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Dissociation in a Forensic Context

DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

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An Introduction to Complex Trauma and Dissociation in a Forensic Setting

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Defining Forensic Practice

- Any practice of psychology within the legal context
  - Various roles:
    - Testifying expert – Evaluating, providing testimony on the results of the evaluation, and/or testifying as to research findings
    - Consulting expert – Working with attorneys behind the scenes
    - Fact witness – Discussing your work with a client whose mental health is part of a case
    - Treating provider in forensic facility – Prison
  - Can be a pull to take on a dual role
    - Example: You are the treating therapist and the attorney wants you to be the testifying expert.

Trauma Exposure and Effects

- Lenore Terr (1991) defined the following criteria for trauma exposure:
  - Type I (Single Incident) – One time, short-term, unexpected event
    - MVA, Natural Disaster, Sexual Assault
    - Unlikely to create a prolonged dissociative reaction
  - Type II (Repetitive or Complex) – Ongoing trauma (physical, sexual, emotional, attachment) that are the result of intentional acts, or the failure to act appropriately, by another human being
    - Chronic neglect, maltreatment, abuse
    - Highly likely to create long-term, complex posttraumatic reactions, including dissociation
    - (as cited in Courtois & Ford, 2013, p. 11)

Forensic vs. Clinical

- "Forensic assessment, [as compared to clinical], is devoted to the elucidation of facts that address psycholegal questions—questions that serve the interest of "triers of fact" (judges and juries)." (Frankel, 2009, p. 577)
  - The client is the attorney, the examiner is a neutral, benefit is for the court, etc.
- Brown (2009) also noted "In any forensic setting, malingering is an ever present concern. With money or freedom on the line, the stakes are high for the test-taker; the potential for secondary gain is magnified." (p. 585).

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Dissociation

- Putnam (1997) stated "Dissociative states are characterized by alterations in accessibility o fcertain types of memories, skills, and knowledge, and by alterations in core aspects of sense of self and identity…Pathological dissociation represents a marked deviation from normal trajectories, with an increase in the numbers, types, and frequency of dissociative states in response to social and environmental interactions." (pp. 14-15)
- Frewen and Lanius (2015) discuss the difference between normal waking consciousness (NWC) and trauma-related altered states of consciousness across four domains: time, thought, body, and emotion. This model asserts that traumatized individuals learn to alter various aspects of consciousness to manage overwhelming emotions (dissociation).

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Dissociation

- The structural theory of dissociation (Nijenhuis & van der Hart, 2011) focuses on identity fragmentation, where two (or more) parts develop during exposure to extensive threat. The "apparently normal" parts (ANP) of the person develop to maintain distance from traumatic memories and related emotions, while the "emotional" parts (EP) maintain access.
- Dissociation is "a disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (American Psychiatric Association [APA], 2013, p. 291)

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Complex Trauma

- Interpersonal
- Abuse of all types and neglect/non-response
- Repetitive, prolonged, chronic, cumulative
- Often in attachment relationships
  - Dependence/immaturity, accessibility and entrapment
- Often over the course of childhood
  - Layered, cumulative
  - Impacts development
- May be lifelong: same or different perpetrators
  - (Courtois & Ford, 2009)

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Complex PTSD

- (I) Alteration in Regulation of Affect and Impulses (A and one of B to F required)
  - affect regulation
  - modulation of anger
  - self-destructive behavior
  - suicidal preoccupation
  - difficulty modulating sexual involvement
  - excessive risk-taking
- (II) Alterations in Attention or Consciousness (A or B required)
  - amnesia
  - transient dissociative episodes and depersonalization

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- (III) Alterations in Self-Perception (Two of A to F required)
  - ineffectiveness
  - permanent damage
  - guilt and responsibility
  - shame
  - nobody can understand
  - minimizing
- (IV) Alterations in Relations with Others (One of A to C required)
  - inability to trust
  - revictimization
  - victimizing others

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Complex PTSD

- (V) Somatization (Two of A to E required)
  - problems with the digestive system
  - chronic pain
  - cardiopulmonary symptoms
  - conversion symptoms
  - sexual symptoms
- (VI) Alterations in Systems of Meaning (A or B required)
  - despair and hopelessness
  - loss of previously sustaining beliefs

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Assessment Measures

- Commonly used
  - Minnesota Multiphasic Personality Inventory-2 (Butcher et al., 1989)
    - Trauma survivors often elevate validity scales (more on this later)
  - Personality Assessment Inventory (Morey, 1991)
    - Trauma survivors, particularly those who dissociate, can also elevate overreporting scale (more on this later as well)
  - Millon Clinical Multiaxial Inventory-IV (Millon, Grossman, & Millon, 2015)
    - Very little work has been done on this measure with trauma survivors
    - Continues to utilize base rates instead of a normative sample (scores are developed based on expected occurrence of disordered behaviors within a ***psychiatric/clinical*** population)
    - MCMI-II results indicated those with DID elevated schizoid, avoidant, and schizotypal scales (Brand, 2006)

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Assessment Measures

- Important to use measures that have been specifically validated on trauma survivors
  - Trauma Symptom Inventory-2 (Briere, 2011)
  - Detailed Assessment of Posttraumatic Stress (Briere, 2001)
  - Multidimensional Inventory of Dissociation (Dell, 2006)
    - Validity scales were not developed for a forensic context, so may not be as helpful in this setting
  - Dissociative Experiences Scale (Bernstein & Putnam, 1986)
  - Multiscale Dissociation Inventory (Briere, 2002)
- Also consider using diagnostic interviews that focus on specific symptoms presentations
  - Structured Clinical Interview for DSM-IV® Dissociative Disorders (SCID-D-R) (Steinberg, 1994)
  - Dissociative Disorders Interview Schedule – DSM-5 Version (Ross, n.d.)

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Challenging Myths about Dissociation

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WHY DO DDs ELEVATE ON SOME SUPPOSED "FAKE BAD" SCALES:

1. Have genuinely high levels of a variety of symptoms related to trauma
2. Developers included dissociative and trauma items on some supposed "fake bad" scales
3. Patients' distress about symptoms may contribute to the elevations

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CHRONIC COMPLEX DISSOCIATIVE DISORDERS

- **Dissociative identity disorder (DID)**
- **Dissociative disorder not otherwise specified (DDNOS)**

- Current studies based on DSM-IV criteria and disorders (not DSM 5)

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DISTINGUISHING BETWEEN SIMULATORS VS. TRUE PATIENTS

		Instrument's Prediction	
		Feigning (Simulating)	Genuine (Actual Patient)
Actual Status (Group)	Simulators	True Positives	False Negatives
	Actual Patients	False Positives	True Negatives

Sensitivity: How well can instrument identify **Simulators**?
= % of **Simulators** correctly classified (# of True Positives/Total # of Simulators)

Specificity: How well can instrument identify **True Patients**?
= % of **True Patients** correctly classified (# of True Negatives/Total # of Patients)

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STRUCTURED INTERVIEW OF REPORTED SYMPTOMS (SIRS/SIRS-2)

Brand, B.L., McNary, S.W., Loewenstein, R.J., Kolos, A.C. & Barr, S.R. (2006). Assessment of genuine and simulated dissociative identity disorder on the Structured Interview of Reported Symptoms. *Journal of Trauma & Dissociation, 7(1)*, 63-85. doi:10.1300/J229v07n01_06

Brand, B. L., Tursich, M., Tzall, D., & Loewenstein, R. J. (2014). Utility of the SIRS-2 in distinguishing genuine from simulated dissociative identity disorder. *Psychological Trauma: Theory, Research, Practice, And Policy*, *6*(4), 308-317. doi:10.1037/a0036064

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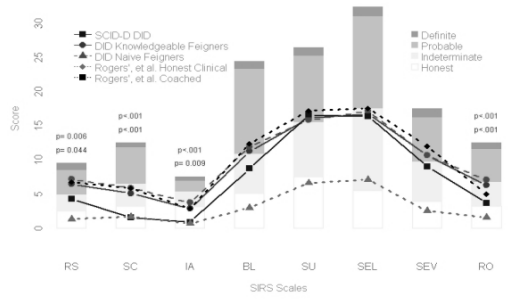
SIRS Primary Scales



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Rogers, Payne, Correa, Gillard, Ross, (2009)

- SIRS classifications – acceptable sensitivity (M = .82), but the false-positive rates were problematic (i.e., patients classified as feigning).
- To minimize false-positives, created a **Trauma Index**:
  - Symptom Combination (SC)
  - Improbable or Absurd (IA)
  - Reported vs. Observed (RO)

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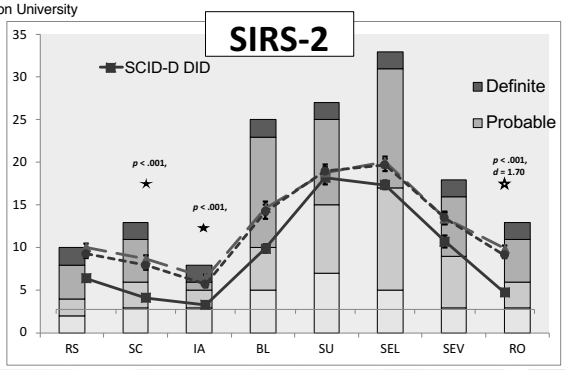

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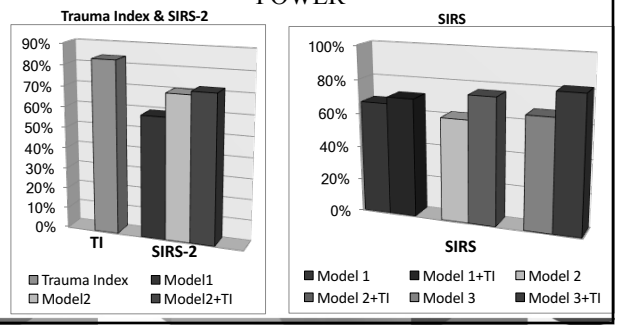
OVERALL DIAGNOSTIC POWER



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"FAKING DID" ON MMPI-2

Brand, B.I. & Chasson, G.S. (2014). Distinguishing simulated from genuine dissociative identity disorder on the MMPI-2. *Psychological Trauma: Theory, Research, Practice, and Policy.*

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MMPI-2

(Butcher, et al. 1989)

- People with chronic trauma, especially with dissociative features – score high on most validity and clinical scales.
- High risk of misclassifying "invalid" due to high validity scale scores even though most individuals with complex trauma are NOT feigning or exaggerating.

(reviewed in Brand & Chasson, 2014)

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MMPI, MMPI-2

Trauma & Dissociation contribute to elevations in Scale 8:

•Dissociation and depression found to predict scale 8 elevations in female CSA survivors and male vets (Elhai et al., 2001; Elhai et al., 2003)

•Dissociation strongly associated with scale 8 in DID patients (Brand & Chasson, 2014)

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MMPI, MMPI-2

Example:

- Elliot (1993) found that 30% of psychiatric inpatients with history of victimization had invalid profiles compared to 15% of non-traumatized sample

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MMPI, MMPI-2

- Most common elevations in dissociative patients:
  - F – Infrequency Scale - "fake bad" scale – elevated if have severe family conflict, passive influence, dissociative symptoms
  - **8** Schizophrenia – includes 2 dissociative items, fear of losing mind, family member has been frightening
  - **7** Psychasthenia- worries, exaggerated fears
  - **2** Depression
  - **4** Psychopathic Deviate

(reviewed in Brand & Chasson, 2014)

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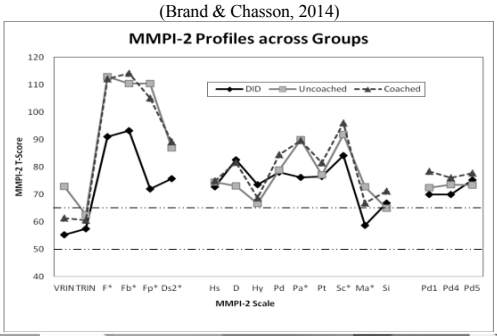
DID MMPI-2 PROFILES

(Brand & Chasson, 2014)



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MMPI-2 (Brand & Chasson, 2014)

Despite elevations, the DID group's mean scores were not unusual for PTSD or child sex abuse survivors

(Brand & Chasson, 2014)

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MMPI-2 (Brand & Chasson, 2014)

- Fp was the most effective scale for correct classification between feigners and DID patients.
- Feigners could not imitate DID well on subtle comorbid problems. Naïve feigners endorsed Hollywood stereotypes.

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PERSONALITY ASSESSMENT INVENTORY
(Morey, 1991)

Roger's et al. (2012):
PAI's validity scales are not necessarily valid with complex trauma patients (50% of sample DID)

- Negative Impression (NIM) - over-classified complex trauma patients as exaggerating symptoms
  - 61.5% classified as feigning
- Malingering Index scale (MAL) and Rogers Discriminant Function (RDF) were valid indicators with complex trauma

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PERSONALITY ASSESSMENT INVENTORY

Dissociative Disorders PAI Study

Participants

- 42 inpatients with a primary diagnosis of DID or DDNOS
- 80% female, 91% Caucasian, Mean age = 37 (*SD* = 10)

(Stadnik, Brand, Savoca, JTD, 2013)

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PERSONALITY ASSESSMENT INVENTORY

NIM Items most often endorsed by DD sample:

"Very often":

- amnesia (29.3% "very true")
- experiencing oneself as having different personalities (29.6% "very true")
- others not understanding one's degree of suffering (26.2% "very true")
- did not have positive memories from childhood (24.4% "very true")

(Brand, Stadnik & Savoca, JTD, 2013)

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PERSONALITY ASSESSMENT INVENTORY

DES highly correlated with:

NIM = .60 **
MAL = .43*
RDF = -.41*
Schizophrenia = .52**
Depression = .22
Borderline Features = .56**

(Brand, Stadnik & Savoca, JTD, 2013)

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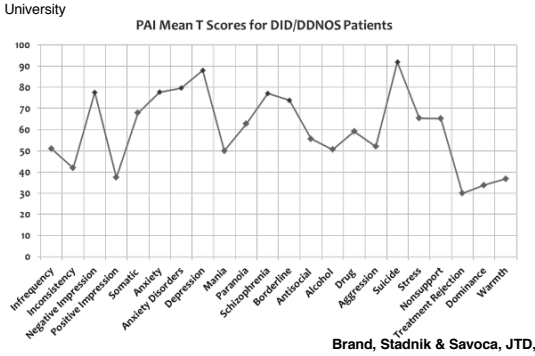

Brand, Stadnik & Savoca, JTD, 2013

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CONCLUSION

Individuals with complex trauma, including DID/DDNOS:

- Show elevations on many clinical scales -- consistent with complex trauma literature
- Elevate on validity scales that include trauma and dissociation items, but are not typically overly high on scales developed for trauma or severely symptomatic samples
- DID can be distinguished from feigned DID

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Forensic Evaluation in a Criminal Setting: A Case Example

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Advance Preparation for Conducting a Forensic Assessment of Dissociation

- What is the referral question?
  - What reason is there to believe that the defendant might be dissociative?
  - If the defendant is dissociative, how is this relevant to the legal case?
  - Be open to the possibility that the defendant is *not* dissociative
- Will the assessment likely lead to expert witness testimony? If so, will that testimony occur in relation to
  - The guilt phase, or
  - The sentencing phase

Major Components of an Initial Forensic Assessment of Dissociation

A detailed interview regarding defendant's: • life history from infancy onward; • family background; • mental status; • trauma, educational, occupational (including military, if relevant), legal, and substance abuse history.

Adverse Childhood Experiences (ACEs) Questionnaire

Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D-R) [*not* the Dissociative Experiences Scale (DES)]

Possibly the Detailed Assessment of Posttraumatic Stress (DAPS) and the Trauma Symptom Inventory -2 (TSI-2)

Relevant Sources of Potentially Corroborative Evidence

Reports from past mental health assessments, treatment records

Medical records, including any medical records from correctional institutions

Any reports made to and investigations by child protection agencies

School records

Interviews with collaterals: family members, friends, romantic partners who are in a position to confirm or refute what the defendant reports

Considerations Regarding Disseminating Findings

A written report of the findings of the psychological assessment is not always requested, but if it is

- explain how the dissociation, if it has been found, is relevant to the defendant's alleged offense(s) [explain, *don't* excuse] or to sentencing considerations [mitigation]

Whether a written report is requested or not, be prepared to address the above issues in deposition and in court testimony

Part of your testimony is to educate: What is dissociation? What is the science supporting the validity of dissociation? How it is relevant to the case at hand? – that is, matters that the average person would not know or understand without the input of a subject matter expert

Stories, anecdotes, examples are convincing and help make more abstract concepts and material comprehensible

A Final Crucial Point:
Be prepared to conclude that dissociation is not present –
Your job is to assess
whether dissociation is present
and if so how it is relevant to the case, if it is at all relevant.

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