Beyond the DES-II: Screening for Dissociative Disorders in EMDR Therapy

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The Dissociative Experiences Scale (DES-II) remains the most widely used brief screening tool for identifying dissociative symptoms despite limitations of the instrument and the training of those who use it. Standard eye movement desensitization and reprocessing (EMDR) therapy procedures require a thorough clinical assessment and formally screening for the presence of a dissociative disorder. This aids development of an accurate case conceptualization prior to the preparation and trauma reprocessing phases of EMDR therapy. Reliance on DES-II mean scores as the sole measure of dissociative features—particularly with persons reporting a history of early childhood neglect or abuse—is insufficient to determine readiness for safely reprocessing traumatic memories. The International Society for the Study of Trauma and Dissociation (ISSTD) Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision, noted that employing standard EMDR therapy with individuals suffering from an unrecognized dissociative disorder was reported as a risk for significant harm. EMDR-trained clinicians' standard practice of screening for dissociative disorders must evolve beyond a casual reliance upon the DES-II. Consistent use of a mental status examination and reliable diagnostic tools is needed. Several relevant assessment tools are reviewed with their strengths and limitations. The authors recommend that clinicians apply these approaches even when their intent is to screen out persons whose presenting difficulties lie outside their scope of practice or research design.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; standards; Dissociative Experiences Scale (DES-II); screening; assessment; dissociation disorders

The dissociative disorders tend to be underdiagnosed or misdiagnosed, and therefore undertreated, in most clinical settings (ISSTD, 2011; Pietkiewicz et al., 2021). While this remains a concern for treatment in general, it is particularly relevant in the application of eye movement desensitization and reprocessing therapy (EMDR). Concerns surrounding the use of standard EMDR therapy procedures with individuals experiencing undiagnosed dissociative disorders were documented in some of the earliest published reports on EMDR therapy and have been highlighted in textbooks (Lazrove & Fine, 1996; Leeds, 2009, 2016; Paulsen, 1995; Shapiro, 1995, 2001, 2018). These concerns were considered by Francine Shapiro, originator of EMDR therapy, as evidenced by formation of the EMDR Dissociative Disorders Task Force to draft recommended guidelines for application of EMDR in treatment of persons with dissociative disorders; these guidelines were published in the first edition of Shapiro's foundational EMDR textbook (1995), and are found in Appendix E of the third edition (2018).

The International Society for the Study of Trauma and Dissociation (ISSTD, 2011) has published widely recognized standards for the treatment of individuals who meet criteria for a dissociative disorder.

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These standards summarize reports that "early use of standard EMDR for patients with unrecognized DID resulted in serious clinical problems, including unintended breaches of dissociative barriers, flooding, abrupt emergence of undiagnosed alternate identities, and rapid destabilization (Lazrove & Fine, 1996; Paulsen, 1995; Shapiro, 1995; Young, 1994)" (p. 158). Guidelines offered by the EMDR Dissociative Disorders Task Force further emphasize that introducing bilateral stimulation, also referred to as bilateral dual-attention stimulus, early in treatment may result in severe decompensation including increased suicidal or homicidal risk (Shapiro, 1995).

Disparities in Standards for Screening and Diagnosis of Dissociative Disorders

In the textbook which is required reading in all EMDR International Association (EMDRIA), EMDR Europe, and Global Alliance-approved basic training programs in EMDR therapy, Shapiro (2018, p. 96) clearly states:

> *Because many clinicians are not educated in the treatment of dissociative disorders and greatly underestimate their prevalence, the appropriate safeguards must be stressed (see Ross, 2015) . . . Therefore, the clinician intending to initiate EMDR should first administer the Dissociative Experiences Scale–II (DES-II; Carlson & Putnam, 1993) and do a thorough clinical assessment with every client. When the DES score is above 30, the application of a structured diagnostic interview for the dissociative disorders, such as the Structural Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994a), is indicated.*

For situations when the DES-II score is above 30, Shapiro (2018) helpfully lists eight areas to be explored as part of a standard mental status exam (MSE) for a dissociative disorder. However, no guidance is offered for conducting an MSE when the DES-II score is lower than 30. This gap presents a problem, as most clinicians have little if any education, training, or supervised experience in the elements of conducting an MSE for dissociative disorders (Loewenstein, 2018, p. 230). Shapiro (2018) does not discuss the limitations of the DES-II as a screening tool or provide information such as that recommended by others about how to mitigate these limitations (Brand et al., 2006; Kate et al., 2020; Paulsen, 2009). These omissions allow the opportunity for EMDR therapists to be inadequately prepared to use the information imparted and leave patients vulnerable to potential misapplication of standard EMDR therapy. The present article aims to aid the situation described by offering information and instruction that may fill in this gap.

Although Shapiro (2018) clearly addressed risks of improper application of standard EMDR therapy, current minimum training standards set forth by EMDR therapy credentialing bodies do not explicitly highlight how training in EMDR therapy should address them. The standards range from requiring that the topic of dissociation be touched upon, if only cursorily, with trainees encouraged to pursue advanced training to treat dissociative clients (EMDRIA, 2017, p. 8) to introducing "[p]rinciples and procedures for the assessment, recognition and regulation of anxiety and dissociative states," but only after trainees have a minimum of 8 weeks of experience integrating EMDR therapy into their clinical practice (EMDR Europe, 2020). The "*International Guidelines for Minimum Criteria for EMDR Standards and Training*" (Regional Associations of the Global Alliance, 2014) indicate only that curricula should be consistent with the latest edition of *EMDR: Principles, Procedures and Protocols* (e.g., Shapiro, 2018).

Challenges to the Phase-Oriented Model of Treatment

Traditionally, the phase-oriented model of psychotherapy first proposed by Janet (1907) has been the foundation for EMDR and many trauma-focused therapies (Gelinas, 2003; Van der Hart et al., 2013, 2014). The EMDR Dissociative Disorders Task Force guidelines infer use of EMDR within a phase-oriented model, advising caution against use of EMDR in "early treatment phases," and elaborating upon uses for EMDR in the "middle" phases of treatment (Shapiro, 2018, pp. 501–502). Recent papers and presentations challenge this approach (De Jongh et al., 2016, 2019; De Jongh & Matthijssen, 2020; Zoet et al., 2018). Some of these authors also appeared to presume that a diagnosis of complex posttraumatic stress disorder (PTSD; WHO, 2018) or the dissociative subtype of PTSD (APA, 2013), precludes the possibility of a more complex and co-occurring dissociative disorder, despite research suggesting this has yet to be established (Hyland et al., 2020). In some cases, presumption of exclusion is based on screening with the DES-II, which poses concerns that will be discussed later in this article (Carlson & Putnam, 1993). In contrast, Brand et al. (2016) summarized treatment outcome research for persons with complex dissociative disorders indicating that these individuals can be safely treated when methods are consistent with

published expert consensus guidelines that emphasize a phase-oriented model, which begins with a focus on issues of safety, stabilization, and developing the therapeutic alliance. "Failure to stabilize the patient or a premature focus on detailed exploration of traumatic memories usually results in deterioration in functioning and a diminished sense of safety" (Brand et al., 2016, p. 264).

The Emergence of Modified EMDR Procedures for Those With a Dissociative Disorder

In the decades since EMDR therapy's introduction, numerous clinicians have described modified EMDR therapy procedures reported to be both safe and helpful for persons who meet criteria for a dissociative disorder (e.g., Fine & Berkowitz, 2001; Forgash & Copeley, 2008; Gelinas, 2003; Gonzalez & Mosquera, 2012; Knipe, 2018; Lanius et al., 2014; Mosquera, 2019; Paulsen, 2009). Thus, it is not EMDR therapy, per se, which poses the risk of harm to these individuals. Rather, it is uninformed application of standard EMDR therapy procedures by clinicians who, for any number of reasons, have not adequately screened and recognized persons experiencing dissociative disorders or who lack appropriate education and training for the treatment of those with complex dissociative disorders—both within and beyond the context of EMDR therapy.

The Prevalence of Dissociative Disorders in Clinical Populations

The importance of adequate screening is directly related to the fact that dissociative disorders are actually relatively common in clinical settings and are often misdiagnosed (Brand et al., 2016; Carlson et al., 1993; Ross, 2015). In the general population, persons are found to meet criteria for a dissociative disorder at the prevalence rate of 11.3% and dissociative identity disorder at 1%–1.5% (Brand et al., 2016; Kateet al., 2020); among a sample of university students, the prevalence was found to be 11.4% and 3.7% respectively (Kate et al., 2020). Among various clinical populations, the prevalence of dissociative disorders and dissociative identity disorder have been summarized in Table 1. In a sample relevant to many EMDR-trained clinicians, a study at an outpatient clinic (N = 82) (Foote et al., 2006) found that 29.0% of individuals presenting for services met criteria for a dissociative disorder and 6.0% met criteria for dissociative identity disorder. This collective data suggests that up to one-third of patients in outpatient treatment may meet criteria for a dissociative disorder.

The Nature and Limitations of the DES-II

The DES-II (Carlson & Putnam, 1993) was developed for use as a screening tool to increase the probability of identifying persons who meet criteria for a dissociative disorder. It was designed as a trait measure of dissociation, conceptualizing dissociation on a continuum where the nonclinical and clinical populations are differentiated by number and frequency of symptoms. Thus, respondents are asked to rate each of the 28 items comprising the DES-II according to its presence and frequency in their daily life. Ratings are given on an 11-point scale, from 0% (never) to 100% (always), with higher item ratings and a higher mean score indicating a greater frequency of, thus more severe, dissociation (Carlson & Putnam, 1993). The DES-II was readily adopted by clinicians and researchers due to advantages including brevity, ease of scoring, and clarity of response choices offered to the respondent (Ellason et al., 1994). Original authors of the DES (Carlson et al., 1993; Carlson & Putnam, 1993), as well as subsequent supporters and critics, have repeatedly highlighted its limitations with underdiagnosing (false negative) or overdiagnosing (false positive) dissociative disorders,

TABLE 1. Prevalence of Dissociative Disorders in Various Clinical Settings

Study (meta-analyses)	*N*	Population	%DD	%DID
		Clinical		
Foote et al. (2006)	82	Outpatient clinic	29.0	6.0
Sar (2011)	43	Emergency	34.9	14
Sar (2011)	1,832	Inpatient	4.3–40.8	0.4–7.5
Sar (2011)	511	Outpatient	12–29	2–6
		Nonclinical		
Kate et al. (2020)	2,148	University students	11.4	3.7
Kate et al. (2020)	30,253	Community	9.9	1.2

Note. DD = dissociative disorder; DID = dissociative identity disorder.

especially when mean scores are taken without further investigation or context (Brand et al., 2006; Foote et al., 2006; Ross, 2021). While it is outside the scope of this article to address how to recognize and address such false-positive presentations, a comprehensive review of this topic is found in a recent publication by Pietkiewicz et al. (2021).

History of the DES-II

The DES was originally published in 1986 (Bernstein & Putnam), and was validated and later updated with the intention of providing a tool to support both clinicians in identifying persons with dissociative experiences and researchers in studying and quantifying dissociative psychopathology (Carlson & Putnam, 1993). Concurrently, professionals studying and treating dissociation and trauma-related diagnoses were subject to scrutiny related to allegations of overdiagnosis or iatrogenic (i.e., treatment-induced) creation of what was then referred to as Multiple Personality Disorder (MPD), which has evolved to the current *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*) category of dissociative identity disorder (DID; American Psychiatric Association, 2013). It was acknowledged that most mental health professionals were likely to err on the side of a false-negative diagnosis of MPD due both to a lack of training in recognition of dissociative symptoms and disorders (Loewenstein, 2018) and to the vague diagnostic criteria for dissociative disorders provided by successive editions of the *DSM* (Dell, 2009a, 2009b). Nonetheless, the context of initial studies motivated identification of a cutoff value for mean DES scores to reliably screen for a dissociative disorder without risking a false-positive indicator of a dissociative disorder where one was not present (Carlson et al., 1993).

DES Mean Scores Are Not Enough

While Steinberg et al. (1991), recommended a cutoff score of 15 when administering the DES to screen for the presence of a dissociative disorder, Carlson et al. (1993) settled on a cutoff score of 30, favoring specificity over sensitivity and to reduce the probability of a false-positive screening result. The same data informing this determination indicated that 14% of individuals reporting a mean DES-II score of 20 were determined to have MPD.

Identification and utilization of DES-II mean scores as a reliable indication of the presence of a dissociative disorder has continued to be controversial in the literature. Exploration of the prevalence of dissociative disorders among psychiatric outpatients indicated that a mean DES cutoff score of 30 missed 46%, and a DES cutoff score of 20 resulted in missing 25%, of positive diagnoses of a dissociative disorder later identified via diagnostic interview (Foote et al., 2006). Similar findings indicate that 80% of persons with DID will be rightly detected by a mean DES score of 20, however equivalent detection of any other dissociative disorder required lowering the DES cutoff score to 12 (Meuller-Pfeiffer et al., 2013). Both research groups identified the necessity of further evaluation, after calculating the mean DES score, to detect a dissociative disorder, and recommended utilization of diagnostic instruments and interviews such as those described later in this article.

Clinical Use of the DES-II

For clinical use of the DES-II, Carlson and Putnam (1993) recommended that any items endorsed at 20 or higher be followed up by the clinician, who should ask for examples of the endorsed experience to ensure that the individual understood the item and to assess for pathology. They explicitly stated that "the DES was *not* intended as a diagnostic instrument" and that scores do not necessarily reflect levels of pathology (Carlson & Putnam, 1993, pp. 16–17). Additionally, because the DES does not consider the possibility of under- or overreporting, this may contribute to the possibility of false-negative and false-positive results, respectively. Owing to these and other limitations inherent in a simple screening, when clinicians need to reliably determine the presence and severity of dissociative symptoms or support the determination of whether someone meets criteria for a dissociative disorder, an appropriate diagnostic tool must be used in addition to—or instead of—the DES (Carlson et al., 1993; Carlson & Putnam, 1993; Foote et al., 2006; Shapiro, 2018; Twombly, 2012).

DES Taxon Probability

Waller et al. (1996) proposed a DES "taxon" (DES-T),which would distill the original 28 items down to the eight items most representative of a "type of individual who experiences pathological dissociation" (p. 311). There was a stated hope that this taxon could serve as a "diagnostic profile" discriminating between those who met criteria for DID (then MPD) and those experiencing other nondissociative mental health disorders, based on the statistical probability that an individual belongs to either the "dissociative" or "nondissociative" type, based on specific statistical probabilities.

Each item in the taxon was determined to have its own "threshold score," the point along the 0 to 100 DES scale at which that item reached clinical significance. Overall probability across the eight items was measured on a continuum from 0 to 1, with those scoring greater than 0.50 determined to belong to the dissociative taxon, therefore indicating the probability that an individual would meet criteria for DID/MPD. Waller and Ross (1997) later suggested that the taxon for dissociative individuals was more accurate at a cutoff of 0.90 rather than 0.50 along the 0 to 1 continuum.

Subsequent research has attempted to validate the DES-T and found little to support it as a definitive measure. Modestin and Erni (2004) examined the validity of results comparing taxon results against an established diagnostic instrument, the Dissociative Disorders Interview Schedule (DDIS; Ross, 1997), concluding that, despite notable limitations to their study, "[t]axon membership indicates a high frequency of dissociative experiences, but it does not necessarily indicate the presence of a dissociative disorder" (p. 81). Merritt and You (2008) found that the DES-T did not clearly delineate the persons in their study who experienced pathological dissociation from those who did not, when evaluating both groups using both the DES and the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway, 1982). By contrast, Ross (2021) found that individuals diagnosed with DID via the DDIS were identified by the DES-T quite reliably (false-negative rate of 5.4%); however, the same study showed "a problematic number of false positives in individuals with no dissociative disorder" (p. 6) with 54.2% of DES scores from individuals not diagnosed with a dissociative disorder yielding DES-T membership.

Leavitt (1999) offers a summary of the challenges with the development of the DES-T and presents data that bring the taxon's limitations into stark relief. In his summary, Leavitt concluded that the results of the DES-T do not generalize beyond the most severe manifestations of dissociation (i.e., DID), meaning that other diagnostically important forms of pathological dissociation are missed. He observed that, owing to the relatively low prevalence of dissociative disorders in the general population, relying upon the DES or the DES-T to determine the presence or absence of a dissociative disorder is likely to result in both false-positive and false-negative results. He did, however, conclude that were the DES used as it was originally intended—as a means for (seemingly dissociation-savvy) mental health professionals to collect and contextualize information to enhance their clinical judgment—it takes on greater value.

Absence of Validity Scales and the Risk of False Negatives

A commonly used means to identify a test-taker's inclination to minimize, deny, or exaggerate in their responses on standardized measures is to include "validity" scales. Such scales can aid in discerning the fuller context for a person's symptoms when a responder is inclined to underreport their trauma-related symptoms, either because they have become phobic of their own experience or because they are not consciously aware of their symptoms. Although validity scales are not a replacement for clinical judgment, they offer context for what the responder does, and does not, report in an initial screening for dissociation.

When a clinician administers the DES and both the overall mean score and the taxon score are low, this does not definitively indicate an absence of dissociative symptoms that could complicate treatment. Rather, it can indicate that the person is unaware of, in denial about, or intentionally hiding their own experience—hence the "false-negative" result. It is thus incumbent upon the clinician using the DES-II to (a) understand dissociation well enough to discern less obvious indications of pathological dissociation; (b) recognize and take seriously the aspects of a person's history that may contribute to the development of, or even mask, a dissociative disorder; (c) follow up on responses to the DES items that do not match up observed or reported experiences of the person; and (d) determine when a more comprehensive diagnostic evaluation is necessary.

Case Examples of False Negatives

Two composite case examples are offered where the DES-II scores were low and where individuals were suffering from complex dissociative disorders. Nonessential information was changed to ensure anonymity. These composites are representative of recurrent themes in numerous cases presented to the authors individually for consultation by clinicians who wished to clarify how best to proceed with EMDR therapy.

Hitting the Wall

A clinician presented the following case summary and requested guidance on determining when it was safe to proceed with EMDR reprocessing. A woman in her

40s presented for treatment for PTSD 3 years after a near-fatal single-vehicle crash involving her and her three children. For reasons that were unclear, her car had gone off the road and hit a concrete wall. Two children suffered minor injuries. The third child had a severe head injury. She initially thought this child was dead, but the child eventually made a complete recovery. The woman had a previous diagnosis of PTSD in her medical record after overseas military deployments. She presented as highly intelligent and had held a high-level security clearance. She had been previously married and was experiencing domestic violence in her current marriage. A few years prior, violence perpetrated by her current husband left her with cracked ribs, an assault for which he subsequently served jail time. A few months ago, after he again went off his bipolar medications, he became verbally abusive and sexually assaulted her in her sleep. She was currently pressing charges against him. She reported having had nine miscarriages, all of which she attributed to his violence. The clinician reported not having taken a history of the patient's early family life since she was seeking treatment for adult-onset PTSD.

Routine administration of the DES-II had yielded an overall mean score of 16. The DES-II taxon was not calculated. Despite a DES-II score well below the cut-off of 30, the clinician described this patient as "highly dissociative." For example, when reporting on her trauma history, she was simultaneously "walking up a trail in the mountains" in her mind. She stated that she was able to care for her children, but that when alone her preferred coping method was "trancing" or "zoning out." The patient's "highly dissociative" coping strategies reported by the clinician were strong signals of a need for further assessment for this patient. There was the additional, concerning hypothesis that the single-vehicle crash may have been a suicide attempt by a hopeless and hidden part of the patient's personality who felt trapped in the abusive marriage. The clinician was advised not to attempt to use any EMDR-related procedures with bilateral stimulation, to defer taking an early history, and instead to focus on assessment and diagnosis related to the patient's dissociative symptoms. The clinician was advised to administer the Multidimensional Inventory of Dissociation (MID; Dell, 2006) which includes following up on significant items with a clinical interview. A subsequent consultation with the clinician confirmed that the person's scores on the MID indicated that her experience met criteria for a diagnosis of DID.

The consultant advised the clinician to consider a treatment plan based on the determined diagnosis and to seek advanced training in the diagnosis and treatment of complex dissociative disorders.

Decompensation after Reprocessing

A clinician presented the following case summary for consultation after standard EMDR therapy did not go as expected. A man in his early 30s presented for therapy after the loss of a pet and an apparently positive transition in his work role. He reported that he had been calling in sick to work and was considering filing for temporary disability due to feeling unable to return to work. A history of adoption at age 3 was reported, with no significant memories related to his adoption. The patient described his adoptive parents as "hard-working" and sometimes strict, which resulted in him missing out on social and extracurricular activities during his school-age years. He described his current relationship status as single, with a history of satisfying relationships but no marriages or offspring. He reported completing a bachelor's degree in a field related to human services, noting that he had advanced to supervisory roles in several organizations. Administration of the DES-II yielded a mean score of 14 (the consultant noted that two items measuring possible amnesia were endorsed at a frequency of 10%). Since the patient reported functioning well until the death of his pet, for which he blamed himself, the clinician had begun standard EMDR reprocessing of this memory at the third weekly therapy session.

After two sessions of EMDR reprocessing focused on the loss of his pet, the patient reported severely decreased appetite and heightened anxiety that interfered with his ability to sleep. Upon presenting for what was to be his third session of reprocessing, he reported to the clinician that he had not eaten in 2 days. He reported that when he did sleep, he experienced disturbing dreams during which he would awake in a cold sweat and feeling utterly alone. Although the patient reported no memory of events or people prior to his adoption, he identified feeling "very young" upon waking from these dreams. He described feeling as though he could not go on living, although active suicidal ideation was denied. He voiced his displeasure to the clinician for not helping him but rather making things worse such that he might lose his job. The clinician reported that he had canceled his next appointment and had not responded to the clinician's attempt to reach him by phone or secure messaging—although the clinician could verify that the latter had been opened by the patient.

In consultation, the clinician recognized that several possible indicators of a dissociative disorder had

been present, and that those were disregarded in the interest of proceeding to address the person's presenting concerns. The consultant recommended revision of the clinician's intake process to include a more thorough mental status evaluation and instructed the clinician on how to conduct a follow-up interview on items endorsed in the DES-II. The clinician intended to follow up once more with the person to offer a repair attempt and the option of referral to another clinician specializing in treatment of early attachment trauma.

Growing Beyond the DES-II

While more intentional training and practice in use of the DES-II would benefit many clinicians, there is also a need to consider more in-depth screening and diagnostic procedures. This is essential to avoid the potential for harm as described above. Alternative tools are described here that support clinicians in fulfilling their duty to "first do no (more) harm."

Established Examination and Assessment Tools for Dissociative Disorders

Several tools to assist clinicians in assessment and diagnosis of dissociative symptoms and disorders are mentioned by Shapiro (2018) as methods to screen for and diagnose dissociative symptoms and disorders. Those which are elaborated below were chosen based upon ease of use for the average EMDR trained clinician, accessibility, and their established diagnostic validity and reliability.

The Loewenstein Mental Status Examination. A MSE is a systematic approach to making observations, inquiries, and documentation regarding a person's psychological functioning. It is commonly practiced in psychiatry. The purpose of a MSE is to gather a cross section of information under domains such appearance, attitude, behavior, mood, affect, speech, thought process and content, perception, cognition, insight, and judgment to support the formulation of an accurate diagnosis and treatment plan (Trzepacz & Baker, 1993, p. 202). In 1991, Richard Loewenstein published *"An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder."* Since its publication, this seminal paper has been cited over 250 times. It was the first to offer a naturalistic and semistructured approach to carrying out a MSE for the presence of a severe dissociative disorder without requiring the use of hypnosis. It synthesized elements from the work of other leading scholars in the field, including Eugene Bliss, Bennett Braun, Denise Gelinas, Richard Kluft, Frank Putnam, Colin Ross, and David Spiegel.

Loewenstein (1991) points out that dissociation and dissociative disorders are primarily hidden phenomena and that "Patients may deny, minimize, or rationalize their presence." He comments that "one may need to ask the same MSE question in a number of different ways. It is not uncommon for an MPD patient to admit to a symptom in one part of the interview and deny it in another." He adds, "Kluft notes that symptoms of MPD may only be present during a 'window of diagnosability,' remaining hidden or latent at other times" (p. 568).

Loewenstein (1991) provides a succinct summary of observable features that may alert a clinician to dissociative phenomena. These include the wearing of a mismatching range of clothing styles, the wearing of sunglasses to obscure eye changes during in-session switching, changes in posture, handedness, voice tone, and apparent age, as well as overlapping or discrepant facial expressions. He draws attention to persistent eye closure, blinking, fluttering, eye-rolls, and the avoidance of eye contact. He indicates that common movements in dissociative patients include involuntary rocking, rhythmic leg or foot tapping, and finger twisting. These features are not diagnostic in themselves but are commonly observed in those who meet criteria for a dissociative disorder. He also indicates that when in the presence of a person with a dissociative disorder, clinicians can experience some countertransference self-alterations such as "feeling depersonalized, 'spaced-out,' floating, confused, daydreamy, sleepy, blocked in thinking, and forgetful or amnestic during the interview" (p. 571).

Scoring and Application. While not formally scored, Loewenstein organizes the MSE in six sections in the order of a typical diagnostic interview: amnesia symptoms; autohypnotic symptoms; PTSD symptoms; process symptoms; somatoform symptoms; and affective symptoms. For each of these sections he provides an overview of symptoms, MSE questions, and typical patient answers. In his summary he urges that "all psychiatric patients should be screened for a history of blackouts, time loss, trance experiences, childhood trauma, and PTSD symptoms. This will improve case finding to help clinicians begin to treat the single largest preventable cause of mental illness: the sequelae of childhood abuse, trauma, and family violence." (p. 602)

Benefits and Potential Challenges. While the Loewenstein MSE (1991) was originally developed for diagnosing

DSM-III-R conditions, it remains a useful foundation for assessing *DSM-5* dissociative disorders and a helpful primer for orienting clinicians to the issues involved in identifying persons with these conditions. That said, the risk of false positives has been highlighted owing to the MSE's structure and lack of validated diagnostic clarity (Dinwiddie et al., 1993).

Availability. The original 1991 publication is available via Internet search without any subscription or fee required. A free-standing, unpublished, interview guide version of the 1991 MSE questions was created by John O'Neil (2011) as an aid to clinical use but is not readily available.

The Dissociative Disorders Interview Schedule. The DDIS (Ross, 1997), developed by Colin Ross, MD, is a structured clinical interview consisting of 131 items designed to assess for somatic symptoms, acute substance use issues, positive Schneiderian First-Rank (psychotic) symptoms, features of major depression, and the dissociative disorders. Additionally, the DDIS contains items that focus upon explicit experiences of abuse, including extreme abuse, and extrasensory perception. The DDIS was originally developed for *DSM-III-R* (APA, 1987), and its item wording and overall scoring instructions have been regularly updated to remain relevant to current *DSM-5* diagnostic categories.

Scoring and Application. DDIS results are calculated by adding the scores of individual sections (16 in all). There is no composite score for the DDIS. The average scores in each of the individual sections are determined separately with average scores listed for 166 test-takers diagnosed with DID as a point of reference. False positives are noted to have been confirmed in 1% of 500 separate administrations of the DDIS (Colin A. Ross, Institute for Psychological Trauma, 2021). Ross reported that the instrument's sensitivity in discerning DID across 196 patients diagnosed under clinical conditions was 95.4%. More recently, the language used in the DDIS has been adapted to accommodate its use as a client self-administered assessment, referred to as the SR-DDIS. Initial research (Ross & Browning, 2017) has suggested that the SR-DDIS yields comparable results to the DDIS, specifically with clinical populations, with "no clinically or conceptually significant differences obtained with the 2 (sic) versions" (p. 31).

Benefits and Potential Challenges. A major strength of the DDIS is the attention it gives to interwoven and sometimes confounding factors, such as a substance use, borderline traits, and psychosis, which can make it difficult to definitively diagnose a dissociative disorder. Some individuals may be triggered by questions that explicitly inquire about their trauma history, potentially rendering the DDIS less useful for non-inpatient use. When asked about this possibility, Dr. Ross (2020) stated that he has not heard of this happening and does not see this as a barrier to its use in an outpatient office setting. Although any clinician can administer and tabulate the results of the DDIS, only clinicians with an understanding of complex trauma and dissociation may be prepared to interpret, make meaning from, and conceptualize a treatment plan based on its findings. Because the DDIS is in many respects a narratively elaborated version of the *DSM* criteria written out in a narrative format, it does appear to rely upon someone being at least somewhat aware of their symptoms, based strictly upon the arguably flawed DSM criteria (Dell, 2001; Pietkiewicz et al., 2021; Steinberg, 2001).

Availability and Training. The DDIS, including its clinician- and self-administered formats, and scoring instructions, are available free of charge on the Ross Institute website (www.rossinst.com). No specific training is required to use this instrument. DDIS developer Colin Ross, MD, periodically offers introductory workshops on the use of the DDIS at conferences sponsored by ISSTD and the EMDR International Association, but there is no ongoing source of formal training available at this time.

The Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised. The Structured Clinical Interview for *DSM-IV* Dissociative Disorders (SCID-D; Steinberg et al., 1989–1994a) is a "semistructured interview designed to enable a clinically trained interviewer to assess the nature and severity of dissociative symptoms and to diagnose the presence of Dissociative Disorders" (Steinberg, 1994b, p. ix). The format of the SCID-D is based upon the Structured Clinical Interview for *DSM-II-R* (SCID; Spitzer et al., 1990) and is designed to either be used as an additional module to that interview or used alone. First published in 1985, the SCID-D was initially designed upon *DSM-III* criteria, updated upon promulgation of *DSM-IV*, and most recently updated in 1994 to be known as the SCID-D-Revised, or SCID-D-R. Consisting of eight parts, the SCID-D-R guides the clinician to gather the elements of a general psychiatric history, ask open-ended questions that elicit descriptive responses related to five core symptoms of dissociative disorders (amnesia, depersonalization, derealization, identity

confusion, and identity alteration), and follow up on patient endorsement of these questions via follow-up sections and postinterview ratings. The SCID-D-R is designed to be completed in one or more face-to-face sessions, and requires between 0.5 and 2.5 hours to administer depending on (a) whether the clinician has already gathered a general psychiatric history, and (b) the number and complexity of symptoms endorsed. While numerous studies have found good-to-excellent reliability and validity of the SCID-D-R in many geographic and clinical populations and in use for forensic evaluations, the instrument has not been updated since 1994.

Scoring and Application. Administration and scoring processes are guided via a 96-page booklet (Steinberg, 1994a) and a 155-page *Interviewer's Guide* (Steinberg, 1994b). The clinician asks open-ended questions, rates each answer in one of the following ways: ? (= inadequate information, indicating insufficient information despite attempts to clarify), N (= no, indicating the symptom or experience described is clearly absent), Y (= yes, indicating that the symptom or experience described has been or is present), or I (= inconsistent information, indicating discrepant information). A score summary sheet, guidelines for rating severity of endorsed symptoms, decision trees, diagnostic worksheets, and case examples are included in the *Interviewer's Guide* to assist final diagnosis and production of an evaluation report if necessary.

Benefits and Potential Challenges. The SCID-D is commonly referred to as the "gold standard" for assessment of dissociative disorders. Notably, according to Steinberg (2001), research has indicated that the SCID-D can diagnose DID in persons for whom it was previously undetected, which likely adds to its value as a diagnostic instrument. That said, the SCID-D requires more time and training to obtain the desired clinical information compared to other instruments discussed in this article. A reissued version of the SCID-D is reported to be in press (Mychailyszyn et al., 2021), however the current lack of an updated version to reflect *DSM-5* categories diminishes its utility.

Availability and Training. The interview booklet and *Interviewer's Guide* are available for purchase via online retailers. The *Interviewer's Guide* recommends training in clinical interviewing, familiarity with *DSM* diagnostic criteria, knowledge of the literature on dissociation, and review of three textbooks focused on systematic assessment of dissociative symptoms and disorders as prerequisites for administration and scoring of the SCID-D-R (1994b, p. 32). Ongoing training opportunities specifically focused on the SCID-D-R are unknown at the time of this writing.

The Multidimensional Inventory of Dissociation. The MID (Dell, 2006) was developed by Paul F. Dell, to assess pathological dissociation and the dissociative disorders. The current version of the MID itself is 6.0, and the current version of the *MID Analysis*, which is used to calculate results and generate the report, is v5.2 (as of February, 2021). One hundred sixty-eight of the 218 MID items are concerned with dissociative phenomena, and aid in assessing the frequency and clinical significance of 23 symptoms of dissociation, with the remaining 50 items focused on validity and characterological factors. Ultimately, the MID items yield a detailed report comprising 74 scales, which provide a wealth of information regarding the person's internal experience that may otherwise take many sessions to discover. The MID's diagnostic impression for pathological dissociation has a predictive power of .89 that distinguishes DID and DDNOS-1 (OSDD in *DSM-5*) from other clinical presentations (Dell, 2011). Although it is self-administered, the MID is not a screening instrument, but a multiscale inventory that yields a detailed account of the person's dissociative symptoms and likely diagnoses. With Dell having conceptualized a subjective-phenomenological model of dissociation (versus an objective, explanatory model), the MID is based upon the following definition of dissociative experience: "The phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive functioning and sense of self" (Dell, 2009b, p. 226).

Scoring and Application. The MID takes 30–60 minutes for the test-taker to complete, and about 10 minutes for the clinician to score using the *Excel*-based MID Analysis. Answers can be submitted in pencil and paper format or electronically according to the clinician's practice. Valid use of the MID requires a clinician-directed follow-up interview, the procedure for which is outlined in the third edition of the MID *Interpretive Manual* (Dell et al., 2020).

Benefits and Potential Challenges. The MID assesses dissociative symptoms more broadly, deeply, and reliably than the DES-II without requiring specific training. Empirically derived cutoff values are applied for each item, and for each symptom, and six validity scales offer indications of possible response bias, including both under- and overreporting of symptoms. Diagnostic impressions and observations are offered, and the mean, clinical significance, and other relevant scores for discrete symptoms are visually depicted in

the context of clinical norms in a series of line and bar graphs. Despite these benefits, it takes time to complete (though, no longer than comparable instruments), and some clinicians report finding the wealth of data generated in the report to be overwhelming, meaning they may not adequately follow up via clinical interview to substantiate the validity of the calculations-based diagnostic impressions.

Availability and Training. No specific training is required to use this instrument, beyond basic familiarity with the DES and Microsoft Excel. All documents required to administer, score, and interpret the MID, as well as all known non-English translations, are available without charge to clinicians and researchers at www.mid-assessment.com. Training sessions have been offered at international and regional conferences of the EMDR International Association and ISSTD. Training opportunities, both live and on-demand, are listed on the MID website, as are periodically updated versions of MID documents.

A Potential Alternative to the DES-II

A comprehensive, brief tool to screen for the full range of *DSM-5* dissociative disorders has long been needed. While such a tool cannot substitute for a formal diagnostic assessment of the kind discussed above, it would advance the cause of assisting clinicians who lack formal training in screening patients for the *DSM-5* dissociative disorders, as well as assisting researchers to better screen subjects in or out of their trials. Such a tool has now been developed based on a subset of 60 items from the 218 items making up the MID (Dell, 2006).

The MID-60 (Kate et al., 2020) is a 60-item *screening* based upon the MID developed to capture the full range of dissociative symptoms that characterize each of the *DSM-5* dissociative disorders. Kate et al. report that "the MID-60 has a nearly identical factor structure to the full MID, excellent internal reliability, and content and convergent validity" (p. 1). In contrast to the DES-II as a general dissociation screening tool, "the MID-60 includes items that capture phenomena specific to each DD" (p. 4).

Scoring and Application. The MID-60 can generally be completed in 20 minutes or less either in the clinician's office or a suitably private home environment. It can be self-administered with paper and pencil or using an Excel-based questionnaire. The MID-60 mean score and subscale scores are calculated automatically in an Excel file. In contrast to the DES-II which contains a majority of clinically irrelevant items, all 60 items in MID-60 yield clinically relevant information. For clinicians unfamiliar with recognizing or diagnosing individuals with dissociative disorders, the MID-60 is likely to provide more immediately useful information than the DES-II.

Benefits and Potential Challenges. Although the authors emphasize that the MID-60 is intended for screening purposes and is *not a diagnostic tool*, the MID-60 does yield diagnosis-related clinical cutoff scores via subscales that provide specific information about potential diagnoses to be considered. When the MID-60 mean and subscale scores indicate the likelihood of a dissociative disorder, clinicians should consider administering the full MID, the SCID-D, the DDIS, or a dissociation-focused MSE. Initial research on the MID-60 was conducted with a nonclinical population of college students. Further research will be needed with clinical population to confirm the reliability and validity of the preliminary findings. Kate et al. (2020) opine that it "may prove useful in clinical settings where clients and therapists may find it convenient and expedient to complete a short version [of the MID]" (p. 18).

Availability and Training. An overview of the MID-60 is available through the article by Kate et al. (2020). A series of documents related to the MID-60, including MS Excel files for administering and scoring are provided by Mary-Anne Kate on her Research Gate project page (www.researchgate.net/project/The-60-item-version-of-the-Multidimensional-Inventory-of-dissociation-MID60). An introductory 30-minute video from Kate on the MID-60, which clarifies the administration of the MID-60 and its similarities and differences with the DES-II and the MID, is also available (youtu.be/08rfohth-hc). No further training on the MID-60 is known to be available.

Discussion

Implications for Clinical Practice

Practice Standards. Best practices for trauma-resolution therapies, including EMDR therapy, benefit from strengthening in the areas of recognizing and diagnosing pathological dissociation (Shapiro, 2018). Failure to recognize those with dissociative disorders contributes to inadequate treatment and poor prognosis (Brand et al., 2013) and increases the risks of self-harm and suicidality. Among those with borderline personality disorder, PTSD, alcohol abuse, and dissociative disorder, those with dissociative disorders

are at the highest risk of episodes self-harm and multiple suicide attempts (Foote et al., 2008) and yet the presence of these disorders tend to remain the least often recognized. The specific potential for harm in offering standard EMDR therapy to those with diagnosed and undiagnosed dissociative disorders alike has been recognized since the first decade of EMDR training (ISSTD, 2011). Articulating and implementing enhanced screening and assessment practices is overdue. Research suggests that among persons appropriately diagnosed and treated for dissociative disorders positive treatment outcomes have been widely observed (Brand et al., 2013). Case reports and preliminary research suggest that EMDR therapy can be adapted to meet the needs of patients with complex dissociative disorders (Lanius et al., 2014; Twombly, 2005; Wong, 2019). We believe that best clinical practices for EMDR therapy include specific training, education, practice or case consultation, and access to resources related to screening and assessment of dissociative symptoms and disorders.

Practice Recommendations. For clinicians trained in trauma-resolution therapies, including EMDR therapy, without exposure to these proposed best practices and assessment tools for the dissociative disorders, it is time to look beyond the DES-II. Used alone, the DES-II is often insufficient for the detection of complex dissociative disorders. The risks of false negative scores are significant, and as discussed above it offers no specific diagnostic or validity subscales. *If a mean DES-II score is to be used in a meaningful and reliable way, studies reviewed indicate a cutoff score of between 12 and 20 should be used as a brief screen for a dissociative disorder and to indicate the need for more in-depth assessment.* As Carlson and Putnam (1993) recommended, the authors also strongly recommend that the clinician conduct a follow-up interview focused on any DES items endorsed at 20 or higher, and any items endorsed indicating amnesia. The recently released MID-60 offers a more comprehensive screening tool that includes diagnostic subscales that must be similarly explored via a follow-up interview or subsequent assessment.

Clinicians are strongly encouraged to become familiar with (and, if necessary, trained to administer) at least one of the diagnostic evaluation or assessment instruments described above. This attention to factors known to be present in and reported by persons with a previously undiagnosed dissociative disorder will provide context for any screening or assessment tools. The primary ethical standard to "first, do no harm" demands no less.

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