



Measuring Dissociative Symptoms and Experiences in an Australian College Sample Using a Short Version of the Multidimensional Inventory of Dissociation

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ABSTRACT

This paper investigated a 60-item version of the Multidimensional Inventory of Dissociation (MID) with the potential to capture the full range of dissociative symptoms that characterize each of the dissociative disorders (DD). The 28-item Dissociative Experiences Scale (DES) was designed to capture a wide range of dissociative phenomena, but college population studies indicate it may not be adept at identifying the full range of dissociative symptoms and disorders. The 218-item MID has the advantage of capturing the full range of dissociative symptoms and has diagnostic capabilities for all DSM-5 DD, but the disadvantage of taking considerably longer than the DES to complete. Using university students and staff ($N = 313$), this paper investigated a 60-item version of the MID with the potential to capture the full range of dissociative symptoms that characterize each of the DD. Results indicate the MID-60 has a nearly identical factor structure to the full MID, excellent internal reliability, and content and convergent validity. Using the MID-60, at least 8% of participants at an Australian university were positive for a DD and, on average, participants self-reported having dissociative experiences 13% of the time. The present study's findings suggest the MID-60 is a promising alternative to the DES, with results about the prevalence of DDs and dissociative experiences consistent with those found using clinical interviews and the DES.

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The 28-item Dissociative Experience Scale (DES; Bernstein & Putnam, 1986) is the most commonly used instrument measuring dissociation in both research and clinical settings. Yet in non-clinical samples or people newly presenting for treatment its clinical cutoff often misses dissociative disorders (DD) other than dissociative identity disorder (DID). The 218-item Multidimensional Inventory of Dissociation (MID; Dell, 2006) can be used as an alternative to the DES and is more accurate but takes longer to complete. This paper

introduces a 60-item version of the MID to provide a middle ground between the comprehensiveness of the MID and the brevity and specificity of the DES.

Over its 28 items, the DES assesses mild dissociative experiences through to severe dissociative symptoms (Bernstein & Putnam, 1986). A recent meta-analysis by Kate et al. (2020) raised concerns about the effectiveness of the DES in capturing the full range of symptoms experienced by college students meeting criteria for DD. Kate et al. (2020) suggest that, at its pathological end, the DES focuses heavily on the symptoms of dissociative identity disorder (DID) but does not contain items that specifically assess the two more common DD, explaining there are no items that inquire about memory problems pertaining to traumatic events that are characteristic of dissociative amnesia, and it only contains one item about partially dissociated intrusions into consciousness from another self-state that are characteristic of other specified dissociative disorder-type one (OSDD-1), a subclinical form of DID (Dell, 2009).

Whilst only ever developed as a screening tool for DD, the shortcomings of the DES in capturing less severe dissociative symptoms and disorders are evident in college population studies. Nilsen (2000) interviewed 415 females with the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994) and found that if she applied the recommended DES cutoff of 30 for identifying pathological dissociation (Carlson et al., 1993) only one of the 23 (4.3%) cases of dissociative amnesia and one of the four (25%) cases of depersonalization would have been identified, whereas this cutoff identified all cases of DID. A similar pattern was apparent using the Dissociative Disorders Interview Schedule (DDIS; Ross et al., 1989) alongside the DES. The DDIS subscale capturing multiple features of DID was strongly correlated with DES scores (Murphy, 1994: $r = .60$, $p < .01$; Ryan, 1988: $r = .78$, $p < .05$). Yet the correlation between the DES and the DDIS subscale of depersonalization was weaker or non-significant (Murphy, 1994: $r = .49$, $p < .05$; Ryan, 1988: *ns*). Moreover, the DES was not related to the DDIS dissociative amnesia subscale (Ryan, 1988). Although these are college population studies, the problem is likely to extend to those conducted in clinical populations given many participants with a DD, including DID, may not reach the DES cutoff of 30 that identifies those for further clinical assessment (Coons & Millstein, 1992; Simeon, 2009; Van Ijzendoorn & Schuengel, 1996). There is greater potential for individuals with DD to have a DES score below the 30 cutoff in non-clinical populations as it can be expected that those who are more symptomatic are more likely to present to mental health services.

Multidimensional Inventory of Dissociation (MID)

The Multidimensional Inventory of Dissociation (MID; Dell, 2006) is a self-report instrument that assesses the full range of dissociative symptoms for all DSM-5 DDs. Although the MID captures a wider range of dissociative

symptoms than the DES, the two instruments are strongly correlated ($r = .94$; Dell, 2006). Dell (2006) found the MID strongly correlated with diagnostic clinical interviews (i.e., SCID-D; $r = .78$).

While the MID assesses derealization, depersonalization, and amnesia symptoms, its diagnostic capacities are limited to DID and OSDD-1, posttraumatic stress disorder (PTSD), and conversion disorder. Hence, it does not generate a diagnostic impression for derealization/depersonalization disorder or dissociative amnesia. However, MID reports can be useful in discerning whether derealization/depersonalization disorder or dissociative amnesia is present to the exclusion of DID and OSDD-1 (Dell et al., 2017).

The MID assesses 12 factors, including self-confusion (i.e., profound and chronic self-puzzlement), angry and persecutory intrusions, dissociative disorientation, amnesia (e.g., time loss, “coming to”, fugues, and disremembered actions), distress about severe memory problems, subjective awareness of alter personalities and self-states, derealization/depersonalization, trance, flashbacks, body symptoms, and circumscribed loss of remote autobiographical memory. The MID is often used in clinical settings, but rarely used in research, perhaps due to it being seven times longer than the DES, making it significantly more time-consuming to complete. Consequently, a short-form of the MID would be valuable in research, as the option of clinical interviews may not be possible for researchers due to time and resource constraints.

This paper introduces a 60-item version of the MID as a potential screening tool to capture the full range of dissociative symptoms characteristic of each DD and assesses the instrument’s internal reliability, and content and concurrent validity in a non-clinical sample.

Method

Participants

The sample consisted of 269 female and 44 male students and academic staff ($N = 313$) from a regional Australian university. Although data on student status were not collected, the majority of participants were likely to have been first-year psychology students who were eligible to receive course credit for their participation.

Females were overrepresented in the sample. Although males comprise 22% of psychology students at the university, only 14% of the sample were male indicating that females were proportionally more likely to choose to participate in this particular study than males. The average age of participants was 32.88 years ($SD = 10.52$), which was higher than that found in a meta-analysis of college students ($M = 21.0$ $SD = 3.7$; Kate et al., 2020), which can be explained by the university specializing in online and distance education, that attracts mature-age students balancing work or family life.

MID-60

Following consultation with the MID's creator Paul Dell, the decision was taken to use a 60-item version based on the five questions with the highest pattern matrix loading for each of the MID's 12 factors (Dell & Lawson, 2009, pp. 685–689). Hence, the MID-60 includes items that capture phenomena specific to each DD, broader dissociative symptoms, and related experiences that are characteristic of people with DDs, including PTSD symptoms and the self-confusion that arises from dissociative symptoms and experiences. The MID-60 response format is a Likert scale where respondents indicate how often they have dissociative symptoms and experiences from 0 (never) to 10 (always).

Procedure

Participants were informed about the opportunity to take part in the study in a number of ways. The study was listed as one of the research participation options for first-year psychology students and the psychology department's website, and information about the study was e-mailed through, and posted on, various internal university networks. Once consent was given, participants were directed to the questionnaire that was hosted online by Qualtrics. The study, titled "Dissociative Experiences in Adulthood", was introduced by advising participants "you will be asked about any dissociative experiences you have had in the past or are continuing to experience in your life". The timeframe for reportable experiences is not specified in the MID, although Dell et al. (2017) recognize that experiences occurring years ago may still be relevant. The instructions that followed were identical to those that accompany the full MID. The order in which the 60 items appeared was randomized for each participant. The contact details of university counseling and other support services were given to participants should they consider this beneficial.

Student participants were not taught about DDs as part of their Introductory Psychology classes during the three trimesters of data collection, and the required textbook questioned the validity of dissociation and DD (Lilienfeld et al., 2014). Thus, the sample was thought to have little or no scientific knowledge of the nature of DDs.

Main analysis

To establish the validity and reliability of the MID-60 in a non-clinical sample the following criteria were tested:

- (1) Structural validity – a Confirmatory Factor Analysis was conducted to evaluate the instrument's similarity to the full MID.

- (2) Reliability – Cronbach’s coefficient alpha was calculated to assess the internal consistency of the 60 items and that of each subscale. The minimum criteria set for acceptability was $r = 0.70$ (Cortina, 1993).
- (3) Concurrent validity – The extent to which scores on the MID-60 have concurrent validity was tested by assessing whether the prevalence of both dissociative experiences and clinical levels of dissociation found using the MID-60 was comparable to that found in studies with a similar cohort and in those using the full MID, DES and structured clinical interviews.

To assess concurrent validity benchmarks needed to be established to determine whether the prevalence of dissociative symptoms and experiences and clinical levels of dissociation as measured by the MID-60 were consistent with findings from studies in normal and clinical populations using clinical interviews, the DES or the full MID. For the MID-60 to be considered a valid measure, the prevalence of symptoms, experiences, and clinical levels of dissociation must be consistent with other college populations, broadly similar to normal populations, and markedly lower than those found in clinical populations.

Establishing a benchmark for the prevalence of dissociative symptoms and experiences

DES and MID scores are calculated by averaging the percentage of time a person self-reports having each dissociative symptom and experience described in the respective instruments. The DES measures both dissociative experiences common in the general population, as well as dissociative symptoms, whereas the MID is limited to more pathological manifestations of dissociation. For this reason, it can be expected that in a normal population the MID mean score will be slightly lower than the DES mean score. Support for this premise is evident in Table 1. “Non-clinical adults” (Dell et al., 2017) were experiencing the dissociative symptoms and experiences described in the MID slightly less often than “normal adults” were experiencing the dissociative symptoms and experiences described in the DES (Van Ijzendoorn &

Table 1. Comparison of MID and DES scores in non-clinical and clinical populations.

	MID				DES			
	Studies	N	M	SD	Studies	N	M	SD
Normal	1 ^a	510	8.0	10.9	11 ^c	1578	11.05	10.63
College	2 ^b	142	6.9	8.0	81 ^d	26,821	16.62	11.0
OSDD-1	1 ^a	40	39.0	19.4	6 ^c	121	35.29	15.83
DID	1 ^a	79	51.3	18.7	18 ^c	472	45.63	20.26

^aDell et al., 2017.

^bLauterbach et al., 2008.

^cVan Ijzendoorn and Schuengel, 1996.

^dKate et al., 2020.

Schuengel, 1996), i.e., 8.0 vs. 11.1. Lauterbach et al. (2008), which is the only study to report MID scores in a college population, found students reported having dissociative symptoms and experiences described by the MID considerably less often than in college population studies using the DES (Kate et al., 2020), i.e., 6.9 vs. 16.6. In contrast, the percentage of time dissociative symptoms and experiences was being experienced by people diagnosed with DID or OSDD-1 was slightly higher using the MID as compared to the DES (see Table 1), which is consistent with the MID focussing more heavily on dissociative symptoms rather than experiences.

Establishing a benchmark for prevalence of DDs

A meta-analysis by Kate et al. (2020) found a DD prevalence rate of 11.4% ($N = 2,148$) in college samples following diagnostic interview using the SCID-D, DDIS, or mini SCID-D (Steinberg et al., 1990) with 1) all participants or 2) after pre-screening with the DES. The authors found that 16.6% ($N = 4,061$) of students were experiencing clinical levels of dissociation on the DES (i.e., 30 or more). This rate is higher than the average of 9.9% found in general population samples from around the world using a variety of methods and diagnostic tools (Kate et al., 2020).

Establishing a benchmark for normal and clinical levels of dissociation using the MID-60

As the MID-60 is not a diagnostic tool, the threshold for clinical levels of dissociation needs to be established. Dell et al. (2017) recommend clinicians examine cases with a MID score of 20 or higher carefully due to the elevated risk of a DD, noting that respondents scoring between 21 and 30 *may* have a DD *or* PTSD; those scoring between 31 and 40 *may* have a DD *and* PTSD; and those with a score of over 41 *likely* have DID *and* PTSD. Dell and colleagues advise that respondents scoring between 15 and 20 *may* also have PTSD *or* a mild dissociative disorder. In the present study, the MID-60 cutoff score for identifying clinical levels of dissociation was 21. While it is possible that this cutoff excludes a small number of individuals with a mild DD scoring between 15 and 20, this was preferable to reducing the threshold to 15 and thereby potentially including numerous individuals who would not meet DD diagnostic criteria. With benchmarks for clinical levels of dissociation in place, the percentage of respondents who met these criteria was calculated and compared to those found in studies using the MID and the DES.

The analysis also employed thresholds for clinical significance for each MID item established by Dell (2004). For example, if the respondent reports having DID-type amnesic experiences 10% of the time, this is deemed to be clinically significant. Dissimilarly, it is not uncommon for people to have the feeling that pieces of their past are missing, so that particular item is only considered clinically significant if the person reports having this experience more than

50% of the time. To examine the prevalence of clinically significant symptoms and experiences in the present sample, clinically significant cutoff markers for all MID-60 factors were established by averaging the scores for each item assigned by Dell (2004). With clinical cutoff scores for each MID-60 subscale in place, the percentage of participants in the present study with clinically significant symptoms was calculated for each of the subscales that correspond to Dell's specific DD, PTSD, and conversion disorder markers. In addition, the mean scores for all MID-60 subscales were compared to the mean for the corresponding MID subscales found in non-clinical adults, and those with PTSD, OSDD-1, and DID (Dell, 2004).

Results

Structural validity

To assess whether the MID-60 measures the same construct as the full MID-60 a factor analysis with oblique rotation was conducted on all 60 items to establish whether the short version retains a similar factor structure to the original instrument. The Kaiser-Meyer Olkin (KMO) measure of sampling adequacy exceeded 0.5 (KMO = .943), suggesting the sample was factor analyzable, and Bartlett's test of sphericity was significant, $\chi^2(1,770) = 16,576.57, p < .001$.

In exploring the potential for multicollinearity the correlations between the 60 items were screened for any above 0.8, with four evident. These related to self-confusion and memory issues, specifically: "feeling very confused about who you really are" and "feeling uncertain about who you really are" ($r = .85$); as well as between the items relating to memory, "poor memory causing serious difficulty for you" and "being bothered or upset by how much you forget" ($r = .81$); "being able to remember very little of your past" and "not remembering large parts of your childhood after age 5" ($r = .85$); and "being able to remember very little of your past" and "feeling that there are large gaps in your memory" ($r = .81$).

Eleven items had initial Eigenvalues of one or more, and these cumulatively accounted for 73% of the variance in MID-60 scores (full details can be viewed via Open Science Foundation [OSF] link: <https://osf.io/y96dc/>). The item "feeling very confused about who you really are" accounted for 41% of the variance alone. Self-puzzlement is not a dissociative symptom per-se, but results from the dissociative individual's inexplicable feelings, reactions, and behaviors (Dell et al., 2017). It is therefore likely that the reason this single item accounts for such a large amount of variance is that self-confusion is the cumulative effect of all of the different aspects of the dissociative symptoms and experiences. No items were deleted on the basis of multicollinearity and Eigenvalues to ensure the MID-60 was fully comparable with the MID.

Principal Axis Factoring was conducted by specifying that all 12 factors and 60 items be retained to enable a comparison between the MID-60 and the original instrument. An oblique promax rotation was conducted as it was expected that many items would be correlated with more than one factor. The pattern matrix can be viewed via OSF link: <https://osf.io/y96dc/>

The factor structure of the MID-60 was similar to the original instrument replicating 11 of the 12 identified in the full MID (Dell & Lawson, 2009). The 12th factor, named here as psychogenic non-epileptic seizures (PNES), contained a single item that fell into Dell and Lawson (2009) “body (somatoform/conversion) symptoms” factor. The missing original factor was the broad category of “dissociative disorientation” that contains five items. The “dissociative disorientation” factor had contained the somatoform item “having difficulty swallowing”, which, not surprisingly, had the strongest correlation in this study to the “body symptoms” factor, although curiously, another of the somatoform items (“having difficulty walking”) from the “body symptoms” factor had a far stronger correlation with the current “trance” factor. The “dissociative disorientation” item “having trance-like episodes where you stare off into space and lose awareness of what is going on around you” could have been expected to move to the “trance” factor, but had the strongest correlation with “self-confusion”. Two “dissociative disorientation” items about not remembering eating and forgetting what was done earlier in the day had the strongest correlation with the “distress about severe memory problems” factor. The final “dissociative disorientation” item, “being told of things that you had recently done, but with absolutely no memory of having done those things” might have been expected to move to “amnesia” or “distress about severe memory problems” but actually had the strongest correlation with “depersonalization/derealization”. A similar item (“coming to” and finding that you have done something you don’t remember doing), originally in the amnesia factor, also moved to “depersonalization/derealization”, as did “totally forgetting how to do something that you know very well how to do”, which shared a slightly stronger correlation than it did with its original factor (distress about severe memory problems). Although there were minor differences, the factor structure was highly similar to the original instrument. Furthermore, amnesia and depersonalization showing up in unexpected factors may be attributed to these being interlinked, rather than wholly distinct, categories. For example, if a person becomes so depersonalized and experiences a sense of “absence”, they may fail to encode salient aspects of their experience leading them to report amnesia for some of the events during an episode of depersonalization (Krause-Utz et al., 2017).

Content validity

As the factor structure is highly similar to the original instrument, the MID-60 demonstrates content validity.

Reliability

Cronbach's coefficient alpha (60 items; $\alpha = .97$) indicates the MID-60 has excellent internal reliability, with the alpha being identical to that found with the full MID (Dell, 2006). Excellent internal consistency was confirmed by comparing odd and even-numbered items (Guttman Split-half = .98).

The internal reliability of each of the 11 subscales was acceptable. The alpha exceeded .70 for: self-confusion (6 items; $\alpha = .92$), angry intrusions (5 items; $\alpha = .85$), persecutory intrusions (5 items; $\alpha = .92$), amnesia (4 items; $\alpha = .81$), distress about severe memory problems (6 items; $\alpha = .90$), subjective awareness of alter personalities and self-states (5 items; $\alpha = .90$), derealization/depersonalization (8 items; $\alpha = .92$), trance (6 items; $\alpha = .88$), flashbacks (5 items; $\alpha = .90$), body symptoms (4 items; $\alpha = .71$), circumscribed loss of remote autobiographical memory (5 items; $\alpha = .94$).

Assessing concurrent validity: the prevalence of dissociative experiences and clinical levels of dissociation

The average MID-60 score in this study reveals that the sample ($N = 313$) reported dissociative experiences 13.04% of the time ($SD = 13.82$, *median* = 8.67) with scores ranging from zero to 90. MID-60 scores were non-normally distributed, with skewness of 2.23 ($SE = .138$) and kurtosis of 6.53 ($SE = 0.10$). The distribution and skew of the full MID have not been reported (Dell et al., 2017; Dell, 2006), but the findings of the present study are consistent with the right-skewed and leptokurtic distribution of dissociative experiences as measured by the DES in normal and clinical populations (Bernstein & Putnam, 1986). Of the total sample, 57 (18.2%) had a MID score equal to or greater than 21, which includes 31 respondents (10.2%) who had scores between 21 and 30 indicating a DD or PTSD likely; 12 (3.8%) who had a score between 31 and 40 indicating a DD with comorbid PTSD was likely; and 14 (4.5%) who had a score of over 41 indicating DID with comorbid PTSD was likely. Forty-one individuals (13.1%) scored between 15 and 20 where a mild DD was possible, but their score was considered to indicate sub-clinical levels of dissociation for the purposes of the present study.

No significant differences in mean MID-60 scores were found between males ($M = 13.02$) and females ($M = 13.04$) or any of the subscales, with similar proportions having levels of dissociation consistent with DD or PTSD (i.e., 10 males [22.7%] and 47 females [17.5%] had MID-60 scores equal to or above 21). Due to the markedly older age of the present sample compared to other college samples, the mean MID-60 for the 223 respondents that were aged 25 or older ($M = 12.30$) was compared to the 90 respondents aged 24 or under ($M = 14.86$), but these differences were not significant, $t(311) = -1.49$, $p = .139$. The age of 25 was chosen as it marks the end of the neurological changes observed in adolescence (Siegel, 2013).

However, those aged 24 or under had significantly higher scores compared to their older peers on the subscales of self-confusion (i.e., 19.32 vs. 14.58), $t(311) = -2.75$, $p = .007$, and angry intrusion (i.e., 9.99 vs. 6.57), $t(314) = -2.93$, $p = .004$. There was a weak negative correlation between age and MID-60 scores, $r = -.114$, $p = .044$; however, only three of the 12 subscales had a significant correlation, the two identified in t -tests, that is, self-confusion ($r = -.228$, $p = .000$) and angry intrusions ($r = -.180$, $p = .001$), and the third was the mixed category of dissociative disorientation ($r = -.184$, $p = .001$).

Presence of clinically significant symptoms

The percentage of participants meeting clinically significant cutoff for specific disorder-related subscales is presented in Table 2. The findings show clinically significant symptoms specific to DDs were generally uncommon (i.e., ranging from zero to 4%) in the group scoring between zero and 14 on the MID-60, although 12% reported experiencing clinically significant angry intrusions and autobiographical memory problem. No member of this group met the clinical cutoff for subscales specific to DID, OSDD-1, or dissociative amnesia. DD symptoms were not uncommon in those with a MID-60 score of 15–20, with 14% and 17%, respectively, meeting the clinical cutoffs for the subscales specific to depersonalization/derealization, and dissociative amnesia. Clinically significant angry and persecutory intrusions were reported by 12% and 4%,

Table 2. University sample grouped by MID-60 score: percentage with clinically significant symptom clusters.

MID-60 scoring range	0–14	15–20	21–30	31–40	41+	all
<i>Equivalent MID mean score classification</i>	Non-dissociative	Mild symptoms	PTSD or DD	DD and PTSD (OSDD-1)	DD and PTSD (DID)	
<i>N</i>	214	42	31	12	14	313
<i>DID</i>						
Amnesia	0.94	16.67	29.03	50.00	64.29	10.58
<i>DID/OSDD-1</i>						
• Subjective awareness of alter personalities and self-states	0.47	2.38	19.35	33.33	71.43	7.03
• Angry intrusions	11.68	45.24	70.97	91.67	100	29.07
• Persecutory intrusions	4.21	30.95	51.61	66.67	92.86	18.85
• All three of the above	0	0	12.90	33.33	71.43	5.75
• All of the above plus Amnesia	0	0	6.25	8.33	57.14	3.53
<i>Depersonalization/Derealization Disorder</i>						
• Derealization/Depersonalization	2.34	14.29	45.16	100	100	16.29
<i>Dissociative Amnesia</i>						
• Distress about severe memory problems	2.34	45.24	61.29	100	100	22.04
• Loss of autobiographical memory	11.68	35.71	54.84	83.33	85.71	25.24
• Both of the above	0	16.67	29.03	83.33	85.71	12.14
<i>PTSD</i>						
• Flashbacks	15.42	50.00	77.42	75.00	100	32.27
<i>Conversion Disorder</i>						
• Body symptoms	10.75	12.20	35.48	41.67	71.43	17.31
• PNES (Pseudoseizures)	2.80	4.76	3.23	33.33	42.86	6.07

respectively, of this group (although no respondent met the cutoff for all DID and OSDD-1 related subscales). In the DD or PTSD group (i.e., 21–30), 45% met the clinical cutoffs for the depersonalization/derealization subscale, 29% met the clinical threshold for both subscales relevant to dissociative amnesia, and 12.9 met the cutoff for the three shared DID and OSDD-1 related subscales and 77% reported clinically significant PTSD flashback-type symptoms. OSDD-1 was expected to be common in participants scoring between 31 and 40 on the MID-60, and although angry intrusions were experienced by most (92%), and half met the clinical cutoff for DID-type amnesia, only a third met all three relevant subscale cutoffs for OSDD-1. However, all had depersonalization/derealization, and distress about memory problems with most meeting the clinical cutoffs for both memory scales relevant to dissociative amnesia. Dell et al. (2017) advise a score of 41 on the MID is consistent with DID, yet just under two-thirds met the clinical cutoff for the DID-type amnesia scale, and only 57% met the cutoffs for all relevant subscales. However, there were high rates of all other DD-related symptoms beyond amnesia (ranging from 71% to 100%) in addition to PTSD (100%). This suggests that approximately one-third of those scoring over 41 may have a DD, but not DID, in addition to PTSD (and for many, conversion disorder as well).

Percentage of time the symptom clusters described in MID-60 and MID subscales are being experienced

Table 3 compares the MID-60 subscales (revised based on the factor analysis described above) to the 12 MID subscale data drawn directly from the calculation tab of the MID V3.6 (Dell, 2004). The table also lists the clinical cutoff for each subscale, with the groups' mean score for each subscale underlined if it met or exceeded the cutoff score.

Broad similarities should be apparent between the two non-dissociative groups (i.e., those scoring between zero and 14 on the MID-60 and non-clinical adults), and between those scoring between 31–40 and OSDD-1, and those scoring over 41 and DID. An examination of the means and standard deviations demonstrates consistency across the majority of items, yet there are some clear points of divergence. There were far higher rates of self-confusion in the group scoring between zero to 14 (MID-60) than in non-clinical adults (MID). DD-specific symptoms and experiences were more common in non-clinical adults (i.e., memory problems, DID-type amnesia, subjective awareness of self-states, and persecutory intrusions), although depersonalization and derealization were similar, and angry intrusions were slightly less common. Angry intrusions and self-confusion were also higher in the group scoring between 31 and 40 than in the group with OSDD-1 (as was distress about memory problems, DID-type amnesia, and depersonalization/derealization), whereas the experience of subjective awareness of self-states, and

Table 3. MID-60 and MID comparison of the percentage of time the symptoms clusters described in subscales is being experienced.

N	Cut off	MID-60												MID				
		0-14		15-20		21-30		31-40		41+		Non-clinical	PTSD	OSDD-1	DID			
		M	SD	M	SD	M	SD	M	SD	M	SD	M	M	M	M			
		214		42		31		12		14				1359				
34	11.32	17.32	28.14	25.44	42.71	28.46	52.67	24.38	65.29	29.14	18.91	30.36	66.41					
33.3	17.86	15.82	44.72	13.88	59.35	16.86	75.00	11.91	83.57	14.93	12.79	19.83	63.43					
30	8.69	8.65	30.87	15.82	37.42	17.51	50.28	15.81	77.02	13.68	12.32	19.39	57.06					
18	7.18	10.16	19.76	14.59	29.23	18.03	45.17	22.95	58.29	19.86	5.88	6.03	55.21					
16	6.84	10.44	21.14	20.37	30.58	23.11	38.67	31.19	60.86	26.56	8.50	23.04	54.17					
20	1.19	3.57	3.71	5.84	9.03	13.16	17.17	21.48	51.57	33.79	4.53	5.36	33.22					
18	2.79	6.15	14.05	13.47	19.23	17.30	31.33	22.78	66.59	30.43	4.49	5.32	37.54					
20	4.03	5.01	14.05	8.42	22.46	15.24	37.81	10.47	70.00	18.72	4.30	4.91	24.72					
11.7	0.90	2.57	6.27	6.17	11.88	12.71	10.42	7.82	38.45	25.42	4.05	11.73	20.63					
10	0.59	2.09	3.27	6.16	6.45	8.08	11.67	11.55	33.93	29.80	2.79	3.57	40.51					
10	2.59	5.12	3.29	4.86	9.68	11.76	7.92	8.78	38.04	28.07	1.99	3.06	5.70					

SD and group N not reported for MID subscales.

persecutory intrusions were higher in the OSDD-1 group. A similar pattern was apparent in the group scoring over 41 on the MID-60 when compared to the DID group. As expected DID-type amnesia and subjective awareness were slightly higher in the diagnosed DID group, yet self-confusion, distress about memory problems, and derealization and depersonalization were higher in the MID-60 group scoring over 41.

The mean for all subscales was higher in the 15 to 20 group (recalling a mild DD is possible in people scoring in this range on the MID) than the group scoring below 15, and substantially higher than the non-clinical group for all but two subscales (amnesia and subjective awareness of self-states were fractionally higher). Furthermore, 15 to 20 group's subscale means for self-confusion, distress about severe memory problems, and flashbacks were clinically significant. As those scoring between 21 and 30 may have PTSD or a DD, this group can be contrasted to Dell's (2004) PTSD group to assess whether the symptom profile is more consistent with PTSD or a DD. Compared to the PTSD group, those scoring between 21 and 30 rates had higher mean scores on all scales, including flashbacks (with the exception of the trance subscale which was identical). Based on the mean score subscales, the 21 to 30 group met the clinical threshold for 8 of the 11 subscales, whereas the PTSD group only met the clinical threshold for flashbacks and trance.

Discussion

The factor structure of the MID-60 proved to be nearly identical to the full MID, and the 60 items displayed a very high level of internal consistency indicating that the MID-60 is a reliable measure of dissociation. The findings on mean and clinical levels of dissociation suggest the MID-60 has concurrent validity as these are consistent with those found using clinical interviews, the DES and the full MID.

The prevalence of dissociative symptoms and experiences

Comparisons with the DES

The prevalence of dissociative symptoms and experiences using the MID-60 is consistent with studies using the DES. In the present study, respondents reported experiencing dissociative symptoms, on average, 13.04% of the time. This is somewhat lower than the DES mean of 16.62 found in a recent meta-analysis of 26,821 students from 16 different countries (Kate et al., 2020). Lower mean scores were expected using the MID-60 as the questions are derived from the MID, which focuses more on pathological dissociative symptoms, than the DES, which also focuses on dissociative experiences that are more commonly found in the general population. Although the DES

measures “normal” dissociation, these items are valuable in distinguishing people who have clinical levels of dissociation from those who do not. For example, people with DID have far higher scores on the “normal” items than “normal” people, and therefore, they have “normal” experiences (such as staring off into space and missing part of a conversation) to a pathological degree.

Two other factors may contribute to the lower rate found here. Firstly, Kate et al. (2020) found cross-country variation in mean DES scores with nations that afforded personal safety and security to citizens having lower levels of dissociation. Australia’s ranking (i.e., 20th out of 149 countries), was considerably more favorable than the mean country ranking for personal safety across all studies (i.e., 45th). Australia had correspondingly lower DES scores ($M = 13.3$). Hence, the lower rate may simply reflect Australia being a relatively safe country. The second factor that may play a minor role is age. Consistent with Van Ijzendoorn and Schuengel (1996), the present study found a weak negative correlation between age and dissociation, although the findings indicate this is due to specific dissociative symptoms and experiences such as angry intrusions declining with age rather than a relationship between dissociative symptoms and age per-se. Recalling that participants in the present study were, on average, 10 years older than that found in most other college population studies using the DES, the MID-60 score in the present study is highly similar to the mean DES scores of 12.4 and 12.1 found in two studies with similarly aged cohorts at the same Australian university (Irwin 1998a; Irwin 1998b). These three factors (i.e., the MID-60 focus on dissociative symptoms, national safety, and age of participants) all provide plausible explanations for the slightly lower rate in the present study compared to those using the DES.

It was hypothesized that the rate of dissociation in the present study must be slightly higher than that found in the general population. Indeed, the rate in the present study is slightly higher than DES scores in normal adults ($M = 11.05$; Van Ijzendoorn & Schuengel, 1996). The reason for higher levels of dissociation in college students compared to the general population has been attributed to age, but as this correlation is only weak, it is likely student status may be a contributing factor given the higher prevalence of mental health problems in college students compared to the general population (Stallman, 2010).

Comparisons with the MID

The present study’s findings on the prevalence of dissociation in a university population ($M = 13.04$) was less aligned with the MID than the DES. As expected, the prevalence of dissociation was higher than that found in non-clinical adults using the MID ($M = 8.0$; Dell et al., 2017).

Only one study has reported MID means in college populations, and that produced results that are slightly inconsistent with Dell et al. (2017) and the present study. Lauterbach et al. (2008) found that, compared to non-clinical adults, students in the US had identical (rather than higher) levels of dissociation ($M = 7.9\%$), and students in Israel had slightly lower (rather than higher) levels of dissociation as assessed by the Hebrew version of the MID ($M = 5.9\%$). The difference was attributed to the lower levels of abuse reported by the Israeli students compared to their American peers, but this does not explain why the rates were lower in college students than in non-clinical adults.

The statistics presented in Table 3 demonstrate broad consistencies between the prevalence of symptoms and experiences for each subscale in the present sample and Dell's (2004) non-clinical and clinical samples (i.e., when comparing those scoring between zero and 14 on the MID-60 to non-clinical adults, those scoring between 31 and to OSDD-1, and those scoring over 41 to DID). Although the means and standard deviations supported consistency between the two instruments across the majority of subscales, there were some exceptions. The higher means for the scales of self-confusion and angry intrusions found in the present sample compared to Dell (2004) may be attributed to our earlier finding that participants aged 24 or under had significantly higher scores compared to their older peers on these two subscales, coupled with the present sample having a higher proportion of younger people ($M = 32.88$, $SD = 10.52$) than samples with non-clinical adults ($M = 49.0$, $SD = 14.4$; Dell, 2006). It is likely that the reason DD-specific symptoms were less common in those scoring between zero and 14 on the MID-60 compared to non-clinical adults is simply that the ceiling of 14 provides a constraint on the scores that are possible. That is, if the respondent scored higher on specific dissociative traits, their MID-60 score is likely to be 15 or more, which would remove them from this category, whereas the sample of non-clinical adults includes those scoring above 15 on the MID ($M = 8.0$; $SD = 10.9$; Dell et al., 2017). Moderate differences in symptoms and experiences between those with MID-60 scores in the range of OSDD-1 (i.e., 31–40) and DID (i.e., 41+), and Dell's (2004) clinical groups are likely to reflect the wide range of MID scores seen in those clinically diagnosed with DID ($M = 51.3$, $SD = 18.7$) and OSDD-1 ($M = 39.0$, $SD = 19.4$; Dell et al., 2017), which demonstrates it is not uncommon for those with DID and OSDD-1 to score less than 41 and 31, respectively. These findings are a reminder that raw cutoff scores are useful for assessing the severity of dissociative symptoms, but are no substitute for a full diagnostic assessment.

There may also be limitations in comparing Dell's diagnosed DD groups with those in the present sample with a symptom profile consistent with a DD who would largely, if not exclusively, never been given a DD diagnosis (Brand et al., 2016). While general population studies show that people meeting DD

diagnostic criteria (who would predominantly have been undiagnosed prior to the study) do have clinically significant impaired functioning (Johnson, Cohen, Kasen, & Brook, 2006), it could be expected that individuals who have not ended up in the mental health-care system with a DD diagnosis are less symptomatic, on average, than individuals who have and are clinically diagnosed with a DD. Support for this premise may be evidenced by the present sample's participation in tertiary education, which suggests a reasonably high level of functioning. Secondly, although the mental health and quality of life of those with DD are generally very poor (Mueller-Pfeiffer et al., 2012), it improves significantly as a result of tri-phasic trauma-focused psychotherapy (Brand et al., 2016). Hence, diagnosed individuals may have, on average, a higher initial baseline of dissociation, but this has the potential to reduce, whereas those with a DD in the present sample, most of who would be undiagnosed (Brand et al., 2016), may have a lower initial baseline of dissociation, but without the same opportunity for symptom reduction.

The prevalence of clinical levels of dissociation

The present study found 57 (18.2%) participants had levels of dissociation consistent with a DD and/or PTSD diagnosis (i.e., these people reported experiencing dissociative experiences and symptoms more than 21% of the time). However, as the MID-60 is not a diagnostic instrument, the true percentage of participants meeting diagnostic criteria is not known, as some in the group may have had PTSD or subclinical levels of dissociation.

The 26 participants (8.3%) scoring over 31 had levels of dissociation consistent with OSDD-1 or DID according to Dell et al. (2017). Therefore, 8.3% could be used as potential baseline for the rate of DDs in the sample as it seems likely that a person experiencing dissociative symptoms nearly a third or more of the time would meet criteria for a DD. The comparison between MID-60 and MID disorder-related subscales in Table 2 supports the assertion that those scoring over 41 had marked dissociative experiences and symptoms. While only two-thirds of those scoring above 41 met the clinically significant cutoff for all four DID-specific subscales, and only one-third of those scoring between 31 and 40 met the clinically significant cutoff for all three OSDD-1 related subscales, a post hoc analysis shows that 93% of those scoring over 41, and 75% of those scoring between 31 and 40, had at least one clinically relevant symptom from the subscales of amnesia and subjective awareness of alter personalities and self-states. Hence, those in the sample scoring over 31 have a symptom profile that is consistent with OSDD-1, DID, or another DD.

The true rate of DDs may be higher as a subset of the 31 participants scoring between 21 and 30 is likely to have a DD rather than having PTSD or subclinical levels of dissociation. While three-quarters of the 31 individuals scoring between 21 and 30 reported clinically significant flashback-type

symptoms, this PTSD *or* DD group had noticeably higher mean scores on all DD-specific subscales compared to the MID group with a PTSD diagnosis. This provides support for the clinical cutoff of 21 used in the present study and by Dell et al. (2017), but also suggests that some in this group may have PTSD *and* DD. The findings also provide support for the advice offered by Dell et al. (2017) that a mild DD is possible in those scoring between 15 and 20, with 14% and 17%, respectively, of those scoring in this range in the present sample having symptoms and experiences consistent with depersonalization/derealization disorder and dissociative amnesia.

On balance, it is likely that the true rate of DDs in this sample falls somewhere between 8.3% and 18.2%. This finding is consistent with Kate et al. (2020) who found 16.6% of students ($N = 4,061$) had levels of dissociation that indicated a DD was likely (i.e., scoring over 30 on the DES), and 11.4% ($N = 2,148$) met criteria for a DD based on a clinical interview. The similarity in findings on the prevalence of clinical levels of dissociation using the MID-60, the DES, and clinical interview suggests the instrument has concurrent validity.

Convergent validity

The convergent validity of the MID-60 can be established by confirming a relationship between variables considered to be antecedents of dissociation and DDs (i.e., sexual or physical maltreatment, sudden unexpected negative events, frightening parental behavior, or parental abandonment; Dalenberg et al., 2014). Although the convergent validity of the MID-60 was not explored in this paper, Kate's (2018) use of the present sample indicates the instrument has convergent validity. Kate (2018) was able to predict 51% of MID-60 scores in females using self-reports of an insecure attachment style, the number of sexual abuse episodes, being choked, and the number of different types of sexual and physical abuse; and 53% of MID-60 scores in males based on the number of sexual abuse episodes and negative parent-child dynamics. Kate (2018) also found that the 20 females in the university group identified by the MID-60 as having pathological levels of dissociation (i.e., a score of 31 or more) had similar MID-60 scores ($M = 51.13$, $SD = 16.36$) to a clinical sample of 30 females with a DD diagnosis ($M = 56.81$, $SD = 18.84$). Furthermore, Kate (2018) found the MID-60 mean found in female students scoring over 31 was identical to the MID mean in 76 individuals with a DID diagnosis ($M = 51.3$, $SD = 18.7$; Dell et al., 2017).

Future research and clinical implications

It would be valuable to conduct a study that compares scores using the MID-60, the full MID, the DES, and ideally clinical interview, in clinical and non-clinical samples to establish, not only the relationships between scores on these instruments but also whether the range of scores associated with normal and clinical levels of dissociation is the same for the MID-60, the

MID, and the DES. Given the MID-60 captures a broader range of dissociative symptoms than the DES, it would be valuable to confirm whether the scores indicating clinical levels of dissociation recommended by Dell et al. (2017), and that have been applied here to the MID-60 (i.e., 21 and 31), are indeed more effective than the DES in identifying less severe DDs, particularly dissociative amnesia, and depersonalization/derealization disorder. To ensure these disorders are not missed, the MID-60 will include the clinically significant cutoff scores developed by Dell (2004) as part of the scoring of each item and subscale, to draw attention to the symptoms and experiences that require further exploration by the clinician or researcher. This will also enable clinically significant PTSD and conversion symptoms to be identified, particularly given the latter may not attract a score of more than 21. Item order was randomized in the present study. Items in the final instrument are presented in the same order these appear in the MID. To ensure consistency with the DES and MID, the opening sentence of the MID-60 was revised to refer only to “experiences” rather than “dissociative experiences”. The final instrument and accompanying scoring guidance are presented at the end of this paper. Guidance on interpreting the mean MID-60 score was adapted from Dell et al. (2017) in light of the present study’s findings.

Conclusion

Preliminary findings suggest the MID-60 is a valid and reliable instrument for measuring dissociative symptoms in a non-clinical population. However, further work to validate the instrument would be valuable. The MID-60 was developed for its potential application in research settings, but may prove useful in clinical settings where clients and therapists may find it convenient and expedient to complete a short version. If the mean MID-60 and subscale scores indicate a DD is likely, the respondent could go on to complete the remaining questions in the full MID or be administered the SCID-D or DDIS to provide diagnostic clarity.

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Appendix

You will be asked 60 questions about experiences you may have had in the past or are continuing to have in your life.

How often do you have the following experiences *when you are not under the influence of alcohol or drugs?*

Please circle zero if the experience *never* happens 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. Circle 10 if the experience is *always* happening to you.

1	Forgetting what you did earlier in the day	0 1 2 3 4 5 6 7 8 9 10
2	Having an emotion (e.g., fear, sadness, anger, happiness) that doesn't feel like it is "yours."	0 1 2 3 4 5 6 7 8 9 10
3	Hearing the voice of a child in your head	0 1 2 3 4 5 6 7 8 9 10
4	Reliving a traumatic event so vividly that you totally lose contact with where you actually are (that is, you think that you are "back there and then")	0 1 2 3 4 5 6 7 8 9 10
5	Having difficulty swallowing (for no known medical reason)	0 1 2 3 4 5 6 7 8 9 10
6	Having trance-like episodes where you stare off into space and lose awareness of what is going on around you	0 1 2 3 4 5 6 7 8 9 10
7	Being told of things that you had recently done, but with absolutely no memory of having done those things	0 1 2 3 4 5 6 7 8 9 10
8	Not remembering what you ate at your last meal-or even whether you ate	0 1 2 3 4 5 6 7 8 9 10
9	Things around you feeling unreal	0 1 2 3 4 5 6 7 8 9 10
10	Not being able to see for a while (as if you are blind) for no known medical reason	0 1 2 3 4 5 6 7 8 9 10
11	Feeling very detached from your behavior as you "go through the motions" of daily life	0 1 2 3 4 5 6 7 8 9 10
12	Feeling uncertain about who you really are	0 1 2 3 4 5 6 7 8 9 10
13	Feeling that other people, objects, or the world around you are not real	0 1 2 3 4 5 6 7 8 9 10
14	Being paralyzed or unable to move (for no known medical reason)	0 1 2 3 4 5 6 7 8 9 10
15	Being so bothered by flashbacks that it was hard to get out of bed and face the day	0 1 2 3 4 5 6 7 8 9 10
16	Not remembering large parts of your childhood after age 5	0 1 2 3 4 5 6 7 8 9 10
17	Feeling disconnected from everything around you	0 1 2 3 4 5 6 7 8 9 10
18	Not being able to hear for a while (as if you are deaf) (for no known medical reason)	0 1 2 3 4 5 6 7 8 9 10
19	Feeling that pieces of your past are missing	0 1 2 3 4 5 6 7 8 9 10
20	Immediately forgetting what other people tell you	0 1 2 3 4 5 6 7 8 9 10
21	Having difficulty walking (for no known medical reason)	0 1 2 3 4 5 6 7 8 9 10
22	Hearing a voice in your head that wants you to hurt yourself	0 1 2 3 4 5 6 7 8 9 10
23	Feeling very confused about who you really are	0 1 2 3 4 5 6 7 8 9 10
24	Feeling that important things happened to you earlier in your life, but you cannot remember them	0 1 2 3 4 5 6 7 8 9 10
25	Feeling as if you were looking at the world through a fog so that people and objects felt far away or unclear	0 1 2 3 4 5 6 7 8 9 10
26	Having seizures for which your doctor can find no reason	0 1 2 3 4 5 6 7 8 9 10
27	Going into trance so much (or for so long) that it interferes with your daily activities and responsibilities	0 1 2 3 4 5 6 7 8 9 10
28	Words just flowing from your mouth as if they were not in your control	0 1 2 3 4 5 6 7 8 9 10
29	Feeling that there are large gaps in your memory	0 1 2 3 4 5 6 7 8 9 10
30	Going into trance for hours	0 1 2 3 4 5 6 7 8 9 10
31	Bad memories coming into your mind and you can't get rid of them	0 1 2 3 4 5 6 7 8 9 10
32	Drifting into trance without even realizing that it is happening	0 1 2 3 4 5 6 7 8 9 10

(Continued)

(Continued).

33	Words come out of your mouth, but you didn't say them; you don't know where those words came from	0 1 2 3 4 5 6 7 8 9 10
34	Being able to remember very little of your past	0 1 2 3 4 5 6 7 8 9 10
35	When you are angry, doing or saying things that you don't remember (after you calm down)	0 1 2 3 4 5 6 7 8 9 10
36	Feeling that you have multiple personalities	0 1 2 3 4 5 6 7 8 9 10
37	Hearing a voice in your head that calls you names (e.g., wimp, stupid, whore, slut, bitch, etc.)	0 1 2 3 4 5 6 7 8 9 10
38	Poor memory causing serious difficulty for you	0 1 2 3 4 5 6 7 8 9 10
39	Having other people (or parts) inside you who have their own names	0 1 2 3 4 5 6 7 8 9 10
40	Reliving a past trauma so vividly that you see it, hear it, smell it, etc	0 1 2 3 4 5 6 7 8 9 10
41	Going into trance several days in a row	0 1 2 3 4 5 6 7 8 9 10
42	Discovering that you have changed your appearance (e.g., cut your hair, or changed your hairstyle, or changed what you are wearing, or put on cosmetics, etc.) with no memory of having done so	0 1 2 3 4 5 6 7 8 9 10
43	Being bothered or upset by how much you forget	0 1 2 3 4 5 6 7 8 9 10
44	Hearing a voice in your head that wants you to die	0 1 2 3 4 5 6 7 8 9 10
45	Suddenly finding yourself somewhere odd at home (e.g., inside the closet, under a bed, curled up on the floor, etc.) with no knowledge of how you got there	0 1 2 3 4 5 6 7 8 9 10
46	Feeling as if there is something inside you that takes control of your behavior and speech	0 1 2 3 4 5 6 7 8 9 10
47	Totally forgetting how to do something that you know very well how to do (e.g., how to drive, how to read, how to use the computer, how to play the piano, etc.)	0 1 2 3 4 5 6 7 8 9 10
48	Suddenly finding yourself somewhere (e.g., at the beach, at work, in a nightclub, in your car, etc.) with no memory of how you got there	0 1 2 3 4 5 6 7 8 9 10
49	Feeling that there is another person inside who can come out and speak if it wants	0 1 2 3 4 5 6 7 8 9 10
50	"Coming to" and finding that you have done something you don't remember doing (e.g., smashed something, cut yourself, cleaned the whole house, etc.)	0 1 2 3 4 5 6 7 8 9 10
51	Having difficulty staying out of trance	0 1 2 3 4 5 6 7 8 9 10
52	Suddenly not knowing how to do your job	0 1 2 3 4 5 6 7 8 9 10
53	Your body suddenly feeling as if it isn't really yours	0 1 2 3 4 5 6 7 8 9 10
54	Being bothered by flashbacks for several days in a row	0 1 2 3 4 5 6 7 8 9 10
55	Being confused or puzzled by your emotions	0 1 2 3 4 5 6 7 8 9 10
56	Hearing a voice in your head that tells you to "shut up"	0 1 2 3 4 5 6 7 8 9 10
57	Having another part inside that has different memories, behaviors, and feelings than you do	0 1 2 3 4 5 6 7 8 9 10
58	There were times when you "woke up" and found pills or a razor blade (or something else to hurt yourself with) in your hand	0 1 2 3 4 5 6 7 8 9 10
	Hearing a voice in your head that calls you no good, worthless, or a failure	0 1 2 3 4 5 6 7 8 9 10
60	Having a very angry part that "comes out" and says and does things that you would never do or say	0 1 2 3 4 5 6 7 8 9 10

CALCULATING AND INTERPRETING THE MID-60: ADVICE FOR CLINICIANS AND RESEARCHERS

The mean MID-60 score is calculated by adding all items and dividing by 6. It represents the percentage of time the person reports having dissociative experiences, and can be interpreted as follows:

0 – 7	Does not have dissociative experiences
7 – 14	Has few diagnostically significant dissociative experiences
15 – 20	Mild dissociative symptoms and experiences. PTSD or a mild dissociative disorder (such as dissociative amnesia, depersonalization / derealization disorder) are possible
21 – 30	May have dissociative disorder <i>and/or</i> PTSD
31 – 40	May have a dissociative disorder (such as OSDD-1 or DID) <i>and</i> PTSD
41 – 64	Probably has DID or a severe dissociative disorder <i>and</i> PTSD
64 +	Severe dissociative and posttraumatic symptoms. High scores may also reflect neuroticism, attention-seeking behavior, exaggeration or malingering of symptoms, or psychosis

To assist in your assessment, the scores for relevant MID- subscales can be calculated to determine whether these are clinically significant.

		Clinical cut-off
DID		
Amnesia	Add items 42, 45, 48, and 58 then divide by .4	10
DID / OSDD-1		
Subjective awareness of alter personalities and self-states	Add items 3, 36, 39, 49 and 57 then divide by .5	20
Angry intrusions	Add items 28, 33, 35, 46 and 60 then divide by .5	18
Persecutory intrusions	Add items 22, 37, 44, 56 and 59, then divide by .5	18
Depersonalization / Derealization Disorder		
Derealization/Depersonalization	Add items 2, 7, 9, 13, 25, 47, 50 and 53 then divide by .8	20
Dissociative Amnesia		
Distress about severe memory problems	Add items 1, 8, 20, 38, 43 and 52 then divide by .6	30
Loss of autobiographical memory	Add items 16, 19, 24, 29 and 34 then divide by .5	34
PTSD		
Flashbacks	Add items 4, 15, 31, 40 and 54 then divide by .5	16
Conversion Disorder		
Body symptoms	Add items 5, 10, 14 and 18 then divide by .4	10
Psychogenic nonepileptic seizures	Multiply item 26 by 10	10
General subscales		
Trance	Add items 21, 27, 30, 32, 41 and 51 then divide by .6	11.7
Self-confusion	Add items 6, 11, 12, 17, 23 and 55 then divide by .6	33.3

CAUTION: The MID-60 is for screening purposes only. It is not a diagnostic tool. If the mean scores for the MID-60 and relevant subscales indicate a dissociative disorder is likely, you may wish administer the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) or Dissociative Disorders Interview Schedule (DDIS), or ask the respondent to complete the full MID, to provide diagnostic clarity.

An electronic copy of the MID-60 questionnaire, and a scoring template that automatically calculates the score the MID-60 and its subscales and compares these to the clinical cut-offs, are available online at: https://www.researchgate.net/profile/Mary_Anne_Kate/research