CLINICAL ASSESSMENT OF DISSOCIATIVE SYMPTOMS AND DISORDERS: THE *STRUCTURED CLINICAL INTERVIEW FOR DSM-IV DISSOCIATIVE DISORDERS (SCID-D)*

Marlene Steinberg, M.D.
Domenic Cicchetti, Ph.D.
Jospehine Buchanan, B.S.
Pamela Hall, Psy.D.
Bruce Rounsaville, M.D.

Marlene Steinberg, M.D., is Associate Research Scientist at Yale University School of Medicine, New Haven, Connecticut. Domenic Cicchetti, Ph.D., is Senior Research Scientist at Yale University School of Medicine, and Senior Research Psychologist and Biostatistician at VA Medical Center, West Haven, Connecticut. Josephine Buchanan, B.S., is Project Supervisor, SCID-D Program, Yale University School of Medicine. Pamela Hall, Psy.D., is Adjunct Associate Professor in the Graduate Psychology Department, Pace University, New York, NY, and is in private practice in Summit and Perth Amboy, New Jersey. Bruce Rounsaville, M.D., is Associate Professor of Psychiatry, Director of Research at the Substance Abuse and Treatment Unit, at Yale University School of Medicine.

For reprints write Marlene Steinberg, M.D., 100 Whitney Avenue, New Haven, Connecticut 06510.

Supported by NIMH First Independent Research Support and Transition Award MH-43352 and 2 RO1-43352 - 04 (Dr. Steinberg), grants DA-00089 and DA-04060 from the National Institute on Drug Abuse (Dr. Rounsaville), and by VA Merit Review Grant MRIS 1416 (Dr. Cicchetti).

The authors thank Betsy Frey, M.Div., M. Phil; and Jonathan Lovins, B.A., for reviewing this manuscript.

ABSTRACT

Early detection of dissociative symptoms is essential for effective initiation of appropriate treatment. The author reviews a new diagnostic tool, the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) *(Steinberg, 1993), which comprehensively evaluates the severity of five posttraumatic dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, identity alteration) and the dissociative disorders. Several investigations have reported good-to-excellent reliability and validity of the SCID-D. This article describes the clinical assessment of dissociative symptoms, as well as the diagnosis of dissociative disorders using the SCID-D, based upon research at Yale University involving over 400 interviews over a 10-year time period. It is recommended that screening for dissociative disorders, as described in the SCID-D and the* Interviewer's Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) *(Steinberg, 1993), be included in the diagnostic evaluation of patients with either dissociative symptoms or with suspected/documented histories of trauma.*

Dissociation is defined by *DSM-III-R* (American Psychiatric Association, 1987) as "a disturbance or alteration in the normally integrative functions of identity, memory or consciousness." Severe dissociative symptoms and the dissociative disorders are recognized as posttraumatic (Braun, 1990; Coons, et al., 1990; Fine, 1990; Goodwin,1990; Kluft, 1985c; 1988; Kluft, Braun & Sachs, 1984; Putnam, 1985; Ross, Norton & Wozney, 1989; Spiegel, 1984, 1991; Spiegel & Cardeña, 1991; Terr, 1991). Dissociation, as a psychological defense, is used by survivors of abuse and trauma to cope with overwhelming anxiety and pain. Victims of recurrent child abuse develop chronic dissociative symptoms or disorders, which include dissociative (psychogenic) amnesia, dissociative (psychogenic) fugue, depersonalization disorder, multiple personality disorder (MPD) (dissociative identity disorder, *DSM-IV* proposed name change), and dissociative disorder not otherwise specified (DDNOS). Studies of the dissociative disorders have noted reported histories of abuse in 85% to 97% of cases of MPD (Coons & Milstein, 1986; Kluft, 1988, 1991; Putnam, et al., 1986; Ross, Norton & Wozney, 1989; Schultz, Braun & Kluft, 1989).

Investigators report that individuals with MPD are frequently misdiagnosed for many years (Kluft, 1987b). Recent investigations indicate that MPD 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, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton & Wozney, 1989). Furthermore, the occurrence of dissociative symptoms has been documented in numerous psychiatric disorders, including personality disorders (such as borderline personality), eating disorders, anxiety disorders (including obsessive-compulsive disorder and post-traumatic stress disorder), (depression, and schizophrenia (Clary, Burstin & Carpenter, 1984; Fine, 1990; Fink & Golinkoff, 1990; Goff, et al., 1992; Havenaar, Boon & Tordoir, 1992; Kluft, 1988; Marcum, Wright & Bissell, 1985; Roth, 1959; Schultz, Braun & Kluft, 1989; Torem, 1986).

For much of this century, patients with dissociative disorders have been misdiagnosed as having schizophrenia, manic depressive illness, hysteria, epilepsy, or a variety of other psychiatric disorders (Coons, 1984; Kluft, 1991; Putnam, et al., 1986; Rosenbaum, 1980; Ross & Norton, 1988; Schenck & Bear, 1981). The neglect of dissociative symptoms and disorders by the medical establishment has resulted from several factors, including the reluctance to discuss issues related to child abuse and the concealed nature of dissociative symptoms themselves. Assessment is often complicated because patients with dissociative disorders may deny or be

amnestic for both their abuse history and/or their dissociative symptoms; and may experience "amnesia for amnesia" (Kluft, 1988).

Early identification of patients who suffer from dissociative symptoms and disorders is essential to successful treatment. The recent development of screening (Bernstein & Putnam, 1986; Riley, 1988; Sanders, 1986) and diagnostic tools (Ross, et al., 1989; Steinberg, 1985, 1993a, 1993b) for dissociative symptoms and disorders permits early detection of patients suffering from dissociative symptoms and disorders.

This article is intended to help familiarize clinicians with the systematic assessment of dissociative symptoms and disorders. A review of five core dissociative symptom areas and the differential diagnosis of the dissociative disorders are presented in the context of a new diagnostic tool, the *Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)*. Excerpts from SCID-D interviews illustrate the semistructured format of the SCID-D, the multifaceted nature of dissociative symptoms, and relevant clinical information that can be gathered by this tool. A sample SCID-D protocol for chart documentation and psychological reports is also included.

THE *STRUCTURED CLINICAL INTERVIEW FOR* DSM-IV *DISSOCIATIVE DISORDERS (SCID-D)*

The *Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)* (Steinberg, 1985; Steinberg, 1993b) is a semistructured diagnostic interview that systematically assesses the severity of five dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, and identity alteration) in all psychiatric patients; and diagnoses the dissociative disorders according to *DSM-IV* criteria. The SCID-D evaluates the severity of five specific dissociative symptoms in patients with all DSM Axis I and II diagnoses, and assesses the presence of Dissociative (Psychogenic) Amnesia, Dissociative (Psychogenic) Fugue, Depersonalization Disorder, Multiple Personality Disorder (MPD; Dissociative Identity Disorder, proposed name change), and Dissociative Disorder Not Otherwise Specified (DDNOS), according to *DSM-IV* criteria.

The SCID-D systematizes the assessment of dissociative symptoms by defining the 5 core symptoms of dissociation and the dissociative disorders 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 dissociation, together with clinical experience with patients that suffer from abuse and dissociative disorders. Major contributors to this written and "oral" literature include pioneers in the field of dissociation, such as the late David Caul and the late Cornelia Wilbur, as well as Ralph Allison, Bennett Braun and Richard Kluft. In addition, Drs. Cicchetti and Rounsaville at Yale School of Medicine have generously contributed over a decade of expertise in methodology and diagnostic testing in the field trials of the SCID-D. Finally, critical contributions to the multicenter field trials of the reliability of the SCID-D were made by expert investigators, Drs. Bowman, Cicchetti, Coons, Fine, Fink, Hall, Kluft, and Rounsaville.

Originally developed to incorporate *DSM-III-R* criteria, the SCID-D was updated for publication in 1993 to incorporate *DSM-IV* criteria for the Dissociative Disorders. NIMH-funded field trials of the SCID-D at Yale have indicated good-to-excellent reliability and discriminant validity for each of the five dissociative symptoms, as well as for the dissociative disorders (Steinberg, Buchanan, Cicchetti, Hall & Rounsaville, 1989-1992; Steinberg, Rounsaville & Cicchetti, 1990). These results have been replicated by Goff, Olin, Jenike, Baer, Buttolph (1992) at Harvard, and by Boon and Draijer (1991) in a cross-national replication study in Amsterdam. In addition, preliminary findings from 3 of the 4 sites in the multicenter field trials of the SCID-D (involving expert researchers from New Haven, Philadelphia, Indianapolis, and Summit, New Jersey) also indicate good-to-excellent reliability and validity (Steinberg, Kluft, Coons, et al., 1989-1993).

The clinician-administered SCID-D interview assesses the phenomenology and severity of dissociative symptoms using open-ended questions, with individualized follow-up questions for exploring endorsed symptoms, as well as 9 additional sections for exploration of specific aspects of identity disturbances, such as feelings of possession, sudden mood changes, etc. This format elicits informative descriptions of dissociative experiences, rather than mere yes or no responses. As the reader will discover in the course of this article, patients frequently spontaneously elaborate on histories of trauma while describing their dissociative experiences. This feature of the SCID-D allows clinicians to obtain information regarding traumatic histories, without the use of leading or intrusive questions.

Another advantage of the SCID-D's specific design is its long-term utility. The SCID-D allows interviewers to evaluate dissociative symptoms in various psychiatric and nonpsychiatric populations, independent of changes in DSM criteria for the dissociative disorders. The organization of the SCID-D also allows the clinician to evaluate new disorders that may be defined by future revisions of *DSM-IV*. For instance, *Dissociative Trance Disorder* (a subcategory of DDNOS) can be evaluated with the SCID-D interview through specific questions regarding feelings of possession in the follow-up section on possession symptoms.

Although administration of the full SCID-D requires two to three hours of the interviewer's time, the instrument is highly cost-effective in terms of its demonstrated ability to detect previously undiagnosed cases of dissociative disorder. Given present figures regarding the average dissociative patient's length of time in misdirected therapy prior to establishment of the correct diagnosis (7-10 years; Coons, Bowman & Milstein, 1988; Kluft, 1987; Putnam, et al., 1986), earlier detection of a dissociative disorder using the SCID-D allows for rapid implementation of appropriate treatment strategies.

THE FIVE SCID-D DISSOCIATIVE SYMPTOMS

Amnesia can 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, et al., 1990). It is endorsed by patients as "gaps" in their memory or "lost time", ranging from seconds to years. Patients may describe episodes of forgetting their name, age or address. Patients with severe amnesia are often unable to recall the frequency or duration of their amnestic episodes (Kluft, 1988; Steinberg, et al., 1990). Individuals with chronic amnesia often confabulate or rely on 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.

Depersonalization involves the experience of detachment from one's body or self; for example, feeling the self to be strange or unreal, feeling a sense of physical separation from the body, detachment from emotions, or feeling like a lifeless robot. Depersonalization experiences are frequently described in "as if" terms, reflecting intact reality testing (Ackner, 1954). SCID-D research has found that patients with dissociative disorders often experience depersonalization within the context of ongoing, coherent dialogues with the self (Steinberg, 1991; Steinberg, et al., 1990). Depersonalization is particularly difficult for patients to describe, and can sometimes go unnoticed or can be experienced by patients habituated to it as "normal." Depersonalization occurs as an isolated symptom in a variety of psychiatric disorders (Brauer, Harrow & Tucker, 1970; Noyes, et al., 1977). Additionally, transient depersonalization is a common response to alcohol and drug use, sleep and sensory deprivation, severe emotional stressors; and also occurs as a side effect of medications (Roberts, 1960; Trueman, 1984b).

Derealization involves the sense that the physical and/or interpersonal environment has lost its sense of familiarity or reality. During derealization episodes, the patient experiences friends and relatives as strange and unfamiliar, as may also be the patient's home, place of work, or personal belongings. Derealization often occurs in the context of flashbacks, in which a person regresses in age and re-enters a past experience, as if it were current reality. During the flashback, the present feels unreal to the person. Derealization involves the loss of an affective link between the individual and another person or object that seems unfamiliar or unreal (Siomopoulos, 1972). Isolated episodes of derealization may occur in subjects without psychiatric disorders, in response to substance use, sensory and sleep deprivation, and significant social stressors (e.g., bereavement).

Identity confusion, as assessed in the SCID-D, is defined as a sense of uncertainty, puzzlement or conflict regarding personal identity (Steinberg, et al., 1990; Steinberg, 1993b). Patients who experience dissociative symptoms often express confusion as to who they really are. They feel that they have little sense of self and have difficulty maintaining a feeling of inner coherence, stability, or continuity. They experience conflicting wishes and opinions. 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. In MPD, identity confusion assumes the form of alternate personalities fighting for control of the person's thoughts and behavior. Although identity confusion may occur transiently during adolescence or life crises, the symptom tends to be more chronic and distressing in patients with dissociative disorders.

Identity alteration, as assessed by the SCID-D, refers to objective behavior that indicates the assumption of different identities (Steinberg, et al., 1990; Steinberg, 1993a). 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 multiple personality disorder 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 MPD is characterized by its complexity, distinctness, the ability of the states to take control of behavior, and interconnection with other dissociative symptoms. SCID-D research has found that identity switches often occur in conjunction with experiences of severe depersonalization and derealization.

Severity Rating Definitions found in the *Interviewer's Guide to the SCID-D* allow the interviewer to rate the severity of each of the five dissociative symptoms based on standardized criteria of duration, frequency, distress and dysfunction (Steinberg, 1993a). These definitions provide guidelines for rating the severity of the five dissociative symptoms based on specific SCID-D responses. Table 1 presents the severity rating definitions for depersonalization. For further information on these symptoms and severity ratings, the reader is referred to the *Interviewer's Guide to the SCID-D* (Steinberg, 1993b).

DSM-IV DISSOCIATIVE DISORDERS

Evaluation of the five dissociative symptoms 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 above. A brief review of the dissociative disorders is presented, followed by a review of their specific dissociative symptom profiles (see Figure 1).

Dissociative Amnesia (Psychogenic Amnesia) is a common disorder, regularly encountered in hospital emergency rooms (Nemiah, 1985). Dissociative Amnesia is characterized by the inability to recall important personal information (American Psychiatric Association Task Force on *DSM-IV*, 1993). The forgotten information is often related to a traumatic event. The amnesia must be too extensive to be explained by ordinary forgetfulness, and 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., multiple personality disorder). Due to similarities with organic memory loss, Dissociative Amnesia can be easily overlooked (Loewenstein,1991). Dissociative Amnesia often manifests in combat veterans and in the victims of single severe trau-

mas such as an automobile accident, witnessing a murder, natural disaster, or near-death experience. In contrast to MPD, the course of Dissociative Amnesia is usually marked by sudden onset and resolution.

Dissociative Fugue (Psychogenic Fugue) involves sudden, unplanned wandering away from home or work. It includes amnesia for one's past; and the assumption of a new identity, or confusion about personal identity (American Psychiatric Association Task Force on *DSM-IV*, 1993). The patient remains alert and oriented, and is capable of performing sophisticated tasks. This disorder is distinguished from Multiple Personality Disorder by its sudden, acute onset, the presence of a single severe stressor or trauma, and the absence of the recurrent appearance of distinct personalities. To meet the criteria for Dissociative Fugue, the memory and identity disturbances cannot occur as part of Multiple Personality Disorder 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 Task Force on *DSM-IV*, 1993) (Steinberg, 1991). A patient suffering from Depersonalization Disorder retains intact reality testing. For a diagnosis of Depersonalization Disorder, the depersonalization must occur independently of Schizophrenia, Multiple Personality Disorder, or a substance abuse disorder.

Dissociative Disorder Not Otherwise Specified (DDNOS) includes dissociative syndromes that do not meet the full criteria of any of the other dissociative disorders. DDNOS includes variants of Multiple Personality Disorder in which

TABLE 1
Severity Rating Definitions of Depersonalization

Depersonalization—Detachment from one's self, e.g., a sense of looking at one's self as if one is an outsider.

MILD

- Single episode or rare (total of 1-4) episodes of depersonalization which are brief (less than 4 hours) and are usually associated with stress or fatigue.

MODERATE (One of the following)

- Recurrent (more than 4) episodes of depersonalization. (May be brief or prolonged. May be precipitated by stress.)
- Episodes (1-4) of depersonalization which (One of the following)
  - — produce impairment in social or occupational functioning.
  - — are not precipitated by stress.
  - — are prolonged (over 4 hours).
  - — are associated with dysphoria.

SEVERE (One of the following)

- Persistent episodes of depersonalization (24 hours and longer).
- Episodes of depersonalization occur daily or weekly. May be brief or prolonged.
- Frequent (more than 4) episodes of depersonalization that (One of the following)
  - — produce impairment in social or occupational functioning.
  - — do not appear to be precipitated by stress.
  - — are prolonged (over 4 hours).
  - — are associated with dysphoria.

**Note: The Severity Rating Definitions are not an inclusive list. The purpose of these definitions is to give the rater a general description of the parameters of the spectrum of dissociative symptoms and their severity.*

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

Q. 38. 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?) (Have you ever had an "out of body" experience?"	***DEPERSONALIZATION*** *An alteration in the perception or experience of the self so that the feeling of one's own reality is temporarily lost. This is manifested in a sense of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size, or a sense of seeming to perceive oneself from a distance (usually from above) (DSM-III-R, p. 397).* *Patients feel that their point of conscious "I-ness" is outside their bodies, commonly a few feet overhead, from where they actually observe themselves as if they were a totally other person (Nemiah, 1989a, p 1042)*	*? 1 3 4*

? = inadequate information 1 = absent 3 = present 4 = inconsistent information

Reprinted with permission from: Steinberg, M.: Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D). Washington, DC, American Psychiatric Press, 1993.

personality "states" may take over consciousness and behavior but are not sufficiently distinct, and variants of Multiple Personality Disorder in which there is no amnesia for personal information. Other forms of DDNOS include possession and trance states, 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.

Multiple Personality Disorder (MPD) (Dissociative Identity Disorder, DSM-IV proposed name change) is the most chronic and severe manifestation of dissociation (Kluft, Steinberg & Spitzer, 1988). MPD is believed to follow severe and persistent sexual, physical, and/or psychological child abuse (American Psychiatric Association, 1987; Braun & Sachs, 1985; Coons, Bowman & Milstein, 1988; Fine, 1990; Kluft, 1985a; Kluft, 1991; Putnam, 1985 #50; Wilbur, 1984a). In this disorder, distinct, coherent identities exist within one individual and are able to assume control of the person's behavior and thought. In MPD, the patient experiences amnesia for personal information, including some of the identities and activities of alternate personalities. MPD may mimic a spectrum of psychiatric conditions, including the psychotic, affective, and character disorders (Bliss, 1980; Braun & Sachs, 1985; Coons, 1984; Greaves, 1980; Kluft, 1984a; 1987; Putnam, et al., 1986; Ross & Norton, 1988).

THE *STRUCTURED CLINICAL INTERVIEW FOR* DSM-IV *DISSOCIATIVE DISORDERS (SCID-D)*

In addition to the evaluation of the severity of five dissociative symptoms, the SCID-D also assesses the dissociative disorders according to *DSM-IV* criteria. Follow-up questions within these sections elicit descriptions of the endorsed symptoms, as well as reports of frequency and duration. Since dissociative symptoms are often multifaceted, the SCID-D uses multiple open-ended questions to explore each of the dissociative symptoms. This semi-structured format is advantageous because patients tend to describe dissociative symptoms in varied ways that are ignored or overlooked by shorter or highly structured interviews.

The 3-column format of the SCID-D is modeled on that of the *Structured Clinical Interview for DSM-III-R (SCID)* (1990), developed by Spitzer, Williams, Gibbon, and First. The SCID is a widely used diagnostic interview for the evaluation of a variety of major psychiatric disorders including the mood, psychotic, anxiety, and substance use disorders and has reported good reliability. However, the SCID does not evaluate the dissociative disorders. The SCID-D can be used in conjunction with the SCID or independently.

An example of the SCID-D's multicolumn format is shown above.

The SCID-D also assesses associated features of MPD and Dissociative Disorder, Not Otherwise Specified, such as internal dialogues, mood changes and flashbacks. Finally, the interviewer has the option of administering one or two follow-up sections to further assess the severity of identity confusion and identity alteration. After the interview, the clinician rates the presence of intra-interview dissociative cues, including intra-interview amnesia, changes in demeanor, and trance-like appearance. In the SCID-D, both verbal and nonverbal responses of patients are examined to obtain an accurate assessment of dissociative symptoms and disorders, thus approximating an experienced clinician's diagnostic judgment.

ASSESSMENT OF THE FIVE DISSOCIATIVE SYMPTOMS: EXAMPLES OF SCID-D RESPONSES

Below are examples of SCID-D questions regarding dissociative symptoms and characteristic responses from patients with dissociative disorders.

Assessing Amnesia

Questions in this section explore the multifaceted nature of amnesia and assess both the subject's awareness of lost time, as well as behavioral manifestations such as finding oneself in a place and not knowing how one got there. Intra-interview dissociative cues suggestive of amnesia include the patient seeming disoriented during the interview or having difficulty recalling the frequency of endorsed symptoms.

The first question of the amnesia section asks: "Have you ever felt as if there were large gaps in your memory?" One patient responded:

> Yes. My childhood. I'm not able to do math. I mean I can't do it, but I've gone back and I've looked at my test scores in school and I did fine in math...Or I won't remember that we [the patient and her husband] went someplace, but if it's said I can then remember it. I have to be told. I have like a blank. (SCID-D interview, unpublished transcript.)

Many patients with dissociative disorders understand their amnesia as "blank spells" or as "spaciness." Many are not aware that their inability to remember is a psychiatric symptom that may have resulted from trauma. The previous patient, like many others, relies on information from others to fill in the lacunae in her memory. This is a form of compensation that allows the patient to retain some sense of temporal continuity in her life.

Question # 7 asks, "Have you ever found yourself in a place and been unable to remember how or why you went there?" One patient replied:

> Yeah. When I disappeared for four hours and I didn't know where I was and I ended up on a neighbor's front doorstep...I was covered with bruises at that point and I thought it was 'cause I had fallen down and stumbled. In retrospect, I think that was the first punching out I got from my husband and I stumbled around for several hours. (SCID-D interview, unpublished transcript.)

In response to this item, the patient endorsed an amnestic episode lasting hours, for recent events. The amnesia was related to physical abuse from her husband. Often, severe stress or trauma, occurring in the present, triggers memories of childhood abuse and dissociation.

Assessing Depersonalization

Depersonalization is also a complex dissociative symptom, and patients experience it in a number of ways. These can include out-of-body experiences, numbing of emotions, a feeling of strangeness, and the sense that parts of the body are changing in size. Nonverbal cues such as a trance-like 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 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 interview, unpublished transcript.)

In addition to endorsing symptoms of depersonalization this patient's response is an illustrative example of the SCID-D's ability to elicit a history of abuse without asking direct or intrusive questions about trauma.

Another patient described depersonalization related to body perception in a different way. In contrast to out-of-body experiences, the following episode involves a part of the body feeling foreign. 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).

Depersonalization may also involve the feeling that one's hands or feet are separated from the rest of one's body. Additionally, this patient expressed confusion and disbelief at the experience of depersonalization, reflecting intact reality testing. Finally, the lengthy pause and sigh in her response reflect an emotional response to the questions, commonplace in patients who experience recurrent dissociative symptoms.

A common, perceptual form of depersonalization involves the individual's "splitting" into a participator and an observer. This experience often contains 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:

> [There is] this body that walks around and somebody else just watches. But there are others. It's so complicated I don't know how to explain it...Like I know I'm here and I won't remember a lot of it. Like I'll leave here and I'll have a lot of guilt and

> I'll worry and it probably will take me two days to remember what went on...It's like you have to filter through the ranks–layers–I don't know.

This patient's depersonalization is connected to symptoms of amnesia, identity confusion and identity alteration (a common occurrence in patients with MPD). Additionally, like many patients with dissociative disorders, she has difficulty putting her experiences into precise terms.

The experience of ongoing internal dialogues in the context of depersonalization occurs in patients with dissociative disorders (Steinberg, 1991). One patient with DDNOS provided this example of an internal dialogue:

> 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 me on 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 interview, unpublished transcript)

Thus this patient experiences severe depersonalization in conjunction with identity confusion.

Assessing Derealization

The SCID-D allows the interviewer to explore the subject's experiences of feeling that friends or family members are unfamiliar or unreal. Patients who experience severe derealization during the interview may comment that the therapist or the interview experience does not seem real. Question # 79 asks: "Have you ever felt as if familiar surroundings or people you knew seemed unfamiliar or unreal?" One patient answered:

> Sometimes people will feel unreal to me, like, you know, what am I doing with this person. I don't even know this person. (SCID-D interview, unpublished transcript.)

Positive responses to this question often involve derealization of a patient's parents or spouse. Commonly, derealization occurs in the context of a flashback, in which a friend or parent reminds the patient of a past abuser, and the patient consequently feels that the person they are with is unreal. For instance, one patient experienced derealization when she had flashbacks involving her abusive father. Question # 84 asks: "Have you ever felt puzzled as to what is real and what's unreal in your surroundings?"

> 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 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 melt 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 interview, unpublished transcript.)

As seen in the previous example, derealization can involve perceptual distortions. Derealization is often a necessary defense during traumatic experiences, in which a victim may need to detach his or her consciousness from the painful reality of the trauma. Derealization may be triggered when the individual is reminded of a past trauma or when confronted with a stressful situation in the present.

Assessing Identity Confusion

In response to SCID-D questions regarding identity confusion, subjects with dissociative disorders often describe a battle for inner survival and use metaphors of war. Moreover, patients with MPD often elaborate spontaneously on symptoms of identity alteration in their responses. Question # 101 asks: "Have you ever felt as if there was a struggle going on inside of you?" One patient responded:

> Oh God. Yes. That's like daily, hourly. I feel like an amoeba with fifteen thousand different ideas about where it wants to go. And it's like literally a being pulled in every direction possible until there's nothing left, and it's like split in half. That's a constant battle.

Patients with dissociative disorders typically feel confused about their identity. This experience 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 patient 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 interview, unpublished transcript.)

This patient spontaneously elaborated on an episode of identity alteration involving age regression.

Assessing Identity Alteration

Because amnesia for altered identity states can mask the assessment of identity alteration, the SCID-D explores both direct and indirect evidence of this symptom. Indirect evidence for identity alteration comes from two sources: feedback from relatives or friends and behavioral indications, such as finding objects in one's possession for which one cannot account. For instance, the SCID-D asks if others have noted the patient acting like a child, acting like a different person, or answering to a different name. Direct information includes the patient's awareness of referring to himself by different names, acting like a child or like a different person, or feeling possessed. Nonverbal cues during the interview can also help the clinician assess the extent of identity alteration. Severe mood change, particularly in conjunction with amnesia, change of voice, and other intra-interview cues during the interview, may also indicate different manifestations of identity alteration.

Question # 114 asks: "Have you ever acted as if you were a completely different person?" One patient answered:

> Yeah...It can be kind of funny, when I'm Paula or Judy. It can be funny if I look at it a certain way. You would love Paula. She is the biggest clean freak in the universe. I mean you couldn't tolerate her really, but if you wanted your house cleaned, you'd love her. And Judy can be funny too. If I look at her as funny rather than embarrassing. I don't like Jill, because Jill screams at me if I spill milk on the floor. (SCID-D interview, unpublished transcript.)

This patient, who had multiple personality disorder, listed a series of different names, and the coexistence of the personalities in ongoing dialogues. This would be considered severe identity alteration according to the guidelines of the *Severity Rating Definitions* (Steinberg, 1993a). For instance, question # 116 asks: "Have you ever been told by others that you seem like a different person?" One patient 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 interview, unpublished transcript.)

Other types of indirect evidence for identity alteration include finding objects that were purchased by an alternate personality. Question # 122 asks: "Have you ever found things in your possession that seemed to belong to you, but you could not remember how you got them?" One patient with MPD replied:

> 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 – I 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 interview, unpublished transcript.)

These responses demonstrate that patients with severe identity alteration experience subjective confusion resulting from their identity changes. This patient was markedly perplexed by the unexpected occurrences. The patient also mentioned external verification of her identity alteration (i.e., her mother told her about the different clothing she wears).

FOLLOW-UP SECTIONS

The SCID-D allows a trained clinician to administer up to 2 of 9 individualized follow-up sections to explore previously reported dissociative symptoms. Each of the follow-up modules consists of 9-13 questions that provide further information regarding the severity of identity disturbance. Some of the follow-up sections include: rapid mood changes, the use of different names, internal dialogues, the presence of a childlike part, acting like a different person, and feelings of possession. Each follow-up section assesses the degree of complexity and volition associated with personality states that the subject had previously endorsed.

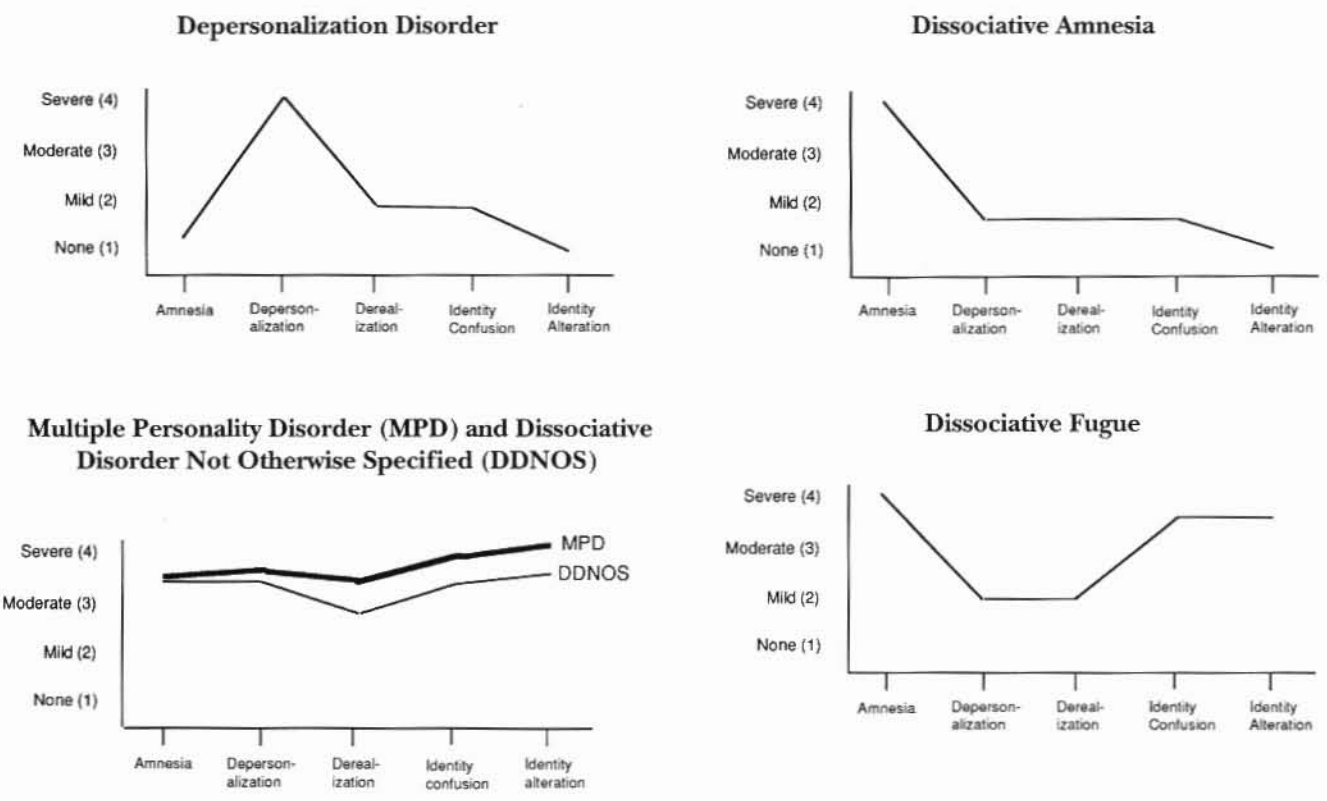
SCORING OF THE SCID-D INTERVIEW: THE SCID-D SUMMARY SCORE SHEET

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* (Steinberg, 1993a). The severity of dissociative symptoms is evaluated in terms of distress, dysfunctionality, 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 individual symptom severity scores are added together to yield a total SCID-D symptom score, which ranges from 5 (no symptomatology) to 20 (severe manifestations of all five dissociative symptoms). Table 1 lists the severity rating definitions of the symptom of depersonalization.

DIFFERENTIAL DIAGNOSIS BASED ON SYSTEMATIC ASSESSMENT OF DISSOCIATIVE SYMPTOMS

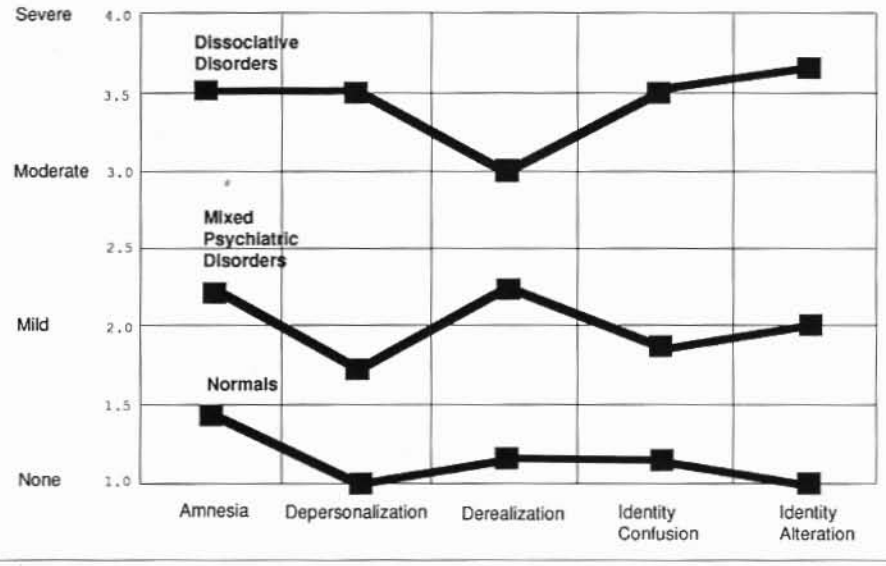
Diagnosis proceeds from the consideration of the full constellation of dissociative symptoms. If the subject received ratings of none-to-mild on all symptoms, dissociative disorder may be ruled out. If, however, one or more symptoms were found to be severe, the presence of a dissociative disorder should be considered. *Diagnostic Worksheets* are included in the *Interviewer's Guide to the SCID-D* to assist systematic assessment of a dissociative disorder. Diagnosis of dissociative disorder is based on a specific pattern of SCID-D items

FIGURE 1
SCID-D Symptom Profiles of the Dissociative Disorders



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

FIGURE 2
SCID-D Symptom Profiles in Psychiatric Patients and Normal Controls



in support of *DSM-IV* criteria. For further details on the scoring and interpretation of the SCID-D, see the *Interviewer's Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)* (Steinberg, 1993a).

Figure 1, "The Disorder Profiles," illustrates the profiles of dissociative symptoms for each of the five Dissociative Disorders, as found in SCID-D research. These graphs use numerical scaling (1-5) of the severity of dissociative symptoms. With the use of this guide, the interviewer can now evaluate whether the patient meets the criteria for a specific dissociative disorder.

SYMPTOM PROFILES IN OTHER DISORDERS AND IN CONTROL SUBJECTS

Figure 2 plots 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 non-dissociative disorders score between none and moderate (1-3). Subjects with dissociative disorders experience recurrent to persistent (moderate to severe [3-4]) dissociative symptoms.

ADMINISTRATION OF THE SCID-D

The SCID-D should be administered by experienced clinicians familiar with the tool and with the *Interviewer's Guide to the SCID-D*. The interview can be administered to psychiatric outpatients and inpatients, as well as subjects without psychiatric illness. A follow-up session should be scheduled to review the results with the subject and to discuss issues the subject may have considered since the interview.

CLINICAL APPLICATIONS OF THE SCID-D

The SCID-D is a time- and cost-effective instrument with a variety of clinical applications. In addition to its diagnostic utility, it is a tool that can be used for patient education regarding the nature and significance of dissociative symptoms during the follow-up session with the subject. Moreover, the SCID-D's format facilitates long-term follow-up of patients' symptoms; a clinician can administer the instrument at 6-month or yearly intervals in order to monitor changes in symptomatology and reassess treatment strategy accordingly. Lastly, since the SCID-D is designed to be filed with patients' charts, it provides easily accessible documentation of symptoms, for record-keeping and psychological reports.

Practitioners of hypnosis will find the SCID-D particularly relevant to their work because the instrument allows accurate assessment of the patient's baseline dissociative symptomatology. By nature, hypnosis involves inducing controlled dissociation. Without the information obtained by pre-hypnotic assessment of dissociative symptoms, as performed by the SCID-D, the clinician may not know if the symptoms elicited under hypnosis are secondary to hypnosis or primary to a dissociative disorder. Since the SCID-D is intended to be filed with patients' charts, therapists who practice hypnosis will have documentation of patients' baseline dissociative symptoms.

INTERVIEWER TRAINING WORKSHOPS

Additional training can be obtained by attending SCID-D interviewer training workshops which are conducted several times a year by two of the authors (M.S. and P.H.). These workshops illustrate the diagnostically discriminating features of the dissociative symptoms and disorders evaluated by the SCID-D and provide relevant training in the SCID-D's administration, interpretation, and scoring.

CASE STUDY AND SAMPLE PROTOCOL

The following case study is included in order to demonstrate the incorporation of SCID-D findings into a diagnostic evaluation summary suitable for patient records and psychological reports.

[For the sake of conciseness, the past psychiatric history of this patient is abbreviated and this sample protocol will focus primarily on the SCID-D evaluation.]

Sample SCID-D Evaluation Report

Jane Smith is a 35-year-old single woman and is employed as a receptionist. She has experienced intermittent panic attacks, depression, auditory hallucinations, "trances," "blackouts," and self-mutilating behaviors, since she was twelve years-old. Jane reports a family history of emotional and physical abuse at the hands of both parents, including long periods of being locked in a closet and recurrent whippings with a belt by her father. She has been treated in outpatient psychotherapy four times since age fourteen, for periods of up to two years; past diagnoses include bi-polar disorder, schizophrenia, atypical psychosis, and depression. She was referred to me for a diagnostic consultation by her present therapist, due to the presence of suspected dissociative symptoms.

Dates of Evaluation

I evaluated Jane Smith on 5/17/93, 5/24/93, and 5/31/93. A complete psychiatric history was taken and a mental status examination performed on 5/17/93 . On 5/24/93, I administered the Structured Clinical Interview for DSM-IV *Dissociative Disorders (Steinberg M, American Psychiatric Press, 1993b). Scoring and interpretation of the SCID-D were performed according to the guidelines described in the Interviewer's Guide to the SCID-D (Steinberg M, American Psychiatric Press, 1993a). On 5/31/93, I met with Jane Smith to review the findings of the SCID-D interview and discussed recommendations for treatment.*

SCID-D Assessment Summary

A review of the significant findings from the SCID-D interview is as follows: Jane suffers from bimonthly episodes of severe amnesia since age 9, which are the "blackouts" she describes. She also experiences recurrent episodes of depersonalization which include her "trances", during which she feels she leaves her body and is sitting on her own shoulder. She reports that she occasionally cuts herself with a razor in order to alleviate the feelings of depersonalization. She endorses symptoms of recurrent derealization and

identity confusion. In addition, Jane reports evidence of identity alteration: she receives mail addressed to "Samantha" and "Freddie," from two other students at different undergraduate institutions; she has also had people greet her on the street as "Samantha." During administration of the follow-up sections, Jane endorsed having recurrent feelings that different people existed inside her, including a child of toddler age, a "Biker" in her late teens, a rageful person called "Son-of-a-Bitch" of uncertain age, and a person named "Idiot." She reported ongoing internal dialogues between "Son-of-a-Bitch" and "Biker." She reported that she experiences these people as separate from her "normal self" and that they assume control of her behavior. As examples, she mentioned that "Idiot" was talking to me during part of the interview; and that her boyfriend broke up with her because the "Biker" came out several times during their dates and displayed inappropriate behavior. During the SCID-D interview, I observed changes in Jan's affect, speech and physical posture consistent with her child alter, such as curling up in the chair and sucking her thumb.

Assessment

Jane's SCID-D symptom profile and past history of traumatic experiences are consistent with a primary diagnosis of a dissociative disorder. Based on my evaluation, Jane's symptoms of amnesia, depersonalization, derealization, identity confusion, and identity alteration are all present at a severe level. She has suffered from chronic dissociative symptoms that interfere with her schoolwork and relationships, and appear to be related to her self-cutting. She has also described the presence of other personalities within her which take control of her behavior to the extent of forming alternate sets of relationships and behaviors. The constellation of Jane's symptoms meets DSM-IV *criteria for a diagnosis of multiple personality disorder. Her depression appears to be secondary to the disruptions in her life caused by the alter personalities.*

Recommendation

I recommend weekly individual therapy focused on the reduction of Jane's dissociative symptoms. Patient education regarding these symptoms and their triggers is recommended during the initial treatment phase. A subsequent goal should be increased cooperation among the alternate personalities in order to reduce the severity of Jane's amnesia, identity confusion and identity alteration. Finally, the use of an anti-depressant may relieve some of the immediate symptoms of 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 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 has reported good-to-excellent reliability and validity and has been field-tested on over 500 patients (Boon & Draijer, 1991; Goff, et al., 1992; Steinberg, et al., 1989-1992; Steinberg, et al., 1989-1993; Steinberg, et al., 1990). It can be used in clinical and research settings with outpatients and inpatients, as well as in training programs. It is recommended that screening for the five dissociative symptoms, as described in the SCID-D and *Interviewer's Guide to the SCID-D*, be incorporated in diagnostic evaluations of all patients with recurrent dissociative symptoms or suspected/documented histories of trauma. ■

REFERENCES

Ackner, B. (1954). Depersonalization I: Aetiology and phenomenology. *Journal of Mental Science*, 100, 838-853.

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders, 3rd Ed., Revised*, Washington, DC: American Psychiatric Association.

American Psychiatric Association Task Force on *DSM-IV*. (1993): *DSM-IV draft criteria*. Washington, DC: American Psychiatric Association.

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

Bliss, E.L. (1980). Multiple personalities: a report of 14 cases with implications for schizophrenia. *Archives of General Psychiatry*, 37, 124-137.

Bliss, E.L., & Jeppsen, E.A. (1985). Prevalence of multiple personality among inpatients and outpatients. *American Journal of Psychiatry*, 142(2), 250-251.

Boon, S., & Draijer, N. (1991). Diagnosing dissociative disorders in the Netherlands: a pilot study with the Structured Clinical Interview for *DSM-III-R* Dissociative Disorders. *American Journal of Psychiatry*, 148(4), 458-462.

Brauer, R., Harrow, M., & Tucker, G. (1970). Depersonalization phenomena in psychiatric patients. *British Journal of Psychiatry*, 117, 509-515.

Braun, B.G. (1990). Dissociative disorders as sequelae to incest. In R.P. Kluft (Eds.), *Incest-related syndromes of adult psychopathology* (pp. 227-246). Washington, DC: American Psychiatric Press.

Braun, B.G., & Sachs, R.G. (1985). The development of multiple personality disorder: predisposing, precipitating, and perpetuating factors. In R.P. Kluft (Eds.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press.

Clary, W.F., Burstin, K.J., & Carpenter, J.S. (1984). Multiple personality and borderline personality disorder. *Psychiatric Clinics of North America*, 7, 89-100.

Coons, P.M. (1984). The differential diagnosis of multiple personality: a comprehensive review. *Psychiatric Clinics of North America*, 12, 51-67.

Coons, P.M., Bowman, E.S., & Milstein, V. (1988). Multiple personality disorder: A clinical investigation of 50 cases. *Journal of Nervous and Mental Disease*, 176(5), 519-527.

Coons, P.M., Cole, C., Pellow, T., & Milstein, V. (1990). Symptoms of posttraumatic stress and dissociation in women victims of abuse. In R.P. Kluft (Ed.), *Incest-related syndromes of adult psychopathology* (pp. 205-226). Washington, DC: American Psychiatric Press.

Coons, P.M., & Milstein, V. (1986). Psychosexual disturbances in multiple personality: characteristics, etiology, and treatment. *Journal of Clinical Psychiatry*, 47, 106-110.

Fine, C.G. (1990). The cognitive sequelae of incest. In R.P. Kluft (Ed.), *Incest-related syndromes of adult psychopathology* (pp. 161-182). Washington, DC: American Psychiatric Press.

Fink, D., & Golinkoff, M. (1990). Multiple personality disorder, borderline personality disorder and schizophrenia: A comparative study of clinical features. *DISSOCIATION*, III(3), 127-134.

Goff, D.C., Olin, J.A., Jenike, M.A., Baer, L., & Buttolph, M.L. (1992). Dissociative symptoms in patients with obsessive-compulsive disorder. *Journal of Nervous and Mental Disease*, 180(5), 332-337.

Goodwin, J.M., Cheeves, K., & Connell, V.: Borderline and other severe symptoms in adult survivors of incestuous abuse. Psychiatric Annals 20, 1:22-32, 1990b.

Greaves, G.B. (1980). Multiple personality: 165 years after Mary Reynolds. *Journal of Nervous and Mental Disease*, 168, 577-596.

Havenaar, J.M., Boon, S., & Tordoir, C.E.M. (1992). Dissociative symptoms in patients with eating disorders in the Netherlands: a study using a self rating scale (DES) and a structured clinical interview (SCID-D). *In Dissociative Disorders 1992: Proceedings of the Ninth International Conference on Multiple Personality/Dissociative States.* Rush-Presbyterian-St. Luke's Medical Center, Rush North Shore Medical Center, Skokie, Illinois.

Kluft, R.P. (1984a). An introduction to multiple personality disorder. *Psychiatric Annals*, 14, 19-24.

Kluft, R.P. (Ed.). (1985a). *Childhood antecedents of multiple personality*. Washington, DC: American Psychiatric Press.

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

Kluft, R.P. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry*, 38, 363-373.

Kluft, R.P. (1987b). Making the diagnosis of multiple personality disorder. In F.F. Flach (Eds.), *Diagnostics and psychopathology* (pp. 207-225). New York: Norton.

Kluft, R.P. (1988). The dissociative disorders. In J. Talbott, R. Hales, & S. Yudofsky (Eds.), *The American Psychiatric Press textbook of psychiatry* (pp. 557-585). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1991). Multiple personality disorder. In A. Tasman & S. Goldfinger (Eds.), *American Psychiatric Press review of psychiatry* (vol. 10, pp. 161-188). Washington, DC: American Psychiatric Press.

Kluft, R.P., Braun, B.G., & Sachs, R.G. (1984). Multiple personality, intrafamilial abuse, and family psychiatry. *International Journal of Family Psychiatry*, 5, 283-301.

Kluft, R.P., Steinberg, M., & Spitzer, R.L. (1988). *DSM III-R* revisions in the dissociative disorders: an explanation of their observation and rationale. *DISSOCIATION*, I(1), 39-46.

Loewenstein, R.J. (1991). Psychogenic amnesia and psychogenic fugue: a comprehensive review, Tasman, A. & Goldfinger, S. (Eds.), *American Psychiatric Press review of psychiatry* (vol 10, pp. 189-222). Washington, DC: American Psychiatric Press, 1991

Marcum, J.M., Wright, K., & Bissell, W.G. (1985). Chance discovery of multiple personality disorder in a depressed patient by amobarbital interview. *Journal of Nervous and Mental Disease*, 174, 489-492.

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

Nemiah, J.C. (1989a). Dissociative disorders (hysterical neurosis, dissociative type). In H. Kaplan & B. Sadock (Eds.), *Comprehensive textbook of psychiatry* (pp. 1028-1044). Baltimore, MD: Williams & Wilkins.

Noyes, R.J., Hoenk, P., Kuperman, S., & et al. (1977). Depersonalization in accident victims and psychiatric patients. *Journal of Nervous and Mental Disease*, 164, 401-407.

Putnam, F.W. (1985). Dissociation as a response to extreme trauma. In R.P. Kluft (Eds.), *Childhood antecedents of multiple personality* (pp. 65-97). Washington, DC: American Psychiatric Press.

Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293.

Riley, K. (1988). Measurement of dissociation. *Journal of Nervous and Mental Disease*, 176, 449-450.

Roberts, W. (1960). Normal and abnormal depersonalization. *Journal of Mental Science*, 106, 478-493.

Rosenbaum, M. (1980). The role of the term schizophrenia in the decline of the diagnoses of multiple personality. *Archives of General Psychiatry*, 37, 1383-1385.

Ross, C.A., Heber, S., Norton, G.R., Anderson, D., Anderson, G., & Barchet, P. (1989). The Dissociative Disorders Interview Schedule: a structured interview. *DISSOCIATION*, II(3), 169-189.

Ross, C.A., & Norton, G. (1988). Multiple personality disorder patients with a prior diagnosis of schizophrenia. *DISSOCIATION*, I(2), 39-42.

Ross, C.A., Norton, G., & Wozney, K. (1989). Multiple personality disorder: an analysis of 236 cases. *Canadian Journal of Psychiatry*, 34, 413-418.

Roth, M. (1959). The phobic anxiety-depersonalization syndrome. *Proceedings of the Royal Society of Medicine*, 52, 587-595.

Sanders, S. (1986). The Perceptual Alteration Scale: a scale measuring dissociation. *American Journal of Clinical Hypnosis*, 29, 95-102.

Schenck, L., & Bear, D.M. (1981). Multiple personality and related dissociative phenomena in patients with temporal lobe epilepsy. *American Journal of Psychiatry*, 138(10), 1311-1326.

Schultz, R., Braun, B.G., & Kluft, R.P. (1989). Multiple personality disorder: phenomenology of selected variables in comparison to major depression. *DISSOCIATION*, II(1), 45-51.

Siomopoulos, V. (1972). Derealization and déjà vu: formal mechanisms. *American Journal of Psychotherapy*, 26(1), 84-89.

Spiegel, D. (1984). Multiple personality as a posttraumatic stress disorder. *Psychiatric Clinics of North America*, 7, 101-110.

Spiegel, D. (1991). Dissociation and trauma. In A. Tasman & S. Goldfinger (Eds.), *American Psychiatric press review of psychiatry*, (vol 10 , pp. 261-275). Washington, DC: American Psychiatric Press.

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

Spitzer, R.L., Williams, J.B.W., Gibbon, M., & First, M.B. (1990). *The structured clinical interview for DSM-III-R (SCID)*. Washington, DC: American Psychiatric Press.

Steinberg, M. (1985). *Structured clinical interview for DSM-III-R dissociative disorders (SCID-D)*. New Haven, CT, Yale University School of Medicine.

Steinberg, M. (1991). The spectrum of depersonalization: assessment and treatment. In A. Tasman & S. Goldfinger (Eds.), *American Psychiatric Press review of psychiatry, vol 10*, pp. 223-247). Washington, DC: American Psychiatric Press.

Steinberg, M. (1993a). *Interviewer's guide to the structured clinical interview for DSM-IV dissociative disorders (SCID-D)*. Washington, DC: American Psychiatric Press.

Steinberg, M. (1993b). *Structured clinical interview for DSM-IV dissociative disorders (SCID-D)*. Washington, DC, American Psychiatric Press.

Steinberg, M., Cicchetti, D.V., Buchanan, J., Hall, P.E., & Rounsaville, B.J. (1989-1992). NIMH field trials of the *structured clinical interview for DSM-IV dissociative disorders (SCID-D)*. Yale University School of Medicine, New Haven, CT.

Steinberg, M., Kluft, R.P., Coons, P.M., Bowman, E.S., Buchanan, J., Fine, C.G., Fink, D.L., Hall, P.E., Rounsaville, B.J., & Cicchetti, D.V. (1989-1993). *Multicenter field trials of the structured clinical interview for DSM-IV dissociative disorders (SCID-D)*. New Haven, CT, Yale University School of Medicine.

Steinberg, M., Rounsaville, B.J., & Cicchetti, D.V. (1990). The structured clinical interview for *DSM-III-R* dissociative disorders: Preliminary report on a new diagnostic instrument. *American Journal of Psychiatry*, 147(1), 76-82.

Stern, C.R. (1984). The etiology of multiple personalities. *Psychiatric Clinics of North America*, 7, 149-160.

Terr, L.C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, 148(1), 10-20.

Torem, M. (1986). Dissociative states presenting as eating disorders. *American Journal of Clinical Hypnosis*, 29, 137-142.

Trueman, D. (1984b). Depersonalization in a non-clinical population. *Journal of Psychology*, 116, 107-112.

Wilbur, C.B. (1984a). Multiple personality and child abuse. *Psychiatric Clinics of North America*, 7, 3-8.