- Blank spells (signs of amnesia)
- Screening (e.g., Dissociative Experiences Scale) indicates dissociative symptoms may be present

Prior unsuccessful treatment attempt(s), especially unsuccessful treatment of trauma-related symptoms, are strong indications that further assessment is necessary. Inquiry about medical issues, current or past substance abuse, sleep deprivation, dementia, traumatic brain injury, etc., is also helpful to provide a framework for conceptualizing and planning the person's treatment. Refer to the section discussing Differential Diagnosis if other contributing or confounding factors and experiences are present.

A Knowledge Foundation for Clinicians Who Use the MID

ISSTD Treatment Guidelines and Phase-Oriented Treatment of Trauma

The International Society for the Study of Trauma and Dissociation has published recommendations for assessment and treatment of dissociative disorders. The third edition of the *Guidelines for Treating Dissociative Identity Disorder in Adults* (International Society for the Study of Trauma and Dissociation, 2011) are available for free download at www.isst-d.org (an updated fourth edition is expected to be published in 2023). Guidelines for treatment of children and adolescents are similarly posted. The recommendations in these guidelines will greatly inform those clinicians who are new to the dissociative disorders.

Most clinicians have received little or no training about dissociation and dissociative symptoms. Subsequently, many clinicians to fail to notice dissociative symptoms or to misclassify them in terms of a clinical diagnosis with which they are more familiar (e.g., depression, bipolar disorder, or psychosis). Questions about specifically dissociative symptoms are absent from most standard clinical or psychological questionnaires and assessments. Thus, an instrument such as the MID is an essential addition to clinical practice - especially when serving populations that are known to have a history of traumatic experience.

Stages of Treatment for Complex Trauma and Dissociative Disorders

Effective treatment of complex trauma and dissociative disorders has three discrete but interwoven stages:

1. Establishing safety, stabilization, and facilitating symptom reduction;
2. Working through, and integrating traumatic memories; and,
3. Integration and development of a healthy, flexible self

Adequate completion of the goals of Stage 1 is often necessary to ensure appropriate preparation to safely and efficiently engage in trauma resolution work in Stage 2.

Sometimes, trauma accessing/resolution is a critical part of stabilization…however, complete discussion of this area of clinical discernment is outside the scope of this manual.

Dissociative Experiences Scale (DES)

The 28-item DES (Carlson & Putnam, 1993) has an extensive research base, and is the most widely-used **screening** instrument for clinical dissociation. However, the DES is not a diagnostic instrument and poses a high risk for both false-negative and false-negative results.

EMDR therapy training teaches clinicians to administer the Dissociative Experiences Scale, at minimum as part of Phase 2 (Preparation) to screen for anti-therapeutic dissociation. Shapiro (2018) stated that "the clinician intending to initiate EMDR should first administer the Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993) and do a thorough clinical assessment with every client" (p. 96-97). If dissociative symptoms are clearly present, she advises further assessment, mentioning the MID as one of the appropriate options to clarify diagnosis (p. 499). For a comprehensive discussion of how to use the DES well, and alternatives to its use, refer to *Beyond the DES-II: Screening for Dissociative Disorders in EMDR Therapy* (Leeds, Madere, & Coy, 2022).

Research continues to indicate that careful psychopathological assessment of dissociative symptoms is important across the entire range of mental disorders. A more recent meta-analysis of 216 publications found the following association between diagnostic categories and mean DES scores (Lyssenko, et al., 2018):

Mean DES Score	*Diagnostic Category*
> 35	Dissociative Disorders
> 25	Posttraumatic Stress Disorder, Borderline Personality Disorder, Conversion Disorder

> 15	Somatic Symptom Disorder, Substance-related and addictive Disorders, Feeding and Eating Disorders, Schizophrenia, Obsessive Compulsive Disorder, most affective disorders
14.8	Bipolar Disorders

We recommend bypassing simple screening in favor of a thorough diagnostic evaluation using the MID for persons who report or evidence the common signs of dissociation described above. When in doubt, or if a person presents a DES score of 15 or higher, clinicians should administer the MID to clarify diagnosis and aid treatment planning.

Unlike the DES, the MID does not assess normal dissociative experiences (e.g., absorption).

The MID uses cut-off scores for each item and scale to determine whether an endorsed dissociative symptom has reached a clinically significant frequency.

Psychological Theories of Dissociation

Clinicians who are unfamiliar with psychological theories of dissociation are urged to pursue further reading and learning on this topic. Each theory or model offers a perspective that explains and/or describes the development of pathological dissociation and how it may be addressed psychotherapeutically.

Structural Model of Dissociation

For instance, the Structural Model of Dissociation is both an explanatory and descriptive model. It identifies primary, secondary, and tertiary degrees of dissociation, in ascending severity, and offers verbiage to differentiate dissociative parts of self from ordinary self-states: 'Emotional' Part(s), and 'Apparently Normal' Part (s). A key aspect of this model is the identification of dissociative phobias that may block treatment if unrecognized and unaddressed. Much literature is available on this topic, including and following *The Haunted Self: Structural dissociation and the treatment of chronic traumatization* (Van der Hart, Nijenhuis, & Steele, 2006).

Structural Model & Levels of Dissociation

Level of Dissociation	*Structure*	*Diagnostic Presentation*	*Prep for Trauma Accessing*
Tertiary	Multiple ANPs, Multiple EPs	Dissociative Identity Disorder	High
Secondary	One ANP, Multiple EPs	Complex PTSD, trauma-related Borderline Personality Disorder, Other Specified Dissociative Disorder, Unspecified Dissociative Disorder	Medium to High
Primary	One ANP, One EP	PTSD, Acute Stress Disorder	Low to Medium

Trauma Model

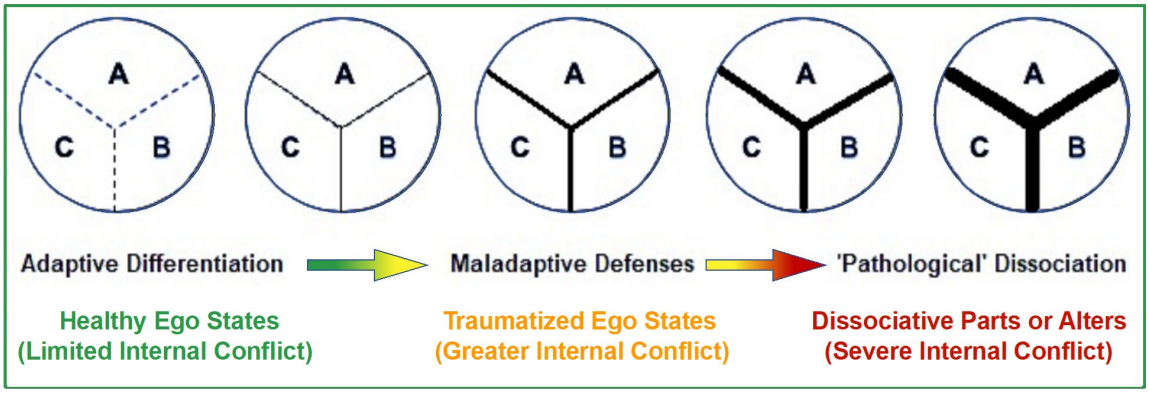
The Trauma Model offers an explanatory perspective; it posits that when humans are unable to integrate ongoing stressors and traumas, people may develop dissociative coping, or dissociative disorders (Putnam, 1985). Childhood abuse, as well as emotional and physical abuse and neglect are indeed frequently reported by individuals who meet criteria for dissociative disorders (Kate et al., 2021; Şar, 2011). However, experience of childhood trauma doesn't fully explain why some persons do, and others do not, develop dissociative disorders.

Autohypnotic Model

Paul Dell's more recent work offers an explanatory model for pathological dissociation building upon earlier work by Bliss (1983, 1986) and Kluft (1985). The autohypnotic model of dissociative disorders (Dell, 2017, 2019, 2022) posits that individuals who possess a higher-than-normal autohypnotic capacity and experience prolonged, inescapable pain can develop a dissociative disorder, while individuals without one or both of those factors will not. Harmful, inescapable events motivate the initial autohypnotic response; repeated use and elaboration of this response may lead to the development of a dissociative disorder.

Ego State Differentiation Model

Ego state theory, as developed by Watkins & Watkins (1997) offers both explanation for and description of dissociative parts or self-states. Conceptualizing ego states on a continuum from undifferentiated to highly differentiated (pictured below), increased internal conflict leads to heightened differentiation until very thick 'walls' are developed between ego states.



Copyright 2019 D. Michael Coy, MA, LICSW, adapted from Watkins & Watkins (1997)

Continuum vs. Pathological Domain

When it comes to describing and defining dissociation, a variety of opinions may be found in the literature. These may be deduced to the "continuum model" where more symptoms and/or greater frequency equates to higher severity, and the "pathological domain model" which states that distinct symptoms indicate a different kind and severity of dissociation. The DES-II, for instance, presumes the continuum model, whereas the MID is based upon the pathological

domain model. Most specifically, the MID is based on a descriptive model which Dell refers to as the subjective-phenomenological model of dissociation – to be described in detail below.

Dissociation According to the MID

Mindset of the 3 Domains

Dissociation has been conceptualized via three different levels or domains of description/explanation (Dell, 2009a):

1) *Neuroanatomical-neurophysiological* (e.g., structural and functional MRI studies).
2) *Psychological* (e.g., theory).
3) *Phenomenological*. Observable signs and subjective symptoms.

NOTE: Dissociative symptoms are overwhelmingly internal and subjective, not external and observable.

This phenomenological portrayal of dissociative symptoms directly implies that the entire domain of human experience can be invaded by dissociative experiences: Thinking, believing, knowing, recognizing, remembering, feeling, wanting, speaking, acting, seeing, hearing, smelling, tasting, touching/felt sense (i.e., body sensations), and so on.

This phenomenological model of dissociation does not specify the *cause* of these dissociative intrusions. It is not an explanatory model. Therefore, it is neutral regarding the cause of dissociation, and is congruent with many explanations of dissociative phenomena (Somer & Dell, 2005; Dell, 2009).

The Phenomenological Definition of Dissociation

"*The phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive functioning and sense of self."* (Dell, 2009a, p. 226)

The MID Assesses 23 Symptoms of Dissociation

The MID operationalizes the domain of dissociative phenomena (i.e., the entirety of human experience) via 23 dissociative symptoms. With one exception (Puzzlement about Oneself), each of the 23 symptoms of dissociation are experienced as intrusions into executive functioning and/or sense of self. These 23 symptoms constitute the dissociative symptom-domain of DID (Somer & Dell, 2005; Dell, 2009a). Each symptom scale listed here will be discussed in greater detail in subsequent sections. For a composite list of symptom descriptions, see Appendix V.

Criterion A: General posttraumatic symptoms of pathological dissociation

1. General memory problems
2. Depersonalization
3. Derealization

4. Posttraumatic flashbacks
5. Somatoform symptoms
6. Trance

Criterion B: Consciously experienced intrusions of another self-state into executive functioning and sense of self

7. Child voices
8. Two or more parts that converse, argue, or struggle
9. Persecutory voices that comment harshly, make threats, or command self- destructive acts
10. Speech insertion (unintentional or disowned utterances)
11. Thought insertion or withdrawal
12. Made or intrusive feelings and emotions
13. Made or intrusive impulses
14. Made or intrusive actions
15. Temporary loss of well-rehearsed knowledge or skills
16. Disconcerting experiences of self-alteration
17. Profound and chronic self-puzzlement

Criterion C: Amnesia: Fully-dissociated intrusions into executive functioning and self

18. Time loss
19. Coming to
20. Fugues
21. Being told of disremembered actions
22. Finding objects among their possessions
23. Finding evidence of one's recent actions

Part II: Administering, Scoring, and Interpreting the MID

What's New in *MID Analysis* v6.0?

Owing to valuable feedback from MID users since v5.2 was released, we have been able to render a v6.0 that corrects some additional, undetected issues that were inherited from previous iterations of *MID Analysis*. Those, plus additional enhancements, are as follows:

Overall Changes/Updates

- Change of color for data entry fields on *Questions* tab from green (v5.x) to lavender
- Date fields changed to be region-responsive (mm/dd/yy vs. dd/mm/yy)

Changes/Updates to *Calculations*, *The MID Report and The Extended MID Report*

- Minor updates to default language for 'blank' demographics fields on The MID Report worksheet
- Changes to the arrangement of data below Line 491 on the *Calculations* tab, which allowed for extensive updating and refinement of the formulae that generate the *MID Initial Impressions and Observations*
- Extensive updates to feedback provided in *MID Initial Impressions and Observations*
    - *Diagnostic Impressions*: Refinement of formulae and descriptive language for non-DID diagnostic impressions to improve quality of results, and addition of ICD-11 terminology where applicable
    - *Observations Based on Validity and Characterological Scales Scoring*: Increased sensitivity of feedback to guide interpretation, conceptualization, and follow-up interview—including improved indicators for under-reporting and intentional over-reporting, as well as the influence of cultural and characterological factors upon the results
- Minor changes to improve readability for isolated scales/results on *The MID Report*
- Addition of 'conditional formatting' highlighting to draw attention to clinically significant *Critical Items* (red) and *Criterion A, B, and C* symptom (green) scores
- Revision of *'Self-State and Alter Activity Scales'* to *'Self-State Activity Scales'* to better align with the evolving use of language in the dissociative disorders field
- Addition of *'Different Gender Parts'* scale detail in *The Extended MID Report*; it had been unintentionally excluded from the report in all prior *MID Analysis* versions
- Minor changes to page formatting, spacing, and text alignment

Changes/Updates to the *MID Line/Bar Graphs*

- Update of Clinical Significance scores to 2011 norms; this was incorrectly documented as having occurred with the introduction of MID Analysis v5.x
- Removal of PTSD norms from graphs, with the exception of the Factor Scales Graph; these were only added to all graphs with the introduction of MID Analysis v4.x, but no PTSD data were included with the 2011 norms, so it was decided to remove them from most graphs but to keep them as part of the Calculations tab data for the sake of historical importance and continuing research
- Test-taker data points slightly enlarged and changed to a more prominent shade of blue on all graphs for improved readability

- Slight rearrangement of the legend on graphs to a) reflect progression from least to most severe psychopathology (Nondissociative → DID) and b) move of test-taker to the right side to allow those data points to sit in front of all other data points (line graphs only)
- On Clinical Summary (line and bar) Graphs, notation added to clarify what each scale actually shows (i.e., Mean Scores and % of Items 'Passed') to improve usability
- Correction of data bars on BPD-DID Mean MID Score Comparison and BPD-DID Dissociation Items 'Passed'; first introduced in MID Analysis v5.x, the DID and BPD data bar colors and labels were reversed

Please note that the language of the 218 items of the MID remain entirely unchanged.

MID Basics

MID Document Checklist

To administer, score, and interpret the MID, you will need:

1) *MID* – Microsoft *Word* document for the test-taker to complete, containing 218 items/questions (or alternative formats found at www.mid-assessment.com)
2) *MID Analysis* – Because *MID Analysis* is an Excel spreadsheet, you must have Microsoft *Excel* for Windows, Mac, or iOS installed on your desktop computer or tablet. (A free, online version of Excel is available through Microsoft: https://www.microsoft.com/en-us/microsoft-365/free-office-online-for-the-web). Although *MID Analysis* technically can be used with Apple's *Numbers* software for Mac or iOS, LibreOffice, OpenOffice, Google *Sheets*, etc., it was not designed for these software applications. If you are not using Excel, you can expect that the report formatting, print layout, colors, and graphs will not appear as intended. You may also encounter corruption of the underlying programming that makes *MID Analysis* what it is, which will render the spreadsheet unusable. If you use a non-Excel application with *MID Analysis*, we recommend you make a copy of your 'clean' original to avoid needing to download another copy.
3) *An Interpretive Manual for the Multidimensional Inventory of Dissociation (MID), 4th Edition*, which you are presently reading.

Current versions of these documents may be downloaded from *www.mid-assessment.com*.

Administering the MID

As with any assessment, care must be given to proper administration and consideration of factors unique to the individual. Standard administration entails giving the test-taker the 7-page MID to complete. Most often this is done before, during, or after a session and takes between 30-60 minutes. While the MID questions do not address traumatic experience directly, a small percentage of test-takers are distressed by MID questions, particularly those that might stir up 'parts' activity for a given person.

Instructions to test-takers (as listed on the MID) are as follows:

> *How often do you have the following experiences when you are **not under the influence of alcohol or drugs?** Please circle the number that best describes you. Circle a "0" if the experience never happens to you; circle a "10" if it is always happening to you. If it happens sometimes, but not all the time, circle a number between 1 and 9 that best describes how often it happens to you.*

> *No timeframe for the experiences described in the MID is specified (e.g., "the last six months") because episodes of amnesia are very diagnostically important and often infrequent or undetected.*
>
> *Thus, if a person endorses ever having the experience indicated, even so far back as childhood, the score for that item is 1 or higher.*
>
> *However, for re-assessment during the course of treatment, you might ask the test-taker to only report on experiences they recall since the previous administration of the MID.*

Administration Methods

The MID may be administered before, during, or after an in-person session:

- Before session: We recommend either instructing the test-taker to arrive about an hour early to complete the MID before a session. This is preferable because the timing allows the clinician to observe the test-taker immediately after administration, offer support and address questions as needed, and ensure all items have been answered.
- During session: Clinicians often find administering the MID in session to be a rich source of information (e.g., if a test-taker answers some items quickly and deliberates over others). Whenever possible, the test-taker should be the one to read the MID items (quietly our aloud). This method may take longer than 60 minutes, and the clinician must be careful to avoid explaining items or influencing answers. Remember: the MID measures the phenomenological experiences of dissociation, which may be internal to the test-taker and incongruent with the external observations/perceptions of the clinician.
- After session: Test-takers may stay after session to complete the MID, if the clinician's practice setup allows this and a plan for checking in for safety is in place.

Administering on paper

There can be great benefit to administering the MID on paper. Among other things, it allows the test-taker to write contextual notes in the margins, which can aid understanding of their experience. For some, you may also be able to track observable changes in handwriting as the test-taker makes their way through the items, due to passive influence. The original MID document instructs the test-taker to circle the number, 0 to 10, that best reflects their experience.

However, transferring the scores to the *MID Analysis* from this document can be taxing for some eyes. An alternate version of the MID, available at www.mid-assessment.com, is in MS *Word* format and closely resembles the **Questions** worksheet in *MID Analysis.* For some clinicians, this enhances the ease (and speed) of transferring scores into *MID Analysis*.

Administering electronically

There are two options for administering the MID electronically. The first is to ask the test-taker to type their response onto the alternate MS *Word* version of the MID to be transferred into the *MID Analysis* later, via copy-paste. The most direct and time efficient means of administering the MID is to ask the test-taker to enter their responses directly into the **Questions** worksheet in the *MID* Analysis. This makes the results available as soon as they have responded to all 218 items. Interpretation and the follow-up interview will, of course, still take additional time.

Remote Administration

For clinicians practicing via telehealth platform, the above considerations may be applied according to one's clinical judgement. A single-sheet set of directions, *Directions for Completing the MID*, is available at www.mid-assesssment.com. Providing this to your client may better ensure reliable MID results. ***NOTE: The 'direct entry' means of administering the MID should only be done in-office. You should not send the MID Analysis file to your client to complete at home, as it is intended for clinician and researcher use only.***

Becoming Familiar with *MID Analysis*

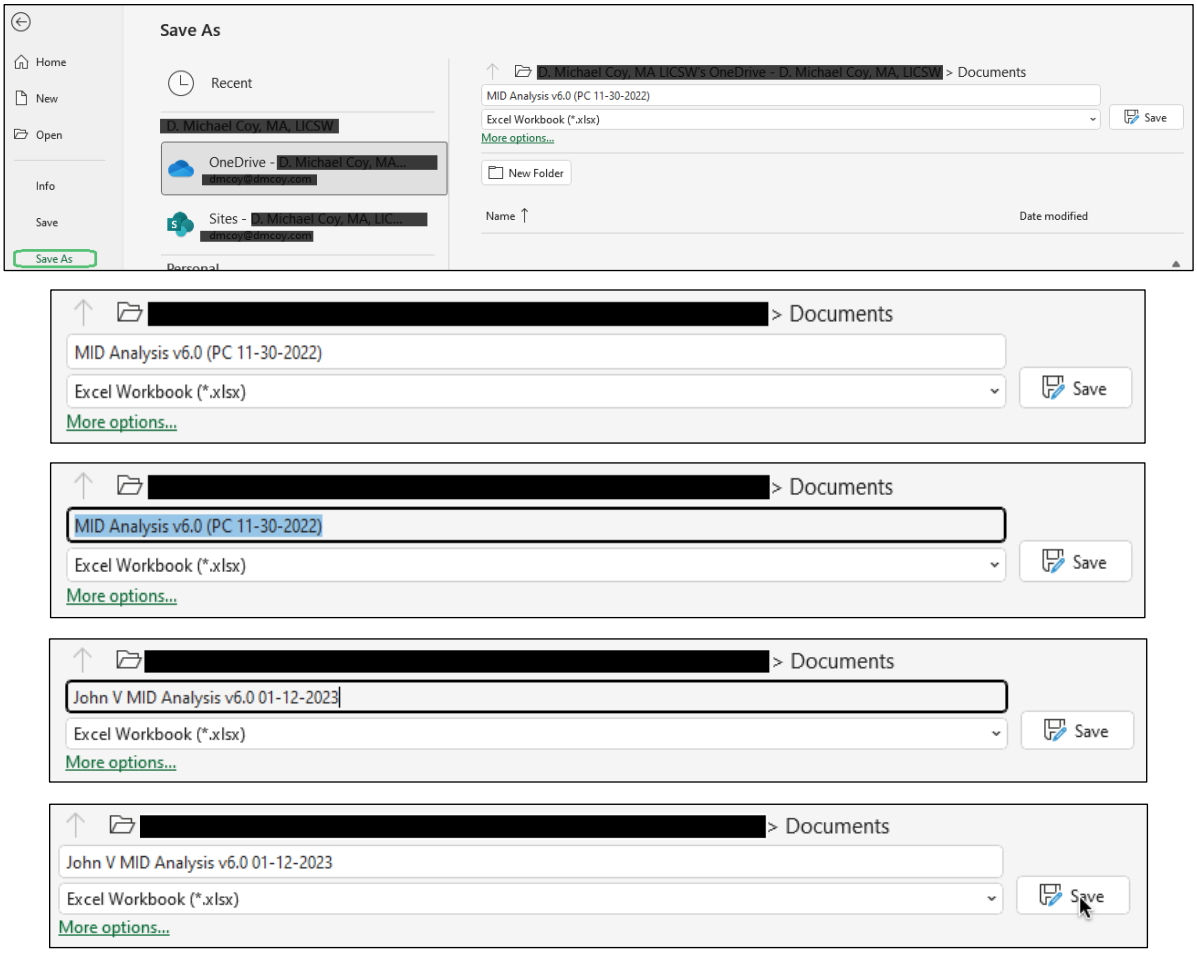
Opening MID Analysis for the First Time

Newer versions of MS *Excel* include an 'Autosave' feature to avoid losing one's work:

To avoid overwriting one's original, pristine copy of the *MID Analysis*, be certain to "Save As…" immediately and rename the test-taker's *MID Analysis* to something recognizable to you. This ensures that the original template remains intact for future use. *To export the MID to a word processing program or to create a .pdf file that can be shared with other clinicians, please refer to* Appendix II.

Although the illustrations below are taken from the Windows PC MS *Excel* version of the *MID Analysis*, the same general directions apply when opening the MID on other platforms that support documents in MS *Excel* formats. Be forewarned, however, that the formatting of the graphs, coloration, and print layout, will look significantly different outside of an *Excel* environment (e.g., in Mac *Numbers*, Google *Sheets*, etc.). NOTE: The appearance of this procedure will differ based on the version of Excel you are using.

Figure 1. 'Save As' Procedure



Once the test-taker's *MID Analysis* has been saved, you can begin entering the individual's data to generate *The MID Report*.

Layout of MID Analysis

MID Analysis is composed of the following elements, broken into tabbed sections at the bottom left of the spreadsheet:

Questions – The only place in this document where the clinician may enter/alter information. This is the worksheet into which the test-taker's scores for each question are entered to generate results.

Calculations – Where calculations occur, usually only viewed when needing to see exact scale scores for research.

The MID Report and **The Extended MID Report** – This is the core of the *MID Analysis*, containing the test-taker's scores on 61 of the 74 MID scales, as well as diagnostic impressions based on the test-taker's responses. *The MID Report* itself is only one page long; the remainder of the report is *The Extended MID Report*.

MID Line Graphs – In several distinct graphs, a visual representation of the diagnostic information derived from the test-taker's scores on the **Questions** tab. Each graph contains unique information about the person, with comparisons between their scoring on each measure and those of the clinical samples from relevant diagnostic categories: Non-dissociative, PTSD (Factor Scales Graph only), OSDD, Type 1a, and DID. An additional graph, new to *MID Analysis* as of v5.0 in 2020, also includes BPD scores. These norms are based on the data gathered during the development of the MID.

MID Bar Graphs – The same information contained in the **Line Graphs**, but in the form of bar graphs, which some clinicians and researchers prefer to the line graphs.

Credits and Notes – Information about the creation and evolution of *MID Analysis*, brief instructions to clinicians on accessing MID-related materials, and information relevant to spreadsheet programmers (but irrelevant in the clinician's regular use of the *MID Analysis*).

Each of these tabs, aside from *Credits and Notes*, will be discussed in greater depth in subsequent sections. Information about the Calculations tab may be found in Appendix III.

Scoring the Multidimensional Inventory of Dissociation in *MID Analysis*

The Questions Worksheet: Entering Test-taker Data into the MID Analysis

The only worksheet tab into which it is possible to enter any data is found on the **Questions** tab. The top of the blank **Questions** worksheet looks like this:

Figure 2. MID Analysis – Questions worksheet (top)

Item/ Question Number	Answer	**Instructions:** How often do you have the following experiences when you are not under the influence of alcohol or drugs? Please choose the number that best describes you. Choose a "0" if the experience never happens to you; choose a "10" if it is always happening to you. If it happens sometimes, but not all the time, choose a number between 1 and 9 that best describes how often it happens to you. Never 0 1 2 3 4 5 6 7 8 9 10 Always
Client ID:		
Sex:		
Age:		
Date:		
Race:		
Education:		
	Pre-MID Diagnosis:	
	Comments:	
1		While watching TV, you find that you are thinking about something else.
2		Forgetting what you did earlier in the day.
3		Feeling as if your body (or certain parts of it) are unreal.
4		Having an emotion (for example, fear, sadness, anger, happiness) that doesn't feel like it is 'yours.'

On the **Questions** worksheet, the fields into which a clinician may enter pertinent client data have been helpfully shaded in lavender (v6.x), green (v5.x), or cyan (v4.0 and earlier). Those fields are:

Client ID – Enter a signifier that allows for recognition of the identity of the person. It is suggested, though, for the sake of privacy, that the person's full last name not be entered here. *If this field is left blank, it will default to 'No Client ID provided' on The MID Report.*

Date – Enter the date that the MID was administered. *If no date is entered, this field will default to the current date. MID Analysis v6.0 date fields are region-responsive and will format in either mm/dd/yy or dd/mm/yy based on how your computer formats dates.*

Sex, Age, Race and **Education –** Useful for research purposes, these fields may be filled in or left blank. *If these fields are left blank, they will default to 'None specified' on The MID Report.*

Pre-MID Diagnosis – The test-taker's present and/or rule-out diagnosis. *If this field is left blank, it will default to 'None provided' on The MID Report.*

Comments – Any (brief) comments or clinical observations that seem relevant to the administration of the MID. This field may also be left blank. With subsequent testing with a test-taker, it can be helpful to note here that this is a reassessment, along with prior assessment dates. *If this field is left blank, it will default to 'None provided' on The MID Report.*

Questions ('Items') – Numbered 1 through 218 along the left side of the worksheet (items 1 through 4 can be seen in *Figure 2* above) and accompanied by corresponding questions (or 'items'), the person's response (0-10) is entered in the lavender-shaded fields between the number on the left and the question on the right, all the way through to item 218.

Most Common MID Scoring Issue

MID Analysis is organized into six tabs (visible at the bottom of the worksheet in Excel, and at the top of the worksheet in Mac *Numbers*): *Questions, Calculations, MID Report, MID Line Graphs, MID Bar Graphs,* and *Credits and Notes.*

Data reported by the test-taker is entered in the lavender* cells on the ***Questions*** tab. This is the only of the six tabs into which data may be entered. All other sheets/cells are locked to maintain the integrity of the underlying programming in the MID Analysis.

**These cells were shaded green in MID Analysis v5.x and cyan blue in v4.0 and earlier*

Understanding and Interpreting Results in *MID Analysis*

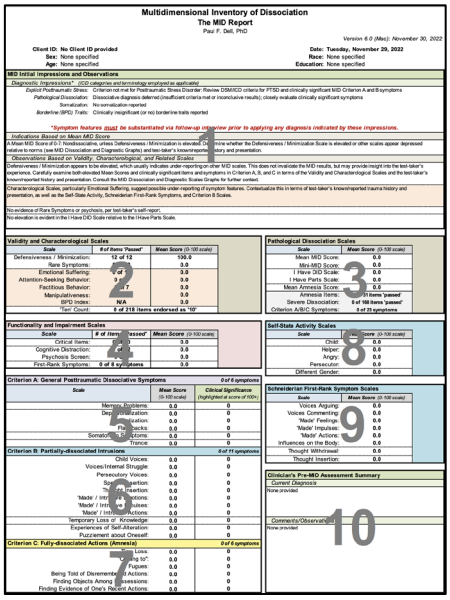
The MID Report

The MID Report tab contains the following elements:

- *The MID Report* – Only one page long, *The MID Report* offers up diagnostic impressions, observations based on validity scales, an a 'snapshot' summary of most scales.
- *The Extended MID Report* – Seven pages long, *The Extended MID Report* contextualizes information shown in *The MID Report*. It is a fine-grained breakdown of information in which the MID items are classified according to the symptom(s) and scale(s) for which they are a representative feature.

The MID Report itself includes the following sections, which are numbered below:

Figure 3. MID Analysis – The MID Report



1. MID Initial Impressions and Observations
2. Validity and Characterological Scales
3. Pathological Dissociation Scales
4. Functionality and Impairment Scales
5. Criterion A: General Posttraumatic Dissociative Symptoms
6. Criterion B: Partially-dissociated Intrusions
7. Criterion C: Fully-dissociated Actions (Amnesia)
8. Self-State Activity Scales
9. Schneiderian First-Rank Symptom Scales
10. Clinician's Pre-MID Assessment Summary

Each of these sections will be given individual attention and discussed at length below, in number order, with accompanying illustrations. Clinicians who are familiar with early versions of *The MID Analysis* will find that there are significant changes to the organization of *The MID Report*. These changes reflect the observations of and feedback received by the authors upon reviewing and consulting on hundreds of MID results, and resulting efforts to support a more intuitive sequence of steps in the review of *The MID Report*.

Mean Scores and Clinical Significance Scores

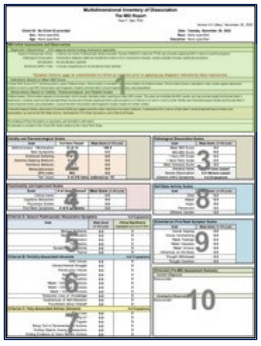
Mean Scores: On the Dissociative Experiences Scale (DES), all items are assessed on a "0 to 100" scale of frequency. In contrast, the MID employs a "0 to 10" scale and relies heavily on average or "mean" scores to compare the test-taker's results to those of MID research participants whose symptoms fell into standard diagnostic categories. For the ease of understanding, mean scores in *The MID Report* and graphs have been translated into the DES's standard "0 to 100" scale. All mean scores still reflect "how much of the time" in keeping with the person's original responses. Thus, a mean score of "40" indicates that the person experiences that symptom or scale 40% of the time. The person's mean scores for the 23 dissociation scales can be seen in their proper context, as compared to the standardized diagnostic scores, on the *MID Dissociation Scales Graph*.

Clinical Significance Scores: Each of the 23 dissociation scales has its own cut-off value (i.e., the number of items on that scale that must be "passed" for the person to have that symptom). Transformed into a *Clinical Significance Score*, a score of 100 or more means that the test-taker has "passed" enough items on that scale to have that symptom. Other scales, such as the *Validity Scales*, are measured as 1 to 100, with clinical significance beginning somewhere above 20, depending on the specific scale.

The test-taker's clinical significance scores for 6 validity scales and the 23 dissociation scales can be seen in context, as compared to the standardized diagnostic scores, on the *MID Diagnostic Graph*.

1. The MID Report – MID Initial Impressions and Observations

Figure 4. The MID Report – MID Initial Impressions and Observations



MID Initial Impressions and Observations

Diagnostic Impressions (ICD categories and terminology employed as applicable)*

Explicit Posttraumatic Stress:	Posttraumatic Stress Disorder (PTSD), Dissociative Sub-type: Consult DSM for full diagnostic criteria
Pathological Dissociation:	Dissociative Identity Disorder (DID): Ensure that symptoms are not due to substance use or part of a broadly accepted cultural/religious practice
Somatization:	Functional/Dissociative Neurological Symptom Disorder: Consult DSM/ICD for full diagnostic criteria
Borderline (BPD) Traits:	A few problematic borderline traits reported: Consult BPD-DID Comparison Graphs for further context

**Symptom features must be substantiated via follow-up interview prior to applying any diagnosis indicated by these impressions.*

Indications Based on Mean MID Score

A Mean MID Score of 31-40: Many cases of PTSD, OSDD-1 and DID fall within this range.

Observations Based on Validity, Characterological, and Related Scales

Defensiveness / Minimization does not appear to be elevated in relation to the Mean MID Score. Examine Criterion A, B, and C symptoms and the MID Diagnostic and Clinical Summary Graphs for further context.

One or more Characterological Scales appear to be elevated, suggesting clinically relevant personality traits as well as significant attachment wounding and/or potential over-reporting of some symptom features. Evaluate 'passed' items in these scales and consult the BPD-DID Comparison Scales Graphs. Also consider the potential influence of covert self-state activity, particularly if the endorsed traits are not obvious, and clarify their past and present relevance to the overall clinical picture.

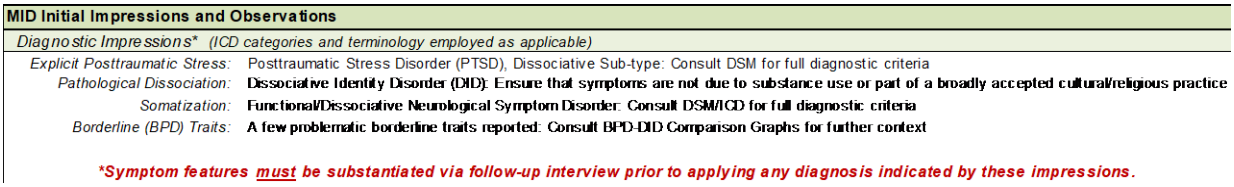
Elevation is evident for both Rare Symptoms and the Psychosis Screen. Evaluate 'passed' items to differentiate trauma-related or cultural factors from over-reporting or psychosis.

Although no elevation is evident in the I Have DID Scale relative to the I Have Parts Scale, a lack of awareness of the extent of the dissociation (particularly amnesia symptoms) is suggested by a comparison of the Criterion B/C and I Have Parts/I Have DID Scales. Consult Criterion B and C symptoms as well as the Self-State Activity and Schneiderian First-Rank Symptom Scales for further context.

The information shown in this section of *The MID Report* includes the overall diagnostic impressions from the test-taker's initial item responses; indications of dissociative features based on the *Mean MID Score* shown in the section of *The MID Report* entitled *Pathological Dissociation Scales*; and, observations about the person gleaned from their responses to items from the *Validity and Characterological Scales* items.

Diagnostic Impressions

Figure 4a. The MID Report – MID Initial Impressions and Observations: Diagnostic Impressions



MID Initial Impressions and Observations	
Diagnostic Impressions (ICD categories and terminology employed as applicable)*	
Explicit Posttraumatic Stress:	Posttraumatic Stress Disorder (PTSD), Dissociative Sub-type: Consult DSM for full diagnostic criteria
Pathological Dissociation:	**Dissociative Identity Disorder (DID): Ensure that symptoms are not due to substance use or part of a broadly accepted cultural/religious practice**
Somatization:	**Functional/Dissociative Neurological Symptom Disorder: Consult DSM/ICD for full diagnostic criteria**
Borderline (BPD) Traits:	**A few problematic borderline traits reported: Consult BPD-DID Comparison Graphs for further context**

Symptom features must be substantiated via follow-up interview prior to applying any diagnosis indicated by these impressions.

The MID Report offers diagnostic impressions are given in the following categories:

1) *Explicit Post-Traumatic Stress* (i.e., classic PTSD), where the possibilities are:
    - *Criterion not met for Posttraumatic Stress Disorder: Review DSM/ICD criteria for PTSD and clinically significant MID Criterion A and B symptoms*: This means that the test-taker did not endorse flashback symptoms at a clinically significant level.
    - *Posttraumatic Stress Disorder (PTSD): Consult DSM/ICD for full diagnostic criteria*: This means that the test-taker endorsed flashback symptoms, which are considered the hallmark of PTSD, at a clinically significant level.
    - *Posttraumatic Stress Disorder (PTSD), Dissociative Sub-type: Consult DSM for full diagnostic criteria:* This means that the test-taker reported clinically significant scores for depersonalization and/or derealization, in combination with flashbacks.
2) *Pathological Dissociation*, where the possibilities are:
    - *Nondissociative, with no overt indication of under-reporting: Review any 'passed' items to aid case conceptualization and treatment.* There is insufficient evidence to support any kind of dissociative diagnosis. Clinical significance was met for less than 3 of the 23 dissociative symptoms.
    - *Nondissociative, but with overt indication of under-reporting: Refer to Validity and Characterological Scales scoring for further context.* There is insufficient evidence to support any kind of dissociative diagnosis, but there are strong indicators, based on Validity and Characterological Scales scoring, that the test-taker under-reported symptom features. Clinical significance was met for less than 3 of the 23 dissociative symptoms.
    - *Nondissociative, but with indicators of dissociated self-state activity: Refer to clinically significant Criterion B symptoms for further context:* While there is insufficient evidence to support a dissociative diagnosis (less than 3 symptoms met clinical significance), at least 1 Criterion B symptom was endorsed at a clinically significant level.

- *Dissociative diagnosis deferred (insufficient criteria met or inconclusive results): Examine any symptoms below, but near, clinical significance:* A total of 3 to 5 out of 23 symptoms met clinical significance. There is some evidence of dissociative features in Criterion B or Criterion C (or both), but not enough of them across Criterion A, B, and C to support the diagnosis of a dissociative disorder.
- *Unspecified Dissociative Disorder (UDD):* Between 6 and 8 of the 23 symptoms met clinical significance. There is greater evidence of dissociative features in Criterion B or Criterion C (or both), but not enough of them across Criterion A, B, and C to support the diagnosis of a severe dissociative disorder. NOTE: You should consider a diagnostic impression of UDD a 'placeholder' diagnosis under more information about the test-taker's experience is evident.
- *Other Specified Dissociative Disorder, Type 1a (OSDD-1a/ICD-11 Partial DID; less-than-marked discontinuities in sense of self and agency):* A total of at least 9 out of 23 symptoms met clinical significance, including at least 1 symptom of amnesia in Criterion C.
- *Other Specified Dissociative Disorder, Type 1b (OSDD-1b; alterations of identity or episodes of possession with no report of dissociative amnesia):* More than 3 Criterion A symptoms, more than 5 Criterion B symptoms, but no symptoms of amnesia in Criterion C, met clinical significance.
- *Dissociative Identity Disorder (DID): Ensure that symptoms are not due to substance use or part of a broadly accepted cultural/religious practice:* At least 4 Criterion A symptoms, 6 Criterion B symptoms, **and** 2 Criterion C symptoms (***or*** Criterion B9: Temporary Loss of Knowledge plus one of the Criterion C symptoms) met clinical significance.

Note: Although the MID and *The MID Report* account for derealization, depersonalization, and amnesia and fugue symptoms, diagnostic impressions for *Depersonalization/Derealization Disorder* and *Dissociative Amnesia* (with or without *Dissociative Fugue*) are not offered, as data collected during the development of the MID could not substantiate them with enough evidence to develop metrics for these diagnoses.

The MID Report, *The MID Extended Report*, and the *Line* and *Bar Graphs* can be useful in discerning whether these diagnoses may be present, to the exclusion of UDD, OSDD-1, and DID.

3) *Somatization*, which reflects symptoms that indicate *Functional/Dissociative Neurological Symptom Disorder* (DSM-5/ICD-11). The possibilities here are:
   - *No somatization reported*
   - *Diagnostically sub-elevated, but possibly clinically relevant, somatization reported: Review 'passed' Somatoform Symptoms Scale items.* This indicates that

the test-taker endorsed some experiences of medically unexplained physical symptoms but did not meet the clinical significance threshold.

- *Clinically significant somatization reported: Consult DSM/ICD to rule out Functional/Dissociative Neurological Symptom Disorder:* This indicates that the test-taker's self-report of medically unexplained physical symptoms is meaningful but requires further exploration to clarify clinical significance that would warrant this diagnosis.
- *Functional/Dissociative Neurological Symptom Disorder: Consult DSM/ICD for full diagnostic criteria*: This indicates that the test-taker's self-report of medically unexplained physical symptoms is clinically significant. Somatization is considered present if the person's *Clinical Significance Score* for Criterion A: Somatoform Symptom is 151 or greater.

4) *BPD (Borderline Personality Disorder) Index*, which indicates whether borderline traits are present, and to what degree. Refer to the section below addressing the BPD Index for information regarding Mean scores for each impression. *The MID Analysis, v5.0* and later, includes the addition of four *BPD-DID Comparison Graphs*, which can be consulted to better understand the test-taker's symptoms compared to these other two diagnostically relevant populations. The possible impressions offered in this section are:

   - *Clinically insignificant (or no) borderline traits reported*
   - *A few problematic borderline traits reported: Consult BPD-DID Comparison Graphs for further context*
   - *Several problematic borderline traits reported: May meet DSM criteria for BPD; consult BPD-DID Comparison Graphs for further context*
   - *Many problematic borderline traits reported: Likely meets DSM criteria for BPD; consult BPD-DID Comparison Graphs for further context*
   - *Severe borderline and other pathological personality traits reported: Consult BPD-DID Comparison Graphs for further context*
   - *Extreme borderline and other pathological personality traits reported: Consult BPD-DID Comparison Graphs for further context*

   Again, please note that, although a *diagnostic impression* is offered, *it is only an impression,* which is based on either a paucity or a preponderance of identifiable and generally recognized severe borderline traits included in the MID.

CONTINUED ON NEXT PAGE

A Note on MID Initial Diagnostic Impressions

Diagnostic impressions are recommendations based on initial self-report, but there is a caveat noted at the bottom of this subsection on the *MID Report in red*:

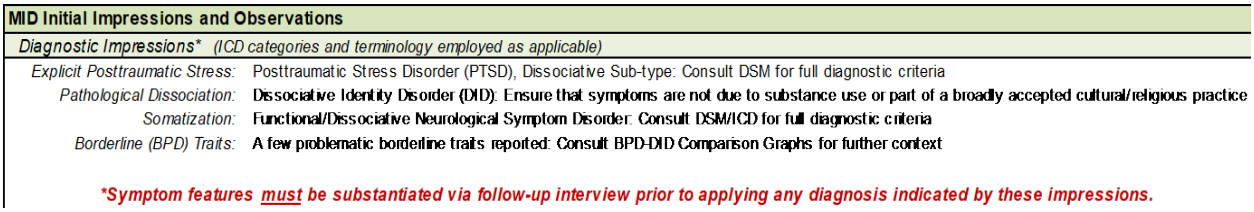
****Symptom features must be substantiated by supporting evidence prior to applying any diagnosis indicated by these impressions.***

In other words, the impressions given are not adequate to apply a diagnosis without taking the additional step of obtaining actual evidence of the person's symptom features through careful—and, as appropriate and necessary, repeated—follow-up interviews with the test-taker and/or corroboration via collateral contacts.

Discussion

Referring to the example test-taker's *Diagnostic Impressions*, we see the following:

Figure 4b. The MID Report – MID Initial Impressions and Observations: Diagnostic Impressions



MID Initial Impressions and Observations

*Diagnostic Impressions** *(ICD categories and terminology employed as applicable)*

Explicit Posttraumatic Stress:	Posttraumatic Stress Disorder (PTSD), Dissociative Sub-type: Consult DSM for full diagnostic criteria
Pathological Dissociation:	Dissociative Identity Disorder (DID): Ensure that symptoms are not due to substance use or part of a broadly accepted cultural/religious practice
Somatization:	Functional/Dissociative Neurological Symptom Disorder: Consult DSM/ICD for full diagnostic criteria
Borderline (BPD) Traits:	A few problematic borderline traits reported: Consult BPD-DID Comparison Graphs for further context

**Symptom features must be substantiated via follow-up interview prior to applying any diagnosis indicated by these impressions.*

Explicit Posttraumatic Stress: The example test-taker meets criteria for PTSD, Dissociative Sub-type based on their *Clinical Significance Score* on the *Flashbacks, as well as the Depersonalization and/or Derealization* Scales.

According to the MID, a diagnosis of DID requires clinically significant scores on at least 4 Criterion A symptoms, 6 Criterion B symptoms, and 2 Criterion C symptoms (or Criterion B9 plus one Criterion C symptom).

Pathological Dissociation: A diagnostic impression of DID has been offered up for the example test-taker.

Somatization is considered present if the person's *Clinical Significance Score* for *Somatoform Symptoms* (Criterion A) is 151 or greater.

- The example test-taker met criteria for *Functional Neurological Symptom Disorder* (DSM-5), with a *Clinical Significance Score* of 250.

A test-taker must score of at least 10 on the *BPD Index* to register as having even a few borderline traits. The example test-taker scored only 'a few' problematic borderline traits. It could be helpful to follow up on these indicators to determine how they manifest throughout the self-system and in the person's day-to-day life.

Indications Based on Mean MID Score

The *Indications Based on Mean MID Score* compare the test-taker's mean scores on 14 essential (composite) dissociation scales to norms developed during MID data collection. The norms were previously described under *Mean MID Score* in the section entitled *2. Pathological Dissociation Scales*.

The possible results for *Mean MID Score Indications* are:

- A Mean MID Score of 0-7: Nondissociative, unless Defensiveness / Minimization is elevated. Determine whether the Defensiveness / Minimization Scale is elevated or other scales appear depressed relative to norms (see MID Dissociation and Diagnostic Graphs) and test-taker's known/reported history and presentation.
- A Mean MID Score of 8-14: This level of dissociation is common in test-takers who do not have a dissociative disorder, but may be mediated by under-reporting. Refer to Criterion B and C for any isolated, clinically significant results. If such indicators exist, further investigation is recommended.
- A MID Score of 15-20: PTSD may be present if Flashbacks, Depersonalization, and Derealization scales are elevated.
- A Mean MID Score of 15-20: PTSD may be present if Flashbacks, Depersonalization, and Derealization scales are elevated.
- A Mean MID Score of 21-30: Many cases of PTSD and some cases of OSDD-1 and DID fall within this range.
- A Mean MID Score of 31-40: Many cases of PTSD, OSDD-1 and DID fall within this range.
- A Mean MID Score of 41-64: Some cases of PTSD, many cases of DID, and some test-takers with problematic borderline features fall within this range.
- Mean MID Score of 65 or higher: Some cases of PTSD and DID, and many cases of especially severe BPD fall within this range. Mean MID Scores in this range require a close examination of the Validity and Characterological Scales and a thorough follow-up interview.

NOTE: Although the Mean MID Score is roughly analogous to an overall score on the Dissociative Experiences Scale, 2nd Edition (DES-II; Carlson & Putnam, 1993), it is not intended to be a definitive measure of dissociation and must be contextualized in terms of other MID scales (Dell, 2006b).

Figure 4c. The MID Report – MID Initial Impressions and Observations: Mean MID Score Indications

Indications Based on Mean MID Score
A Mean MID Score of 31-40: Many cases of PTSD, OSDD-1 and DID fall within this range.

We can see in *Figure 4c* that the example test-taker's *Mean MID Score* of 36.4 is consistent with the diagnostic impression of DID offered up by the MID.

Observations Based on Validity, Characterological, and Related Scales

This section offers observations in four distinct areas to instruct the clinician's review of *The MID Report* and inform the direction of the follow-up interview:

1) Defensiveness / Minimization (in relation to the Mean MID Score)
2) Characterological Scales (Emotional Suffering, Attention-Seeking, Factitious Behavior, and Manipulativeness)
3) Rare Symptoms/Psychosis Screen
4) I Have DID/I Have Parts Scales

The possible observations for *Defensiveness / Minimization* are:

- Defensiveness / Minimization does not appear to be elevated in relation to the Mean MID Score. Examine Criterion A, B, and C symptoms and the MID Diagnostic and Clinical Summary Graphs for further context.
- The test-taker's reporting on the Defensiveness / Minimization Scale does not agree with typical results on other validity-related scales. Consider bias-related inconsistencies among the Validity and Characterological Scales, Severe Dissociation Scales, Functionality and Impairment Scales, and Criterion B and C Scales when compared to the test-taker's known/reported history and presentation.
- Defensiveness / Minimization may be elevated, suggesting possible (isolated) under-reporting on other MID scales. This does not invalidate the MID results, but may provide insight into the test-taker's attachment history, self-awareness, and any tendency to minimize their symptoms. Carefully examine both elevated Mean Scores and clinically significant items and symptoms in Criterion A, B, and C in terms of the Validity and Characterological Scales scoring and the test-taker's known/reported history and presentation. Consult the MID Dissociation and Diagnostic Scales Graphs for further context.
- Defensiveness / Minimization appears to be elevated, which usually indicates under-reporting on other MID scales. This does not invalidate the MID results, but may provide insight into the test-taker's attachment history, self-awareness, and any tendency to minimize their symptoms. Carefully examine both elevated Mean Scores and clinically significant items and symptoms in Criterion A, B, and C in terms of the Validity and Characterological Scales scoring and the test-taker's known/reported history and presentation. Consult the MID Dissociation and Diagnostic Scales Graphs for further context.

The possible observations specifically addressing the *Characterological Scales* are:

- Characterological Scales scores indicate no unusual elevation. Nevertheless, these results may offer context for the overall clinical picture and inform treatment planning. Refer to Self-State Activity, Schneiderian First-Rank Symptoms, and Criterion B Scales for further insight into test-taker's overall functioning.

- Characterological Scales, particularly Emotional Suffering, suggest possible under-reporting of symptom features. Contextualize this in terms of test-taker's known/reported trauma history and presentation, as well as the Self-State Activity, Schneiderian First-Rank Symptoms, and Criterion B Scales.
- One or more Characterological Scales appear to be elevated, suggesting clinically relevant personality traits as well as significant attachment wounding and/or potential over-reporting of some symptom features. Evaluate 'passed' items in these scales and consult the BPD-DID Comparison Scales Graphs. Also consider the potential influence of covert self-state activity, particularly if the endorsed traits are not obvious, and clarify their past and present relevance to the overall clinical picture.

The possible observations for the *Rare Symptoms/Psychosis Screen* are:

- No evidence of Rare Symptoms or psychosis, per test-taker's self-report.
- Evaluate sub-clinical elevation and 'passed' items in Rare Symptoms and/or the Psychosis Screen to differentiate trauma-related or cultural factors from over-reporting or psychosis.
- Elevation is evident on non-psychosis-related Rare Symptoms Scale items. Evaluate 'passed' items to differentiate trauma-related or cultural factors from over-reporting.
- Elevation is evident for both Rare Symptoms and the Psychosis Screen. Evaluate 'passed' items to differentiate trauma-related or cultural factors from over-reporting or psychosis.

The possible observations for the *I Have DID* and *I Have Parts Scales* are:

- Although no elevation is evident in the I Have DID Scale relative to the I Have Parts Scale, a lack of awareness of the extent of the dissociation (particularly amnesia symptoms) is suggested by a comparison of the Criterion B/C and I Have Parts/I Have DID Scales. Consult Criterion B and C symptoms as well as the Self-State Activity and Schneiderian First-Rank Symptom Scales for further context.
- No elevation is evident in the I Have DID Scale relative to the I Have Parts Scale. A possible lack of conscious awareness of Criterion B symptoms is suggested, when comparing those scales with test-taker's I Have Parts Scale score. Consult Criterion B and C, as well as the Self-State Activity and Schneiderian First-Rank Symptoms Scales, for further context.
- No elevation is evident in the I Have DID Scale relative to the I Have Parts Scale.
- The I Have DID Scale is elevated relative to the I Have Parts Scale. Rule out over-reporting by examining possible bias-related inconsistencies among the Validity and Characterological Scales, Functionality and Impairment Scales, and Criterion B and C Scales results when compared to the test-taker's known/reported history and presentation.

Discussion

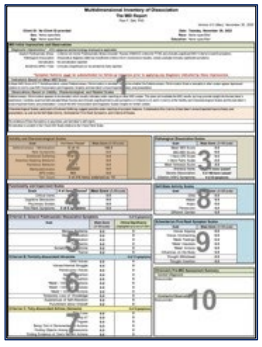
Figure 4d. The MID Report – MID Initial Impressions and Observations: Observations Based on Validity and Characterological Scales Scoring

Observations Based on Validity, Characterological, and Related Scales
Defensiveness / Minimization does not appear to be elevated in relation to the Mean MID Score. Examine Criterion A, B, and C symptoms and the MID Diagnostic and Clinical Summary Graphs for further context.
One or more Characterological Scales appear to be elevated, suggesting clinically relevant personality traits as well as significant attachment wounding and/or potential over-reporting of some symptom features. Evaluate 'passed' items in these scales and consult the BPD-DID Comparison Scales Graphs. Also consider the potential influence of covert self-state activity, particularly if the endorsed traits are not obvious, and clarify their past and present relevance to the overall clinical picture.
Elevation is evident for both Rare Symptoms and the Psychosis Screen. Evaluate 'passed' items to differentiate trauma-related or cultural factors from over-reporting or psychosis.
Although no elevation is evident in the I Have DID Scale relative to the I Have Parts Scale, a lack of awareness of the extent of the dissociation (particularly amnesia symptoms) is suggested by a comparison of the Criterion B/C and I Have Parts/I Have DID Scales. Consult Criterion B and C symptoms as well as the Self-State Activity and Schneiderian First-Rank Symptom Scales for further context.

Results in *Figure 4d* indicate that, amongst the four areas discussed above, although the results overall indicate no elevation in the Defensiveness / Minimization scale, which would suggest possible under-reporting, the test-taker may have reached a threshold requiring the clinician to closely investigate the items passed in either the *Rare Symptoms* scale or *Psychosis Screen*. Additionally, there does appear to be elevation in one or more of the Characterological Scales, and this will need to be investigated, as this could indicate either over-reporting of symptoms or covert self-state (e.g., child part) activity that may offer greater insight into the test-taker's overall functioning.

2. The MID Report – Validity and Characterological Scales

Figure 5. The MID Report – Validity and Characterological Scales



Validity and Characterological Scales		
Scale	*# of Items 'Passed'*	*Mean Score (0-100 scale)*
Defensiveness / Minimization:	0 of 12	34.2
Rare Symptoms:	3 of 12	3.3
Emotional Suffering:	5 of 12	41.7
Attention-Seeking Behavior:	1 of 7	18.6
Factitious Behavior:	2 of 7	8.6
Manipulativeness:	3 of 4	12.5
BPD Index:	N/A	11.2
'Ten' Count:	0 of 218 items endorsed as '10'	

The MID is designed to evaluate individuals who present with dissociative, posttraumatic, and borderline symptoms. The *Validity Scales* assess the most common response biases that such persons exhibit:

- Defensiveness / Minimization: Denial, minimization, or lack of awareness of symptoms
- Rare Symptoms: Bizarre, less common (but not non-existent), and potentially culturally-significant symptoms
- Emotional Suffering: Emotional intensity correlated with intense psychological pain, which may lead to over-reporting
- Attention-Seeking: Overt needs-meeting behaviors that may precipitate over-disclosure and/or overemphasis of symptoms

- Factitious Behavior: Exaggeration or frank malingering of symptoms, trauma, and abuse to achieve a specific diagnostic outcome
- Manipulativeness: Strategies employed to (indirectly) meet less obvious/covert emotional needs

The sixth validity scale, the *BPD (Borderline Personality Disorder) Index*, is an empirically-derived scale that distinguishes a subset of persons with personality traits that lend themselves to exaggerating and falsifying symptoms and history of abuse as a maladaptive means of needs-meeting.

Forensic evaluators want validity scales to *detect falsified responding*. Clinicians, however, want validity scales to *assess emotionally-biased responding* (which is far more common than falsified responding). Response biases usually reflect a strong personality trait. With rare exceptions, the MID assesses response bias—NOT invalid responding or an effort to defeat or falsify the results. The *Validity and Characterological Scales* may point to certain personality traits (e.g., repressive personality style, neuroticism, attention-seeking) and aspects of clinical severity (e.g., psychotic experiences) that can skew response to the MID dissociation items.

For these reasons, elevated MID validity scales should be interpreted from a clinical point of view (see below) rather than from a forensic one. Even the *Factitious Behavior* Scale is more indicative of personality pathology than it is of invalid responding.

NOTE: *An elevation of one or more validity scales on the MID always means that the test-taker's dissociation scores cannot be blithely accepted at face value. Elevated validity scales reveal that the person's responses to MID items are likely skewed by a response bias (described above). Clinicians should explore what the person had in mind when he or she endorsed those certain validity items during the follow-up interview to allow best understanding of the individual's answers.*

Extreme elevation of the *Rare Symptoms* Scale is the MID's best indicator of truly invalid responding (e.g., deliberate false endorsement of items; active psychosis). Nevertheless, severe elevations of the *Rare Symptoms* scale can also be caused by other factors discussed below.

Figure 5a. Validity Scales (detail)

Validity and Characterological Scales

	Scale	# of Items 'Passed'	Mean Score (0-100 scale)
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

In *Figure 5a*, the separate scales are labeled A) through H) at the far left. The first column with numbers represents *the number of questions the person "passed"* (i.e., met or exceeded the cut-off value) for that scale. For example, the *Emotional Suffering Scale* in *Figure 5a* shows that the

example test-taker "passed" 5 out of 12 items. The column to the right reflects the test-taker's Mean Score (average) for that scale.

1) Defensiveness / Minimization

The *Defensiveness / Minimization* Scale assesses a person's willingness and capacity to endorse *normal* cognitive lapses, such as "Forgetting where you put something," "Having to go back and correct mistakes that you made," and "Making decisions too quickly." Because these twelve items describe universal shortcomings, 'defensiveness' is apparent when a test-taker endorses an answer of "0" to a *Defensiveness* item. Consistently low ratings of *Defensiveness* items (e.g., "0," "1," or "2") indicates that the test-taker is claiming to have remarkably few *normal* shortcomings—whether this is due to outright denial, a lack of awareness, or even learning early on in life that making mistakes, etc., was undesirable to their caregiver(s).

Discussion

In *Figure 5b* below, the example test-taker obtained a mean *Defensiveness / Minimization Scale* score of 34.2, within the range typical for a person with DID, per the *MID Clinical Summary Graph*.

Figure 5b. Validity Scales (detail)

	Validity and Characterological Scales		
	Scale	*# of Items 'Passed'*	*Mean Score (0-100 scale)*
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

When Is a Defensiveness / Minimization Score Clinically Significant? In the same way that a professor might 'curve' the results of a tough exam when students' highest exam score was lower than expected, the *MID Diagnostic Graph* indicates a score of 91 (equivalent to a Mean Score of 64) for outpatient therapy clients without PTSD or dissociative symptoms.

We would expect non-dissociative persons to experience *fewer* normal cognitive shortcomings than persons with DID. High *Defensiveness / Minimization* scores in non-dissociative individuals usually indicate a personality style largely incompatible with dissociation. Test-takers with a high *Defensiveness / Minimization* Scale score on the MID may also tend to have high scores on measures of repressive personality style, such as the Weinberger Adjustment Inventory (WAI; Weinberger & Schwartz, 1990). Only 3% of outpatient therapy clients with DID manifest a clinically significant level of defensiveness on the MID.

Relationship to Cognitive Distraction – The *Defensiveness / Minimization* Scale and the *Cognitive Distraction* Scale (see below) are comprised of the same 12 items. Extremely low scores (0, 1, or 2) on these items indicate defensiveness/minimization of normal cognitive lapses, whereas very high scores (between 6 and 9, depending on the item cutoff) indicate cognitive

distraction. Cognitive distraction, as a phenomenon, will be discussed further under *Functionality and Impairment Scales*.

2) Rare Symptoms

Items on the *Rare Symptoms* scale describe phenomena that are quite uncommon, distinctly unlikely, and, in some cases, even bizarre (e.g., "Having flashbacks of poor episodes of your favorite television show," "Feeling that the color of your body is changing," and "Part of your body (for example, arm, leg, head, etc.) seems to disappear and doesn't re-appear for several days").

Figure 5c. Validity Scales (detail)

Validity and Characterological Scales

	Scale	# of Items 'Passed'	Mean Score (0-100 scale)
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

Discussion

"Passed" Items – In *Figure 5c*, the example test-taker "passed" 3 out of 12 *Rare Symptoms* items, which will need to be given attention in the follow-up interview, both to clarify the person's understanding of their experience and to attempt to correlate their responses here with dissociative phenomena. See *Rare Symptoms* items (on Page 2, within *The Extended MID Report*) for specific items and their respective cut-off values.

Interpreting an Elevated Score on the Rare Symptoms Scale

The *Rare Symptoms Scale* was designed to detect deliberate exaggeration of symptoms, but follow-up interviews often reveal a variety of different reasons for a significantly elevated *Rare Symptoms* score:

- Intentionally endorsing many symptoms to simulate extreme psychopathology. This is most commonly done to attract attention, for instance, by persons who are invested in having a diagnosis of DID.
- A distress-driven "plea for help" (i.e., desperate endorsement of very many items as a means of communicating the intensity of the person's need and pain).
- Serious cognitive impairment or psychosis (i.e., symptom-driven distraction and confusion while taking the test); see the *Psychosis Screen* below, within *Cognitive and Behavioral Psychopathology*.

- Random endorsement of test items.
- A "game-playing" or hostile "screw you" approach to the test.
- A persecutor self-state may intentionally endorsement rare symptoms to discredit and harass other self-states.
- A "loose" cognitive style that causes idiosyncratic (and often inaccurate) interpretation of test items. These are the "dreaded 5-7%" of test-takers who wreak havoc on any psychological test due to their loose thinking and desire to say "Yes" to items.
- Dissociative hyper-responsiveness that genuinely has produced many uncommon, but not non-existent, symptoms.

The above possibilities are not mutually exclusive. Indeed, when a person demonstrates an elevated *Rare Symptoms* score, more than one of these factors may be 'at work.' As noted above, an elevated *Rare Symptoms* score is the MID scale that may most readily indicate invalid responding (i.e., deliberate, false endorsement of items, or florid psychosis).

3) Emotional Suffering

The Emotional Suffering Scale was designed to reflect neuroticism or negative affectivity. The *MID*'s *Emotional Suffering Scale* correlates .65 with the Neuroticism Scale of the Eysenck Personality Questionnaire-Revised (EPQ-R; (Eysenck, Eysenck, & Barrett, 1985).

Individuals with high emotional suffering are quite reactive to the impingements and misfortunes of daily life. Their reactivity intensifies or amplifies their pain, suffering, and dysphoria. When these individuals encounter major misfortune (e.g., traumatic experience), their pain and distress is both intense and long-lasting.

When an individual with high emotional suffering has been repeatedly hurt or traumatized, a very negative outlook on their daily life often develops. Still, even when extreme, emotional suffering does *not* indicate deliberate exaggeration, falsification, or faking of distress. Such individuals really do hurt that much – and often dwell on their pain. Many *Emotional Suffering* items were intentionally constructed to include a borderline flavor (e.g., "Feeling empty and painfully alone," and "Wishing that somebody would finally realize how much you hurt.").

Discussion

"Passed" Items – In *Figure 5d* (next page), we see that the example test-taker "passed" 5 out of 12 *Emotional Suffering* items. See *Emotional Suffering* on page 2 of *The Extended MID Report* to examine this scale's items and their respective cut-off values.

Figure 5d. Validity Scales (detail)

	Validity and Characterological Scales		
	Scale	*# of Items 'Passed'*	*Mean Score (0-100 scale)*
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

Emotional Suffering Scale Mean Score – The example test-taker has a mean score of 41.7, which, when converted to reflect clinical significance (shown on the *MID Diagnostic Graph*), indicates that this response is closely clustered with test-takers with OSDD-1.

When is an Emotional Suffering Score Clinically Significant? On the *MID Diagnostic Graph*, an *Emotional Suffering Scale* score of 73.3 receives a score of 100 (i.e., the cut-off score for clinical significance). A score of 73.3 falls at the 95th percentile of non-dissociative individuals and the 77th percentile of outpatients with DID. Thus, 23% of outpatient therapy clients with DID have a clinically significant level of emotional suffering.

4) Attention-Seeking Behavior

Attention-seeking is a strategy for obtaining attention and emotional gratification from others. The *Attention-Seeking Behavior* Scale has seven items that assess:

- How frequently a person tells others about their misfortunes (e.g., "Talking to others about very serious traumas that you have experienced");
- How gratified the person is to receive attention (e.g., "Being pleased by the concern and sympathy of others when they hear about the traumas that you have suffered");
- How motivated the person is to engage in attention-seeking behavior (e.g., "Being willing to do or say almost anything to get somebody to think that you are special").

Discussion

"Passed" Items – In *Figure 5d*, the example test-taker "passed" 1 out of 7 *Attention-Seeking* items. It is critical that the clinician give attention both to the specific *Attention-Seeking* items that the person "passed," and their relationship to other scales – especially, the other *Validity Scales*, the *Self-State Activity Scale,* and the *Schneiderian First-Rank Symptoms Scale*. Taken together, these scales shed light on the composition, activity, and characterological strategies of the test-taker's self-system as a whole.

Attention-Seeking Scale Mean Score – The example test-taker has a mean score of 18.6, placing them very closely in range with the population of outpatient therapy clients with DID.

When is an Attention-Seeking Score Clinically Significant? On the *MID Diagnostic Graph*, an *Attention-Seeking Scale* Mean Score of 32.9 would be equivalent to a score here of 100 (i.e., the cut-off score for clinical significance). 22 percent of outpatient clients with DID have been found to manifest a clinically significant level of attention-seeking behavior.

5) Factitious Behavior

The *Factitious Behavior* Scale assesses exaggerated or entirely false reports of traumatic life events, pain, physical illness, or psychological illness.

It is important to note that the factitious behavior items on the MID are not subtle. These items are so harsh and socially undesirable that they can easily be 'dodged' by a test-taker who does not wish to admit to these behaviors. When endorsed, however, these items suggest that the person may be willing to do almost anything to get attention and sympathy from others. Items on this scale include:

- "Exaggerating something bad that once happened to you (for example, rape, military combat, physical or emotional abuse, sexual abuse, mistreatment by your spouse, etc.) in order to get attention or sympathy;"
- "Having to 'stretch the truth' to get your doctor's concern or attention;"
- "Pretending that something upsetting happened to you so that others would care about you (for example, being raped, being adopted or orphaned, military combat, physical or emotional abuse, sexual abuse, etc.)."

There is a subset of respondents with severe borderline traits who readily endorse these items without shame. Indeed, this subset of persons with severe borderline traits seem to endorse these items with an air of righteous justification that says, "See how miserable and rejected I am? I frequently have to do these things to get people to pay any attention to me at all!"

Interpreting an Elevated Score on the Factitious Behavior Scale

Interpreting an elevated score on the *Factitious Behavior Scale* is not always a straightforward endeavor. Although the *Factitious Behavior Scale* was constructed to detect intentional exaggeration and/or falsification of symptoms, follow-up interviews have identified four explanations for a significantly elevated *Factitious Behavior Scale* score:

1) A genuine history of exaggerating and/or falsifying symptoms to gain attention and sympathy. There is a subset of individuals with severe borderline personality traits who readily admit to faking experiences and symptoms. They seem to believe that admitting to such behavior is a justifiable and valid demonstration of how mistreated and desperately unhappy they are.
2) Random endorsement of test items.
3) Severely shame-laden executive/'fronting' self-states who wrongly accuse themselves of "making too much of" their traumas and their pain.
4) Persecutor parts (introjects, most notably) who falsely 'admit' to lying or exaggerating as a means of invalidating and discredit another (executive/'fronting') self-state's reporting. The clinician should keep in mind that persecutor parts commonly tell other

self-states that memories (e.g., of abuse by a parent) are "not true," mimicking the behaviors of an external, past and/or present perpetrator of harm, thus—paradoxically—protecting some self-states from exposure to intolerable realities.

NOTE: There is a subset of individuals with severe borderline personality traits who readily admit to faking experiences and symptoms. They seem to believe that admitting to such behavior is a justifiable and valid demonstration of how mistreated and desperately unhappy they are. See also: Characterological and Legal Factors.

Discussion

"Passed" Items – In *Figure 5e* (next page), we see that the test-taker "passed" 2 out of 7 *Factitious Behavior* items. In instances where an elevated score is shown here, it is critical that the clinician give attention both to the specific items that the person "passed" and to their relation to other scales – especially, the other *Validity and Characterological Scales*, the *Self-State Activity Scales,* and the *Schneiderian First-Rank Symptoms Scales*. Taken together, these scales provide a rich picture of how the test-taker's symptoms manifest both intra- and interpersonally.

Figure 5e. Validity Scales (detail)

Validity and Characterological Scales

	Scale	# of Items 'Passed'	Mean Score (0-100 scale)
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

Factitious Behavior Scale Mean Score – The example test-taker has a mean score of 8.6—relatively low, but still worth exploring, especially to determine how (and whether) these symptoms have manifest in both the past and the present.

When Is a Factitious Behavior Score Clinically Significant? On the *MID Diagnostic Graph*, a *Factitious Behavior* Scale Mean Score of 30.00 would receive a score of 100 (i.e., the cut-off score for clinical significance). A score of 30.00 falls at the 90th percentile of outpatient therapy clients with DID and the 97th percentile of non-dissociative individuals. Thus, 10 percent of persons with DID endorse a clinically significant level of factitious behaviors.

6) Manipulativeness

Baron (2003) said:

> "…it is the character trait of manipulativeness, not manipulation, that is uncharacteristically bad… The manipulative person often takes considerable pleasure in getting [their] way, engineering outcomes, plotting and scheming, and *leading another to make a particular choice without the other realizing that [they are] being manipulated"* (p. 50; emphasis added).

The *Manipulativeness Scale* items reflect behavior that is intended to "lead another to make a particular choice without the other realizing that [they are] being manipulated" (usually with the purpose of meeting the manipulator's emotional needs):

- Item 12: "Trying to make someone jealous."
- Item 21: "Pretending that something upsetting happened to you so that others would care about you (for example, being raped, military combat, physical or emotional abuse, sexual abuse, etc.)."
- Item 38: "Pretending that you have a physical illness in order to get sympathy (for example, flu, cancer, headache, having an operation, etc.)."
- Item 75: "Hurting yourself so that someone would care or pay attention."

Discussion

"Passed" Items – In *Figure 5f,* we see that the test-taker "passed" 3 out of 4 *Manipulativeness Scale* items. In instances where an elevated score is shown here, as with the other *Validity and Characterological Scales*, it is critical that the clinician give attention both to the specific items that the person "passed" and to their relation to other scales.

Manipulativeness Scale Mean Score – In *Figure 5f*, the example test-taker demonstrated a *Manipulativeness Scale Mean Score* of 12.5—notably elevated, compared to Mean Scores for established diagnostic populations, as indicated on the *MID Clinical Summary Graph*. It would be important to clarify which items the test-taker endorsed on that scale (The Extended MID Report, page 2), then conduct follow-up with them to determine how the endorsed behaviors may, for example, have been helpful in the past, maladaptive in the present, and potentially impactful of the overall MID results.

Figure 5f. Validity Scales (detail)

Validity and Characterological Scales

	Scale	*# of Items 'Passed'*	*Mean Score (0-100 scale)*
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

Relationship to Other Scales – The test-taker's responses to *Manipulativeness Scale* items should be closely examined in relation to several other scales:

- *Attention Seeking*
- *Factitious Behavior*
- *Interpersonal Intrusiveness* (reflected in context under *Additional Characterological Scales on* page 8 of *The MID Report/The Extended MID Report*)

- *BPD Index* (immediately below)
- *Manipulative Self-Injury* (see *4. Functionality and Impairment Scales: Critical Items* for more information)

"Trying to make someone jealous," "pretending that something upsetting happened," "pretending [to] have a physical illness," and "hurting [one]self so that someone would pay attention" could have a variety of clinical meanings. For example, it may be an enactment of a past traumatic experience; or, a cry for attention that points to an unacknowledged trauma narrative.

7) BPD (Borderline Personality Disorder) Index

The *BPD Index* does not assess for or diagnose borderline personality disorder, *per se*. Rather, the *BPD Index* assesses aspects of borderline pathology that are particularly problematic: attention-seeking behavior, factitious behavior, and reports of bizarre and unlikely symptoms.

This scale was empirically derived by comparing the MID protocols of 51 persons diagnosed with DID to those of 100 persons reliably diagnosed with BPD. The *BPD Index* consists of the 17 MID items that were significantly associated with a diagnosis of BPD rather than with a diagnosis of DID. Notably, none of these 17 items assess dissociation; instead, all 17 come from the MID's *Validity and Characterological* Scales. Items on the *BPD Index* include all seven *Factitious Behavior* items, six of the seven *Attention-Seeking Behavior* items, three *Rare Symptoms* (e.g., alien abduction), and one item from the *Emotional Suffering* Scale (i.e., being rejected by others).

Like the items on the *Factitious Behavior* Scale, many of which are included in the *BPD Index*, the *BPD Index* items are not subtle. Many of these items are so harsh, so socially undesirable, and/or so peculiar that they can easily be 'dodged' by a person who does not wish to admit to these behaviors. When endorsed, however, these items usually suggest that the person is willing to do almost anything to get attention and sympathy from others.

BPD Index Score – The *BPD Index* score is reported in a variety of forms, through multiple facets: (1) the *Mean BPD Index Score* and (2) the *BPD Index Clinical Significance Score* (on the *MID Diagnostic Graph*), and (3) the *BPD-DID Comparison Scales Graphs*.

Clinical Meaning of BPD Index Scores	
0 – 9.99	No borderline pathology
10 – 19.99	A few problematic borderline traits
20 – 29.99	Several problematic borderline traits: May have BPD
30 – 39.99	**Clinical cut-off** – Many problematic borderline traits: Almost certainly has BPD
40 – 49.99	Severe borderline pathology: Severe BPD and other pathological personality traits
50+	Extreme borderline pathology: Extreme BPD and other pathological personality traits

Discussion

In *Figure 5g* below, the example test-taker demonstrated a *BPD Index* score of 11.2. Referencing the clinical meaning of the *BPD Index* scores (next page), it appears that the example test-taker's score is relatively low, indicating 'a few' problematic borderline traits.

When Is the BPD Index Score Clinically Significant?

A *BPD Index Score* of 30.00 receives a *BPD Clinical Significance Score* of 100 (i.e., the cut-off score for clinical significance). A *BPD Index* Score of 30.00 falls at the 91st percentile of outpatient therapy clients with DID and the 96th percentile of non-dissociative individuals. Thus, 9 percent of persons with DID obtain a clinically significant score on the *BPD Index*. This does not mean that 9% of outpatient clients with BPD also have DID. In fact, the incidence of BPD in outpatient therapy clients with DID is higher than 9%.

Figure 5g. Validity Scales (detail)

Validity and Characterological Scales

	Scale	*# of Items 'Passed'*	*Mean Score* (0-100 scale)
1)	Defensiveness / Minimization:	0 of 12	34.2
2)	Rare Symptoms:	3 of 12	3.3
3)	Emotional Suffering:	5 of 12	41.7
4)	Attention-Seeking Behavior:	1 of 7	18.6
5)	Factitious Behavior:	2 of 7	8.6
6)	Manipulativeness:	3 of 4	12.5
7)	BPD Index:	N/A	11.2
8)	'Ten' Count:	0 of 218 items endorsed as '10'	

The meaning of the MID's *BPD Index* is, perhaps, better appreciated in light of the fact that only 39% of outpatient therapy clients with BPD obtained a clinically significant *BPD Index Score* (see the *MID Diagnostic Graph*). In other words, the *BPD Index* does not measure "borderline-ness" per se; it assesses the presence of severe and problematic borderline behaviors. An elevated *BPD Index* is best understood by reviewing the above sections that explain the *Attention-Seeking Behavior Scale* and the *Factitious Behavior Scale*. If the BPD Index and Amnesia scales are both clinically or surprisingly elevated, refer to the section below discussing Differential Diagnosis.

Here are the mean *BPD Index* scores for five groups:

	Mean BPD Index Score	Mean BPD Index Clinical Significance Score
Non-dissociative	8.97	29.90
OSDD, Type 1a	8.58	28.90
DID	15.98	53.17
BPD	26.61	88.73

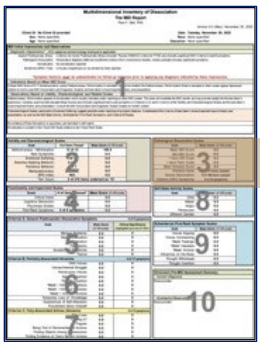
8) 'Ten' Count

The '*Ten' Count* is not an actual scale; it is a simple indicator of the test-taker's tendency to engage in extreme responding. The '*Ten' Count* shows how many of the MID's 218 items were

rated with a "10." In *Figure 5g*, we see that the example test-taker scored a "0" out of 218 questions. In other words, the person did not endorse as "10" ***any*** of the MID's 218 items.

3. The MID Report – Pathological Dissociation Scales

Figure 6. The MID Report – Pathological Dissociation Scales



Pathological Dissociation Scales

Scale	*Mean Score (0-100 scale)*
Mean MID Score:	**36.4**
Mini-MID Score:	**19.5**
I Have DID Scale:	**5.0**
I Have Parts Scale:	**38.6**
Mean Amnesia Score:	**25.2**
Amnesia Items:	**18 of 31 items 'passed'**
Severe Dissociation:	**119 of 168 items 'passed'**
Criterion A/B/C Symptoms:	**20 of 23 symptoms**

The MID Report's *Pathological Dissociation* section provides eight invaluable measures of dissociation and the test-taker's attitude toward/awareness of self-state related experiences of dissociation.

1) *Mean MID Score*
2) *Mini-MID Score*
3) *I Have DID Scale*
4) *I Have Parts Scale*
5) *Mean Amnesia Score*
6) *Amnesia Items*
7) *Severe Dissociation*
8) *Criterion A/B/C Symptoms*

Pathological Dissociation Scales: At-a-Glance

The following points are a quick primer for the clinician who just wants to know "the basics":

- ***Mean MID Score*** (0 – 100): Explore carefully any cases with a score of 20 or higher.
- ***Dissociative Symptoms*** (0 – 23): Explore carefully any cases with a score of 9 or higher.
- ***I Have DID*** (0 – 100): Diagnosed DID ≈ 60, with many previously undiagnosed DID ≈ 40 or lower.
- ***I Have Parts*** (0-100): Diagnosed DID ≈ 60, with previously undiagnosed DID ≈ 40 or higher.

NOTE: If the ***I Have DID*** score is markedly higher than the ***I Have Parts*** score, it suggests that the person is emotionally attached to the diagnosis of DID.

Figure 6a. Pathological Dissociation Scales (detail)

	Pathological Dissociation Scales	
	Scale	***Mean Score*** *(0-100 scale)*
1)	Mean MID Score:	**36.4**
2)	Mini-MID Score:	**19.5**
3)	I Have DID Scale:	**5.0**
4)	I Have Parts Scale:	**38.6**
5)	Mean Amnesia Score:	**25.2**
6)	Amnesia Items:	**18 of 31 items 'passed'**
7)	Severe Dissociation:	**119 of 168 items 'passed'**
8)	Criterion A/B/C Symptoms:	**20 of 23 symptoms**

1) Mean MID Score

Shown in *Figure 6a* above, the *Mean MID Score* assesses the test-taker's frequency of dissociative symptoms. Mean MID scores are comparable to mean scores on the Dissociative Experiences Scale (DES-II) (Carlson & Putnam, 1993). Mean MID scores lie on the same "0 to 100" metric as the DES. Mean MID scores correlate .90 – .93 with mean DES scores. The clinical difference between mean MID scores and mean DES scores is that the MID contains no items that measure so-called "normal" dissociation such as absorption, fantasizing, hypnotizability, and so on.

Interpreting Mean MID Scores

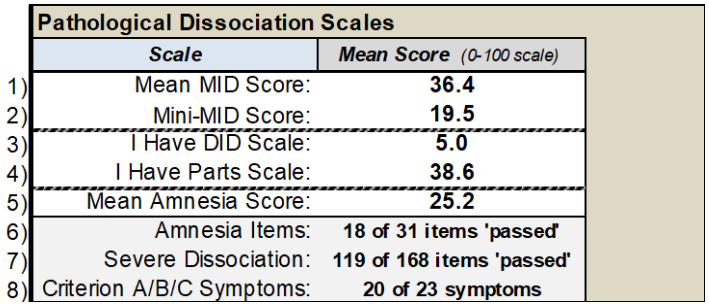
0 – 7	Does not have dissociative experiences.
8 – 14	Has a few diagnostically-insignificant dissociative experiences. This level of dissociation is common in persons who do not have a dissociative disorder
15 – 20	May have PTSD or a mild dissociative disorder.
21 – 30	May have OSDD, Type 1a or DID. May have PTSD.
31 – 40	May have PTSD and either OSDD, Type 1a or DID.
41 – 64	Probably has both DID and PTSD.
65 or greater	Usually indicates an admixture of severe dissociative, posttraumatic, and personality-related symptoms. Accurate diagnosis requires a close examination of the validity scales and a careful follow-up interview.

Discussion

In *Figure 6a*, we see that the example test-taker has a *Mean MID Score* of 36.4. According to this data point, they may have PTSD and either OSDD Type 1a or DID. This score can be contextualized via the MID Criterion A, B, and C symptoms that are endorsed by the test-taker. Note that some dissociative individuals defensively minimize or deny the existence of their dissociative symptoms, or else they are consciously unaware of them and so are unable to

acknowledge them. This would be relevant for the example test-taker if we observed a very low *Mean MID Score* and a high *Defensiveness / Minimization Scale* score.

Figure 6b. Pathological Dissociation Scales (detail)



	Pathological Dissociation Scales	
	Scale	***Mean Score*** *(0-100 scale)*
1)	Mean MID Score:	**36.4**
2)	Mini-MID Score:	**19.5**
3)	I Have DID Scale:	**5.0**
4)	I Have Parts Scale:	**38.6**
5)	Mean Amnesia Score:	**25.2**
6)	Amnesia Items:	**18 of 31 items 'passed'**
7)	Severe Dissociation:	**119 of 168 items 'passed'**
8)	Criterion A/B/C Symptoms:	**20 of 23 symptoms**

2) Mini-MID Score

In *Figure 6b,* the *Mini-MID Score* is based on 19 dissociative items that strongly discriminate between persons with DID and non-dissociative persons (i.e., those with a MID score of less than 15). The Mini-MID Score is the person's mean score on those 19 items (i.e., items 6, 64, 74, 84, 85, 106, 107, 117, 118, 133, 141, 179, 180, 197, 191, 197, 209, 212, and 217). We can think of the Mini-MID Score as a 'narrowed down' number that focuses more specifically on features of DID than the MID Score, which accounts for experiences of pathological dissociation more broadly.

The example test-taker has a *Mini-MID Score* of 19.5, meaning that, when the scores for the 19 *Mini-MID Score* items were summed, averaged, and multiplied by 10 to conform to the DES "0 to 100" scale, the result was 19.5 out of 100.

3) I Have DID Scale

The *I Have DID Scale* measures the *mean score* of the four *I Have DID* items. Persons with previously undiagnosed DID are often reluctant to endorse the *I Have DID* items, but feel more comfortable endorsing items from the *I Have Parts Scale* (see directly below). The four *I Have DID Scale* items are:

- Item 138: "Feeling that you have multiple personalities."
- Item 139: "Having other people (or parts) inside you who have their own names."
- Item 174: "Feeling that there is another person inside you who can come out and speak if it wants."
- Item 202: "Having another part inside that has different memories, behaviors, and feelings than you do."

We can see in *Figure 6b* that the example test-taker has an *I Have DID Scale* score of 5.0, which indicates that their mean score for those four items was very low. The mean for this scale is multiplied by 10 to conform to the DES "0 to 100" scale.

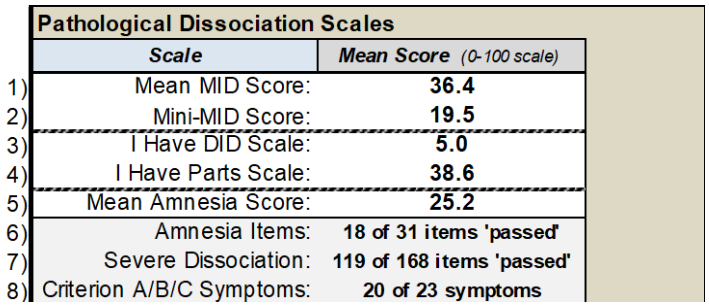
4) I Have Parts Scale

The *I Have Parts* Scale, measures the mean score of the scale's seven items. These items are qualitatively different from the *I Have DID* items:

- Item 8: "Having another personality that sometimes 'takes over.'"
- Item 28: "Feeling divided, as if there are several independent parts or sides of you."
- Item 112: "Feeling the presence of an angry part in your head that tries to control what you do or say."
- Item 208: "Having a very angry part inside you that 'comes out' and says and does things that you would never do or say."
- Item 212: "Feeling that another part or entity inside you tries to stop you from doing or saying something."
- Item 214: "More than one part of you has been reacting to these questions."
- Item 215: "Feeling the presence of an angry part in your head that seems to hate you."

We can see in *Figure 6c* that the example test-taker has an *I Have Parts* scale score of 43.3, which suggests a notable degree of awareness of parts activity. As with the *I Have DID Scale*, the *I Have Part*s scale score is multiplied by 10 to conform to the DES "0 to 100" scale.

Figure 6c. Pathological Dissociation Scales (detail)



	Pathological Dissociation Scales	
	Scale	***Mean Score*** *(0-100 scale)*
1)	Mean MID Score:	**36.4**
2)	Mini-MID Score:	**19.5**
3)	I Have DID Scale:	**5.0**
4)	I Have Parts Scale:	**38.6**
5)	Mean Amnesia Score:	**25.2**
6)	Amnesia Items:	**18 of 31 items 'passed'**
7)	Severe Dissociation:	**119 of 168 items 'passed'**
8)	Criterion A/B/C Symptoms:	**20 of 23 symptoms**

5) Mean Amnesia Score

The *Mean Amnesia Score* is the average score of the 31 amnesia-related items (multiplied by 10 to conform to the "0 to 100" DES scale). Here are the Mean Amnesia Scores for four groups:

Diagnosis	Mean Amnesia Score
Non-dissociative	2.79
PTSD	3.57
OSDD-1	5.70
DID	40.51

In *Figure 6c*, we see that the example test-taker demonstrated a *Mean Amnesia Score* of 25.2, which invites careful examination of their responses to the MID's amnesia-related items.

6) Amnesia Items

The MID contains 31 amnesia-related items. The *Amnesia Items* Scale reports the number of amnesia-related items that the test-taker endorsed at or above the level of clinical significance. The 31 amnesia items can be found in two sections of *The Extended MID Report: Temporary Loss of Knowledge* Scale and *Criterion C: Fully-dissociated Actions*.

In *Figure 6c* (previous page), the example test-taker has an *Amnesia Items* Scale score of 18, meaning that they "passed" 18 out of 31 of the MID's amnesia-related items.

7) Severe Dissociation

Each of the MID's 168 dissociation items has its own cut-off value for clinical significance. The *Severe Dissociation* Scale specifies how many dissociation items met or exceeded their cut-off score. The *Severe Dissociation* Scale score is highly correlated (r = .63) with a person's reported history of trauma. For more information about clinical significance, refer to Appendix III. For a visual representation of the *Severe Dissociation Score*, refer to the *MID Clinical Summary Graph*.

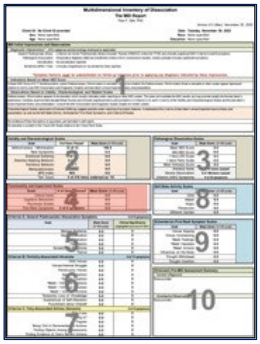
In *Figure 6d*, the example test-taker has a *Severe Dissociation* Scale score of 119, meaning that they gave clinically significant ratings to 119 (70.83%) of the MID's 168 dissociation items.

8) Criterion A/B/C Symptoms

The MID measures 23 major dissociative symptoms, which determine diagnostic impressions for pathological dissociation. The *Criterion A/B/C Symptoms* Scale indicates how many of those symptoms the test-taker endorsed at a clinically significant level.

In *Figure 6e*, the example test-taker has a *Criterion A/B/C Symptoms* score of 20, meaning that they met or exceeded the cut-off score for clinical significance for 20 of the 23 dissociative symptoms. The 20 dissociative symptoms in question are those that received a Clinical Significance score of 100 or greater on the symptoms encompassed by *Criterion A: General Posttraumatic Dissociative Symptoms*, *Criterion B: Partially-dissociated Intrusions*, and *Criterion C: Fully-dissociated Actions (Amnesia)*, reflected in *The MID Report* (see also the *MID Diagnostic Graph)*.

Figure 7. The MID Report – Functionality and Impairment Scales



Functionality and Impairment Scales

Scale	*# of Items 'Passed'*	*Mean Score* (0-100 scale)
Critical Items:	5 of 10	25.0
Cognitive Distraction:	5 of 12	65.8
Psychosis Screen:	1 of 4	5.0
First-Rank Symptoms:	8 of 8 symptoms	43.4

Referred to as the *Cognitive and Behavioral Psychopathology Scales* prior to MID Analysis v5.x, these four scales in *The MID Report* evaluate cognitive, behavioral, and perceptual impairment:

1) *Critical Items*
2) *Cognitive Distraction*
3) *Psychosis Screen*
4) *First-Rank Symptoms*

Functionality and Impairment Scales: At-a-Glance

- The *Critical Items* Scale offers information about ten posttraumatic, dissociative symptoms that are harmful or potentially dangerous. 99% of non-dissociative persons "pass" three or fewer critical items, whereas 85% of persons with DID "pass" four or more critical items. The test-taker's responses to *Critical Items* should be given special attention. The individual's responses to these ten Critical Items can be found on page 2 of *The Extended MID Report: Functionality and Impairment Scales*.
- *Cognitive Distraction* is the inverse of *Defensiveness:* Low *Cognitive Distraction* equates to High *Defensiveness,* and high *Cognitive Distraction* equates to low *Defensiveness.* See below for more information about the *Cognitive Distraction* scale.
- *Psychosis Screen*: The *Items 'Passed'* score here ideally equals 0. Two or more passed items strongly suggest that the person is experiencing psychotic/delusional symptoms. This can occur both for some persons with more severe borderline features and some with more complex experiences of dissociation. Persons whose symptoms are distinctly psychotic may obtain an *Items 'Passed'* score of 3 or 4.
- *First-Rank Symptoms* offers a summary of items passed and an aggregate Mean Score for the eight symptoms included in this scale. Results for individual symptoms are detailed in the *Schneiderian First-Rank Symptoms* section of *The MID Report.*

In *Figure 7a*, the *Functionality and Impairment Scales*, each of its four scales reports (1) the number of items that the test-taker "passed" (i.e., met or exceeded the cut-off value), and (2) the *mean score* for that scale. The mean scores here are multiplied by 10 here to conform to the "0 to 100" DES scale.

Figure 7a. Functionality and Impairment Scales (detail)

	Functionality and Impairment Scales		
	Scale	**# of Items 'Passed'**	**Mean Score** *(0-100 scale)*
1)	Critical Items:	5 of 10	25.0
2)	Cognitive Distraction:	5 of 12	65.8
3)	Psychosis Screen:	1 of 4	5.0
4)	First-Rank Symptoms:	8 of 8 symptoms	43.4

1) Critical Items

The *Critical Items* are dissociative and posttraumatic symptoms that are harmful or potentially dangerous. For example:

- Internal voices that tell a person to hurt or kill themselves;
- Flashbacks that provoke impulses to harm oneself;
- Fugues (i.e., travel while in a state of amnesia);
- Fully-dissociated episodes of self-injury or suicidal harm; and
- Self-injury with the purpose of eliciting empathy or attention from others

"Passed" Items – The *Critical Items* Scale shows both the items 'passed' and the Mean Score of the 10 critical items on the MID. It is useful to note that 99% of non-dissociative test-takers 'pass' three or fewer critical items, whereas 85% of persons with DID 'pass' four or more critical items. Thus, unlike most individuals who seek psychiatric care, *persons with DID can routinely be expected to have several (or even many) of these harmful or potentially dangerous symptoms*.

In *Figure 7a*, we see that the example test-taker "passed" 5 out of 10 *Critical Items* that need to be very carefully evaluated in follow-up.

Critical Item Mean Score – In *Figure 7b*, the example test-taker's mean score on this measure was 25.0, which invites close examination of potential risk factors and safety issues.

If a test-taker 'passes' any of the Critical Items, then this field will change from black text on white background to red text on a red background to highlight the importance of following up on any 'passed' items here.

Figure 7b. Functionality and Impairment Scales (detail)

Functionality and Impairment Scales

	Scale	# of Items 'Passed'	Mean Score (0-100 scale)
1)	Critical Items:	5 of 10	25.0
2)	Cognitive Distraction:	5 of 12	65.8
3)	Psychosis Screen:	1 of 4	5.0
4)	First-Rank Symptoms:	8 of 8 symptoms	43.4

2) Cognitive Distraction

The *Cognitive Distraction* Scale and the *Defensiveness / Minimization* Scale are composed of the same 12 items, but they are scored in the opposite direction from one another. A very high Cognitive Distraction score indicates high levels of forgetfulness, distractibility, absent-mindedness, mistake-proneness, and having difficulty sustaining concentration and focus. An abnormally low *Cognitive Distraction* Scale score suggests that the test-taker may be highly defended, per the *Defensiveness / Minimization Scale*.

Cognitive distraction (due to intrusive dissociative and post-traumatic symptoms) is a typical feature of DID. Most individuals with DID experience clinically significant levels of cognitive distraction; some suffer truly disabling levels of cognitive distraction.

Cognitive Distraction Scale Mean Score – The example test-taker in *Figure 7c* scored a mean of 65.8, in line with the mean score for a person with DID, per the *MID Clinical Summary Graph* norms.

Figure 7c. Functionality and Impairment Scales (detail)

	Functionality and Impairment Scales		
	Scale	# of Items 'Passed'	Mean Score (0-100 scale)
1)	Critical Items:	5 of 10	25.0
2)	Cognitive Distraction:	5 of 12	65.8
3)	Psychosis Screen:	1 of 4	5.0
4)	First-Rank Symptoms:	8 of 8 symptoms	43.4

3) Psychosis Screen

This scale is comprised of a subset of four of the *Rare Symptoms* Scale items, and includes:

- Item 11: "Feeling that your mind or body has been taken over by a famous person (for example, Elvis Presley, Jesus Christ, Madonna, President Kennedy, etc.)."
- Item 26: "Your mind being controlled by an external force (for example, microwaves, the CIA, radiation from outer space, etc.)."
- Item 52: "Your thoughts being broadcast so that other people can actually hear them."
- Item 98: "Hearing voices, which come from unusual places (for example, the air conditioner, the computer, the walls, etc.)."

The cut-off value for each of these questions is "1." If the person endorses any of these items, they may either be delusional, or having auditory hallucinations, or experiencing unusual (but not impossible) phenomena emanating from another self-state. Only 3% of outpatient therapy clients with DID endorse three or more of the items on the *Psychosis Screen*.

The example test-taker appears to have endorsed one of these four items. This will necessitate referring to the *Psychosis Screen* items in *The Extended MID Report* to clarify the person's experience and how it relates to the characterological and dissociative symptoms they endorsed.

Psychosis Screen Scale Mean Score – The example test-taker in *Figure 7c* scored a mean of 5.0, which is relatively low in comparison to the mean score for persons with DID, per the norms shown in the *MID Clinical Summary Graph*.

4) First-Rank Symptoms

This scale assesses 'first-rank,' or most important, features of schizophrenia identified by Kurt Schneider (1959). Eight of Schneider's eleven symptoms also occur, due to dissociation, for persons with a severe dissociative disorder. Please refer to *9. The MID Report - Schneiderian First-Rank Symptom Scales* for further information.

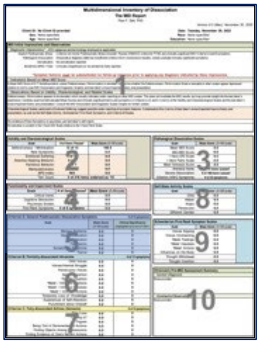
The example test-taker in *Figure 7d* 'passed' 8 of 8 possible Schneiderian First-Rank Symptoms, with an overall mean score of 43.4, suggesting relatively acute self-state activity when looked at through this lens.

Figure 7d. Functionality and Impairment Scales (detail)

	Functionality and Impairment Scales		
	Scale	# of Items 'Passed'	Mean Score (0-100 scale)
1)	Critical Items:	5 of 10	25.0
2)	Cognitive Distraction:	5 of 12	65.8
3)	Psychosis Screen:	1 of 4	5.0
4)	First-Rank Symptoms:	8 of 8 symptoms	43.4

5. The MID Report – Criterion A: General Posttraumatic Dissociative Symptoms

Figure 8. Criterion A: General Post-Traumatic Dissociative Symptoms



Criterion A: General Posttraumatic Dissociative Symptoms		6 of 6 symptoms
Scale	Mean Score (0-100 scale)	Clinical Significance (highlighted at score of 100+)
Memory Problems:	65.8	240
Depersonalization:	37.5	200
Derealization:	34.2	225
Flashbacks:	54.2	180
Somatoform Symptoms:	10.8	250
Trance:	39.2	200

As *Figure 8* shows, there are six *General Posttraumatic Dissociative Symptoms*. These symptoms occur not only for persons with a dissociative disorder, but also for persons with certain other disorders: PTSD, Acute Stress Disorder, Functional Neurological Symptom Disorder, Somatic Symptom Disorder, Panic Disorder, Major Depressive Disorder, Schizotypal Personality Disorder, and Borderline Personality Disorder.

Mean Scores – The first column of numbers in *Figure 8a* are the "0 to 100" mean scale scores.

Clinical Significance Scores – The second column of numbers in *Figure 8a* are the *Clinical Significance Scores* for those scales. In *The MID Report*, these *Clinical Significance Scores* are your single best source of instant information about the test-taker. Scores of 100 or higher indicate that the person **has** that symptom. The higher the number, the more manifestations of that symptom the test-taker has.

Thus, in *Figure 8a* (next page), we see that the example test-taker met criteria for 6 of the 6 General Dissociative Symptoms: Memory Problems, Depersonalization, Derealization, Flashbacks, Somatoform Symptoms, and Trance.

Figure 8a. Criterion A: General Posttraumatic Dissociative Symptoms (detail)

	Criterion A: General Posttraumatic Dissociative Symptoms		6 of 6 symptoms
	Scale	Mean Score (0-100 scale)	Clinical Significance (highlighted at score of 100+)
1)	Memory Problems:	65.8	240
2)	Depersonalization:	37.5	200
3)	Derealization:	34.2	225
4)	Flashbacks:	54.2	180
5)	Somatoform Symptoms:	10.8	250
6)	Trance:	39.2	200

1) Memory Problems

Symptom Description: Memory problems include lack of memory for significant life events, inability to recall substantial portions of one's childhood, and chronic day-to-day forgetfulness. Research has shown that the *Memory Problems* scale taps two separate aspects of dissociative amnesia: *amnesia for remote memory* (e.g., childhood) and *amnesia for recent memory*.

Discussion

Memory Problems Scale Mean Score – In *Figure 8a*, the example test-taker demonstrated a *Memory Problems Scale Mean Score* of 65.8—which places them squarely in the range for persons with DID.

When Is the Memory Problems Score Clinically Significant? When the test-taker reports a clinically significant level of five or more memory problems. About 95% of persons diagnosed with DID obtain a clinically significant score (100+) on this scale. In *Figure 8a*, the example test-taker demonstrated a *Clinical Significance Score* of 240 for *Memory Problems*, which indicates that they have reported a high level of forgetfulness that would be hard to pass off as a typical occurrence. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

2) Depersonalization

Symptom Description: Depersonalization involves odd changes of one's experience of *self*, *mind*, or *body*. Depersonalization experiences include feeling unreal, being a detached observer of oneself, and feeling distant, changed, estranged, or disconnected from one's self, one's mind, or one's body.

Discussion

Depersonalization Scale Mean Score – In *Figure 8a*, the example test-taker demonstrated a *Depersonalization Scale Mean Score* of 37.5 in initial reporting, in line with persons with OSDD-1, as reflected on the *MID Dissociation Scales Graph*.

Depersonalization Score for Clinical Significance – About 95% of persons diagnosed with DID obtain a clinically significant score on this MID scale. In *Figure 8a*, the example test-taker's results indicate a *Clinical Significance Score* of 200 for *Depersonalization*, which means that they endorsed twice as many symptom features as needed for their experience of

depersonalization to be clinically significant on the MID. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

3) Derealization

Symptom Description: In derealization, the world feels unreal, strange, unfamiliar, distant, or changed.

Figure 8b. Criterion A: General Posttraumatic Dissociative Symptoms (detail)

	Criterion A: General Posttraumatic Dissociative Symptoms		6 of 6 symptoms
	Scale	Mean Score (0-100 scale)	Clinical Significance (highlighted at score of 100+)
1)	Memory Problems:	65.8	240
2)	Depersonalization:	37.5	200
3)	Derealization:	34.2	225
4)	Flashbacks:	54.2	180
5)	Somatoform Symptoms:	10.8	250
6)	Trance:	39.2	200

Discussion

Derealization Scale Mean Score – In *Figure 8b,* the example test-taker demonstrated a *Derealization Scale Mean Score* of 34.2 in initial reporting, indicating they fall between the means for OSDD-1 and DID, per the *MID Dissociation Scales Graph*.

When Is the Derealization Score Clinically Significant? When the person reports a clinically significant level of four or more depersonalization experiences. About 92% of persons diagnosed with DID obtain a clinically significant score (100+) on this scale. In *Figure 8b*, the example test-taker demonstrated a *Clinical Significance Score* of 200 for *Derealization*, indicating that they endorsed a variety of aspects of this symptom well above the threshold for clinical significance. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

4) Flashbacks

Symptom Description: Flashbacks typically manifest as sudden, intrusive memories, pictures, internal 'videotapes,' nightmares, or body sensations of previous traumatic experiences. During dissociative flashbacks, a person may lose contact with here and now, and suddenly be back 'there and then.'

Discussion

Flashbacks Scale Mean Score – The example test-taker has a mean of 54.2 on this scale, in line with the mean for persons with DID, as reflected on the *MID Dissociation Scales Graph*.

When Is the Flashbacks Score Clinically Significant? When the test-taker reports a clinically significant level of five or more of the flashback items. About 92% of persons diagnosed with DID obtain a clinically significant score (100+) on this MID scale.

Figure 8c. Criterion A: General Posttraumatic Dissociative Symptoms (detail)

	Criterion A: General Posttraumatic Dissociative Symptoms		6 of 6 symptoms
	Scale	Mean Score (0-100 scale)	Clinical Significance (highlighted at score of 100+)
1)	Memory Problems:	65.8	240
2)	Depersonalization:	37.5	200
3)	Derealization:	34.2	225
4)	Flashbacks:	54.2	180
5)	Somatoform Symptoms:	10.8	250
6)	Trance:	39.2	200

In *Figure 8c*, the example test-taker demonstrated a *Clinical Significance Score* of 180. This person has highly symptomatic PTSD. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

5) Somatoform Symptoms

Symptom Description: Somatoform symptoms have been referred to as *somatoform dissociation* by Ellert Nijenhuis (1999). They are bodily experiences and symptoms that have no medical basis. These somatic symptoms may affect vision, hearing, sight, smell, taste, body sensation, body functions, or physical abilities. They are often a partial re-experiencing of a past traumatic event.

Discussion

Somatoform Symptoms Scale Mean Score – In *Figure 8c*, the example test-taker has a mean of 10.8 on this scale, on par with the mean for DID, as reflected on the *MID Dissociation Scales Graph*.

When Is the Somatoform Symptoms Score Clinically Significant? When the test-taker reports a clinically significant level of four or more somatoform symptoms. About 79% of outpatient therapy clients with DID obtain a clinically significant score on the ***Somatoform Symptoms Scale***. In *Figure 8c*, the example test-taker demonstrated a *Clinical Significance Score* of 250, indicating persistent experiences of somatoform dissociation. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

6) Trance

Symptom Description: Trance refers to episodes of staring off into space, thinking about nothing, and being unaware of what is going on around oneself. During a trance, the person is 'out of touch' with what is going on around them, and it may be difficult to get their attention.

Discussion

Trance Scale Mean Score – The example test-taker in *Figure 8d* has a mean score of 39.2, which falls between the respective mean scores for persons with OSDD-1 and persons with DID, as reflected on the *MID Dissociation Scales Graph*.

Figure 8d. Criterion A: General Dissociative Symptoms (detail)

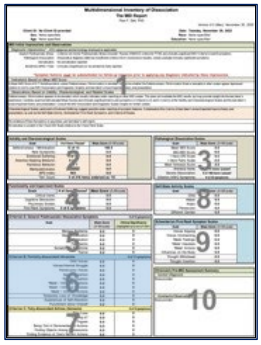
	Criterion A: General Posttraumatic Dissociative Symptoms		6 of 6 symptoms
	Scale	Mean Score (0-100 scale)	Clinical Significance (highlighted at score of 100+)
1)	Memory Problems:	65.8	240
2)	Depersonalization:	37.5	200
3)	Derealization:	34.2	225
4)	Flashbacks:	54.2	180
5)	Somatoform Symptoms:	10.8	250
6)	Trance:	39.2	200

When Is the Trance Score Clinically Significant? When the person reports a clinically significant level of five or more trance items. About 88% of persons diagnosed with DID obtain a clinically significant score on the *Trance* scale. In *Figure 8d*, the example test-taker demonstrated a *Clinical Significance Score* of 200, indicating high levels of trance. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

In all, the example client 'passed' (met the threshold for clinical significance for) all six of the Criterion A symptoms: *Memory Problems*, *Depersonalization*, *Derealization, Flashbacks, Somatoform Symptoms*, and *Trance*.

6. The MID Report – Criterion B: Partially-dissociated Intrusions into Executive Functioning and Consciousness from Another Self-State

Figure 9. The MID Report – Criterion B: Partially-dissociated Intrusions



Criterion B: Partially-dissociated Intrusions		10 of 11 symptoms
Child Voices:	30.0	100
Voices/Internal Struggle:	48.0	300
Persecutory Voices:	76.0	250
Speech Insertion:	33.3	150
Thought Insertion:	34.0	100
'Made' / Intrusive Emotions:	57.1	125
'Made' / Intrusive Impulses:	36.7	50
'Made' / Intrusive Actions:	32.2	175
Temporary Loss of Knowledge:	64.0	250
Experiences of Self-Alteration:	20.0	250
Puzzlement about Oneself:	36.3	133

The symptoms in Criterion B are described as "partially dissociated" because the experiencer registers them as being generated from outside their conscious intention or choice and thus, frequently, as intrusive or disruptive. The essential aspect of these partially-dissociated symptoms is that, unlike fully-dissociated symptoms, *they are consciously experienced and consciously noticed at the time that they occur*. As such, they are jarring and intrusive disruptions of a person's normal functioning, as they are unexpected experiences.

Shown in the right-hand column of *Figure 9,* the example test-taker reported clinically-significant scores (i.e., 100 or higher) on 10 of the 11 *Partially-Dissociated Intrusions*.

1) Child Voices

Symptom Description: The voice of a child is heard inside the head. The voice may speak or cry, or may be experienced as yelling or non- verbal 'noise'.

Discussion

Child Voices Scale Mean Score – Research has shown that persons diagnosed with DID more often hear child voices than do persons diagnosed with schizophrenia (Laddis & Dell, 2012). In *Figure 9a*, the example test-taker's results indicate a *Child Voices Scale Mean Score* of 30.0, which means that they register in the lower range of OSDD Type 1a for frequency of child self-state activity, per the *MID Dissociation Scales Graph*.

When Is the Child Voices Score Clinically Significant? When the test-taker reports a clinically significant level of one or more child voices items. About 93% of persons diagnosed with DID obtain a clinically significant score (100+) on this MID scale. In *Figure 9a* (next page), the example test-taker is just at the threshold of clinical significance for this symptom, with a score of 100. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

Figure 9a. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		*10 of 11 symptoms*
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

2) Voices/Internal Struggle

Symptom Description: Dissociated self-states may argue, or struggle with one another or with the 'fronting' self-state(s). The internal struggle may manifest as voices or 'loud thoughts' that argue or as non-auditory internal forces that struggle with one another (or with the 'fronting' self-state(s)). This is one of the two most frequently elevated scales in persons with a complex dissociative disorder (i.e., DID and OSDD-1). (The other most frequently elevated scale is *Puzzlement about Oneself*.)

'Do Loud Thoughts Count?': A Note on Dissociative Voices

Şar and Öztürk (2009) note that loud thoughts in dissociative patients

> *...feel intrusive, and are perceived as discordant with the person's own tendencies and identity ('not-me' quality). They may be even attributed to a 'foreign entity' (i.e. alter personality)* ***inside of the person*** *(bolded emphasis added).*

So, some test-takers may experience their "voices" as "loud thoughts" and reject the label "voices" for their internal experience.

Discussion

Voices/Internal Struggle Scale Mean Score – The example test-taker in *Figure 9b* has a highly elevated mean score of 47.8, which is clearly in the range for DID, per the *MID Dissociation Scales Graph*.

When Is the Voices/Internal Struggle Score Clinically Significant? When the test-taker reports a clinically significant level of three or more voices/internal struggle items. About 97% of persons diagnosed with DID obtain a clinically significant score on the *Voices/Internal Struggle* scale. In *Figure 9a*, the example test-taker's results show a *Clinical Significance Score* of 200, indicating pronounced experiences of dissociative voices and/or internal struggle. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

Figure 9b. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		*10 of 11 symptoms*
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

3) Persecutory Voices

Symptom Description: Persecutory voices call the person (or particular self-states) names, are harshly disparaging, and command the person (or particular self-states) to commit acts of self-injury or suicide.

CONTINUED ON NEXT PAGE

Discussion

Persecutory Voices Scale Mean Score – The example test-taker in *Figure 9c* has a highly elevated mean score of 47.8, which is nearer/in the range for DID, as reflected on the *MID Dissociation Scales Graph*.

When Is the Persecutory Voices Score Clinically Significant? When the test-taker reports a clinically significant level of two or more persecutory voices items. About 87% of persons diagnosed with DID obtain a clinically significant score on the *Persecutory Voices* scale. In *Figure 9b*, the example test-taker demonstrated a *Clinical Significance Score* of 250, indicating acute experience of persecutory voices. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

4) Speech Insertion

Symptom Description: In speech insertion, a dissociated self-state 'intrudes' into the executive functioning of a 'fronting' self-state by seizing control of what is being said. The 'fronting' self-state typically feels that the words coming out of their mouth are being controlled by someone or something else from within.

Discussion

Speech Insertion Scale Mean Score – The example test-taker in *Figure 9b* has a mean score of 33.3, placing them roughly between OSDD-1 and DID, per the *MID Dissociation Scales Graph*.

When Is the Speech Insertion Score Clinically Significant? When the test-taker reports a clinically significant level of two or more speech insertion items. About 84% of persons diagnosed with DID obtain a clinically significant score on the *Speech Insertion* scale. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

In *Figure 9c*, the example test-taker demonstrated a *Clinical Significance Score* of 150, indicating a significant experience of speech insertion.

Figure 9c. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		*10 of 11 symptoms*
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

5) Thought Insertion

Symptom Description: In thought insertion, the ideas of a dissociated part suddenly 'intrude' into consciousness. Intrusive thoughts feel like they have "come from out of nowhere" and may feel like they do not really "belong" to the experiencer.

Discussion

Thought Insertion Scale Mean Score – The example test-taker in *Figure 9d* has a mean score of 34.0, placing them nearer the mean score for persons who meet criteria for OSDD-1, as reflected on the *MID Dissociation Scales Graph*.

When Is the Thought Insertion Score Clinically Significant? When the test-taker reports a clinically significant level of three or more thought insertion items. About 93% of persons diagnosed with DID obtain a clinically significant score on the *Thought Insertion* scale. In *Figure 9c*, the example test-taker demonstrated a *Clinical Significance Score* of 100, indicating that they reached the threshold for thought insertion to be a clinically relevant symptom. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

6) 'Made'/Intrusive Emotions

Symptom Description: Intrusive emotions (or feelings) are experienced as "coming from out of nowhere," often with no apparent reason. The person frequently experiences intrusive emotions as not really "mine."

Figure 9d. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		*10 of 11 symptoms*
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

Discussion

'Made'/Intrusive Emotions Scale Mean Score – The example test-taker in *Figure 9d* has a mean score of 57.1, placing them between the means for OSDD-1 and DID, per the *MID Dissociation Scales Graph*.

When Is the 'Made'/Intrusive Emotions Score Clinically Significant? When the test-taker reports a clinically significant level of three or more 'made'/intrusive emotions items. About 93% of persons diagnosed with DID obtain a clinically significant score on the *'Made'/Intrusive Emotions* scale. In *Figure 9d*, the example test-taker demonstrated a *Clinical Significance Score*

of 125, indicating that they have significant experiences of 'made'/intrusive emotions. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

7) 'Made'/Intrusive Impulses

Symptom Description: Intrusive impulses are often strong, apparently inexplicable, and may be experienced as not really "mine."

Discussion

'Made'/Intrusive Impulses Scale Mean Score – The example test-taker in *Figure 9e* has a mean score of 36.7, indicating that their experience is in line with the mean score for persons with OSDD-1, per the *MID Dissociation Scales Graph*.

When Is the 'Made'/Intrusive Impulses Score Clinically Significant? When the test-taker reports a clinically significant level of two or more 'made'/intrusive impulses items. About 87% of persons diagnosed with DID obtain a clinically significant score on the *'Made'/Intrusive Impulses* scale. In *Figure 9e*, the example test-taker demonstrated a *Clinical Significance Score* of 50.0, indicating that they did not "pass" enough items to have this symptom, despite their mean score. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

Figure 9e. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		*10 of 11 symptoms*
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

8) 'Made'/Intrusive Actions

Symptom Description: Intrusive actions tend to feel as if they were done by someone or something else inside the person. This is a particularly common, ego-alien experience for persons with a complex dissociative disorder (i.e., DID and OSDD-1).

Discussion

'Made'/Intrusive Actions Scale Mean Score – The example test-taker in *Figure 9e* has a mean score of 32.2, placing them in line with the mean for OSDD-1, per the *MID Dissociation Scales Graph*.

When is the 'Made'/Intrusive Actions Score Clinically Significant? When the test-taker reports a clinically significant level of four or more 'made'/intrusive actions items. About 96% of persons diagnosed with DID obtain a clinically significant score on the *'Made'/Intrusive Actions* scale. In *Figure 9f* below, the example test-taker demonstrated a *Clinical Significance Score* of 175, indicating that they have extensive experience of 'made'/intrusive actions. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

9) Temporary Loss of (Well-Rehearsed Skills and) Knowledge

Symptom Description: Temporary loss of well-learned knowledge or skills is intensely puzzling to the person. Suddenly and inexplicably, they forget how to do their job, how to drive the car, their name, and so on. Unlike the other 10 consciously experienced intrusions (which are positive symptoms), temporary loss of skills or knowledge is a *negative* symptom. That is, what *should* be there (e.g., skill, knowledge of one's own name) is suddenly absent. This is a unique dimension of amnesia because *it is consciously experienced at the time that it occurs*. This is a partially-dissociated form of amnesia—in contrast to the more common, fully-dissociated forms of amnesia (see below).

Figure 9f. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		*10 of 11 symptoms*
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

Discussion

Temporary Loss of Knowledge Scale Mean Score – The example test-taker in *Figure 9f* has a mean score of 64.0, placing them well over the mean score for persons with DID, per the *MID Dissociation Scales Graph*.

When is the Temporary Loss of Knowledge Score Clinically Significant? When the test-taker reports a clinically significant level of two or more temporary loss of knowledge items. About 86% of persons diagnosed with DID obtain a clinically significant score on the *Temporary Loss of Knowledge* scale. In *Figure 9f*, the example test-taker demonstrated a *Clinical Significance Score* of 250, indicating extensive temporary loss of knowledge and/or well-rehearsed skills. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

10) Experiences of Self-Alteration

Symptom Description: Sudden experiences of self-alteration are disconcerting. They involve very odd changes in one's sense of self: feeling like a different person, switching back and forth between feeling like a child and an adult, switching back and forth between feeling like a man and a woman (or different genders), seeing someone else in the mirror, and so on.

Discussion

Experiences of Self-Alteration Scale Mean Score –The example test-taker in *Figure 9e* has a mean score of 20.0, just below the mean for OSDD-1, per the *MID Dissociation Scales Graph*.

When is the Experiences of Self-Alteration Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of self-alteration items. About 96% of persons diagnosed with DID obtain a clinically significant score on the *Experiences of Self-Alteration* scale. In *Figure 9g*, the example test-taker demonstrated a *Clinical Significance Score* of 250, indicating that they have profound, disturbing experiences of self-alteration. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

Figure 9g. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion B: Partially-dissociated Intrusions		10 of 11 symptoms
1)	Child Voices:	30.0	100
2)	Voices/Internal Struggle:	48.0	300
3)	Persecutory Voices:	76.0	250
4)	Speech Insertion:	33.3	150
5)	Thought Insertion:	34.0	100
6)	'Made' / Intrusive Emotions:	57.1	125
7)	'Made' / Intrusive Impulses:	36.7	50
8)	'Made' / Intrusive Actions:	32.2	175
9)	Temporary Loss of Knowledge:	64.0	250
10)	Experiences of Self-Alteration:	20.0	250
11)	Puzzlement about Oneself:	36.3	133

11) Puzzlement about Oneself

Symptom Description: Unlike the other ten consciously experienced, *Partially-dissociated Intrusions,* self-puzzlement is not a dissociative symptom. ***It is the result of dissociative experiences.*** The more dissociative experiences, the more self-puzzlement. Dissociative individuals are recurrently puzzled by their inexplicable feelings, reactions, behaviors, and so on. Self-puzzlement is one of the two most frequently elevated scales in persons with a complex dissociative disorder (i.e., DID and OSDD-1). Notably, puzzlement and confusion about oneself is significantly stronger for persons with DID than in either schizophrenia or borderline personality disorder.

Discussion

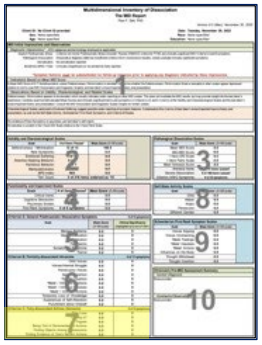
Puzzlement about Oneself Scale Mean Score – The example test-taker in *Figure 9f* has a mean score of 36.3, nearer the mean for persons with OSDD-1, according to the *MID Dissociation Scales Graph*.

When is the Puzzlement about Oneself Score Clinically Significant? When the test-taker reports a clinically significant level of three or more experiences of self-puzzlement items. About 97% of persons diagnosed with DID obtain a clinically significant score on the *Self-Puzzlement* scale. In *Figure 9f*, the example test-taker demonstrated a *Clinical Significance Score* of 133, indicating that they surpassed the threshold for self-puzzlement to be a symptom. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

In summary, the example test-taker met clinical significance for 10 of 11 Criterion B symptoms (the exception being '*Made'/Intrusive Impulses*), suggesting that the test-taker experiences quite a lot of frequent, possibly jarring, and often confusing dissociative 'intrusions' into their executive functioning.

7. The MID Report – Criterion C: Discovering the Fully-dissociated Actions of Another Self-State (Amnesia)

Figure 10. The MID Report – Criterion C: Fully-Dissociated Actions (Amnesia)



Criterion C: Fully-dissociated Actions (Amnesia)		*4 of 6 symptoms*
Time Loss:	40.0	200
"Coming to":	10.0	100
Fugues:	22.0	200
Being Told of Disremembered Actions:	20.0	50
Finding Objects Among Possessions:	7.5	0
Finding Evidence of One's Recent Actions:	8.0	100

1) Time Loss

Symptom Description: Time loss involves incidents of "losing time." The person DISCOVERS that they cannot account for several minutes, hours, a day, or even longer. The person has a total "blank" for what happened during that period of time. About 86% of persons diagnosed with DID obtain a clinically significant score on this MID scale.

Discussion

Time Loss Scale Mean Score – The example test-taker in *Figure 10a* (next page) has a mean score of 40.0, nearest to the mean for DID, per the *MID Dissociation Scales Graph*.

When is the Time Loss Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of time loss items. About 86% of persons diagnosed with DID obtain a clinically significant score on the *Time Loss* scale. In *Figure 10a* (next page), the example test-taker demonstrated a *Clinical Significance Score* of 200, indicating extensive, pathological experience of time loss. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

2) "Coming to"

Symptom Description: The person suddenly "comes to" and (1) DISCOVERS that they have done something, but they have no memory of having done it, or (2) becomes aware that they are in the middle of doing something that they have no memory of having started doing in the first place.

Figure 10a. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion C: Fully-dissociated Actions (Amnesia)		4 of 6 symptoms
1)	Time Loss:	40.0	200
2)	"Coming to":	10.0	100
3)	Fugues:	22.0	200
4)	Being Told of Disremembered Actions:	20.0	50
5)	Finding Objects Among Possessions:	7.5	0
6)	Finding Evidence of One's Recent Actions:	8.0	100

Discussion

'Coming to" Scale Mean Score – The example test-taker in *Figure 10b* has a mean score of 10.0, notably elevated for OSDD-1, but well below the mean for DID, per the *MID Dissociation Scales Graph*.

When is the "Coming to" Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of "coming to" items. About 82% of persons diagnosed with DID obtain a clinically significant score on the *"Coming to"* scale. In *Figure 10a*, the example test-taker demonstrated a *Clinical Significance Score* of 100, right at the threshold for "coming to" to be considered a symptom. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

3) Fugues

Symptom Description: Fugues are incidents where a person suddenly DISCOVERS that they are somewhere, but they have no memory whatsoever of going to that place.

Discussion

Fugues Scale Mean Score – The example test-taker in *Figure 10a* has a mean score of 10.0, notably elevated compared to the mean for OSDD-1, and well below the mean for DID, according to the *MID Dissociation Scales Graph*.

When is the Fugues Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of fugue items. About 82% of persons diagnosed with DID obtain a clinically significant score on the *Fugues* scale. In *Figure 10a*, the example test-taker demonstrated a *Clinical Significance Score* of 200, indicating that they experience fugue in a variety of ways, and often enough for this to be potentially dangerous (see *Fugues* under *Critical Items* in the *Functionality and Impairment Scales* section of *The MID Extended Report*). A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

'Have Fugue, Will Travel:' What Counts?

Stark examples of fugue (e.g., suddenly finding yourself in another city) understandably receive significant attention in treatment (and in popular culture). The MID has only one item that addresses amnesic travel outside the home. The remaining fugue items on the MID address travel ***within*** the home:

Finding yourself lying in bed (on the sofa, etc.) with no memory of how you got there.

After a nightmare, you wake up and find yourself not in bed (for example, on the floor, in the closet, etc.).

Suddenly finding yourself standing someplace and you can't remember what you have been doing before that.

Suddenly finding yourself somewhere odd at home (for example, inside the closet, under a bed, curled up on the floor, etc.) with no knowledge of how you got there.

Most fugues are at-home "mini-fugues" such as these. Evidence of fugue may be subtle and difficult to corroborate, in part because it's often difficult to report evidence of something that is seemingly innocuous as well as woven into the fabric of daily life. Thorough, ongoing evaluation of any non-zero responses when fugue is suspected—especially when a high *Defensiveness* score is present—is highly recommended.

4) Being Told of (One's Recent) Disremembered Actions

Symptom Description: Persons with a major dissociative disorder may be told about their recent actions yet have absolutely no memory of having done those things. Thus, the experiencer DISCOVERS what they have done.

Discussion

Being Told of Disremembered Actions Scale Mean Score – The example test-taker in *Figure 10b* (next page) has a mean score of 20.0—high compared to the mean for OSDD-1, but well below the mean for DID, per the *MID Dissociation Scales Graph*.

When is the Being Told of Disremembered Actions Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of "being told of disremembered actions" items. About 87% of persons diagnosed with DID obtain a clinically significant score on the *Being Told of Disremembered Actions* scale. In *Figure 10b*, the example test-taker demonstrated a *Clinical Significance Score* of 50, indicating sub-clinical elevation. As their score is below 100, they do not have this symptom, based on their initial reporting. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

Figure 10b. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion C: Fully-dissociated Actions (Amnesia)		4 of 6 symptoms
1)	Time Loss:	40.0	200
2)	"Coming to":	10.0	100
3)	Fugues:	22.0	200
4)	Being Told of Disremembered Actions:	20.0	50
5)	Finding Objects Among Possessions:	7.5	0
6)	Finding Evidence of One's Recent Actions:	8.0	100

5) Finding Objects Among (One's) Possessions

Symptom Description: Persons with a severe dissociative disorder may DISCOVER objects, writings, or drawings among their possessions, but have no idea where those things came from.

Discussion

Finding Objects Among Possessions Scale Mean Score – The example test-taker in *Figure 10b* has a mean score of 7.5, suggesting that they have relatively infrequent experiences of finding objects among their possessions compared to persons with DID, though still elevated in relation to persons with OSDD-1, per the *MID Dissociation Scales Graph*.

When is the Finding Objects Among Possessions Scale Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of "coming to" items. About 68% of persons diagnosed with DID obtain a clinically significant score on the *Finding Objects Among Possessions* scale. In *Figure 10b*, the example test-taker demonstrated a *Clinical Significance Score* of "0," indicating that, though they did endorse having such experiences, none of their item scores met or exceeded the cutoffs for clinical significance. A visual representation of the test-taker's score in relation to diagnostically relevant populations would be found on the *MID Diagnostic Graph*.

6) Finding Evidence of One's Recent Actions

Symptom Description: Persons with a severe dissociative disorder may DISCOVER evidence of their recent actions, but they will have no memory of having done those things. Examples include things at home being moved around or changed and no one else could have been responsible for it; finding that tasks have been completed that only the experiencer could have done; discovering previously unnoticed injuries—even a fully-dissociated suicide attempt.

Discussion

Finding Evidence of One's Recent Actions Scale Mean Score – The example test-taker in *Figure 10b* has a mean score of 8.0, which suggests they experience this symptom almost twice as often as the average person in outpatient treatment with OSDD-1.

When is the Finding Evidence of One's Recent Actions Scale Score Clinically Significant? When the test-taker reports a clinically significant level of two or more experiences of "finding evidence of one's recent actions" items. About 78% of persons diagnosed with DID obtain a clinically significant score on the *Finding Evidence of One's Recent Actions* scale.

In *Figure 10c*, the example test-taker demonstrated a *Clinical Significance Score* of 100, right at the threshold for *Finding Evidence of One's Recent Actions* to be considered a symptom.

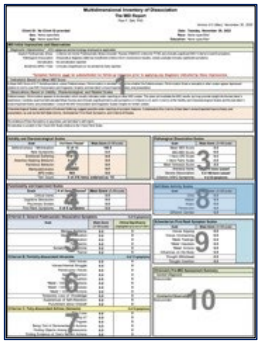
Figure 10c. Criterion B: Partially-dissociated Intrusions (detail)

	Criterion C: Fully-dissociated Actions (Amnesia)		4 of 6 symptoms
1)	Time Loss:	40.0	200
2)	"Coming to":	10.0	100
3)	Fugues:	22.0	200
4)	Being Told of Disremembered Actions:	20.0	50
5)	Finding Objects Among Possessions:	7.5	0
6)	Finding Evidence of One's Recent Actions:	8.0	100

In all, we have found that the test-taker has met clinical significance for 6 of 6 Criterion A symptoms, 10 of 11 Criterion B symptoms, and 4 of 6 C symptoms (the latter excepting *Being Told of Disremembered Actions* and *Finding Objects Among Possessions*). This is an invitation to identify items/symptoms of particular note in the MID results themselves that need clarification, and to begin to develop hypotheses about the test-taker's functioning based on their verbal reports outside of the MID in combination with these results, in preparation for the follow-up interview.

8. The MID Report – Self-State Activity Scales

Figure 11. The MID Report – Self-State Activity Scales



Self-State Activity Scales	
Scale	Mean Score (0-100 scale)
Child:	37.1
Helper:	30.0
Angry:	50.0
Persecutor:	74.3
Different Gender:	10.0

1) Child Parts

The *Child Parts Scale* portrays the mean score of the seven items on the Child Self-States Scale. These items reflect the presence and activity of a child ego state, self-state, or alter:

- Item 6: "Hearing the voice of a child in your head."
- Item 18: "Seeing images of a child who seems to 'live' in your head."
- Item 83: "Switching back and forth between feeling like an adult and feeling like a child."
- Item 97: "Hearing a lot of noise or yelling in your head."
- Item 118: "Hearing voices crying in your head."
- Item 188: "Suddenly feeling very small, like a young child."
- Item 218: "Noticing the presence of a child inside you."

Discussion

Child Parts Scale Mean Score – The example test-taker in *Figure 11a* has a mean score of 37.1, in line with the mean for outpatient therapy clients with OSDD-1, and suggests frequent, consciously registered experiences of child self-state activity. Details about the test-taker's scores on this scale are available in *The Extended MID Report*. A visual representation of this scale with comparisons to diagnostically relevant populations is available in the *MID Clinical Summary Graph*.

Figure 11a. Self-State Activity Scales (detail)

Self-State Activity Scales

	Scale	Mean Score (0-100 scale)
1)	Child:	**37.1**
2)	Helper:	**30.0**
3)	Angry:	**50.0**
4)	Persecutor:	**74.3**
5)	Different Gender:	**10.0**

2) Helper Parts

The *Helper Parts Scale* contains only one item:

- Item 216: "Hearing a voice in your head that is soothing, helpful, or protective."

Helper Parts Scale Mean Score – The example test-taker in *Figure 11a* has a mean score of 30.0, notably below the mean for outpatients with OSDD-1, as reflected on the *MID Clinical Summary Graph*. Details about the test-taker's scoring on this scale are available in *The Extended MID Report*.

3) Angry Parts

The Angry Parts Scale portrays the *mean score* of four items:

- Item 99: "Words just flowing from your mouth as if they were not in your control."

- Item 112: “Feeling the presence of an angry part in your head that tries to control what you do or say.”
- Item 129: “When you are angry, doing or saying things that you don’t remember (after you calm down).”
- Item 208: “Having a very angry part that ‘comes out’ and says and does things that you would never do or say.”

Angry Parts Scale Mean Score – The example test-taker in *Figure 11b* has a mean score of 50.0, in line with the mean for outpatients with DID, suggesting persistent angry parts activity, within and/or outside conscious awareness. Details about the test-taker’s scoring on this scale are available in *The Extended MID Report*. A visual representation of this scale is available in the *MID Clinical Summary Graph*.

Figure 11b. Self-State Activity Scales (detail)

Self-State Activity Scales

	Scale	*Mean Score (0-100 scale)*
1)	Child:	**37.1**
2)	Helper:	**30.0**
3)	Angry:	**50.0**
4)	Persecutor:	**74.3**
5)	Different Gender:	**10.0**

4) Persecutor Parts

The Persecutor Parts Scale portrays the mean score of seven items that reflect auditory harassment and persecution, in the form of voices or “loud thoughts”:

- Item 84: “Hearing a voice in your head that wants you to hurt yourself.”
- Item 140: “Hearing a voice in your head that calls you names (for example, wimp, stupid, whore, slut, bitch, etc.).”
- Item 159: “Hearing a voice in your head that wants you to die.”
- Item 171: “Hearing a voice in your head that calls you a liar or tells you that certain things never happened.”
- Item 199: “Hearing a voice in your head that tells you to ‘shut up.’”
- Item 207: “Hearing a voice in your head that calls you no good, worthless, or a failure.”
- Item 215: “Feeling the presence of an angry part in your head that seems to hate you.”

Persecutor Parts Scale Mean Score – The example test-taker in *Figure 11b* has a mean score of 74.3, highly elevated compared to the mean for outpatient therapy clients with DID, suggesting a profoundly high frequency of persecutory self-state activity. Special attention would need to be given to any persecutor parts activity that correlates with high-risk or self-harming behavior (see *Critical Items* under *Functionality / Impairment Scales* in *The Extended MID Report*).

E) Different Gender Parts

The Different Gender Parts Scale contains only one item:

- Item 201: "Switching back and forth between feeling like a man and feeling like a woman."

Different Gender Parts Scale Mean Score – Because this scale does not measure a specific kind of self-state, but rather the frequency of consciously-registered switches or shifts between parts of different genders, there are no comparative mean scores. Rather, this scale offers evidence of differently-gendered self-state activity in general. The example test-taker in *Figure 11b* has a mean score of 10.0, indicating that they are consciously aware of differently-gendered parts activity about ten percent of the time ("10 of 100"). Details about the test-taker's scoring on this scale are available in *The Extended MID Report*. A visual representation of this scale is available in the *MID Clinical Summary Graph*. See also: Differential Diagnosis: Transgender Identity.

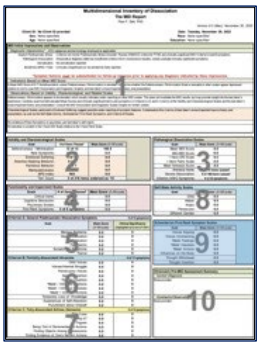
He, She, or They? A Note on "Different Gender" Parts

Although all *MID* items that refer to gender are written in terms of a man-woman gender binary, test-takers who identify as non-binary, trans*, genderqueer, genderfluid, or agender may not find this language accessible or applicable to them. So, this item can instead be explained to test-takers as "switching back and forth between feeling like your most familiar, subjective experience of gender (even if that's non-gendered) and something other (or different) than that most familiar experience."

The Dissociative Initiative (http://di.org.au) offers further information that can be helpful in discerning diagnosis and treatment regarding questions of gender identity and dissociation. It can be helpful to be aware that trans* experiences are common for people with multiplicity, and experiences of multiplicity are common for trans* persons.

9. The MID Report – Schneiderian First-Rank Symptom Scales

Figure 12: The MID Report – Schneiderian First-Rank Symptom Scales



Schneiderian First-Rank Symptom Scales

Scale	*Mean Score (0-100 scale)*
Voices Arguing:	**50.0**
Voices Commenting:	**63.3**
'Made' Feelings:	**58.3**
'Made' Impulses:	**46.0**
'Made' Actions:	**28.0**
Influences on the Body:	**30.0**
Thought Withdrawal:	**27.5**
Thought Insertion:	**35.0**

According to Somer & Dell (2005),

> Kurt Schneider (1959) enumerated 11 "first-rank" symptoms of schizophrenia, which he claimed were pathognomonic [solely characteristic] of schizophrenia: (1) voices arguing,

> (2) voices commenting, (3) "made" feelings, (4) "made" impulses, (5) "made" actions, (6) influences playing on the body, (7) thought insertion, (8) thought withdrawal, (9) thought broadcasting, (10) audible thoughts, and (11) delusional perception. Kluft (1987a) reported that *the first eight of Schneider's first-rank symptoms were common in persons with DID, but that the last three were not* (emphasis added). Each of these eight first-rank symptoms have something in common: Each is a peculiar intrusion into the person's executive functioning and/or sense of self (pp. 33-34).

Persons with schizophrenia experience psychotic forms of intrusion (e.g., "The President of the United States is implanting their thoughts in my head."), whereas dissociative persons experience non-psychotic intrusions (e.g., "Sometimes I have thoughts that do not feel like they are mine," (Dell, 2001)). In schizophrenia, the person's explanations for their symptoms tend toward the fantastical or bizarre (i.e., their reality testing is impaired), whereas the person experiencing non-psychotic, dissociative intrusions tend toward logical and reality-based observations regarding their symptoms (i.e., their reality testing remains intact).

Although Criterion B symptoms (i.e., partially-dissociated intrusions of another self-state) are within the domain of *Schneiderian First-Rank Symptoms*, the mean scores reflected in this section do not precisely line up with the Criterion B symptoms. The mean scores here reflect more narrowly defined criteria in keeping with Schneider's original definitions.

We will not go into detail with the first-rank symptoms as we have in other sections, but please note that the mean scores here are on the same "0 to 100" scale as other mean scores on *The MID Report*.

Additionally, you may recall that the *Fu**nctionality and Impairment Scales* included both the *Passed Items* tally and the overall Mean Score for the eight *First-Rank Symptoms*. *The MID Extended Report* includes this information, as well as all items that comprise each of the eight scales fully delineated, in a section corresponding to the *Schneiderian First-Rank Symptoms Scales.*

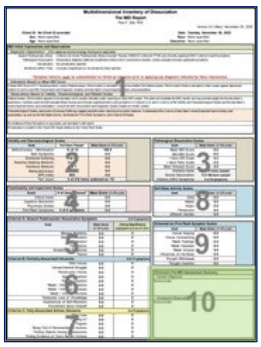
Discussion

We can see in *Figure 12* (previous page) that the example test-taker frequently experiences these eight first-rank symptoms, which would be given thorough attention in follow-up interviewing. These scales can be contextualized in terms of the *Validity and Characterological Scales*, *Critical Items*, *Self-State Activity Scales*, and the *Clinical Significance Scores* in *Criterion A*, *B*, and *C*.

CONTINUED ON NEXT PAGE

10. The MID Report – Clinician's Pre-MID Assessment Summary

Figure 13. The MID Report – Clinician's Pre-MID Assessment Summary



Clinician's Pre-MID Assessment Summary
Current Diagnosis
F33.1 Major Depressive Disorder, Recurrent, Moderate; F41.1 Generalized Anxiety Disorder
Comments/Observations
Initial administration of MID, with no prior hx of trauma-related dx; initial client self-report indicates possible PTSD. He notes chronic 'forgetfulness', feeling 'disconnected' from his body, and frequent, brief headaches that cannot be explained by MD or headache clinic; hx of ineffective depression and anxiety meds.

The information shown here on *The MID Report* is carried directly from data entered on the ***Questions*** tab (see *Figure 14* below), and is included in the report for easy reference.

It is not possible to type directly into this or any other field on *The MID Report*. All data must be entered on the ***Questions*** tab of the *MID Analysis*.

Figure 14. MID Analysis v6.0 Questions Tab

Client ID:	JD062517	
Sex:	M	
Age:	43	
Date:	12/31/22	
Race:	W/N-H	
Education:	BA	
	Pre-MID Diagnosis:	F33.1 Major Depressive Disorder, Recurrent, Moderate; F41.1 Generalized Anxiety Disorder
	Comments:	Initial administration of MID, with no prior hx of trauma-related dx; initial client self-report indicates possible PTSD. He notes chronic 'forgetfulness', feeling 'disconnected' from his body, and frequent, brief headaches that cannot be explained by MD or headache clinic; hx of ineffective depression and anxiety meds.

The Extended MID Report

Figure 15. The Extended MID Report

The Extended MID Report

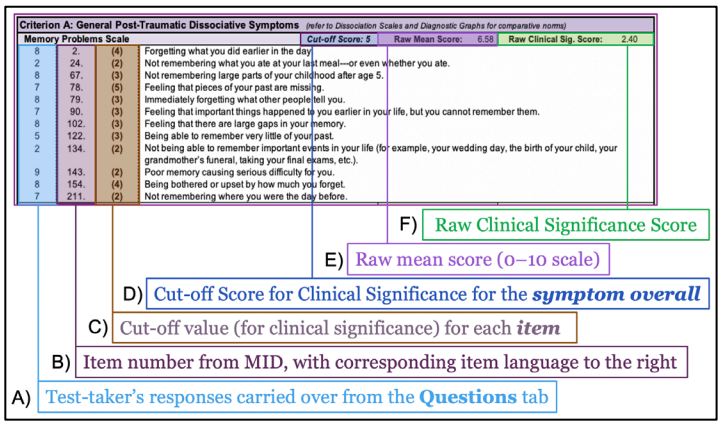
Version 6.0 (Mac): December 30, 2022

Validity and Characterological Scales *(refer to Diagnostic and Clinical Summary Graphs for comparative norms)*					
Defensiveness / Minimization Scale				Raw Mean Score*: 3.42	# of Items 'Passed': 0 of 12
7	1.	(0)	While watching TV, you find that you are thinking about something else.		
8	10.	(0)	Forgetting errands that you had planned to do.		
7	33.	(0)	While reading, you find that you are thinking about something else.		
5	65.	(0)	Being impulsive.		
8	87.	(0)	Not being able to remember something, but feeling that it is "right on the tip of your tongue."		
5	88.	(0)	Making decisions too quickly.		
8	100.	(0)	Listening to someone and realizing that you did not hear part of what he/she said.		
8	109.	(0)	Forgetting where you put something.		
2	110.	(0)	Having dreams that you don't remember the next day.		
7	121.	(0)	Daydreaming.		
6	132.	(0)	Being unable to recall something—then, something "jogs" your memory and you remember it.		
8	142.	(0)	Having to go back and correct mistakes that you made.		
Rare Symptoms Scale				Raw Mean Score: 0.33	# of Items 'Passed': 3 of 12
0	11.	(1)	Feeling that your mind or body has been taken over by a famous person (for example, Elvis Presley, Jesus Christ, Madonna, President Kennedy, etc.)		

The Extended MID Report elaborates upon the results offered up on the first page of *The MID Report*, reorganizing the 218 MID items into their symptom categories.

Reading the Scales in The Extended MID Report Format

Figure 16. The Extended MID Report – Memory Problems (detail)



The MID Extended Report includes the following information for each symptom:

A) The test-taker's "0 to 10" response to the item on the MID (transferred from the ***Questions*** worksheet), with corresponding question to the right.

B) *Item Number* as it appears on the MID and the ***Questions*** worksheet.

C) *Item Cut-off Value for Clinical Significance* – Remember, for the test-taker's response on a specific item to be considered clinically significant in any way, it must be greater than or equal to this number.

D) *Symptom Cut-off Score for Clinical Significance* – This is the *overall* number of items (greater than or equal to) the test-taker must 'pass' to meet criteria for the symptom.

E) *"Raw" Mean Score* – The average of the test-taker's responses on the "0 to 10" scale, before it is multiplied by 10 as we see it on *The MID Report*.

F) *"Raw" Clinical Significance Score* – This the *Clinical Significance Score* before it is multiplied by 100, as we see it on *The MID Report*. This number is displayed only for the 23 Criterion A, B, and C symptoms.

From Cut-off Score to Clinical Significance Score

The **Cut-off Score** is the number of items the test-taker needs to 'pass' on a scale for the symptom to be clinically significant. Clinical significance is determined by comparing the proportion of questions the person "passed" to the number of items they ***needed*** to 'pass.'

Figure 16a. The Extended MID Report – Memory Problems (detail)

Criterion A: General Post-Traumatic Dissociative Symptoms *(refer to Dissociation Scales and Diagnostic Graphs for comparative norms)*

Memory Problems Scale			*Cut-off Score: 5*	Raw Mean Score: 6.58	Raw Clinical Sig. Score: 2.40
8	2.	(4)	Forgetting what you did earlier in the day.		
2	24.	(2)	Not remembering what you ate at your last meal—or even whether you ate.		
8	67.	(3)	Not remembering large parts of your childhood after age 5.		
7	78.	(5)	Feeling that pieces of your past are missing.		
8	79.	(3)	Immediately forgetting what other people tell you.		
7	90.	(3)	Feeling that important things happened to you earlier in your life, but you cannot remember them.		
8	102.	(3)	Feeling that there are large gaps in your memory.		
5	122.	(3)	Being able to remember very little of your past.		
2	134.	(2)	Not being able to remember important events in your life (for example, your wedding day, the birth of your child, your grandmother's funeral, taking your final exams, etc.).		
9	143.	(2)	Poor memory causing serious difficulty for you.		
8	154.	(4)	Being bothered or upset by how much you forget.		
7	211.	(2)	Not remembering where you were the day before.		

*Example: Test-taker 'passed' 12 Memory Problems Scale items. They **needed** to 'pass' 5 (circled above). If 5 items 'passed' ÷ 5 items needed = 1 (i.e., 100 percent), then 12 items 'passed' ÷ 5 items needed = 2.4 (240 percent) for Memory Problems. If we want this score of 2.4 to scale on a '0 to 100' metric rather than a '0 to 1' metric, as it currently does, we multiply by 100. The Clinical Significance Score for Memory Problems is 240.*

Part III: After the MID Report

Visualizing MID Results: The Line and Bar Graphs

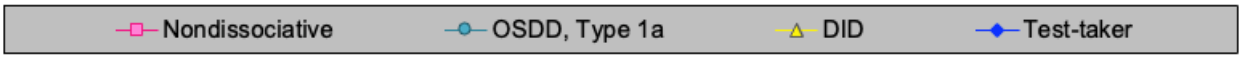
The various *MID Scales* are laid out visually in the *Line* and *Bar Graphs*. Each graph depicts information described in the *MID Report* in a particular and unique way. Each graph will be described below, with visuals from the *Line Graphs*.

MID Line Graphs Legend

The test-taker's and different comparison populations' scores are each given their own color/symbol on six of the eight different graphs (which appear in different greyscale shades in black-and-white):

Figure 17a. MID Line Graphs Legend (MID Factor Scales Graph only)

Figure 17b. MID Line Graphs Legend (all other Line Graphs)



Nondissociative – Represents the testing sample found not to experience PTSD or any, more severe form of pathological dissociation. This population's scores/data points appear as magenta squares connected by a magenta line.

PTSD (MID Factor Scales Line Graph only) – Represents the testing sample diagnosed with PTSD. This population's scores/data points appear as darker purple stars (six points) connected by a purple line.

DID – Represents the testing sample diagnosed with DID. This population's scores/data points appear as bright yellow triangles (with black outline) connected by a bright yellow line.

OSDD, Type 1a – Represents the testing sample diagnosed with OSDD, Type 1a (insufficiently distinct self-states, with transient experiences of contemporaneous amnesia). This population's scores/data points appear as dark cyan circles connected by a dark cyan line.

[Test-taker] – Represents the test-taker's scores on the MID. In color, the test-taker's scores/data points appear as brilliant blue diamonds connected by a bright blue line. The text for this field is carried over from the *Client ID* field on the ***Questions*** worksheet; if nothing is entered in that field, this data series will appear as 'None'. *In the illustration above, 'Test-taker' had been entered in the Client ID field on the Questions worksheet.*

MID Analysis v5.0+ features four graphs focused on the experiences of persons diagnosed with borderline personality disorder (BPD; n=100) as compared to person's with DID (n=75), with the test-taker's scoring plotted as well. The legend for two of those graphs are:

Figure 17c. MID Line Graphs Legend (BPD-DID Comparison Scales only)

BPD – Represents the testing sample diagnosed with borderline personality disorder in the study. This population's scores/data points appear as burnt orange Xs connected by an orange line.

DID – Represents the testing sample diagnosed with DID in the study. This population's scores/data points appear as bright yellow triangles (with black outline) connected by a bright yellow line.

[Test-taker] – Represents the test-taker's scores on the specific scales examined in the study from which these graphs were derived. The text for this field is carried over from the *Client ID* field on the **Questions** worksheet; if nothing is entered in that field, this data series will appear as 'None'. *In the illustration above, 'Test-taker' had been entered in the Client ID field on the Questions worksheet.*

Two of the four BPD-DID Comparison scales are smaller (vertically oriented) bar graphs, which use the same color conventions shown in *Figure 17c.*

MID Bar Graphs Legend

The information contained in the eight *Bar Graphs* is identical to that reflected in the *Line Graphs* and is included for the simple reason that some people prefer to read line graphs, and others prefer to read bar graphs. The test-taker's and different comparison populations' scores are each given their own color on the four diagnostic graphs (which appear in different greyscale shades when printed in black-and-white):

Figure 18a. MID Bar Graphs Legend and Detail (MID Factor Scales Graph only)

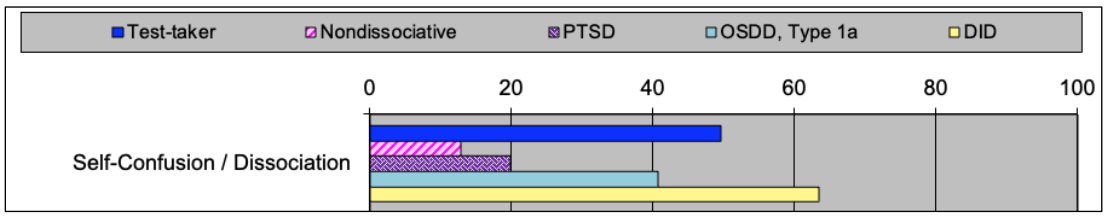
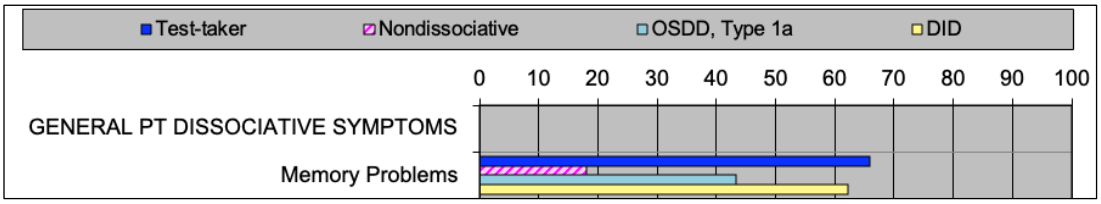


Figure 18b. MID Bar Graphs Legend and Detail (all other Bar Graphs)



[Test-taker] – Represents the test-taker's scores on the MID. The test-taker's scores/bar lines appear as bright blue in *MID Analysis v6.0*. The text for this field is carried over from the *Client ID* field on the **Questions** worksheet; if nothing is entered in that field, this data series will appear as 'None.' *In the illustration above, 'Test-taker' had been entered in the Client ID field on the Questions worksheet.*

Nondissociative – Represents the testing sample found not to experience PTSD or any, more severe form of pathological dissociation. This population's scores/bar lines appear as a patterned magenta/light pink.

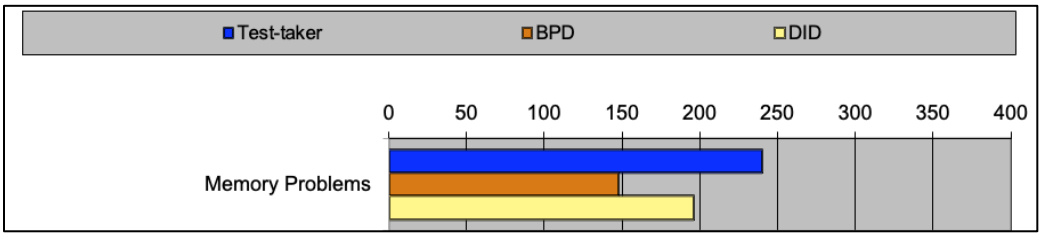
PTSD (MID Factor Scales Graph only) – Represents the testing sample diagnosed with PTSD. This population's scores/bar lines appear as a patterned violet and lighter purple.

OSDD, Type 1a – Represents the testing sample diagnosed with OSDD, Type 1a (insufficiently distinct self-states, with transient experiences of contemporaneous amnesia). This population's scores/bar lines appear as cyan.

DID – Represents the testing sample diagnosed with DID. This population's scores/bar lines appear as pastel yellow.

The bar graphs also include four new graphs focused on the experiences of persons diagnosed with borderline personality disorder (BPD; n=100) as compared to persons with DID (n=75), with the test-taker's scoring plotted as well. The legend for two of those graphs are:

Figure 19. MID Bar Graphs Legend and Detail (BPD-DID Comparison Scales only)



[Test-taker] – Represents the test-taker's scores on the specific scales examined in the study from which these graphs were derived. The test-taker's scores/bar lines appear as bright blue.

BPD – Represents the testing sample diagnosed with borderline personality disorder in the study. This population's scores/data points appear as orange Xs connected by an orange line.

DID – Represents the testing sample diagnosed with DID in the study. This population's scores/bar lines appear as pastel yellow.

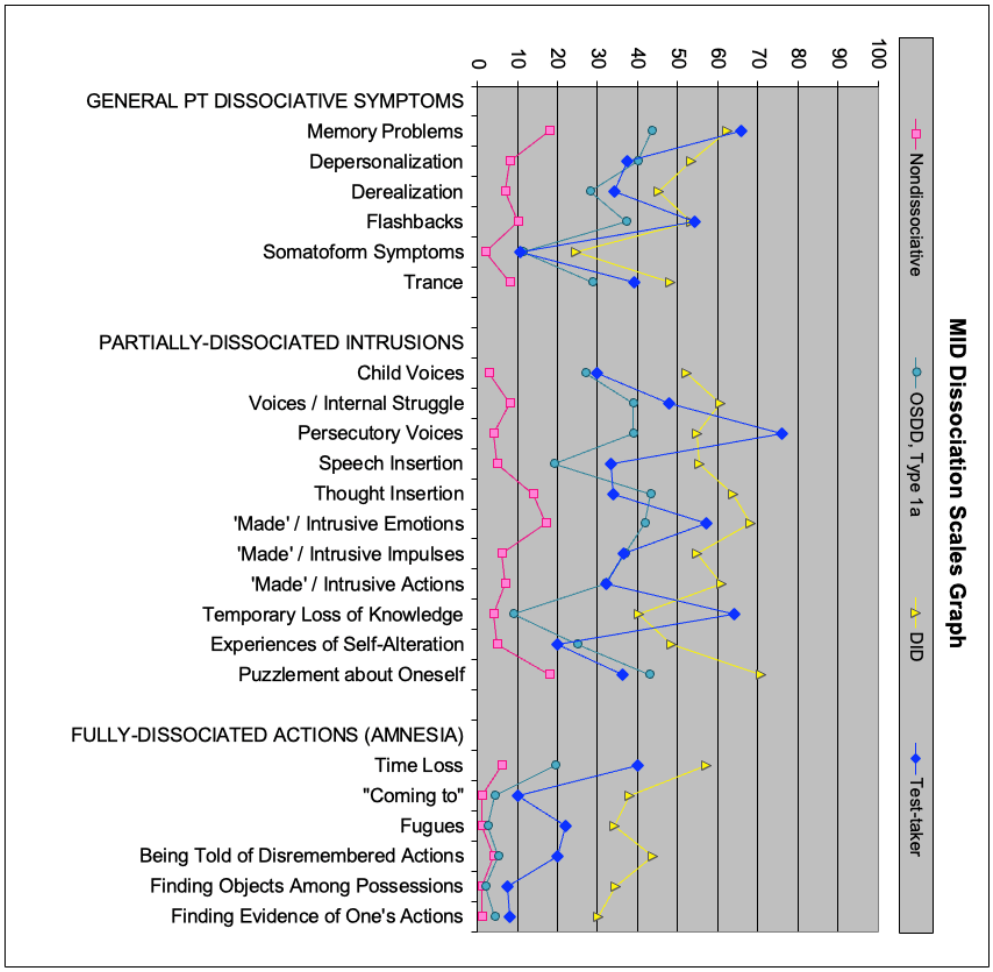
Two of the four BPD-DID Comparison scales are smaller (vertically oriented) bar graphs, identical to those shown above for the Line Graphs, which use the same color conventions shown in *Figure 19*.

The MID Dissociation Scales Graph

The MID's fundamental assumption is that dissociation affects the entirety of human experience. And, because DID is the prototypical dissociative disorder, the domain of symptoms of DID is identical to the domain of pathological dissociation. The MID operationalizes the domain of pathological dissociation (and the domain of symptoms of DID) via 23 dissociative symptoms that are organized into three clusters of symptoms. These clusters are the Criterion A, B, and C symptoms discussed in Part II in greater detail.

The *MID Dissociation Scales Graph* reflects the test-taker's *Mean Scores* for the 23 dissociative symptoms, as compared to norms for other diagnostic categories: Nondissociative, PTSD, OSDD Type 1a, and DID. The PTSD profile on this graph is for PTSD patients who are not dissociative. It is most easily read by printing the page and turning it sideways:

Figure 20. The MID Dissociation Scales Line Graph

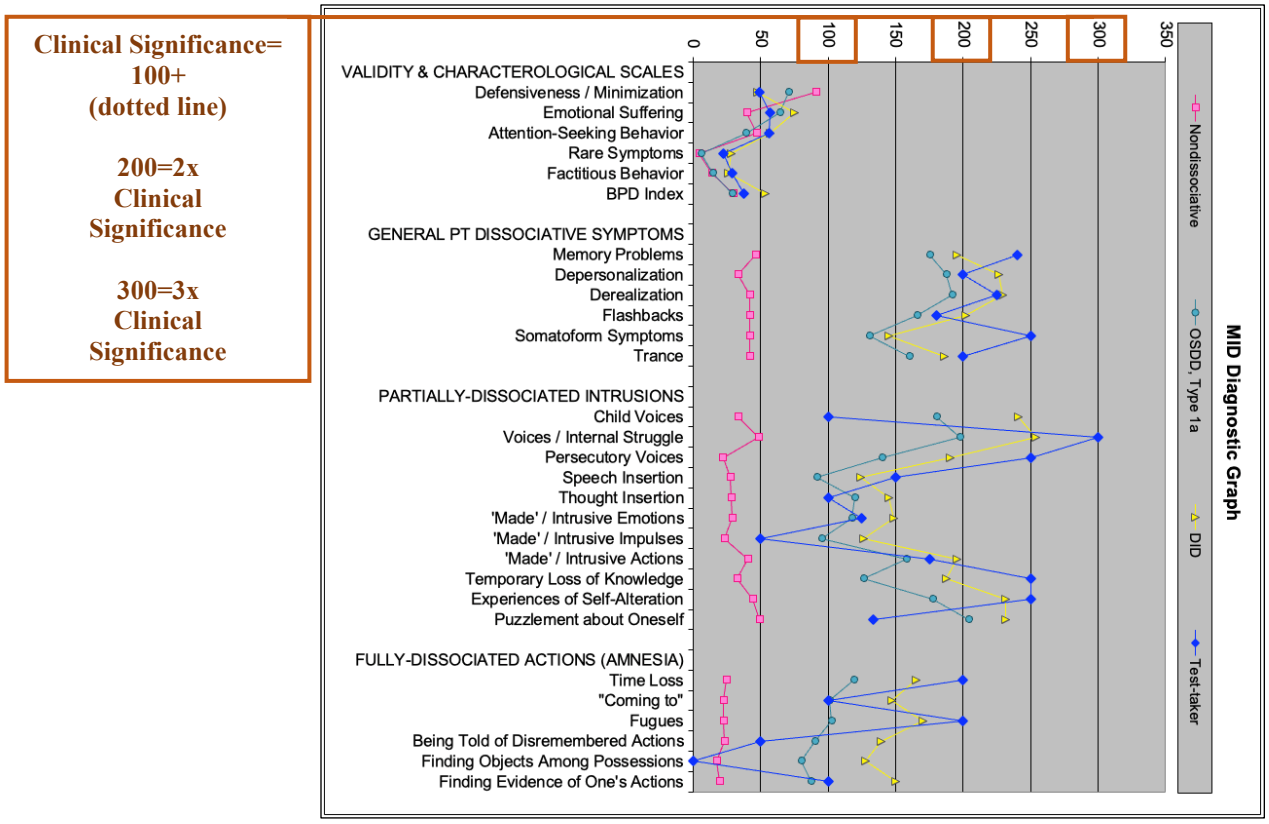


The MID Diagnostic Graph

The *MID Diagnostic Graph* is the core of the MID Report. It shows (1) whether each of the 23 dissociative symptoms is *present or absent,* and (2) whether the test-taker shows a significant level of *response bias* (as assessed by the six validity indicators: *Defensiveness*; *Emotional Suffering*; *Attention-Seeking Behavior*; *Rare Symptoms*; *Factitious Behavior*; and, Borderline traits, through the *BPD Index*).

The graph also shows the severity of each symptom, reflected in *Clinical Significance Scores*. A score of 100 on the graph indicates that the person has that symptom at a clinically significant level; that is, the person 'passed' enough items on that scale to show that they experience that symptom. A score of 200 indicates that the test-taker 'passed' twice as many items on that scale as are necessary to show that they *have* that symptom. Thus, a score of 200 means that the person has *a very high level* of that symptom. Conversely, a score of 50 means that the test-taker 'passed' only half as many items on that scale as are necessary for the MID to consider that symptom to be present. A score of less than 100 suggests that the person does *not* have that symptom. Analysis of a test-taker's pattern of scores on the *MID Diagnostic Graph* allows the clinician to diagnose PTSD, dissociative identity disorder (DID), other specified dissociative disorder (OSDD, Type 1a; ICD Partial DID), and 'Unspecified Dissociative Disorder,' as indicated in DSM-5 (2013)/-TR (2022).

Figure 21. The MID Diagnostic Line Graph



The MID Clinical Summary Graph

The MID enables clinicians to make accurate diagnostic distinctions at the 'messy' clinical interface between dissociation, PTSD symptoms, and borderline pathology. The MID *Clinical Summary Graph* contains 27 scales that help to accomplish that goal. The *Clinical Summary Graph* has five clusters of scales:

1) **Dissociation Scales** – Depicts the percentage of items passed, and in some instances mean scores, for the most essential *Pathological Dissociation Scales* on *The MID Report.*

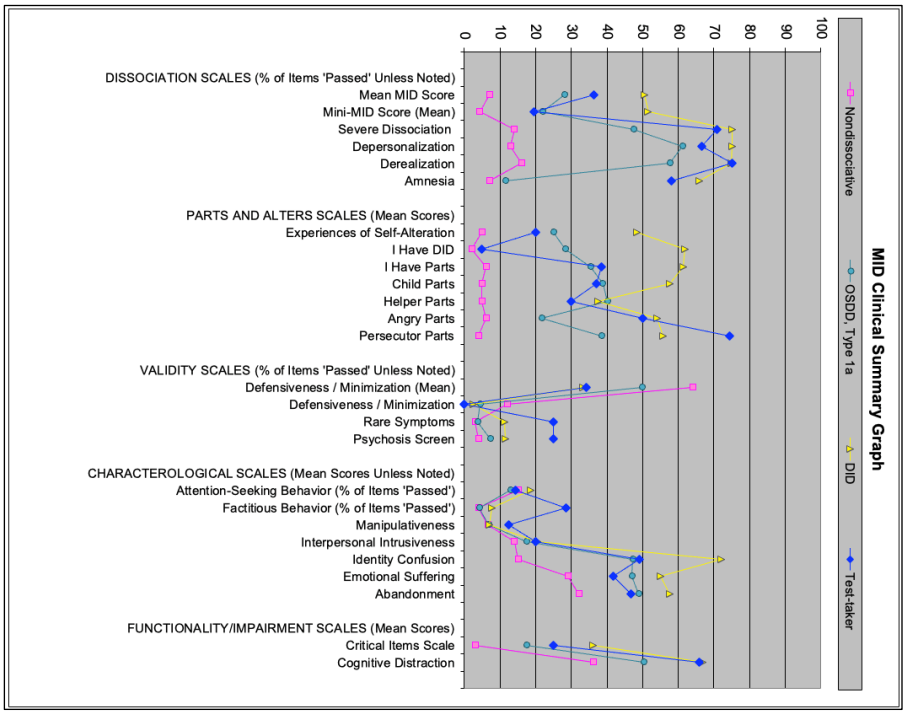
2) **Parts and Alters Scales** – Depicts mean scores from the *Pathological Dissociation Scales* concerning self-state activity, as well as those from the *Self-State Activity Scales*, all from *The MID Report*, as well as an aggregation of specific symptom features combined into a measure called *self-alteration.* NOTE: The term 'alters' is retained here for the sake of research data consistency.

3) **Validity Scales** – Depicts percentage of items passed and, in some instances, mean scores for the most salient of the *Validity Scales* reflected in *The MID Report.*

4) **Characterological Scales** – Depicts mean scores and other measures both from the *Validity and Characterological Scales* on *The MID Report* and particular features of borderline personality disorder assessed by the MID, which give greater context to the MID's other scales and, ultimately, to the test-taker's subjective experience.

5) **Functionality/Impairment Scales** – Depicts mean scores from two scales that highlight potentially harmful impairment: a) Critical Items and b) Cognitive Distraction. Previously, this graph also included Flashbacks, but this has been removed since the information is already included on the *Dissociation Scales Graph*.

Figure 22. The MID Clinical Summary Line Graph

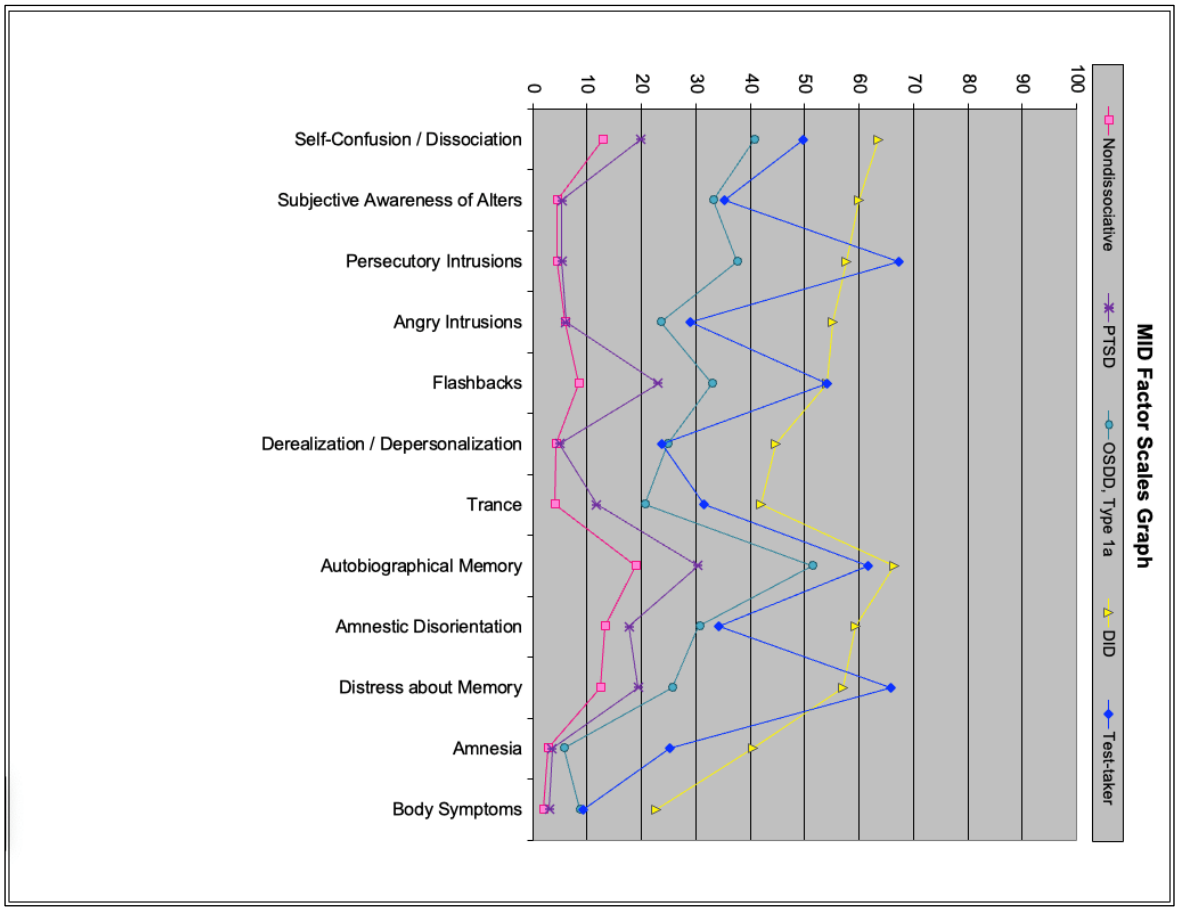


If we compare the scores on the *MID Clinical Summary Graph* with scores found elsewhere in the *MID Report* (or on other MID graphs), we will discover that the scores often differ. They differ because most of the scores on the *Clinical Summary Graph* are neither mean scores nor clinical significance scores, per se. While a few scales do, indeed, present the test-taker's mean score, most scales on the *Clinical Summary Graph* present the percentage of items that the person 'passed' on that scale. Higher scores indicate greater impairment of functioning. *It is probably worth pointing out that the reason 'percentage of items passed' does not translate to 'clinical significance' is because, as has been noted elsewhere in this manual, clinical significance scores on the MID are reserved for those symptoms that are relevant to DSM-5 diagnostic categories.*

Careful study of a person's scores on the *Clinical Summary Graph* are often especially revealing of characterological aspects of their unique clinical 'picture.' Nowhere in the data reported by *MID Analysis* are problematic personality traits so readily visible in relation to other factors as they are in the *Clinical Summary Graph*.

The MID Factor Scales Graph

Figure 23. The MID Factor Scales Line Graph



The *MID Factor Scales* are based on a large (N = 1,359) factor analysis of the MID's 168 dissociation items. That factor analysis identified 12 'first-order' factors (symptoms). Hierarchical factor analysis of the 12 first-order factors extracted a single 'second-order' factor: Dissociation.

The MID *Factor Scales Graph* reports mean scores for each of the 12 first-order factors. (In this case, because dissociation cannot be measured directly, as it has many facets, Dell conceptualized factors that would allow dissociation to be measured indirectly. These indirect means are the 12 categories of symptoms derived through statistical analysis of test-takers' responses to MID items.) The PTSD profile on this graph is for PTSD patients who are not dissociative.

The MID BPD-DID Comparison Graphs

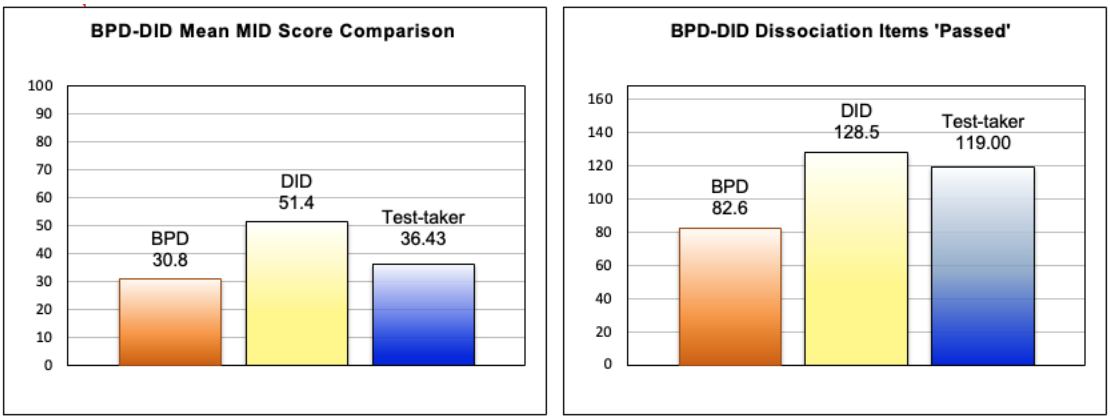
The *BPD-DID Comparison Graphs*, four in all, were a new addition to *MID Analysis* as of version 5.0. These graphs compile results from a study published by Laddis, Dell, and Korzekwa (2017), which compared the MID results of 100 persons diagnosed with Borderline Personality Disorder (BPD) and 75 persons diagnosed with Dissociative Identity Disorder (DID), with the intention of identifying overlaps and differences between the symptoms of these two populations—and, to further clarify the ongoing question of whether BPD can (or should) be classified as a dissociative disorder based on the existing diagnostic criteria. Although the sample sizes are significantly smaller than those that the MID norms are based upon, the potential value of making this data available to clinicians and researchers, in this format, was a compelling enough reason to include it. (That said, it is worth taking into account the caveats noted by the authors, and for those we will refer you to the *Limitations* section of the aforementioned study.) While a full discussion of the paper is beyond the scope of this manual, we highly recommend referencing the section of this manual discussing the differential diagnosis of BPD and the article as a companion for understanding the data for the diagnostic populations delineated in the *BPD-DID Comparison Graphs.*

BPD-DID Mean MID Score Comparison **and** *Dissociation Items 'Passed' Graphs*

These graphs, respectively, compare the test-taker's Mean MID Score and the number of the MID's 168 dissociation items passed to the 2017 study's sample of persons with DID (n=75) and BPD (n=100). These graphs appear at the top third of the same page on which the *BPD-DID Mean Score Comparison Graph* is displayed.

CONTINUED ON NEXT PAGE

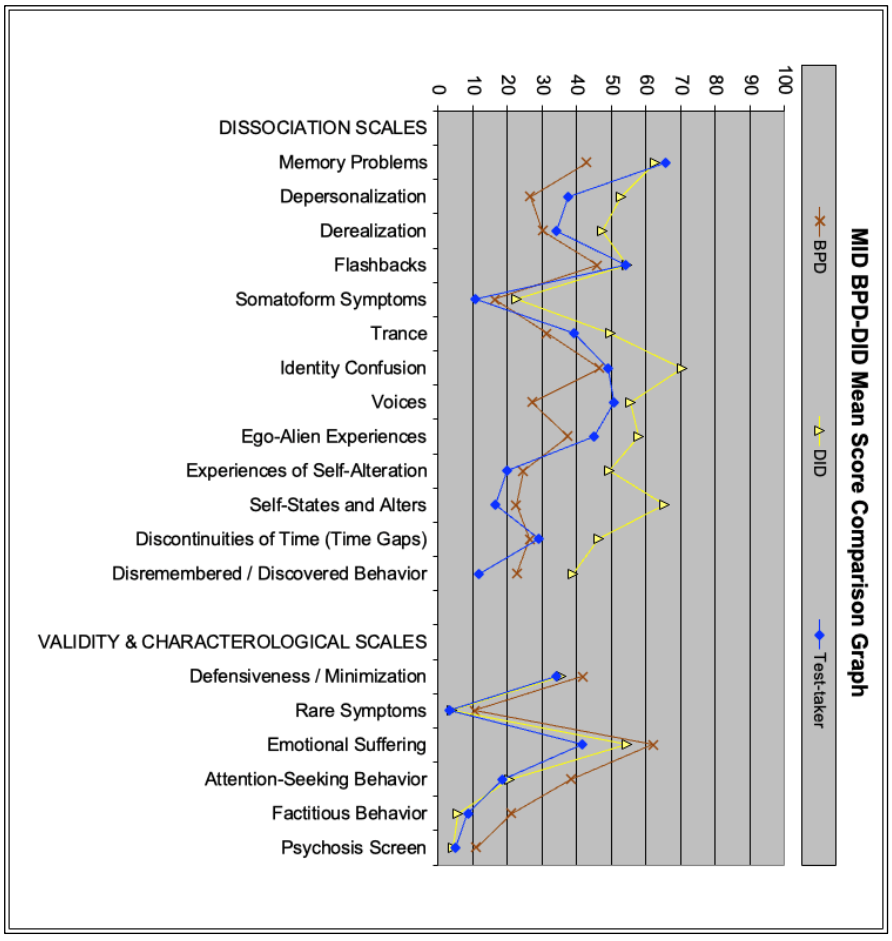
Figure 24. BPD-DID Mean MID Score Comparison and Dissociation Items 'Passed' Graphs



The MID BPD-DID Mean Score Comparison Graph

Relying upon the same sample as noted above, the *BPD-DID Mean Score Comparison Graph* looks at the test-taker's mean ("average of how much of the time") scores on thirteen core dissociation scales—you can actually see these listed, with all the raw data, on the Calculations tab—as well as on select *Validity (and Characterological) Scales*.

Figure 25. The MID BPD-DID Mean Score Comparison Graph

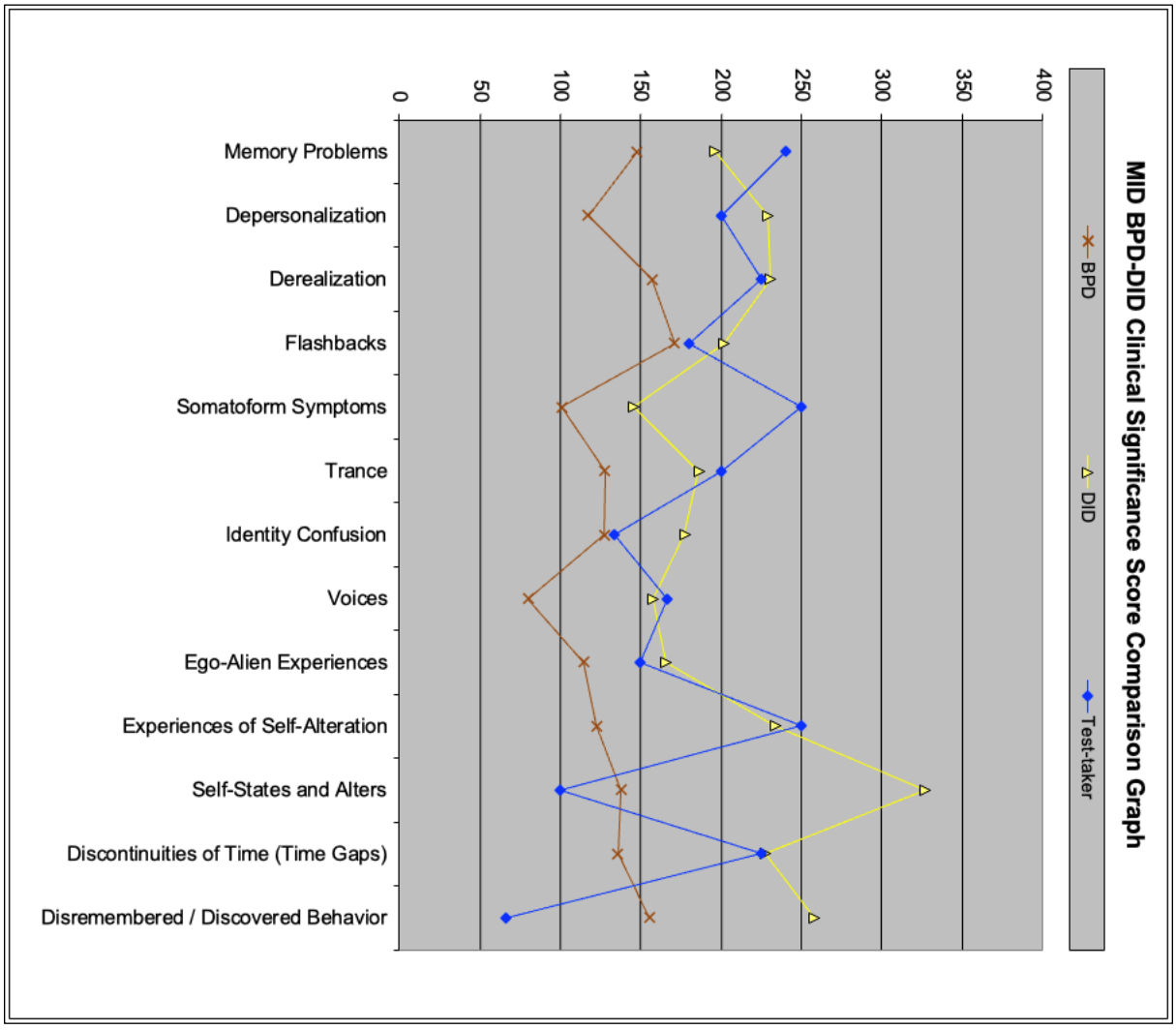


The MID BPD-DID Clinical Significance Score Comparison Graph

Although we've noted elsewhere that Clinical Significance scores are reserved for the 23 Criterion A, B, and C symptoms, it is actually possible to measure clinical significance (i.e., whether a symptom is present) for other scales—particularly, in this case, when we are looking at another diagnostic group: Persons with BPD, when compared to persons with DID, in an attempt to identify overlaps and differences between the dissociative experiences of those two populations.

So, the *BPD-DID Clinical Significance Score Comparison Graph* (*Figure 26*, below) superimposes the test-taker's clinical significance scores for thirteen core MID dissociative scales upon those of persons in the 2017 study with DID and BPD, respectively.

Figure 26. The MID BPD-DID Clinical Significance Score Comparison Graph



Part IV: MID-informed Treatment Planning

The *MID Report* provides a diagnostic impression which the clinician may consider clinically. Most of the time, the MID's diagnostic impression is valid. As discussed above, MID scores of less than 20 are usually insignificant for dissociative disorders, unless accompanied by high *Defensiveness* and/or contrasting qualitative data.

A follow-up interview must always be conducted after administering and scoring the MID in clinical settings; this will greatly aid the clinician in understanding the subjective nature of this particular test-taker's experience, clarify diagnostic impressions offered in *The MID Report*, and guide the clinician in choosing appropriate approaches to treatment.

The Follow-up Interview

To prepare for the clinician-directed, follow-up interview clinicians will score the MID using the *MID Analysis*, study *The MID Report*, *The Extended MID Report*, and *Graphs* to identify areas where clarification and collection of qualitative data are needed. Usually, the follow-up interview will occur at the session following administration of the MID. The following is a guide to this process for clinicians to adapt to their settings as they see fit.

1. In first review of *The MID Report* and *The Extended MID Report*, take note of observations and results that are:
    - Surprising based on prior knowledge of the person; and
    - Congruent with information already known about the person.

Identifying several items or scales from each vantage point will set the tone for the follow-up interview and determine how the MID relates to previous conceptualization of the person's presenting symptoms and issues. If dissociative symptoms have been previously identified, inquiry may be made as to how an item relates to information identified in prior sessions.

2. Second, scan *The MID Report* (and graphs, if you prefer), to identify elevated scales that are often essential to differential diagnosis. Carefully review any items the person endorsed which may be of immediate concern, such as those within:

    - *Validity and Characterological Scales* – identifying possible response bias and characterological traits
    - *First-Rank Symptoms* – endorsed experiences of internal parts activity
    - *Psychosis Screen* – identifying possible areas of reality-testing and differential diagnosis
    - *Critical Item Score* – areas of present and/or past safety concern
    - *Persecutor Parts Scale* – endorsed experiences that may thwart awareness, endorsement of MID items, and/or progress in therapy

- *Amnesia Scales (Criterion C)* plus *Criterion B9 (Temporary Loss of Knowledge)* – crucial to determining whether the test-taker meets criteria for DID, specifically, and appropriate next steps for treatment

3. Third, consider reviewing items within highly endorsed scales, scales just above or below clinical significance or "passing," and items which were endorsed by the person but at an item score slightly less than the cutoff score. Asking about these items will clarify many presentations yielding more than one MID-generated diagnostic impression.

   Qualitative data is then elicited by asking questions such as:

   "What did you have in mind when you said that?" or

   "Can you give me an example of this, in your experience?"

Clinician knowledge of the phenomenological definition of dissociation and the definitions of the 23 symptom features measured by the MID (refer to Appendix V) is critical to determine whether the person's descriptions of their experience fit with the nature/definition of the symptom.

The Phenomenological Definition of Dissociation

"*The phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive functioning and sense of self."* (Dell, 2009; p. 226)

For example, when following up on the items within *Criterion C*, does the person have the experience of DISCOVERING, or a jarring intrusion (as per definition above)? If yes, then their qualitative experience likely matches what that item was intending to measure. If not, and instead they describe a foggy awareness or willful unknowing of an experience, then consider whether that experience might better fit the definition of depersonalization, derealization, or characterological features.

Rescoring after the follow-up interview is not necessary unless several items are identified to be endorsed at significantly higher/lower frequency than originally reported. S*ignificantly* means either that 1) the revised/corrected response for a *lower-scored* item changes to be equal to or *greater than* the cutoff value for that item (as shown in *The Extended MID Report*), or 2) the revised/corrected response for a *higher-scored* item changes to be *less* than the cutoff value for that item. In other words, the clinical significance for the item needs to change to warrant updating the **Questions** worksheet tab with this new data.

Differential Diagnosis

Symptoms of a number of psychological and medical presentations may be comorbid, conflated, or confused with symptoms of dissociation. The follow-up interview will help to determine whether or not the MID items and symptoms endorsed by test-takers best meet the criteria for a

dissociative disorder, if another frame or diagnosis better explains their symptoms, or if the test-taker may both meet criteria for dissociative disorder and experience a comorbid diagnosis. Based upon the experience of the authors administering and consulting on the results of hundreds of MIDs, the most common areas of differential diagnosis are discussed below.

Simpler Differential Diagnosis

Determining which of the trauma-related diagnostic categories best fits the clinical presentation, MID results and other factors presented by the test-taker is a common clinical consideration. For a full explanation of how the MID Diagnostic Impressions and Observations are calculated, review the above section on *Diagnostic Impressions* or the Calculations tab of the *MID Analysis*.

Posttraumatic Stress

The line of the diagnostic impressions offered by the *MID Report* states whether the test-taker's scores met criteria for posttraumatic stress. Largely, the impressions offered here are dependent upon whether the test-taker endorses items in the *Flashbacks* scale at a clinically significant level. Possible impressions offered within this field and what they mean are as follows:

Diagnostic Impression	**What this means...**
Criterion not met for Posttraumatic Stress Disorder; review Criterion A and B symptoms to rule out Complex PTSD.	Items within the *Flashbacks* scale were not endorsed at a clinically significant level.
Posttraumatic Stress Disorder	Items within the *Flashbacks* scale were endorsed at a clinically significant level.
Posttraumatic Stress Disorder, Dissociative Sub-type	Items within the *Flashbacks* scale, and *Depersonalization* and/or *Derealization* scales were endorsed at a clinically significant level.

A diagnostic impression for "Explicit Post-traumatic Stress" will be offered regardless of whether the test-taker's scores also 'pass' clinical significance for a dissociative disorder.

For differential diagnosis, consider:

1. The time of onset for 'passing' items (especially Criterion A symptom scales)
    - The MID does not assess directly for Acute Stress Disorder or Peritraumatic Dissociation because no timeframe of experience is given in the instructions.
2. If the symptoms (in Criterion A, as well as Criterion B and C) have occurred at a clinically significant levels ONLY since an identifiable time or event, Acute Stress, PTSD, or PTSD, Dissociative Subtype may be the most appropriate diagnosis

Peritraumatic Dissociation

Peritraumatic dissociation is a relatively new term in the literature referring to dissociative symptoms that arise during and/or persist following a presumably traumatic experience. DSM-5 refers to peritraumatic factors in the discussion of *Risk and Prognostic Factors* of Posttraumatic Stress Disorder, and identifies "dissociation, fear, panic, and other peritraumatic responses that occur during the trauma and persist afterward are risk factors" for developing PTSD (American Psychiatric Association, 2022, p. 310).

Differential Diagnosis Tips

Timing of onset of symptoms is a key differentiating factor. If a test-taker presents with clinically significant dissociative symptoms (in particular, symptoms in *Criterion C*), and reports recent traumatic experience, the clinician can seek clarity by asking:

> "When was the first time you experienced this?" or
>
> "Did you ever have this experience before (the recent incident)?"

When a pronounced change in functioning is evident following a traumatic experience, and/or the test-taker and corroborating information suggest that key symptoms emerged only after a relatively recent incident (i.e., symptoms are not intermittent over a longer period of time or chronic), this may build a case for diagnosis and treatment of acute traumatic symptoms rather than a dissociative disorder.

It is possible that someone may experience an 'acute trauma load' on top of a dissociative personality structure. Knowing the person's trauma and symptom history (and your scope of competency) will help to determine whether it is safe to do trauma resolution work.

Dissociative Disorders

When a test-taker's responses meet criteria for a dissociative disorder, the clinician must consider the person's history and other factors such as indications of response bias to determine whether the person indeed meets criteria for the given diagnosis, or another diagnosis fits better. The possible diagnostic impression offered within this field are as follows:

Diagnostic Impression	What this means…
Other Specified Dissociative Disorder, Criterion 1 (OSDD-1, Type 1a)	At least 9 of 23 symptoms were passed, including at least 1 amnesia symptom (Criterion C)
Other Specified Dissociative Disorder, Criterion 1 (OSDD-1, Type 1b)	At least 9 symptoms across Criterion A (>3) and B (>4) symptoms, and no Criterion C symptoms, were passed
Unspecified Dissociative Disorder	More than 5 but less than 9 of the 23 symptoms were passed
Dissociative Identity Disorder	At least 4 of 6 Criterion A symptoms, 6 of 11 Criterion B symptoms, and 2 of 6 Criterion C symptoms (or Criterion B9 plus 1 Criterion C symptom) were passed.

For differential diagnosis, consider:

1. Has experience of pathological dissociation that fits with phenomenological definition been substantiated?
    - Consider Validity, Characterological, and *'I Have DID'* scales – could response-bias be producing this diagnostic impression?
    - In the follow-up interview, did qualitative data offered by the test-taker confirm presence of pathological dissociation?
    - Does this collective data indicate that the severity of pathological dissociation experienced by the test-taker may be greater or less than the diagnostic impression offered?
2. Proceed to evaluate which Dissociative Disorder fits best, or if (other) explanations for symptoms or signs of malingering are present.

Nondissociative or Deferred

Sometimes, the diagnostic impression offered in the "Pathological Dissociation" line of the *MID Report* is less definitive; we call these the grey areas. One of these diagnostic impressions may be offered when the test-taker is highly defended and/or has low awareness of their symptoms.

The possible diagnostic impressions offered within this field are as follows:

Diagnostic Impression	**What this means…**
Nondissociative (see below for qualifying indications)	Insufficient evidence. Less than 3 of the 23 dissociative symptoms were passed.
Nondissociative, but with evidence of some clinically relevant self-state activity	Less than 3 symptoms passed, with 1 or more Criterion B symptoms passed.
Dissociative diagnosis deferred (insufficient criteria met)	3 to 5 symptoms passed. Some evidence of dissociative features in Criterion B, Criterion C, or both.
Dissociative diagnosis deferred; closely evaluate Criterion A and B symptomology	More than 2 and less than 11 symptoms passed. No symptoms of amnesia (B9 and Criterion C) were passed.

For differential diagnosis, consider:

1. Is any indication of pathological dissociation present?
    - Consider Defensiveness Scale, Characterological Scales, and 'Persecutor Parts/Voices' Scales. Could response-bias be producing this diagnostic impression?
    - In the follow-up interview, did inquiry into any Amnesia items (Criterion B9 and Criterion C) endorsed by the test-taker indicate pathological dissociation?

    - Does this collective data indicate that the severity of pathological dissociation experienced by the test-taker may be greater or less than the diagnostic impression offered?
2. Proceed to evaluate whether the diagnosis of a dissociative disorder or posttraumatic stress fits best, or if (other) explanations for symptoms are present.

Complex Differential Diagnosis

The presentations and diagnostic categories that follow may be comorbid, conflated, or confused with symptoms of dissociation. The follow-up interview will always help to determine whether or not the MID items and symptoms endorsed by test-takers meet criteria for a dissociative disorder.

Attention Deficit-Hyperactivity Disorder (ADHD)

Persons experiencing symptoms of ADHD commonly report memory problems and other experiences that could also be dissociative symptoms. When a history of trauma and/or treatment failures are also present, differentiating between potentially comorbid presentations can be necessary. Possible differentiating factors include:

- Has the person participated in treatment for ADHD (meds, therapy, etc.)? If so, was this treatment effective? What symptoms changed?
- Was there a time of onset? When did the test-taker became aware of symptoms?
- Does the person also have a history of childhood and/or developmental trauma?
- What happens when they are calm? Are there signs of dissociative phobias?

Differential Diagnosis Tips

1. Evaluate the Defensiveness/Minimization and Cognitive Distraction Scales. We would expect that a test-taker with ADHD would score low and high respectively.
2. Inquire about Criterion B and Parts Scales. Can these experiences be explained by emotional impulsivity, etc.?
3. Follow-up on Memory Problems, Temporary Loss of Knowledge, and Criterion C items passed. Can these experiences be explained by ADHD?

Autism Spectrum Disorders (ASD)

Perhaps due to increasing awareness (general and social media-based) of both ASD and pathological dissociation, we have seen this differential diagnosis question arise more frequently. Possible confounding and differentiating factors between persons with ASD and those experiencing pathological dissociation:

- Both tend to have vivid *internal experiences* or disruptions in their connection with self or environment; however, persons with ASD are not known to have a high *autohypnotic capacity* (autohypnotic model of explanation for DID (Dell, 2017; 2019)).
- Both may experience *intrusions into executive functioning and sense of self*; trauma could heighten difficulties interpreting social cues, repetitive patterns, inflexible routines, etc., which may be carefully differentiated from *dissociative phobias*.

- Both may endorse jarring discoveries or lapses in *memory*; however, for the person with ASD, this may be attributed to absorption or surprise (e.g., it's not exactly how I remember).

Differential Diagnosis Tips

1. Evaluate your qualifications for assessing whether the test-taker's experience fit the criteria for ASD. If not, focus on discerning whether pathological dissociation is present.
2. Review *Criterion A* symptom scales, in particular *Depersonalization, Derealization,* and *Trance.* What experiences are endorsed? Ask for examples in the follow-up interview.
3. Review *Criterion B* symptom scales. Follow up on approximately 1 item per scale, asking additional questions such as "when does this happen for you?" and "what is your explanation for this experience?"
4. Follow-up on *Criterion C* items endorsed. Do the experiences described fit the phenomenological definition of dissociation?

If the test-taker has not already been professionally diagnosed with ASD, and you remain unsure whether they (also) experience pathological dissociation, consider making a referral.

Bipolar Disorder

In dissociative disorders, mood symptoms may be compartmentalized in specific self-states, and experienced by the test-taker as intrusive or puzzling. Rapidly shifting mood states do not often meet DSM criteria for an affective disorder; some have observed that "it seems most helpful to conceptualize affective symptoms in (DID) as a manifestation of a secondary affective disorder" (Loewenstein, 1991, p. 601). The follow-up interview will be helpful in clarifying whether the test-taker's experience matches the phenomenological definition of dissociation. Additional differentiating factors include:

- Has the person participated in treatment for Bipolar Disorder (meds, therapy, etc.)? If so, did they have the expected response to medication(s)?
- Was there a clear time of onset? Does the person also have a history of trauma?
- What is the pattern of mood shifts? Are they sudden or gradual? Are 'episodes' lengthy or sometimes less than 1 day long?

Differential Diagnosis Steps:

1. Evaluate *Rare Symptoms / Psychosis Screen*, and *Critical Item* scales, following up on any items endorsed. How are these experiences explained?
2. Follow-up on *Criterion B* and *Schneiderian First-Rank Symptom* scales that begin with 'Made…' Could these experiences be intrusions of parts, or are they fully explained by Bipolar Disorder?
3. Did any experiences associated with endorsed *Criterion C/Amnesia* occur outside the times attributed to severe episodes of mania or depression?

Borderline Personality Disorder (BPD)

Features of BPD commonly appear to coincide with dissociative experiences, so much so that BPD has its own space on the MID Report – both in the *Validity and Characterological Scales* and *Diagnostic Impressions* sections. In *MID Analysis v5.0,* four line and bar graphs were added to illustrate the data reflected in a study utilizing the MID comparing persons with BPD and DID across 13 core MID dissociation scales and a selection of relevant *Validity (and Characterological) Scales* (Laddis, Dell, & Korzekwa, 2017). These are titled:

- *BPD-DID Mean MID Score Comparison,*
- *BPD-DID Dissociation Items 'Passed,'*
- *BPD-DID Mean Score Comparison Scales Graph, and*
- *MID BPD-DID Clinical Significance Score Comparison Graph.*

As illustrated by this data, test-takers who present with BPD tend to endorse MID items more highly in general and pass significantly more dissociation items on the MID than test-takers who present with DID. Clinicians who commonly face the comorbid or differential diagnosis intersection of DID and BPD are encouraged to obtain and read that article in its entirety.

Similarly, Sar et al., (2017b) found that individuals with dissociative disorders tended to under-report experiences of identity alteration compared to individuals with BPD, even when they happen in the presence of the clinician, possibly due to amnesia for those experiences. While instruments other than the MID were used in these studies, Sar and colleagues also offer data that may inform and interpret data gathered in the follow-up interview when attempting to differentiate between dissociative disorders and BPD features (Sar et al., 2017a).

Predictors of DID vs. BPD symptoms

While both individuals with BPD tend to endorse dissociative experiences quite highly, Laddis, Dell & Korzekwa (2017) identified that BPD-like dissociative experiences appeared to be stress-driven, non-defensive disintegration of affective and cognitive functioning, and involve mechanisms of defensive distancing or detachment. In contrast, shifts between or intrusions of dissociative self-states/parts accounted for the generation of most dissociative experiences in individuals with DID.

Differential Diagnosis Tips

1. Are the *BPD Index* and other *Validity and Characterological Scales* elevated relative to the *Mean MID Score*?
2. When following up on items endorsed in *Criterion B, Self-State and Schneiderian First-Rank Symptom Scales,* does the test-taker seem aware of experiences of self-alteration?
3. Experiences of amnesia in particular have been found to differ between individuals who have DID and those who have BPD.

- In dissociative amnesia (including DID), the memory is present while the awareness of it is not present – (except for intrusions into executive functioning and sense of self). Memory problems in the present are precipitated primarily by intrusions into executive functioning by self-states.
- In 'amnesia' particular to BPD, both the memory and the awareness of the memory may be absent via a mechanism called 'absorptive detachment.' This absorptive state can be void of content (e.g., thinking about nothing), and can leave a person with irreversible memory gaps in both past and present (Allen, Console & Lewis, 1999; Laddis, Dell & Korzekwa, 2017).
- Follow-up on *Criterion C/Amnesia* items endorsed, especially items including the words 'suddenly' and 'discovering.' Does the qualitative data offered match the phenomenological definition of dissociation, or is the test-taker's experience described as 'blank,' 'fuzzy,' or 'zoned out'?

4. According to Sar et al., (2017b), self-report of identity alteration has been associated with BPD, while clinician-observed identity alteration (of which the subject was not aware) represented was representative of a dissociative disorder/condition. Self-report of identity alteration was also found to most clearly differentiate the BPD-only group from the control group.

If the BPD Index is elevated, and none of the above seems to fit the presentation of the test-taker, the scores may reflect covert aspects of self-system functioning rather than overt behavioral traits. Said differently, there may be a borderline dynamic between/among parts of self.

Culturally and Spiritually-oriented Experiences

The psychological community has long struggled to differentiate between phenomenon related to cultural and spiritual experiences, and psychological diagnoses. For a specific example, DSM-5 and DSM-5-TR address spirit possession as a potential symptom feature of DID (especially within Culture Related Diagnostic Issues of DID) and within criterion for OSDD-1 (APA, 2013; APA, 2022), whereas DSM-IV included and ICD-11 includes a distinct category of Possession/Trance Phenomena (APA, 2000) or Disorder (WHO, 2018). One item on the MID, in the *Rare Symptom Scale*, asks about such experience directly:

> Item 167: Going into trance and being possessed by a spirit or demon.

Test-takers may present with culturally and/or spiritually-oriented explanations for their experiences, and may or may not also endorse MID items on a level that meets criteria for a dissociative disorder.

Differential Diagnosis Tips

Mental health professionals are not often qualified to fully assess spiritual and cultural phenomenon; however, clinicians can inquire in ways that may lend clarity to whether or how to take the test-taker's experience into account in diagnosis and treatment planning. When

individuals endorse Item 167 and/or refer to internal states from a cultural or spiritual frame, the following considerations may be helpful:

1. Does the person identify a timing of onset of this experience? What social and relational factors coincide(d) with the experience?
2. How does the person conceptualize this experience within their spiritual, religious, or cultural perspective? Is it considered pathological (negative) or non-pathological (neutral or positive)?
3. Are the experiences described congruent with the phenomenological definition of dissociation?
4. Without the features which the person attributes to cultural or spiritual factors, do they meet criteria for a dissociative disorder or another psychological diagnosis?

Dementia and Other Neurological Conditions

It is important to rule out organic causes to symptoms that could also be viewed as pathological dissociation. In addition to ensuring that the individual seeks or has sought testing and/or treatment to rule out organic causes, consider the following:

- Inquire regarding timing of symptom onset when conducting the follow-up interview. It is very unusual for a middle-aged person to suddenly develop symptoms which meet full criteria for a dissociative disorder.
- Be alert to odd clusters of symptoms, and symptoms that do not fit with the person's history (even after verifying with loved ones or past medical records).

Psychogenic Non-Epileptic Seizures

Persons presenting with this medical diagnosis are likely to endorse experiences of somatoform dissociation, and such test-takers may yield a MID Diagnostic Impression of Functional Neurological Symptom Disorder. Interestingly, ICD-11 refers to this cluster of symptoms as 'Dissociative Neurological Symptom Disorder' (WHO, 2018). In this case, the question is not so much whether the person experiences symptoms of dissociation, but rather to what extent, and what approach to treatment may be most appropriate.

Differential Diagnosis Tips

Clarity in areas of diagnosis and treatment may be gained by exploring several areas of the MID report, and considering the following questions in the process of interpreting the MID Report and conducting the follow-up interview.

1. When did the symptoms begin? Could they be peritraumatic, or are they part of a more chronic pattern?
2. Do the *Validity Scales* indicate any tendency toward over-reporting or under-reporting of normal or unusual experience?
3. What *Criterion B and C* symptoms does the test-taker endorse? How about the *Self-State Activity Scales* and *Schneiderian First-Rank Symptoms*?

4. Does the person experience amnesia for/related to these symptoms?

Psychosis

Historically, dissociative symptoms have been mistaken for psychotic features by clinicians and diagnosticians, and sometimes by persons themselves. Remember, 13 MID items involve voice-hearing, and the Schneiderian First-Rank symptoms include 8 (of 11) features of schizophrenia (Schneider, 1959) that have been observed to occur in persons with a severe dissociative disorder. Individuals who are aware and concerned about how they may be perceived may deny experiencing any/all voice-hearing items. Dissociation is often about hiding and acting 'normal.' For a recent comprehensive analysis of this issue and how to distinguish between kinds of voice-hearing, consider reading a recent article by Shinn et al. (2020).

Differential diagnosis tips:

1. Follow-up on any endorsed *Psychosis Screen* and *Rare Symptom* items. Does the qualitative data offered match the phenomenological definition of dissociation, or are there signs of impaired reality testing?
2. Consider items endorsed within the *Schneiderian First-Rank Symptoms*, *Child Voices*, *Voices/Internal Struggle*, and *Persecutory Voices* scales.
3. Notice whether *Criterion C*/Amnesia items are also endorsed. Does the test-taker's experience fit the phenomenological definition of dissociation?
4. Consider reading this article:
   Shinn, A. K., Wolff, J. D., Hwang, M., Lebois, L., Robinson, M. A., Winternitz, S. R., Öngür, D., Ressler, K. J., & Kaufman, M. L. (2020). Assessing voice hearing in trauma spectrum disorders: A comparison of two measures and a review of the literature. *Frontiers in psychiatry, 10*, 1011.

Substance Abuse Sequalae

Memory loss and experiences of 'coming to' are common to the experience of persons using and abusing various substances. Despite the initial instructions excluding experiences involving the influence of alcohol or drugs, some test-takers forget this, and many identify with experiences listed in *Criterion B and C* as a result of recent or past substance abuse.

Differential Diagnosis Tips

As with other areas, timing and context of the experiences reflected by the MID results is essential to differential diagnosis. Questions to ask during the follow-up interview to clarify diagnostic symptom features include:

> "Have you ever experienced this at a time when you were <u>not</u> under the influence of alcohol or drugs?" or
>
> "Have you had this experience since gaining sobriety?"

Other individuals may not endorse MID items (potentially yielding a false negative) because they have developed a different language for describing their symptoms. For instance, someone

who has been in 12-step recovery may label experiences related to items listed within the *Intrusive Impulses*, or *Thought Insertion* scales as "stinkin' thinkin,'" and thus may not identify with MID items as written. Inquiry into qualitative data as described above may clarify whether or not such experiences match the phenomenological definition of dissociation.

Traumatic Brain Injury

When presence of a head injury is known, it is essential to differentiate as much as possible between symptoms that are a direct result of the injury, and symptoms that predated the injury or reflect psychological or physiological sequelae related to the incident when the injury occurred.

Differential Diagnosis Tips

As with other areas, timing and context of the experiences reflected by the MID results is essential to differential diagnosis. Questions to ask during the follow-up interview to clarify diagnostic symptom features include:

1. What was the nature of the head injury, and have this person's post-head injury symptoms been, versus their functioning prior to the first and any subsequent head injuries?
2. What area(s) of the brain have the head injuries directly impacted?
3. Has a brain scan taken place to determine organic or observable damage? Has a neurologist been able to identify that this person has problems with working/short-term memory that are specifically organic in nature (i.e., related to the head injuries)?
4. Does this person have any history of early, chronic attachment injury, neglect, and/or abuse?
5. Does this person have any history of chronic substance misuse or adverse reactions to prescribed medications?
6. Do the person's loved ones/coworkers view this as being how they have always been, or is this viewed as something that changed since the injury?

Odd cluster of symptoms are observed to be common to TBI. Measuring the test-taker's experience against the phenomenological definition of dissociation, timing of onset, information received from medical professionals, and the person's response to prior treatment often offer clarity.

Transgender Identity & Gender Fluidity

The question of gender identity, including evolving identity, in terms of the MID is a complex one (See also: Different Gender Parts Scale). It is of value in differentiating between gender-related and trauma-related experiences to return to Dell's definition of pathological dissociation to ask yourself:

Are the test-taker's experiences recurrent, jarring, and intrusive?

If not, then it is ethical to avoid labeling as dissociative the person's evolving experience of, or experimentation with, gender identity. It is POSSIBLE that, in some instances, a person could be intentionally seeking a dissociative diagnosis (See Characterological and Legal Factors).

Characterological and Legal Factors

False Negatives & False Positives

When test-takers have developed a view of themselves and their symptoms from the perspective of a particular diagnostic lens, there may be a risk of a "false negative" due to low endorsement of MID items without other indications of response bias (e.g., *Defensiveness/Minimization*). Conversely, other test-takers may be invested in a specific outcome on the MID: Dissociative Identity Disorder; this can lead to a "false positive" diagnostic impression.

Factitious Presentations & Malingering

False-positive presentations of dissociative disorders have occurred over time, and seem to be increasing in recent years (Pietkiewicz et al., 2021). False-positive diagnostic impressions on the MID may be a result of factitious or malingered presentations. Factitious Disorder Imposed on Self (APA, 2022) refers to intentional falsification of physical or psychological symptoms, where the individual may present themselves to others as ill, impaired, or injured, regardless of obvious external rewards. Malingering, by contrast, refers to "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives…" (APA, 2022, p. 835).

Common traits of test-takers who may yield a factitious presentation and a false positive MID diagnostic impression include:

- The client arrives to treatment already knowing about DID and specifically seeking that diagnosis. It is not typical in these instances for someone to try to simulate or be diagnosed with OSDD or any of the other dissociative or post-traumatic disorders—it's always DID;
- A fair bit of time spent on the Internet, using social media;
- A lack of obvious trauma exposure markers/traits;
- No evident lack of co-conscious awareness amongst self-states, with the aspect of self who 'fronts' insisting they know all their parts;
- No evidence of dissociative/traumatic phobias of any kind; and
- A distinctly 'performative' aspect to the client's presentation, with a notable need for validation of the diagnosis of DID.

On the MID Report, common scale and scores associated with factitious presentations include:
Validity and Characterological Scales – Very low *Defensiveness*, higher '*Ten Count*,' and sometimes elevation in other *Characterological Scales*.

Pathological Dissociation Scales – '*I Have DID*' is significantly higher than '*I Have Parts*' scale score.
Criterion A symptom scales – The test-taker may describe experiences of depersonalization and derealization that do not align with how research demonstrates that people actually experience these symptoms.
Criterion B symptom scales – There may be contradiction re: the *Puzzlement about Oneself* scale in relation to other *Criterion B* scales, with no evident lack of co-conscious awareness amongst self-states, and the aspect of self who 'fronts' insisting they know all their parts. High elevation of *Temporary Loss of Knowledge*.
Criterion C – Scores may be unusually high (when compared to statistical norms) on most (or all) amnesia scales.

- In the follow-up interview, the client will be unable to offer up any actual evidence of amnesia
- The client also may insist they always know what's happening for them, as though they are actually depersonalized rather than amnestic.

Malingered presentations may present similarly as outlined above. In either case, persons seeking a diagnosis of DID without experiencing its symptoms often cannot substantiate their reporting, because they do not have lived experience of it. Although amnesia may be endorsed, any clinician who knows what it looks like, how it can manifest, etc., can discern its absence. For more on this topic, see Kluft (1987b) and Pietkiewicz et al. (2021).

Common Challenges

Several scenarios yielding complicated or confusing MID results have repeatedly surfaced:

- *Test-taker asks to clarify multiple items, asking essentially "what does this mean?"* Clinicians may clarify that the items are intended to be interpreted literally, and if the person identifies with the subjective experience indicated, they may answer according to the original instructions. If they do not clearly identify with the subjective experience indicated, the answer is '0.'
- *Test-taker writes many qualifying notes surrounding MID items, answers/notes given do not match the items as they are written, and/or the person brings their own meaning to the item wording.* A test-taker such as this is likely to be an "atypical responder," highly defended, and may or may not experience a dissociative disorder. A careful and thorough follow-up interview is particularly important for these cases.
- *Test-taker answers '0' and the clinician suspects defensiveness or a dissociative component to this answer.* Reviewing other items within the same scale (see *Extended MID Report*) and/or following up again at a later session may be helpful. Corroboration via collateral contacts (when possible and authorized by the test-taker) may also provide clarification.

- *Many items are endorsed highly ('6'-'10'), resulting in the test-takers results meeting clinical significance for nearly every symptom and diagnostic threshold.* Consider what this response pattern might be illustrating, alongside the response pattern in the Validity Scales. For example, are the *Emotional Suffering* and *Attention-Seeking Behavior* scales elevated while the *Rare Symptoms* and *Factitious Behavior* scores are relatively low? This response pattern is common in test-takers who have experienced multiple treatment failures and may feel a desperate need to be understood and helped, and results are likely to be inflated but valid. If the scores of the *Rare Symptoms* and *Factitious Behavior* scales also quite elevated, the validity of other responses and therefore diagnostic impressions may be called into question.

Additionally, atypical responders may present severe characterological traits (falsifying), confused or psychotic, loose cognitive style or as "me, too" people (Dell, 2011). Such responders will likely offer atypical MID results; however, a careful examination of responses through the lens of the validity observations offered may still offer clues to guide the clinician in further diagnostic and treatment decisions.

Should I share the MID results with the test-taker?

Some clinicians will show a portion of the *MID Report*, a line chart or bar chart to the test-taker. Remember that the MID measures phenomenological experiences of dissociation, and offers the clinician a window into the experience of the test-taker. It is a known phenomenon that individuals, particularly those who have experienced complex traumatization, tend to receive clinician "interpretations" as blaming or shaming (Dalenberg, 2000).

Persons who are learning to understand their symptoms as a dissociative disorder for the first time have many varied responses. Some find it to be a huge relief and validating to their experience, others may present a phobic response. The decision of whether to share MID results of minors (adolescents) with parents/guardians is uniquely multiplex. Use your good clinical judgment here.

Preparing a Report for a Third Party

Sometimes the MID is administered as part of a psychological battery or other circumstance in which a report is to be rendered for a third party. Varying circumstances will influence what information and how much detail is included in such a report, however a general outline of basic areas to include is as follows:

- Why the MID was administered;
- What diagnostic impressions were rendered by the test-taker's scores;
- Any indication of response bias as per the *Validity and Characterological* scales;

- Whether or not the symptom features were substantiated in the follow-up interview; and
- Conclusions (diagnostic or otherwise).

I've never treated someone who has DID before. Now what?

It is essential to carefully consider whether to (continue to) treat the person and pursue consultation and training in treating dissociative disorders, or refer them to someone already trained and experienced in this area. Recall the study regarding prognosis and treatment guidelines as mentioned above (Brand et al., 2016; Kluft, 1985, 2017).

If you have detected and assessed someone who was not previously identified as having a dissociative disorder and you obtain training and consultation to treat them accordingly, their prognosis has already improved significantly! Educating the person on their treatment options and probable prognosis, as well as ensuring careful and ongoing informed consent, is also extremely important. Refer to the *Guidelines for Treating Dissociative Identity Disorder in Adults* (ISSTD, 2011) as a first step.

Retesting to Measure Change

Treatment of dissociative disorders tends to be rather lengthy and complex, which leads some clinicians to use the MID to measure changes in symptom areas and frequency. This may be appropriate at intervals of one (1) year or more, or when other major changes have occurred, such as transition from one clinician to another. However, keep in mind that the MID does not measure daily life functioning capacity or quality; thus, other assessments may better validate such changes.

Appendix I: Revised MID Norms (August 2011)

Scale ***Diagnosis*** *Sample size*	**SCID-D** ***DID*** *n=76*		**SCID-D** ***DDNOS*** *n=40*		***Nonclinical*** *n=510*	
	Mean (SD)	% YES	Mean (SD)	% YES	Mean (SD)	% YES
MID Symptom/Measure						
Defensiveness	35.5 (16.0)	2.6	32.3 (19.0)	2.5	67.3 (17.9)	19.4
Rare Symptoms	4.5 (8.7)	7.8	5.1 (8.2)	7.5	3.2 (8.2)	6.3
Emotional Suffering	54.7 (23.0)	23.3	57.7 (22.9)	30.0	17.1 (16.0)	1.0
Attention-Seeking	20.9 (20.4)	22.0	27.2 (18.2)	32.5	3.8 (13.9)	8.8
Factitious Behavior	6.7 (11.8)	3.9	8.6 (11.5)	7.5	5.5 (9.8)	4.5
BPD Index	12.9 (12.8)	9.1	15.6 (11.0)	15.0	9.3 (10.1)	5.1
Psychotic Screen	4.4 (10.5)	2.6	6.8 (11.7)	7.5	3.4 (9.1)	4.5
Mean MID	51.3 (18.7)		39.0 (19.4)		8.0 (10.9)	
MID Severe	127.9 (32.7)		100.1 (39.2)		25.1 (33.3)	
Dissociative Sx (23)	20.3 (4.4)		16.3 (6.4)		3.6 (6.0)	
"I Have DID"	70.2 (31.1)		36.0 (33.6)		4.4 (13.5)	
"I Have Parts"	62.5 (25.5)		42.8 (25.6)		7.5 (14.0)	
Child Part	59.4 (28.4)		39.1 (23.0)		6.9 (12.6)	
Helper Part	42.3 (35.6)		29.0 (32.7)		10.0 (21.3)	
Angry Part	53.3 (27.1)		38.9 (28.4)		7.2 (13.5)	
Persecutor Part	54.3 (30.1)		42.4 (31.3)		5.1 (13.2)	
Opposite Sex	24.9 (31.9)		10.0 (22.8)		4.2 (14.8)	
Mean Amnesia	41.5 (22.5)		26.7 (22.0)		5.1 (9.3)	
Amnesia items (31)	21.8		14.1		3.2	

MID Clinical Significance* Scores

	DID		DDNOS		Nondissociative	
	Clin. Sig. (SD)	% YES	Clin. Sig. (SD)	% YES	Clin. Sig. (SD)	% YES
MID Symptom						
Memory Problems	195.5 (53.8)	94.7	175.5 (69.4)	85.0	46.5 (57.6)	19.2
Depersonalization	226.6 (69.3)	94.7	187.5 (82.8)	90.0	43.9 (67.1)	17.8
Derealization	229.6 (77.3)	92.1	191.9 (91.7)	87.5	41.8 (77.5)	27.1
Flashbacks	202.1 (58.7)	92.1	165.5 (83.5)		41.8 (61.6)	18.6
Somatoform Symptoms	145.1 (74.6)	79.0	130.6 (81.9)	67.5	41.8 (66.4)	16.1
Trance	186.1 (60.6)	88.2	160.0 (79.5)	77.5	41.9 (55.4)	17.5
Child Voices	240.8 (95.5)	93.4	180.0 (122.4)	77.5	33.3 (72.1)	21.7
Internal Struggle	253.5 (62.6)	97.4	197.5 (88.5)	85.0	48.5 (76.0)	20.6
Persecutory Voices	190.1 (82.5)	86.8	140.0 (95.5)	65.0	22.0 (56.0)	11.4
Speech Insertion	123.7 (45.8)	84.2	91.3 (60.9)	67.5	27.2 (43.0)	14.3
Thought Insertion	144.7 (38.7)	93.4	120.0 (53.8)	70.0	28.1 (45.6)	13.7
Made Emotions	148.4 (37.7)	93.4	117.5 (58.3)	67.5	29.2 (48.5)	13.7
Made Impulses	126.3 (39.6)	86.8	95.0 (51.6)	67.5	23.3 (42.1)	11.9
Made Actions	195.7 (46.1)	96.1	158.1 (64.6)	85.0	40.7 (56.4)	16.1
Loss of Knowledge	187.5 (78.8)	85.5	126.3 (88.4)	62.5	32.3 (58.0)	15.9
Self-Alteration	231.3 (70.0)	96.1	177.5 (74.2)	87.5	43.7 (67.9)	16.9
Self-Puzzlement	231.6 (55.2)	97.4	204.2 (70.5)	90.0	48.7 (71.5)	22.5
Time Loss	165.1 (61.7)	85.5	118.8 (74.0)	70.0	24.2 (46.3)	12.9
Coming to	147.4 (68.3)	81.6	101.3 (76.4)	60.0	22.5 (43.8)	11.0
Fugues	170.4 (88.4)	82.9	102.5 (94.7)	50.0	22.1 (51.8)	10.4
Disremembered Behavior	139.5 (63.4)	86.8	90.0 (71.8)	50.0	22.9 (47.1)	11.0
Finding Objects	127.6 (81.0)	68.4	80.0 (82.3)	50.0	17.3 (41.6)	8.6
Forgotten Behavior	150.0 (84.1)	77.6	87.5 (85.3)	45.0	19.5 (48.4)	8.6

*A score of 100+ is clinically significant (i.e., the symptom is present)

Appendix II: Exporting the MID Analysis

Exporting to Adobe PDF

From the desktop version of MS Excel, these are the steps to export the report as a PDF file:

1) Open *MID Analysis v6.0* and be certain that the desired worksheet tab is highlighted, and that the desired worksheet (MID Report, etc.) is visible.

2) Click 'File' → 'Save As'

3) Under the name of the current file, its format is shown. The format is defaulted to 'Excel Workbook (*.xlsx)'. Click on the down arrow at the far right of this box (just to the left of the 'Save' button), and choose 'PDF (*.pdf)', which appears about three-quarters of the way down.

4) Be certain to choose a folder (and a file name) that can be easily identified once the file has been saved. Click the 'Save' button to the right of the format box. If an Adobe Acrobat/Reader product is installed, it will likely automatically open what was just saved.

5) Highlight either **The MID Report**, **MID Line Graphs**, or **MID Bar Graphs** worksheet tab (or each, in turn, if all are needed).

6) Repeat steps 2) through 5) until all needed worksheets have been exported.

7) Note that if a single, combined PDF file is needed, then it will be necessary to combine the report and graphs using Adobe Acrobat or a similar PDF editing software.

Exporting to Word Processing Software

For those who cannot, for some reason, convert the *MID Report*, etc., to a PDF file, exporting the *MID Report* and *The Extended MID Report*, as well as the *Line* and/or *Bar Graphs* to a word processing program is cumbersome, but possible. The *easiest* way to accomplish this is:

1) Open the word processing program and create a new, blank document (if one is not already created)

2) Open *MID Analysis v6.0* and be certain that the desired worksheet tab is highlighted, and that the desired worksheet (*The MID Report*, etc.) is visible.

3) Select *only* the cells containing the information to copy to the word processing software. Be aware that each page will need to be copied separately in order for the pages to be properly formatted into the word processing document.

[Note: To highlight, (1) place the cursor in the upper left-hand corner of the section to highlight; (2) press the left mouse button or press the trackpad with your thumb; (3) move the cursor to the upper right-hand corner of the cells to be copied; and, (4) move the cursor down the right-hand side of to the end of the cells to be copied.]

4) Release the left mouse button (if applicable).

3) Click ‘Copy’ in the toolbar, or in the right-click menu

4) Switch to the blank document in the word processing program.

5) Click ‘Paste – ‘Paste Special’ in the toolbar, or in the right-click menu

6) Choose ‘Picture (enhanced metafile)’ if navigating via the toolbar, and ‘Picture’ if navigating via the right-click menu

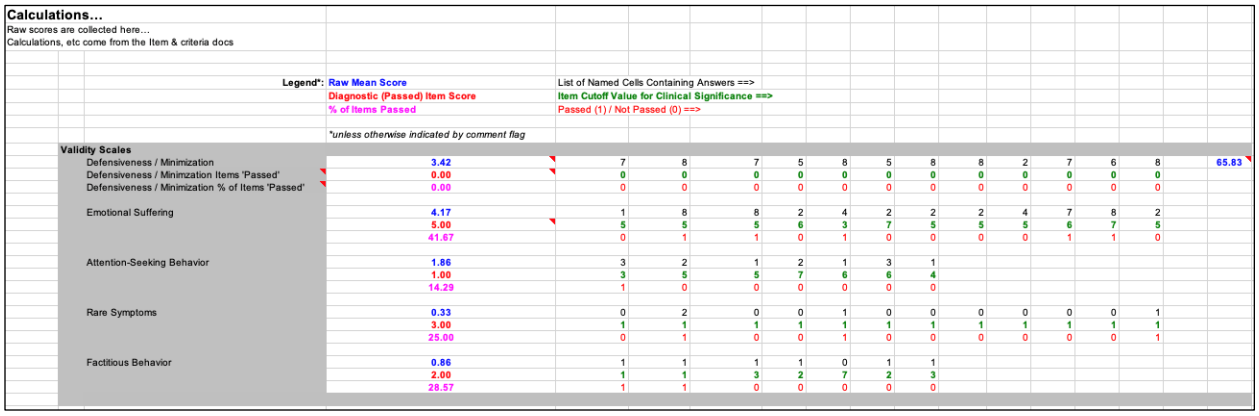
7) Repeat steps 2) through 6) *for each page of each worksheet* to be copied into the word processing document. Follow the same procedure for each page of *The Extended MID Report* and for each graph until you have copied the entire report to your word processing document.

Appendix III: The Calculations Worksheet

The complex data analysis contained in the *Calculations* worksheet forms the basis for virtually all of the information shown (in a more digestible form) in *The MID Report*, *The Extended MID Report*, and the *Line* and *Bar Graphs*. The typical clinician will have little need to consult the *Calculations* worksheet unless they are conducting research, since the data reflected here is raw and abstract. For the curious and interested, however, the *Calculations* worksheet can offer a treasure trove of information, as it contains the exact values of the *MID*'s 74 scales.

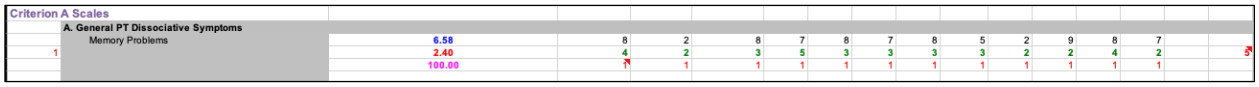
Although an extended discussion of the research applications of the MID and *MID Analysis* is beyond the scope of this manual, it may be helpful, even for the casual consumer, to understand a bit of what all those numbers on the *Calculations* worksheet actually mean—especially when it comes to reading the *Extended MID Report*, which contains some of the specific data contained here. Therefore, the following will go some distance toward 'demystifying' the *Calculations* worksheet.

Figure A1. MID Analysis – Calculations worksheet (top)



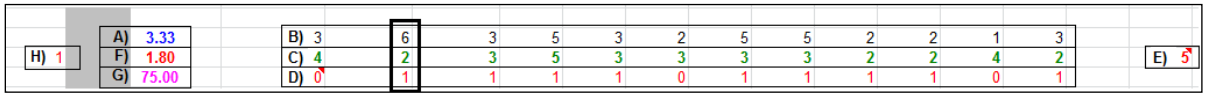
Looking further down the worksheet, the clinician will see, in bolded purple text, *Criterion A Scales*. The following example will refer specifically to *Criterion A: General Posttraumatic Dissociative Symptoms – Memory Problems:*

Figure A2. Criterion A: General Dissociative Symptoms – Memory Problems



Zooming in to look only at the numbers, we see the following:

Figure A3. Criterion A: General Posttraumatic Dissociative Symptoms – Memory Problems (detail)



In the *Figure A3* above, the elements are labeled A) through H):

A) **Mean Value –** Shown in the upper near left above in *Figure A3*, and in bolded blue text on the *Calculations* worksheet, this number is the mean score for all 12 items pertaining to memory problems. *The mean is computed by adding together the test-taker's scores on all 12 items—see* B) Item Score *directly below—and dividing by the number of items for that symptom.*

B) **Item Score –** The 12 *Memory Problems* items, shown directly below A) in *Figure A3* and in plain, unbolded black text on the *Calculations* worksheet. *These numbers correspond with the test-taker's responses for items 2, 24, 67, 78, 79, 90, 102, 122, 134, 143, 154, and 211, and are called directly from the responses entered into the lavender-shaded fields on the* MID Analysis – Questions *worksheet. These items may be reviewed in greater detail in the* Memory Problems *subsection on* The Extended MID Report.

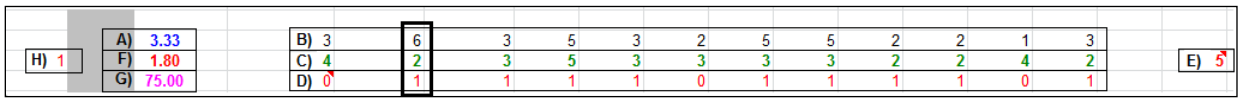
C) **Item Cut-off Score –** For the test-taker's response on a specific item to be considered clinically significant in any way, it must be greater than or equal to this number, as shown directly below B) in *Figure A3* and in bolded green text on the *Calculations* worksheet.

D) **Diagnostic Item Calculation** – Shown below C) in *Figure A3*, and in unbolded red text below the **Item Cut-off Values** on the *Calculations* worksheet. The only number that will be shown here is "0" or "1"; a "1" means that the person "passed" that particular item, and a "0" means that they "did not pass" the corresponding item. *A "pass" indicates that the person's response for the specific item was equal to or greater than the corresponding* **Item Cut-off Value.**

NOTE: In Figure A3, *the relationship among* B) **Item Scores**, C) **Item Cut-off Values**, *and* D) **Diagnostic Item Calculation** *is highlighted within a bold-lined box. Looking at the vertically-aligned numbers as a "matched set" from left to right (with 12 sets in all for* Memory Problems*) the significance of these numbers becomes much clearer.*

E) **Overall Cut-off Score –** Shown on the far-right side in *Figure A3,* and in bolded red text on the *Calculations* worksheet, this is the number of items that the test-taker must "pass" in order for *Memory Problems* to be considered a clinically significant feature of the diagnostic picture. *This same number appears on* The Extended MID Report *in the* Memory Problems *subsection as* Cut-off Score (x):y, *where* x *is the* **Overall Cut-off Value**. *Please refer below for an in-depth explanation of the present example as it is reflected in* The Extended MID Report.

Figure A4. Criterion A: General Posttraumatic Dissociative Symptoms – Memory Problems (detail)



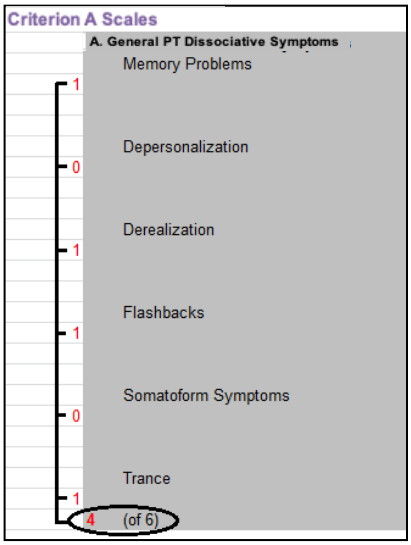
F) **Diagnostic Item Score –** Shifting back to the near left, directly below A) in *Figure A4*, and in bolded red text on the *Calculations* worksheet, is a number that represents the sum of all **Diagnostic Item Calculation** scores, divided by the **Overall Cut-off Value**. If the result is greater than or equal to "1", then the symptom is recognized as diagnostically significant. In

Figure A4 *above, this number, multiplied by 100 to correspond with the familiar 0 to 100 metric of the Dissociative Experiences Scale, translates into results reflected in the* Cut-off Score (x):y *measure (as* y) *in the* Memory Problems *subsection on* The Extended MID Report and, more importantly for the clinician, the MID Diagnostic Line *and* Bar Graphs. *This holds for all of Criterion A, B, and C on the* MID Diagnostic Graphs, *but differs for the* Validity Scales, *which are measured slightly differently*. *Please refer below to the section regarding the* MID Diagnostic Graphs *for additional information.*

G) **% Passed** – Shown on the near left side below F) in *Figure A4,* and in bolded magenta text on the *Calculations* worksheet, this number equals the number of items "passed" (as reflected in the sum of D) **Diagnostic Item Calculations**) divided by the total number of items for that symptom. In the *Memory Problems* example above, that would be 9 "passed" items, divided by 12 total items, which equals .75—or 75%. *Many of the* **% Passed** *items are illustrated in the* MID Clinical Summary Line *and* Bar Graphs. *Please refer below to the section regarding the* MID Clinical Summary Graphs *for additional information.*

H) **Overall Diagnostic Score –** For each symptom, this number indicates whether the **Diagnostic Item Score** shown as F) above is greater than or equal to "1". From above, we know that the **Diagnostic Item Score** indicates whether the test-taker's aggregate score for a symptom should be considered clinically significant. The only number that will be shown for **Overall Diagnostic Score** is "0" or "1": If the **Diagnostic Item Score** is greater than or equal to "1", then the **Overall Diagnostic Score** will be "1", and if the **Diagnostic Item Score** is less than "1", then the **Overall Diagnostic Score** will be "0". Readers previously familiar with *The MID Report* may already realize why this number is important. Although this will be addressed in more detail below, note that, for the *MID Analysis* to come up with its impressions, a certain number of symptoms in each of *Criteria A, B*, and *C* must be considered clinically significant.

Figure A5: Criterion A Scales (detail)



Referring to the example shown to the left in *Figure A5*, we see *Criterion A Scales – General Dissociative Symptoms*, of which there are six: *Memory Problems, Depersonalization, Derealization, Flashbacks, Somatoform Symptoms,* and *Trance*. The number to the lower left of each symptom is its **Overall Diagnostic Score**. Following the thick line to the left of these scores, of the six Criterion A symptoms, the only two for which clinical significance was not indicated were *Depersonalization* and *Somatoform Symptoms.* This results in a total of four out of six Criterion A – General Dissociative Symptoms (which encompasses PTSD and somatoform dissociation).

Although there is significantly more data contained within the *Calculations* worksheet, the illustrations above are intended to

serve as a “primer”, as well as an invitation for the adventurous clinician and/or intrigued researcher to learn more about the wealth of information offered up by the *MID Analysis*.

Appendix IV: For Clinicians Using EMDR and Other Trauma-Focused Psychotherapies

For clinicians who have been trained in EMDR therapy and other body-oriented therapies, the MID is most appropriate for use during the earliest phases of treatment, e.g., Phases 1 and 2, History Taking and Preparation, in EMDR therapy; and Phase I in Sensorimotor Psychotherapy.

A WORD OF CAUTION FOR EMDR AND OTHER TRAUMA-FOCUSED THERAPISTS

If these or other clear signs and symptoms of dissociation are present, the therapeutic next step is to slow down and shift the focus to resourcing, stabilization, containment, *and further assessment* until you determine it is safe to proceed.

Step back, calmly and thoughtfully, from working with the traumatic memory material. Do not attempt to 'push through' the person's symptoms by diving deeper into reprocessing. Higher levels of structural dissociation may not respond well to this approach, and can be both re-traumatizing for the person and profoundly harmful to your working relationship.

Avoid activating explicit traumatic material right now, until you know more.

EMDR Therapy

The MID can assist clinicians in making an accurate diagnosis of the person's presenting issues, and inform decisions regarding whether to apply 'Standard Protocol' methods on their own, to employ established adaptations tailored to the needs of persons dealing with more complex presenting problems, or to defer use of EMDR therapy and employ a 3-stage treatment model instead.

EMDR therapy training teaches clinicians to administer the Dissociative Experiences Scale, at minimum as part of Phase 2 (Preparation) to screen for anti-therapeutic dissociation. Shapiro (2018) stated that "the clinician intending to initiate EMDR should first administer the Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993) and do a thorough clinical assessment with every client" (p. 96-97). If dissociative symptoms are clearly present, she advises further assessment, mentioning the MID as one of the appropriate options to clarify diagnosis (p. 499).

Curt Rounzoin (2011) offered 3 factors of readiness for EMDR reprocessing using the standard protocol:

- DES and clinical screening completed without concerns.
- Person has demonstrated the ability to function in daily living – or enough support to allow for changes in functioning.

- Successful installation of Safe/Calm Place, and in-session evidence of the capacity for smooth emotional 'state shifts' (e.g., from agitated to calm).

These three factors serve as a simple and reliable guide for determining the readiness for EMDR Phases 3 through 8 when persons do not present with complex histories of trauma or prior unsuccessful mental health treatment. Remember to also specifically ask about any previous incomplete EMDR therapy reprocessing sessions!

If the clinician has already begun Assessment (Phase 3) or Desensitization (Phase 4), and has not already identified pathological dissociation, these are a few common indicators for concern that may present in the course of EMDR therapy:

- Standard containment methods are not successful.
- If EMDR Phase 2 (Preparation) or 4 (Desensitization) 'stalls,' or the person abreacts ('goes back there') or seems disoriented for no apparent reason.
- Avoidance or refusal of EMDR reprocessing, even if seeming to have a positive experience.
- Consistent difficulty accessing traumatic material.
- Being emotionally or physically "numbed out," avoidant of, or phobic in relation to traumatic material.
- SUD does not decrease, drops rapidly, or drops in-session then has increased upon Re-evaluation.
- Many (or persistent) blocking beliefs – In Phase 4 reprocessing, or that interfere with identification or installation of PC.

These are some post-hoc indicators to administer of the MID. If any of these signs and symptoms seem foreign, unfamiliar, or 'scary' to you, then please do yourself, your clinical license, and especially the person seeking treatment a favor: Seek consultation with a clinician skilled in assessing and treating complex trauma and dissociation.

Appendix V: MID Criterion A, B, and C Symptom Descriptions

The Phenomenological Definition of Dissociation

"*The phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive functioning and sense of self."* (Dell, 2009; p. 226)

To view how the MID inquires about and measures each of the 23 symptoms, open the MID Analysis, MID Report tab, and scroll down to view the Extended MID Report. There, the items comprising each symptom scale are listed, along with their respective cutoff scores.

Criterion A: General Posttraumatic Dissociative Symptoms

General Posttraumatic Dissociative Symptoms occur not only in persons with a dissociative disorder, but also in persons with certain other disorders: PTSD, acute stress disorder, somatic symptom disorder, conversion disorder, panic disorder, major depression, schizotypal personality disorder, and borderline personality disorder.

General memory problems
Memory problems include lack of memory for significant life events, inability to recall substantial portions of one's childhood, and chronic day-to-day forgetfulness.

Depersonalization
Depersonalization involves odd changes of one's experience of *self*, *mind*, or *body*. Depersonalization experiences include feeling unreal, being a detached observer of oneself, and feeling distant, changed, estranged, or disconnected from one's self, one's mind, or one's body.

Derealization
In derealization, the world feels unreal, strange, unfamiliar, distant, or changed.

Post-traumatic flashbacks
Flashbacks typically manifest as sudden, intrusive memories, pictures, internal 'videotapes,' nightmares, or body sensations of previous traumatic experiences. During *dissociative* flashbacks, a person may lose contact with the 'here and now', and suddenly be back 'there and then.'

Somatoform symptoms
Somatoform symptoms are bodily experiences and symptoms that have no medical basis. These somatic symptoms may affect vision, hearing, sight, smell, taste, body sensation, body functions, or physical abilities. They are often a partial re-experiencing of a past traumatic event.

Trance
Trance refers to episodes of staring off into space, thinking about nothing, and being unaware of what is going on around oneself. During a trance, the person is 'out of touch' with what is going on around them, and it may be difficult to get their attention.

Criterion B: Partially-dissociated Intrusions into Executive Functioning and Consciousness from Another Self-State

The symptoms in Criterion B are described as "partially dissociated" because the experiencer registers them as being generated from outside their conscious intention or choice—though not from outside themselves as a person—and thus, frequently, as intrusive or disruptive.

Child voices
The voice of a child is heard inside the head. The voice may speak or cry.

Two or more parts that converse, argue, or struggle
Dissociated parts may argue, or struggle with one another or with the front part(s). The internal struggle may manifest itself as voices or 'loud thoughts' that argue or as non-auditory internal forces that struggle with one another (or with the front part(s)). *Internal Struggle* is the first of the two most frequently elevated scales in clients with a complex dissociative disorder (i.e., DID and OSDD-1).

Persecutory voices
Persecutory voices call the person names, are harshly disparaging, and command the person to commit acts of self-injury or suicide.

> ***Do Loud Thoughts Count as 'Voices'?***
>
> Şar and Öztürk (2009) note that loud thoughts in dissociative patients
>
> *...feel intrusive, and are perceived as discordant with the person's own tendencies and identity ('not-me' quality). They may be even attributed to a 'foreign entity' (i.e. alter personality)* ***inside of the person*** *(bolded emphasis added).*
>
> So, some test-takers may experience their "voices" as "loud thoughts" and, for a variety of reasons, reject the label "voices" for their internal experience.

Speech insertion
In speech insertion, a dissociated part intrudes into the executive functioning of the front part/'host' by seizing control of what is being said. The person typically feels that the words coming out of their mouth are being controlled by someone or something else.

Thought insertion
In thought insertion, the ideas of a dissociated part suddenly intrude into conscious awareness. Intruding thoughts feel like they have "come from out of nowhere" and may feel like they do not really "belong" to the experiencer.

'Made' / intrusive emotions
Intrusive emotions (or feelings) are experienced as "coming from out of nowhere," often with no apparent reason. The person often experiences intrusive emotions as not really "mine."

'Made' / intrusive impulses
Intrusive impulses are often strong, apparently inexplicable, and may be experienced as not really "mine."

'Made' / intrusive actions
Intrusive actions tend to feel as if they were done by someone or something else inside the person. This is a particularly common, ego-alien experience in persons with a complex dissociative disorder.

Temporary loss of (well-rehearsed skills and) knowledge
This experience is intensely puzzling to the person. Suddenly and inexplicably, they forget how to do their job, how to drive the car, their name, and so on. Unlike the other 10 consciously-experienced intrusions (which are positive symptoms), temporary loss of skills or knowledge is a *negative* symptom. That is, what *should* be there (e.g., skill, ability, knowledge of one's own name) is suddenly absent.

This is a unique dimension of amnesia because it is consciously experienced at the time that it occurs. Thus, it is a *partially-dissociated* form of amnesia—in contrast to the more common, *fully-dissociated* forms of amnesia reflected in *Criterion C*.

Experiences of self-alteration
Sudden experiences of self-alteration are disconcerting. They involve very odd changes in one's sense of self: feeling like a different person, switching back and forth between feeling like a child and an adult, switching back and forth between feeling like a man and a woman (or different genders), seeing someone else in the mirror, and so on.

Puzzlement about oneself
Unlike the other 10 consciously-experienced, Partially-Dissociated Intrusions, self-puzzlement is not a dissociative symptom. Rather, ***it is the result of dissociative experiences.*** The more dissociative experiences, the more self-puzzlement a person may experience. Dissociative individuals are recurrently puzzled by their inexplicable feelings, reactions, behaviors, and so on. Self-puzzlement is the second of the two most frequently elevated scales in clients with a complex dissociative disorder (i.e., DID and OSDD-1).

Criterion C: Discovering the Fully-dissociated Actions of Another Self-State (Amnesia)

Time loss
Time loss involves incidents of "losing time". The person DISCOVERS that they cannot account for several minutes, hours, a day, or even longer. The person has a total "blank" for what happened during that period of time.

"Coming to"
The person suddenly "comes to" and (1) DISCOVERS that they have done something, but they have no memory of having done it, or (2) becomes aware that they are in the middle of doing something that they have no memory of having started doing in the first place.

Fugues
Fugues are incidents where a person suddenly DISCOVERS that they are somewhere, but they have no memory whatsoever of going to that place. Such travel may occur at home (e.g., from the living room to the kitchen) or outside, in public.

Being told of one's recent disremembered actions
Persons with a severe dissociative disorder may be told about their recent actions but have absolutely no memory of having done those things. Thus, the experiencer DISCOVERS what they have done.

Finding objects among one's possessions
Persons with a severe dissociative disorder may DISCOVER objects, writings, or drawings among their possessions, but have no idea where those things came from.

Finding evidence of one's recent actions
Persons with a severe dissociative disorder may DISCOVER evidence of their recent actions, but they will have no memory of having done those things. Examples include things at home being moved around or changed and no one else could have been responsible for it; finding that tasks have been completed that only the experiencer could have done; and, discovering previously unnoticed injuries—even a fully-dissociated suicide attempt.

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For those who may need to cite the MID for any reason, its correct citation is:

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