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Dissociative absorption: An empirically unique, clinically relevant, dissociative factor

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Research of dissociative absorption has raised two questions: (a) Is absorption a unique dissociative factor within a three-factor structure, or a part of one general dissociative factor? Even when three factors are found, the specificity of the absorption factor is questionable. (b) Is absorption implicated in psychopathology? Although commonly viewed as "non-clinical" dissociation, absorption was recently hypothesized to be specifically associated with obsessive–compulsive symptoms. To address these questions, we conducted exploratory and confirmatory factor analyses on 679 undergraduates. Analyses supported the three-factor model, and a "purified" absorption scale was extracted from the original inclusive absorption factor. The purified scale predicted several psychopathology scales. As hypothesized, absorption was a stronger predictor of obsessive–compulsive symptoms than of general psychopathology. In addition, absorption was the only dissociative scale that longitudinally predicted obsessive–compulsive symptoms. We conclude that absorption is a unique and clinically relevant dissociative tendency that is particularly meaningful to obsessive–compulsive symptoms.

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1. Introduction

The term "absorption" refers to the tendency to become immersed in a single stimulus, either external (e.g., a movie or a book) or internal (e.g., a thought or an image), while neglecting other stimuli in the environment. According to Tellegen and Atkinson (Tellegen Absorption Scale; *TAS*, 1974), it represents an inclination to enter states of "total attention". A similar construct has been labeled "absorption and imaginative involvement" (Carlson & Putnam, 1993), a title that emphasizes a preference for internal imagery at the expense of attending to external reality (e.g., being so absorbed in a daydream that one becomes unresponsive). Absorption and imaginative involvement is considered one of the three subscales of trait dissociation together with depersonalization–derealization and dissociative amnesia, based on the widely used, revised version of the Dissociative Experiences Scale (*DES-II*; Carlson & Putnam, 1993). Compared to the other two dissociative factors, dissociative absorption as measured by the DES is more strongly related to absorption as measured by the TAS, as well as to hypnotizability (Frischholz et al., 1991; Smyser & Baron, 1993), supporting the validity of this subscale as a

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separate and unique entity within the DES. However, despite the similarity of Tellegen's definition of absorption (measured by the TAS), with that of dissociative absorption (measured by the DES), the former involves both a narrowing and an expansion of attention (Tellegen, 1982, October 10), while the latter refers mainly to the *narrowing* of the attentional span. Such narrowing relegates the neglected – or dissociated – domains to the periphery of consciousness (Leavitt, 2001; Putnam, 1997). While there are some studies in which very high correlations were found between the DES and TAS ($r = 0.82$ in Wolfradt & Meyer, 1998; and $r = 0.70$ in Nadon, Hoyt, Register, & Kihlstrom, 1991, in which response scales were altered), most studies found only a moderately strong correlation, supporting their separateness ($r = 0.39$ both in Frischholz et al., 1991 and in Green & Green, 2010; $r = .44$ in Smyser & Baron, 1993; and $r = 0.45$ in Eisen & Carlson, 1998). Correlations specifically between the absorption subscale of the DES and the TAS, despite being somewhat higher, are still much lower than $r = 0.70$, an effect size which would have indicated 50% shared variance between the constructs (e.g., $r = .46$ in Frischholz et al., 1991; and $r = 0.52$ in Smyser & Baron, 1993). Evidence that the DES and TAS absorption constructs are not identical is also exhibited by patients with a dissociative disorder who scored higher on the DES absorption scale than patients with PTSD, but for whom the same difference was not found on the TAS (Simeon, Giesbrecht, Knutelska, Smith, & Smith, 2009).

Notably, the definition and the scope of the concept of dissociation are controversial. The two major clinical diagnostic systems – the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*, American Psychiatric Association, 2013) and the International Statistical Classification of Diseases and Related Health Problems (*ICD-10*, World Health Organization, 1992) include different phenomena under the dissociation category. Moreover, researchers as well as clinicians do not necessarily agree as to whether several dissociative phenomena constitute distinct entities or rather, if there is a broad dissociative continuum, ranging from mild to pathological dissociation (Holmes et al., 2005). Resting on this confusion, the conceptualization of dissociative absorption is marked by at least two controversies in the psychology literature. First, there are conflicting findings as to what constitutes the factor structure underlying the DES in non-clinical populations. Some studies (Armour, Contractor, Palmieri, & Elhai, 2014; Carlson & Putnam, 1993; Ross, Joshi, & Currie, 1991; Sanders & Green, 1994; Stockdale, Gridley, Balogh, & Holtgraves, 2002) support a three-factor model—comprising dissociative amnesia, depersonalization–derealization, and dissociative absorption as the DES subscales—that is compatible with the factor structure usually found in clinical populations (Stockdale et al., 2002). A recent study suggested a somewhat different, two-factor solution consisting of dissociative absorption and a combined depersonalization–amnesia factor (Olsen, Clapp, Parra, & Beck, 2013). Other researchers, however, favor a one-factor general dissociation model (Bernstein, Ellason, Ross, & Vanderlinden, 2001; Fischer & Elnitsky, 1990; Holtgraves & Stockdale, 1997; Zingrone & Alvarado, 2001–2002), suggesting that in non-clinical samples, these allegedly separate subscales actually assess one non-specific, general dissociative trait. Such findings lead one to question whether a unique dissociative absorption factor in fact exists in the DES.

The prospect that there is no unique dissociative absorption factor in the DES is reinforced by the following observations: (1) Studies on non-clinical samples that favored a solution of more than one factor always contained a disproportionately large first factor, identified as dissociative absorption, which carried most of the variance of the questionnaire (Carlson et al., 1991; Olsen et al., 2013; Ray & Faith, 1995; Ray, June, Turaj, & Lundy, 1992; Ross et al., 1991; Sanders & Green, 1994; Stockdale et al., 2002). This observation raises the possibility that the first factor is associated with general dissociation rather than specifically with absorption. (2) While the contents of all amnesia and depersonalization–derealization items are theoretically compatible with their respective factors, the interpretation of the first factor as dissociative absorption is less clear-cut; certain absorption items seem to be incompatible. For example item 16 of the DES ("Some people have the experience of being in a familiar place but finding it strange and unfamiliar") is clearly compatible with the notion of depersonalization–derealization, however it is included as part of the dissociative absorption factor in several studies (e.g., Armour et al., 2014; Carlson et al., 1991; Stockdale et al., 2002). Also, item 22 ("Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people"), which is also included as part of the dissociative absorption factor in these studies, is more in alignment with general dissociation and compartmentalization or perhaps even with dissociative identity disorder. The inclusion in several studies of these items in the large first factor (labeled dissociative absorption) supports the notion that this factor may instead represent general dissociation, or even a general, negative emotionality factor (see Lilienfeld, 1997, for evidence that absorption loads on a negative emotionality factor; see also Lynn et al., 2014; Muris, Merckelbach, & Peeters, 2003, who suggested that dissociation may be a marker of negative emotionality such as trait anxiety and depression). (3) When all 28 DES items are arranged in a three-factor structure (i.e., each item is "forced" to belong to a factor), as in Stockdale et al. (2002), dissociative absorption tends to become inflated by large number of items with complex loadings (i.e., they may also load highly on other factors). To conclude, while studies with non-clinical samples that support the three-factor structure for the DES suggest that dissociative absorption is an empirical entity, they do not successfully establish the specificity of this entity, making it difficult to draw conclusions about the relevance of dissociative absorption to other entities.

The relation of dissociative absorption to other entities is at the heart of the second controversy regarding absorption. Specifically, in addition to the lack of consensus over the factor structure of the DES, there is also a lack of consensus as to whether dissociative absorption is a clinical entity. While depersonalization–derealization and dissociative amnesia each have matching clinical disorders (depersonalization–derealization disorder and dissociative amnesia, respectively; *DSM-5*, American Psychiatric Association, 2013), absorption does not. The absence of a clinical-level counterpart for absorption has led to the claim that absorption is not necessarily psychopathological, but rather, it is a personality trait that describes changes in attention that manifest as normal, benign experiences, such as daydreams and automatisms (e.g., Kihlstrom, 2005; Kihlstrom, Glisky, & Angiulo, 1994). Likewise, it has been suggested that pathological and "non-clinical" dissociation

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