Advances in the clinical assessment of dissociation: The SCID-D-R

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A comprehensive assessment of dissociative symptoms is recommended for effective treatment of trauma survivors. The author reviews the systematic detection of dissociative symptoms and disorders using the Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised (SCID-D-R) in adolescents and adults (Steinberg, 1994b). Numerous investigations have reported good-to-excellent reliability and validity of the SCID-D-R, both in the United States and abroad. Clinical applications, including the SCID-D-R's utility for psychological and forensic evaluations, treatment planning, differential diagnosis, and evaluation of malingering, are reviewed. (Bulletin of the Menninger Clinic, 64[2], 146-163)

The dissociative disorders are increasingly recognized to be posttraumatic syndromes (Bowman, Blix, & Coons, 1985; Coons, Cole, Pellow, & Milstein, 1990; Fine, 1990; Kluft, 1985b; Kluft, Braun, & Sachs, 1984; Spiegel, 1984, 1991). Dissociation as a psychological defense is used by survivors of abuse and trauma to cope with overwhelming anxiety and pain. Studies of the dissociative disorders have noted histories of abuse in 85–97% of all reported cases of dissociative identity disorder (DID; formerly multiple personality disorder; Coons & Milstein, 1986; Chu & Dill, 1990; Kluft, 1991; Putnam, Guroff, Silberman, Barban, & Post, 1986; Schultz, Braun, & Kluft, 1989). Cases of DID may be misdiagnosed for many years (Bliss & Jeppsen, 1985; Coons, 1980; Kluft, 1985a; Goodwin, 1988; Putnam et al., 1986; Steinberg, 1995). Recent investigations indicate that DID, the most severe of the dissociative disorders, is much more common than previously recognized, and estimates of its prevalence range from 1% to 10% of psychiatric patients (Bliss & Jeppsen, 1985; Kluft, 1991; Putnam, et al., 1986).

The neglect of dissociative symptoms and disorders by the medical establishment has resulted from several factors, including the reluctance to

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discuss issues relating to child abuse and the concealed nature of dissociative symptoms themselves. Assessment is often complicated because patients with dissociative disorders may (1) find their dissociative symptoms difficult to describe, (2) experience numerous psychological and somatic symptoms, and (3) deny or be amnestic for their abuse history. In addition, patients suffering from dissociative disorders have a high rate of comorbid Axis I and Axis II disorders, and may present with a confusing array of presenting symptomatology, such as anxiety, depression, psychosis, and substance abuse (Bliss, 1980; Coons, 1984; Horevitz & Braun, 1984; Kluft, 1985a; Putnam et al., 1986; Ross & Norton, 1988; Steinberg, Cicchetti, Buchanan, Rakfeldt, & Rounsaville, 1994; Torem, 1990). Because of these factors, dissociative symptoms are rarely the patient's presenting complaint.

Early identification of patients who suffer from dissociative symptoms and disorders is essential for successful treatment, because these disorders do not resolve spontaneously. In addition, dissociative disorders are not alleviated by treatment directed toward an intercurrent disorder. However, because the dissociative disorders are among the few psychiatric syndromes that appear to respond favorably to appropriate treatment (Spiegel, 1993), improved accuracy in differential diagnosis is critical.

Recent clinical advances in the field of dissociation have resulted in self-administered tools for screening (Bernstein & Putnam, 1986; Riley, 1988) as well as clinician-administered interviews for diagnosis of dissociative symptoms and disorders. This article is intended to help clinicians become familiar with the systematic assessment of dissociative symptoms and disorders using the diagnostic interview, the Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised (SCID-D-R; Steinberg, 1994b). A review of five core dissociative symptom areas and the differential diagnosis of the dissociative disorders are presented. Excerpts from SCID-D-R interviews demonstrate the semistructured format of the SCID-D-R, the multifaceted nature of dissociative symptoms, and the richness of clinical data that can be collected by use of this tool.

The Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised (SCID-D-R)

The Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised (SCID-D-R; Steinberg, 1994b) is a semistructured diagnostic interview that systematically assesses the severity of five posttraumatic dissociative symptoms as well as the diagnoses of the dissociative disorders and acute stress disorder, based on criteria from

the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994). I systematized the assessment of dissociative symptoms by defining the five core symptoms of dissociation as follows: amnesia, depersonalization, derealization, identity confusion, and identity alteration, each representing basic disturbances in the processes of memory, identity, or consciousness. This conceptualization of dissociation was derived from a critical synthesis of the literature on trauma and dissociation, together with clinical experience with patients with dissociative disorders. In addition, Drs. Cicchetti and Rounsaville at Yale University School of Medicine have contributed decades of expertise in methodology and diagnostic testing to the field trials of the SCID-D.

Originally developed to incorporate *DSM-III-R* criteria, the SCID-D was revised in 1993 to incorporate *DSM-IV* criteria for the dissociative disorders. Modifications in the SCID-D include an improved user-friendly format for rating the individual items, as well as the incorporation of *DSM-IV* criteria for the dissociative disorders. The clinician-administered SCID-D-R interview assesses the phenomenology and severity of the five dissociative symptoms using open-ended questions, with individualized follow-up questions for exploring endorsed symptoms. This format elicits informative descriptions of dissociative experiences, rather than mere "yes" or "no" responses. Because of the comprehensive nature of the individual items originally included in the SCID-D, it was not necessary to revise the items in the SCID-D-R.

Initially field tested in adults, the SCID has also recently been documented to be useful with adolescents as young as 11 years (Carrion & Steiner, in press; Steinberg & Steinberg, 1995). The administration, scoring, and interpretation of the SCID-D-R is described in the *Interviewer's Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised* (SCID-D-R); Steinberg, 1994a). Clinicians and researchers may also review the process of diagnostic assessment with the SCID-D-R in two audiotapes accompanied with manuals (Steinberg, 1996a, 1996b).

Psychometric information

Reliability. Numerous investigations, both in the United States and abroad (using Dutch, German, Norwegian, and Turkish translations of the SCID-D), have reported good to excellent interrater and test-retest reliability and very good discriminant validity of the SCID-D for the assessment of dissociative symptom severity and for the dissociative disorders in a variety of populations (Boon & Draijer, 1991; Goff, Olin, Jenike, Baer, & Buttolph, 1992; Kundaker et al., 1998; Steinberg, Rounsaville, & Cicchetti, 1990). The SCID-D field trials conducted by

Steinberg, Rounsaville, and Cicchetti utilized a test-retest reliability design, blind examiners, and a sample consisting of 141 psychiatric patients to examine both interexaminer and temporal reliability of the SCID-D over three time periods (baseline, at 2 weeks, and at 6-month follow-up). The range of weighted kappas, for both the presence and extent of dissociative symptomatology, was between very good and excellent (.77–.86) for each period (baseline, 2-week and 6-month follow-up). Interexaminer agreement levels for the type of dissociative disorder also ranged between very good (.72) and excellent (.86). Test-retest reliability analyses indicated very good reliability for the total overall assessment of the presence of a dissociative disorder (kappa = .88).

Discriminant validity. Numerous investigations have reported that the SCID-D-R is effective in distinguishing between patients with clinically diagnosed dissociative disorders and other psychiatric disorders (Boon & Draijer, 1991; Goff et al., 1992; Kundaker et al., 1998; Steinberg, Cicchetti, Buchanan, et al., 1994; Steinberg, Rounsaville, & Cicchetti, 1990). These investigations found that subjects receiving SCID-D diagnoses of a dissociative disorder had significantly higher dissociative symptom severity scores and total SCID-D scores than subjects with other psychiatric disorders. In addition, the range, severity, and nature of the five dissociative symptom areas can assist clinicians in distinguishing between individuals with dissociative disorders and individuals with other psychiatric disorders.

Investigators have also noted that the SCID-D is able to distinguish between patients with seizures and pseudoseizures based on clinician diagnosis and electroencephalogram (EEG) (Bowman & Coons, 2000). Last, in addition to the SCID-D's ability to statistically discriminate between dissociative and nondissociative subjects, analysis of patient responses to SCID-D items reveals elaborate descriptions of dissociative experiences that provide useful diagnostic and therapeutic information. For a complete review of the diagnostically discriminating features of each of the five dissociative symptoms, see *The Interviewer's Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised* (Steinberg, 1994a).

Differential diagnosis of the DSM-IV dissociative disorders

Evaluation of the five dissociative symptoms assessed by the SCID-D-R is essential for accurate differential diagnosis of the dissociative disorders. Each of the dissociative disorders is characterized by a specific constellation of the five symptoms described earlier. A brief review of the dissociative disorders follows.

Dissociative amnesia (formerly psychogenic amnesia) is a common

disorder regularly encountered in hospital emergency rooms. Dissociative amnesia is characterized by the inability to recall important personal information (American Psychiatric Association, 1987) . The forgotten information is often related to an earlier traumatic event. The amnesia must be too extensive to be explained by ordinary forgetfulness; must not be due to organic mental disorder, such as alcoholic blackout, drug intoxication, or seizure disorder; and must not be due to the activities of alternate personalities (i.e., dissociative identity disorder). Dissociative amnesia is often seen in combat veterans and in the victims of single severe traumas, such as being involved in an automobile accident, witnessing a murder, experiencing a natural disaster, or having a near-death experience. In contrast to DID, dissociative amnesia is usually acute.

Dissociative fugue (formerly psychogenic fugue) involves sudden, unplanned wandering from home or work, with the assumption of a new identity or confusion about personal identity (American Psychiatric Association, 1987). The patient remains alert and oriented, yet is amnestic for the former identity. This disorder is distinguished from DID by the sudden, acute onset, the presence of a single severe stressor or trauma, and the lack of recurrently appearing distinct personalities. For a diagnosis of dissociative fugue, the memory and identity disturbances cannot occur as part of DID or as part of a substance-induced disorder.

Depersonalization disorder involves persistent and recurrent experiences of severe depersonalization that lead to distress and dysfunction (American Psychiatric Association, 1987). A patient suffering from depersonalization disorder retains intact reality testing. For a diagnosis of depersonalization disorder, the depersonalization must occur independently of schizophrenia, DID, or a substance abuse disorder.

Dissociative disorder, not otherwise specified (DDNOS) is an inclusive category for classifying dissociative syndromes that do not meet the full criteria of any of the other dissociative disorders. DDNOS includes variants of DID in which personality "states" may take over consciousness and behavior but are not sufficiently distinct, and variants of DID in which there is no amnesia for personal information. Other forms of DDNOS include possession and trance states, Ganser's syndrome, derealization unaccompanied by depersonalization, dissociated states in people who have undergone intense coercive persuasion (e.g., brainwashing, kidnapping), and loss of consciousness not attributed to a medical condition.

Dissociative identity disorder (DID) is the most chronic and severe manifestation of dissociation. DID is believed to follow severe and persistent psychological, physical, or sexual abuse. In this disorder, dis-

tinct, coherent identities exist within one individual and are able to assume control of the person's behavior and thought (American Psychiatric Association, 1987). In DID, the patient experiences amnesia for personal information, including some of the identities and activities of alternate personalities. DID may mimic a spectrum of psychiatric conditions, including the psychotic, affective, and character disorders. It may also coexist with a variety of Axis I and Axis II disorders.

Assessment of the five SCID-D-R dissociative symptoms

Accurate assessment of the severity as well as the presence of the core symptoms is essential to differential diagnosis of the *DSM-IV* dissociative disorders.

Assessing amnesia. Amnesia, which is the first symptom assessed by the SCID-D-R, may be defined as the inability to recall a significant block of time that has passed, and/or the inability to recall important personal information (Steinberg, 1994a, 1995). It is described by patients as "gaps" in their memory or "lost time," ranging from seconds to years. Many patients with dissociative disorders understand and describe their amnesia as "blank spells" or as "spaciness." Patients may report failure to recall their name, age, or address. Patients with severe amnesia are often unable to remember the frequency or duration of their amnestic episodes (Steinberg, 1994a). Individuals with chronic amnesia often confabulate or use reports from relatives or friends in attempts to fill the gaps in their memory (Kluft, 1991). Amnesia of psychogenic etiology must be distinguished from that found in organic brain dysfunction or secondary to substance abuse.

Questions in this section of the SCID-D-R explore the different manifestations of amnesia. The first question of the amnesia section asks: "Have you ever felt as if there were large gaps in your memory?" One patient with DID responded: "Yeah. Like, say, a friend of mine will talk about something we did a month ago, or some place we went, or whatever, and I have no memory of it. It's scary" (SCID-D-R interview, unpublished transcript).

It is very common for patients suffering from severe amnesia to report difficulty remembering basic items of personal information. One patient with DID first became aware of her symptom when she had problems filling out job applications and similar forms: "It's embarrassing. There are things I need to know sometimes that I can't remember. It could be like a phone number, it could be my street address, it could be things like that. Or my salary. If I have to fill out a form or something, and it asks for that kind of stuff, it's like I suddenly don't remember it" (SCID-D-R interview, unpublished transcript).

Assessing depersonalization. Depersonalization involves the experience of detachment from one's body or self, for example, feeling that the self is strange or unreal, or feeling that one is "going through the motions of life" like a robot. Transient depersonalization may be found in the general population as a common response to alcohol and drug use, sleep and sensory deprivation, or severe emotional stressors, and it also has been seen as a side effect of medications (Roberts, 1960; Trueman, 1984b). SCID-D-R research has found that patients with dissociative disorders often experience depersonalization within the context of ongoing, coherent dialogues with the self (Steinberg, 1994a, 1995). Depersonalization is difficult for patients to describe, and can sometimes go unnoticed or can be experienced as "normal" by patients who have become habituated to it.

The depersonalization section of the SCID-D-R includes questions intended to evaluate the different manifestations of depersonalization that patients may experience. In addition, the presence of some nonverbal cues, such as a trancelike state, may suggest depersonalization during an interview. Question 38 asks: "Have you ever felt that you were watching yourself from a point outside of your body, as if you were seeing yourself from a distance (or watching a movie of yourself)?" One patient with DID responded: "I can remember when I was delivering my daughter, of being up on the ceiling and watching the whole process of labor and delivery while she was born ... and I've had the same experience when I've finally remembered my husband raping me, and I had the same experience when my father sexually assaulted me when I went down to visit my mother after she had a hysterectomy, and I remember being in the corner of the bedroom ceiling when that happened" (SCID-D-R interview, unpublished transcript).

In addition to providing information about depersonalization, this patient provided information spontaneously about her history of abuse. This feature of the SCID-D-R allows clinicians to document that they obtained information regarding traumatic histories without the use of leading or intrusive questions.

Another patient responded to the same depersonalization question by saying, "Yeah, I have felt like that. I always described it as being like a zombie" (SCID-D-R interview, unpublished transcript).

In terms of another aspect of depersonalization, Question 41 asks: "Have you ever felt as if a part of your body or your whole being was foreign to you?" One patient responded: (*pauses*) "Yeah. Sometimes my hands don't seem like my hands. I've always hated my legs and they don't ... sometimes they're not mine. This is very weird" (*sighs*).

A very common variant of depersonalization involves experiences of splitting into a participator and an observer. This experience often con-

tains elements of identity alteration. Question 47 asks: "Have you ever felt as if you were two different people, one person going through the motions of life, and the other part observing quietly?" One patient responded: (*takes deep breath*) "Again, it's an unreal feeling, of not really being connected to other humans in some way. Because it's as though there's a fake self out there living my life" (SCID-D-R interview, unpublished transcript).

The experience of ongoing internal dialogues in the context of depersonalization occurs in patients with dissociative disorders (Steinberg, 1995). One patient with DDNOS had the following description: "I start to argue with somebody that's in that chair, but I see that person in that chair and I see it's me ... he's looking at me and he's laughing at me, and he's calling on me to fight him ... and I don't want to fight him.... I see me outside myself, in other words, and he's laughing at me, calling out saying, "Come on, punk, fight me, come on, punk, fight me" (SCID-D-R interview, unpublished transcript). Thus this patient experiences severe depersonalization in conjunction with identity confusion.

Assessing derealization. Derealization involves the sense that one's physical and/or interpersonal environment has lost its sense of familiarity or reality. Isolated episodes of derealization may occur in subjects without psychiatric disorders, in response to substance use, sensory and sleep deprivation, and mild social stressors such as examinations or minor car accidents. In dissociative disorders, patients with derealization report that friends and relatives seem strange and unfamiliar, as may their home, workplace, or immediate physical environment (Steinberg, 1994a, 1995). Derealization often occurs in the context of flashbacks in which a person reexperiences a past trauma. As a result, the present feels unreal to the person.

The SCID-D-R allows the interviewer to explore different aspects of the symptom of derealization. Question 79 asks: "Have you ever felt as if familiar surroundings or people you knew seemed unfamiliar or unreal?" One patient with DID responded: "Yes, I have felt that. That's like every place that I've ever lived has never felt familiar to me, even if I lived there for years. It never feels like *I* live there. It's kind of like a Twilight Zone experience" (SCID-D-R interview, unpublished transcript).

Derealization commonly occurs in the context of a flashback in which a friend or parent reminds the patient of an abuser, and the patient feels that the person he or she is with becomes unreal. Question 84 often elicits descriptions of flashbacks: "Have you ever felt puzzled as to what is real and what's unreal in your surroundings?" A patient's response follows: "Yes. When I have flashbacks. That's what I call them. It's like I'd be out on a date with a boyfriend and see a totally different

guy. It's like really weird. That's happened where it's a flashback of one of the guys that raped me. You know, I'd be with him, and then, oh my god, I'd run out of the theater or something" (SCID-D-R interview, unpublished transcript).

The next question, 81, asks: "Have you ever felt as if your surroundings or other people were fading away? One patient responded: "I have had that experience when I visit my family. They become blurry, they become almost invisible. Their voices all meld together. I have a wonderful time by myself.... I had no idea what the conversations were about, what was said, who was there, or anything" (SCID-D-R interview, unpublished transcript).

As seen in the previous example, derealization can involve auditory and visual distortions.

Assessing identity confusion. Identity confusion, as assessed in the SCID-D-R, is defined as a sense of uncertainty, puzzlement, or conflict regarding personal identity (Steinberg, 1994a, 1995). Patients who experience dissociative symptoms often express confusion as to who they really are. In dissociative disorders, identity confusion often manifests as a fierce battle for inner survival, where the subject experiences conflicting and opposing attitudes regarding issues and events in his or her life (Steinberg, 1994a, 1995). Although identity confusion may occur transiently during adolescence or life crises, identity confusion in patients with dissociative disorders tends to be more chronic and distressing.

In response to SCID-D-R questions on identity confusion, subjects with dissociative disorders often use metaphors of conflict or battle to describe their inner struggles. In the identity confusion section of the SCID-D-R, Question 101 asks: "Have you ever felt as if there was a struggle going on inside of you?" One woman with DID responded: "Yes. It happens 95% of the time, and it's like having a bunch of different opinions about absolutely everything, from what to wear to what task to do first at work. It sort of permeates everything" (SCID-D-R interview, unpublished transcript).

Patients with dissociative disorders typically feel confused about the stability of their identity. This feeling is compounded by the inability to recall significant portions of time and conflicting states of consciousness. Question 105 asks: "Have you ever felt confused as to who you are?" One man who presented with global amnesia responded: "I was confused. 'Confused' is a mild word. I just didn't know. I think 'confused' is too mild. I just did not have any idea of what happened to me, like how could I go from wherever I was to now... I didn't know who I was, I didn't know basically where I was.... I was terrified. I can still remember myself crawling on one side of the bed. I could have been in a

ball this big, all crunched up scared to death. Felt like a baby in a crib" (SCID-D-R interview, unpublished transcript).

In patients with DID, severe amnesia may cause them to doubt the continuity or integrity of their personality. The first patient cited in this section went on to say, "There is no real me. I don't feel that there is a single real part of me. Everything feels 'pretend,' all of these different opinions" (SCID-D-R interview, unpublished transcript).

Assessing identity alteration. Identity alteration, as defined in the SCID-D-R, involves objective behavior indicating the assumption of different identities (Steinberg, 1994a, 1995). Examples of identity alteration include the use of different names, finding possessions that one cannot remember acquiring, and possessing a skill that one cannot remember having learned. Patients with DID sometimes refer to themselves as "we" or "us" (Kluft, 1991). Severe identity alteration that occurs in dissociative disorders is accompanied by amnesia for events experienced under alternate personality states. Identity alteration in DID is characterized by its complexity, distinctness, the ability of the states to take control of behavior, and the interconnection with other dissociative symptoms assessed in the SCID-D-R.

Because amnesia for identity alteration can mask its assessment, the SCID-D-R explores both direct and indirect evidence of this symptom. The evidence for identity alteration comes from three sources: reports of identity alteration from the subject; feedback from relatives or friends; and behavioral indications, such as finding objects in one's possession that one cannot account for. These occurrences are independent of a patient's amnesia for his or her identity alteration. For instance, the SCID-D-R asks if others have noted the patient acting like a child, acting like a different person, or calling himself or herself a different name. The patient may volunteer information obtained from other people concerning different behaviors or personalities, while not knowing that he or she has alternate personalities. Direct information includes the patient's awareness of referring to himself or herself by different names, acting like a child or like a different person, or feeling possessed. Nonverbal cues during the interview can also help assess the extent of identity alteration. Severe mood changes, particularly in conjunction with amnesia during the interview, may indicate the presence of identity alteration.

Question 114 asks: "Have you ever acted as if you were a completely different person?" One man with DDNOS responded: "Yeah, I think so. Sometimes it could be nice, if I'm having a good time. Going out dancing—just being a totally different person from how I am now. And sometimes I'm really mean, nasty, and irritable. And that's not my usual personality" (SCID-D-R interview, unpublished transcript).

In some instances, the patient is made aware of personality changes by others in his or her family or workplace. Question 116 asks: "Have you ever been told by others that you seem like a different person?" One patient with DID responded: "Yes. Guys that I've dated, my family, people that I work with ... some of them even said that, it's like, different ways, different opinions—my opinion might change right in the middle of a conversation. One way definitely over here, and then the next time, just within seconds, over here" (SCID-D-R interview, unpublished transcript).

Other types of indirect evidence for identity alteration include finding objects that were taken home by an alternate personality. Question 122 asks: "Have you ever found things in your possession (for instance, shoes) which belong to you, but you could not remember how you got them?" One patient responded: "Yes ... Weekly. Like I'd go shopping. I'd buy things. I'd remember that I'd purchased it. I had the receipt. So I know I didn't steal it or something. But why I bought it, where I bought it—buy things that I don't even wear—wouldn't be caught dead wearing. Totally strange items—a thousand scarves, ponchos, and shawls. And I've never worn one of them. But I have a whole mess of them. My mom says I wear them a lot, but I don't know of ever wearing one of them. It's odd" (SCID-D-R interview, unpublished transcript).

Associated features and follow-up sections

The SCID-D-R also assesses associated features of DID and DDNOS, such as internal dialogues, mood changes, and flashbacks. Finally, follow-up sections are administered to obtain further assessment of the severity of identity confusion and alteration.

Positive responses in any of the five symptom areas should be explored further if it appears as though the patient is suffering from a dissociative disorder. The SCID-D-R contains nine optional follow-up modules, each consisting of approximately 10 questions that explore different aspects of dissociative symptomatology. The follow-up sections explore identity confusion, rapid mood changes, depersonalization, using different names, internal dialogues, childlike part, age regression/flashbacks, acting like a different person, and feelings of possession. The interviewer explores up to two symptom areas that the subject endorsed previously.

Scoring of the SCID-D-R interview

Following the interview, the clinician is able to rate the severity of each of the 5 symptoms using the severity rating definitions found in the interviewer's guide to the SCID-D-R (Steinberg, 1994a). The severity of dissociative symptoms is evaluated in terms of distress, dysfunction-

ality, frequency, duration, and course of the symptom. The severity ratings of the dissociative symptoms receive numeric codes: A score of "absent" is rated as 1, "mild" is rated as 2, "moderate" is rated as 3, and "severe" is rated as 4, the maximum. The symptom severities are summed up to yield a total SCID-D-R symptom score, which ranges from 5 (no symptomatology) to 20 (severe manifestations of all five dissociative symptoms).

Differential diagnosis

Diagnosis proceeds from the consideration of the constellation of dissociative symptoms. If the subject received ratings of none to mild on all symptoms, a dissociative disorder may be ruled out. If, however, one or more symptoms was found to be severe, the presence of a dissociative disorder should be considered. Figure 1 shows the profile of dissociative symptoms in each of the five dissociative disorders, as found in SCID-D-R research. These graphs use the numerical scaling (1–5) of the severity of dissociative symptoms. With the use of this information as a guide, the interviewer can now evaluate whether the patient meets criteria for a specific dissociative disorder based on *DSM-IV* criteria. Diagnosis of a dissociative disorder is based on a specific pattern of SCID-D-R items in support of *DSM-IV* criteria (Steinberg, 1994a).

Symptom profiles in other disorders and in control subjects

Figure 2 graphs the symptom profiles of subjects with dissociative disorders, mixed psychiatric patients, and normal controls. As demonstrated, control subjects (without psychiatric disorders) tend to score between "none" and "mild" (1–2) for all five symptoms. Subjects with a variety of nondissociative disorders score between "none" and "moderate" (1–3). People with dissociative disorders experience recurrent to persistent—that is, "moderate" to "severe" (3–4)—dissociative symptoms.

Clinical applications of the SCID-D-R

The SCID-D-R is a time- and cost-effective diagnostic instrument with a variety of clinical applications (Benjamin, Benjamin, & Rind, 1996; Bowman & Coons, 2000; Carrion & Steiner, in press; Gast et al., 2000; Goff, Brotman, Kindlon, Waites, & Amico, 1991; Goff et al., 1992; Hall & Steinberg, 1994; Steinberg et al., 1994; Steinberg & Steinberg, 1995). First, because the SCID-D-R is designed to be filed with patients' charts, it provides easily accessible documentation for record keeping and for psychological and forensic evaluations. Since patient education is essential to the therapy of individuals with dissociative disorders (Allen, 1995), this specialized interview offers clinicians an opportunity for patient education regarding the nature and significance of

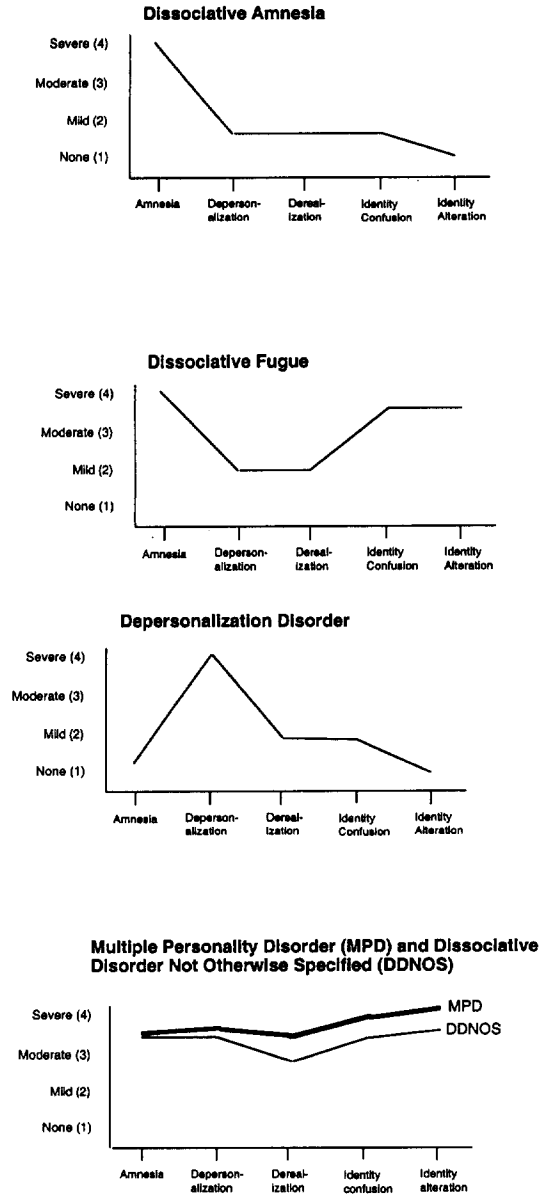

Figure 1. *SCID-D symptom profiles of the dissociative disorders.*

Reprinted with permission from Steinberg, M. (1994). *The Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised* (SCID-D-R). Washington, DC: American Psychiatric Press.

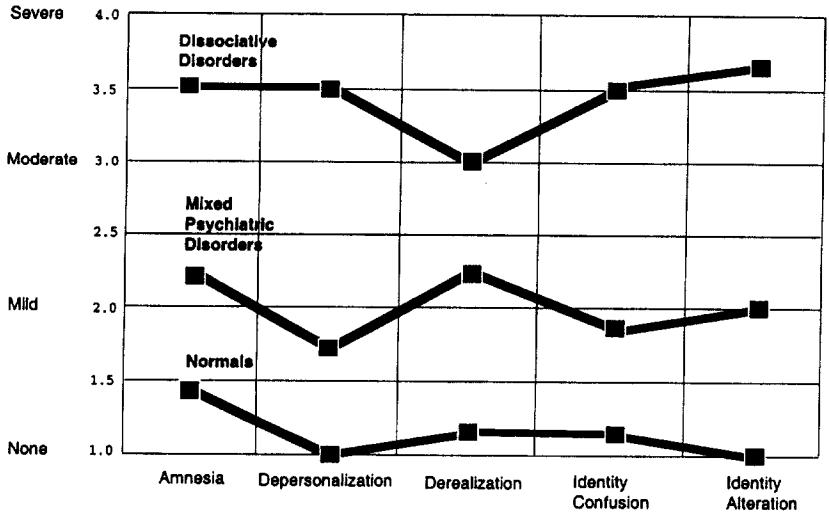

Figure 2. ***SCID-D symptom profiles in psychiatric patients and normal controls.***

Data from Steinberg, M., Rounsaville, B., & Cicchetti, D. (1994). The Structured Clinical Interview for DSM-III-R Dissociative Disorders: Preliminary report on a new diagnostic instrument. *American Journal of Psychiatry, 147,* 76–82. Figure reprinted with permission from Steinberg, M. (1994). *The Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised* (SCID-D-R). Washington, DC: American Psychiatric Press.

dissociative symptoms (Benjamin, Benjamin, & Rind, 1996; Hall & Steinberg, 1994; Steinberg & Hall, 1997). Moreover, the SCID-D-R's format facilitates treatment planning and long-term follow-up of patients; a clinician can administer the instrument at 6-month or yearly intervals in order to monitor changes in symptomatology and reassess treatment strategy accordingly (Steinberg & Hall, 1997). Finally, the SCID-D-R can assist clinicians in the evaluation of malingering. The interview's format is particularly relevant to the evaluation of malingering in that it requires subjects to provide elaborate descriptions in support of all endorsed dissociative symptoms (as opposed to yes/no response sets). Experienced clinicians can systematically differentiate true dissociative disorder cases from individuals simulating DID based on a variety of factors, including the complexity and content of responses to SCID-D-R items (Fraser et al., 1999).

Sample SCID-D-R diagnostic evaluation summary

The following psychological report is suitable for inclusion in patient records and psychological evaluations:

Client: Jane Smith
Dates of evaluation: 7/21/98, 7/30/98, 8/10/98
Referral source: Patient's therapist
Reason for referral: Diagnostic evaluation; patient suffers from dissociative episodes.

Brief summary: Ms. Smith is a 28-year-old woman employed part time as an administrative assistant. She has a history of outpatient therapy with her current therapist since 1988 and is aware of episodes of "dissociation." "At times I dissociate and then I can't respond." She denies a history of alcohol or drug abuse or prior inpatient psychiatric treatment. She reports that her episodes of dissociation interfere with her social relationships and her ability to function at work.

Family history: Ms. Smith reports that her father was an alcoholic who was verbally and physically abusive. Her sister has a history of alcohol abuse.

Evaluation summary: In addition to performing a routine diagnostic evaluation, I administered the Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised (SCID-D-R; Steinberg, 1994b) in order to systematically evaluate posttraumatic dissociative symptoms and the dissociative disorders. The SCID-D-R Interview was then scored according to the guidelines described in the *Structured Clinical Interview for DSM-IV Dissociative Disorders–Revised* (Steinberg, 1994a). Review of the significant findings from the SCID-D-R interview include the following:

Ms. Smith is suffering from amnestic episodes that occur daily (she has gaps in her memory for conversations she is having with other people). She experiences recurrent depersonalization episodes manifested by feeling "detached," and "not able to be present," and by a "feeling of watching a movie" of herself. She also suffers from daily derealization or a feeling that her "family or therapist" is unfamiliar or unreal. Ms. Smith reports experiencing daily identity confusion manifested by an internal struggle "between a part that wants to be present and a part that wants to be out the door." She also reports experiencing alterations in her sense of identity to a "scared little girl who is trying to hide and is crying" who is age 5–6 years; an "angry child" (age 9–10); and an "adult" part who is able to function at work. She denies having dialogues with these parts and states that she is unsure whether they feel separate. She also was unsure if they took full control.

Mental status exam: Ms. Smith was casually dressed, calm, and cooperative. She spoke fluently and answered questions with relevant replies. She gave relevant replies to questions and denied experiencing voices, psychotic symptoms, or suicidal or homicidal ideas.

Assessment: Based on this evaluation, Ms. Smith's symptoms and past history of abuse are consistent with a primary diagnosis of a dissociative disorder. She has suffered from chronic dissociative symptoms that appear to interfere with her concentration. Ms. Smith reports that she experiences dissociative symptoms recurrently, including severe amnestic episodes, depersonalization, derealization, identity confusion, and identity alteration. Because it is not clear whether the different childlike parts are distinct and take full control of her behavior, her symptoms are consistent with a diagnosis of DDNOS, based on *DSM-IV* criteria. Due to the severe level of Ms. Smith's dissociation, I would recommend a repeat SCID-D-R evaluation in 6 months to further evaluate the extent of her identity disturbance.

Recommendation: Individual therapy focused on the treatment of Ms. Smith's dissociative symptoms is recommended. Pharmacotherapy may be useful if Ms. Smith is experiencing consistent anxiety or depression.

Summary

Systematic assessment of the five dissociative symptom areas is essential for early detection and appropriate treatment of the dissociative disorders. The SCID-D-R assesses the severity of five dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, and identity alteration) as well as the dissociative disorders, based on *DSM-IV* criteria. The SCID-D-R has reported good to excellent reliability and validity and has been field tested on more than 500 patients. It can be used in clinical and research settings with adolescent or adults. It is recommended that evaluation of dissociative symptoms, as described in the SCID-D-R, be included in diagnostic evaluations of all patients with a history of trauma.

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