Epilogue

Using the DES-II

This explanation is provided so that you may become familiar with the Dissociative Experiences Scale (DES), version II. A series of references are listed so that you may have a resource for looking at some of the work done with the Dissociative Experiences Scale (Bernstein, 1986; Carlson, 1993a; Carlson, 1993b; Ross, 1990). Effort was made to include references readily available to most readers. The DES is a screening tool in the evaluation of persons thought to have post-traumatic or dissociative symptomatology. It is not a diagnostic tool. The DES, and a short manual on its use, is available from the Sidran Foundation at (410) 825-8888 (email: sidran@ access.digex.net) or on the Internet at http://www.sidran.org.

The DES can be used to screen for dissociative experience in large populations in a short period of time, or as an introduction to differential clinical formulation for the clinician who is otherwise unfamiliar with dissociative phenomena. The more experienced clinician may find it a time saver. Its most useful application may actually be in the post-test discussion of the patient's responses to different items on the scale. In my clinical practice, I find that discussion of the rationale of answers to questions on the DES quickly opens an inquiry into the private experience of the person with dissociative adaptations. In combination with questions from the Structured Clinical Interview for DSM-IV Dissociative Disorders (Steinberg, 1993), the thoughtful clinician may find a comprehensive compendium of language to use in defining a mental status examination which includes post-traumatic symptoms related to dissociation.

To obtain a raw score for the DES, total the numerical sum of responses for all 28 items on the DES. In order to obtain a proper score, all 28 items must be endorsed. While some persons may have questions about the meaning of an item, you may not explain the meaning to the patient. Instruct the patient to do the best job they can in understanding the item and to endorse it in the manner in which they interpret it. You may advise them to mark that item for discussion in the post-test period. Divide the raw score by 28. This is the test score. Values above 30 suggest the likelihood of a dissociative disorder. Values above 45 suggest the likelihood of Dissociative Identity Disorder (DID). It should be emphasized that these scores are not diagnostic, and scores may not be interpreted as proving any diagnosis. In fact, scores less than 30 do not exclude the presence of DID. I have seen a person with DID who endorsed a score of 11. This is unusual. Scores above 75 may deserve careful post test evaluation regarding the possibility of a factitious response. Some persons may present a "pseudo-false positive" response. In this scenario, the patient is desperate for someone to believe their symptomatology, and they over-endorse items on the DES to be sure that they are believed. Post-test evaluation may be essential. Even if the DES score is low, inquiry into the meaning of heavily endorsed items may prove exceedingly useful. For example, a person with an eating disorder may endorse items 13, 19, and 20 at the 50% level. They may experience depersonalization, and they may have a capacity to block the experience of pain, or other affect. They may also enter a trance-like state. Does this occur at the time of binge eating? Does this occur afterward, or before? How much do altered states of perception and consciousness play a role in the automatic ("it's not under my control") nature of their experience.

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