

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

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Multidimensional Inventory of Dissociation (MID)

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The following pages provide a detailed description of the MID, its different scales, and the meaning of a client's scores. MID scores are depicted in three major graphs:

I. The MID Dissociation Scales Graph:

The MID Scales Graph provides a profile of the person's scores on the 23 MID dissociation scales.

II. The MID Diagnostic Graph:

The MID Diagnostic Graph has 6 validity scales and 23 dissociation scales. Each scale indicates whether the client has a *clinically significant level* of that particular dissociative symptom.

III. The MID Clinical Summary Graph:

The Clinical Summary Graph has five clusters of scales: (1) dissociation scales, (2) parts and alters scales, (3) validity scales, (4) characterological scales, and (5) functionality/impairment scales. These five clusters of scales help to explain the client's MID responses.

I. 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 contiguous with the entire 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.

General Dissociative Symptoms

The general dissociative symptoms not only occur in persons with a dissociative disorder; they also occur in certain nondissociative disorders: PTSD, somatization disorder, conversion disorder, panic disorder, schizotypal personality disorder, and borderline personality disorder.

- 1. Memory Problems.** Memory Problems include lack of memory for significant life events, inability to recall substantial portions of childhood, and chronic day-to-day forgetfulness.
 - 2. 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.
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3. **Derealization.** In derealization, the world feels unreal, strange, unfamiliar, distant, or changed.
4. **Flashbacks.** Flashbacks typically manifest as sudden, intrusive memories, pictures, internal ‘videotapes,’ nightmares, or body sensations of previous traumatic experiences. During strongly dissociated flashbacks, a person may lose contact with here and now. When this happens, the person is ‘there and then’ rather than here and now.
5. **Somatic Symptoms.** Somatic symptoms have been referred to as *somatoform dissociation* by Nijenhuis. Specifically, these are bodily experiences and symptoms that have no medical basis. Such 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
6. **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 so ‘out of touch’ with what is going on around him or her that it may be difficult to get his/her attention.

Consciously Experienced Intrusions from a Dissociated Self-State

7. **Child Voices.** The voice of a child is heard inside the head. The voice may speak or cry.
 8. **Voices/Internal Struggle.** Dissociated parts may argue, or struggle with one another or with host person. The internal struggle may manifest itself as voices that argue or as non-auditory internal forces that struggle with one another (or with the person).
 9. **Persecutory Voices.** Persecutory voices engage in name-calling, harsh disparagement, and commands for the person to commit acts of self-injury or suicide.
 10. **Speech Insertion.** In speech insertion, a dissociated part intrudes into the executive functioning of the host. Specifically, the dissociated part seizes control of what is being said and the person feels that the words coming out of his/her mouth are being controlled by someone or something else.
 11. **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 person.
 12. **‘Made’/Intrusive Feelings.** Intrusive feelings are experienced as “coming from out of nowhere,” often with no apparent reason. The person often experiences intrusive emotions as not really “mine.”
 13. **‘Made’/Intrusive Impulses.** Intrusive impulses are often quite strong, apparently inexplicable, and may be experienced as not really “mine.”
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14. **‘Made’/Intrusive Actions.** Intrusive actions tend to feel as if they were done by someone or something else inside the person.
15. **Temporary Loss of Well-Rehearsed Knowledge and/or Skills.** Temporary loss of knowledge or skill is a very puzzling phenomenon to the person. Suddenly and inexplicably, he or she forgets things that one simply does not forget: how to do one’s job, how to drive a car, one’s own name, etc.
16. **Disconcerting Experiences of Self-Alteration.** Sudden experiences of self-alteration are, indeed, 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, seeing someone else in the mirror, etc.
17. **Self-Puzzlement.** Self-puzzlement is the inevitable accompaniment of frequent, intrusive dissociative experiences. The person is recurrently puzzled by his or her inexplicable feelings, reactions, behavior, and so on.

Fully-Dissociated Activities of Another Self-State (i.e., Amnesia)

18. **Time Loss.** Time loss involves incidents of ‘losing time. The person cannot account for several hours, a day, or even longer. He or she has a total blank for what happened during that period of time.
19. **“Coming to”.** “Coming to” refers to incidents where a person suddenly “came to” and discovered that he or she had done something, but had no memory of having done it. “Coming to” also refers to incidents of “coming to” in the middle of doing something that the person had no memory of having started to do in the first place.
20. **Fugues.** Fugues are incidents where a person suddenly found himself/herself somewhere, but had no memory whatsoever of going to that place.
21. **Being Told of One’s Recent Actions.** Persons with a major dissociative disorder may be told about their recent actions, but have absolutely no memory of having done those things.
22. **Finding Objects Among One’s Possessions.** Persons with a major dissociative disorder may discover objects, writings, or drawings among their possessions, but have no idea where those objects came from.
23. **Finding Evidence of Your Recent Behavior.** Persons with a major dissociative disorder may discover evidence of their recent actions, but you have no memory of having done those things: e.g., things moved around or changed, tasks completed that only he or she could have done, injuries, or even suicide attempts.

II. The MID Diagnostic Graph

Interpreting 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 person shows a significant level of response bias (as assessed by the six validity indicators).

The graph also shows the severity of each symptom. A score of 100 on the graph indicates that the person definitely *has* that symptom. A score of 100 means that the person ‘passed’ enough items to show that he or she is clearly experiencing that symptom. A score of 200 means that the person ‘passed’ twice as many items as are necessary to show that he or she has 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 person ‘passed’ only half as many items as are necessary for the MID to consider that symptom to be present. A score of less than 100 suggests that the person does not have that symptom.

Analysis of a client’s pattern of scores on the MID Diagnostic Graph allows the clinician to make diagnoses of PTSD, depersonalization disorder, dissociative identity disorder (DID), dissociative disorder not otherwise specified Type 1b (DDNOS-1b; i.e., a DID-like dissociative disorder, but without amnesia), and other types of DDNOS.

Validity Scales

Because the MID is designed to make accurate diagnoses in patients who present with an admixture of dissociative, posttraumatic, and borderline symptoms, the MID’s validity scales (and characterological scales) were designed to address the most common response biases that occur in dissociative, posttraumatic, and borderline patients: (1) defensiveness denial or minimization of symptoms, (2) negative emotional reactivity, (3) attention-seeking overemphasis of symptoms, (4) indiscriminate endorsement of bizarre and unlikely symptoms, and (5) factitious or malingered report of symptoms and past history. The sixth validity scale, The Borderline Personality Disorder Index (BPD Index), is an empirically-derived scale that consists of items that are endorsed by a subset of BPD patients who are especially given to symptom-exaggeration and symptom-falsification (see below).

The Validity Scales are represented with four different metrics: (1) Number of items passed (See Page 1 of The MID Report); (2) Mean scale scores (see page 1 of the MID Report); (3) Clinical Significance Score (see MID Diagnostic Graph); and (4) percent of items ‘passed’ on the validity scale (see Clinical Summary Graph).

From a forensic point of view, validity scales are generally considered to be detectors of falsified responding to test items. From a clinical point of view, however, this is rarely the case. Instead, validity scales are understood to assess certain personality traits (e.g., repressive personality style, neuroticism, attention-seeking) and certain aspects of clinical severity (e.g., psychotic experiences) that can skew a person’s responses to test items. In the vast majority of instances, such skew should be interpreted from a clinical point of view (see below) rather than a forensic one. Even the MID’s Factitious Behavior Scale is more indicative of personality pathology than it is of invalid responding. As can be seen in the discussion of each validity scale (below),

follow-up interviews during test construction consistently revealed that elevated validity scores primarily reflected clinically-important personality traits (rather than frank deception). Extreme elevation of the Rare Symptoms Scale is probably 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 (see below).

In short, an elevation of one or more validity scales on the MID simply indicates that the test-taker's dissociation scores cannot be blithely accepted by the clinician. These elevations demonstrate that certain factors are affecting how the test-taker is responding to the test items. As is always the case in a clinical situation, evidence of such factors must be explored so that the clinician can accurately understand the test-taker and the meaning of his or her answers.

Defensiveness Scale

The Defensiveness Scale is comprised of normal items, such as "Forgetting where you put something;" "Having to go back and correct mistakes that you made;" and "Making decisions too quickly." Each of us, to some degree, must say "yes" to these items. Because these are universal shortcomings, a person shows defensiveness whenever he or she gives a rating of "0" to such items. Consistently low ratings of Defensiveness items (e.g., "1" or "2") indicate that the person is claiming a remarkably low incidence of normal shortcomings.

Defensiveness Scale Mean Scores. Nondissociative individuals have a mean raw score of 3.63 on the 12 Defensiveness *items*; outpatients with DID have a mean raw score of 6.46. When these scores are converted to a 0-100 metric (and inverted so that higher scores indicate higher defensiveness), nondissociative individuals have a Defensiveness Scale mean score of 63.74; outpatients with DID have a Defensiveness Scale mean score of 35.45.

Defensiveness Scale Cut-off Score for Clinical Significance. On the MID Diagnostic Graph, a Defensiveness Scale score of 70.00 receives a score of 100 (i.e., the cut-off score for clinical significance). **A Defensiveness Scale score of 70.00 falls at the 73rd percentile of nondissociative individuals and the 95th percentile of outpatients with DID.** Thus, five percent of outpatients with DID manifest a clinically significant level of defensiveness on the MID. Because nondissociative persons appropriately report fewer normal shortcomings than do highly symptomatic dissociative patients, the cut-off score for a clinically significant level of defensiveness should be set higher for them. A score of 83.00 or higher is a more appropriate Defensiveness Scale cut-off score for the nondissociative population. **A Defensiveness Scale score of 83.00 falls at the 90th percentile of the nondissociative population.** High Defensiveness scores in this population usually indicate a character style that is largely incompatible with dissociation. Persons who have a high Defensiveness score on the MID tend to have high scores on measures of repressive personality style.

Emotional Suffering Scale

Emotional suffering is closely related to the personality trait of neuroticism or negative affectivity. The MID Emotional Suffering Scale correlates .65 with the Neuroticism Scale of the Eysenck Personality Questionnaire-Revised. ***Individuals with high neurotic suffering***

are quite reactive to the impingements and misfortunes of daily life. This reactivity intensifies or amplifies their pain, suffering, and dysphoria. When these individuals encounter major misfortune (e.g., trauma), their pain and distress is both intense and long-lasting. When these individuals have repeatedly been hurt or traumatized, they usually develop a very negative outlook on their daily life. Even when such emotional suffering is extreme, however, *it does not indicate deliberate exaggeration, falsification, or faking of distress.* Emotional suffering does, however, **amplify and prolong** pain and suffering. The distress of individuals with high emotional suffering is quite genuine and quite intense. Many of the items on the Emotional Suffering Scale have a borderline flavor (e.g., “Feeling empty and painfully alone;” and “Wishing that somebody would finally realize how much you hurt.”).

Emotional Suffering Scale Mean Scores. Nondissociative individuals have a mean score of 28.89 on the Emotional Suffering Scale; outpatients with DID have a mean score of 56.12.

Emotional Suffering Scale Cut-off Score for Clinical Significance. On the MID Diagnostic Graph, an Emotional Suffering Scale score of 73.33 receives a score of 100 (i.e., the cutoff score for clinical significance). **A score of 73.33 falls at the 95th percentile of nondissociative individuals and the 68th percentile of outpatients with DID.** Thus, 32% of outpatients with DID have a clinically significant level of emotional suffering.

Attention-Seeking Behavior Scale

Attention-seeking is a strategy for obtaining attention and emotional gratification from others. The items on the Attention-Seeking Scale assess attention-seeking in three ways: 1) by measuring how frequently a person tells others about his or her misfortunes (e.g., “Talking to others about very serious traumas that you have experienced”); 2) by measuring how gratified the person is by others’ attention (e.g., “Being pleased by the concern and sympathy of others when they hear about the traumas that you have suffered”); and 3) by assessing the person’s motivation to engage in frankly attention-seeking behavior (e.g., “Being willing to do or say almost anything to get somebody to think that you are special”).

Attention-Seeking Behavior Scale Mean Scores. Nondissociative individuals have a mean score of 15.34 on the Attention-Seeking Scale; outpatients with DID have a mean score of 20.66.

Attention-Seeking Behavior Scale Cut-off Score for Clinical Significance. On the MID Diagnostic Graph, an Attention-Seeking Scale score of 32.86 receives a score of 100 (i.e., the cut-off score for clinical significance). **A score of 32.86 falls at the 90th percentile of nondissociative individuals and the 82nd percentile of outpatients with DID.** Thus, 18 percent of outpatients with DID manifest a clinically significant level of attention-seeking behavior.

Rare Symptoms Scale

The items of the Rare Symptoms Scale describe phenomena that are uncommon, 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;” “Part of your body (for example, arm, leg, head, etc.) seems to disappear and doesn’t re-appear for several days.”).

Rare Symptoms Scale Mean Scores. Nondissociative individuals have a mean score of just 0.64 on the Rare Symptoms Scale; even outpatients with DID have a mean score of only 4.60.

Rare Symptoms Scale Cut-off Score for Clinical Significance. On the MID Diagnostic Graph, a Rare Symptoms Scale score 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 90th percentile of outpatients with DID and the 99th percentile of nondissociative individuals.** Thus, 10 percent of outpatients with DID endorse a clinically significant level of rare symptoms.

Although the Rare Symptoms Scale was designed to detect deliberate exaggeration of symptoms, follow-up interviews have identified eight reasons for a significantly elevated score: (1) deliberate endorsement of very many symptoms in order to simulate extreme psychopathology (i.e., a factitious or malingered approach to the test); (2) 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); (3) serious cognitive impairment or psychosis (i.e., symptom-driven distraction and confusion while taking the test); (4) random endorsement of test items; (5) a “game-playing” or hostile “screw you” approach to the test; (6) intentional false endorsement of rare symptoms by a persecutor alter (who wants to discredit and harass the host alter); (7) a “loose” cognitive style that causes idiosyncratic (and often inaccurate) responses to items throughout the test; or (8) extreme dissociative hypersensitivity that genuinely has produced many peculiar symptoms. These eight sources of an elevated score on the Rare Symptoms Scale are not mutually exclusive. When a person attains an elevated Rare Symptoms score, more than one of these factors may be ‘at work.’ Of all the validity scales on the MID, the Rare Symptoms Scale is most likely to indicate the occurrence of genuinely invalid responding (i.e., deliberate false endorsement of items, or florid psychosis).

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;” and “Pretending that something upsetting happened to you so that others would care about you (for example, being raped, being adopted or orphaned, military combat, physical or emotional abuse, sexual abuse, etc.)” There is a subset of severe borderlines who readily endorse these items without shame. Indeed, this subset of severe borderlines seems 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.”

Factitious Behavior Scale Mean Scores. Nondissociative individuals have a mean score of only 4.62 on the Factitious Behavior Scale; outpatients with DID have a mean score of 20.66.

Factitious Behavior Scale Cut-off Score for Clinical Significance. 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 outpatients with DID and the 97th percentile of nondissociative individuals.** Thus, 10 percent of outpatients with DID endorse a clinically significant level of factitious behaviors.

Interpretation of an elevated score on the Factitious Behavior Scale is not always a straightforward matter. 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 score: (1) a genuine history of exaggerating and/or falsifying symptoms in order to gain attention and sympathy; (2) random endorsement of test items; (3) severely guilty host alters who wrongly accuse themselves of “making too much” of their traumas and their pain; and (4) persecutor alters who falsely ‘admit’ to lying or exaggerating—in order to harass and discredit the host. In regard to this last explanation, the clinician should keep in mind that persecutor alters commonly tell the host that her memories (e.g., of abuse by a parent) are not true. With regard to Explanation #1, and as noted above, there is a subset of individuals with severe borderline personality who readily admit to faking. They seem to believe that admitting to such behavior is a justifiable and valid demonstration of how unhappy and desperate they are.

The Borderline Personality Disorder Index (BPD Index)

The BPD Index assesses *especially-problematic aspects of borderline pathology*: attention-seeking behavior, factitious behavior, and reports of bizarre and unlikely symptoms. This scale was empirically derived by comparing the MID protocols of 51 DID patients to those of 100 well-diagnosed BPD cases. 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). It is interesting to note that none of the 17 items are dissociation items; all 17 items that distinguish BPD patients from DID patient come from the MID’s validity scales.

Like the factitious behavior items, many of which are included in the BPD Index, the items that comprise the BPD Index are *not* subtle. Many of these items are so harsh, socially undesirable, and/or 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 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 Scores. BPD Index scores are reported in two forms: (1) Mean BPD Index Score (see page 1 of The MID Report) and (2) BPD Index Clinical Significance Score

(see MID Diagnostic Graph). Mean BPD Index scores for four diagnostic groups are presented below:

	Mean BPD Index Score	Mean BPD Clinical Significance Score
Nondissociative	8.97	29.90
Simple PTSD	7.52	25.06
DDNOS-1b	8.58	28.90
DID	15.98	53.17

BPD Index Cut-off Score for Clinical Significance. On the MID Diagnostic Graph, 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 Mean BPD Index Score of 30.00 falls at the 85th percentile of DID patients and the 96th percentile of nondissociative individuals.** Thus, 15 percent of outpatients with DID obtain a clinically significant score on the MID BPD Index. On the other hand, **39 percent of outpatient borderlines obtain a clinically significant score on the MID BPD Index.** This is a very important point: the MID BPD Index does not measure borderlineness *per se*; it measures especially severe and problematic borderline behaviors. Only 39% of borderline patients obtain a clinically significant score on this measure of especially problematic borderline behavior.

Like the Attention-Seeking Scale and the Factitious Behavior Scale, whose items collectively comprise 76% of the BPD Index, an elevated BPD Index does *not* always indicate the presence of borderline pathology. An elevated BPD Index is best understood by consulting the guides to interpreting the Attention-Seeking Behavior Scale and the Factitious Behavior Scale (see above).

III. 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 25 scales that help to accomplish that goal. The Clinical Summary Graph has five clusters of scales: (1) dissociation scales, (2) self-states and alters scales, (3) validity scales, (4) characterological scales, and (5) cognitive and behavioral functionality scales.

The 27 Clinical Summary Scales

The Dissociation Scales

The dissociation cluster contains six major dissociation scales: (1) Mean MID Score, (2) Mini-MID Score, (3) MID Severe Dissociation Score, (4) Depersonalization, (5) Derealization, and (6) Amnesia. These scales cover overall dissociation and the three major components of dissociation (i.e., depersonalization, derealization, and amnesia).

1. **Mean MID Score:** The Mean MID Score assesses the *frequency of occurrence of dissociative symptoms*. Mean MID scores are comparable to mean scores on the Dissociative Experiences Scale (DES). To place MID scores on the same 0-100 metric as the DES, MID scores have been multiplied by 10. Mean MID scores correlate .90 with mean DES scores. The clinical difference between mean MID scores and mean DES scores is that the MID is a pure measure of pathological dissociation. That is, unlike the DES and other self-report measures of dissociation, 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 patients who do not have a dissociative disorder.
15-20	May have PTSD or a mild dissociative disorder.
21-30	May have DDNOS or DID. May have PTSD.
31-40	May have PTSD and either DDNOS or DID.
41-64	Probably has both DID and PTSD.
65-	Usually indicates an admixture of severe dissociative, posttraumatic, and Axis II symptoms. Accurate diagnosis requires a close examination of all MID scales, especially the validity scales.

2. **Mini-MID Score:** The Mini-MID consists of the 19 dissociative items that most strongly discriminate between persons with DID and nondissociative psychotherapy patients (i.e., with a MID score of less than 15). The Mini-MID Score presents the person’s *mean score* on those 19 items.
3. **Severe Dissociation Score:** The Severe Dissociation Score assesses a person’s *range or breadth of dissociative symptoms* (as opposed to the frequency with which those

symptoms occur). A cut-off score for clinical significance has been established for each of the MID's 168 dissociation items. The Severe Dissociation Score specifies how many of the person's ratings (of those 168 dissociation items) met or exceeded their cut-off scores for clinical significance. On the Clinical Summary Graph, the Severe Dissociation Score portrays the *percentage* of dissociation items that the person 'passed.' Thus, a score of 82 indicates that the person gave clinically significant ratings to 137 of the 168 dissociation items on the MID (i.e., 82%). Research has shown that the Severe Dissociation Score is highly related to a person's history of trauma.

4. **Depersonalization Scale.** On the Clinical Summary Graph, the Depersonalization Scale portrays the *percentage* of depersonalization items that the person 'passed.' Thus, a score of 75 indicates that the person gave clinically significant ratings to 9 of the 12 items on the Depersonalization Scale (i.e., 75%).
5. **Derealization Scale.** On the Clinical Summary Graph, the Derealization Scale portrays the *percentage* of derealization items that the person 'passed.' Thus, a score of 92 indicates that the person gave clinically significant ratings to 11 of the 12 items on the Derealization Scale (i.e., 92%).
6. **Amnesia Scale.** On the Clinical Summary Graph, the Amnesia Scale portrays the *percentage* of amnesia items that the person 'passed.' Thus, a score of 87 indicates that the person gave clinically significant ratings to 27 of the 31 amnesia items on the MID (i.e., 87%).

The Self-States and Alters Scales

These seven scales measure phenomena that indicate the presence and/or activity of ego states, self-states, or alter personalities: (1) Self-Alteration, (2) "I Have DID," (3) "I Have Parts," (4) Child Parts, (5) Helper Parts, (6) Angry Parts, and (7) Persecutor Parts.

7. **Self-Alteration Scale.** The Self-Alteration Scale portrays the *mean score* of the 12 self-alteration items.
8. **"I Have DID" Scale.** The "I Have DID" Scale portrays the *mean score* of the four "I Have DID" items. Patients who have not previously received a diagnosis of DID are often reluctant to endorse the "I Have DID" items, but feel more comfortable endorsing items from the "I Have Parts" Scale.
 - Item 138: "Feeling that you have multiple personalities."
 - Item 149: "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."
9. **"I Have Parts" Scale.** The "I Have Parts" Scale portrays the *mean score* of the six items. These items are qualitatively different from the items on the "I Have DID" Scale:
 - 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.”

10. Child Parts Scale. The Child Parts Scale portrays the *mean score* of the seven items on the Child Parts Scale. These items are a sensitive predictor of 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.”

11. Helper Parts Scale. The Helper Parts Scale contains only one item:

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

12. Angry Parts Scale. 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.”

13. Persecutor Parts Scale. The Persecutor Parts Scale portrays the *mean score* of seven phenomena of auditory harassment and persecution:

- 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.”

The Validity Scales

The MID’s validity scales measure the response sets that most commonly bias the test responses of patients who present with an admixture of dissociative, posttraumatic, and Axis II symptoms: defensiveness, symptom exaggeration, attention-seeking, and symptom falsification. On the

Clinical Summary Graph, seven scales help to assess the latter response sets: (1) Mean Defensiveness, (2) Raw Defensiveness, (3) Rare Symptoms, (4) Psychosis Screen, (5) Attention-Seeking Behavior, (6) Factitious Behavior, and (7) Emotional Suffering. Pages 5-9 (see above) provide detailed information about the validity scales and their interpretation. It should be noted that three of the validity scales (Attention-Seeking Behavior, Factitious Behavior, and Emotional Suffering) are grouped with the Characterological Scales on this graph.

14. **Mean Defensiveness Scale.** This scale portrays the *reversed mean score* of the 12 Defensiveness items. For a more detailed discussion of the Defensiveness Scale, see pages 5-10 above.
15. **Raw Defensiveness Scale.** This scale portrays the *percentage* of the Defensiveness items that the person rated as “0.” Thus, a score of 50 indicates that the person gave a rating of “0” to 6 of the 12 items on the Raw Defensiveness Scale (i.e., 50%).
16. **Rare Symptoms Scale.** This scale portrays the *percentage* of the Rare Symptoms items that the person rated as “1” or higher. Thus, a score of 33 indicates that the person gave a rating of “1” or higher to 4 of the 12 items on the Rare Symptoms Scale (i.e., 33%). For a more detailed discussion of the Rare Symptoms Scale, see pages 5-10 above.
17. **Psychosis Screen.** This scale portrays the *percentage* of psychotic-like items on the MID that the person rated as “1” or higher. Thus, a score of 75 indicates that the person gave a rating of “1” or higher to 3 of the 4 items on the Psychotic Screen (i.e., 75%). A score of 75 falls above the 99th percentile of nondissociative psychiatric patients and falls at the 97th percentile of outpatients with DID. Thus, only 3% of DID outpatients endorse three or more of the items on the Psychosis Screen.
 - 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 Characterological Scales

Seven scales shed light on characterological functioning and Axis II pathology: (1) Attention-Seeking Behavior, (2) Factitious Behavior, (3) Manipulativeness, (4) Interpersonal Intrusiveness, (5) Identity Confusion, (6) Emotional Suffering, and (7) Abandonment Concerns. Persons with borderline pathology, for example, tend to show elevations on all of these scales except Factitious Behavior. A subset of severely borderline individuals have an elevated Factitious Behavior Scale as well.

18. **Attention-Seeking Behavior Scale.** This scale portrays the *percentage* of attention-seeking items that the person ‘passed.’ Thus, a score of 71 indicates that the person gave clinically significant ratings to 5 of the 7 items on the Attention-Seeking Behavior Scale (i.e., 71%). For a more detailed discussion of the Attention-Seeking Behavior Scale, see pages 5-10 above.

- 19. Factitious Behavior Scale.** This scale portrays the *percentage* of factitiousness items that the person ‘passed.’ Thus, a score of 57 indicates that the person gave clinically significant ratings to 4 of the 7 items on the Factitious Behavior Scale (i.e., 57%). For a more detailed discussion of the Factitious Behavior Scale, see pages 5-10 above.
- 20. Manipulativeness Scale.** This scale portrays the *mean score* of the four manipulativeness items:
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.”
- 21. Interpersonal Intrusiveness Scale.** This scale portrays the *mean score* of the five intrusiveness items:
Item 21: “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.)”
Item 47: “Talking to others about how you have been hurt or mistreated.”
Item 52: “Your thoughts being broadcast so that other people can actually hear them.”
Item 132: “Being unable to recall something—then, something “jogs” your memory and you remember it.”
Item 155: “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.”
- 22. Identity Confusion Scale.** This scale portrays the *mean score* of the 12 identity confusion items. These items focus on (a) confusion and puzzlement about oneself, one’s behavior, and one’s emotions; (b) “not feeling together;” and (c) uncertainty about who one is.
- 23. Emotional Suffering Scale.** This scale portrays the *mean score* of the 12 emotional suffering items. Emotional suffering is closely related to the personality trait of neuroticism or negative affectivity. For a more detailed discussion of the Emotional Suffering Scale, see pages 5-10 above.
- 24. Abandonment Concerns Scale.** This scale portrays the *mean score* of the six abandonment items:
Item 29: “Nobody cares about you.”
Item 35: “Feeling empty and painfully alone.”
Item 54: “Being rejected by others.”
Item 111: “Desperately wanting to talk to someone about your pain or distress.”
Item 124: “Feeling hurt.”
Item 213: “Wishing that someone would finally realize how much you hurt.”

The Functionality/Impairment Scales

Three scales assess impaired cognitive and behavioral functioning: Critical Items, Flashbacks, and Cognitive Distraction. Elevations on one or more of these scales are consistently associated with compromised cognitive and behavioral functioning. This compromised functioning is most commonly a byproduct of severe PTSD, severe dissociative symptoms, and/or severe characterological pathology.

- 25. Critical Items.** The Critical Items are dissociative and posttraumatic symptoms that are harmful or potentially dangerous (e.g., flashbacks that provoke impulses to self-harm, voices that tell you to die or to hurt yourself, fugues, fully-dissociated episodes of self-injury or suicide, etc.). The Critical Items Scale portrays the *mean score* of the 10 critical items on the MID. Although this scale does not portray the number of critical items that were ‘passed,’ it is useful to note that 99% of nondissociative patients ‘pass’ three or fewer critical items, whereas 85% of DID patients ‘pass’ four or more critical items. Thus, unlike most psychiatric patients, DID patients can routinely be expected to have several (or even many) of these harmful or potentially dangerous symptoms.
 - 26. Flashbacks Scale.** This scale portrays the *mean score* of the 12 flashbacks items.
 - 27. Cognitive Distraction Scale.** This scale portrays the *mean score* of the 12 cognitive distraction items. It should be noted that the Defensiveness Scale and the Cognitive Distraction Scale are composed of the same 12 items. Extremely low scores on these items indicate defensiveness, whereas very high scores indicate cognitive distraction. Cognitive distraction is manifested by high levels of forgetfulness, distractibility, absent-mindedness, being mistake-prone, and having difficulty sustaining concentration and focus. Conversely, defensiveness is indicated by abnormally low levels of these phenomena. Cognitive distraction (due to intrusive dissociative and posttraumatic symptoms) is one of the hallmarks of DID. Most DID patients manifest clinically significant levels of cognitive distraction; some suffer truly disabling levels of cognitive distraction.
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