Dissociation in adults with a diagnosis of substance abuse

INDIVIDUALS who abuse substances are now often screened for depression and anxiety, but there has been little in-depth research addressing the assessment of trauma/dissociation in those with a primary diagnosis of substance abuse (McDowell et al, 1999). Indeed, Carlson and Putnam (1993) stated that substance abusers are a particular subgroup that has not been studied for dissociation. This exploratory study set out to address this issue by assessing individuals with a primary diagnosis of substance abuse for dissociative symptoms.

Dissociation
Dissociation is a defence mechanism whereby individuals under stress separate affect and/or behaviour from the normal flow of consciousness. Repression is a special type of dissociation that occurs when people have been subjected to overwhelming life events and is used as a defence against trauma. Memories and feelings connected with unacceptable events are forgotten and return at vulnerable times as intrusive recollections, feeling states, delusions, states of depersonalisation and finally as behavioural re-enactments (North, 1997).

Despite its possible complications and ultimate negative effects, the process of dissociation can have some adaptive value. Dissociative defences help people who have experienced trauma to maintain a sense of detachment during an episode of physical or emotional helplessness. However, these same defences may later cause them to lose psychological mastery of important episodes of their lives if they dissociate the traumatic episode and their consequent reliving from the general mode of conscious experience with which they have a greater familiarity and sense of control (Bernstein and Putnam, 1986).

Dissociation in substance abuse
People who abuse substances are a group of clients considered to be traumatised by the excessive use of alcohol and drugs and the effects of these substances on their lifestyles. In addition, many grew up in alcoholic families, which is in itself a traumatic event (Brown and Lewis, 1999), while uncontrolled substance abuse in parents increases the likelihood that children will experience physical and mental abuse (Edwards, 1994).

Much of the literature on trauma and dissociative disorders reports that the associated symptoms are rarely identified, particularly in relation to substance abuse. The disorders are not generally evaluated in the routine psychiatric examination (McDowell et al, 1999), but appear to be more pronounced in individuals with a diagnosis of substance abuse (Dunn et al, 1995).

Substance abuse counselling separated from the field of mental health some time ago (Evans and Sullivan, 1995). As a result, many mental health professionals have had limited training and experience in the assessment and treatment of substance abuse disorders, while many drug and alcohol counsellors have had only minimal education in mental health issues (Frankel, 1996).

People who survive traumatic events can experience episodes of psychotic-like symptoms and severe dissociative disorders, while substance abuse or dependency is a frequent coexisting disorder (Wing, 1997). Evans and Sullivan (1995) identified 10 core issues they found consistently in the treatment of survivors – the first is the use of denial or dissociation to deal with problems.

It is important to explore ways to identify substance-dependent survivors of trauma who have dissociative symptoms and to assess their treatment needs (Dunn et al, 1995). This enables clinicians to identify those who may be using alcohol or drugs to manage the uncomfortable effects of dissociation resulting from trauma. Appropriate treatment can then be planned, which may be more effective in reducing the risk of relapsing back into substance abuse.

While it can be challenging to develop a trusting therapeutic relationship with substance-abusing clients, this is imperative for healing to take place. It is also crucial that the client remembers and accurately names what happened in the traumatic experience underlying the dissociative defence mechanism (Putnam and Lowenstein, 1999).

Methodology
This descriptive, exploratory study addressed the frequency of dissociative events in adults with a primary diagnosis of substance abuse. Subjects enrolled in the study were members of an outpatient alcohol or other drug abuse programme.

The Dissociative Experiences Scale (DES), developed by Bernstein and Putnam (1986), was used to measure subjects’ self-reporting of frequencies of dissociative events. The DES was developed for use with adults as a clinical tool to help identify those with dissociative psychopathology and as a research tool to quantify dissociative experiences. The tool is valid and reliable and is currently the most widely used self-report measure of dissociation in clinical studies of dissociative disorders. It consists of a brief self-report measure of the frequency of dissociative experiences (Box 1), and uses a response scale so that the data reflects a wider range of symptomatology in informants’ answers than would be possible with a yes/no format.

Each statement was followed by a visual analogue scale, which was scored by measuring the mark made by
the subject to the nearest 5mm for each item. Scores on each item can range from 0–100. A total score for the entire scale is determined by calculating the average score for all items.

Bernstein and Putnam (1986) state that low scores such as four represent a degree of dissociation experienced by a person from a normal adult group, while those with clinically diagnosed post-traumatic stress disorder (PTSD) score approximately 31.25. Scores of 50 or more are diagnosed with dissociative identity disorder. The DES distinguishes patients who have dissociated disorder from patients who do not at a confidence level (p<0.0001).

### Sample

Fifty-one subjects agreed to participate in the study. The age range was 24-61 years (see Box 2, p36). Thirty-five (69 per cent) of the participants were aged 30–44 years, and the average age was 39.8 years. The subjects in this study reflected the typical gender breakdown seen in service users of alcohol and drug treatment facilities in that one-third (17) of them were female and two-thirds (34) were male.

Subjects were given directions on the cover sheet of the DES tool, and were instructed to consider only those experiences that did not occur while they were under the influence of drugs or alcohol when responding to statements. The researchers emphasised this point, because it significantly affected the validity and reliability of the study. It was also made clear that if any participants wished to withdraw from the study they could do so without penalty, and that information collected up to that point would be destroyed.

### Results

Descriptive statistics were used to analyse the findings from the DES reports. The mean DES score for the sample was 13.57 (standard deviation 12.09), with a range of 0.53–56.60. These results demonstrate that the group as a whole reported a higher degree of dissociation than normal adults, whose mean score is 4.0. The investigation indicated that 25 per cent of the subjects had a score of 15 or higher (see Fig 1), which suggests that dissociative experiences are common in this population and that routine screening for dissociative disorders should be considered for people who are chemically dependent.

### Discussion

The findings of this study were consistent with those of Dunn et al (1993), which indicated that 41 per cent of subjects who were chemically dependent had a DES score of 15 or more. The findings support the need for nurses to have an understanding of trauma, dissociation and the related role of substance abuse.

Lack of trust is a principal sign in individuals with dissociative disorders and a primary diagnosis of substance abuse. Often as a result of parental substance abuse, children learn that their primary care givers cannot be trusted. This may be exacerbated if they suffered abuse at the hands of their parents or others. Stress is constant and the threat is always present (Ursano et al, 1994).

Nurses need to be particularly sensitive to trust issues with individuals and groups in this population (Burgess, 1998). This may mean allowing for more time for the therapeutic alliance to build or for transference to develop. It is possible that clients may identify nurses with their abusing parents or perpetrators. Therefore, it is important for nurses to be aware of transference issues that may prevent individuals with a diagnosis of substance abuse from engaging in treatment.

Seven participants of this study reported significant DES scores, all of whom came from families with backgrounds where alcohol or drugs appeared problematic. This suggests that those clients who were thus traumatised may have treatment needs that differ from those not so severely traumatised. McDowell et al (1999), noting the high incidence of dissociative and PTSD symptomatology in people who have been abused, suggest that special attention should be paid to their diagnosis and treatment. This special attention would include the ability to properly identify dissociative symptomatology and the knowledge and skill to appropriately intervene.

Nurses may also need to ask clients about their experiences that did not occur while they were under the

### References

dissociative episodes, what happened before they dissociated, current stressors, any triggers and whether there are intrusive memories associated with the dissociation. In cases of severe abuse, individuals may need to be referred to professionals who are qualified to treat dissociative disorders. It is, therefore, important to obtain complete histories, including histories of physical and mental abuse, in order to provide the most appropriate treatment.

Psychopharmacological interventions may be used to minimise the symptomatology of anxiety and depression associated with dissociative disorders. While benzodiazepines can improve sleep and help decrease nightmares, the issue of cross-addiction needs to be addressed when working with people who abuse substances.

Antidepressants have also been effective with nightmares and depression – selective serotonin reuptake inhibitors (SSRIs) are most frequently prescribed. All antidepressants can help decrease depressive symptoms, stabilise sleep patterns and reduce intrusive thoughts (Townsend, 2000).

Another consideration regarding psychopharmacological interventions is the possible negative consequences of using them to artificially eliminate symptoms rather than obtaining an adequate history to identify underlying core issues and the dynamics of target symptoms. Nurses need to be aware of this possibility and conduct a particularly thorough and sensitive history into the potential issues and dynamics that may affect patients with symptomatology of abuse.

The findings of this study also suggest issues for nurse administrators in facilities that treat patient populations who have dissociative symptoms, PTSD or substance abuse disorders, who must understand the complexity of these disorders. This is a unique group of patients with special needs related to safety because of cognitive impairments (problems in assimilating and accommodating information and experiences) and behaviour problems related to their anxiety and impulsiveness.

Nursing administration needs to be proactive and supportive with staff working with these patients. They need to allocate money for continuing staff education and development to ensure they can provide knowledgeable care. Administrators must understand and provide appropriate time and treatment modalities in both inpatient and outpatient programmes to address the long-term effects of abuse, including PTSD and dissociative symptomatology, and possibly related substance abuse.

**Conclusion and recommendations**

The results of this study suggest that dissociative experiences are common among people who abuse substances. Further research is needed to determine the actual prevalence of dissociative disorders in this group. Research with a larger sample group would provide more concrete and generalisable data for those treating people who abuse substances.

**TABLE 2** THE AGE PROFILE OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Number of participants</th>
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<tbody>
<tr>
<td>24–29</td>
<td>4</td>
</tr>
<tr>
<td>30–35</td>
<td>14</td>
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<td>57–59</td>
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</tr>
<tr>
<td>60–61</td>
<td>3</td>
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</tbody>
</table>

**FIGURE 1. PARTICIPANTS’ MEAN DISSOCIATIVE EXPERIENCE SCALE (DES) SCORES**

The figure shows the distribution of mean DES scores among participants. The x-axis represents the mean DES score, ranging from 0 to 15, and the y-axis represents the number of participants. The figure includes bars for post-traumatic stress disorder and dissociative identity disorder.