Multiple Personality Disorder and Major Depression: A Comparative Study

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Western Michigan University

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MULTIPLE PERSONALITY DISORDER AND MAJOR DEPRESSION: 
A COMPARATIVE STUDY

by

Mary L. Wassink

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education
and Counseling Psychology

Western Michigan University
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ACKNOWLEDGMENTS

The study of dissociative disorders, and particularly multiple personality disorder, has taught me much about survival, adaptation, persistence, and motivation; indeed, it was preparation for completing a dissertation.

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Mary L. Wassink
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Multiple personality disorder (MPD) and other dissociative disorders are being diagnosed and treated with increasing frequency (Ross & Norton, 1988; Kluft, 1985a). In 1980, the American Psychiatric Association officially recognized MPD as a legitimate psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders-Third Edition (DSM-III). The criteria were revised in the 1987 DSM-III-R, and again in 1994, and with the most recent DSM-IV which has now defined MPD as Dissociative Identity Disorder (DID) (American Psychiatric Association, 1994). For the purposes of this paper, I will continue to use the term MPD, because the new term (DID) has not been fully incorporated into the literature as of this date.

The definition of MPD in the DSM-IV (1994) is as follows:

1. 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).

2. At least two of these identities or personality states recurrently take control of the person’s behavior.

3. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
4. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures) (p. 487).

The essential feature of dissociation is "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (DSM-IV, p. 477). There are five categories of dissociative disorders recognized in the DSM-IV: dissociative amnesia, dissociative fugue, depersonalization disorder, dissociative identity disorder (formerly MPD), and dissociative disorder not otherwise specified. Of the five categories listed, MPD has been the subject of the most research and has been the category of dissociative disorders most thoroughly investigated (Boon & Draijer, 1991).

Severe dissociative symptoms and the dissociative disorders are recognized as posttraumatic (Braun, 1984; Fine, 1990; Kluft, 1988; Putnam, 1985; Ross, Norton & Wozney, 1989; Spiegel, 1984, 1991). Dissociation, as a psychological defense, is used by survivors of abuse and trauma to cope with overwhelming anxiety and pain. Victims of recurrent child abuse may develop chronic dissociative symptoms or disorders as listed above (Steinberg, Cicchetti, Buchanan, Hall & Rounsaville, 1993).

Background of the Problem

Research on MPD in the last 10 years has generated a growing body of knowledge about the etiology and epidemiology of the disorder. It is generally
considered a childhood-onset, dissociative, post-traumatic condition that emerges as the consequence of overwhelming, severe, and repetitive physical and/or sexual abuse or neglect, generally beginning before the age of five (Putnam, Guroff, Silberman, Barban & Post, 1986; Spiegel, 1984; Ross, 1989).

The reported female-to-male ratio of MPD varies from 5:1 (Putnam, 1989) to 9:1 (Ross et al., 1989). It has been suggested that the higher female-to-male ratio may be misrepresentative because many males with MPD may be in prison or do not seek treatment and, therefore, go unrecognized (Kluft, 1988; Lowenstein & Putnam, 1990). Recent studies have reported prevalence rates for the disorder that range from 2.4 to 11.3 percent of inpatient psychiatric samples (Bliss & Jeppsen, 1985; Graves, 1989; Ross, 1991; Ross, Anderson, Fleisher, & Norton, 1991). Coons (1984) estimates the prevalence of MPD at 1 per 10,000 general population; however, other authors report that this is an underestimate (Kluft, 1987; Coons, 1986; Ross, 1989).

As a clinical group, MPD patients first enter the mental health system at a mean age of 21.4 years (Kluft, 1988). Their mean age at the time of their first psychiatric hospitalization is 26.5 years and many are not diagnosed with MPD until after they are 30 years old (Kluft, 1988). The mean length of time between the first diagnosis and the MPD diagnosis is 6.8 years (Putnam et al., 1986). Putnam et al. report there are frequently other diagnoses made prior to the MPD diagnosis. The most common previous diagnoses are major depression (42%), drug abuse or dependence (28%), alcohol abuse or dependence (24%),
schizophrenia (24%), bipolar disorder (12%), brief reactive psychosis (12%),
borderline personality disorder (10%) and eating disorders (10%) (Coons,
Bowman & Milstein, 1988).

One of the difficulties in recognizing and diagnosing MPD is that its
manifestations and symptoms often coexist with, or are obscured by, other
phenomena (Kluft, 1987). MPD is rarely the initial presenting problem with
MPD patients as it usually emerges during treatment with secondary features
(Ross, 1989). Thus, the polysymptomatic presentation and/or history of MPD often
leads to misdiagnosis and misdirected treatment.

Theoretical Rationale

In the 19th century, and until 1910, the study of dissociation was in the
mainstream of Western psychology and psychiatry. Dissociation as a theoretical
concept was studied by major figures such as Freud, Jung, Charcot, Janet, Binet,
James, and Prince (Ross, 1989). As is evident, there has been strong influence
from the psychoanalytic and psychodynamic position.

Dissociative disorders have been conceptualized on a continuum of increas­
ing amounts of dissociated psychic material from minor dissociations of everyday
life, such as daydreaming, to the major psychopathological forms, such as MPD
(Bernstein & Putnam, 1986). It has been hypothesized that dissociation is a
normal process that is initially used defensively by an individual to handle trauma­
tic experiences and evolves over time into a maladaptive or pathological process
with repeated exposure to trauma. The concept of the adaptive value of disso-
ciation is proposed by the following theoretical models of MPD.

The two most recent theories about MPD are proposed by Kluft (1984a)
and Braun and Sachs (1985). Both of these theories place the following condi-
tions at the center of etiology of MPD: (1) high dissociative potential and the
ability to use dissociation as an ego defense and, (2) childhood exposure to
severe, repeated, and often bizarre physical, sexual, and/or emotional abuse that
overwhelms the individual’s defenses and is most often administered by the
child’s parents or other family members who may irrationally intersperse abuse
with expressions of love.

Kluft (1984a) has developed a “four-factor theory” which reflects the con-
cept that there are biological and environmental factors which interact with devel-
velopmental and psychodynamic processes in each individual in a unique way. The
uniqueness of this interaction is what leads to the wide diversity of the con-
dition’s symptom manifestations, structures and treatment outcomes. The four
factors he identifies for the development of MPD are: (1) a biological capacity
for dissociation, (2) a history of severe trauma or abuse, (3) specific psychological
structures or contents that can be used in the creation of alternative personalities,
and (4) a lack of adequate nurturing or opportunities to recover from abuse.

The second theory proposed by Braun and Sachs (1985) has been called
the 3-P model of MPD because it focuses on the predisposing, precipitating, and
perpetuating factors that are associated with development of the disorder. This
model is depicted in Figure 1.

Figure 1. The 3-P Model of Multiple Personality Disorder.


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Two predisposing factors are hypothesized to be necessary: (1) an inborn biological/psychological capacity to dissociate that is usually identified by excellent responsivity to hypnosis, and (2) repeated exposure to an inconsistently stressful environment. The inconsistency is in the child receiving double-bind messages of love and abuse for the same behavior, at unpredictable times. Both of these predisposing factors are necessary for MPD to develop. Neither alone is sufficient (Braun & Sachs, 1985).

The precipitating event in this model refers to an initial, specific overwhelming traumatic episode to which the potential MPD individual responds by dissociating. If such events are not common and frequent the individual may only experience a dissociative episode. As long as these episodes are not linked by a common affective theme and/or neurophysiological state (Braun, 1984), the person is unlikely to develop MPD. Dissociative episodes are necessary but not sufficient conditions for the development of MPD.

The perpetuating phenomena associated with the development of MPD are interactive behaviors usually with the abuser and enabler and include separate memories that the child ultimately links together by a common affective theme. After repeated exposure to inconsistently abusive situations, the child with dissociative capacity begins to file the memories of the traumatic events separately, and they begin to take on a life history of their own. For each fragment of affectively linked memories, a specific adaptive response to similar traumatic experiences develops. This chaining together of memories and development of
associated response patterns is perpetuated by continuous unpredictable environmental trauma (Braun, 1984). Gradually, the individual’s personality is split because the different adaptive responses to the trauma have become functionally separated by an amnestic barrier. This leads to the development of different personality states, each whom may have its own adaptive function in the face of a particular kind of trauma (Braun & Sachs, 1985).

Ross (1989) has summarized and stated quite simply the answer to the question, “What is MPD?” MPD is a little child imagining that the abuse is happening to someone else. The condition of MPD is not a simple disorder. There is a great deal of data to support the clinical model of MPD and a more comprehensive account of the etiology of MPD will be discussed in Chapter II. For now, it is proposed that MPD is a complex biopsychosocial disorder, and that it is a strategy for surviving a traumatic childhood (Ross, 1989).

While the development of MPD is adaptive for a child who is helpless to escape an abusive or traumatic situation, it can become maladaptive for the individual when he/she becomes an adult and the abusive situations are no longer occurring. The splitting into fragmented personality states under stress does not allow for a more integrated problem solving approach. It also leads to fragmented affective states and rapid mood cycling, particularly depression (Ross, 1989). The depression will serve to protect the individual from “associating” their abusive experiences with their helplessness and pain in uncontrollable and undesirable conditions. The depression may insulate or protect the individual
from the anger, rejection, hurt, abandonment, and/or fear, and serve as a defense against the anxiety s/he might feel without splitting off the affective states. Again, a pattern of repression, depression, and dissociation becomes pathological for an adult MPD.

A depressed mood becomes a prominent feature for an MPD patient and may be the presenting symptom when treatment is sought. Sometimes this occurs because the MPD pathology is hidden behind amnestic barriers and the individual is not aware of the personality states. Another reason may be because the individual is fearful of being labeled “crazy” and will conceal the pathology until trust is adequately established and it is viewed as “safe” to reveal the multiple personality states.

The study undertaken has been designed to examine a sample of MPD adults and a sample of adults who are not MPD, but who have been diagnosed with major depression. Based on the above theory, it was expected the sample of MPD individuals would have a history of severe child abuse, and a high degree of depression. It was also projected that the MPD sample would have consulted more therapists for treatment and that they had received more ineffective treatment in the past. It was hypothesized that the sample of individuals who had major depression, but who were not MPD, would have significantly lower accounts of child abuse history and their depression would be less severe.
Statement of the Problem

At the present time, there are few psychiatric screening protocols for differentiating the diagnosis of MPD from that of other major psychiatric disorders. One problem is that MPD patients usually do not present primary dissociative symptoms in an overt and florid manner (Kluft, 1985b). Kluft (1985a) found that 5% of the patients presented as self-diagnosed but were generally disbelieved by their psychiatrists, 15% openly dissociated during assessment or treatment, 40% presented with signs that could alert a clinician with a high index of suspicion for MPD, and 40% of cases were highly disguised.

Historically, MPD features have been subsumed within the definitions of other major psychiatric disorders. Although knowledge of the etiology and symptomology of MPD has increased proportionally with the increase of reported incidence, a differential diagnosis of the disorder from other related emotional disorders remains problematic (Ross, 1989). There have been research studies which have examined the links between MPD and a variety of other diagnoses, including borderline personality disorder (Kemp, Gilbertson, & Torem, 1988; Boon & Draijer, 1991; Fink & Golinkoff, 1990), major affective disorders, such as depression (Schultz, Braun, & Kluft, 1989) and schizophrenia (Ross & Norton, 1988).

In particular, depression is one of the most common symptoms in MPD patients. Kluft (1987) summarized many research contributions in his update on
MPD, and concurred that depressive symptoms are nearly universal in MPD patients. Putnam et al. (1986) reported that 80% of 100 MPD patients studied at the National Mental Health (NIMH) originally presented sufficient depressive symptoms for a diagnosis of major affective disorder.

The difficulty with the diagnosis of depression for individuals with concomitant MPD is that receiving the diagnosis of depression is generally considered to conclude the diagnostic phase of the treatment planning process. Many clinicians accurately diagnose the depression, however, look no further for associated disorders, such as MPD.

Early detection of MPD symptoms (such as depression) and identification of diagnostic variables (such as childhood abuse) may be important signals to continue the assessment phase of treatment. Therefore, the present study was designed to gather data and add to the existing pool of knowledge which may lead clinicians to accurately diagnose MPD and differentiate it from another psychiatric disorder, especially one that is also commonly experienced by individuals with MPD (such as depression).

Purpose of the Study

The study compared participants with a principal diagnosis of MPD and participants with a principal diagnosis of major depression, without dissociative features. The depression features of MPD participants were compared to the features of depression in Major Depression Disorder (MDD) participants. Data
about demographic characteristics, psychiatric history, dissociative features, and childhood history of abuse were also collected, compared, and reported.

Findings of this study examined the features and characteristics which significantly differentiated MPD participants from participants with MDD. It is anticipated that results obtained will assist clinicians in developing assessment methods which will lead to more accurate diagnoses with patients who have MPD and other dissociative disorders. Additionally, results will assist clinicians develop treatment strategies for MPD clients. Implications for training therapists to work with dissociative disorders will also be identified.

Definition of Terms

The following terms are defined according to their usage in this study.

Principal diagnosis: The condition that is primarily responsible for the admission to therapy. It is the condition that is the main focus of attention and treatment. It is the same as “principal diagnosis” used in Axis I and/or Axis II diagnoses in the DSM-III-R.

Major Depression Disorder (MDD): A pervasive negative mood that has lasted at least two weeks and includes negative feelings such as disappointment, frustration, guilt, sadness, despair, helplessness, hopelessness, and worthlessness. There also is some evidence of sleep and eating disturbance. The mood cannot be explained by organic factors, psychotic states, a history of bipolar illness, and is not a normal reaction to the death of a loved one. For this study, depression
must meet the diagnostic criteria in the DSM-III-R for Major Depression Disorder (Appendix A).

**Multiple Personality Disorder:** Two or more personalities existing within one person. The alternate personalities are of varying complexity and distinctness, and each has its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and one's self. Each of these personalities can and will recurrently take full control of the individual's behavior. For this study, MPD must meet the diagnostic criteria in the DSM-III-R for Multiple Personality Disorder (Appendix B).

Research Questions

There following questions served to guide the course of the present study:

Are there differences in demographic characteristics of the participants in the two diagnostic groups? The factors of age, income level, number of children, gender, race, relationship status, education, gender preference, economic status, and previous incarceration were compared to determine if there were significant differences between the two participant groups.

Do the two diagnostic groups have differences in their psychiatric histories? The knowledge of previous psychiatric diagnoses, having received psychiatric medication, having received electroshock treatment, the number of therapists consulted for treatment, and the report of the effectiveness of previous treatment
were evaluated for significant differences.

Is there a difference in the severity of depression between persons diagnosed with MPD and persons diagnosed with MDD? The levels of depression, as measured by the Beck Depression Inventory (BDI), were compared between the two diagnostic groups for significant differences. Participants were also asked to rate the severity of their depression in terms of the condition being “in remission” or “active, recurrent.”

Do participants in this study diagnosed with MPD report more dissociative features than study participants diagnosed with MDD? A comparison of scores obtained on the Dissociative Experiences Scale (DES), as well as the Dissociative Disorders Interview Schedule (DDIS), Section VIII, Secondary Features of MPD, was made to determine if there was a significant difference in this category between the two diagnostic groups.

Do persons diagnosed with MPD report more childhood abuse (physical and/or sexual abuse) than persons diagnosed with MDD? An examination of the percentage of participants in each diagnostic group who reported childhood physical and/or sexual abuse was made. Additionally, inquiries were made to both diagnostic groups regarding the perpetrator identity, age at onset of abuse, type of sexual abuse, age at which abuse ended, number of incidents up until age 18, and after age 18, to determine what the characteristics of childhood abuse were for the study participants.
Limitations of the Study

There are limitations which come from the inherent biases of the quantitative methods employed, and the sample participants who volunteered or the study. The results of the data can only be generalized to a population with characteristics similar to the sample, i.e. outpatient clients, diagnosed by their therapists, with MPD or major depression, in Michigan, who volunteered to participate in a research study. The sampling procedure was not random but purposeful (Patton, 1990). Therapists were identified who met selection criteria, who then selected one or two of their outpatient clients, who also met diagnostic and selection criteria, and, who volunteered to participate, and, then, met screening criteria.

The nature of a MPD diagnosis may limit accuracy of the data reported by clients. Alternate personalities of MPD clients may have different perceptions, feelings, and attitudes about depression, abuse and their diagnosis and it is not possible to control for the possibility of inconsistent reporting.

The selection of the particular instruments chosen for this study or for any study, limit the range of potential data obtained. The structure of the Beck Depression Inventory (BDI) and Dissociative Experiences Scale (DES) is self-report and each participant self-administered the instruments with no check on accuracy or uninterrupted testing conditions.
Methodological Assumptions

As in all research endeavors, assumptions have been accepted in order to conduct the present study. First of all, it was assumed that experienced, licensed therapists would make accurate diagnoses and appropriate referrals to the study. Second, it was assumed that the research participants would respond as directed to the measures, themselves (self-administered and/or telephone interviews), and the data would be as accurate as possible. This includes the assumption that the person responding to the telephone interview would be the same as the person and/or personality who completed the BDI and DES. With MPD there are alternate personalities who may have different views or memories, however, they would agree to provide as consistent information as they can provide.

Third, it was assumed that the two diagnoses of MPD and MDD are relatively stable and they would not change significantly between referral and completion of the data gathering phase of the study. Fourth, the researcher assumed the presence or absence of MPD can be adequately determined by the DES and the DDIS, and the severity of depression can be adequately determined by the BDI.

Summary

As is evident, identifying MPD features and making the MPD diagnosis
can be problematic. The research study examined the feature of depression because it is one of the major related and presenting symptoms in MPD patients. It was compared to the severity of depression in non-MPD patients to determine if there are significant differences. Additionally, demographic data, psychiatric history, childhood abuse history, and secondary dissociative features were also compared and examined to determine if those factors also might differentiate the two diagnostic groups. The next chapter, Chapter II, provides a review of the literature and a historical perspective of the problem. Chapter III includes a description of the methodology which was employed to evaluate the selected variables of the two diagnostic groups. In Chapter IV the results are presented and a discussion of the results and their implications comprises Chapter V.
CHAPTER II

REVIEW OF RELATED LITERATURE

A Historical Perspective

Ellenberger (1970) has chronicled the history of the dissociative disorders, including multiple personality disorder (MPD), back into the first century where references to demon possession are described. He describes the phenomena as:

An individual suddenly seems to lose his identity to become another person. His physiognomy changes and shows a striking resemblance to the individual of whom he is, supposedly, the incarnation. With an altered voice, he pronounces words corresponding to the personality of the new individual. (p. 13)

The concept of demonic possession dominated Western thinking for many centuries. Paracelsus is credited by Bliss (1980) as identifying the first case of MPD, in 1646, involving a woman, Mary Mitchell, who was amnesiac for an alter personality who stole her money.

Beginning in the 18th century, the possession phenomenon began to decline as the explanation for disordered mental behavior. A new theory emerged of MPD based on magnetic somnambulism or magnetic sleep (Crabtree, 1993). In 1784, the Marquis de Puysegur discovered an unusual state of consciousness in one of his patients, Victor Race. He labeled this altered state of consciousness "magnetic sleep," after "animal magnetism." The discovery pointed to a second or alternative consciousness that possesses distinct personal qualities and a
separate memory chain. This state of divided consciousness became the basis for all modern psychotherapies that accept the notion of unconscious mental activity (Crabtree, 1993).

An early attempt to delineate a specific MPD disorder was described by Eberhardt Gmelin in 1791 (Ellenberger, 1970). He treated a 20 year old German woman who would suddenly "exchange" her personality, language, and manners with an alter personality who spoke perfect French and behaved like an aristocratic lady. The first American MPD case, that of Mary Reynolds, was reported in 1815 (Ellenberger, 1970).

The next period of time, in the history of MPD, has been called the "dissociation period" (Crabtree, 1993). In the late 1880's, a theory emerged with two insights. The first insight is an awareness of dissociation and the idea that the psyche can partition off segments of experience. The second is that dissociation often occurs in response to trauma, and that dual, or multiple psychic centers may be formed (Crabtree, 1993).

By the end of the nineteenth century, interest and investigation in MPD were at a high point. The work of Janet in France and Prince in the United States on the origins, structure, and dynamics of MPD and its implications for a general theory of consciousness and psychopathology was the culmination of this important period in the history of psychiatry and psychology.

By the early twentieth century there was a dramatic decline in the number of MPD cases reported and in the theoretical contributions to the literature. A
waning of interests in hysteria, hypnosis and MPD, and, concurrently, the studying of psychoanalytical theory and schizophrenia moved into the foreground, which led to this decline (Rosenbaum, 1980). Kluft (1991) summarized this shift by saying, "Dismissed as a subject of importance by the rising tides of psychoanalysis, descriptive and organicist psychiatry, and behaviorism, the study of dissociation and MPD declined to near extinction within a generation" (p. 168).

In 1944, Taylor and Martin noted that the literature contained approximately 100 cases of MPD, also noting that only 76 cases had been reported during the 127 years since the report of Mary Mitchell in 1816. In 1954, with the report on "Eve" (Thigpen & Cleckley, 1954) attention was again drawn back toward MPD. Greaves (1980) noted that only 14 cases of this disorder had been reported from 1944 to 1969. The presentation of "Sybil" (Schreiber, 1973) marked a turning point, stimulating an increase in reports of MPD cases that continues today. Coons (1986) believes that the growth of interest in MPD has paralleled that of incest, which is closely related. The reports of both incest and MPD have increased significantly since 1970. Greaves (1980) and Boor (1982) noted that more than 80 cases of MPD were reported and added to the literature from 1970 to 1981 bringing the total number of cases reported since the beginning of its history to approximately 200. More recently, Braun (1984) reported there were approximately 100 contemporary cases of MPD in treatment, and Coons (1986) estimated 6000 cases of MPD had been diagnosed in North America.

In 1980, the American Psychiatric Association recognized MPD in the
Diagnostic and Statistical Manual of Mental Disorders (DSM-III) as a distinct psychiatric condition and provided landmark clinical descriptions. Kluft, Steinberg and Spitzer (1988) reported that DSM-III serendipitously coincided with the publication of six major articles on MPD (Bliss, 1980; Braun, 1980; Coons, 1980; Greaves, 1980; Marmer, 1980; Rosenbaum, 1980). Kluft (1987) reported that between 1983 and 1985 five journals devoted special issues to the disorder. A comprehensive bibliography published in 1983 (Boor & Coons, 1983) required revision within two years because of the expansion of articles being reported to the psychiatric community. The rise of interest in and scientific study of MPD contributed to more information which then required a revision of the diagnostic criteria published in 1987 in the DSM-III-R, and again in 1994 in the DSM-IV.

The rise in reporting rekindled long-standing controversies about MPD. Thigpen and Cleckley (1984) have said that the increase is spurious, reflecting misdiagnosis and iatrogenesis, or the creation of MPD by the therapist through suggestion and hypnosis. It has been questioned whether the disorder's prevalence has increased, whether diagnostic criteria have changed, whether the diagnosis is now made more astutely or whether a small number of clinicians are contributing a disproportionate number of cases (Kluft, 1987).

Etiology of MPD

The etiology of MPD and models for its diagnosis and treatment have been studied by several writers (Braun, 1986b; Braun & Sachs, 1985; Kluft, 1984b;
Putnam, 1989; Stern, 1984). The four-factor theory (Kluft, 1984b) encompasses most of the observations in the literature. It is proposed that MPD will develop when a child has: (1) an inborn biological/psychological capacity to dissociate, (2) repeated life experiences that traumatically overwhelm the nondissociative defenses and adaptational capacities of the child’s ego, (3) secondary structuring of these altered states leads to the development of the MPD "personalities", and (4) inadequate nurturing, soothing and restorative experiences by significant others to recover from abuse.

Very high rates of childhood traumatization have been described in virtually all modern systematic studies of MPD. The trauma is usually severe, with repetitive physical and/or sexual abuse beginning before the age of five (Lowenstein & Putnam, 1990). Ninety-seven percent of North American MPD patients reported alleged histories of child abuse, especially sexual abuse and incest (Putnam et al., 1986; Schultz, Braun, & Kluft, 1987b, 1989). Research with child and adolescent cases of MPD where actual legal documentation of reported trauma has been possible, has largely confirmed the self-report findings for adult samples (Dell & Eisenhower, 1990; Hornstein & Putnam, 1992; Hornstein & Tyson, 1991). Nonabuse etiologies are also known (Kluft, 1991), among which are exposure to the death of a loved one, accidents, carnage of war, severe pain, illness, near-death experience, cultural dislocation and family chaos.
Epidemiology of MPD

Coons (1984) estimated the incidence of MPD at 1 per 10,000 in the general population. He estimated 6000 cases of MPD had been diagnosed in North America in 1986. In 1989, Ross et al. published a series of 236 cases of MPD reported to them by 203 clinicians who had jointly seen 1807 cases. By May 1990, five large series of cases totaling 843 individuals had been published in a span of four years (Ross et al., 1991).

Ross et al. (1991) estimated the prevalence of complex posttraumatic MPD at 1% of adults in North America. His calculation is based on the estimated prevalence of serious, chronic childhood physical and/or sexual abuse, combined with data from existing adult studies of clinical and non-clinical populations with MPD (Ross et al., 1991).

The epidemiological data suggests that, in our culture, females are more likely to be sexually abused than males (Lowenstein & Putnam, 1990). Bagley and King (1990) recently summarized all major studies on the prevalence of childhood sexual abuse in North America. They stated that, "serious sexual abuse in childhood (up to age 16 or 17) involving unwanted or coercive sexual contact occurs in at least 15% of females in the population surveyed, and in at least 5% of males" (p. 70). It would follow then that the ratio of females to males with MPD would reflect this proportion. Prevalence figures for males among patients with MPD have ranged from 8.0% in a study of 100 cases of MPD (Putnam et al.,
1986) to 31.4% in a study of 70 MPD patients (Bliss, 1984, 1986). Compared to female MPD patients, relatively little systematic data has been collected on males with MPD and other dissociative disorders. Speculation is that this could be due to clinicians' low index of suspicion that males have dissociative disorders, or that they are found more in the prison system and therefore go unrecognized (Kluft, 1988; Lowenstein & Putnam, 1990).

Diagnostic Considerations and Complications

Unfortunately, the indications of trauma and dissociative defenses are not often correctly identified in children and adolescents. Too often children and adolescents with dissociative conditions are thought to meet the criteria for one or more of the following diagnoses: major depression or depressive psychosis, oppositional defiant disorder, conduct disorder, and attention deficit hyperactivity disorder (Homstein, 1993). Dissociative children and adolescents are all too often misdiagnosed. Homstein and Tyson (1991) found that dissociative symptoms such as amnesia, switching, affect disturbances, thought disturbances, somatoform symptoms, anxiety and posttraumatic stress disorder were thought to be related to disorders other than dissociation. Those disorders include: attention deficit disorder, conduct disorder, developmental learning disorder, affective disorder, psychosis, somatoform and Tic disorders, and primary anxiety disorder.

Much of the available research comes from studies on adult MPD patients. As a clinical group, adult MPD patients first enter the mental health system at a
mean age of 21.4 years and they experience their first psychiatric hospitalization at mean age 26.5 years (Coons et al., 1988). Putnam et al. (1986), Ross et al. (1989), and Coons et al. (1988) reported the mean length of time between the first diagnosis and the MPD diagnosis was 6.8, 7.1, and 7.0 years respectively. The mean number of alternative personalities has been reported to vary from 13.9 (Putnam et al., 1986) to 17 (Schultz et al., 1989). They also reported in these studies that MPD patients have had more than three prior diagnoses. Common previous diagnoses include major depression, alcohol and drug abuse, schizophrenia, borderline personality disorder, eating disorder, epilepsy, anxiety and somatoform disorder.

MPD is often a highly disguised disorder. Usually a MPD patient does not present primary dissociative symptoms in an overt and florid manner (Kluft, 1985b). Kluft (1985a) found that 5% of the patients presented admitting the MPD diagnosis, however, they were disbelieved by their psychiatrists. Additionally, 15% of the patients openly dissociated during assessment or treatment, 40% presented with signs that could alert a clinician with a high index of suspicion for MPD, and 40% of cases were highly disguised. Ross (1989) also reported that MPD is rarely the initial presentation; it usually presents itself with only secondary features. The general consensus is that MPD has a polysymptomatic presentation and history and this often leads to misdiagnosis and misdirected treatment.
Differential Diagnosis

Given that MPD is often hidden next to, or behind, other presenting symptomatology (Ross, 1989), it is not surprising that MPD is found in a diverse group of individuals with a wide range of Axis II pathologies, concomitant Axis I diagnoses and varying constellations of ego strengths and dynamics (Kluft, 1985b). Although knowledge of the etiology and symptomatology of MPD has increased proportionately with the increase of reported incidence, it is still difficult to differentiate the disorder from others who share commonalities. There are research studies which compare MPD with a variety of other diagnoses, including borderline personality disorder (Boon & Draijer, 1991; Fink & Golinkoff, 1990; Horevitz & Braun, 1984; Kemp et al., 1988; Schultz, Braun, & Kluft, 1987a), schizophrenia (Ross & Norton, 1988), posttraumatic stress disorder (Schultz et al., 1987b) and with chronic seizure disorder (Lowenstein & Putnam, 1988). All these studies have shown that MPD can be distinguished from these other disorders, although they may show similar symptomatology.

Kluft (1991) stated, "MPD is usually a polysymptomatic and plethoric condition, varying widely over its clinical course even within a single patient" (p. 154). Putnam, Lowenstein, Silberman and Post (1984) suggested that MPD is best understood as a superordinate diagnosis, under which an array of other symptomatology of other diagnostic categories may be subsumed. Other dissociative disorders, psychotic states, personality disorders such as borderline and histrionic
personality, drug and alcohol abuse, epilepsy, malingering, conversion and somatization disorders, depression, and psychosexual disorders can co-exist with MPD.

Establishing the Diagnosis

The most common clinical presentation of MPD is that of an atypical depression, unresponsive to treatment, usually accompanied by a variety of anxiety symptoms, panic attacks, and somatic symptoms (Coons et al., 1988; Putnam et al., 1986; Ross et al., 1989; Schultz et al., 1989). The patient may report extreme lability of mood with frequent periods of rapid cycling depression. Depressive vegetative signs, such as loss of appetite, weight loss, decline in sexual function, and lowered energy level are usually absent. There will often be examples of obsessive thinking and compulsive behaviors. The individual may report significant problems with sleep which include traumatic nightmares, sleep terrors, difficulty falling asleep, and fear of returning to sleep after awakening (Putnam, 1993). A history of suicide attempts is reported in about 80% of cases or about two times more often than in major depression (Coons et al., 1988; Ross et al., 1989). Self-mutilation, done secretly, is common.

Somatic complaints are also common in MPD patients. Migraine headaches, seizures, gastrointestinal symptoms, dizziness, faintness, nausea, panic attacks, and other unexplained sources of pain may be investigated. In most instances, no organic cause can be found that accounts for the patients' physical symptoms (Putnam, 1993).
The diagnosis of MPD is primarily based on clinical and historical data. In many instances, the clinician experiences perplexing interactions with the patient and slowly develops a growing suspicion over time that there is the existence of a dissociative disorder. While there are no definitive psychological or laboratory tests for MPD, there are three instruments which have been developed and tested which do provide clear diagnostic indicators regarding dissociative symptoms and MPD features. They are the Dissociative Experiences Scale (DES) (Ross, Norton & Anderson, 1988), the Dissociative Disorders Interview Schedule (DDIS) (Ross et al., 1989), and the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1993). These instruments can be used for screening and as diagnostic tools for early detection and confirmation of dissociative symptoms.

The DSM-IV criteria for MPD cited at the beginning of this paper was written with the intention to facilitate the diagnosis of MPD, which was believed to be under-recognized (Putnam, 1993). Some research studies are now using the National Institute of Mental Health (NIMH) research diagnostic criteria. The NIMH criteria specify that in addition to meeting DSM-III-R criteria, the clinician must: (1) witness a switch between two alter personality states; (2) must meet a given alter personality on at least three separate occasions to assess the degree of uniqueness and stability of that alter personality state; and (3) must establish that the patient has amnesias, either by witnessing amnesic behavior or by the patient's report (Putnam, 1993).
Once the clinician has made an accurate diagnosis of MPD the recommended course of treatment should follow. The literature supports the view that the primary treatment for MPD is a long-term intensive psychotherapy with adjunctive hypnotherapy and pharmacotherapy (Putnam, 1989).

Summary and Future Directions

To summarize, the diagnosis of MPD is difficult for many reasons. The incidence of MPD in outpatient settings is infrequent and many clinicians are ignorant of the existence of MPD or its authenticity. Most patients with MPD deny dissociative symptoms or are secretive about them. And, the coexistence of other disorders and their symptoms often obscures the diagnosis of MPD.

Under-recognition of dissociative disorders and MPD has resulted in delayed accurate diagnosis and appropriate treatment, thus imposing emotional and fiscal costs on both the afflicted individuals and on society (Kluft, 1987). Early recognition by more clinicians could greatly enhance the chances of correct diagnosis and early treatment. The earlier the condition is diagnosed, the more readily and rapidly it responds to treatment (Kluft, 1985a).

The authors in the aforementioned studies consistently refer to depression as one of the most common symptoms in MPD patients. Putnam et al. (1986) reported that 80% of 100 patients studied at the National Institute for Mental Health (NIMH) originally presented sufficient depressive symptoms or a diagnosis of major affective disorder. Goodwin, Cheeves & Connell (1988) reported that
100% of the MPD victims they studied who survived severe incestuous abuse had been diagnosed as having major affective disorders. Lowenstein and Putnam (1990) reported that both males and females reported between 70% to 100% of affective-like symptoms with depression, mood swings, suicidal behavior and sleep disturbances among the most common presenting symptoms. Kluft (1987) summarized many research contributions in his update on MPD and concurred that depressive symptoms are nearly universal in MPD patients.

Fine (1988) reported that problems with mood are central in MPD patients although their affective presentation may be remarkably nonspecific. Kluft (1984a) and Coryell (1983) have described the coexistence of affective disorders and MPD. Kluft suggested the diagnoses were autonomous; however, Coryell wondered if affective disorders can be an epiphenomenon of MPD. Graves (1989) questioned whether the intersection of some of the disorders (e.g., depression, eating disorders and personality disorders) represents two independent variables in a population or if there may be pathologic connections.

To date, only one study in the literature compared MPD and major depression (Schultz et al., 1989). This retrospective study gathered data from therapists who treated MPD patients and major depression patients. Utilizing a two-page questionnaire, researchers gathered data about MPD and major depression clients from therapists’ memory and notes including: prevalence, demographic and social characteristics, history of abuse and neglect; and clinical symptoms. Schultz et al. (1989) highlight the findings which include: MPD female to
male ratio of 9:1; comparison group 4:1; more MPD patients never being married and having incomes under $10,000 or no income; and the MPD group having attained less education than the depression group. Statistically significant findings were reported for incidents of reported abuse (MPD 98% / major depression 54%); physical abuse (MPD 82% / major depression 24%); sexual abuse (MPD 86% / major depression 25%); and reported physical and sexual abuse in the same patient (MPD 74% / major depression 14%).

The present study will also compare MPD and major depression; however it will examine depression as it is currently being experienced by patients in the two diagnostic categories and reported directly by the clients, not by the therapists. Data about demographic characteristics, psychiatric history, and childhood history of abuse were also collected from the clients directly in an attempt to avoid interpretation or distorted memories from the therapists. The previously mentioned study encouraged research in a prospective manner to further corroborate the authenticity of the MPD disorder, to assist in verifying the clinical skills of those treating MPD patients, and to add to the understanding of MPD’s prevalence and phenomenology (Schultz et al., 1989).

This research endeavor is an attempt to examine MPD as a principal diagnosis, and to view a frequently associated feature, depression, to see if it can be distinguished from the depression of persons with the principal diagnosis of major depression, who do not have dissociative features. The additional factors of demographics, childhood abuse, and dissociative features were evaluated to
determine if the sample was comparable to others research studies. The significance of this study will assist in developing diagnostic and screening techniques to be able to differentiate MPD from other psychiatric disorders, and alert clinicians to further screen for MPD in the assessment phase of treatment.
CHAPTER III

METHOD

This research is an exploratory field study which employed quantitative methods to compare selected persons who had been diagnosed with multiple personality disorder (MPD) and selected persons who had been diagnosed with major depression disorder (MDD) without MPD. Therapists in outpatient settings referred clients to the study who provided data regarding the severity of depression, MPD features, demographic characteristics, and childhood abuse histories.

Sample Selection

Participants for the study were selected using a two-tier process. In the first tier, 275 outpatient therapists were selected using the following procedure. First, outpatient therapist names were compiled from the following sources:

1. A membership directory of the International Society for the Study of Multiple Personality & Dissociation (ISSMP&D) (an international directory of 3100 clinicians interested in the treatment of MPD) was consulted for members who reside in the state of Michigan (80 members).

2. The names and addresses of the southeast Michigan MPD Study Group (a group of 40 clinicians who meet once a month to discuss and study MPD) was secured. Members may or may not be affiliated with the ISSMP&D group.
3. The names of professional colleagues in Michigan who work with dissociative and/or depressive disorders known by this researcher were compiled.

4. The names of other professionals who work with dissociative and/or depressive disorders and, who were recommended by other professional colleagues who treat clients with MPD and/or depression were compiled.

5. The names of therapists from outpatient mental health clinics and private practices who treat MPD and/or depression within a 100 mile radius of Kalamazoo were compiled.

6. A cross-check was employed to eliminate duplications evident in the various sources accessed.

The above sources generated a purposeful sample of 275 outpatient therapists who comprised the first tier of study participants, i.e., the referral therapists.

Invitations for the 275 therapists to participate was issued through personal meetings or phone contact. At the time of the initial contact, the full research plan was outlined and therapists’ questions were answered. If a therapist indicated a willingness to continue, a determination was made of their eligibility to refer MPD and/or depressed participants to the study.

The following criteria needed to be met by referring therapists: (a) psychotherapy practice in an outpatient setting; (b) treat clients with a diagnosis of MPD and/or depression; (c) licensed in Michigan as a professional counselor, licensed or limited licensed psychologist, a master’s of social work, or psychiatrist; (d) have at least two years of clinical experience; and (e) agree to participate in
the study by referring clients as participants. If a therapist met these criteria, he/she was selected as a member of the therapist sample.

In the second tier of participant selection, a sample of clients in treatment for depression or MPD with the therapists chosen in the first tier was identified (with potentially one to two clients per therapist, this would have been 275 to 550 clients). Therapists previously identified could refer one or two of their out-patient clients who met the following criteria: (a) diagnosed with MPD or Major Depression by DSM-III R criteria; (b) if diagnosed with major depression, had been in therapy with the selected therapist at least one month; (c) if diagnosed with MPD, had been in therapy with the selected therapist for at least six months; and (d) willing to volunteer. At this point, therapists who agreed to participate invited an estimated 60 potential participants to assist in the study and those participants were given information (Appendices C and D) about the project by their therapist.

Those who volunteered comprised the sample of research participants and were asked to read and sign the informed consent form and authorization to release confidential information (Appendices E and F). They were then provided by their therapists the Beck Depression Inventory (BDI) and Dissociative Experiences Scale (DES) (Appendix G), which are self-administered, and a self-addressed stamped envelope to return the informed consent form and the instruments to the researcher.

Forty-two participants who returned the materials continued in the study.
As the instruments were received, they were scored by the researcher. Participants who scored in the target range on the DES (29 or below for MDD participants and 30 or above for MPD participants) remained in the study. There were five individuals who scored outside the target range, and a letter was sent thanking them for their participation in the study, however, also informing them they would not be continuing any further in the study (Appendix H).

For the 37 participants who remained in the study sample, a telephone interview was arranged for administration of the Demographic Questionnaire (Appendix I) and designated sections on the Dissociative Disorders Interview Schedule.

The two-tier procedure was followed until 20 participants diagnosed with Major Depression by their referring therapists and 17 participants diagnosed with MPD by their referring therapists were obtained. These 37 individuals comprised the sample for analysis.

Permission to conduct this study was granted by the Human Subjects Institutional Review Board at Western Michigan University (Appendix J). A letter of informed consent was signed by each participant and returned to the researcher in accordance with university policy and federal regulations.

Instruments

The three instruments chosen for the study were the Beck Depression Inventory (BDI), the Dissociative Experiences Scale (DES) and the Dissociative.
Disorders Interview Schedule (DDIS). A brief Demographic Data Questionnaire designed by the researcher was also administered.

Beck Depression Inventory (BDI)

The BDI is the most widely used self-report measure of depression (Wetzel, 1984; Wolman & Stricker, 1990). It has been validated by nearly 30 years of research and well over 1000 studies (Wolman & Stricker, 1990). The BDI is a 21-item scale that assesses the presence and severity of affective, cognitive, motivational, vegetative and psychomotor components of depression (Beck, Ward, Mendellson, Mock & Erbbaugh, 1961). Each item on the BDI relates to a particular symptom of depression, and respondents indicate on a scale from 0 to 3 the severity of their current state of each symptom. Of the 21 items; 11 deal with cognition, two with affect, two with overt behavior, one with interpersonal symptoms and five with somatic symptoms. The BDI was originally standardized on a clinical population, but it has subsequently been used with a wide range of groups including clinical and nonclinical populations.

Reliability

The BDI is reported to have “good” to “excellent” reliability. Split-half reliabilities ranging from .78 to .93 have been reported indicating "good" to "excellent" internal consistency (Beck & Steer, 1984). Test-retest reliabilities have been reported to range from .48 for psychiatric patients after three weeks to .74 for
undergraduate students after three months (Corcoran & Fischer, 1987).

**Validity**

The BDI has "good" to "excellent" validity. Wolman and Stricker (1990) report that research has shown significant correlations with a number of other depression measures indicating strong concurrent validity. Beck, Steer, and Garbin (1988) have found a mean correlation of .72 between clinical ratings of depression and the BDI for psychiatric patients, and a mean correlation of .60 between clinical ratings of depression and BDI scores for nonpsychiatric patients.

**Dissociative Experiences Scale (DES)**

The DES was developed as a clinical tool to help identify persons with dissociative psychopathology and as a research tool to provide a means of quantifying dissociative experiences (Bernstein & Putnum, 1986). It is a screening instrument for dissociative disorders, not a diagnostic instrument. The DES is a brief, 28 item, self-report measure of the frequency of a number of types of dissociative experiences, including disturbances in identity, memory, awareness, and cognition, as well as feelings of depersonalization in the daily lives of participants.

Respondents are asked to indicate how frequently they have had each of 28 life experiences when not under the influence of drugs or alcohol. Frequency is recorded by making a slash on a 100 mm line labeled 0 percent to 100 percent of the time. Scores for each item are determined by measuring the slash mark...
to the nearest 5 mm from the left-hand end of the line. The DES score is an average of the 28 item score. Published studies have shown that median scores on the scale differentiate patients with MPD from those with other psychiatric disorders and non-clinical groups (Bernstein & Putnam, 1986; Ross et al., 1988).

The DES is self-administered and takes about five to 10 minutes to complete. It was scored by the researcher using standardized methods. Scores above 30 were interpreted as indicative of the presence of dissociative disorders (Carlson & Putnam, 1993).

Reliability

DES data on a wide range of clinical and non-clinical populations have been reported in numerous studies (Carlson & Putnam, 1993). Reliability studies (Bernstein & Putnam, 1986; Frischholz, Braun, Sachs, Hopkins et al., 1990; and Pitblado & Sanders, 1991) show that the DES has good test-retest reliability (0.84) and internal reliability (split-half .83 and .93) (Carlson & Putnam, 1993).

Validity

The validity of the DES has been established in studies which collected data relevant to the construct and criterion validity of the scale (Carlson & Putnam, 1993), and the authors reported it to be "good". The most obvious evidence of the construct validity of the DES is the fact that those who are expected to score high on the test do score high and those who are expected to score low
do score low (Carlson & Putnam, 1993). Frischholz, Braun, Sachs, Schwartz et al. (1991) reported a Pearson correlation of .52 between the DES and the Perceptual Alteration Scale and Nadon, Hoyt, Register, and Kihlstrom (1991) reported a Pearson correlation of .82 between the two measures.

**Dissociative Disorders Interview Schedule (DDIS)**

The DDIS, a structured interview, has been developed to make diagnoses of dissociative disorders, somatization disorder, major depressive episode, and borderline personality disorder (Ross et al., 1989). Additional items identify historical and mental status factors associated with MPD such as drug abuse, history of childhood sexual and physical abuse, Schneiderian first rank symptoms of schizophrenia, supernatural and extrasensory experiences, history of numerous previous diagnoses and treatments and secondary features of MPD not included in the diagnostic criteria. These items provide useful information in the differential diagnosis of dissociative disorders.

The DDIS is highly structured to minimize and control for biases of the interviewer. There are 16 sections and a total of 131 questions, however, for purposes of this study, only Section III, Psychiatric History; Section IV, Major Depressive Episode; Section VII, Childhood Abuse; and, Section VIII, Secondary Features Associated With MPD, were administered. These sections were chosen because they are pertinent to the research questions and hypotheses, and the other sections were not pertinent to this study; therefore, they were not
administered to the participants.

Questions were read verbatim by the interviewer and were sequenced in a manner to avoid cueing the participants to the diagnosis of MPD before the formal criteria were presented. The entire DDIS can be administered in 30-40 minutes, however, the four sections used in this study were administered in 10-15 minutes.

Scoring for the DDIS is based on DSM-III-R scoring rules for each of the diagnostic categories. The other sections are scored by adding up the total number of positive responses. There is no overall score for the instrument. Norms were developed on psychiatric patients who had received clinical diagnosis of MPD, schizophrenia, panic disorder and eating disorders. There has been additional research using the instrument with other populations as well but that research has not yet been published.

**Validity**

The DDIS has excellent clinical validity (Ross et al., 1989). It has an overall inter-rater reliability of 0.68 with a specificity of 100% and a sensitivity of 90% for the diagnosis of MPD (Ross et al., 1989).

**Reliability**

There were no other reliable instruments for diagnosing dissociative disorders when this instrument was developed, therefore, it could not be compared
to other instruments. The Dissociative Experiences Scale (DES) was used as a measure to screen the dissociative experiences. Research is underway which will contribute to establishing additional validity, reliability, and clinical utility of this instrument (Ross et al., 1989).

Data Collection

The DES and BDI were given to the group of participants by their referral therapists and were self-administered. The tests were returned to the researcher in a pre-paid, stamped, self-addressed envelope. When they were received, the tests were hand scored by the researcher, and, if screening criteria was met (scores on the DES), a telephone interview was arranged as soon as possible to complete the Demographic Questionnaire and DDIS, Sections III, IV, VII, and VIII. The major depression group was screened with the DES to rule out the presence of MPD in those individuals. The recommended cut-off score of 30 and above to signal the presence of a dissociative disorder was used, so they needed to score 29 or below. Concurrently, the MPD group was screened with the DES to confirm the presence of a dissociative disorder by scoring in the 30 and above range.

Research Questions and Related Hypotheses

Following are the research questions and the related research hypotheses.
Question 1: Are There Differences in Demographic Characteristics of the Participants in the Two Diagnostic Groups?

Hypothesis 1: There is a significant difference in the age, income level, and number of children of participants with MPD compared to participants with MDD.

Hypothesis 2: There is a significant difference in gender distribution, racial composition, marital status, educational level attained, gender preference, economic status, and previous incarceration between MPD participants compared to MDD participants.

Question 2: Are There Differences in Psychiatric Histories of the Participants of the Two Diagnostic Groups?

Hypothesis 3: There is a significant difference in knowledge of previous psychiatric diagnoses between MPD participants compared to MDD participants.

Hypothesis 4: There is a significant difference in the self-report of a former diagnosis of (a) depression, (b) mania, (c) schizophrenia, (d) anxiety disorder, and (e) other psychiatric disorder between MPD participants compared to MDD participants.

Hypothesis 5: There is a significant difference in the history of receiving a prescription for psychiatric medication between MPD participants compared to MDD participants.

Hypothesis 6: There is a significant difference in the history of receiving
a prescription for (a) antipsychotic, (b) antidepressant, (c) lithium, (d) anti-anxiety or sleeping medication, or (e) other medication between MPD participants compared to MDD participants.

**Hypothesis 7:** There is a significant difference in the report of receiving electroshock treatment between MPD participants compared to MDD participants.

**Hypothesis 8:** There is a significant difference in the number of therapists consulted for emotional problems by MPD participants compared to MDD participants.

**Hypothesis 9:** There is a significant difference in the report about the effectiveness of previous treatment between MPD participants compared to MDD participants.

**Question 3:** Is There a Difference in the Severity of Depression Between Persons Diagnosed With MPD and Persons Diagnosed With MDD?

**Hypothesis 10:** There is a significant difference in the severity of depression as determined by the self-report of each participant whether their depression was “in remission” or “active, recurrent”, and on the BDI scores between participants diagnosed with MPD compared to participants diagnosed with MDD.

**Hypothesis 11:** There is a significant difference in the percentage of study participants in each diagnostic group who report the presence of a major depressive episode at some time in their life.
Question 4: Do Persons Diagnosed With MPD Report More Childhood Abuse (Physical and/or Sexual Abuse) Than Persons Diagnosed With Major Depression?

Hypothesis 12: There is a significant difference in the percentage of study participants in each diagnostic group who report instances of physical abuse in childhood or adolescence.

Hypothesis 13: There is a significant difference in the percentage of study participants in each diagnostic group who report instances of sexual abuse in childhood or adolescence.

Question 5: What Are the Characteristics of the Childhood Sexual Abuse, Such as Age of Onset of Abuse, Relationship to Perpetrator, Age of Cessation of Abuse, Number of Incidents of Abuse, and Types of Sexual Abuse Experienced by Participants in the Two Diagnostic Groups?

Question 6: What Is the Relationship Between Number of Dissociative Features Reported and Diagnosis of the Two Groups?

Hypothesis 14: Participants diagnosed with MPD report significantly more dissociative features as determined on the DES and DDIS, Section VIII compared to participants diagnosed with MDD.

Testable null forms of the hypotheses are stated in Chapter IV.

Data Analysis

Referral therapist diagnosis as well as individual participants' scores on the DES were used to partition participants into two groups: (1) participants with
MPD and (2) participants without MPD. A score of 30 and above on the DES was used to distinguish participants with MPD from the MDD participants without MPD.

**Demographic Questionnaire**

Tables and narrative were used to describe the characteristics of participants in the two diagnostic groups. They include: gender, gender preference, relationship status, race, education, occupational status, age, and economic status. Additionally, t-tests were used to evaluate differences in mean scores for age, economic status, and number of children. Chi-square analyses were used to evaluate differences in other demographic characteristics, all of them nominal in nature. Results were evaluated in terms of the degree to which the observations differ from those predicted by chance, p<.05 (Maxwell & Delaney, 1990). The Levene’s test was used to test for unequal variances (Miliken & Johnson, 1984).

**DDIS, Section III**

Tables and narrative are used to describe the psychiatric history characteristics of participants in the two diagnostic groups. They include: previous diagnoses, prescribed psychiatric medication, electroshock treatment, number of therapists seen for emotional problems, and whether or not previous treatment was effective. Additionally, Chi-square analyses were used to evaluate whether the distribution of nominal psychiatric history characteristics differed between the
two groups of participants. A $p<.05$ level of significance (two-way) with one degree of freedom was utilized to evaluate whether the observed results differed significantly from chance.

**BDI**

Mean BDI scores were obtained for both diagnostic groups. Results were evaluated with two-tailed, $t$-tests, at the $p<.05$ level of significance. The degrees of freedom were based on final sample size. The $t$-tests results allow a determination of the likelihood of the observed outcome occurring by chance. The null hypothesis was rejected if $p<.05$.

**DDIS, Section IV**

The percentage of participants in each diagnostic group reporting the presence of a major depressive episode at some time in their life was obtained. The results were evaluated using Chi-square statistic, two-tailed test, at $p<.05$ level of significance with one degree of freedom. The $x^2$ value allows a determination of the degree to which the results differ from chance alone. The null hypothesis was rejected if $p<.05$.

**DDIS, Section VII**

The percentage of participants in each diagnostic group reporting childhood physical and/or sexual abuse was obtained. The results were evaluated using
Chi-square statistic, two-tailed test, at $p<.05$ level of significance with one degree of freedom. Tables and narrative are used to describe the characteristics of the childhood abuse by the two diagnostic groups. Such data as perpetrator identity, age at onset of abuse, physical abuse independent of sexual abuse, sexual abuse relationship to perpetrator, type of sexual abuse, number of incidents of abuse up until age 18, and number of incidents of abuse after age 18 are described.

DDIS, Section VIII

Mean scores regarding secondary features of MPD were obtained for both diagnostic groups and the data was evaluated with a one-tailed t-test, using $p<.05$ level of significance. Results were evaluated in terms of the degree to which the observations differ from those predicted by chance.

All information was scored and coded by the researcher. The data were entered in the Statistical Package for Social Sciences (SPSS) program (Norusis, 1988). The findings were examined to determine if the data supported the hypotheses which had been generated.
CHAPTER IV

RESULTS

Study Participants

Demographic Profile

Thirty-seven participants participated in the study. Twenty of these were individuals with a diagnosis of a major depressive disorder (MDD); seventeen were individuals with a diagnosis of multiple personality disorder (MPD). Participants were included in the MPD subsample based on their diagnoses from referral sources and their scores on the DES, a standardized self-report measure focused on quantifying dissociative experiences. Mean scores on the DES can range from 0 to 100. The range that was achieved within this study’s 37 participants was from .8 to 82.6. In the MDD subsample, DES raw scores ranged from .8 to 26.9 while in the MPD subsample, scores ranged from 32.3 to 82.6. The mean score from MPD participants was 48.86; the mean for MDD participants was 12.44.

Of the 37 participants, 94% (n= 32) were female. In the MPD subsample, 16 participants were female, one was male. In the MDD subsample, 16 participants were female, 4 were male (Table 28, Appendix M). In terms of race these participants were even more homogeneous: 98% (n=36) were Caucasian. The
only non-Caucasian was a MPD participant. The 37 study participants ranged in age from 19 to 59, with an average age for MDD participants of 33.75 years and an average age for MPD participants of 39.59 years. Through simple inspection of the data, it is clear that racial, gender, and age differences between MDD and MDD participants cannot be ascertained from this sample.

In terms of gender preference, 30 participants reported their preference as "heterosexual;" five reported their preferences as "bisexual;" two were "undecided" about their gender preference; and, one reported a "gay/lesbian" preference. Of the 20 MDD-diagnosed participants, 19 reported a heterosexual preference and 1 reported a bisexual preference. Of the 17 MPD-diagnosed participants, 2 were undecided on their sexual preference, 11 reported a heterosexual preference; 3, a bisexual preference, and 1 reported a gay/lesbian preference (Table 29, Appendix K).

Within the total participant group, 15 individuals were single; 13 were married; 5 were living with a partner; 3 others were partnered, but not living with their partner; and 1 was separated. Table 30 (Appendix K) displays the summary of participants' marital status within each diagnostic category.

In terms of parental status, 19 of the participants had no children while the remaining 18 participants had from one to six children each (Table 31, Appendix K).

Some seventy percent of all participants (n=26) held a high school diploma as their highest educational credential; the remaining 11 participants had at least
some college coursework. In the MDD subsample, 14 participants reported to be high school graduates and 6 participants had some additional college credit. There were 12 MPD participants who reported having attained high school diplomas and 5 participants with college credits (Table 32, Appendix K).

Occupationally, 22% (n=8) of the participants were unemployed; another 22% (n=8) were employed part-time; and 56% (n=21) were employed full-time. Table 33 (Appendix K) displays the distribution of this characteristic for the individuals in each diagnostic category.

Insofar as economic status, 1 participant reported no income; 8 participants reported an income of under $10,000; 8 reported an income between $10,001 and $20,000; 5, between $20,001 and $30,000; 6, between $30,001 and $40,000; 5, between $40,001 and $50,000; 1, between $50,001 and $60,000; and 3, of over $60,000 (Table 33, Appendix K). For further analysis, this information was dichotomized into two income categories: Income under $30,000 and income over $30,000. Of the MDD participants, exactly half of the participants (n=10) fell into each income category; of the MPD participants, about 71% (n=12) had incomes of less than $30,000; and 29% (n=5) had incomes greater than $30,000 (Table 34, Appendix K).

In response to a question about previous incarceration, 92% of the participants (n=34) responded that they had never been in jail. A breakdown of the responses of each diagnostic group is provided in Table 35 in Appendix K.
In addition to providing demographic information, participants were asked to provide certain information about their psychiatric histories. Thirty-four participants responded to the question related to whether they had knowledge of a previous psychiatric diagnosis. Approximately 71% (n=24) participants did have knowledge of such a diagnosis. Eleven of the MDD participants reported knowing of a previous diagnosis; 8 did not. There were 13 MPD participants who were aware of a previous diagnosis and 2 who were not (Table 36, Appendix L).

Asked to self-report specific previous diagnoses, 97% (n=35) of the participants in both diagnostic categories who answered this question reported that they had been previously diagnosed with depression; 11% (n=4) reported that they had been diagnosed with mania; and 11% (n=4) reported that they had been diagnosed with schizophrenia. As to other diagnoses, 65% of the participants (n=22) indicated they had previously been diagnosed with an anxiety disorder; and 40% indicated that they had been diagnosed with some other psychiatric disorder that was not specifically named. Table 37 in Appendix L summarizes the information about these self-reports for both diagnostic groups.

Asked whether they had previously received psychotropic medications, 92% (n=33) of the 36 participants responding answered in the affirmative. Only 1 participant with a diagnosis of MPD and 2 participants with a diagnosis of MDD reported that they had never received such medication. Focusing on specific
medications received, about 23% (n=8) of the participants had received antipsychotic medication; 83% (n=31) had received an antidepressant; 8% (n=3) had received lithium; 62% (n=23) had received an anti-anxiety or sleeping medication; and 20% (n=7) had received some other type of psychiatric medication.

None of the participants in either diagnostic category reported ever having received electroshock treatments.

In response to a query regarding the number of therapists consulted for their psychiatric problems, individuals with a diagnosis of MDD had consulted an average (mean) of 3.3 therapists while individuals with MPD had consulted 6.7. Rating the treatment received for their psychiatric disorders, 71% (n=25) of the participants reported that some of their treatment had not been effective. Table 38, in Appendix L displays each diagnostic category’s rating of treatment effectiveness.

Severity of Current Depression

Participants were asked to describe the current status of their depressive illnesses. Some 43 percent (n=16) noted their illness was "in remission" while nearly 57% (n=21) reported their depressions to be "active or recurrent." Table 1 shows the status of each diagnostic group's current depressive illnesses.

With respect to having experienced a major depressive episode at some time in their lives, all 37 participants in the study reported having experienced such an episode.
Table 1
Status of Current Depression by Diagnostic Category (N=37)

<table>
<thead>
<tr>
<th>Status of depression</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>In remission</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Active, recurrent</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
</tbody>
</table>

Physical and Sexual Abuse History

Physical Abuse

Participants were asked to report whether or not they had ever been physically abused in childhood and/or adolescence. More than 78% of the participants (n=29) reported such abuse. Table 2 affords a comparison of patterns within each diagnosis.

Describing the perpetrators of physical abuse, participants were encouraged to indicate all of the individuals who had been involved. Within the 29 participants who had experienced physical abuse, some 86 different perpetrators were named, an average of more than 3 per participant. Table 41 in Appendix M provides an ordered listing showing how frequently category of perpetrator was identified by the participants as a whole.
Table 2

History of Physical Abuse by Diagnostic Category (N=37)

<table>
<thead>
<tr>
<th>History of Physical Abuse</th>
<th>MDD</th>
<th>Diagnosis MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
</tbody>
</table>

Comparing the responses about the perpetrators of physical abuse between the two diagnostic categories, the pattern displayed in Table 3 is generated. This table shows each perpetrator and the number of individuals in each diagnostic group who reported being physically abused by such a person.

Describing the age when abuse started, the participants who had been abused discussed a range between younger than one year to age 15. Of the 29 formerly physically abused participants who responded, about 11 percent (n=4) were first physically abused before the age of one year; approximately 25% (n=9) more were physically abused for the first time before the age of 3; about 11% (n=4) first experienced physical abuse at the age of 3-4 years; about 8% (n=3), at the age of 5-6 years; 11% (n=4), at 7-8 years; and 11% (n=4) at ages 9 through 11. One participant first experienced physical abuse at the age of 15. Table 39 in Appendix M provide a graphic comparison of the age at which
Table 3
Patterns of Perpetrators of Physical Abuse by Diagnostic Category

<table>
<thead>
<tr>
<th>Physical Abuse by</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Mother</td>
<td>9</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>Stepmother</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Steppfather</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Sibling</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Male relative</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Female relative</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other male</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Other female</td>
<td>2</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

Physical abuse was first experienced by individuals in the two diagnostic groups.

In terms of the age at which the physical abuse of these individuals ceased, the range of ages was much more broad, ranging from 6 years of age to 44, for these 29 participants. Slightly more than half of the physically abused participants (51.7%, n=15) experienced an end of physical abuse before age 17. Another third of the physically abused participants (n=10) experienced an end between the ages of 17 and 19. There was one participant each who experienced the end of
physical abuse at ages 21, 25, 31, and 44. Table 40 in Appendix M provides a more detailed visual comparison of individuals in the MDD and MPD categories with respect to the ages at which physical stopped.

**Sexual Abuse**

Participants also responded to similar questions related to sexual abuse, including whether they had ever been sexually abused in childhood and/or adolescence. Some 63% of the participants (n=22) reported being sexually abused in this period of their lives. Two participants were unsure about whether they had been sexually abused. Table 4 provides a breakdown of how this abuse was reported within each diagnostic category by the 37 participants.

Participants provided further elaborations about the nature of the physical

<table>
<thead>
<tr>
<th>History of Sexual Abuse</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
</tbody>
</table>
and sexual abuse they had experienced, including whether physical and sexual abuse were independent of one another, who the perpetrator(s) of the abusive practices were, what the abusive practices involved, and the participant's age when the abuse started and stopped.

Within the overall group of 37 participants, the 29 respondents who had been physically abused responded to the question related to whether physical and sexual abuse in childhood and/or adolescence occurred independent of one another. For more than 70% of those who responded (n=26), the two types of abuse were perpetrated independently of one another. For 8% (n=3) the abusive practices were not perpetrated independently.

Of the 20 MDD participants, 13 responded to this question and, of these, nearly 85% (n=11) had experienced the two types of abuse independently of one another. In the MPD-diagnosed participants, 16 individuals responded to this question and, of these, 94% (n=15) had experienced the two types of abuse independent of one another.

Describing the perpetrators of sexual abuse, participants were encouraged to indicate all of the individuals who had been involved. Within the 22 participants who responded to this question, 67 different perpetrators were named, an average of slightly more than 3 per participant. Table 42 in Appendix M provides an ordered listing showing how frequently type of each sexual abuse perpetrator was identified by the participants as a whole.

Comparing the responses about the perpetrators of sexual abuse between
the two diagnostic categories, the pattern displayed in Table 5 was generated. This table displays each perpetrator and the number of individuals in each diagnostic group who reported being sexually abused by such a person.

Describing the age when sexual abuse started, the 24 participants who responded to this question reported a range between younger than one year to age 13, with two participants unsure of the age when the sexual abuse began. Of the 22 who provided an age of onset for sexual abuse, about 55% (n=12) dated it as

Table 5

Perpetrators of Sexual Abuse by Diagnostic Category

<table>
<thead>
<tr>
<th>Sexual Abuse by</th>
<th>MDD</th>
<th>Diagnosis MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>0</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Mother</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Stepmother</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stepfather</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sibling</td>
<td>1</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Male relative</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Female relative</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other male</td>
<td>2</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Other female</td>
<td>1</td>
<td>9</td>
<td>19</td>
</tr>
</tbody>
</table>

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occurring before age 4. Five other participants (14% of respondents) reported sexual abuse as beginning between the ages of 4 and 7. One respondent noted such abuse began at age 8; two reported it began at age 10; and one, that it began at age 13. Table 6 shows the comparison of the age at which sexual abuse was first experienced by individuals in the two diagnostic groups.

In terms of the age at which the sexual abuse of these individuals ceased,

Table 6
Age of First Sexual Abuse by Diagnostic Category (n=22)

<table>
<thead>
<tr>
<th>Age</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9-12</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>13-16</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>16</td>
<td>22</td>
</tr>
</tbody>
</table>
the range of ages was much broader, ranging from 2 years of age to 42, for the 24 participants. Again, 22 participants reported specific ages of cessation, and two were unsure. Slightly more than two-thirds of the sexually abused participants (66.7%, n=14) experienced an end of physical abuse before age 17. About 11% (n=4) experienced an end between the ages of 17 and 19. There was one participant each who experienced the end of sexual abuse at ages 21, 24, 25, and 42, and two participants who experienced an end of such abuse at age 28. Table 7 provides a comparison of individuals in the MDD and MPD categories with respect to the ages at which sexual abuse ceased.

Sexually abused participants also provided an estimate of the number of incidents of sexual abuse they had experienced before 18 years of age. Twenty-four participants provided this information, reporting a range of from one to five

### Table 7

<table>
<thead>
<tr>
<th>Age</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-5</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>6-10</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11-15</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>21-25</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>17</td>
<td>24</td>
</tr>
</tbody>
</table>

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incidents to more than 50 incidents. Five participants were unsure of the number of incidents they had experienced. Among all participants, two had experienced between one to five incidents of sexual abuse in childhood and adolescence; two had experienced between six to 10 incidents; 8 had experienced between 11 and 50 incidents; and 9 had experienced more than 50 incidents. Table 8 depicts the number of sexual abuse incidents prior to age 18 by diagnostic category.

Participants also described incidents of sexual abuse occurring after age 18, providing a range from none to greater than 50. Five respondents were not sure how many incidents they had experienced after age 18. Two participants indicated they had not been sexually abused after age 18; 18 reported they had been abused between one and five times; 7 reported they had been abused between 6 to 10 times; 2 reported they had been abused between 11 to 50 times; and 1

Table 8
Number of Sexual Abuse Incidents Experienced Prior to Age 18 by Diagnostic Category

<table>
<thead>
<tr>
<th>Number of Incidents</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6-10</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11-50</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>&gt;50</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>16</td>
<td>22</td>
</tr>
</tbody>
</table>
reported being abused more than 50 times.

**Types of Sexual Abuse Perpetrated on Participants: Male.** Three of the five male participants provided information on the type of sexual abuse they had experienced. Two of the three reporting had experienced touching (one of these participants was the MPD male participant, the only male participant to also report other fondling). None of the males reported sexual abuse via sexual intercourse with a female or other male.

For two male participants (one each from the MPD and MDD diagnostic subsamples), sexual abuse was reported to involve performing oral sex on a male. None of the male participants reported sexual abuse involving performing oral sex on a female. Two male participants, one MPD and one MDD, reported having oral sex performed on them by a male. No male participants reported having oral sex performed on them by a female.

In response to a question about sexual abuse via passive sexual intercourse, two of the three male participants who responded had not been abused in this fashion; the third was unsure. A similar response pattern was seen in terms of sexual abuse via pornographic photography. Two male participants reported they had not been abused in this way; the third was not sure.

None of the male participants reported having sex with animals as a type of abuse they had experienced, nor did any male report any "other" type of sexual abuse which had not already been surveyed.
Types of Sexual Abuse Perpetrated on Participants: Female. Female participants responded to the questions related to the same types of sexual abuse experienced. Twenty-one participants responded to this series of questions. Of these, 18 reported they had been touched (15 of these from the MPD subsample); and 19, that they had experienced other types of fondling (16 of these MPD participants). Two females in the MDD sample were unsure about whether they had experienced these types of abusive practices.

Fifteen females in the total sample had experienced sexual abuse in terms of intercourse with a male. Of these, 13 were MPD participants. Three women were unsure, two of these were in the MDP subsample. Nine of the female respondents had experienced sexual intercourse with a female as a form of sexual abuse. Eight of these were MPD participants.

Of the 14 females who had been abused via oral sex on a male, all 14 were MPD participants. Similarly, of the 6 whose sexual abuse took the form of performing oral sex on a female, all were MPD participants as well. This pattern persisted in terms of oral sexual abuse performed by a male: All ten of the participants who had experienced such abuse were in the MPD subsample. Moreover, of the 8 females who had been subjected to oral sexual abuse by a male, 7 were MPD participants.

Nine female participants had been abused via anal intercourse. All 9 of these were MPD participants, as were the 2 female participants who had experienced sexual abuse via sex with animals.
In terms of sexual abuse through pornographic photography, 8 female participants overall had experienced such abuse. Seven of these were in the MPD subsample. Eight female participants described incidents of "other" sexual abuse, 7 of these MPD diagnosed women.

Dissociative Profile

Two measures of dissociative features were secured from all participants. First of all, responses to the DES were used to secure this information. The average score on the DES for individuals diagnosed with MPD was 48.85; the average score for MDD participants was 12.44. In the MDD subsample, DES raw scores ranged from .8 to 26.9 while in the MPD subsample, scores ranged from 32.3 to 82.6.

Secondly, the DDIS generated information about 16 secondary features associated with dissociative disorders. Scores on the DDIS can range from 0 to 16, a range that was achieved within this study's 37 participants. The mean score for MPD participants in the study was 12.0, with a standard deviation of 2.6. In contrast, the mean score for the MDD participants was 1.0, with a standard deviation of 1.6. Table 9 provides a comparison of participants in the MDD and MPD categories with respect to the scores they attained on the DDIS.

Evaluation of Hypotheses

Fourteen null hypotheses were evaluated utilizing the information provided
Table 9
Scores Attained on the DDIS, Section VIII, Secondary Dissociative Features Associated With MPD by Diagnostic Category (n=37)

<table>
<thead>
<tr>
<th>DDIS Raw Scores Range</th>
<th>MDD</th>
<th>MPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>5 - 8</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9 - 12</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>13 - 16</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>

by participants related to their demographic characteristics, psychiatric diagnosis and history, history of abuse (physical and sexual), and dissociative characteristics.

Null Hypothesis 1: There is no difference in the age, income levels, and number of children of individuals with MPD and MDD.

The three separate null hypotheses embedded in this overall null hypotheses were evaluated by a series of t-tests and Chi-square analyses of each of the demographic variables of interest. Table 10 provides the information used to make the decision for each variable.

In terms of age, although the cohort diagnosed with MPD was, on average, 5.8 years older than the cohort diagnosed with MDD, this age difference was not statistically significant. The rejection of this portion of the null hypothesis at the .05 level of significance is not supported.
Table 10
Comparison of Participants' Age by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>Number of Cases</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
<td>17</td>
<td>39.588</td>
<td>10.16</td>
</tr>
<tr>
<td>MDD</td>
<td>20</td>
<td>33.750</td>
<td>8.68</td>
</tr>
</tbody>
</table>

Mean difference 5.8384

<table>
<thead>
<tr>
<th>t-value*</th>
<th>df</th>
<th>2-tailed significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.89</td>
<td>35</td>
<td>.068</td>
</tr>
</tbody>
</table>

* for equal variances

Differences in income level were also explored. These differences were evaluated using the chi-square statistic. Results are displayed in Table 11.

In terms of income level, there was also no statistically significant difference between the participants who were diagnosed as MPD and MDD when this information was dichotomized into categories of under $30,000 and over $30,000. The portion of the null hypothesis related to this participant characteristic therefore cannot be rejected.

The number of children, on average, for participants in each group were also compared using the t-test statistic. Table 12 provides the result of this
null hypothesis of no difference between the participants in the two diagnostic categories in terms of age, income or number of children.

**Null Hypothesis 2:** There is no difference in the gender distribution, racial composition, marital status, occupational status, educational level attained, gender preference, and previous incarceration between MPD and MDD participants.
Table 12

Comparison of Number of Children per Participant by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>Number of Cases</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
<td>17</td>
<td>1.71</td>
<td>.468</td>
</tr>
<tr>
<td>MDD</td>
<td>20</td>
<td>1.00</td>
<td>.324</td>
</tr>
</tbody>
</table>

Mean difference .7059

<table>
<thead>
<tr>
<th>t-value*</th>
<th>df</th>
<th>2-tailed significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.27</td>
<td>35</td>
<td>.213</td>
</tr>
</tbody>
</table>

* for equal variances

The small number of males in the overall sample (n=5) made evaluation of the gender distribution statistically invalid. In the Chi-square analysis, half of the cells (the 2 related to males) had fewer than 5 expected observations.

The homogeneity of the participants with respect to race (all but one participant was Caucasian) also rendered evaluation of racial differences by diagnostic category invalid.

Occupational status, however, was evaluated. For this analysis, full- and part-time employment was combined into a single category so that the comparison was between "Employed" participants and "Unemployed." This comparison is displayed in Table 13.
<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Employed</td>
<td>13</td>
<td>16</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.06775</td>
<td>1</td>
<td>.7949</td>
</tr>
</tbody>
</table>

On the basis of the chi-square analysis, there is no statistically significant difference between the diagnostic categories in terms of employment status and no evidence is provided upon which to base rejection of the null hypothesis.

Marital status was evaluated with chi-square as well. This is illustrated in Table 14.

For marital status, these data show no significant difference between the MPD and MDD participants and the null hypothesis is not rejected.

Chi-square was also used to analyze differences in educational levels attained by the two subsamples. Table 15 displays the results of this analysis.

Based on this evidence, there is no basis for rejecting the null hypothesis of no differences in the educational attainments of individuals in the two diagnostic groups.
### Table 14

Marital Status by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>9</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Married</td>
<td>8</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>20</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0318</td>
<td>1</td>
<td>0.8585</td>
</tr>
</tbody>
</table>

### Table 15

Educational Attainment by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HS Graduate</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>College</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>20</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00152</td>
<td>1</td>
<td>0.96888</td>
</tr>
</tbody>
</table>
Gender preference was dichotomized into "heterosexual" and "other" as the initial step in analysis of participant characteristics. Within the sample as a whole, 5 participants identified themselves as other than heterosexual: 4 in the MPD subsample, 1 in the MDD subsample. Because the participants were so uniform with respect to gender preference, further statistical analysis of this distribution was not possible. These results do not provide support for rejecting the null hypothesis of no difference between the two groups in terms of gender preference.

Prior incarceration was also evaluated as a dichotomized variable, however, the small number of participants with a history of incarceration (n=3) made it impossible to utilize chi-square or any other statistic for further analysis. These results do not provide support for rejecting the null hypothesis of no difference between the two groups in terms of prior incarceration.

Overall, the homogeneity of the sample with respect to gender, race, gender preference and history of incarceration did not provide adequate evidence upon which to evaluate the hypotheses related to these variables. For the variables for which sufficient information was available-marital status, occupational status, and educational level attained--no statistically significant results were generated upon which to base rejection of the null hypothesis that MDD and MPD participants do not differ in these demographic characteristics.

Null Hypothesis 3: There is no difference in knowledge of previous psychiatric diagnoses between MPD and MDD participants.

Participants' responses to a specific interview question related to whether
they were aware of any previous psychiatric diagnosis/es (of their own) were used
to evaluate this hypothesis. Thirteen MPD participants and 11 MDD participants
were aware of such a diagnosis. This difference was evaluated using Chi-square,
with the results shown in Table 16.

These results do not provide evidence upon which to base a rejection of the
null hypothesis of no difference in the two groups with respect to knowledge of
previous psychiatric diagnosis/es.

**Null Hypothesis 4**: There is no difference in the self-report of a former
diagnosis of depression, mania, schizophrenia, anxiety disorder, and other psychi­
atric disorder between MPD and MDD participants.

**Table 16**

<table>
<thead>
<tr>
<th>Knowledge of Previous Psychiatric Diagnosis/es by Diagnostic Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Knowledge</td>
</tr>
<tr>
<td>No Knowledge</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square*</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3423</td>
<td>1</td>
<td>.0675</td>
</tr>
</tbody>
</table>

*1 of 4 cells (25%) have expected frequency < 5
Each participant responded in a yes/no format to questions related to each diagnosis as his or her previous diagnosis. Each diagnosis was evaluated separately, utilizing Chi-square analyses.

For the previous diagnosis of depression, the participant group as a whole was so homogeneous, that no statistical analysis was possible. All but one of the 36 respondents (an MPD participant) indicated they had such a diagnosis in the past.

There were similar problems in evaluating differences in other diagnoses between the two subsamples. Of the diagnoses of interest in this research, only the categories of "anxiety disorder" and "other psychiatric disorder" were distributed in a manner which could be further analyzed; that is, 50% of more of the cells in each of the distributions for mania and schizophrenia had an expected frequency of less than 5.

For anxiety disorder, 80% (n=12) of the 15 MPD participants and 53.6% (n=10) of the 19 MDD participants who responded had been diagnosed with such a psychiatric illness. The resulting chi-square distribution is shown in Table 17.

This analysis does not provide support for rejecting the null hypothesis of no difference in these participants insofar as previous diagnosis with anxiety disorders is concerned.

In the "other psychiatric diagnosis category," 85% (n=12) of the 14 MPD participants responding had some other psychiatric diagnosis; only 5.6% (n=1) of the MDD subsample reported having some other psychiatric diagnosis. The Chi-square is shown in Table 18.
Table 17

Previous Diagnosis of Anxiety Disorder by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorder</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>No Anxiety Disorder</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>19</td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7492</td>
<td>1</td>
<td>.09730</td>
</tr>
</tbody>
</table>

Table 18

"Other" Psychiatric Diagnosis by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Other&quot; Disorder</td>
<td>12</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>No &quot;Other&quot; Disorder</td>
<td>2</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>18</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.97757</td>
<td>1</td>
<td>.0000</td>
</tr>
</tbody>
</table>
These results provide adequate support for rejecting the null hypothesis of no difference between the two diagnostic categories in terms of a history of previous diagnosis with a psychiatric illness other than depression, mania, schizophrenia, or anxiety disorder.

**Null Hypothesis 5:** There is no difference in the history of receiving a prescription for psychiatric medication between MPD and MDD participants.

The homogeneity of the sample in terms of a history of psychotropic medications was such that a statistical evaluation of this hypothesis was not necessarily. Only 3 participants—2 MDD and 1 MPD—had never received such a prescription. Inspection provide adequate evidence that support for rejecting the null hypothesis is not provided by this distribution.

**Null Hypothesis 6:** There is no difference in the history of receiving a prescription for antipsychotic, antidepressant, lithium, anti-anxiety or sleeping medication or other medication between MPD and MDD participants.

A series of chi-square analyses were used to evaluate differences in the two subsample’s uses of various specific psychiatric medications. All of the types of medications had been used by these participants, with the greatest use seen of antidepressants. Some 83% (n=31) of the overall sample of 37 had been prescribed an antidepressant at some point in their treatment history. Of these 31 participants, 15 were in the MPD sample and 16 in the MDD sample. Because only 6 participants had no history of antidepressant use, chi-square analysis was not considered appropriate; therefore there is no support for rejecting the null
hypothesis related to use of antidepressants by the two groups.

A similar result was obtained in relationship to the use of lithium, except that for this specific medication, some 92% (n=33) of the participants had no history of use and just 3 participants (two of them MPD) did have such a history. Further statistical analysis was not warranted, and no support for rejecting the null hypothesis was provided.

In terms of the use of anti-anxiety or sleeping medications, about 62% (n=23) of the total sample reported a history of such use. The chi-square analysis of this distribution is shown as Table 19.

Based on this result, there is no support for rejecting the null hypothesis.

<table>
<thead>
<tr>
<th>Table 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Anti-Anxiety/Sleeping Medications by Diagnostic Category</td>
</tr>
<tr>
<td>MPD</td>
</tr>
<tr>
<td>Use Anti-Anxiety/Sleeping Meds</td>
</tr>
<tr>
<td>Don’t Use Anti-Anxiety/Sleeping Meds</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Chi-square value</td>
</tr>
<tr>
<td>.08652</td>
</tr>
</tbody>
</table>
related to no difference in the use of anti-anxiety and/or sleeping medications by the two groups.

About 20% (n=7) of all participants had used "other" medicines. Six of these participants were in the MPD subsample. Although MPD users of other medications outnumbered MDD users by a 6:1 ratio, a chi-square could not be calculated because 2 of the four cells had an expected frequency of less than 5 participants. This evidence did not support rejection of the null hypothesis of no differences in the two groups with respect to use of "other" medications.

On the basis of the data collected, it is not possible to reject the null hypothesis of no overall difference in the medication history of MPD and MDD participants with respect to the specific types of drugs they have been prescribed.

**Null Hypothesis 7:** There no difference in the number of electroshock treatments received by MPD and MDD participants.

Since none of the participants in this study had received electroshock treatments, the evaluation of this hypothesis was not possible.

**Null Hypothesis 8:** There no difference in the number of therapists consulted for emotional problems by MPD participants and MDD participants.

This null hypothesis was evaluated using a t-test. Table 20 shows the results.

Based on this evidence, the null hypothesis of no difference in the number of therapists consulted can be rejected: Participants diagnosed with MPD do consult a significantly greater number of therapists for emotional problems.
Table 20

Number of Therapists Consulted by Diagnostic Category

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
<td>17</td>
<td>6.7647</td>
</tr>
<tr>
<td>MDD</td>
<td>20</td>
<td>3.300</td>
</tr>
</tbody>
</table>

Mean difference 3.4647

<table>
<thead>
<tr>
<th>t-value*</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.08</td>
<td>29.87</td>
<td>.004</td>
</tr>
</tbody>
</table>

*unequal variances (Levene’s test $F = 7.597 \ p = .009$)

Null Hypothesis 9: There is no difference in the reports of MPD and MDD participants about the effectiveness of previous treatment.

About 71% ($n = 25$) of all participants reported that they had received ineffective treatment in the past. A chi-square analysis of the distribution of the results across diagnostic categories provided the results shown in Table 21.

No evidence is provided upon which to base the rejection of the null hypothesis of no difference between the reports of ineffective treatment from each subsample.

Null Hypothesis 10: There is no difference in the severity of depression
Table 21
Receipt of Previous Ineffective Treatment by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received Ineffective Treatment</td>
<td>13</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Did Not Receive Ineffective Treatment</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>19</td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value*</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3931</td>
<td>1</td>
<td>.2379</td>
</tr>
</tbody>
</table>

*Cells with expected frequency < 5 = 1 in 4 (25%)

of participants diagnosed with MPD and participants diagnosed with MDD.

This hypothesis was evaluated based upon the self-report of each participant regarding whether the depression experienced was "in remission" or "active, recurrent." In all, 16 of the 37 participants reported that their depressions were "in remission." A chi-square analysis of the distribution of the depression severity description between the two diagnostic categories is provided in Table 22.

Based on this data, there is no support for rejecting the null hypothesis of no difference in the two groups on the basis of severity of depression as defined by the current status of this disorder.
Table 22

Status of Depression by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>In remission</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Active, recurrent</td>
<td>10</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>20</td>
<td>37</td>
</tr>
</tbody>
</table>

Chi-square value df Significance

| .05474 | 1 | .8150 |

Additionally, this hypothesis was evaluated based upon the BDI mean scores of each subsample. A t-test analysis of the distribution of the mean scores between the two diagnostic categories is depicted in Table 23.

Based on this evidence, the null hypothesis of no difference in the two diagnostic groups and their severity of depression as measured by the BDI cannot be rejected.

Null Hypothesis 11: There is no difference in the percentage of participants in each group who report the presence of a major depressive episode at some time in their lives.

All 37 participants in the study reported the presence of at least one major depressive episode in their lives, providing no evidence upon which to base the
Table 23

**BDI Scores by Diagnostic Category**

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
<td>17</td>
<td>28.8235</td>
</tr>
<tr>
<td>MDD</td>
<td>20</td>
<td>26.0500</td>
</tr>
</tbody>
</table>

Mean difference .7735

<table>
<thead>
<tr>
<th>t-value*</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>.93</td>
<td>23.93</td>
<td>.362</td>
</tr>
</tbody>
</table>

*unequal variances (Levene’s test F = 8.452, p = .006)

rejection of the null hypothesis of no difference in the MPD and MDD groups in this respect.

Null Hypothesis 12: There is no difference in the percentage of participants in each diagnostic group who report instances of physical abuse in childhood or adolescence.

Slightly more than 88% (n = 29) of all participants reported a history of physical abuse in childhood or adolescence. Only 8 participants did not report being physically abused during this period of their lives. Distribution of physical abuse across diagnostic categories is shown in Table 24.

Evaluation of these statistical findings was rendered difficult since the chi-
Table 24

Physical Abuse by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically Abused</td>
<td>16</td>
<td>13</td>
<td>29</td>
</tr>
<tr>
<td>Not Physically</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Abused</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>20</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value*</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5973</td>
<td>1</td>
<td>.0320</td>
</tr>
</tbody>
</table>

*2 of 4 cells (50%) have expected frequencies of < 5

Table square distribution had an expected frequency of less than 5 in 2 of its 4 cells. If this were not a consideration, however, this difference would have been significant at the .05 level, 2-tailed test.

**Null Hypothesis 13:** There no difference in the percentage of participants in each diagnostic group who report instances of sexual abuse in childhood or adolescence.

In the total sample, 62.9% (n=22) of the participants had experienced sexual abuse early in their lives. In the MPD subsample, all 17 participants had experienced such abuse while in the MDD subsample, five participants had been abused in this way. An evaluation of the significance of this difference is shown in Table 25.
Table 25

Sexual Abuse by Diagnostic Category

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>MDD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually Abused</td>
<td>17</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Not Sexually Abused</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>18</td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-square value</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.5328</td>
<td>1</td>
<td>.00001</td>
</tr>
</tbody>
</table>

On the basis of this finding, there is strong statistical support for rejection of the null hypothesis of no difference in the percentage of participants experiencing sexual abuse in each diagnostic category. Clearly, participants diagnosed with MPD have a significantly higher rate of sexual abuse in their histories.

Null Hypothesis 14: Participants diagnosed with MPD report the same number or fewer dissociative features than participants diagnosed with MDD.

Mean cores on the DES instrument related to the quantity of dissociative symptoms experienced for each subsample were compared utilizing a t-test to test this hypothesis. This is displayed in Table 26.

Based on this statistical result, the null hypothesis that participants with MPD have the same or fewer dissociative symptoms as MDD participants can be
Table 26

**DES Number of Dissociative Symptoms by Diagnostic Category**

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
<td>17</td>
<td>48.8588</td>
</tr>
<tr>
<td>MDD</td>
<td>20</td>
<td>12.4350</td>
</tr>
</tbody>
</table>

Mean difference 36.4338

<table>
<thead>
<tr>
<th>t-value*</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.19</td>
<td>23.83</td>
<td>.0000</td>
</tr>
</tbody>
</table>

*unequal variances (Levene’s test F = 11.412, p = .002)

rejected. It is demonstrated that MPD participants have more dissociative symptoms.

The **DDIS** scores for the two subsamples were also compared to ascertain whether there were significant differences between the groups. The results of this t-test are shown in Table 27.

Based on this assessment, there is evidence upon which to reject the null hypothesis that the MPD group has the same or fewer dissociative features than the MDD group: The MPD subsample evidences a greater number of these features.
Table 27
DDIS Scores by Diagnostic Category

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPD</td>
<td>17</td>
<td>12.00</td>
</tr>
<tr>
<td>MDD</td>
<td>20</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Mean difference 11.00

<table>
<thead>
<tr>
<th>t-value*</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.28</td>
<td>25.27</td>
<td>.000</td>
</tr>
</tbody>
</table>

*unequal variances  (Levene's test $F = 11.777, p = .002$)

Summary

The data collected from 17 participants diagnosed with MPD and 20 participants diagnosed with MDD provides the basis for summarizing the statistically significant differences between the two groups as follows: MPD participants report being diagnosed with more "other" psychiatric disorders (excluding depression, mania, schizophrenia, and anxiety disorders); MPD participants consult a greater number of therapists; MPD participants report a history which more often includes sexual abuse in childhood or adolescence; and MPD participants experience more dissociative symptoms than MDD participants.
These findings, on the other hand, indicated the subsamples did not differ significantly in terms of rating the effectiveness of previous treatment; experience with a major depressive episode or severity of depression experienced; or reported incidence of physical abuse. Furthermore, significant differences were not demonstrated between participants diagnosed with MPD and MDD in terms of a variety of other characteristics and experiences. These include the following: age, racial composition, marital status, occupational status, educational level attained, gender preference, economic status, and previous history of incarceration. Neither were differences seen in knowledge of previous psychiatric diagnoses; differences in self-report of a previous diagnoses of depressive, schizophrenic, manic or anxiety-related psychiatric illnesses; receipt of prescriptions for psychotropic medications; or receipt of electroshock therapy.

Although these subsamples are alike in many ways, the findings related to sexual abuse in childhood or adolescence, greater number of dissociative symptoms, number of therapists consulted and history of diagnosis with "other" psychiatric disorders is of considerable interest and potential value for clinical practice. As will be discussed in Chapter V, the four differences between MPD and MDD patients are theoretically linked to one another in ways which have implications for therapists who provide services to either or both groups and to educators who train those therapists for practice.
Chapter V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Multiple personality disorder (MPD) and other dissociative disorders are being diagnosed and treated with increasing frequency. Research on MPD in the last 10 years has generated a growing body of knowledge about the etiology and epidemiology of the disorder; but there have been only a few studies systematically comparing MPD patients with patients diagnosed with other psychiatric disorders. One study of particular importance to the current effort, however, was a retrospective analysis conducted by Schultz et al. in 1989, comparing patients with MPD to those diagnosed with a major depressive disorder (MDD). The findings of this earlier study suggest that certain significant differences exist between individuals in selected diagnostic categories, particularly male: female ratio's, marital history, income, and educational level. Other significant differences were reported in each group including physical abuse, sexual abuse, and physical and sexual abuse combined.

Schultz et al.'s sources (research participants) were therapists who treated patients diagnosed with MPD and MDD, rather than individuals who themselves had received these diagnoses. While the present study shared the earlier work's
interest in assessing the relationship between certain characteristics and life experiences of MPD and MDD patients, the information used to make determinations on the hypothetical propositions was secured from clients themselves, not from a third party. This is an important difference between the current study and Schultz et al.’s. The resources of therapists were secured early in this research when they were involved in making a referral of their client(s) and administering selected standardized instruments; however, the data were gathered directly from volunteer participants.

One of the underlying purposes of the present research was to determine whether the information gained about similarities and differences between MDD and MPD clients from individuals themselves provides a different perspective on the relationship between these two disorders than is provided by Schultz et al.’s 1989 survey of therapists.

MPD is generally considered a childhood-onset, dissociative, post-traumatic condition that emerges as the consequence of overwhelming, severe, and repetitive physical and/or sexual abuse or neglect, generally beginning before the age of five (Putnam et al., 1986; Ross, 1989; Spiegel, 1984). One of the difficulties in recognizing and diagnosing MPD is that its manifestations and symptoms often coexist with, or are obscured by, other phenomena. Dissociative symptoms are rarely the initial presenting problem with MPD patients; the diagnosis usually is made later in treatment, if at all, with the emergence of secondary features. Thus, the polysymptomatic presentation and/or history of MPD often leads to
misdiagnosis and misdirected treatment.

Depression has been noted as one of the most common presenting symptoms in MPD patients. Its presence is viewed as a defense to protect the traumatized individual from the overwhelming memories and affective states of hurt, fear, anger, sadness, and anxiety. Putnam et al. (1986) reported that 80% of 100 MPD patients studied at the National Institutes of Mental Health (NIMH) originally presented sufficient depressive symptoms to support a diagnosis of major affective disorder. The difficulty with diagnosis of depression for individuals with concomitant MPD is that receiving the diagnosis of depression is generally considered to conclude the diagnostic phase of the treatment planning process. While many clinicians accurately diagnose the depression, however, they look no further for associated disorders such as MPD. Early detection of MPD symptoms (such as depression) and identification of MPD-related diagnostic variables (such as childhood abuse) are important signals to continue the assessment phase of treatment.

Licensed therapists, within a 150 mile radius of a mid-sized midwestern community, who provide outpatient therapy to individuals with MPD and MDD were invited by the researcher through personal meeting or telephone interview to refer clients to the study. The invitations generated a sample of 37 participants, of whom 17 were diagnosed by their therapist with a principal diagnosis of MPD and 20 who were diagnosed by their therapist with a principal diagnosis of MDD, without dissociative features. The depression features of MPD participants
were compared to the features of depression in MDD participants. Data about demographic characteristics, psychiatric history, secondary dissociative features, and childhood history of abuse were also collected, compared, and reported.

The instruments used to collect the data were the Dissociative Experiences Scale (DES), Beck Depression Inventory (BDI), Demographic Data Questionnaire, and the Dissociative Disorders Interview Schedule (DDIS), Sections III, IV, VII, and VIII. The results were hand scored by the researcher and correlations between variables were calculated using Chi-square analysis and t-tests with Statistical Package for Social Sciences (SPSS) system (Norusis, 1988).

Statistically significant differences were found between the two groups on the following variables: MPD participants report being diagnosed with more "other" psychiatric disorders (excluding depression, mania, schizophrenia, and anxiety disorders); MPD participants consulted a greater number of therapists; MPD participants reported a history which more often includes sexual abuse in childhood or adolescence; and MPD participants experienced more dissociative symptoms than MDD participants.

The findings did not demonstrate significant differences between participants diagnosed with MPD and MDD in the effectiveness of previous treatment; experience with a major depressive episode or severity of depression experienced; or reported incidence of physical abuse.

The participants in this study in each diagnostic category did not differ significantly from one another in terms of age, racial composition, marital status,
occupational status, educational level attained, gender preference, economic status, and previous history of incarceration. Neither were there significant differences observed in knowledge of previous psychiatric diagnoses, differences in self-report of a previous diagnosis of depressive, schizophrenic, manic or anxiety-related illnesses; receipt for psychotropic medications; or receipt of electroshock therapy. Thus, many of the differences reported in Schultz et al.'s study are not found between the two subsamples in this research. On the other hand, certain important differences were found; some were also differences reported by Schultz et al. The results of this study further substantiate earlier works' recommendations that clinicians must be persistent to accurately diagnose MPD and differentiate it from another psychiatric disorders, especially those that are commonly experienced by individuals with MPD such as depressive disorders.

Discussion

The present study provided strong support to reject the null hypothesis of no difference between the two diagnostic groups in terms of history of sexual abuse. This analysis was clearly the most striking significant difference of the study. All of the MPD participants (17) had experienced sexual abuse in childhood while only five of the MDD participants had reported sexual abuse in their childhoods.

These findings lend strong support to earlier research studies which have reported that as many as 90% of North American MPD patients report histories
of sexual abuse (Coons & Milstein, 1986; Putnam et al., 1986; Schultz et al., 1987b, 1989; Ross et al., 1989). In particular, these results are very similar to those of Schultz et al. (1989) who compared therapists' reports of MPD and MDD patients experiencing childhood sexual abuse. In their 1989 study, therapists' reported 86% of the MPD group experienced sexual abuse history compared to 25% for the MDD group.

Another finding was no significant difference in the percentage of participants in each diagnostic group who reported instances of physical abuse in childhood or adolescence. Eighty-eight percent (88%) of all participants reported a history of physical abuse in childhood. It may be concluded from this finding that while physical abuse alone is seen as a strong factor in the development of depressive symptoms, physical abuse alone is not usually a sufficient cause of dissociative behaviors. This is an important finding since most of literature suggests the combination of physical and sexual abuse in childhood history are antecedents for MPD (Braun & Sachs, 1985; Putnam, 1989; Putnam et al., 1986; Ross, 1991). Since the current study confirmed a high incidence of physical abuse for all but one of the MPD participants, this combination is also documented in the MPD subsample.

Based on the self-reported histories of this research sample, there appears to be a strong relationship between sexual abuse and dissociative disorders. Physical abuse is common in the backgrounds of both groups as well as considerable depression symptoms, but the addition of sexual abuse is generally seen only in
participants who have MPD. It is posited that physical abuse in childhood and adolescence has a causative relationship in the development of depression as a pattern of defense and coping for these individuals. Moreover, physical abuse in addition to sexual abuse may be a strong factor in the development of both depression and a variety of dissociative features and/or MPD. In addition, closer inspection of the data regarding age of first physical and/or sexual abuse, age of cessation of physical and/or sexual abuse, number of incidents of physical and/or sexual abuse identified strong differences in historical patterns associated with the development MPD participants. In general, the MPD participants experienced more incidents of abuse which began earlier in their childhoods, and occurred over longer a duration of time. They also identified more perpetrators for physical and sexual abuse. This data also correlates with studies reported by Ross et al. (1989); Schultz et al. (1989); Putnam et al. (1986); and Ross et al. (1990).

The findings additionally support the theory that childhood trauma, especially sexual and physical abuse, appears to be a primary etiological factor in the origins of MPD. This study group's report of abuse is similar to Putnam et al.'s (1986) findings of an abuse incidence 97% in MPD patients. As in the study reported by Schultz et al. (1989), the incidence of physical and sexual abuse is notably higher in the history of MPD participants than major depression participants.

Differences were hypothesized in the self-report of a former diagnosis of depression, mania, schizophrenia, anxiety disorder, and “other” psychiatric
disorder between MPD and MDD participants; however, all but one of the 36 participants in this study (an MPD participant) indicated they had received a diagnosis of depression in the past. While no significant difference was demonstrated between the two diagnostic groups in this study on this variable, the results do provide useful information which concurs with previous studies that most MPD patients have been diagnosed with depression prior to, or concurrently, with an MPD diagnosis. Eighty-eight percent (88%) of this MPD sample were previously diagnosed with depression, a finding comparable to the results of the meta-analysis of research studies completed by Kluft (1991). Kluft reviewed Coons et al. (1988), Bliss (1986), Putnam et al. (1986), and Ross et al. (1989) and summarized research efforts which found depression in 90% of the MPD participants. The previous results are in congruence, as virtually the entire sample of the present study had at one time been formally diagnosed with a depressive illness. Moreover, the participants' current scores on the BDI documented that depressive features continued to be present at a moderate to generally high level.

It is noteworthy that both groups in this study were found to have BDI scores indicative of an active depressive state, even though most individuals in both groups describe their depressions as "in remission." It is speculated that individuals in both diagnostic groups have experienced depressions of such severity and with such frequency that their uses of the terms "active" and "in remission" are no longer comparable to the ways these terms are used or understood by others, including professionals. When a measure of depression is required for
individuals who have a lengthy history of serious depressions (with or without dissociative disorders), these results suggest that standardized, objectives measures provide very different results than self reports. Participants tend to minimize or underestimate the severity of a current depression even when it can be measured in the moderate to severe range clinically on the BDI.

In considering the relationship between depressive characteristics and dissociative characteristics, it must be remembered that the presenting complaint of depression from a MPD individual may at first appear to be an ordinary, unexceptional neurotic depression. However, the dynamics contributing to the MPD person's experience of helplessness, hopelessness, and worthlessness are often very different, as this study has described. The MPD patient may feel powerless to influence or change his or her life, because he or she is continually confronted with painful evidence that his or her behavior is not under "conscious" control. In this respect, the current results provide support for Putnam's (1989) similar conclusions.

In addition to depressed mood, the participants in this study reported or provided evidence of experiencing additional symptoms which reinforced the diagnosis of major affective disorder. In this respect, this MPD sample is congruent with other MPD cohorts, about 75% of whom described themselves as having "mood swings" (Bliss, 1984; Coons, 1984; Putnam et al., 1986). Interviews with the 17 participants included in the present research confirmed that a typical "host" personality initially presenting for treatment usually has low self-esteem,
is overwhelmed, and generally expressed a negative outlook toward life. There
is often a history of suicide attempts or gestures, and self-destructive ideation is
present, confirming earlier findings of Bliss (1980, 1984), Coons (1984), and
Putnam et al. (1986). Such findings as these underscore the necessity for carefully
taking the history of depression clients, with an intent to rule out a dissociative
disorder in mind. A clinical approach aware of the likelihood of MPD, using
instruments to assess depression and secondary features of dissociation, and
inquiring about childhood abuse, can uncover evidence of the features that differ­
entiate between the two disorders.

There were no significant differences found between the two groups of
participants in this study with respect to having received diagnoses of mania,
schizophrenia, or anxiety. It is interesting, however, to compare the percentage
of MPD participants with these previous diagnoses with reported incidence figures
from earlier studies. For example, for mania and schizophrenia, 23% of the cur­
rent MPD sample had previously received these diagnoses, and 70% had received
an anxiety disorder diagnosis. The percentages compare with a report by Ross
et al. (1989) of 44.3% of MPD patients who had received a prior diagnosis of
anxiety and 40.8% who had received a prior diagnosis of schizophrenia. The dif­
ferences between the results of these two studies is striking and perhaps an expla­
nation lies in the relatively early stage at which research on this topic currently
exists. Many factors, including the methods of selecting samples, methods of mea­
surement, and interpretations of results currently vary significantly from study to
At this time, no generally acceptable research protocol has been proposed, adopted or implemented to guide researchers with an interest in MPD in their separate efforts, even though all efforts share common research problems. Among these problems, one of the most significant and potentially most confounding for the comparability of results between studies is that each research participant may, in actuality, be several "participants," at least insofar as the term "participant" is used to denote an individual with a certain personality, set of memories, attitudes and other attributes. Researchers who conduct research in this field are constantly faced with clients who experience amnesias and other dissociative states, who "switch" personalities, and who may display few of the stable characteristics depended upon in psychological research to provide the foundation for reliable and valid measures. Although instruments themselves may be shown to be valid and reliable, in the MPD population, participants may not demonstrate these characteristics with respect to who they actually are. Results of studies would, therefore, be expected to be far less comparable because, at any point in time, specific samples can exhibit wide and unpredictable variability in their composition, depending upon which personalities of MPD participants are in control at the time of data collection.

Results demonstrating that MPD patients do receive more diagnoses in other DSM categories prior to receiving an accurate diagnosis of MPD may also be related to this phenomenon. This finding is congruent with finding of Ross et
al. (1989) and Putnam (1989) who reported that their MPD patients had received an average of 2.7 to 3.6 previous psychiatric diagnoses before their MPD diagnosis.

The question naturally arises from the aggregate of this research and these earlier studies of whether previous diagnoses are in error or whether they are correct concurrent diagnoses. Ross (1991) suggests that to make other diagnoses is not always a mistake; the error is not to have diagnosed the MPD. Ross further notes that a diagnostic clue is the failure of a patient to respond to conventional treatment for the initial diagnosis, supported here by the very large number of therapists each MPD client had seen prior to entering treatment with his or her current therapist. This result is seen as indicative of earlier treatments which were ineffective in recognizing or addressing the participants' MPD.

In fact, in this study, the number of therapists consulted for emotional problems by MPD participants and MDD participants was found to be significantly different, with an average of almost seven therapists consulted by MPD participants compared to an average of slightly more than three consulted for MDD participants. This finding is consistent with studies cited earlier indicating MPD patients consult with many therapists. Many reasons are stated, such as receiving inaccurate diagnosis, concern over their condition for fear of being labeled "crazy," or having different personalities present different symptoms for treatment.

Of particular note is that all 17 MPD participants in this study did
continue to seek a therapist until they located one who recognized and treated MPD. Since all participants were referred by therapists who were identified as knowledgeable about, and provide treatment for, dissociative disorders, this finding may have been an artifact of the study design. No other literature was discovered which examined the true rate of persistence and/or success MPD patients experience in finding appropriate treatment resources. The current results did point to a relatively high degree of resilience on the part of this subgroup of MPD patients. Again, the distribution of resilience cannot be gauged from these results because only persistent and resilient individuals had an opportunity to participate in the present study, that is, because participant selection occurred through therapist referral, MPD participants who had not persisted or found a therapist had no chance of being selected for this sample.

Note should be taken of the reports participants in this research make about the effectiveness of previous treatment they have received, particularly since, as an MPD group, they have received so much treatment from so many different therapists. About 71% (n = 25) of the participants reported they had received ineffective treatment in the past (13 MPD participants and 12 MDD participants). While research studies have indicated this problem for MPD patients (Putnam et al., 1986; Ross et al., 1989; Ross et al. 1990), it is noteworthy that the experiences of this MPD subsample are not significantly different from the experiences of the MDD group. Both groups reported receiving ineffective past treatment and have tried, on average about five therapists. This raises questions about
the overall quality of treatment available, as well as about the tenacity individuals with clinical disorders must display to find appropriate psychological help. Again, one must be careful to avoid over-generalizing the current findings since all of the individuals in both samples were currently in therapy. This study must be considered to represent the experiences of successful persisters; it is likely that the overall experiences of individuals with MPD and MDD (and perhaps other psychiatric diagnoses) is even more bleak with respect to experiences with ineffective treatment and misdiagnosis. On the other hand, it can be posited that individuals are really their own best expert when it comes to “knowing” when they are compatible with a therapist. They will know when an incompatible alliance exists and seek to find a more appropriate match, and perhaps, more effective treatment.

It came as little surprise that the subsample diagnosed with MPD reported a significantly greater number of dissociative features than the MDD subsample. In fact, the primary importance of this finding is that it verified the participants in this group had accurately been diagnosed by their referring therapists. The referring therapists used observation and gathered clinical data, while the research study utilized clinical instruments to verify the diagnoses. In addition, it lends some credence to the general level of awareness that MPD patients appear to have about their psychological disorder. The fact that this sample had received many different diagnoses, probably from the large variety of therapists they had consulted, and continued to seek treatment for the symptoms they readily report on the DES and DDIS, suggests that, at least for a group such as this which has
successfully pursued and found appropriate treatment resources, a high level awareness about their dissociative behaviors exists. It is worth noting the contrast of the mean scores between the MPD (48.86) and MDD (12.44) subsamples is similar to results obtained by Ross (1991) where the DES mean score for the general population was found to be 10.8. The MDD subsample mean score of 12.44 does distinguish it as sample which is within the normal range, and the MPD subsample mean score of 48.86 is clearly in the range for MPD.

It is also worth noting that almost all individuals in the general population have some experience with dissociation and that dissociative behaviors may serve a useful function when they do not disrupt an individual's normal ability to function. The problem for MPD patients is that dissociative symptoms predominate as a method of coping and do not allow the individual to maintain a single stable personality.

The results of evaluating secondary dissociative features, as measured by the DDIS, provided a greater difference between MPD and non-MPD participants than even the initial research on this instrument had revealed. The mean score for the MPD group was 12.0 while the mean score for the MDD group was 1.0. Ross et al. (1989) reported an average of 8.3 secondary dissociative features for a MPD group, 2.4 for a schizophrenic group, 0.7 for persons diagnosed with panic disorders, and 1.4 for persons diagnosed with an eating disorder. These results suggest that while the MPD group did share similar features of depression with the MDD subsample, the MDD group has significantly fewer secondary
dissociative features.

Unlike some findings from earlier studies, this research found no significant differences between MPD and non-MPD participants on most demographic variables, including gender, age, racial composition, marital status, occupational status, educational level attained, gender preference, economic status, and previous history of incarceration. It must be remembered that there was only one male MPD referred to this study. Ross (1991) reported 12.3% and 8.0% of males in earlier studies, a gender distribution which may account for, or be associated with, other differences reported as well.

In regard to the large proportion of females found in all MPD studies, Putnam (1989) proposed the following possible explanations: (a) MPD may be a genetic disorder with sex-linked characteristics; (b) there may be cultural determinants which influence women to "choose" this expression of psychological defense or psychopathology rather than another form; an inner rather than outer form; (c) females have been demonstrated to be at a higher risk for physical and sexual abuse over longer periods of time and this may directly result in more MPD in this gender; (d) there may be sampling biases; and (e) males may tend to react to early experiences of abuse with violence outwardly and end up in correctional facilities, while women will self-direct violence toward themselves and develop depression, eating disorders, substance abuse problems, dissociative characteristics, and suicidal behaviors which are treated in the mental health system. This research does not provide additional support for any of these conjectures,
but does lend support to the need for further exploration of the dramatic differences in the proportion of individuals who are receiving treatment for MPD, are referred for studies of this type, and/or volunteer as participants.

Lowenstein and Putnam (1990) reported the phenomenology, clinical history, and history of antecedent severe child abuse were very similar between male and female MPD patients. They believe male MPD patients may have not been adequately represented or sampled in research due to (a) clinicians have a low index of suspicion that males have MPD, (b) a belief that males are more often in the prison system, drug and alcohol treatment programs rather than outpatient therapy, (c) males are more subtle in their clinical presentation of MPD, and (d) a lack of systematic inquiry of childhood abuse in males. Again, because of the small number of males in the sample, this study had no opportunity to explore these hypothetical explanations in any depth; however, all seem worth examining in future research.

The study did provide information related to the age of most MPD patients. That is, although the etiology of MPD is apparently early in childhood, the disorder is usually not diagnosed until the third of fourth decade, although there is usually prior psychiatric history and misdiagnosis. This has been the pattern described by the 17 individuals in this study's MPD subsample. The mean age of 39.59 years for the study's MPD participants gives another estimate of how long MPD participants live with the disorder before they secure a treatment resource focused on this specific concern.
As for other participant characteristics, there is scant additional data available to provide a comprehensive perspective on the ethnic and socioeconomic characteristics of MPD patients. Coons and Sterne (1986), Stern (1984), Solomon (1983), and Putnam et al. (1986) report that MPD does occur across all major racial groups and socioeconomic settings, but most studies are weakened, as this one is, by a reliance on participants who are in treatment or who have access to or are known by therapists. This limits samples to individuals with a certain (higher) level of awareness about and concern for their mental health and to individuals who have enough self-confidence and strength of personality to participate in research studies. Clearly, this sample did not represent a broad section of ethnic and socioeconomic backgrounds and was probably not representative of the full spectrum of individuals who live daily with MPD. It is speculated that a large number of these are not diagnosed at all, are currently misdiagnosed, or are being served in another community system, such as corrections or medicine.

Limitations

This study had a number of limitations, many of which have been at least partially alluded to throughout this chapter. Among the most significant limitations is the sample which may or may not be representative of the MPD (or even the MDD) populations. Although this was a purposeful sample, generally represented by a sample of the MPD population in Michigan, in outpatient therapy, who are 30-40 year old Caucasian females with sufficient education, income, and
relationships and are similar to participants utilized in most other studies in the MPD literature (Putnam, 1989; Ross, 1991), it is recognized that they are probably the MPD participants who have made the best adaptation to this disorder. Although they continue to experience significant levels of depression and numerous dissociative experiences, they have the resources (personal and financial) to seek and secure professional treatment, and the self-confidence and enough personality integration to participate in an organized research effort. It is highly likely that not all individuals with MPD have these characteristics, but such individuals have not been available for study.

Another limitation of the current study is that much of the data is provided by self-report of participants. Self-reporting always has limitations, because of differences in participants' abilities to accurately recall and relate their current and historical information; however, with MPD participants there is an added concern that the presence of more than a single distinct personality combined with certain deficits of memory (or amnesias) may result in a single participant having many different self-reports of his or her subjective experiences. That is, each personality of an MPD participant has experienced the world in a very different fashion and has reacted to it in distinctive ways. Indeed, this is the essence of the disorder. The dissociative nature confounds the researcher who generally administers an instrument or makes an observation of only one (or, at most) a few of the personalities of any one participant. Common research considerations such as reliability demonstrated by test-retest are threatened when the personality
being tested is not the same from administration to administration. A researcher can never know with certainty if a study's results would be different if a different "set" of personalities from among all those present in the MPD participants under study would have provided different results. That is definitely the case in this study.

Another limitation of this study is that the sample was of a relatively small size and on many of the variables of interest was extremely homogeneous. The absence of minorities, economically disadvantaged, and those who may be less stable, hospitalized or never treated for MPD makes the results much less valuable than they would be if members of these populations were represented.

Implications for Future Research

Under-recognition of dissociative disorders and MPD has resulted in delayed accurate diagnosis and appropriate treatment, thus imposing emotional and fiscal costs on both the afflicted individuals and on society (Kluft, 1987). Since the disorder develops in childhood, it would be helpful to look to the systems which provide services to abused children to identify those at risk for the disorder earlier. Child guidance clinics, protective service agencies, courts, schools, and family medical clinics are possible screening sites. Early recognition by more clinicians could greatly enhance the chances of correct diagnosis and early treatment. The earlier the condition is diagnosed, the more readily and rapidly it responds to treatment (Kluft, 1985).
There is a growing interest in MPD from the field of a heterogeneous group of clinicians including psychiatrists, psychologists, social workers, psychiatric nurses, and a variety of individual, family, and marital counselors. As a group, MPD therapists come from very different training backgrounds and often do not speak the same clinical language. The quality and level of research, communication within the disciplines, education, supervision, and training about dissociative disorders and MPD is not systematically established or regulated.

Making a differential diagnosis of MPD implies that the condition can be differentiated from other disorders. A differential diagnosis also implies that there may be a difference in treatment and prognosis; otherwise such a diagnosis is clinically useless. This study has demonstrated that the DDIS and DES can be used in screening clinical and nonclinical populations for MPD. These instruments can aid clinicians in making differential diagnoses between depressed and dissociative patients, and they can provide detailed systematic information for clinical use. These instruments are readily available as practical, easy-to-use clinical tools for screening and diagnosing dissociative illnesses.

Implications for training individuals to provide services, including accurate screening, include insuring greater familiarity with screening instruments such as those used in this study; as well as more emphasis on continuing the diagnostic screening process for individuals with presenting symptoms of depression, many years in therapy with many different therapists without responding to conventional therapy, and a history of childhood physical and sexual abuse. Training programs
should include more education on the dissociative disorders, including their etiology, diagnosis, and effective treatment strategies. New research on this disorder should be incorporated into educational programs and in-service training as soon as possible. In-service training options for therapists should include attending conferences, involvement in support and study groups for therapists who treat dissociative disorders, and subscribing to publications which regularly feature research on the dissociative disorders.

The issues addressed in this study regarding the diagnosis of MPD reflect how complex and complicated the psychological condition of MPD is. Moreover, much about dissociative illnesses remains unknown. The study underscores the need to continue research that increases professionals’ ability to detect, identify, and diagnose the disorder more accurately and efficaciously so that appropriate treatment can be provided.
Appendix A

DSM-III-R Diagnostic Criteria
for Major Depression
DSM-III-R DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION

SINGLE EPISODE 296.2 OR 296.3 RECURRENT

Note: A "Major Depressive Syndrome" is defined as criterion A below.

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations).

   (1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others

   (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)

   (3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to expected weight gains)

   (4) insomnia or hyperinsomnia nearly every day

   (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

   (6) fatigue or loss of energy nearly every day

   (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-approach or guilt about being sick)

   (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

   (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. (1) It cannot be established that an organic factor initiated and maintained the disturbance

   (2) The disturbance is not a normal reaction to the death of a loved one (uncomplicated bereavement)

Note: Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by major depression.

C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).

D. Not superimposed on Schizophrenia, Schizotypal Disorder, Delusional Disorder, or Psychotic Disorder NOS.


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Appendix B

DSM-III-R Diagnostic Criteria for Multiple Personality Disorder
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.

Appendix C

Script for Therapists to Follow When Inviting Their Clients to Participate
Script for Therapists to follow when inviting their clients to participate in the research study:

"I have been contacted by Mary Wassink, a Doctoral Candidate from Western Michigan University, who is conducting a research study for her dissertation. She has asked me to invite some clients who meet certain criteria to volunteer to participate in that study. I believe you meet the criteria she is looking for and I would like to give you the opportunity to review the information she has made available so that you can decide if you wish to participate.

It is important that you understand your participation is completely voluntary, and you are free to decline the invitation, or to drop out at any time without any consequence to your therapy or relationship with me. I am not involved in the research study in any way, other than to offer the invitation to you to participate. The only information I will share with the researcher, if you agree to participate, is clinical diagnoses. Any information she gathers from you will be anonymous and confidential. All results will be reported as group scores only. You will be able to read the details of these conditions, and keep a copy of the informed consent form for reference. How you answer the questions will have no effect on how you are treated in your therapy now, or in the future.

If you would like to know more about this research study, I can give you the information packet now."

The therapist will provide the client with the information packet if he/she desires to read more about it and the decision to participate can be made then or later.

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Appendix D

Invitation to Participate
in Research Study
To: Research Participants

From: Mary L. Wassink
Doctoral Candidate
Counseling Psychology
Western Michigan University

Re: Invitation to participate in research study

Date: June 21, 1994

As a doctoral candidate, I am conducting a research study to examine the condition of depression as it is experienced between two different groups of people; those with a diagnosis of Major Depression and those with a diagnosis of Multiple Personality Disorder. I am looking for adult participants, who have been in therapy with qualified therapists for at least one month for Major Depression, or at least six months for Multiple Personality Disorder, and who are willing to volunteer. If you qualify according to that criteria and are interested in assisting with my research, I will need approximately one hour total of your time.

Initially, there is an informed consent form and a release of information form for you to read over and sign. It explains more fully all the conditions you may expect to encounter. Then there are two screening tests, the Beck Depression Inventory and the Dissociative Experiences Scale, which are self-administered, pencil-and-paper tests, and require approximately 15 minutes to complete. You will return these items to me in a pre-addressed, postage-paid envelope as soon as possible. You will keep one copy of the signed consent form for your records.

Once I receive these items and score them, I will contact you at the telephone number you give me to inform you of whether or not you will be eligible to continue in the study. If necessary, I will then arrange for the administration of the last two tests, the Demographic Data Questionnaire and the Dissociative Disorders Interview Schedule. A telephone interview will be arranged at your convenience and will take approximately 20 to 30 minutes.

It is important that you understand that your responses are completely anonymous and confidential. All results will be reported only as group scores. Your participation is completely voluntary, and you are free to drop out at any
time without any consequence to your therapy or relationship with your therapist. The only information your therapist will share with me is included on the “Release of Information” form, which is previous and current psychiatric diagnoses.

If you wish to receive a final report of the study it will be provided to you.

I appreciate your consideration of this opportunity. Your participation will be very helpful in the on-going pursuit of knowledge regarding dissociative disorders.

Sincerely,

Mary L. Wassink
Doctoral Candidate
Appendix E

Informed Consent Form
Western Michigan University
Department of Counselor Education and Counseling Psychology

Informed Consent Form

Principal Investigator: Robert Betz, Ph.D

Student Investigator: Mary L. Wassink, M.A.

I have been invited to participate in an experimental research project entitled "Multiple Personality Disorder and Major Depression: A Comparative Study". This study will examine problems about dissociative disorders and depression. Dissociative disorders involve problems with memory and depression involves problems with mood. I further understand that this project is Mary L. Wassink's dissertation project.

My consent to participate in this project indicates that I will be asked to complete four questionnaires, and will require about one hour of my time. Two of the questionnaires (Beck Depression Inventory and Dissociative Experiences Scale) are self administered and when completed will be sent in a pre-paid self-addressed envelope to Ms. Wassink. After she receives them and scores them, she will determine if I will continue in the study. I will be notified by her either way. If I continue in the study, she will contact me and set up a telephone interview for the administration of the remaining two questionnaires, the Dissociative Disorders Interview Schedule, Sections III, IV, VII, and VIII, and the Demographic Data Questionnaire.

I understand that the interview contains some personal questions about my sexual and psychological history, however all information that I give will be kept confidential. I am aware that there are specific situations when therapists are legally required to report, to the appropriate authorities, information I reveal which clearly indicates danger or injury to myself or others (e.g. potential suicide or homicide). A therapist is also required by law to report any knowledge of current abuse or neglect of a child, or an incompetent, disabled or otherwise restricted person.

I understand that one potential risk of my participation in this project is that I may experience some discomfort.
regarding the personal questions about my sexual and psychological history. If so, I can bring those issues to my personal therapist who referred me to this study and discuss it in my regular therapy sessions, however no compensation or treatment will be made available to me except as otherwise specified in this consent form.

I understand that the information I give to the interviewer will not be available to any doctor, authority, therapist, case worker or any other person involved with me. My answers will have no direct effect on how I am treated in the future.

I understand that my name or any identifying data will not appear on the research questionnaire, and only overall statistical data will be used in reporting the results of the study. I understand that the overall results of this research will be published and these results will be available to authorities or therapists involved with me. The results will be published in such a way that no one who participated can be identified.

I understand that the interviewer cannot offer me treatment and cannot intervene on my behalf with any authorities or therapists involved with me.

I understand that the purpose of this interview is for research and that I cannot expect any direct benefit to myself other than knowing that I have helped the researchers understand dissociative disorders better.

I agree to answer the interviewer's questions as well as I can but I know that I am free not to answer any particular questions I do not want to answer. I understand that I am free to terminate my participation at any time during the interview and withdraw from the study without any effect on my treatment or relationship with my therapist.

Although I have signed my name to this form, I know that it will be kept separate from my answers and that my answers cannot be connected to my name, except by the interviewer and her research colleagues. The forms will be coded, and Ms. Wassink will keep a separate master list with the names of the participants and the corresponding code numbers. All
forms will be retained for one year in a locked file in Ms. Wassink’s office after which time they will be destroyed.

If I have any questions or concerns about this study, I may contact either Ms. Wassink at (616) 327-4722 or Robert Betz, Ph.D. at (616) 387-5107. I may also contact the Chair of Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President for Research at (616) 387-8298 with any concerns that I have.

You may contact me at the following address and telephone number(s) in order to arrange and complete the telephone interview for the administration of the Dissociative Disorders Interview Schedule, Sections III, IV, VII, and VIII, and the Demographic Data Questionnaire.

My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

Signature: ___________________________ Date: ________________

Address: ________________________________________________

_________________________________________________________

Telephone number(s): _____________________________________
Appendix F

Authorization to Release Confidential Information
I hereby authorize my therapist ____________________________
Address: _______________________________________________
Telephone: ______________________________________________

to share information with: Mary L. Wassink, M.A.
257 Mandalay
Kalamazoo, MI 49009

re: (Name of participant) __________________________________
whose date of birth is:____________________________________

Specific information to be shared:
Psychiatric diagnoses currently active:
(List in DSM-III-R code if possible)
 a. _______________________________________________________
 b. _______________________________________________________ 
 c. _______________________________________________________

Psychiatric diagnoses currently in remission:
(List in DSM-III-R code if possible)
 a. _______________________________________________________ 
 b. _______________________________________________________ 
 c. _______________________________________________________ 

To be used for the following authorized purpose: To compile
statistical data for Mary L. Wassink’s dissertation project.
Information may be disclosed during the time period from
when the release form is signed to one year following.

This release is subject to revocation upon written
notification from the participant.

Participant Signature: _________________________________
Date: ________________________________________________

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Appendix G

Dissociative Experiences Scale (DES)
DIRECTIONS

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and mark the line with a vertical slash at the appropriate place, as shown in the example below.

Example:

\[0\% \quad \underline{\text{-------------------------/------------------}} \quad 100\%\]
1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

8. Some people are told that they sometimes do not recognize friends or family members. Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Mark the line to show what percentage of the time this happens to you.

0% |------------------------------------------------------| 100%
20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that this (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

25. Some people find evidence that they have done things that they do not remember doing. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Mark the line to show what percentage of the time this happens to you.

0% -----------------------------1 100%
10. Some people have the experience of being accused of lying when they do not think that they have lied. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%

19. Some people find that they sometimes are able to ignore pain. Mark the line to show what percentage of the time this happens to you.

0% |---------------------------------------------------------------| 100%
Appendix H

Participation in Study
Date:
To: Research participants
From: Mary L. Wassink, M.A., Doctoral Student Researcher
Re: Participation in Study

Thank you for volunteering to participate in my research study "Multiple Personality Disorder and Major Depression: A Comparative Study". I have received and scored the tests you have returned. The results have not met the criteria for the study so your participation is now concluded. I appreciate your willingness to assist me in this endeavor.

Sincerely,

Mary L. Wassink, M.A.
257 Mandalay
Kalamazoo, MI 49009
(616) 375-2657
Appendix I

Demographic Data Questionnaire
DEMOGRAPHIC DATA QUESTIONNAIRE

Name: ____________________________ Age: ______

Gender: ______ Gender preference: a. heterosexual__
 b. gay/lesbian__
 c. bisexual__

Current relationship status:
 a. single__
 b. married__
 c. partnered/co-habitating__
 d. partnered/non-cohabitating__
 e. separated__

Number of children: ______

d. Asian__ e. Other__________________________

Education: a. high school graduate: no__ yes__
 b. some college__
 c. college graduate__
 d. professional school graduate__

Current occupational status:
 a. student__
 b. unemployed__
 c. employed: part time__ full time__ retired__

Occupation: _______________________

Current economic status:
 a. no income__ b. under $10,000__
 c. $10,000 to $20,000__ d. $20,001 to $30,000__
 e. $30,001 to $40,000__ f. $40,001 to $50,000__
g. $50,001 to $60,000__ h. over $60,000__

Receive Federal or State financial aid? no__ yes__

Have you been in jail in the past? no__ yes__ unsure__

Physical diagnoses currently active:
 a. ____________________________
b. ____________________________
c. ____________________________
Appendix J

Human Subjects Institutional Review Board Approval
Date: July 8, 1994
To: Mary L. Wassink
From: Kevin Hollenbeck, Chair
Re: HSIRB Project Number 94-06-04

This letter will serve as confirmation that your research project entitled "Multiple personality disorder and major depression: A comparative study" has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: July 8, 1995

xc: Betz, CECP
Appendix K

Demographic Tables
Table 28
Gender Distribution of Participants by Diagnostic Category (N=37)

<table>
<thead>
<tr>
<th>Gender</th>
<th>MDD</th>
<th>Diagnosis MPD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>16</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
</tbody>
</table>

Table 29
Gender Preference by Diagnostic Category (N=37)

<table>
<thead>
<tr>
<th>Gender Preference</th>
<th>MDD</th>
<th>Diagnosis MPD</th>
<th>Total</th>
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<tbody>
<tr>
<td>Heterosexual</td>
<td>19</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Gay/Lesbian</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Undecided</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
</tbody>
</table>
### Table 30

Marital Status of Participants by Diagnostic Category (N=37)

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<thead>
<tr>
<th>Marital Status</th>
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<th>MPD</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Single</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Married</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Partnered/Cohabitating</td>
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<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Partnered/Noncohabitating</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
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</table>

### Table 31

Number of Children by Diagnostic Category (N=37)

<table>
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<tr>
<th>Number of Children</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
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<tbody>
<tr>
<td>None</td>
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<td>7</td>
<td>19</td>
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<td>One</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Two</td>
<td>2</td>
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<td>Five</td>
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<tr>
<td>Six</td>
<td>-</td>
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Table 32
Educational Level Attained by Participants by Diagnostic Category (N=37)

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<th>Educational Level</th>
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<tbody>
<tr>
<td>HS Graduate</td>
<td>14</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>College or above</td>
<td>6</td>
<td>5</td>
<td>11</td>
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<tr>
<td>Total</td>
<td>20</td>
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Table 33
Occupational Status of Participants by Diagnostic Category (N=37)

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<tr>
<th>Occupational Status</th>
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<tr>
<td>Unemployed</td>
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<td>Employed Full-Time</td>
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Table 34
Economic Status by Diagnostic Category

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<th>Income Level</th>
<th>MDD</th>
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<tr>
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<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
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</table>

Table 35
Participants' History of Incarceration by Diagnostic Category (N=37)

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<th>Incarceration History</th>
<th>MDD</th>
<th>MPD</th>
<th>Total</th>
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<tbody>
<tr>
<td>No</td>
<td>19</td>
<td>15</td>
<td>34</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
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<tr>
<td>Total</td>
<td>20</td>
<td>17</td>
<td>37</td>
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Appendix L

Psychiatric History Tables
Table 36
Participants’ Knowledge of a Previous Diagnosis by Diagnostic Category (N=34)

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<th>Knowledge of Previous Diagnosis</th>
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<th>Total</th>
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<td>Yes</td>
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<td>13</td>
<td>24</td>
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<tr>
<td>No</td>
<td>8</td>
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<td>Total</td>
<td>19</td>
<td>15</td>
<td>34</td>
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</table>
Table 37
Type of Previous Psychiatric Diagnosis by Diagnostic Category

<table>
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<tr>
<th>Previous Diagnosis</th>
<th>MDD</th>
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<td></td>
<td>MPD</td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>1</td>
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<tr>
<td>Total</td>
<td>20</td>
<td>16</td>
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<td>Mania</td>
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<tr>
<td>Yes</td>
<td>-</td>
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<td>Anxiety Disorder</td>
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<td>10</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
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<td>15</td>
<td>34</td>
</tr>
<tr>
<td>Other Disorder</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>1</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>14</td>
<td>32</td>
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</table>
Table 38
Treatment Effectiveness by Diagnostic Category (N=35)

<table>
<thead>
<tr>
<th>Did you receive ineffective psychiatric treatment?</th>
<th>MDD</th>
<th>Diagnosis</th>
<th>Total</th>
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<tr>
<td>Yes</td>
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<td>13</td>
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</tr>
<tr>
<td>No</td>
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<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>16</td>
<td>35</td>
</tr>
</tbody>
</table>
Appendix M

Childhood Abuse Tables
Table 39
Age of First Physical Abuse by Diagnostic Category (N=29)

<table>
<thead>
<tr>
<th>Age</th>
<th>MDD</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
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<td>3</td>
</tr>
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</tr>
<tr>
<td>3</td>
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</tr>
<tr>
<td>4</td>
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<td>7</td>
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<td>8</td>
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<td>1</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
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<td>10</td>
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<tr>
<td>15</td>
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</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>16</td>
</tr>
</tbody>
</table>
### Table 40

Age of Cessation of Physical Abuse by Diagnostic Category (N=29)

<table>
<thead>
<tr>
<th>Age</th>
<th>MDD</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
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<td>0</td>
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<tr>
<td>7</td>
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<td>0</td>
</tr>
<tr>
<td>8</td>
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<td>0</td>
</tr>
<tr>
<td>9</td>
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<tr>
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<tr>
<td>Total</td>
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<td>16</td>
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</tbody>
</table>

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Table 41
Perpetrators of Physical Abuse (in Order by Number of Participants Describing)

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Number of Participants Naming This Perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>22</td>
</tr>
<tr>
<td>Father</td>
<td>17</td>
</tr>
<tr>
<td>Other Male</td>
<td>13</td>
</tr>
<tr>
<td>Other Female</td>
<td>11</td>
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<tr>
<td>Sibling</td>
<td>9</td>
</tr>
<tr>
<td>Male Relative</td>
<td>7</td>
</tr>
<tr>
<td>Female Relative</td>
<td>5</td>
</tr>
<tr>
<td>Stepmother</td>
<td>2</td>
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</tbody>
</table>
Table 42
Perpetrators of Sexual Abuse (in Order by the Number of Participants Naming Each)

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Number of Participants Naming This Perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Male</td>
<td>16</td>
</tr>
<tr>
<td>Father</td>
<td>12</td>
</tr>
<tr>
<td>Other Female</td>
<td>10</td>
</tr>
<tr>
<td>Sibling</td>
<td>9</td>
</tr>
<tr>
<td>Mother</td>
<td>8</td>
</tr>
<tr>
<td>Male Relative</td>
<td>8</td>
</tr>
<tr>
<td>Stepfather</td>
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</tr>
<tr>
<td>Female Relative</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix N

Permission to Use the DES
October 27, 1995

Dear Ms. Wassink:

I am writing to give you my permission to reprint the Dissociative Experiences Scale in your dissertation appendix. University Microfilms also has my permission to reprint the DES as part of your dissertation. Best of luck in your work.

Sincerely,

Eve Bernstein Carlson, Ph.D.
Assistant Professor
BIBLIOGRAPHY


