

DISSOCIATIVE
EXPERIENCES AND
DISSOCIATIVE DISORDERS
IN A NON-CLINICAL
UNIVERSITY STUDENT
GROUP

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ABSTRACT

In a non-random sample of 415 students at the University of Idaho, the distribution of Dissociative Experience Scale (DES) scores was positively skewed with 9% of the sample scoring above 30 on the instrument. Dissociative Disorders Interview Schedule (DDIS) interviews were conducted with eighteen individuals who scored above 30 on the DES and a stratified random sample of nine people who scored less than 30. The interviewers were blind to the participants' DES scores. Of the eighteen people who were interviewed and scored above 30 on the DES, sixteen met the criteria for one of the dissociative disorders (89%), including four who met the criteria for multiple personality disorder (MPD). This suggests that those who score above 30 on the DES in a university sample may be at risk for one of the dissociative disorders. It further suggests that from 5% to 10% of groups similar to those sampled may be at risk for a dissociative disorder.

INTRODUCTION

The Dissociative Experiences Scale (DES) was developed in 1986 and was one of the first instruments that attempted to measure dissociative experiences (Bernstein & Putnam, 1986). The authors were testing the hypothesis that the number and frequency of experiences and symptoms attributable to dissociation lie along a continuum where normal individuals would have fewer and less frequent dissociative experiences than those with dissociative disorders or disorders with a significant dissociative component (i.e., post-traumatic stress disorder — PTSD). It was further hypothesized that individuals with non-dissociative psychiatric disorders would fall somewhere in between the two extremes. In the original study the DES was used with a clinical population who had previously diagnosed psychiatric disorders. This research found support for the original hypotheses and found that scores above 31 were indicative of a dissociative disorder in a clinical population.

Since the publication of the original DES study, other research focused on clinical populations has provided further support for the original hypotheses (Coons, Bowman, Pellow, & Schneider, 1989; Frischholz et al., 1990; Ross, Norton,

& Anderson, 1988). However, few efforts have examined the DES with non-clinical populations. Sanders, McRoberts, and Tollefson (1989) found a correlation between self reports of childhood trauma and DES scores in college students. Ross and his colleagues provided evidence that dissociative experiences diminish with age (Ross, Ryan, Anderson, Ross, & Hardy, 1989). A recently published article compared the incidence of dissociative disorders among high and low DES scorers in a college sample (Ross, Ryan, Voight, & Eide, 1991). In that study, the Dissociative Disorders Interview Schedule (DDIS) was used to determine whether the individual met the criteria for one of the DSM-III dissociative disorders (American Psychiatric Association, 1980). High and low scorers were clearly differentiated on the DDIS with 70% of the high scorers (DES scores above 20) meeting the criteria for one of the dissociative disorders and none of the low scorers (DES scores below 5) meeting the criteria. The study also suggests a prevalence of dissociative disorders at 11% among college students.

This current paper finds added support for the contention that DES scores above 30 in a non-clinical university population are suggestive of a dissociative disorder and thus at least 5% to 10% of a non-clinical population may be at risk for one of the dissociative disorders.

METHOD

Subjects

Approval for the project was obtained from the University Institutional Review Board of the University of Idaho. The subjects were a selected sample of 415 undergraduate students at the University of Idaho. Although this was not a random sample, efforts were made to obtain as wide a cross-section of the student body as possible. There were six different sources for completed DES forms used for the study. They were: drawing classes in the College of Art and Architecture (92 subjects, 4 different classes), basic engineering classes in the College of Engineering (114 subjects, 4 different classes), a child development class in the Home Economics school in the College of Agriculture (64 subjects), a cognitive psychology class in the College of Arts and Letters (42 subjects), clients using the Student Counseling Service at the University of Idaho (71 subjects), and users of the Student Health Service (32 subjects). Students gave written informed consent at the time of administration of the DES and also indicated if they were willing to participate in a personal interview.

From the pool of 415 students there were 37 people who

scored above 30 on the DES, of whom 27 agreed to a personal interview using the DDIS (73%). Of those, 20 people could be contacted and interviewed. Two of those interviews were later discarded as invalid. Of the remaining 378 people who completed the DES and scored below 30, 185 people agreed to a personal interview (49%). From those 185 people, a stratified random sample of 20 people, broken into categories of scoring, was selected for a personal interview using the DDIS. Nine DDIS interviews were completed with this group.

Measures

In the first phase of the study, 415 students completed the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1989). The DES describes a variety of dissociative experiences and asks the respondent to indicate the extent to which he/she has that experience, from 0% to 100% of the time (Bernstein & Putnam, 1986). The DES score is the mean score for the 28 questions. Thus, it attempts to measure the level of dissociative experiences. Reliability testing in the original study showed that the scale had good test-retest reliability (.84), and strong split-half reliability. Reliability coefficients of the items ranged from .19 to .75 with 25 of the 28 items yielding coefficients reaching a significance level of $p < .05$. The median correlation coefficient was .60. Discriminant validity was investigated using the Spearman rank-order correlation to ensure that the scale scores could not be accounted for by theoretically unrelated variables.

One replication study of the DES found an inter-scoring reliability of .96 (four raters independently scored the same 20 protocols), a test-retest reliability of .93 and an internal consistency of .95 (Frischholz et al., 1990).

Most of the studies to date have examined the DES scores of established clinical populations in comparison to other clinical and/or non-clinical groups. In those clinical groups, high scores on the DES are correlated with dissociative pathology. Ross, Norton, and Anderson (1988) maintain that scores above 30 are almost always associated with *DSM-III-R* diagnosis of MPD or PTSD while scores over 50 are rarely achieved in persons without MPD. Putnam (1991) reports on a multi-center study of 1300 patients by Carlson et al. that demonstrated a blind hit-rate of 89% correct classification of MPD versus non-MPD subjects by using a cutting score of 30 on the DES.

In this current study two additional questions were added to the DES form which asked whether the participant had ever used counseling services for personal and family problems and if he/she had used the Student Health Service more than once in the previous six months. These questions were designed to see the connections between DES scores and use of counseling and/or health services.

In the second phase, twenty-nine individuals participated in personal interviews using the Dissociative Disorders Interview Schedule (DDIS) (Ross, Heber et al., 1989). The DDIS is the first of the diagnostic interviews to be developed and the one most widely used to date. It is a structured interview designed to make diagnoses of the dissociative disor-

ders, somatization disorder, major depressive disorder, and borderline personality disorder. There are sixteen sections and 131 questions. The *DSM-III* criteria for the above-mentioned disorders are incorporated into the instrument (American Psychiatric Association, 1980). Questions also include information about substance abuse, childhood physical and sexual abuse, Schneiderian first-rank symptoms, extrasensory experiences, and secondary features of multiple personality. The instrument is highly structured to reduce concerns about demand characteristics of the interviewer. In the original study, the DDIS was administered to eighty psychiatric patients, twenty MPD, twenty schizophrenic, twenty panic disorder, and twenty eating disorder patients (Ross, Heber et al., 1989). The results found an inter-rater reliability of .68 (Ross, Heber et al., 1989). The authors state that the DDIS has excellent validity with a specificity of 100% and sensitivity of 90% for the diagnosis of MPD. The "specificity" relates to the fact that none of the patients in the categories other than MPD met the criteria for MPD. The "sensitivity" refers to the fact that two of the twenty MPD patients did not meet the criteria for MPD.

The DDIS can be administered in forty-five to sixty minutes and is designed to be used by a variety of mental health professionals. Questions are read verbatim from the protocol.

MPD can be differentiated from other psychiatric disorders on a large number of interview items found on the DDIS. Most patients with MPD have numerous somatic and Schneiderian symptoms, borderline criteria symptoms, extrasensory experiences, and depression. Additionally, most report numerous secondary features of MPD. Secondary features include such things as: experiencing another person inside oneself, hearing internal voices, amnesia for childhood, and referring to the self as "we" or "us."

Each of the twenty-nine DDIS participants also was offered an opportunity to meet privately with the researcher for a debriefing interview. The individuals' responses to the DES and DDIS were discussed and reviewed and the participant was provided with information concerning dissociation and dissociative disorders. The primary purpose of the debriefing was to provide closure for the participant in this process. The depth and sensitive nature of the questions were potentially unsettling for participants and thus the debriefing was seen as an important part of the process. Since the focus was on closure, additional exploration of the individual's experience was not sought, except to the extent that the individual chose to share more information about his/her experience. However, it did provide the researcher with an opportunity to observe and discuss the participant's dissociative experiences.

Procedure

In the classroom settings, the DES was explained briefly by the researcher and administered during class time along with the informed consent and a separate agreement for a later, personal interview, if the participant would be willing. If students were willing to participate in a personal interview, they so indicated and provided contact information.

In the case of the counseling center and health center participants, a sign explaining the request and assuring confidentiality was left along with the DES forms and informed consent where students would see them.

In the second phase the DDIS was administered by four graduate students in the Counseling program at the University of Idaho (three men and one woman). They were blind to the DES scores of the subjects. The interviewers were trained by the researcher on current concepts of dissociation and

the administration of the DDIS. The consent form offered by the DDIS developers was used. Since the DDIS is read verbatim, the primary concern was that the questions were being read in a uniform manner and the interviewers did not deviate from the interview protocol. To provide this assurance, besides the training received, the researcher observed each of the interviewers at least once and each interviewer observed another interviewer through a one-way mirror.

If a respondent answered yes to the applicable criteria, that person was deemed to have met the criteria for that disorder. In the case of a diagnosis of atypical dissociative disorder or dissociative disorder not otherwise specified (DDNOS), there are no clearly articulated criteria, only that the individual have a disorder in which the prominent feature is a dissociative symptom that does not meet the criteria for another dissociative disorder. The interviewers met weekly to review the DDIS protocols, to discuss all of the interviews, and to reach consensus on the diagnosis. As an added follow-up to those potential DDNOS cases, the completed DDIS forms where the diagnosis was questionable were sent to Dr. Colin Ross, the developer of the DDIS, for his evaluation.

Following the administration of the DDIS, participants were given the opportunity to meet with the researcher to discuss dissociation and their individual responses to the DDIS. Only one person, a low scorer, did not participate in this review process.

RESULTS

Distribution of DES Scores

As shown in Figure 1, the distribution of DES scores was positively skewed, with thirty-seven people (8.9%) scoring above 30. Because of the skew of the distribution, the median score is more representative of central tendency than is the mean score. However, in order to use the more robust parametric measures, mean scores were used. The fact that

FIGURE 1
Histogram of DES Scores

Count	Midpoint	
47	2.04	I*****
54	5.02	I*****
54	8.04	I*****
56	11.04	I*****
49	14.04	I*****
38	17.04	I*****
24	20.04	I*****
20	23.04	I*****
24	26.04	I*****
15	29.04	I*****
6	32.04	I*****
8	35.04	I*****
7	38.04	I*****
4	41.04	I*****
4	44.04	I*****
0	47.04	I*****
1	50.05	I*****
1	53.04	I*****
1	56.04	I*****
0	59.04	I*****
1	62.04	I*****
1	65.00	I*****

NOTE: One symbol = approximately 1.20 occurrences.
: = normal curve distribution

HISTOGRAM DESCRIPTIVE DATA:

MEAN	14.693	MEDIAN	12.321	MODE	7.321
STD DEV	10.765	VARIANCE	115.892		
RANGE	64.464	MINIMUM	.536	MAXIMUM	65.000
VALID CASES	415				
MISSING CASES	0				

all subgroups demonstrated the same skew and the sizes of the subgroups were fairly consistent (with one exception), supports the use of mean scores and parametric statistics. Some subgroups were combined to provide equality of subgroup size and for assumptions of homogeneity to be met. Additionally, the developers of the DES currently support the use of parametric statistics (Frischholz et al., 1990).

The mean DES score for the sample was 14.7 ($SD = 10.8$) and the mean age was 23.7 ($SD = 6.7$) years. (The median DES score was 12.32.) There were no differences in scoring outcomes between men and women. Both sexes averaged 14.7 on the DES. Men represented 49% of the sample. The average age for women in the study ($M = 24.6$) is almost two years older than for the men ($M = 22.7$), $t(410) = 2.88$, $p = .004$, two-tailed. Even factoring out an older, predominantly female sample from the Counseling Center and Student Health Service, the average age of women in the balance of the sample ($M = 23.4$) is 1.5 years older than the average of the males ($M = 21.9$), $t(308) = 2.24$, $p = .026$, two-tailed.

A question posed to all respondents was if they had ever used counseling for personal or family problems. A chi-square calculation revealed a significant difference between men and women in response to this question, $\chi^2(1, N = 412) = 31.4$, $p < .0001$. Only 30% of men in the sample have used counseling while 57% of the female participants have had counseling for personal or family problems.

All participants were also asked if they had used the Student Health Service more than once in the previous six months. The question was designed to identify more regular users of the health service. Women were significantly more likely to

have used those services, $\chi^2(1, N = 411) = 14.27$, $p < .0002$. Almost 43% of the women responded positively to this question whereas only 25% of the males said yes.

There were no significant differences on any demographic parameters, between those who scored above 30 on the DES and the balance of the sample. Significance was set at .05.

DDIS Diagnostic Categories

Of the eighteen valid DDIS interviews with those scoring over 30 on the DES, sixteen met the criteria for one of the dissociative disorders. Dr. Colin Ross, developer of the DDIS, independently reviewed eight of the completed DDIS interviews where the diagnosis was potentially questionable. He was blind to the DES scores and the interviewers' diagnoses. He agreed with the interviewers in all cases except one where he felt there was not sufficient dissociation to support a diagnosis of DDNOS.

Of the remaining nine participants in the lower scoring categories, two subjects who scored over 25 on the DES were found to meet the criteria for a dissociative disorder. None of the participants who scored below 25 on the DES met the criteria for a dissociative disorder.

Of those found positive for a dissociative disorder, ten people were positive for psychogenic amnesia with one "unsure," five were positive for DDNOS (four by Dr. Ross), four met the criteria for depersonalization disorder with one "unsure," and four met the criteria for MPD along with three people who were "unsure." An "unsure" categorization was made if the person responded "unsure" to any of the criteria required for the diagnosis. There were no subjects who

TABLE 1
Correlation Coefficients: DES Scores Paired with Dissociative Symptoms

Score Paired With:	Pearson Coefficient	r^2	Significance
MPD Symptoms	.599	.359	.001**
BPD Symptoms	.527	.278	.005**
2nd Symptoms of MPD	.519	.269	.006**
Depression Symptoms	.499	.249	.008**
Depersonalization Symptoms	.489	.239	.010**
Somatic Symptoms	.421	.177	.029*
Schneiderian Symptoms	.309	.095	.117
Number of Therapists	.263	.069	.185
Types of Self-Injury	.201	.040	.316
ESP Experiences	.087	.008	.665
Substance Abuse	.045	.002	.822

NOTE: $N = 27$

* $p < .05$ ** $p < .01$

met the criteria for psychogenic fugue.

DES Score and DDIS Symptom Clusters

The DDIS asks information about the number of symptoms that an individual experiences relative to specific disorders and experiences that are related to dissociation (Ross, Heber et al., 1989). For example, the individual is asked about the symptoms of major depression, somatization disorder, and borderline personality features. Additionally, the person is asked about substance abuse, self-injury, secondary symptoms of MPD, extrasensory experiences, Schneiderian first-rank symptoms, and number of therapists they have seen. In order to explore the conceptualization of dissociation being on a continuum and to see the relationship of associated symptoms to DES score, correlation coefficients were calculated between DES score and the number of symptoms in each of the categories just described. The symptoms of MPD and depersonalization disorder from the DDIS were added because they both offered a number of symptoms to which the person could subscribe. As observed in Table 1, all the correlations are positive and six of them reach significance at the .05 level.

DISCUSSION

There were two primary research questions that were the focus of this study. The first addressed the distribution of DES scores in a non-clinical population. The positively skewed distribution of scores follows a pattern consistent with other studies which have replicated the original DES study in non-clinical populations (Ross, Ryan, Anderson, Ross, & Hardy, 1989; Sanders et al., 1989). A score of 30 or above was taken to suggest extensive dissociation since this level of score is indicative of dissociative disorders in clinical groups (Bernstein & Putnam, 1986).

In fact, 8.9% of the sampled group of 415 students scored above 30 on the DES protocol. This is consistent with Ross, Joshi, and Currie's (1990) general population study ($N = 1,055$) which reported a positively skewed distribution with 5% of the population scoring above 30 on the DES. These results also support those of Sanders et al. (1989) who likewise found a positively skewed distribution in a sample of 309 college undergraduates. In that study, eight percent of the sample scored above 31.25, the median score for PTSD in Bernstein and Putnam's original study (1986). Frischholz and colleagues (1990) found a mean score of 20 in a college population, and although they did not report the distribution, the mean score does suggest a percentage of high scorers.

The second and more difficult question posed by this study was whether those high-scoring individuals on the DES also qualified as having one of the dissociative disorders. This is a question not so easily answered in a non-clinical population. If the question is whether most of the high scorers met the criteria for one of the dissociative disorders, clearly the answer is yes. Most of the individuals who scored above 30 on the DES and who were interviewed met the criteria for one of the dissociative disorders, including four positive for

MPD. A person was deemed to have met the criteria for a dissociative disorder if he/she responded positively to the required criteria as specified in *DSM-III* (American Psychiatric Association, 1980).

These figures find support for Ross, Ryan, Voight, and Eide's (1992) findings of dissociative disorders in a college population.

A recent study by Sandberg and Lynn (1992) found only a small percentage of the DES high-scoring population meeting the criteria for one of the dissociative disorders. However, their high-scoring population included individuals who scored above 20 on the DES. This study and studies in clinical settings have suggested that 30 is an appropriate cutting score. More importantly, the researchers used less than half of the over 130 questions which constitute the DDIS to make their diagnostic decisions.

The most ambitious study using the DES and DDIS in the general population has used a three-stage, stratified random sample of 1055 adults in the city of Winnipeg, Canada (Ross, Joshi, & Currie, 1990). The first phase of the study looked at the DES scores of the respondents. The second stage has been to follow up with DDIS interviews on the sample group. To date, 442 of those interviews have been conducted (Ross, 1991). The DDIS found 11.2% with one or more dissociative disorders and 3.1% with MPD. These interviews were conducted by individuals without experience with MPD and blind to the results of the first phase. There was no follow-up by trained clinicians with those deemed positive to determine the validity of those diagnoses. In reviewing the MPD-positive interviews, Ross found eight of the fourteen MPD cases identified in the general population to be very different from clinical MPD patients. They had low DES scores and no history of abuse. He raised several possible explanations: the *DSM-III-R* criteria are not applicable to non-clinical groups, MPD exists in a non-pathologic endogenous form, the DDIS is not valid with non-clinical groups, or that entry into the mental health system exacerbates MPD symptoms. He recommends additional interviews with those deemed positive to better determine which explanation(s) is (are) valid.

Because simply meeting the criteria for a dissociative disorder could be called into question in a non-clinical population, it is important to consider both the process used in this study and to examine other determinants of emotional disorder. The DDIS is highly structured and each question is read verbatim to the participant. A person is deemed as having met the criteria for a dissociative disorder if he/she responds positively to the specific criteria from the *DSM-III*. In the case of psychogenic amnesia for example, if the person acknowledges the sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness and it is not due to MPD or to an organic mental disorder, he/she meets the criteria for that disorder. In this study, although the person who responded positively was said to have met the criteria, the graduate students met weekly as a group to review the entire DDIS of each individual to see what other of the characteristics associated with dissociative disorders the individual possessed.

Although there was no attempt to change a diagnosis, the interviewers were interested in whether there appeared to be consistency in the responses. In all cases, the interviewers felt that individuals who met the criteria also subscribed to a number of other related symptoms that supported the diagnosis. All of those who met the criteria for a dissociative disorder also had DES scores of at least 25. Additionally, results of the DES score and symptom clusters confirm significant correlations not only between DES score and clearly dissociative symptoms such as depersonalization symptoms and primary and secondary symptoms of MPD, but also between DES scores and symptoms of depression and somatization disorder. In fact, fifteen of twenty-one people who scored over 25 on the DES met the criteria for major depression.

Likewise, other studies have found significant correlations between DES scores and other pathology. Sandberg and Lynn (1992) found significantly more maltreatment, maladjustment, and pathology among the high DES scorers compared to the low scorers. This is consistent with a study by Norton, Ross, and Novotny (1990) which found significant correlations between a large number of measures of pathology and DES scores. They add that only a few, logically linked variables contribute significantly to the prediction of DES scores which suggests that the DES is measuring a distinctive phenomena.

Another determinant of emotional distress is entry into the mental health system. Of the nine people who scored below 30 on the DES, five had had limited counseling (family therapy or briefly seeing a counselor for one or two sessions), and four had received no counseling.

Of the eighteen people interviewed who scored above 30 on the DES, five people had received no counseling. All five admitted to recurrent thoughts of death or suicide, with two acknowledging self-harm. Two were positive for MPD and two were positive for DDNOS. Dr. Ross suspected MPD in both of those instances. The other individual was positive for psychogenic amnesia.

The three high scorers who did not meet the criteria for a dissociative disorder (including the one person that Dr. Ross had deemed insufficiently dissociative) all had received limited counseling and no medications.

Of the remaining ten people who scored above 30 on the DES, all had received counseling by at least one counselor, with six people seeing four or more different therapists. Nine of the ten had received medications; seven had received anti-depressants; six had received anti-anxiety medication, and three had received lithium. Thus more than half of the high scorers had received extensive therapy including medication. Some had used or were using the services of the Student Counseling Center. There is no evidence that any had previously been diagnosed with a dissociative disorder.

Of the eighteen high scorers, thirteen admitted to recurrent thoughts of death or suicide, and nine acknowledged self-harm: four by mutilation, four by overdose, and one by using a weapon.

Another determinant of emotional disorder was through what the participants themselves felt about their experiences.

The debriefing session provided an opportunity for the participants to discuss dissociation generally and their own individual responses to the DES and the DDIS. Essentially, all of the high scorers acknowledged high levels of dissociative experiences but some felt they were able to function better than others. Some were less distressed by their symptoms; some did not feel that they had a disorder despite having significant identity and memory difficulties; others were currently in no apparent crisis, and still others had developed elaborate compensations for their memory difficulties, such as datebooks, calendars, and reminders written in several places. The fact that all were in college and presumably functioning adequately supports the contention that they had learned to accommodate their symptoms to the extent that they were able to lead outwardly normal lives. It must be remembered, however, that most of these participants were quite young and perhaps had not developed a more established array of symptoms. Also, most were not in crisis situations. Thus, from the outside, although some may not have appeared to be deeply troubled, their inner experience, as reflected by their answers to the DDIS, qualified most of them as having a dissociative disorder. Each participant was explained the symptoms and presumed etiology of dissociation and how it was often exhibited in behavior. Many seemed relieved to have an explanation of their experience. They were told that the main criterion for an emotional disorder was the extent to which the symptoms interfered with and/or controlled behavior. If the person met the criteria for one of the dissociative disorders, he/she was told that he/she was at risk and the decision for help in dealing with the symptoms was with the individual. However, counseling was recommended to all high scorers. A list of resources was provided, and if the person was already in counseling it was suggested that he/she discuss the results of the DES and DDIS with the counselor.

The results of this study present a compelling argument that those individuals who scored above 30 on the DES, who met the criteria for a dissociative disorder, and who have experienced counseling including medication, do, in fact, have a dissociative disorder. The correlations with dissociative symptoms supports this contention. A question might be raised about those individuals who scored above 30 on the DES, who met the criteria for a dissociative disorder, who exhibited other dissociative symptoms but who had received limited or no counseling. One could argue that these individuals have not sought counseling because they have experienced no emotional difficulties, hence could hardly qualify for an emotional disorder. This is somewhat paradoxical. It actually appeared that those who had had some therapy or who had developed other ways, like artistic expression, to express their trauma, often had developed skills in dealing with their dissociative difficulties. Those with no counseling experience were among the most disturbed, as evidenced by the diagnoses.

A final question posits why women are more likely to be diagnosed with a dissociative disorder when DES scores between men and women are virtually the same. Thus, a potentially important finding of this study is that men appear to use

counseling and health services to a lesser degree than do women. This suggests that men may use other means to deal with their dissociative experiences. The identity and memory problems created by extensive dissociation can be terribly isolating. There may be reluctance to become too intimate with others for fear of exposure or betrayal. Anger may be dissociated and consequently may remain quite concentrated in one part of the personality system. The process of reaching out may protect women from some of the isolating factors and provide them with skills to deal with their symptoms. For men, this sense of alienation can be dangerous, particularly in combination with dissociated anger. It may be why it is suggested that men with dissociative disorders are found more readily in the criminal justice system than in the mental health system (Kluft, 1988). On a more positive note, those people who scored above 30 on the DES evidenced a much greater willingness to come in for a personal interview to discuss those experiences than did those in the lower scoring groups (73% compared to 49%). This includes both men and women. It appears that appropriate outreach may be effective with high dissociators.

In conclusion, this study provides further support for the supposition that dissociative disorders are fairly common and may affect 5% to 10% of the population. As much as one percent of the population may be at risk for MPD. Finally, it begins to suggest why men are diagnosed with dissociative disorders less frequently than are women. ■

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