

A VALIDATION STUDY OF THE DES IN THE NETHERLANDS

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ABSTRACT

In the Netherlands we did a small-scale validation study of the Dissociative Experiences Scale (DES) developed by Bernstein and Putnam (1986). The questionnaire was administered in two versions, with and without dummy questions, to 80 students (40 students in each condition) and in one version to 20 patients with a clinically diagnosed dissociative disorder (7 with multiple personality disorder and 13 with other dissociative disorders). The results show that the DES has a good internal consistency and a good criterion validity. If the DES is administered to normals it is advisable to insert dummies (less extreme dissociative items not counted in the statistics). This counteracts normal subjects' reactions to the extremity of the DES item. The score of the Dutch normals is higher than for American normals. There may be cultural differences either in attitudes toward and/or in the level of actual dissociation between the populations of North America and the Netherlands.

INTRODUCTION

The essential feature of dissociative disorders is "disturbance or alteration in the normal integrated functions of identity, memory or consciousness" (American Psychiatric Association, 1987). The Dissociative Experiences Scale (DES) has been developed by Bernstein and Putnam (1986) to offer a means of reliably measuring dissociation in normal and clinical populations. It is a 28-item self-report questionnaire. The DES has been translated into Dutch. With the Dutch version of the DES we undertook validation research (Otterloo, 1987).

The purpose of the present study is to check the reliability of the DES in a normal Dutch population and a group of Dutch patients with diagnosed dissociative disorders, and to repeat the scales' criterion-referenced validity.

METHODS

The questionnaire was given to 80 psychology students.

Forty-one were 22 years of age or younger, 39 were 23 years of age or older. It was also given to 20 patients with diagnosed dissociative disorders. To test the criterion validity, 100 therapists were contacted, who attended a workshop about dissociative disorders (van der Hart, 1987). We found 45 therapists willing to participate; 16 had patients with dissociative disorders. The DES was given to 23 ambulatory dissociative disorder patients by their therapists. The therapists filled in a questionnaire about their patient's diagnosis and symptoms. Two therapists mentioned symptoms not specific to dissociative disorders; they were excluded. Twenty questionnaires were useful for the research. Seven patients were diagnosed as having a multiple personality disorder (MPD), and 13 had other dissociative disorders.

The items in the DES are constructed to screen for the presence of dissociative disorders; most items are extreme for normals. Therefore, we expected the DES to be susceptible to answer tendencies because subjects respond to a total configuration. For example, if most items evoke an answer "0% of the time," subjects tend to "correct" this skewness by being more positive on the items they do recognize. To check the reliability of the DES in normal populations, we administered two versions. The first was the standard DES in Dutch translation. In the second version, dummy questions were inserted in a balanced way between the DES items. Dummy questions are items about common dissociative phenomena. (See Table 1 for English translation of dummy items.) They do not count in the statistics (see Figure 1). Each of the two versions of the DES were given to 40 students. They filled in the questionnaires individually and anonymously.

RESULTS

There are some assertions (Fahy, 1988) that multiple personality disorder is nowadays a typical American diagnosis. In this light it is remarkable that seven MPD patients were diagnosed in the Netherlands. All the patients with dissociative disorders gave histories of having abused severely as children (15 patients had been sexually abused, 13 physically).

The DES had a good internal consistency (Cronbach alpha [a coefficient for inter-item consistency] students = 0.90, patients = 0.91).

The mean scores on the DES with dummies of the three groups (students, dissociative others and multiple personality disorder) were compared with the non-parametric Mann-Whitney Wilcoxon Test (see Table 2).

TABLE 1
List of Dummies

1. Some people sometimes have the experience that they walk to the kitchen and don't know anymore why they are there.
2. Some people have the experience of listening to the radio and suddenly realize that they don't know what has been said.
3. Some people are that much absorbed in a book that they are unaware of other events happening around them.
4. Some people sometimes forget certain appointments.
5. Some people sometimes notice that what has been said to them enters into their minds later on.
6. Some people sometimes have the experience that for a moment they have forgotten what they were just doing.
7. Some people sometimes find that they have been acting automatically, without thinking over it.
8. Some people sometimes have the experience that they are mixing up two acts, for instance they throw away the sweets and put the paper in the mouth.
9. Some people sometimes have the experience that they have forgotten for a moment what they were just talking about.

TABLE 2
Scores on the DES students, dissociative patients

	Students	Other Dissoc. Disorders	MPD
mean	17.3	36.4	53.4
median	16.3	40.7	55.4
s.d.	9.7	11.7	11.0

The differences are significant (students/others, $p < 0.001$; MPD and others $p < 0.005$).

We looked at other factors that might explain the difference between students and patients. Both groups differed in age (most students were between 20 and 30 years old, most patients between 31 and 47) and sex (35% of the students were male as were 15% of the patients). The

younger the students, the more likely they will score high on DES. Moreover, the male students score higher on the DES than the female students. The differences in variables like sex and age were all in the direction that would have narrowed the gap between students and patients. This makes the conclusion that the difference between the groups is based on the level of dissociation quite plausible.

If we look closer at the data and compare the results of the students and the patients on each item (see Figure 1), we see that on all items except one the patients' score is higher than the students'. The students score higher on one item (#6), about being approached by somebody they don't know, but who insists that they have met before. This is a way for men in Holland to get in contact with a girl.

The results confirm Bernstein and Putnam's result: the DES has a good criterion validity. The median scores of the Dutch multiple personality disorder patients were comparable to the scores of the American MPDs (respectively 55.4 and 57.06).

There was a big spread in scores in the different subgroups. Therefore, it was not possible to specify a scoring-interval for multiple personalities.

The scores of the students on the two different versions of the DES are given in Table 3.

There is a consistent difference between the scores on the DES with and without dummies (Student's $t p = .007$). The scores on the DES without the dummies is higher than the scores on the DES with the dummies. This result gives a confirmation to our expectation about the susceptibility of the DES to answer-tendencies as noted above. It is our opinion that by inserting dummies this tendency is counteracted.

A dummy is serving its role adequately if the students score high (> 30) on it and there is not that much difference between students and patients. All the dummies except one (#4) are fulfilling their purpose. The insertion of the dummies in the DES does not seem to affect the patients' score-pattern. Their average score on the DES with dummies was the same as the average score on the standard DES.

The scores on the DES of the Dutch students (more than 22 years, median = 21.8; 22 years or less, median = 25.3) are higher than the scores of the Americans (normals' median = 4.38, students' median = 14.11).

If we consider the results of students on each item (Figure 1), we see that on nine items of the DES the normals score more than 20. The results are in Figure 1. These items are mainly about attention deficiencies and absorption (#2, 15, 17, 20, 24). On the black-out items the normals score less than 10 (#3, 4, 5, 8). Their score on the depersonalisation and derealisation items is less than 10 (#11, 13, 28) or between 10 and 20 (#7, 12, 16).

CONCLUSIONS

This small scale study of the DES shows that this questionnaire has a good internal consistency and a good criterion validity. If a person scores high, MPD can be suspected. If a person scores low on the DES, one needs to be careful. Not all those afflicted with multiple personalities are aware

of, or are willing to admit their dissociative symptoms (Kluft, Steinberg, & Spitzer, 1988). More research should be done with the DES, especially prospective researches, to check the percentages of true and false predictions of MPD from the DES scores. If the DES is used in research on other groups than patients with dissociative disorders, it is useful to include dummies to balance answer-tendencies.

The Dutch normals' score is higher on the DES than the Americans'. This result is consistent with other research in non-American cultures (Sherill Mulhern, personal communications, 1988 - 1989). It is not clear how to interpret these results. In two recent Dutch research projects, one on phobias and depersonalisation (MacNab, 1987), and one on depersonalisation (Van Goozen, 1988), it is found that 1/4 of the adolescents (students) have regular experiences of depersonalisation and derealisation. This is in accordance with other British and American studies (Van Goozen, 1987).

The difference in scores between the Americans and the Dutch can be mainly attributed to the high levels of attention deficiencies and daydreamlike activities reported by the Dutch students. This may be a characteristic of the group of "normals" that participated in the research. There may be cultural differences either in attitudes to and/or in the

actual level of dissociation between North America and the Netherlands. ■

REFERENCES

American and Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (third edition revised), Washington, DC:Author.

Bernstein, E.M., & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale, *Journal of Nervous and Mental Disease*, 174, 727-735.

Fahy, Thomas A. (1988). The diagnosis of multiple personality disorder: A critical review, *British Journal of Psychiatry*, 153, 597-606.

Kluft, R.P., Steinberg, M., & Spitzer, R.L. (1988). D.S.M.-III-R revisions in the dissociative disorders: An exploration of their derivation and rationale, *DISSOCIATION*, 1(1), 39-46.

MacNab, Beulah I.E. (1987). *Perception of phobia and phobias: The quest for control*. Unpublished dissertation, Department of Psychology, University of Amsterdam.

van Goozen, S. (1988). *Desorientatie en depersonalisatie*. Unpublished dissertation, Department of Psychology, Psychonomie, University of Amsterdam.

van Goozen, S. (1987). *Depersonalisatie*. Unpublished dissertation, Department of Psychology, Psychonomie, University of Amsterdam.

van der Hart, O. (ed.) (1987). *Workshop on Diagnostics and Treatment of Dissociative and Post-traumatic Stress Disorders*, Post Academisch Onderwijs Geneeskunde, Vrije Universiteit, Amsterdam.

van Otterloo, D. (1987). *Onderzoek naar de validiteit en betrouwbaarheid van een dissociatie vragenlijst*. Unpublished dissertation, Department of Psychology, University of Amsterdam.

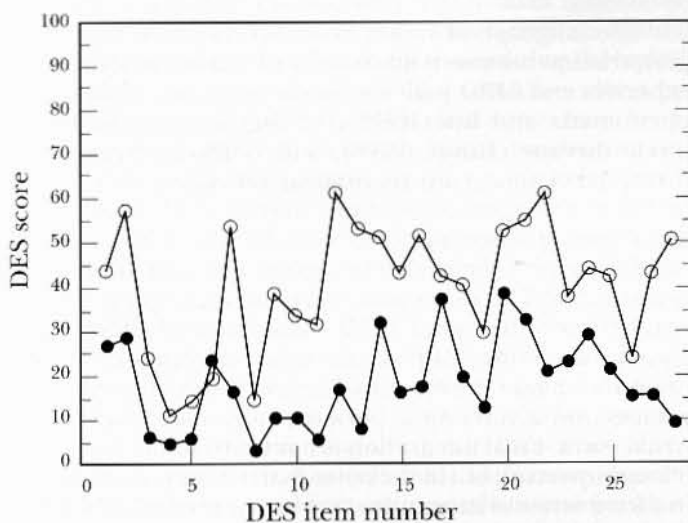


FIGURE 1
Median DES scores for patients (white)
and students (black)

TABLE 3
Student scores on two different versions of the DES

Groups	mean	median	s.d	mean	median	s.d.
Total	24.2	22.7	12.3	17.3	16.3	9.7
Age ≤ 22 yrs.	24.7	25.3	11.5	21.2	21.6	9.8
Age > 22 yrs.	22.7	21.8	14.6	15.7	13.6	9.3