# Testifying About Trauma: A Call for Science and Civility

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Traumatic events and their impact on the psyche often find their way into legal matters. It is the trauma, the wound to the body and mind, not the label of posttraumatic stress disorder (PTSD), that is the substance of the expert witness's message. Trauma is real, but not always measurable, irrespective of the congruence between reported symptoms and diagnostic criteria. The label represents the wound, but does not describe it palpably. Yet, for the expert witness, the label seems to be the ticket to the show. With PTSD, a person has it or not, based on the presence or absence of criteria. If a diagnosis of PTSD is not made, the personal narrative may go for naught. In our recent experience, expert testimony can be derailed when the explanation of the effects of psychic trauma deteriorates into a falsely dichotomous nitpicking romp through the diagnostic criteria. We are talking about opposing attorneys and the expert witnesses who (over)identify with them. Our nomenclature gives trauma-related events a wide berth and dimensionality. Concurrently, trauma-informed interviewing and therapies have ascended. Is it possible for psychiatric expert testimony to be trauma informed? The adversarial nature of criminal and civil proceedings militates against it, and we would like to see this change. It is important that a change be brought about, as it applies to both perpetrators of violence with histories of trauma and to victims of traumatic incidents seeking legal recourse for harm done to them. When we allow falsely binary measures to arise in the court room, it affects real people who have been through real trauma, and this is unacceptable practice, both professionally and ethically.

Psychic trauma is a wound on many levels: gene expression, neurotransmitters, perception, behavioral predispositions, and worldview. Although we have identified types of situations that give rise to psychic trauma, we are now beginning to learn who is most vulnerable and how protective factors and neuroplasticity shape clinical presentation and prognosis after traumatic incidents. At this moment, we cannot speak the machine language of the brain. We cannot visualize psychic trauma or measure brain healing. Instead, we have personal narratives that variably comport with the idealized template that is our diagnosis.

In the following paragraphs, we examine ways in which the label of PTSD limits us, overshadowing the clinical and science-based information of the effects of trauma on humans. We have been deeply disappointed at the manipulation of diagnostic criteria to invalidate a person's narrative, and offer the view that trauma-informed evaluations and testimony represent an ethical alternative.

## Does DSM-5 Help?

Try as we may, there is no keeping the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[1] out of legal matters. In proceed-

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ings such as veterans' benefits, personal injury litigation, and criminal prosecutions, fact finders and litigators require a diagnosis. Indeed, a PTSD diagnosis can be a threshold for service-connected benefits, a cash cow for personal-injury attorneys,[2] or a convincing reason to grant criminal leniency[3] or exculpation.[4] We do not dispute the general importance of diagnoses for clinical and business purposes or for professional communication.

There was never a question that psychiatric labels would enter the legal arena. We were warned:

> When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis [Ref. 1, p 25, Cautionary Statement for Forensic Use of DSM-5].

Psychiatric labels can be helpful or harmful. So potent are our pronouncements that we are prohibited from commenting on manifest psychopathology of public figures.[5] The diagnosis of an incurable condition, sociopathy, equated with a death penalty in a not-too-distant iteration of Texas death-penalty law.[6,7] A recent flurry of post-*Atkins* litigation (*Atkins v. Virginia*, 536 U.S. 304 (2002)) has caused the Supreme Court to revisit the diagnostic scheme for intellectual disability.[8] It appears that the state of Texas wishes to reserve the option to use DSM-IV diagnostic criteria,[9] which give weight to the numerical IQ score, a matter partially resolved in *Hall v. Florida*.[10] However, Texas's position would tend to retain several inmates, presumably *Atkins*-qualified under DSM-5 intellectual disability, on death row. Thus, according to AAPL's *Amicus* brief in *Moore v. Texas* (not decided at the time of this writing),[11,12] the respondent is violating the "evolving standards of decency" that have marked progress in mental health and disability law. We consider the government's high-stakes gamesmanship anathema to our code of conduct.

What about expert witnesses who knowingly participate for the state in these matters? That a psychiatrist would violate an evaluee's rights in death-penalty matters by using a retired diagnostic scheme is indefensible. Yet, when we testify in other matters, for example, personal injury, we can be seduced by a chance to better our colleagues. The subject matter and intricate diagnostic scheme of PTSD are a perfect medium for losing mindfulness of our role in aiding the legal process via fair and reasonably objective information. Trauma is an area in which our diagnostic schema can be particularly limited, in that PTSD is only one of multiple potential psychiatric sequelae of trauma: depression, psychosis, antisocial personality disorder, and other outcomes also may follow traumatic incidents.

## It's the Trauma, Not the Label

A few basic assumptions: first, the experience of adverse events is highly individualized. Second, the expression of psychological trauma, largely subjective, takes many forms, some of which are atypical of the idealized DSM version, for example, racism-induced trauma.[13] Third, because all learning involves neurochemistry, trauma may have effects that may not be measurable in the short term or by today's technology. Fourth, the practice of trying to appreciate the effects of trauma by descriptive symptom inventories alone is bad clinical practice and worse forensic practice.

That the pathologic anatomy of mental disorders is beyond our reach has often been observed. Expert witnesses cannot be held to a higher standard. Isaac Ray, in his lectures at Jefferson Medical College in the early 1870s,[14] provided sound advice for students who may otherwise disbelieve the physical basis of mental disorders. Ray modeled respect for science, tolerance of our ignorance, and maturity in his implicit call for restraint in judgment, his own serenity prayer:

> Of course, it is not to be doubted that there is in every case of mania an organic change, a deviation from the normal condition. This conclusion, I admit, is almost solely a matter of faith, for as yet the microscope has supplied none of the deficiencies of the scalpel . . . . At any rate, we have no right to deny any molecular change in insanity, merely because neither the knife nor the microscope has unfolded it to the inspection of our senses (Ref. 14, p 1049).

Trial lawyers have embraced the equation of DSM labels with the diseases themselves. This kind of reification distracts court proceedings from the central question of what happened to a person and the physical basis of consequent phenotypes. We have been impressed that, in both civil and criminal cases, the battleground becomes a question of whether the civil plaintiff or criminal defendant meets criteria for PTSD, not whether there was an index traumatic event that could inform the litigation. If it can be argued by defense counsel (civil) or prosecution (criminal) that the diagnosis does not apply because all criteria have not been met, the trajectory becomes

a total negation of the underlying condition. This approach wrongly objectifies the experience and effects of trauma, substituting in their place a list of surface features that can be dispatched by cross-examination. We feel this viscerally in court when opposing counsel has a copy of DSM-5 on the table.

In criminal cases, not only does a history of trauma contribute to the forces that shape violence, but there is a trend toward using trauma in dynamic formulations of behavior. On the defense side, the typical arguments involve how traumatized individuals experience and process information differently, may not immediately appreciate the impact of their reactions on others and should be regarded as less culpable because they are damaged. These dynamics have been most successful in defense of military veterans and victims of domestic violence, but less so with other stressors.[15] How does the defendant demonstrate the damage? Not by brain scans, blood tests, or biological markers. The proof is in the symptoms and, of course, in the narrative. But the diagnosis is only as good as the congruence with DSM criteria, and the narrative must have folk-psychological validity. The prosecutor can take the position that trauma never took place, using the gatekeeper criterion A, itself subject to interpretation.[16] The easier tack is to deflate the other criteria, which include subjective factors that can be feigned, or by suggesting that the documentation is faulty. For example, in a homicide case with which we are familiar, the prosecutor argued that the defendant could not have PTSD because there was no record of his having functional impairment. That he had undergone war-related trauma and involuntary separation as a child took a back seat to an argument about what amounts to functional impairment in these diagnostic criteria. The jurors, presumably left with the impression that the defendant was manufacturing a psychiatric problem, convicted him quickly.

In the civil domain, because the label of PTSD is so important to personal injury plaintiff attorneys, the pressure on expert witnesses can create distortions, both in the attorney's expectations and in the opinions themselves. It is not uncommon, in our experience, when our diagnosis reflects adjustment disorder, for the attorney to respond, "Can't you give me PTSD?" This is a chilling experience for us, because it raises questions of ethics, such as modifying diagnoses on demand, and conflicts in the economics of practice. As if that were not bad enough, on the defense side, an attorney might say, "The plaintiff's expert says their client has PTSD, but we don't think so." This is equally disturbing, since the expectation is for us to shoot down the label. We have no quarrel with reasonable disagreement, as long as we acknowledge that there is a verifiable trauma, when applicable. Exceptions occur when, for example, a rape is alleged and there are no witnesses, or remote experiences were never documented. Even so, rebuttal experts need not vanquish the evaluee by negating the clinical presentation in its entirety. Perhaps both sides can agree to taking what the evaluee reports, the symptoms are consistent with a trauma- and stressor-related disorder. To do more harm to the evaluee, in our view, is gratuitously competitive and likely evidence of overidentification with the attorney. When we attempt to distill a human being's narrative into discrete criteria, too much nuance is lost. Anyone who works with individuals who have suffered trauma knows that these individual differences in response to trauma are not trivial; they are everything in working with traumatized persons clinically.

## Help From Science

Traumatic events create enduring changes within the nervous system that affect not only an individual's experience and memory, but also his predispositions, attitudes, and physical adaptations. These phenotypic variations have the potential to alter and inform posttrauma behavior, which may become the subject of criminal or civil litigation. As one would expect with a complex phenomenon, there is wide variability in the clinical expression of psychological trauma. Some individuals will have full-blown PTSD, whereas others will have an attenuated form. What we considered a common pathway for criterion A in DSM-IV, experiencing the event with intense fear, helplessness, or horror, is now passé. The substrate of human experience and consciousness is beyond our grasp. It is reasonable to set a gatekeeper criterion for the diagnosis of PTSD, since we need a common language and consensus for coding disorders. In doing so, we invite nitpicking over the label, which can become an overvalued focus, obscuring the personal narrative. Beyond that, and despite the best efforts of DSM-5, the clinical presentation of PTSD is hopelessly idiographic: that is, it may be as individualized as a fingerprint or snowflake. Perhaps neuroscience and genetics can help.

Reviewing the importance of neuroscience literacy for psychiatry, Schildkrout stated, "Recent genetic studies have dealt a decisive blow to the notion that DSM/ICD disorders are biologically distinct" (Ref. 17, p 724). Indeed, lists of putative disorders containing surface criteria may soon give way to a substantially broader view of illness. For example, Schildkrout notes: "The field of epigenetics is collapsing the artificial difference between nature and nurture, revealing the true unity of biopsychosocial" (Ref. 17, p 725). Such a transition will be a change in paradigm similar to that described in the 19th century shift in focus from symptoms to coherent phenotypic descriptions of mental disorders.[18] The next iteration of nosology will presumably invoke the manifestation of intragenomic changes that have personal and intergenerational effects on what has come to be known as the endophenotype: occupying the "space" between genetics and disease.[19] The interaction of genes and environment (G × E), an active research area,[20] may play a role in expanded formulations of behavioral dynamics.

The fact of trauma and the nature and magnitude of clinical symptoms are not a perfect match. Intrinsic vulnerability factors for PTSD have been subject to a genome-wide study, with some success.[21] It is unlikely that vulnerability will play a significant role in personal-injury litigation, because of the "eggshell plaintiff" principle. However, recent research suggests that generalization of fear stemming from trauma may take longer to return to baseline in persons with clinical PTSD.[22] This approach may be useful in explaining why a plaintiff is not necessarily malingering or magnifying symptoms, a perennial bugbear in litigation rhetoric. Neuroplasticity, on the other end of the process, may play a role in the prognostication of PTSD and potentially inform its treatment.[23] If it becomes measurable, it opens the door to a new calculus of monetary damages.

## Discussion

Our understanding of the effects of traumatic events, in psychological and biological terms, has been incomplete, which is a handicap for those wishing to educate court proceedings. In a review of biological responses to stress, van der Kolk and Saporta[24] note the disconnect between 19th (Janet) and 20th (Sigmund Freud, Ivan Petrovich Pavlov, Abraham Kardiner, and Roy Richard Grinker, Sr.) century formulations of psychic trauma, on the one hand, and more contemporary studies, on the other. In both instances, there is an emphasis on the association of traumatic events with physiological adaptations, which we regard as symptoms. The disconnect seems to have occurred by our overreliance on the DSM, inattention to fields of science not immediately applicable to our work, and a loss of mindfulness about our being physicians first and agents of litigation second.

Meanwhile, psychiatry has been striving for a comprehensive understanding of mental diseases, and the zeitgeist of our field is moving toward symptom clusters and spectra. We cannot explain these conditions by listing their symptoms alone. To date, however, the language we use in our reports and testimony must reflect the state of the art and avoid untestable or pseudoscientific pronouncements. Kendler recently quoted Burton's 1651 *Anatomy of Melancholy*: "The tower of Babel never yielded such confusion of tongues, as the chaos of melancholy doth variety of symptoms" (Ref. 25, p 771). So too, in the application of trauma assessments to legal settings, confusing judges and juries is of no value.

In our view, the moral high road is to make the folk-psychological assumption that traumatic events have functional consequences, to discuss these beyond DSM descriptors, and to add science as it becomes available and admissible. That having been said, a word of caution is necessary: the evaluee's narrative must be regarded with circumspection in the forensic setting,[26] and not merely channeled by the examiner.[27] Instead, as Griffith has suggested, the examiner should be attentive to structuring the narrative, evaluating it, and being mindful of its vocabulary, rhetorical power, and ethics-related dimensions (Ref. 26, pp 126–8). In conveying the trauma victim's history, we must refrain from wearing our hearts on our sleeves, leaving us with lopsided performances on the ethics border.[26,28]

Instead of playing the shallow DSM game, forensic professionals should take the position that each person experiences and expresses trauma individually, whether the DSM conforms or not. We recommend focusing on what we do best: taking detailed histories and constructing verified personal narratives that shed light on the behavior or damage in question. This suggestion is not meant in the trivial sense: that we record an examination, read records, and supply a formulation. Instead, we would like to see evaluations of individuals claiming psychic

trauma elevated to a value higher than winning, regarding sensitivity to an individual's life story and respect for interindividual differences. In effect, we recommend trauma-informed forensic formulations that promote the search for truth above adversarial considerations. This approach leaves room for interpretation of behavior against standards governing criminal behavior, assessment of damages, and eligibility for entitlements, without our falling into a rhetorical quagmire. Let the attorneys form the arguments. In our model, expert witnesses, on both sides of cases, can demonstrate respect for the importance of trauma in the worldview, behavior, and psychobiology of individuals relying on us to contribute to proceedings with dignity and civility.

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