

Validation of the Hebrew Version of the Dissociative Experiences Scale (H-DES) in Israel

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ABSTRACT. Objectives: The pur pose of this re search was to ex plore the va lid ity of the con cept of dis so ci a tion as mea sured by a He brew ver sion of the Dis so ci a tive Ex pe ri ences Scale (H-DES) in Is rael.

Design The first study ex am ined the re li abil ity and va lid ity of the H-DES by as sess ing 340 con sec u tive ad mis sions to an Is raeli out pa tient clinic, and 290 non-clin i cal sub jects. The sec ond study ex plo red the con struct va lid ity of the con cept of dis so ci a tion by study ing re la tion ships be tween re ported past traumatization and cur rent lev els of dis so ci a tion among a dif fer ent co hort of 70 women Is raeli out pa tients.

Results: The H-DES has good test-re test and split-half re li abil ity in clin i cal and non-clin i cal sub jects, and is in ter nally con sis tent. Its con ver gent va lid ity with the MMPI 2 Philips Dis so ci a tion Scale is good, and it has good cri te rion-re lat ed va lid ity with DSM-IV dis so ci a tive dis order di ag nos es. The con cept of dis so ci a tion as mea sured in Is rael by the H-DES has high re li abil ity and va lid ity.

Conclusions: The re li able iden ti fi ca tion of dis so ci a tive ex pe ri ences in Is rael as well as in sev eral cul tures out side North Amer ica sup ports dis so ci a tion as a valid psy cho log i cal con struct with wide spread cross- cul tural ap pli ca bil ity. This study con tra dicts claims that dis so ci a tion is merely a pass ing North Amer i can pro fes sion al fash ion. [Article copies available for a fee from The Haworth Doc u ment De liv ery Ser vice: 1-800-342-9678. E-mail ad dress: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2001 by The Haworth Press, Inc. All rights re served.]

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The essential feature of dissociative disorders (DDs) is “disturbance or alteration in the normally integrated functions of identity, memory or consciousness” (American Psychiatric Association, 1994). DDs have been reported by clinicians to have a posttraumatic etiology (e.g., Kluft, 1991, Spiegel and Cardena, 1991). Nevertheless, the concept has generated considerable controversy centered on whether DDs, and particularly Dissociative Identity Disorder (DID) are valid clinical diagnoses (Mersky, 1992; Spanos, 1994) and on the meaning of the increased number of diagnosed cases (Horevitz, 1995). Some mental health authors have claimed that clinicians inadvertently elicit these clinical phenomena during therapy because of their fascination with the dissociation model (Bowers, 1991; Frankel, 1990). Other authors have suggested that the notable increase in the diagnosis of DID reflects a North American popular/professional trend that has developed into a form of social hysteria (Aldridge-Morris, 1989; Radwin, 1991). To determine whether DDs are a culture-specific phenomenon, systematic international large-scale studies of the prevalence of DDs need to be conducted. Such endeavors had been virtually impossible in Israel, because a reliable screening instrument was lacking. The only self-report instrument used to systematically study the prevalence of dissociative experiences in the general population has been the Dissociative Experiences Scale (DES). This instrument has been developed in the United States (Bernstein & Putnam, 1986; Carlson & Putnam, 1993) and was used to measure the frequency of 28 dissociative experiences that are aspects of the dissociation construct (Putnam, 1991). The instrument was shown to be a valid and reliable screening instrument (Frischholtz et al., 1990; Waller, 1995) that in conjunction with clinical diagnosis has enabled the accumulation of data supporting the reliability and validity of the diagnosis of DID and other DDs. The DES, which was initially developed in English in 1986, is now available in at least 18 languages, indicating the extent of the international interest in this clinical phenomenon (Bowman, 1996). The validity of the translated instrument has been investigated in the Netherlands (Ensink & Van Otterloo, 1989), Turkey (Yargic, Tutkun & Sar, 1993) Japan (Umesue, Matsuo, Iwata & Tashiro, 1996), Germany (Spitzer et al., 1998) and in France (Darves-Bornoz, Degiovanni, & Galliard, 1999).

In Israel, several clinical and theoretical papers on dissociation have been presented in professional conferences and published in local scientific journals (e.g., Margalit & Witztum, 1997a, 1997b; Somer, 1987, 1989, 1993, 1994, 1995; Somer & Somer, 1997). However, no empirical studies have been conducted in the Middle East to ascertain the relevance of the DES to the local population.

The purpose of the present research was to test the validity and reliability of the DES in Israel. Two studies were conducted. In study 1 we assessed the applicability of a translated version of the DES to Israeli subjects by examining the reliability and validity of the scale. There is a growing body of research in indicating a causal connection between a history of trauma in childhood and dissociative experiences and symptoms (e.g., Fine, 1990; Hornstein & Tyson, 1991; Kirby, Chu, & Dill, 1993; Spiegel, 1991). Therefore, construct validity for dissociation scales has also been assessed by comparing them to trauma indices (e.g., Putnam, Helmers & Trickett, 1993). In study 2 we explored the construct validity of the scale by studying relationships between past traumatization and current levels of dissociation among Israeli subjects.

STUDY 1: THE PSYCHOMETRICS OF THE H-DES

Methods

Subjects

Six hundred thirty subjects participated in this study. Our research sample consisted of two main groups: (1) A clinical group of 340 consecutive patients admitted for outpatient psychotherapy at Maytal–Israel Institute for Treatment and Study of Stress, and (2) A comparison group consisting of 290 non-clinical subjects sampled from university students and faculty. The clinical group included 89 patients with adjustment disorders and DSM-IV V-codes, 87 patients with anxiety disorders (other than Posttraumatic Stress Disorder or Acute Stress Disorder (PTSD/ASD)), 36 patients with dissociative disorders, 32 with personality disorders, 21 with schizophrenia, 17 with affective disorders, and 15 with PTSD or ASD. Forty-three patients received no diagnosis.

The mean \pm SD age of the clinical and non-clinical groups were 31.9 \pm 10.8 (range = 15–70) and 23.4 \pm 7.9 (range = 16–52), respectively. Of the 340 patients, 207 were women (61%) and 133 were men (39%). Of

the 290 comparisons, 202 were women (70%) and 80 were men (30%). Thus, our non-clinical group was younger and comprised of more women than the clinical group. Past research has shown significant age effects on DES scores for younger people (e.g., Bernstein & Putnam, 1986; Ross et al., 1989) and for women (e.g., Putnam et al., 1996). Psychopathological effects on the DES would be more difficult to demonstrate in this study and would increase the power of statistically significant differences.

Measures

1. The DES-II (Carlson & Putnam, 1993), a 28-item questionnaire, scored on a 10-point Likert scale, was translated into Hebrew by the first author (a native Hebrew speaker) and later was back-translated into English by a native English speaker who was blind to the original English version. The back-translation was compared to the original version and differences were reconciled.
2. The clinical group was evaluated with the Structured Clinical Interview for DSM-III-R (SCID), a guided semi-structured diagnostic interview (Spitzer & Williams, 1986) and with the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1993).
3. As part of their intake assessment procedure, the patients were also asked to complete the Hebrew versions of the MMPI-2. Convergent validity in this study was calculated by comparing scores of the H-DES with scores of the Phillips Dissociation Scale (PDS), a 20-item instrument derived from the MMPI-2 (Phillips, 1994).

Procedure

The clinical sample was evaluated during their intake procedure and included all consecutive Hebrew speaking patients. All eligible subjects gave their consent to participate in the study. The non-clinical subjects were recruited in faculty meetings and lecture halls. Subjects were informed that the purpose of the study was to investigate the frequency of the experiences described in the questionnaire. Seventy-six per cent of the non-clinical subjects we approached gave consent for participation. One hundred forty-one comparison subjects were approached again one month following their first completion of the H-DES and asked to com

plete the questionnaire again. These 141 subjects represented an 89% response rate.

Data Analysis

Initial review of our data revealed that the distribution of the H-DES scores within the investigated sample was skewed. Therefore, in data analysis we applied non-parametric statistical methods whenever possible.

Results

Reliability Measures

Students in one of the large introductory university classes that had originally completed the H-DES were approached again after one month and were asked to repeat the task. The H-DES total score test-retest reliability coefficient was .87 ($p < 0.0001$, $N = 141$). The internal consistency was examined at several levels: split-half reliability coefficient, Cronbach's alpha coefficient, and corrected item-to-total correlations. Split-half reliability coefficient (calculated using the Spearman Brown formula) was .86 both for the entire sample ($p < 0.0001$, $N = 584$), and for our normal comparisons ($p < 0.0001$, $N = 290$). For the clinical sub-groups the Split-half reliability coefficient scores ranged between .75 (for patients with Adjustment Disorders and V-Codes) to .93 (for patients with Schizophrenia and for those suffering from Affective Disorders). The Split-half reliability for the 36 patients presenting with Dissociative Disorders coefficient was .84. All reliability coefficients for the clinical sub-groups were significant at a $p < 0.0001$ level. Cronbach's alpha coefficient for the H-DES scores was 0.91 for both the non-clinical group ($N = 290$) and the clinical group ($N = 293$). Reliability coefficients of the corrected item-to-total ranged from 0.26 to 0.73, with a median of 0.59 score for the non-clinical group and 0.34 to 0.66, with a median of 0.55 score for the clinical group. All of these values are significant at $p < 0.0001$.

Validity Measures

Convergent validity was calculated by comparing scores of the H-DES with scores of the Phillips Dissociation Scale (PDS), a 20-item instrument derived from the MMPI-2. There is no item overlap between

the H-DES and the PDS. Tau tology was, there fore, ruled out. Testing of the PDS scale by the de vel oper with a dissociative group and a gen eral psy chi a try group showed the PDS to be in ter nally re li able and to dif fer en tially di ag nose dissociative dis or ders (Phil lips, 1994). A Spearman Correlation between the H-DES and the PDS scores for 284 patients was cal cu lated and yielded $r = 0.59$ ($p < 0.0001$). Di ver gent va lid ity was cal cu lated by com par ing the scores of the H-DES and the Male/Fe male scale of the MMPI-2 and yielded $r = 2.03$ ($p < 0.28$). H-DES scores did not dif fer by sex in the non-clin i cal group [$t(280) = 21.51$, NS] or in the clin i cal group [$t(291) = 21.18$, NS], but scores were sig nif i cantly neg a tively cor re lated with age in both the non-clin i cal group ($r = 20.31$, $p < 0.0001$) and the clin i cal group ($r = 20.19$, $p < 0.001$).

Criterion-referenced validity was calculated when we compared H-DES scores across the dif fer ent di ag nos tic groups. The mean H-DES score for the non-clin i cal group was 13.06. The mean H-DES scores for the var ious clin i cal groups were as fol low ing: Anx i ety Dis or ders: 9.62; Ad justment Dis or ders and V Codes: 9.82; Per son al ity Dis or ders: 11.25; Af fec tive Dis or ders: 13.07; Schizo phre nia: 16.22; Posttraumatic Stress Disorder and Acute Stress Dis or der: 20.36; and Dissociative Dis or ders: 29.45. A Kruksal-Wallis test dem on strated that H-DES scores dif fered sig nif i cantly between the groups (chi-square = 62.19, $N = 290$, $df = 7$, $p < 0.0001$). Pairwise com par i sons of each group's mean score by Scheffe's test re vealed that all but one clin i cal group yielded sig nif i cant dif fer ences. H-DES mean score dif fer en ti ated the DD group from other di ag nos tic groups and from the non-pa tient pop u la tion.

STUDY 2: CONSTRUCT VALIDITY OF THE H-DES

Methods

Subjects

The sec ond re search sam ple con sisted of a new cohort of sev enty con sec u tive women ad mit ted for out pa tient psy cho ther apy at Maytal-Is rael In sti tute for Treat ment and Study of Stress. Their mean age \pm SD was 33.5 ± 12.2 (range: 16-55). Thirty-five suf fered from Anx i ety Dis or ders, 19 were given ei ther a V-code or an Ad justment Dis or der di ag no sis, 10 had an Af fec tive Dis or der and 6 were as sessed as hav ing a Per son al ity Dis or der. No DDs were in cluded in this sam ple.

Procedures and Measures

The intake procedure employed at Maytal includes a structured trauma history interview based on the Traumatic Experiences Questionnaire (TEQ), an instrument developed by Nijenhuis, Van der Hart and Vanderlinden and later slightly modified and relabeled *Traumatic Experiences Checklist* (Nijenhuis, Van der Hart, & Vanderlinden, 1999). The TEQ is a self-report questionnaire inquiring about 25 types of interpersonal and non-interpersonal life events that could be potentially traumatic. When interpersonal violence was explored, subjects were asked to indicate if immediate family members, relatives or, others had hurt them. TEQ items inquire if respondents had suffered from the following stressors: parentification (a child needing to act in a parental role) (P), major loss, such as a death of a loved one (L), interpersonal life-threats (e.g., having been assaulted with a weapon) (TH), other traumatic life events (e.g., fires, natural disasters, road accidents) (LE), emotional neglect (EN), emotional abuse (EA), physical abuse (PA), sexual harassment (SH) or, sexual abuse (SA). The TEQ specifically addresses the subjective impact of the event (i.e., how traumatic was it for the respondent), and also requests information about the number of perpetrators of emotional, physical, and sexual abuse. The questions contain short descriptions that define the events of concern. All items are preceded by the phrase: "Did this happen to you?" An example of sexual harassment within the family is: "Sexual harassment (acts of a sexual nature that DO NOT involve physical contact) by your parents, brothers, or sisters." A sexual abuse by extended family item is: "Sexual abuse (unwanted sexual acts involving physical contact) by other relatives."

Moderate to strong associations of the TEQ total score and composite scores, in particular physical and sexual abuse, with current psychological and somatoform dissociation, support the construct validity of the TEQ. These associations were found when studying psychiatric outpatients with dissociative disorders and other mental disorders (Nijenhuis et al., 1998), gynecology patients with chronic pelvic pain (Nijenhuis et al., 1999), and women who reported childhood sexual abuse (Nijenhuis, 1999). Recent research with this instrument indicated that the reliability of the TEQ was supported by satisfactory indices of internal consistency. Cronbach's alpha for the first administration of the TEQ was .86, and was .90 for the retest. The test-retest reliability of the TEQ total score was $r = .91$, $p < .0001$. The correlation between the TEQ and the *Stressful Life Events Screening Questionnaire* (SLESQ; Goodman,

Corconan, Turner, Yuan, & Green, 1998) total scores is strong, $r = .77$, $p < .0001$, suggesting that both instruments assess a highly similar construct. The composite trauma score of the TEQ and the SLESQ that assess physical abuse and deliberate threat to life from a person, and sexual trauma were also correlated, i.e., respectively, $\rho = .56$, $p < .0001$ and $\rho = .78$, $p < .0001$ (Nijenhuis, Van der Hart, & Kruger, submitted).

Among the key factors that determine what makes an event traumatic are the perception of the event as having highly negative valence (e.g., Carlson, 1997), multiple perpetrators (e.g., Peters, 1988), duration and frequency of the abuse (e.g., Elliott & Briere, 1992), and abuse at an earlier age (e.g., Zivney, Nash, & Hulsey, 1988). The TEQ composite trauma score reflects these relevant traumatogenic factors. Each experience identified as a trauma item was given one point. Subjects could score 0-3 trauma points, depending on the number of perpetrating sources. Additional points were given to each trauma event endorsed if the trauma occurred when the subject was younger than age 10, if the trauma lasted more than one year, and if the impact of the traumatic event was rated as 4 or 5 on a 5-point subjective severity scale. Scores for specific trauma events in each of the nine categories range from 0-7. Composite trauma scores range from 0-63. Subjects were also given the H-DES.

Results

Emotional Neglect was the TEQ trauma category with the highest mean score ($M = 1.22$; $SD = 1.47$; $N = 39$) in our sample. This score reflects the number of different perpetrators or, if not abuse-related, discrete traumatic events, early age onset, duration of exposure and subjective effect. Sexual Abuse received the lowest mean trauma score ($M = 0.27$; $SD = 0.50$; $N = 19$), reflecting a relatively low representation of this variable in the trauma history of our sample. A Spearman correlation between the mean composite TEQ trauma score ($M = 14.14$; $SD = 16.35$; $N = 70$) and the mean composite H-DES score ($M = 12.02$; $SD = 11.56$; $N = 70$) was $r = 0.62$ ($p < 0.0001$; $N = 70$). The H-DES was also significantly correlated with the number of trauma sources in all the trauma subcategories except Sexual Abuse (see Table 1). Table 1 reveals that the number of different persons who had sexually abused the respondent (trauma sources) was not a significant statistical predictor of dissociation. We also computed correlations between the means of the other components of the non-sexual trauma scores and the H-DES.

TABLE 1. Significant Correlations of Hebrew-DES with Number of Trauma Sources by Category

Trauma category	N subjects	r
Parentification	69	0.34**
Loss	69	0.29*
Life threats	70	0.32**
Threatening life events	70	0.32**
Emotional neglect	70	0.42***
Emotional abuse	70	0.46***
Physical abuse	70	0.25*
Sexual harassment	70	0.42***
Sexual abuse	70	0.20 (NS)

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

NS not significant

Early age during the trauma, length of victimization, and perceived severity of the experience were not significant predictors of the mean H-DES score for all the trauma categories but Sexual abuse. Spearman correlations between the mean H-DES score and the other sexual trauma components were as follows: Early age of onset: $r = 0.59$ ($p < 0.05$; $N = 17$); Lengthy duration: $r = 0.61$ ($p < 0.01$; $N = 17$); Perceived severity: ($r = 0.47$; $p < 0.05$; $N = 19$).

DISCUSSION

Our results demonstrate the reliability and validity of the Hebrew version of the DES. The H-DES has good test-retest and split-half reliability and is internally consistent. Evidence for good criterion-related validity was provided by showing evidence that the H-DES scores agree with criteria of DSM-IV and SCID-D dissociative disorder diagnoses and differentiate between different diagnostic groups. H-DES scores also agree with PDS, an MMPI-2 dissociation scale with no overlapping items with the H-DES. If the H-DES measures dissociation, it should be associated with the sequelae of traumatic experiences. Construct validity of the H-DES was provided by an association between

H-DES scores (dissociative experiences) and a reported trauma history. These findings are in agreement with 26 studies reporting an association between the DES and physical or sexual abuse experiences (N = 2,108) (Van Ijzendoorn & Schuengel, 1996). Our findings also demonstrate that aggravating variables of sexual trauma such as intense severity, prolonged duration, and young age during abuse were uniquely related to dissociative experiences. These latter findings are in line with studies in which the authors have been able to obtain documentation for children and adolescents with dissociative disorders (Hornstein and Putnam, 1992; Coons, 1994) and with studies that showed relationships between indices of trauma severity and dissociation (e.g., Chu and Dill, 1990; Anderson et al. 1993).

The current findings from a Jewish population in the Middle East replicate the high degree of reliability and validity of DES that has been demonstrated by previous studies conducted in North America (Bernstein & Putnam, 1986; Ross et al., 1989; Frischoltz et al., 1990; Sandberg & Lynn, 1992; Dobester & Braun, 1995), the Netherlands (Ensink & Van Otterloo, 1989), Turkey (Yargic, Tutkun, & Sar, 1995), Japan (Umesue et al., 1996), Germany (Spitzer et al., 1998) and France (Darves-Bornoz, Gegiovanni, & Gaillard, 1999) as well as in a meta-analytic study (van Ijzendoorn & Schuengel, 1996). The accumulated data suggest that dissociative experiences are not North American culture-bound phenomena and that the concept, originally named in France at the end of the 19th century (Janet, 1905; Van der Hart & Horst, 1989) remains a valid psychological construct with cross-cultural applicability.

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