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EMDR & Dissociation

The Ultimate Clinician's Guide — spotting, assessing and safely adapting EMDR for dissociative presentations

Unrecognised dissociation is one of the most frequently cited reasons EMDR goes badly. This guide covers how to spot it in session, how to assess it properly, how to ground and prepare, and the protocol modifications — CIPOS, Loving Eyes, titrated processing — that make EMDR safer with dissociative presentations.

WHAT'S INSIDE

- ✓ The Theory of Structural Dissociation — primary, secondary, tertiary
- ✓ Four lenses for spotting dissociation, and ten in-session signs
- ✓ Assessment: DES-II item review → MID / SCID-D, with decision rules
- ✓ Grounding toolbox across somatic, sensory and cognitive channels
- ✓ Verbatim scripts: Back-of-the-Head Scale and introducing parts language
- ✓ Protocol modifications and a phase-by-phase adaptation table
- ✓ Red flags, referral thresholds, closure and an intake-to-reprocessing pathway

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1. Why this guide exists

Standard EMDR assumes one integrated experiencer who can hold the memory, the body sensation and present-moment awareness at the same time. When the system holding the memory is dissociatively organised — cut off from the body, divided across parts, or moving in and out of presence — the standard protocol can deepen the very split it is trying to resolve (Shapiro, 2018; Leeds, Madere & Coy, 2022).

This guide covers what dissociation is and isn't, how to spot it through four assessment lenses, how to stabilise with grounding and parts-aware resourcing, and the modifications that make EMDR safer with dissociative presentations.

2. What dissociation is — and what it isn't

Dissociation is a disruption of, or discontinuity in, the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour (DSM-5-TR; American Psychiatric Association, 2022). Functionally, pieces of experience that should be linked are not.

It sits on a continuum. Everyone has mild, normal dissociation — highway hypnosis, getting lost in a book. Trauma-related dissociation sits further along: depersonalisation, derealisation, time loss, emotional numbing, identity confusion, and parts that hold experience the rest of the person cannot reach.

It is not simply ‘checking out’, it is not the same as avoidance, it is rarely what television shows, and it is not a character flaw. Most dissociative clients look fine in the waiting room. The presentations that derail EMDR are subtle: flat affect on a high-SUD target, a long pause before answering, a client who can't recall what was said two minutes ago.

3. The Theory of Structural Dissociation

Van der Hart, Nijenhuis and Steele (2006) describe trauma as preventing the integration of action systems: an **Apparently Normal Part of the personality (ANP)** that manages daily life, and one or more **Emotional Parts (EPs)** that hold trauma-related affect, sensation, defence responses and memories.

Level	Structure	Typical presentations	EMDR implication
Primary	One ANP + one EP	PTSD, often after single-incident trauma	Standard protocol is usually appropriate
Secondary	One ANP + several EPs	Complex PTSD, trauma-related BPD, many OSDD presentations	Needs explicit parts-aware preparation before reprocessing
Tertiary	Several ANPs + several EPs	DID	Phase-oriented, adapted EMDR only, by clinicians with dissociation training

Knowing which level you are working with decides whether you run the standard protocol, a modified protocol, or stay in stabilisation for an extended period first.

4. Why dissociation derails EMDR specifically

EMDR relies on dual attention: holding the memory and present-moment input in awareness at once while bilateral stimulation (BLS) supports processing. Dissociation breaks dual attention in three ways:

1. **The client is not in the present.** BLS without a felt sense of present safety risks re-experiencing rather than processing.
2. **The part that holds the memory is not the part doing the talking.** The ANP reports SUD 2 on a memory an EP experiences as 10. Processing seems to 'complete' without the holder of the memory being engaged, and symptoms return.
3. **The window of tolerance is narrower than it looks.** Hypoarousal can look like calm. The clinician reads it as smooth processing and continues; hours later the client is dissociated, unsafe or amnestic for the session.

This is why EMDR training teaches dissociation screening in Phase 1 (Shapiro, 2018). It is cheap insurance against a preventable adverse event.

5. Spotting dissociation — four lenses

No single lens is enough. Combine them.

- **Lens 1 — History markers.** Early and prolonged childhood abuse or neglect, attachment disruption, gaps in autobiographical memory, time loss, fugue episodes, finding objects you don't remember buying, being told about behaviour you don't remember.
- **Lens 2 — Formal screening.** DES-II for everyone, read item by item; MID, SCID-D or DDIS as follow-up (Section 7).
- **Lens 3 — In-session behaviour.** See Section 6.
- **Lens 4 — Response to BLS.** Some clients dissociate only once BLS starts. A clean history and a low DES-II total do not rule out dissociation that appears under activation.

6. In-session signs of dissociation

Any single sign is data. A cluster of signs is grounds for a decision.

Cue	What it may indicate	Immediate action
Long pauses, flat affect on a high-SUD target	Hypoarousal / depersonalisation	Stop BLS. Orient: 'Can you look at me? Name three things in the room.'
Sudden shift to mundane content mid-set	Shift to the ANP, or avoidance via dissociation	Pause. 'Something just shifted. What happened for you just then?'
Glazed eyes, fixed stare, looking 'through' you	Trance, absorption or freeze	Stop BLS. Tactile orienting — something cool or textured in the hand.
Unexpected change in voice, vocabulary or age-feel	Part shift (secondary or tertiary)	Stop. 'I want to make sure I know who I'm with right now.'
'I can see it but I don't feel anything'	Depersonalisation from affect	Don't push BLS through it. Somatic resourcing; reconnect to the body first.
Can't recall what was said minutes ago	Micro-amnesia / time loss	Stop reprocessing for the session. Ground, close, reassess between-session symptoms.
Body part feels numb, 'not mine' or absent	Somatoform dissociation	Stop BLS. Body-specific resourcing before resuming.
Sudden sleepiness, head dropping	Shutdown / freeze	Stop. Orient with movement — stand, walk, cool water. Don't resume that session.
Says 'we' for 'I', or speaks of self in third person	Possible parts-organised system	Pause. Ask calmly: 'Help me understand who's speaking.'
Feels 'far away', 'underwater', 'behind glass'	Derealisation	Stop. Sensory orienting (taste, smell, temperature). Check the Back-of-the-Head Scale.

Practice heuristic

If several of these appear in one session, pause Phase 3–6 work, reassess (item-level DES-II review, MID or structured interview) and consider a phase-oriented adaptation before any further reprocessing.

7. Formal assessment — which instrument, when

Use a tiered approach: a quick screen in Phase 1, fuller assessment when anything points to dissociation.

- **DES-II** (Carlson & Putnam, 1993) — 28 items, self-report, about 10 minutes, free. A total of 30 or more, or a DES-Taxon of 20 or more, calls for further assessment. **A low total does not rule out a dissociative disorder**: review every item, especially the amnesia items, and follow up any endorsement with a clinical interview (Leeds, Madere & Coy, 2022).
- **MID** (Dell, 2006) — 218 items, self-report, 30–60 minutes, free to clinicians. Measures 14 facets and 23 symptom scales of dissociation, with validity scales. Score with the official analysis workbook and read the full profile.
- **SCID-D** (Steinberg, 1994; revised editions since) — semi-structured interview, typically 1–2 hours, requires training. The reference standard for diagnosing dissociative disorders.
- **DDIS** (Ross et al., 1989) — structured interview with a similar use case to the SCID-D.
- **SDQ-5 / SDQ-20** (Nijenhuis et al., 1996, 1997) — somatoform dissociation, which the DES-II under-samples. SDQ-5 ≥ 8 is a positive screen. Useful with chronic pain, conversion symptoms or unexplained somatic complaints.
- **A-DES** (Armstrong et al., 1997) for ages 11–18; **CDC** (Putnam et al., 1993), completed by caregivers, for younger children.

8. Decision rules: assessment → treatment frame

Practice heuristics for after Phase 1 screening. Clinical judgement and consultation take precedence.

If…	Then…
Low DES-II, no endorsed amnesia items, no history markers or in-session signs	Standard 8-phase protocol. Keep routine window-of-tolerance monitoring in Phase 4.
DES-II roughly 12–29, any amnesia items endorsed, or some history markers	Look closer: clinical interview about time loss and identity; consider the MID. Extend Phase 2, add somatic resourcing, slow target sequencing, check presence more often.
DES-II ≥ 30, DES-T ≥ 20, or persistent depersonalisation / derealisation	Administer the MID and/or refer for SCID-D. Don't start Phase 3 until phase-oriented stabilisation is documented.
Assessment indicates secondary structural dissociation	Parts-aware EMDR: parts mapping in Phase 2, parts check before each target, Loving Eyes and CIPOS, titrated processing. Expect a longer preparation phase.
SCID-D or MID consistent with DID	Phase-oriented treatment with adapted EMDR only — e.g. the Progressive Approach (González & Mosquera, 2012), Forgash & Copeley (2008), Fraser's Dissociative Table — by a clinician with dissociation training, or refer (ISSTD, 2011).
Dissociation appears only when BLS starts	Pause reprocessing. Add Phase 2 sessions practising dual attention with low-charge material; consider body-based stabilisation work.

9. Grounding: the core skill before reprocessing

A dissociative client who cannot reliably ground cannot tolerate reprocessing. Grounding is the most teachable, most rehearsable Phase 2 skill — and the easiest to under-dose. Teach at least one technique on each channel — somatic, sensory, cognitive — and confirm the client can use it without you.

> **A practical readiness test (heuristic)**
>
> Ask the client to bring up a mildly activating memory (SUD 3–4), then return to baseline using their own grounding tools. If they can do this repeatedly without your help, they're likely ready to move on. If you have to walk them out every time, there is more Phase 2 work to do.

10. Grounding techniques: when to use which

Match the technique to the direction of dysregulation (hyper- or hypoarousal) and the channel the client can reach most easily.

Technique	Best for	How to use it
5-4-3-2-1 sensory scan	Mild dissociation, derealisation	Name 5 things you see, 4 you hear, 3 you can touch, 2 you smell, 1 you taste. Slow pace.
Feet on floor, notice body weight	Floating, mild hyperarousal	Press feet down; feel the chair at your back and the weight of your hands.
Cool water on wrists, cold object in hand	Shutdown, freeze	Strong temperature input can interrupt shutdown. Keep a cold pack in the office.
Paced breathing (long exhale)	Hyperarousal with a tolerable connection to breath	e.g. in for 4, out for 6–8. Skip if breath focus is itself a trigger.
Slow butterfly hug / self-tapping	Mild activation during preparation	Slow, client-paced, paired with a resource — calming, not processing (Artigas & Jarero, 2014).
Peripheral-vision orienting	Trance, fixed stare	'Without moving your head, notice what's at the edges of your vision.'
Movement: stand, walk, push a wall	Hypoarousal, immobility	Engages large muscles and proprioception; helps discharge freeze.
Present-day facts	Time confusion, age regression	'What's today's date? How old are you now? Where do you live now?'

Technique	Best for	How to use it
Pleasant strong scent (peppermint, citrus)	When visual cues don't reach	A quick, strong orienting cue. Check for scent sensitivities first.
Back-of-the-Head Scale (Knipe)	Measuring presence mid-session	See Section 11.

11. Script: teaching the Back-of-the-Head Scale (Knipe)

Knipe's Back-of-the-Head Scale (BHS) gives a moment-to-moment readout of presence, far more sensitive than 'are you with me?'. Teach it in Phase 2; use it throughout Phase 4 with dissociative clients (Knipe, 2019).

THERAPIST	I'd like to teach you a quick way for us to check how present you are. Imagine a line that starts about a foot in front of your face, runs through your head, and ends at the back of your head.
THERAPIST	The front of that line means you're completely here with me, aware of this room. The back of your head means you're completely caught up in something else — a memory, a feeling, or just 'not here'.
THERAPIST	Right now, with your finger, show me where you are on that line.
CLIENT	About here. (Points a few inches in front of the face.)
THERAPIST	Good — that's your baseline. During our work I'll sometimes ask you to point. If you've moved back, we'll pause and come forward before doing anything else.
NOTE	*In Phase 4, check the BHS before each set and whenever you see a dissociative sign. If the client moves toward the back of the head, stop, orient, and re-establish presence before resuming.*
THERAPIST	Let's practise. Think of something neutral — what you had for breakfast. Where are you on the line now?
CLIENT	Maybe about here. (Points near the face.)
THERAPIST	Now look around and tell me three things you can see. Where are you now?
CLIENT	Back out at the front.
THERAPIST	That's the move we'll use every time: eyes on the room, name what's here, and come back to the front.

If the client cannot reach the front of the line during Phase 2 practice, don't move to Phase 3. Continue grounding and somatic resourcing, and consider consultation.

12. Parts work: the missing layer in Phase 2

When **secondary structural dissociation** is suspected, standard Phase 2 resourcing — Calm Place, Container, RDI — is necessary but not enough. The system holding the trauma is parts-organised, and the parts need to be met, acknowledged and included explicitly.

This is not DID treatment. For complex PTSD, parts work is a smaller intervention: recognising that the client experiences different 'sides', 'modes' or younger ages that hold different material. The core moves are to name the parts the client already notices, acknowledge each part's protective function, create an internal meeting place where parts can communicate (Fraser, 1991), and ask for consent from all parts before targeting any memory (Knipe, 2019; González & Mosquera, 2012).

13. Script: introducing parts language

Use when a client describes themselves in divided terms ('part of me wants to, part of me doesn't') or when assessment suggests secondary structural dissociation. This builds shared language for EMDR Phase 2; it is not a separate therapy model.

THERAPIST	You said 'one part of me wants to come to therapy and another part really doesn't.' I'd like to take that seriously — it sounds like a real description of how things work inside.
THERAPIST	Many people who've been through what you have end up with different sides — one that handles daily life, one that holds the scared memories, sometimes one that protects by getting angry or shutting down. Does that fit for you?
CLIENT	Yeah. There's a part that gets very small. And one that goes cold and just leaves.
THERAPIST	Thank you for telling me. Before we do any deeper work, I'd like to get to know each of them a little — not to do anything with them yet, just so nobody inside gets surprised.
NOTE	*If the client takes to this language easily, move on to mapping. If they pull back, slow down — that may itself be a protective part. Name it: 'Something just got cautious. I want to respect that.'*
THERAPIST	Can we agree on one ground rule? Before we go near any difficult memory, we'll check in with all of you — not just the part that's most willing. If any part isn't ready, we don't push.

14. Checking with parts before EMDR targets

Once the client has language for their parts, the move from Phase 2 to Phase 3 includes an explicit check: 'Before we work on [target], I want to check inside. Is there any part of you that doesn't want to do this today?' Wait. Listen. If any part objects — even subtly — the answer is not today, and the objection becomes the next piece of work.

It adds a few minutes and prevents a common destabilisation pattern in complex trauma: a willing ANP consents while an EP that actually holds the memory does not, then surfaces during BLS with no preparation and no agreed stop signal.

15. Modifying the protocol for dissociation

These modifications layer on top of the standard protocol rather than replacing it.

- **CIPOS** — Constant Installation of Present Orientation and Safety (Knipe, 2019). For clients who can't tolerate sustained contact with trauma material: present orientation is strengthened with short BLS, the client contacts the memory for a few counted seconds, then returns to the present, and the cycle repeats.
- **Loving Eyes** (Knipe, 2019) — the adult self looks at the younger self in the memory with compassion. Strengthens the distinction between adult-now and child-then and helps resolve shame-based blocking beliefs.
- **Titrated (fractionated) processing** — instead of running a target to SUD 0 in one session, process a slice at a time across sessions, with grounding and closure between each (González & Mosquera, 2012; Knipe, 2019).
- **Dissociative Table** (Fraser, 1991) — imagery that gives the parts system an internal meeting place. Useful preparation for secondary and tertiary structural dissociation.
- **Progressive Approach** (González & Mosquera, 2012) — a comprehensive adaptation of the 8-phase protocol for complex dissociative presentations, attending to parts, attachment and the therapeutic relationship.
- **Ego-state–informed EMDR** (Forgash & Copeley, 2008) — integrating ego-state therapy with EMDR for dissociative clients.

> **CIPOS in brief**
>
> (1) Establish present orientation — feet, room, date, your face — and install it with a short, slow BLS set. (2) Invite the client to contact the memory for a few counted seconds only. (3) Bring attention straight back to the present. (4) Re-install present orientation with BLS — on the present, not the memory. (5) Recheck the Back-of-the-Head Scale. (6) Repeat, lengthening contact only as presence holds. See the EMDR Assist CIPOS & Back-of-the-Head Scale guide for the full procedure.

16. Standard protocol → dissociation-aware adaptations

What changes at each phase when dissociation is part of the picture — a quick reference for treatment planning and consultation.

Phase	Standard protocol	Dissociation-aware adaptation
1 — History	Trauma history, screening	DES-II for everyone, read item by item; MID / SCID-D when indicated. Map dissociative history explicitly (time loss, amnesia, parts experiences).
2 — Preparation	Calm Place, Container, BLS rehearsal	Add parts mapping, Back-of-the-Head Scale, somatic grounding, Loving Eyes, internal meeting place, internal safety agreements. Expect a longer phase.
3 — Assessment	Target, NC/PC, SUD, body	Check with all parts before each target. If any part objects, choose a different target.
4 — Desensitisation	Standard sets to SUD 0	CIPOS for low-tolerance clients; titrated processing; frequent BHS checks. Stop at any sign of switching.
5 — Installation	PC installed to VoC 7	Check that the PC fits for all parts, not just the speaking part.
6 — Body scan	Scan until clear	Numb areas are not 'clear' — note them and return with body-specific resourcing.
7 — Closure	Calm Place / Container	Extended closure: presence, parts check, safety plan, grounding plan, next contact. Allow 10–15 minutes.
8 — Reevaluation	Recheck SUD on prior target	Ask each known part. A target may be 'clear' for the ANP and still active for an EP.

17. Red flags — stop and consult

These signs suggest the work is moving faster than the system can integrate. Stop reprocessing, close carefully and consult before the next session:

- New amnesia for sessions or content the client previously recalled.
- A part neither of you had met appears, especially mid-Phase 4 — mapping was incomplete and consent was partial.
- Self-harm, suicidal behaviour or substance relapse that starts after a reprocessing session.
- Switching becoming more frequent across sessions.
- New somatic symptoms — pain, conversion symptoms, sensory loss — after EMDR sessions.
- The client can't remember the last session, or remembers it very differently from what happened.

None of these mean EMDR has failed. They mean the treatment frame needs to move back to stabilisation.

If you're not trained, refer

If a client screens positive for a dissociative disorder (for example DES-II ≥ 30 with MID or SCID-D confirmation) and you haven't completed dissociation-specific training — such as EMDRIA-approved advanced courses or ISSTD training — refer, or take the case on only with ongoing consultation from a dissociation specialist. Basic Training alone does not prepare clinicians for DID (ISSTD, 2011).

18. Closure that holds

Closure for dissociative clients is longer, more structured and more rehearsed than standard closure. A session that ends well helps prevent the destabilisation that can arrive a day or two later.

- Presence confirmed — the client is at the front of the Back-of-the-Head line.
- All known parts checked in and settled.
- Grounding tools rehearsed for the week; Container used for unprocessed material; Calm Place re-installed if needed.
- Between-session contact plan and next appointment confirmed; brief between-session log agreed.

Document the closure plan in the record. If the client deteriorates between sessions, this documentation supports a sound adverse-event review.

19. A practical pathway from intake to reprocessing

A sample sequence when dissociation is on the differential. Session numbers are illustrative, not prescriptive.

Stage	Focus
Sessions 1–2	Intake, DES-II (item review), PCL-5, ACE. Note in-session signs. Start orienting and somatic work alongside history.
Sessions 3–4	If the DES-II is elevated, amnesia items are endorsed or in-session signs appear: MID and/or SCID-D referral. Begin parts language and teach the BHS.
Next stage	Phase 2 stabilisation: Calm Place, Container, RDI, Loving Eyes where appropriate, grounding under low-charge activation, parts mapping if indicated.
Before Phase 3	Move on when capacity is shown, not when a date arrives: reliable self-grounding from mild activation, parts cooperation, stable functioning between sessions.
Phase 3 onward	Standard reprocessing plus parts checks, CIPOS where indicated, titrated processing, frequent presence checks and extended closure. A single target may take several sessions.

Treatment for complex, dissociative presentations usually takes considerably longer than for single-incident PTSD. Set expectations with the client early.

20. Clinical FAQs

Can I do EMDR with a client who has DID?

Only within a phase-oriented treatment frame, using adapted EMDR, if you have dissociation-specific training and ongoing consultation (ISSTD, 2011; González & Mosquera, 2012). The unmodified standard protocol is not appropriate. If you don't have that training, refer.

What DES-II score means I shouldn't do EMDR yet?

A total of 30 or more (or a DES-T of 20 or more) calls for further assessment before reprocessing — but a low score is not clearance. Review the items and the clinical picture. An elevated score doesn't rule EMDR out permanently; many clients do well with extended Phase 2 and parts-aware adaptations.

What if dissociation only shows up when I start BLS?

Stop BLS as soon as you see it. Add Phase 2 sessions on dual-attention practice with low-charge material until the client can hold internal experience and external orienting together.

How do I tell dissociation from avoidance?

Avoidance is usually deliberate — the client knows they're steering away. Dissociation is usually involuntary — the client may not realise they've gone. Ask, 'What just happened for you?' A client who can explain is more likely avoiding; 'I don't know' or a gap in recall points toward dissociation. Mistaking dissociation for resistance can lead to pushing a client past their window of tolerance.

When should I defer reprocessing?

Active psychosis, acute suicidality without a safety plan, current intoxication, and a dissociative disorder you aren't trained to treat are reasons to defer or refer. Elevated DES-II scores, complex PTSD and secondary structural dissociation are not by themselves reasons to rule EMDR out — they call for preparation.

How long should Phase 2 take?

It varies widely. The marker is capacity, not calendar time: reliable self-grounding from mild activation, parts cooperation, and stable functioning between sessions.

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