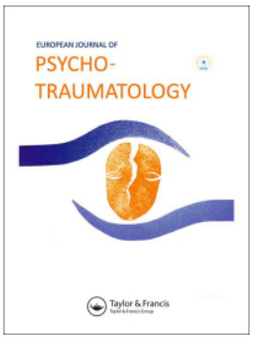

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BASIC RESEARCH ARTICLE

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Psychometric properties of the Ukrainian version of the Dissociative Subtype of Posttraumatic Stress Disorder Scale (DSPS)

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ABSTRACT

Background: The dissociative subtype of posttraumatic stress disorder (D-PTSD) was introduced in the DSM-5 to identify individuals with PTSD who experience dissociative symptoms, such as derealization and depersonalization. The Dissociative Subtype of PTSD Scale (DSPS) was developed to assess these symptoms but has yet to be validated in Ukrainian, a necessity due to the psychological impact of the ongoing conflict in Ukraine.
Objective: This study aimed to develop and validate the Ukrainian version of the DSPS, examining its psychometric properties in a sample of trauma-exposed Ukrainian individuals.
Methods: 1,119 Ukrainian participants, recruited using convenience and snowball sampling, took part in an online study assessing dissociative symptoms with the DSPS as well as symptoms of PTSD, depression, generalized anxiety disorder, somatic symptom disorder, and fear of sleep with established questionnaires. DSPS factor structure, internal consistency, and convergent and discriminant validity were assessed.
Results: Confirmatory factor analysis confirmed the three-factor structure of the DSPS (derealization/depersonalization, loss of awareness, and psychogenic amnesia) with acceptable model fit indices for both lifetime and current severity items. Internal consistency was high for lifetime and current total scales (Cronbach's alpha = 0.83-0.87). Significant correlations with PTSD, depression, anxiety, and somatic symptoms were in the expected size-ranges, supporting convergent and discriminant validity.
Conclusions: The Ukrainian DSPS demonstrated robust psychometric properties, validating its use as a reliable and valid tool for assessing dissociative symptoms in individuals exposed to war-related trauma. Its adaptation fills a critical gap in the diagnostic landscape, enabling timely intervention for trauma-exposed populations in Ukraine.

Propiedades psicométricas de la versión Ucraniana de la Escala de Estrés Postraumático Subtipo Disociativo (DSPS)

Antecedentes: El subtipo disociativo del trastorno de estrés postraumático (TEPT-D) se introdujo en el DSM-5 para identificar individuos con TEPT que experimentan síntomas disociativos, como desrealización y despersonalización. La Escala de TEPT Subtipo Disociativo (DSPS) se desarrollo para evaluar estos síntomas, pero aun tiene que validarse en ucraniano, una necesidad debida al impacto psicológico del conflicto en curso en Ucrania.
Objetivo: Este estudio tuvo como objetivo desarrollar y Validar la versión ucraniana de la DSPS, examinar sus propiedades psicométricas en una muestra de individuos ucranianos expuestos a trauma.
Métodos: 1.119 participantes ucranianos, reclutados mediante muestreo por conveniencia y por bola de nieve, tomaron parte en un estudio en línea que evaluó los síntomas disociativos con la DSPS, así como los síntomas de TEPT, depresión, trastorno de ansiedad generalizada, trastorno de síntomas somáticos y temor a dormir con cuestionarios establecidos. Se evaluaron la estructura factorial de la DSPS, la consistencia interna, la validez convergente y discriminante.
Resultados: El análisis factorial confirmatorio confirmó la estructura trifactorial de la DSPS (desrealización/despersonalización, perdida de conciencia y amnesia psicogénica) con índices de ajuste del modelo aceptables tanto para los ítems de gravedad actual como para

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KEYWORDS
Dissociation; PTSD; assessment; questionnaire; psychometrics; validation; Ukraine

PALABRAS CLAVE
Disociación; TEPT; evaluación; escala; psicométricos; validación; Ucrania

HIGHLIGHTS
- First Ukrainian validation of the DSPS among 1,119 trauma-exposed adults.
- CFA confirmed the three-factor structure for lifetime and current symptoms.
- Scale shows high internal consistency and strong convergent validity.
- Dissociation strongly correlates with somatic symptoms in war-affected samples.
- DSPS is a reliable tool for identifying D-PTSD in ongoing conflict settings.

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los de gravedad a lo largo de la vida. La consistencia interna fue alta para las escalas totales de por vida y actual (α de Cronbach = 0,83-0,87). Las correlaciones significativas con el TEPT, depresión, ansiedad y síntomas somáticos se mantuvieron dentro de los rangos esperados, lo que respalda la validez convergente y discriminante.
Conclusiones: La DSPS ucraniana demostró sólidas propiedades psicométricas, lo que valida su uso como un instrumento fiable y valido para evaluar síntomas disociativos en individuos expuestos a trauma relacionado con la guerra. Su adaptación cubre una brecha critica en el panorama diagnóstico, permitiendo una intervención oportuna para poblaciones expuestas a trauma en Ucrania.

1. Introduction

Posttraumatic stress disorder (PTSD) represents a significant psychological challenge for individuals exposed to trauma, encompassing symptoms such as intrusive memories, avoidance behaviours, and heightened arousal. Among these cases, the dissociative subtype of PTSD (D-PTSD), introduced in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), identifies a subset of individuals additionally experiencing dissociative symptoms such as depersonalization (i.e. feeling detached from oneself) and derealization (i.e. feeling detached from the world) (American Psychiatric Association, 2022; Lanius et al., 2012; Schiavone et al., 2018). These symptoms create an additional layer of complexity in diagnosis, treatment, and understanding of PTSD, requiring targeted approaches.

Given the ongoing war in Ukraine, the prevalence of trauma exposure and its associated psychological consequences, including PTSD and dissociative PTSD (D-PTSD), has likely surged among both military personnel and civilians (Eshel et al., 2023; Kurapov et al., 2024; Kurapov, Kalaitzaki, et al., 2023; Wolf et al., 2017). This necessitates the availability of reliable tools to assess PTSD and dissociative symptoms, as timely identification and intervention are critical in mitigating long-term psychological harm in affected populations. However, while Ukrainian language diagnostic instruments to assess PTSD symptoms have been made available (e.g. Karachevskii, 2016), a Ukrainian tool to assess D-PTSD symptoms is still lacking. Hence, addressing this gap becomes a priority in clinical and research settings.

D-PTSD is marked by distinct characteristics, including heightened symptom severity, chronicity, and high comorbidity with other psychiatric conditions (Hill et al., 2020; Lanius et al., 2012; Swart et al., 2020). Research suggests that dissociative symptoms, such as depersonalization and derealization, not only complicate the clinical presentation of PTSD but also contribute to significant functional impairments and differential treatment outcomes (Atchley & Bedford, 2021; Schiavone et al., 2018). Prevalence estimates of D-PTSD vary across populations, with 22.8% identified through latent class analysis and up to 48.1% using DSM-5 criteria (White et al., 2022). However, the variability in findings may stem from inconsistencies in diagnostic approaches, as many studies employ instruments not specifically tailored to assess D-PTSD, thereby lacking full conformity with its DSM-5 definition (Schiavone et al., 2018; Wolf et al., 2017). This methodological challenge underscores the need for robust and precise diagnostic measures, especially in trauma-exposed populations with diverse demographic and trauma characteristics, such as those in Ukraine.

Efforts to accurately identify and measure dissociative symptoms in PTSD have led to the development of various diagnostic instruments tailored to assess the unique features of D-PTSD. Structured interviews like the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) and the Dissociative Subtype of PTSD Interview (DSP-I), have demonstrated their utility in research and clinical settings but face practical challenges due to their time-intensive nature (Eidhof et al., 2019; Weathers et al., 2018). Consequently, the need for efficient and scalable self-report measures prompted the development of the Dissociative Subtype of PTSD Scale (DSPS) by Wolf et al. (2017). The DSPS is a 15-item self-report instrument that addressed the limitations of prior tools, such as overlaps with nonpathological traits and difficulties interpreting response options (Giesbrecht et al., 2008; Wolf et al., 2017). Crucially, the DSPS is designed for a step-by-step diagnostic process: it does not replace a primary PTSD assessment but is intended for use with individuals already identified as having PTSD to determine if they meet the DSM-5 criteria for the dissociative subtype. The scale evaluates three symptom clusters: derealization/depersonalization, loss of awareness, and psychogenic amnesia, using frequency (0-4) and intensity (0-5) ratings for the past month. By incorporating a three-factor structure to capture derealization/depersonalization, loss of awareness and psychogenic amnesia, the DSPS aligns closely with the DSM-5 criteria, making it a robust instrument for identifying D-PTSD (Guetta et al., 2019). Validation studies of the DSPS have shown promising psychometric properties across diverse populations, including primarily older male veterans (Guetta et al., 2019; Wolf et al., 2017) and samples with broader ranges of age, sex, and trauma type (Danböck

et al., 2023; İçin et al., 2023). However, the generalizability of findings to general populations exposed to war has not been tested yet. Further, the DSPS has so far only been made available in validated English (Guetta et al., 2019; Wolf et al., 2017), German (Danböck et al., 2023), and Turkish versions (İçin et al., 2023).

Introducing the DSPS in Ukrainian would fill a crucial gap in the diagnostic landscape, enabling the timely identification of D-PTSD cases and guiding corresponding interventions. This study aims to develop and validate a Ukrainian language version of the DSPS in participants from the general population exposed to traumatic experiences related to the war in Ukraine. Building on prior research, we hypothesize that the Ukrainian DSPS will replicate the three-factor structure observed in previous studies (Danböck et al., 2023; Guetta et al., 2019; Wolf et al., 2017) and show high internal consistency as well as convergent and discriminant validity. Specifically, we expect high correlations with PTSD measures and somewhat lower but still high correlations with measures of depression, generalized anxiety, somatic symptoms, and fear of sleep.

2. Methods

2.1. The DSPS

The DSPS consists of three subscales assessing derealization/depersonalization with seven items (1, 3, 5, 7, 8, 9, 12), loss of awareness with six items (2, 4, 6, 10, 11, 13), and psychogenic amnesia with two items (14, 15). For each item, participants report the following: (a) whether they have ever experienced the symptom ('yes/no'), (b) whether they have experienced it in the past month ('yes/no'), (c) symptom frequency in the past month (0 = 'never', 1 = 'once or twice', 2 = 'once or twice a week', 3 = 'three or four times a week', 4 = 'daily'), (d) symptom intensity in the past month (0 = 'N/A', 1 = 'not very strong', 2 = 'somewhat strong', 3 = 'moderately strong', 4 = 'very strong', and 5 = 'extremely strong'), and (e) whether the symptom only occurred when they were tired, or under the influence of alcohol, medication, or drugs ('yes/no'). If participants affirm the last question, all responses for that item are set to zero (Wolf et al., 2017).

Three primary scores are derived from the DSPS: (1) endorsed lifetime items, calculated as the sum of symptoms ever experienced; (2) endorsed current items, reflecting symptoms present in the past month; and (3) current symptom severity, representing the total sum of frequency and intensity ratings. Following the procedure established by Wolf et al. (2017), current symptom endorsement is operationalized as a frequency ≥ 1 and an intensity ≥ 3. This intensity threshold (at least 'moderately strong') is used to ensure that the symptoms capture clinically significant dissociative pathology rather than transient or non-pathological experiences. Furthermore, question (b), whether the symptom occurred in the past month (yes/no), serves as a clinical screening filter to help respondents orient themselves to the specific timeframe before providing detailed frequency and intensity ratings, though it is not used in the final sum scores.

The DSPS was translated into Ukrainian following established guidelines (Sousa & Rojjanasrirat, 2011). Two native Ukrainian speakers, one familiar with the concept of dissociation and one not, independently translated the DSPS. Discrepancies in their translations were discussed and resolved by the research team, resulting in a preliminary Ukrainian version. In addition, beyond literal translation, the research team performed cultural and linguistic adaptations to ensure items resonated with the Ukrainian context. For example, descriptions of 'feeling in a daze' (Item 11) were carefully reformulated to distinguish pathological dissociation from general fatigue or 'war-weariness' common in the current environment. These refinements ensured that the items captured the specific phenomenological experience of dissociation as understood by native speakers, rather than relying on direct word-for-word translations that might be clinically ambiguous. The process was performed by evaluating variations with English-speaking and Ukrainian-speaking members of the research team. This version was then back-translated by two native English speakers, with and without knowledge of the dissociation construct, who were blind to the original version. The final Ukrainian DSPS which is provided in the Supplements (Table 4).

2.2. Participants and procedure

We used a snowball sampling methodology by recruiting students of the Faculty of Psychology at the Taras Shevchenko National University of Kyiv, who were asked to share the questionnaire with friends and relatives; in parallel, we utilized a convenience sampling methodology by recruiting participants from different social media channels (Telegram FZ-LLC.) and through the official Facebook page of the Faculty of Psychology, to target a wide range of demographic backgrounds and regions in Ukraine. Informed consent was obtained from all participants. The data were collected from 15 June until 28 June 2023, using an online questionnaire survey. Inclusion criteria were an age between 18 and 70 years and the ability to provide informed consent, yielding $N = 1119$ valid responses with age $M = 28.92 \pm 11.24$. Sociodemographic details are presented in Table 1.

In addition to D-PTSD, we also assessed key mental health indicators, including symptoms of PTSD,

Table 1. Sociodemographic characteristics of the sample.

		Count	Percentage
Gender	Female	910	81.32
	Male	194	17.34
	Other	15	1.34
Region	Central	555	49.59
	Western	259	23.14
	Eastern	106	9.48
	Southern	70	6.26
	Crimea	0	0
Settlement Type	Big city (>200.000)	638	57.02
	City	153	13.67
	Small town (<50.000)	131	11.71
	Big village	74	6.61
	Other	14	1.25
Employment	Employed	669	59.79
	Unemployed	450	40.22
Self-Reported Traumatic Events			
Exposure to war-related events (e.g. flying rockets, drones, air raid alarms)	Not exposed	77	6.88
	Exposed	1042	93.12
Direct witnessing of military-related events (e.g. direct fighting, marching troops, etc.)	Not exposed	786	70.24
	Exposed	333	29.76
Exposure to physical and/or sexual violence	Not exposed	871	77.84
	Exposed	248	22.16
The loss of a close relative	Not exposed	968	86.51
	Exposed	151	13.49

Note: Total number of participants $N = 1119$.
For regional division see supplementary Figure 1.

depression, anxiety, somatic symptoms, and fear of sleep. A summary of psychometric sample characteristics is presented in Table 2.

While the sample size is substantial, it is important to note that it is not fully representative of the general Ukrainian population. The recruitment through university channels resulted in a sample that is primarily female (81.32%) and likely possesses a higher education level than the national average. Furthermore, while exposure to war-related events was nearly universal (93.12%), the convenience sampling method may have attracted individuals more inclined to participate in psychological research, potentially impacting the observed prevalence rates.

3. Measures

Employed measures are summarized in Table 3.

4. Statistical analysis

All statistical analyses were conducted using R version 2023.03.0 (R Core Team, 2014). For group comparisons and correlations, we used two-sided tests with $\alpha = .05$ and report exact p-values (and 95% confidence intervals where applicable). Confirmatory factor analyses were estimated in lavaan using Weighted Least Square Mean and Variance Adjusted (WLSMV) for dichotomous lifetime items and Robust Maximum Likelihood (MLR) for current severity items; model adequacy was evaluated primarily via RMSEA, SRMR, CFI, and TLI.

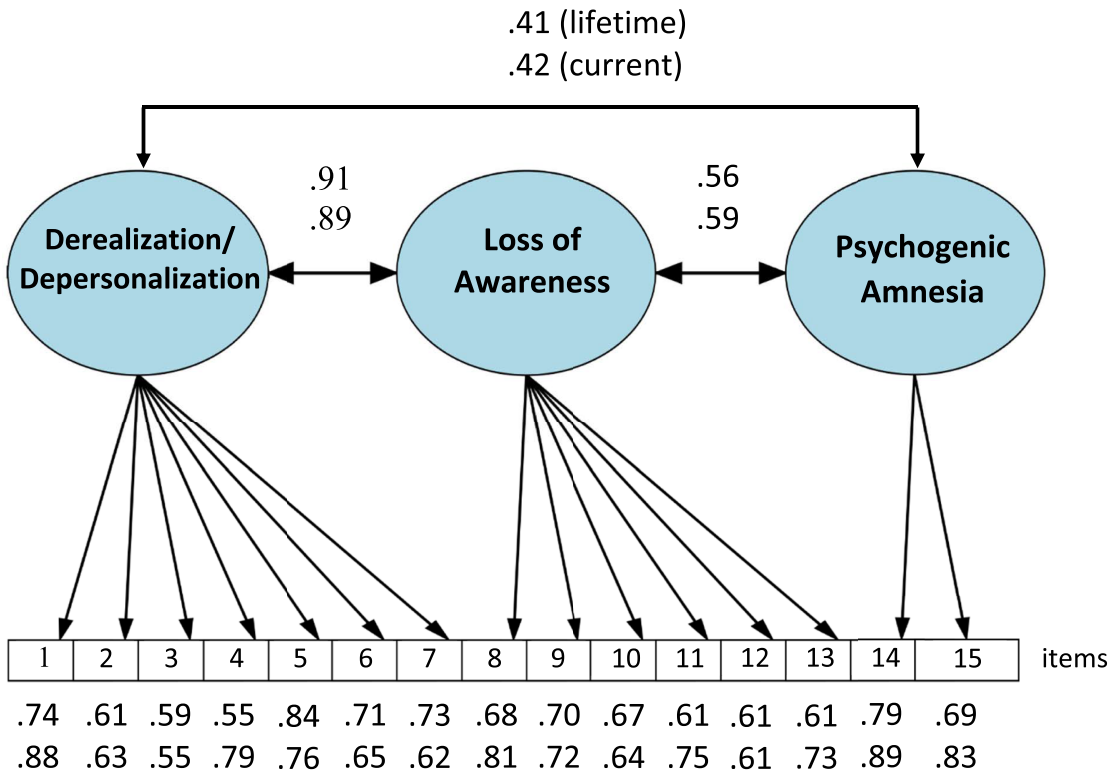

Figure 1. DSPS Factor Structure.

Note. DSPS Factor Structure. The standardized loadings of lifetime and current severity items on their respective latent factors, along with correlations between latent factors, are presented. Upper values indicate values for lifetime items, while lower values indicate values for current severity items. For detailed item descriptions, refer to Table 3.

Table 2. Psychometric sample characteristic.

Variable	Questionnaire	Range	Clinical Cutoff	M (SD)	% > Cutoff
PTSD	PC-PTSD-5	0–5	≥ 3	2.71 (1.46)	52.19%
Depression	PHQ-9	0–27	≥ 10	11.58 (5.52)	61.23%
Anxiety	GAD-7	0–27	≥ 10	9.69 (4.45)	48.79%
Somatic Symptoms	SSS-8	0–32	≥ 9	9.64 (4.94)	55.23%
Fear of Sleep	FoSI	0–40	-	15.85 (14.25)	-
D-PTSD	DSPS current severity	0–135	-	10.95 (14.84)	-

Note. A **PC-PTSD-5** score of ≥3 indicates clinically relevant current PTSD symptoms according to the dimensional cutoff (Williamson et al., 2022). A **PHQ-9** score of ≥10 indicates at least moderate depressive symptoms (Kroenke et al., 2001). A **GAD-7** score of ≥10 indicates at least moderate generalized anxiety disorder symptoms (Spitzer et al., 2006). An **SSS-8** score of ≥9 signals an increased risk of somatic symptom disorder (Gierk et al., 2014). The **FoSI** estimates fear of sleep, without a specific clinical cutoff, providing a general measure of fear of sleep (Pruiksma et al., 2014). **DSPS current severity** reflects overall dissociative symptom burden without a specific clinical cutoff, providing a general measure of dissociative symptoms. Abbreviations: **PC-PTSD-5** = PTSD Checklist for DSM-5 (5-item version); **PHQ-9** = Patient Health Questionnaire-9; **GAD-7** = Generalized Anxiety Disorder-7; **SSS-8** = Somatic Symptom Scale-8; **FoSI** = Fear of Sleep Inventory; **DSPS** = Dissociative Subtype of PTSD Scale.

Given the sample-size sensitivity of χ^2, it is reported for completeness but not used as the sole fit criterion.

4.1. Dissociative symptom endorsement

First, dissociative symptom endorsement is reported and compared between participants with and without probable PTSD (based on PC-PTSD score > 3) using χ^2 tests.

4.2. Factor structure

The factor structure of DSPS lifetime and current severity items was then analysed using confirmatory factor analysis (CFA) with the *lavaan* package (Rosseel, 2012). To account for non-normally distributed, dichotomous data in lifetime DSPS items, the WLSMV estimator was applied. For current severity items, the MLR estimator was used. Fit was evaluated using χ^2, RMSEA, SRMR, CFI, and TLI. Following Hu and Bentler (1999), RMSEA values close to .10, SRMR close to .08, and CFI and TLI close to .95 were considered acceptable. A non-significant χ^2 value was interpreted as good model fit, though significance in large samples was not considered evidence of poor fit.

4.3. Internal consistency

Internal consistency of the DSPS lifetime and current total and subscales was evaluated using Cronbach's alpha. Values were interpreted based on conventional thresholds: alpha ≥ .70 was considered acceptable (George & Mallery, 2006). Omega total was also computed for additional reliability checks.

5. Results

5.1. DSPS item endorsement

Endorsement rates of dissociative symptoms were analysed for both lifetime and current experiences. Based on the scoring criteria by Wolf et al., 50.85% of participants met the criteria for lifetime dissociative symptoms of D-PTSD (≥2 on the depersonalization/ derealization subscale), while 10.09% met the criteria for current dissociative symptoms of D-PTSD (≥2 currently endorsed items on the depersonalization/ derealization subscale). Individuals with probable current PTSD endorsed more current dissociative symptoms than individuals without probable current PTSD.

5.2. Factor structure

Confirmatory factor analysis indicated an acceptable fit of the three-factor structure for lifetime items, $\chi^2(87) = 501$, $p < .001$, CFI = .905, TLI = .886, RMSEA = .059 [90% CI: .054; .064], and SRMR = .039. All items loaded significantly on their respective factors. The factor covariances were significant, with Factor 1 and Factor 2 showing the highest covariance (r = .856, $p < .001$). The three-factor structure demonstrated a significantly better fit compared to alternative one-factor and two-factor models (see Supplementary Table 1 for details).

Confirmatory factor analysis for current severity items indicated an acceptable fit, $\chi^2(87) = 400$, $p < .001$, CFI = .923, TLI = .907, RMSEA = .051 [90% CI: .046; .056], and SRMR = .0350. The factor loadings were strong for all items, with Factors 1 and 2 being highly correlated (r = .819, $p < .001$). Similar to the lifetime items, the three-factor structure provided a significantly superior fit for current severity items compared to more parsimonious models (see Supplementary Table 1 for details).

5.3. Internal consistency

Internal consistency scores of lifetime and current DSPS total scales and subscales are reported in Table 5. Overall, the scales demonstrated acceptable to excellent internal consistency. For lifetime scales, internal consistency ranged from acceptable to excellent, except for the lifetime Loss of Awareness subscale, which showed a lower reliability (α = .67). The current severity scales also demonstrated acceptable to excellent internal consistency.

Table 3. Description and internal consistency of the measures.

Measures	Instrument	Description	Time Period	Internal Consistency of the Used Scale		
				Raw Alpha	Standardized Alpha	Average Inter-item Correlation
PC-PTSD-5	5-item PTSD Checklist for DSM-5 (Prins et al., 2016); Ukrainian version adapted by Karachevskii (2016)	PTSD symptoms according to DSM-5 (5 items). Each item describes one symptom. Rating of current symptom burden on a yes/no scale. A score ≥3 suggests PTSD.	Past month	0.67	0.67	0.29
PHQ-9	Patient Health Questionnaire-9 (Kroenke et al., 2001); Ukrainian version adapted by The Ministry of Health of Ukraine	Depressive symptoms according to DSM-IV (9 items). Rating of current symptom frequency on a 4-point Likert scale (0 = 'Not at all', 1 = 'Several days', 2 = 'More than half the days', 3 = 'Nearly every day'). A score ≥10 suggests moderate depression.	Past month	0.83	0.84	0.36
GAD-7	Generalized Anxiety Disorder Scale-7 (Spitzer et al., 2006); Ukrainian version adapted by Shyroka and Mykolaychuk (2020)	Generalized anxiety disorder symptoms according to DSM-IV (7 items). Rating of current symptom frequency on a 4-point Likert scale (0 = 'Not at all', 1 = 'Several days', 2 = 'More than half the days', 3 = 'Nearly every day'). A score ≥10 suggests moderate anxiety.	Past month	0.83	0.83	0.42
SSS-8	Somatic Symptom Scale-8 (Gierk et al., 2014); translated by the authors	Somatic symptoms of Somatic Symptom Disorder (SSD) according to DSM-5 (8 items). Rating of current symptom burden on a 5-point Likert scale (0 = 'Not at all', 1 = 'A little bit', 2 = 'Somewhat', 3 = 'Quite a bit', 4 = 'Very much'). A score ≥9 suggests high risk of SSD.	Past month	0.78	0.78	0.34
FoSI	Fear of Sleep Inventory (Pruiksma et al., 2014); translated by the authors	Assesses fear of sleep, including avoidance of sleep due to nightmares, fear of vulnerability while asleep, and nighttime vigilance. The scale contains 23 items, with response options rated on a 5-point Likert scale (0 = 'Not at all', 1 = 'A few times per month', 2 = 'Once or twice per week', 3 = 'Several times per week', 4 = 'Nearly every night').	Past month	0.79	0.81	0.33

Note. Cronbach's alpha values are reported for both raw and standardized forms. Alpha values of ≥0.90 are considered excellent, ≥0.80 good, ≥0.70 acceptable, ≥0.60 questionable, ≥0.50 poor, and <0.50 unacceptable (George & Mallery, 2006). The 'Reliability if an item is dropped' values suggest that removing any item would not substantially impact the overall reliability.

6. Convergent and discriminant validity

Correlations between DSPS subscales and self-report measures of PTSD symptoms, depression, anxiety, somatic symptoms, and fear of sleep are reported in Table 6. As expected, DSPS subscales exhibited the strongest correlations with PTSD symptoms (PC-PTSD-5), followed by moderate correlations with depression (PHQ-9), anxiety (GAD-7), and fear of sleep (FoSI). Notably, correlations between DSPS subscales and somatic symptoms (SSS-8) were also quite high, suggesting a substantial association between dissociative experiences and somatic complaints.

7. Discussion

The present study aimed to validate the Ukrainian version of the Dissociative Subtype of PTSD Scale (DSPS) and to evaluate its psychometric properties in a sample of trauma-exposed individuals. Consistent with prior research (Danböck et al., 2023; Guetta et al., 2019; İçin et al., 2023; Wolf et al., 2017), the findings confirmed the three-factor structure of the DSPS, comprising Derealization/Depersonalization, Loss of Awareness, and Psychogenic Amnesia subscales. Both lifetime and current severity items demonstrated strong factor loadings and acceptable to good fit indices. While the current severity items showed slightly lower fit compared to the lifetime items, the three-factor structure remained statistically superior to more parsimonious models. The slightly lower fit indices for current severity (e.g. TLI = 0.894) likely reflect the inherent complexity and high intercorrelations of dissociative symptoms in a population experiencing active, ongoing war-related trauma, rather than a failure of the scale's underlying structure. These results further support the DSPS as a valid tool for assessing dissociative symptoms in PTSD, particularly in trauma-affected regions like Ukraine.

7.1. Internal consistency and validity

The DSPS demonstrated strong internal consistency, with Cronbach's alpha values exceeding acceptable thresholds for both lifetime and current severity items. However, lifetime loss of awareness showed lower reliability ($\alpha = 0.67$), which is consistent with one of the two samples in Danböck et al. (2023). This might suggest that loss of awareness symptoms, when assessed retrospectively over a lifetime, capture a broader range of experiences that may not necessarily align with pathological dissociation, whereas current symptoms reflect a more defined clinical construct. The subscales exhibited good convergent and discriminant validity. Notably, while strong associations were found with PTSD symptoms ($r = .35$ to $.65$), the DSPS subscales, particularly 'Loss

Table 4. DSPS lifetime and current item endorsement.

Item Description	Subscales	Lifetime Endorsement (%)	Current Endorsement (%)		
			Current PTSD ($n = 447$)	No PTSD ($n = 672$)	φ
1. Feeling disconnected from one's body	DD	44.95%	5.27%	3.04%	0.14***
2. Feeling 'checked out'	LA	47.45%	6.61%	4.02%	0.15***
3. Feeling outside of one's body	DD	28.69%	2.68%	1.43%	0.10***
4. Having 'lost time'	LA	65.86%	12.33%	8.40%	0.20***
5. Not recognizing oneself in the mirror	DD	20.20%	4.29%	1.97%	0.15***
6. A familiar place seeming strange	LA	34.23%	2.41%	1.70%	0.07*
7. One's body not feeling real	DD	17.16%	1.88%	0.80%	0.10**
8. The world not seeming real	DD	39.14%	6.17%	2.59%	0.19***
9. One's body feeling strange or unfamiliar	DD	18.05%	2.32%	1.07%	0.10***
10. Feeling lost, disoriented, or confused	LA	40.04%	4.02%	2.59%	0.11***
11. Feeling as if in a daze or fog	LA	35.39%	6.17%	2.50%	0.19***
12. Watching the world as an outsider	DD	39.32%	6.26%	2.59%	0.19***
13. Having trouble remembering how one got somewhere	LA	19.48%	1.79%	0.98%	0.08***
14. Having trouble remembering details about traumatic event	PA	40.66%	6.43%	1.61%	0.24***
15. Thinking one should remember more about traumatic event	PA	30.83%	4.92%	1.61%	0.19**

Note. The table reports the percentage of participants endorsing each item in both lifetime and current contexts, as well as comparing endorsement rates between participants with and without probable current PTSD. Endorsement for lifetime items is defined by a 'yes' response, while current endorsement is based on a frequency score ≥1 and intensity score ≥3. The probably PTSD group (n = 447) was assessed using the Primary Care PTSD Screen for DSM-5 based on the suggested cutoff of >3 (Prins et al., 2016), while probable non-PTSD participants (n = 672) were included for comparison. Endorsement rates between PTSD and non-PTSD groups were compared using χ^2 tests, with φ coefficients representing effect sizes. Significance levels indicate the strength of group differences, with the following thresholds applied: *$p < .05$; **$p < .01$; ***$p < .001$.
Subscale legend: Derealization/Depersonalization (DD), Loss of Awareness (LA), Psychogenic Amnesia (PA).

Table 5. DSPS internal consistency.

Scale	Lifetime	Current
Total (15 items)	0.83	0.87
Derealization/Depersonalization (7 items)	0.77	0.82
Loss of Awareness (6 items)	0.67	0.73
Psychogenic Amnesia (2 items)	0.75	0.76

Note. Cronbach's alpha for lifetime and current total scales and subscales are reported. Lifetime scales refer to endorsed lifetime items. Current scales refer to current item severity. Cronbach's alpha ≥ .90 is considered excellent, ≥ .80 is good, ≥ .70 is acceptable, ≥ .60 is questionable, ≥ .50 is poor, and < .50 is unacceptable (George & Mallery, 2006).

of Awareness', exhibited their highest correlations with somatic symptoms ($r = .61$ to .68). This finding is consistent with a broader pattern of interrelated psychological distress in war-affected populations, where dissociative experiences often co-occur with physical manifestations of trauma. Rather than standing out as an independent cluster, the DSPS results suggest that PTSD symptoms are part of a wider spectrum of psychopathology, including depression and anxiety, observed in this sample.

This pattern, also observed in previous studies (Danböck et al., 2023; Guetta et al., 2019), likely reflects the well-documented comorbidity between dissociation and these psychopathological domains. Notably, the high correlations between DSPS and somatic symptoms may be particularly relevant in this sample, given the high prevalence of war-related trauma exposure (see Table 1) and associated psychological distress, regardless of the region where the participants live. The sociodemographic composition of the sample, predominantly young and female (see Table 1), reflects a population segment that may experience dissociative symptoms differently from traditionally studied groups, such as older male combat veterans (Wolf et al., 2017). Given that nearly all participants experienced exposure to war-related events and nearly one-third reported witnessing military-related events firsthand, the high prevalence of PTSD symptoms and moderate-to-high rates of depression, anxiety, and somatic symptoms suggest a trauma-related mental health burden that extends beyond combat exposure alone. Prior research has shown that civilians in conflict zones may exhibit heightened dissociative responses due to chronic stress (Gušić et al., 2018; Stein et al., 2013), displacement, and uncertainty about the future (Eshel et al., 2023; Kurapov, Pavlenko, et al., 2023; Pavlova & Rogowska, 2023). The observed pattern of dissociative symptoms in this sample, the pronounced lifetime vs. current discrepancy on the Loss of Awareness subscale (high

Table 6. Pearson correlations between DSPS and clinical questionnaires.

DSPS Subscale	PTSD PC-PTSD-5	Depression PHQ-9	Anxiety GAD-7	Somatic Symptoms SSS-8	Fear of Sleep FoSI
Lifetime Derealization/Depersonalization	.55*	.48*	.43*	.58*	.47*
Loss of Awareness	.65*	.55*	.51*	.68*	.51*
Psychogenic Amnesia	.50*	.40*	.36*	.48*	.41*
Current Derealization/Depersonalization	.44*	.43*	.36*	.46*	.48*
Loss of Awareness	.54*	.53*	.47*	.61*	.55*
Psychogenic Amnesia	.35*	.33*	.29*	.34*	.38*

Note. Abbreviations: DSPS = Dissociative Subtype of PTSD Scale; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder Scale-7; PTSD = Post Traumatic Stress Disorder; SSS-8 = Somatic Symptom Scale-8; FoSI = Fear of Sleep Scale. The significance levels of the correlations are indicated as ***$p < 0.001$, **$p < 0.01$, *$p < 0.05$.

lifetime, low current), consistent with episodic, state-like features, may reflect the enduring and pervasive nature of war-related trauma among civilians compared to acute battlefield trauma in military populations. At the same time, the high intercorrelations observed between the lifetime and current subscales (particularly Derealization/Depersonalization and Loss of Awareness) raise questions regarding their distinctiveness. However, maintaining both scales remains clinically relevant. The lifetime scale captures the respondent's general vulnerability and history of dissociative responding, while the current scale is vital for treatment planning and monitoring immediate symptom severity during the ongoing conflict. This distinction allows clinicians to differentiate between those with chronic dissociative tendencies and those experiencing temporary dissociative reactions to recent traumatic escalations.

7.2. Regional relevance and implications

The ongoing war in Ukraine has exposed large segments of the population to severe and unpredictable trauma, significantly increasing the risk for PTSD and related conditions. Despite this, research on D-PTSD remains limited, largely due to the lack of validated assessment tools. In our sample, 50.85% of participants met criteria for lifetime dissociative symptoms of D-PTSD, and 10.09% met criteria for current dissociative symptoms (see Wolf et al., 2017), suggesting a considerable burden of dissociative experiences in trauma-exposed individuals. These rates are in line with prior studies reporting dissociative PTSD prevalence between 22% and 48% across different trauma-affected populations (White et al., 2022), underscoring the need for more systematic investigations in war-affected regions. The high proportion of individuals meeting lifetime criteria for the dissociative symptoms of D-PTSD may be influenced by the nature of war-related trauma, which is often characterized by prolonged exposure, unpredictable threats, and collective suffering (e.g. Stieger et al., 2023).

The relatively lower prevalence of current dissociative symptoms (10.09%) compared to lifetime symptoms (50.85%) suggests the fluctuating, episodic nature of dissociation, which may be more prevalent during acute distress phases (Lanius et al., 2012). In the Ukrainian context, this discrepancy is more pronounced than in other language versions. This may reflect the 'state-like' response of civilians to the acute phases of the invasion versus the chronic 'trait-like' symptoms often seen in clinical veteran samples exposure (Schauer & Elbert, 2010). Consequently, the DSPS should be used as part of a step-by-step diagnostic process. Given that D-PTSD is associated with distinct neurobiological and treatment response profiles compared to standard PTSD (Atchley & Bedford, 2021; Schiavone et al., 2018), failing to assess it may lead to misdiagnosis or ineffective treatment strategies. Clinical practitioners should first establish a primary PTSD diagnosis using tools like the PCL-5 or CAPS-5, and then utilize the DSPS to identify the presence of the dissociative subtype to guide specific treatment interventions. Our findings highlight that without culturally and linguistically appropriate diagnostic instruments, dissociative symptoms in war-affected populations may remain under-reported or misclassified.

7.3. Limitations and future directions

Despite its contributions, this study has several limitations that should be acknowledged. First, the use of convenience sampling limits the generalizability of the findings, as the sample primarily consisted of young and female participants. Future studies should aim to replicate these results in more diverse samples, including clinical populations and individuals from regions with different levels of war exposure (e.g. Kurapov et al., 2024) to assess the full spectrum of dissociative PTSD symptomatology. Second, the study did not assess test-retest reliability, which is crucial for evaluating the longitudinal stability of the DSPS. While the instrument demonstrated strong internal consistency, future research should examine its reliability over time to determine whether dissociative symptom patterns remain stable or fluctuate depending on stress exposure and PTSD progression. Third, our study did not assess sensitivity to treatment-related change, meaning it remains unclear how DSPS scores might shift following psychological interventions. Given that dissociative symptoms can influence treatment response and symptom course in PTSD (Atchley & Bedford, 2021; Danböck et al., 2024; Lanius et al., 2012), future work should examine whether DSPS scores decrease with trauma-focused therapies or if specific dissociative profiles predict differential treatment outcomes. Finally, while the DSPS captures key dissociative symptoms for trauma-exposed populations, it does not assess all possible dissociative experiences, such as alterations in body perception or time distortion, which have been noted in war-affected populations (Rabellino et al., 2018). Future research should explore whether additional dissociative dimensions are relevant in this context and consider supplementing the DSPS with other measures capturing all dissociative phenomena relevant for the current sample and research question (for an overview on how to assess different dissociative phenomena, see Danböck et al., 2025).

8. Conclusion

The Ukrainian version of the DSPS demonstrates strong psychometric properties overall. It is important to differentiate between its various properties: the internal consistency was good to excellent for most scales, and the validity results were robust. However, the CFA fit indices for the three-factor structure, while meeting established benchmarks, should be described as acceptable. Specifically, the TLI and CFI values for lifetime items (.886 and .905, respectively) fell slightly below the more stringent .95 threshold, which may reflect the inherent complexity and high intercorrelations of dissociative symptoms in a population experiencing active, ongoing trauma.

Author contribution

AK – data collection, data analysis, manuscript writing; IV – manuscript writing; SE – manuscript writing and editing ML – technical support, data collection; FH – conceptualization of a study, manuscript editing; SD – conceptualization of a study, manuscript editing

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Data availability statement

Data are, in conjunction with an appropriate data sharing agreement, available on request.

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