

SYSTEMATIC ASSESSMENT
OF DISSOCIATIVE
SYMPTOMS AND
DISORDERS USING THE
SCID-D IN A
CLINICAL OUTPATIENT
SETTING: THREE CASES

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ABSTRACT

This paper presents three case studies illustrating the range and scope of the clinical applications of the SCID-D, a semi-structured interview for the assessment and diagnosis of dissociative symptoms and disorders according to DSM-IV criteria. The studies indicate the effectiveness of the SCID-D in differential diagnosis between medical and psychiatric conditions, in symptom documentation for forensic cases, and in treatment planning for patients previously diagnosed with dissociative identity disorder (DID), formerly multiple personality disorder (MPD), who are experiencing impasses in therapy. Although the SCID-D is not a trauma questionnaire, its ability to elicit spontaneous descriptions of trauma from patients without the use of leading or intrusive questions makes it a valuable instrument for diagnosis and assessment as well as treatment planning and implementation. Early diagnosis of dissociative disorders with the SCID-D can lead to timely and effective treatment for those suffering from DID and the dissociative disorders.

INTRODUCTION

Accurate diagnosis and assessment of the presence and severity of dissociative symptomatology are essential first steps toward planning and implementation of proper therapy (Kluft, 1984b; Steinberg, Cicchetti, Buchanan, Hall, & Rounsaville, 1993). As the recent literature has indicated, patients with dissociative identity disorder (DID), formerly multiple personality disorder (MPD), the most severe of the dissociative disorders, are in treatment for an range of 6.8 to 7 years prior to establishment of the correct diagnosis (Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons, Bowman, & Milstein, 1988). With the publication of the SCID-D, a reliable diagnostic instrument for the detection and assessment of dissociative symptoms and disorders is now available to

clinicians (Steinberg 1993a, 1993b). The SCID-D is a semi-structured interview intended to elicit patients' experiences of five core symptoms (amnesia, depersonalization, derealization, identity confusion, and identity disturbance) without the use of intrusive or leading questions. While the SCID-D is not a trauma questionnaire as such, the 400 interviews that were conducted as part of the instrument's field testing indicate that patients frequently spontaneously volunteer a history of trauma (Steinberg, Cicchetti, Buchanan, Hall, & Rounsaville, 1989-1992). Since current research indicates a connection between a history of abuse in childhood and dissociative symptomatology in later life (Chu & Dill, 1990; Coons, Bowman, & Pellow, 1989; Goodwin, 1988; Kluft, Braun & Sachs, 1984; Steinberg et al., 1989-1992), the SCID-D's ability to elicit a spontaneous history of traumata makes it particularly useful to clinicians concerned about asking leading questions. Moreover, the SCID-D is also useful in planning the course of a patient's therapy. The SCID-D's inclusion of nine sets of optional follow-up questions permits an experienced interviewer to tailor the interview to patients' specific histories and endorsed dissociative experiences. As a result, the SCID-D offers clinicians a time- and cost-effective instrument with a variety of clinical applications in addition to diagnosis. *The Interviewer's Guide to the SCID-D* contains guidelines for the administration, scoring and interpretation of the SCID-D. Because the SCID-D is a clinician administered tool, it is recommended that clinicians and researchers familiarize themselves with these published guidelines and/or attend SCID-D workshops. Professionals who are interested in a comprehensive overview of the phenomenology of dissociative symptoms and disorders, as well as issues of differential diagnosis and clinical treatment, are referred to the *Handbook for the Assessment of Dissociation: A Clinical Guide* (Steinberg, 1995).

We have selected three case studies for this article which demonstrate the range and scope of the SCID-D's utility in clinical practice. These cases have been drawn from the authors' outpatient private practices, and represent a variety of patients in different age brackets, with different presenting complaints and different sources of referral. Case 1 indicates the SCID-D's utility in differential diagnosis between psychiatric and medical conditions; Case 2 demonstrates the instrument's usefulness in diagnosis and symptom documentation in a forensic context. Since the SCID-D includes a score sheet intended to be filed with patients' charts, it provides clinicians with a reliable form of documentation for patients involved with the criminal justice system. Lastly,

Case 3 illustrates the SCID-D's applications in treatment planning and implementation, insofar as it concerns a patient whose diagnosis was already known but whose previous therapy had been abruptly terminated, resulting in a severe setback. Because present reports suggest that the number of patients with MPD whose therapies have been prematurely terminated is larger than might be supposed (Kluft, 1989b; Putnam, 1989a), the SCID-D can be particularly useful to a clinician assuming the care of a patient in this category.

CASE 1

Clinical History

Our first case concerns a patient who typifies the category of the undiagnosed dissociative patient. This 55-year-old single Caucasian woman was referred by her general practitioner for adjunctive management of hypertension through psychophysiological conditioning. The patient presented with complaints of recurrent attacks of stress, anxiety, depression, fearfulness, feelings of inferiority, and self-contempt. She was referred with an initial psychiatric diagnosis of generalized anxiety disorder [GAD]. She suffered high blood pressure, which is not unusual in a typical GAD patient. A program of biofeedback training was implemented, including progressive relaxation techniques and guided imagery. Additional techniques aimed at enhancement of the patient's self-esteem and increasing the likelihood of her continuing with her anxiety reduction program upon termination were employed. The patient responded well to all the interventions. She mastered the relaxation training program rapidly and maintained significantly lowered EMG readings over the course of treatment. She then terminated treatment with documented decreases in blood pressure, no longer in need of her previously prescribed hypertension medication.

Two years after the completion of therapy, this patient presented at a local ER with disorientation and amnesia for major items of personal identification. The patient was completely amnesic for a period of several hours, after which her memory gradually returned. By the next morning, she was able to identify herself to the hospital staff, who in turn notified her physicians. The ER medical examination, which included a neurological consultation, CT scan, and EEG, was unremarkable. The medical diagnosis was transient global amnesia (TGA); a hospital psychiatric consultation additionally diagnosed "hysterical reaction." The recommendations upon discharge included psychotherapy together with continued monitoring by her general physician for possible recurrence of the hypertension.

The patient returned to psychotherapy with concerns about the anxiety that resulted from her amnesic episode in the ER. The SCID-D was administered by one of the authors (P.H.) in order to thoroughly assess the endorsed symptom of amnesia and to rule out the possibility of a dissociative disorder. The SCID-D had not been administered previously. Surprisingly, this patient endorsed symptoms that covered the full spectrum of dissociation. Prior to administration of the SCID-D, these symptoms had been completely hidden.

SCID-D Results

The patient was administered the *Structured Clinical Interview for DSM-IV Dissociative Disorders* (SCID-D) (Steinberg, 1993), to systematically assess the presence and severity of post-traumatic and dissociative symptoms. The interview was then scored in accordance with the guidelines established in the *Interviewer's Guide to the SCID-D* (Steinberg, 1993b). The results were as follows:

The patient endorsed recurrent episodes of forgetfulness and memory deficits, including the whereabouts of friends and family, failure to remember her phone number, getting lost driving home from work, etc. Additional manifestations included recent comments from a friend who was surprised that the patient had forgotten significant events from the early years of their friendship, together with the major episode of disorientation diagnosed as TGA. The frequency, intensity, and duration of the patient's amnesia yielded a rating of "severe."

In the section of the interview regarding depersonalization, the patient endorsed a number of manifestations of this symptom, including feeling as if her entire body had been unreal in connection with her amnesic episode in the emergency room. She also described associated manifestations, including the inability to control her speech and a sense of internal struggle. The patient spontaneously volunteered a description of identity confusion as well as depersonalization. She mentioned feeling as if a battle were raging inside of her, which made her anxious and interfered with her ability to practice her relaxation exercises. Her rating for depersonalization was also "severe." The patient's rating for the symptom of derealization was "moderate," reflecting endorsed experiences of finding her surroundings unfamiliar to the point of passing by her residence on several occasions. She reported a high level of discomfort and distress connected to these episodes of derealization.

With respect to identity confusion, the patient reported internal battles which she experienced as beyond her control occurring at least once a week. In addition, she mentioned several somatic complaints, including insomnia, headaches, earache, involuntary spasms in her extremities, feelings of floating, etc. Medical tests for these symptoms had been consistently negative. She endorsed experiences of her own, together with indirect reports from others, regarding acting like a different person. At times she reported having behaved like a whining child, a "crazy lady," a "nice, bubbly person," and feeling depressed, withdrawn, and generally anxious.

In response to SCID-D questions regarding "different person" and "internal dialogues," the patient was uncertain as to whether her personality 'parts' felt separate or not. However, her uncertainty illustrates one of the SCID-D's advantages as a diagnostic instrument; i.e., that it permits the clinician to note certain intra-interview cues, such as intra-interview amnesia in regard to certain questions, inconsistent answers, facial expressions, eye movements, spontaneous traces or switches, and other indicators over an extended period of time. An experienced interviewer can compile a tightly woven individualized clinical profile over the course of a SCID-D evaluation, by allowing the patient to describe per-

sonal experiences of dissociation, as intricately or extensively as they wish. For example, this patient provided spontaneous elaborations of identity confusion as early as the depersonalization section of the interview. She was rated as "severe" for the symptom of identity confusion but only "moderate" for the symptom of identity alteration, insofar as she was unclear about the separateness or distinctiveness of these various identity fragments.

This patient was diagnosed as DDNOS, present episode. In the course of subsequent treatment, she revealed that she had been quite fearful of her father and of men in general for most of her life. She began to reveal some incidents of sexual molestation in her workplace as an adult, and of her having reluctantly complied with the harassment, to her distress and shame. In addition, she also recalled sexual violation during adolescence, to which she had also submitted without verbal protest. The patient is still in active treatment for her dissociative disorder. She is progressing well in accessing all her strengths and abilities, which appear compartmentalized into separate ego states. Her psychiatric symptomatology, particularly her somatic complaints, has decreased dramatically.

CASE 2

Clinical History

Case 2 is a 45-year-old Caucasian blue-collar worker assessed by the SCID-D subsequent to involvement with the criminal justice system for molesting his twelve-year-old daughter. The patient had little specific recall of the incidents in question. However, following the daughter's disclosure, he acknowledged responsibility for having committed the sexual acts in question. The case went through the usual child protective channels, and the patient was remanded to treatment, being permitted only supervised visits with his four children. He is now separated from his family and lives by himself.

The patient endorsed a significant history of family violence and abuse, beginning with his mother's mistreatment at the hands of her in-laws. He had been told that he had almost been aborted when his mother was allegedly kicked down a flight of stairs by her sister-in-law. He is amnesic for his early childhood before age 11, with only patchy memory of his later childhood. The patient had been abandoned at age 3 by his biological father, of whom the patient had vague memories of emotional abuse. In contrast to this problematic relationship, the patient did form an attachment to his non-abusive stepfather. The patient also reported having been molested by an adolescent neighbor when he was a small child. Although he had never been in treatment for substance abuse, he admitted to heavy alcohol consumption prior to age 41. He had completed a year and a half of college but left before completing his course of study. At the outset of the SCID-D evaluation, he was vacillating between the suggestion of his daughter's therapist that he was suffering from a dissociative disorder and discounting this tentative diagnosis altogether.

SCID-D Results

Administration of the SCID-D revealed that this patient suffered from severe amnesia, indicated by recurrent episodes of inability to recall basic personal information, such as his wife's name or his own name, as well as forgetting previously learned skills, such as how to care for farm animals. He reported amnesia for significant portions of his earlier life, including a four-year period of living in New England. He reported considerable distress connected with his loss of memory, which he summarized as "my tendency to zone out, space out." With respect to depersonalization, the patient described recurrent experiences, as frequently as once a week, of seeing himself "as if there were two people there— like looking at yourself in a full body mirror without the framework." He added that he lost control of his behavior, speech, and emotions from time to time. He stated, "I'd be doing something, and then start to talk; and what is coming out is such violence— it just comes out, and I don't even recall starting the conversation!" His depersonalization was also rated as severe. In addition, the patient endorsed episodes of derealization, lasting several minutes, during which he could not recognize his friends and other people he knows; he remarked that he sometimes sees others as if they are at a distance, "in a hazy fog." Because these episodes occur less frequently (several times a year), his derealization was rated as moderate.

In response to SCID-D questions regarding identity confusion, the patient said that he experiences an ongoing internal struggle between "myself and a more violent side." Although he suspected that this "violent side" might occasionally assume control of his behavior, he was unable to elaborate further about this part of his personality. He stated that he sometimes hears internal dialogues: "there are times when the one I'm talking to is not me." However, the patient's descriptions of identity confusion and identity alteration (although rated as severe) do not meet all four *DSM-IV* criteria for DID, in that his "separate state" is not a fully differentiated alternate personality. As a result, he was diagnosed as DDNOS, present episode.

CASE 3

Clinical History

A 30-year-old Caucasian woman presented for treatment with knowledge of her diagnosis of multiple personality disorder (MPD), at that time the condition's official designation. Prior to referral, she had been in treatment with a therapist who abruptly discontinued her treatment due to personal health reasons. The patient experienced this sudden termination as a harsh abandonment, a repetition of a pattern which she had experienced on numerous previous occasions. The patient's host personality was so traumatized and hopeless that she had stopped emerging during therapy sessions.

The patient stabilized in ongoing outpatient psychotherapy for DID over a period of 1-1/2 years, despite previous setbacks resulting in several hospitalizations and suicide attempts. During this period, several new alters manifested

and participated in the treatment process. Whenever the issue of the host personality surfaced, these alters would take turns describing the host's devastation as a result of past mistakes in treatment. It was revealed that the patient had once undergone an amytal interview, during which some incestuous material emerged for which the host personality was amnesic. The amnesia appeared to be connected to the patient's idealization of her abuser as the only adult in her life who had demonstrated what she considered nonsexual affection for her. This hospital therapist had unwisely disclosed the contents of the interview to the host personality at an inappropriate juncture in treatment; according to the patient, the host personality was "blown away." Various alters cautioned the current therapist that the host not only could not endure the diagnosis of DID, but would also continue to block assimilation of knowledge about her incest, as she had done in the past.

Over the course of treatment, the clinician introduced a description of the SCID-D interview to the patient, together with an explanation of its underlying concept. It was eventually suggested that the host personality might find it helpful to review some of her own dissociative experiences in this interview format, even though the diagnosis had already been well established. At a later point, the host personality indicated her desire to be interviewed with the SCID-D, which was then administered.

SCID-D Results

This patient's rating for all five core symptoms was "severe," as might be expected. The interviewer noted classic descriptions of DID symptomatology. In this context, the host personality had an opportunity to examine, verbalize, and reflect upon her dissociative experiences in a safe situation and non-confrontational manner, without the pressure of debating questions of diagnosis or traumatic recollections. As a result, this particular application of the SCID-D as a clinical intervention was extremely fruitful, in terms of therapeutic insights. The usual delays in the treatment process that are caused by various alters' reluctance to accept the diagnosis of DID were considerably diminished.

During the follow-up session, the patient reported that the host personality had benefited from the opportunity to express her own experiences in an organized and coherent manner, and that the SCID-D had posed some practical and logically ordered questions which had brought her to a satisfactory conclusion about her own condition. The host regarded the process of hearing her own descriptions of her experiences as empowering, because she felt like an active participant in her therapy rather than the passive recipient of a diagnosis. This case indicates that the SCID-D offers a sensitive yet precise interview format, for use with DID patients whose alters may be frightened or struggling to validate their experiences.

SUMMARY AND CONCLUSION

Numerous studies have reported good-to-excellent reliability and discriminant validity of the SCID-D for the assess-

ment of dissociative symptoms and the diagnosis of dissociative disorders (Boon & Draijer, 1991; Goff, Jenike, Paer, & Buttolph, 1992; Steinberg, Rounsaville, & Cicchetti, 1990; Steinberg et al., 1989-1992; Steinberg et al., 1989-1993). These first case reports illustrate its effectiveness and versatility in clinical applications, with patients of different ages and backgrounds. The SCID-D facilitates accurate differential diagnosis between dissociative disturbances and medical complaints, as well as differential diagnosis between the dissociative disorders and other psychiatric conditions. In addition, its format recommends it for use with patients whose symptoms require examination and documentation for forensic purposes. Finally, the SCID-D can be a valuable resource for clinicians in therapeutic interventions for DID patients whose diagnosis has already been established; thus it can assist the recovery of patients suffering from dissociative disorders as well as detect the presence of previously unsuspected dissociative disturbances. Its semi-structured format and non-intrusive questions allow patients to volunteer information or elaborate on endorsed experiences without undue anxiety or embarrassment. Follow-up interviews indicate that patients often feel empowered by the insights and reflections stimulated by the instrument. In sum, the SCID-D is a tool with a variety of effective applications in treatment of a patient population with a favorable prognosis for recovery. ■

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