ROUTLEDGE

EMDR, DISSOCIATION, AND BEYOND

Reexamining and Expanding the Frame for Impactful Trauma Treatment

Jennifer A. Madere and
D. Michael Coy

"In this highly readable book, Madere and Coy fill the gaps in the literature and EMDR training courses on the use of EMDR in dissociation with chapters such as 'Stumbling into Dissociation with EMDR Therapy,' 'Present and Future Prongs in the Three-Stage Model,' and 'Not All Flashbacks Are Created Equal.' They integrate wisdom from older literature, recent findings, and their extensive experience to create a treatment framework that is nuanced and flexible. The crown jewel is the detailed chapter on perpetrator introjects. This text is required reading for any therapist who would like to be guided safely on the often-treacherous path that is EMDR therapy in dissociative clients."

Marilyn Korzekwa, *MD, FRCPC, EMDRIA-approved consultant and ISSTD fellow; McMaster University, Ontario, Canada*

"*EMDR, Dissociation, and Beyond* truly mirrors the lived complexity of dissociative systems. Madere and Coy write with rare attunement and without pathologizing or oversimplifying. Their reframes, like seeing 'resistance' as boundary setting, or assuming all self-states are listening, show deep respect for inner worlds and responsiveness to lived experience voice and community. The 'Id Protocol' stands out as a model of dignity and collaboration, asking not 'how do we get rid of this part?' but 'do they still want this job?' From mapping to memory networks to trance logic, this book honors every layer of the healing journey. For systems and therapists alike, it offers both precision and compassion... and, most of all, possibility."

Emma Sunshaw, *PhD*, System Speak *podcast*

"Madere and Coy have meticulously adapted Shapiro's EMDR protocols to accommodate the treatment of complex trauma and dissociative disorders. What this approach has given EMDR is a more thoughtful psychotherapy that takes into account the dynamic mind of the client. As therapeutic toolboxes have proliferated, the art of psychotherapy has tended to become more marginalized. This book teaches technique as a measured response to the exigencies of complex minds and thus allows for the integration of technique within a thoughtfully constructed psychotherapy. This is a project whose time is long past due!"

Richard Hohfeler, *PsyD, private practice, Wisconsin, USA; ISSTD fellow*

"When I initially trained in EMDR therapy, I did not believe I worked with clients who struggled with dissociation or met the criteria for a dissociative disorder, so I was not invested in pursuing training in this area. Integrating EMDR therapy into my clinical work rapidly changed that belief and this was the book I desperately needed. This is not a simple 'float on the surface of the topic' type of book—it is a deep dive into an important and complex issue that offers a life raft of explanation, instruction, and hope to those of us doing this work."

Hope Payson, *LCSW, LADC, EMDRIA-approved basic and advanced trainer*

"*EMDR, Dissociation, and Beyond* is a masterful piece of work that is an essential addition to the bookshelves of all levels of EMDR trained therapists. This text offers a conceptual expansion that exquisitely weaves in case examples, bringing to life a nuanced, intentional approach that can be extended to other trauma-specific treatment modalities and approaches. Inviting readers to deepen their thinking beyond simply 'doing' EMDR, this text expertly bridges the fields of complex trauma, dissociation, and EMDR therapy, honoring the learned experience of past and present and the wisdom of lived experience, to offer a more dissociation-attuned EMDR therapy."

Jill Hosey, *LICSW, trauma therapist, author, EMDR trainer, and ISSTD fellow*

"Madere and Coy offer a solid, research-informed guide to treating dissociative disorders, grounded in theory and clinical practice. Their perspective draws from what seems like the entirety of the existing, related literature and distills it into a practical, insightful, and clinically relevant teaching manual."

Dorinna S. Ruh, *LCSW, Advanced EMDR Education, Colorado, USA*

"This text is a goldmine for EMDR practitioners who want to take their clinical work to the next level. The authors synthesize years of clinical experience, professional training, and advanced learning to offer expert treatment approaches and in-depth knowledge and insights about dissociation from multiple related disciplines, all in this one unparalleled resource. I was thrilled to see ego state therapy take a prominent place in this work of integration as I believe it is a game-changer when appropriately combined with EMDR."

Gerry Ken Crete, *PhD, EMDRIA-approved consultant, author, Litanies of the Heart, Advanced EMDR Education, Colorado, USA*

"The authors have diligently worked on research, exploratory thinking, innovation, and engaging communication in this very valuable book, integrating knowledge and wisdom from the fields of dissociation and psychotherapy to find answers for the quest of EMDR therapists for working with dissociation."

Adithy, *PhD, counseling psychologist, Pune, India; ISSTD fellow and founder, ISSTD EMDR Special Interest Group*

EMDR, Dissociation, and Beyond

EMDR, Dissociation, and Beyond delves more deeply into the dissociative disorders' literature than any previous text on this topic, providing much-needed connectivity between two fields that are often at odds. This book expands the possibilities for case conceptualization by more comprehensively integrating wisdom from the study and treatment of dissociative disorders with the practice of EMDR therapy.

Readers will be invited to deepen their knowledge of working with pathological dissociation, reexamine familiar protocols and widely held beliefs, and consider new ways to approach enduring treatment challenges. The chapters lead readers through dimensions of theory and practice applicable to the treatment of dissociation and dissociative disorders, both within and beyond the practice of EMDR therapy. Weaving together strands from many schools of thought and infused with the authors' decades of experience, this book brings together EMDR therapy and the treatment of dissociation in a way that invites the past into the present and opens doors to the future.

Jennifer A. Madere, MA, LPC-S, CSAT, is a psychotherapist, EMDR consultant, trainer, and fellow of the International Society for the Study of Trauma and Dissociation (ISSTD). She is the co-founder of Intuitus Group, a trauma-focused practice in Cedar Park, Texas, USA.

D. Michael Coy, MA, LCSW, LICSW, is a clinical social worker, EMDR consultant, and trainer working in private practice in Bremerton, Washington, USA. He/they are a past president and fellow of ISSTD.

EMDR, Dissociation, and Beyond

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To my husband Greg, for your patience, support, and care. To my colleagues, for your dedication to helping people reach healing and recovery. To my clients, for sharing your experience and your trust with me.
~ Jennifer

To my husband Anthony and our boys Milo and Frankie, for tolerating me working seven days a week for months on end. To my mentors, colleagues, and clients, for everything I've learned from you. And to my sister Lisa, who eons ago predicted a book was on the horizon. ~ Michael

Contents

Preface

This is an advanced clinical text, not a starter book or a primer. It is intended for practitioners who have been swimming in the water for some time and are ready to explore the deep end of the pool. While we will briefly define and introduce most concepts, we will also assume that the reader has a robust understanding of Eye Movement Desensitization and Reprocessing (EMDR) therapy (Shapiro, 2018), and at least a cursory understanding of the prominent theories of dissociation and the basic tenets of treating pathological dissociation (ISSTD, 2011), including relationally informed psychodynamic psychotherapy and hypnotic phenomena. If any of these topics are new to you, we hope you will feel inspired to seek further training and consultation to expand your basic clinical understanding and skills. From our experience, one cannot 'dabble' in treating dissociative disorders – it's a real investment – if anyone is to benefit in the end. Ongoing learning and development are hallmarks of an effective and resilient practitioner, and we hope that this book will be a useful component of your learning journey.

We come to you with each of us having 20+ years of full-time clinical experience, and, in our respective journeys, finding a shared passion for the assessment and treatment of clients for whom disruptive (or intrusive) dissociative experiences are part of daily life. We each came to discover the necessity of recognizing, understanding, and treating dissociation after training in EMDR therapy. Our prior collaborations have focused on developing connective tissue between the worlds of EMDR and dissociation – this book is both a fruit of those labors and builds upon them. Please allow us to share a bit of our background with you to provide context for our approach to this book.

Jennifer was persuaded to enter a graduate program in counseling psychology at the University of Denver – instead of law school – following an internship in which she worked with at-risk youth. That experience showed her that (a) she could do it and (b) perhaps greater good

could be done in working with people directly. Her journey as a clinician commenced in shelter, hotline, and outpatient settings serving victims of intimate partner violence and low-income populations. While trauma and posttraumatic symptoms were ubiquitous there, most treatment was focused on crisis intervention and stabilization. Upon moving across state lines a few years after graduate school, Jennifer found herself building a private practice, and learning more about what treatment looks like *after* the crisis has abated. This led her to seek training in EMDR therapy in 2009. Jennifer's mentors had mentioned how effective and powerful EMDR was in resolving trauma, so it was the natural next step for her. At the time, utilizing the Dissociative Experiences Scale (DES-II, Carlson & Putnam, 1993) to screen for dissociation prior to engaging in reprocessing was not strongly emphasized, so, finding it to feel 'cold,' she didn't use it. She noticed that a few of her clients were not responding as expected to bilateral dual attention stimulation (BL-DAS). Eventually, she realized, through clients' feedback and her EMDR consultant, Rick Levinson, that 'dissociation' was the reason that EMDR was going differently for them. She was curious, and Rick suggested that she find training to support her in helping these clients through the International Society for the Study of Trauma and Dissociation (ISSTD). At the time, there was no one in Jennifer's geographical area who specialized in assessing or treating dissociation; she wondered if she might become able to support other practitioners who encountered similar challenges with their clients. Thus began the journey that led Jennifer to meet Michael, and the development of what you will read in this book.

Michael did not enter graduate-level social work studies with the intention of becoming a clinical practitioner. Instead, he believed that studying clinical social work would make him a more effective social activist. However, he became increasingly interested in this path while working with individuals and groups, first with those in need of case management services to secure housing and employment, and subsequently with those who were diagnosed with HIV/AIDS with co-occurring mental health and substance use challenges. Michael's interest in the impacts of complex attachment wounding – including his own – was fostered by working in residential treatment with severely abused and neglected, adolescent wards of the state and in a locked, inpatient psychiatric facility. Notably, it was during his time working in a residential setting, in late 2007, that Michael was introduced to EMDR therapy. He learned about it as a client, after beginning work with a therapist to help him following a panic attack triggered by working in a setting where violence was the norm, which paralleled the environment in which Michael grew up. And treatment with EMDR helped – so much so that Michael decided he needed to save up to train in the approach, which he did during 2011. Michael's exposure to

information about screening for dissociation during EMDR therapy basic training mirrored Jennifer's. However, after completing the course, it did not take long for Michael to begin attracting clients who were much more complex. On the same day in February 2012, he joined both the EMDR International Association (EMDRIA) and ISSTD, the latter specifically to gain access to the Multidimensional Inventory of Dissociation (MID; Dell, 2006). Although Michael began to read more intently about and access EMDR-based training on dissociation, it was only in 2013, when he made a serious error with a client, that he stepped back and began to take dissociation seriously. He had not adequately screened for dissociation, missed and/or did not heed clear contraindications for moving into trauma processing, then breached a client's dissociative amnesia during reprocessing a supposedly single-episode trauma. He decided soon thereafter that he would, in his words, "never allow this to happen again." Michael began to study more intently and obtained ongoing consultation with a foundational thinker/practitioner in the use of EMDR therapy to treat dissociation. In the early years of this journey of learning and discovery, Michael crossed paths with Jennifer. The enduring collaboration that resulted from that meeting has resulted in many shared interests, several of which are documented for you in this book.

We have gained so much from those who traveled on similar roads before us in the fields of trauma, dissociation, and EMDR therapy. This book synthesizes our learning and experience, which is unique in its sum total if not in its parts. We recognize there is nothing new under the sun – nothing that has not been explored or written about before. (Well, almost.) Instead of something brand new, we offer our perspectives on several concepts to help you deepen your understanding and foster your continued growth. We cite our forebears extensively, with the intent of both integrating (and most definitely honoring) the past and offering new avenues of learning beyond this volume.

> *Every intervention is risky if you don't know your client.*
>
> (Kinsler, 2018)

Although it is possible to read chapters *à la carte*, we designed the book to be read sequentially, across four distinct yet overlapping parts. Part I lays out the foundations for the treatment of dissociation from psychological theory, neuroscientific research, and standards of care as we understand them. Knowing and learning from the collective wisdom in both the EMDR therapy and dissociative disorders fields can ground and inform our clinical practice. We discuss the limitations we see in the adaptive information processing (AIP) model for guiding the treatment of people with dissociative disorders (DDs). We then offer our ideas for enhancing

the AIP model, based on both historical and contemporary science and theory, to guide treatment. This also informs our proposed, multilayered conceptual framework, which encompasses a three-stage, relational model of trauma treatment, Ego State Theory and Therapy (EST; Watkins & Watkins, 1997), and EMDR therapy. These elements provide connective tissue throughout every chapter in this book.

Part II explores ways that practitioners, consultants, and trainers can apply and promote tenets of ethical and competent practice when employing EMDR therapy with this population. Although the often complex and long-term healing process is usually focused on the client's experience, we must also consider the impact of the therapist's personal history, training, and professional way(s) of being. As such, in Chapter 5, Jennifer specifically discusses the development of the practitioner and some ways in which EMDR therapy consultants and trainers can recognize and address the knowledge and skills gaps that new learners, supervisees, and consultees frequently carry with them into this work.

You can close your eyes to reality but not to memories.
(Lec, 1967, p. 129)

Part III delves into the dissociation-informed practice of EMDR therapy. Jennifer is the lead author for this section, walking through the standard eight phases and three prongs of EMDR therapy within the larger framework proposed in Chapter 3. Employing EMDR in the treatment of clients with DDs demands a nuanced approach. These chapters do not offer a 'recipe' or protocol directing practitioners on what to do. Neither do they serve as a comprehensive literature review of adapted protocols purported to treat dissociation. Instead, practitioners are invited to think critically about what they're doing – and why and how they're doing it – to more nimbly navigate the moment-to-moment challenges of treating dissociation. When EMDR therapy is framed in this way, simple adjustments to the standard procedures that are attuned to the person and present-moment context can be quite effective. Experiences of dissociation often create confusion – for client and therapist alike – about what belongs to past, present, and future realities. Jennifer helpfully situates the three prongs of EMDR therapy within the three-stage model, intentionally incorporating present and future prongs to make them applicable for dissociation-informed treatment.

In Part IV, Michael integrates multiple layers of the treatment frame introduced in Part I to expand the realm of possibility when navigating the most complex dissociative processes. Over the past number of years, Michael has explored in some depth the wisdom contained in older literatures concerned with the study and treatment of dissociation. He has

very intentionally integrated Ego State Therapy and clinical hypnosis into his work, both in acknowledgement of the importance of informed clinical practice and expanding conceptualization and treatment in an EMDR therapy frame. He first reexamines the dominant paradigm for 'parts' work, comparing and contrasting Internal Family Systems therapy (Schwartz, 1995) and Ego State Therapy (Watkins & Watkins, 1997). His in-depth explorations of self-system mapping and more complex manifestations of flashbacks consolidate and expand upon ideas drawn from the dissociative disorders literature to enhance the application of EMDR therapy methods. Finally, Michael introduces a protocol he developed in his practice: The *Introject Decathexis (Id) Protocol*. Both we and other practitioners have found this approach to be invaluable when working with perpetrator introjects throughout every stage of treatment.

As you embark on your journey through this book, we urge you to be an informed consumer: Do not simply take it at face value. Carefully examine this, and any other publication (and training) you digest, with a critical eye. No therapy approach or protocol is a replacement for (or short-cut to) the solid knowledge, understanding, and skills needed to treat persons with complex trauma and dissociation – and it unavoidably takes time and dedicated effort to cultivate all of those.

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Part I

Foundations

Chapter 1

The Complexities of Dissociation

Jennifer A. Madere and D. Michael Coy

Introduction

Foundations are critical for ensuring a solid, sturdy, and enduring structure. The carefully laid foundation of a house supports the frame, the floors, and everything with which we furnish its rooms. Most importantly, when the ground into which that foundation is set is relatively firm, that prevents the structure from sinking or becoming otherwise unstable. Similarly, there are many theories, concepts, and empirical data that support or confound the application of eye movement desensitization and reprocessing (EMDR) therapy and the adaptive information processing (AIP) model in the treatment of persons with dissociative disorders (DDs). Our understanding of each – EMDR, AIP, and DDs – builds on efforts and mis-takes of those who have come before us (yes, mis-takes is intentional).

Francine Shapiro (2001) stated, "I have continued to claim that treating a trauma is like 'removing a quilt from a mattress'; only then are you able to observe the other problems that must be addressed" (p. 420). Based upon our learning, observation, and experience, we are not sure that this is universally true. Instead, we read it as one example of problematic truisms that have become embedded in the foundation and worked their way into the carpentry that forms the overall structure of EMDR therapy training, consultation, and practice. Other EMDR therapy truisms relevant to discussions throughout this book include 'memory networks and self-states are the same thing' and 'the AIP model explains dissociation.' We will address some of these truisms in this chapter, which explores the nature of dissociation, and explicate factors that have negatively impacted mental health practitioners' ability to recognize, diagnose, and learn to treat dissociation, both more broadly and with EMDR therapy specifically.

After establishing that context, three different domains of explanation for dissociation will organize our discussion of the extant literature: Neuroanatomical/neurophysiological, psychological, and subjective/phenomenological. A wealth of historical and recent literature is introduced

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here, which provides a foundation for our understanding of dissociation throughout this book.

What Is Dissociation?

How we conceptualize dissociative symptoms and disorders depends heavily upon the way(s) in which we define the term itself. Is dissociation a discrete, spontaneous, but easily recognized experience of detachment, like 'zoning out' or 'going away' that can be managed during reprocessing using special techniques (e.g., Knipe, 2010a, 2010b)? Is dissociation the same as having different, compartmentalized self-states that can be treated with a combination of EMDR therapy and 'parts' work (e.g., Forgash & Copeley, 2008)? Or, does dissociation encompass a complex matrix of overlapping and at times conflictual phenomena that often elude detection, recognition, and/or treatment, requiring significant modifications of standard EMDR therapy procedures to treat (e.g., Paulsen, 1995; Lazrove & Fine, 1996; Shapiro, 2018)? It's complicated.

A long-standing debate exists about whether some or all experiences of dissociation are fundamentally pathological, or whether the frequency/severity of dissociative experiences exists along a continuum from 'normal' to 'pathological' (Holmes et al., 2005; Loewenstein, 2018; Waller et al., 1996). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychiatric Association [APA, 2022]) seems to subscribe to the former stance. It defines dissociation as the "disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (p. 330). This phrasing suggests that dissociation is inherently pathological.

Dalenberg and Paulson (2009) more pragmatically suggest "it is possible that the difference between normal and pathological dissociation depends upon *how* the dissociative mechanisms are used" (p. 151; emphasis in original). This invites us to consider the form, frequency, and function of different kinds of dissociative experiences, as well as the context(s) in which they occur.

On the question of *form*, research offers evidence for two distinct categories or types of dissociation: detachment and compartmentalization (Butler et al., 2019; Holmes et al., 2005). Butler et al. (2019) found that *detachment* is characterized by experiences of depersonalization, derealization, and (trance-like) absorption, while compartmentalization is marked by ego-alien ('not me') experiences such as feeling split or divided inside; having a subjective sense of other parts (of self) that have different memories, feelings, motivations, and behaviors; somatoform dissociation; amnesia, etc.

The question of *function* invites us first to examine *peritraumatic* dissociation, which Dell (2009a, p. 760) describes as an "evolution-prepared biological defense against immediate danger." In the face of inescapable overwhelm, we may experience peritraumatic dissociation, a "complex array of reactions [...] that include depersonalization, derealization, dissociative amnesia, out-of-body experiences, emotional numbness, and altered time perception" (Thompson-Hollands et al, 2017, p. 19). Frank Corrigan and colleagues highlight that depersonalization and derealization may arise from high-impact shock at the moment of overwhelm, with the latter four of these symptoms resulting from the near-simultaneous release of anesthetic neurochemicals associated with tonic and/or collapsed immobility (Corrigan et al., 2025).

Peritraumatic dissociation, while helpful for reflexive distancing in the face of inescapable pain, has been identified as the single best predictor for the development of posttraumatic stress disorder (PTSD; American Psychiatric Association, 2022). In fact, all of the symptoms of peritraumatic dissociation cited above are recognized by DSM-5(-TR) as symptoms of PTSD and its dissociative subtype. When passive defenses, and the anesthetic neurochemicals associated with them, become a person's primary means for avoiding perceived threat, the brain's processing of information may become chronically disrupted. This, in combination with other factors, can result in the development of a DD (Lanius et al., 2014; Kluft 1985a).

The (De)realization of Dissociation

There is a long history of un(der)awareness of and confusion about dissociation among mental health professionals. We see this as a consequence of a combination of factors – some historical, some enduring – all of which are important to acknowledge. These include (1) a continuing lack of clarity in the diagnostic criteria for DDs; (2) active retaliation against trauma survivors and therapists by those who deny the impacts of abuse and the existence of traumagenic dissociation; and (3) the endurance of myths, misconceptions, and distortions related to dissociation and dissociative identity disorder (DID) specifically. Together, these factors have resulted in limited awareness of and/or access to education and training about the complexities of diagnosing and treating dissociation, and inadequate use of formal evaluative measures of dissociation in clinical practice (Madere & Coy, 2022).

Lack of Clarity in the Diagnostic Criteria

Even today, with a comparatively more nuanced set of diagnostic criteria in both the DSM-5-TR and ICD-11 (International Classification

of Diseases, 11th edition; World Health Organization [WHO], 2018), barriers to accurately diagnosing DID remain significant except in perhaps the most florid of client presentations. Why is this? It may come down to a combination of factors: The DSM criteria themselves, clinician's lack of awareness (or avoidance) of diagnostic criteria, and the relative hiddenness of dissociative features (Dell, 2009a, 2009d; Kluft, 1985b, 1991).

The earliest iterations of the DSM categorized dissociation as a form of neurosis (i.e., anxiety), the description of which included a mixture of psychoanalytic conceptualizations and behavioral features. With the advent of DSM-III (American Psychiatric Association [APA], 1980), the standalone diagnosis of multiple personality ['disorder' was added later] came into existence. This third edition of the diagnostic manual marked a major turning point, toward what was considered a more objective, scientifically grounded, consistent, and reliable means for diagnosing in general (Dell, 2001). Those initial criteria, in concert with media depictions of multiplicity, probably helped cement the enduring diagnostic stereotype of DID. Recognition of problems with the criteria focusing heavily upon the observable existence of 'personalities,' and an oversimplification of the complexities of MPD/DID (Dell, 2009d; Kluft et al., 1988), and later revisions of the criteria for MPD/DID, have not been able to remedy this. Table 1.1 depicts the evolution of these criteria comprehensively.

Consultees have expressed to us the belief that one must still see an actual dissociative switch to accurately diagnose DID. Out of necessity, this *was* the case earlier on, owing both to the focus on observable traits in the diagnostic criteria and to the absence of standardized measures of dissociation. It was only in DSM-5 (APA, 2013) that the diagnostic criteria for DID explicitly stated that, "These signs and symptoms may be observed by others *or reported by the individual*" (p. 330; emphasis added). You might wonder why this distinction matters. Kluft (1985b, citing a personal communication with Robert Gurtheil, MD) described MPD/DID as a "pathology of hiddenness" (p. 206) and subsequently reported that, in a sample of 210 patients, only 6.2 percent of these demonstrated obvious dissociative switching. That amounts to 13 patients – and Kluft specializes in treating this population. We are of the opinion that even the current diagnostic criteria for DID and other specified dissociative disorder are inadequate in helping the average clinician definitively diagnose. (For an in-depth discussion of factors that may contribute to this inadequacy, see Dell, 2009d.)

If a therapist is looking for obvious indicators of dissociation as a means for determining whether to proceed with EMDR therapy treatment as

usual, the covert nature of dissociative symptoms and a lack of clarity in the diagnostic manual – especially for clinicians new to dissociation – pose significant barriers to ethical practice. Moreover, additional challenges are inherent in identifying and acknowledging the suffering that fostered the dissociation.

Active Retaliation Against Trauma Survivors and Therapists

One need only look at the news to see how denial of the impacts of inescapable pain and human atrocity is alive and well. The same is the case for dissociation, a concomitant result of chronic exposure to physically inescapable pain, at least for some people (someone with dissociative capacities can escape inside rather than via an active defense). Although this denialism has assumed many shapes over hundreds of years (Van der Kolk et al., 1996; Middleton & Dorahy, 2024), since the late 1980s it has surfaced as accusations that trauma survivors suffer from 'false memory syndrome' and therefore cannot be trusted to offer an accurate account of their experience. Therapists have been targeted as active agents in the development of false memories, the argument being that they would suggest to their highly suggestible (female) clients that they had been sexually abused. The False Memory Syndrome Foundation (FMSF), which existed from 1992 to 2019, was the primary organizational proponent of this viewpoint. The FMSF was founded "[t]o seek the reasons for the spread of FMS that is so devastating for families, to work for ways to prevent it, [and] to aid those who were affected by it and to bring their families into reconciliation" (False Memory Syndrome Foundation, 2013). The resulting controversies were collectively referred to as the 'memory wars' (Crook, 2022).

Francine Shapiro (1995, p. 292) was contemporaneously aware of this:

> Currently there is a great deal of controversy regarding the possibility that false allegations of sexual abuse are being made as a result of inappropriate therapy. Although some of these claims may well be coming from perpetrators in denial, it is clear that there is a need for quality control in the mental health profession. There is no question that some therapists are using psychological tools, such as hypnosis, with little or no training and are therefore ignorant of the limitations of these tools and of their potential for contaminating memories or creating false impressions.
>
> Consequently, it is not surprising to learn that some clients have been led to accept images that have surfaced under hypnosis, guided

Table 1.1 Evolution of the DSM Criteria for Multiple Personality Disorder/ Dissociative Identity Disorder, 1952–2022[1]

DSM-I (APA, 1952, p. 32)	**DSM-II (APA, 1968, pp. 39-40)**
Dissociative Reaction (000-x02)	Hysterical Neurosis, Dissociative Type (300.14)
Psychoneurotic Disorders, Dissociative Reaction This reaction represents a type of gross personality disorganization, the basis of which is a neurotic disturbance, although the diffuse dissociation seen in some cases may occasionally appear psychotic. The personality disorganization may result in aimless running or "freezing." The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc. The diagnosis will specify symptomatic manifestations. These reactions must be differentiated from schizoid personality, from schizophrenic reaction, and from analogous symptoms in some other types of neurotic reactions. Formerly, this reaction has been classified as a type of "conversion hysteria."	300.1 Hysterical neurosis is characterized by an involuntary psychogenic loss or disorder of function. **Symptoms characteristically begin and end suddenly in emotionally charged situations and are symbolic of the underlying conflicts.** **Often they can be modified by suggestion alone.** **This is a new diagnosis that encompasses the former diagnoses "Conversion reaction" and "Dissociative reaction" in DSM-I.** **This distinction between conversion and dissociative reactions should be preserved by using one of the following diagnoses whenever possible.** 300.14 Hysterical neurosis, dissociative type In the dissociative type, **alterations may occur in the patient's state of consciousness or in his identity**, to produce such symptoms as amnesia, somnambulism, fugue, and **multiple** personality.

1 The criteria in Table 1.1 are arranged in the chart according to their alignment with the preceding and subsequent DSM editions' corresponding criteria, when possible. Text in **bold type** indicates language added/changed, and [ ] indicates that language (usually a single word) was removed, in the transition from the previous iteration of the diagnostic manual.

Table 1.1 (Continued)

DSM-III[2] **(APA, 1980, p. 259)**	**DSM-III-R (APA, 1987, p. 272)**
MP(D) (300.14)	MPD (300.14)
A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time.	A. The existence within the **person** of two or more distinct personalities **or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).**
B. The personality that is dominant at any particular time determines the individual's behavior.	B. **At least two of these personalities or personality states recurrently take full control of the person's** behavior.
C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships.	

2 Amnesia as a symptom is discussed in the section that precedes the delineation of the diagnoses in DSM-III/-R, but it is not actually included in the criteria for MP(D)/DID until DSM-IV.

Table 1.1 (Continued)

DSM-IV (APA, 1994, p. 487)	**DSM-IV-TR (APA, 2000, p. 529)**
DID (300.14)	DID (300.14)
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).	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.	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.	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).	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).
Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.	Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

Table 1.1 (Continued)

DSM-5 (APA, 2013, p. 292)	**DSM-5-TR* (APA, 2022, p. 330)**

DID (300.14/F44.81)
* *DSM-II diagnosis codes fully retired in favor of ICD F-codes*

A. Disruption of identity characterized by two or more distinct personality states, **which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity** in sense of self and sense of agency, accompanied by related alterations in **affect,** behavior, consciousness, **memory,** perception, cognition, **and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.**

B. **Recurrent gaps in the recall of everyday events,** important personal information, **and/or traumatic events that are inconsistent with** ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.

Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the [ ] physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or **another** medical condition (e.g., complex partial seizures).

> visualization, or dream analysis as definitive evidence of actual memories, even when corroboration is often impossible. *Clinicians should be aware of their boundaries of competence and of the limitations of their methods before utilizing them in clinical practice. This is why it is vital that the use of EMDR be restricted to trained, licensed clinicians who have been supervised in its practice. Simply reading the cautions offered in the following pages is not a substitute for adequate training.* (Emphasis added)

While Shapiro expresses concern about the risks posed by clinicians' lack of recognition of the "boundaries of [their] competence" and "limitations of their methods," she fails to mention the risk posed by a lack of awareness of the limitations of one's knowledge. *What if a therapist believes they know more than they do?* Implicit bias takes many forms, and our clinical decision-making is sometimes shaped by influences just as invisible as dissociation.

Myths, Misconceptions, and Distortions

It is difficult to grasp what we do not (yet) know. Myths, misconceptions, and distortions easily fill the vacuum, even without our being aware that this has happened. For many of the clinicians we have trained and consulted with over the years, the process began in graduate school, with little to no attention given to trauma in general and dissociation more specifically. Sometimes, distortion can be an intentional act driven by hidden agendas.

Sorting myth from fact can sometimes be a bit like trying to grab smoke. Across two articles, Piper and Merskey (2004a, 2004b) offered several questionable 'facts' about DID. It is beyond the scope of this book to discuss these points in depth; however, it seems important to highlight their pervasive impact and currency.

In their first article, Piper and Merskey (2004a, p. 592) summarize:

1. The literature on Dissociative Identity Disorder (DID) contains "logical inconsistencies" "internal contradictions" and "conflict[s] with known facts and settled scientific principles."
2. "DID cannot be reliably diagnosed."
3. "The diagnosis of DID often leads to clinical deterioration in patients."

In their second article, Piper and Merskey (2004b, p. 678) highlight:

1. "The arguments offered to support the concept of dissociative identity disorder (DID) are illogical."

2. "DID proponents' diagnostic and treatment methods iatrogenically encourage patients to behave as if they have multiple selves."
3. "The unsatisfactory, vague, and elastic definition of 'alter personality' makes a reliable diagnosis of DID impossible."

We are not certain how "known facts and settled scientific principles" (Piper & Merskey, 2004b, p. 678) refute the realities of what many EMDR therapists have seen in practice (e.g., *Dissociative Disorders Task Force Recommended Guidelines* [Shapiro, 1995, 2001, 2018]). Both of us discovered DDs in our practice rather accidentally and sought the necessary training to be able to treat clients with dissociative experience who do, indeed, spontaneously switch from one self-state to another (see Kluft, 2013, for his take on the role of EMDR in proving the existence of DID). As such, we are intrigued that a 'concept' that allegedly does not really exist could make its way into two different diagnostic manuals (the DSM and the ICD) and merit an entire section in each devoted to its phenomenology and symptoms. Experts in the diagnosis and treatment of dissociation have concluded that DID *can* be reliably diagnosed using research-validated measures (e.g., Brand et al., 2016). It seems evident to us that Paul Dell developed the Multidimensional Inventory of Dissociation (MID; Dell, 2006b), at least in part, to challenge the dominant paradigm of DID as 'an alter disorder' (Dell, 2001). This translates to defining DID according to "a person having alters as opposed to identification of a broader range of dissociative symptoms" (Coy & Madere, 2023, p. 668).

Kluft (1989, pp. 83–84) responded to the myth of iatrogenically creating DID in a client (iatrogenesis is the development of unintended, undesirable effects due to the treatment itself), pointing out that

> To prove the iatrogenesis of MPD [DID], it would be necessary to begin with a normal individual and demonstrate that as a result of specified [therapist-driven] interventions, that individual demonstrated the phenomena of MPD on an ongoing basis, with the phenomena manifesting themselves spontaneously and repetitively in a classical manner over time. This has not been done; furthermore, a strong case could be made that it would be ethically reprehensible to do so.

The risk of decompensation is context-specific and by no means universal. As Shapiro (1995) was aware, there can be unanticipated or unwanted treatment effects when working with persons with trauma-laden histories. And what about the risk of a client deteriorating simply by being diagnosed? There is some substance to this claim, particularly if someone is not prepared for that information (Brand et al., 2016). We propose that the *meaning* or implications of a diagnosis often seem to be more jarring

than the diagnosis itself. This is a nuanced issue that is not exclusive to diagnosing DDs (Benito-Lozano et al., 2023; Sims et al., 2021). We have encountered plenty of situations when clients responded with relief and hope to someone finally validating that their symptoms mean something. It can be empowering for people to learn that their symptoms are not just 'in their head,' and that, ultimately, both they and their experience matter.

Limited Awareness of and/or Access to Education and Training

How many of us actually have read Francine Shapiro's EMDR therapy text from cover to cover? How many of our basic training programs directed our attention to the *Dissociative Disorders Task Force Recommended Guidelines*, which are nestled in the appendicized section on *Client Safety* in each of the three editions *of* that text? You read that right – these recommendations have existed and remain largely unchanged since their first publication in 1995. The 1995 version stated that "The therapist should screen every patient for the presence of an underlying dissociative disorder regardless of the complaint" (Shapiro, 1995, p. 366). These guidelines offer important information about the use of EMDR therapy to treat persons diagnosed with DDs.

Although the visibility of dissociation – and attention given to assessing it – has changed a lot since we each participated in EMDR therapy basic training, a lot of gaps remain. Unfortunately, some of those gaps are likely influenced by Francine Shapiro's own words.

Shapiro (2018, p. 96) writes that

> While the dissociative disorders constitute a separate section in DSM-5, EMDR specialists regard DID as a complex form of PTSD (Spiegel, 1993) in which the victimization was so great that, for survival, the global memory was compartmentalized to hold different aspects of the pain and disturbance and becomes divided into more dissociative personality states. Thus, *the personality states can be conceptualized as neural network configurations that serve as memory compartments* (Braun, 1988; Lanius & Bergmann, 2014).

We recall Shapiro's (2001) likening of treating a trauma to "removing a quilt from a mattress," and suggesting that "only then are you able to observe the other problems that must be addressed" (p. 420). We see these viewpoints as being in direct contradiction to what the *Task Force* stated as two important therapist-dependent factors (Shapiro, 2018, p. 500):

a. It should be determined whether the therapist is sufficiently trained in the dissociative disorders, as evidenced by the therapist's (1) having taken formal courses in the area and (2) having been supervised in the psychotherapy of dissociative patients.
b. It should be determined whether the therapist is sufficiently skilled in the treatment of dissociative disorders, as evidenced by such abilities as (1) troubleshooting with hostile alters, child alters, and perpetrator alters; (2) anticipating and accommodating transferences; (3) recognizing and working with hypnotic and dissociative phenomena; (4) managing crises; and (5) determining the need for medical and/or inpatient backup.

Unfortunately, we have both encountered therapists who learned that EMDR therapy is the method by which one removes the quilt, only to discover too late that the mattress was not at all what they expected it to be. Further on in the guidelines, the *Task Force* offered guidance on where to obtain training in the DDs, stating that, "Clinicians who seek additional training in the diagnosis and treatment of dissociative disorders should contact the International Society for the Study of Trauma and Dissociation (ISSTD)" (Shapiro, 2018, p. 502).

Chapter 5 will give more in-depth attention to the issue of training and education. Presently, let's revisit a statement drawn from the *Task Force* guidelines (Shapiro, 2018, p. 499) that we frequently quote in presentations: "[T]here is a high cost to patient, therapist, and the therapeutic alliance in failing to adequately consider the possibility of dissociative disorders before first using EMDR in a patient's treatment." How many of us learned specifics about "consider[ing] the possibility of dissociative disorders" in our basic training? We did not learn about that in basic training either.

Inadequate Use of Measures of Dissociation

At a minimum, screening for DDs is critical to avoid prematurely ripping that quilt off the bed. Shapiro finally stated this in the main body of the 2018 text (pp. 96–97). However, significant variance regarding whether, when, and how EMDR therapy basic training courses address dissociation persists – both in North America and worldwide (Leeds et al., 2022). That variance leaves room for significant risk.

EMDR therapy basic training in the USA and Canada consists of 20 hours of didactic learning, at a minimum. Think about how much is crammed into those 20 hours. In 2017, the EMDRIA's training standards required that "Dissociation should be mentioned; learners are encouraged to pursue advanced training to treat dissociative clients" (EMDR

International Association, 2017, p. 8). Updated standards were published in December 2022 and most recently revised again in March 2025. These stated that "Assessment tools and procedures for screening for dissociation" must be taught (EMDR International Association, 2022/2025, p. 17). Though significant, this change occurred only after being made explicit in the main body of Shapiro's text in 2018 and in response to significant lobbying. Even then, for so long, the guardrails in place for using EMDR therapy with dissociation have been dictated by what we don't know and the risks of finding out in ways that are uncontrolled (and potentially uncontrollable).

Frameworks for conceptualizing what we are doing can be quite helpful, not only for avoiding a collision with the unknown but also for making informed decisions based on what we *do* know. Born out of extensive observation, Francine Shapiro (2018) conceptualized three domains of experience that help us track the progression of clients' healing, thematically, via negative and positive cognitions. EMDR trained practitioners will be familiar with those. Now, let us present a different set of three domains. Based on his own observations and study, Dell (2006a) proposed that there are at least three domains of explanation for dissociation. These are (1) the neuroanatomical/neurophysiological, (2) the psychological, and (3) the subjective/phenomenological.

The Neuroanatomical/Neurophysiological Domain

Consideration of the impact of trauma on the human nervous system dates at least as far back as 1900 B.C. (Figley et al., 2017). Our attention is particularly drawn to writings dating to the late-19th and early-20th centuries. The work of Boris Sidis has stood out as having particular, previously unrecognized salience for AIP and EMDR therapy. Sidis was a student of William James and a contemporary of Pierre Janet, Sigmund Freud, and Morton Prince. Among other things, Sidis was interested in association and dissociation at the *cellular* level. He studied how neurons coalesce, or fail to coalesce, into clusters – and networks/systems of clusters. He also examined how established neuronal connections may be *severed* or simply *not connect* in reaction to 'toxins' (Sidis, 1898; Sidis & Goodhart, 1904/1968). This course of study was not mere scientific noodling. Sidis began to more fully explicate his understanding of how pathological dissociation develops. We will revisit this in greater detail in Chapter 2.

Much more recently, significant strides have been made toward revealing the neurobiological correlates of posttraumatic and dissociative symptoms as well as data to support their distinct presence and resolution. Here, we will focus on scientific models and studies that explain and substantiate the observable reality of dissociative symptoms in the brain.

Mapping the Dissociative Subtype of PTSD (DSM) and Complex PTSD (ICD)

The work of Ruth Lanius et al. (2010, 2012) and colleagues in Ontario, Canada, represented a tipping point in neurobiological research related to PTSD. A mound of scientific evidence, including fMRI scans and script-driven imagery, contributed to their argument for a dissociative of PTSD (PTSD+DS) as distinct from non-dissociative or 'simple' PTSD. Distinguishing clinical and neurobiological features was identified. "The dissociative subtype is characterized by overmodulation of affect, while the more common under-modulated type involves the predominance of reexperiencing and hyperarousal symptoms" (Lanius et al., 2010, p. 640). In PTSD+DS they noted patterns of overmodulation of the limbic regions by the areas of the prefrontal cortex involved in arousal modulation and emotion regulation.

For example, in response to reminders of the traumatic memory, subjects with PTSD+DS experienced emotional disengagement via depersonalization or derealization that appeared to be mediated by the prefrontal cortex (specifically, the dorsal anterior cingulate and medial prefrontal cortices). Clinically speaking, this sounds quite like what theorists call non-realization – acting and even feeling as though something isn't happening, that it isn't real – which is a cornerstone of many models of dissociation. The authors went on to highlight how "[t]hese findings have important implications for treatment of PTSD, including the need to assess patients with PTSD for dissociative symptoms and to incorporate the treatment of dissociative symptoms into stage-oriented trauma treatment" (Lanius et al., 2010, p. 641).

A few years later, PTSD was moved from the *Anxiety Disorders* section of the DSM-IV to a section titled *Trauma- and Stressor-Related Disorders* in DSM-5 and the dissociative subtype of PTSD was added as a specifier (APA, 2013, p. 272). The *Dissociative Disorders* section immediately followed, representing an acknowledgement of relatedness between them, while keeping DDs distinct. Following the inclusion of PTSD+DS in the DSM-5 in 2013, and Complex PTSD (C-PTSD) in the ICD-11 (WHO, 2018) in 2018, a flurry of research has begun to produce measures, report on prevalence, and offer considerations for treatment. Considerable overlap was found between PTSD+DS and DDs by Swart et al. (2020), in their investigation of a clinical sample. A combination of clinical interview and psychometric tools indicated that more than 50% of clients who met criteria for PTSD+DS also met criteria for a DD.

Philip Hyland et al. (2020, 2024) examined the relationship of dissociative experiences to the ICD-11 criteria for PTSD and C-PTSD. In a clinical sample, "those meeting the diagnostic criteria for C-PTSD had

significantly higher levels of dissociative experiences than those with PTSD" (Hyland et al., 2020, p. 67). Because of how the C-PTSD criteria are organized, dissociative experiences are part of the overall symptom profile rather than a distinct symptom cluster; therefore, dissociation is *not* an essential requirement in making a diagnosis of C-PTSD. A general population sample found that 10% of respondents reported statistically significant dissociative experiences above and beyond meeting the criteria for C-PTSD. The same respondents were also more likely to report more severe physical and mental health issues, as well as a history of emotional neglect and a household member who was mentally ill or had attempted suicide (Hyland et al., 2024). Taken together, these findings imply that making a diagnosis of C-PTSD or PTSD+DS can occur without assessing for dissociative symptoms, *and* that relevant dissociative symptoms and other clinical features may be missed if they are not explored intentionally via a structured clinical assessment.

Researchers also began to explore whether and how EMDR therapy works in treating people who meet these new sets of diagnostic criteria. A series of Dutch studies beginning with Zoet et al. (2018) measured the effects of an intensive treatment program that included EMDR therapy. They argued that a stabilization phase is not needed and that individuals with C-PTSD benefit from unmodified EMDR therapy. Voorendonk et al. (2020) claimed that over 85% of participants diagnosed with C-PTSD no longer met the criteria after eight days of intensive trauma-focused treatment. Posttreatment follow-up was conducted just nine days after discharge from the program, however, and no information was given about what may have influenced participants to decline consent, drop out of the study, or not complete the follow-up measures – all of which were stated to occur. In this study, the CAPS-5 (Clinician-Administered PTSD Scale for DSM-5, Weathers et al., 2018) was employed to identify C-PTSD. No measure was used to screen for or rule out a DD; in fact, the term 'dissociat…' is found *nowhere* in the article. Screening for dissociation *is* an element of practicing EMDR therapy with fidelity; therefore, we think that is a serious oversight and demonstrates either bias or ignorance with regard to dissociation. Further investigation with a more comprehensive diagnostic evaluation is needed in order to consider their argument in a reasonable, ethical practice.

The Realization of DID

Long before the invention of neuroimaging, public and professionals alike have questioned whether DID is real, made up in the mind of the experiencer (fantasy-based), iatrogenic, or altogether factitious by clients and believing clinicians. Fortunately, a number of studies have tested a variety

of angles to show that *DID seems to be an observable reality*. It has been observed physiologically, functionally, and anatomically.

Boris Sidis was one of the first to study and substantiate how "the influence of hurtful stimuli…may give rise to functional dissociations" both at the cellular level and in the development of "different individualities" (Sidis & Goodhart, 1904/1968, p. 53). He consistently emphasized that the connections between nerve cells are *functional* rather than organic (Sidis, 1898; 1909; Sidis & Goodhart, 1904/1968). According to Sidis, disruptions in functional connectivity – caused by the contraction of nerve cells and the severing of existing connections in favor of new ones shaped by the reflexive avoidance of hurtful stimuli – could ultimately result in the formation of dissociated personalities, which he understood as sophisticated neural networks operating independently. Recent neuroimaging studies have increasingly highlighted differences in brain connectivity and structure among individuals with PTSD, PTSD with dissociative symptoms (PTSD+DS), and DID. Numerous laboratories and researchers worldwide have contributed to identifying neuroanatomical biomarkers that strongly support the validity of dissociative symptoms, especially in relation to DID.

Building on PTSD-related research, Simone Reinders et al. (2014) launched a series of studies based in the Netherlands. They replicated the script-driven imagery and neuroimaging studies that distinguished between PTSD and PTSD+DS, using PET scan imagery, and added a group: persons with DID. Clinical observation had indicated that persons with DID experience *both* hyper-aroused states *and* hypo-aroused states. Reinders et al. proposed a neurobiological model for DID, based on the PTSD/PTSD+DS model described above, as follows: "the hypo-aroused identity state activates the prefrontal cortex, cingulate, posterior association areas and parahippocampal gyri, thereby overmodulating emotion regulation; the hyper-aroused identity state activates the amygdala and insula as well as the dorsal striatum, thereby under-modulating emotion regulation" (p. 236). Further analysis showed that hyper-arousal in the amygdala and activity in the dorsal striatum appeared *even more* highly inhibited by the prefrontal cortex in the DID group (compared to PTSD+DS). This research substantiated two phenomena that are familiar to clinicians who treat dissociation: (1) dissociative symptoms/self-states manifest patterns of hyper- *and* hypo-activation and (2) internal conflict is a frequent complaint and subject of treatment.

In collaboration with Reinders's lab, Yolanda Schlumpf et al. (2014), based at the University of Zurich, Switzerland, used fMRI data to examine whether: (a) actors could be distinguished from individuals who had been previously diagnosed with DID, and (b) whether any difference in activation could be observed between ANPs (apparently normal parts) and EPs (emotional parts), according to the language of the theory of structural

dissociation of the personality (TSDP; Van der Hart et al., 2006). The results of this study showed clear differences between people with DID and actors. Moreover, distinctions were also observed when ANPs were thought to be activated versus when EPs (designated as the subtype of active defense) were activated. These observations indicate that "DID involves dissociative part-dependent resting-state differences" (Schlumpf et al., 2014, p. 1).

Utilizing neuroimaging data from preceding studies, Reinders et al. (2019) found that researchers using pattern classifiers of brain structure/morphology were able to accurately identify the MRI data from individuals with DID as distinct from the images from 'healthy controls.' Impressively, this machine-based system was able to classify true positives (DID) 72% of the time (sensitivity), and true negatives (healthy controls) were correctly identified 74% of the time (specificity). The results of this study indicate that the map of known brain structures and variations associated with DID was starting to fill in quite nicely.

Stepping toward building a functional connectivity 'fingerprint' of trauma-related dissociation, Lauren Lebois et al. (2021), out of McLean Hospital near Boston, Massachusetts (USA), tested whether "brain-based measures of dissociation are sufficiently sensitive and robust to enable individual-level estimation of dissociation severity based on brain function" (p. 166). Findings indicated, yes; fMRI data predicted the severity of trauma-related dissociative symptoms rated on self-report measures of dissociation (they used the 168-item severe dissociation scale from the MID). Intrinsic connectivity analysis of functional brain networks indicated patterns of *uniquely* aberrant network connectivity (differing from the normal course or pattern), with preliminary evidence pointing toward *dissociative experiences as dependent on connections* between regions in the default mode and frontoparietal control networks. "Because [this] model controlled for childhood trauma and PTSD symptom severity, this suggests that trauma-related dissociation has neurobiological substrates that are distinct from PTSD and childhood trauma load." (Lebois et al., 2021, p. 170). When this model is replicated and confirmed in future studies, it could be utilized to establish or objectively corroborate the diagnosis of a DD (e.g., for psychopharmacologic or forensic purposes).

The study of functional connectivity in PTSD+DS is relevant here. In another paper from Ruth Lanius' lab, Shaw et al. (2023) illustrated widespread functional *hyper*connectivity as a characteristic of PTSD+DS in relation to the default mode network (DMN). They hypothesized this to be a compensatory function to preserve global brain function when knowing or feeling would otherwise be too much for the person to tolerate. Several earlier publications from the same lab (Kearney & Lanius,

2022; Terpou et al., 2019) identified increased DMN activity to interfere with self-related processing of traumatic experiences. Terpou et al. (2019) stated that "[f]ragmentation of traumatic memories may result from the overwhelming affect that occurs during original encoding, thus interfering with the consolidation of the memory to long-term storage" (p. 9). As humans, we need sensory integration in order to have a sense of self and a continuous personal history (Lanius & Bergmann, 2014; Sidis & Goodhart, 1904/1968). When sensory information is unconsolidated, reliving of trauma-related sensory information can occur *without* episodic memory or autobiographical recall – as has been experienced by people with DDs. There is no episodic memory, or journey, without a traveler – or in this case, a self (Kearney & Lanius, 2022).

A Biomarker for Dissociative Amnesia

Dissociative amnesia – actions that are fully dissociated from one's conscious awareness – is one of the most specific symptoms that distinguishes DID from other diagnoses. Working with Reinders, Dimitrova et al. (2023) sought to identify a neurostructural biomarker for dissociative amnesia, specifically examining the hippocampus due to its known and vital role in memory. This study built upon previous findings, which pointed to a significant relationship between lower hippocampal volume, higher severity of childhood traumatization, and dissociative symptoms (Chalavi et al., 2015). Dimitrova et al. found *dissociative amnesia* (as measured by the DES) to be *significantly and negatively correlated with hippocampal volume*, while other items on the DES were not found to be significantly related. This relationship with dissociative amnesia was isolated to the CA1 hippocampal subfield of the hippocampus. Similar negative correlations were found between *emotional neglect* and bilateral global hippocampal volume. Thus, Dimitrova et al. proposed that dissociative amnesia and emotional neglect appear to be interlinked.

How else might the CA1 subfield functioning relate to psychotherapy for individuals with severe dissociation? Dimitrova et al. (2023) discussed their findings alongside earlier research observing the CA1 to be associated with memory impairment (*autobiographical* or self-referencing memory in particular [Bartsch et al., 2011]), and the misattribution of self-generated representations (memory) *as external* ('not me') (Chiu et al., 2019; Forrest, 2001). When people register their experiences as 'not me,' we argue that there are bigger considerations for EMDR therapy beyond mere 'processing of traumatic memories.' Can you imagine the dual-attention awareness deemed essential for reprocessing in EMDR therapy co-existing with these phenomena? Our conceptualization must expand to accommodate greater functional and psychological complexity.

The Psychological Domain

Psychological theories of dissociation are explanatory (positing how dissociation develops), descriptive (representing what dissociative experiences are like), or both. Owing to the wealth of resources available about different psychological models, we will not go into great depth here. However, we will touch very briefly upon the predominant theories that will inform later discussions in this book.

The *trauma model* explains that, when humans are unable to integrate ongoing stressors and traumas, they may develop dissociative coping, or DDs (Putnam, 1985; Ross, 2007). Kluft's (1985a) *four-factor theory* attempts to explain the context for the development of DDs by identifying specific conditions, in combination, that underlie them: (1) innate dissociative capacity; (2) exposure to overwhelming experiences (e.g., abuse); (3) underlying individual qualities and characteristics that would support the development of dissociative self-states; and (4) a lack of support from adults who can help the child transcend the overwhelming experience and protect them from future harm.

The TSDP (Van der Hart et al., 2006; Van der Hart & Steele, 2023), or the *structural model*, posits an explanation for and elaborates the features of DDs. According to TDSP, a child who has not yet developed an integrated sense of self is exposed to overwhelming experience, which is essentially traumatic; in response, the personality tends to divide along 'fault-lines,' which results in a 'structural dissociation' of the personality, in which dissociative structures lack integration. However, neither the trauma model nor TSDP adequately explains why some persons who are abused or neglected as children develop DDs, while others do not.

The *autohypnotic model* has a long lineage (Bliss, 1986; Ellenberger, 1970), but was sidelined by the trauma model and TSDP for some years. Dell (2017, 2019) dusted it off and, expanding upon Kluft's four-factor theory, proposed that only a subset of highly hypnotizable individuals (i.e., so-called *virtuosos*; Kihlstrom, 2004), under particular conditions, have the ability to develop a DD, specifically when they are subject to chronic, inescapable pain – regardless of whether it might be considered a 'big-T' trauma. (For a comprehensive discussion of this model, please see Coy, 2025.)

The Subjective/Phenomenological Domain

We have separated this model from the others discussed above because it is Paul Dell's third explanatory domain of dissociation, and also because it is especially relevant to the challenge of recognizing and conceptualizing

the treatment of dissociative symptoms. According to Dell (2006a, p. 8), "the phenomena of pathological dissociation are recurrent, jarring intrusions into executive functioning and sense of self by self-states or alter personalities. Such dissociative phenomena are startling, alien invasions of one's mind, functioning, and experience." Based on this proposition, Dell (2006a, pp. 8–9) drew the following conclusions:

1. Pathological dissociation can affect every aspect of human experience;
2. Most phenomena of pathological dissociation are subjective and invisible;
3. There are two major kinds of pathological dissociation: intrusions and amnesias; and
4. Most dissociative symptoms are not fully dissociated from consciousness.

Arguably, Dell's third conclusion is not entirely true, particularly concerning depersonalization and derealization, which are also considered forms of pathological dissociation, both as a discrete disorder in the DSM and within the dissociative subtype of PTSD. Elsewhere, Dell (2019, p. 2) has suggested that "*the dissociation of the dissociative disorders* [emphasis added] has only one generative mechanism: autohypnotic maneuvers that distance the person from circumstances that cause pain, distress, and suffering." Because experiences of pathological dissociation are "overwhelmingly internal and subjective, not external and observable" (Dell, 2009c, p. 226), we find this model particularly relevant with respect to diagnostic assessment, to be addressed in Chapter 6.

Conclusion

Challenges abound for practitioners to recognize, acknowledge, understand, and treat dissociation. These challenges can be magnified when EMDR meets – and sometimes collides with – dissociation. Despite what practitioners may have been taught or assume, severe dissociation is a critical treatment consideration. Dissociative features may not be – and often are not – obvious to the casual observer, but this does not render them irrelevant. Contemporary neurobiological evidence validates the existence of DID and allied disorders, and diagnostic instruments have been developed to illuminate what *is* so often hidden. The literature demonstrating and explicating (disruptions in) functional connectivity in DDs is particularly relevant to EMDR therapy and will inform later chapters. A number of theoretical models offer us means to understand etiology and conceptualize treatment. Having laid this ground, what lies ahead in Chapter 2 is a closer examination of two important components of EMDR therapy in

relation to dissociation: The hypothesized mechanisms of action of bilateral dual attention stimulation and the AIP model.

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Afterword

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