

Why “Trauma-Related Dissociation” is a Misnomer in Courts: A Critical Analysis of Brand et al. (2017a, b)

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### **Abstract**

Forensic psychologists are sometimes faced with the task of educating triers of fact about the evidential weight of dissociative experiences reported by claimants in litigation procedures. In their two-part essay, Brand et al. (2017a,b) provide advice to experts who find themselves in such situation. We argue that the Brand et al. approach is problematic and might induce confirmation bias in experts. Their approach is not well connected to the extant literature on recovered memories, dissociative amnesia, memory distortions, and symptom validity testing. In some instances, Brand et al. (2017a,b) simplify the current body of knowledge about dissociation; in other instances, they ignore relevant empirical studies to an extent that is worrisome.

*Keywords.* Dissociative symptoms, symptom validity, biases, expert witness testimony.

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Claimants in litigation procedures sometimes report dissociative symptoms. What is the meaning of such symptoms in courts of law? How should triers of fact, such as judges and juries, weigh the evidential value of such symptoms? Most triers of fact will have limited knowledge of the technical literature on dissociative symptomatology. Thus, counsels and/or — triers of fact may call upon expert witnesses to provide testimony about the nature and meaning of dissociative symptoms. The two-part essay in this journal of Brand and co-workers (2017a,b) intends to inform forensic experts about the methods they “can use to assist counsel and courts in understanding dissociative reactions and their importance in personal injury cases” (p. 284). In our opinion, this essay does not succeed in giving good or accurate advice. Below we present our arguments for this. Our criticism of the approach that Brand et al. unfold in their essay falls into the three categories: 1. The Brand et al. approach may bias expert testimony by assuming or emphasizing the traumatic origins of dissociative experiences (and ignoring other pathways); 2. The Brand et al. approach might make experts who present testimony about dissociative experiences overconfident, because Brand et al. ignore some of the inherently problematic features of dissociative symptoms reports (e.g., their overlap with fantasy proneness); and 3. The Brand et al. approach may insulate potential expert witnesses from the corpus of knowledge about dissociation, because they do not discuss essential parts of the extant literature (e.g., the literature on dissociative amnesia).

**The Brand et al. Articles Give a Biased Theory and Advice**

We are concerned that the model of dissociation and trauma presented in the Brand et al. (2017a,b) articles will bias expert testimony and thereby bias the triers of facts. There is an extensive literature on biases in forensic experts and how they may compromise impartial testimony (e.g., Murrie & Boccaccini, 2015; Dror & Murrie, in press). Many authors agree

that examining, testing, and interpreting findings along the lines of likelihood ratio's act as a safeguard against biasability (e.g., Jackson, 2000). Relying on likelihood ratio's essentially means that the forensic expert considers at least two rivalizing interpretations of the case at hand. In the words of Jackson (2000; p. 84): "If it is the role of a forensic scientist to test a hypothesis, and evaluate findings, then it can only be done if an alternative is also considered."

Brand et al. (2017a, b) address one particular forensic problem: the claimant in litigation who reports dissociative symptoms. By reframing dissociative symptoms as "trauma-related dissociation," the authors capitalize on one interpretation of dissociative symptoms, namely that these symptoms stem from trauma exposure. Their article fails to adequately discuss the research and skepticism by others that challenges the idea that trauma causes dissociation (e.g., Patihis & Lynn, 2017), dissociative amnesia (Pope, Poliakoff, Parker, Boynes, & Hudson (2007), and dissociative identity disorder (Piper & Merskey, 2004). If forensic experts would come to adopt the nomenclature and doctrine of "trauma-related dissociation", then this may bias them from the outset in favor of the claimant and their counsel who attempt to prove that trauma exposure preceded the dissociative symptoms of the claimant and that the defendant is to be held accountable for the traumatic event and its damaging results. It may also put undue trust in memories that were reconstructed in therapy, if such memories come to be understood to be part of dissociative amnesia (see Loftus, 1993). This nomenclature trivializes other potential hypotheses about the origins of dissociation. For example, sleep problems (Van der Kloet et al., 2012), deficient affect regulation (Briere & Runtz, 2015), and response bias (Merckelbach et al., 2015) may all be antecedents of dissociative symptom reports. The concept of "trauma-related dissociation" obscures these alternative pathways to dissociation and in doing so, makes an impartial likelihood approach difficult to entertain. Thus, the very term "trauma-related dissociation" acts as a *petitio*

*principi*: it fuels the misunderstanding that dissociative symptoms of the claimant substantiate the presence of a traumatic history.

To back up their concept of “trauma-related dissociation”, Brand et al. refer to the review paper of Dalenberg et al. (2012) that, according to Brand et al., shows that “antecedent trauma was causally linked to the development of dissociation” (Brand et al., 2017a, p. 289). We do not agree that causal link has been established from that correlational data, and even the correlation between trauma and dissociation is not especially large. Dalenberg et al. (2012) summarized clinical and non-clinical studies that examined the correlation between measures of trauma exposure and measures of dissociative symptoms. The overall weighted  $r$  estimate was .32, which reflects an associative strength that is moderate and, at minimum, suggests that it is wise to consider other correlates and antecedents of dissociative symptoms. A correlation of .32 suggests that variable accounts for 10% of the variance in the other variable, and in addition never should be forget the core knowledge that correlation does not equal cause (for a more in depth critique of Dalenberg et al., 2012, see Lynn et al., 2014).

Several studies of people suffering from dissociative psychopathology found that a sizeable minority did *not* report a traumatic history (e.g., 24%, Duffy, 2000; 39%, Sar et al., 2007). Accordingly, trauma exposure may not play a singular or uniformly impressive role in the genesis of dissociative symptoms. Further support for this comes from Briere and Runtz (2015), who studied people who denied a traumatic history. In this group, affect dysregulation predicted dissociative symptomatology, leading the authors to conclude that “not all individuals suffering dissociative symptoms will require classic trauma-focused treatment [...] because trauma does not seem to be relevant to at least some dissociative presentations (Briere & Runtz, 2015, p. 441). Brand et al. (2017a,b) do not discuss such essential provisos. Rather their essay conveys the message to potential expert witnesses that the traumatic origins of dissociative symptomatology is the only serious interpretation to consider. The authors

even go one dangerous step further: they frame criticism of the trauma interpretation of dissociative symptoms as reflecting ignorance. They write: “A number of factors may lead to doubts about reports of individuals with dissociative reactions to trauma. These include a lack of education about dissociation, exposure to inaccurate or sensationalized portrayals of dissociation, a lack of personal experience with dissociative symptoms, and the natural tendency to not want to believe that horrible events could be real or common” (Brand et al., 2017a, p. 288). This listing may serve as a desperate effort to explain away negative findings and contradictions, and immunizes the trauma interpretation against criticism, thereby encouraging tunnel vision and confirmation bias in the forensic expert (see also Lilienfeld & Landfield, 2008).

### **The Brand et al. Articles Provide Problematic Simplifications**

The tendency to simplify the extant literature on dissociative symptomatology is ubiquitous throughout the essay of Brand et al. (2017a, b). For example, the authors claim that “[O]ne of the most common myths about dissociation is that it is “fantasy-based” rather than trauma-based” (Brand et al., 2017a,b; p. 288). This statement hides from potential expert witnesses that scores on fantasy proneness scales do correlate significantly with reports of dissociative symptoms. Lynn et al. (2014; see table 1) summarized the results of nine studies that looked into the overlap between fantasy proneness and dissociative symptomatology. The sample sizes in these studies varied from 43 to 1224 and 8 out of 9 correlations were above  $r = .30$ , whereas 3 out of 9 were  $r = .50$  or higher. In the legal context, the overlap between fantasy proneness and dissociative symptomatology is relevant. Fantasy proneness is related to good storytelling skills; it endows people with the talent to tell a deceptive story that makes an authentic impression (Merckelbach, 2004; Schelleman-Offermans & Merckelbach, 2010). Furthermore, Peace and Masliuk (2011) found in their experimental study indications that fantasy proneness is related to a stronger symptom over-reporting tendency.

Much has been written about how forensic psychological expert testimony may be plagued by self-report bias (Richards et al., 2015; Young, 2016), i.e., the tendency of experts to rely extensively on what claimants say about their history and symptoms. Such self-reports can be unreliable, especially in forensic settings where incentives may play a role. However, even if incentives play no obvious role, memory amplification in retrospective accounts of trauma might occur. For example, veterans may initially deny having seen human remains, having been injured because of an attack, or having been shot at during their mission, but later claim that they did experience these events (Engelhard et al., 2008). Symptom escalation predicts such inconsistencies in trauma reports (Larsen et al., 2016). More generally, research on memory amplification documents that it would be a simplification to exclusively focus on the causal connection between trauma exposure and symptomatology and to overlook how symptomatology might affect subsequent reports of trauma.

Given these considerations, it is essential that forensic experts collect collateral information (e.g., academic record, third party records, incident records, medical documents, physical evidence if appropriate to the case) to supplement the subjective reports of the claimant. And yet Brand et al. (2017b; p. 302) recommend to “[U]se the evaluatee’s own words rather than professional jargon as much as possible.” The authors emphasize the informational value of the expert’s interview with the claimant and they even go so far as to state that “it is necessary to ‘tell the story’ of traumatic experiences over the plaintiff’s lifespan” (Brand et al., 2017b, p. 302). They argue that self-reports are “ideally supplemented with collateral information” (Brand et al., 2017b, p. 302). In our view, presenting collateral information as provisional conflicts with principles that should guide professional forensic expertise, one of which is to “use multiple source of information for each area assessed (e.g., self-report, psychological test data, collateral interviews, and records)” (Young, 2016, p. 215).

### **Lack of Connectivity to Existing Science**

Many legal principles that control standards for the admissibility of expert witness testimony emphasize that expert testimony should be grounded in scientific, technical, or other specialized knowledge (e.g., Risinger et al., 2002). Some authors have pointed out that absence of connectivity, that is, the failure to build on the extant corpus of evidence generated by previous research, is a sign of pseudoscience (Lilienfeld & Landfield, 2008). In their essay, Brand et al. (2017a,b) repeatedly articulate claims that have no empirical basis. Below, we consider five examples.

First, Brand et al. (2017b) write that there are typical signs of dissociation that the professional should watch for during the interview with the plaintiff. They mention blank staring, absent appearance, losing track of the conversation, excessive eyelid flutter, and becoming sleepy when difficult topics are discussed. As far as we know, these indicators have not been substantiated by empirical research. One concern is that these symptoms are vague enough that if we sufficiently lower our threshold for these indicators, we might recognize these symptoms in everyone, thus leading to the problem that the trauma-centric clinician may then suspect trauma in everyone. These vague symptom lists can be compared with the symptom lists in the notorious book *A Courage to Heal* (Bass & Davis, 1988), and this in turn can lead to the assumption of dissociative amnesia for anyone who does not report being traumatized. These vague symptom lists and the assumption of a traumatic cause can then lead to unearthing of false memories of abuse in therapy or outside of therapy (see Pendergrast, 2017; for a fuller discussion). In addition, it is easy to feign the behavioral signs that Brand et al. describe. Indeed, research has shown that people who are instructed to malingering have a preference for slow response times, general confusion, frequent hesitations, and total amnesia for personal identity and past knowledge (Iverson, 1995; Tan et al., 2002). This should make forensic experts cautious when they interpret the meaning of behavioral signs during interviews.

Second, Brand et al. (2017b) claim that plaintiffs with a diagnosis of Dissociative Identity Disorder (DID) may switch from one identity state to another that is amnesic for the trauma. Here, Brand et al. (2017b) disregard the work of Huntjens and co-workers. A series of studies by these researchers assessed the transfer of information between personality states in patients with a diagnosis of DID. Both tests of explicit and implicit memory were included, as well as neutral, emotional, and autobiographical information. The data across studies were consistent in that *subjectively*, DID patients reported amnesia between their personality states, but *objectively*, no evidence emerged for inter-identity amnesia (e.g., Dorahy & Huntjens, 2007; Huntjens et al., 2012). These findings raise important questions about how people come to adopt the metacognitive belief that they have multiple selves with amnesic barriers between them. One distinct possibility is that this belief is the result of iatrogenic therapy (see for case examples, Pendergrast, 1996), an issue that should be explicitly addressed when the meaning of dissociative symptoms is discussed within the legal context.

Third, Brand et al. (2017b; p. 303) claim that “research has established the reliability of recovered memories of trauma.” This cavalier way of summarizing the evidence ignores studies showing that many people have retracted trauma memories that they recovered in therapy (Maran, 2010; Ost, 2017). It also overlooks the vast literature on how certain therapeutic maneuvers have created false memories (e.g., imagination inflation, Thomas & Loftus, 2004; dream interpretation, Mazzoni et al., 1999; hypnosis, Lynn et al., 1997; suggestion, Loftus & Pickrell, 1995) –. Again, this literature drives home the point that it is essential that expert witnesses examine the extent to which therapeutic interventions have induced trauma memories and dissociative symptoms. Germane to this is also the recent study of Patihis and Pendergrast (2018) who found in their sample of 2,326 adults that 9% (8% weighted to be representative) reported consulting therapists who discussed the possibility of repressed abuse and 5% (4% weighted) recovered memories of abuse in therapy. Importantly,

there was a 20-fold increase in rates of recovered memories among respondents who discussed the possibility of recovered memories compared with individuals who did not engage in such discussions.

Fourth, Brand et al. (2017; p. 303) state that “[E]xperts need to be informed that memory deficits, including dissociative amnesia, have been documented in the medical literature for more than a century for a wide range of traumas, including combat and genocides.” This is an incomplete summary of the state of art as far as dissociative amnesia in the forensic domain is concerned. There are convincing case descriptions of people who feigned dissociative amnesia and fugue so as to obtain certain benefits (e.g., Marcopulos et al., 2016). Authors of review papers have noted that in cases where plaintiffs or defendants present with dissociative amnesia malingering should be considered (Jenkins et al., 2009; Tysse, 2006). In line with this, Cima et al. (2003) compared forensic patients who claimed with patients who did not claim amnesia. In the first group, 53% exhibited a tendency to over-report symptoms against 18% in the second group. McSherry (2004) noticed that invoking a dissociative defense such as complete amnesia is typical for cases of male anger and violence against women.

Fifth, Brand et al. (2017b) contend that dissociative individuals often have raised scores on tests measuring symptom over-reporting (i.e., symptom validity tests) because they are impaired, highly symptomatic, and emotionally distressed. Thus, the authors suggest that in the case of dissociative individuals, a failure on tests tapping into symptom validity validates rather than invalidates symptom presentation. There is, indeed, ample evidence that people who report dissociative symptoms tend to over-endorse bizarre, rare, and/or non-existent symptoms that typically are listed on tests that gauge symptom exaggeration (Merckelbach et al., 2017). However, the interpretation of this is a complex issue as several factors may contribute to the link between dissociation and symptom over-reporting. In

clinical samples, a third factor – e.g., alexithymia (experiencing difficulties in verbalizing internal sensations such as symptoms) – may underlie this link. However, in the forensic setting, malingering is an (additional) factor to consider when accounting for the overlap between dissociative symptom reports and endorsement of bizarre complaints. Elsewhere, Brand et al. (2016) themselves mention that it is their experience that one in five patients (20%) presenting with DID is a false positive, i.e., a person feigning his or her symptoms (see also Farrell, 2011). In a survey by Mittenberg et al. (2002) among certified neuropsychologists who frequently served as experts in litigating and compensation seeking cases respondents estimated the base rate of malingering to be in the order of 30%. For specifically cases in which dissociative symptomatology was claimed, the estimated base rate of probable malingering or symptom exaggeration was 10%.

Given these statistics, it would be naïve to start the forensic examination of claimants reporting dissociative symptoms with the assumption that these symptoms must be genuine and that failure on a test of symptom exaggeration can be explained away by extreme stress or cognitive impairment of the claimant. This circular argument is known as the “psychopathology = superordinate” fallacy. It is a fallacy because most symptom validity tests, particularly so called performance validity tests, are quite insensitive to real pathology. Patients with brain damage and genuine impairments rarely fail such tests and this is particularly true when a pairwise failure model is used to identify non-credible symptom presentation (Victor et al, 2009).

## **Conclusion**

Brand et al. (2017b) write that the base rate of dissociative psychopathology range from 9-18%. Base rate estimates of sleep problems such as insomnia vary between 7 and 37% (e.g., Leger & Poursain, 2005). The prevalence of malingering in litigation and compensation cases might be as high as 15-30% (Young, 2015). The simple trauma approach advocated by

Brand et al. (2017a,b) completely ignores these statistics and if adopted by potential expert witnesses may lead to what has been termed base rate neglect (Richards et al., 2015), the failure to take into account alternative causal pathways that are as likely or even more likely than the diagnostic option with which the expert starts. Disregarding alternatives may result in a confirmatory mission and ultimately, in a false-positive error (e.g., misdiagnosing a person with a dissociative disorder). This is all the more problematic because there are, as far as we know, no field trial data about the interrater reliability of dissociative disorder diagnoses. Brand et al. (2017a,b) discuss a number of self-report and diagnostic interviewing tools for assessing dissociative symptoms, but they do not address the error rates of these instruments. Still, information about the known or potential error rates of diagnostic tools is important for evaluating the admissibility of expert testimony (as per e.g., the Daubert standards; Grove & Barden, 1999).

Given that dissociative symptom reports might have different causes – trauma history, sleep problems, affect dysregulation, malingering – and considering that we do not know the diagnostic accuracy with which experts can diagnose severe dissociative pathology, it is impossible to deduce the cause of dissociative symptoms from the symptoms themselves. The very term trauma-related dissociation is therefore misleading and will hinder expert witnesses to offer responsible expert testimony to the courts.

We do not believe that the approach advocated by Brand et al. (2017a,b) would survive a Daubert/Kumho analysis of the type described by Grove and Barden (1999). But if it would and an expert witness would offer testimony along the lines of Brand et al. (2017a,b), the following six questions should be asked:

- What is the interrater agreement and error rate for diagnosing dissociative symptoms?

- Did the expert consider and test other causal pathways to the dissociative symptoms than trauma?

- How did the expert control for biases (e.g., confirmation bias, hindsight bias, base rate neglect, affiliation bias)?

- Did the expert collect collateral data?

- Did the expert consider and rule out iatrogenic therapy effects?

- Did the expert include symptom validity tests?

Brand et al. (2017a; p. 294) propagate a “trauma-informed framework for the jury to make the best legal decisions”. In our view, their essay provides potential experts with poor guidance concerning the meaning of dissociative symptoms in a legal context. Their simple trauma-approach may foster unjustified overconfidence in forensic experts, which ultimately may contribute to miscarriages of justice.

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