

THE DISSOCIATIVE EXPERIENCES SCALE:

A Replication Study

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ABSTRACT

The authors administered the Dissociative Experiences Scale to medical student controls and patients with multiple personality disorder, schizophrenia, panic disorder, and chemical dependency. Patients with MPD scored significantly higher than the other clinical groups and the medical student controls.

Dissociative disorders are diagnosed according to formal criteria in DSM-III-R (American Psychiatric Association, 1987). Dissociative symptoms and experiences occur in both clinical and nonclinical populations which do not have diagnosable dissociative disorders. To date only two instruments have been reported which reliably document the dissociative experiences of clinical and nonclinical groups. These are the Dissociative Experiences Scale (DES) (Bernstein and Putnam, 1986) and the Perceptual Alternation

Scale (PAS) (Sanders, 1986). The PAS has not been adequately tested in clinical settings and consists of a subset of MMPI questions.

The DES has good reliability and differentiates multiple personality disorder from a variety of other clinical groups and normal controls, an essential characteristic of any useful screening instrument. It is a 28-item self-report inventory. For the DES to be useful as a screening instrument for dissociative experiences and disorders, replication of the original findings in other centers is essential.

We have administered the DES to medical students and patients with DSM-III-R diagnoses of panic disorder, alcohol and/or anxiolytic abuse, schizophrenia, and multiple personality disorder (MPD).

METHOD

The DES was completed by 28 medical students, 13 panic disorder patients, 24 chemical dependency patients, 20 schizophrenics and 17 patients with MPD. Subjects were the first available members of each group who could be recruited to complete the DES within the time limit of the study. All subjects met DSM-III-R criteria for their disorders. The nature of the study was explained to the subjects and verbal consent given. All information was given anonymously. Prior consent for the study of the prevalence of dissociation in selected populations had been obtained from the Faculty Committee on the Use of Human Subjects in Research, Faculty of Medicine, University of Manitoba.

TABLE I
Dissociative Experiences Scale Scores in Selected Groups

	Multiple Personality Disorder	Medical Students	Panic Disorder	Chemical Dependency	Schizophrenia
	N = 17	N = 28	N = 13	N = 24	N = 20
Median Score	40.7	4.9	3.9	10.3	12.6
		(.00001)	(.0004)	(.0004)	(.007)

*p value denotes difference between that group and MPD

The MPD subjects all received a longitudinal diagnosis from the senior author. The panic disorder subjects were recruited from an Anxiety Disorders Clinic with an active research program of which the senior author is Medical Director. Chemical dependency subjects were drawn from a specialty clinic of the same department, and had been diagnostically assessed by physicians specializing in the treatment of chemical dependency. The schizophrenic subjects were recruited from a long-term depot neuroleptic clinic in the same department, and their charts were reviewed to ensure that they had stable diagnoses of schizophrenia.

The score for each item and the overall score for each subject were calculated using the method of Bernstein and Putnam (1986). Statistical comparisons of the subitem and overall scores between MPD and the other groups were made using the Mann-Whitney U test.

RESULTS

As shown in Table 1, the median for the MPD group was significantly higher than that for the other clinical groups or the medical student controls. The Mann-Whitney U was used because we were interested only in comparing each group to MPD. Although non-parametric statistics were used, mean scores are presented here to show that means and medians do not differ very much for any group. Mean scores for each group are: MPD 37.2 (S.D. 21.3); schizophrenia 17.1 (S.D. 15.3); chemical dependency 12.6 (S.D. 10.1); panic disorder 8.6 (S.D. 9.9); medical students 5.6 (S.D. 4.8). There were 7 (25.0%) items which differentiated MPD from schizophrenia at the $p < 0.05$ level: these were items 6, 14, 15, 16, 21, 22 and 27.

All items except 19 differentiated MPD from medical students; all but 1, 19, 24 and 28 differentiated MPD from panic disorder; and all but 1, 4, 5, 8, 9, 19, 20, and 26 differentiated MPD from chemical dependency at $p < 0.05$.

DISCUSSION

These findings replicate those of Bernstein and Putnam and further validate the DES. The MPD patients in the

original series had slightly higher median scores than ours (57.06), as did the schizophrenics (20.63). The alcoholics (4.72) and agoraphobics (7.42) in Bernstein and Putnam's study were similar to our subjects, as were the normal controls (4.38). We do not think that the slightly lower scores of MPD and schizophrenic subjects in our study are conceptually significant. Such a degree of variation between centers can be expected due to differences in patient populations.

We strongly recommend that any instruments developed for the measurement of dissociative symptoms in the future should be validated against the DES. For three reasons: because the DES is valid and reliable; because it is the only published instrument tested on clinical and control groups; and because it has been replicated at another center.

The DES can be used to screen for the presence of dissociative experiences in clinical and nonclinical populations. Scores above 30 are almost always associated with DSM-III-R diagnoses of MPD or post-traumatic stress disorder in populations screened to date. Scores above 50 are rarely achieved by persons without MPD. The DES can therefore be used as a screening tool in clinical populations to identify patients who require further assessment for dissociative disorders.

The ability of the DES to differentiate MPD from schizophrenia on the item for auditory hallucinations, with MPD scoring higher, is consistent with previous reports that Schneiderian symptoms are common in MPD (Kluft, 1987). The fact that only seven items on the DES differentiate MPD from schizophrenia suggests that there is an extensive clinical overlap between the two disorders and that a short form of the DES might be useful. Many MPD patients are misdiagnosed as schizophrenic (Rosenbaum, 1980): use of the DES might help to reduce false positive diagnoses of schizophrenia and false negative diagnoses of MPD.

In summary, the DES is a reliable and valid self-report instrument for dissociative experiences. It has been shown to be useful in differentiating MPD from other clinical groups and controls in a center which did not participate in the original development of the DES. ■

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