DISTRICT COURT, JEFFERSON COUNTY, COLORADO

Case No. 96 CR 1886, Division 4

REPORTER'S TRANSCRIPT — **AFTERNOON SESSION** DECEMBER 19, 1996

PEOPLE OF THE STATE OF COLORADO

v.

JAMES DARRON McDANIEL,

Defendant.

Trial in the above-entitled matter was held on December 16, 17, 18, 19, 20, 26 and 27, 1996, before the HONORABLE MICHAEL C. VILLANO, Judge of the District Court and a jury of twelve.

THIS VOLUME CONTAINS ONLY TESTIMONY OF JEAN MCALLISTER

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 19, 1996

(The Court reconvened at 1:22 p.m., and the following proceedings were held in the presence and hearing of the jury:)

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 Good afternoon.

A Good afternoon.

Q Please tell us who you are, your name and how you spell your last name.

A I'm Jean McAllister, M-c-A-l-l-i-s-t-e-r. And I'm a therapist with the Assault Survivor's Assistance Program at West Pines at Lutheran Medical Center.

Q And what work do you do there?

A I provide psychotherapy to victim survivors of a variety of different sorts of trauma, one of them being sexual assault. And I also provide training and education to professionals in the community around the issue of understanding and responding to victims.

Q What is your educational background?

A I have a master's degree in social work from the University of Denver.

Q And your education, did that include theory on the understanding of psychological

injury, psychological effect, emotional state, that sort of thing?

A Yes, it did. I had a two-year degree program post my bachelor degree and two years of intensive clinical training, a 20-hour a week internship. And all of those things were designed to teach the relationship between theory and how people behaved in the real world and so have extensive training in that way.

I also have many years' supervision from two different clinical psychologists who supervise my therapeutic work, and many, many educational experiences in terms of workshops and classes and training with specific people who have worked with trauma over the years.

Q What about hands-on experience with people who have experienced trauma?

A Would you like me to tell you my history?

Q Well, let's see if we can.

A I have --

Q If you have an abbreviated form, yes?

A I have seven years' experience working as a therapist at the Assault Survivors' Assistance Program at Lutheran Medical Center. Previous to that I worked at the Senior Resource Center in

Jefferson County for about a year and coordinated a victim program for seniors and a peer counseling program for them.

Prior to that I was the program supervisor, which was the clinical director of a battered women's shelter, Gateway Battered Women's Shelter in Arapahoe County. I worked there about seven and a half years and directed the programs that provided emergency care to battered woman and their children in the shelter program and then also the out-client counseling program for woman and children and couples.

Q All right.

A There's more but...

Q Let me stop you there. In the course of your career, how many trauma victims, rough numbers, have you seen, have you treated?

A I estimate that I've seen 3,000, possibly more than.

Q Of those, how many reported being victims of a sexual assault?

A Probably somewhere over 500.

Q Have you testified as an expert before?

A Yes, I have.

Q And have you offered opinions regarding

the effect of trauma on a person's emotional state?

A Yes, I have.

Q How many times have you testified as an expert?

A Probably close to 50, somewhere around 50? I would have to look to be exact.

MR. SARGENT: Your Honor, at this time the People offer Ms. McAllister as an expert in the field of -- in the area of the psychological effects of trauma on a person's psychology, including people who are sexually assaulted.

MS. ROAN: I'm sorry, Your Honor. That was trauma on someone's psychology?

MR. SARGENT: Let's try that again. On the psychological effects of trauma on people, including victims of sexual assault.

MS. ROAN: May I voir dire?

THE COURT: Certainly.

MS. ROAN: Thank you.

VOIR DIRE EXAMINATION

BY MS. ROAN:

Q Ms. McAllister, first of all, good afternoon.

A Good afternoon.

Q You've testified that just now when we

were going through your qualifications that you've -- you've dealt with a lot of people who have gone through trauma, correct?

A That's correct.

Q So that's one of your qualifications?

A Yes.

Q And you think your education has also helped you develop this expertise on the psychological effects of trauma?

A Yes.

Q In 1970 -- let's talk about your education. Okay?

A Okay.

Q In 1978 you graduated from the University of Northern Colorado?

A Yes.

Q That was with a bachelor's degree in sociology?

A Yes.

Q That was a 4-year liberal arts degree?

A Yes.

Q And that degree program required you to take a certain number of courses in your major, which was sociology?

A Yes.

Q Can you please tell the jury what sociology is?

A Sociology is essentially the study of human behavior with a focus on how they interact in group settings, whether that's family systems, small groups, or larger groups such as social institutions, and that sort of thing.

Q Okay. All four of your years of education at the University of Northern Colorado were not devoted exclusively to the study of sociology, correct?

A No, it was an undergraduate degree. And there was a requirement that there were a broad variety of courses that were included as well as the focus on sociology.

Q So in that four years, in other words, you had to complete a curriculum?

A Yes.

Q That's a series of courses in areas that each liberal arts major is required to satisfy prior to graduation?

A Yes.

Q Because the point of a liberal arts degree is to have broad spectrum of knowledge over a whole bunch of varied subject matters, correct?

A Yes.
Q As opposed to a specific focus on one subject matter.
A That's correct.
Q So you satisfied the same curriculum that all liberal arts graduates from U.N.C. have to pass, correct?
A Yes.
Q You would agree with me that liberal arts is a fairly broad category in terms of the major it encompasses, correct?
A Yes, it is.
Q Liberal arts includes political science?
A Yes, psychology -- political science, psychology, English.
Q Communication arts?
A Communication arts.
Q It includes journalism, does it not?
A Yes.
Q Okay. And as you said, it also includes psychology. But you didn't get a major in psychology as an undergraduate, did you?
A No, I did not.
Q And until three years ago, this degree was all the academic background you had to assist

you in your work?

A In terms of formal academics, yes.

Q Okay. You have a resume, don't you, Ms. McAllister?

A Yes, I do.

Q And that resume is designed to cover, in writing, all of your qualifications?

A I will say the majority of my qualifications. I don't think you can cover in writing in three pages all of the experience I've had.

Q Okay. But that was --

A But it's an overview, yes.

Q In that sense, it's thorough, isn't it?

A Yes.

Q And it's up to date?

A Yes.

Q And that resume is divided into three areas, correct?

A Yes.

Q First area is professional experience?

A Um-hum. Yes.

Q So that would be on-the-job types of things?

A Um-hum, yes.

Q The second area is education?
A Yes.
Q And the third area is what you call community service and professional development?
A Yes.
Q Under each of these areas, you've listed all of your major accomplishments that pertain to that particular category?
A Most of my major accomplishments, yes.
Q You leave "major accomplishment" out of your recent resume?
A It's not a list of all the trainings I've done, all the places I'm asked to present. It's not exhaustive in terms of my experience, doesn't list all of my specific -- doesn't list all of my training, all of my ongoing continuing education. But it lists my primary job duties and my primary assignments in terms of community contact and that sort of thing.
Q It lists your major accomplishments in those areas, doesn't it?
A Yes.
Q Thank you. So if we look under "professional experience," we can assume that your major accomplishments since 1978 will be listed

there, correct?

A Yes.

Q Because the resume begins in '78?

A Um-hum.

Q Sorry, you have to say yes.

A Yes. I'm sorry. Yes.

Q And goes to 1996?

A Yes.

Q There are just two entries on your resume under the heading "education"; is that right?

A That's correct.

Q One entry is sociology from U.N.C. you got back in 1978?

A Yes.

Q The other is social work degree you got from D.U. that you got in 1993?

A That's correct.

Q There are no other entries for training you participated in to further your education and training in your field under the portion that's entitled "education"?

A That's correct, only my formal degree education is entered there.

Q You never got additional certification in terms of formal classroom work in the area of

counseling, did you, Ms. McAllister?

A No, that is not required with a master's degree in social work.

Q And you didn't attend any other courses other than your master's offered in the field of counseling, did you?

A Not any formal academic "for credit" courses. I have attended many courses in different types of counseling, and particularly in counseling trauma victims that are continuing education courses, conferences, research presentations, and other sorts of courses.

Q Okay. But I'm talking about formal academic courses. And you never attended any other formal academic courses in counseling, did you?

A That's correct.

Q You could have?

A I could have, yes.

Q You didn't, did you?

A That's correct.

Q The first job that you got after you earned your sociology degree -- and this is under your professional experience on your resume -- was as a summer youth counselor with Weld County Human Resources, correct?

A Yes.

Q And according to your resume, you worked as a counselor at that job, didn't you?

A Yes. And it was a youth employment counselor --

Q You counsel --

A -- very minimal counseling skills.

MR. SARGENT: I ask the witness be allowed to answer the question.

MS. ROAN: Apologize.

Q (By Ms. Roan) You counseled youths in part-time summer employment situations, right?

A Yes.

Q Describe this counseling, please?

A Essentially that was identifying high-risk youth with -- or connecting high-risk youth with possible employment situations to the risk that they would be having problems in the community or acting-out delinquent behavior. It required identifying strengths and skills, identifying problem areas, helping them learn basic skills to prevent problems from occurring, learned basic skills to control acting-out behaviors. It was a very basic counseling position.

Q So when you used the term "counseling" in

that part of your resume, you aren't talking about -- you're not describing an ongoing therapeutic relationship with these teenagers?

A No. It's a short-term summer work program. So the relationship lasted about three months at that time.

Q By using the term "counseling," you aren't claiming that you helped these youths to address significant psychological shortcomings?

A No, I was not.

Q By using the term "counseling," you aren't claiming that you formulated psychological diagnoses concerning these youths and then took appropriate action as a mental health professional based on these diagnoses?

A With those children, I did not.

Q What you did in that job was to match up kids who were unemployed --

A Yes.

Q -- with summer jobs?

A Um-hum.

Q And that was the counseling that you offered?

A Right. And that's typically called employment counseling. And there are even master's

programs in the employment counseling field.

Q You don't --

A However, I do not have that. And that's not my field of expertise. That was my first job post my B.A.

Q You don't have a master's today in counseling, do you?

A No, I do not.

Q How long did you hold that job?

A Just one summer.

Q Three months?

A Um-hum.

Q The next job you got was at the Excelsier Youth Center in Aurora?

A Yes.

Q There you describe yourself in your resume as a group live-in counselor, correct?

A Yes.

Q It's a whole different kind of counseling?

A Absolutely.

Q This isn't employment counseling?

A It is not employment counseling, that's correct.

Q You did employment counseling three

months, and then you became a group live-in counselor?

A Um-hum, yes.

Q You provided individual and group counseling to the adolescent girls who lived at that institution, correct?

A Yes.

Q The girls who live at Excelsier are troubled, correct?

A That's correct.

Q They live there because a lot of the time by Court order they've been taken out of their homes?

A That's right.

Q And some of these girls have behavioral problems?

A Yes.

Q And they don't always follow the rules as a result, correct?

A That's correct.

Q And Excelsior Youth Center is highly structured, right?

A Yes, there's a very structured program there.

Q Which means there are a lot of rules

governing these girls' behavior and activity?

A Yes, sir.

Q And you supervised the daily activity of the girls?

A Yes.

Q One of your responsibilities was to make sure that these girls were following the structured environment at Excelsior, correct?

A Yep, that was one of my responsibilities.

Q To make sure they were abiding by the rules, correct?

A Yes.

Q You weren't the only person responsible for supervising these girls, were you?

A No, there was a team of people, which included a number of group live-in counselors. There was a team leader, which was the lead counselor for each cottage. And then there was a social worker who was the clinical supervisor for the entire team and provided the family therapy and the clinical expertise to intervene with the girls and their families over time.

Q And then there was a mental health professional or professionals over that social worker, correct?

A Actually the social workers were the team leaders. There was a -- there was at the time I worked there, a psychiatrist who consulted when certain girls needed medication or potentially needed hospitalization. But the chief clinicians at that time were social workers.

Q And it was the medical doctor, the psychiatrist that oversaw the medication issues and the therapeutic treatment that the girls received?

A No, it was the social workers who oversaw the therapeutic treatment. It was the psychiatrist who was called in to consult when there were medication issues or when there were a need for eval for hospitalization.

Q Because evaluating possible mental disorders and prescribing medication, those things require specialized academic training, don't they?

A Yes. And they require different training. Evaluating mental disorders can be done by training in -- and education at the master's level in the State of Colorado. And prescribing medication can only be done by medical doctors in the state of Colorado.

Q In your resume you claim that Excelsior you were also providing counseling, just as you

provided counseling at the Unemployed Youths in Weld County. Can you describe the counseling you were providing to the girls at Excelsior?

A Yes, I can. It was a different sort of counseling. And people in the field understand that to a great degree the context where you're working determines the type of counseling that will be provided.

What I provided for those girls essentially was counseling that focused on their ability to interact effectively with the other girls and the staff in the group living setting giving them a chance to do some minimal processing of feelings so that they could learn to behave in ways that weren't acting out their feelings, helping them learn how to resolve conflicts effectively in inter-personal situations, and helping them learn how to understand some of their own behaviors.

Q Okay. So you're saying when behavior issues came up with these girls, you would talk to them?

A Behavioral or feeling, yes.

Q When they were not following the rules, when they were acting out, you would address that

behavior?

A And also when they were doing a good job, we address that behavior also when they were learning things. It wasn't just that you talk to someone when they were in trouble. That would be a very negative therapeutic experience for a child.

Q But when you use the term counseling, you aren't describing an ongoing therapeutic relationship with these girls as a group live-in counselor, perhaps as a team leader, but not what you were doing?

A Actually, each of us did case notes on each child. Every day we were considered to be their primary counselors. We were assigned different girls in the milieu, which is the cottage setting, the therapy living setting. The team leaders did counseling with their families and did their primary individual counseling.

Q So a year out of college with a sociology degree, your only other job experience, summer youth counseling, you're claiming you helped these girls at Excelsior address significant psychological shortcomings in a clinical setting?

A That's not how I framed it. I did address some of their psychological problems. And

it was in a therapeutic milieu setting, which is a group interactive living setting, which is the primary format for treating very troubled teens.

Q By use of the term "counseling," though, you're not claiming you formulated psychological diagnoses concerning these girls and then took appropriate action as a mental health professional based on these diagnoses?

A I did not diagnose on this job. We -- I helped formulate treatments. We formulated the plans in a team setting.

Q That was supervised?

A By the social worker.

Q The team leader?

A Yes.

Q Who in turn was consulting with a psychiatrist if need be?

A Only on cases where medications or hospitalization were needed.

Q Now, you held that job for a year?

A Yes, a little over a year.

Q And then you were hired by the Arapahoe County Department of Social Services as a caseworker?

A Yes.

Q How large a caseload did you have?
A When I arrived, I had 77 active cases. By the time I left, it was closer to 60 some. There were very large case loads at that time.
Q Okay. And you dealt in that job with families who were having severe family conflict?
A Yes.
Q You told them resources are available in the community for help?
A Yes.
Q And sometimes if you felt it would be beneficial, you told the people on your caseload about County Mental Health programs and services?
A Yes.
Q And at that job for the 60 to 70 cases that you were managing, you again claimed that you performed individual and family counseling?
A Yes.
Q But you are also agreeing with me that if mental health issues came up you -- you told these folks, there's places out in the community for you to go get help?
A Yes, we referred both to mental health centers and to residential treatment facilities and worked usually in concert with residential

treatment facilities to get kids back into their homes and functioning back out in the community.

Q So when you use this term "counseling" to talk about what you did at the Arapahoe County Department of Social Services, you aren't claiming that you formulated psychological diagnoses concerning your cases -- the people that made up your cases, and then took appropriate action as a mental health professional based on these diagnoses?

A We did not diagnose at the Department of Social Services, no.

Q And counseling wasn't the only thing you did as part of being a caseworker, you performed six other tasks, correct?

A Correct. And we evaluated cases coming in regularly, the 60 to 70 people at any given time that was -- they turned over, some of them fairly quickly and some of them stayed.

Q Your six other tasks, the first task was assessment?

A Yes.

Q The second task was intake?

A Yes.

Q The third task was referal to other

agencies?

A Yes.

Q Fourth task was making recommendations to the court?

A Yes.

Q And some of those recommendations would be that kids should be taken out of their home and placed elsewhere?

A Yes, or receive other kinds of treatment.

Q The fifth task was treatment plan?

A Planning, yes.

Q That's coming up with a game plan of what people need to do to either get their kids back in the home, what programs they need to go through, things like that?

A Yes.

Q And the sixth task was coordinating services?

A Yes.

Q So counseling was in addition to six other tasks that you had to perform at the Arapahoe County Department of Social Services?

A That's correct.

Q And you refer people out, if they had psychological needs, you didn't provide that help

to them yourself, correct?

A Generally, that's true. When there was short-term crisis situations there were times when I might provide family counseling for -- if it was a very short-term crisis that could be resolved quickly, but generally they were referred for long-term therapy.

Q Right. Because as you've already admitted, providing psychological -- well, doing psychological diagnoses and providing psychiatric treatment to people, that requires specialized academic training, correct?

A Um-hum. That's right.

Q That's not just your opinion, Ms. McAllister. The laws of the State of Colorado require that at least certain minimal requirements be met before somebody holds themself out as a therapist, correct?

A That's correct.

Q You have to at least be registered with the State, don't you?

A With the data base, yes.

Q That's the bare minimum legal requirement for calling yourself a therapist?

A Yes, that's correct.

Q Now, you also held this job at Arapahoe County Department of Social Services for about a year?

A Well, that was closer to a year and a half, but, yes.

Q Okay. And then you got hired at Gateway Battered Women's Shelter in Aurora?

A Yes.

Q You were a caseworker there, too?

A For the first two years, yes.

Q Let's talk a little bit about how Gateway is set up. One of the purposes of that shelter is to --

THE REPORTER: Slow down.

THE COURT: We're going to give you a break Rhonda. Things have been moving pretty fast for you. We're going to take a 15-minute recess.

(Recess taken.)

THE COURT: All right. Ms. Roan.

MS. ROAN: Thank you, Judge.

Q (By Ms. Roan) Ms. McAllister, before the break we were talking about whether you got hired at Gateway Battered Women's Shelter. I think that was in '81.

A Yes.

Q One of the purposes of Gateway is to provide immediate crisis intervention for battered women, correct?

A That's correct.

Q So when a woman calls up and says she's being battered, Gateway is a place she can come to get away from that situation if she chooses?

A Yes, that's one of the things that happen.

Q Once she's there, there are people at Gateway to help her?

A Yes.

Q That help is usually at first in the nature of crisis intervention?

A Yes.

Q Giving her a place to sleep?

A Yes.

Q Getting her food to eat?

A Yes.

Q Helping her get a restraining order?

A In some cases, yes.

Q And eventually maybe helping her with job placement?

A In some cases many woman already have jobs when they come to shelters. Sometimes they

need help with job placement or housing, other physical assistance.

Q And if a woman needed help, Gateway would help her in those areas?

A Yes.

Q And you were involved in -- from '81 to '83 when you were --

A I believe the title was caseworker.

Q Yes. Thank you, when you were a caseworker, you were involved in that kind of helping, right?

A That was one of the areas I was involved in.

Q Because you also did other stuff. For example, you answered telephones on the crisis hot line?

A Yes.

Q And, again, the main function there was on-the-spot assistance, comfort, advice?

A Yes.

Q Okay. Gateway also has mental health professionals who associate with you?

A There is a -- actually at the time I worked there and still work there, the caseworkers -- at the time I worked there the

caseworkers responded to both women and children who were in the shelter and to an ongoing case of out-client counseling, patients. And the caseworkers were all supervised by the clinical director, or the program supervisor is what the title was called then. And there was also a consulting licensed clinical psychologist who came in once a week to supervise the entire staff and go over cases with the staff as a part of the ongoing clinical support for the counseling staff.

Q Okay. So with that explanation, I'll ask my question again. Gateway also has mental health professionals associate with it, correct?

A Yes. The caseworkers are considered mental health professionals. And actually in the out-client program billed insurance, diagnosed, and still do that as far as I understand.

Q But there's a licensed clinical psychologist that oversaw everything that went on?

A That provided clinical supervision, yes.

Q And that person had earned a Ph.D. degree, a doctor in psychology?

A Yes.

Q After two years working as a caseworker at Gateway, you moved into administration at that

shelter, didn't you?

A It was a combined clinical and administrative position. I supervised all of the caseworkers and the crisis workers, and I also carried a counseling caseload in the out-client counseling program as well.

Q But you didn't supervisor and direct the licensed clinical psychologists, did you?

A No, I did not. Actually, that's untrue. We had for a little over a year Carson Henderson, who was a psychologist, worked as one of our caseworkers. And she was under my supervision at the time when she worked as a caseworker at the Shelter.

Q But when she was performing, was she then the licensed clinical psychologist that would direct once a week?

A No, she was one of my staff. The licensed clinical psychologist who consulted with us was Kathryn Jens. And --

THE REPORTER: Could you spell that, please.

THE WITNESS: K-a-t-h-r-y-n, last name is Jens, J-e-n-s.

A She came in once a week to provide

clinical supervision during our team meetings when we did treatment planning and went over cases.

Q That's what I'm asking you. You did not direct and supervise her, Ms. Jens?

A No, I did not direct and supervise Kathryn.

Q Okay.

A She consulted with our program.

Q In the -- you also had many, many other tasks once you became the program director, correct?

A Yes.

Q You did evaluations of programs, correct?

A Yes. That was ongoing statistical collection and evaluating outcomes of clients meeting their goals, their therapeutic goals, and that sort of thing.

MR. SARGENT: Your Honor, I'm sorry, but I guess I do have an objection to this line of questioning. That Ms. McAllister has considerable experience, in addition to her background, in treating and diagnosing trauma victims, is interesting but it's simply not relevant to her credentials whether or not she's done that and is an expert in that field.

THE COURT: We could go through her life history and spend a great deal of the day, which we don't have available to us. I would kind of like to concentrate on her expertise or lack thereof in the field she's being offered, and that would include recent work. I don't think that going back to '83 really does much for us, Ms. Roan.

MS. ROAN: Your Honor, what I'm attempting to do here, she's testified on direct that one of her qualifications is the fact that she was program director at Gateway. I think it's relevant to explore how much of that was providing counseling as opposed to all the other tasks she was responsible for. And so that's what I'm asking about. I only have a few more questions in this area.

THE COURT: Okay.

Q (By Ms. Roan) So you also did some grant writing when you were program supervisor?

A Yes. And that was several times a year we would have grants that were funding specific parts of our program. And I would participate in writing those.

Q And you also did budget planning?

A Yes.

Q And you also did public relations work for the shelter?

A Yes.

Q And after five years of that, you moved on to the Seniors' Resource Center in Wheat Ridge?

A That's correct.

Q And you were a social worker there? That was your title?

A Yes, that was my title.

Q And, again, you say you provided counseling to senior citizens and their families?

A Yes.

Q And part of that counseling was just crisis intervention, wasn't it?

A Part of it was criteria intervention. Part of it was often grief counseling around loss of loved ones. Part of it was grief counseling related to life losses that go with aging, things like major mental -- major physical illnesses mental deterioration, losing skills, losing work life, trying to help people integrate into new living situations. Often older people were moving into assisted living or nursing home situations that were very painful for them to adjust to. So there was a range of -- some of it was crisis

counseling, some of it was a variety of different things.

Q Okay. You held that job for a year, and then you moved to West Pines?

A At that time our program was only a part of Lutheran. We had not -- Lutheran purchased West Pines about three years ago. So at that time it was just Lutheran that we worked for. It was the Assault Survivors' Assistance Program.

Q Okay. That's where you're still employed?

A Yes, it is.

Q It wasn't until four years into that job that you earned a master's degree in social work?

A That's correct.

Q But your job title didn't change once you got that degree?

A It did not.

Q And master's degree in social work took two years of course work?

A Um-hum, yes.

Q Also during that two years, you did field work, that's the internship you're talking about?

A Yes.

Q When you testified on direct that your

master's degree took two years of course work --

A Yes.

Q -- and then two years of field work, that happened within the same two-year time frame?

A Yes.

Q And that's the way the degree is set up?

A Actually it's set up in many different ways. That's one of the ways it's set up. That's how I took mine.

Q That was the way your program was set up?

A Yes.

Q And the field work that you did during the two years you were earning that degree that was supervised by a qualified psychologist, correct?

A That field work was supervised by Leann Slizeski, who was social worker, who was the director of the program I worked for.

THE REPORTER: Would you spell that, please.

THE WITNESS: L-e-a-n-n S-l-i-z-e-s-k-i.

A And I also received consultation from a licensed clinical psychologist and still do twice a month in my position at the assault survivor's assistance program.

Q (By Ms. Roan) So you consult with

somebody who actually does have a Ph.D. in psychology?

A Yes.

Q There's a mechanism that a social worker has to go through even after she gets her degree, her master's degree?

A Yes.

Q To get licensed as a clinical social worker, correct?

A That's correct.

Q That mechanism requires the social worker to do even more field work?

A Supervised field work.

Q That field work, that has been supervised by a qualified --

A Either a licensed social worker a psychologist or M.D., the choice is the clinician's choice.

Q There's also a written test that has to be taken and passed?

A Yes.

Q You aren't a licensed clinical social worker, are you, Ms. McAllister?

A No, I'm not.

Q You haven't taken and passed the test

yet, have you?

A No, I'm not. I'm planning to do that after the first of the year.

Q You would agree with me that having a master's in social work without being licensed is like going through law school and not passing the bar exam?

A In terms of not having taken the test, there is a difference that in Colorado you can practice as a psychotherapist without having a license. And my understanding is you cannot practice as an attorney without passing the bar. And I may be incorrect about that, but that was my understanding.

Q Okay. You would agree that the situations are similar, though you haven't taken this national test?

A I haven't taken the test yet, that's correct.

Q Now, you were in this courtroom on December the 12th, do you recollect that?

A Yes, I do.

Q So that was last Thursday?

A Yes.

Q And at that time you recollect that I

asked you about specific books and publications in the field of psychiatry, and specifically the study of memory?

A Yes.

Q Because I was wondering about your knowledge about trauma on the effects of memory, not just trauma on the effects of people's psyches?

A That's correct.

Q And one of books I asked you about was this one which is Synopsis of Psychiatry?

A Yes, that's correct.

Q And that was written by two doctors, Dr. Kaplan and Sadock?

A Yes.

Q And you said you heard of it?

A And have seen it, but I'm not fully familiar with it.

Q You haven't actually read it?

A No.

Q But you agreed that many psychiatrists, medical doctors use it?

A Use it as a reference, yes.

Q And even though you hadn't personally familiarized yourself with this book, you agreed with me that it was a reputable publication in the

area of mental health treatment?

A As I understand it, yes. And that is from information I have from other people, not from my direct experience.

Q Okay. Please tell the jury all the formal academic training you've had specifically in the area of fragmented memory and dissociated memory in the formal academic training, Ms. McAllister?

A The only formal academic training I have had would have be in two courses, partially because there was very little research done until 1995, which was after I received my degree that had been completed on memory, but specifically on fragmented or dissociated memory, two courses that we did case assessments. And one was psychodynamic assessment and intervention, and the other was a course in psychodynamic -- or advanced psychodynamic interventions in my second year course work. And that is specifically because I chose to focus on victim issues in my course work when I had a choice about that matter.

Q So with regard to your formal academic training in disturbances of memory, you've had no formal academic training with regard to anterograde

amnesia?

A No, I have not.

Q You've had no formal academic training with regard to retrograde amnesia.

A No, I have not.

Q You've had no formal academic training with regard to para amnesia?

A No, I have not.

Q You've had no formal academic training with regard to what's called fausse reconnaissance?

A No.

Q You've had no formal academic training with regard to retrospective falsification?

A I have had some training in that in terms of looking at the impact that looking backward can have in terms of distorting our memory.

Q You've had formal academic training with regard to that?

A That's been discussed. Some of the differences in people who are looking backward and assessing their life from their current present needs and sometimes have distortions in what they remember based on that.

Q Okay. You've had no formal academic training with regard to confabulation?

A Yes, I have. That's clearly a part of -- essentially that means lying or making up things. And that's always a part of any training that teaches people to do psychological assessment. Which I had multiple courses.

Q You've had no formal academic training with regard to hypermnesia?

A Yes, I have had training in that arena.

Q Could you define that, please?

A As I understand hypermnesia, that is the escalated sense of memory for certain aspects of memory or for certain events. And people have strong escalated memories often related to highly emotional content, and that's not what you have in your book?

Q Would you agree with me that actually hypermnesia is just exaggerated degree of retention and recall?

A Which is essentially what I said. If you look at the clinical literature, it says that that usually takes place when there is an escalated sense of emotional content in the material that the person's remembering. And that's fairly consistent throughout the memory literature.

Q Have you had formal academic training

with regard to idedic (phonetic) image?

A No, I have not.

Q Have you had formal academic training with regard to lethologica?

A No.

Q You are not familiar with that those terms mean?

A No.

MS. ROAN: Your Honor, at this time I object to qualifying Ms. McAllister as an expert in any psychological testimony about trauma as it relates to dissociated memory or fragmented memory. I don't think she has the background.

THE COURT: Well, I've already accepted qualifications, and I'm going to again. My understanding is it's not insofar as diagnosis, any type of psychological diagnosis, but her experience in observing the effects of trauma on individuals, including sexual assault victims. That's my understanding. Is that correct?

MR. SARGENT: Yes, Your Honor. But not based just on her experience, but reading in the field, her educational background, but also primarily reading in the field, yes.

THE COURT: We're not going to go into

any type of diagnosis, psychological or medical diagnosis.

MR. SARGENT: No, she's never seen Mrs. Smith.

THE WITNESS: I couldn't diagnose someone I hadn't seen. That would be unethical.

MS. ROAN: If she would just respond to questions instead of commenting, that would be good.

THE COURT: That's probably a very informative comment, and we'll accept it, go ahead.

DIRECT EXAMINATION RESUMED

BY MR. SARGENT:

Q Ms. McAllister, I touched on your experience at West Pines.

A Yes.

Q You've been there for how many years?

A About seven and a half.

Q And in your time -- in your time at West Pines, you treat -- the name of the program is Assault Survivor Program?

A Yes, that's correct.

Q And you treat people who have suffered some form of trauma?

A That's correct.

Q Are all of those people sexual assault survivors?

A When I started in the program they were all sexual assault survivors. At this point they are not. We've expanded to treat others beside sexual assault survivors.

Q Do you have a rough approximation of what percentage of your practice dealings with or what percentage of your patients who you treat are survivors a sexual assault?

A Probably somewhere between 75 and 80 percent are sexual assault survivors.

Q Before I go any further, I think probably ought to have you define for the jury what trauma is?

A Trauma is defined in the literature as an experience that is so threatening to a person's physical or psychological being or emotionally overwhelming in terms of the threat it presents that it requires what's called in the literature "extraordinary coping mechanisms." That means that it's so overwhelming that what we normally do to get by in the world, even with problems, doesn't work for us. And it requires us to do something even more extraordinary than our normal ways of

coping with problems in difficult situations.

Q What are some examples of trauma?

A The examples listed in the literature are usually inclusive to physical and sexual assault, extended exposure to combat; natural disasters, such as earthquakes or tornadoes; human created disasters, such as bombings, that sort of thing, or accidents or severe injuries that are sometimes -- that sometimes result from accidents where there's a life threatening component, or witnessing any of these events happening to other people.

We found that witnessing another person being severely harmed can be as traumatic as if the person was harmed themselves.

Q And is there an identifiable set of symptoms reported by those who suffer trauma?

A Yes, there is. And that's been in the clinical literature and in the DSM, the diagnostic and statistical manual that all therapists use since 1980, since the DSM-III. We additionally use DSM-IV. But it's been present --

Q Let me stop you. That's Diagnostic and Statistical Manual used by social workers by people -- by psychologists?

A Social workers, psychologists

psychiatrists when diagnosing mental disorders that they're treating. And there are also now codes available which there were not initially for treating symptoms that are not mental disorders but that are life situation circumstances, and there is in the current diagnostic manual a code for sexual abuse of a child or an adult which doesn't require that there be a mental disorder accompanying that.

Q What are the psychological effects of trauma?

A Of trauma? The -- there are three primary symptoms -- or symptom sets that are related to trauma. The first is called the reexperiencing symptoms or intrusive symptoms. And the kind of classic understanding of those, I think most people have heard about Vietnam Vets who have flashbacks or who have intrusive thoughts about combat.

They are symptoms that essentially are reminders of the traumatic event, and those reminders are usual stored differently than normal events are stored in our memories. They're stored as sensations, images, and affective or emotional responses that aren't really connected as much to our cognitive functioning part of our brain that

allows us to have a narrative discussion about what happened to us. So they're essentially strongly felt either sensory or emotional images that represent the trauma.

And the reexperiencing symptoms set has people experiencing -- reexperiencing different aspects of the trauma. People that talk about flashbacks, nightmares, intrusive thoughts, often sexual assault survivors will say, "I couldn't get this face out of my head. I kept thinking I was seeing him all the time," that sort of thing. And it can get to the point where people are overwhelmed to the point that they can't sleep. Those symptoms come up and frighten them often.

Q You jumped ahead of me a little bit there. The next question I was going to ask was memory affected by trauma. I think the short answer is yes?

A Yes.

Q Now, the next question: Is there literature to support the idea that the memory of those who have been -- of trauma victims is or can be affected by the trauma?

A Yes. There's a strong body of literature that's been developed. It's been worked on for

many years. There's always been a strong body of clinical literature which is that people observe behavior in people they're treating, and they make note of that.

And there's record back as far as the 1800s that people observed people who had been harmed by other people having disturbed memories for that event or those sets of events.

Clearly, we have clinical research that is conducted in a scientific manner now that indicates that memories stored as a result of a traumatic experience are stored differently and experienced differently by people than are memories that are part of normal daily experience are experienced -- normal daily experience.

We have an experience, and we are able to integrate it. We understand it. We have all the information available to us, and it goes into what's called narrative, or declarative memory, which means we can talk about it, we understand what it means to us. We can tell people about it. And it's subject to our voluntary recall. We can bring it up when we want to. We can put it away when we don't want to think about it.

If I had a really bad meeting with my

boss, I can tell my friend about it when I'm upset and put it away later and say, "I'm not going to think about that because I'm going to spend time with my kids."

The difference when you have traumatic memory is that the material is so overwhelming that the person can't absorb it. And there's an essential metaphor that's consistent with physiological trauma. We don't absorb all physiological trauma either. The blood slows, heart rate slows, that's protective so a wound doesn't bleed out as quickly.

But with psychological trauma, what's protective is we can't take in all the information at once. So it becomes fragmented, and it tends to be stored in the more primitive parts of the brain as sensations, images, and feeling responses that are not always connected to our declarative memory, which is our ability to put things together in a nice pretty picture that we can talk about and explain to everyone else.

The other -- the other three things that happen, our normal memory tends to be subject to voluntary recall. That means if we want to think about something or remember it, we can. And if we

don't, we can't.

Traumatic memory is not subject to voluntary recall, which means people have access only to what they are experiencing as those intrusive symptoms at any given time.

And they can't always bring up all of the information about a trauma even if they want to because it's not yet integrated into the thinking cognitive part of our brain. The other two things are that with normal memory can be -- it's social and adaptable, which essentially means that we know when it's appropriate to think about or talk about being with our partners and that that's not appropriate in a meeting so we don't think about that there, or at least we can control our responses if we do.

Traumatic memory is not social and adaptable. It seems to be invariable.

It can come up very strongly at any time. And it's, again, not subject to voluntary recall, so it can come up and bother people in situations where they don't want to be thinking about having experienced a rape or seeing someone shot or something like that.

And then the last one is that

non-traumatic memory can be expanded or condensed at will by the person who's remembering. If I am in a situation where I have an argument with a friend, I may tell my partner many, many hours worth of "Do you know what they said then, and they said that then," and I have lots of information.

And I may tell another friend who I don't want to color their perception of that person, "We had an argument, and we're working it out." So I can shorten it or lengthen it. My responses are based on what's socially appropriate.

With traumatic memory that's not usually the case. Again, people don't have access to be able to contain part of the memory or put it away. So whatever they remember is based on whatever images or sensations or feelings are up, and they're not able to sometimes give all the information because they may not have access to it.

At other times they may be flooded with information in a place where it's not appropriate to talk about it. A lot of people have difficulty initially in working relationships immediately after a trauma because of those sorts of symptoms.

I want to say the other thing I missed, the other two sets around trauma so I don't want

people to I think it's just intrusive trauma.

Q What are those?

A The other two symptom sets with trauma are the avoidant or numbing symptom set. And that's the other part of our reaction. The intrusive symptoms are derived to remember those horrible things that happen to us and cope with them, deal with them, and have them integrated. The avoidance symptoms are clearly an attempt to not have it impact us so strongly. And people describe having real -- what we call flat affect or feeling kind of numb and not emotionally responsive to things.

Sometimes they will feel like they -- they will be missing pieces of the trauma, that -- it's called psychogenic amnesia in the literature and in the DSM-IV where people are unable to remember certain aspects of the trauma, usually those are the most traumatic or the most threatening or aspects where they feel like they could have had some control and were unable to.

You also see over time people avoiding situations or things that remind them of the trauma. For instance, if someone was the victim of a robbery at a certain 7-Eleven that's in their

neighborhood, they may go way out of their way to go get something for the house rather than return to that 7-Eleven. And we used to have our office right down the hall from the emergency department in Lutheran Hospital, and we had real trouble getting rape victims to come back in because they would say that coming back by the emergency room was a reminder of the night they got raped, and they don't want to do that again.

So that's very common. And then if it develops into a long-term problem, people can begin to do things like use drugs or alcohol to try to forget consciously.

And then the third set is hypervigilance. And that is hyperarousal and hypervigilance. That essentially means the physiological arousal that goes with excessive fear. It's not being able to sleep, being very jumpy, the classic kind of picture of that that I think many Americans have is of Vietnam Vet on the 4th of July who's in his backyard who hears a firecracker, goes over and takes a dive under the picnic table. He doesn't really think he's in Vietnam, but, no, that moment he's experiencing a feeling related to a loud noise or an explosion that brings back all the intrusive

traumatic symptoms right away, can include anxiety shakiness, excessive fears, those sorts of things.

Q And that's basically -- those that we've just described is you've drawn that information from material in the field; is that right?

A That's correct, material and my personal experience working with victims.

Q That was my next question. Does your experience back that up, the idea that memory can be disturbed by trauma?

A Yes. I've actually seen that -- fully throughout my career with less understanding when I was much younger. Many times kids who had been abused when I was working at Social Services would not remember certain aspects of the trauma. And many -- and that's been consistent throughout everyone I've seen. Battered women often have difficulty remembering different incidents that have happened to them.

Children who have lived in violent homes sometimes become very frightened around raised voices, but yet they can't remember anybody fighting in their house. That's very common. And with sexual assault survivors, I see now it's actually more consistent that people don't have

every single piece of a traumatic event available to them right away.

And it's very troubling. Often victims will say things like, "I must be crazy. I don't understand why I can't remember this. I have a good memory. I don't know what's wrong with me." There's a very common experience for people who have experienced trauma.

Q I want to ask you, if you could, to give the jury an example of how that operates in someone other than the sex assault victim, I think last week you gave an example of someone who was exposed to a robbery, for lack of a better description.

A Okay.

Q And how that affected their memory?

A This was a case where one of my colleagues from several years ago had -- and our team had worked on a bank debriefing after a robbery. And essentially what happened is a man came into a bank and pulled a gun on the teller and asked for money. One of the other tellers jumped over the teller box, which would be like jumping over here, or jumping over where you are and taking the gun away from the guy.

And the, you know, the other teller

pushed the button, the police were called, the security guard ran in, and the man was apprehended right away. But the employees were relatively upset afterwards, and they asked for a debriefing. When the group got together for the debriefing, which was the whole group of tellers and managers who had been in the bank lobby at the time of the robbery, the man who had jumped over the teller box was being congratulated by other people. And he said, "What are you talking about?" And they said, "Oh, you're a hero." And he said, "No, I'm not, what are you talking about." He had literally blanked out that he had jumped over the teller box and didn't remember until several people said to him, "Don't you remember? You grabbed the gun."

What had happened was as he was jumping over the box, he realized that the guy had a gun, and he could die. And even though he was receiving very positive feedback from his peers, which is the most -- the easiest way to remember something traumatic is when people are saying good things to you about it, he had blocked it out for a period of time immediately following that robbery.

And it took him almost an hour to get back to being able to tolerate the fear he felt

when he realized he was jumping at a guy with a gun actually is what he was blocking out.

Q When somebody -- when their memory is disrupted because of trauma, does it ever return?

A In most all cases, it does. There are times when it may not. But in many cases it does return, and the common -- the most common presentation is it will return little by little after the trauma over time.

And, for instance, often when I see rape victims, there are pieces of things that they don't remember. They don't remember how they got from the couch into the bedroom, or they don't remember how someone bust into the door of their house.

And I actually worked with a 14-year-old girl who was brought in for treatment. She had been the victim of an attempted sexual assault and had done what everybody around her said was everything right. She was given lots of support. A man came to her door. She was home alone after school.

He said he was selling carpet. She said, My parents aren't home. They're down -- she didn't say my parents aren't home. She said, "They're downstairs working on remodeling the house. Can I

have you come back later when they're done?"

And he came back in about a half hour, forced his way into the house, pulled a knife on her, attacked her. She tried to call 911. He pulled the phone out of the wall. She fought him so hard and kicked him so hard that he ran out of the house.

She ran out in the yard screaming. Neighbors immediately called the police. The guy was caught. Everybody said, "You're wonderful. You did a great job." She was brought into treatment because she was having nightmares and severe intrusive symptoms about fear.

And what she said the first time I talked with her is "I can't remember how he got through the door. I must have let him in. I must have done something wrong to let him do this." She was struggling with that. And that was -- with several week's work what she was able to do was identify that she had been terrified when the guy yanked the door out of her hand and pulled the knife on her and backed up, but she came in thinking she must have done something wrong in not being able to access that information. For her that was the most terrifying aspect of the assault when she realized

he was planning to hurt her.

Q Let me ask you this. Are there certain areas of the assault or traumatic experience that, through your experience, that survivors find the most difficult to remember?

A I don't know if areas is the correct word, but I'll use that. Actually, the most likely things that are dissociated or not integrated into memory are things that are either intensely threatening or frightening, that are sensorial overwhelming. That means very painful or harmful to the victim, or is issues where they feel like they may have had some ability to control things but didn't, like the girl who thought she must have let the guy in the house because he assaulted her, where there's some aspect of either self-blame or believe they should have done something differently to protect themselves from an assault.

Those, in my clinical experience, are the most commonly dissociated memories that people have the most difficulty integrating.

Q Immediately after a trauma, significant assault, a sexual assault, how do you expect -- how does the person assaulted remember things?

A In most cases they're going to be

fluctuating to some degree between that intrusive re-experiencing set of symptoms, very upset, crying, distressed.

And the most common presentation I see with sexual assault victims is the feeling like somebody is after them, feeling very frightened, feeling the person is going to come back and get them, or having those sensations like "I can't get this out of my head. I feel so dirty I can't stand what's happened to me." So very much the sensory and imagistic and feeling kind of things are coming up.

Q In terms of memory, how do they often describe --

A They will often have very specific descriptions for certain parts of the event and have missing -- missing pieces, missing chunks of time sometimes. Sometimes they will say they don't remember certain kinds of details, or they don't remember what happened for a period of time, or they can't -- some women will say things, "I know he did this to me, and he did that. I know he did both those things. But I don't know which he did when."

Q How often does that occur?

A Fairly common. It's called in the literature Type II dissociation, which is psychologically the separation of the experiencing ego, the part of us that experiences something from the part of us that observes something is fairly common when there is severe threat to physical safety or severe physical harm.

And so in a sexual assault, most women describe fear of being killed or severely physically harmed as very strongly primary.

Q Do you also, in your experience have you observed people who reported things happening to them that later they say didn't happen?

A That can happen. Sometimes people have a time-sense confused. Sometimes people have literally confused the details and don't have accurate details, but what's -- what's usually consistent is the general theme or the -- or the overall experience of what happened is consistent and powerful. And the details, or some of the time-sense may come back later.

The classic kind of thing with memory is if there's a crime scene, people will remember fifty different heights and colors of hats and colors of gloves, but everyone in the room will

remember that there's a robbery taking place. And that's fairly consistent, even with sexual assault that some of the details, some of the time-sense may be confused or missing, but the idea that a sexual assault happened or a bombing or whatever, the central piece of the trauma is usually clear and present.

Q Does the degree of memory disruption or trauma -- excuse me, we'll leave it at that. Does the degree of memory disruption -- is the degree of memory disruption affected by the severity of the trauma and the different types of trauma that someone suffers?

A Yes, it is. It's impacted by the degree of perceived threat, by the person who is being hurt or in an accident or whatever. By the -- and that can be threat to self or another person if you're witnessing a trauma. But the degree of perceived threat, the extent of the trauma, how long it lasts, most of us manage to cope through something that lasts for only a few seconds or few minutes unless it's extremely overwhelming.

But if something goes on for an extended period of time, it's more likely they would need to resort to the third coping mechanism of

dissociation to cope, to not take it in all at once. And then the degree of physical pain or injury can also contribute to that because it overloads our capacity to have taken information when physical pain or harm is actually happening to us.

Q What about actual threats to the person's life or to the family of that person, would you expect that to affect the degree of trauma in memory disruption?

A Absolutely. In the case of a sexual assault, actual threats, I would say pretty close to without exception would be believed by a victim. Most victims, even when there aren't direct threats made perceive that it's likely they will be killed. And so if someone is making direct threats, I would say that would be likely to increase their perception that they are at risk, and the possibility that they would resort to dissociation to cope.

Q Over time, do you also expect -- always expect -- not expect, do you always find that the victim, the survivor's memory returns -- that all of the memory returns?

A Not in every case. Some people have

missing pieces that they never retrieve. Some people have details that they never retrieve. Generally, what -- what we talk about in terms of being able to help people resolve trauma is they need to have enough information to know what happened to them and to get to what felt the most traumatic to them.

But there are -- there are people who don't remember every detail, who don't remember every single thing. Part of that information can be lost.

Q How long does it take to restore for most memory to be restored?

A Well, that depends on the person and the severity of the trauma. Some people often leave things for long period of time. If there is immediate access to help, and they're getting adequate intervention in terms of -- and I'm assuming that if a rape victim came through the criminal justice system, there would at least be some attention to the crime.

We know that many Vietnam Vets went a long time without getting any help and have some gaps in their memory, but that was because there wasn't a climate where people were being treated

for that. But if someone receives adequate support and isn't being pressured, usually within -- they may start to remember things within a few hours, depending on the feeling of safety, and may do that over the next weeks to sometimes months.

In terms of getting more and more of the information integrated, more of the images that come up are able to integrate, then they're not missing those pieces over time.

Q Let me move onto a different area. I think you already talked about some of the avoidant symptoms. And the idea -- let me not ask, I don't want to use the terms, I prefer you to, actually. I think you said earlier that you found it common that people -- women assaulted express fear of men; is that true?

A That's -- I'm not sure if I said that today. But that is a very common outcome of a sexual assault survivor is particularly -- and many sexual assault survivors, most are female, but it's very common they express fears of men.

I've even had where women need to be escorted out to our waiting room, when there's a cleaning person in the hall who was male, from my office because they're immediately frightened and

reactive after an assault.

Q Have you in your experience or literature in your experience either observed or read about victims of an oral sexual assault who had difficulty with the oral swabbing as part of a rape kit or with the thermometer, oral thermometer, when an oral temperature was attempted?

A That is present in the literature, and I've had clinical experience. Both of those things are accurate. It's very common that someone who's been victimized experiences parts of the sexual assault exam as a re-intrusion that reminds them of the rape.

And if it's an oral assault, it's not uncommon that they are very reactive to swabs. I've even worked with women who have trouble eating certain kinds of foods, different textures, different kinds of things after an assault. And I really have to be able to help them do that again, if the assault is oral, very common. Whatever part of the body is, the effect is going to be more sensitive, and they're going to be more sensitive and reactive around things in that area.

Q What about dizziness or nausea, is that often reported to you by victims of sexual assault?

A Many women who -- and many women who experience trauma and related to sexual assaults have reported nausea to me. Less common is dizziness, but dizziness and confusion and other things can be related to anxiety. It can also be related to physical assault. So that's less common. But nausea is almost always very common when there's been an oral assault.

And actually many women who haven't been orally assaulted, if there's a sexual assault, describe wanting to be sick, the feelings of being dirty and wanting to be sick to their stomach are very common.

Q Okay. What about during the vaginal or genital exam as part of the rape exam, the sexual assault examination. Have you experienced where someone who's been assaulted by a finger, an aversion to the manual part of the sexual part of the exam?

A Yes, I have. And that's very similar to what I talked about with the oral exam. Whatever part of the body that's been affected, whether it's vaginal or anal, if there is something that reminds them of the trauma, whether that's being touched by fingers or having something inserted into the

orifice is going to often cause a trauma reaction. And it's a very common reaction. And it's something we often talk to recent rape survivors about because they will again experience that sexual assault exam as very intrusive and re-triggering to the trauma.

Q Connie Smith is -- have you ever met Connie Smith?

A No, I haven't.

Q Do you know who she is?

A No, I don't.

Q Have you read any of the police reports in this case?

A No, I'm assuming she's the victim in this case. But since you said her name, I had not heard her name.

Q Do you know the details of this case?

A No, I don't.

MR. SARGENT: I don't have anything further.

THE COURT: All right. Thank you.

Ms. Roan.

MS. ROAN: Thank you, Judge.

CROSS-EXAMINATION

BY MS. ROAN:

Q Ms. McAllister, you testified about three groups of symptoms that you believe are reflective of posttraumatic stress disorders?

A Yes.

Q The first group is intrusive thinking?

A Intrusive or re-experiencing symptoms.

Q If I say intrusive thinking, you'll know what I'm talking about?

A Okay. That's only one of the symptoms. I'm trying to be specific, but that's fine.

Q I'm trying to move this along. So if we can use intrusive thinking as a shorthand, is that okay with you?

A That works for me.

Q Second is avoidant or numbing behavior?

A Yes.

Q Third group is increased arousal?

A Yes.

Q These three symptom groups form the psychological diagnosis of posttraumatic stress disorder?

A Certain configurations of them do. And they also are -- are typical of generic reactions

to trauma in the immediate aftermath of trauma.

Q But you would agree with me if you have re-experiencing the traumatic events, persistent avoidance of things that remind you of the event, and persistent symptoms of increased arousal, you've got posttraumatic stress disorder?

A Yes, that's accurate.

Q Those three symptom groups of indicators have the psychological diagnosis of posttraumatic stress disorder?

A Yes, they are.

Q Thank you. Posttraumatic stress disorder can also be referred to as an abbreviation as PTSD, right?

A That's correct.

Q That's how it's commonly referred to?

A Yes.

Q Among mental health people?

A Yes, it is.

Q Again, to keep this moving, I'm going to use that abbreviation, PTSD. You'll understand that I mean posttraumatic stress disorder?

A That's fine.

Q Posttraumatic stress disorder is a formal diagnosis, isn't it?

A Yes, it is.

Q It's a diagnosis that is found in a book, this book which is called the Diagnostic and Statistical Manual of Mental Disorders?

A Yes, that's correct.

Q This book, because it's a long title, is commonly called the DSM-IV?

A That's correct.

Q Again, these questions all just talk about the DSM-IV, and you'll know what I mean, right?

A Yes.

Q In your direct testimony, you talked about people developing PTSD as a result of trauma, correct?

A Yes.

Q That's not the language that's used in the DSM-IV. That book consistently talks about people getting posttraumatic stress disorder as a result of exposure to an extreme traumatic stressor, correct?

A Yes.

Q So for purposes of these questions, I'm going to use the language of that book that you're relying on. So I'll talk about being exposed to an

extreme stressor, you'll know what I mean?

A Yes.

Q The DSM-IV is very well accepted in the field of psychology and of psychiatry, correct?

A And social work, yes.

Q You accept that book as an authority, don't you?

A Yes, I do.

Q Even though you're not a psychologist or a psychiatrist, you would agree with me that that book is the Bible if you're diagnosing mental disorders?

A That book is the best compilation of knowledge we have around assessment and diagnosis of mental disorders yes.

Q You would agree with me that that book was put together by people who have had formal academic training in diagnosing and treating mental disorders?

A Yes.

Q And the DSM-IV covers a lot of different mental disorders, correct?

A Yes, it does.

Q And each section dealing with each specific disorder was written by a group of mental

health professionals?

A Yes, it was.

Q And if you look at the credentials of all the people that contributed to the DSM-IV, all of them either have Ph.D. degrees, or else they are medical doctors?

A I'm not certain about that. I haven't looked at all of their credentials.

Q Okay. I'm going to give you the opportunity to do that now. I'll show you the DSM-IV group. That's what I'm concerned about in the work groups. Please review those.

It goes forward for another few pages.

MR. SARGENT: Your Honor, if this is going to take awhile, the People will stipulate. There are no -- I don't know if there are or not, the people will stipulate that there --

MS. ROAN: If they're willing to stipulate.

A There are several people with master's degrees on this first page.

Q (By Ms. Roan) Okay. But I'm asking you about the work groups, ma'am. Can you look at those?

A That's correct.

Q No one whose formal academic training, whose degree consists of a master degree in social work is a contributor to this book in the work group section?

A In the work group section, that's correct.

Q In this group there's an introductory section that runs on for 11 pages talking about the proper and responsible way to use this book?

A Yes.

Q Your testimony on direct was all in terms of hypotheticals, correct? The District Attorney asked you about hypothetical situations.

A Yes. And general knowledge about certain issues which are not hypothetical, they're fairly generally accepted knowledge.

Q So you weren't trying to imply in your direct testimony that Mrs. Smith can't remember things because she has posttraumatic stress disorders?

A No, I haven't seen Ms. Smith, so I would not know that.

Q And you would agree with me that it would be completely irresponsible and unprofessional to imply that somebody had posttraumatic stress

disorder or any other mental health problem that affects memory without having at least met them face-to-face?

A Absolutely.

Q Because one of the most important things in determining whether somebody has a mental health problem is getting a complete history from them?

A That's correct.

Q And that history has a big impact on any eventual diagnosis that's made?

A Absolutely.

Q That's how psychologists and psychiatrists are trained to proceed when they're asked to diagnose somebody?

A I would assume so.

Q Well, even though you're not a psychologist or psychiatrist, and you don't have any formal training in those areas, you would agree that getting a history is critical?

MR. SARGENT: That's a compound question. The answer is the same to each.

Q (By Ms. Roan) Even though you're not a psychologist or psychiatrist, you would agree getting a history is critical before making a diagnosis?

A Yes, that's what my training included, very clearly.

Q You would also agree with me DSM-IV was not written with the primary goal of providing guidance to juries in criminal cases about whether they should believe what witnesses say?

A No, it was not. It was written to help mental health professionals assess and determine treatment courses for different mental health disorders.

Q Well, the DSM-IV says it in fewer words. The DSM-IV says that the highest priority of that book is to provide a helpful guide for clinical practice?

A Um-hum.

Q Do you agree with that?

A Yes.

Q The DSM-IV has a specific section on PTSD, correct?

A That's correct.

Q It comes under the lead of anxiety disorders?

A Yes, it does.

Q And that section includes a list of symptoms that may indicate someone has

posttraumatic stress disorder.

A Yes.

Q And the three symptom areas you testified about are what make up the diagnosis?

A Yes.

Q And when the --

A That compiled with -- that compiled with exposure to a stressor.

Q Absolutely. And when the prosecutor presented you with that list on direct examination, you said that those symptoms along with a stressor were consistent with posttraumatic stress disorder?

A Yes.

Q In other words, prosecutor gave you a list, and you agreed that the list included the elements of that disorder, according to that book?

A Yes.

Q Now, can you tell me if this book that you use in your practice is organized on categorical or dimensional model of classification?

A I don't use those terms the way -- the way -- and I know that there was a lot of thought put into that. It's organized by different types of disorders and different families of disorders, if you're taking about clinical usage.

Q Ma'am, what I'm talking about is how that book's organized. Is it categorical or dimensional?

A I'm not certain using those two terms.

Q You've read this book though?

A Yes, I have. I've not memorized it.

Q Would you be surprised to know that in the introduction to the book before it gets talking about diagnosis, it says that the DSM-IV is a categorical classification?

A I would not be surprised.

Q Using the categorical model of classification, are you aware that that book specifically refuses to make certain assumptions?

A Yes.

Q First of all, there's no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries describing it from all other mental disorders?

A That's accurate.

Q Or from no mental disorder or not, right?

A That's accurate. There are often many gray areas and lots of overlap and difficulties sorting what symptoms apply and what configuration and what that means about psychological health or

disorder.

Q And so that means that a person can have a list of symptoms present, a list of symptoms that are consistent with a particular mental disorder and not have that specific disorder at all, correct?

A That's accurate.

Q It also means a person can present a list of symptoms which are consistent with a mental disorder and actually not have any mental disorder?

A That's correct as well.

Q And there are different diagnostic tools used to diagnose a mental disorder than there are to diagnose a physical disorder, would you agree?

A Yes.

Q For example, if you're trying to decide if somebody has a broken leg, you could use an x-ray machine?

A Right.

Q And you could also take a history from them, and you could hear them complain about the pain in their leg?

A Yes.

Q But you would have something -- you would have some hard evidence to back it up because you

could do that x-ray, right?

A That's correct.

Q Mental disorders, though, there often isn't any sort of hard evidence like an x-ray, correct?

A That's often correct.

Q For example, if somebody says they have all the symptoms of posttraumatic stress disorder, you can't, I don't know, run a blood test or x-ray them or sort of figure that out once and for all?

A No, there are -- there are some disorders for which there are some clear biochemical components that can be identified. But posttraumatic stress disorder is not one of those.

Q So making a diagnosis of that particular mental disorder requires spending a great deal of time with the patient?

A Great deal of time and having some knowledge about what has happened to them, their history, their exposure to trauma, yes.

Q You've never spent any time with Mrs. Smith?

A No, I have not.

Q You have no knowledge of her history?

A No.

Q You have no knowledge of the details and facts of this case?

A No.

Q You've never even read a police report?

A No, I have not.

Q And diagnosing whether someone has a mental disorder and, if so, what disorder, also requires the careful use of a mental health professional's clinical judgment, correct?

A That's correct.

Q And the quality of that professional clinical judgment can be influenced by how much training and psychology and psychiatry the diagnoser (sic) has, correct?

A Yes.

Q And the field of medicine recognizes that specialized training is often helpful to make the best diagnostic judgment?

A That's correct.

MR. SARGENT: I guess I don't see the relevance since we've already established that Ms. McAllister is not going to diagnose Mrs. Smith.

MS. ROAN: I think the problem, Your Honor, is since she's relied on the Diagnostic and Statistical Manual, I need to talk about whether

she's implying a diagnosis since she is using all the diagnostic out there.

THE COURT: I think we're all agreed, and I assume the People would stipulate that she's not making any diagnosis of Mrs. Smith. I think that's what I tried to say at the beginning of this entire line of testimony, that I would not allow it if that's what it was. So I don't think that's an issue. But...

MS. ROAN: Okay.

Q (By Ms. Roan) Even if you were able to make a diagnosis, which you can't, you would agree with me that making a diagnosis out of that book is only the first step in a comprehensive evaluation of somebody?

A That's accurate.

Q Tell me if you agree or disagree with the following statement, okay?

A Okay.

Q Responsible, competent, mental health professionals who use the DSM-IV agree that a diagnosis of a mental disorder does not carry any necessary implications regarding the cause of that disorder?

A That's accurate.

Q In other words, just because somebody behaves like they have posttraumatic stress disorder, that doesn't mean they were sexually assaulted?

A No, it doesn't.

Q Tell me if you agree or disagree with this statement: The fact that an individual's behavior meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors associated with that diagnosis?

A That's accurate.

Q In other words, if somebody has some mental health symptoms, that doesn't automatically mean that he or she is helpless to control those symptoms?

A That's accurate.

Q You would agree, Ms. McAllister, that when DSM-IV categories and criteria and descriptions are used in a courtroom setting, there are significant risks that diagnostic information will be misused or misunderstood?

A I think that's true in any situation where they're used if people don't have adequate training, yes.

Q But you're aware this book specifically cautions about using them in a courtroom setting?

A Yes.

MR. SARGENT: Again, I don't know why that's relevant since I'm not asking for a diagnosis.

THE COURT: Well, go ahead. We'll give her a little latitude with cross-examination.

MS. ROAN: Thank you.

Q (By Ms. Roan) When a legal situation requires taking into account issues like individual responsibility, DSM-IV categories may not be wholly relevant. Do you agree with that?

A That's accurate.

Q And in every category of mental disorder listed in this book, there are a whole list of what are called differential diagnoses, correct?

A That means things you need to rule out if you're going to make a diagnosis or in some cases you may diagnose more than one disorder at the same time.

Q Okay. So you would have to know about all the symptoms somebody was exhibiting before you could rule out these other mental health disorders?

A Yes.

Q And in the hypothetical that you got, you were only presented with three symptoms, three symptom categories?

A That's correct.

Q If somebody had those three symptom categories and also had other problems, you would have to rule out things like them having an anxiety disorder?

A That's possible, yes.

Q Them having a brief psychotic disorder?

A That's possible.

Q Them having a conversion disorder?

A Possible.

Q Them having a major depressive disorder?

A That's also possible.

Q Them having an acute distress disorder?

A Yes.

Q Okay. And when somebody is complaining of recent or remote memory loss, a mental health professional who's trying to figure out what's causing that memory problem would have to consider whether the person hears what's called factitious disorder, correct?

A Yes. Factitious disorder is people who make up either physical or mental illnesses for

what we call secondary gain, some other reason that would benefit them.

Q And those are intentionally produced or?

A Yes.

Q They are?

A Yes, they are.

Q Made up in order for that person to be able to assume the sick role, correct?

A That's often correct, yes.

Q What does that phrase "assuming the sick role" mean to you, Ms. McAllister?

A In that context, talking about sick as an attempt to get attention or concern or empathy or feeling responses from people who perceive them as having a problem and needing their help. And that's often how those people experience that role of being sick.

Q Okay. The DSM-IV also says that when you're looking at somebody who has symptoms that are consistent with PTSD, if legal determinations play a role, you have to rule out malingering, don't you?

A That's accurate. And that's often -- some of the cases where that came from are people who have been on disability of some sort or

another, and they would financially benefit from maintaining the disorder. That's also present with other disorders as well.

Q Right. And the DSM-IV talks about anytime a legal determination plays a role?

A Yes.

Q You have to rule out malingering?

A Yes.

Q Would you agree with me that malingering is the intentional production of false or grossly exaggerated psychological symptoms?

A Yes. Yes, that's right.

Q And you've had experience at West Pines with people coming in and saying they've been assaulted by someone they've never met in their whole life and being blindfolded and taken away somewhere, and they have all the details of the assault, correct?

A Yes.

Q But later you've discovered that they were at a party or drinking or doing something that they weren't supposed to, and they're saying they got assaulted to get out of trouble?

A Yes, that's some -- false reports are not very common in our department. But when they

happen, they're often adolescents who have been doing something they're not supposed to do and have gotten in trouble. So yes.

Q And sometimes they're adults?

A Sometimes, although more rare.

Q And you would agree with me what I've just described, that's malingering, correct?

A I would consider that malingering, yes.

MS. ROAN: Thanks, Your Honor. I don't have any further questions.

THE COURT: All right.

MR. SARGENT: A few.

REDIRECT EXAMINATION

BY MR. SARGENT:

Q False reports in adults are rare, you said?

A Yes, estimated less than 8 percent. And of those, very few people are willing to follow through with the rape exam or any investigation on the part of the police department.

Q And is there a typical way that a false report is generated? Or describe somebody who's making that up?

A Well, according to people who have studied false reporting.

MS. ROAN: I'm sorry, I'm going to stop because this is beyond the scope of her expertise. This is not the psychological affects of trauma.

MR. SARGENT: It was inquired into.

THE COURT: I think you opened her up, didn't you ask her questions with that --

MS. ROAN: About their specific experience after West Pines, not about her expert opinion and later in general.

THE COURT: Objection's overruled.

A Essentially when we look at false reporting, the most common false report is made by someone who is in trouble for doing something they're not supposed to be doing. Often that's going to a party or drinking or something like that.

And the most common scenarios are describing being -- being abducted by someone they've never seen before. They have no idea who it is, blindfolded and taken somewhere and assaulted. And some of those cases, there's the indication that there's more than one assailant, and that they can't identify anyone, and then they're dropped off somewhere. Although other -- other kinds of false reports happen, those are the

most common.

Q Does that person typically give the name of the person who assaulted them and the means to apprehend them?

A No, that is very uncommon in false reporting, very uncommon that a name is given.

Q Do those people generally want their stories to be exposed at a trial?

A I don't know what people want. But I have never had the experience where somebody who's made a false report that I've identified has been willing to follow through with even the full exam or criminal justice investigation.

Q Or to be able to give enough information and description to lead to a suspect that would lead to an arrest and some day to a trial?

A I can't speak to that. But I would assume that based on just general information, but I can't speak to that formally.

Q You talked about the idea of a differential diagnosis, trying to determine whether a symptom is caused by A or B.

A Yes.

Q If you had to distinguish between memory loss caused by trauma versus some sort of -- well,

a psychotic illness. How would you do that?

A In a psychotic illness, memory loss would -- the patient would not be likely to experience memory loss but would -- to personally have the experience of losing memory, they would be likely to have the experience of remembering some delusions or hallucinations or other things that didn't actually happen during the time that they didn't remember what did actually happen. So they wouldn't tell you they had memory loss specifically. They would be more likely to tell you that some hallucination told them to do something, or something along those lines. And they would not have accurate memory for what was really happening in their world during that time.

Q What about a trauma induced memory disorder versus some sort of an organic or a brain injury which causes memory loss?

A What I look for, to refer to a medical consultation, when I suspect an organic or a brain injury, memory loss is consistent loss of certain sorts of information across all aspects of a person's life. And that would be in direct contradiction to memory loss related to a discrete traumatic event and a certain period of time that

they're having difficulty remembering and they can remember other things that happen to them, and they're not experiencing memory loss across the board.

Usually organicity or some sort of brain injury that requires a medical consultation has a consistent kind of information that's lost. Sometimes it's short-term memory. Sometimes it's details. Sometimes it's new information. But it's usually consistently lost across all arenas of their life.

Q What about memory loss caused by trauma versus factitious disorder?

A Well, one of the things you would want to look to with factitious disorder is whether there was some sort of secondary gain or benefit someone was getting from that.

Q Motive?

A Excuse me?

Q What we call in the legal world "motive"?

A Yes. That would be a good description of that. How it's -- how -- and whether they seem to enjoy, umm, what they're going through. They seem -- and often with factitious disorder, unless someone is very young, there's a long history of

similar reports of that type of illness or that type of trauma over time. So with factitious disorders, it's important to get history from people.

One woman that I saw had reported twenty some rapes in her adult life who had factitious disorder, and it was very clear that she was reporting in the same details to each mental health practitioner she went to. And so there are lots of ways to rule that out. That's a primary one. Often people with factitious disorder will refuse a physical exam when they're making up a trauma because there are often no indicators of the trauma that they report.

Q And the idea behind factitious disorder is the theme that they get some sort of positive reinforcement from reporting to people that this has happened to them?

A Yes, that's accurate.

Q It's pleasurable to them?

A Yes.

Q What about memory loss caused by trauma versus diagnosing or differentiating between that and thought or memory disorder caused by depression, major depression?

A Major depression usually has an onset related to depressive symptoms like a withdrawal from social contact from other people, the patient reporting being less able to engage in their normal activities. There's usually a more gradual development of the memory loss. Again, once it's present, it's obviously related to short term or new short term memory or new information, and it's consistent across the board. If it's someone who's had depression who's being treated with electroshock therapy, it's fairly broad in that they remember very little after certain periods of the treatments of anything in their life. They can't remember five minutes later what you told them five minutes before. So it depends on the type of depression and the treatment they're receiving. But, again, it's more broad-based. It's not discrete to a certain event, it's across certain areas of their life.

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

THE COURT: Ms. Roan.

MS. ROAN: Thanks.

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 _____ day of _____, 1998.

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4/22/04