Professional Issues and Innovative Practice

Clinical Assessment of Dissociative Identity Disorder Among College Counseling Clients

Benjamin Levy and Janine E. Swanson

College counseling professionals address a wide range of complex student mental health concerns. Among these, accurately identifying client presentations of dissociative identity disorder (DID) can be especially challenging because students with DID sometimes present as if they are experiencing another problem, such as a mood, anxiety, or psychotic disorder. This article reviews DID diagnostic criteria, introduces assessment strategies for use during intake and subsequent counseling sessions, and presents case illustrations.

College counseling center directors and practitioners continue to report that students are experiencing more severe mental health concerns (Gallagher, 2004; Gallagher & Weaver-Graham, 2005). Although cautions have been expressed about the need to conduct empirical research to confirm these impressions of increasing severity (Bishop, 2006; Bishop, Gallagher, & Cohen, 2000; Sharkin, 1997), counselors in college settings certainly do confront students with severe mental disorders and psychological disabilities in their day-to-day practice (Archer & Cooper, 1998), and college counselors' caseloads seem to be increasingly complex (Humphrey, Kitchens, & Patrick, 2000). Furthermore, Sharf (1989) suggested that even a few difficult cases can have a draining effect on staff. Although other classes of severe or complex mental disorders, such as substance use and eating disorders, have received attention in the recent literature, less information is available to inform college counselors' work with dissociative disorders. To help fill this gap, in this article, we discuss procedures for the assessment of dissociative identity disorder (DID; formerly multiple personality disorder) as it is experienced by college students. First, we review the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000) diagnostic criteria describing symptoms of the disorder. Next, we discuss the use of screening measures and diagnostic structured interviews in the college context. We then provide three case illustrations drawn from the experiences of staff at one university mental health center and offer some conclusions.

What Is Dissociation?

Dissociation is defined in the *DSM-IV-TR* (APA, 2000) as a significant disruption in a person's usually integrated functions of consciousness, memory, identity, or perception of the environment. An individual may develop the

Benjamin Levy and Janine E. Swanson, Mental Health Services, University of Massachusetts. Janine E. Swanson is now at ProHealth Connecticut Center for ADHD, Middletown, Connecticut. Correspondence concerning this article should be addressed to Benjamin Levy, Mental Health Clinic, University Health Services, University of Massachusetts, 111 Infirmary Way, OFC 1, Amherst, MA 01003 (e-mail: bfl@uhs.umass.edu).

disturbance suddenly or gradually, and it may be transient or become chronic. People sometimes experience transient dissociation in the context of posttraumatic stress disorder, panic disorder, borderline personality disorder, obsessive-compulsive disorder, impulse control disorders, eating disorders, and substance abuse disorders (Gold, 2007). Transient dissociation also occurs during *DSM-IV-TR*–defined psychogenic amnesia or psychogenic fugue states. On the other hand, when a person begins to experience dissociation chronically, he or she is more likely to be experiencing a dissociative disorder (Putnam, 1989). The chronic dissociative disorders include depersonalization disorder, DID, and dissociative disorder not otherwise specified (DDNOS). This article focuses on DID and also discusses those forms of DDNOS that are characterized as clinical presentations similar to DID but failing to meet the full criteria. The reason to consider both DID and these forms of DDNOS together is that similar assessment procedures and counseling interventions have been recommended for both types of disorders (Kluft, 2006).

An Overview of DID

DSM-IV-TR Diagnostic Criteria

The diagnostic criteria for DID in the *DSM-IV-TR* (APA, 2000) are the following:

> A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
> B. At least two of these identities or personality states recurrently take control of the person's behavior.
> C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
> D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). (p. 529)

When individuals are confronted with problematic clinical presentations similar to DID, but experience symptoms that do not quite meet the full criteria for a diagnosis of DID (such as dissociation without two or more distinct personality states, or without amnesia for important personal information), then their difficulties may meet the criteria for a diagnosis of DDNOS (APA, 2000, p. 532).

Associated Features and Disorders

The *DSM-IV-TR* (APA, 2000) states that individuals experiencing DID frequently report a history of physical and sexual abuse, especially during childhood. Individuals may manifest posttraumatic symptoms such as nightmares, flashbacks, and startle responses. In fact, their symptoms may meet the *DSM-IV-TR* criteria for both posttraumatic stress disorder and DID. They may also engage in self-mutilative, suicidal, or aggressive behavior. They may tend to

repeat patterns stemming from past relationships involving physical and sexual abuse. Certain identities may experience conversion symptoms such as pseudoseizures or have unusual abilities to control pain or other physical symptoms. Some clients' symptoms may also meet the criteria for mood, substance-related, sexual, eating, or sleep disorders. Self-mutilative behavior, impulsivity, and sudden and intense changes in relationships, when they are present, may warrant a concurrent diagnosis of borderline personality disorder.

Specific Culture, Gender, and Age Features

DID has been found in a wide range of cultures in the world. For example, Sar (2006) reported that dissociative disorders are "ubiquitous across cultures" (p. 240). It is diagnosed 3 to 9 times more frequently in adult women than in adult men. Examining a university campus population using clinical measures of DID, Ross, Ryan, Voigt, and Eide (1991) found that a notable number of students were experiencing DID.

Course and Familial Pattern

The *DSM-IV-TR* (APA, 2000) describes a fluctuating clinical course that tends to be chronic, with either episodic or continuous dissociative symptoms. However, a number of authors have described the possibility of complete resolution of dissociative symptoms after correct diagnosis and treatment targeting the dissociative symptoms (Kluft, 1999, 2006; Loewenstein, 1994). Steinberg (1995), quoting Spiegel, noted that dissociative disorders belong to the category of "the few serious psychiatric illnesses for which a record of success with appropriate psychotherapy is developing" (p. 381).

Moreover, according to information provided in the *DSM-IV-TR* (APA, 2000), DID occurs more commonly among first-degree relatives of individuals with the disorder.

Differential Diagnosis

The *DSM-IV-TR* (APA, 2000) identifies several competing differential diagnoses to be considered by the counselor. These include symptoms caused by the direct physiological effects of a general medical condition, complex partial seizures, direct physiological effects of a substance, schizophrenia and other psychotic disorders, bipolar disorder with rapid cycling, anxiety disorders, somatization disorders, personality disorders, malingering, and factitious disorder. Chefetz (2006) added addictions and eating disorders to this list. Furthermore, Ross (1997) found that as many as 15% of clients experiencing substance dependency may also be dealing with DID. Given the significant substance abuse problems associated with college populations (Archer & Cooper, 1998; Humphrey et al., 2000), Ross's (1997) findings support the need to screen for dissociative disorders in those students presenting with substance abuse problems. Ross (1997) suggested that some of these students may be "self-medicating their trauma histories and co-morbidity, and reinforc-

ing their dissociation" (p. 131). As seen in the case illustrations that follow, students who are originally thought to be experiencing an anxiety disorder, mood disorder, psychotic disorder, or substance abuse disorder may later be discovered to be dealing with DID.

Assessment Tools for College Counseling Professionals

Historically, counseling professionals have found the diagnosis of multiple personality disorder, or what is now referred to as DID, "difficult and complex" (Solomon & Solomon, 1982, p. 1187). This is important in day-to-day college counseling practice "since misdiagnosis may promote well-intentioned but harmful treatment" (Solomon & Solomon, 1982, p. 1194) that fails to meet the student's needs. In fact, "seven studies of 719 DID patients have shown that they spent five to 11.9 years in the mental health system before they were diagnosed as having DID" (International Society for the Study of Dissociation, 2005, p. 72). However, since screening and diagnostic tools for dissociative disorders became available in the mid-1980s, it has become possible for a counselor to make a more accurate diagnosis of DID earlier in the course of a client's treatment.

Written Screening and Diagnostic Measures

Bernstein and Putnam published the first screening tool for DID, the Dissociative Experiences Scale (DES), in 1986. Ross et al. published the first diagnostic tool, the Dissociative Disorders Interview Schedule (DDIS), in 1989. Then, Steinberg, Rounsaville, and Cicchetti published a second diagnostic tool, the Structured Clinical Interview for *DSM-III-R* Dissociative Disorders (SCID-D), in 1990. The SCID-D was designed to complement the Structured Clinical Interview for *DSM-IV* Axis I Disorders (First, Spitzer, Gibbon, & Williams, 1997) because the latter does not have a dissociative section (Ross, 1997). There is currently a *DSM-IV* version of the SCID-D, the Structured Clinical Interview for *DSM-IV* Dissociative Disorders–Revised (SCID-D-R; Steinberg, 1994b). These screening and diagnostic tools as well as others subsequently developed are reviewed by Cardeña and Weiner (2004) and Courtois (2004). Even more recently, Dell (2006a, 2006b) has published the latest diagnostic tool, the Multidimensional Inventory of Dissociation. Because the DES is the most commonly used screening tool and the DDIS and the SCID-D-R are the most commonly used diagnostic tools (Cardeña & Weiner, 2004), this article explores the use of the DES for screening and the DDIS and SCID-D-R for diagnosing dissociative disorders in the context of three case discussions of students presenting for mental health care at a college mental health service.

Screening Measure

The DES is a 28-item self-report measure of the frequency of dissociative experiences. It was designed to assess for the presence of high levels of dis-

sociation. The client is asked to circle the percentage of time each symptom described in a question is experienced while not under the influence of alcohol or drugs. The total is added up and divided by 28 to achieve the DES score. The measure requires about 5 to 10 minutes for the client to complete and another 5 minutes to score. The latest version of the DES is included in an article by Carlson and Putnam (1993). Carlson and Putnam's article also includes a table with the mean or median DES scores across different diagnostic groups. A cutoff score of 30 identifies 74% of those who experience DID (i.e., sensitivity) and 80% who do not have DID (i.e., specificity).

Structured Diagnostic Interviews

Because some clients with a high DES score might be experiencing posttraumatic stress disorder or another mental health concern that includes significant dissociative symptoms but is not DID, a clinician-administered structured interview (such as the DDIS and the SCID-D-R) is also needed to confidently make the diagnosis. The DDIS and the SCID-D-R are two structured interviews that discriminate DID from other psychiatric disorders.

The DDIS requires 30 to 45 minutes to administer and another 10 to 15 minutes to score. There are 132 items with a yes/no format that assess the symptoms of the five dissociative disorders defined by the *DSM-IV-TR* (APA, 2000), as well as somatization disorder, borderline personality disorder, and major depressive disorder. The five *DSM-IV-TR* dissociative disorders are psychogenic amnesia, psychogenic fugue, depersonalization disorder, DID, and DDNOS (APA, 2000). The instructions for scoring the interview results are included with the materials. (A copy of the DDIS can be found in Ross's, 1997, book *Dissociative Identity Disorder, Diagnosis, Clinical Features, and Treatment of Multiple Personality.*)

The SCID-D-R requires from 30 minutes to 2 (or more) hours to administer and another 30 minutes to score. There are 158 items that assess five symptoms of dissociation: amnesia, depersonalization, derealization, identity confusion, and identity alteration. There are nine optional follow-up sections of about 10 questions each that are designed to increase the understanding of the extent of identity disturbance. It is only necessary to choose one or two follow-up sections, and the choice is based on symptom areas endorsed in the early part of the interview. The SCID-D-R assists the counselor in the diagnosis of the five *DSM-IV-TR* (APA, 2000) dissociative disorders. It also yields a score for each of the five dissociative symptoms and a total score. These scores are based on frequency and intensity of symptoms and reflect the impact of dissociative symptoms on the individual's social functioning and work (or school) performance. Instructions for administering, scoring, and interpreting the SCID-D-R are described in the *Interviewer's Guide to the Structured Clinical Interview for* DSM-IV *Dissociative Disorders (SCID-D)–Revised* (Steinberg, 1994a). The extensive amount of information exchanged during the collaborative SCID-D-R diagnostic interview not only can assist with making an accurate diagnosis but also can be very helpful in engaging a client in the counseling relationship and psychotherapy process (Steinberg & Hall, 1997).

Case Illustrations: Three College Counseling Clients

Case Illustration 1: DID Versus an Anxiety Disorder

Client 1 first presented for mental health treatment before beginning college, when he was 16 years old. However, he attended only one session at that time. When he was 18 years old, he presented at the university's Mental Health Services and reported having problems with anxiety "all my life," and stated that his symptoms had gotten worse since arriving at college. He reported symptoms consistent with intermittent panic episodes and said he subsequently isolated himself in his room because of anticipatory anxiety related to the fear that he might have another embarrassing panic attack while he was out in public on campus. His original presentation was consistent with an anxiety spectrum disorder, although it was not clear whether he might be experiencing a panic disorder, generalized anxiety disorder, and/or social anxiety disorder. In the initial screening interview, he acknowledged, when asked specifically, that at times he experienced a sense of being disconnected, or being like an observer, or even being outside of his body—although these events seemed to occur only at the height of a panic experience. It was presumed by both the counselor and the psychiatrist that this depersonalization was secondary to panic rather than the other way around. A campus psychiatrist prescribed an antianxiety medication, Klonopin (clonazepam), and it seemed, based on subsequent sessions, that Client 1 was experiencing an anxiety disorder that was successfully responsive to medication. However, by the fourth session, he reported experiencing violent dreams and stated that anxiety always covered up what he described as his feelings of murderous rage. At this point, it became unclear whether he was having a paradoxical reaction to Klonopin or whether an underlying problem was emerging after the initially successful treatment of his anxiety with this medication. By the fifth session, Client 1 spontaneously acknowledged feeling as if he were two people and talked about himself in the third person, stating, "[student's name] kills people." By the seventh session, he described feeling chronically detached, spacing out a lot, being forgetful, having feelings of unreality (his parents sometimes felt like strangers), and experiencing sudden mood changes for no apparent reason. Because the symptom picture included amnesia, depersonalization, derealization, and possibly identity alteration (three, if not four, of the five core symptoms of DID), the client was then referred to a psychotherapist who specialized in treating dissociative disorders. The client collaborated in a SCID-D-R interview, which confirmed the diagnosis of DID. Specifically, the student's picture included the five core symptoms of DID (Steinberg, 1995): amnesia, depersonalization, and derealization (that were apparent both in the earlier psychotherapy session and again in the SCID-D-R) as well as identity confusion and identity alteration (that were recognized in the SCID-D-R). It became clear that his anxiety, panic, and agoraphobia were secondary to

his dissociative symptoms. Client 1 then engaged in psychotherapy to address his dissociative symptoms.

Comment on Case Illustration 1

In this case illustration, the client initially presented at the university mental health clinic with what seemed to be an uncomplicated panic disorder. He said that the dissociative symptoms he described in the initial session occurred only at the height of a panic attack and so were believed by the counselor and the psychiatrist to be part of an anxiety disorder and not a dissociative disorder. Yet, as the client spent more time with his counselor (and perhaps because he became more comfortable in the therapeutic relationship over time), he was able to share more information about the full extent of his dissociative experiences. Sharing about the extent of dissociative symptoms only after trust has developed in the psychotherapy relationship is quite common among clients dealing with DID (Putnam, 1989).

Case Illustration 2: DID Versus a Mood Disorder With Psychotic Features

Client 2 was a male, 28-year-old, married graduate student who first came in to the university mental health clinic describing hopeless feelings and extremely wide-ranging mood swings. He stated, "I get pretty manic." He said that he sometimes had lots of energy, needed only 4 hours of sleep but still felt energetic the next day, and accomplished a lot of work. He also reported that at other times he would become so depressed that he would not get out of bed for days at a time. He stated that this mood variability had been going on for as long as he could remember but that so far he had not sought professional help. Because recently he had started to feel agitated (including throwing objects in the house out of frustration) and began to have suicidal thoughts, he agreed with his wife to seek counseling help. The counselor's initial impression was that he might have bipolar disorder that was evolving into a mixed state. Psychiatric hospitalization and mood-stabilizing medication were recommended, but the student declined these options. Because he was not an imminent risk to himself or others, he was not involuntarily admitted to the hospital. However, he did agree to return for further evaluation. During the first few visits, he acknowledged gaps in his memory, hearing two voices in his head, and feeling at times as though he did not have control of the words that came out of his mouth. He therefore agreed to an evaluation to assess the extent of his dissociative symptoms. On the DES, he scored 48. Because of this high DES score, a DDIS was administered. He endorsed 7 of 11 Schneiderian first-rank symptoms (common in DID; see Ross, 2004) and 12 of 14 features of DID. This picture was consistent with the diagnosis of DID. The student's subsequent psychotherapy sessions were devoted to helping him better understand his dissociative symptoms. For example, it was a relief to him to know that misplacing objects in the house was related

to the amnesia of dissociation rather than irresponsibility. Also, as a result of counseling, when he would begin to feel increasing despair and emptiness, rather than travel to a casino to gamble (which had been his traditional way to relieve stress), he came to psychotherapy to talk about his feelings. Much of the subsequent counseling process was directed at education about dissociation; correspondingly, he was able to make sense of the many years he had spent dealing with the disruptive symptoms of DID. Still, because his symptoms were so pervasive, he was not able to maintain academic progress, and so he took a medical leave from his graduate studies while continuing his therapeutic work.

Comment on Case Illustration 2

This student was first seen by an intern at the clinic. Although a psychiatrist provided consultation on the 1st day the student came in, the student declined to consider psychotropic medication and would not return to see the psychiatrist because of fears that he might recommend psychotropic medication or hospitalization. As an alternative, the student engaged in an evaluation process and subsequent psychotherapy with the intern, who received close clinical supervision from a campus psychiatrist. The intern had been trained to recognize dissociative clues in the interview process, and so, when the student described gaps in his memory, hearing voices, and feeling words come out of his mouth without his control, she knew that it was likely this client was experiencing dissociative symptoms. The intern then administered and scored the DES and the DDIS, which confirmed the diagnosis of a dissociative disorder. She then reviewed the results in clinical supervision. The student came to understand that his problems with mood, which were his chief complaint, had stemmed from his dissociative symptoms. The more his dissociative symptoms were addressed in his psychotherapy, the less he would experience disruptive mood symptoms. Because the intern was scheduled to graduate from her internship 3 months after meeting this client, the main goals during this 3-month intervention period were to determine whether a dissociative disorder diagnosis accurately described the client's symptoms, help the client understand how his varied and confusing emotions and behaviors were part of his dissociative experience, help the client recognize the value of psychotherapy, and then help him to accept a referral to a psychotherapist trained to treat DID. Our experience in the university mental health clinic is that many students who deal for years with dissociative symptoms do not understand what has been happening in their lives and therefore find tremendous relief when they are able to consider their combined dissociative symptoms in a way that is both understandable and treatable. In other words, the diagnostic tools for dissociative disorders provide a way to help students organize a confusing myriad of disruptive symptoms into an understandable picture. After 3 months of coming to the clinic, this client eventually understood and accepted the diagnosis of DID and was able to follow through with a referral for long-term psychotherapy.

Case Illustration 3: DID Hidden by a Substance Abuse Disorder

Client 3 was a female, 20-year-old, undergraduate who was referred to the on-campus clinic after a brief in-patient hospitalization following a suicide attempt. While intoxicated with alcohol and in the midst of an argument with her boyfriend, she swallowed a handful of pills and was rushed to the hospital where her stomach was pumped. She was observed for 24 hours until sober and then released. Her past history included one prior psychiatric hospitalization following a suicide attempt and two prior emergency room visits for alcohol intoxication prior to coming to college. Earlier, she had been engaged in counseling and was taking an antidepressant medication, Paxil (paroxetine), to treat her symptoms of depression. However, she had tapered herself off Paxil in the hope of losing weight and acknowledged drinking to the point of intoxication 1 night a week for pleasure. Because her depression had returned upon stopping Paxil, she did agree to begin taking another antidepressant medication that would not have so much impact on her weight. During the course of the initial interview, when asked some screening questions for dissociation, she acknowledged problems with her memory. For example, she stated that she was struck by how much of the shared experience with her high school friends she could not remember. She also acknowledged a heightened sense of being disconnected, or being in a fog, around the time she would experience an inner voice telling her to "party." Competing with this inner voice to party was a reportedly "sane" voice telling her to take better care of herself. Although many students experience such an inner struggle regarding young adult life choices, because of her report of memory gaps and depersonalization, she agreed to complete a SCID-D-R to assess the extent of her experiences of dissociation and to rule out a dissociative disorder. On the SCID-D-R, she did endorse significant symptoms of amnesia, depersonalization, derealization, identity confusion, and identity alteration, which are consistent with the diagnosis of DDNOS. That is, there was enough chronic and severe amnesia, depersonalization, derealization, and identity confusion to warrant a dissociative diagnosis, but her identity alteration was not well enough formed to warrant a full diagnosis of DID. During the course of the evaluation, she acknowledged that as a young child she was sexually abused by a family acquaintance and "everything snowballed since then." She recalled repeated, seemingly involuntary, sexually seductive behavior that some of her friends would report to her and that she would not remember. She recalled also, some of the time, wanting to be "respectful" of herself and others. She said she had long been aware of this inner struggle between being sexually seductive and being respectful and had often used alcohol as a way to quiet this struggle. By completing the SCID-D-R, she felt better able to understand what this struggle represented and felt more motivated to engage in psychotherapy to target her dissociative symptoms (including this inner struggle) and to fulfill her long-term wish to feel more in control of her life.

Comment on Case Illustration 3

As do many college counseling clients, this student presented at the point of an alcohol-related emergency. Ross et al. (1992) reported that out of 100 adults experiencing chemical dependency problems, 39% were also experiencing a diagnosable dissociative disorder (including 14% with DID). Therefore, we recommend that college counseling professionals routinely ask some questions pertaining to dissociative symptoms when conducting intake or screening interviews with students who have problems stemming from substance abuse. In this case illustration, the client readily shared her dissociative symptoms when asked specific questions about dissociation in the initial interview. The follow-up SCID-D-R confirmed the diagnosis of DID. The information from the SCID-D-R helped to inform her psychotherapy by illustrating specifically how she experienced her dissociative symptoms. Over the course of counseling, she began to understand that one alter-identity urged her to party and to engage in sexual behavior, whereas the other alter-identity urged her to stay home and do schoolwork. Increasing the student's understanding of her different identity states permitted the counselor to help enhance the comfort, communication, cooperation, and connection between her different elements of self (Steinberg & Schnall, 2001). Addressing the client's dissociative symptoms allowed her to feel more in control of her life and to feel less of a need to use alcohol as a coping strategy. This case illustration underscores the need to assess for dissociation whenever a student presents with a problem of substance abuse.

Discussion

These three cases illustrate some of the common presentations of college students who are experiencing dissociative disorders. Specifically, college counseling clients dealing with a dissociative disorder often initially present as if they are managing an anxiety disorder (Client 1), a mood and/or psychotic disorder (Client 2), or a substance abuse disorder (Client 3). Notably, although it was ultimately determined that each of these students was experiencing a diagnosable dissociative disorder, none of them initially discussed their disruptive dissociative symptoms.

Our experiences with these 3 clients illustrate why symptoms of dissociation have been described as "hidden phenomena" (Loewenstein, 1991, p. 568). It can be especially challenging for counselors to identify concerns related to dissociation among their clients because its symptoms often are "clandestine and covert" (Kluft, 1991, p. 605), and most people experiencing DID do not present for intakes with obvious signs of the problem. In fact, often, it requires several months or more of contact before a client experiencing DID is able to begin discussing these problematic experiences with his or her counselor (Putnam, 1989). Reasons for such a gradual emergence of the topic during the counseling relationship include memory loss that prevents the recall of dissociative symptoms; fear of being considered "crazy" and so omitting those

dissociative symptoms that are remembered; the idea that because some dissociative symptoms are chronic they are not thought to be unusual; and the attribution of dissociative symptoms to other causes, such as drugs, alcohol, or medical problems (Putnam, 1989). An additional challenge to accurate assessment of this disorder is that "differences may be quite subtle between symptoms produced by a dissociative process and similar ones generated by other disorders" (Loewenstein, 1991, p. 568). Steinberg (1995) reported that clients dealing with dissociative disorders may "mimic" (p. 14) a spectrum of mental health problems, including anxiety, mood, psychotic, substance abuse, eating, and character disorders. These three case illustrations provide examples of this mimicking in the college context. We believe that just as clinicians are trained to listen for suicidal concerns and for psychosis in the clinical interview and mental status examination, it is equally important to listen for indications of dissociation (Loewenstein, 1991). The more a counselor uses the DES, the DDIS, and the SCID-D-R, the more familiar he or she becomes with recognizing dissociative symptoms in the course of a routine interview and asking questions concerning dissociation in a mental status examination. Then, if DID is indicated, administering the DDIS and the SCID-D-R can help confirm a diagnosis of a dissociative disorder.

Regarding treatment, once the client's symptoms are accurately diagnosed and confirmed with the individual, counseling for DID usually is stage oriented because it often emerges with other trauma-related client concerns (Courtois, 2004). Counselors begin by establishing an environment of safety in the collaborative counseling relationship, providing support, and helping strengthen the students' readiness and internal resources for confronting the problem. Subsequent stages of intervention include history gathering and painting a clear picture of the client's problematic experiences; addressing and resolving traumatic aspects of the client's past or present life; moving toward and accomplishing integration and resolution; helping the client learn new coping skills; and, finally, assisting the person to solidify the gains he or she has made and arranging for appropriate follow-up (Kluft, 1999). Counseling also includes recognizing and dealing with the students' different alter-identities (Courtois, 2004). Turkus and Kahler (2006) summarized effective therapeutic interventions that may be potentially helpful in treatment of DID as including psychoeducation, pacing and containment, grounding skills, talking to the personality system as a whole, facilitating internal meetings of the different self-states, anticipating and addressing traumatic reenactment, safety planning, helping clients find a "healing place," keeping a journal, and using artwork as a means of self-expression. Turkus and Kahler described a healing place as a way to help a client to tap into his or her internal strengths and resources by using imagery that is consistent with the client's positive beliefs.

College Counseling Limitations and DID

In this article, we have emphasized the need for college counselors to be cognizant of the signs of DID and DDNOS, as they are presented in the

DSM-IV-TR (APA, 2000), when meeting with clients for intake interviews, walk-ins, other screening meetings, crisis responses, and ongoing counseling. We suggested using written measures (such as the DES) and clinical interview protocols (such as the DDIS and the SCID-D-R) as tools for determining whether some student clients might be experiencing dissociation symptoms and even a dissociative disorder along with their more common presentations of anxiety, mood, and psychotic symptoms, as well as substance use concerns. Cowan and Morewitz (1995) found that when college health center staff were given a mental health checklist to use as a tool for identifying counseling issues among their clients, they were much more likely to identify their students' mental health and wellness needs and make appropriate interventions or referrals. Likewise, we think that if college counselors become more aware of DID and consider using screening and diagnostic tools related to the disorder, they will be more likely to identify situations in which students might be dealing with this complex mental health problem.

We also recognize that there are several limitations regarding assessment and treatment of dissociative disorders in college counseling centers and university mental health centers. First, counseling center resources vary widely among 2-year colleges, smaller college campuses, and larger universities (Thomas, 2000). Whereas we have a multidisciplinary staff including psychiatrists and counseling and psychotherapy professionals, as well as easy access to inpatient hospitalization, other sites such as small-staff college counseling centers often do not have as many treatment and referral options. Second, workload, caseload, and resource demands can delimit the energy and focus needed to address more complex and demanding problems such as DID. Because counseling centers primarily work to support their institution's academic mission (American College Personnel Association, 1996), counseling center directors and staff must often make hard decisions about what services to offer, including where to place the greatest staff focus. In particular, after the assessment phase, treatment for DID can be a multiyear commitment (Putnam, 1989), which is beyond the resources of typical counseling centers. Third, depending on their professional education, training, and level of clinical experience, some college counseling professionals may be better prepared than others to address dissociation experiences in their clients. Naturally, ethical guidelines prohibit clinicians from practicing outside their competencies. In 2005, the International Society for the Study of Dissociation (subsequently named the International Society for the Study of Trauma and Dissociation) established guidelines for treating DID in adults. These guidelines are available at the society's Web site (www.isst-d.org). Fourth, there is ongoing debate in some professional settings about the use and potential misuse or overuse of *DSM-IV-TR* (APA, 2000) diagnostic criteria (Lopez et al., 2006). Our approach explicitly relies on *DSM-IV-TR* diagnoses. All of these issues may limit application of our suggestions by specific professionals or on specific campuses. At the same time, we believe that college counseling professionals are in a good position to make an early diagnosis among students experiencing DID, help stabilize any emergency presentations, and then either engage in counseling with appropriate consultation or help students follow through on a good referral.

References

American College Personnel Association. (1996). *The student learning imperative: Implications for student affairs.* Retrieved January 22, 2008, from http://www.acpa.nche.edu/sli/sli.htm

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Archer, J., Jr., & Cooper, S. (1998). *Counseling and mental health services on campus: A handbook of contemporary practices and challenges.* San Francisco: Jossey-Bass.

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

Bishop, J. B. (2006). College and university counseling centers: Questions in search of answers. *Journal of College Counseling, 9,* 6–19.

Bishop, J. B., Gallagher, R. P., & Cohen, D. (2000). College students' problems: Status, trends, and research. In D. C. Davis & K. M. Humphreys (Eds.), *College counseling: Issues and strategies for a new millennium* (pp. 89–110). Alexandria, VA: American Counseling Association.

Cardeña, E., & Weiner, L. A. (2004). Evaluation of dissociation throughout the lifespan. *Psychotherapy: Theory, Research, Practice, Training, 41,* 496–508.

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation, 6,* 16–27.

Chefetz, R. A. (2006). Why should you read these articles on dissociative processes? *Psychiatric Clinics of North America, 29,* 15–23.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41,* 412–425.

Cowan, P. F., & Morewitz, S. J. (1995). Encouraging discussion of psychological issues at student health visits. *Journal of American College Health, 43,* 197–199.

Dell, P. F. (2006a). *The Multidimensional Inventory of Dissociation (MID).* (Available from the author at PFDell@aol.com)

Dell, P. F. (2006b). The Multidimensional Inventory of Dissociation (MID): A comprehensive measure of pathological dissociation. *Journal of Trauma and Dissociation, 7,* 77–106.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1997). *Structured Clinical Interview for* DSM-IV *Axis I Disorders Clinician Version (SCID-D).* Washington, DC: American Psychiatric Press.

Gallagher, R. P. (2004). *National survey of counseling center directors.* Alexandria, VA: International Association of Counseling Services.

Gallagher, R. P., & Weaver-Graham, W. (2005). *National survey of counseling center directors* (Monograph Series No. 80). Retrieved January 22, 2008, from http://www.education.pitt.edu/survey/nsccd/archive/2005/monograph.pdf

Gold, S. N. (2007, March). *The phenomena of dissociation.* Workshop presented at the Brattleboro Retreat, Brattleboro, VT.

Humphrey, K. M., Kitchens, H., & Patrick, J. (2000). Trends in college counseling for the 21st century. In D. C. Davis & K. M. Humphreys (Eds.), *College counseling: Issues and strategies for a new millennium* (pp. 89–110). Alexandria, VA: American Counseling Association.

International Society for the Study of Dissociation. (2005). Guidelines for treating dissociative identity disorder in adults. *Journal of Trauma and Dissociation, 6,* 69–149.

Kluft, R. P. (1991). Clinical presentations of multiple personality disorder. *Psychiatric Clinics of North America, 14,* 605–629.

Kluft, R. P. (1999). An overview of the psychotherapy of dissociative identity disorder. *American Journal of Psychotherapy, 53,* 289–319.

Kluft, R. P. (2006). Dealing with alters: A pragmatic clinical perspective. *Psychiatric Clinics of North America, 29,* 281–304.

Loewenstein, R. J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America, 14,* 567–604.

Loewenstein, R. J. (1994). Diagnosis, epidemiology, clinical course, treatment, and cost effectiveness of treatment for dissociative disorders and MPD: Report submitted to the Clinton Administration Task Force on Health Care Financing Reform. *Dissociation, 7,* 3–11.

Lopez, S. J., Edwards, L. M., Termonto Pedrotti, J., Prosser, E. C., LaRue, S., Vehige Spalitto, S., & Ulven, J. C. (2006). Beyond the *DSM-IV*: Assumptions, alternatives, and alterations. *Journal of Counseling & Development, 84,* 259–267.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford Press.

Ross, C. A. (1997). *Dissociative identity disorder, diagnosis, clinical features, and treatment of multiple personality* (2nd ed.). New York: Wiley.

Ross, C. A. (2004). *Schizophrenia—Innovations in diagnosis and treatment.* Binghamton, NY: Haworth Maltreatment and Trauma Press.

Ross, C. A., Heber, S., Norton, G. R., Anderson, G., Anderson, D., & Barchet, P. (1989). The Dissociative Disorders Interview Schedule: A structured interview. *Dissociation, 2,* 169–189.

Ross, C. A., Kronson, J., Koensgen, S., Barkman, K., Clark, P., & Rockman, G. (1992). Dissociative co-morbidity in 100 chemically dependent patients. *Hospital and Community Psychiatry, 48,* 840–842.

Ross, C. A., Ryan, L., Voigt, H., & Eide, L. (1991). High and low dissociators in a college student population. *Dissociation, 4,* 147–151.

Sar, V. (2006). The scope of dissociative disorders: An international perspective. *Psychiatric Clinics of North America, 29,* 227–244.

Sharf, R. S. (1989). Have the presenting problems of clients at university counseling centers increased in severity? *NASPA Journal, 27,* 141–146.

Sharkin, B. S. (1997). Increasing severity of presenting problems in college counseling centers: A closer look. *Journal of College Counseling, 8,* 275–281.

Solomon, R. S., & Solomon, V. (1982). Differential diagnosis of the multiple personality. *Psychological Reports, 51,* 1187–1194.

Steinberg, M. (1994a). *Interviewer's guide to the Structured Clinical Interview for* DSM-IV *Dissociative Disorders (SCID-D)–Revised.* Washington, DC: American Psychiatric Press.

Steinberg, M. (1994b). *Structured Clinical Interview for* DSM-IV *Dissociative Disorders–Revised.* Washington, DC: American Psychiatric Press.

Steinberg, M. (1995). *Handbook for the assessment of dissociation—A clinical guide.* Washington, DC: American Psychiatric Press.

Steinberg, M., & Hall, P. (1997). The SCID-D diagnostic interview and treatment planning in dissociative disorders. *Bulletin of the Menninger Clinic, 61,* 108–120.

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,* 76–82.

Steinberg, M., & Schnall, M. (2001). *The stranger in the mirror: Dissociation—The hidden epidemic.* New York: HarperCollins.

Thomas, J. R. (2000). Strategies for small staff college counseling centers. In D. C. Davis & K. M. Humphreys (Eds.), *College counseling: Issues and strategies for a new millennium* (pp. 89–110). Alexandria, VA: American Counseling Association.

Turkus, J. A., & Kahler, J. A. (2006). Therapeutic interventions in the treatment of dissociative disorders. *Psychiatric Clinics of North America, 29,* 245–262.