DISTRICT COURT, JEFFERSON COUNTY, COLORADO

Case No. 96 CR 1886, Division 4

REPORTER'S TRANSCRIPT — MOTION'S HEARING
DECEMBER 12, 1996
TESTIMONY ONLY

PEOPLE OF THE STATE OF COLORADO

v.

JAMES DARRON McDANIEL,

Defendant.

Hearing on motions in the above-entitled matter was held on Thursday, December 12, 1996, before the HONORABLE MICHAEL C. VILLANO, Judge of the District Court.

TESTIMONY of JEAN McALLISTER ONLY

FOR THE PEOPLE:
SCOTT W. STOREY, No. 13482
and
HAL SARGENT, No.14289

FOR THE DEFENDANT:
ANN M. ROAN, No. 18963

AFTERNOON SESSION, THURSDAY, DECEMBER 12, 1996

* * *

JEAN McALLISTER,

called as a witness on behalf of the People, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SARGENT:

Q If you would please tell us your full name and spell your last name.

A My name is Jean McAllister, M-c-A-l-l-i-s-t-e-r.

Q What work do you do?

A I am a therapist with the Assault Survivors Assistance Program at West Pines at Lutheran Medical Center in Wheat Ridge, Colorado.

Q And you are formally trained in what area?

A I am formally trained -- in terms of my degree, I have a master's degree in social work, which is a two-year graduate degree in social work with an emphasis on doing clinical work, which means co-therapy and intervention with individuals, families, and couples with psychological problems.

Q In the course of your experience, how many victims of trauma have you treated or

diagnosed?

MS. ROAN: Your Honor, I'm going to object. It assumes facts not in evidence. She can talk about people who have claimed to have been assaulted.

THE COURT: I think that's the question that's being asked. Objection overruled.

A I would estimate somewhere between three and five thousand.

Q (By Mr. Sargent) Let me turn specifically to the effects of trauma on memory. If you could, tell the Court what your -- both your education and training and -- three, your education, training, and experience is in that area.

A Okay. Well, I need to introduce that by saying that there is fairly substantial clinical research evidence that's now published as well as my clinical experience that indicates that trauma impacts memory in almost every person who experiences trauma to some degree or another. So...

Q Let me stop you there, then.

A Okay.

Q In terms of the literature, how accepted

is that in the psychological community -- community of therapists?

MS. ROAN: Objection, foundation.

THE COURT: Overruled. Go ahead.

A Actually there has been in the last few years some controversy about issues of memory and how traumatic memory is different from normal memory raised by a group of people who do not have psychological training or who do not understand trauma and do not -- and have not participated in the community of psychological research that's been done. And that has been popularized as the false memory syndrome.

What is accurate in the therapeutic community, and in the academic community, is that in the last few years there's been a substantial body of research conducted primarily at Harvard by Bessel van der Kolk and some of his colleagues that addresses how traumatic memory is different, how it is experienced differently by people, who -- how it is stored in the brain differently than normal memory which has been termed declarative or narrative memory. And there's a substantial body of strong, unbiased clinical research using standard control mechanisms that is now very

well-accepted in the therapeutic community.

Q (By Mr. Sargent) Can you give me a fairly brief explanation of how traumatic memory or how trauma can affect memory -- let me rephrase that -- how the memory of someone whose experienced a trauma might be different from someone who -- ordinary memory?

MS. ROAN: Again, I'm going to object based on foundation. I mean, we don't know where this opinion is coming from in terms of this person's actual knowledge.

THE COURT: Unless I hear from her, I can't decide whether or not she has the expertise. So the objection's overruled.

MS. ROAN: Okay.

A Well, essentially what needs to be understood about trauma, first, you need to have that basis to understand how memory is impacted. Trauma is identified in the clinical literature as an event that is so overwhelming, overpowering, personally threatening, or emotionally overwhelming that the person experiencing it must utilize extraordinary coping skills to deal with it. Essentially that means, in layman's terms, it's too big an event to absorb all at once, and it's very

similar in that fashion to -- you can make an analogy to physiological trauma. What happens is parts of the organism in physiological trauma shut down -- blood pressure drops, body temperature drops, and other things -- so that something such as a stab wound won't allow someone to bleed to death immediately. Essentially you absorb less of the trauma because systems shut down.

In psychological trauma, when something is massively overwhelming, some of the ways that the psyche attempts to cope with that are to blunt and numb and not take in so much information. Essentially what the research shows is that information is taken in by the reactive primitive parts of the brain like the medulla and is not fully taken in and integrated in cognitive functioning, essentially.

How that is defined in the clinical literature is that people who experience a trauma have images, sensations, and sensual perceptions, feelings, smells, tastes, and body reactions as well as affective reactions which are emotional responses that are stored fairly independent of what we call normal declarative memory.

When you or I experience something, we

take it in, we experience the sensate and the emotional components, and then we have a story about what happened to us. It's connected to our cognitive functioning, and we can tell about what happened. We can tell when things happened and how they happened and how we experience them.

In trauma it's not connected to cognitive memory. Traumatic memory is generally stored as those immediate images, sensations, and affective responses, that do not connect directly to our cognitive memory.

So people experience bits of information that -- and van der Kolk actually identified several components of traumatic memory, i.e., it is stored in those separate sensate, imagistic kinds of ways. It is not subject to voluntary recall, which means it may either come up when someone doesn't want it to, or they may not be able to pick something to remember if someone asks them a specific question. So they can either be flooded by it, or they can have missing pieces of information about it.

And then it's also not responsive to social demands, i.e., if you ask me a question about "Did I have a car accident," and I'm in a

public place, I can say, "Yes, I had a car accident." If you're a law enforcement officer saying, "Give me the details," I can tell you all the details. I have access to both being able to shorten it or lengthen it or define my experience.

Through my understanding, traumatic memory is not condensed in the same way. People don't have the access to the cognitive understanding of the entire event to be able to tell it from beginning to end or to shorten it or make it more succinct the same way we do about something we've already integrated and already understand.

Q Let me stop you there. Someone who's experienced a severe trauma, how might it affect their ability to relate what happened to them, suppose immediately after the traumatic event?

A It can happen generally in two ways. One is sometimes people are flooded with information, i.e., they are overwhelmed by certain images or feelings or sensations. And so they will repeat specific images or sensations or things that are coming up that frighten them over and over again like they can't get it out of their mind, can't get away from it. A real typical clinical example that

I see is a woman who talks about someone who has assaulted them seeing the face over and over again. And she can't get the face out of her mind. She's having a great deal of difficulty understanding why she can't get that face out of her mind.

The other may be that they experience only parts of the trauma, that they have access to information about only parts of the trauma and they may not remember everything that happened to them.

And a really explicit clinical example of that was a 14-year-old girl who I saw who had been sexually assaulted in her home. She had done literally everything right, they caught the guy. He admitted. But she was referred to me because when he had forced his way into her home she couldn't -- she had blanked it out. She had literally disassociated during the moment he pulled the door open and then pulled the knife on her. She kept saying, "I don't know how he got in the house. I'm afraid. He got in the house. I don't know how he got in the house."

She was aware she was missing information. Some people aren't even aware they're missing information, and they'll have pieces of information with big missing chunks without being

able to tie it together.

Q And that memory that is at least initially not there, does it ever come back?

A In most cases it returns over time. Some of it returns actually even without treatment. The research indicates that the access to having more clear information that's connected to narrative memory about an event usually progresses at the same rate that traumatic symptoms decrease, and you see a normal rate of decrease that's fairly consistent over days and weeks and months away from the trauma.

If there is a traumatic reaction that's unresolved, it may last longer in some people than in others. And in some very, very severe cases, pieces of the information may go unremembered without treatment.

Q In this kind of affective memory, the effect of trauma on memory, is that only in victims of sexual assault?

A No, that is in any sort of life threatening -- the components I talked about earlier, either overwhelming or affective response or a threat to another person that is -- that requires those extraordinary coping mechanisms. So

it could be a car accident, could be exposure to combat. It could be a robbery. It could be a fire, an earthquake, any sort of severe traumatic event.

Q You've talked mainly so far about the literature that supports the effect of trauma on memory. What clinical experience do you have with patients, victims of what you perceive to be victims of trauma, and the effect that that has on their memory?

A Well, I have -- would you like me to go through my work experience?

Q Yes.

A I currently work at the Survivors Assistance Program as a psychotherapist. Our program is a specifically trauma-focused program. So our client population, with the exception of assessments that we do, is generally a population where trauma has been experienced at some time.

We're also asked to do numerous assessments within the West Pines Hospital System, and so I do a lot of sorting with people who do have trauma reactions and don't know it. But primarily my caseload for ongoing work is trauma related. I've had that position for seven years.

Before that I worked for a brief period of time at the Jefferson County Senior Resource Center and coordinated a victim response program and a peer counseling program for seniors.

Before that I was the program supervisor at Gateway Battered Women's Shelter and essentially was the clinical supervisor for both the counseling staff in our residential battered women shelter where we housed women and children who had been assaulted, and our out-client counseling program which did outpatient therapy for battered women and their children.

Before that I worked for Arapahoe County Department of Social Services and did child abuse and neglect investigations and ongoing casework for a youth in conflict unit. Before that I worked in a residential treatment center, Excelsior Treatment Center for adolescents girls.

Q In terms of where the report is of adult sexual abuse, in lay terms, a rape case --

A Um-hum.

Q -- how many victims have you seen clinically, approximately?

A Easily over 500. I would estimate somewhere between 500 and a thousand.

Q And the effects of the trauma that they've experienced on their memory, can you -- how often have you seen that, and have you -- have you seen it, first, clinically, and how often?

A Almost every person who experiences trauma has some impact on their memory from that trauma. I have seen -- I would say the very large majority of the people I've seen have all had some impact on their memory from the trauma.

And I actually have been very happy that the research has come out in the last couple of years because there's been clinical experience, and my clinical experience has been very consistent with the things that the research is pointing out. And I find that very powerful validation of what I've seen over the years.

Consistently people talk about being overwhelmed by images, flashbacks, feeling like things happen to them, that they don't have a way to talk about or understand, having difficulty sorting out what order things happened to them, having difficulty understanding why they have such strong emotional reactions, and yet very little cognitive understanding of what's going on.

And actually treatment focuses on helping

people integrate the overwhelming aspects of the trauma into declarative memory, although that's not the language that was used when I first started doing this work.

Q So the memory is stored in images. It takes a period of time for the person to be able to describe it in words?

A To describe it in words or to describe it consistently in words in a way that makes sense. Sometimes they will describe things that seem not to make sense initially, but once they have a picture of everything that's happened, it makes a great deal of sense.

Oftentimes that makes a lot of sense when they get -- even when they're witnesses. An example of that would be a case where -- and it's actually a case one of my colleagues took the lead on, but we did a debriefing for a bank staff that had been robbed. And one of the -- a man had come in and pulled a gun on one of the tellers. He had literally jumped over the teller box and taken the gun away from the man. He did not have memory of doing that. But in the debriefing, everyone was saying to him, "God, you did a great job." And he said, "All I did was stand there." And they

reported to him the things that he had done, and he was able to integrate that. But he had been afraid he was going to be killed when he did that. As he was jumping over the box, he thought, "God, I'm being stupid." And he disassociated and did not take in the memory until the people around him reported what he had done. And this is even when he had a positive reinforcement for remembering it.

Q Does the effect -- excuse me, the degree of trauma have an effect on the type of memory loss that you've described?

A Yes. The particular coping skill is normally termed "disassociation" in the literature. And, essentially, the greater the threat to one's personal safety, the greater the perceived threat to one's life.

The more intense the level of trauma, i.e., how much physical pain, how much personal humiliation, how much -- the length of time that the trauma is extended, the kinds of things that would make it a more difficult experience, essentially increase the likelihood that there would be a greater use of the extraordinary coping mechanisms in a traumatic event.

Q And that opinion is supported by

literature?

A Yes, it is.

Q And also by your experience?

A Yes.

Q Have you testified as an expert before in this area?

A Yes.

MS. ROAN: Again, I don't understand what this area is. Could he ask with specificity how she's been qualified as an expert.

Q (By Mr. Sargent) How about the effects of trauma on people?

A Yes, I have been qualified as an expert in that area.

Q And how many times have you testified as an expert in that area?

A I'm going to have to say I don't know if those exact words were used each time. I have been qualified as an expert in the effects of trauma and the impact of sexual assault on victims, the impact of domestic violence, so there's been a range of different things. And I would -- I can't say specifically how many times that someone named it just trauma, but I have probably testified close to 50 times since 1985 when I was first qualified as

an expert in a domestic violence case.

Q How many times in this county?

A Probably ten or twelve over the years.

Q And in how many of those cases was the effect of trauma on the person part of your testimony?

A Literally in every case.

Q You have described your training -- or your background and the literature in the field and also your experience. Have you also trained others --

A Yes, I have.

Q -- on the effects of trauma?

A Yes, I have.

Q What groups?

A Well, there are many -- in the last couple of years, I do fairly regular training on trauma and assessing trauma for Lutheran Medical Center and the West Pines staff and Lutheran Social Work Department. I have presented trainings for the Colorado Coalition Against Sexual Assault. I have presented trainings for the Colorado Coalition -- Colorado Organization for Victim Assistance. Last week I was working with the Department of Corrections sex offender treatment

staff on the effects of trauma on their work as therapists. I've presented for the -- I was invited to present on violence against women and how it impacts women for the Bureau of Justice Assistance National Conference two years ago. I presented at a physicians conference earlier this year on domestic violence on the impact of sexual assault in battering cases. Would you like me -- I mean, I can continue.

Q No, let me just speed it up a little bit. I think you answered at least part of it. So doctors are sometimes part of the groups that you train?

A Yes, and -- doctors, psychologists, social workers, people who do clinical treatment, criminal justice personnel. I often do consultations to a -- a substantial portion of my job at the Assault Survivors Assistance Program is to do assessments in the hospital setting about whether trauma treatment is needed for people. And those are always requested when -- when the M.D.s in charge of the case feel they need assistance in assessing whether there's a trauma impact and advice about how to provide treatment in the cases. And that's a part of the job that I do on a regular

basis.

Q When you came in this afternoon, you provided me a list of trainings presented?

A Um-hum.

MR. SARGENT: Giving a copy to, Ms. Roan. Judge, if I could approach?

A That's a partial list over about the last two years.

MR. SARGENT: If I can have just a moment.

(Tendered to the Court and to Ms. Roan.)

Q (By Mr. Sargent) Just one last area, you had talked about the van der Kolk study, about the effects of trauma on memory.

A Um-hum.

Q That's the most recent published article in the field?

A Actually the book Traumatic Stress by -- I've got the authors written down. I should give you exactly their names -- van der Kolk, McFarland and Weisaeth -- published this year is probably the most thorough. They edited the book, and it's a compilation of different studies on trauma, some of which are van der Kolk's. I think his work is actually the strongest.

Q The idea that trauma, how it affects memory, is that something that's just developed in the last year or so, or something that's been in the literature for a period of time?

A It's been in the literature clinically since Janet. And some of the early work from Freud in the 1800s has related that trauma has an impact on memory and an impact on how people experience memory. It has clearly been a part of our diagnostic material for years. The DSM system, which is the Diagnostic and Statistical Manual, which is what any clinician any therapist uses to diagnose patients, that system has included, under post traumatic stress disorder, indications under the numbing and avoidant category of traumatic symptoms that psychogenic amnesia is a possible outcome of trauma since the DSM III.

And then there was DSM III Revised. Now we're using the DSM IV to diagnose. So that's consistently been a part of the clinical literature for years.

MR. SARGENT: Judge, perhaps I can get some clarification from the Court. I don't want to put anybody to sleep. At the last hearing my understanding was the Court needed to hear some

more -- wished to hear some more from Ms. McAllister regarding the effect of trauma on memory. I don't think there was any question of her background or expertise with -- in the general characteristics of rape victims. I wasn't --

THE COURT: I'm not sure. I think that was part of the objection, as I recall.

MR. SARGENT: I'll go through that then, Judge.

THE COURT: If you want to do it briefly.

MR. SARGENT: All right.

THE COURT: Okay.

Q (By Mr. Sargent) You said you had treated many hundreds of people who came in complaining of rape; is that right.

A Yes, that's correct.

Q Is there a discrete -- or there are some recognized symptoms of -- can you tell me the types of effect, emotional effects of rape on people?

A Yes. You generally see -- one of the first indicators is a typical traumatic reaction. And there are three primary symptom sets around trauma and how people present trauma when they are having difficulty with integrating traumatic material.

The first is called the intrusive or reexperiencing symptoms set. And essentially that's the kind of thing that I think a lot of people have heard described as flashbacks, nightmares, what we call intrusive thoughts where people can't get something out of their mind, feeling like they may be experiencing something again for very brief moments in time.

For instance, if somebody was attacked from behind, if they're walking down a hallway and a co-worker comes up behind them, they might be frightened for a period of time. But the central theme is that those fragments and images and sensate responses and feeling responses keep coming up into consciousness almost unbidden and that it feels overwhelming and distressing.

Most people who present for trauma treatment are experiencing, though, the second symptom set that's required -- in the DSM IV that's required to experience a traumatic experience is the avoidant or numbing symptom set. And that essentially means it's the symptoms that people use to try to avoid the overwhelming, uncomfortable, distressing nature of the trauma. And those things include disassociation, what we call psychological

numbing, or cutting off access to their feelings. They talk about feeling flat or not feeling anything. Sometimes people will describe them saying something about something that happened to them as if they're talking about someone else.

When people have long-term traumatic reactions, they may begin to avoid reminders of the trauma. They may try to avoid if they were assaulted, for instance, in a bar, they would stop going out. They wouldn't see other people.

If they were assaulted in an elevator, they would have difficulty getting on elevators. So there are all kinds of sets of numbing. And it can become very dysfunctional. Even long term, people can begin to use drugs or alcohol to try not to feel the overwhelming effect that they're experiencing.

Q That's part of the general category of post traumatic stress disorder?

A Yes. And there's one more symptom set; that's hyper-arousal. I want to be clear so I don't leave anything out. And that is the physiological activity. People have trouble sleeping, get the shakes, get the sweats, hyper-reactive startle response, those sorts of

things.

Other things you would see in rape victims are exaggerated fears, specifically terror of someone coming back to harm them again, feeling shame, humiliation, feeling dirty, sometimes there's a component of self-blame. For rape victims "I must have done something to deserve this. Somebody must have thought that I deserved this. Why is God doing this to me," kind of thing.

You often see difficulty with trust with other people and difficulties being in social situations, confusion, hopelessness, despair, sometimes rage. Those are sort of the general responses from rape victims.

Q There is one other area that can be answered quickly. What about the rape victims' interest in avoiding men. Is that common for rape victims?

A It's actually very common. The majority of rape victims are female, and the majority of offenders are male. From -- and that bears out along all the research lines. And part of that is that the exposure to men is a reminder of the trauma, and particularly when there are still not integrated pieces of the trauma. It may trigger

those memories that come up that are not under voluntary control. And so seeing a man on the street may -- she may freeze. She may experience internal feelings of terror and distress related to the original assault.

So many times women will try to avoid coming into contact with men that they don't know well, or men that they don't feel entirely safe with.

It's actually not uncommon that when I'm seeing a victim in the hospital, if she walks out in the hallway and there's one of the cleaning people in the hallway -- it's a long way down to our receptionist desk -- I've had several women turn around and walk back in my office and say, "Could you walk me back out there," because she's afraid to be in an enclosed space with a man she doesn't know. That's a very common reaction.

Q What about this general category -- first the general, then the specific, rape victims who do not want the part of their body that was affected or traumatized -- affected during the assault, whether it was an oral assault, vaginal, anal, avoiding contact to that area?

A That's very common. And the primary

place we see that -- and I've worked a lot with our volunteers around teaching them how to respond -- we have a volunteer group in Lutheran that attends the rape forensic exams in the hospital and provides support to victims who go through that. That's the most common place we see that activity.

Many victims experience the sex assault exam, when they have to be swabbed for semen, as an intrusion or reexperiencing the rape. It's very common. It's based on the same theoretical basis which is that re-exposure will trigger those not-yet-integrated emotions and sensations and feelings that they experienced during the actual assault.

And so it's not at all uncommon. Some victims will even refuse parts of the exam. Some get sick during the exam in response to even -- even being touched in those areas again.

Q And have you ever seen someone who appeared to gag where that part of their anatomy -- where the gag reflex was not touched? In other words, oral swabbing of the mouth, have you ever seen someone or had it reported that they gagged during that part of the exam?

A I've both seen it and had it reported and

worked with clients who had to work on being able to eat and drink without getting sick again after an oral assault.

MR. SARGENT: Thank you. I have nothing further.

THE COURT: Okay. Ms. Roan.

MS. ROAN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. ROAN:

Q Good afternoon. Ms. McAllister, are you familiar with the book called Synopsis of Psychiatry? It was written by Dr. Kaplan, K-a-p-l-a-n, and Dr. Sadock, S-a-d-o-c-k?

A No, I'm not.

Q You've never heard of the Synopsis of Psychiatry?

A I have not.

Q You are familiar with the DSM IV?

A Yes.

Q Are you aware the Synopsis of Psychiatry is commonly used by mental health professionals as a supplement to the DSM IV?

A I am aware that it is used by some mental health professionals. My experience is that it is generally used by M.D.s, by medical doctors.

Q So you've never looked at it?

A I've seen it. I'm not familiar with it. I would not be able to tell you that I've read most of it.

Q Do you think it's probably a well-accepted treatise among mental health doctors and professionals?

A I believe it is among M.D.s. It is not commonly used at the clinical level in West Pines, and it is not commonly used with most of the therapists that I know that do trauma work. It is with M.D.s.

Q Would you agree with me that it's a reputable publication?

A Yes.

Q And you're not familiar with it, but you're not going so far as to say you don't think it's an accurate or correct book?

A No, I would not say that. I'm just telling you that I haven't used it a lot myself.

Q But doctors, people with medical degrees use it?

A Often, yes.

Q Okay. Now, you have a master's in social work, correct?

A Yes.
Q And you earned that in 1993?
A Um-hum.
Q From the University of Denver?
A Um-hum.
Q You have to say yes or no.
A Yes, I'm sorry, yes.
Q Okay. And that was a two-year program, correct?
A Yes.
Q It involved both classroom work and then you did field study?
A Yes.
Q By 1993 D.U. discontinued its concentration program had it not? You were not able to earn a concentration?
A We did have con -- that was the last year of concentrations. That was the last year of concentrations. And so my concentration was in clinical, child, and family. They called it direct service at that time for clinical -- direct service child and family.
Q How much direct psychology were you taught at the University of Denver in earning your MSW?

A By what do you mean direct psychology?

Q Well, how many classes in psychology did you take?

A Well, I had a clinical concentration, so the majority of my course work was clinical, i.e., talking about doing direct work with individuals, groups, children, and families.

Q Okay. In terms of theoretical underpinnings to psychological theory and the application of that theory, how much formal training did you receive in that area?

A I'm not sure what you're asking. Each of my courses approached the material with a theoretical background for the concentration on clinical work that would be done. My experience in graduate school was that the whole idea of going to graduate school is learning how to use theory to inform your practice and to apply it on a regular basis.

So I would say each of my classes provided theoretical basis for any of the interventive work that we were taught.

Q How many of your teachers were psychologists?

A None of my teachers were psychologists.

They were clinical -- many of them were clinical social workers, who are people who do clinical treatment on an ongoing basis of people in the therapeutic setting.

Q And many of them were also, for example, lawyers, correct? Sharon Seiber was one of your instructors, was she not?

A One of them was, in Ethics and the Law class, yes.

Q You're not a licensed clinical social worker, are you, Ms. McAllister?

A No, I'm not.

Q Can you explain how one becomes a licensed clinical social worker?

A Yes. One receives a -- you have to have an advanced degree, and you need to have a certain number of hours of supervision, which I have completed. And then you need to take an exam which will allow you to be licensed. And I'm planning on doing that early next year.

Q And that exam is somewhat similar to the bar exam for lawyers in terms of --

A Um-hum.

Q It's a national administered thing?

A Yes.

Q You get a registration number?
A Yes.
Q And you're licensed and thus obligated to certain professional standards?
A Yes.
Q That are administered by the State of Colorado?
A And you actually are obligated to those standards if you identify yourself as working in social work whether you're licensed or not.
Q You aren't licensed, are you?
A I'm not.
Q So you wouldn't be similar to a lawyer who has taken the bar exam in that regard?
A Yes.
Q You estimate that over the course of -- well, what did you get your bachelor's in?
A Sociology.
Q And that was in 1978 out of the University of Northern Colorado?
A Yes.
Q So with that sociology degree, you were able to function at the Assault Survivor's Assistance Program at West Pines in the same capacity prior to getting your MSW as you do now

that you have your MSW?

A Yes. They made an exception and hired me because I had had experience. I have experience in trauma work and extensive supervision from several psychologists who had specialized in trauma over the years and hired me over people who had MSWs and master's degrees at that time.

Q So you would agree with me that your MSW -- your MSW is an important personal credential, perhaps. But you were performing the same work before you got that degree that you're performing since receiving that degree at West Pines. You haven't -- would you agree with that?

A Yes.

Q You've also worked in the field of certification in domestic violence treatment, correct?

A Yes, I teach at the Denver Cares Counselor Training Program. I teach a course in understanding adult domestic -- adult victims, survivors of domestic violence. And I teach another course in treating sexual trauma.

Q Don't you also do something with drug and alcohol counseling?

A That's -- Denver Cares is actually run by

ADAD, the associate -- the drug and alcohol counselors' certification program in Colorado.

Q So do you do anything with drug and alcohol counseling through your work at Denver Cares?

A I don't counsel anyone for drugs and alcohol directly through Denver Cares. I teach through Denver Cares.

Q I know. But, see, you provide training courses, correct?

A Yes.

Q Were they just in domestic -- are they just in domestic violence treatment certification, or are they also in drug and alcohol counseling?

A They're used both by ADAD, which is the drug and alcohol counseling certification program in Colorado, for continuing education for social workers, psychologists, drug and alcohol counselors who need continuing education in that area to maintain their drug and alcohol counseling certification, and for treatment providers who need continuing education for domestic violence certification. So both.

Q Okay. You also teach a course at community college that is just called the Community

College of Aurora that evidently is called domestic violence, correct?

A I taught a course. I'm not teaching it currently.

Q Okay. You've also worked with senior citizens and their needs?

A Yes.

Q And you've worked with teenage girls and their needs at the Excelsior Youth Center, correct?

A Um-hum. And that was 18 years ago, essentially.

Q But to this day through West Pines, you're running groups for teenage girls, aren't you?

A Um-hum.

Q So you're still working with teenage girls as well?

A We work with adolescents and adults, usually 13 on up. Sometimes we go down as low as 11.

Q And you're also still working with senior women, senior citizens?

A Sometimes, although the population of senior women in outpatient services is rather low. So, yes, I do periodically. But we don't have a

large population of women over 65 in our outpatient groups.

Q Okay. When you worked at the Department of Social Services, you were working with family crisis, correct?

A Yes.

Q You were working with delinquency problems, correct?

A Yes.

Q You were working with child abuse problems, correct?

A Yes.

Q So you know all about that, too?

A Um-hum.

Q Okay.

MR. SARGENT: Your Honor, I'm not sure that's been answered.

THE COURT: Pardon me?

MR. SARGENT: I don't know that that was answered.

Q (By Ms. Roan) Did you indicate yes?

A I know about those issues, yes.

Q Okay. Would you agree with me that the host of symptoms you've been talking about in terms of claims of failed memory, partial memory,

fragmentary memory, or disassociation can be attributed to a lot of mental health problems that have nothing at all to do with somebody who claims to have been sexually assaulted.

A There are some mental health problems where memory is impacted. I would not -- I don't know what you mean by a lot. There are some other mental health problems where memory is impacted, primarily, depression. You see some difficulty with concentration and memory, although that is usually not memory for a discrete event, that is usually memory related to short-term memory and ability to concentrate and retain information on an ongoing basis because of the disruption of the depression.

Some people with anxiety have difficulty focusing and taking in information. Usually that's not discrete to a single event.

There are other kinds of problems, certainly some of the mental disorders where people experience psychosis, where they're literally not in touch with reality, have impaired memory because their perception of what happened is what's going on in their head instead of what's going on in the world around them that would result, to some

degree, of impairment that would include schizophrenia, manic episodes, that become psychotic, those sorts of things. So, yes, if that qualifies as a lot, I'm sure there are others as well. I'm not covering every disorder. But there are differences in how memory is impacted, but definitely memory is impacted by other mental disorders.

Q Well, Bessel van der Kolk, who you've indicated you respect in this area --

A Um-hum.

Q -- when he did his empirical study that is detailed in the article that was published in Journal of Traumatic Stress in 1995, he had to rule out a lot of things in the putative subjects to his study --

A Um-hum.

Q -- before he could administer the study. Do you agree or disagree with that?

A Yes, he did.

Q He had to rule out organic mental disorders, correct?

A Umm, yes. Yes, I'm sorry.

Q He had to rule out schizophrenia?

A Yes.

Q He had to rule out bipolar illness?
A Yes.
Q He had to rule out substance abuse?
A Um-hum, yes.
Q He had to rule out alcoholism?
A Yes.
Q And he could not do this except in a face-to-face interview?
A That's correct.
Q If somebody was diagnosed with cerebral dysfunctioning, that would impact the way that they remember things whether or not they were raped, correct?
A I'm not a medical doctor. And I would want more detail about what sort of cerebral dysfunction. My understanding with cerebral dysfunction is that it could impact several different functions, memory being one of those. But that general a term, without me having any information about a particular person, I couldn't tell you for certain that it would impact their memory. That would be one of the things I would want to assess, but I wouldn't have enough information from that term alone to tell you exactly what was impacted.

Q And you don't have any information at all about the complaining witness in this case, do you Ms. McAllister?

A The only information I have about this case is that the defendant's name is McDaniel.

Q Okay. You don't remember, then, the fact that you were in the emergency room when the complaining witness in this case came to Lutheran Hospital?

A No, I do not.

Q You don't recollect that at all?

A That's interesting, because I don't work in the emergency room. So if I was there, I'm not sure how I would have been there.

Q Do you know Jean Decker?

A No.

Q Okay.

A I don't know who Jean Decker is. If you can tell me the time of year that this happened, I could -- I could try to remember whether I was walking through the emergency room for a meeting or something. But...

Q Good. You don't remember. You don't remember, Ms. McAllister.

A I don't work there so...

Q That's fine. So you don't have any information about the complaining witness at all, correct?

A None.

Q So if you were presented with hypothetical behaviors, without any information at all about the person who demonstrated those behaviors --

A All I would be doing is addressing those behaviors.

Q But in terms of -- of connecting them with having been raped rather than any of these other problems that one has to rule out before one can say -- one looking at memory affected by trauma, you have to have some sort of history about the person, don't you?

A If you're talking about that person, yes.

Q Right?

A Yes.

Q So somebody who's demonstrating a behavior, for example, of aversion to men --

A Um-hum.

Q -- you cannot say that that person is the victim of trauma involving violence perpetrated by a man, can you?

A No. I could say that behavior is consistent with someone who is experiencing trauma reaction, but I can't say that person has been traumatized because I don't know that person. I haven't seen that person.

Q And that reaction, aversion to men, is also consistent with many other mental illnesses, correct?

A Some other mental illnesses, yes.

Q For instance, it could be also consistent with malingering, correct?

A Yes.

Q In a post-traumatic stress disorder situation, malingering has to be ruled out before making any diagnosis, is that what the DSM IV says?

A That's correct, in any diagnosis malingering has to be ruled out essentially.

Q So while you could testify that many behaviors are consistent with rape trauma, you also have to concede they're equally consistent with a whole host of other mental disorders?

A It depends on how the behaviors are presented to me. If someone presents a constellation of behaviors that any one of which might be consistent with another disorder, and many

of which are consistent with a certain disorder, I might be able to say that there's a greater likelihood based on the information I have. But I wouldn't say, for instance, that malingering is not as common a diagnosis, generally, as post-traumatic stress disorder. It's not as common. Depression is a much more common diagnosis than, for instance, some of the schizophrenias.

So knowing that, I would need to say they're not equally as likely, I guess, is what I'm saying, I guess, depending on the constellation of symptoms and depending on the commonness of the disorder and in the general population. But you're right, they would all have to be addressed if I were saying whether an individual had a certain disorder or not.

Q Well, if you're asked to testify -- and this is what you're going to be asked to testify to, Ms. McAllister, you're going to be given a list of six or seven reactions --

A Um-hum.

Q -- and you're not going to be told any other information and you're going to be asked to infer for a jury that those reactions mean that somebody was raped, are you comfortable doing that

professionally?

A My understanding is that I'm going to be asked to indicate whether those reactions are consistent with symptoms that someone who's been raped is experiencing. And I am comfortable doing that.

I have not at any point said that I am diagnosing this particular victim as having been raped, and I wouldn't be comfortable doing that. I would be comfortable saying certain symptoms are or are not consistent with my experience of the presentation of a sexual assault survivor.

Q Do you remember when you were asked to draw together a bibliography of resources that you relied on --

A Um-hum.

Q -- when you were first involved in this case?

A Yes. And what I --

Q That's the answer to my question. Now I'll ask my next question. Do you remember writing a note on that bibliography and saying, "I will be better able to discuss specific resources after I meet with the DA and am able to work on preparing my testimony"?

A Yes.

Q So until you talked to the DA, you didn't really know which resources you would base this particular opinion on?

A Yes, because the -- the bibliography that I gave was a general bibliography covering a wide range of victim issues and domestic violence, sexual assault and trauma. And I was not clear at all about what I would be asked. So I didn't know which of those resources I might be referring to.

Q You've talked a lot about people who are just unable to remember portions of assault?

A Um-hum. Yes.

Q That you've also -- do you believe that it's a feature of assault victims to make up different stories about what happened to them and how they were assaulted, not to not remember, but to tell completely different stories about events?

A That is not consistent. I have the experience that some victims will try to explain what they believe happened to them before they have integrated all of the information, and sometimes they have confused information. And there are, periodically, some people who make up information about assaults.

Some people have what's called factitious disorder, which is very rare, which is specifically consciously, thoughtfully making up stories about having been assaulted for the attention they get from the medical and psychotherapeutic community from doing that.

People also have factitious disorder around other kinds of issues other than assault. And it's a fairly rare disorder.

And then there are some people who make up assaults. Generally my experience has been in false reports that they are often people who are trying to protect themselves from getting in trouble for something else.

Many -- there have been, I would say, five or six in the years I've worked at ASAP where we've seen adolescents come through our emergency department. We do the follow up on them. They say they've be assaulted by someone they've never met in their whole life and were blindfolded and taken away somewhere, and have all the details of the assault. Later we find out that they were at a party or drinking or doing something they weren't supposed to and they're saying they got assaulted to get out of trouble.

Those usually surface within 24 hours or so. Law enforcement is pretty good at sorting those out. And therapeutically, people are pretty good at identifying that kids are not having consistent reaction.

Q What do you base that on, "law enforcement is pretty good on sorting those out"?

A The ones that we see through the emergency department, which -- and all the sexual assaults that we see through our emergency department come with law enforcement accompaniment. We see many victims in our program that don't come with law enforcement accompaniment because they have not reported to law enforcement or other things, or they come after the fact. But through the emergency department, all are experiencing some law enforcement investigation because that's where the forensic exam takes place.

One of the -- one of the issues is often with these adolescents, there's no evidence of any kind of sexual contact at all. That's what I mean. They're good at identifying things that are very inconsistent very quickly. And someone confronts the girl and she starts crying and says, "I didn't want my parents to know I was at a party."

Q Now, you work with the police fairly regularly, don't you, Ms. McAllister?

A I work with victim-advocate programs through police departments fairly regularly. I work with the police infrequently.

Q Okay. And you're also funded, at least in part, by a grant from victims' assistance and law enforcement, aren't you?

A Yes.

Q You get $5,000 a year through them, don't you?

A Our program gets $5,000 a year through the victims' assistance law enforcement grant, which is administered by the DA's office.

Q You do trainings for the DAs, don't you?

A Um-hum.

Q You're also on the First Judicial District's Board for the Certification of Domestic Violence Treatment Providers, are you not?

A I was. I'm not currently. I was for four years.

Q And all your work is with victims, correct?

A The majority of my work is with victims, yes. Not all. We do some assessment, some family

reunification assessments where we assess the offender and the entire family for safety around when it's safe to reunify a family when there's been child sexual abuse.

I do quite a few assessments of people where people are unclear whether there's a trauma or not. So it's fairly often that I see people who weren't traumatized or have trauma in their history but not presenting trauma in their reaction and are not needing treatment for that.

Q Okay. Have the 500 to 1,000 people you've seen who have complained of sexual assault, have most of them demonstrated these sort of post-traumatic stress disorder, memory problem constellations of symptoms that you've talked about?

A Most of them have experience -- have presented some trauma symptoms. I would say not -- probably slightly over half, but not anywhere near most have been diagnosed with post-traumatic stress disorder. Some have reactions that are not severe enough to meet the criteria for that. Some have primary diagnoses that are more in the area of depression or anxiety. So a good number of them have -- many of them have either experienced the

problems with memory that result from flooding and the overwhelming nature of memories coming back unwanted or having periods of time or pieces of information that they can't put together in ways that feel comfortable to them.

Q And it's your belief, then, that -- your professional belief, I guess, that slightly over half of this particular group of people you deal with demonstrate symptoms of post-traumatic stress disorder?

A I would -- of the group of people that I have dealt with, I would say yes.

Q And that's based on your observation -- observing these people, correct?

A My observing these people and working with them over time.

Q And your interpretation of the symptoms they present?

A Yes, yes. And our program is a skewed sample because we -- generally people who are referred by other people who already assume that there's some trauma present, you would not find anything nearly that high in a general mental health population. The people we assess in our hospital setting, not nearly that many of them have

post-traumatic stress-traumatic stress disorder.

Q Okay. But of the people -- I mean Kaplan and Sadock, I guess, disagree with you. Would you be surprised to know that those two medical doctors feel that even when faced with overwhelming trauma, the majority of people do not experience post-traumatic stress disorder symptoms?

A That's -- that's accurate. Actually only about 33 percent of people who have experienced any particular trauma in their life develop post-traumatic stress disorder symptoms. Only about 33 percent of people develop post-traumatic stress disorder as a result of that trauma.

Q Of all the speaking that you've done and the teaching that you've done, not all of those trainings focus specifically on this specialty you have of dissociative memory and the effect of trauma on fragmented memory; is that correct?

A No, not all of them do.

Q And of all the expert witness -- of all the times that you've been accepted as an expert witness, how many times have you been accepted as an expert in the field of dissociative memory and fragmented memory as a result of trauma?

A I don't think it's ever been worded in

those words.

Q Thank you very much. But you're often accepted as a general, I guess, sort of expert on women or people who claim to have been sexually assaulted and how they act?

A Sexual assault, domestic violence, and the effects of trauma on people.

Q And you could also testify, probably, as an expert in adolescent girls who have been in bad situations and severe family crisis situations. Based on your work, you could testify about that, couldn't you?

A I could testify to some degree. I would not consider my expertise as strong in general adolescent development as I do in trauma. I've really specialized in trauma over the years.

Q Given your field work, you could testify about children as well?

A I could testify about them. I would not hold myself up as an expert in children. I don't have experience -- I have training in working with young children.

Q But with regard to seniors, with regard to all kinds of trauma?

A I would not consider myself an expert in

seniors.

Q Okay. With regard --

A I would consider myself an expert in trauma.

Q All kinds of trauma, not just sexual assault, car wrecks, beating up, anything like that, trauma?

A Trauma reactions are fairly consistent, and I've worked with a broad number of them. And I feel like I could talk about trauma in the general population, yes.

MS. ROAN: I don't have anything further.

THE COURT: Anything else?

MR. SARGENT: No, Your Honor.

* * *

(End of proceedings as requested by ordering counsel.)

REPORTER'S CERTIFICATE

The above and foregoing is a transcription of my stenotype notes taken in my capacity as Official Reporter of Division 4, District Court, Jefferson County, Colorado, at the time and place above set forth.

Dated in Golden, Colorado, this 18th day of December, 1996.

Rhonda Jordan
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