

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

2nd Edition

Paul F. Dell, PhD

2nd Edition Revised and Expanded 2016-2017 by:

D. Michael Coy, MA, LICSW

Jennifer A. Madere, MA, LPC-S

Current versions of this and associated MID documents, including
MID Analysis v4.0, may be found at:

www.mid-assessment.com

The information contained in this manual may not be replicated in whole or in part without the express consent of the authors. This manual is provided free of charge to mental health clinicians and researchers and is not intended to be sold. Copyright 2017 All rights reserved.

Table of Contents

Part I: Introduction and Clinical Foundations.....	4
How to Use this Manual.....	4
Basic Information about the MID	4
What is required of clinicians to use the MID?.....	5
Reasons to Assess for Pathological Dissociation.....	6
To Clarify Diagnosis	6
To Ensure Appropriate Treatment Planning.....	6
To Ensure Non-Maleficence (‘Do No Harm’)	6
When to Assess for Pathological Dissociation.....	7
A Knowledge Foundation for Clinicians Who Use the MID.....	7
ISSTD Treatment Guidelines and Phase-Oriented Treatment of Trauma.....	7
Dissociative Experiences Scale (DES)	8
Dissociation According to the MID	9
Mindset of the 3 Domains	9
The MID Assesses 23 Symptoms of Dissociation.....	9
Part II: Administering, Scoring, and Interpreting the MID	11
What’s New in MID Analysis v4.0?	11
MID Basics.....	11
MID Document Checklist.....	11
Administering the MID	12
Administration Methods	12
Becoming Familiar with MID Analysis v4.0	14
Opening MID Analysis v4.0 for the First Time	14
Layout of MID Analysis v4.0.....	15
Scoring the Multidimensional Inventory of Dissociation in MID Analysis v4.0_	16
The Questions Worksheet: Entering Client Data into the MID Analysis.....	16
Understanding and Interpreting Results in MID Analysis v4.0	17
The MID Report	17

The Extended MID Report	65
Part III: After the MID Report	67
Visualizing MID Results: The Line and Bar Charts	67
The MID Dissociation Scales Graph	69
The MID Diagnostic Graph	70
The MID Clinical Summary Graph	71
The MID Factor Scales Graph	72
Line Charts Legend	67
Bar Charts Legend	67
MID-informed Treatment Planning	73
The Follow-up Interview	73
Common Challenges	74
Appendix I: Revised MID Norms (August, 2011)	76
Appendix II: Exporting the MID Analysis	77
Exporting to Adobe PDF	77
Exporting to Word Processing Software	77
Appendix III: The Calculations Worksheet	79
Appendix IV: For Clinicians Using EMDR and Body-Oriented Psychotherapies	83
EMDR Therapy	83
References	85

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, and to address most questions clinicians and researchers may have about what the items, scales, etc., mean.

Clinical use of the MID is incomplete without conducting an interview following administration and scoring. New and seasoned professionals will benefit from reading this manual and applying informed interpretation of each client'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.

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.'

Instructions for administration and scoring of the MID can be found under the heading 'MID Basics' at the beginning of Part II of this manual.

Basic Information about the MID

The *Multidimensional Inventory of Dissociation* (MID) was developed by Paul F. Dell to assess pathological dissociation and the dissociative disorders. Importantly, the MID is not a clinician-administered instrument, such as the *Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)* (Steinberg, 1994) or the *Dissociative Disorders Interview Schedule (DDIS)* (Ross, 2016, 1989). '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.

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 DDNOS-1b (OSDD in DSM-5) 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 III below).

The MID was 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 v4.0. MID items have a 7th grade reading

level. The MID can be used with clients 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 content).

MID Basics at-a-Glance

- The MID has 218 items, and takes 30-60 minutes for most clients to complete
- If a client 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 strongly recommended.
- For clinicians familiar with the DES, a mean MID score means roughly the same thing as mean DES score of the same value.

The MID has been translated into Hebrew, Spanish, Italian, French, German, Dutch, Norwegian, Swedish, Czech, Arabic, and Chinese. The Hebrew MID has been independently validated in Israel. A validated Spanish language version of the MID is under development.

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.

The MID is available to clinicians and students free of charge. While specialized training is not required, familiarity with dissociative experiences, the Dissociative Experiences Scale, and basic Excel skills will be useful. A mean MID score means roughly the same thing as an equivalent mean DES score. Familiarity with the assessment and treatment of complex trauma and dissociative disorders will enhance your use and application of information provided by *The MID Report*.

The MID has 218 items, each of which measures 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 appropriate amnesia item with at least a 1, even if such events were rare and occurred years ago.

Most clients 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 (defined and described below).

Reasons to Assess for Pathological Dissociation

To Clarify Diagnosis

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

- Dissociative Identity Disorder (DID)
- Other Specified Dissociative Disorder, Type 1 (OSDD-1)
This is DSM-IV's DDNOS-1b (subclinical DID)
- Posttraumatic Stress Disorder (PTSD)
- Somatic Symptom Disorder
- Severe and Problematic Traits of Borderline Personality Disorder

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

NOTE: DSM-5 criteria for DID explicitly allows evidence of distinct personality states (aka switching) to be observed by others or to be reported by the individual (American Psychiatric Association, 2013).

To Ensure Appropriate Treatment Planning

Symptoms and diagnosis inform treatment-planning. An objective tool such as the MID provides such information. Additionally, clinicians may benefit from reading the ISSTD guidelines for treating dissociative identity disorder (2011), which identifies three phases or stages of treatment (described below).

Two clients who meet criteria for Dissociative Identity Disorder 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 client's internal experience that would take many sessions to discover otherwise.

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

Treating complex trauma and pathological dissociation can pose risks to both client and clinician, especially when dissociative symptoms are not accurately assessed. 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](#).

When to Assess for Pathological Dissociation

Assess for pathological dissociation when your client reports or evidences signs that are common in dissociative individuals, such as:

- Extensive trauma history
- Extensive treatment history
- Numerous prior diagnoses
- A prior diagnosis of Bipolar Disorder or Bipolar II
- Borderline Personality Disorder (traits, prior diagnosis)
- Voices
- Blank spells (signs of amnesia)

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 client's treatment.

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. *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. 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. This causes most 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 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 client populations that are known to have a history of trauma.

Phases of Treatment for Complex Trauma and Dissociative Disorders

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

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

Successful achievement of the goals of Phase 1 is necessary for both clinician and client to be prepared to safely address trauma resolution in Phase 2.

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:

17% of participants with a mean score of 30 or higher had DID; 14% of those scoring 20 or less had DID (Carlson & Putnam, 1993).

We recommend using the MID in lieu of the DES for clients who report or evidence the signs of dissociation described above. When in doubt, or if a client obtains a DES score of 15 or higher, clinicians should administer the MID to clarify diagnosis and aid treatment planning.

EMDR therapy training teaches clinicians to administer the Dissociative Experiences Scale as part of Phase 2 (Preparation) to screen for anti-therapeutic dissociation (Shapiro, 2001).

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.

Dissociation According to the MID

Mindset of the 3 Domains

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

- 1) *Neuroanatomical-neurophysiological*. (e.g., structural and functional MRI studies)
- 2) *Psychological*.
- 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, 2009; 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 (i.e., Self-Puzzlement), each of the 23 symptoms of dissociation are experienced as conscious intrusions into executive functioning and/or sense of self. These 23 symptoms constitute the dissociative symptom-domain of DID (Somer & Dell, 2005; Dell, 2009). Each symptom scale listed here will be discussed in greater detail in subsequent sections.

Criterion A: General 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

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 v4.0*?

Quite a lot:

- An unnecessary ‘macro’ that prompted a security warning upon opening the *MID Analysis* was removed. This has enabled the *MID Analysis* to be updated to the modern *.xlsx* Excel file format, making it accessible via Microsoft Excel on mobile devices.
- Separate iterations of the *MID Analysis v4.0* for Windows (2016/Office 365) and Mac (2011/2016) versions of Excel were created, which allows for layout and printing variances Windows and Mac OS).
- Isolated ‘bugs’ in the *Calculations* worksheet were corrected.
- Isolated ‘bugs’ in *The Extended MID Report* were corrected.
- *The MID Report* and *The Extended MID Report* were reformatted to enhance readability and flow.
- PTSD data was added to the four *Line Charts*. This data was previously missing from all but the *Factor Scales* line chart.
- Diagnostic terminology was updated for DSM-5, while retaining DSM-IV-TR language to ease the reader’s transition to DSM-5.
- Coloration of the *Line* and *Bar Charts* was reformatted to enhance their readability for black-and-white or greyscale printing.

Please note that the items of the MID are entirely unchanged.

MID Basics

MID Document Checklist

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

- 1) *MID* – Microsoft *Word* document for the client to complete, containing 218 questions.
- 2) *MID Analysis v4.0* – Because *MID Analysis* is an Excel spreadsheet, you must have Microsoft *Excel* for Windows, Mac, or iOS installed on your desktop computer or tablet. Although *MID Analysis v4.0* technically can be used with Apple’s *Numbers* software for Mac or iOS, it is not formatted for this software (so the report formatting, print layout, colors, and charts/graphs may not appear as intended).
- 3) *An Interpretive Manual for the Multidimensional Inventory of Dissociation (MID), 2nd Edition*, which you are presently reading.

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

Most Common MID Scoring Issue

MID Analysis is organized into 7 tabs (visible at the bottom of the worksheet): **Questions, Calculations, MID Report, Line Charts, Bar Charts, Instructions to Clinicians,** and **Programmer Notes**. Client data is entered in the light blue/cyan cells on the **Questions** tab. This is the only of the seven tabs into which data may be entered.

Administering the MID

As with any assessment, care must be given to proper administration and consideration of unique client factors. 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. A small percentage of test-takers are distressed by MID questions.

Instructions:

*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 client 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 client only to report on experiences they recall since the previous administration of the MID.

Administration Methods

We recommend either instructing the client to arrive early to complete the MID before a session, or administering the MID during the session. Clinicians often find administering the MID in session to be a rich source of information (e.g., if a client answers some items quickly and deliberates over others).

Administering on paper: There can be great benefit to administering the MID on paper. Among other things, it allows the client to write contextual notes in the margins, which can aid understanding of the client’s experience. The original MID document instructs the client 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 <http://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 client to type their response onto the alternate MS *Word* version of the MID to be transferred into the *MID Analysis* later. The most direct and time efficient means of administering the MID is to ask the client to enter their responses directly into the **Questions** worksheet in the *MID Analysis*. This makes the results available as soon as the client has responded to all 218 items. Interpretation and the follow-up interview will, of course, still take additional time.

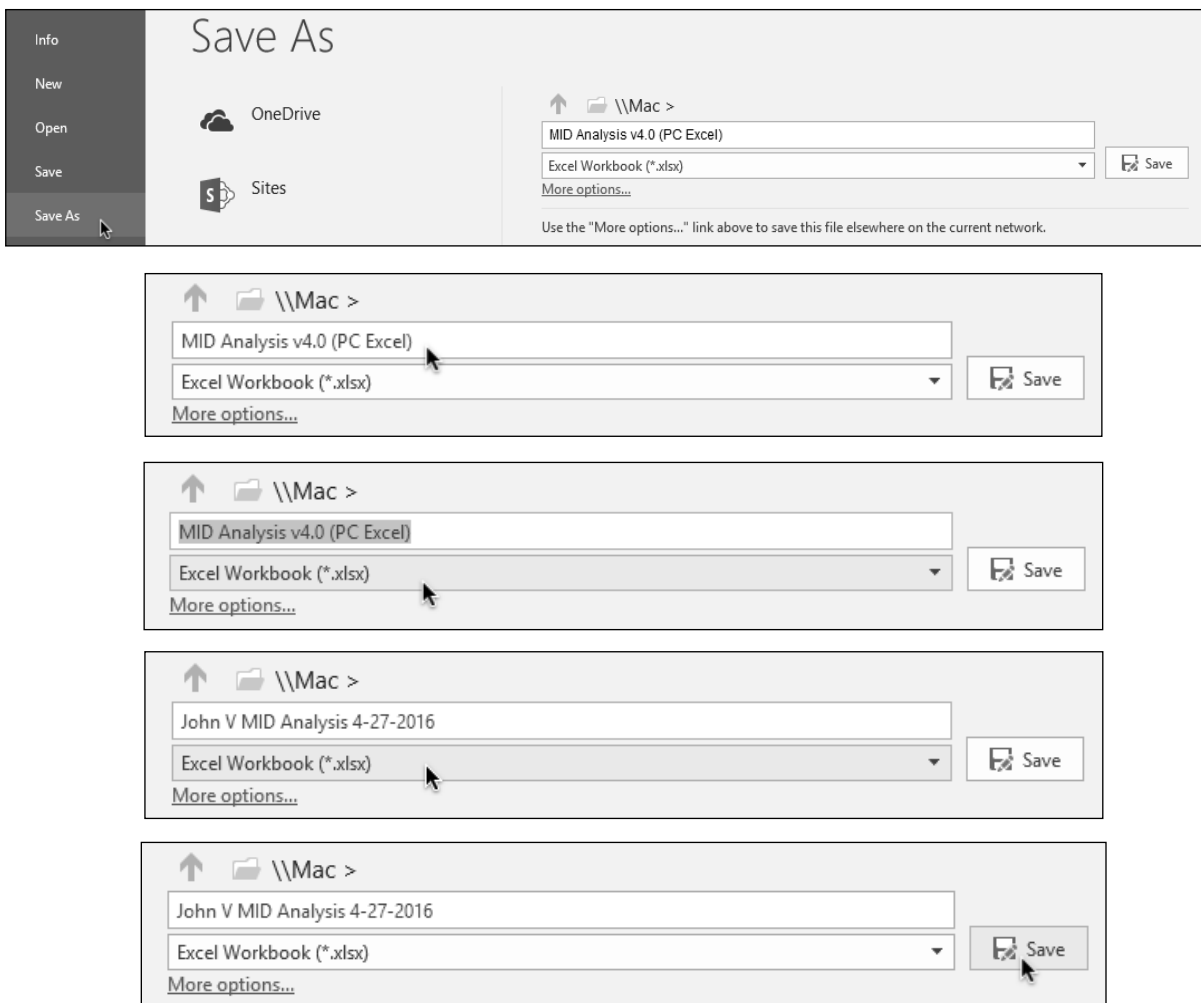
Becoming Familiar with *MID Analysis v4.0*

Opening MID Analysis v4.0 for the First Time

To avoid overwriting one's original, pristine copy of the *MID Analysis*, be certain to "Save As..." and rename the client's *MID Analysis* to something recognizable. 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 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 charts, coloration, and print layout, may look significantly different outside of an *Excel* environment (e.g., in Apple's *Numbers* application).

Figure 1. 'Save As' Procedure



Once the client's *MID Analysis* has been saved, the clinician can begin entering client data to generate *The MID Report*.

Layout of MID Analysis v4.0

MID Analysis v4.0 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 client’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 client’s scores on 61 of the 74 MID scales, as well as diagnostic impressions based on the client’s responses. *The MID Report* itself is only one page long; the remainder of the report is *The Extended MID Report*.

Line Charts – In four distinct charts, a visual representation of the diagnostic information derived from the client’s scores on the **Questions** tab. Each chart contains unique information about the client, with comparisons between the client’s scoring on each measure and those of the clinical samples from relevant diagnostic categories: Non-dissociative, PTSD, DDNOS-1b/OSDD-1, and DID. These norms are based on the data gathered during the development of the MID.

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

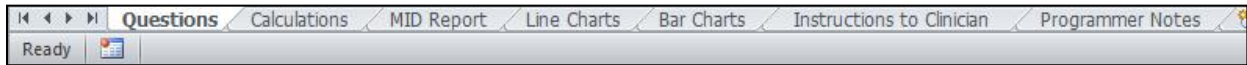
Instructions to Clinicians – Brief instructions to clinicians regarding the MID. This is a ‘legacy’ page which contains limited information and is now superseded by this manual.

Programmer Notes – Information relevant to spreadsheet programmers, but irrelevant in the clinician’s regular use of the *MID Analysis v4.0*.

Each of these tabs, aside from Instructions to Clinicians and Programmer 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 v4.0*

The Questions Worksheet: Entering Client Data into the MID Analysis



The only worksheet 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)*

Question Number	Answer	Instructions: How <u>often</u> 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 <u>often</u> it happens to you.										
		Never										Always
		0	1	2	3	4	5	6	7	8	9	10
Client ID												
Sex												
Age												
Date												
Race												
Edu.												
	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.										

As mentioned above, on the **Questions** worksheet itself, the fields into which a clinician may enter pertinent client data have been helpfully shaded in cyan (but shown in light grey here). Those fields are:

Client ID – Enter a signifier that allows for recognition of the identity of the client. It is suggested, though, for the sake of privacy, that the client’s full last name not be entered here.

Sex and Age – Enter this information as appropriate; these fields may be left blank.

Date – Enter the date that the MID was administered.

Race and Education – Useful for research purposes, these fields may be filled in or left blank.

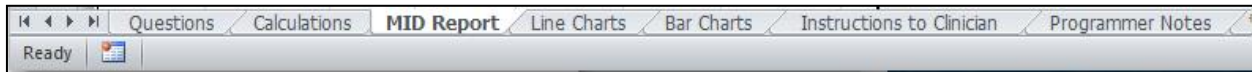
Pre-MID Diagnosis – The client’s present and/or rule-out diagnosis.

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 client, it can be helpful to note here that this is a reassessment, along with prior assessment dates.

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

Understanding and Interpreting Results in MID Analysis v4.0

The MID Report

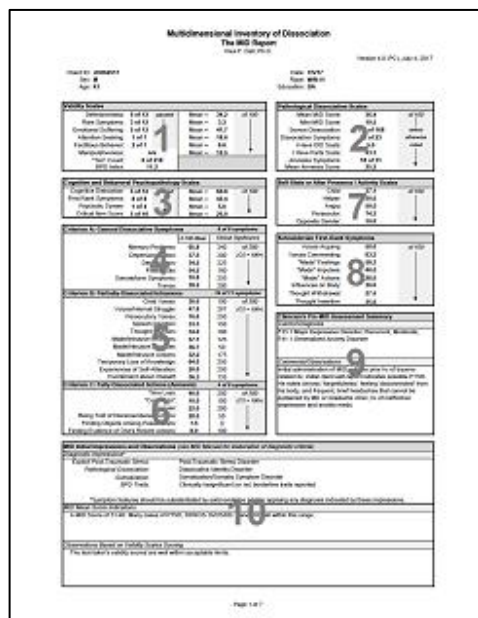


The **MID Report** tab contains the following elements:

- *The MID Report* – Only one page long, *The MID Report* offers up a summary of most measures as well as diagnostic impressions.
- *The Extended MID Report* – Six 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) 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. Validity and Characterological Scales
2. Pathological Dissociation Scales
3. Cognitive and Behavioral Psychopathology Scales
4. Criterion A: General Dissociative Symptoms
5. Criterion B: Partially-Dissociated Intrusions
6. Criterion C: Fully-Dissociated Actions (Amnesia)
7. Self-State or Alter Presence / Activity Scales
8. Schneiderian First-Rank Symptoms
9. Clinician's Pre-MID Diagnostic Summary
10. MID Initial Impressions and Observations

Each of these sections will be given individual attention and discussed at length below, in number order, with accompanying illustrations.

1. The MID Report – Validity Scales

Figure 4. The MID Report – Validity Scales

Validity Scales	
Defensiveness: 0 of 12	passed Mean = 34.2 of 100
Rare Symptoms: 3 of 12	Mean = 3.3
Emotional Suffering: 5 of 12	Mean = 41.7
Attention-Seeking: 1 of 7	Mean = 18.6
Factitious Behavior: 2 of 7	Mean = 8.6
Manipulativeness: n/a	Mean = 12.5
"Ten" Count: 0 of 218	
BPD Index: 11.2	

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

- Defensiveness: Denial or minimization of symptoms
- Rare Symptoms: Bizarre and unlikely symptoms
- Emotional Suffering: Negative emotional reactivity
- Attention-Seeking: Too-ready disclosure and/or overemphasis of symptoms
- Factitious Behavior: Exaggeration or frank malingering of symptoms, trauma, and abuse

The sixth validity scale, the *Borderline Personality Disorder (BPD) Index*, is an empirically-derived scale that distinguishes a subset of clients with borderline traits who exaggerate and falsify their symptoms and history of abuse (see page 28).

Forensic evaluators want validity scales to *detect falsified responding*. Clinicians, however, want validity scales to *assess response biases* (which are 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. Thus, indicating 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 client'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 client'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 4a. *Validity Scales (detail)*

Validity Scales					
A)	Defensiveness:	0 of 12	passed	Mean = 34.2	of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3	↓
C)	Emotional Suffering:	5 of 12		Mean = 41.7	
D)	Attention-Seeking:	1 of 7		Mean = 18.6	
E)	Factitious Behavior:	2 of 7		Mean = 8.6	
F)	Manipulativeness:	n/a		Mean = 12.5	
G)	"Ten" Count:	0 of 218			
H)	BPD Index:	11.2			

In *Figure 4a*, the separate scales are labeled A) through H) at the far left. The first column with numbers represents *the number of questions the client "passed"* (i.e., met or exceeded the cut-off value) for that scale. For example, the *Emotional Suffering Scale* in *Figure 4a* shows that the example client "passed" 5 out of 12 questions. The column to the right reflects the client's Mean Score (average) for that scale.

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. The MID, in contrast, 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 charts 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 client's original responses. The client'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 dissociation scale has its own cut-off value (i.e., the number of items on that scale that must be "passed" for the client to have that symptom). Transformed into a *Clinical Significance Score*, a score of 100 or more means that the client 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 client's clinical significance scores for 6 validity scales and the 23 dissociation scales can be seen in their proper context, as compared to the standardized diagnostic scores, on the *MID Diagnostic Graph*.

A) Defensiveness

Figure 4b. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12		Mean = 41.7
D)	Attention-Seeking:	1 of 7		Mean = 18.6
E)	Factitious Behavior:	2 of 7		Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	"Ten" Count:	0 of 218		
H)	BPD Index:	11.2		

The *Defensiveness Scale* assesses a person's willingness 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 shown when endorsing an answer of "0" to a *Defensiveness* item. Consistently low ratings of *Defensiveness* items (e.g., "0," "1," or "2") mean that the test-taker is claiming to have remarkably few *normal* shortcomings.

"Passed" Items – In Figure 4b above, the example client "passed" 0 out of 12 *Defensiveness* items. These means that the test-taker rated none of the *Defensiveness* items with a "0."

Defensiveness Mean Score – Non-dissociative individuals have a raw mean (average) score of 3.6 on the 12 *Defensiveness Scale* items; outpatients with DID have a raw mean score of 6.5. When these raw scores are converted to a 0 to 100 scale (and inverted so that lower scores indicate greater/higher defensiveness), non-dissociative individuals have a *Defensiveness Scale* mean score of 63.7; clients with DID have a *Defensiveness Scale* mean score of 35.5.

In Figure 4b above, the example client obtained a mean *Defensiveness Scale* score of 34.2, within the range expected for a person with DID.

When Is a Defensiveness Score Clinically Significant? A *Defensiveness Scale* mean score of 70.00 receives a Clinical Significance score of 100—the cut-off score for clinical significance. A *Defensiveness Scale* mean score of 70.00 falls at the 97th percentile of outpatients with DID. Only 3% of DID outpatients manifest a clinically significant level of defensiveness on the MID.

Because non-dissociative persons exhibit *fewer* normal cognitive shortcomings than persons with DID, the cut-off score for a clinically significant level of defensiveness is higher for this diagnostic group: 83. A *Defensiveness Scale* score of 83.00 falls at the 90th percentile of the non-dissociative population. High *Defensiveness* scores in non-dissociative individuals usually indicates a character style largely incompatible with dissociation.

Test-takers with a high *Defensiveness* 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).

Relationship to Cognitive Distraction – The *Defensiveness Scale* and the *Cognitive Distraction Scale* (see below) are composed of the same 12 items. Extremely low scores (0, 1, or 2) on these items indicate defensiveness, whereas very high scores (7, 8, 9, or 10, depending on the item cutoff) indicate cognitive distraction. Cognitive distraction, as a phenomenon, will be discussed further under the *Cognitive and Behavioral Psychopathology* heading.

B) Rare Symptoms

Items on the *Rare Symptoms* scale describe phenomena that are quite uncommon, distinctly unlikely, and, in some cases, frankly 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 4c. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12	↓	Mean = 41.7
D)	Attention-Seeking:	1 of 7	↓	Mean = 18.6
E)	Factitious Behavior:	2 of 7	↓	Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	"Ten" Count:	0 of 218		
H)	BPD Index:	11.2		

“Passed” Items – In Figure 4c above, the example client “passed” 3 out of 12 *Rare Symptoms* items, which will need to be given attention in the follow-up interview, both to clarify the client’s understanding 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.

Rare Symptoms Mean Score – Non-dissociative individuals have a mean score of just 0.6; even clients with DID have a mean score of only 4.5. The example client has scored below the mean for test-takers with DID, at 3.3, so their responses may in fact be diagnostically consistent.

When Is a Rare Symptoms Score Clinically Significant? On the *MID Diagnostic Graph*, a *Rare Symptoms Scale* of 15.00 receives a score of 100 (i.e., the cut-off score for clinical significance). A score of 15.00 falls at the 92nd percentile of outpatients with DID and the 99th percentile of non-dissociative persons. Thus, only 8 percent of clients with DID endorse a clinically significant level of rare symptoms.

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.
- 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 alter may intentionally endorse rare symptoms to discredit and harass the “host” alter.
- 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).
- Extreme dissociative hypersensitivity that genuinely has produced many peculiar symptoms.

The above 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).

C) 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.”).

Figure 4d. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12		Mean = 41.7
D)	Attention-Seeking:	1 of 7		Mean = 18.6
E)	Factitious Behavior:	2 of 7		Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	"Ten" Count:	0 of 218		
H)	BPD Index:	11.2		

“Passed” Items – In Figure 4d above, we see that the example client “passed” 5 out of 12 *Emotional Suffering* items. See *Emotional Suffering* on Page 2 (*The Extended MID Report*) to examine this scale’s items and their respective cut-off values.

Emotional Suffering Scale Mean Score – Non-dissociative individuals have a mean score of 28.9 on the *Emotional Suffering Scale*; outpatients with DID have a mean score of 54.7. The example client has a mean score of 41.7, which, when converted to reflect clinical significance (shown on the *MID Diagnostic Graph*), indicates that the client is closely clustered with test-takers with PTSD and DDNOS-1b/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 DID outpatients have a clinically significant level of emotional suffering.

D) Attention-Seeking

Attention-seeking is a strategy for obtaining attention and emotional gratification from others. The *Attention-Seeking Scale* has 7 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”).

Figure 4e. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12		Mean = 41.7
D)	Attention-Seeking:	1 of 7	↓	Mean = 18.6
E)	Factitious Behavior:	2 of 7		Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	"Ten" Count:	0 of 218		
H)	BPD Index:	11.2		

“Passed” Items – In Figure 4e, the example client “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 client “passed,” and their relationship to other scales – especially, the other *Validity Scales*, the *Self-State and Alter Presence / 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.

Attention-Seeking Scale Mean Score – Non-dissociative individuals have a mean score of 15.3 on the *Attention-Seeking Scale*; outpatients with DID have a mean score of 20.9. The example client has a mean score of 18.6, placing them very closely in range with the outpatient DID population.

When is an Attention-Seeking Score Clinically Significant? On the *MID Diagnostic Graph*, an *Attention-Seeking Scale* score of 32.9 receives a score of 100 (i.e., the cut-off score for clinical significance). A score of 32.9 falls at the 90th percentile of non-dissociative individuals and the 78th percentile of outpatients with DID. Thus, 22 percent of DID outpatients manifest a clinically significant level of attention-seeking behavior.

E) Factitious Behavior Scale

The *Factitious Behavior Scale* assesses exaggerated or faked 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.)”

Figure 4f. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12	↓	Mean = 41.7
D)	Attention-Seeking:	1 of 7	↓	Mean = 18.6
E)	Factitious Behavior:	2 of 7	↓	Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	"Ten" Count:	0 of 218		
H)	BPD Index:	11.2		

There is a subset of respondents with severe borderline traits who readily endorse these items without shame. Indeed, this subset of clients 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!”

“Passed” Items – In Figure 4f, we see that the client “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 client “passed,” and to their relation to other scales – especially, the other *Validity and Characterological Scales*, the *Self-State and Alter Presence / Activity Scale*, and the *Schneiderian First-Rank Symptoms Scale*. Taken together, these scales provide a rich picture of how the test-taker’s symptoms manifest interpersonally.

Factitious Behavior Scale Mean Score – Non-dissociative individuals have a mean score of only 4.62 on the *Factitious Behavior Scale*; DID outpatients have a mean score of 15.98. The example client has a mean score of 8.6—relatively low, but still worth exploring, especially to determine how (and whether) these symptoms manifest in the client’s present experience.

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

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 in order 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 guilty “host” alters/ANP(s) who wrongly accuse themselves of “making too much of” their traumas and their pain.
- 4) Persecutor alters/introjects who falsely “admit” to lying or exaggerating—in order to harass and discredit the host/ANP(s). The clinician should keep in mind that persecutor alters/introjects commonly tell the “host” that memories (e.g., of abuse by a parent) are “not true”, mimicking an external (past and/or present) perpetrator of harm, thus—paradoxically—protecting the “host” from an intolerable reality.

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.

F) 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.”

Figure 4g. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12	↓	Mean = 41.7
D)	Attention-Seeking:	1 of 7	↓	Mean = 18.6
E)	Factitious Behavior:	2 of 7	↓	Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	"Ten" Count:	0 of 218		
H)	BPD Index:	11.2		

“Passed” Items – Information about items “passed” on the *Manipulativeness Scale* is not included in *The MID Report*.

Manipulativeness Scale Mean Score – Non-dissociative individuals have a mean score of only 6.59 on the *Manipulativeness Scale*; DID outpatients have a mean score of 7.03. In *Figure 4g*, the example client demonstrated a *Factitious Behavior Scale Mean Score* of 12.5—notably elevated, compared to mean scores for the diagnostic populations.

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

- *Attention Seeking* (page 23)
- *Factitious Behavior* (page 24)
- *Intrusiveness* (reflected in context under *Characterological Scales* on page 6 of *The MID Report/The Extended MID Report*)
- *BPD Index* (page 28)
- *Manipulative Self-Injury* (see 3. *Cognitive and Behavioral Psychopathology Scales: Critical Item Score* on page 37 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.

G) “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 4g*, we see that the example client scored a “0” out of 218 questions. In other words, the client did not score “10” on *any* of the MID’s 218 items.

H) The Borderline Personality Disorder (BPD) Index

Figure 4h. Validity Scales (detail)

Validity Scales				
A)	Defensiveness:	0 of 12	passed	Mean = 34.2 of 100
B)	Rare Symptoms:	3 of 12	↓	Mean = 3.3
C)	Emotional Suffering:	5 of 12		Mean = 41.7
D)	Attention-Seeking:	1 of 7		Mean = 18.6
E)	Factitious Behavior:	2 of 7		Mean = 8.6
F)	Manipulativeness:	n/a		Mean = 12.5
G)	“Ten” Count:	0 of 218		
H)	BPD Index:	11.2		

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 clients diagnosed with DID to those of 100 clients well-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 scales.

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 test-taker who does not wish to admit to these behaviors. When endorsed, however, these items suggest that the person is willing to do almost anything to get attention and sympathy from others. 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).

BPD Index Mean Score – The *BPD Index* score is reported in two forms: (1) the *Mean BPD Index Score* and (2) the *BPD Index Clinical Significance Score* (see the *MID Diagnostic Graph*).

In *Figure 4h*, the example client demonstrated a *BPD Index* score of 11.2. Referencing the clinical meaning of the *BPD Index* scores (next page), it appears that the example client’s score is relatively low, indicating ‘a few’ problematic borderline traits.

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

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 DID outpatients and the 96th percentile of non-dissociative individuals. Thus, 9 percent of clients with DID obtain a clinically significant score on the *BPD Index*. This does not mean that 9% of BPD outpatients have DID. In fact, the incidence of BPD in DID outpatients is higher than 9%.

The meaning of the MID's *BPD Index* is, perhaps, better appreciated in light of the fact that only 39% of outpatients 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*.

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
Simple PTSD	7.52	25.06
DDNOS-1b/OSDD-1	8.58	28.90
DID	15.98	53.17
BPD	26.61	88.73

2. The MID Report – Pathological Dissociation Scales

Figure 5. The MID Report – Pathological Dissociation Scales

Pathological Dissociation Scales		
Mean MID Score:	36.4	of 100
Mini-MID Score:	19.5	
Severe Dissociation:	119 of 168	unless
Dissociative Symptoms:	20 of 23	otherwise
I Have DID Scale:	5.0	noted
I Have Parts Scale:	43.3	
Amnesia Symptoms:	18 of 31	↓
Mean Amnesia Score:	25.2	

The MID Report's Pathological Dissociation section provides 8 invaluable measures of dissociation and the person's attitude toward DID.

- *Mean MID Score*
- *Mini-MID Score*
- *Severe Dissociation*
- *Dissociative Symptoms*
- *I Have DID Scale*
- *I Have Parts Scale*
- *Amnesia Symptoms*
- *Mean Amnesia Score*

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 \approx 60, with many previously undiagnosed DID \approx 40 or lower.
- ***I Have Parts*** (0-100): Diagnosed DID \approx 60, with previously undiagnosed DID \approx 40 or higher.

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

Figure 5a. Pathological Dissociation Scales (detail)

Pathological Dissociation Scales			
A)	Mean MID Score:	36.4	of 100
B)	Mini-MID Score:	19.5	
C)	Severe Dissociation:	119 of 168	unless
D)	Dissociative Symptoms:	20 of 23	otherwise
E)	I Have DID Scale:	5.0	noted
F)	I Have Parts Scale:	43.3	↓
G)	Amnesia Symptoms:	18 of 31	
H)	Mean Amnesia Score:	25.2	

A) Mean MID Score

Shown in *Figure 5a* 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 therapy clients who do not have a dissociative
15 – 20	May have PTSD or a mild dissociative disorder.
21 – 30	May have DDNOS-1b/OSDD-1 or DID. May have PTSD.
31 – 40	May have PTSD and either DDNOS-1b/OSDD-1 or DID.
41 – 64	Probably has both DID and PTSD.
65 or greater	Usually indicates an admixture of severe dissociative, posttraumatic, and personality-related (DSM-IV Axis II) symptoms. Accurate diagnosis requires a close examination of the validity scales and a careful follow-up interview.

Returning to *Figure 5a*, we see that the example client has a *Mean MID Score* of 36.4. The client may have PTSD and either DDNOS-1b/OSDD-1 or DID. This score can be contextualized via the client's MID Criterion A (page 38), B (page 42), and C (page 49) symptoms. Note that some dissociative individuals defensively refuse to admit their dissociative symptoms, or are consciously unaware of them. This would be relevant for the example client if we observed a very low *Mean MID Score* and a high *Defensiveness Scale* score.

B) Mini-MID Score

In *Figure 5b*, the *Mini-MID Score* is based on 19 dissociative items that strongly discriminate between persons with DID and non-dissociative clients (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).

Figure 5b. Pathological Dissociation Scales (detail)

Pathological Dissociation Scales			
A)	Mean MID Score:	36.4	of 100
B)	Mini-MID Score:	19.5	
C)	Severe Dissociation:	119 of 168	unless
D)	Dissociative Symptoms:	20 of 23	otherwise
E)	I Have DID Scale:	5.0	noted
F)	I Have Parts Scale:	43.3	
G)	Amnesia Symptoms:	18 of 31	↓
H)	Mean Amnesia Score:	25.2	

The example client 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.

C) Severe Dissociation Score

Each of the MID's 168 dissociation items has its own cut-off score for clinical significance. The *Severe Dissociation Score* specifies how many dissociation items met or exceeded their cut-off score. In *Figure 6b*, the example client has a *Severe Dissociation* score of 119, meaning that they gave clinically significant ratings to 70.83% of the MID's 168 dissociation items. The *Severe Dissociation 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*.

D) Dissociative Symptoms

The MID measures 23 major dissociative symptoms. The *Dissociative Symptoms* score indicates how many of those symptoms the test-taker endorsed at a clinically-significant level. In *Figure 6b*, the example client obtained a *Dissociative Symptoms* score of 20, meaning that they met or exceeded the cut-off score for clinical significance on 20 of the 23 dissociative symptoms. The 20 dissociative symptoms in question are those that received a Clinical Significance score of 100 or higher on *Criterion A: General Dissociative Symptoms*, *Criterion B: Partially-Dissociated Intrusions*, and *Criterion C: Fully-Dissociated Actions (Amnesia)* sections of *The MID Report* (see also the *MID Diagnostic Graph*).

E) I Have DID Scale

The *I Have DID Scale* measures the *mean score* of the four *I Have DID* items. Undiagnosed DID clients 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 5c* below that the example client 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.

F) I Have Parts Scale

Figure 5c. Pathological Dissociation Scales (detail)

Pathological Dissociation Scales			
A)	Mean MID Score:	36.4	of 100
B)	Mini-MID Score:	19.5	
C)	Severe Dissociation:	119 of 168	unless
D)	Dissociative Symptoms:	20 of 23	otherwise
E)	I Have DID Scale:	5.0	noted
F)	I Have Parts Scale:	43.3	
G)	Amnesia Symptoms:	18 of 31	↓
H)	Mean Amnesia Score:	25.2	

The *I Have Parts Scale* measures the mean score of the scale’s six 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 215: “Feeling the presence of an angry part in your head that seems to hate you.”

We can see in *Figure 5d* that the example client 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 Parts* Scale score is multiplied by 10 to conform to the DES “0 to 100” scale.

G) Amnesia Symptoms

Figure 5d: Pathological Dissociation Scales (detail)

Pathological Dissociation Scales			
A)	Mean MID Score:	36.4	of 100
B)	Mini-MID Score:	19.5	
C)	Severe Dissociation:	119 of 168	unless
D)	Dissociative Symptoms:	20 of 23	otherwise
E)	I Have DID Scale:	5.0	noted
F)	I Have Parts Scale:	43.3	↓
G)	Amnesia Symptoms:	18 of 31	
H)	Mean Amnesia Score:	25.2	

The MID contains 31 amnesia-related items. The *Amnesia Symptoms* 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: The Fully-Dissociated Effects of Alters and Self-States*.

In *Figure 5d*, the example client has an *Amnesia Symptoms* Scale score of 18, meaning that they “passed” 18 out of 31 of the MID’s amnesia-related items.

H) 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).

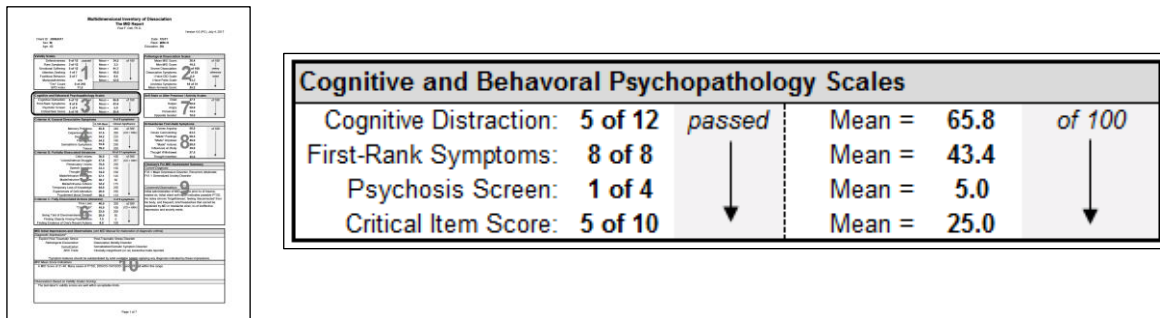
Here are the Mean Amnesia Scores for four groups:

Diagnosis	Mean Amnesia Score
Nondissociative	1.99
PTSD	3.06
DDNOS-1b/OSDD-1	8.73
DID	22.72

In *Figure 5d*, we see that the example client demonstrated a *Mean Amnesia Score* of 25.2, which invites careful examination of the client’s responses to the MID’s amnesia-related items.

3: The MID Report – Cognitive and Behavioral Psychopathology Scales

Figure 6. *The MID Report – Cognitive and Behavioral Psychopathology Scales*



Cognitive and Behavioral Psychopathology Scales			
Cognitive Distraction:	5 of 12	passed	Mean = 65.8 of 100
First-Rank Symptoms:	8 of 8	↓	Mean = 43.4
Psychosis Screen:	1 of 4	↓	Mean = 5.0
Critical Item Score:	5 of 10	↓	Mean = 25.0

Four scales in *The MID Report* evaluate cognitive and behavioral functioning:

- *Cognitive Distraction*
- *First Rank Symptoms*
- *Psychosis Screen*
- Critical items, as reflected in the *Critical Item Score*

Cognitive and Behavioral Psychopathology Scales: At-a-Glance

- Low *Cognitive Distraction* equals high *Defensiveness*; high *Cognitive Distraction* equals low *Defensiveness*. See below for more information about the *Cognitive Distraction* scale.
- *First Rank Symptoms* are reported, symptom by symptom, in the *Schneiderian First-Rank Symptoms* section of *The MID Report*.
- *Psychosis Screen*: This score should always be 0. Scores of 2 or higher strongly suggest that the person is experiencing psychotic/delusional symptoms. This occurs in some clients with more severe borderline features and a few complex dissociative clients. Psychotic clients may obtain a score of 3 or 4.
- The *Critical Item Score* measures the 10 dissociative and posttraumatic symptoms that are harmful or potentially dangerous. 99% of non-dissociative clients “pass” three or fewer critical items, whereas 85% of clients with DID “pass” four or more critical items. The test-taker’s responses to *Critical Items* should be given special attention. The client’s responses to the 10 Critical Items can be found on Page 7 of *The Extended MID Report: Functionality/Impairment Scales*.

In *Figure 6a*, the *Cognitive and Behavioral Psychopathology Scales*, each of its four scales reports (1) the number of items that the client “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 6a. *Cognitive and Behavioral Psychopathology Scales (detail)*

Cognitive and Behavioral Psychopathology Scales				
A)	Cognitive Distraction:	5 of 12	passed	Mean = 65.8 of 100
B)	First-Rank Symptoms:	8 of 8	↓	Mean = 43.4 ↓
C)	Psychosis Screen:	1 of 4	↓	Mean = 5.0 ↓
D)	Critical Item Score:	5 of 10	↓	Mean = 25.0 ↓

A) Cognitive Distraction

The *Cognitive Distraction* Scale and the *Defensiveness* 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 score indicates defensiveness.

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 – Non-dissociative individuals have a mean *Cognitive Distraction* score of 36.0; DID outpatients have a mean *Cognitive Distraction* score of 66.85.

The example client in *Figure 6a* scored a mean of 65.8, in line with the mean score for a person with DID.

B) 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, for dissociative reasons, in persons with a severe dissociative disorder. Please refer to 8) *Schneiderian First-Rank Symptoms* (page 58) for further information.

C) Psychosis Screen

This is a subscale of the *Rare Symptoms Scale*.

The four items that comprise the *Psychosis Screen* are:

- 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 client endorses any of these items, they may be delusional or having psychotic auditory hallucinations. Only 3% of outpatients with DID endorse three or more of the items on the *Psychosis Screen*.

The example client 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 client’s experience and how it relates to the characterological and dissociative symptoms they endorsed.

Psychosis Screen Scale Mean Score – Non-dissociative individuals have a mean score of 4.0 (out of 100) on the four *Psychosis Screen* items; DID outpatients have a mean score of 11.58. The example client in *Figure 6b* scored a mean of 5.0, which is relatively low in comparison to the mean score for persons with DID.

Figure 6b. Cognitive and Behavioral Psychopathology Scales (detail)

Cognitive and Behavioral Psychopathology Scales				
A)	Cognitive Distraction:	5 of 12	passed	Mean = 65.8 of 100
B)	First-Rank Symptoms:	8 of 8	↓	Mean = 43.4
C)	Psychosis Screen:	1 of 4	↓	Mean = 5.0
D)	Critical Item Score:	5 of 10	↓	Mean = 25.0

D) Critical Item Score

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

- Voices that tell a person to die or to hurt themselves;
- Flashbacks that provoke impulses to self-harm;
- Fugues (i.e., amnestic travel);
- 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 Item Score* portrays the mean score of the 10 critical items on the MID. It is useful to note that 99% of non-dissociative clients “pass” three or fewer critical items, whereas 85% of clients with DID “pass” four or more critical items. Thus, unlike most psychiatric clients, *clients with DID can routinely be expected to have several (or even many) of these harmful or potentially dangerous symptoms*. In *Figure 6b*, we see that the example client “passed” 5 out of 10 *Critical Items* that need to be very carefully evaluated in follow-up.

Critical Item Mean Score – Non-dissociative individuals have a mean score of 3.0 (out of 100) on the ten *Critical Items*. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 17.33, and those with DID have a mean score of 36.02. In *Figure 6b*, the example client’s mean score on this measure was 25.0, which invites close examination of potential risk factors and safety issues.

4: The MID Report – Criterion A: General Dissociative Symptoms

Figure 7. Criterion A: General Dissociative Symptoms

Criterion A: General Dissociative Symptoms		6 of 6 symptoms	
	0-100 Mean	Clinical Significance	
Memory Problems:	65.8	240	of 300
Depersonalization:	37.5	200	(CS = 100+)
Derealization:	34.2	225	↓
Flashbacks:	54.2	180	
Somatoform Symptoms:	10.8	250	
Trance:	39.2	200	

As Figure 7 shows, there are 6 *General Dissociative Symptoms*. *General Dissociative Symptoms* not only occur in persons with a dissociative disorder, but also in persons with certain other disorders: PTSD, acute stress disorder, somatization disorder, conversion disorder, panic disorder, major depression, schizotypal personality disorder, and borderline personality disorder.

Mean Scores – The first column of numbers in Figure 7 are the “0 to 100” mean scale scores.

Clinical Significance Scores – The second column of numbers in Figure 7 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 client **has** that symptom. (This threshold is abbreviated on *The MID Report* as “CS = 100+.”) The higher the number, the more of that symptom the test-taker has. Thus, in Figure 8, we see that the example client has 6 of the 6 *General Dissociative Symptoms*: Memory Problems, Depersonalization, Derealization, Flashbacks, Somatoform Symptoms, and Trance.

A) 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. 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*.

Memory Problems Scale Mean Score – Non-dissociative individuals have a mean score of 18 on the *Memory Problems* scale; outpatients with PTSD have a mean score of 27.5; outpatients with DID have a mean score of 62.28. In Figure 7a (next page), the example client demonstrated a *Memory Problems Scale Mean Score* of 65.8—which places the client squarely in the range for 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 DID clients obtain a clinically significant score (100+) on this scale. In Figure 7a, the example client demonstrated a *Clinical Significance Score* of 240 for *Memory Problems*, which indicates that they have reported a high level of abnormal forgetting.

B) 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.

Figure 7a. Criterion A: General Dissociative Symptoms (detail)

Criterion A: General Dissociative Symptoms		6 of 6 symptoms	
		0-100 Mean	Clinical Significance
A)	Memory Problems:	65.8	240 of 300
B)	Depersonalization:	37.5	200 (CS = 100+)
C)	Derealization:	34.2	225
D)	Flashbacks:	54.2	180
E)	Somatoform Symptoms:	10.8	250
F)	Trance:	39.2	200

Depersonalization Scale Mean Score – Non-dissociative individuals have a mean score of 8.0. PTSD experiencers have a mean score of 11.25, and outpatients with DDNOS-1b/OSDD-1 have a mean score of 40.1 on the *Depersonalization* scale. In *Figure 7a*, the example client demonstrated a *Depersonalization Scale Mean Score* of 37.5 in initial reporting, in line with persons with DDNOS-1b/OSDD-1.

Depersonalization Score for Clinical Significance – About 95% of clients with DID obtain a clinically significant score on this MID scale. In *Figure 7a*, the example client demonstrated a *Clinical Significance Score* of 200 for *Depersonalization*, indicating that the client endorsed twice as many symptom features as needed for their experience of depersonalization to be clinically significant.

C) Derealization

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

Derealization Scale Mean Score – Non-dissociative individuals have a mean score of 7.0 on the *Depersonalization* scale, with PTSD experiencers scoring a mean of 8.69. Outpatients with DDNOS-1b/ODD have a mean score of 28.16, and those with DID have a mean of 45.24. In *Figure 7a*, the example client demonstrated a *Derealization Scale Mean Score* of 34.2 in initial reporting, indicating they fall between the means for DDNOS-1b/OSDD and DID.

When Is the Derealization Score Clinically Significant? When the test-taker reports a clinically significant level of four or more depersonalization experiences. About 92% of clients with DID obtain a clinically significant score (100+) on this scale. In *Figure 7a*, the example client demonstrated a *Clinical Significance Score* of 200 for *Derealization*, indicating that the client endorsed a variety of aspects of this symptom well above the threshold for clinical significance.

D) 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 here and now, and suddenly be back ‘there and then.’

Figure 7b. Criterion A: General Dissociative Symptoms (detail)

Criterion A: General Dissociative Symptoms		6 of 6 symptoms	
		0-100 Mean	Clinical Significance
A)	Memory Problems:	65.8	240 of 300
B)	Depersonalization:	37.5	200 (CS = 100+)
C)	Derealization:	34.2	225
D)	Flashbacks:	54.2	180
E)	Somatoform Symptoms:	10.8	250
F)	Trance:	39.2	200

Flashbacks Scale Mean Score – Non-dissociative individuals have a mean score of 10 on the *Flashbacks* scale. Outpatients with PTSD have a mean score of 23.04. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 37.19, and those with DID have a mean score of 53.31. The example client has a mean of 54.2 on this scale, in line with the mean for persons with DID.

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 clients with DID obtain a clinically significant score (100+) on this MID scale. In *Figure 7b*, the example client demonstrated a *Clinical Significance Score* of 180. This person has highly-symptomatic PTSD.

E) Somatoform Symptoms

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.

Somatoform Symptoms Scale Mean Score – Non-dissociative individuals have a mean score of 2 on the *Somatoform Symptoms* scale. PTSD patients have a mean score of 4.29. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 11.15, and, clients with DID have a mean score of about 26.0. In *Figure 7b*, the example client has a mean of 10.8 on this scale, on par with the mean for DID.

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 DID obtain a clinically significant score on the *Somatoform Symptoms Scale*. In *Figure 7b*, the example client demonstrated a *Clinical Significance Score* of 250, indicating persistent experiences of somatoform dissociation.

Figure 7c. Criterion A: General Dissociative Symptoms (detail)

Criterion A: General Dissociative Symptoms		6 of 6 symptoms	
		0-100 Mean	Clinical Significance
A)	Memory Problems:	65.8	240 of 300
B)	Depersonalization:	37.5	200 (CS = 100+)
C)	Derealization:	34.2	225
D)	Flashbacks:	54.2	180
E)	Somatoform Symptoms:	10.8	250
F)	Trance:	39.2	200

F) Trance

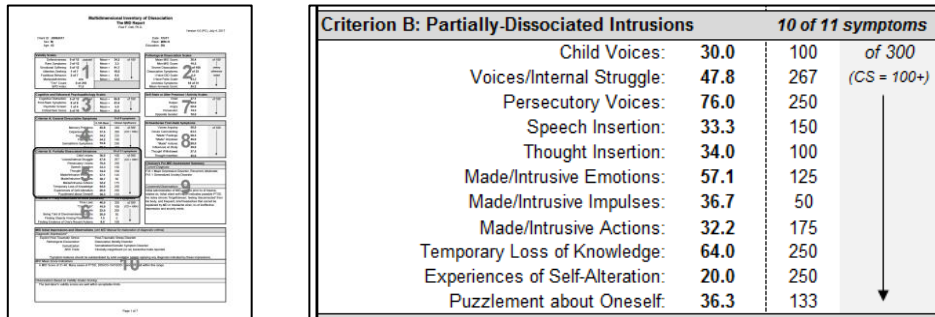
Trance refers to episodes of staring off into space, thinking about nothing, and being unaware of what is going on around oneself. During a trance, the person is ‘out of touch’ with what is going on around them, and it may be difficult to get their attention.

Trance Scale Mean Score – Non-dissociative individuals have a mean score of 8.0 on the *Trance* scale. Outpatients with PTSD have a mean score of 15.71, while those with DDNOS-1b/OSDD-1 have a mean score of 28.79. Clients with DID tend to have a mean score of about 45.0. The example client in *Figure 7c* has a mean score of 39.2, which falls between the means for DDNOS-1b/OSDD-1 and DID.

When Is the Trance Score Clinically Significant? When the test-taker reports a clinically significant level of five or more trance items. About 88% of clients with DID obtain a clinically significant score on the *Trance* scale. In *Figure 7c*, the example client demonstrated a *Clinical Significance Score* of 200, indicating high levels of trance.

5. The MID Report – Criterion B: Partially Dissociated Intrusions into Consciousness from Another Self-State

Figure 8. The MID Report – Criterion B: Partially-Dissociated Intrusions



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 disruptions of normal functioning. Shown in the right-hand column of *Figure 8a*, the example client reported clinically-significant scores (i.e., 100 or higher) on 10 of the 11 *Partially-Dissociated Intrusions*.

Figure 8a. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions		10 of 11 symptoms	
A)	Child Voices:	30.0	100 of 300
B)	Voices/Internal Struggle:	47.8	267 (CS = 100+)
C)	Persecutory Voices:	76.0	250
D)	Speech Insertion:	33.3	150
E)	Thought Insertion:	34.0	100
F)	Made/Intrusive Emotions:	57.1	125
G)	Made/Intrusive Impulses:	36.7	50
H)	Made/Intrusive Actions:	32.2	175
I)	Temporary Loss of Knowledge:	64.0	250
J)	Experiences of Self-Alteration:	20.0	250
K)	Puzzlement about Oneself:	36.3	133

A) Child Voices

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

Child Voices Scale Mean Score – Research has shown that clients with DID more often hear child voices than do clients with schizophrenia (Laddis & Dell, 2012). Non-dissociative individuals have a mean score of 3.0 on the *Child Voices* scale. PTSD experiencers have a mean score of 0.95; those with DDNOS-1b/OSDD-1 have a mean score of 38.84; In *Figure 8a*, the example client demonstrated a *Child Voices Scale Mean Score* of 30.0, indicating that they register in the lower range of DDNOS-1b/OSDD-1 for frequency of child part activity.

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 clients with DID obtain a clinically significant score (100+) on this MID scale. In *Figure 8b*, the example client is just at the threshold of clinical significance for this symptom, with a score of 100.

‘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.

B) Voices/Internal 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)). This is one of the two most frequently elevated scales in clients with a complex dissociative disorder (i.e., DID and DDNOS-1b/OSDD-1). (The other most frequently elevated scale is Self-Puzzlement.)

Figure 8b. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions			10 of 11 symptoms	
A)	Child Voices:	30.0	100	of 300
B)	Voices/Internal Struggle:	47.8	267	(CS = 100+)
C)	Persecutory Voices:	76.0	250	↓
D)	Speech Insertion:	33.3	150	
E)	Thought Insertion:	34.0	100	
F)	Made/Intrusive Emotions:	57.1	125	
G)	Made/Intrusive Impulses:	36.7	50	
H)	Made/Intrusive Actions:	32.2	175	
I)	Temporary Loss of Knowledge:	64.0	250	
J)	Experiences of Self-Alteration:	20.0	250	
K)	Puzzlement about Oneself:	36.3	133	

Voices/Internal Struggle Scale Mean Score – Non-dissociative individuals have a mean score of 8.0 on the *Voices/Internal Struggle* scale. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 38.84. Those with DID have a mean score of 38.84. The example client in *Figure 8b* has a highly elevated mean score of 47.8, which is clearly in the range for DID.

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 clients with DID obtain a clinically significant score on the *Voices/Internal Struggle* scale. In *Figure 8b*,

the example client demonstrated a *Clinical Significance Score* of 200, indicating pronounced experiences of dissociative voices and/or internal struggle.

C) Persecutory Voices

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

Persecutory Voices Scale Mean Score – Non-dissociative individuals have a mean score of 4.0 on the *Persecutory Voices* scale. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 38.75. Those with DID have a mean score of 54.78. The example client in *Figure 8c* has a highly elevated mean score of 47.8, which is nearer/in the range for DID.

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 clients with DID obtain a clinically significant score on the *Persecutory Voices* scale. In *Figure 8c*, the example client demonstrated a *Clinical Significance Score* of 250, indicating acute experience of persecutory voices.

Figure 8c. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions			10 of 11 symptoms	
A)	Child Voices:	30.0	100	of 300 (CS = 100+) ↓
B)	Voices/Internal Struggle:	47.8	267	
C)	Persecutory Voices:	76.0	250	
D)	Speech Insertion:	33.3	150	
E)	Thought Insertion:	34.0	100	
F)	Made/Intrusive Emotions:	57.1	125	
G)	Made/Intrusive Impulses:	36.7	50	
H)	Made/Intrusive Actions:	32.2	175	
I)	Temporary Loss of Knowledge:	64.0	250	
J)	Experiences of Self-Alteration:	20.0	250	
K)	Puzzlement about Oneself:	36.3	133	

D) 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.

Speech Insertion Scale Mean Score – Non-dissociative individuals have a mean score of 5.0 on the *Speech Insertion* scale. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 19.03. Those with DID have a mean score of 55.45. The example client in *Figure 8c* has a mean score of 33.3, placing them roughly between DDNOS-1b/OSDD-1 and DID.

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 clients with DID obtain a clinically significant score on the *Speech Insertion* scale. In *Figure 8d*, the example

client demonstrated a *Clinical Significance Score* of 150, indicating a significant experience of speech insertion.

E) Thought Insertion

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

Thought Insertion Scale Mean Score – Non-dissociative individuals have a mean score of 14.0 on the *Thought Insertion* scale. PTSD experiencers have a mean score of 23.0. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 43.08. The example client in *Figure 8d* has a mean score of 34.0, placing them between the means for PTSD and DDNOS-1b/OSDD-1.

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 clients with DID obtain a clinically significant score on the *Thought Insertion* scale. In *Figure 8d*, the example client demonstrated a *Clinical Significance Score* of 100, indicating that they reached the threshold for thought insertion to be a clinically relevant symptom.

Figure 8d. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions			10 of 11 symptoms	
A)	Child Voices:	30.0	100	of 300
B)	Voices/Internal Struggle:	47.8	267	(CS = 100+)
C)	Persecutory Voices:	76.0	250	↓
D)	Speech Insertion:	33.3	150	
E)	Thought Insertion:	34.0	100	
F)	Made/Intrusive Emotions:	57.1	125	
G)	Made/Intrusive Impulses:	36.7	50	
H)	Made/Intrusive Actions:	32.2	175	
I)	Temporary Loss of Knowledge:	64.0	250	
J)	Experiences of Self-Alteration:	20.0	250	
K)	Puzzlement about Oneself:	36.3	133	

F) '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 Emotions Scale Mean Score – Non-dissociative individuals have a mean score of 17.0 on the *'Made'/Intrusive Emotions* scale. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 41.79, and those with DID have a mean score of 68.12. The example client in *Figure 8d* has a mean score of 57.1, placing them between the means for DDNOS-1b/OSDD-1 and DID.

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 clients with DID obtain a clinically significant score on the *'Made'/Intrusive Emotions*

scale. In *Figure 8e*, the example client demonstrated a *Clinical Significance Score* of 125, indicating that they have significant experiences of ‘made’/intrusive emotions.

G) ‘Made’/Intrusive Impulses

Intrusive impulses are often strong, apparently inexplicable, and may be experienced as not really “mine.”

‘Made’/Intrusive Impulses Scale Mean Score – Non-dissociative individuals have a mean score of 6.0 on the ‘Made’/Intrusive Impulses scale. PTSD experiencers have a mean score of 6.19, and outpatients with DDNOS-1b/OSDD-1 have a mean score of 36.81. The example client in *Figure 8e* has a mean score of 36.7, indicating that the client is in line with the mean score for people with DDNOS-1b/OSDD-1.

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 clients with DID obtain a clinically significant score on the ‘Made’/Intrusive Impulses scale. In *Figure 8e*, the example client demonstrated a *Clinical Significance Score* of 50.0, indicating that they did not “pass” enough items for this to be a symptom, despite their mean score.

Figure 8e. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions			10 of 11 symptoms	
A)	Child Voices:	30.0	100	of 300 (CS = 100+) ↓
B)	Voices/Internal Struggle:	47.8	267	
C)	Persecutory Voices:	76.0	250	
D)	Speech Insertion:	33.3	150	
E)	Thought Insertion:	34.0	100	
F)	Made/Intrusive Emotions:	57.1	125	
G)	Made/Intrusive Impulses:	36.7	50	
H)	Made/Intrusive Actions:	32.2	175	
I)	Temporary Loss of Knowledge:	64.0	250	
J)	Experiences of Self-Alteration:	20.0	250	
K)	Puzzlement about Oneself:	36.3	133	

H) ‘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.

‘Made’/Intrusive Actions Scale Mean Score – Non-dissociative individuals have a mean score of 7.0 on the ‘Made’/Intrusive Actions scale. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 31.94. The example client in *Figure 8e* has a mean score of 32.2, placing them in line with the mean for DDNOS-1b/OSDD-1.

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 clients with DID obtain a clinically significant score on the ‘Made’/Intrusive Actions scale. In *Figure 8f*,

the example client demonstrated a *Clinical Significance Score* of 175, indicating that they have extensive experience of ‘made’/intrusive actions.

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

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).

Temporary Loss of Knowledge Scale Mean Score – Non-dissociative individuals have a mean score of 4.0 on the *Temporary Loss of Knowledge* scale. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 8.83, and those with DID have a mean score of 40.24. The example client in *Figure 8f* has a mean score of 64.0, placing them well over the mean for DID.

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 clients with DID obtain a clinically significant score on the *Temporary Loss of Knowledge* scale. In *Figure 8f*, the example client demonstrated a *Clinical Significance Score* of 250, indicating extensive temporary loss of knowledge and/or well-rehearsed skills.

Figure 8f. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions			10 of 11 symptoms	
A)	Child Voices:	30.0	100	of 300 (CS = 100+) ↓
B)	Voices/Internal Struggle:	47.8	267	
C)	Persecutory Voices:	76.0	250	
D)	Speech Insertion:	33.3	150	
E)	Thought Insertion:	34.0	100	
F)	Made/Intrusive Emotions:	57.1	125	
G)	Made/Intrusive Impulses:	36.7	50	
H)	Made/Intrusive Actions:	32.2	175	
I)	Temporary Loss of Knowledge:	64.0	250	
J)	Experiences of Self-Alteration:	20.0	250	
K)	Puzzlement about Oneself:	36.3	133	

J) 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.

Experiences of Self-Alteration Scale Mean Score – Non-dissociative individuals have a mean score of 5.0 on the *Experiences of Self-Alteration* scale. PTSD experiencers have a mean score of 6.85. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 25.0. The example client in *Figure 8g* has a mean score of 20.0, just below the mean for DDNOS-1b/OSDD-1.

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 clients with DID obtain a clinically significant score on the *Experiences of Self-Alteration* scale. In *Figure 8g*, the example client demonstrated a *Clinical Significance Score* of 250, indicating that they have profound, disturbing experiences of self-alteration.

Figure 8g. Criterion B: Partially-Dissociated Intrusions (detail)

Criterion B: Partially-Dissociated Intrusions			10 of 11 symptoms	
A)	Child Voices:	30.0	100	of 300 (CS = 100+) ↓
B)	Voices/Internal Struggle:	47.8	267	
C)	Persecutory Voices:	76.0	250	
D)	Speech Insertion:	33.3	150	
E)	Thought Insertion:	34.0	100	
F)	Made/Intrusive Emotions:	57.1	125	
G)	Made/Intrusive Impulses:	36.7	50	
H)	Made/Intrusive Actions:	32.2	175	
I)	Temporary Loss of Knowledge:	64.0	250	
J)	Experiences of Self-Alteration:	20.0	250	
K)	Puzzlement about Oneself:	36.3	133	

K) Self-Puzzlement

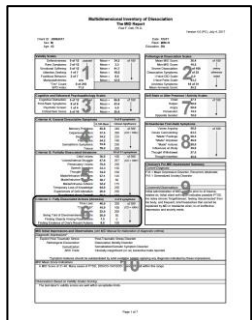
Unlike the other 10 consciously-experienced, *Partially-Dissociated Intrusions*, self-puzzlement is not a dissociative symptom. ***It is the result of dissociative experiences.*** The more dissociative experiences, the more self-puzzlement. Dissociative individuals are recurrently puzzled by their inexplicable feelings, reactions, behaviors, and so on. Self-puzzlement is one of the two most frequently elevated scales in clients with a complex dissociative disorder (i.e., DID and DDNOS-1b/OSDD-1). Notably, puzzlement and confusion about the self is significantly stronger in DID than in either schizophrenia or borderline personality disorder.

Self-Puzzlement Scale Mean Score – Non-dissociative individuals have a mean score of 18.0 on the *Self-Puzzlement* scale. PTSD experiencers have a mean score of 28.66, and outpatients with DDNOS-1b/OSDD-1 have a mean score of 42.97. The example client in *Figure 8g* has a mean score of 36.3, roughly between the means for PTSD and DDNOS-1b/OSDD-1.

When Is the Experiences of Self-Puzzlement Score Clinically Significant? When the test-taker reports a clinically significant level of three or more experiences of self-puzzlement items. About 97% of clients with DID obtain a clinically significant score on the *Self-Puzzlement* scale. In *Figure 8g*, the example client demonstrated a *Clinical Significance Score* of 133, indicating that they surpassed the threshold for self-puzzlement to be a symptom.

6. Criterion C: Discovering the Fully-Dissociated Actions of Another Self-State (Amnesia)

Figure 9. The MID Report – Criterion C: Fully-Dissociated Actions (Amnesia)



Criterion C: Fully-Dissociated Actions (Amnesia)			4 of 6 symptoms	
A)	Time Loss:	40.0	200	of 300
B)	"Coming to":	10.0	100	(CS = 100+)
C)	Fugues:	22.0	200	↓
D)	Being Told of Disremembered Actions:	20.0	50	
E)	Finding Objects Among Possessions:	7.5	0	
F)	Finding Evidence of One's Recent Actions:	8.0	100	

A) 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. About 86% of clients diagnosed with DID obtain a clinically significant score on this MID scale.

Time Loss Scale Mean Score – Non-dissociative individuals have a mean score of 6.0 on the *Time Loss* scale. PTSD experiencers have a mean score of 10.54. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 19.27, and those with DID have a mean score of 57.07. The example client in *Figure 9a* has a mean score of 40.0, nearest to the mean for DID.

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 clients with DID obtain a clinically significant score on the *Time Loss* scale. In *Figure 9a*, the example client demonstrated a *Clinical Significance Score* of 200, indicating extensive, pathological experience of time loss.

Figure 9a. Criterion C: Fully-Dissociated Actions (detail)

Criterion C: Fully-Dissociated Actions (Amnesia)			4 of 6 symptoms	
A)	Time Loss:	40.0	200	of 300
B)	"Coming to":	10.0	100	(CS = 100+)
C)	Fugues:	22.0	200	↓
D)	Being Told of Disremembered Actions:	20.0	50	
E)	Finding Objects Among Possessions:	7.5	0	
F)	Finding Evidence of One's Recent Actions:	8.0	100	

B) “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.

‘Coming to’ Scale Mean Score – Non-dissociative individuals have a mean score of 1.0 on the *Time Loss* scale. PTSD experiencers have a mean score of 4.29. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 4.27 and those with DID have a mean score of 38.11. The example client in *Figure 9b* has a mean score of 10.0, notably elevated for DDNOS-1b/OSDD-1, and well below the mean for DID.

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 clients with DID obtain a clinically significant score on the “Coming to” scale. In *Figure 9b*, the example client demonstrated a *Clinical Significance Score* of 100, right at the threshold for “coming to” to be considered a symptom.

Figure 9b. Criterion C: Fully-Dissociated Actions (detail)

Criterion C: Fully-Dissociated Actions (Amnesia)			4 of 6 symptoms	
A)	Time Loss:	40.0	200	of 300
B)	"Coming to":	10.0	100	(CS = 100+)
C)	Fugues:	22.0	200	↓
D)	Being Told of Disremembered Actions:	20.0	50	
E)	Finding Objects Among Possessions:	7.5	0	
F)	Finding Evidence of One's Recent Actions:	8.0	100	

C) Fugues

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

Fugues Scale Mean Score – Non-dissociative individuals have a mean score of 1.0 on the *Fugues* scale. PTSD experiencers have a mean score of 4.29. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 4.27, and those with DID have a mean score of 38.11. The example client in *Figure 9b* has a mean score of 10.0, notably elevated compared to the mean for DDNOS-1b/OSDD-1, and well below the mean for DID.

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 clients with DID obtain a clinically significant score on the *Fugues* scale. In *Figure 9b*, the example client 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 / Impairment Scales* section of *The MID Extended Report*).

‘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 in DID are in-house “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.

D) Being Told of (One’s Recent) Disremembered Actions

Persons with a major 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.

Being Told of Disremembered Actions Scale Mean Score – Non-dissociative individuals have a mean score of 4.0 on the *Being Told of Disremembered Actions* scale. PTSD experiencers have a mean score of 3.75. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 5.2, and those with DID have a mean score of 43.72. The example client in *Figure 9c* has a mean score of 20.0—high compared to the mean for DDNOS-1b/OSDD-1, but well below the mean for DID.

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 clients with DID obtain a clinically significant score on the *Being Told of Disremembered Actions* scale. In *Figure 9c*, the example client demonstrated a *Clinical Significance Score* of 50, indicating sub-clinical elevation. As the client’s score is below 100, this is not a symptom, based on their initial reporting.

Figure 9c. Criterion C: Fully-Dissociated Actions (detail)

Criterion C: Fully-Dissociated Actions (Amnesia)		4 of 6 symptoms	
A)	Time Loss:	40.0	200 of 300
B)	"Coming to":	10.0	100 (CS = 100+)
C)	Fugues:	22.0	200
D)	Being Told of Disremembered Actions:	20.0	50
E)	Finding Objects Among Possessions:	7.5	0
F)	Finding Evidence of One's Recent Actions:	8.0	100

E) 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 Objects Among Possessions Scale Mean Score – Non-dissociative individuals have a mean score of 1.0 on the *Finding Objects Among Possessions* scale. PTSD experiencers have a mean score of 2.14. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 1.88, and those with DID have a mean score of 34.45. The example client in *Figure 9d* has a mean score of 7.5, suggesting that the client has relatively infrequent experiences of finding objects among their possessions compared to persons with DID.

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 clients with DID obtain a clinically significant score on the *Finding Objects Among Possessions* scale. In *Figure 9d*, the example client 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.

Figure 9d. Criterion C: Fully-Dissociated Actions (detail)

Criterion C: Fully-Dissociated Actions (Amnesia)			4 of 6 symptoms	
A)	Time Loss:	40.0	200	of 300
B)	"Coming to":	10.0	100	(CS = 100+)
C)	Fugues:	22.0	200	↓
D)	Being Told of Disremembered Actions:	20.0	50	
E)	Finding Objects Among Possessions:	7.5	0	
F)	Finding Evidence of One's Recent Actions:	8.0	100	

F) 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; discovering previously unnoticed injuries—even a fully-dissociated suicide attempt.

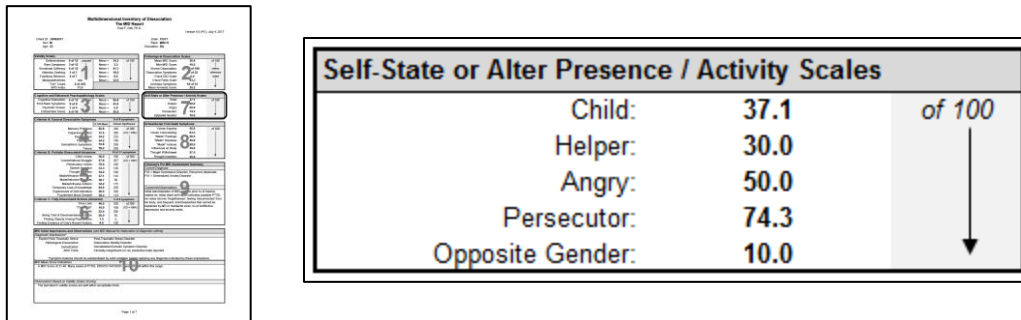
Finding Evidence of One's Recent Actions Scale Mean Score – Non-dissociative individuals have a mean score of 1.0 on the *Finding Evidence of One's Recent Actions* scale. PTSD experiencers have a mean score of 1.43. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 4.25, and those with DID have a mean score of 30.1. The example client in *Figure 9d* has a mean score of 8.0, which suggests they experience this symptom almost twice as often as the average outpatient client with DDNOS-1b/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 clients with DID obtain a clinically

significant score on the *Finding Evidence of One's Recent Actions* scale. In *Figure 9d*, the example client demonstrated a *Clinical Significance Score* of 100, right at the threshold for *Finding Evidence of One's Recent Actions* to be considered a symptom.

7. Self-State or Alter Presence / Activity Scales

Figure 10. The MID Report – Self-State or Alter Presence / Activity Scales



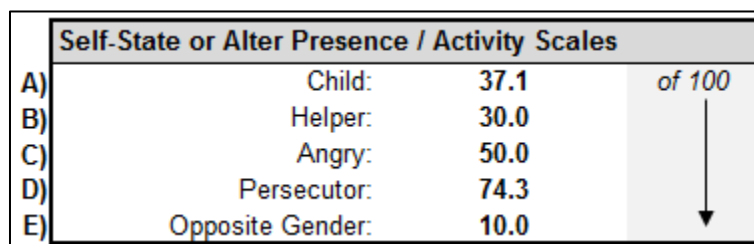
A) Child Parts

The *Child Parts Scale* portrays the mean score of the seven items on the Child Parts 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.”

Child Parts Scale Mean Score – Non-dissociative individuals have a mean score of 5.0 on the *Child Parts* scale. PTSD experiencers have a mean score of 7.24. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 38.81, and those with DID have a mean score of 57.66. The example client in *Figure 10a* has a mean score of 37.1, in line with the mean for outpatients with DDNOS-1b/OSDD-1, and suggests frequent, consciously-registered experiences of child parts activity. Details about the client’s scores 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 10a. Self-State or Alter Presence / Activity Scales (detail)



B) 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 – Non-dissociative individuals have a mean score of 5.0 on the *Helper Parts* scale. PTSD experiencers have a mean score of 6.43. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 40.0, and those with DID have a mean score of 37.56. The example client in *Figure 10b* has a mean score of 30.0, notably below the mean for outpatients with DDNOS-1b/OSDD-1, suggesting that the client has conscious awareness of helper parts activity. Details about the client’s scores 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 10b. Self-State or Alter Presence / Activity Scales (detail)

Self-State or Alter Presence / Activity Scales			
A)	Child:	37.1	of 100
B)	Helper:	30.0	↓
C)	Angry:	50.0	
D)	Persecutor:	74.3	
E)	Opposite Gender:	10.0	

C) 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 – Non-dissociative individuals have a mean score of 6.0 on the *Angry Parts* scale. PTSD experiencers have a mean score of 4.46. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 21.78, and those with DID have a mean score of 54.02. The example client in *Figure 10b* 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 client’s scores on this scale are available in *The Extended MID Report*. A visual representation of this scale is available in the *MID Clinical Summary Graph*.

D) 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 – Non-dissociative individuals have a mean score of 4.0 on the *Persecutor Parts* scale. PTSD experiencers have a mean score of 5.82. Outpatients with DDNOS-1b/OSDD-1 have a mean score of 38.51, and those with DID have a mean score of 55.6. The example client in *Figure 10c* has a mean score of 74.3, highly elevated compared to the mean for outpatients with DID, suggesting a high level of persecutor parts 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*). Details about the client’s scores 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 10c. Self-State or Alter Presence / Activity Scales (detail)

Self-State or Alter Presence / Activity Scales			
A)	Child:	37.1	of 100 ↓
B)	Helper:	30.0	
C)	Angry:	50.0	
D)	Persecutor:	74.3	
E)	Opposite Gender:	10.0	

E) Opposite Gender Parts

The Opposite Gender Parts Scale contains only one item:

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

He, She, or They? A Note on “Opposite Gender” Parts

Although this MID item originally written in terms of a gender binary, test-takers who identify as non-binary, transgender, or genderqueer may not find this language accessible or applicable to them. So, this item can be explained to test-takers instead as “switching back and forth between feeling like your typical, subjective experience of gender and something other (or different) than that typical experience.”

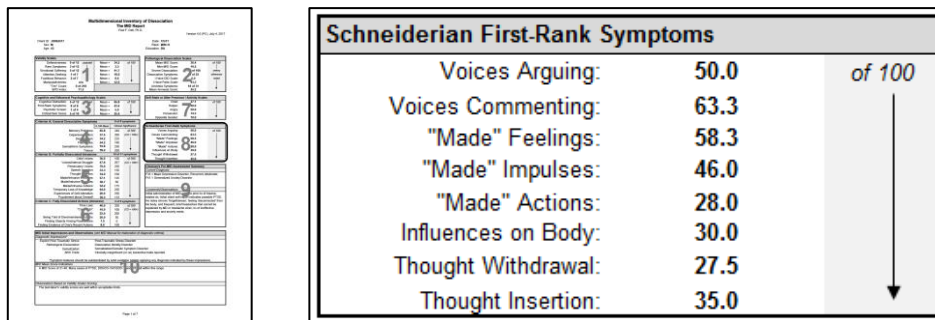
Opposite Gender Parts Scale Mean Score – Because this scale does not measure a specific kind of part, but rather the frequency of consciously-registered switches or shifts between parts of different genders, there are no comparative mean scores. Rather, this scale offers evidence of differently-gendered parts activity in general. The example client in *Figure 10d* 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”).

Figure 10d. Self-State or Alter Presence / Activity Scales (detail)

Self-State or Alter Presence / Activity Scales			
A)	Child:	37.1	of 100
B)	Helper:	30.0	↓
C)	Angry:	50.0	
D)	Persecutor:	74.3	
E)	Opposite Gender:	10.0	

8. Schneiderian First-Rank Symptoms

Figure 11: The MID Report – Schneiderian First-Rank Symptoms



Kurt Schneider (1959) identified 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 (1987) reported that *the first eight of Schneider’s first-rank symptoms were common in clients with DID, but that the last three were not*. 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 (Sommer & Dell, 2005).

Clients with schizophrenia experience psychotic forms of intrusion (e.g., “John Ashcroft is implanting his thoughts in my head.”), whereas dissociative clients experience non-psychotic intrusions (e.g., “Sometimes I have thoughts that do not feel like they are mine;” Dell, 2001). In schizophrenia, the client’s explanations for their symptoms tend toward the fantastical or bizarre (i.e., their reality testing is impaired), whereas the client experiencing non-psychotic, dissociative intrusions tends toward logical and reality-based observations regarding their symptoms (i.e., their reality testing remains intact).

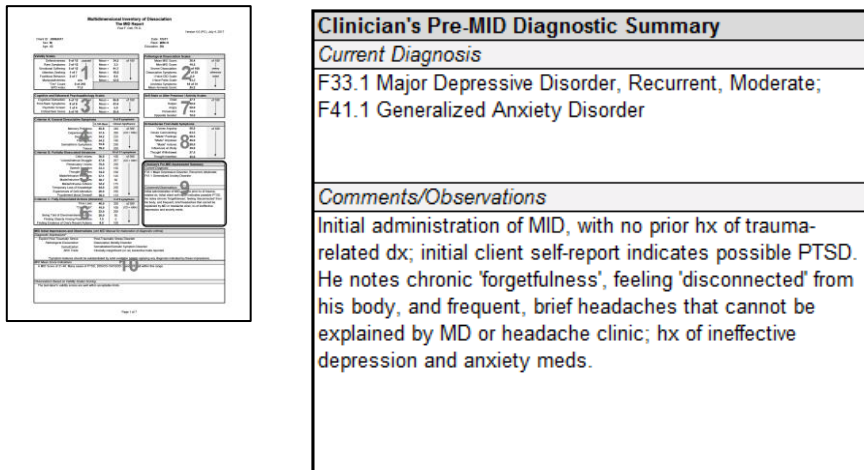
Although Criterion B symptoms (i.e., partially-dissociated intrusions of another self-state) are within the domain of *Schneiderian First-Rank Symptoms*, the mean scores reflected in this section do not precisely line up with the Criterion B symptoms. The mean scores here reflect more narrowly defined 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” DES scale as other mean scores on *The MID Report*.

We can see in *Figure 11* that the example client 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 Scales*, *Critical Items*, *Self-State or Alter Presence / Activity Scales* and the *Clinical Significance Scores* in *Criterion A*, *B*, and *C*.

9. Clinician’s Pre-MID Diagnostic Summary

Figure 12. The MID Report – Clinician’s Pre-MID Diagnostic Summary



The information shown here on *The MID Report* is carried directly from data entered on the **Questions** tab (see *Figure 12a* 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 v4.0*.

Figure 12a. *MID Analysis v4.0* Questions Tab

Client ID		JD062517
Sex	M	
Age	43	
Date	7/5/2017	
Race	W/N-H	
Edu.	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.	

10. MID Initial Impressions and Observations

Figure 13. The MID Report – MID Initial Impressions and Observations

MID Initial Impressions and Observations (see MID Manual for elaboration of diagnostic criteria)	
Diagnostic Impressions*	
Explicit Post-Traumatic Stress:	Post-Traumatic Stress Disorder
Pathological Dissociation:	Dissociative Identity Disorder
Somatization:	Somatization/Somatic Symptom Disorder
BPD Traits:	A few problematic borderline traits
*Symptom features should be substantiated by solid evidence prior to applying any diagnosis indicated by these impressions.	
Mean MID Score Indications	
A MID Score of 31-40: Many cases of PTSD, DDNOS-1b/OSDD-1, and DID fall within this range.	
Observations Based on Validity Scales Scoring	
The test-taker's validity scores are well within acceptable limits.	

The information shown in this section of *The MID Report* includes the overall diagnostic impressions from the client’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* (page 30); and, observations about the client gleaned from their responses to items from the *Validity Scales* items (page 18).

Diagnostic Impressions

Figure 13a. The MID Report – MID Initial Impressions and Observations: Diagnostic Impressions

Diagnostic Impressions*	
Explicit Post-Traumatic Stress:	Post-Traumatic Stress Disorder
Pathological Dissociation:	Dissociative Identity Disorder
Somatization:	Somatization/Somatic Symptom Disorder
BPD Traits:	A few problematic borderline traits
*Symptom features should be substantiated by solid evidence prior to applying any diagnosis indicated by these impressions.	

The MID Report’s impressions are given in the following categories:

- 1) *Explicit Post-Traumatic Stress* (i.e., classic PTSD): This means that the test-taker met criteria for flashback symptoms, which are considered the hallmark of PTSD. The test-taker may also have reported clinically significant scores for depersonalization and derealization, in combination with flashbacks.
- 2) *Pathological Dissociation*, where the possibilities are:
 - *Nondissociative*: There is insufficient evidence to support any kind of dissociative diagnosis.
 - *Dissociative diagnosis deferred*: There is some evidence of dissociative features under Criterion B or Criterion C (or both), but not enough of them under either criterion to support any of the possible diagnoses at this time.
 - *Dissociative Disorder Not Otherwise Specified-1/OSDD-1*: Client met criteria for at least five (5) of the 11 Criterion B symptoms.

- *Dissociative Identity Disorder*: Client met criteria for at least five (5) of the 11 Criterion B symptoms, **and** two (2) of the Criterion C symptoms **or** Criterion B9 (*Temporary Loss of Knowledge*) plus one of the Criterion C symptoms.

Note that, although the MID and *The MID Report* account for derealization, depersonalization, and amnesia and fugue symptoms, diagnoses of *Derealization/Depersonalization Disorder* and *Dissociative Amnesia* (with or without *Dissociative Fugue*) are not offered up.

That said, DSM-5 (2013) criteria for *Derealization/Depersonalization Disorder* are:

- Persistent or recurrent experiences of depersonalization, derealization, or both.
- Reality testing be intact (refer to *Psychotic Screen* in the *MID Report*).
- Symptoms to cause clinically significant distress or impairment in important areas of life functioning.
- The disturbance not be attributable to the physiological effects of a substance (such as a drug of abuse or medication).
- The disturbance not be better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, ***PTSD, or another dissociative disorder*** [emphasis added].

For *Dissociative Amnesia*, DSM-5 (ibid) requires the following:

- An inability to recall important autobiographical information, usually of a traumatic nature, that is inconsistent with ordinary forgetting; additionally, it is noted that *Dissociative Amnesia* most often consists of localized or selective amnesia for a specific event or events, or generalized amnesia for identity and life history.
- Symptoms to cause clinically significant distress or impairment in important areas of life functioning.
- The disturbance not be attributable to the physiological effects of a substance (such as alcohol, other drug of abuse, or medication) or other neurological or medical condition, such as complex partial seizures, transient global amnesia, or effects from a closed head/traumatic brain injury.
- The disturbance not be better explained by ***Dissociative Identity Disorder, PTSD, acute stress disorder, Somatic Symptom Disorder***, or a major or mild neurocognitive disorder [emphasis added].

The MID Report, The MID Extended Report, and the Line and Bar Charts can therefore be useful in discerning whether these additional DSM-5 diagnoses may be present, to the exclusion of DDNOS-1b/OSDD-1 and DID.

- 3) *Somatization*, which reflects symptoms that indicate *Somatization Disorder* (DSM-IV-TR)/*Somatic Symptom Disorder* (DSM-5). The possibilities here are:
 - *Clinically insignificant (or no) somatization reported*
 - *Rule out: Somatization/Somatic Symptom Disorder*, indicating that the client’s self-report of medically unexplained physical symptoms is meaningful, but requires further exploration to clarify clinical significance that would warrant this diagnosis
 - *Somatization/Somatic Symptom Disorder*, indicating that the client’s self-report of medically unexplained physical symptoms is clinically significant and warrants this diagnostic impression

- 4) *BPD (Borderline Personality Disorder) Traits*, which indicates whether borderline traits are present, and to what degree. The possibilities here are:
 - *Clinically insignificant (or no) borderline traits reported*
 - *A few problematic borderline traits*
 - *Several problematic borderline traits: May have BPD*
 - *Many problematic borderline traits: Almost certainly has BPD*
 - *Severe borderline other pathological personality traits*
 - *Extreme borderline and other pathological personality traits*

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 borderline traits represented in the MID.

Referring to the example client’s *Diagnostic Impressions*, we see the following:

Figure 13b. The MID Report – MID Initial Impressions and Observations: Diagnostic Impressions

Diagnostic Impressions*	
Explicit Post-Traumatic Stress:	Post-Traumatic Stress Disorder
Pathological Dissociation:	Dissociative Identity Disorder
Somatization:	Somatization/Somatic Symptom Disorder
BPD Traits:	A few problematic borderline traits
*Symptom features should be substantiated by solid evidence prior to applying any diagnosis indicated by these impressions.	

- The example client meets criteria for PTSD, based on their *Clinical Significance Score* on the *Flashbacks* scale. They met the threshold for clinical significance on all five of the Criterion A symptoms: *Memory Problems, Depersonalization, Derealization, Flashbacks, Somatoform Symptoms, and Trance.*

According to the MID, a diagnosis of DID requires clinically significant scores on 4 Criterion A symptoms, 5 Criterion B symptoms, and 2 Criterion C symptoms (or Criterion B9 plus one Criterion C symptom).

- A diagnostic impression of Dissociative Identity Disorder has been offered up for the example client. They met clinical significance for 10 of 11 Criterion B symptoms

(excepting *Made/Intrusive Impulses*), and 4 of 6 Criterion C symptoms (excepting *Being Told of Disremembered Actions* and *Finding Objects Among Possessions*). We will next look further on in the impressions to check the *Mean MID Score Indications* and the *Observations Based on Validity Scales Scoring* for anything unusual or anomalous. Regardless, follow-up on clinically significant symptoms via *The Extended MID Report* is most certainly called for.

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

- The example client met criteria for *Somatization (DSM-IV-TR)/Somatic 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 client 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 client's day-to-day life.

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*:

Symptom features should be substantiated by solid evidence prior to applying any diagnosis indicated by these impressions.

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

Mean MID Score Indications

The *Mean MID Score Indications* 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* (page 31).

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

- *A MID Score of 0-7*: Nondissociative (unless denial is present). If the MID score is 4 or lower, check to see if the Defensiveness Scale is elevated.
- *A MID Score of 8-14*: This level of dissociation is common in therapy patients who do not have a dissociative disorder. A few, diagnostically irrelevant, dissociative experiences may be present.

- *A MID Score of 15-20:* PTSD may be present if the Flashbacks, Depersonalization, and Derealization scales are elevated.
- *A MID Score of 21-30:* Many cases of PTSD and some cases of DDNOS-1b/OSDD-1 and DID fall within this range.
- *A MID Score of 31-40:* Many cases of PTSD, DDNOS-1b/OSDD-1, and DID fall within this range.
- *A MID Score of 41-64:* Some cases of PTSD, many cases of DID, and some clients with problematic borderline features fall within this range.
- *A MID Score of 65 or higher:* Some cases of PTSD and DID, and many cases of especially severe BPD fall within this range. MID scores in this range require a close examination of the Validity Scales and a very careful follow-up interview.

Figure 13c. The MID Report – MID Initial Impressions and Observations: Mean MID Score Indications

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

We can see in *Figure 13c* that the example client's *Mean MID Score* of 36.4 is consistent with the diagnostic impression of DID offered up by the MID.

Observations Based on Validity Scales Scoring

The possible results in *Observations Based on Validity Scales Scoring* are:

- One or more validity scales are elevated (see MID Diagnostic Graph). This rarely indicates invalid MID results. Elevated validity scales usually mean that clinically meaningful personality traits or response sets are present. They must be investigated via (1) reading the section on Validity Scales in the Mini-Manual, and (2) a thorough follow-up interview regarding pertinent validity items (see Extended MID Report).
- This person's validity scores are within acceptable limits. Nevertheless, one or more validity scales are subclinically elevated. It is appropriate to take such subclinical elevations into consideration when interpreting the test-taker's MID scores and the MID Diagnostic Impressions and Observations.
- The test-taker's validity scores are well within acceptable limits.

Figure 13d. The MID Report – MID Initial Impressions and Observations: Observations Based on Validity Scales Scoring

Observations Based on Validity Scales Scoring
The test-taker's validity scores are well within acceptable limits.

Results in *Figure 13d* show that the example client's *Validity Scores* are within acceptable limits.

The Extended MID Report

Figure 14. The Extended MID Report

The Extended MID Report			
Version 4.0 (PC); July 4, 2017			
Validity Scales			
Defensiveness Scale		Mean*: 3.4	% of Items Passed: 0.0
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.	
Emotional Suffering Scale		Mean: 4.2	# of Items Passed: 5
1	29. (5)	Nobody cares about you.	

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 14a. The Extended MID Report – Memory Problems (detail)

Criterion A: General Dissociative Symptoms			
Memory Problems Scale		Mean:	Cutoff Score (5):
8	2 (4)	6.6	2.4
2	24 (2)		
8	67 (3)		
7	78 (5)		
8	79 (3)		
7	90 (3)		
8	102 (3)		
5	122 (3)		
2	134 (2)		
9	143 (2)		
8	154 (4)		
7	211 (2)		

A) Client's responses carried over from the Questions tab
 B) Item number from MID, with corresponding question to the far right
 C) Cutoff value (for clinical significance) for each item
 D) 'Raw' mean score (0–10 scale)
 E) Cutoff Score for Clinical Significance

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 far right.

- B) *Item Number* as it appears on the MID and the **Questions** worksheet.
- C) *Item Cutoff Value for Clinical Significance* – Remember, for the client’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) *“Raw” Mean Score* – The average of the client’s responses on the “0 to 10” scale.
- E) *Cutoff Score* – This is the *Clinical Significance Score* before it is multiplied by 100. Different language and information may appear in this field, depending on the scale/symptom. (Example: *Psychosis Screen* shows the *Psychosis Screen* score rather than the cutoff score.)

From Cutoff Score to Clinical Significance Score

(**x**) is the number of items the client needs to ‘pass’ on a scale for the symptom to be clinically significant. Clinical significance is determined by comparing the proportion of questions the client “passed” to the number of items they **needed** to “pass”.

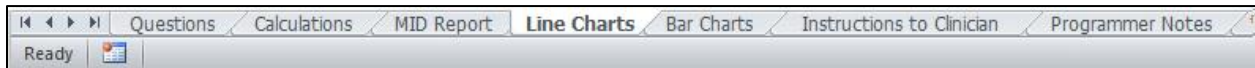
*Example: Client “passed” 12 Memory Problems Scale items. They **needed** to “pass” (5). $5 \div 5 = 1$...so, $12 \div 5 = 2.4$ times as many items for Memory Problems to be a symptom. If we want this score to scale on a ‘0 to 100’ metric rather than a ‘0 to 1’ metric, as it currently does, we multiply by 100. The Clinical Significance Score for Memory Problems is 240.*

Part III: After the MID Report

Visualizing MID Results: The Line and Bar Charts

The various *MID Scales* are laid out visually in the *Line* and *Bar Charts*. 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 Charts*.

Line Charts Legend



The client's and different comparison populations' scores are each given their own color/symbol on the four charts (which appear in different greyscale shades in black-and-white):

Figure 19. MID Line Charts Legend



[Client ID] – Represents the client's scores on the MID. In color, the client's scores/data points appear as violet diamonds connected by a violet line. The text for this field is carried over from the *Client ID* field on the **Questions** worksheet.

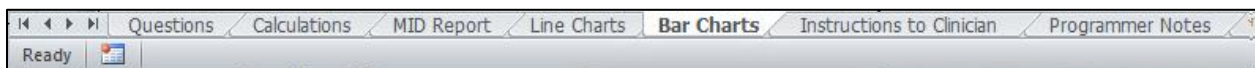
Nondissociative – Represents the testing sample found not to experience PTSD or any, more severe form of pathological dissociation. This population's scores/data points appear as fuchsia squares connected by a fuchsia line.

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

DDNOS-1b/OSDD-1 – Represents the testing sample diagnosed with DDNOS-1b/OSDD-1. This population's scores/data points appear as dark cyan Xs connected by a dark cyan line.

PTSD – Represents the testing sample diagnosed with PTSD. This population's scores/data points appear as lighter purple stars (six points) connected by a lighter purple line.

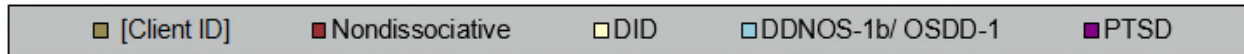
Bar Charts Legend



The information contained in the four *Bar Charts* is identical to that reflected in the *Line Charts*, and is included for the simple reason that some people prefer to read line graphs, and others prefer to read bar graphs. The client's and different comparison populations' scores are each

given their own color on the four charts (which appear in different greyscale shades in black-and-white):

Figure 20. Bar Charts Legend



[Client ID] – Represents the client’s scores on the MID. The client’s scores/bar lines appear as pea green. The text for this field is carried over from 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 maroon.

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

DDNOS-1b/OSDD-1 – Represents the testing sample diagnosed with DDNOS-1b/OSDD-1. This population’s scores/bar lines appear as cyan.

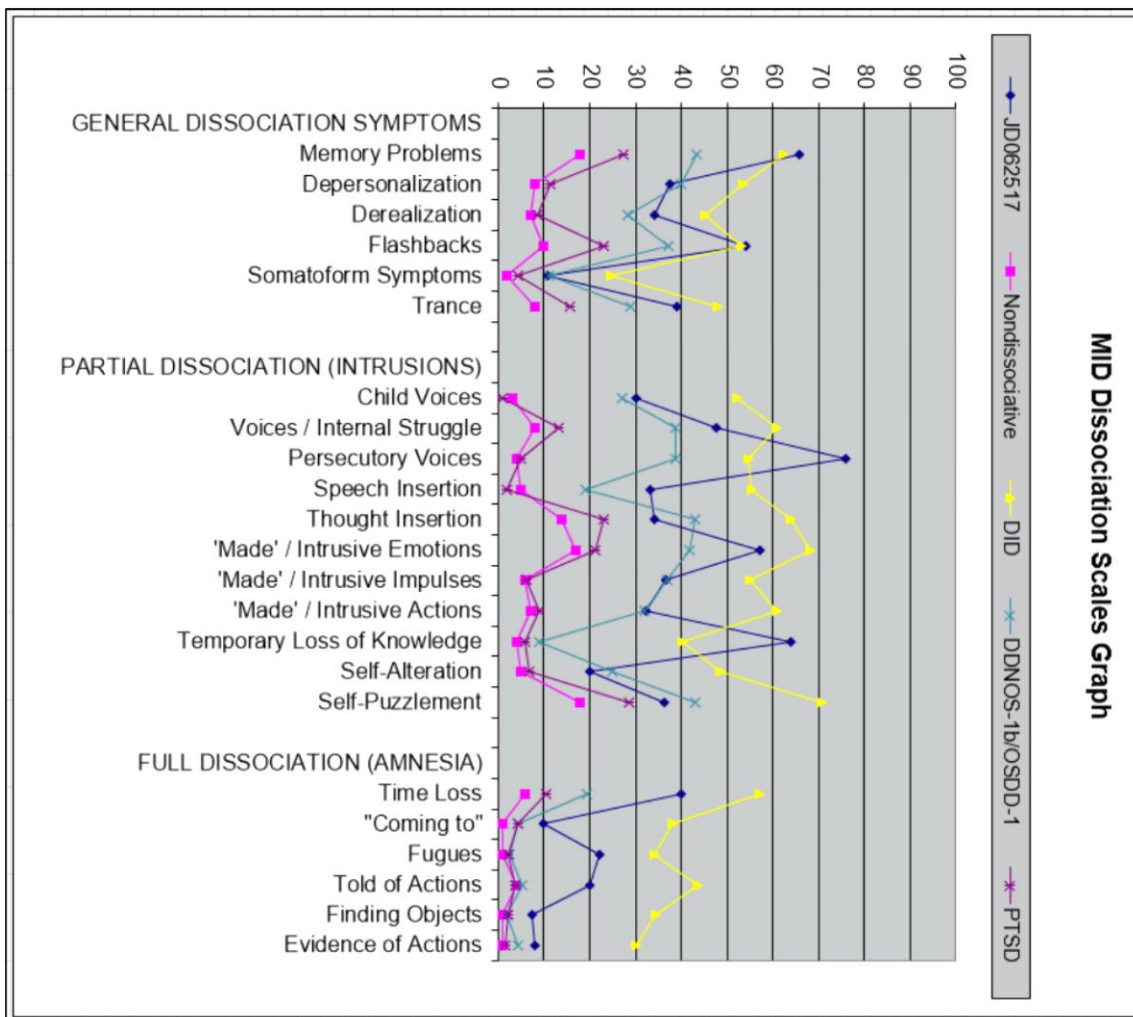
PTSD – Represents the testing sample diagnosed with PTSD. This population’s scores/bar lines appear as violet.

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 client’s *Mean Scores* for the 23 dissociative symptoms, as compared to norms for other diagnostic categories: Nondissociative, PTSD, DDNOS-1b/OSDD-1, 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 15. The MID Dissociation Scales Line Graph

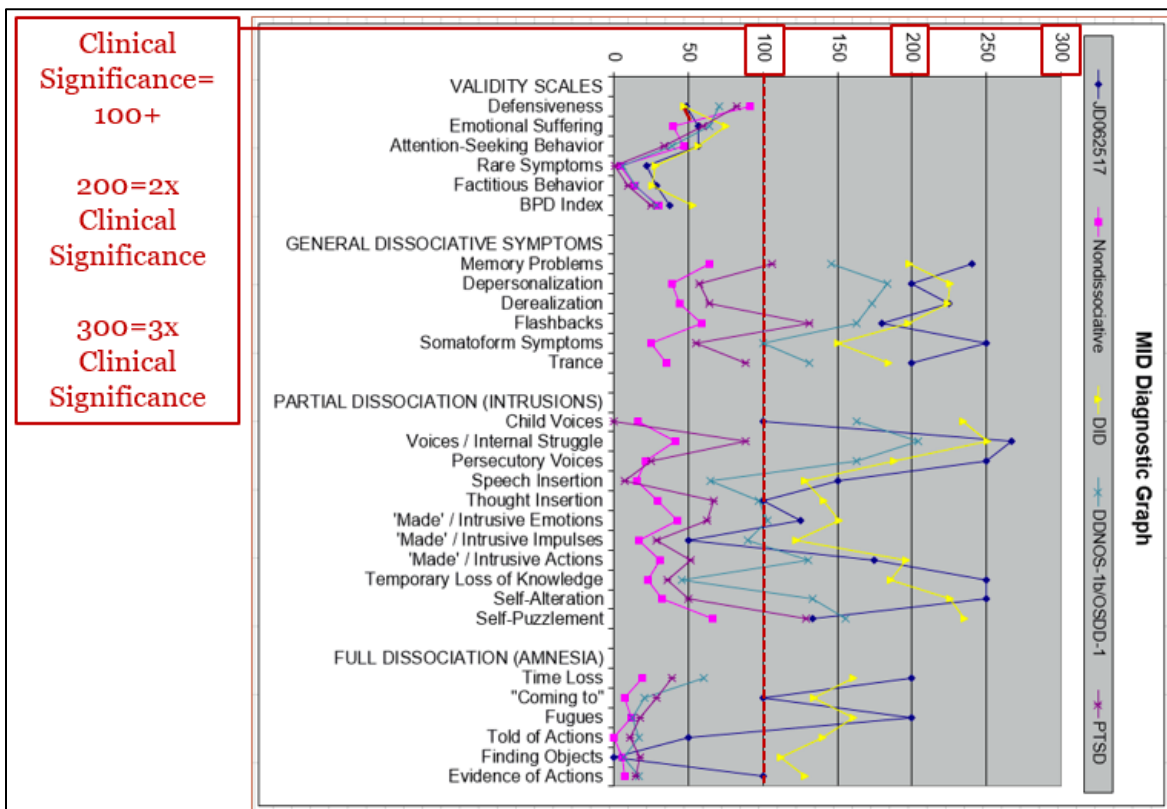


The MID Diagnostic Graph

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 client 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 client definitely has that symptom; that is, the person ‘passed’ enough items on that scale to show that they experience that symptom. A score of 200 indicates that the client ‘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 client ‘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 client does *not* have that symptom. Analysis of a client’s pattern of scores on the *MID Diagnostic Graph* allows the clinician to diagnose PTSD, depersonalization/derealization disorder, dissociative identity disorder (DID), other specified dissociative disorder (OSDD-1; formerly known as DDNOS-1b, a DID-like dissociative disorder, but without amnesia), and other types of DDNOS/OSDD (including ‘Unspecified Dissociative Disorder’, as indicated in DSM-5 (2013)).

Figure 16. The MID Diagnostic Line Graph

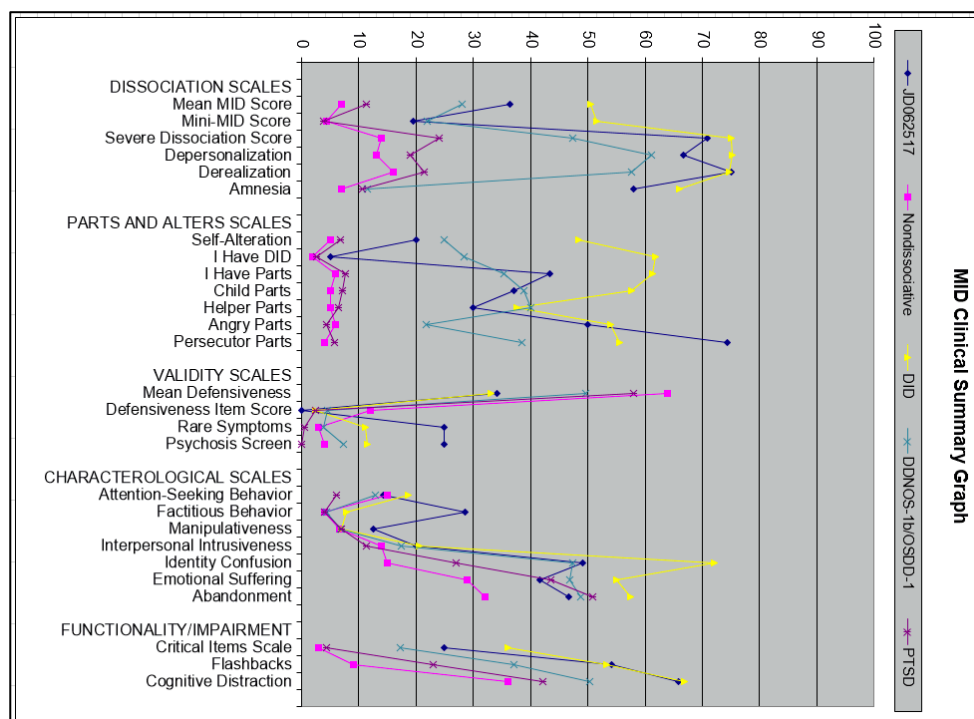


The MID Clinical Summary Graph

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 mean scores from the most essential *Pathological Dissociation Scales* on the *MID Report*.
- 2) **Self-States and Alters Scales** – Depicts mean scores from the *Pathological Dissociation Scales* concerning parts activity, as well as those from the *Self-State or Alter Presence/Activity Scales*, all from the *MID Report*, as well as an aggregation of specific symptom features combined into a measure called *self-alteration*.
- 3) **Validity Scales** – Depicts mean scores from the most salient of the *Validity Scales* reflected in the *MID Report*.
- 4) **Characterological Scales** – Depicts mean scores both from the *Validity and Characterological Scales* on the *MID Report* and particular features of BPD assessed by the MID, which give greater context to the MID’s other scales and, ultimately, to the client’s subjective experience.
- 5) **Cognitive and Behavioral Functionality/Impairment Scales** – Depicts mean scores from three scales that highlight potentially harmful impairment: a) Critical Items; b) Flashbacks; and c) Cognitive Distraction.

Figure 17. 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. While a few scales do, indeed, present the client'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.

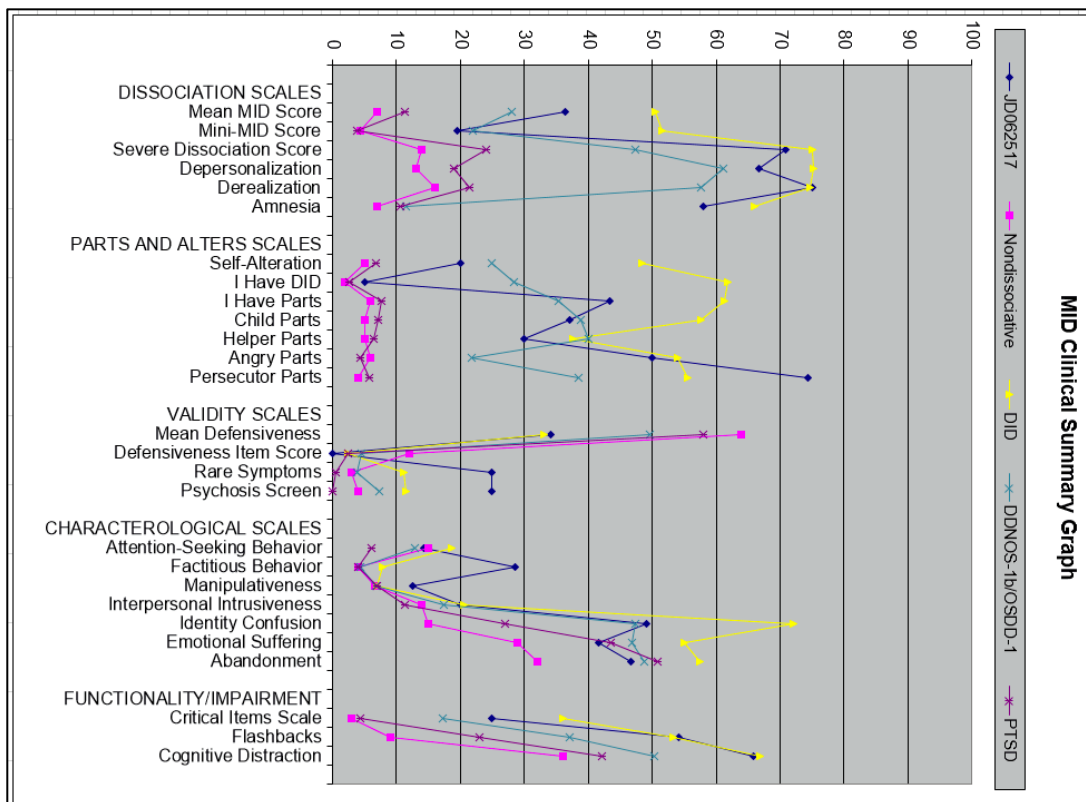
Careful study of a client's scores on the *Clinical Summary Graph* are often especially revealing of characterological aspects of that person's clinical 'picture.' Nowhere in the data reported by *MID Analysis* are problematic personality traits so readily visible as they are in the *Clinical Summary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

The MID Factor Scales 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 (most important) factors. The PTSD profile on this graph is for PTSD patients who are not dissociative.

Figure 18. The MID Factor Scales Line Graph



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 scores and/or 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 client'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 – usually to occur the session following administration and scoring of the MID – clinicians will study *The MID Report*, *The Extended MID Report*, and graphs to identify areas clarify and collect qualitative data. The following is a guide to this process for clinicians to adapt to their settings as they see fit.

In first review of *The MID Report* and *The Extended MID Report*, take note of:

- Results that are surprising based on previous knowledge of the client; and
- Results congruent with information already known about the client

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 client. If dissociative symptoms have been previously identified, inquiry may be made as to how an item relates to information identified in prior sessions.

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

- *Validity Scales*
- *First Rank Symptoms*
- *Psychosis Screen*
- *Critical Item Score*
- *Persecutor Parts Scale*
- *Amnesia Scales (Criterion 'C') plus Criterion B9 (Temporary Loss of Knowledge)*

Third, consider reviewing items within highly endorsed scales, scales just above or below clinical significance or “passing,” and items which were endorsed by the client 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

“Tell me an example of this in your experience.”

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. *Significantly* 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 with updated data. For more on clinical significance, see [page 19](#).

Common Challenges

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

- Client 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 client identifies with the subjective experience indicated, they may answer according to the original instructions. If the client does not identify with the subjective experience indicated, the answer is ‘0.’
- Client 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 client) may also provide clarification.
- Client writes many qualifying notes surrounding MID items, answers/notes given do not match the items as they are written, and/or the client brings their own meaning to the item wording. A client 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.

Additionally, atypical responders may present severe characterological traits (falsifying), confused or psychotic, loose cognitive style or as “me, too” people (Dell, 2011).

Should I share the MID results with my client?

Some clinicians will show a portion of the *MID Report*, a line chart or bar chart to the client. Clients 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. Use your good clinical judgment here.

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

It is essential to carefully consider whether to treat the client and pursue consultation and training in treating dissociative disorders, or refer the client to someone already trained and experienced in this area. Recall Kluff's study regarding prognosis mentioned above.

If you have detected and assessed a client who was not previously identified as having a dissociative disorder, and begin to seek training and consultation to treat the client accordingly, the client's prognosis has already improved significantly! Careful and thorough informed consent and educating the client on their treatment options and probable prognosis is also extremely important. Refer to the *Guidelines for Treating Dissociative Identity Disorder in Adults* (ISST-D, 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 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						
<i>Defensiveness</i>	35.5 (16.0)	2.6	32.3 (19.0)	2.5	67.3 (17.9)	19.4
<i>Rare Symptoms</i>	4.5 (8.7)	7.8	5.1 (8.2)	7.5	3.2 (8.2)	6.3
<i>Emotional Suffering</i>	54.7 (23.0)	23.3	57.7 (22.9)	30.0	17.1 (16.0)	1.0
<i>Attention-Seeking</i>	20.9 (20.4)	22.0	27.2 (18.2)	32.5	3.8 (13.9)	8.8
<i>Factitious Behavior</i>	6.7 (11.8)	3.9	8.6 (11.5)	7.5	5.5 (9.8)	4.5
<i>BPD Index</i>	12.9 (12.8)	9.1	15.6 (11.0)	15.0	9.3 (10.1)	5.1
<i>Psychotic Screen</i>	4.4 (10.5)	2.6	6.8 (11.7)	7.5	3.4 (9.1)	4.5
<i>Mean MID</i>	51.3 (18.7)		39.0 (19.4)		8.0 (10.9)	
<i>MID Severe</i>	127.9 (32.7)		100.1 (39.2)		25.1 (33.3)	
<i>Dissociative Sx (23)</i>	20.3 (4.4)		16.3 (6.4)		3.6 (6.0)	
<i>"I Have DID"</i>	70.2 (31.1)		36.0 (33.6)		4.4 (13.5)	
<i>"I Have Parts"</i>	62.5 (25.5)		42.8 (25.6)		7.5 (14.0)	
<i>Child Part</i>	59.4 (28.4)		39.1 (23.0)		6.9 (12.6)	
<i>Helper Part</i>	42.3 (35.6)		29.0 (32.7)		10.0 (21.3)	
<i>Angry Part</i>	53.3 (27.1)		38.9 (28.4)		7.2 (13.5)	
<i>Persecutor Part</i>	54.3 (30.1)		42.4 (31.3)		5.1 (13.2)	
<i>Opposite Sex</i>	24.9 (31.9)		10.0 (22.8)		4.2 (14.8)	
<i>Mean Amnesia</i>	41.5 (22.5)		26.7 (22.0)		5.1 (9.3)	
<i>Amnesia items (31)</i>	21.8		14.1		3.2	

MID Clinical Significance* Scores

	DID		DDNOS		Nondissociative	
	Clin. Significance ()	% YES	Clin. Significance ()	% YES	Clin. Significance ()	% YES
MID Symptom						
<i>Memory Problems</i>	195.5 (53.8)	94.7	175.5 (69.4)	85.0	46.5 (57.6)	19.2
<i>Depersonalization</i>	226.6 (69.3)	94.7	187.5 (82.8)	90.0	43.9 (67.1)	17.8
<i>Derealization</i>	229.6 (77.3)	92.1	191.9 (91.7)	87.5	41.8 (77.5)	27.1
<i>Flashbacks</i>	202.1 (58.7)	92.1	165.5 (83.5)		41.8 (61.6)	18.6
<i>Somatoform Symptoms</i>	145.1 (74.6)	79.0	130.6 (81.9)	67.5	41.8 (66.4)	16.1
<i>Trance</i>	186.1 (60.6)	88.2	160.0 (79.5)	77.5	41.9 (55.4)	17.5
<i>Child Voices</i>	240.8 (95.5)	93.4	180.0 (122.4)	77.5	33.3 (72.1)	21.7
<i>Internal Struggle</i>	253.5 (62.6)	97.4	197.5 (88.5)	85.0	48.5 (76.0)	20.6
<i>Persecutory Voices</i>	190.1 (82.5)	86.8	140.0 (95.5)	65.0	22.0 (56.0)	11.4
<i>Speech Insertion</i>	123.7 (45.8)	84.2	91.3 (60.9)	67.5	27.2 (43.0)	14.3
<i>Thought Insertion</i>	144.7 (38.7)	93.4	120.0 (53.8)	70.0	28.1 (45.6)	13.7
<i>Made Emotions</i>	148.4 (37.7)	93.4	117.5 (58.3)	67.5	29.2 (48.5)	13.7
<i>Made Impulses</i>	126.3 (39.6)	86.8	95.0 (51.6)	67.5	23.3 (42.1)	11.9
<i>Made Actions</i>	195.7 (46.1)	96.1	158.1 (64.6)	85.0	40.7 (56.4)	16.1
<i>Loss of Knowledge</i>	187.5 (78.8)	85.5	126.3 (88.4)	62.5	32.3 (58.0)	15.9
<i>Self-Alteration</i>	231.3 (70.0)	96.1	177.5 (74.2)	87.5	43.7 (67.9)	16.9
<i>Self-Puzzlement</i>	231.6 (55.2)	97.4	204.2 (70.5)	90.0	48.7 (71.5)	22.5
<i>Time Loss</i>	165.1 (61.7)	85.5	118.8 (74.0)	70.0	24.2 (46.3)	12.9
<i>Coming to</i>	147.4 (68.3)	81.6	101.3 (76.4)	60.0	22.5 (43.8)	11.0
<i>Fugues</i>	170.4 (88.4)	82.9	102.5 (94.7)	50.0	22.1 (51.8)	10.4
<i>Disremembered Behavior</i>	139.5 (63.4)	86.8	90.0 (71.8)	50.0	22.9 (47.1)	11.0
<i>Finding Objects</i>	127.6 (81.0)	68.4	80.0 (82.3)	50.0	17.3 (41.6)	8.6
<i>Forgotten Behavior</i>	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 v4.0* 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**, **Line Charts**, or **Bar Charts** 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 charts 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 Charts* graphs to a word processing program is cumbersome, but possible. The *easiest* way to accomplish this is:

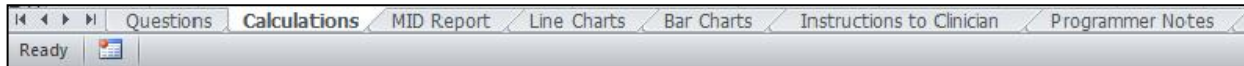
- 1) Open the word processing program and create a new, blank document (if one is not already created)
- 2) Open *MID Analysis v4.0* and be certain that the desired worksheet tab is highlighted, and that the desired worksheet (*The MID Report*, etc.) is visible.
- 3) Select *only* the cells containing 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 – Past 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*, *Extended MID Report*, and the *Line* and *Bar Charts*. 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)

Calculations...														
Raw scores are collected here... Calculations, etc come from the Item & criteria docs		List of Named Cells Containing Answers ->												
		Cutoff Values												
		Mean Values												
		Diagnostic Item Score												
		% Passed												
Validity														
Defensiveness	6.67	8	0	3	5	2	4	2	3	4	5	2	2	33
Defensiveness Item Score	1.00	0	0	0	0	0	0	0	0	0	0	0	0	
	8.33	0	1	0	0	0	0	0	0	0	0	0	0	
Emotional Suffering	4.33	3	8	3	4	4	5	4	5	2	4	5	5	
	4.00	5	5	5	6	3	7	5	5	5	6	7	5	
	33.33	0	1	0	0	1	0	0	1	0	0	0	1	
Attention-Seeking Behavior	3.29	4	5	5	1	2	5	1						
	3.00	3	5	5	7	6	6	4						
	42.86	1	1	1	0	0	0	0						

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

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

Criterion A Scales														
A. General Dissociative Symptoms														
Memory Problems		3.33	3	6	3	5	3	2	5	5	2	2	1	3
1		1.80	4	2	3	5	3	3	3	3	2	2	4	5
		75.00	0	1	1	1	1	0	1	1	1	1	0	1

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

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

H) 1	A) 3.33	B) 3	6	3	5	3	2	5	5	2	2	1	3	E) 5*
	F) 1.80	C) 4	2	3	5	3	3	3	3	2	2	4	2	
	G) 75.00	D) 0	1	1	1	1	0	1	1	1	1	0	1	

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 client’s scores on all 12 items—see B) Client Item Score directly below—and dividing by the number of items for that symptom.*

B) **Client 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 client’s responses for items 2, 24, 67, 78, 79, 90, 102, 122, 134, 143, 154, and 211, and are called directly from the client’s responses entered into the cyan-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 client’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 client “passed” that particular item, and a “0” means that the client “did not pass” the corresponding item. *A “pass” indicates that the client’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) Client 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 client 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 Dissociative Symptoms – Memory Problems (detail)

H) 1	A) 3.33	B) 3	6	3	5	3	2	5	5	2	2	1	3	E) 5
	F) 1.80	C) 4	2	3	5	3	3	3	3	2	2	4	2	
	G) 75.00	D) 0	1	1	1	1	0	1	1	1	1	0	1	

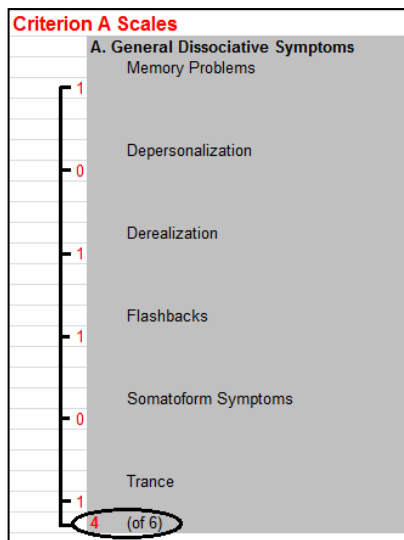
F) **Diagnostic Item Score** – Shifting back to the near left, directly below A) in *Figure A4*, and in bolded red text on the *Calculations* worksheet, is a number that represents the sum of all **Diagnostic Item Calculation** scores, divided by the **Overall Cut-off Value**. If the result is greater 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 client’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.

(Continued on next page)

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 Body-Oriented Psychotherapies

For clinicians who have been trained in EMDR 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 BODY-ORIENTED 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.

Step back, calmly and thoughtfully, from working with the trauma material. EMDR therapists should avoid attempting to ‘push through’ the client’s symptoms by diving deeper into reprocessing, because higher levels of dissociation (beyond simple PTSD) do not respond well to this approach, and can be both serially re-traumatizing for your client 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 client’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 clients dealing with more complex presenting problems, or to defer use of EMDR and employ a 3-stage treatment model instead. Curt Rounzoin (2011) teaches 3 factors of readiness for reprocessing using the ‘Standard Protocol’:

- DES and clinical screening completed without concerns.
- Client 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 clients 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 reasons for concern in the course of EMDR therapy:

- Standard containment methods are not successful.
- If EMDR Phase 2 (Preparation/Resource) or 4 (Desensitization) ‘stalls’, or client 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 your client a favor: Seek consultation with a clinician skilled in assessing and treating complex trauma and dissociation.

References

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

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

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Baron, M. W. (2003). Manipulativeness. *Proceedings and Addresses of the American Philosophical Association*, 77(2), 37-54.

Bleuler, E. (1911). *Dementia Praecox or the Group of Schizophrenias*. Zinkin J. (Trans.), New York, International Universities Press, 1950.

Carlson E., Putnam, F. (1993). An update on the dissociative experiences scale. *Dissociation*, 7(1), 16-27.

Child, D. (2006). *The Essentials of Factor Analysis*. (3rd ed.). New York, NY: Continuum International Publishing Group.

Dell, P. F. (2001). Why the diagnostic criteria for dissociative identity disorder should be changed. *Journal of Trauma & Dissociation*, 2(1), 7-37.

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

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

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. (2011). *How to use the Multidimensional Inventory of Dissociation (MID)*. Presented at ISSTD 29th Annual International Conference, Montreal, QC, Canada.

Dell, P. F. (2013). Three dimensions of dissociative amnesia. *Journal of Trauma & Dissociation*, 14(1), 25-39.

Dell, P. F. (2017). Is high hypnotizability a necessary diathesis for pathological dissociation? *Journal of Trauma & Dissociation*, 18(1), 58-87.

Dell, P. F., & Lawson, D. (2009). An empirical delineation of 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, NY: Routledge.

Eysenck, S. B. G., Eysenck, H. J., & Barrett, P. (1985). A revised version of the Psychoticism Scale. *Personality and Individual Differences*, 6, 21-29.

Gast, U., Rodewald, F., Dehner-Rau, C., (2003). *Validation of the German version of the Multidimensional Inventory of Dissociation (MID-d)*. Paper presented at the 20th Annual Conference of the International Society for the Study of Trauma and Dissociation, Chicago, IL, 2003.

International Society for the Study of Trauma and Dissociation. (2011). [Chu, J. A., Dell, P. F., Van der Hart, O., Cardena, E., Barach, P. M., Somer, E., Loewenstein, R. J., Brand, B., Golston, J. C., Courtois, C. A., Bowman, E. S., Classen, C., Dorahy, M., Sar, V., Gelinias, D. J., Fine, C. G., Paulsen, S., Kluft, R. P., Dalenberg, C. J., Jacobson-Levy, M., Nijenhuis, E. R. S., Boon, S., Chefetz, R.A., Middleton, W., Ross, C. A., Howell, E., Goodwin, G., Coons, P. M., Frankel, A. S., Steele, K., Gold, S. N., Gast, U., Young, L. M., & Twombly, J.J]. Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation*, 12, 115-187.

- Kluft, R. (1985). The natural history of multiple personality disorder. In R. Kluft (Ed.) *Childhood Antecedents of Multiple Personality*, (pp. 197-238). Washington D.C.: American Psychiatric Press.
- Kluft, R. P. (1987). First-rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry*, 144, 293-298.
- Kluft, R. P. (2017, March). Back to the future – rediscovering the past to improve treatment results in DID and allied dissociative conditions in the present. Paper presented at the 34th Annual Conference of the International Society for the Study of Trauma and Dissociation, Washington, D.C., 2017.
- Laddis, A. & Dell, P. F. (2012). Dissociation and psychosis in dissociative identity disorder and schizophrenia. *Journal of Trauma & Dissociation*, 13(4), 397-413.
- Laddis, A., Dell, P. F., & Korzekwa, M. (2017). Comparing the symptoms and mechanisms of “dissociation” in dissociative identity disorder and borderline personality disorder. *Journal of Trauma & Dissociation*, 18(2), 139-173.
- Nijenhuis, E. R. S. (1999). *Somatiform dissociation: Phenomena, measurement, and theoretical issues*. Assen, the Netherlands: Van Gorcum.
- Pearce, S., & Yong A. G. (2013). A beginner’s guide to factor analysis: focusing on exploratory factor analysis. *Tutorials in Quantitative Methods for Psychology*, 9(2), 79-94.
- Ross, C.A., Anderson, G., Fleisher, W., & Norton, G.R. (1991). Frequency of multiple personality disorder among psychiatric inpatients. *American Journal of Psychiatry*, 148, 1717-1720.
- Ross, C., Heber, S., Norton, G., Anderson, G., Anderson, D., Barchet, P. (1989). The Dissociative Disorders Interview Schedule: A structured interview. *Dissociation*, 2(3):169-189.
- Rouanzion, C. (2011, August). *EMDR Update and Refresher Course*. Presented at 17th EMDR International Association Conference, Anaheim, CA, 2011.
- Şar V., & Öztürk, E. (2009). Psychotic presentations of dissociative identity disorder. In P. F. Dell & J. A. O’Neil (Eds.). *Dissociation and the dissociative disorders: DSM-V and beyond* (pp.535-545). New York: Routledge.
- Schneider, K. (1959). *Clinical psychopathology*. (M. W. Hamilton, trans.). New York, NY: Grune & Stratton.
- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed). New York, NY: Guilford Press.
- Somer, E. & Dell, P.F. (2005). Development of the Hebrew-Multidimensional Inventory of Dissociation (H-MID): A valid and reliable measure of pathological dissociation. *Journal of Trauma & Dissociation*, 6(1), 31-53.
- Steinberg, M. (1994). *Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D), Revised*. Washington, DC: American Psychiatric Press.
- Weinberger, D. A. & Schwartz, G. E. (1990). Distress and restraint as superordinate dimensions of adjustment: a typological perspective. *Journal of Personality*, 58, 381-417.
-