25 The Long Struggle to Diagnose Multiple Personality Disorder (MPD): Partial MPD

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In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association), the first example of Dissociative Disorder Not Otherwise Specified (i.e., DDNOS-1) is "clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder" (p. 490). This definition of DDNOS-1 has a necessary implication. As the criteria for DID change, so, too, must the nature of DDNOS-1 change.

Before discussing DDNOS-1, a few prefatory comments are necessary regarding the Not Otherwise Specified (NOS) category of the modern DSM (American Psychiatric Association, 1980, 1987, 1994). The examples that are listed in an NOS category do not have the same DSM-status as do the specific disorders. In fact, NOS *examples* have no diagnostic status whatsoever, except as almost a footnote in the NOS category. NOS examples simply identify *some clinical presentations that the DSM does not recognize as specific disorders*. So, even though the DSM lists some NOS examples, they are not official disorders. That is why NOS examples do not have their own numerical ICD-9 codes. Only the NOS category as a whole (e.g., DDNOS) has a numerical ICD-9 code (i.e., 300.15). Note also that NOS examples do not have a set of framed "Diagnostic Criteria," as do all of the specific disorders in the DSM.

So, what does this mean for DDNOS-1? It means that partial DID (i.e., DDNOS-1) exists in the minds of clinicians, but that it has no diagnostic status in the DSM. It means that partial DID exists in the empirical literature (which diagnoses it as DDNOS and reports its prevalence and dissociative characteristics), but partial DID has no official existence in the DSM.[1] This is a significant problem because, in studies of clinical populations, DDNOS-1 is the most common diagnosis (see the following). In fact, partial forms of DID are so common that the term *DDNOS* has come to mean "DDNOS-1" in the dissociative disorders field. The bottom line is that clinicians and researchers in the dissociative disorders field

[1] It is my impression that many clinicians incorrectly believe the NOS examples to be either (1) officially recognized disorders, or (2) disorders that, by virtue of being listed as NOS examples, are being considered for promotion to a specific disorder. Clinical presentations that are being evaluated for possible promotion to specific disorders are not listed as NOS examples; they are listed in Appendix B, Criteria Sets and Axes Provided for Further Study.

treat DDNOS as if it were a specific disorder (see the following), but it is not.[2]

25.1 DSM-III

25.1.1 The Official Birth of MPD—But Not of Partial MPD

DSM-III (American Psychiatric Association, 1980) set forth the first diagnostic criteria for MPD:

> A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time.
> B. The personality that is dominant at any particular time determines the individual's behavior.
> C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships. (DSM-III, p. 259)

On the other hand, DSM-III did not provide diagnostic criteria for partial MPD. In fact, DSM-III did not even acknowledge the possibility that partial MPD might exist. Clinicians, however, promptly overcame this nosological lacuna by using the Atypical category to diagnose what they witnessed in some of their patients.

25.1.2 Immediate Clinical Usage of Atypical Dissociative Disorder

Almost immediately, clinicians in the dissociative disorders field adopted the DSM-III's residual dissociative category (i.e., Atypical Dissociative Disorder) as a rule-out for MPD. That is, patients who were strongly suspected to have MPD were routinely issued a diagnosis of atypical dissociative disorder (ADD). This usage of the term *ADD* became a form of "diagnostic shorthand." That is, "ADD" generally *meant* "ADD, rule out MPD" (Boon & Draijer, 1993; Coons, 1992; Franklin, 1988; see also Ross et al., 1992;). A second usage of the diagnostic label soon evolved: ADD was used to refer to true partial MPD (Coons, 1992; Ross et al., 1992). By the time that the Dissociative Disorders Work Group for DSM-III-R was appointed, the dual usage of the diagnosis ADD was well-established: (1) ADD as a rule-out place-holder for MPD, and (2) ADD as a diagnostic label for partial forms of MPD.

Meanwhile, another nosological difficulty was brewing; all three of MPD's diagnostic criteria were misleading (Kluft, 1985b, 1987; Kluft, Steinberg, & Spitzer, 1988). In the following pages, I hope to show that revising the DSM-III diagnostic criteria for MPD was just the first step in a long struggle to clarify (1) the phenomena of MPD, and (2) the diagnostic criteria that would reflect those phenomena.

25.2 DSM-III-R

25.2.1 A Minimalist Version of MPD

DSM-III-R removed three glaring inaccuracies from the DSM-III diagnostic criteria for MPD: (1) Criterion A: at any given time, one of the personalities is dominant or in control[3]; (2) Criterion B: the personality that is dominant, determines the individual's behavior[4]; and (3) Criterion C: all personalities are complex and have their own behavior patterns and social relationships.[5] These DSM-III criteria were erroneous overgeneralizations from a small, atypical subset of people with MPD. The DSM-III-R Work Group then produced a stripped-down, minimalist description of MPD:

> A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
> B. At least two of these personalities or personality states recurrently take full control of the person's behavior. (DSM-III-R, p. 273)

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[2] What kind of existence does partial MPD have in the DSM? Put simply (and informally), DDNOS-1 is not even in the same ballpark as the specific dissociative disorders. Not even close. To quote my colleague, John O'Neil, "DSM's partial MPD ballpark is really just a little vacant space between the stands and the parking lot where 6-year-olds toss a ball back and forth and pretend they're ballplayers."

[3] "Criterion A mistakenly implies that at any given time, one person is dominant. In fact, periods of mixed, shared, contested, or rapid and unstable alternating dominance are commonly seen in many cases." (Kluft et al., 1988, p. 40)

[4] "Criterion B is potentially confusing. The personality that appears to be dominant and may represent itself as dominant may in fact be strongly influenced by another, of whose influence it may or may not be aware." (Kluft et al., 1988, p. 40)

[5] "Criterion C is problematic. The degree of elaboration and complexity of the separate entities has proven to be an expression of the interaction style of the personalities, the structure of the dissociative defenses, overall adaptive patterns, and character style of the individual patient rather than a core criterion of the illness." (Kluft et al., 1988, p. 40)

DSM-III-R defined MPD as multiple-personalities-that-switch. That's it. Nothing else. This was Kluft's view of MPD:

> what is essential to multiple personality disorder … is no more than the presence … of more than one structured entity with a sense of its own existence. (Kluft, 1985b, p. 231)

25.2.2 The Unofficial Birth of Atypical/Partial MPD: DDNOS

DSM-III-R acknowledged the existence of atypical or partial MPD—but minimally, by listing it as an example of DDNOS:

> *DSM-III-R's Example 2 of DDNOS:*
>
> cases in which there is more than one personality state capable of assuming executive control of the individual, but not more than one personality is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete executive control. (DSM-III-R, p. 277)

The addition of this new type of DDNOS was anything but whole-hearted on the part of the DSM-III-R Work Group (Dell, 2009a). The Work Group was divided about whether these cases were a different disorder (i.e., different from MPD), or whether they were just a less symptomatic form of MPD. This division of opinion can be seen in the article that described the decisions of the DSM-III-R Dissociative Disorders Work Group:

> Proposals were received to create separate classifications for patients who have syndromes that have the same structure as Multiple Personality Disorder, but with less overt manifestations.... The committee acknowledged that these conditions exist and have been documented, but that at this time the evidence remains too preliminary to serve as the basis of new classifications. *Longitudinal data suggests that they may all prove to be phases of the same disorder* (Kluft, 1985b). A decision was made to … include examples under Dissociative Disorder NOS that explicitly acknowledged less overtly manifested conditions. (Kluft et al., 1988, p. 44. italics added)

So, how did DSM-III-R differentiate these new examples of DDNOS from MPD? DSM-III-R suggested two differences between MPD and MPD-like forms of DDNOS: (1) whether a second personality is *sufficiently distinct*, and (2) whether a second personality ever *assumes complete control*. I believe that these boundary-defining criteria are not as transparent as they may seem. In particular, I contend that the MPD criterion of "distinct personalities" is a quagmire of vagueness that has impaired research, burdened clinical assessment, and undermined our understanding of both DID[6] and partial forms of DID.

25.2.3 The Distinct Personalities Criterion

The *distinct personalities* criterion resides in every edition of the DSM since 1980; it is, arguably, *the* central diagnostic criterion of MPD/DID. That is, both Criterion A (personalities) and Criterion B (complete switches of control) depend upon the second personality being "sufficiently distinct" to actually *be* a second personality. Thus, the distinctness of a second personality is the DSM's foundation for the diagnosis of MPD. The "distinct personalities" criterion lies at the heart of (1) the criteria for MPD and (2) the descriptions of partial/atypical MPD in (3) all three editions of the modern DSM (American Psychiatric Association, 1980, 1987, 1994).

And yet, despite its foundational importance, the "distinct personalities" criterion has never been defined! The DSM has never specified the clinical phenomena or the diagnostic rules for determining whether a personality is "sufficiently distinct." The DSM hasn't even clarified which meaning of the word *distinct* is intended (i.e., "different from" vs. "clearly perceivable").[7]

What, exactly, is a *personality*? DSM-III-R tells us that a personality has "its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self" (p. 273). That's all that DSM-III-R tells us about alter personalities. How well does this prepare the average clinician to diagnose MPD? Fortunately, there is some more sophisticated help. As is true of so much that pertains to MPD, Kluft has offered the literature's best description of an alter personality:

> I have tended to define a personality, alter, or disaggregate self state in a manner that stresses what such an entity does and how it behaves and functions rather than by emphasizing quantitative dimensions: A disaggregate self state (i.e., personality) is the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli.... It has

[6] DSM-IV renamed multiple personality disorder as *Dissociative Identity Disorder* (DID).

[7] "**distinct** *a.* [1] Not identical, separate, individual, different in quality or kind, unlike (*from*, or abs.); [2] clearly perceptive, plain, definite." (Oxford, 1976)

> a sense of its own identity and ideation, and a capacity for initiating thought processes and actions. (Kluft, 1988, p. 51)

In MPD, there are two or more of these that are "distinct." In DDNOS-1a, there are two or more of these, but only one of them is "sufficiently distinct" (DSM-III-R, p. 277). Clear? My question is, "Why haven't the clinicians and researchers in the dissociative disorders field complained loudly about this situation?"

25.2.4 Two Basic Facts About MPD

So, how can clinicians discern the presence of alter personalities? What do alter personalities look like? The best answers to these questions can be found in Kluft's (1985b) superb clinical description of MPD: "The natural history of multiple personality disorder." This 20-year-old clinical-descriptive essay is still the single best account of the appearance and behavior of alter personalities. Upon re-reading this remarkable piece of clinical-descriptive psychiatry, we (re)discover two basic facts about MPD.

First, *although the DSM requires the presence of distinct personalities, naturally occurring DID does not.* Quite the contrary. DID is a defensive adaptation that protects the person from a chronically dangerous environment. DID's first priority is defense—not the conspicuous display of distinct personalities:

> The *raison d'être* of multiple personality disorder is to provide a structured dissociative defense against overwhelming traumata. The emitted observable manifestations of multiple personality disorder are epiphenomena and tools of the defensive purpose. In terms of the patient's needs, the personalities need only be as distinct, public, and elaborate as becomes necessary in the handling of stressful situations. (Kluft, 1985b, p. 231)

In fact, most multiples self-protectively *hide* their multiplicity from others (Kluft, 1985b). Second, visible switches from one distinct personality to another are infrequent: "visible switching from one alter to another probably ranks among the least frequent phenomena of DID" (Dell, 2009a).

In short, "overtness is not a basic ingredient of MPD" (Kluft, 1985a, p. 6)—even if the DSM implies that it is (or that it should be). Remember, the DSM *requires* overt DID; if the clinician cannot discern the presence of two or more distinct identities who switch (i.e., overt DID), then the patient cannot receive a diagnosis of DID.

Now, obviously, many cases of DID have been successfully diagnosed on the basis of the "distinct personalities" criterion. What about them? Kluft (1985b) has discussed five factors that render the personalities distinctly visible (and, thus, susceptible to being diagnosed as MPD): (1) lack of psychological resilience, (2) significant stress, (3) contention and conflict among the alters, (4) certain styles of exerting influence over the host personality (e.g., inner verbalized threats and seizure of executive control), and (5) alters who have a narcissistic investment in appearing visibly different. These five clinical factors unmistakably facilitate the diagnosis of MPD on the basis of the "distinct personalities" criterion. The problem is that these factors pertain to a small minority of MPD patients at the sicker end of the scale or during episodic decompensations. The overwhelming majority of MPD patients do not manifest "distinct personalities" (or, they do so very infrequently).

I do not believe that it is possible to operationalize the "distinct personalities" criterion in a way that will allow clinicians to successfully diagnose those MPD patients who are currently undetectable (according to the "distinct personalities" criterion). Kluft cut to the heart of this matter when he urged the dissociative disorders field to ask the following question:

> How can one discover the presence of multiple personality disorder in the absence of its classical manifestations [i.e., distinct personalities and switching]? (Kluft, 1985b, p. 203)

In my opinion, *this* is the question that we must ask (and answer) in order to devise diagnostic criteria for DID (and DDNOS-1) that are both efficacious and user-friendly.[8]

25.2.5 Too Little Awareness of the Impediments to Diagnosing DID?

Let us summarize the situation that clinicians faced between 1987 and 1994 when they sought to diagnose DID with DSM-III-R: (1) DSM-III-R says that the diagnosis of DID requires the presence of two or more "distinct personalities" that switch; (2) in contrast, DID itself

[8] Some would assert that there is a more important question: "*Can* we diagnose DID in the absence of switching?" That is, if identity alteration does not occur, then how can we say that there is an *identity* disorder? How can we say that there are multiple personalities? From the perspective of the modern DSM, it would seem that the answer to these latter two questions must be: "We can't." And yet, I believe that this prohibitory answer stems from the DSM's *definition* of the disorder, rather than from *the nature of the disorder itself.*

does not require that personalities be overtly visible;[9] (3) in fact, persons with DID typically hide and dissemble any evidence of their alters (Kluft, 1985b); (4) visible switching from one distinct alter to another is one of the most infrequent phenomena of DID (Dell, 2009a; Kluft, 1985b); and (5) the DSM provides no guidance whatsoever (i.e., signs and symptoms) about how to discern the presence of alter personalities.

These facts were known to the DSM-III-R Dissociative Disorders Work Group back in 1985. Nevertheless, efforts to base the diagnostic criteria for MPD upon signs and symptoms were voted down, thereby reaffirming the "distinct personalities" criterion. Accordingly, it would seem that the Work Group was unresponsive to, or did not seem to appreciate, the almost untenable position of the average clinician when faced with the task of diagnosing DID.

This was also the context for the unofficial birth of partial MPD. True to its commitment to the "distinct personalities" criterion of MPD, the Work Group described the personalities of partial MPD as being "not … sufficiently distinct." Thus, DSM-III-R described partial MPD as:

> cases in which there is more than one personality state capable of assuming executive control of the individual, *but not more than one personality is sufficiently distinct* to meet the full criteria for Multiple Personality Disorder. (p. 277, italics added)

In my opinion, the DSM-III-R Work Group made a fateful error when they described this example of DDNOS with the phrase, "not … sufficiently distinct." This phrase has profoundly influenced the diagnostic practices of both clinicians and researchers. Specifically, given the hiddenness of alter personalities and the infrequency of visible switching, it was inevitable that many persons with DID would be diagnosed as having DDNOS (because their alter personalities were "not … sufficiently distinct" to the diagnostician). In short, I contend that the Work Group built into DSM-III-R[10] a slippery diagnostic slope that relegates many persons with DID to the DDNOS category.[11]

25.3 DSM-IV

25.3.1 A Work Group Riven by Dissent

Has any psychiatric disorder evoked as much controversy as MPD? Have disagreements about a psychiatric disorder ever produced such intense skepticism, contempt, and *ad hominem* arguments? Was the DSM-IV Work Group assisted in its endeavors by the inclusion of representatives from both sides of this vitriolic debate? The answer to these three questions is, "No." As Putnam (2001) has declared, "The political need to 'balance' the committee with proponents and critics … insured virtual paralysis" (p. 48).

At that point in history, MPD was surrounded by a firestorm of attack and controversy. Challenges to the scientific literature on MPD more closely resembled the emotional rhetoric of courtroom prosecutors than the reasoned analysis of scientific debate. If ever there was a time when a Work Group needed to put its scientific house in order, this was it. Unfortunately, the controversy about DID afflicted the DSM-IV Work Group itself; this circumstance made it impossible for the Work Group to remedy the DSM's problematic adherence to the criterion of "distinct personalities" (see the following).

25.3.2 Finally—An Amnesia Criterion for DID

Following years of debate (since 1980 or earlier; see Dell, 2009a), the DSM-IV Work Group voted to add an amnesia criterion to DID:

> Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. (DSM-IV, p. 529)

[9] Strictly speaking, the DSM does not say that personalities must be overtly visible—just that they exist. The bottom line, of course, is that the DSM should, but does not, enumerate a set of signs and/or symptoms whereby the clinician can determine the presence or existence of other distinct personalities. This issue is further complicated by the fact that this determination is more easily and reliably based on the patient's subjective report of symptoms (rather than the clinician's observation of the signs of a distinct personality). The gold standard for assessing DID (i.e., the SCID-D-R), for example, makes this determination on the basis of the patient's reports of symptoms rather than the clinician's observation of signs (see footnote 16).

[10] To be precise, this slippery slope originated with DSM-III (which was the first DSM to place the "distinct personalities" criterion in the diagnostic criteria for Multiple Personality Disorder). DSM-III-R retained DSM-III's distinct personalities criterion and imposed it upon DDNOS (i.e., partial MPD) as well.

[11] The pragmatic clinical view may be that the incorrect DDNOS diagnosis "doesn't really matter." This view correctly notes that DID and partial DID are treated similarly; therefore, either diagnosis will lead (or should lead) to appropriate treatment for the patient. As a clinician, I am quite sympathetic to this point of view. As a nosologist and a researcher, however, I am not. The pragmatic clinical perspective may be quite appropriate to the arena of clinical care (although we really don't know for sure because we still know so little about the differences between DID and DDNOS-1), but this pragmatic clinical perspective has no place in the arena of nosology and nosological research.

Although defined in a vague and unhelpful manner, this amnesia criterion is important for at least two reasons. First, it redrew the boundaries of DID. Second, it finally placed an actual diagnostic sign or symptom within the diagnostic criteria for DID—DID's first true diagnostic criterion (in the usual DSM sense of the term).

25.3.3 The Continued Reign of the "Distinct Personalities" Criterion

On the other hand, the Work Group did not enumerate any other signs or symptoms of DID that could explicate (or replace) the "distinct personalities" criterion:

> The "amnesia" criterion was added, but other attempts to increase criterion specificity stalled amid the contention, confusion, and inertia of the group. (Putnam, 2001, p. 48)

And so, the reign of the criterion of "distinct personalities" would continue—in both DID and DDNOS-1a—for at least another 18 years (i.e., 1994–2012):

> **Criterion A for DID:** The presence of two or more *distinct identities or personality states* (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self). (DSM-IV, p. 529, italics added)
>
> **Description of DDNOS-1a:** Clinical presentations similar to Dissociative Identity Disorder … in which a) there are not two or more *distinct personality states* … (DSM-IV, p. 532, italics added)

25.3.4 DDNOS-1: Hostage to the Diagnostic Criteria for DID

As I noted above, partial DID (i.e., DDNOS-1) is defined in reference to DID. As DID changes, so, too, must DDNOS-1 change. In DSM-IV, DID's Criterion A and B did not change (except that the "distinct personalities" criterion became the "distinct identities or personality states" criterion). Criterion C, however, was completely new. This necessitated a change in the DSM's characterization of DDNOS-1. Whereas DSM-III-R allowed for cases of MPD without amnesia, DSM-IV labeled these cases, *DDNOS-1b*:

> Clinical presentations similar to Dissociative Identity Disorder … in which … amnesia for personal information does not occur. (DSM-IV, p. 532)[12]

DSM-IV made one additional change to DDNOS. Whereas DSM-III-R DDNOS had included "cases in which a second personality never assumes complete executive control" (DSM-III-R, p. 277), the DSM-IV Work Group elected to remove these cases from DDNOS-1. According to Spiegel and Cardeña (1991), these cases were left out "because of the changes in the criteria for MPD" (p. 374). The reasoning for this, however, is not readily apparent. Are Spiegel and Cardeña claiming that amnesia is the defining marker of complete assumption of executive control by a second personality?

In closing, I contend that the 28-year reign of the "distinct personalities" criterion has seriously undermined the quality of research data on both DID and DDNOS. For the last 29 years, and for the next 3 years (until the publication of DSM-V), the slippery diagnostic slope in the DSM will continue to label many persons with DID as "DDNOS" (-1a). This means that most of the published data on DID may be based on biased samples that contain only the obvious cases of DID (i.e., those with sufficiently "distinct personalities"). If so, it necessarily follows that the reported prevalence-rates of DID are artifactually low. Finally, most of the research data on DDNOS may be contaminated with cases of covert DID (see the following). If so, it necessarily follows that the reported prevalence rates of DDNOS are artifactually high.

25.4 THE PREVALENCE OF DDNOS

In 1991, the chair of the DSM-IV Dissociative Disorders Work Group stated that something was seriously amiss with the DSM-III-R nosology of the dissociative disorders (Spiegel & Cardeña, 1991). Namely, epidemiological studies had shown that DDNOS was the most common dissociative disorder diagnosis. A high rate of any NOS diagnosis indicates a faulty nosology. When a nosology is accurate, NOS disorders should *never* be more common than the specific disorders. Cardeña and Spiegel recommended that the developers of DSM-V should solve this nosological problem:

> One of the greatest challenges for editors of future editions of the DSM will be to obtain greater taxonomical clarity, considering that the majority of diagnosed dissociative disorders do not fit the established criteria [for the specific dissociative disorders]. (Cardeña & Spiegel, 1996, p. 235)

Table 25.1 lists the published data on the prevalence of DDNOS and DID. Table 25.2 condenses and summarizes the findings in Table 25.1.

The most striking aspect of the data in Table 25.2 is the wide range of estimates of prevalence for each setting. Inspection of Table 25.1 reveals that the variance *within*

[12] Thus, a subset of DSM-III MPD patients and DSM-III-R MPD patients (i.e., those with no amnesia) would be classified as DDNOS-1b under DSM-IV.

TABLE 25.1
The Prevalence of Dissociative Disorders, DDNOS, and DID in 33 Samples

			N			Prevalence (%)			Proportion	
Study	**Research Population**	**Country**	**DD**	**NOS**	**DID**	**DD**	**NOS**	**DID**	**NOS**	**DID**
				Non-clinical						
Ross 1991	454 adults[a]	Canada	51	1	14	11.2%	0.2%	3.1%	2.0%	27.5%
	14 DDIS DID[b]				6			1.3%[a]		11.8%[a]
Akyüz et al. 1999	994 adults	Turkey								
	17 (of 62 w DES > 17)[a]		17	6	0	1.7%	0.6%	0%	35.3%	0%
	8 (of 17 w DDIS DD)[c]		7	1	4	0.7%	0.1%	0.4%	14.3%	57.1%
Xiao et al. 2006	618 factory workers[a]	China	2	0	0	0.3%	0%	0%	0%	0%
Şar et al. 1998	648 adult women[a]	Turkey	115	52	7	18.3%	8.3%	1.1%	45.2%	6.1%
				26[d]			4.1%[b]		22.6%[b]	
Ross, et al. 1991	345 college students	USA	14	2	8	4.1%	0.6%	2.3%	10.0%	40.0%
	20 w DES > 22.6[a]									
Murphy 1994	415 college students	USA	16	5	4	3.9%	1.2%	1.0%	31.3%	25.0%
	20 (of 37 w DES > 30)[a]									
				Outpatient series						
Mezzich et al. 1989	11,292 OPs[f]	USA	13	4	0	0.1%	0.04%	0%	30.8%	0%
			7[g]	4	0	0.06%	0.04%	0%	57.1%	0%
Graves 1989	125 CMHC OPs[c]	USA	11	8	3	8.8%	6.4%	2.4%	72.7%	27.3%
Dell 1998	58 consec. DD OPs[c]	USA	58	16	42				27.6%	72.4%
Sar et al. 2000b	150 Ops	Turkey								
	20 (of 23 w DES > 30)[a]		18	12	6	12.0%	8.0%	4.0%	67.7%	33.3%
	12 (of 18 w DDIS DD)		12	9	3	8.0%	6.0%	2.0%	75%	25%
Dell 2002	57 consec. DD OPs[c]	USA	57	23	34				40.4%	59.6%
Coons 1992	50 consec. DDNOS OPs[c]	USA		50						
				27[h]					54.0%	
Şar et al. 2003	240 OPs	Turkey								
	129 of 153 hi DES/ BPD[a]		33	23	6	13.8%	9.6%	2.5%	69.7%	18.2%
	44 w BPD or DDID DD[e]									
Somer & Dell 2005	16 DD OPs[e]	Israel	16	6	4				37.5%	25.0%
Lussier et al. 1997	70 day hosp. pts[i]	USA	6	1	5	8.6%	1.4%	7.1%	16.7%	83.3%
Foote et al. 2006	82 82 OPs[a]	USA	24	7	5	29.0%	9.0%	6.0%	29.0%	21.0%
				Inpatient series						
Horen et al. 1995	48 IPs	Canada								
	11 (of 14 w DES ≥ 25)[a]		8	0	4	16.7%	0%	8.3%	0%	50.0%
	9 (of 14 w DES ≥ 25)[e]		8	1	3	16.7%	2.1%	6.3%	12.5%	37.5%
Modestin et al. 1996	207 IPs	Switzerland								
	37 (of 41 w DES ≥ 20)[a]		10	4	1	4.8%	1.9%	0.5%	40.0%	10.0%
Gast et al. 2001	115 IPs	Germany								
	15 (of 25 w FDS > 20)[e]		5	3	0	4.3%	2.6%	0%	60.0%	0%
Tutkun et al. 1998	166 IPs	Turkey								
	21 of 24 w DES > 30)[a]		17	6	11	10.2%	3.6%	6.6%	35.3%	64.7%
	17 (of 17 w DDIS DD)[c]		17	8	9	10.2%	4.8%	5.4%	47.1%	52.9%
Friedl & Draijer 2000	122 IPs	NL								
	34 (of 36 w DES ≥ 25)[e]		10	8	2	8.2%	6.6%	1.6%	80.0%	20.0%

TABLE 25.1
The Prevalence of Dissociative Disorders, DDNOS, and DID in 33 Samples *(Continued)*

Lipsanen et al. 2004	34 IPs[a] 37 OPs	Finland	17	7	4	15.5%	9.9%	5.6%	41.2%	23.5%
Saxe et al. 1993	110 state hosp. IPs	USA								
	15 (of 17 w DES > 25)[a]		15	9	4	13.6%	8.2%	3.6%	60.0%	25.0%
Latz et al. 1995	176 state hosp. IPs[a]	USA	102	34	21	58.0%	19.3%	11.9%	33.3%	20.6%
Specialty series										
Bowman et al. 1996	45 pseudoseizure OPs[c,e]	USA	41	28	7	91.1%	62.2%	15.6%	68.3%	17.1%
Frischholz et al. 1990	62 DD Unit IPs[c]	USA	62	29	33	100.0%	46.8%	53.2%	46.8%	53.2%
Ross et al. 2002	201 Trauma Unit IPs[a]	USA				40.8%	15.4%	7.5%	37.7%	18.4%
	110 of 201[e]					44.5%	20.0%	9.1%	44.9%	20.4%
	52 of 201[c]					26.9%	5.8%	9.6%	21.6%	35.7%
Şar et al. 2003	108 male prisoners	Turkey	17	10	0	15.7%	9.3%	0%	58.8%	0%
Multisite research series										
Ensink et al.1989	20 recruited DD pts[c]	NL	20	13	7				65.0%	35.0%
Carlson & Putnam 1993	327 accum. DD pts[c]	USA		99	228				30.3%	69.7%
Dell 2005	73 accum. DD OPs[c]	USA	73	19	47				26.0%	64.4%
Non-Western series										
Saxena & Prasad 1989	2,651 OPs[j]	India	62	56	0	2.3%	0.02%	0%	90.3%	0%
Das & Saxena 1991	1,517 OPs[j]	India	78			5.1%				
			42[k]	40	0	2.8%	2.6%	0%	95.2%	0%
Umesue et al. 1996	19 consec. DD OPs[e]	Japan	19	8	1				43.1%	5.3%
Alexander et al. 1997	720 IPs[j]	India	36	20	0	5.0%	2.8%	0%	55.6%	0%
Chand et al. 2000	1,294 IPs[j]	Oman	111	0	0	8.6%	0.0%	0%	0%	0%
Xiao et al. 2006	423 IPs[a]	China	7	3	2	1.7%	0.7%	0.5%	42.9%	28.6%
	304 OPs[a]		15	6	1	5.0%	2.0%	0.3%	40.0%	7.7%

Notes:

[a] Diagnoses in this row are based on the Dissociative Disorder Interview Schedule (DDIS)
[b] Diagnoses in this row require a history of trauma in addition to a DDIS diagnosis of DID
[c] Diagnoses in this row are based on clinical interview
[d] "DID-like conditions" (i.e., DDNOS-1)
[e] Diagnoses in this row are based on the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)
[f] Diagnoses in this study were based on the Initial Evaluation Form
[g] Data in this row consist solely of patients with a primary diagnosis of dissociative disorder
[h] Data in this row consist solely of DDNOS patients with ego states
[i] Diagnoses in this row are based on the Mini-SCID-D
[j] Diagnoses in this row are based on chart review
[k] Data in this row consist of patients whose only diagnosis was a dissociative disorder

settings is due to the countries in which the studies were conducted. China, Germany, and Switzerland have low prevalences; the Netherlands has a moderate prevalence; and Canada, United States, Turkey, and Finland have high prevalences. For the most part (with the exception of DDNOS outpatients), the settings show a linear relationship between level of care and prevalence of DID and DDNOS.

25.4.1 Is DDNOS the Most Common Dissociative Diagnosis?

Scholars in the dissociation field have been divided about this matter. Some have argued that DDNOS is the most common dissociative diagnosis (Chu, 1996; Dell, 2001a; Fraser, 1994; Ross, 1997). Others have argued

TABLE 25.2
Prevalence of DDNOS and DID

	DDNOS		DID	
	Median (%)	**Range (%)**	**Median (%)**	**Range (%)**
Nonclinical	0.6	0–8.3	1.1	0–2.3
Outpatient	6.4	1.4–9.6	2.5	2.0–7.1
Inpatient	3.1	0–9.9	3.5	0–6.3
State Hospital	13.8	8.2–19.3	7.8	3.6–11.9

that diagnoses of Dissociative Amnesia are (or should be) most common (Coons & Milstein, 1992; Nemiah, 1985; Steinberg, 1993, 1995).

The relative prevalences of Dissociative Amnesia and DDNOS in the studies listed in Table 25.1[13] are as follows: (1) DDNOS tended to be the most prevalent dissociative diagnosis in psychiatric settings (Ensink et al., 1989; Friedl & Draijer, 2000; Frischholz et al., 1990; Gast et al., 2001; Graves, 1989; Mezzich et al., 1989; Modestin et al., 1996; Ross et al., 2002; Şar et al. 2000b, 2003; Saxe et al., 1993; Somer & Dell, 2005), but (2) Dissociative Amnesia was usually the most prevalent dissociative diagnosis in the general population (Akyüz et al., 1999; Ross, 1991; Xiao et al., 2006). In epidemiological samples of the general population, Dissociative Amnesia had an overall prevalence of 0.2% in China, 0.9% and 7.3% in Turkey, and 3.0% in Canada (versus 0%, 0.6%, 8.3%, and 0.09%, respectively for DDNOS).

25.4.2 What Proportion of Dissociative Diagnoses Are DDNOS?

Of all persons who are diagnosed with a dissociative disorder, what proportion has Dissociative Amnesia? What proportion has DDNOS? In China, the proportion of dissociative-disordered persons in the general population with Dissociative Amnesia was 50.0%; in Turkey, 52.9% and 40%; in Canada, 59.3%; and in the United States, 33% (versus 0%, 35.3%, 45.2%, and 2.0%, respectively for DDNOS).

In short, Dissociative Amnesia tends to be the most frequent dissociative diagnosis in the general population, whereas DDNOS is the most common dissociative diagnosis in psychiatric clinics and psychiatric hospitals. This difference may be due to (1) the particular patient population that inhabits psychiatric settings, or (2) the different diagnostic criteria and diagnostic habits of epidemiological researchers versus practicing clinicians.

25.4.3 Proportion of DDNOS Cases Among All Patients With a Dissociative Diagnosis[14]

In eight outpatient prevalence studies that specifically assessed the presence of dissociative disorders, the median proportion of DDNOS cases was 39.0% (range = 16.7% to 72.7%); the median proportion of DID cases was 26.1% (range = 18.2% to 83.3%). In six inpatient prevalence studies that specifically assessed for the presence of dissociative disorders, the median proportion of DDNOS cases was 40.6% (range = 12.5% to 80.0); the median proportion of DID cases was 21.8% (range = 0% to 52.9%). Finally, in two state hospital prevalence studies that specifically assessed for the presence of dissociative disorders, the median proportion of DDNOS cases was 46.7% (range = 33.3% to 60.0%); the median proportion of DID cases was 22.8% (range = 20.6% to 25.0%). Thus, the median proportion of DDNOS cases (compared to all DD

[13] Note: data on the prevalence of Dissociative Amnesia are *not* included in Table 25.1.

[14] Although Table 25.1 contains data from six non-Western clinical studies, none of the discussion in this chapter addresses these studies. DSM-IV is extremely ill-suited to non-Western dissociative disorders (Wig, 1983), but the reasons for that are quite different from the DSM's shortcomings vis-à-vis DID and DDNOS-1 in Western settings. In brief, many non-Western countries are characterized by a very different kind of self from that of Western countries (Martínez-Taboas, 1991; Takahashi, 1990; Umesue et al., 1996). Thus, from a Western perspective, most non-Western dissociative disorders are considered to be strongly culture-bound. Similarly, from a non-Western perspective, many DSM-IV dissociative disorders (especially DID and DDNOS-1) appear to be strongly culture-bound (Adityanjee, 1990). In short, DSM-IV is inadequate for non-Western settings because it is very culturally biased in its coverage of the dissociative disorders (Alexander et al., 1997; Das & Saxena, 1991; Saxena & Prasad, 1989; Wig, 1983). Hopefully, this bias will be rectified by DSM-V.

cases) is 39.0%, 40.6%, and 46.7% in outpatient, general inpatient, and state hospital settings, respectively.

This consistent finding (i.e., that 39% or more of dissociative cases are DDNOS) is *prima facie* evidence of nosological strain; too many NOS cases are being diagnosed.

But what *kind* of DDNOS cases are these? Are they almost-DID cases with insufficiently distinct personalities (i.e., DDNOS-1a) or are they almost-DID cases with no amnesia (i.e., DDNOS-1b)? Or some other type of almost-DID? Or are they examples of derealization, brainwashing, trance, stupor/coma, or Ganser's syndrome (as DDNOS also invites)? Or are they instances of DDNOS that the DSM hasn't mentioned at all? Tacit knowledge, based on formal and informal gossip among researchers and clinicians worldwide, provides one answer to these questions; namely, that DDNOS generally means DDNOS-1. Tacit knowledge indicates that other forms of DDNOS (i.e., DDNOS-2 to DDNOS-6) are exceedingly rare in comparison.[15]

Citing her database for the Structured Clinical Interview for the DSM-IV Dissociative Disorders-Revised (SCID-D-R), Steinberg has made two relevant observations: (1) that the DSM nosology produces too many diagnoses of DDNOS (Steinberg, 2001), and (2) that the most common form of DDNOS is DDNOS-1a:

> SCID-D research indicates that the most common forms of DDNOS appear to be variants of DID in which personality states may take over consciousness and behavior but are not sufficiently distinct to qualify as full personalities. (Steinberg, 1995, p. 288)

Still, Steinberg's data about DDNOS-1a may not be as definitive as they appear. That is, the existence of her finding about DDNOS-1a is only possible because the SCID-D has specified its own standard for "sufficiently distinct," a standard that is lacking in the DSM (and, consequently, in general clinical practice as well). Thus, Steinberg's finding about the prevalence of DDNOS-1a is necessarily dependent on her particular standard for "sufficiently distinct." If that standard is lax, the SCID-D will generate relatively more diagnoses of DID and relatively fewer diagnoses of DDNOS-1a. Conversely, if that standard is strict, the SCID-D will generate relatively fewer diagnoses of DID and relatively more diagnoses of DDNOS-1a. In fact, the SCID-D-R standard for "distinct personalities" is reasonably strict.[16] Accordingly, the SCID-D-R would be expected to generate a substantial number of DDNOS-1a diagnoses.

25.4.4 There Is a High Incidence of Recurring Amnesia in DDNOS Cases

Table 25.3 summarizes the psychometric literature on dissociation in persons with DDNOS; these data imply that only a minority of these DDNOS cases have DDNOS-1b (i.e., almost-DID but without amnesia). In 12 of 16 studies, the DDNOS samples' mean scores on dissociation instruments *indicate the presence of substantial amnesia* (i.e., DES scores > 25, MID scores > 25, SCID-D total scores > 15, and DIS-Q scores > 2.5). Accordingly, these DDNOS cases cannot have DDNOS-1b (i.e., "Clinical presentations similar to Dissociative Identity Disorder … in which … *amnesia for personal information does not occur*"; italics added). Instead, they may have DDNOS-1a (i.e., "Clinical presentations similar to Dissociative Identity Disorder … in which … there are not two or more distinct personalities").[17] Indeed, one group of investigators considered the DSM-III-R criteria for DDNOS to be so vague that they created their own diagnostic criteria for DDNOS. Their criteria *required* the presence of amnesia (and at least four features associated with DID; Saxe et al., 1993), thereby excluding DDNOS-1b.

Only two studies have reported data on subtypes of DDNOS (see also Boon & Draijer, 1993). Coons (1992) reported that nearly half of his series of 50 clinic patients

[15] When reviewing this paper, Elizabeth Bowman commented that the disproportionate number of DDNOS cases in psychiatric settings is probably accurate, but that the relative proportion of DDNOS cases may be lower in other settings. For example, she noted that, in neurology clinics, the most frequent dissociative symptom, by far, is amnesia.

[16] The SCID-D-R's standard for "distinct identities or personality states" (DSM-IV, p. 487) is: "Persistent manifestations of the presence of different personalities, as indicated by at least four of the following: a) ongoing dialogues between different people; b) acting or feeling that the different people inside of him/her take control of his/her behavior or speech; c) characteristic visual image that is associated with the other person, distinct from the subject; d) characteristic age associated with the different people inside of him/her; e) feeling that the different people inside of him/her have different memories, behaviors, and feelings; f) feeling that the different people inside of him/her are separate from his/her personality and have lives of their own" (Steinberg, 1994, p. 106). [The author believes that it is of considerable importance that *none* of the SCID-D-R's six criteria for "distinct personalities or personality states" are observable signs; each of the six is a subjective symptom or experience that must be reported to the test administrator. This striking fact supports the contention that assessment of dissociation should be based on subjective symptoms rather than signs (Dell, 2006b, 2009b).] Finally, those who do not meet the SCID-D-R standard for "distinct identities or personality states," but who do meet the SCID-D-R's other four standards (for DSM-IV's Criterion A and Criterion B) for DID, receive a SCID-D-R diagnosis of DDNOS-1a.

[17] They may also have other types of DDNOS (e.g., a dissociative presentation of amnesia, depersonalization, and derealization, but without parts or ego states).

TABLE 25.3
Psychometric Measurement of Dissociation in 16 Samples of DDNOS and DID

			N		DES		SCID-D		DIS-Q		SDQ-20		MID	
Study	**Research Population**	**Country**	**NOS**	**DD**	**NOS**	**DID**	**NOS**	**DID**	**NOS**	**DID**	**NOS**	**DID**	**NOS**	**DID**
					Outpatient series									
Dell 1998	58 consec. DD OPs	USA	16	42	25.9	54.9								
Dell 2002	57 consec. DD OPs	USA	23	34	18.4	46.2								
Coons 1992	50 consec. DDNOS	USA	50	50	32.0	41.0								
Somer & Dell 2005	16 DD Ops	Israel	6	4	22.0	51.9	15.0	18.8					29.2	54.8
					Inpatient series									
Latz et al. 1995	176 state hosp. Ips	USA	34	21	38.3	59.5								
Frischholz et al. 1990	62 DD Unit Ips	USA	29	33	40.8	55.0								
Multisite research series														
Ensink et al. 1989	20 recruited DD pts	NL	13	7	36.4	53.4								
Boon & Draijer 1991	23 accum. DD pts	NL	11	12			14.9	18.2						
Ross et al. 1992	223 multisite DID/ NOS pts	USA/ Can.	57	166	21.7	39.7								
Carlson & Putnam 1993	327 accum. DD pts	USA	99	226	29.8	42.8								
Boon & Draijer 1993	•• accum. DD pts	NL	24	49			18.2	18.9						
Vanderlinden 1993	•• accum. DD pts	NL	23	30					2.9	3.5				
Nijenhuis et al. 1999	44 DD pts	NL	21	23	43.0	55.1								
Şar et al. 2000a	50 accum. DD pts	Turkey	25	25							46.3	58.7		
Dell 2005	73 accum. DD OPs	USA	19	47			15.0	19.0					27.9	49.2
					Non-Western series									
Umesue et al. 1996	19 consec. DD OPs	Japan	8	1	49.0	32.2								

with DDNOS had no apparent ego states. Şar, Akyüz, and Doğan (2007) reported that 50% of their general population DDNOS cases had DDNOS-1 and that another 29% of their DDNOS cases had a variation of DDNOS-1a (i.e., internal voices, passive influences symptoms, and amnesias). These two studies imply that half or more of the empirical literature on DDNOS may be based on DDNOS-1a.

25.4.5 When DDNOS Patients Encounter the DSM

DSM-IV-TR states that there are "four situations in which an NOS diagnosis may be appropriate" (p. 4): (1) cases that seem to fall within a given diagnostic class, but where the symptomatic presentation does not meet the criteria for a specific disorder (due to the symptoms being either atypical or below the diagnostic threshold); (2) cases with a symptom pattern that is not a specific disorder, but the symptoms cause clinically significant distress or impairment; (3) cases with an uncertain etiology—that is, cases where it is unclear "whether the disorder is due to a general medical condition, is substance induced, or is primary" (p. 4); and (4) cases where the data collected by the clinician are incomplete or inconsistent, but there is still sufficient information to place the case within a particular diagnostic class. From this, it can be seen that some NOS diagnoses are only temporary (because they are due to insufficient information). On the other hand, when clinicians have finally gathered sufficient information, they may still judge some patients to have an NOS diagnosis (because the patient's symptomatic picture is either atypical of any specific disorder, or subthreshold for one of the specific diagnoses). Such NOS diagnoses are assumed to be *final*. They are also supposed to be rare. As Ross has noted, however, DDNOS is neither atypical nor rare:

> DDNOS currently encompasses partial forms of DID which in fact are not at all atypical, and are probably more common than full DID. (Ross, 1997, pp. 98–99)

Precisely because partial forms of DID are so common, they should not be assigned to the NOS category.

There is another reason why partial forms of DID should not be assigned to the NOS category. The DSM often forbids it; a diagnosis of DDNOS-1 often conflicts with the diagnostic rules of the DSM. Despite providing a description of partial DID (i.e., DDNOS-1), DSM-IV often *prohibits* the clinician from issuing a diagnosis of DDNOS to patients who fit that description (Dell, 2001a; Ross, 1985, 1997; Ross et al., 2002):

> By DSM-IV rules [these persons] should receive a diagnosis of dissociative disorder not otherwise specified because they meet the DDNOS description of partial forms of DID. They cannot, however, because they often meet criteria for dissociative amnesia and/or depersonalization disorder: *DSM-IV states that a DDNOS diagnosis is to be made only when the person does not meet criteria for one of the other [specific] dissociative disorders*. (Ross et al., 2002, p. 15, italics added)

Thus, if the patient has amnesia, the DSM tells clinicians not to diagnose DDNOS. Since most cases of partial DID have amnesia, this is a problem. Worse, a diagnosis of Dissociative Amnesia is an inadequate and unhelpful characterization of a person with partial DID (Ross et al., 2002).

Given this clash between clinical reality and the diagnostic rules of the DSM, it is not surprising that three teams of investigators have chosen to override the DSM in their research on DDNOS (Şar et al., 2000b; Saxe et al., 1993; Tutkun et al., 1998). Each of these research teams redefined DDNOS as a supraordinate disorder with respect to amnesia, fugue, and depersonalization. For example:

> Any patient who met criteria for dissociative amnesia, dissociative fugue, or depersonalization disorder and also met criteria for dissociative identity disorder or dissociative disorder not otherwise specified received the overall diagnosis of either dissociative identity disorder or dissociative disorder not otherwise specified. Thus, dissociative identity disorder and dissociative disorder not otherwise specified were considered supraordinate diagnoses. (Şar et al., 2000b, p. 21)

I believe that these three research teams have described a routine diagnostic practice of dissociation experts; when it comes to patients with partial forms of DID, dissociation experts routinely violate the diagnostic rules of DSM-IV. I contend that this diagnostic practice should be ratified by removing partial DID from the DDNOS category and reclassifying it as a specific dissociative disorder.

25.4.6 Many Cases That Are Diagnosed as DDNOS-1a Really Have DID

I argued above that the "distinct personalities" criterion for DID relegated many persons with DID to the DDNOS category. Is there evidence that this is actually occurring? Is there evidence that DDNOS samples are contaminated with DID cases? Yes.

The authors of six studies in Table 25.2 have stated in print that many of their DDNOS cases probably had DID

(Akyüz et al., 1999; Boon & Draijer, 1993; Gast et al., 2001; Graves, 1989; Saxe et al., 1993; Tutkun et al., 1998). Here are three examples from three different continents:

> Of the nine patients who received a diagnosis of dissociative disorder not otherwise specified, three met all three criteria for multiple personality disorder, and four responded affirmatively to two of the three criteria and "unsure" to the third. This suggests that a number of patients [as many as 7 out of 9] who were given a diagnosis of dissociative disorder not otherwise specified may, upon further examination, meet diagnostic criteria for multiple personality. (Saxe et al., 1993, pp. 1040–1041)

> In six of these [8 DDNOS] patients, some personality states were observed repeatedly, but they were not considered sufficiently distinct and separate to diagnose a dissociative identity disorder at this stage of the evaluation. (Tutkun et al., 1998, p. 802)

> Finally we would like to comment on the patients in this study with the diagnosis DDNOS. In a majority of these cases the diagnosis MPD was strongly suspected during the research interview. This diagnosis could not be made because the patient was unaware of the existence of alter personalities or unable to talk about this subject. In those cases we assigned the diagnosis DDNOS, although it might be better to speak of "covert MPD" to differentiate these cases from true atypical cases. From a follow-up one year later, we obtained information on 20 of the 24 patients with DDNOS; 19 of the 20 patients were given the diagnosis MPD, instead of DDNOS, by the treating clinician and a description of distinct alter personalities could be given. (Boon & Draijer, 1993, pp. 120–121)

This has significant consequences. *If "DDNOS" samples routinely contain persons with DID, then the research literature on both DID and DDNOS is skewed.* Thus, in Table 25.3, the dissociation scores for DDNOS may be artifactually high and the dissociation scores for DID may be artifactually high as well (because covert DID cases, which have lower dissociation scores than do overt DID cases [Boon & Draijer, 1993], have been excluded from the DID samples).

25.4.7 Pause for Reflection

So, where does this leave us? It leaves us with remarkably little clarity about "clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder" (DSM-IV, p. 532).

The struggle to understand and diagnose what is presently called *DDNOS-1* began with a basic question. Are cases of so-called "partial DID" truly atypical (and, therefore, deserving of NOS status) or are they just covert cases of DID? A quarter-century of struggle with the nosology of the dissociative disorders and their diagnostic criteria has not provided an easy answer to this question.

At this juncture, I believe that our thinking about DDNOS-1 can be enriched by revisiting Watkins' concept of *ego state disorders*—an important clinical-conceptual precursor of modern DID and DDNOS-1.

25.5 A Continuum of Ego State Disorders

Modern study of dissociation was founded upon a continuum model of dissociation (e.g., Bernstein & Putnam, 1986; Braun, 1988; Hilgard, 1977). According to this model, dissociation stretches from normal phenomena (e.g., absorption, dreams, highway hypnosis) to increasingly pathological phenomena (e.g., episodes of amnesia, fugues, and DID). This original continuum model of dissociation has been called into question, however, by data suggesting that pathological dissociation is a discontinuous process (rather than a continuum that stretches smoothly from low dissociation to high dissociation; Putnam et al., 1996; Waller, Putnam, & Carlson, 1996). Putnam et al. (1996) have interpreted their data as suggesting "the possible existence of two or three [discrete] dissociative types (e.g., low, moderate, and high)" (p. 677).

Watkins has proposed a different continuum of dissociation that is consistent with Putnam's et al. putative dissociative types—whereas the original continuum model of dissociation (see previous paragraph) is not.

Watkins has described a continuum of ego states or "covertly segmented personality structures" (Watkins & Watkins, 1997, p. ix) that extend from flexible and adaptive ego states to rigid *ego state disorders*. From Watkins's perspective, DDNOS-1 and DID are both ego state disorders.

25.5.1 Features of All Ego States

All ego states have seven important characteristics (Watkins & Watkins, 1997). First, most arise when the person is young. Many ego states are fixated in development and think like a child (i.e., concretely) or an adolescent (i.e., rebelliously). Second, ego states come into being to deal with specific situations or problems:

> Thus, one ego state may have taken over the overt, executive position when dealing with parents, another on the playground, another during athletic contests, etc. (Watkins & Watkins, 1997, p. 29)

Third, ego states *want to exist*:

> Once created, ego states are highly motivated to protect and continue their existence.… Part-persons seek to protect their existence as do whole persons. (Watkins & Watkins, 1997, p. 29)

Fourth, the initial purpose of each ego state is to "protect and facilitate the adaptation of the primary person" (Watkins & Watkins, 1997, p. 29). Fifth, ego states have a sense of separateness and a sense of their own selfhood. Sixth, ego states influence one another covertly. *Covert influence is the primary means by which ego states accomplish their goals (and generate symptoms).* The seventh characteristic of ego states is the bridge to the ego state disorders: ego states may become engaged in conflict with one another or with the primary person. These conflicts generate symptoms.

25.5.2 Four Points on the Continuum of Ego States

25.5.2.1 Ego States of Normal, Well-Adjusted Persons

Most normal people have ego states that are separated from one another by very permeable boundaries. These ego states share much content in common and they are quite aware of each other:

> The general principle is that these more normal ego states come about through adaptive segmentation by the personality in the solving of fairly normal problems of living. (Watkins & Watkins, p. 78)

These ego states originate mostly from adaptive processes of differentiation, seldom from trauma.

25.5.2.2 Ego State Disorders That Generate Neurotic Symptoms and Maladaptive Behaviors

25.5.2.2.1 The Ego States

These ego states conflict with one another and generate neurotic symptoms and maladjusted behavior:

> In this region [of the dissociative continuum] we find that a conflict between states may be manifested by headaches, anxiety, and maladaptive behaviors, such as found in the neuroses and psychophysiologic conditions. (Watkins & Watkins, p. 33)

Despite their conflict, these ego states have much in common. They are quite aware of one another; they retain communication, they interact, and they share content. They influence the person, but they never assume full executive control. They can be "activated into executive position by hypnosis" (p. 33). These ego states have semipermeable boundaries; they see themselves as parts of the whole self. These ego states do not undergo further elaboration during adulthood; they do not become more fully developed or more separate from one another.

Ego states at this point on the continuum originated in an effort to solve recurrent problems in childhood (e.g., critical parents). Typically, these recurrent childhood problems fall short of being frankly abusive; nevertheless, these problems may be quite psychologically significant (e.g., chronic difficulties with one's parents' caretaking and attachment behavior).

25.5.2.2.2 The Person

The person is aware that he/she is unable to control certain behaviors or symptoms, but is generally unaware of the presence of well-defined parts. When persons with this kind of ego state disorder do become aware of the presence of distinct parts, they experience them as being part of them. There is no amnesia, little disturbance of consciousness, and very little identity disturbance; these persons have continuity in their experience of self.

25.5.2.3 Ego State Disorders That Are "Almost MPD"

25.5.2.3.1 The Ego States

These ego states have strong reactions and conflicts, often because they have trauma-driven priorities and sensitivities. They have substantial awareness of each other. For the most part, they retain communication, interact, share much content, and consider themselves to be part of the whole self. Still, they consider themselves to be very separate from what Watkins calls *the primary person*. These ego states do not assume full executive control, but they exert profound, and often frequent, influence on the person's experience and behavior. They can be activated into the executive position by hypnosis. Their boundaries are fairly impermeable, but less so than those of MPD alters. These ego states typically originated in an effort to deal with recurrent harsh problems in early life, including trauma and abuse. They generally do not become more fully developed or more separate from one another during adulthood.

25.5.2.3.2 The Person

These persons are intensely aware of, and discomfited by, the ego-alien intrusions that they undergo. They hear

voices and/or experience strong, ego-alien thoughts, feelings, and urges. They are uncomfortably aware of the presence and activities of well-defined parts. Although they experience these parts as very separate from them, they still own them as "parts of me" (Beahrs, 1982; Bloch, 1991; Chu, 1996):

> Each subpart or "personality," no matter how discrete and different, is still experienced as an aspect of an overall cohesive selfhood, not *as if* it were a separate self as is the case in true multiples. (Beahrs, 1982, p. 96)

Persons with this kind of ego state disorder experience so many peculiar intrusions and inexplicable influences that they are puzzled, apprehensive, and somewhat estranged from themselves. They have frequent disturbances of consciousness and substantial identity disturbance. They have only moderate continuity in their experience of self. Although mostly nonamnestic, these persons may experience some contemporary incidents of amnesia (Bloch, 1991; Watkins & Watkins, 1997).

25.5.2.4 The Most Severe Ego State Disorder: MPD

25.5.2.4.1 The Ego State

MPD alter personalities are starkly dissociated from one another. They have rigid, impermeable, amnestic barriers. They often have little interaction or communication; many alter personalities are unaware that other parts exist. Their sense of separateness is complete or nearly complete; they even may consider themselves to be different persons with different bodies. Their trauma-driven priorities and sensitivities are so strong that, when activated, these ego states easily seize full executive control or interfere so powerfully from within that they completely disempower the primary personality. Some MPD alters continue to develop; they become more complex, more active, and come to occupy a larger proportion of the person's life-space. Unlike persons with less severe ego state disorders, persons with MPD may develop additional ego states (i.e., alter personalities) during adolescence and adulthood.

25.5.2.4.2 The Person

Persons with MPD experience peculiar intrusions and inexplicable influences with great frequency—they hear voices; undergo "made" feelings, thoughts, urges, and actions; experience weird bodily changes and influences, and so on. They know that they are being affected by autonomous centers of functioning within them. Their understanding of (or admissions about) these internal parts is often strongly limited by denial. They experience frequent disturbances of consciousness and severe identity disturbance. They have little continuity in their experience of self. They have recurring, contemporary episodes of time loss and amnesia, and often have little memory of their childhood.

25.5.3 Four Features of Ego State Disorders That Are Relevant to DDNOS-1

We revisited Watkins's concept of ego state disorders in order to assist our analysis of DDNOS-1. Watkins was not very interested in diagnoses or the diagnostic signs and symptoms of ego state disorders. Bloch (1991) was more interested in these matters. When I study ego state disorders with DDNOS-1 in mind, four points stand out.

25.5.3.1 DID and DDNOS-1 Lie Upon a Dissociative Continuum of Ego State Disorders

Ego state disorders lie upon a dimension of increasing dissociation. Nevertheless, to draw diagnostic boundaries at certain places on that continuum is an arbitrary act about which no agreement has yet been reached:

> no firm consensus has been achieved to date to guide the categorical diagnosis of the essentially dimensional phenomena of dissociation … (Bloch, 1991, p. 25)

Proposals for such diagnostic boundaries need to be clearly articulated and justified.

Watkins seems to distinguish MPD from almost-MPD on the basis of two clinical phenomena: (1) ego states that spontaneously assume full executive control, and (2) recurring incidents of amnesia. Beahrs (1982) and Bloch (1991) agree with Watkins that MPD is characterized by recurring incidents of amnesia. Bloch (1991) agrees with Watkins that only persons with MPD spontaneously assume full executive control; Beahrs (1982) is ambiguous about this issue.

25.5.3.2 DID Patients Have Recurring Incidents of Amnesia

DSM-IV requires the presence of amnesia in DID, but does not specify (1) what kind of amnesia must be present (i.e., contemporary incidents of amnesia vs. amnesia for part of one's childhood) or (2) how frequent or extensive that amnesia must be. The role of amnesia in almost-DID (i.e., DDNOS-1) is not completely clear. According to DSM-IV, persons who have alters that switch and assume full executive control have DDNOS-1b *if they do*

not have amnesia. On the other hand, DSM-IV is silent about the role of amnesia in DDNOS-1a; DDNOS-1a is solely defined by failure to meet the "distinct personalities" criterion. Nevertheless, analysis of the DDNOS literature (see previous discussion) argues that many (most?) persons diagnosed with DDNOS could fall under DDNOS-1a by default, owing to their recurring incidents of amnesia.

25.5.3.3 DID Patients Exhibit Spontaneous Switching

Watkins and DSM-IV implicitly agree that spontaneous switching[18] must occur in DID. On the other hand, Watkins and DSM-IV implicitly disagree about the role of spontaneous switching in DDNOS-1. Watkins insists that almost-DID cases cannot switch spontaneously; they require hypnotic facilitation to assume full executive control. DSM-IV, on the other hand, implies spontaneous switching in both DDNOS-1a and DDNOS-1b.[19] This means that Watkins would diagnose many DDNOS-1 cases as DID.

Still, the text for DDNOS-1 remains very sketchy; DSM-IV actually says nothing about spontaneous switching in DDNOS-1. In DSM-III-R, DDNOS explicitly included "cases in which a second personality never assumes complete executive control" (DSM-III-R, p. 277). As noted earlier in this chapter, the DSM-IV Work Group deleted this issue from DDNOS-1, leaving some ambiguity in its wake.

Although the DSM-IV Work Group discarded it as irrelevant, the spontaneous assumption of full executive control may be of major diagnostic import. Watkins and Bloch have asserted that spontaneous switching defines the boundary between MPD and almost-MPD. If Watkins and Bloch are correct—and I think that they are—then persons with DDNOS-1a who exhibit spontaneous switching actually have DID.

This notion, that many DDNOS cases really have DID, is not new. Kluft, in particular, has long taken this position (Kluft et al., 1988).

[18] Throughout this chapter, the term *switching* refers to the phenomenon of an ego state (i.e., alter personality) spontaneously assuming full executive control.

[19] Strictly, this discussion about DDNOS-1 cannot be resolved solely on the basis of DDNOS-1a and DDNOS-1b. DSM-IV declines to suggest (but does not preclude) that other forms of DDNOS-1 may exist. Thus, for example, a putative DDNOS-1c might have highly distinct personalities with no switching but, with amnesia. Similarly, DDNOS-1d might have highly distinct personalities with neither switching nor amnesia.

25.5.3.4 Influencing-From-Within Is the Central Clinical Phenomenon of All Ego State Disorders—Including DID and DDNOS-1

The central clinical phenomenon of ego state disorders is influencing-from-within. The primary means by which ego states assert their interests and pursue their goals is by influencing, intruding into, and interfering with the primary personality (or the ego state that is currently in executive control). The most extreme form of influencing, intruding, and interfering is the spontaneous, complete switch that occurs in DID. Even in DID, the most common form of influencing and intruding is done from within, not by switching and coming out (Dell, 2006a, 2009a, 2009b; Kluft, 1985b).

If influencing-from-within (rather than switching) is the primary clinical phenomenon of DID and DDNOS-1, then the DSM has completely overlooked (1) the core dynamic of DID and (2) the core dynamic of DDNOS-1. Three studies have shown that rigorous assessment of (1) influences-from-within and (2) incidents of contemporary amnesia allows accurate assessment of DID (Dell, 2001b, 2006b; Gast et al., 2003). I believe that rigorous assessment of (1) influences-from-within and (2) incidents of contemporary amnesia will afford accurate assessment of DDNOS-1 (i.e., less symptomatic forms of DID).

25.6 IN SUMMARY

What has the foregoing examination of DDNOS-1 shown us so far? I consider eight points to be important.

First, the proportion of diagnosed dissociative persons that are diagnosed with DDNOS (40%) is too high. This undue proportion of NOS diagnoses indicates that something is seriously amiss with the nosology of the dissociative disorders and/or with the diagnostic criteria for the dissociative disorders.

Second, assignment of DDNOS-1 to the NOS category makes neither clinical nor nosological sense; several authors have recommended that DDNOS-1 be reclassified as a subtype of DID (Coons, 2001; Dell, 2001; Ross et al., 2002). If this were done, then DDNOS-1, that most diagnosed of dissociative disorders, would finally have its own diagnostic criteria.

Third, the debate about whether a portion of DDNOS cases really have DID (Boon & Draijer, 1993; Dell, 2001a; Franklin, 1988; Kluft, 1985b; Ross et al., 2002) has not been resolved, but the evidence suggests that many DDNOS-1a cases are actually false-negative cases of DID (because many DDNOS cases in the literature were later found to be unambiguous cases of DID).

Fourth, the "distinct personalities" criterion for DID has been very counterproductive; it is probably responsible for most DDNOS diagnoses. The "distinct personalities" criterion for diagnosis is phenomenologically indefensible because DID is a disorder of hiddenness. Switching is relatively infrequent and most persons with DID routinely hide their alter personalities. In short*, the "distinct personalities" criterion guarantees that only a subset of persons with DID will be correctly diagnosed as DID. Conversely, given the average clinician's lack of knowledge about DID, the "distinct personalities" criterion guarantees that the majority of persons with DID will be misdiagnosed*.

In retrospect, it can also be seen that the diagnostic practice, which uses DDNOS as place-holder or rule-out for patients who are suspected of DID, is yet another undesirable side effect of the "distinct personalities" criterion.

Fifth, DDNOS-1 and DID lie on a continuum of increasingly dissociated ego states (see also Van der Hart, Nijenhuis, & Steele, 2006). Diagnostic criteria for DID should reflect this continuum of dissociation by specifying two (or more) subtypes of DID.

Sixth and seventh, Watkins used two clinical features of DID to draw the boundary between DID and almost-DID: (1) spontaneous switching, and (2) recurring incidents of contemporary amnesia. There are clear similarities between Watkins' criteria for DID and DSM-IV's criteria for DID, but (1) Watkins does a better job of specifying amnesia (i.e., recurring incidents of contemporary amnesia) and, most important, (2) Watkins does not burden his criteria for DID with the "distinct personalities" criterion.

Eighth, Watkins demonstrates that the central clinical phenomenon of all ego state disorders is influencing-from-within. Influencing-from-within has long been recognized by authorities in the dissociative disorders field (i.e., Janet's *idée fixe* and subconscious acts, Kluft's passive influence phenomena, Loewenstein and Putnam's process symptoms of dissociation, and Ross's secondary features of DID), but the full significance of influencing-from-within does not seem to have been recognized or acknowledged.[20] Influencing-from-within goes unmentioned by the modern DSM, but, in my view, it should play a central organizing role in the diagnosis of both DID and DDNOS-1.

At this juncture in our analysis, we should briefly revisit an important historical example of failure to understand the meaning and significance of influencing-from-within. In the first half of the 20th century, skeptical researchers of dissociation claimed (incorrectly) that the activities of a dissociated part of the mind should *not* interfere with the functioning of the rest of the mind (e.g., Messerschmidt, 1927–1928). Janet never claimed that dissociation entailed noninterference (Hilgard, 1977; Kihlstrom, 1992; Perry & Laurence, 1984). The original version of dissociative influencing-from-within (i.e., Janet's subconscious acts) had clearly stated the opposite (Janet, 1889). Nevertheless, these debunkers of dissociation (1) demonstrated that the activity of a dissociated part of the mind *did* interfere with the operation of the rest of the mind, and (2) claimed that this disproved the construct of dissociation![21] In reality, of course, these debunkers were demonstrating a core phenomenon of dissociation—influencing, intruding into, or interfering with the functioning of the rest of the mind. The early 20th century debunkers of dissociation had it backwards. *The hallmark of dissociated functioning is the occurrence of influencing-from-within* (rather than the absence of such influencing).[22]

25.7 TOWARD A RECONCEPTUALIZATION OF DID AND ALMOST-DID

From all of the preceding, I draw two clinical-conceptual conclusions, two diagnostic conclusions, and one nosological conclusion.

[20] Exceptions to this generalization include Loewenstein (1991) who said that the process symptoms of dissociation "reflect the core aspects of the patient's multiplicity" (p. 593) and Ross (1997) who said that the secondary features of DID are "most valuable to the clinician … [because] usually, in most cases, DID does not present in an obvious overt fashion" (p. 101).

[21] Kihlstrom discussed this same issue in reference to White and Shevach (1942), who followed Messerschmidt in rejecting dissociation due to the phenomenon of interference: "White and Shevach expected that dissociated mental processes would be so isolated from other ongoing mental life that the one stream of consciousness would not interfere with the other. It is not at all clear where they got this idea, since it has no basis in the classic statements of dissociation by Janet. For Janet, a dissociated stream of thought is isolated from conscious awareness and from the phenomenal experience of agency and control, but he never suggested that the dissociation will extend to the matter of interference. Quite the contrary: from Janet's point of view, one of the hallmarks of hysteria was the manner in which *dissociated mental contents intruded on conscious experience, thought, and action. These intrusions are a form of interference*" (p. 307).

[22] Matters may be different, however, with simple Dissociative Amnesia—which raises an interesting question. How does simple Dissociative Amnesia differ from complex dissociative disorders such as DID and DDNOS-1? And how different are they?

25.7.1 Two Clinical-Conceptual Conclusions About Dissociation in Ego State Disorders

The most important marker of dissociation in ego state disorders (including DDNOS-1 and DID) is influencing-from-within. The most important marker of *severity* of dissociation in ego state disorders is recurring incidents of contemporary amnesia.[23]

25.7.2 Two Diagnostic Conclusions About DID and Almost-DID

The best diagnostic indicators of DID are (1) pervasive and frequent symptoms of influencing-from-within, and (2) frequent incidents of contemporary amnesia. Similarly, the best diagnostic indicators of DDNOS-1 are (1) frequent symptoms of influencing-from-within (but less frequent than in DID), and (2) recurring incidents of contemporary amnesia (but less frequent than in DID). From this perspective, DID and DDNOS-1 differ only in the frequency and severity of their dissociative symptoms.[24]

25.7.3 One Nosological Conclusion About DDNOS-1

DDNOS-1, as redefined in the previous paragraph, should be reclassified as a *specific* dissociative disorder, probably as a less symptomatic subtype of DID.

25.7.4 New Diagnostic Criteria for DDNOS-1 and DID

The diagnostic criteria for DID ought to be based on the two most powerful indicators of dissociation in ego state disorders—influences-from-within and recurring incidents of contemporary amnesia. These two indicators of dissociation answer Kluft's (1985b, p. 203) question, "How can one discover the presence of multiple personality disorder in the absence of its classical manifestations [i.e., distinct personalities that switch]?" One can discover the presence of MPD by assessing the frequency of influences-from-within and the frequency and duration of incidents of contemporary amnesia. Of course, one can also discover the presence of (some cases of) MPD by observing distinct personalities that switch. The diagnostic criteria in Table 25.4 allow MPD to be diagnosed via either route—that is, (1) by observing distinct personalities that switch, or (2) by documenting the presence of classic dissociative symptoms[25] plus pervasive influences-from-within plus recurring incidents of amnesia.

25.7.5 Reconceptualizing DID as a Complex Dissociative Disorder

Whereas the modern DSM portrays DID as an Alter Personality Disorder, the diagnostic criteria that are proposed in Table 25.4 portray the disorder as a complex dissociative disorder. I contend that complex dissociative disorder is more accurate, less controversial, has greater face validity, and is much easier for the average clinician to diagnose than DSM-IV DID (see also Dell, 2009a).

The criteria in Table 25.4 provide two ways to satisfy Criterion B and two ways to satisfy Criterion C. The first way requires witnessing a switch. Criterion B1 requires witnessing a switch that is *not* followed by amnesia, whereas Criterion C1 requires witnessing a switch that *is* followed by amnesia.

The second way to satisfy Criterion B is to document the presence of five or more kinds of influence-from-within. Similarly, the second way to satisfy Criterion C is to document the occurrence of four or more incidents of amnesia.

25.7.6 Complex Dissociative Disorder I and II

Complex Dissociative Disorder II (i.e., DDNOS-1) is a less symptomatic variant of Complex Dissociative Disorder I (i.e., DID). The diagnosis of Complex Dissociative

[23] I have limited my assertions about dissociation to dissociation in ego state disorders. I know rather little about dissociation in simple dissociative disorders such as Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorders, and Conversion Disorders. Elizabeth Bowman (personal communication, 9-23-05) suggests that the most important marker of dissociation in simple dissociative disorders is the unavailability of mental content (e.g., lack of awareness of emotions that are obvious in facial expressions, lack of memory for events during conversion seizures in patients who show no evidence of altered identity, lack of awareness of physical sensations or movements [i.e., conversion sensory deficits or motor symptoms], and recurrent involuntary entrance into trance states with subsequent amnesia for conversations that were held during the trance.).

[24] Persons with DDNOS-1 also manifest fewer kinds of dissociative symptoms (i.e., fewer of the symptoms in Table 25.4) than do persons with DID.

[25] The classic dissociative symptoms (i.e., circumscribed amnesia for autobiographical memory, depersonalization, derealization, flashbacks, somatoform dissociation, and trance) are common influences-from-within that routinely occur in major ego state disorders (i.e., DID and DDNOS-1). These classical dissociative symptoms may also occur in simpler dissociative disorders (i.e., disorders that are not driven by clinically important ego states).

TABLE 25.4
Diagnostic Criteria for Complex Dissociative Disorder I

A. Classic dissociative symptoms, as indicated by three (or more) of the following:
  (1) Circumscribed amnesia for autobiographical memory (e.g., cannot remember childhood before age 12; no memory of age 9–11; no memory of an important life event such as getting married, giving birth, grandmother's funeral)
  (2) Depersonalization (e.g., feeling detached/distant from self; body feeling unreal or not all there; feeling separate from self and/or watching self from outside one's body)
  (3) Derealization (e.g., feeling disconnected/distant from everything; surroundings feel strange, unreal, oddly different; not recognizing familiar people or places)
  (4) Posttraumatic flashbacks (e.g., reexperiencing some or all of the sensory elements of a past trauma)
  (5) Somatoform symptoms (e.g., motor symptoms, sensory alterations, genital pain without physical explanation)
  (6) Trance (e.g., recurrent involuntary episodes of staring off into space, being "gone" from conscious awareness, and unresponsive to environmental stimuli)

B. The person has conscious awareness of the intrusions/influences from another self-state, as indicated by *either* (1) or (2):
  (1) Switching without concomitant amnesia: The clinician or a collateral informant witnesses a self-state that claims (or appears) to be someone other than the person in question, as indicated by a, b, and c:
    (a) The visible presence of a different self-state, as evidenced by one (or more) of the following:
      (i) An announced change of identity (e.g., "I'm not her; I'm Janice.")
      (ii) A relatively sudden change of self-presentation as manifested by changes in two (or more) of the following;
        (1) Facial expression
        (2) Body posture
        (3) Tone of voice
        (4) Mannerisms
        (5) Affect
        (6) Opinions
        (7) Attitudes
    (b) The person's conscious awareness of that self-state, as evidenced by both of the following features: the person's
      (i) Reported coconscious awareness of the activities of that other self-state
      (ii) Subsequent remembering of what the other self-state said and did
    (c) The person reports experiencing that self-state as "other," "not me," or not self
  (2) The person has conscious awareness of intrusions/influences from another self-state, as indicated by five (or more) of the following (in the absence of a delusional or psychotic explanation for these intrusions/influences):
    (a) Hearing the voice of a child in his/her head
    (b) Noticing an internal struggle (that may or may not involve voices that argue). Note: internal struggle goes well beyond ambivalence; it involves a sense of the presence of different parts that are strongly opposing one another.
    (c) Hearing a persecutory voice (usually in the head) that comments harshly, makes threats, or commands self-destructive acts (in the absence of formal thought disorder or delusions)
    (d) Speech insertion (unintentional or disowned utterances)
    (e) Thought insertion or withdrawal
    (f) "Made" or intrusive feelings and emotions (or sudden withdrawal/absence of feelings and emotions)
    (g) "Made" or intrusive impulses
    (h) "Made" or intrusive actions (i.e., actions that are perceived/experienced as depersonalized) or actions or behaviors that are blocked
    (i) Atypical experiences of self-alteration (e.g., feeling very physically small or mentally young like a young child; having emotions, thoughts, or feelings that don't feel like they belong to oneself; seeing someone else instead of oneself in the mirror, etc.)
    (j) Self-puzzlement secondary to 2a-2i

C. Recurring incidents of amnesia secondary to intrusions by another self-state, as indicated by *either* (1) or (2):
  (1) Switching that is accompanied by amnesia: The clinician or a collateral informant witnesses a self-state that claims (or appears) to be someone other than the person being interviewed, *followed by the person's subsequent amnesia for what the other self-state was witnessed to do or say, as evidenced by a and b.*
    (a) The visible presence of a different self-state, as evidenced by one (or more) of the following:
      (i) An announced change of identity (e.g., "I'm not *her*; I'm Janice.")
      (ii) A relatively sudden change of self-presentation as manifested by changes in two (or more) of the following;
        (1) Facial expression

TABLE 25.4
Diagnostic Criteria for Complex Dissociative Disorder I *(Continued)*

(2) Body posture
(3) Tone of voice
(4) Mannerisms
(5) Affect
(6) Opinions
(7) Attitudes

(b) Amnesia: the person is subsequently unable to recall what the other self-state said and did.

(2) Recurring incidents of amnesia, as indicated by the person's report of two (or more) incidents of two (or more) of the following:

(a) Discovering that he/she has amnesia for a discrete interval of time ("lost time"): being completely unable to account for a period of time—an hour or longer—including the loss of memory for up to years of one's life)
(b) "Coming to": discovering that he/she was in the middle of doing something that he/she did not remember initiating (e.g., conversing with someone, disciplining the children, cooking dinner, performing occupational tasks, etc.) or suddenly discovering that he/she had done something he/she does not remember doing (e.g., smashed something, cut self, cleaned the whole house, etc.)
(c) Fugues: suddenly discovering that he/she was somewhere with no memory of having gone there in the first place (e.g., finding self at the mall, at the beach, in one's car, under the bed, in a closet, etc.)
(d) Being told of things that he/she had recently done, but with no memory of having done those things
(e) Finding objects among his/her possessions or in his/her shopping bags—that he/she does not remember acquiring, purchasing, or producing (e.g., shoes, clothes, toys, toilet articles, drawings, handwritten materials, etc.)
(f) Finding evidence of his/her recent actions, but with no memory of having done those things (e.g., mowed the lawn, produced written work, completed a task at work, cleaned the house, changed one's apparel or personal appearance, having a significant injury—a cut, a burn, many bruises, having attempted suicide, etc.)
(g) Not remembering who he/she is or what her/his name is
(h) Being unable to remember well-established skills (e.g., how to read, how to drive, how to play the piano, how to do his/her job, etc.)
(i) Other incidents of being unable to recall personal information that is so unlikely or so extensive that it cannot be explained by ordinary forgetfulness

D. The disturbance is not better accounted for by Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Mood Disorder With Psychotic Features, or Borderline Personality Disorder and is not due to the direct physiological effects of a substance (e.g., a drug or substance of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Disorder II requires that the person meet only two of the three criteria for Complex Dissociative Disorder I.[26]

[26] DSM-IV DDNOS-1a would be diagnosed by meeting Criterion A and Criterion C, but not Criterion B. Readers who are following closely will notice that this assertion *adds* an amnesia requirement to DDNOS-1a. DSM-IV is silent about whether DDNOS-1a must have amnesia. I have required that amnesia be present (because I do not know how a clinical presentation could be similar to DID (i.e., DDNOS-1) if it has neither distinct personality states nor recurring amnesia). DSM-IV DDNOS-1b would be diagnosed by meeting Criterion A and Criterion B, but not Criterion C. Finally, a third kind of DDNOS-1 that is not described in DSM-IV would be diagnosed by meeting Criterion B and Criterion C, but not Criterion A. Please note that I am *not* suggesting that Complex Dissociative Disorder II has three subtypes or that these subtypes should be diagnosed. The description above of DDNOS-1a, -1b, and so on is offered merely to illustrate the relationships between the DSM-IV description of DDNOS-1 and the criteria in Table 25.4.

25.7.7 Three Clinical Presentations of DID

Most scholars and researchers in the dissociative disorders field agree upon the existence of a less symptomatic variant of DID (e.g., Beahrs, 1982; Bloch, 1991; Boon & Draijer, 1993; Coons, 1992; Dell, 2001a; Franklin, 1988; Kluft, 1985b; Ross et al., 1992, 2002; Şar et al., 2007; Watkins & Watkins, 1997). A review of the literature, however, shows that scholars have identified *two kinds of less symptomatic DID.*

Boon and Draijer have discussed one kind of less symptomatic DID: *covert DID.* They showed that many difficult-to-diagnose cases of MPD were defensive:

> these patients showed more defensive reactions—such as amnesia or blank spells, strong interference of voices—and denial during the SCID-D interview. (Boon & Draijer, 1993, p. 121)

Although they classified these patients as having DDNOS on the basis of SCID-D interviews, Boon and Draijer considered these patients to have "covert MPD" (p. 120). They noted that these patients had lower DES scores than patients with overt MPD. Franklin (1988) has described the differences between covert DID and a second kind of less symptomatic DID: *subtle DID*. According to Franklin, covert MPD patients are especially skilled at hiding their distinct personalities, whereas subtle MPD patients have subdued symptoms because their dissociation is truly less frequent and less severe than that of covert MPD patients:

> Patients with subtle forms of MPD have less dissociation among many of their alters, which have more permeable boundaries and share more memories and behavior patterns. Their alters are, in general, less distinct and substantial. (Franklin, 1988, p. 29)

Franklin's distinctions among overt, covert, and subtle MPD provide a phenomenological typology of three major presentations of MPD; this tripartite typology sheds some additional light on DID and DDNOS-1.

25.7.7.1 Overt DID

Persons with overt DID are diagnosable by means of the "distinct personalities" criterion in the DSM. They have higher DES scores than do persons with covert DID (Boon & Draijer, 1993). The empirical literature on DID is largely based on overt DID.

25.7.7.2 Covert DID

The overwhelming majority of persons with DID have covert DID (Kluft, 1985b). It is uncommon for a person with covert DID to be diagnosed as DID by means of the DSM's "distinct personalities" criterion. Consequently, many cases of covert DID are diagnosed as DDNOS-1a. Because of this, much of the empirical literature on DDNOS may actually be based on cases of covert DID.

Although patients with covert DID have lower DES scores than patients with overt DID (i.e., mean DES = 39.6 vs. 57.8, respectively), these two groups of DID patients obtain almost identical scores on the SCID-D (i.e., SCID-D total = 18.5 vs. 19.3, respectively; Boon & Draijer, 1993). Thus, overt DID and covert DID differ dramatically in the *visibility* of their alter personalities, but differ minimally in their other dissociative symptoms (i.e., amnesia, depersonalization, derealization, identity confusion, and identity alteration; see Boon & Draijer; Steinberg, 1995). Because the criteria for Complex Dissociative Disorder I can diagnose DID without an observed switch between personalities (i.e., the diagnosis is based solely on classic dissociative symptoms, influences-from-within, and amnesia; see Dell, 2001b, 2006b; Gast et al., 1993), I predict that Table 25.4's diagnostic criteria will readily diagnose covert DID as DID (i.e., as Complex Dissociative Disorder I) rather than as DDNOS-1. Said differently, the criteria in Table 25.4 would classify both overt DID and covert DID as Complex Dissociative Disorder I.

25.7.7.3 Subtle DID

We know rather little about subtle DID other than the fact that such cases exist (Coons, 1992; Franklin, 1988: Kluft, 1985b; Ross et al., 1992) and that their dissociation is less frequent and less severe than that of overt and covert DID:

> The data also clearly show that a subcategory of a dissociative disorder exists with less identity disturbance and less amnesia than are seen with MPD. (Coons, 1992, p. 193)

I believe that the original purpose of DDNOS-1 was to detect and diagnose subtle DID. Unfortunately, the current empirical literature on DDNOS-1 can tell us little about subtle DID because the data on DDNOS-1 have probably been contaminated by numerous cases of covert DID. Under the criteria in Table 25.4, I would classify subtle DID as Complex Dissociative Disorder II. Unpublished MID data show that persons who meet the criteria for Complex Dissociative Disorder II have significantly fewer dissociative symptoms than persons with Complex Dissociative Disorder I (i.e., 10–13 vs. 19–20 of the 23 dissociative symptoms that are assessed by the MID).

25.8 A FEW RESEARCH PREDICTIONS

The proposed diagnostic criteria for DID and DDNOS-1 (i.e., for Complex Dissociative Disorder I and Complex Dissociative Disorder II) need to be empirically evaluated. Three studies have already shown that the criteria in Table 25.4, as measured by the Multidimensional Inventory of Dissociation (MID; Dell, 2006a), can successfully diagnose DID cases. The results of these three studies are interesting because they demonstrate two points: (1) the criteria for Complex Dissociative Disorder I are diagnostically effective (i.e., they readily identify persons with a SCID-D diagnosis of DID), and (2) DID/Complex Dissociative Disorder I cases can be diagnosed solely on the basis of classical dissociative symptoms, influences-from-within, and amnesia—in other words, *without* observing distinct personalities that switch.

As noted above, we know very little about subtle cases of Complex Dissociative Disorder II (i.e., true DDNOS-1).

I predict that these cases will prove to have (1) lower DES, MID, and SCID-D scores than persons who meet Criteria A, B, and C (i.e., cases of Complex Dissociative Disorder I), (2) higher DES, MID, and SCID-D scores than all other dissociative diagnoses (except Complex Dissociative Disorder I), (3) some amnesia (rather than "no amnesia" as per DDNOS-1b in DSM-IV), (4) alters that spontaneously switch less frequently than do alters in Complex Dissociative Disorder I, (5) alters that sometimes (often?) require trance-facilitated emergence, and (6) lower levels of depression, anxiety, general psychopathology, and functional impairment than persons with Complex Dissociative Disorder I.

25.8.1 Prevalence of Complex Dissociative Disorder I

The criteria for Complex Dissociative Disorder I should prevent cases of covert DID from being misclassified as DDNOS-1; therefore, the prevalence of Complex Dissociative Disorder I should be higher than existent reports of the prevalence of DID. In other words, the prevalence of Complex Dissociative Disorder I is probably the sum of the prevalence of overt DID *plus* the prevalence of covert DID. I estimate that the prevalence of Complex Dissociative Disorder (see Table 25.5) will approximate the current reported prevalence of DID (i.e., overt DID) *plus* one-third to two-thirds the current reported prevalence of DDNOS (i.e., covert DID).

TABLE 25.5
Estimated Prevalence of Complex Dissociative Disorder I in Various Settings

		Estimated Range of Prevalence (%)
Nonclinical	China	0
	Canada	1.36–1.42
	USA	3.30–5.10
	Turkey	3.80–6.60
Outpatient	USA	7.9–10.7
	Turkey	4.8–7.4
Inpatient	Canada	7.0–7.7
	Switzerland	1.1–1.7
	Germany	0.9–1.7
	Turkey	7.0–8.9
	Netherlands	3.8–6.0
	Finland	8.9–12.1
State Hospital	USA	12.3–16.8

Note: Because these estimates are based on the studies listed in Table 25.1, they are also "based on" the defining characteristics of those particular research settings.

25.8.2 What Is the Most Common Dissociative Disorder?

The most common dissociative disorder should be reconsidered in light of Complex Dissociative Disorder I. Given that 40.6% of diagnosed dissociative disorders have DDNOS and 22.8% have DID, I estimate that 36.3% to 49.5% of dissociative cases diagnosed in clinical settings will have Complex Dissociative Disorder I.

25.8.3 Prevalence of Complex Dissociative Disorder II

We know so little about subtle MPD (i.e., Complex Dissociative Disorder II) that we can make no predictions regarding its prevalence. What we *can* predict is the likelihood that over 50% of dissociative presentations in psychiatric settings will be diagnosed as complex dissociative disorders (i.e., either Complex Dissociative Disorder I or Complex Dissociative Disorder II). Said differently, at least half of the dissociative cases encountered by present-day clinicians have chronic, complex dissociative disorders. Both their clinical diagnoses and the diagnostic nosology of DSM-V should reflect that fact: *50% or more of DD patients have a chronic complex dissociative disorder.*

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REFERENCES

Adityanjee, G. S. (1990). Multiple personality in India: Dr. Adityanjee replies. *American Journal of Psychiatry, 147*, 1260–1261.

Akyüz, G., Doğan, O., Şar, V., Yargıç, I. L., & Tutkun, H. (1999). Frequency of dissociative identity disorder in the general population in Turkey. *Comprehensive Psychiatry*, *40*, 151–159.

Alexander, P. J., Joseph, S., & Das, A. (1997). Limited utility of ICD-10 and DSM-IV classification of dissociative and conversion disorders in India. *Acta Psychiatrica Scandinavica, 95*, 177–182.

American Psychiatric Association (1980). *DSM-III – Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association (1987). *DSM-III-R– Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

American Psychiatric Association (1994). *DSM-IV – Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Beahrs, J. O. (1982). *Unity and multiplicity: Multilevel consciousness of self in hypnosis, psychiatric disorder and mental health.* New York: Brunner/Mazel.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174*, 727–735.

Bloch, J. P. (1991*). Assessment and treatment of multiple personality and dissociative disorders.* Sarasota, FL: Practitioner's Resource Series.

Boon, S., & Draijer, N. (1991). Diagnosing dissociative disorders in The Netherlands: A pilot study with the Structured Clinical Interview for DSM-III-R Dissociative Disorders. *American Journal of Psychiatry, 148*, 458–462.

Boon, S., & Draijer, N. (1993). *Multiple personality disorder in The Netherlands: A study on reliability and validity of the diagnosis.* Amsterdam/Lisse: Swets & Zeitlinger.

Braun, B. G. (1988). The BASK (behavior, affect, sensation, knowledge) model of dissociation. *Dissociation*, *1*(1), 4–23.

Cardeña, E., & Spiegel, D. (1996). Diagnostic issues, criteria, and comorbidity of dissociative disorders. In L. K. Michelson & W. J. Ray (Eds.), *Handbook of dissociation: Theoretical, empirical, and clinical perspectives* (pp. 227–250). New York: Plenum Press.

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation*, *6*, 16–27.

Chand, S. P., Al Hussaini, A. A., Martin, R., Mustapha, S., Zaidan, Z., Viernes, N., & Al-Adawi, S. (2000). Dissociative disorders in the Sultanate of Oman. *Acta Psychiatrica Scandinavica, 102*, 185–187.

Chu, J. A. (1996). Posttraumatic responses to childhood abuse and implications for treatment. In L. K. Michelson & W. J. Ray (Eds.), *Handbook of dissociation: Theoretical, empirical, and clinical perspectives* (pp. 381–397). New York: Plenum Press.

Coons, P. M. (1992). Dissociative disorder not otherwise specified: A clinical investigation of 50 cases with suggestions for typology and treatment. *Dissociation, 5*(4), 187–195.

Coons, P. M. (2001). On changing the diagnostic criteria for dissociative identity disorder. *Journal of Trauma & Dissociation, 2*(1), 43–46.

Coons, P. M., & Milstein, V. (1992) Psychogenic amnesia: A clinical investigation of 25 cases. *Dissociation*, 5, 73–79.

Das, P. S., & Saxena, S. (1991). Classification of dissociative states in DSM-III-R and ICD-10 (1989 Draft): A study of Indian outpatients. *British Journal of Psychiatry, 159*, 425–427.

Dell, P. F. (1998). Axis II pathology in outpatients with dissociative identity disorder. *Journal of Nervous and Mental Disease, 186*, 352–356.

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

Dell, P. F. (2001b). Should the dissociative disorders field choose its own diagnostic criteria for dissociative identity disorder? Reply to Cardeña, Coons, Putnam, Spiegel, and Steinberg. *Journal of Trauma & Dissociation, 2*(1), 65–72.

Dell, P. F. (2001c). Why DSM-III's portrayal of DID is a problem. *ISSD News, 19(2)*, 4–7.

Dell, P. F. (2002). Dissociative phenomenology of dissociative identity disorder. *Journal of Nervous and Mental Disease, 190*, 10–15.

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

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

Dell, P. F. (2009a). The long struggle to diagnose multiple personality disorder (MPD) I. Multiple Personality Disorder. In P F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 383–402). New York: Routledge.

Dell, P. F. (2009b). The phenomena of pathological dissociation. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 225–238). New York: Routledge.

Ensink, B. J., & van Otterloo, D. (1989). A validation study of the DES in The Netherlands. *Dissociation, 2*(4), 221–223.

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *American Journal of Psychiatry, 163*(4), 623–629.

Franklin, J. (1988). Diagnosis of covert and subtle forms of multiple personality disorder. *Dissociation, 1*(2), 27–33.

Fraser, G. A. (1994). Dissociative phenomena and disorders: Clinical presentations. In R. M. Klein & B. K. Doane (Eds.), *Psychological concepts and dissociative disorders* (pp. 131–151). Hillsdale, NJ: Lawrence Erlbaum Associates.

Friedl, M. C., & Draijer, N. (2000). Dissociative disorders in Dutch psychiatric inpatients. *American Journal of Psychiatry, 157*, 1012–1013.

Frischholz, E. J., Braun, B. G., Sachs, R. G., Hopkins, L., Schaeffer, D. M., Lewis, J., Leavitt, F., Pasquotto, M. A., & Schwartz, D. R. (1990). The Dissociative Experiences Scale: Further replication and validation. *Dissociation, 3*(3), 151–153.

Gast, U., Rodewald, F., Nickel, V., & Emrich, H. M. (2001). Prevalence of dissociative disorders among psychiatric inpatients in a German university clinic. *Journal of Nervous and Mental Disease, 189*, 249–257.

Graves, S. M. (1989). Dissociative disorders and dissociative symptoms at a community mental health center. *Dissociation, 2*(3), 119–127.

Hilgard, E. R. (1977). *Divided consciousness: Multiple controls in human thought and action.* New York: Wiley.

Horen, S. A., Leichner, P. P., & Lawson, J. S. (1995). Prevalence of dissociative symptoms and disorders in an adult psychiatric inpatient population in Canada. *Canadian Journal of Psychiatry, 40*(5), 185–191.

Janet, P. (1889). *L'automatisme psychologique: Essai de psychologie expérimentale sur les formes inférieures de l'activité humaine* [Psychological automatism: Essay of experimental psychology on the lower forms of human activity]. Paris: Félix Alcan.

Kihlstrom, J. F. (1992). Hypnosis: A sesquicentennial essay. *International Journal of Clinical and Experimental Hypnosis, 40*, 301–314.

Kluft, R. P. (1985a). Making the diagnosis of multiple personality disorder (MPD). In F. F. Flach (Ed.), *Directions in Psychiatry, 5*(23), 1–10.

Kluft, R. P. (1985b). The natural history of multiple personality disorder. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 197–238). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1987). Dissociative disorders. In A. E. Skodol & R. L. Spitzer (Eds.), *An annotated bibliography of DSM-III* (pp. 119–124). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1988). The phenomenology and treatment of extremely complex multiple personality disorder. *Dissociation, 1*(4), 47–58.

Kluft, R. P., Steinberg, M., & Spitzer, R. L. (1988). DSM-III-R revisions in the dissociative disorders: An exploration of their derivation and rationale. *Dissociation, 1*(1), 39–46.

Latz, T. T., Kramer, S. I., & Hughes, D. L. (1995). Multiple personality disorder among female inpatients in a state hospital. *American Journal of Psychiatry, 152*(9), 1343–1348.

Lipsanen, T., Korkeila, J., Peltola, P., Järvinen, J., Langen, K., & Lauerma, H. (2004). Dissociative disorders among psychiatric patients: Comparison with a nonclinical sample. *European Psychiatry, 19*, 53–55.

Loewenstein, R. J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America, 14*(3), 567–604.

Lussier, R. G., Steiner, J., Grey, A., & Hansen, C. (1997). Prevalence of dissociative disorders in an acute care day hospital population. *Psychiatric Services, 48*(2), 244–246.

Martínez-Taboas, A. (1991). Multiple personality disorder as seen from a social constructionist viewpoint. *Dissociation, 4*(3), 129–133.

Messerschmidt, R. (1927–1928). A quantitative investigation of the alleged independent operation of conscious and subconscious processes. *Journal of Abnormal and Social Psychology*, *22*, 325–340.

Mezzich, J. E., Fabrega, H., Coffman, G. A., & Haley, R. (1989). DSM-III disorders in a large sample of psychiatric patients: Frequency and specificity of diagnoses. *American Journal of Psychiatry, 146*, 212–219.

Modestin, J., Ebner, G., Junghan, M., & Erni, T. (1996). Dissociative experiences and dissociative disorders in acute psychiatric inpatients. *Comprehensive Psychiatry, 37*(5), 355–361.

Murphy, P. E. (1994). Dissociative experiences and dissociative disorders in a non-clinical university group. *Dissociation, 7*(1), 28–34.

Nemiah, J. (1985). Dissociative disorders. In H. Kaplan & B. Sadock (Eds.), *Comprehensive textbook of psychiatry* (4th ed., pp. 942–957). Baltimore: Williams & Wilkins.

Nijenhuis, E. R. S., Van Dyck, R., Spinhoven, P., van der Hart, O., Chatrou, M., Vanderlinden, J., & Moene, F. (1999). Somatoform dissociation discriminates among diagnostic categories over and above general psychopathology. *Australian and New Zealand Journal of Psychiatry, 33*, 511–520.

Perry, C., & Laurence, J.-R. (1984). Mental processing outside of awareness: The contributions of Freud and Janet. In K. S. Bowers & D. Meichenbaum (Eds.), *The unconscious reconsidered* (pp. 9–48). New York: Wiley.

Putnam, F. W. (2001). Reclaiming dissociative disorders. *Journal of Trauma & Dissociation, 2*(1), 47–49.

Putnam, F. W., Carlson, E. B., Ross, C. A., Anderson, G., Clark, P., Torem, M., Bowman, E. S., Coons, P., Chu, J. A., Dill, D. L., Loewenstein, R. J., & Braun, B. G. (1996). Patterns of dissociation in clinical and nonclinical samples. *Journal of Nervous and Mental Disease, 184*, 673–679.

Ross, C. A. (1985). DSM-III: Problems in diagnosing partial forms of multiple personality disorder: discussion paper. *Journal of the Royal Society of Medicine*, *78,* 933–936.

Ross, C. A. (1991). Epidemiology of multiple personality disorder and dissociation. *Psychiatric Clinics of North America, 14*(3), 503–517.

Ross, C. A. (1997). *Dissociative Identity Disorder: Diagnosis, clinical features, and treatment of multiple personality.* New York: Wiley.

Ross, C. A., Anderson, G., Fraser, G. A., Reagor, P., Bjornson, L., & Miller, S. D. (1992). Differentiating multiple personality disorder and dissociative disorder not otherwise specified. *Dissociation, 5*(2), 87–90.

Ross, C. A., Duffy, C. M. M., & Ellason, J. W. (2002). Prevalence, reliability and validity of dissociative disorders in an inpatient setting. *Journal of Trauma & Dissociation, 3*(1), 7–17.

Ross, C. A., Ryan, L., Voigt, H., & Eide, L. (1991). High and low dissociators in a college population. *Dissociation, 4*(3), 147–151.

Şar, V., & Akyüz, G. (2003, November). *Trauma and dissociation among prisoners*. Paper presented at the 20th annual conference of the International Society for the Study of Dissociation. Baltimore, MD.

Şar, V., Akyüz, G., & Doğan, O. (2007). Prevalence of dissociative disorders among women in the general population. *Psychiatry Research, 149*(1–3), 169–176.

Şar, V., Kundakçı, T., Kızıltan, E., Bakım, B., & Bozkurt, O. (2000a). Differentiating dissociative disorders from other diagnostic groups through somatoform dissociation in Turkey. *Journal of Trauma & Dissociation, 1*(4), 67–80.

Şar, V.,Tutkun, H., Alyanak, B., Bakım, B., & Baral, I. (2000b). Frequency of dissociative disorders among psychiatric outpatients in Turkey. *Comprehensive Psychiatry, 41*, 216–222.

Şar, V., Kundakçı, T., Kızıltan, E., Yargıç, I. L., Tutkun, H., Bakım, B., Bozkurt, O., Özpulat, T., Keser, V., & Özdemir, Ö. (2003). The Axis-I dissociative disorder comorbidity of borderline personality disorder among psychiatric patients. *Journal of Trauma & Dissociation, 4*(1), 119–136.

Saxe, G. N., van der Kolk, B. A., Berkowitz, R., Chinman, G., Hall, K., Lieberg, G., & Schwartz, J. (1993). Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry, 150*, 1037–1042.

Saxena, S., & Prasad, K. V. S. R. (1989). DSM-III subclassification of dissociative disorders applied to psychiatric outpatients in India. *American Journal of Psychiatry, 146*, 261–262.

Somer, E., & Dell, P. F. (2005). Development of the Hebrew-Multidimensional Inventory of Dissociation (H-MID): A valid and reliable measure of pathological dissociation. *Journal of Trauma & Dissociation, 6*(1), 31–53.

Spiegel, D., & Cardeña, E. (1991). Disintegrated experience: The dissociative disorders revisited. *Journal of Abnormal Psychology, 100*(3), 366–378.

Steinberg, M. (1993*). Interviewer's guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D).* Washington, DC: American Psychiatric Press.

Steinberg, M. (1994). *Interviewer's guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)-Revised.* Washington, DC: American Psychiatric Press.

Steinberg, M. (1995). *Handbook for the assessment of dissociation: A clinical guide*. Washington, DC: American Psychiatric Press.

Steinberg, M. (2001). Updating diagnostic criteria for dissociative disorders: Learning from scientific advances. *Journal of Trauma & Dissociation, 2*(1), 59–63.

Takahashi, Y. (1990). Is multiple personality disorder really rare in Japan? *Dissociation, 3*, 57–59.

Tutkun, H., Şar, V., Yargıç, L. I., Özpulat, T., Yanık, M., & Kızıltan, E. (1998). Frequency of dissociative disorders among psychiatric inpatients in a Turkish University Clinic. *American Journal of Psychiatry, 155*, 800–805.

Umesue, M., Matsuo, T., Iwata, N., & Tashiro, N. (1996). Dissociative disorders in Japan: A pilot study with the Dissociative Experience Scale and a semi-structured interview. *Dissociation, 9*(3), 182–189.

Van der Hart, O., Nijenhuis, E., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic dissociation.* New York: W. W. Norton.

Vanderlinden, J. (1993). *Dissociative experiences, trauma and hypnosis: research findings & clinical applications in eating disorders.* Delft, The Netherlands: Uitgeverij Eburon.

Waller, N. G., Putnam, F. W., & Carlson, E. B. (1996). Types of dissociation and dissociative types: A taxometric analysis of dissociative experiences. *Psychological Methods, 1*(3), 300–321.

Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy*. New York: W. W. Norton and Company.

White, R. W., & Shevach, B. J. (1942). Hypnosis and the concept of dissociation. *Journal of Abnormal and Social Psychology*, 37, 309–328.

Wig, N. N. (1983). DSM-III: A perspective from the Third World. In R. L. Spitzer, J. B. W. Williams & A. E. Skodol (Eds.), *International perspectives on DSM-III*. Washington, DC: American Psychiatric Press.

Xiao, Z., Yan, H., Wang, Z., Zou, Z., Xu, Y., Chen, J., Zang, H., Ross, C. A., & Keyes, B. B. (2006). Trauma and dissociation in China. *American Journal of Psychiatry, 163,* 1388–1391.