

Assessing Trauma-Related Dissociation in Forensic Contexts: Addressing Trauma-Related Dissociation as a Forensic Psychologist, Part II

Bethany L. Brand¹ · Hugo J. Schielke² · Jolie S. Brams³ · Rachel A. DiComo¹

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Abstract Chronic dissociative reactions and dissociative disorders can occur following traumatic events and are associated with suffering and impaired functioning. Therefore, trauma-related dissociation could be part of the claims made in civil actions or contribute to mitigation or an insanity defense in criminal actions. Dissociative reactions to trauma, including dissociative disorders, are more common than most mental health professionals realize. Unfortunately, few professionals have training in the assessment of dissociation, and forensic experts may be unaware of research indicating that standard interpretations of well-regarded assessment instruments can result in inaccurate determinations of symptom exaggeration in cases with dissociation. This paper is the second paper of a two-part series that aims to expand assessors' knowledge about trauma-related dissociation (TRD) and enhance their ability to assess and present information about dissociation. In this article, we focus on the forensic assessment of TRD and discuss: dissociative symptoms; complex trauma; trauma-related disorders; an approach to assessment of TRD; trauma-related reactions that can impede the detection of TRD; and

differential diagnosis of genuine versus feigned dissociation. In addition, we review research related to the validity and appropriate interpretation of the following measures in use with persons with TRD: Dissociative Experiences Scale, Multiscale Dissociation Inventory, Somatoform Dissociation Questionnaire, Trauma Symptom Inventory-2, Multidimensional Inventory of Dissociation, Structured Clinical Interview for Dissociative Disorders-Revised, Minnesota Multiphasic Personality Inventory-2, Personality Assessment Inventory, Structured Interview of Reported Symptoms, Test of Memory Malingering, and the Gudjonsson Suggestibility Scale.

Keywords Dissociation · Dissociative disorders · Trauma · Forensic · Personal injury · Malingering · PTSD

Although research and clinical interest in dissociation have increased exponentially in recent years, few mental health professionals receive training in the assessment of trauma-related reactions, and fewer still in the assessment of trauma-related dissociation (TRD) and the dissociative disorders (DDs; Brand, Armstrong, & Loewenstein, 2006; Cook, Dinnen, Rehman, Bufka, & Courtois, 2011; Cook & Newman 2014; Cook, Simiola, Ellis, & Thompson, 2017; Courtois & Gold, 2009). As a result, trauma-related disorders are frequently under-diagnosed or misdiagnosed by mental health and medical professionals (Şar, Akyuz, Ozturk, & Alioglu, 2013; Taubman-Ben-Ari, Rabinowitz, Feldman, & Vaturi, 2001). Forensic practitioners may be unaware of data indicating that standard interpretations of well-regarded assessment instruments can result in inaccurate determinations of symptom exaggeration in cases with dissociation. Additionally, they may not be aware of information that could

✉ Bethany L. Brand
bbrand@towson.edu

Hugo J. Schielke
hugo.schielke@gmail.com

Jolie S. Brams
jsbrams@outlook.com

Rachel A. DiComo
rdicom1@students.towson.edu

¹ Towson University, Towson, MD, USA

² California Department of State Hospitals, Napa, CA, USA

³ Ohio State University, Columbus, OH, USA

aid in differential diagnosis related to TRD, or of the range of instruments available for assessing dissociative symptoms.

To address these knowledge gaps, we have written a two-article series about TRD. In the first article in the series (Brand, Schielke, & Brams, 2017, this issue), we attempt to assist forensic assessors in making TRD relevant and comprehensible to the court. Specifically, we describe TRD and TRD-related research, the importance of attending to TRD in forensic matters, barriers to understanding dissociation, and suggestions regarding consulting and testifying about TRD. In this second article, we focus on the forensic assessment of TRD and discuss: dissociative symptoms; trauma-related disorders; complex trauma; an approach to assessment that is successful with individuals with TRD; trauma-related reactions that can impede the detection of TRD; TRD assessment measures and interviews; and differential diagnosis of genuine versus feigned dissociation.

Dissociative Symptoms

Broadly recognized dissociative symptomology includes depersonalization, derealization, flashbacks, dissociative amnesia, identity alteration, identity confusion, and somatoform dissociation. *Depersonalization* includes experiences such as feeling unreal or emotionally numb or seeing oneself at a distance, as if in a movie. Seeing oneself at a distance is one of the most common forms of dissociation among trauma survivors, including individuals involved in civil litigation. Thus, assessors should ask about these experiences in all cases of reported exposure to trauma or threat of harm. Within the framework of standard questions about common psychiatric symptoms, the assessor should inquire whether the individual has ever had an out of body experience. Asked in this manner, the evaluatee is not tipped off that this could be a trauma-related symptom, thus reducing the motivation among some individuals to exaggerate the presence or severity of this symptom. Depersonalization may occur during periods of acute stress, as a by-product of drug consumption, and in disorders such as borderline personality disorder (BPD), anxiety disorders, and psychotic disorders. *Derealization* occurs when an individual perceives the world around her/him as surreal or foreign. *Dissociative amnesia* is the inability to recall personal information that is not due to ordinary forgetfulness or a medical condition, such as dementia or a head trauma. The marked differences in behavior and disruptions in sense of self present in persons with dissociative identity disorder (DID) are linked with identity alteration and confusion. *Identity alteration* refers to a person behaving in ways that are markedly variable in different states of self, and *identity confusion* refers to a person being confused about who one is due to experiencing variable ways of thinking, feeling, and behaving in different states. *Somatoform dissociation* involves a disruption of bodily

experiences and functions not attributable to a medical condition. Of note, experiences of *absorption*, being so caught up in thoughts or inner experience that there is a disconnection (dissociation) between mind and environment (such as when someone drives by the highway exit they need to take to get home) are not necessarily indicative of pathology in and of themselves, but do tend to increase alongside dissociative and non-dissociative symptoms (Leavitt, 2001) and are therefore useful to evaluate. (For additional discussion of dissociative symptoms, see Part I of this series.)

Trauma-Related Disorders and Dissociation

Although dissociative experiences such as absorption can occur in a variety of nonpathological, non-trauma contexts, such as while driving or during peak athletic performances, dissociation is most prevalent in disorders linked to traumatic stress. A recent meta-analysis of over 15,000 cases in 19 different diagnostic categories (Lyssenko et al., 2017) found that dissociation is most prevalent in the dissociative disorders (DDs), followed by posttraumatic stress disorder (PTSD), borderline personality disorder (BPD), and conversion disorder. These diagnostic categories have each been linked with traumatic exposure (Afifi et al., 2011; Boon & Draijer, 1993; Brand & Lanius, 2014; Dalenberg et al., 2012; Nijenhuis, Spinhoven, van Dyke, & Vanderlinden, 1998a; Nijenhuis, van der Hart, Kruger, & Steele, 2004; Şar, Akyuz, Kugu, Ozturk, & Ertem-Vehid, 2006; van Dijke et al., 2012), and dissociative symptoms are listed as diagnostic criteria or associated features of each of these disorders in the DSM-5. The empirically demonstrated link between these disorders and dissociation underscores the importance of assessing for the range of outcomes associated with trauma, including TRD when an individual has been traumatized. The importance of assessing for dissociation following trauma is further reinforced by the finding that dissociation is associated with the development and maintenance of PTSD (Halligan, Michael, Clark, & Ehlers, 2003; Ehlers, 2006; Ehlers & Clark, 2000). Thus, those that demonstrate dissociation well after trauma are at risk for having a worse prognosis and may require longer treatment. (See Part I for more information on this issue.) An overview of the most prevalent trauma-related disorders follows.

PTSD PTSD is the most common, well known, and well researched of the trauma-related disorders. Core PTSD criteria involve exposure to trauma, intrusion symptoms (including dissociative intrusions, i.e., flashbacks), avoidance symptoms, negative changes in cognitions (including dissociative amnesia) and/or mood, and notable changes in reactivity and arousal. PTSD has an estimated 12-month prevalence of 3.5% (APA, 2013). A significant subgroup (14–30%) of PTSD

patients demonstrate depersonalization and/or derealization in addition to core PTSD diagnostic criteria (Lanius et al., 2010, 2012, 2014; Stein et al., 2013). The presence of either results in a diagnosis of PTSD with dissociative symptoms, commonly referred to as the dissociative subtype of PTSD (PTSD-D). A World Health Organization sample of 25,018 individuals involving 16 countries (Stein et al., 2013) found that PTSD-D was associated with adverse childhood events, childhood separation anxiety, childhood PTSD onset, specific phobia, significant impairment, and high suicidality. This general population study found PTSD-D to be more prevalent among males. Among clinical populations, however, PTSD-D appears more prevalent among females (Steuwe, Lanius & Frewen, 2012; Wolf et al., 2012). Research on this population has underscored the importance of assessing for dissociation in possible PTSD cases, in that incorrect diagnosis of PTSD type may inadvertently lead to patient harm as a result of contraindicated treatment (Lanius et al., 2012, 2014).

Acute Stress Disorder The diagnostic criteria for acute stress disorder (ASD) are similar to that of PTSD, including possible dissociative amnesia, depersonalization, derealization, and flashbacks. The two disorders are primarily differentiated by timing of onset and remission. ASD is characterized by acute onset and duration of up to 1 month. PTSD is indicated when symptoms persist more than a month, and full expression of symptoms can be delayed more than 6 months. The DSM-5 notes that ASD rates are highest following reports of interpersonal trauma (20–50%; APA, 2013); recent research (Briere et al., 2017), however, suggests that the emergence of ASD may be more related to cumulative exposure to trauma.

Borderline Personality Disorder BPD is characterized by instability in affect, cognitions (including perceptions of self and other), behaviors, and interpersonal relationships. BPD is often (but not always) linked with exposure to significant childhood trauma and adverse childhood experiences, comorbid PTSD, and stress-related dissociative experiences (Afifi et al., 2011; Korzekwa, Dell, & Pain, 2009; van Dijke et al., 2012; Vermetten & Spiegel, 2014; Zanarini et al., 2008; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989). Recent research (Tomko, Trull, Wood, & Sher, 2014) suggests a population prevalence for BPD of 2.7% among US adults.

Dissociative Disorders The DSM-5 (APA, 2013) includes five DDs: dissociative amnesia, depersonalization/derealization disorder, DID, other specified DD (OSDD), and unspecified DD (formerly DD not otherwise specified). Depersonalization/derealization disorder involves repeatedly experiencing detachment or a sense of unreality from the self and/or the environment. Dissociative amnesia includes autobiographical memory loss that ranges from a single event to

longer or recurrent periods of time that are not better accounted for by normative forgetting or organic issues, such as intoxication or head injury. DID is characterized by at least two identity states coupled with recurrent dissociative amnesia. Example criteria for OSDD include mixed dissociative symptoms similar to DID that fail to meet full criteria; identity disturbance due to coercive persuasion, such as brainwashing; dissociative trance; or acute dissociative symptoms due to stress that has lasted less than 1 month. Unspecified DD occurs when dissociation is present, but the symptom profile does not meet criteria for one of the other DDs.

Population estimates of the lifetime prevalence of any DD range from approximately 9 to 18%, with DID occurring in approximately 1% (Johnson, Cohen, Kasen, & Brook, 2006; Ross, 1991; Şar, Akyüz, & Doğan, 2007). These rates are generally consistent between Europe and North America (Friedl, Draijer, & de Jonge, 2000). Most cases of DDs are associated with a variety of types of childhood trauma, although depersonalization/derealization is linked only with emotional abuse (Simeon & Loewenstein, 2009). Clinicians often expect obvious, dramatic switching of personality states in DID, despite such presentations occurring in only 5% of cases (Kluft, 2009). In contrast, DID patients typically present with a complex and severe range of dissociative symptoms, depression, chronic self-harm and suicidality, eating disorders, substance abuse, and somatoform symptoms (e.g., Brand et al., 2013; Dell, 2002; Putnam, Guroff, Silberman, Barban, and Post, 1986).

Conversion Disorder Conversion disorder is characterized by symptoms of altered motor function that goes against intention and is inconsistent with medical findings (and so deemed “psychogenic” in origin). It is often (but not always) associable to trauma or psychological stressors that may be identified by others, and is frequently accompanied by depersonalization, derealization, and dissociative amnesia. Although prevalence is uncertain (Brown & Lewis-Fernández, 2011), persistent individual symptoms are estimated to occur at a rate of 2–5/100,000 annually (DSM-5).

Complex Trauma, Complex Outcomes

Individuals who have experienced complex trauma, that is, traumatic events that reoccur throughout an individual’s lifetime, particularly if beginning in childhood, are especially likely to experience dissociation (Brand et al., 2009; Briere & Elliott, 2003; Dalenberg et al., 2012; Maaranen et al., 2004). The more traumas an individual has experienced, the greater their resulting symptom complexity and the greater risk for dissociative symptoms (Briere, Dietrich, & Semple, 2016; Cloitre et al., 2009; Hodges et al., 2013).

Exposure to complex trauma can be associated with a range of clinical difficulties, such as a fragmented or damaged identity, difficulty with relationships, under-developed emotion regulation, behavioral dyscontrol, poor decision making, self-destructiveness, suicidality, poor concentration, academic and career difficulties, and myriad medical symptoms and disorders (Briere & Rickards, 2007; Cloitre et al., 2009; Felitti & Anda, 2010; Herman, 1997). In the most severe cases of chronic dissociation related to long-term childhood abuse or interpersonal violence, the person may dissociate due to the level of betrayal engendered by victimization by a trusted, loved caregiver or partner (Freyd, 1996).

Individuals who have experienced childhood traumatization are at risk to experience higher rates of revictimization (Classen, Paresh, & Aggarwal, 2005; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003; Webermann, Brand, & Chasson, 2014) and to have more dissociative reactions to stressful experiences than people who have not experienced developmental trauma (Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012; Stein et al., 2013). Individuals with chronic DDs report high levels of childhood maltreatment, with up to 95% of people with DID reporting having been abused in childhood (Brand et al., 2009; Dalenberg et al., 2012; Putnam et al., 1986) and may have dissociative reactions in response to further stressful experiences.

A Useful Approach to Assessing Traumatized Individuals

Before assessing for trauma-related symptoms and outcomes, it is crucial to establish a working relationship that emphasizes creating as safe an environment as possible with an evaluatee and to make the process less overwhelming by explaining the procedures, as well as allowing for plenty of breaks if the evaluatee becomes distressed (Armstrong, 2017). For evaluatees who have been terrified by unpredictable traumas, knowing what to expect in new situations enables them to be more open and reflective, and therefore able to share more valid and useful information. Even when serving as the opposition's expert, it is important to develop as much rapport as possible with the patient: if a person has been traumatized, especially if the event was interpersonal in nature, the patient may be highly mistrusting of people, particularly the opposing legal side's experts. If a working relationship is not established at the beginning, the evaluatee will be unlikely to share enough information about their experiences to provide the basis for a valid assessment.

Detecting dissociation (or its absence) during the interview is crucial (Armstrong, 2017; Armstrong, 1994). Observe the individual and carefully record signs of emotional *over-arousal* as well as *under-arousal*. Professionals are well versed in watching and noting obvious distress such as tearfulness,

rocking, and hyperventilation, but relatively few know to watch for signs of possible dissociation. These include: prolonged blank staring, particularly with a glazed, absent appearance; repeatedly losing track of the conversation or needing questions to be re-stated; excessive eyelid flutter (ascertain whether dry eyes or contacts are causing the fluttering); denial of information already reported earlier in the interview; and suddenly becoming "spacey" or "sleepy," particularly when discussing emotionally difficult topics. Some assessors without education about dissociation have misinterpreted evaluatees' absence of affect while reporting traumatic events to indicate malingering, when in fact this absence of affect could indicate the avoidance of overwhelming emotion via dissociation.

Dissociation can be a transient or chronic sequelae of trauma. The ability to manage the emotions that follow a traumatic event, along with the combination of pre-trauma and post-trauma variables, including stressors, social supports, prior trauma, prior psychiatric symptoms, individual characteristics, and culture, can contribute to recovery from trauma's impact or the development and maintenance of trauma-related symptoms including dissociation (Brewin, Andrews, & Valentine, 2000; Briere, 2006; McLaughlin et al., 2013; Ozer, Best, Lipsey, & Weiss, 2003; Yehuda & Flory, 2007). Forensic evaluators should assess this range of pre-trauma and post-trauma variables.

Detailed notes can be an invaluable resource for the expert's report or testimony. Detailed descriptions about what was occurring before, during, and after the alleged injury can document subtle trauma-based shifts in language. For example, traumatized people sometimes slip back and forth between present tense and past tense verbs as they describe moment by moment the reported trauma, possibly illustrating how the traumatic event continues to feel intrusively and unexpectedly present as if it is happening again, rather than being a past experience that is no longer cognitively or emotionally disruptive. Verbatim transcripts and accurate, detailed behavioral observations that track the evaluatee's cognitive and emotional shifts can later become a resource for writing a report of one's findings and testifying. For example, in a civil suit against a church about alleged sexual abuse by a priest decades earlier, an evaluatee shifted back and forth between the use of present vs. past tense verbs, such as "He came up behind me and grabbed me. He's...uh...he's choking... and screaming...and I can't breathe." In the latter sentence, the plaintiff shifts to present tense verbs and becomes less coherent and organized in his speech, demonstrating the fragmented and intrusive quality that memories of abuse can have (Andrews et al., 2000; Malmo & Laidlaw, 2010). In cases in which multiple earlier traumas or overwhelming stressors have been reported, it helps to pay careful attention to the evaluatee's degree of organization, level of reflective capacity, and extent of being grounded in present vs. past reality (e.g., being able to distinguish past trauma that has been survived

versus one that is occurring in the moment) as they recount these events. Such moments of intra-interview intrusions and resulting moments of cognitive disorganization provide insight into which of the traumas might be unresolved and possibly still contributing to distress and/or dysfunction.

Initially, assessors should inquire about the evaluatee's pre-trauma level of functioning, as well as carefully eliciting the individual's reactions during and after exposure to stressors and/or trauma. In a torts claim, as in criminal defense, it is necessary to make critical linkages between real events and experiences in the life of an individual and their post-injury condition, so detailed questions about aspects of life that trauma might interrupt and be the basis for a claim include: ability to eat, sleep, manage one's home and hygiene; concentration; ability to enjoy quiet time (e.g., some traumatized people frantically fill up their schedules and their minds because when they are quiet, traumatic intrusions become problematic); sexual intimacy and socializing; and ability to function productively at work. Assessing whether there were post-event changes in these activities of daily living, and if so, if reductions in functioning are current as well as likely to endure, is a crucial determination to a torts claim.

To avoid inadvertently providing training to individuals who are inclined to exaggerate or malingering symptoms, assessors should not use professional language such as "dissociation" and "flashbacks." If an evaluatee uses the word dissociation, ask what he/she means. Many people do not understand the meaning (or even the pronunciation) of the word dissociation. (Note: we have encountered forensic experts who do not spell or say dissociation accurately; rather, they call it "disassociation.") Such a lack of knowledge of terminology reveals how little the expert knows about dissociation and opens up potential questions for a challenging cross examination about the expert's knowledge about dissociation.)

Use the evaluatee's own words rather than professional jargon as much as possible. Ask the patient to provide multiple examples of experiences that might be dissociative in nature. Individuals who are genuinely suffering from chronic dissociation should be able to describe multiple examples of past and recent dissociative experiences. However, these experiences are often challenging to articulate, particularly for evaluatees who have below average intelligence and those for whom dissociation is so chronic that they may not recognize these experiences as symptoms. That is, they may be so accustomed to feeling numb or disconnected from their environment that they do not think to report it to assessors. Thus, after requesting an evaluatee's own description of peritraumatic and posttraumatic reactions, assessors need to routinely assess for a variety of trauma-based reactions, including dissociative experiences, using semi-structured interview questions and validated, standardized measures.

In clinical and forensic settings, use of evidence-based assessment measures as well as structured interviews to

diagnose dissociation and DDs has increased over the past decade as more clinicians are becoming trauma-informed. It is beyond the scope of this article to review trauma exposure interviews and measures, how to assess for trauma without using leading questions, and discuss assessment and differential diagnosis of comorbid disorders or disorders with overlapping symptoms, but good resources are available (Armstrong, 2017; Brand, Armstrong, & Loewenstein, 2006; Brand & Loewenstein 2010; Briere & Scott, 2015; Briere & Spinazzola, 2009; Courtois & Ford, 2013; Dalenberg & Briere, 2017; Dalenberg, Straus, & Ardill, 2017; Frankel & Dalenberg, 2006); Reardon, Brief, Miller, & Keane, 2014; Young, 2017).

It is helpful for forensic experts to anticipate challenges from the opposing counsel and prepare for them by addressing possible alternate interpretations of the assessment data and the patient's reported symptoms. A conclusive diagnosis can then be reached with the combination of these diagnostic alternatives, ideally supplemented with collateral information. In forensic reports and testimony for tort cases, it is necessary to 'tell the story' of traumatic experiences over the plaintiff's lifespan, describing the current tort's trauma-related responses, and emphasize why this particular outcome would not have occurred if not for the purposeful or negligent actions of the defendant. It is one thing for a juror to acknowledge that an accident or assault victim may experience some period of anxiety after the incident, but the issue at stake is whether this debilitating pain or other enduring damage was purposefully or negligently caused, which will then lead to the matter of what the compensation should be.

Trauma-Related Reactions that Impede Detection of Dissociation

Trauma survivors, particularly of sexual assault and traumas within a close personal relationship, often have difficulty identifying and talking about their symptoms (Brazelton, 2015; DeCou, Cole, Lynch, Wong, & Matthews, 2017; Dorahy et al., 2013; Herman, 2011; Platt & Freyd, 2015). This can contribute to survivors making conflicting statements about their symptoms and/or trauma-related experiences or lead them to be ambivalent about pursuing treatment or litigation related to trauma (Brown, 2009). Trauma-related shame, distrust, avoidance, and dissociation can contribute to traumatized individuals not wanting to talk about, curtail discussions of, or actively disavow their trauma or trauma-related reactions.

Shame Many survivors of interpersonal trauma feel shame about having been traumatized and for having trauma-related symptoms and may even blame themselves for both (DeCou et al., 2017; Dorahy et al., 2013; Nathanson, 1989; Platt & Freyd, 2015; Talbot, Talbot, & Xin, 2004). Trauma-

related shame is both a symptom of PTSD (APA, 2013) and a predictor of maintained PTSD (e.g., Andrews, Brewin, Rose, & Kirk, 2000; Feiring & Taska, 2005). Trauma-related shame and fear of mental health-related stigma can also negatively impact desire to engage with mental health treatment (e.g., Hoge et al., 2008) and to pursue litigation against perpetrators of assault and harassment.

Distrust Individuals who have experienced interpersonal trauma may have difficulty trusting that they will be treated fairly or that a good/fair outcome is even a possibility, and so may avoid taking the risks involved (e.g., increased psychological distress, possible social stigma) in discussing their trauma and/or symptoms. This can be problematic for the experts and attorneys who need to know about the details of trauma and its impact for court. Trauma can shatter positive expectancies such that survivors no longer expect favorable outcomes to their actions and future experiences, including potentially in litigation (Ehlers & Clark, 2000). This may be particularly difficult in relation to someone they believe unlikely to genuinely understand (or want to understand) their experiences.

Avoidance Another symptom of PTSD, avoidance of reminders of trauma because they are emotionally overwhelming, can also lead to a reluctance to talk about trauma and/or its impact (Brown, 2009; Ehlers & Clark, 2000). Avoidance is a core aspect of dissociative reactions and disorders.

Dissociation Discussions of trauma and trauma-related symptoms can be emotionally overwhelming and therefore trigger dissociative symptoms. For example, Lanius et al. (2002, 2005) found that reading survivors of trauma the written transcripts of their traumatic experience could provoke depersonalization, derealization, and distress. In persons with dissociative self-states, this can, at times, lead to a “switch” or shift of self-state from one dissociative self-state (DSS) to another that is amnesic for the trauma. Alternately, when asked to confirm a previously reported trauma, it is possible that the active self-state is fully amnesic for the events, and so the individual may disavow a previously reported event that actually occurred. As indicated above, the neurobiologically driven changes in brain activation patterns can influence dissociative individuals’ level of emotional and physiological responses when discussing or recalling trauma, and likely also relate to these individuals’ sometimes variable access to traumatic memories and recall of their own trauma-related symptoms. Finally, individuals who have experienced trauma at the hands of a person important to them (e.g., a significant other or family member) may be conflicted about both wanting acknowledgement and justice for the trauma perpetrated by the loved one, yet also want to protect that person and their relationship with them (DePrince et al., 2012).

Difficulties with Attention and Memory Poor attention, concentration, and difficulties with memory, particularly related to events around the trauma and its aftermath, are common in TRD (McKinnon et al., 2016; Parlar, Frewen, Oremus, Lanius, & McKinnon, 2016). Experts 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 (Brewin, Kleiner, Vasterling, & Field, 2007; Loewenstein, 2014; Markowitsch, 2003). It is beyond the scope of this article to review the extensive research documenting that a substantial proportion of adult survivors of childhood trauma experience a period of partial or complete forgetting of the childhood trauma, although recent reviews are available (Barlow, Pezdek, & Blandón-Gitlin, 2017; DePrince et al., 2012). Research has established the reliability of recovered memories of trauma (reviewed in Brewin, 2012; Brewin & Andrews, 2017; Dalenberg, 2006). These difficulties in attention and memory can impede information gathering, preparing for trial, and the trial process itself. Memory lapses and inconsistencies in a deposition or testimony may work against a case for a psychological injury plaintiff, who may be penalized for the condition for which they are seeking damages unless this is meaningfully addressed by the plaintiff’s experts and attorneys. Defense attorneys may also be impeded in presenting counter arguments to TRD claims, because the changing information may be difficult to contradict.

Similarities Between Presentations of Trauma and Malingering Trauma survivors can be highly motivated to convince evaluators that their symptoms are real, intense, and severely impairing, a phenomenon that has been described as akin to a “cry for help” (Courtois & Ford, 2013). In trying to ensure that their request for help is heard, Brown (2009) warns that trauma survivors may act in ways that are “hauntingly similar to that of malingerers” (p. 587) even though their behavior is driven by very different motives. Indeed, some individuals who have experienced disbelief from others may try to convince evaluators that their trauma and posttraumatic reactions are “real.” This can come across as malingering to an evaluator, particularly when the individual’s scores on some of the standard validity scales that are supposed to measure exaggeration and malingering are elevated (see below).

Furthermore, trauma-based symptoms can also appear extreme. For example, a survivor who is re-experiencing the smells, images, and feelings related to a trauma can appear to be suffering so dramatically that he/she may appear to be exaggerating. As Brown noted, the assessor may be confused when the same person who earlier has presented as highly dramatic later appears to have a contradictory presentation,

such as appearing to be emotionless and “flat.” These variable presentations are even more confusing if the individual later downplays the importance or frequency of a symptom, or, perhaps even more perplexing for assessors not familiar with severe dissociation, when the individual seems to have no recall for something they have already reported. It is important that assessors are aware that traumatized individuals can appear vastly different depending on whether they are in an avoidant or dissociative state, or an emotionally flooded state with high levels of traumatic intrusions (Brand, Armstrong, & Loewenstein, 2006).

Assessment of Dissociation Using Standardized Instruments

There has been a surge in the development and utilization of assessment tools for dissociation. Screening for dissociation among all traumatized individuals is beneficial, for it identifies evaluatees who may need to be assessed more thoroughly for DDs with structured interviews. Due to space constraints, we limit our discussion to assessing dissociation using well-validated instruments, but additional resources about assessment of complex trauma including dissociation are available (Armstrong, 2017; Brand, Webermann, & Frankel, 2016; Briere & Scott, 2015; Briere & Spinazzola, 2009; Brown, 2009; Courtois & Ford, 2013; Dalenberg & Briere, 2017; Dalenberg, Straus & Ardill, 2017; Frankel, 2009; Frankel & Dalenberg, 2006). As always, multiple sources of assessment data are necessary, including careful behavioral observations, testing with measures and interviews that have been validated for the population and issue at hand, corroboration from multiple sources, and thorough review of discovery materials, to develop an accurate assessment of the individual.

Self-Report Dissociation Screening Instruments

In the context of forensic assessments, even the most reliable and validated self-report measures of dissociative symptoms must be considered aids in detecting or supporting the possible presence of dissociative symptoms, not as freestanding diagnostic tools (Frankel & Dalenberg, 2006). Formal diagnoses of dissociative symptoms should be made with the inclusion of a structured or semi-structured diagnostic interview conducted by a clinician who has received specialized training in the assessment of trauma and DDs. For an up-to-date overview of screening measures and diagnostic interviews for dissociation and dissociative disorders with demonstrated reliability and validity, see Loewenstein, Frewen, and Lewis-Fernandez (2017). The following self-report measures are those that are most useful in screening for TRD in forensic contexts.

The Dissociative Experiences Scale (DES; Carlson & Putnam, 1993) is widely used in clinical and research settings.

Referenced in over 2000 publications (Lyssenko et al., 2017), the DES is by far the most commonly used measure of dissociative experience. It consists of 28 items querying a range of mental (or “psychoform”) dissociation-related phenomena; higher mean scores indicate greater dissociation. Meta-analyses (van IJzendoorn & Schuengel, 1996) of studies using the measure indicate high internal consistency ($\alpha = 0.93$; 16 studies) and strong test–retest reliability (ranging from 0.78–0.93; 6 studies), as well as strong convergent validity (mean Cohen’s $d = 1.82$; $N = 5916$). The DES has demonstrated three factors: amnesia, absorption, and depersonalization/derealization, although its factor structure remains the subject of some debate (Lyssenko et al., 2017; Ross, Ellason, & Anderson, 1995; Ross, Joshi, & Currie, 1991; Stockdale, Gridley, Balogh, & Holtgraves, 2002; van Ijzendoorn & Schuengel, 1996). However, caution is warranted when using the DES in forensic contexts because it is a face valid measure that does not contain validity scales and is widely available on the internet, and so could easily be accessed and used by individuals who seek to feign dissociation. Thus, use of it and other self-report measures that are face valid and readily available on the internet may be challenged in court, particularly if it is the only or primary measure of dissociation used.

The Multiscale Dissociation Inventory (MDI; Briere, 2002) is the only stand-alone dissociation self-report measure that is population-normed and yields T scores. This 30-item instrument assesses six forms of dissociation (depersonalization, derealization, memory disturbance [i.e., dissociative amnesia], disengagement, emotional constriction, and identity dissociation) and has demonstrated good internal consistency, factorial validity, and construct validity (Briere, Weathers, & Runtz, 2005). Its identity dissociation subscale has shown 0.92 specificity and 0.93 sensitivity in classifying individuals with DID. These qualities have led this measure to be a favorite among forensic assessors of dissociation (e.g., Brown, 2009; Frankel & Dalenberg, 2006), with the caveats that it does not include validity scales and is a face valid measure of dissociation.

The Somatoform Dissociation Questionnaire (SDQ-20; Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1996) is a 20-item measure of somatoform dissociation, including physical numbness, pain insensitivity, and loss of physical functioning not due to a medical condition or substance with strong psychometrics (Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1998b). It does not include validity scales and is available on the internet, but may not be as obvious a measure of dissociation as is the DES.

The Trauma Symptom Inventory-2 (TSI-2; Briere, 2011) is a standardized, population-normed 136-item measure helpful in screening a wide range of trauma-related symptoms and difficulties, including posttraumatic stress symptoms, somatization, attachment and relationship difficulties, sexual difficulties, and externalizing behaviors,

among others. The TSI-2 has demonstrated good psychometrics and offers 4 summary scales and 12 clinical scales. Although a face valid self-report measure, it does offer two validity scales (Response Level and Atypical Response [ATR]). Unfortunately, its dissociation scale does not specifically include many items related to DID, and its ATR scale does not show adequate ability to distinguish feigned from clinical DID (Palermo & Brand, [under review](#)).

The Multidimensional Inventory of Dissociation (MID; Dell, 2006) is a 216-item measure of dissociation-related symptoms with good psychometrics. Because it is lengthy, it is best suited for evaluating levels of reported symptoms and aiding in supporting and/or differential diagnosis rather than as an initial screen. It is also available on the internet. The MID includes validity scales (e.g., scales for detecting factitious and attention-seeking behavior as well as over-identification in having a DD); the author notes that elevations on these may well occur in genuine cases, however, and that assessors should follow up with inquiries about concerning endorsements (e.g., if an evaluatee admits to sometimes embellishing the truth to garner care). Because the MID does not specify a time frame for reporting symptoms, assessors should also query how recently any endorsed symptom has been a problem.

Experts differ on their view about whether face valid measures should be used in forensic assessments. While some eschew them, particularly if the measures are readily available to the public, another approach can be useful. If an assessor is familiar with the range of responses typically endorsed on a face valid measure such as the DES by malingerers, genuine DD patients, and individuals strongly identified with having a DD, as well as those who have factitious DDs, having the evaluatee complete the face valid measure can provide one additional useful data point in a battery of other tests. For example, if an expert is hired by the plaintiff to assess for psychological damages including a possible DD, the expert might want to compare the severity and frequency of reported dissociative symptoms on an easily accessible face valid measure to the individual's report of dissociative experiences given on a structured clinical interview for DDs. If the plaintiff endorses relatively low frequencies of many, but not all, dissociative symptoms on a self-report measure, and during the interview is observed to dissociate, as well as articulate multiple, detailed examples of dissociative experiences on the diagnostic interview such that they meet criteria for a DD, there is a greater likelihood of the person having a genuine DD. However, if the evaluatee reports very severe and frequent dissociative symptoms on a test like the DES but cannot back them up when queried on a structured interview, the possibility of a malingered presentation is greater.

Diagnostic Interviewing for Dissociative Disorders

If an individual reports or demonstrates dissociative symptoms in the initial interview or is elevated on a self-report measure of dissociation, assessors should follow up with careful interviewing about a range of dissociative experiences, preferably using an empirically validated interview. The Structured Clinical Interview for Dissociative Disorders-Revised (SCID-D-R; Steinberg, 1994, 2000; Steinberg, Hall, Lareau, & Cicchetti, 2001) is a semi-structured interview that assesses the presence and severity of five core dissociative symptoms: depersonalization, derealization, amnesia, identity confusion, and identity alteration. This instrument demonstrates strong reliability and validity (e.g., Goff, Olin, Jenike, Baer, & Buttlif, 1992; Boon & Draijer, 1991; Gast, Rodewald, Nickel, & Emrich, 2001; Steinberg, 2000) and is the interview most recommended for the assessment of DDs in forensic contexts (e.g., Brand et al., 2016; Brown, 2009; Frankel & Dalenberg, 2006), in part because of the inclusion of detailed follow-up questions in which onset, frequency, and severity of the symptoms may be determined. The SCID-D-R has proven useful in distinguishing clinical DID from factitious and feigned presentations in preliminary research investigations (Draijer and Boon, 1999; Welburn et al., 2003). Experts in DDs, including the first author (BB), have found the SCID-D-R useful in differentiating clinical from malingered DID in clinical and forensic settings. The SCID-D-R's primary drawback is that administration can take two hours or more for evaluatees who report a significant number of dissociative symptoms. The development of a DSM-5 version of the SCID-D-R is underway (Steinberg, personal communication, September 3, 2017).

General Use Measures with Dissociative Individuals

General use measures with good psychometric properties can provide a more complete diagnostic picture with respect to comorbid difficulties and personality patterns (Briere & Scott, 2015; Briere & Spinazzola, 2009; Courtois & Ford, 2013). However, assessors must ensure that their interpretations are informed by empirical findings about the use of these tests with traumatized populations. Traumatized individuals tend to endorse a wide range of symptoms, some of which were thought to be uncommon when most general use instruments were created and/or normed on non-trauma samples. As a result, research has repeatedly shown that severely traumatized people, particularly those who experienced developmental trauma or chronic interpersonal trauma, tend to elevate on many clinical and/or validity scales, although not typically the validity scales that do not include trauma-related items (Brand & Chasson, 2015; Brand et al., [in press](#); Brand, McNary, Loewenstein, Kolos, & Barr, 2006; Brand, Tursich, Tzall, and Loewenstein, 2014; Brand et al., 2016; Brown, 2009;

Caldwell, 2001; Rogers, Payne, Correa, Gillard, & Ross, 2009). This pattern can lead to false-positive interpretations of symptom exaggeration or feigning when the overwhelmed, highly symptomatic traumatized individuals are reporting their myriad symptoms accurately.

Minnesota Multiphasic Personality Inventory-2 (Butcher et al., 1989)

Research has shown that people with a history of trauma tend to demonstrate elevated clinical and validity scales on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; e.g., Engels, Moisan, & Harris, 1994; Klotz Flitter, Elhai, and Gold, 2003; Korbanka, 1997; Korbanka & McKay, 2000; McGrath et al., 2000; Wolf, Reinhard, Cozolino, Caldwell, & Asamen, 2009). Caldwell (2001) argued that interpretations of the MMPI-2 overlook diagnostic information related to childhood trauma. Wolf and colleagues (Wolf, Reinhard, Cozolino, Caldwell, & Asamen, 2009) discovered that 11 items from scale 8 (schizophrenia scale) distinguished 81% of adults abused in childhood from non-abused controls. These researchers found that these 11 items captured trauma-related characteristics found among adults maltreated as children, including emotion dysregulation, dissociation, impulsivity, poor concentration, and somatic complaints. Two of the 11 items explicitly assess dissociative processes (i.e., daydreaming and “blank spells”). (For additional scales developed for detecting child abuse histories in adults, see Korbanka, 1997, Korbanka & Gaede, 2003, and Korbanka & McKay, 2000).

Researchers have also found that dissociation is associated with validity scale elevations. Among 88 treatment-seeking women who had experienced childhood sexual abuse, four variables (dissociation, PTSD, depression, and family backgrounds) correlated significantly with F scale scores and accounted for 40% of F scale score variance (Klotz Flitter, Elhai, & Gold, 2003). Dissociation was the strongest predictor of F scale scores ($r = 0.51$). One fifth of the sample had F scores $> 100T$, and 13% had F scores higher than 120T. The authors suggested that evaluatees' presentations included genuine, although severe, problems, including problems associated with trauma and early family dysfunction.

A meta-analysis indicated that using general norms to interpret the F, Fb (infrequency-back), and Fp (infrequency-psychopathology) scales resulted in high rates of false-positive classifications in traumatized individuals (Rogers, Sewell, Martin, & Vitacco, 2003). Rogers et al. (2003) recommended a cutoff score of 9 on Fp as most accurate in assessing feigned PTSD. Others have concurred in recommending Fp when examining the profile of a person with adverse childhood history (Elhai, Gold, Sellers, & Dorfman, 2001; Elhai, Naifeh, Zucker, & Gold, 2004; Klotz Flitter, et al., 2003).

Research using the MMPI-2-RF (Ben-Porath & Tellegen, 2008) is important, given that this version of the MMPI-2 is shorter, and therefore easier, to administer. The MMPI-2-RF validity scales show promising ability to distinguish feigned from genuine PTSD (Marion, Sellbom, & Bagby, 2011). Unfortunately, to the best of our knowledge, there is no research on the MMPI-2-RF using dissociative samples.

Few studies have examined DID profiles on the MMPI-2. Welburn and colleagues (Welburn et al., 2003) found elevations ($M > 80T$) on scales 2, 4, 6, 7, and 8, and extreme F score elevations ($M > 100T$) among DID patients. More recently, Brand and Chasson (2015) compared 53 SCID-D-R-diagnosed DID patients to 75 coached DID simulators and 67 uncoached DID simulators on the MMPI-2. They found that scale 8 was the highest clinical elevation among SCID-D-R-diagnosed DID patients, and replicated the significant elevations ($> 70T$) found by Welburn et al. on scales 2, 4, 6, and 7. Scale 8 was linked ($r = 0.47$) with dissociation among DID patients. F, Fb, and Fp distinguished simulators from genuine DID patients, although Fp was best able to discriminate simulated DID. However, none of the validity scales demonstrated adequate positive predictive power. Using discriminant function analysis, seven MMPI indices were combined and correctly classified 85.3% of all cases and 86.0% of the DID sample. The authors provide a classification equation that can be used to aid in classifying individual profiles as indicative of genuine or simulated DID (see p. 97 of their report). In a separate study using these same three samples, Brand and colleagues studied patterns of most common and least common item endorsements on F, Fp, Fb, Sc, and D scales. DID patients most frequently endorsed items related to dissociation, trauma, depression, fearfulness, conflict within family, and self-destructiveness. The coached DID simulators more successfully imitated the item endorsements of the DID group than did the uncoached group. Both simulating groups frequently endorsed items that were uncommonly endorsed by the DID group, however. The uncoached group endorsed items consistent with popular media portrayals of people with DID being violent, delusional, and unlawful. Item endorsement patterns may provide useful information to assessors making determinations about whether an individual is presenting with DID or feigning. In summary, these findings suggest that the MMPI validity scales should be interpreted with caution in use with trauma survivors, especially those with DDs.

Personality Assessment Inventory (Morey, 1991)

Multiple studies (Calhoun, Collie, Clancy, Braxton, & Beckham, 2010; Rogers, Gillard, Wooley, & Ross, 2012; Stadnik, Brand, & Savoca, 2013) have suggested that the Personality Assessment Inventory (PAI) does not demonstrate acceptable validity with severely dissociative populations. Similar to the MMPI-2, the PAI profiles of traumatized patients demonstrate a pattern of elevated clinical and validity

scales (Calhoun et al., 2010). The most concerning elevation occurs on the Negative Impression Management (NIM) scale, which is supposed to assess symptom exaggeration (rather than malingering). Research has demonstrated that these items are frequently endorsed by patients assessed to have trauma histories. Rogers, Gillard, Wooley, and Ross (2012) found an average score of 71.977 ($SD = 15.38$) on the NIM scale among inpatients with severe trauma exposure and an average score of 85.857 ($SD = 22.02$) among complex DD patients. Given that the NIM includes two items that specifically address dissociation (having amnesia and personality states), it should not be surprising that the DD patients elevate on the NIM. Indeed, Stadnik, Brand, and Savoca (2013) found high elevations on NIM among inpatients diagnosed with DDs (NIM $M = 77.597$, $SD = 18.72$), with somewhat lower elevations on another exaggeration subscale on the Malingering Index (MAL). The DD patients did not elevate on Rogers Discriminant Function (RDF), making this potentially the most useful PAI validity scale for DD patients, although replication is needed.

Distinguishing Between Feigned and Clinical Dissociative Disorders

Malingering occurs in 2 to 14% of individuals with DDs (Coons & Milstein, 1994; Friedl & Draijer, 2000; Thomas, 2001). Distinguishing exaggerated versus malingered versus genuine DDs is complicated because feigning individuals may entirely fabricate their symptoms, or they may have a genuine DD yet exaggerate some of their symptoms (Brown & Schefflin, 1999; Chu, 1991; Kluft, 1987).

Early studies of DID feigning found that individuals with clinical DID as diagnosed by the SCID-D (the earlier version of the SCID-D-R) scored lower on amnesia, identity confusion, and identity alteration than DID feigners (Draijer and Boon, 1999). No notable disparities on depersonalization or derealization were found. New research has recently emerged to guide assessors in the detection of feigned from clinical DID; we review this below.

Structured Interview of Reported Symptoms

Multiple studies have suggested that the Structured Interview of Reported Symptoms (SIRS and SIRS-2; Rogers et al., 1992, Rogers et al., 2010), as typically scored, misclassifies severely traumatized individuals as falsifying symptoms (Brand, McNary, Loewenstein, Kolos, & Barr, 2006; Brand, Tursich, Tzall, & Loewenstein, 2014; Rogers, Payne, Correa, Gillard, & Ross, 2009). Similar to the MMPI-2 and PAI, three studies have found that severely traumatized individuals genuinely responding on the SIRS and/or SIRS-2 demonstrate elevations that might lead to a determination of feigning

(Brand, et al., 2006; Brand et al., 2014; Rogers et al., 2009). Brand and colleagues first discovered that the SIRS misclassified approximately 35% of patients diagnosed with DID, primarily in high endorsements of symptoms on the Subtle and Selectivity scales (Brand, McNary, Loewenstein, Kolos, and Barr, 2006). Rogers and colleagues replicated this, finding the SIRS misclassified 31% of patients with severe trauma histories as feigners (Rogers et al., 2009). Rogers suggested that the elevated profiles were due to trauma-based distress and dissociation as opposed to feigned symptoms, because the elevations were on scales measuring amplified symptoms (e.g., Subtle and Selectivity) rather than scales not typically endorsed in clinical populations.

In light of their findings, Rogers et al. (2009) developed a Trauma Index that did not over-classify complex trauma survivors as feigners comprised of the sum of three scales (SC = symptom combination, IA = improbable or absurd symptoms, and RO = reported versus observed symptoms) not endorsed at high levels by traumatized individuals. Brand and colleagues (Brand et al., 2014) investigated the performance of Trauma Index with SCID-D-R diagnosed patients and found that the Trauma Index (which can be calculated based on either the SIRS or SIRS-2) accurately distinguished clinical from simulated DID. The Trauma Index performed better than the SIRS or SIRS-2 classification rules among the SCID-D-R-diagnosed DID sample.

Test of Memory Malingering

The Test of Memory Malingering (TOMM; Tombaugh, 1997) is a symptom validity test of cognitive effort; to individuals taking it, however, it appears to be a challenging test of memory. This makes the TOMM a uniquely useful measure for assessing malingering of memory problems among individuals who report dissociative amnesia. New research shows that the TOMM can accurately distinguish SCID-D-R-diagnosed DID patients ($N = 31$) from coached DID simulation ($N = 74$) (Brand, Webermann, Snyder, & Kaliush, *under review*). The TOMM Trial 1 demonstrated high specificity (87%) and positive predictive power (94%) and moderate sensitivity (78%), negative predictive power (63%), and overall diagnostic power (81%). Despite coaching, the simulators were not able to accurately feign the DID group's performance on the TOMM. This suggests that the TOMM may be one of the most promising measures for use in distinguishing feigned from clinical DID with respect to dissociative amnesia.

One additional area of testing that can be useful in possible dissociative cases is testing for suggestibility, given the claims that dissociative individuals are prone to false memories and to falsely believing they have a DD. (See Part I of this series for a review of the research in this area; Brand et al., 2017.) While research does not support this notion, presenting data about a given individual's level of suggestibility can provide

useful validation (or lack thereof) regarding a specific person's vulnerability to suggestion and compliance with authority figures. The Gudjonsson Suggestibility Scale (Gudjonsson & Clark, 1986) is useful for assessing an individual's degree of suggestibility.

Conclusion

Chronic dissociative reactions and DDs can occur following traumatic events and are often associated with considerable suffering and impaired functioning. Research consistently indicates that traumatized and severely dissociative individuals often elevate on many validity and clinical scales. This has led to a consensus among trauma, forensic, and assessment experts that the high elevations on validity and clinical scales often reflect the functional impairment, severe symptomatology, and emotional distress common among those with complex trauma. Interpretations of elevated profiles should be informed by a review of literature on the use of measures with traumatized populations, and interpretations or caveats based on these citations should be included in an assessor's report and testimony. When no such literature exists, this should be noted and interpretations made with considerable caution. It may be more defensible in forensic contexts to use only measures that have been validated with complex trauma samples in order to follow the recommendations of the guidelines for forensic psychology advising the use of "assessment instruments whose validity and reliability have been established for members of the population assessed" (American Psychological Association, 2013, p. 15). Finally, forensic experts involved in the assessment of individuals with complex trauma should strive to keep informed about emerging research related to the assessment of trauma, including dissociative reactions and confounds in assessing them.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Informed Consent No human studies were carried out by the authors for this article.

Animal Rights No animal studies were carried out by the authors for this article.

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