EMDR clinicians are taught to screen all clients for the possibility of a dissociative disorder (Shapiro, p 442, 2001), using the Dissociative Experience Scale (DES) (Bernstein & Putnam, 1986). This is important since clients with undiagnosed dissociative disorders are easily destabilized by standard EMDR. This paper will provide basic information on screening for dissociative disorders (DD) and on maximizing the use of the DES; and will provide an appendix of resources for further information about diagnosis and treatment.

First of all it is important to realize that diagnosis of persons with DDs is often not difficult. For most of us, what we’ve experienced as difficult, has simply been the result of no training in DD diagnostic procedures and of reliance on standard batteries of psych testing which do not test for dissociative disorders. Characteristics, symptoms, and suggestive signs of people with dissociative disorders have been well researched and described (e.g. Kluft, 1999). Noticing one or more of these signs is an indication of the possibility a client has a DD. These signs include a history of child abuse, neglect, attachment problems, history of failed prior treatment, three plus prior diagnoses, amnesia for periods of time during childhood and/or adulthood, somatic symptoms (headaches, stomach aches, dizziness, etc.), uneven functioning, and the existence of parts who seem to have a separate existence. (See appendix for a more complete list.)

Next, it is important to understand that the DES is a screening test, not a diagnostic test. Thus while scores can at times accurately rule in or out the presence of a dissociative disorder, they can also sometimes be inaccurate (Brand et al. 2006). Whether accurate or inaccurate with a specific client, the DES questions provide a language for asking and finding out more
about dissociative symptoms. While for non dissociative clients this may not have any clinical relevance, for a dissociative client it is invaluable.

When given the DES, dissociative clients may have one or more of the following experiences and responses. Remember, different parts will often answer the same question differently depending on the part’s range of experience and knowledge and amnesia:

- It may be the first time a client hears a description of symptoms she/he has lived with their entire lives and feel a sense of relief. One client said, “I thought I was crazy. You mean other people have these same symptoms?” This woman scored high on the DES.
- The part (or parts) who knows about the symptoms, might not be the one answering the questions. Some weeks after one man took the DES, several parts came to session and, using language from the DES, described dissociative symptoms. This man initially scored low on the DES. For several months, he remained amnestic for the presence of parts, but the rest of his parts, became active in the treatment.
- The client may not feel comfortable answering the questions. One of my clients rapidly answered each question with, “No, that never happens to me.” Months later, she admitted she felt exposed and too vulnerable to answer accurately. This woman also scored low on the DES.
- A therapist reported that her client had answered questions openly and scored high on the DES. Following the session, the client cut herself severely. Eventually, the therapist found out that a different part had been against answering questions. She expected to be abused for doing so, and had preemptively abused the body. Note: Recommendation is to let clients know they have control over answering questions or not.

The DES has mainly been used as a self-report measure filled out independently by the client and then scored by the therapist. While there is value to giving it this way, the DES’ usefulness is enhanced when it is given during the course of face to face assessment sessions. This enables
clinicians to pick up non-verbal diagnostic clues that indicate the possibility of a dissociative disorder. Specifically, watch how the client answers the questions, and if the client answers too fast, pauses, appears confused, or shows signs of trance behavior (e.g. eye lids fluttering or rolling up) ask the client what’s happening as they think about the question. What you might be seeing is the impact of parts arguing about what to answer or whether to answer at all. One client told me, “It’s hard to answer questions because there’re always 10 different answers going on in my head.” Another client told me, “If I answer your question parts will punish me.” Remaining curious and open to the possibility that there might be more going on beneath the surface of an answer, provides the space for information to be eventually revealed.

Other tests that are easy to give, can provide additional information and are available on line include the Somataform Dissociation Questionaire www.enijenhuis.nl which measures somatoform dissociation (Nijenhuis, et al 1996) and the Dissociative Disorder Interview Scale (Ross, 1989) www.rossinst.com. The extremely useful “Office mental status examination for complex chronic dissociative symptoms and multiple personality disorder” (Loewenstein, 1991) is a natural conversational test which is well worth getting a copy of because of the ease of giving it. All of these provide access and knowledge about dissociative symptoms and experiences, and can be helpful to give formally to augment the DES and other clinical observation.

If diagnosis remains unclear, it can be helpful to get a consultation and/or look into more extensive diagnostic testing e.g. the Structured Clinical Interview for DSM–IV Dissociative Disorders–Revised (SCID-D-R; Steinberg, 1994a, 1994b, 1995), or the Multidimensional Inventory of Dissociation (MID, Dell, P, 2006) which is available for free from the author. Diagnosis can be a process to be clarified, tested and validated over time.

Given that DD clients have spent on the average 6-8 years in treatment prior to diagnosis (Sar et al: http://www.isst-d.org/education/nimh-strategic-plan-ltr.pdf), plus the fact that dissociation is a symptom of disconnection/hiding from oneself and/or others, it makes sense to learn
something about diagnosis and treatment. Recommended reading is the International Society for the Study of Trauma and Dissociation (2011) Guidelines for Treating Dissociative Identity Disorder in Adults: http://dx.doi.org/10.1080/15299732.2011.537247 The “Diagnostic Interviewing” section will provide more information on diagnosis plus there’s a great overview of the general recommendations for treatment and a section on EMDR.

EMDR has been used very productively with DD clients, and is most productively done in a framework of coping and stabilization skills. For more information on using EMDR treatment with DD clients see references listed in the Bibliography.

Appendex

Symptoms Indicative of Possible Presence of a Dissociative Disorder

List compiled by J. Twombly from Kluft (1999), Ross (1997), Steinberg (2000), and personal experience.

Note: It is important to realize that these symptoms may occur in many of our clients, not just clients who have dissociative disorders. It can be important to consider the possibility of a dissociative disorder if you see a cluster of these symptoms. Some of these symptoms are signs of possible alter or part behavior; some are symptoms that are frequent components of a dissociative disordered client’s general clinical presentation. Depending on the symptom, noticing one or more may indicate that it’s time to think about checking for the presence of a dissociative disorder. Easy to administer, clinically validated screening tools are available to help initial screening for the presence or absence of a dissociative disorder. For more information, go to the International Society for the Study of Trauma and Dissociation’s web site at: www.ISST-D.org.

- BASK symptoms (Behavior, Affect, Sensation, Knowledge) these symptoms stand for the 4 dimensions of traumatic material. Any one or all of these dimensions can be dissociated. Example: a person
who has knowledge of a traumatic event but doesn’t have access to any affect about it. (Braun, 1988)

- Reported history of child abuse, especially a complex one beginning young, a traumatic medical history, or a client who grew up in a war torn country
- History of a “wonderful childhood” in person who has symptoms e.g. anxiety, depression, somatic symptoms, etc. Some people with dissociative disorders have very little memory for their childhoods and initially report they had a happy childhood.
- History of being abused by a prior therapist(s)
- History of 3 or more diagnoses
- Prior treatment failure especially by “good” therapist (average number of years in treatment before diagnosis for people with dissociative disorders is 6.8 years)
- Depersonalization and/or derealization
- Flashbacks and other post traumatic symptoms.
- Lots of psychiatric and somatic symptoms, headaches, stomach and gynecological problems with no medical cause, eating disorders
- Mood swings, behavior changes, e.g. client comes in sometimes totally groomed, sometimes messy, unevenness in presentation
- Time distortion, blank spells, amnesia (often for periods of one’s childhood, or for prior session material)
- Client reports doing things, and later has no recall of them.
- Temporary loss of ability to do something that client knows how to do (e.g. drive)
- Therapist feeling confusion and/or dissociating during session can be indicative of the therapist picking up some of the client’s dissociating through projective identification.
- Intrusive feelings, impulses, and/or actions.
- Easily learns coping skills in session, but is unable to use them outside session
- Trance behavior (person “spaces” out, eye rolls)
- Blatant signs: a child part appears or client suddenly does not know who you are
- Indications of disorganized attachment
- Others noting changes in behavior or reporting client “lies”
- Use of “we” or third person references, language style or tone changes
- Hearing voices inside his/her head
• Headaches – 78% of clients report headaches (Ross). They often indicate a sign of switching, or internal turmoil.
  • Difficulty speaking a coherent sentence
  • “Black outs” reportedly from drugs or alcohol that occurred prior to drug or alcohol use
  • Client reports feeling crazy and or confused
  • Lots of day dreaming
  • Ability to block out pain, high pain tolerance
  • Lag time between question and response (can be indicative internal influence of alters/parts)

**How to Use EMDR with DD Clients: Partial Reference List**

Forgash, C. ed. *Deepening EMDR Treatment Effects Across the Diagnostic Spectrum: Integrating EMDR And Ego State Work*

Knipe, J. The Methods of the Back-of-the-Head Scale and Constant Installation present orientation and safety.:


**Plus 1 Invaluable Non-EMDR Treatment Resource**

Bibliography


Braun, B.G. BASK Model of Dissociation, *Dissociation*, 1:1March 1988: [https://scholarsbank.uoregon.edu/xmlui/.../Diss_1_1_2_OCR_rev.pdf](https://scholarsbank.uoregon.edu/xmlui/.../Diss_1_1_2_OCR_rev.pdf)


