

No. 36797-1-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

SUPERIOR COURT OF WASHINGTON FOR CLARK COUNTY

KAREN CARLTON and MARJORIE HOLLAND, Co-Administrators/
personal representatives for the estate of Miriam Elizabeth Carlton

Plaintiff/Appellant

v.

VANCOUVER CARE LLC, dba STONEBRIDGE
MEMORY CARE,

Defendant/Respondent

FILED
COURT OF APPEALS
DIVISION II
08 FEB 15 AM 11:09
STATE OF WASHINGTON
DEPUTY

BRIEF OF APPELLANT

WILLIAM H. REED
Attorney for Appellant

REED, JOHNSON & SNIDER, P.C
201 NE Park Plaza Dr., Suite 248
Vancouver, WA 98684
Telephone:(360) 696-1526
WSBA #13764

TABLE OF CONTENTS

I. Introduction 1

II. ASSIGNMENTS OF ERROR 2

 Assignments of Error

 No. 1. The trial court erred by excluding expert testimony regarding implicit memory, explicit memory, conditioned fear response and paired associations as novel scientific evidence 2

 No. 2. The trial court erred by excluding expert testimony on Rape Trauma Syndrome and Compounded Rape Trauma Syndrome 2

 No. 3. The trial court erred by requiring a specific DSM-IV diagnosis as a prerequisite for an expert witness to express an opinion of psychological harm to a degree of medical probability 2

 No. 4. The trial court erred by excluding expert testimony based upon its evaluation of the weight of the evidence, rather than upon the admissibility of the evidence 2

 Issues Pertaining to Assignments of Error

 No. 1. Whether expert testimony regarding implicit memory, explicit memory, conditioned fear response and paired associations is novel scientific evidence 2

| | |
|--|----|
| No. 2. Whether expert testimony regarding Rape Trauma Syndrome and Compounded Rape Trauma Syndrome, not offered as a direct assessment of the credibility of the victim, is admissible | 2 |
| No. 3. Whether a specific DSM-IV diagnosis is a necessary prerequisite for an expert witness to express an opinion of psychological harm to a degree of medical probability | 2 |
| No. 4. Whether the trial court excluded expert testimony based upon the weight of the evidence, rather than upon the admissibility of the evidence | 3 |
| III. Statement of the Case | 3 |
| IV. Argument | 12 |
| A. STANDARD OF REVIEW | 12 |
| B. IMPLICIT MEMORY AND EXPLICIT MEMORY DO NOT INVOLVE NOVEL SCIENTIFIC EVIDENCE | 12 |
| C. EVIDENCE OF RAPE TRAUMA SYNDROME IS ADMISSIBLE, WHEN NOT OFFERED AS A DIRECT ASSESSMENT OF THE CREDIBILITY OF THE VICTIM | 14 |
| D. A DSM-IV DIAGNOSIS IS NOT A NECESSARY PREREQUISITE FOR AN EXPERT TO EXPRESS AN OPINION OF PSYCHOLOGICAL HARM TO A DEGREE OF MEDICAL PROBABILITY | 17 |

| | | |
|------|--|----|
| E. | QUESTIONS REGARDING THE WIGHT OF THE EVIDENCE SHOULD GO TO THE JURY | 19 |
| F. | THE ESTATE IS ENTITLED TO ATTORNEY FEES AND COSTS ON APPEAL | 22 |
| VI. | Conclusion | 22 |
| VII. | Appendix | 24 |

TABLE OF AUTHORITIES

Table of Cases

| | |
|---|-----------------------------|
| Conrad v. Alderwood Manor , 119 Wn. App. 275, 299 (2003) | 22 |
| Detention of Campbell , 139 Wn.2d 341 (1999) | 19, 21 |
| Detention of Halgren , 156 Wn.2d 795 (2006) | 19, 21 |
| Detention of Thorell , 149 Wn.2d 724 (2003) | 19, 21 |
| Frye v. United States , 293 F. 1013 (D.C. Cir. 1923) | 1, 4, 6, 12, 13, 19, 21, 22 |
| Kaech v. Lewis County Public Util. Dist. No. 1 , 106 Wn. App. 260. (2001) | 13, 19, 21 |
| Personal Restraint of Young , 122 Wn.2d 1 (1993) | 13 |
| State v. Baity , 140 Wn.2d 1 (2000) | 12, 19, 20, 21 |
| State v. Black , 109 Wn.2d 336 (1987) | 14, 15, 16, 17 |
| State v. Ciskie , 110 Wn.2d 263 (1988) | 15 |
| State v. Cleveland , 58 Wn. App. 634 (1990) | 15, 20 |
| State v. Copeland , 130 Wn.2d 244, 255-6 (1996) | 12 |
| State v. Graham , 59 Wn. App. 418 (1990) | 15, 20 |
| State v. Ortiz , 119 Wn.2d 294 (1992) | 12 |
| State v. Stevens , 58 Wn. App. 478 (1990) | 15, 16, 20 |

Statutes

RCW 74.343, 22, 23
RCW 74.34.200(3) 2, 22

Other Authorities

DSM-IV-TR, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Ed., Text Revision, published by the American Psychiatric Association, Arlington, PAEx 1, pgs 1-7

I. INTRODUCTION

This is an action for damages in negligence and under RCW 74.34, the Vulnerable Adults Statute (VAS). It is brought by Karen Carlton and Marjorie Holland, Co-Administrators/Personal Representatives of the Estate of Miriam Elizabeth Carlton (Estate) against Vancouver Care, LLC, dba Stonebridge Memory Care (Stonebridge). It arises out of the sexual assault of Miriam Carlton on July 3, 2004 by a male resident of Stonebridge. Stonebridge has admitted liability under the negligence claim and the VAS claim.¹ Stonebridge has further acknowledged that the assault on Mrs. Carlton was a rape.² The issue for trial is damages suffered by Mrs. Carlton.

The Estate proffered expert testimony to show that Mrs. Carlton suffered ongoing psychological harm as a result of the rape. The trial court granted Stonebridge's motion to exclude such expert testimony, holding that it did not satisfy the *Frye*³ standard.

¹ RP, May 14, 2007 at 120; RP, May 22, 2007 at 199-200.

² Id.

³ *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923); *State v. Copeland*, 130 Wn.2d 244, 255 (1996) (holding that evidence of a novel scientific theory or treatment may be presented to the trier of fact only when the theory or treatment has been "general[ly] accept[ed] in the relevant scientific community).

The Estate requests reversal of the trial court's ruling, with a remand to allow the Estate to present the evidence excluded. The Estate further requests attorney fees and costs, pursuant to RCW 74.34.200(3).

II. ASSIGNMENTS OF ERROR

Assignments of Error

1. The trial court erred by excluding expert testimony regarding implicit memory, explicit memory, conditioned fear response and paired associations as novel scientific evidence.
2. The trial court erred by excluding expert testimony on Rape Trauma Syndrome and Compounded Rape Trauma Syndrome.
3. The trial court erred by requiring a specific DSM-IV diagnosis as a prerequisite for an expert witness to express an opinion of psychological harm to a degree of medical probability.
4. The trial court erred by excluding expert testimony based upon its evaluation of the weight of the evidence, rather than upon the admissibility of the evidence.

Issues Pertaining to Assignments of Error

1. Whether expert testimony regarding implicit memory, explicit memory, conditioned fear response and paired associations is novel scientific evidence.
2. Whether expert testimony regarding Rape Trauma Syndrome and Compounded Rape Trauma Syndrome, not offered as a direct assessment of the credibility of the victim, is admissible.
3. Whether a specific DSM-IV diagnosis is a necessary prerequisite for an expert witness to express an opinion of psychological harm to a degree of medical probability.

4. Whether the trial court excluded expert testimony based upon the weight of the evidence, rather than upon the admissibility of the evidence.

III. STATEMENT OF THE CASE

On July 3, 2004, Miriam Carlton had been a resident at Stonebridge for over three years. She suffered from severe dementia; her language skills were very limited, and she required assistance with all aspects of her care. On July 3, 2004, Mrs. Carlton was sexually assaulted by a male resident of Stonebridge. Stonebridge has acknowledged that the assault on Mrs. Carlton was a rape.⁴ Stonebridge has admitted that it was negligent, and that its actions were in violation of RCW 74.34, the Vulnerable Adult Statute.⁵ On July 12, 2004, Mrs. Carlton was moved by her family to an adult family home, Canyon Creek, where she resided until her death approximately 13 months later.

The Estate claims that, in addition to the physical assault itself, Mrs. Carlton suffered ongoing psychological harm, that continued until her death. These claims are based upon a description of the rape itself, elevated vital signs of Mrs. Carlton at the emergency room and afterward, behaviors exhibited by Mrs. Carlton after the rape, and upon expert

⁴ Supra, note 1.

⁵ Id.

testimony of Dr. Ann Burgess and Dr. Robert Olsen.

At a hearing on Motions in Limine, the court excluded expert opinions of the Estate's witnesses.⁶ The court also excluded testimony of observed behaviors of Mrs. Carlton at Canyon Creek.⁷ The court ruled that the only issue to be presented to the jury would be the harm, if any, suffered by Mrs. Carlton during the time of the rape itself.⁸ The court also granted the Estate a *Frye* hearing.⁹

On May 22 and 23, 2007, a *Frye* hearing was conducted regarding the admissibility of opinion testimony regarding the ongoing psychological harm suffered by Mrs. Carlton. The Estate presented testimony from Dr. Ann Burgess, Dr. Robert Olsen, and Dr. Kirk Johnson. Dr. Burgess is a professor of psychiatric nursing, a board-certified psychiatric nurse practitioner and a certified sexual assault examiner.¹⁰ She is licensed to treat patients, unsupervised, with full prescriptive authority.¹¹ She has

⁶ RP, May 14, 2007 at 118 to 119, 125.

⁷ Id.

⁸ Id.

⁹ Id.

¹⁰ RP, May 22, 2007 at 7-10.

¹¹ Id.

conducted extensive research into the psychological effects of sexual assault, and has published peer-reviewed articles on Rape Trauma Syndrome (RTS) and Compounded Rape Trauma Syndrome (CRTS).¹² In 2000, she began a study of sexual assault on elderly victims, including those residing in long term care settings.¹³ Her research has been published in more than 130 psychiatric publications.¹⁴ Dr. Olsen is a board-certified physician of internal medicine, general psychiatry and forensic psychiatry.¹⁵ His practice has included significant numbers of geriatric patients, victims of sexual assault and dementia patients.¹⁶ Dr. Kirk Johnson is a licensed psychologist and a certified sex offender evaluation treatment specialist.¹⁷ His practice includes treatment of victims of sexual assault.¹⁸ Stonebridge presented testimony from psychiatrists, Dr. Ladson Hinton and Dr. Deena Klein.¹⁹

¹² RP, May 22, 2007 at 14, 23.

¹³ RP, May 22, 2007 at 15-17.

¹⁴ RP, May 22, 2007 at 13.

¹⁵ RP, May 22, 2007 at 110.

¹⁶ RP, May 22, 2007 at 112, 114.

¹⁷ RP, May 23, 2007 at 210-211.

¹⁸ Id.

¹⁹ RP, May 23, 2007 beginning at 207 and 276.

At the *Frye* hearing, Drs. Olsen and Burgess gave expert testimony regarding the implicit memory system of the human brain.²⁰ Both testified that the implicit memory system is separate and distinct from the explicit, or cognitive, memory system of the brain.²¹ The implicit memory system is sensory based and is located in the brain stem and mid brain, while the explicit memory system, which is cognitively based, is located in the outer lobes of the brain.²² Drs. Olsen and Burgess testified that it is unnecessary for the individual who experiences trauma to maintain a cognitive, or subjective, memory of the specific event in order to suffer subsequent harm from that event.²³ If presented with a stimulus similar to traumatic event, the implicit memory system will cause the individual to become anxious or fearful.²⁴ Even someone with severe dementia, like Mrs. Carlson, who is unable to form any lasting, cognitive memories can re-experience the fear of the traumatizing event, in this case, the rape.²⁵ This

²⁰ RP, May 22, 2007 at 17-22; 116-123.

²¹ Id.

²² Id.

²³ Id.

²⁴ Id.

²⁵ Id.

is a function of the autonomic nervous system.²⁶ It is an automatic, involuntary reaction, triggered by some external stimulus.²⁷ It is also referred to as “conditioned fear response” or “paired associations.”²⁸ Drs. Burgess and Olsen testified that conditioned fear response and implicit memory are not novel scientific evidence or information, and that both are generally accepted in the scientific community.²⁹

Drs. Olsen and Burgess further testified that RTS and CRTS are generally accepted in the community of mental health care providers, and that they are helpful in addressing questions raised about Mrs. Carlton’s behaviors subsequent to the assault.³⁰ Dr. Burgess testified that RTS is a “clustering . . . of signs and symptoms” that she observed in adult victims of sexual assault.³¹ CRTS adds an additional “compounding” factor, such as dementia, or some other physical or mental disorder, that can prevent the victim from reporting the sexual assault or describing the effects of

²⁶ Id.

²⁷ Id.

²⁸ Id.

²⁹ Id.

³⁰ RP, May 22, 2007 at 23-4; 131-133.

³¹ Id. at 23-4.

that assault.³² In her 2000 study, Dr. Burgess found that many elderly victims of sexual assault delayed in reporting; that the assault seemed to trigger a need to talk; that the elderly victims entered a physiological shock, became immobile and comforted themselves by curling into a fetal position.³³

Drs. Olsen and Burgess testified that, in conducting forensic evaluations, experts rely on others' observations of the victim, especially in situations where the victim is not available or is unable to communicate.³⁴ Both testified that changes in vital signs, such as blood pressure and heart rate, as well as changes in behavior can indicate psychological harm.³⁵ Both testified that information contained in records of the victim can give insight into the trauma suffered by the victim.³⁶ As Dr. Olsen testified, Mrs. Carlson's medical records recorded that she suffered from expressive aphasia.³⁷ This fact makes Mrs. Carlson's

³² RP, May 22, 2007 at 31-32.

³³ *Supra*, note 13.

³⁴ RP, May 22, 2007 at 28-33; 126-131.

³⁵ *Id.*

³⁶ *Id.*

³⁷ RP, May 22, 2007 at 139-140.

records and the observations of others more critical.

Drs. Burgess and Olsen both expressed opinions, to a degree of medical probability, that Mrs. Carlton sustained psychological trauma from the rape that lasted for the rest of her life.³⁸ They both reviewed Mrs. Carlton's medical records, records of Stonebridge and Canyon Creek, the police report regarding the assault, an incident report prepared by Stonebridge, the deposition transcripts of Mrs. Carlton's daughters, Karen Carlton and Marjorie Holland, and the deposition transcripts of staff from Stonebridge and Canyon Creek.³⁹ Both experts testified that this harm occurred as a result of the functioning of the implicit memory system of the brain and upon conditioned fear response.⁴⁰

Drs. Olsen and Burgess testified that the increase in Mrs. Carlton's blood pressure and heart rate subsequent to the assault, as well as aggravated or intensified behaviors subsequent to the rape, demonstrated to them, on a more probable than not basis, that Mrs. Carlton was suffering a form of psychological trauma that lasted beyond the rape itself

³⁸ RP, May 22, 2007 at 40-64; 144-150.

³⁹ Id.

⁴⁰ Id.

and until her death.⁴¹ They based these opinions on the function of the implicit memory system of the brain and the principle of conditioned fear response.⁴²

Dr. Kirk Johnson testified that rape trauma syndrome is generally accepted in the community of mental healthcare providers, and it is used as a tool by those mental healthcare providers to treat victims of sexual assault.⁴³ Dr. Johnson further testified that he is familiar with the research of Dr. Burgess; that it is something he and other mental health professionals, who treat victims of sexual assault, rely upon in the course of treating patients.⁴⁴

Defense expert Ladson Hinton testified that it was impossible to tell whether Mrs. Carlton had suffered any psychological harm beyond the assault itself.⁴⁵ He testified that Mrs. Carlton had a very advanced dementia, and that she was unable to form any lasting cognitive memories

⁴¹ Id.

⁴² Id.

⁴³ RP, May 23, 2007 at 211-213.

⁴⁴ RP, May 23, 2007 at 213-214.

⁴⁵ RP, May 23, 2007 at 257-259.

of the rape.⁴⁶ Dr. Hinton further testified that subsequent behaviors exhibited by Mrs. Carlton could be explainable by other factors.⁴⁷ Dr. Hinton also acknowledged, on cross-examination, that neither implicit memory nor conditioned fear response are novel scientific evidence, and that both are generally accepted in the scientific community.⁴⁸ Dr. Hinton further acknowledged that it is possible for a severely demented person to experience ongoing psychological trauma as the result of the functioning of the implicit memory system or as the result of a conditioned fear response.⁴⁹ Defense expert Dr. Deena Klein testified that she had never heard of implicit memory, and that she had never heard of rape trauma syndrome.⁵⁰

After the close of testimony, the court made its ruling, as set forth in the Order of August 31, 2007. CP 73. The court ruled that the Estate was not allowed to introduce any testimony, including expert testimony, regarding rape trauma syndrome, compounded rape trauma syndrome,

⁴⁶ Id.

⁴⁷ Id.

⁴⁸ RP, May 23, 2007 at 315-316.

⁴⁹ RP, May 23, 2007 at 339-340.

⁵⁰ RP, May 23, 2007 at 280, 296, 308-309.

implicit memory or conditioned fear response.⁵¹ Further, the court ruled that Dr. Burgess could not testify regarding her observations in similar populations of elderly people who had suffered sexual assault.⁵² The effect of the court's ruling is to preclude all of the Estate's expert testimony, and to limit the Estate's case only to harm suffered by Miriam Carlton at the time of the rape itself, and not afterward.

IV. ARGUMENT

A. STANDARD OF REVIEW.

The scope of review for *Frye* questions is de novo and involves a mixed question of law and fact. *State v. Copeland*, 130 Wn.2d 244, 255-6 (1996). Moreover, the reviewing court may extend its review beyond the record and may consider scientific literature and secondary legal authority. *id.*

B. IMPLICIT MEMORY AND EXPLICIT MEMORY DO NOT INVOLVE NOVEL SCIENTIFIC EVIDENCE.

Evidence is to be considered under *Frye* only when it involves novel scientific evidence. Otherwise, a *Frye* analysis is unnecessary. *State v. Baity*, 140 Wn.2d 1 (2000); *State v. Ortiz*, 119 Wn.2d 294 (1992);

⁵¹ RP, May 23, 2007 at 377-384.

⁵² *Id.*

Kaech v. Lewis County Public Util. Dist. No. 1, 106 Wn. App. 260 (2001); *Personal Restraint of Young*, 122 Wn.2d 1 (1993). Expert opinions regarding psychological harm do not involve novel scientific evidence.

“The sciences of psychology and psychiatry are not novel; they have been an integral part of the American legal system since its inception. Although testimony relating to mental illnesses and disorders is not amenable to the types of precise and verifiable cause and effect relation petitioners seek, the level of acceptance is sufficient to merit consideration at trial.” *Personal Restraint of Young*, 122 Wn.2d 1, 57 (1993).

This case involves exactly this type of psychiatric or psychological evidence. While there may be no precise way to measure, test or quantify the impact of the rape on Mrs. Carlton, psychological and psychiatric experts have developed opinions, to a degree of medical probability, as to its existence. Their opinions are based on their review of her records and upon testimony of observed behaviors of Mrs. Carlton after the rape. At the *Frye* hearing, there was no evidence introduced that the analysis applying the implicit memory structure of the brain and conditioned fear response was novel scientific evidence. Even defense expert, Dr. Hinton, acknowledged that such evidence was not novel scientific evidence, and that implicit memory and conditioned fear response are generally accepted

in the scientific community.⁵³ The only possible contrary testimony was that of Dr. Klein, who stated she had never heard of implicit memory.⁵⁴ Her lack of knowledge should not be a basis to deny the admissibility of evidence.

C. EVIDENCE OF RAPE TRAUMA SYNDROME IS ADMISSIBLE, WHEN NOT OFFERED AS A DIRECT ASSESSMENT OF THE CREDIBILITY OF THE VICTIM.

Stonebridge has admitted that Mrs. Carlton was raped.⁵⁵ The fact of the rape is not at issue. Despite this admission, the trial court ruled that *State v. Black*, 109 Wn.2d 336 (1987) precludes any evidence of Rape Trauma Syndrome or Compounded Rape Trauma Syndrome.⁵⁶

The specific holding of *Black* is that Rape Trauma Syndrome is not a scientifically reliable means of proving lack of consent in a criminal rape prosecution. *Black* at 348. In this case, all parties agree that Miriam Carlton had severe dementia. *Stonebridge's Response to Motion for Discretionary Review* at page 3. Therefore, Mrs. Carlton wasn't capable of giving consent. The Estate is not offering evidence of Rape Trauma

⁵³ Supra, note 48.

⁵⁴ Supra, note 50.

⁵⁵ Supra, note 2.

⁵⁶ Supra, note 51.

Syndrome to show lack of consent or as a comment on her credibility.

Rather, the Estate is offering evidence of Rape Trauma Syndrome for other purposes. Stonebridge has raised issues regarding Mrs. Carlton's lack of response immediately following the rape, as well as in the few days subsequent to it. Evidence regarding Rape Trauma Syndrome can be helpful to explain a particular response, or lack of response, on the part of a victim.⁵⁷

In subsequent decisions, our courts have consistently distinguished *Black* and held that syndrome evidence may be admitted for other purposes. *State v. Graham*, 59 Wn. App. 418 (1990) (syndrome evidence admissible to explain that delay in reporting is not inconsistent with the presence of abuse); *State v. Cleveland*, 58 Wn. App. 634 (1990) (expert testimony admissible where it was essentially a description of the expert's personal observation of some of the characteristics of child sex abuse victims); *State v. Stevens*, 58 Wn. App. 478 (1990) (expert testimony admissible as to behaviors consistent in sexually abused children that had been observed by the expert in her own experience working in the field); *State v. Ciskie*, 110 Wn.2d 263 (1988) (expert testimony on Battered Woman's Syndrome admissible to assist the jury in understanding the

⁵⁷ Supra, note 30.

victim's delays in reporting alleged sexual assaults and for continuing the battering relationship). "Washington cases decided since *Black* have made clear that expert testimony generally describing symptoms exhibited by victims may be admissible when relevant and when not offered as a direct assessment of the credibility of the victim." *State v. Stevens*, 58 Wn. App. 478, 496 (1990).

In the present case, evidence relating to Rape Trauma Syndrome is being offered, not to prove lack of consent or as a comment on the credibility of Mrs. Carlton, but rather, to address questions raised by the Stonebridge regarding her behavior subsequent to the rape. Dr. Ann Burgess testified that, in her research, she found certain characteristics that were common to demented, elderly adults, who had been victims of sexual assault.⁵⁸ Rape Trauma Syndrome is used by mental health providers who counsel victims of sexual assault.⁵⁹ Dr. Johnson further stated that Rape Trauma Syndrome is generally accepted in the scientific community of mental health counselors.⁶⁰ Dr. Robert Olsen also testified that Rape Trauma Syndrome was helpful in explaining subsequent behaviors, and

⁵⁸ *Supra*, note 13.

⁵⁹ *Supra*, note 43.

⁶⁰ RP, May 23, 2007 at 212-213.

the delay in onset of symptoms, as described earlier.⁶¹

Evidence of Rape Trauma Syndrome should be admissible for the purposes set forth herein.

D. A DSM-IV DIAGNOSIS IS NOT A NECESSARY PREREQUISITE FOR AN EXPERT TO EXPRESS AN OPINION OF PSYCHOLOGICAL HARM TO A DEGREE OF MEDICAL PROBABILITY.

In rendering its decision, the trial court stated that a DSM-IV diagnosis was necessary for evidence to be presented to the jury.⁶² The court cited no case law as authority for that position, nor has Stonebridge in this case. The only authority relied on by the court is the law review article by Dr. Brett Trowbridge.⁶³

Washington courts have allowed this testimony, when not offered as a direct assessment of the credibility of the victim. The cases cited above that distinguish *Black* all address the admissibility of syndrome evidence. Syndrome is defined in the DSM-IV as, “A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment

⁶¹ Supra note 30.

⁶² Supra, note 51.

⁶³ Id.

selection.”⁶⁴ A mental disorder may be composed of one or more syndromes, but a syndrome is not a mental disorder in and of itself.⁶⁵

These cited cases confirm that syndrome evidence is admissible for particular purposes, with no mention of a requirement of a diagnosis of a specific DSM-IV mental disorder. The trial court’s holding is contrary to established case law.

The DSM-IV was never intended as a complete, exhaustive list of mental disorders. It does not encompass all the conditions for which people may be treated.⁶⁶ It involves the application of clinical judgment by a trained expert.

It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for diagnosis as long as the symptoms that are present are persistent and severe.
Id.

The publishers of the DSM-IV caution against its use in forensic settings, such as legal proceedings, as “additional information may be required

⁶⁴ DSM-IV-TR, Fourth Ed. At 828.

⁶⁵ Ex 1, pgs 3-4.

⁶⁶ Ex 1, pgs 5-7; RP, May 23, 2007 at 211.

beyond that contained in the DSM-IV diagnosis.”*Id.*

At the *Frye* hearing in this case, expert testimony was introduced regarding psychological harm suffered by Miriam Carlton.⁶⁷ The testimony described Mrs. Carlton as suffering from psychological trauma resulting from conditioned fear response, or paired associations, caused by the rape.⁶⁸ Even defense expert, Dr. Hinton, acknowledged that someone with severe dementia could suffer ongoing psychological harm through the function of implicit memory or conditioned fear response.⁶⁹ The Estate’s experts expressed their opinions to a degree of medical probability, as described above, using their clinical judgment.⁷⁰

E. QUESTIONS REGARDING THE WEIGHT OF THE EVIDENCE SHOULD GO TO THE JURY.

Questions regarding the reliability of an expert’s analysis go to the weight of the expert’s testimony, not to its admissibility. *Baity, supra*; *Kaech, supra*; *Detention of Campbell*, 139 Wn.2d 341 (1999); *Detention of Halgren*, 156 Wn.2d 795 (2006); *Detention of Thorell*, 149 Wn.2d 724 (2003). Questions of reliability should be submitted to the finder of fact.

⁶⁷ *Supra*, note 38.

⁶⁸ *Id.*

⁶⁹ *Supra*, note 49.

⁷⁰ *Supra*, note 38.

Questionable reliability can be explored on cross-examination, as part of the court's adversary process. *Baity* at 14; *Campbell* at 358.

Evidence regarding an expert's observation and experience is admissible in explaining the basis of the expert's testimony and opinions. *State v. Graham*, 59 Wn. App. 418 (1990); *State v. Cleveland*, 58 Wn. App. 634 (1990); *State v. Stevens*, 58 Wn. App. 478 (1990). In the present case, Stonebridge questions the Estate's claims of ongoing harm, based on Miriam Carlton's severe dementia and on her purported lack of response following the rape. The Estate has been precluded from introducing evidence to explain any such claimed lack of response. In particular, Dr. Ann Burgess is prepared to testify regarding the impact of sexual assaults on the elderly population, and their response to such assaults.⁷¹ Dr. Burgess' testimony is based on her observations and research into the area of sexual assaults on elderly people in long-term care settings.⁷² Dr. Burgess is the preeminent authority with regard to this research.⁷³

Under ER 702, expert testimony is admissible if it will assist the

⁷¹ *Supra*, note 33.

⁷² *Supra*, notes 12, 13, 14.

⁷³ *Supra*, note 44.

trier of fact, is beyond the common understanding, and is relevant to the case at issue. The evidence that the court has excluded fits all of these criteria.

Experts may disagree in their evaluation of relevant health records, RP, May 23, 2007 at 323-324; 332-333, but that disagreement goes to the weight of the evidence, not to its admissibility. *State v. Baity*, 140 Wn.2d 1 (2000); *Kaech v. Lewis County Public Util. Dist. No. 1*, 106 Wn. App. 260 (2001); *Detention of Campbell*, 139 Wn.2d 341 (1999); *Detention of Halgren*, 156 Wn.2d 795 (2006); *Detention of Thorell*, 149 Wn.2d 724 (2003).

In the present case, the trial court has chosen to weigh the credibility of the testimony, a function to be performed by the jury. The trial court has held that evidence relating to implicit memory and conditioned fear response are not admissible under *Frye*, when all of the experts, including defense experts, agree that this evidence is not novel scientific evidence and is generally accepted in the scientific community. The trial court has substituted its judgment for that of the finder of fact, in this case, the jury. The court has excluded evidence based on its weight, and has improperly ruled on its admissibility.

F. THE ESTATE IS ENTITLED TO ATTORNEY FEES AND COSTS ON APPEAL.

RCW 74.34.200(3) provides that a prevailing plaintiff shall be awarded fees and costs. This provision is mandatory and is available to plaintiffs only. *Conrad v. Alderwood Manor*, 119 Wn. App. 275, 299 (2003).

Stonebridge has admitted liability under RCW 74.34, as well as under a negligence theory.⁷⁴ The responsibility for fees under the statute is already triggered. If successful, the Estate should be awarded all fees and costs for this appeal.

V. CONCLUSION

The standard of review for *Frye* questions is de novo. The reviewing court is not limited to the record before the trial court, but may consider material outside the record.

Implicit and explicit memory are not novel scientific evidence. Therefore, they are not subject to *Frye* scrutiny. The Estate should be allowed to present this evidence.

RTS and CRTS are generally accepted in the community of mental health care providers. These concepts are helpful in understanding Mrs.

⁷⁴ *Supra*, note 1.

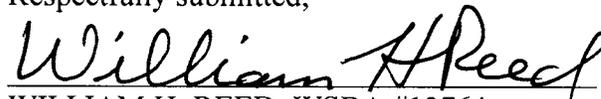
Carlton's behaviors, or lack of behaviors, after the rape, especially in light of her expressive aphasia. Courts have allowed this testimony when not offered as a direct assessment of the credibility of the victim. The Estate should be allowed to present this evidence for the purposes set forth herein.

A DSM- IV diagnosis is not a necessary prerequisite for an expert to give an opinion regarding psychological harm. Washington case law allows introduction of syndrome evidence that does not fit into a specific DSM-IV diagnosis. The Estate's experts should be allowed to express the opinions they have developed to a degree of medical probability.

The trial court has improperly weighed the evidence in this matter, and excluded expert testimony. This ruling is not properly based on the admissibility of this evidence.

The trial court's ruling should be reversed and remanded, with instruction to allow the Estate to put into evidence the expert opinions excluded in that ruling. The Estate should be awarded its attorney fees and costs, pursuant RCW 74.34.200(3).

Respectfully submitted,

A handwritten signature in cursive script that reads "William H. Reed". The signature is written in black ink and is positioned above the printed name.

WILLIAM H. REED, WSBA #13764

Attorney for Appellant

VII. APPENDIX

DSM-IV-TR, Diagnostic and Statistical Manual of Mental
Disorders, Fourth Ed., 7 pages Ex 1

**DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS**

FOURTH EDITION

TEXT REVISION

DSM-IV-TR[®]



Published by the
American Psychiatric Association
Arlington, VA

Ex 1, Pg 1

Copyright © 2000 American Psychiatric Association

DSM, DSM-IV, and DSM-IV-TR are trademarks of the American Psychiatric Association. Use of these terms is prohibited without permission of the American Psychiatric Association.

ALL RIGHTS RESERVED. Unless authorized in writing by the APA, no part of this book may be reproduced or used in a manner inconsistent with the APA's copyright. This prohibition applies to unauthorized uses or reproductions in any form, including electronic applications.

Correspondence regarding copyright permissions should be directed to DSM Permissions, American Psychiatric Publishing, Inc., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901.

Manufactured in the United States of America on acid-free paper.

ISBN 978-0-89042-024-9 6th Printing March 2007

ISBN 978-0-89042-025-6 10th Printing March 2007

American Psychiatric Association

1000 Wilson Boulevard

Arlington, VA 22209-3901

www.psych.org

The correct citation for this book is American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Library of Congress Cataloging-in-Publication Data

Diagnostic and statistical manual of mental disorders : DSM-IV.—4th ed., text revision.

p. ; cm.

Prepared by the Task Force on DSM-IV and other committees and work groups of the American Psychiatric Association.

Includes index.

ISBN 0-89042-024-6 (casebound : alk. paper)—ISBN 0-89042-025-4 (pbk. : alk. paper)

1. Mental illness—Classification—Handbooks, manuals, etc. 2. Mental illness—Diagnosis—Handbooks, manuals, etc. I. Title: DSM-IV. II. American Psychiatric Association. III. American Psychiatric Association. Task Force on DSM-IV.

[DNLM: 1. Mental Disorders—classification. 2. Mental Disorders—diagnosis.

WM 15 D536 2000]

RC455.2.C4 D536 2000

616.89'075—dc21

00-024852

British Library Cataloguing in Publication Data

A CIP record is available from the British Library.

Text Design—Anne Barnes

Manufacturing—R. R. Donnelley & Sons Company

Ex 1, Pg 2

The chairs of the original DSM-IV Work Groups were consulted first regarding the composition of these Text Revision Work Groups. Each Text Revision Work Group was given primary responsibility for updating a section of the DSM-IV text. This entailed reviewing the text carefully to identify errors or omissions and then conducting a systematic, comprehensive literature review that focused on relevant material that has been published since 1992. Text Revision Work Group members then drafted proposed changes, which were accompanied by written justifications for the changes along with relevant references. During a series of conference calls, the proposed changes, justifications, and references were presented by a Text Revision Work Group member to other members of the Text Revision Work Group, who provided input regarding whether the changes were justified on the basis of the supporting documentation. Once drafts of the proposed changes were finalized by the Text Revision Work Groups, the changes were more widely disseminated to a group of section-specific advisers (consisting of the original DSM-IV Work Group members supplemented by additional consultants) for further comment and review. These advisers were also given the opportunity to suggest additional changes if they could provide sufficient convincing evidence justifying inclusion in the text. After consideration of the adviser comments, final drafts of proposed changes were produced and submitted for final review and approval by the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment.

Most of the proposed literature-based changes were in the Associated Features and Disorders (which includes Associated Laboratory Findings); Specific Culture, Age, and Gender Features; Prevalence; Course; and Familial Pattern sections of the text. For a number of disorders, the Differential Diagnosis section also was expanded to provide more comprehensive differentials. Appendix D (see p. 829) provides an overview of the changes included in this text revision.

Definition of Mental Disorder

Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.

Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each

is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Despite these caveats, the definition of *mental disorder* that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV (as did the text of DSM-III-R) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."

Issues in the Use of DSM-IV

Limitations of the Categorical Approach

DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features. This naming of categories is the traditional method of organizing and transmitting information in everyday life and has been the fundamental approach used in all systems of medical diagnosis. A categorical approach to classification works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive. Nonetheless, the limitations of the categorical classification system must be recognized.

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. This outlook allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional

Ex 1, Pg 4

clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, DSM-IV often includes polythetic criteria sets, in which the individual need only present with a subset of items from a longer list (e.g., the diagnosis of Borderline Personality Disorder requires only five out of nine items).

It was suggested that the DSM-IV Classification be organized following a dimensional model rather than the categorical model used in DSM-III-R. A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations and thus far have been less useful than categorical systems in clinical practice and in stimulating research. Numerical dimensional descriptions are much less familiar and vivid than are the categorical names for mental disorders. Moreover, there is as yet no agreement on the choice of the optimal dimensions to be used for classification purposes. Nonetheless, it is possible that the increasing research on, and familiarity with, dimensional systems may eventually result in their greater acceptance both as a method of conveying clinical information and as a research tool.

Use of Clinical Judgment

DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication.

In addition to the need for clinical training and judgment, the method of data collection is also important. The valid application of the diagnostic criteria included in this manual necessitates an evaluation that directly accesses the information contained in the criteria sets (e.g., whether a syndrome has persisted for a minimum period of time). Assessments that rely solely on psychological testing not covering the criteria content (e.g., projective testing) cannot be validly used as the primary source of diagnostic information.

Use of DSM-IV in Forensic Settings

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be mis-

Ex 1, Pg 5

used or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology. Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

It must be noted that DSM-IV reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM-IV, to the identification of new disorders, and to the removal of some disorders in future classifications. The text and criteria sets included in DSM-IV will require reconsideration in light of evolving new information.

The use of DSM-IV in forensic settings should be informed by an awareness of the risks and limitations discussed above. When used appropriately, diagnoses and diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

Ethnic and Cultural Considerations

Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and

Ex 1, Pg 6

Cautionary Statement

The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.

These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts.

The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

CERTIFICATE OF SERVICE

I hereby certify that I served the foregoing *Brief of Appellant* on the following parties at the following addresses:

Douglas F. Foley (Fax to (360)944-6808)
Katie D. Buxman
FOLEY & BUXMAN, PLLC
13115 NE 4th St., #260
Vancouver, WA 98684

Barbara J. Duffy (Fax to (206)223-7107)
Ryan P. McBride
Andrew G. Yates
LANE POWELL PC
1420 Fifth Avenue, Suite 4100
Seattle, WA 98101

FILED
COURT OF APPEALS
DIVISION II
08 FEB 15 AM 10:09
STATE OF WASHINGTON
BY _____
DEPUTY

by facsimile and by mailing full, true and correct copies thereof in sealed, first-class postage-prepaid envelopes, addressed to the attorneys as shown above, the last-known office addresses of the attorneys, and deposited with the United States Postal Service at Vancouver, Washington on the date set forth below.

The undersigned hereby declares, under the penalty of perjury, that the foregoing statements are true and correct to the best of my knowledge.

Executed at Vancouver, Washington this 14th day of February, 2008.



Lori Blunt, Legal Assistant
Reed, Johnson & Snider, P.C.