

DISSOCIATIVE DISORDER  
NOT OTHERWISE SPECIFIED:  
A CLINICAL INVESTIGATION  
OF 50 CASES WITH  
SUGGESTIONS FOR  
TYPOLOGY AND TREATMENT

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#### ABSTRACT

*Although the DSM-III-R lists six examples of subcategories of dissociative disorder not otherwise specified (DDNOS), the literature contains little about DDNOS proper, and only one subcategory, Ganser syndrome, has been studied in any depth, all studies having been completed before its inclusion under DDNOS in 1987. This is a comprehensive study of 50 individuals with DDNOS. Data from clinical history, mental status examination, collateral interviews, neurological examination, electroencephalogram (EEG), intelligence testing Minnesota Multiphasic Personality Inventory (MMPI), and the Dissociative Experience Scale (DES), were analyzed on 50 consecutive individuals diagnosed with DDNOS by DSM-III-R criteria. The data suggest a number of different diagnostic subcategories including childhood dissociative disorder, ego-state disorder, dissociative psychosis, nocturnal dissociative disorder, gender identity disorder (dissociative type), and a truly not otherwise specified type. Each of these subcategories will be described including case vignettes and supporting data from previous studies and papers. Nosological issues are discussed as well as treatment implications.*

#### INTRODUCTION

With the exception of the Ganser syndrome, the literature contains little about dissociative disorder not otherwise specified (DDNOS). Two major psychiatric texts contain but two pages each on DDNOS (Kluft, 1988; Nemiah, 1989) and a recent and otherwise excellent, comprehensive review of dissociative disorders excludes DDNOS almost entirely (Spiegel, 1991). The most comprehensive discussion of DDNOS to date (Horton, 1989) describes treatment but little about the various subcategories of DDNOS beyond what is contained in the *DSM-III-R*.

The term "DDNOS" was not introduced until the pub-

lication of the *DSM-III-R* in 1987 (American Psychiatric Association, p.277). Prior to 1987, miscellaneous forms of dissociative disorder were labeled "atypical dissociative disorder" (American Psychiatric Association, 1980). However, from 1980 to 1987 there was only one paper on atypical dissociative disorder which focused narrowly on extremist religious cult involvement (Galper, 1983). Subsequent to the publication of *DSM-III-R*, there was one paper on DDNOS variants of MPD in practicing psychotherapists (Kluft, 1990b). The most comprehensive discussion of how Watkins and Watkins' ego-state disorder should be classified as DDNOS and how this **MPD** variant resembles MPD is contained in Bloch's excellent monograph on MPD (1991).

#### DEFINITION AND EXAMPLES OF DISSOCIATIVE DISORDER NOT OTHERWISE SPECIFIED.

The *DSM-III-R* (American Psychiatric Association, 1987, p.277) defines DDNOS as including "disorders in which the predominant feature is a dissociative symptom (i.e., a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness) that does not meet the criteria for a specific dissociative disorder." The *DSM-III-R* provides the following six examples of DDNOS:

- (1) Ganser's syndrome: the giving of "approximate answers" to questions, commonly associated with other symptoms such as amnesia, disorientation, perceptual disturbances, fugue, and conversion symptoms.
- (2) cases in which there is more than one personality state capable of assuming executive control of the individual, but not more than one personality state is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete executive control.
- (3) trance states, i.e., altered states of consciousness with markedly diminished or selectively focused responsiveness to environmental stimuli. In children this may occur following abuse or trauma.
- (4) derealization unaccompanied by depersonalization.
- (5) dissociative states that may occur in people who

have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while the captive of terrorists or cultists).

- (6) cases in which sudden, unexpected travel and organized, purposeful behavior with inability to recall one's past are not accompanied by the assumption of a new identity, partial or complete. (p. 277)

#### **Ganser Syndrome**

The Ganser syndrome is a well-known, but little understood, disorder which used to be classified with the factitious disorders (American Psychiatric Association, 1980). Since a number of good reviews are available, it will not be described in detail here (Goldin & McDonald, 1955; Whitlock, 1967; Cocores, Santa, & Patel, 1984. Based upon a single review of 41 previous case reports and two new cases, Cocores and his colleagues (1984) suggested that this syndrome should be reclassified as an atypical dissociative disorder because of the occurrence of symptoms of amnesia (93%), dissociation (56%), hallucinations (51%), fugue (33%), and conversion (33%). An almost pathognomonic feature of this syndrome is "vorbeireden" or the giving of approximate answers to simple questions about knowledge or calculations. Ganser (1898) initially described this syndrome in prisoners. Since that time the Ganser syndrome has been variously described as a hysterical disorder, malingering, factitious disorder, psychosis, organic brain disorder, or dissociative disorder. Although this syndrome may develop among prisoners, where the possibility of malingering is increased, it also occurs in clinical populations where criminal and civil involvement is absent in 58% (Epstein, 1991).

#### *Ego-State Disorder*

Variants of MPD, where personality states are indistinct or do not assume complete executive control were originally called ego-state disorders by Watkins and Watkins (1979). Bloch (1991) has recently described these cases in more detail. There is less amnesia and less identity disturbance than in MPD and spontaneous switching behaviors are usually not seen. The "host" usually experiences the other ego states as parts of herself rather than completely separate persons.

These MPD variants are now classified under DDNOS. With the addition of amnesia as a criterion for MPD in the *DSM-IV* (American Psychiatric Association, 1991), additional cases that once were labeled MPD will be classified in this category.

#### **Trance States**

This category of miscellaneous trance states includes such states in children which follow physical abuse or trauma. Currently this is the only category into which children can be classified when they have a severe dissociative disorder which falls short of adult MPD. Because the evidence is pervasive and overwhelming that this form of childhood dissociative exists, but often in attenuated forms (Fagan & McMahan, 1984; Kluft, 1990a; Lewis, 1991; Peterson, 1990; Putnam, 1991; Spiegel, 1984; Vincent & Pickering, 1988).

Petersen (1991) has proposed the term "dissociation identity disorder" for this group of youngsters.

#### **Derealization Unaccompanied by Depersonalization**

Derealization is defined as "a strange alteration in the perception of one's surroundings so that a sense of the reality of the external world is lost. Alterations in the size and shape of objects in the external world are commonly perceived. People may seem dead or mechanical" (American Psychiatric Association, p. 276). Derealization commonly accompanies depersonalization disorder, panic disorder with and without agoraphobia, and multiple personality disorder and its variants. What is unclear at present is if derealization can occur unaccompanied by depersonalization. Although the literature contains nearly 150 references to derealization, depersonalization, and depersonalization disorder (Goettman, Greaves, & Coons, 1991, 1992), only nine of these mention derealization. Of these nine references only two suggest that derealization can occur alone (Rosen, 1955; Krizek, 1989) and careful reading of these two case reports reveals that symptoms of derealization and depersonalization occurred together in both patients. This area obviously requires further study.

#### **Dissociated States Occurring After Coercive Persuasion**

Although there is a small but rich literature which describes the occurrence of dissociative symptoms in those who have undergone brainwashing or indoctrination while held captive by the military, terrorists, or cultists (Brende & Benedict, 1980; Galper, 1983; Jaffe, 1968; Morse & Morse, 1987), this was not recognized officially until the publication of the *DSM-III-R* in 1987, when this example was added to DDNOS and there was corresponding recognition that persons with posttraumatic stress disorder (PTSD) could also experience dissociative symptoms. This type of DDNOS generally occurs in association with PTSD. Most commonly dreamlike or trancelike states occur in association with posttraumatic flashbacks, depersonalization, derealization, perplexity, confusion, depression, somatization, or occasionally complex hallucinations.

#### **Fugue Without Assumption of a Partial or Complete New Identity**

Although this type of fugue is currently classified under DDNOS, it is clear from a historical review that the classical fugue only rarely resulted in the formation of a new identity (Loewenstein, 1991). New identity formation generally only occurs when the fugue is prolonged. In the *DSM-IV* this example will be deleted from DDNOS and the absolute requirement for new identity formation under psychogenic fugue will also be deleted (American Psychiatric Association, 1991).

#### **Other DDNOS**

A method of signifying diagnostic uncertainty is by listing a diagnostic class and following it with the designation "NOS." For example, the DDNOS classification is commonly used by clinicians who think an individual has MPD but are not positive because they have not actually witnessed switching among personality states. This classification is also used for patients who present a variety of dissociative symp-

toms, but who fail to meet the diagnostic criteria for the other major dissociative disorders.

### **OTHER ATYPICAL DISSOCIATIVE STATES NOT LISTED IN THE DSM-III-R**

#### *Nocturnal Dissociative Disorder*

Schenck, Milner, and Hurwitz (1989) presented a series of eight cases of dissociative disorder presenting with night-time aggressive behavior. Although two of these patients had MPD, the other 7 were classified as DDNOS, one of which was labeled "nocturnal dissociative disorder." This newly discovered disorder should probably be listed in the Sleep Disorders section of the *DSM-IV*, or if not there, under DDNOS.

#### *Secondary Dissociative Disorder Due to a Nonpsychiatric Medical Condition*

This new diagnostic category will appear in *ICD-10* and has been proposed for *DSM-IV* (American Psychiatric Association, 1991). This category was proposed because of a number of studies which show an increased prevalence of dissociative symptoms (fugue, depersonalization, derealization, and occasionally identity alteration), in persons with complex partial seizures (Bensen, Miller, & Signer, 1986; Drake, 1986; Mesulam, 1981; Schenk & Bear, 1981). In order to diagnose this condition, the dissociative symptoms must cause "significant impairment in social or occupational functioning, or cause marked distress" (American Psychiatric Association, 1991, p. K4).

#### *Dissociative and Trance Phenomena Caused by Culture-Bound Syndromes*

This newly proposed DDNOS category consists of a diverse group of culture bound disorders, a predominant feature of which involves "a disturbance in the normally integrative functions of memory, identity, or consciousness" (American Psychiatric Association, 1991). Such disorders include amok, bebainan, benzi mazarazura, guria, kupenga, and kwelit-sko. Space prevents their description here, but excellent references are available (Lebra, 1976; Simons & Hughes, 1985).

#### *Trance and Possession Disorder*

This newly proposed dissociative disorder is distinct from trance and possession states which are common components of religious and nonreligious rituals and ceremonies throughout the world (American Psychiatric Association, 1991). Evidence for such a diagnosis is overwhelming (Adityanji, Raju, & Khandelwal, 1989; Bourguignon, 1989; Coons, Bowman, Kluff, & Milstein, 1991; Goodman, 1988; Krippner, 1986; Richeport, 1991; Varma, Bouri, & Wig, 1981) and it can be clearly differentiated from ritual possession trance (Crapanzano & Garrison, 1977; Prince, 1966; Sargant, 1974; Ward, 1980). In fact, most dissociative disorders diagnosed in nonindustrialized nations would probably be diagnosed as DDNOS.

Proposed diagnostic criteria for trance and possession disorder include the following:

#### A. Either (1) or (2)

1. Trance, i.e., temporary alteration in the state of consciousness, as evidenced by two of the following:
  - a. loss of customary sense of personal identity
  - b. narrowing of awareness of immediate surroundings, or usually narrow and selective focusing on environmental stimuli
  - c. stereotyped behaviors or movements that are experienced as being beyond one's control
2. Possession, i.e., conviction that the individual has been taken over by a spirit, power, deity, or other person.

**B.** The trance or possession state is not authorized as a normal part of a collective cultural or religious practice.

**C.** The trance or possession state causes significant impairment in social or occupational functioning, or causes marked distress.

**D.** Not occurring exclusively during the course of a psychotic disorder. . . or Multiple Personality Disorder, and is not due to a Substance-Induced Disorder... or a Secondary Dissociative Disorder. (American Psychiatric Association, 1991, p. K3)

#### *Berserker/Blind Rage Syndrome*

In 1987 Simon proposed this diagnostic category for the *DSM-III*. It is characterized by, "(a) violent over reaction to physical, verbal, or visual insult, (b) amnesia during the actual period of violence, (c) abnormally great strength, (d) specifically target-oriented violence" (Simon, 1987). Currently these cases would be diagnosed as intermittent explosive disorder. In my clinical experience, the three individuals that I have diagnosed with intermittent explosive disorder experienced either partial or full amnesia at the height of their rage. This area deserves further study.

#### *Dissociation Associated with Gender Identity Disorder*

Occasionally individuals with gender identity disorder experience dissociation. A few individuals with transsexualism develop very distinct male and female personality states with different names, dress, mannerisms, etc. This transformation is distinct from the roleplaying behavior that most transsexuals engage in prior to undergoing surgical transformation (Money & Primrose, 1968; Money, 1974). Amnesia was not present in these case reports. Such cases could be diagnosed as DDNOS in addition to transsexualism or as a dissociative variant of gender identity disorder.

### *Dissociative Psychosis*

Both Gruenewald (1978) and Steingard and Frankel (1985) have published case reports in which psychotic and dissociative symptoms occur together. Using current nomenclature, most of these would be diagnosed as psychosis NOS and DDNOS.

## **SUBJECTS AND METHODS**

### *Subjects*

The subjects were the first 50 consecutive patients diagnosed with DDNOS upon presentation to a dissociative disorders clinic for treatment or consultation. All patients who were administered experimental assessment instruments gave their voluntary informed consent.

### *Methods*

DDNOS and its various subtypes were strictly defined by DSM-III-R criteria (American Psychiatric Association, 1987). Where criteria did not exist for other subtypes suggested by this study, previous literature was used as a guide.

As in previous studies of MPD and psychogenic amnesia (Coons, Bowman, & Milstein, 1988; Coons & Milstein, 1992), patients were assessed on intake with a comprehensive history including psychiatric, medical, family, and social portions in addition to a mental status examination. Previous records were requested and the referring clinician was consulted. In most cases a collateral history was taken from a family member. Inpatients were given a neurological examination and EEG. Intelligence testing was measured by use of the Shipley-Hartford Vocabulary Test (Zachary, 1986) or Wechsler Adult Intelligence Scale Revised or WAIS-R (Wechsler, 1981). The MMPI (Hathaway & McKinley, 1967) was administered to measure personality functioning. When the Dissociative Experiences Scale or DES was developed (Bernstein & Putnam, 1986), it was added to the assessment package.

The data are described with descriptive statistics only and have not been further analyzed because of the small number of cases represented by each subcategory of DDNOS.

## **RESULTS**

### *Demographic Characteristics*

The subjects included 43 women and 7 men with a mean age of 33 years (range, 14-50 years). Mean educational level was 12.8 years (range 6-18 years). Race included 94% white and 6% black. Marital status included 45% single, 32% married, and 22% divorced. Occupational level included 20% professional, 16% skilled, 10% unskilled, 14% students, 24% unemployed, and 16% disability.

### *Subcategory of DDNOS in This Study*

The subjects in this study fell into the following subcategories of DDNOS: ego-state disorder (N=17), not further specified (N=16), dissociative psychosis D (N=10), gender identity disorder, dissociative type (N=3), childhood dissociative disorder (N=2), Ganser syndrome (N=1), and nocturnal dissociative disorder (N=1).

### *Presenting Psychiatric and Dissociative Symptoms*

All except two subjects had amnesia. Depression, found in 82%, was evenly distributed among the various subcategories. Depersonalization was experienced by 58% overall. In the psychotic subcategory 70% of those hallucinating perceived their hallucinations as originating from outside the head. Sexual dysfunction was experienced by 70%. The prevalence of ego states was unevenly distributed, as these were present in all of the ego-state disorders and gender identity disorders, but in only 40% of the psychotic group, and in none of the not further specified category. Fugue was present in 44% of all subjects. Self-mutilation was present in 34%.

Headaches were present in 32%. Visual hallucinations were present in 60% of the psychotic group and 38% of the not further specified group but in none of the other groups. Alcohol and drug abuse were fairly evenly distributed (16% and 14% respectively) as were conversion symptoms (14%).

The duration of the amnesia episodes was from a few minutes to an hour, with the exception of the gender identity disorder where the amnesia lasted from 1-4 hours. The amnesia was localized in 82% and selective in 18%.

Evidence of other ego states included the usual manifestations including changes in handwriting (38%), rapid mood changes (38%), disremembered anger (32%), being recognized by unfamiliar people (26%), change in apparent age (26%), change in voice (24%), finding unfamiliar possessions (20%), inner dialogues (18%), different dress style (14%), and opposite sexed personality states (8%). The mean number of ego states was 3.6 (range 2-16). The presence of greater than 6 ego states occurred only by the ego-state group. The number of reported ego states per person was 2-5 in the psychotic group and 2 in the gender identity disorder group.

### *Types of Reported Childhood Trauma and Perpetrators of Child Abuse*

Types of reported childhood trauma included the following: sexual abuse (78%), physical abuse (52%), neglect (10%), other (4%), and none (4%). The trauma was evenly distributed except for the single male with nocturnal dissociative disorder who reported none. Perpetrators of the child abuse included fathers/stepfathers (50%), mothers/stepmothers (38%), siblings (20%), other relatives (24%), and nonfamily members (24%). There was a mean of 1.4 abusers per subject.

### *Age of Onset of Symptoms as Reported by the Patient*

Although the mean age of onset was 17 years (range 4-38 years), there was much variation within and among the groups. The group whose means varied the most included the Ganser syndrome (5 years), gender identity disorder (8 years), childhood dissociative disorder (14 years), and nocturnal dissociative disorder (38 years).

### *Additional Diagnoses and Family History of Psychiatric Disorder*

Additional DSM-III-R diagnoses in the entire sample included personality disorders (66%), affective disorders (56%), substance abuse (32%), psychoses (20%), eating dis-

orders (14%), somatoform disorders (6%). Although the mean number of diagnoses including DDNOS was three, it was similar in all groups, except in gender identity disorder, with a reported history of the following psychiatric illnesses: substance abuse (28%), affective disorder (20%), psychosis (5%), and dissociative disorder (1%). Three of the five reported psychoses occurred in relatives of patients in the psychotic subcategory.

#### *Electroencephalographic and Psychological Testing Data*

Thirty subjects (60%) had EEGs. Of that number 22 were normal, 4 showed medication effects, 2 were mildly abnormal, and 2 showed paroxysmal spike and slow wave deformities. No one in the entire sample had a clinical history of epilepsy or abnormal neurological findings.

Thirty three patients took the DES. The mean DES score for the group was 32 (range 1-65). Mean scores for the various subgroups were as follows: psychotic (47), not otherwise specified (34), Ganser syndrome (32), ego-state disorder (27), gender identity disorder (13), and nocturnal dissociative disorder (1).

The mean MMPI T-scores on 31 adult females were as follows: L (49), F (78), K (50), Hs (65), D (73), Hy (67), Pd (77), Mf (51), Pa (74), Sc (86), Ma (68), and Si (65). The means were fairly uniform amongst the various groups except for the single individual with Ganser syndrome. This person had an invalid profile with an F-scale T-score of 110.

Twenty six patients, nearly all inpatients, had IQ testing. The mean IQ score for the entire group was 96 with a range of 72-121.

### CASE EXAMPLES

Since these patients present diverse symptomatology, a number of case vignettes will be described.

#### *Ego-State Disorder*

A 32-year-old woman had symptoms of depersonalization, derealization, inner voices, and depression since the birth of her first child five years previously. During therapy, evidence of at least 16 ego states was uncovered. Most of these states went by her first name and had limited functions (i.e., wife, mother, daughter, evil one, anger, depressed, controller, etc.). Some were transitory in nature. Although the "host" had partial amnesia for child abuse, there was no interpersonality amnesia. Most of the time these ego states were experienced as made thoughts, feelings, and behaviors. Only when she was under severe distress could observers note clearly differing ego states, but no switching behaviors were observed.

#### *Childhood Dissociative Disorder*

A 14-year-old female had a two-year history of trance-like states in which she would become agitated, growl, laugh, cry, hum, snarl, lunge or dart about, and throw objects. These states were accompanied by amnesia of about 15-minutes duration. On at least one occasion she was noted to talk in "baby talk." She had been sexually abused on at least two occasions by her mother's boyfriend. Neurological workup, including EEG and brain scan, was negative.

#### *Dissociative Psychosis*

A 35-year-old woman had a 15-year history of over a dozen hospitalizations for symptoms of depression, prominent suicidality, and psychosis including somatic delusions and auditory hallucinations. Dissociative symptoms included depersonalization, derealization, fugue, partial amnesia for childhood, and infrequent current memory loss. She had been physically and sexually abused as a child. Antipsychotic and antidepressant medication kept her psychotic and depressive symptoms under control. Even when she was functioning at her highest level, her dissociative symptoms were decreased but not entirely absent.

#### *Ganser Syndrome*

A 50-year-old man had a three-year history of depression, somatization, and disability since a job-related back injury. He admitted to vague symptoms of amnesia, fugue, and depersonalization for this same period but was evasive about their exact nature. He denied other evidence of dis-

TABLE 1  
Comparison of Dissociative Disorders

Psychiatric Symptoms	Psychogenic Amnesia (N=25)	DDNOS (N=50)	MPD (N=50)
Amnesia	100%	96%	100%
Ego States	0	52	100
Depression	82	84	88
Sexual Dysfunction	60	48	84
Auditory Hallucinations	24	66	72
Headaches	64	32	56
Fugue	4	44	48
Drug Abuse	20	16	46
Alcohol Abuse	24	46	42
Conversion	24	14	40
Depersonalization	40	70	38
Somatization	44	26	36
Self-mutilation	20	34	34

sociative disorder and this was confirmed by his son. Mental status examination revealed a rather dramatic presentation in which he drew attention to his back pain by kneeling on one knee as he talked. He was unable to state his precise age, although he knew his birth date and the present date and was able to do other arithmetic calculations. His MMPI was invalid due to an extremely high F-Scale (110). Six clinical scales were over 100. Although he reported physical and sexual abuse as a child, this could not be substantiated.

*Nocturnal Sleep Disorder*

A 38-year-old man had episodes of sleep walking and talking in which he talked in at least two different voices, one called "Jack" and the other called "Squirrel," both nicknames given to him by his father. Jack said he was bored with his girlfriend and wanted to "chase around." This behavior was precipitated by his father's recent stroke and the accompanying loss of his father's company. There were no other dissociative symptoms, nor was there any history of childhood trauma. His EEG was normal. His DES score was 1. Brief psychotherapy ameliorated his symptoms.

*Gender Identity Disorder, Dissociative Type*

A 34-year-old man had a history of gender identity confusion since age 8 and began cross dressing at age 15. During

his 20's he developed two alternate personas, one male and the other female. The male was much more assertive than he, and the female was a partial identification with his mother. No interpersonality amnesia was present, although there was some partial amnesia for childhood physical abuse. These parts disappeared promptly with psychotherapy and medication for his depression and schizoid personality disorder.

*Dissociative Disorder-Not Further Specified*

A 42-year-old woman had symptoms of depression for six years. Dissociative symptoms included selective amnesia for childhood sexual abuse as well as current memory lapses of 2-3 hours duration, several short fugues while driving a car, and depersonalization. Symptoms characteristics of MPD, including other personality states, were denied. DES was 20.

**DISCUSSION**

**The Dissociative Spectrum**

Comparison of the results of this study of patients with DDNOS with previous studies of patients with MPD (Coons, Bowman, Milstein, 1988) and psychogenic amnesia (Coons & Milstein, 1992) reveals some striking similarities (See Table 1). Demographic data are strikingly similar with the excep-

tion of the mean age at first diagnosis - 33 years for DDNOS and 29 years and 31 years respectively for MPD and psychogenic amnesia. Only 52% of subjects with DDNOS had other ego states compared to 100% in MPD and none in psychogenic amnesia. The incidence of depression, auditory hallucinations, amnesia, fugue, and self-mutilation were approximately equal between MPD and DDNOS. Compared with MPD, there was less sexual dysfunction, headache, substance abuse and conversion in DDNOS.

There appears to be a stepwise progression in the DES scores as one progresses along the dissociative spectrum from psychogenic amnesia to MPD. There also seems to be a stepwise progression in MMPI F and Sc scores from psychogenic amnesia to MPD. The Mean IQ was about average for all three groups. The presence of abnormal EEG's was about

TABLE 2  
Comparison of Dissociative Disorders

Objective Measures	Psychogenic Amnesia	DDNOS	MPD
Dissociative Experiences Scale	(N=4)	(N=33)	(N=13)
Mean (Range)	14 (10-22)	32 (1-65)	41 (21-80)
MMPI T-Scores	(N=19)	(N=30)	(N=30)
F	77	78	87
Sc	82	86	92
Intelligence Quotient	(N=18)	(N=26)	(N=32)
Mean (Range)	102 (80-124)	96 (72-121)	102(77-123)
EEG	(N=19)	(N=30)	(N=30)
% Abnormal EEG	16	13	23

half of that seen in MPD. This data appears provides further proof of the dissociative spectrum.

#### **Looking Towards DSM-V**

These data confirm that a number of diverse states underlie the DDNOS category of dissociative disorder. The evidence is now overwhelming that dissociation not only occurs in childhood, but that this type of dissociation may fall short of the adult form of MPD and is best described as childhood dissociative disorder, distinct from DDNOS (Peterson, 1990, 1991). The data also clearly shows that a subcategory of a dissociative disorder exists with less identity disturbance and less amnesia than are seen with MPD. Watkins and Watkins (1979) have proposed that this type of dissociative disorder be called ego-state disorder.

I would agree with Schenck, et al. (1989) that nocturnal sleep disorder should be a separate diagnostic category. I would propose the following diagnostic criteria:

- A. A sleep disorder characterized by dissociation (primarily identity alteration) which occurs only during the sleep cycle and is associated with a waking EEG.
- B. Amnesia is present for the dissociative behavior.
- C. Not due to MPD.

There is also mounting evidence that a dissociative type of gender identity disorder exists. I would propose the following diagnostic criteria for this disorder:

- A. A gender identity disorder characterized by alteration between a male and a female personality state.
- B. No interpersonality amnesia is present.
- C. Not due to MPD.

Finally there is evidence that a dissociative psychosis exists. Diagnostic criteria for this disorder would include the following:

- A. Psychotic symptoms (delusions, hallucinations, incoherence, loose associations, disorganized behavior) which occur in association with marked dissociative symptomatology (amnesia, fugue, depersonalization, derealization, identity confusion, or identity alteration).
- B. Not due to schizophrenia, MPD, or organic psychosis. A possible disorder needing additional study is the occurrence of derealization without depersonalization. (Of course DDNOS would continue to exist as a diagnostic category used when dissociative symptoms do not meet the diagnostic criteria of a specific dissociative disorder. This category would also be used to indicate diagnostic uncertainty.)

#### **Treatment**

Knowledge about the treatment of the various types of DDNOS is in its infancy. Little is known about treatment of Ganser syndrome, derealization, or nocturnal dissociative disorder. The treatment of ego-state disorders and childhood dissociative disorder should, in general, follow the treatment of MPD. In the case of children, play therapy techniques are utilized (Kluft, 1990a) as is hospital treatment of the more severe cases (Hornstein & Tyson, 1991). In patients with dissociative psychosis, antipsychotic medication should be utilized and exploration and/or abreaction of traumatic material should progress very slowly if at all. Treatment of the dissociative form of gender identity disorder should focus on underlying gender identity issues. Likewise, the treatment of secondary dissociative disorder should focus on the underlying medical condition. The treatment of trance and possession disorder and the various culture-bound conditions should pay close attention to relevant cultural and/or religious issues. The treatment of the victims of cults and brainwashing is a controversial *area* and the reader is urged to consult other sources. Watchfulness for underlying ego state disorder or MPD should be maintained when the NOS category is utilized. The categories of nocturnal dissociative disorder and derealization without depersonalization require further study.

#### **SUMMARY**

DDNOS is a diverse category of dissociative states. It appears that, like MPD, patients with ego-state disorder, dissociative psychosis, and the NOS category are polysymptomatic. Evidence from the DES and MMPI confirm that a dissociative spectrum exists, with DDNOS intermediate between psychogenic amnesia and MPD. As yet, there is no evidence of a neurological causation for any of the currently accepted DDNOS subtypes. The treatment of DDNOS is in its infancy, and treatment approaches may ultimately be quite diverse.

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