

The Admissibility of Expert Testimony in Washington
on Post Traumatic Stress Disorder and Related Trauma
Syndromes: Avoiding the Battle of the Experts by
Restoring the Use of Objective Psychological Testimony
in the Courtroom

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I. INTRODUCTION

There is considerable controversy regarding the use of syndrome testimony in Washington and other state courts. Consider an expert witness's testimony during a criminal case, in which an expert asserted that it appeared likely that the alleged victim had truly been raped because she showed symptoms of "rape trauma syndrome." Specifically, the expert testified: "[I]n every rape victim I have seen they exhibit consistent symptoms For example, body soreness, guilt, shame, feelings about the trial, nightmares, and flashbacks are all common symptoms that rape victims experience. There is a profile for rape victims and [she] fits it."¹ Suppose this testimony was allowed despite an objection from defense counsel.

Should an appellate court uphold the testimony about rape trauma syndrome? In the actual case, the Washington Supreme Court determined that a literature review of the scientific evidence was necessary in order to empirically determine whether rape trauma

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1. This testimony was given in *State v. Black*, 109 Wash. 2d 336, 745 P.2d 12 (1987).

syndrome is a “scientifically reliable method admissible in evidence and probative of the issue of whether an alleged rape victim was raped.”² The Court concluded that “[t]he literature on the subject demonstrates that it is not.”³

The court’s analysis of the scientific reliability and legal admissibility of rape trauma syndrome testimony illustrates how psychology and law intersect. In such cases, the court evaluates psychological science to determine whether a given syndrome is generally accepted in its field. The court, in effect, conducts its own meta-analysis of the literature by reviewing relevant studies to determine which syndromes will be considered admissible as expert evidence. The result of such an analysis influences the admissibility of the syndrome evidence.

Several factors are important in determining whether a scientific study would be relevant in evaluating syndrome evidence. First, it would be important to determine whether studies show universal or near universal symptoms for each type of trauma, and whether studies show a wide divergence of symptom patterns, including true victims who reported no symptoms at all. Also, it would be significant if the studies demonstrate that less traumatized individuals only rarely exhibit the same symptoms as traumatized individuals. Second, it would matter whether the symptoms described fit a diagnosis listed in the manual utilized by clinicians when diagnosing mental disorders, the DSM-IV-TR.⁴ If the factors listed in the DSM-IV-TR are not present, then the syndrome evidence should not be deemed admissible by the court.

This article will explore the legal and scientific validity of some syndromes that purport to show that abuse and/or battering likely occurred, and the validity of some syndromes that purport to show that abuse and/or battering probably did not occur. Although the syndromes in question may be useful in the clinical context, this article argues that none of these syndromes are forensically useful because they do not have diagnostic utility in differentiating between those who have been traumatized by rape, child abuse, or battering, and those who have not. Indeed, research evidence indicates that traumatized individuals may exhibit any of a broad range of psychological reactions—there are no universal symptoms of rape, child abuse, or battering.⁵

2. This standard for admissibility was first articulated in *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923). See *infra* note 7 and accompanying text for a discussion of the *Frye* test.

3. *Black*, 109 Wash. 2d at 347, 745 P.2d at 18.

4. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) (4th ed. 2000) [hereinafter DSM-IV-TR].

5. See generally, 2 DAVID FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 2–143 (2002).

Courts that allow mental health professionals to personally evaluate a person who may have been traumatized and allow such experts to make diagnostic statements in court that the person they have evaluated suffers or does not suffer from such syndromes have reached incorrect conclusions about the scientific acceptability and validity of these syndrome concepts. Furthermore, courts that allow such testimony from “experts” on one side in a criminal case will usually have to allow the opposing side to present “experts” of their own. This battle of the experts can launch an unnecessary investigation into all areas of the person’s life in a search for possible other traumas which might explain the observed symptoms.

The better approach is for courts to *not* allow experts to personally evaluate the allegedly abused person, and for courts to allow only general mental health testimony about the symptoms that traumatized individuals commonly exhibit. This general mental health testimony should only be introduced when the other side has “opened the door” by claiming that the alleged victim’s post-trauma behavior was not normal or common for victimized persons. Even in those instances, such testimony should not be allowed unless the expert can support his testimony with published research. In other words, experts should not be allowed to testify about what is “common” post-trauma behavior based merely on their own clinical experience.

This article focuses on three types of syndrome evidence—rape trauma syndrome, child abuse syndromes, and battered person syndrome—all of which seem to be closely related to the diagnosis of post traumatic stress disorder (PTSD). Part II provides background regarding the *Frye* test, explains how mental disorders are defined in the manual clinicians use, DSM-IV-TR, and outlines PTSD and associated syndromes. Parts III, IV, V, and VI address both legal and psychological concerns regarding specific syndromes and identify what types of testimony Washington law allows in each of these three areas. Part VII discusses the concerns regarding the scientific validity of such diagnoses. Finally, Part VIII concludes this article by calling for a standard of admissibility for syndrome testimony based on reliable science, rather than less reliable testimony based on an individual clinician’s experiences.

II. BACKGROUND

A. *The Frye Test*

Jurisdictions use different legal tests to determine whether a particular mental diagnosis or syndrome will be admissible as

evidence.⁶ Washington uses the test expounded in *Frye*.⁷ The *Frye* test requires that the trial judge find that the expert testimony be based on scientific evidence that is “sufficiently established to have general acceptance in the field to which it belongs.”⁸ In other words, the scientific techniques upon which the expert is basing his or her testimony must be viewed as accepted in the relevant scientific community. The primary diagnostic manual used by psychologists and psychiatrists, the DSM-IV-TR, discussed below, contains only those diagnoses which are considered to be generally accepted by psychologists and psychiatrists; therefore, restricting one’s diagnostic statements to those contained in DSM-IV-TR would make particular sense in Washington.

B. Mental Disorders as Defined in the DSM-IV-TR

The Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM-IV-TR), which was published in 2000 by the American Psychiatric Association, is the latest in a series of diagnostic manuals that is updated every few years. Each DSM version purports to list all of the currently accepted diagnoses in the fields of psychiatry and psychology. DSM-IV-TR reflects a consensus within the mental health community regarding the classification and diagnosis of mental disorders. Although there has been some criticism of DSM-IV-TR diagnoses,⁹ the disorders listed are thought to be the most reliable and valid diagnoses, and they are considered to be the most defensible scientifically.¹⁰ Expert testimony by mental health professionals often includes the rendering of a diagnosis, and an argument can be made that only diagnoses included in DSM-IV-TR should be utilized, as it

6. The two primary tests that courts use for novel scientific evidence are the *Frye* test and the test articulated in *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993).

7. See *State v. Copeland*, 130 Wash. 2d 244, 259–61, 922 P.2d 1304, 1314–15 (1996) (reaffirming adherence to *Frye* test for scientific evidence in Washington). The *Frye* court articulated the test as follows:

Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while the courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.

293 F. at 1014.

In *Copeland*, the Washington Supreme Court declined to follow the test articulated in *Daubert*. 130 Wash. 2d at 259–61, 922 P.2d at 1314–15.

8. See *supra* note 7 and accompanying text.

9. See, e.g., David Faust & Jay Ziskin, *The Expert Witness in Psychology and Psychiatry*, 241 SCIENCE 31 (1988).

10. DSM-IV-TR, *supra* note 4, at xxvi–xxviii (explaining how DSM-IV-TR criteria are developed through both literature reviews and field trials).

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“reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication.”¹¹

Despite the general acceptance of DSM-IV-TR in the fields of psychiatry and psychology, the rendering of a DSM-IV-TR diagnosis does not equate with any specific legal standard. DSM-IV-TR explicitly recognizes that “dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in clinical diagnosis.”¹² Furthermore, “a diagnosis does not carry any necessary implications regarding the causes of the individual’s mental disorder.”¹³

Almost all accepted DSM-IV-TR diagnoses are listed as “mental disorders,” and none are described as a “syndrome.” DSM IV-TR defines a mental disorder as follows:

[E]ach of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and 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, or 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.”¹⁴

DSM-IV-TR defines syndrome as “[a] grouping of signs or symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.”¹⁵ Thus, all mental disorders are syndromes that also meet certain additional criteria.

Perhaps the most important difference between a DSM-IV-TR mental disorder and a syndrome is that DSM-IV-TR mental disorders are thought to be accepted by a consensus of the fields of psychiatry and psychology and have agreed upon and well-defined diagnostic criteria listed in DSM-IV-TR. Syndromes, however, are not accepted by a consensus of psychiatrists and psychologists, and do not have well-defined and accepted diagnostic criteria.¹⁶ One of the biggest problems in dealing with syndromes is that different commentators have different ideas about which symptoms define a given syndrome, such that each

11. *Id.* at xxxiii.

12. *Id.*

13. *Id.*

14. *Id.* at xxxi.

15. *Id.* at 828.

16. *See id.*

commentator invents his or her own syndromes.¹⁷ What one commentator means by rape trauma syndrome, child abuse syndrome, or battered woman syndrome, for example, may be quite different from the symptoms another commentator is referring to when using the same terms.

1. Post Traumatic Stress Disorder

The diagnosis of post-traumatic stress disorder (PTSD) first appeared in the 1980 version of the DSM (DSM-III), and the criteria for diagnosing PTSD have changed slightly with each iteration of the manual. PTSD is the primary trauma-related diagnosis included in DSM-IV-TR. To qualify for a PTSD diagnosis a person must satisfy six criteria, listed as Criteria A-F. The central features of each criterion are as follows:

Criterion A requires that the person has been exposed to a traumatic event in which the person both “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and had a response that “involved intense fear, helplessness, or horror.”¹⁸

To meet Criteria B, C, and D, a person must qualify for at least one Criterion B re-experiencing symptom of the event (e.g. have recurrent and intrusive distressing recollections [“flashbacks”] or nightmares), three Criterion C avoidance symptoms (e.g. avoid stimuli associated with the trauma), and two Criterion D increased arousal symptoms (e.g. experience difficulty falling asleep, hypervigilance, or difficulty concentrating).¹⁹

Criterion E requires that the symptoms occur at a clinically significant level, and Criterion F requires that the person experience the symptoms for at least one month.²⁰

Although PTSD was originally conceived to address the trauma experienced by combat veterans, it was soon recognized that the diagnosis had broad applications to all types of trauma, including “interpersonal stressors” such as rape, sexual abuse, and physical

17. See generally, J. David Kinzie & Rupert R. Goetz, *A Century of Controversy Surrounding Posttraumatic Stress-spectrum Syndromes: The Impact on DSM-III and DSM-IV*, 9 J. TRAUMATIC STRESS 159 (1996).

18. DSM-IV-TR, *supra* note 4, at 467. The requirement that the trauma be “outside the range of usual human experience” was included in the DSM-III-R, an earlier version of the DSM-IV-TR, but has not been included in the DSM-IV or the DSM-IV-TR.

19. *Id.*

20. *Id.*

battering. Obviously, a person can suffer from PTSD based on more than one traumatic event.

Two types of assessment tools are used to assess PTSD. One set of instruments assesses the trauma (Criterion A), and the second assesses the symptoms (Criteria B-F).²¹ Structured diagnostic interviews, trauma-specific self report measures, and objective tests such as the MMPI-2 can all be used.²² Research findings show that a person who scores high on one measure of PTSD is also likely to have a high score on other measures of PTSD (construct validity).²³ However, the few existing studies that test whether the PTSD measures are measuring a construct separate and distinct from other diagnoses (divergent validity) do not show especially promising results.²⁴ Many of the validated instruments that measure PTSD seem to have good internal consistency and good test-retest correlations, so several measurements of PTSD can provide reliable assessments.²⁵ Studies that have assessed the sensitivity of instruments have found that these instruments can generally correctly identify 80% to 90% of the people who have PTSD, and studies that have assessed the specificity of these instruments have also found rates of 80% to 90%, suggesting that these scales diagnose non-PTSD sufferers incorrectly only about 10% to 20% of the time.²⁶

2. Other PTSD Associated Syndromes

While DSM-IV-TR does not mention battered person syndrome, rape trauma syndrome, or child abuse syndrome, it does state the following:

The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, or domestic battering): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened;

21. Laura E. Boeschen et al., *Rape Trauma Experts in the Courtroom*, 4 PSYCHOL. PUB. POL'Y & L. 414, 421 (1998).

22. *Id.* at 422.

23. *Id.* at 423.

24. *Id.*

25. *Id.*

26. *Id.*

impaired relationships with others; or a change from the individual's previous personality characteristics.²⁷

Thus, DSM-IV-TR acknowledges that a wide variety of symptoms can result from "interpersonal stressors."

"Interpersonal stressors" such as childhood sexual or physical abuse, rape, or domestic battering can cause a wide constellation of symptoms in conjunction with PTSD, especially when the abuse is prolonged and repeated.²⁸ PTSD symptoms often overlap with the diagnostic criteria for several other disorders, including depression, panic disorder, phobias, and obsessive-compulsive disorder.²⁹ Epidemiological studies have found that 62% to 88% of those with PTSD meet criteria for at least one other disorder.³⁰

III. RAPE TRAUMA SYNDROME

There is a considerable body of scientific literature about the commonly occurring psychological effects of rape.³¹ Rape victims often experience symptoms of PTSD, such as hypervigilance, an exaggerated startle response, difficulty concentrating, psychic numbing, and repeated experiencing of the traumatic event (e.g. flashbacks and nightmares).³² In addition to these PTSD related symptoms, research indicates that rape victims show more depression, anxiety, fear, substance abuse, sexual problems, and social maladjustment than non-victims, particularly in the first year after the assault.³³ In describing testimony about these symptoms, courts often refer to "rape trauma syndrome" because the argument on some level is that the alleged victim either fits or does not fit the syndrome of having been raped.

There are conflicting uses for the term "rape trauma syndrome." These uses include the following:

27. DSM-IV-TR, *supra* note 4, at 465.

28. See JOHN N. BRIERE, CHILD ABUSE TRAUMA: THEORY AND TREATMENT OF THE LASTING EFFECTS (1992).

29. See Jonathan R.T. Davidson & John A. Fairbank, *The Epidemiology of Posttraumatic Stress Disorder*, in POSTTRAUMATIC STRESS DISORDER AND BEYOND 147, 155-58 (Jonathan R.T. Davidson & Edna B. Foa eds., 1993).

30. J.A. Fairbank et al., *An Epidemiological Profile of Post-Traumatic Stress Disorder: Prevalence, Comorbidity, and Risk Factors*, in NEUROBIOLOGICAL AND CLINICAL CONSEQUENCES OF STRESS: FROM NORMAL ADAPTATION TO PTSD 415 (M.J. Friedman et al. eds., 1995).

31. See generally 2 DAVID FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 104-143 (2002).

32. See generally Patricia A. Frazier, *Rape Trauma Syndrome: The Scientific Status of Research on Rape Trauma Syndrome*, in 2 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 117-143 (2002).

33. See *id.*

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The term rape trauma syndrome was coined by Burgess and Holmstrom to describe a two-stage model of recovery [consisting of an “acute” phase and “reorganizational” phase] from rape among adult women. However, subsequent research has conceptualized rape trauma in terms of specific symptoms rather than stages of recovery. Moreover, rape is an example of a traumatic event that can lead to the development of [PTSD].³⁴

Further, rape trauma syndrome “often is described as a specific type of PTSD.”³⁵ Thus, rape trauma syndrome has been described as a two-stage model of recovery, as several post rape symptoms, or as a specific type of PTSD, none of which are synonymous with each other.

The question remains whether there is virtue or even validity in suggesting the presence of a “syndrome.” Thus, many experts avoid using the term rape trauma syndrome since it is not in DSM-IV or any of the previous DSMs, which suggests that it is not “commonly accepted” in the scientific community.³⁶ Also, because many courts find the use of that term excessively prejudicial, experts generally only testify about PTSD and the other scientifically well-accepted commonly occurring psychological sequelae of rape.³⁷

Expert testimony on rape trauma syndrome seems to fall into two broad categories. The first includes testimony about obvious symptoms that one would expect as a consequence of rape, such as fear of offender retaliation, fear of being raped again, fear of being out alone, and fear of men. Other symptoms include depression, sleeplessness, PTSD, anger, guilt, and sexual dysfunction.³⁸ The literature seems to suggest that these are common, but not universal, symptoms after a rape.³⁹ The second category is the explanation of “counterintuitive” behaviors that rape victims show, such as not leaving the relationship,⁴⁰ being calm and composed after the rape,⁴¹ failing to report the rape for days or even months,⁴² recanting or giving contradictory testimony,⁴³ and failing to

34. *Id.* at 104. (citations omitted).

35. *Id.*

36. *See supra* note 10 and accompanying text.

37. Washington courts recognize PTSD as an accepted diagnosis under ER 702. *See, e.g., State v. Janes*, 121 Wash. 2d 220, 233, 850 P.2d 495, 501 (1993); *State v. Florczak*, 76 Wash. App. 55, 73, n.11, 882 P.2d 199, 209, n.11 (1994).

38. Laura E. Boeschen et al., *Rape Trauma Experts in the Courtroom*, 4 PSYCHOL. PUB. POL'Y & L. 414, 418 (1998).

39. *See generally* Patricia A. Frazier, *Rape Trauma Syndrome: The Scientific Status of Research on Rape Trauma Syndrome*, in 2 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 117–143 (2002).

40. *See, e.g., State v. Ciskie*, 110 Wash. 2d 263, 751 P.2d 1165 (1988).

41. *See, e.g., State v. Robinson*, 431 N.W.2d 165 (Wis. 1988).

42. *See, e.g., People v. Glover*, 585 N.Y.S.2d 873 (App. Div. 1992).

43. *See, e.g., People v. Housley*, 8 Cal. Rptr. 2d 431 (Ct. App. 1992).

identify the assailant or remember some of the assault.⁴⁴ Testimony in this category is offered to rebut misconceptions or “myths” that jurors may hold about rape. It is generally only allowed after the defense has “opened the door” by implying the victim’s post rape behavior was inconsistent with having been raped.⁴⁵ The notion that these symptoms are common after rape is more debatable and may not be supported by the research literature.⁴⁶

A. Expert Testimony Regarding Psychological Symptoms in Rape Cases

Most states allow at least some forms of expert testimony about the psychological effects of rape in rape cases,⁴⁷ and there is a continuing scientific and legal controversy about such expert testimony.⁴⁸ Most commonly, such expert testimony is used by the prosecution in an attempt to bolster the credibility of an alleged rape victim when the defendant claims the sexual act was consensual.⁴⁹ Often the defense uses an attack on the alleged victim’s credibility through analysis of her behavior after the alleged incident, with the suggestion that her behavior is inconsistent with having been raped.⁵⁰ For example, the defense may argue that the alleged victim’s inconsistent statements, lack of specific memory for certain details, failure to promptly report the incident, her calm demeanor, or other behaviors are not consistent with having been raped. To counter such arguments, the prosecution may present expert testimony that such behaviors are not unusual among rape victims, or that her behavior was typical of rape victims.⁵¹

Proponents of allowing the State to present an expert who has evaluated the alleged victim argue that rape allegations are particularly

44. See, e.g., *Commonwealth v. Gallagher*, 510 A.2d 735 (Pa. 1986).

45. See, e.g., *Williams v. State*, 928 P.2d 600 (Alaska App. 1996).

46. See, e.g., Laura E. Boesch et al., *Rape Trauma Experts in the Courtroom*, 4 PSYCHOL. PUB. POL’Y & L. 414, 418 (1998).

47. See, e.g., *People v. Bledsoe*, 681 P.2d 291 (Cal. 1984), *State v. Marks*, 647 P.2d 1292 (Kan. 1982), *State v. Robinson*, 431 N.W.2d 165 (Wis. 1988), *People v. Hampton*, 746 P.2d 947 (Colo. 1987), *State v. Liddell*, 685 P.2d 918 (Mont. 1984), *Scadden v. State*, 732 P.2d 1036 (Wyo. 1987), *State v. Allewalt*, 517 A.2d 741 (Md. 1986), *Simmons v. State*, 504 N.E.2d 575 (Ind. 1987), *State v. Huey*, 699 P.2d 1290 (Ariz. 1985), *People v. Taylor*, 552 N.E.2d 131 (N.Y. 1990), *State v. Hall*, 412 S.E.2d 883 (N.C. 1992), *Com. v. Mamay*, 553 N.E.2d 945 (Mass. 1990), *State v. Bachman*, 446 N.W.2d 271 (S.D. 1989), *State v. Gettier*, 438 N.W.2d 1 (Iowa 1989), *State v. McCoy*, 366 S.E.2d 731 (W.Va. 1988), *State v. Alberico*, 861 P.2d 192 (N.M. 1993), *State v. Ogle*, 668 S.W.2d 138 (Mo. App. 1984), *People v. Stull*, 338 N.W.2d 403 (Mich. App. 1983), *State v. Roles*, 832 P.2d 311 (Idaho App. 1992), *Taylor v. Com.*, 466 S.E.2d 118 (Va. App. 1996), *Williams v. State*, 928 P.2d 600 (Alaska App. 1996).

48. See, e.g., *Black*, 109 Wash. 2d at 341–350, 745 P.2d at 15–19.

49. See, e.g., *Black*, 109 Wash. 2d at 354, 745 P.2d at 21–22.

50. See, e.g., *Black*, 109 Wash. 2d at 341–352, 745 P.2d at 15–19.

51. See, e.g., *Black*, 109 Wash. 2d at 338, 745 P.2d at 338.

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difficult to prosecute because jurors subscribe to certain “myths” about rape, which can sometimes only be rebutted through expert testimony.⁵² These myths include the idea that only chaste women are raped, whereas women with a “history” must have done something to encourage it.⁵³ Because of such myths, women who claim rape are typically viewed with some skepticism, therefore leading to challenges regarding the alleged victim’s credibility. Often the result seems to put the alleged victim on trial rather than the alleged perpetrator.⁵⁴

Courts that admit RTS testimony usually do so because they believe the testimony is being used to dispel such “myths.”⁵⁵ Courts that do not admit RTS evidence usually believe the evidence is being offered to prove that rape occurred.⁵⁶

Some jurisdictions allow the State’s expert to testify only about behaviors that the defense has already described as unusual for someone who has been raped.⁵⁷ In these jurisdictions, the expert’s opinion would generally be put on by the State in rebuttal, and it could only address those topics for which the defense had already “opened the door.” Usually in these cases, the expert would not have personally evaluated the alleged victim.

Another approach is for the expert to be allowed to testify about common reactions to rape and about general diagnostic criteria for PTSD,⁵⁸ again, in these cases the expert usually would not have personally evaluated the alleged victim. Often friends and relatives of the alleged victim will testify about her symptoms after the alleged rape. Such lay testimony is allowed in Washington.⁵⁹

Courts are more inclined to allow expert testimony from an expert who has not personally evaluated the alleged victim.⁶⁰ If the expert has

52. This opinion is also expressed in *People v. Roscoe*, 215 Cal. Rptr. 45, 48 (1985). The court noted: “Expert testimony regarding rape trauma syndrome may play a particularly useful role in prosecution for rape by disabusing jury of some widely held misconceptions about rape and rape victims, so that jury may evaluate evidence free of constraints of popular myths.” *Id.*

53. Laura E. Boeschen et al., *Rape Trauma Experts in the Courtroom*, 4 PSYCHOL. PUB. POL’Y & L. 414, 418 (1998).

54. See Michael Donahue, *Another Door Closed: Rape Trauma Syndrome*, 23 GONZ. L. REV. 1 (1988).

55. See, e.g., *Black*, 109 Wash. 2d at 338, 745 P.2d at 18.

56. *Id.* “The defendant contends that expert testimony on rape trauma syndrome is unfairly prejudicial because it constitutes an opinion as to the guilt of the defendant, thereby invading the exclusive province of the finder of fact. We agree.” *Id.*

57. See, e.g., *Williams v. State*, 928 P.2d 600 (Alaska App. 1996).

58. “[C]ourts are mostly in agreement that expert testimony can be offered to show that the alleged victim’s behavior is not inconsistent with being raped, especially including a diagnosis of PTSD.” 2 D. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE 117 (2002).

59. See, e.g., *State v. Black*, 109 Wash. 2d 336, 745 P.2d 12 (1987); *State v. Jaquez*, 99 Wash. App. 1049, 2000 WL 241260 (App. Div. 2 2000).

60. See, e.g., *State v. Black*, 109 Wash. 2d 336, 745 P.2d 12 (1987).

not evaluated the alleged victim, he cannot make diagnostic statements about her. Courts favor expert testimony in which the expert has not evaluated the alleged victim because of the fear that experts who have evaluated the alleged victim will add a special aura of credibility to the victim, thus unfairly prejudicing the defendant. However, even if the expert has not personally evaluated the alleged victim, he may still be allowed to state whether her behavior was consistent with PTSD or RTS, if the behavior is described to him by means of a hypothetical question. Obviously this “opens the door” for the defense to bring in its own expert to testify that the behavior is not consistent with PTSD or RTS, or that the behavior is also consistent with not having been raped, or that the symptoms could have been the result of some other trauma.

Maryland is the only state in which a court has allowed the expert to go beyond a diagnosis by stating that the victim was telling the truth, or that she actually was raped, or both.⁶¹ However, that opinion has been criticized for allowing testimony that was beyond the scientific knowledge of the expert and better left for the trier of fact to determine.⁶² This type of testimony clearly bears directly on the victim’s credibility, which should be left up to the judge or the jury. Because the expert was allowed to offer an opinion about whether the victim had been raped, the court stated that in such cases compulsory psychiatric examination of the victim by a defense expert would likely have to be allowed.⁶³

There are also practical and emotional consequences to consider in making decisions concerning rape trauma syndrome testimony. As soon as a court allows the State to present expert diagnostic information about the alleged victim from an expert who has personally evaluated her, the defense will seek to compel an evaluation conducted by a defense expert. In order to make a diagnostic statement the expert will have to explore all possible traumas which could have caused the symptoms, especially prior traumatic sexual experiences, since the PTSD could have resulted from traumas other than the alleged rape. Indeed, many if not most aspects of the victim’s life would become fair game, since diagnosticians are not supposed to make diagnostic statements until they have acquired a thorough history of the individual’s entire life. Past psychiatric and counseling records would have to be turned over to the defense attorney for examination. As a

61. *State v. Allewalt*, 517 A.2d 741 (Md. 1986).

62. Laura E. Boeschen et al., *Rape Trauma Experts in the Courtroom*, 4 PSYCHOL. PUB. POL’Y & L. 414, 428 (1998).

63. *Allewalt*, 517 A.2d at 751. See also *State v. Chapman*, 18 P.3d 1164, 1174 (Wyo. 2001).

result, many if not all aspects of the victim's life would likely be explored in the courtroom.

B. Washington's Approach to Rape Trauma Syndrome

Washington generally does not allow evidence of rape trauma syndrome to be admitted into the courtroom. In *State v. Black*, the Washington State Supreme Court established the rule that expert testimony about rape trauma syndrome is inadmissible in rape cases because it is "not [a] scientifically reliable means of proving lack of consent" and it unfairly prejudices a person accused of rape."⁶⁴ In that case, the sixteen-year-old alleged victim said that a close family friend and neighbor had raped her, but the defendant said their sexual contact had been consensual.⁶⁵ The victim's mother and friends testified that she was emotionally distraught after the incident as she had nightmares for several days thereafter, and the court held that such lay testimony was proper.⁶⁶ However, the State also called a counselor from a rape crisis center where the alleged victim had sought treatment, who said she had counseled the victim on a weekly basis for several months "after the rape."⁶⁷ Over objection from defense counsel, she was allowed to testify that "[i]n every rape victim that I have seen, they exhibit consistent symptoms For example, body soreness, guilt, shame, feelings about the trial, nightmares, flashbacks, these are common symptoms that rape victims experience. There is a specific profile for rape victims and [she] fits in."⁶⁸ In response to defense counsel's questions as to whether the trauma could have come from sources other than rape, the witness explained that she relied upon "what the symptoms show according to the rape trauma syndrome."⁶⁹

The trial court found the defendant guilty of third degree rape.⁷⁰ However, the Court of Appeals reversed, holding that the testimony about rape trauma syndrome should not have been admitted,⁷¹ and the Washington Supreme Court upheld that finding, invalidating the conviction.⁷² In doing so, the court did its own literature review of the scientific evidence, and it concluded that "the issue is whether the presence of various symptoms, denominated together as 'rape trauma

64. *Black*, 109 Wash. 2d at 348, 745 P.2d at 18.

65. *Id.* at 338, 745 P.2d at 13.

66. *Id.*

67. *Id.* at 338, 745 P.2d at 14.

68. *Id.* at 339, 745 P.2d at 14.

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.* at 350, 745 P.2d at 19.

syndrome' is a scientifically reliable method admissible in evidence and probative of the issue of whether an alleged victim was raped. The literature on the subject demonstrates that it is not."⁷³ To bolster this point, the court cited a number of scientific treatises and concluded, "One overriding theme permeates the literature on this subject: namely, that there is no 'typical' response to rape."⁷⁴ The court also expressed concern as to whether a rape counselor could really be impartial, stating that "rape counselors are taught to make a conscious effort to avoid judging the credibility of their clients."⁷⁵ The court pointed out that the concept of rape trauma syndrome had been developed to assist with treatment, not to determine in which cases rape has occurred.⁷⁶

Besides being scientifically unreliable, the court also opined that testimony about rape trauma syndrome is unfairly prejudicial "because it constitutes an opinion as to the guilt of the defendant, thereby invading the exclusive province of the finder of fact."⁷⁷ Indeed, the court went further, stating that even if the expert had not used the term rape trauma syndrome and had instead testified about "a form of post-traumatic stress disorder with rape as the likely stressor," the testimony would still have been unfairly prejudicial to the defendant.⁷⁸ In his concurring opinion, Justice Utter agreed with the majority's result,⁷⁹ but he indicated in his opinion that there could be some cases in which rape trauma syndrome testimony might be allowed.⁸⁰ The Washington

73. *Id.* at 347, 745 P.2d at 18 (citation omitted).

74. *Id.* at 343, 745 P.2d at 16.

75. *Id.* at 347, 745 P.2d at 18.

76. *Id.*

77. *Id.* at 348, 745 P.2d at 19.

78. *Id.* at 349, 745 P.2d at 19 (quoting *Allewalt*, 517 A.2d 741). The court reasoned as follows:

[W]e do not share the view, espoused by some courts, that an expert witness' decision to avoid the term "rape trauma syndrome" thereby renders such testimony admissible. . . . We find such semantic distinctions unpersuasive. In the present case, the testimony of [the expert], whether it be denominated as a form of "post-traumatic stress disorder," "rape trauma syndrome" or otherwise, was unfairly prejudicial and hence inadmissible. We do not imply, of course, that evidence of emotional or psychological trauma suffered by a complainant after an alleged rape is inadmissible in a rape prosecution. The State is free to offer lay testimony on these matters, and the jury is free to evaluate it as it would any other evidence. We simply hold that the State may not introduce expert testimony which purports to scientifically prove that an alleged rape victim is suffering from rape trauma syndrome.

Id.

79. *Id.* at 350, 745 P.2d at 19.

80. *Id.* at 357, 745 P.2d at 23 (Utter, J., dissenting). Justice Utter stated:

The facts presented in this case and the failure of the State to lay an adequate foundation for its offered evidence compel the result reached. I do not believe that we should keep from juries and judges in all cases the potential benefit of a field of study accepted in many other jurisdictions. This type of testimony, properly qualified, may help triers of

Supreme Court is one of very few courts that have categorically rejected expert testimony on rape trauma syndrome,⁸¹ and the decision has been heavily criticized.⁸²

While Washington has categorically rejected expert testimony on rape trauma syndrome, it does allow general testimony as to common symptoms suffered by rape victims if the defense “opens the door” by asserting that the alleged victim’s post-rape behavior was inconsistent with having been raped. In *State v. Ciskie*,⁸³ the issue was raised as to whether the prosecution (as opposed to the defense) may make use of expert testimony on rape trauma syndrome in cases in which a victim (as opposed to a defendant) is making the claim that she suffers from rape trauma syndrome. In that case, the defendant and the alleged victim had lived separately, but maintained an intimate relationship for two years.⁸⁴ According to the victim, she had tried to “cool” the relationship during that two year period.⁸⁵ She claims that the defendant forced her to have intercourse or engage in other unwanted sexual activity on five separate occasions.⁸⁶ After each incident, the defendant would apologize.⁸⁷ After the fifth occurrence, she contacted the police, and he was arrested and charged with four counts of rape.⁸⁸

fact to understand the mental state and behavior of the rape victim with muted demeanor and behavior, or an incest victim who recants, or other rape victims who do not conform to our legal system’s shameful legacy of “out-dated beliefs, and deep-seated prejudices.”

Id. (citations omitted).

81. See *Black*, 109 Wash. 2d at 346–47, 745 P.2d at 17–18. The Washington Supreme Court stated:

The admissibility of expert testimony on rape trauma syndrome has been considered in a number of other jurisdictions. We find the opinions which exclude the testimony persuasive. The courts which have admitted rape trauma syndrome testimony believe it sufficient that the myriad of symptoms encompassed therein are “generally accepted to be a common reaction to sexual assault.” We find, however, that this is not the relevant question. The issue is not whether rape victims may display certain symptoms; the issue is whether the presence of various symptoms, denominated together as “rape trauma syndrome,” is a scientifically reliable method admissible in evidence and probative of the issue of whether an alleged victim was raped. The literature on the subject demonstrates that it is not.

Id. (citations omitted).

82. See Michael Donahue, *Another Door Closed: Rape Trauma Syndrome*, 23 GONZ. L. REV. 1, 35 (1988).

83. See *State v. Ciskie*, 110 Wash. 2d 263, 751 P.2d 1165 (1988) (decided less than one year after *Black*).

84. *Id.* at 265, 751 P.2d at 1167.

85. *Id.* at 266, 751 P.2d at 1167.

86. *Id.* at 266–67, 751 P.2d at 1167.

87. *Id.*

88. *Id.* at 268–69, 751 P.2d at 1168.

At trial during his opening statement, the defense attorney attacked the alleged victim's credibility, describing the State's case as "carefully rehearsed" and stating that all sexual contact had been consensual.⁸⁹ In his testimony, the defendant stated she would easily have been able to call the police at any time if it had truly been necessary.⁹⁰

Karil Klingbeil, the head of the sexual assault unit at Harborview Hospital, was called to testify as an expert witness for the State.⁹¹ The trial court ruled that she could testify, but she could not use the term rape trauma syndrome or offer an opinion as to the ultimate issue of whether the victim was raped.⁹² The trial judge stated, "What Mrs. Klingbeil, then, is really testifying to . . . is [the victim's] state of mind. I rule that that's relevant . . . as the basis for inferring why [the victim] acted or did not act in certain ways, failing to report or failing to break off the relationship. It may not be used for inferring what Mr. Ciskie did or did not do."⁹³ Klingbeil did state at one point that she had personally evaluated the victim and diagnosed her as suffering from PTSD.⁹⁴ She stated that the trauma which led to PTSD could have been any unusual stressful event, not necessarily a rape or an assault, and the trial court did not allow the State to question Klingbeil on what she believed the trauma had been in the victim's case.⁹⁵ When the State asked Klingbeil to express her opinion about the victim's behavior, at defense counsel's request the question was phrased as a hypothetical case history that paralleled the evidence presented by the State.⁹⁶ Klingbeil said the facts in the hypothetical example were consistent with the cycle theory of violence and said that the failure of the woman in the hypothetical to report the assaults until two days after the last incident and nine months after the first was characteristic of a person suffering from battered woman syndrome.⁹⁷

Upon appeal, the Washington Supreme Court upheld the conviction, finding the expert testimony admissible under ER 702.⁹⁸

89. *Id.* at 269, 751 P.2d at 1169.

90. *Id.* at 269–70, 751 P.2d at 1169.

91. *Id.* at 271, 751 P.2d at 1169.

92. *Id.* at 272, 751 P.2d at 1170.

93. *Id.*

94. *Id.* at 279, 751 P.2d at 1173.

95. *Id.* at 279, 751 P.2d 1173–74.

96. *Id.* at 278, 751 P.2d at 1173.

97. *Id.* at 278–79, 751 P.2d at 1173.

98. *Id.* ER 702 provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

WASH. R. EVID. 702.

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However, the Washington Supreme Court went on to state that an additional analysis also needed to be made under ER 403, which requires courts to exclude evidence if there is any danger of unfair prejudice.⁹⁹ The court stated that if Klingbeil had indicated her assessment of the victim's credibility regarding whether she had been raped that would have been overly prejudicial.¹⁰⁰ The court went on to say that "[w]ith the benefit of hindsight, it would perhaps have been preferable to bar the diagnosis portion of the testimony altogether, to avoid the danger of the jury's inferring a diagnosis of rape," but concluded that undue prejudice had not occurred, stating that the trial judge had done "an admirable job of limiting the expert's testimony to that which would be of maximum benefit to the jury."¹⁰¹

C. Other Considerations Regarding the Use of RTS Testimony

1. Defense Use of RTS—Battle of the Experts

If a victim is evaluated by an expert and the expert testifies that she suffers from rape trauma syndrome, can the defense also have her evaluated by their expert? If a prosecution expert personally evaluates the alleged victim, he usually will take a history and make a diagnosis based on that history. Most courts that allow one side to put on testimony by an expert who has personally evaluated the victim will also allow the other side to present a competing expert as "[i]t would be fundamentally unfair to allow the use of such testimony by the State. . . and then to deny its use by a defendant here."¹⁰²

The prospect that each side could present an expert who has evaluated the victim to offer their differing opinions of her history and her diagnosis should give us some pause. For many years rape victims could be cross-examined during trial as to their prior sexual experiences.¹⁰³ The defense would attempt to show that the victim had

99. *State v. Ciskie*, 110 Wash. 2d 263, 269, 751 P.2d 1165, 1173 (1988). ER 403 provides:

Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

WASH. R. EVID. 403.

100. *Ciskie*, 110 Wash. 2d at 279, P.2d at 1174.

101. *Id.* at 280, 751 P.2d at 1174.

102. *Henson v. State*, 535 N.E.2d 1189, 1193 (Ind. 1989). See also *People v. Wheeler*, 602 N.E.2d 826, 833–34 (Ill. 1992).

103. For a critical analysis of historical court practices related to rape cases, see Vivian D. Berger, *Man's Trial, Woman's Tribulation: Rape Cases in the Courtroom*, 77 COLUM. L. REV. 1, 15–20 (1977).

a promiscuous nature to support the idea that any sexual activity with the defendant had been consensual.¹⁰⁴ Most evidence codes now provide special protection for alleged victims of sexual assault, in what are commonly called “rape shield statutes,” which severely restrict defense inquiries into the personal sexual histories of rape victims.¹⁰⁵ Washington’s rape shield statute¹⁰⁶ provides that evidence of a victim’s “marital history, divorce history, or general reputation for promiscuity, non-chastity, or sexual mores contrary to community standards is not admissible if offered to attack the credibility of the victim and is inadmissible on the issue of consent” unless a special hearing is held to consider the appropriateness of such testimony in advance. Thus, there is an obvious tension between rape shield statutes and the concept of allowing both sides to present diagnostic information, since a diagnosis involves delving into virtually all areas of the individual’s life, especially prior sexual experiences that might also have been traumatizing. For this reason, some states do not allow the defense to present expert testimony until the State has “opened the door” by bringing up the issues of PTSD or RTS.¹⁰⁷ This gives the State (and presumably the victim) the option of deciding whether she wants to have her traumatic symptoms be part of the contested case.

2. Unsubstantiated Claims by Experts in Rape Cases

We have already established that the use of RTS or PTSD symptoms is not a “scientifically reliable” means of determining whether a given woman was actually raped.¹⁰⁸ In some cases, experts may be able to provide important information when testifying, but unsubstantiated, non-scientific testimony on PTSD and/or RTS can harm not only victims and alleged offenders, but also the field of psychology as a whole. There have been a number of cases, which are discussed below, in which experts made false or unsubstantiated claims despite an ethical obligation to avoid doing so. For example, expert witnesses have sometimes described symptoms that have not been documented empirically. In one case, an expert testified it is “very common” for a rape victim to ask the rapist not to tell anyone about the

104. *Id.* at 15.

105. *See, e.g.*, WASH. REV. CODE § 9A.44.020(3) (2003). The federal government and forty-eight states currently enforce some form of a rape shield law. Cristina Tilley, *A Feminist Repudiation of Rape Shield Laws*, 51 *DRAKE L. REV.* 45 (2002). For a list of state and federal statutes restricting the admissibility of sexual conduct evidence in rape cases, see Harriett R. Galvin, *Shielding Rape Victims in the State and Federal Courts: A Proposal for the Second Decade*, 70 *MINN. L. REV.* 763, 765, n. 3 (1986).

106. WASH. REV. CODE § 9A.44.020 (2003).

107. *See, e.g.*, *Lessard v. State*, 719 P.2d 227 (Wyo. 1986).

108. *See infra* pp. 464–466.

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assault, but there does not seem to be a firm basis for this in the research literature.¹⁰⁹

For example, failure to recall details of the assault has been described by an expert as a common symptom,¹¹⁰ and an inability to identify the rapist until years after the rape has been described as not unusual.¹¹¹ However, neither of these symptoms has been documented in the research literature as a “common” symptom.¹¹² In *Black*, an expert testified that “in every rape victim that I have seen they exhibit consistent symptoms,”¹¹³ but that contention is clearly not supported by the research evidence, which shows a wide range of responses to rape.¹¹⁴ The claim of universality of symptoms is probably never valid, and it may lead to problems in another case if the victim does not suffer from a supposedly universal symptom of rape. Used this way, RTS becomes a prescription for how all women who have been raped must behave. The claim that symptoms are common is often made, sometimes without much scientific basis. The claim that certain symptoms are “consistent” with having been raped is almost always valid, because some rape victims show virtually all symptoms.

Thus, it appears that one problem with allowing such testimony is that courts must grapple with whether each point raised by the expert has scientific validity. A more even-handed approach would be to never allow such testimony except in cases in which the state has “opened the door” to discussion of the psychological state of the alleged victim. Testimony that is not research based often occurs in response to claims by the defense that the alleged victim’s behavior was inconsistent with having been raped. Such unsubstantiated testimony is truly more prejudicial than probative. On the other hand, most statements made which *are* supported by the research literature are arguably more probative than prejudicial.

3. Prejudicial Impact Under Evidence Rule 403

By far the most common objection to expert testimony on PTSD or RTS in rape cases is that it is unfairly prejudicial to the defendant.¹¹⁵

109. *Lessard*, 719 P.2d at 233 (Wyo. 1986).

110. *Simmons v. State*, 504 N.E.2d 575, 579 (Ind. 1987).

111. *Commonwealth v. Gallagher*, 510 A.2d 735, 739 (Pa. 1986).

112. See Patricia A. Frazier, *Rape Trauma Syndrome: The Scientific Status of Research on Rape Trauma Syndrome*, in *MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY* 117–143 (2002).

113. *Black*, 109 Wash. 2d at 339, 745 P.2d at 14.

114. See Patricia A. Frazier, *Rape Trauma Syndrome: The Scientific Status of Research on Rape Trauma Syndrome*, in *2 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY* 117–43 (2002).

115. See, e.g., *Black*, 109 Wash. 2d at 348, 745 P.2d at 19.

Courts are less likely to allow testimony that uses the term rape trauma syndrome, and are more likely to allow an opinion about PTSD.¹¹⁶ PTSD does not presume to be a scientific technique for identifying common symptoms of rape. It makes no pretense of distinguishing between traumatic events that are sexual and those that are not. Furthermore, as opposed to RTS, PTSD has clearly defined diagnostic criteria. If the testimony is used only to rebut defense claims that the alleged victim's behavior was unusual for a rape victim, the testimony is thought to be less prejudicial.¹¹⁷ Some courts have admitted testimony regarding a wide range of behavior for rebuttal purposes.¹¹⁸ Other courts have excluded testimony offered to rebut a defense claim that an alleged victim's behavior was inconsistent with that of a rape victim, such as testimony about the frequency of false allegations among alleged victims.¹¹⁹ Proposed PTSD evidence is more likely to be allowed if the expert discusses the symptoms experienced by victims as a class, rather than those reportedly experienced by a particular alleged victim.¹²⁰ Some legal scholars recommend that experts not interview alleged victims in order to reduce the risk of prejudice.¹²¹

4. Feminist Critique of Rape Trauma Syndrome

Feminists in particular have critiqued the concept of rape trauma syndrome.¹²² They point out that focusing on a woman's "symptoms" after a rape makes her distress seem aberrational or pathological, and it removes her reactions from their social and political context.¹²³ All of her subsequent negative reactions are attributed to the trauma of being raped—although some of the distress is clearly caused by insensitive treatment by the police, the examining medical professionals, and the judicial system, as well as the reactions of family members.¹²⁴ If women who acknowledge having been raped are given psychiatric diagnoses, and their reactions to rape are deemed to be pathologies and

116. See, e.g., *Allewalt*, 517 A.2d 741.

117. See *People v. Bledsoe*, 681 P.2d 291 (Cal. 1984); *Commonwealth v. Mamay*, 553 N.E. 2d 945 (Mass. 1990).

118. See, e.g., *Lessard v. State*, 719 P.2d 227 (Wyo. 1986); *Simmons v. State*, 504 N.E. 2d 575 (Ind. 1987); *Commonwealth v. Gallagher*, 547 A.2d 355 (Pa. 1988).

119. See *United States v. Funds Held in the Name of or for the Benefit of John Wetterer*, 991 F. Supp 112 (E.D.N.Y. 1998). See also *State v. Kinney*, 762 A.2d 833 (Vt. 2000), cited in 2 FAIGMAN, MODERN SCIENTIFIC EVIDENCE at ch. 13, n. 10.

120. See, e.g., *State v. Ritt*, 599 N.W. 2d 802 (Minn. 1999).

121. Deborah A. Dwyer, *Expert Testimony on Rape Trauma Syndrome: An Argument for Limited Admissibility—State v. Black*, 63 WASH. L. REV. 1063, 1084 (1988).

122. See generally, Susan Stefan, *The Protection Racket: Rape Trauma Syndrome, Psychiatric Labeling, and Law*, 88 NW. U. L. REV. 1271 (1994).

123. *Id.* at 1306.

124. *Id.* at 1298.

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syndromes, women's reactions to rape can be delegitimized,¹²⁵ turning their coping mechanisms into symptoms of disorders.¹²⁶ The use of rape trauma syndrome to explain counter-intuitive reactions, such as a woman's delay in reporting rape, precludes examining these reactions as adaptive behavior in the context of male violence against women.¹²⁷ Rape is transformed from a political or societal issue to a professional issue—the focus shifts from stopping the violence to treating its victims, and further shifts the focus from the “fear” of rape victims to their phobic reactions and adjustment problems.¹²⁸ Women are implicitly told they do not need protection from rape, or more determined punishment of violent men; instead, what they need is “treatment.”¹²⁹ The goal of the professionals is to resolve the “symptom” of distrusting men.¹³⁰

The problem with using rape trauma syndrome evidence is that it replaces one set of myths with another. The myth that a woman who does not report having been raped immediately has consented to sex is replaced with the myth that the delay in reporting is a “symptom” of a disorder. The myth that a woman who continues to see or visit a man accused of raping her must have consented to sex is replaced by the myth that such behavior is a product of a mental disorder, since “normal” women would not react this way. Expert testimony may be needed to explain that a woman may rationally choose not to report a rape due to the likelihood of disbelief by police, the possibility of retaliation by the rapist, the hostility of family and support network, the stress caused by judicial proceedings, and the stigma of being a rape victim.¹³¹

IV. CHILD ABUSE SYNDROMES

Another controversial “syndrome” that is the subject of expert testimony is child sexual abuse accommodation syndrome (CSAAS), which was formulated to explain contradictory and counter-intuitive behaviors sometimes seen among victims of child sexual abuse. As originally formulated in 1983 by Dr. Roland Summit, a California psychiatrist, CSAAS describes five types of behavior that purport to

125. *Id.* at 1273.

126. *Id.*

127. *Id.* at 1306.

128. *Id.*

129. *Id.* at 1306–07.

130. *Id.* at 1308–09.

131. Robert Garcia, *Rape, Lies, and Videotape*, 25 LOY. L. REV. 711, 742 (1992) (recommending expert testimony to explain these factors in a woman's decision not to report a rape).

explain why some victims of child sexual abuse retract their allegations or delay reporting them:

Secrecy. The perpetrator often swears the child victim to secrecy, sometimes with threats the family will dissolve.

Helplessness. The perpetrator is often a family member or someone trusted by the child, leading to passive acceptance of the sexual behavior.

Entrapment and accommodation. The child learns to accept the situation in order to survive it.

Belated, conflicting and unconvincing disclosure.

Retraction. The child may retract the allegations because the offender and/or other family members influence the child to return the family life to normal.¹³²

CSAAS was not formulated as a way to prove that abuse happened because it assumes that abuse has occurred.

Summit expressly stated that the purpose of the CSAAS was not to provide a sexual abuse “test,” but to improve therapy and advocacy for children.¹³³ The article provided impressionistic, clinical findings, but no data of any kind. No comparison was made between child sexual abuse cases in which the “syndrome” appeared and child sexual abuse cases in which it did not appear. Similarly, no comparison was made between unproven cases, or cases involving false allegations, and “true” cases, so there was no information provided that could help distinguish actual cases of child sexual abuse from false allegations. In short, no information was provided that showed whether the “syndrome” could determine (or even corroborate) whether child sexual abuse had occurred.

The syndrome is essentially unfalsifiable because the defining features are contradictory. That is, if a child says that sexual abuse occurred, CSAAS presents an explanation that asserts such behavior is consistent with abuse, but if a child recants the allegations, CSAAS asserts that the recantation is also corroborative of child sexual abuse; thus, claims of child sexual abuse cannot be falsified. In response to such criticism, Summit himself stated that CSAAS was never designed

132. Roland C. Summit, M.D., *The Child Sexual Abuse Accommodation Syndrome*, 7 CHILD ABUSE & NEGLECT 177 (1983).

133. *Id.* at 190.

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for the purpose of proving sexual abuse in any given case, even though he acknowledged it had been so applied in several cases.¹³⁴

Various other terms have been used to describe the reactions of child sexual abuse victims including child sexual abuse syndrome (CSAS) and child abuse syndrome (CAS)¹³⁵ as “profiles” of behaviors that may occur in child sexual abuse victims. These profiles may include a wide variety of symptoms such as a sense of danger, sleep disturbance, decreased interest in school and other activities, anger, concentration problems, hypervigilance, exaggerated startle response, eating disorders, bed wetting, sexual behavior such as excessive masturbation, and sexualized behavior with anatomically correct dolls.¹³⁶ Children’s reactions to sexual abuse are also commonly described as PTSD, a diagnosis that DSM-IV-TR allows to be used with any age group. As mentioned above, PTSD neither presumes nor concludes what is the source of the trauma. Thus, just as with rape trauma syndrome, many different “syndromes” or profiles of symptoms have been put forth as common among child sexual abuse victims, and it is often not clear which clusters of symptoms are being referred to when terms such as CSAS and CAS are used.

Child sexual abuse cases are typically difficult to prosecute because there is usually no physical evidence and there are rarely eyewitnesses. The court must often rely solely on the child victim. The child’s description of what happened may appear to be questionable, as children often do not report the incidents immediately, and when they do, they may not give all the relevant details in the initial revelation.¹³⁷ Furthermore, children often retract or alter their allegations, especially in cases of intra-family sexual abuse.¹³⁸ The mere fact that the child is young and immature may make the testimony of the child appear questionable, and children are often not ideal witnesses. Furthermore, many jurors may be distrustful of a child’s accusations of sexual abuse.¹³⁹ The obvious defense approach is to challenge the credibility

134. See Joseph T. McCann et al., *The Science and Pseudoscience of Expert Testimony*, in *SCIENCE AND PSEUDOSCIENCE IN CLINICAL PSYCHOLOGY* 77, 101 (Scott D. Lilienfeld et al., eds., 2003).

135. See *Commonwealth v. Dunkle*, 602 A.2d 830, 832–36 (Pa. 1992) for a discussion of various terminologies. See also *Steward v. State*, 652 N.E.2d 490, 492–99 (Ind. 1995).

136. Dara Loren Steele, *Expert Testimony: Seeking an Appropriate Admissibility Standard for Behavioral Science in Child Sexual Abuse Prosecutions*, 48 *DUKE L.J.* 932, 943 (1999).

137. See John E.B. Myers et al., *Expert Testimony in Child Sexual Abuse Litigation*, 68 *NEB. L. REV.* 1, 110–20 (1989).

138. Dwight M. Wells, *Expert Testimony: To Admit or Not Admit?*, *FLA. B.J.*, Dec. 1983, at 673, 675–76.

139. Several jury studies have concluded that adult juries find children’s testimony less credible than adults’ testimony because of skepticism over a child’s ability to accurately observe and recall events. See, e.g., Michael R. Leippe et al., *Discernibility or Discrimination?*

of the child witness, suggesting that the allegations are fanciful or fabricated. In response, prosecutors often attempt to present expert testimony to suggest that the child's behavior is not unusual among victims of child sexual abuse, or to explain why the child may be showing the "counter-intuitive" behaviors that a jury might otherwise interpret as showing lack of credibility on the child's part.¹⁴⁰

Testimony about common symptoms of child sexual abuse can be introduced by the State in two ways: either in the State's case-in-chief or in rebuttal. Some courts allow the evidence to be presented as part of the State's case-in-chief, a form of "anticipatory rebuttal" to the expected attack on the child victim's credibility. For example, California has adopted a rule that permits admissible expert testimony to be presented as anticipatory rebuttal.¹⁴¹ Other courts only allow expert testimony from the State if the defense has "opened the door," attacking the child victim's credibility by suggesting the child's behaviors were not typical of child sexual abuse victims.¹⁴²

Some states will allow the expert to personally evaluate the child victim, and to make a diagnosis of CSAAS, CSAS, CAS, or PTSD.¹⁴³ Others will not admit any diagnosis or syndrome evidence, not allowing anything other than the expert's statement that the child's behaviors are not uncommon among (not "inconsistent" with) child sexual abuse cases. The Louisiana Supreme Court decided in a recent decision that the state cannot introduce expert evidence that the alleged child victim suffers from PTSD in an attempt to prove that sexual abuse occurred absent the defendant's "opening the door."¹⁴⁴ The Court stated that "[t]he literature concludes that a PTSD diagnosis is essentially a therapeutic aid, rather than a tool for the detection of sexual abuse" and went on to say that "[b]ecause causes other than sexual abuse may

Understanding Jurors' Reactions to Accurate and Inaccurate Child and Adult Eyewitness, in CHILD VICTIMS, CHILD WITNESSES: UNDERSTANDING AND IMPROVING TESTIMONY 169-196 (Gail S. Goodman & Bette L. Bottoms eds., 1993).

140. See, e.g., *State v. Middleton*, 657 P.2d 1215, 1220 (Or. 1982). The *Middleton* court stated:

It would be useful to the jury to know that not just this victim but many child victims are ambivalent about the forcefulness with which they want to pursue the complaint, and it is not uncommon for them to deny the act ever happened. Explaining this superficially bizarre behavior by identifying its emotional antecedents could help the jury better assess the witness's credibility.

Id.

141. *People v. Patino*, 32 Cal.Rptr.2d 345, 349 (Ct. App. 1994).

142. See, e.g., *State v. Chuvin*, 846 So. 2d 697 (La. 2003); *Steward v. State*, 652 N.E. 2d 490 (Ind. 1995).

143. See *Hutton v. State*, 663 A.2d 1289, 1302 (Md. 1995) (allowed PTSD testimony for context only).

144. *State v. Chuvin*, 846 So.2d 697, 707-09 (La. 2003).

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trigger PTSD . . . a diagnosis of PTSD does not reliably prove the nature of the stressor.”¹⁴⁵ Like Louisiana, most jurisdictions will allow some type of rebuttal testimony. Various jurisdictions allow expert testimony introduced by the State to rebut claims by the defense that the child’s behavior is inconsistent with the claim of sexual abuse.¹⁴⁶

More controversial is the introduction of statistical evidence to bolster the claim that the child is telling the truth. For example, in a Delaware case,¹⁴⁷ the trial court allowed the expert to testify that “between thirty percent and forty percent of children recant, alter, or otherwise minimize their original allegations of sexual abuse, but that fewer than five percent recant and maintain the altered statement.”¹⁴⁸ The expert was also allowed to testify that it is “very uncommon” for a victim’s initial account to include all instances and details of the abuse.¹⁴⁹ In that case, the Delaware Supreme Court reversed, refusing to uphold the statistical evidence because “the expert was permitted to establish a mathematical standard by which the trier of fact could evaluate the complainant’s trial testimony.”¹⁵⁰ Perhaps the most extreme example of this type of evidence is the “children never lie about sexual abuse” nostrum, now uniformly discredited as inaccurate.¹⁵¹ The question remains whether accurate statistical information should be admissible in alleged child sexual abuse cases.

A. *Expert Testimony Regarding Child Abuse*

Jurisdictions differ widely as to what types of expert testimony they will allow the State to present in cases of alleged child sexual abuse. At least two states take the absolutist position that no expert testimony can be admitted in such cases. In Pennsylvania, despite the fact that an expert did not “relate any of her testimony to the child in question,” the CSAS testimony did not meet the *Frye* test.¹⁵² That court went further, however, stating that even a general listing of behavioral patterns, without any diagnostic term or “syndrome,” would not be relevant because the patterns could neither be identified as “abuse specific” nor be limited to sexually abused children.¹⁵³ Indeed, that

145. *Id.* at 707.

146. *See Steward v. State*, 652 N.E.2d 490, 499 (Ind. 1995).

147. *Wheat v. State*, 527 A.2d 269 (Del. 1987).

148. *Id.* at 271.

149. *Id.*

150. *Id.* at 274.

151. A. Vrig, *Deception in Children: A Literature Review and Implications for Children’s Testimony*, in *CHILDREN’S TESTIMONY: A HANDBOOK OF PSYCHOLOGICAL RESEARCH AND FORENSIC PRACTICE* 175–94 (H. Wescott et al., eds., 2002).

152. *Commonwealth v. Dunkle*, 602 A.2d 830, 834 (Pa. 1992).

153. *Id.* at 836.

court even held that testimony offered to explain delays and inconsistencies was not helpful to the jury because the versions offered by the expert to explain them “are easily understood by lay people and do not require expert analysis.”¹⁵⁴ Kentucky’s Supreme Court has also totally excluded behavioral science testimony in child sexual abuse cases.¹⁵⁵ In that case, the State’s expert had only listed some general reactions of abuse and had not testified as to a “syndrome,” but the court held such testimony was not even “relevant.”¹⁵⁶ Florida has held that expert testimony offered to prove the alleged victim of sexual abuse exhibits symptoms consistent with one who has been sexually abused should not be admitted.¹⁵⁷ On the other hand, South Dakota has held that expert testimony that the victim’s allegations were “truthful” should have been admissible.¹⁵⁸ Michigan courts allow testimony about common symptoms of child sexual abuse, but refuse to allow any use of diagnostic terms or “syndromes.”¹⁵⁹

B. Washington’s Approach to Testimony Regarding Child Abuse

1. Expert Testimony Used to Prove that Abuse Occurred

Just as was true for rape trauma syndrome, Washington does not generally allow the prosecution to introduce expert opinion testimony about child abuse syndromes in an attempt to prove that abuse occurred. Generally, these attempts to prove that sexual abuse occurred through testimony as to trauma related syndromes are thought to be inadmissible comments on the guilt of the defendant, which do not meet the *Frye* test. The courts often complain that the syndromes testified about could be due to trauma other than that which results from sexual abuse.

In *State v. Jones*, Division One of the Washington Court of Appeals addressed two of these issues: (1) whether an expert can state that she believes the alleged child sexual abuse victim is telling the

154. *Id.* at 836–37.

155. *Newkirk v. Commonwealth*, 937 S.W.2d 690 (Ky. 1996). The *Newkirk* court reasoned: In final analysis, the more that courts permit experts to advise the jury based on probability, classifications, syndromes and traits, the more we remove the jury from its historical function of assessing credibility. While a criminal may be facile with his denials and explanations and a child may be timid and halting, we entrust to the wisdom of the twelve men and women who comprise the jury the responsibility to sort between the conflicting versions of events and arrive at a proper verdict.

Id. at 696.

156. *Id.* at 695.

157. *Hadden v. State*, 690 So.2d 573, 580–581 (Fla. 1997).

158. *State v. Bachman*, 446 N.W.2d 271, 276–77 (S.D. 1989).

159. See *People v. Beckley*, 456 N.W.2d 391, 409–10 (Mich. 1990); *affirmed by People v. Peterson*, 537 N.W.2d 857, 859 (Mich. 1995).

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truth, and (2) whether the expert can assert an opinion as to common post-sexual abuse behavior.¹⁶⁰ In *Jones*, the defendant Donnie Jones was living with his girlfriend and her children from a previous marriage, including her seven-year-old daughter, who had some history of sexual acting-out.¹⁶¹ The girlfriend testified she walked into the bedroom and found Jones unclothed with the seven year old, who was not wearing underwear, and whose nightgown was pulled up to her chest. Jones was sexually aroused, and had his hand on the girl's stomach.¹⁶² The next day the girlfriend spoke with her daughter, who said Jones had rubbed her vaginal area.¹⁶³ Eventually, a school counselor contacted Child Protective Services (CPS) after the girl told him Jones had touched her vaginal area.¹⁶⁴

Jones was charged with first degree child molestation and first degree rape of a child.¹⁶⁵ The girl was found competent to testify.¹⁶⁶ The trial court ruled that the girl's statements to her mother, the school counselor, the CPS caseworker, and the physician were all admissible.¹⁶⁷ The CPS caseworker was called by the State as an expert witness.¹⁶⁸ She testified over defense objection that her assessment of the seven-year-old was "that this child had been sexually molested by Donnie."¹⁶⁹ The case worker was cross-examined about the sexual acting-out, and on re-direct the prosecutor asked if it was common to see sexual acting-out among sexually abused children.¹⁷⁰

Over defense objection, she testified both that it was common for children who have been sexually abused to show sexualized behaviors and also testified that it was common for sexually abused children to "talk about having nightmares and dreams," which the case worker referred to as "night terrors."¹⁷¹ The CPS worker and the school counselor also testified that the girl had told them that Jones had engaged in sexual behavior with her on more than one occasion.¹⁷² During his testimony, Jones admitted touching the girl's vagina area

160. *State v. Jones*, 71 Wash. App. 798, 863 P.2d 85 (1993).

161. *Id.* at 802, 863 P.2d at 89.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.* at 803, 863 P.2d at 89.

166. *Id.*

167. *Id.*

168. *Id.* at 804, 863 P.2d at 89.

169. *Id.* at 804, 863 P.2d at 90.

170. *Id.*

171. *Id.*

172. *Id.* at 804-05, 863 P.2d at 90.

briefly during the one incident, but denied he had done so for purposes of sexual gratification.¹⁷³ Jones was convicted.¹⁷⁴

Upon appeal, the Court of Appeals ruled that “no witness may testify as to an opinion on the guilt of the defendant” and stated that allowing the CPS worker’s statement that she felt Jones had molested the girl had been error of constitutional magnitude.¹⁷⁵ However, because the evidence of Jones’ guilt was “overwhelming,” the court found the error to be harmless.¹⁷⁶

The court then addressed whether the trial court had committed error in allowing the CPS worker to testify that sexually acting-out and nightmares were common symptoms of child sexual abuse.¹⁷⁷ Noting that Washington had no clear-cut precedent regarding the admissibility of generalized sexual abuse syndrome,¹⁷⁸ the court held that generalized testimony regarding a profile of behaviors exhibited by victims of child sexual abuse must meet the *Frye* test.¹⁷⁹ The court pointed out that the prevalent objection to such testimony is that a general profile of specific behaviors is not specific to sexual abuse; rather, the behaviors may be produced by other traumatic events in the child’s life.¹⁸⁰ The court also pointed out that a substantial number of other state courts had decided that expert testimony regarding a profile or syndrome of child sexual abuse victims is neither admissible to prove the existence of abuse nor to prove that the defendant is guilty.¹⁸¹ The Court reasoned:

Because the use of testimony on general characteristics of sexually abused children is still the subject of contention and dispute among experts in the field, we find that its use as a general profile to be used to prove the existence of abuse is inappropriate. However, we do agree with the current trend of authority that such testimony may be used to rebut allegations by the defendant that the victim’s behavior is inconsistent with abuse (cites omitted). We further note that sexual acting-out behavior has been viewed as more logically and clinically indicative of sexual abuse than other generalized reactions to emotional traumas such as nightmares and phobic behaviors.¹⁸²

173. *Id.* at 805, 863 P.2d at 90.

174. *Id.* at 806, 863 P.2d at 91.

175. *Id.* at 813, 863 P.2d at 95.

176. *Id.*

177. *Id.* at 813–14, 863 P.2d at 95.

178. *Id.* at 817, 863 P.2d at 97.

179. *Id.* at 818, 863 P.2d at 97.

180. *Id.* at 818–19, 863 P.2d at 97.

181. *Id.* at 819, 863 P.2d at 98.

182. *Id.*

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The Court found that the testimony about nightmares had been improper, but the error had not been sufficiently preserved; thus, the case was affirmed.¹⁸³

In another Division One Court of Appeals case, *State v. Cleveland*, the court addressed testimony concerning a child's reluctance to testify.¹⁸⁴ The defendant in the case, Cleveland, was accused of statutory rape and indecent liberties with his eight-year-old stepdaughter.¹⁸⁵ At trial, the girl testified that the defendant had rubbed her private parts with his finger; however, this version of what happened was somewhat different than what she had said earlier to other people.¹⁸⁶

Barbara Huffman, a child and family therapist, testified for the State.¹⁸⁷ She testified that she had not seen the child in this case; consequently, she only testified about typical behaviors of child victims of sexual abuse and did not testify that this particular child was a victim of sexual abuse.¹⁸⁸ Huffman testified that it was not unusual for a child sexual abuse victim to be reluctant to tell about it, and it was common for the abused child not to tell the full story initially and to add or subtract facts as the events were retold.¹⁸⁹ The court, however, did not allow Huffman to testify that recanting of claims of sexual abuse was also not unusual.¹⁹⁰ After Huffman's testimony, the defendant testified, denying ever having abused the child.¹⁹¹ Mrs. Cleveland offered similar testimony, saying that the girl had never reported her claim of sexual abuse to her, and that she did not believe the accusations.¹⁹² The defendant was convicted of both statutory rape and indecent liberties.¹⁹³ The Court of Appeals stated:

Huffman's testimony did not espouse a theory proving guilt. In fact, her testimony was not really an explanatory theory or opinion requiring acceptance by the scientific community by ER 702 (footnote omitted). Huffman's testimony was essentially a description of her personal observations of some of the characteristics of child sex abuse victims. Her observations are comparable to testimony of a physician describing characteristics

183. *Id.* at 821–22, 863 P.2d at 99–100.

184. *State v. Cleveland*, 58 Wash. App. 634, 794 P.2d 546 (1990).

185. *Id.* at 636, 794 P.2d at 547.

186. *Id.* at 637, 794 P.2d at 547.

187. *Id.* at 637, 794 P.2d at 548.

188. *Id.* at 644, 794 P.2d at 551.

189. *Id.* at 644–45, 794 P.2d at 551–52.

190. *Id.* at 645, 794 P.2d at 552.

191. *Id.* at 637, 794 P.2d at 548.

192. *Id.*

193. *Id.* at 636, 794 P.2d at 547.

he has personally observed in his treatment of a particular injury or disease. Huffman did not at any time offer an opinion that [the child] was a victim of sexual abuse. Nor did she ever say the testimonial deficits she described were limited to victims of sexual abuse. Huffman did not imply, as Cleveland argues, that Cleveland was guilty of the acts attributed to him by [the child]. Nor did she ever say or imply that [the child] was telling the truth.¹⁹⁴

In that case, the Court of Appeals affirmed the conviction.¹⁹⁵

Thus, in Washington, it appears that a properly qualified expert may testify generally about the reluctance of children to testify, and may testify generally that children commonly do not tell the full story initially and add or subtract facts as the events are retold. Such testimony will be admissible as long as the expert witness does not comment on the child's credibility, make references about the defendant's guilt, or offer testimony about a particular syndrome or diagnosis.

Similarly, another Washington Court of Appeals Division One case indicates that evidence concerning recantation and delays in reporting may be admissible. The case, *State v. Madison*,¹⁹⁶ involved recantation from a five-year-old girl whom the expert had not personally evaluated.¹⁹⁷ The defendant, Madison, was charged with one count of statutory rape in the first degree.¹⁹⁸ A hearing was held to determine the competency of the girl as a witness and to determine the admissibility of the child's out-of-court statements.¹⁹⁹ After "strong reluctance, necessitating a recess," the child took the stand.²⁰⁰ The State did not question her about her accusations against Madison, but over objection, the defense counsel was allowed to ask her if the defendant had done anything to her, and she answered no.²⁰¹ The court found that she was not competent to testify, but that the out-of-court statements were admissible under the special child hearsay statute.²⁰²

At trial, the State presented all of the out-of-court statements, and the defense presented the child's mother, father, and other relatives, who testified the child had recanted her allegations against Madison, and

194. *Id.* at 646, 794 P.2d at 552.

195. *Id.* at 649, 794 P.2d at 554.

196. *State v. Madison*, 53 Wash. App. 754, 770 P.2d 662 (1989).

197. *Madison*, 53 Wash. App. at 758, 770 P.2d at 665.

198. *Id.* at 757, 770 P.2d at 664.

199. *Id.*

200. *Id.*

201. *Id.*

202. WASH. REV. CODE §9A.44.120 (2003); *Madison*, 53 Wash. App. at 758, 770 P.2d at 664.

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now claimed that someone had raped her at knifepoint on a nearby trail.²⁰³ In rebuttal, the State called Nina Auerbach as an expert witness.²⁰⁴ Auerbach testified that in her experience and in her review of the literature there existed a “recantation phenomenon.”²⁰⁵ She testified that there were a number of possible reasons for the recantation, including the possibility that the original allegation was false.²⁰⁶

The Court of Appeals ruled that Auerbach’s testimony was “offered to explain that one cannot necessarily conclude that a present recantation proves the original accusation was false.”²⁰⁷ However, since Auerbach merely stated that her review of the literature and of major writers in the field was the foundation for her belief in the “recantation phenomenon,” the court determined that the foundation for her testimony was “inadequate to permit an informed appellate review.”²⁰⁸ Furthermore, defense counsel had not made necessary objections or motions to strike to preserve the issue of admissibility of her testimony for appeal.²⁰⁹ As a result, the case was affirmed.²¹⁰ The court stated,

We express no opinion as to the admissibility of testimony explaining recantation by a child victim in future cases [W]e note there has been a considerable recent discussion of the significance of recantation by child witnesses. A list of the behavioral, psychological, and legal literature regarding recantation in child victims collected by this Court is contained in the appendix following this opinion²¹¹

Later in the opinion the Court also stated that “[a] substantial majority of courts considering the issue have approved the admission of testimony regarding recantation and delays in reporting, so long as the testimony is not presented to prove an element of the crime.”²¹² Thus, in future cases, provided that a proper foundation has been laid, it appears very likely that recantation testimony will be allowed from a properly qualified expert who has not personally examined the child victim and has not offered any “syndrome” or diagnosis testimony.

203. *Madison*, 53 Wash. App. at 758, 770 P.2d at 664.

204. *Id.* at 758, 770 P.2d at 665.

205. *Id.*

206. *Id.*

207. *Id.* at 764–65, 770 P.2d at 668.

208. *Id.* at 765, 770 P.2d at 668.

209. *Id.* at 766, 770 P.2d at 669.

210. *Id.*

211. *Id.*

212. *Id.* at 766–67, 770 P.2d at 669.

Finally, in another similar Division One case, *State v. Stevens*,²¹³ the Court approved the use of expert testimony that described nightmares as being common behaviors of sexually abused children in general. The approval of such testimony apparently overruled *State v. Maule*, a case that also involved testimony about nightmares as a common symptom of child sexual abuse.²¹⁴ Prior to the trial in *Stevens*, the court had ruled that the State could not introduce evidence that the two children involved fit a “medical profile” of sexual abuse.²¹⁵ However, the court did allow the State to elicit the expert testimony of Dr. Jenny that, based on the expert’s own experience or training, she found common symptoms to exist in sexually abused children generally.²¹⁶ In response to a question as to “what behavioral signs and symptoms would be important for you to have in putting together the whole picture,” Dr. Jenny was allowed to give the following testimony:

Things that are commonly found as part of sexual abuse which (need) to be treated when they’re found, things like sexually acting-out, enuresis, which is bed-wetting, or daytime wetting, and lack of bowel control, psychosomatic problems like abdominal pain, headache, tantrums, nightmares, difficult behavior that children have that make their management complicated.²¹⁷

The Court of Appeals ruled that because the defense had opened the door by attempting to show the girls’ atypical behaviors were not the result of sexual abuse by Stevens, “[t]he court did not abuse its discretion in admitting the evidence” of common symptoms of child sexual abuse.²¹⁸ Dr. Jenny had not testified that the victims fit any controversial profile or syndrome of abuse, and in a footnote the Court stated, “Stevens does not argue and we decline to decide whether any evidence of syndrome of sexual abuse is admissible under *Frye*.”²¹⁹ In another footnote, the Court stated, “There is substantial support for the theory that recurring dreams or nightmares are a common symptom of sexual abuse,” and it cited six authorities for that proposition.²²⁰

Thus, in Washington, the status of the admissibility of expert opinion that nightmares are a common symptom of child sexual abuse

213. *State v. Stevens*, 58 Wash. App. 478, 794 P.2d 38 (1990).

214. *State v. Maule*, 35 Wash. App. 287, 667 P.2d 96 (1983).

215. *Stevens*, 58 Wash. App. at 496, 794 P.2d at 47.

216. *Id.*

217. *Id.*

218. *Id.* at 496–98, 794 P.2d at 47–48.

219. *Id.* at 497, 794 P.2d at 48.

220. *Id.* at 491, n.6, 794 P.2d at 45, n.6.

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seems confusing, particularly with *Jones* arguably over-ruling *Maule*²²¹ by making a case for the admissibility of such testimony,²²² and with *Stevens*²²³ also supporting such testimony. It appears that the relevant factor in *Stevens* is that both of the child victims had reportedly had nightmares in which they voiced the defendant's name, thus tying the defendant to the nightmares, whereas in *Jones* there was no way of tying the nightmares to the defendant, which led to the inference that the nightmares could have been entirely unrelated to sexual abuse, and could have been caused by other trauma.

2. Expert Testimony Profiles Suggesting the Defendant Committed Abuse

There is considerable authority in Washington that an expert may not comment upon characteristics of the defendant as being common among child molesters, thus implying a profile or syndrome of a child sexual abuser. These cases, discussed below, usually involve commenting on the defendant's relationship to the child. For example, in *State v. Petrich*,²²⁴ Kathleen Kennelly of the Harborview Sexual Assault Center was called by the State, and over objection was allowed to testify that in "eighty-five to ninety percent of our cases, the child is molested by somebody they already know."²²⁵ The Washington Supreme Court ruled that "[w]hile this statement was made in the context of explaining the extent of delayed reporting in certain types of cases, we believe its potential for prejudice is significant compared to its minimal probative value (citations omitted). On retrial, expert testimony should be excluded that invites the jury to conclude that because of defendant's particular relationship to the victim, he is statistically more likely to have committed the crime."²²⁶

221. *Maule*, 35 Wash. App 287, 295–297, 667 P.2d 96, 100–101 (1983).

Even if [the expert's] theory possesses probative value, in the abstract, the record does not show the underlying facts or data are of a type "reasonably relied upon by experts in the particular field." There is no evidence that [the expert] conducted any statistical study or that any other expert in the field made such a study. There is no evidence that people working in the field attach particular significance to one or more characteristics and whether certain broad characteristics noted by [the expert], e.g., "nightmares," are, without further explanation, considered adequate indicia of child sexual abuse.

Id. at 296, 667 P.2d 100 (citations omitted).

222. *See supra* note 182 and accompanying text.

223. *Stevens*, 58 Wash. App. at 491, n.6, 794 P.2d at 45, n.6 (1990) (finding substantial support for theory that recurring dreams or nightmares are common symptoms of sexual abuse).

224. *State v. Petrich*, 101 Wash. 2d 566, 683 P.2d 173 (1984).

225. *Id.* at 569, 683 P.2d at 176.

226. *Id.* at 576, 683 P.2d at 180.

Similarly, in *State v. Steward*,²²⁷ a case involving physical abuse, the State's expert was allowed to testify that in eight out of nine cases he had seen "the injuries were inflicted by either live-in or babysitting boyfriends."²²⁸ The Court of Appeals ruled that "[t]here was no scientific basis for that testimony and it was certainly highly prejudicial. To admit it was reversible error."²²⁹

In another case,²³⁰ State expert Nina Ousley from the Sexual Assault Center at Harborview testified over objection that "the majority [of cases] involve a parent-figure, a male parent-figure, and of those cases that would involve a father-figure, biological males are in the majority."²³¹ The Court of Appeals concluded that "[s]ubstantive evidence prejudicial to an opposing party does not lose its prejudicial character because it is offered during qualification of an expert The relevancy of this evidence is not discernible. On the other hand, the prejudice to [the defendant] is great."²³² The Court held that even if the theory that the majority of perpetrators were fathers were valid, and thus relevant under ER 404, its admission was prejudicial under ER 403. The case was reversed and remanded for a new trial.

In another case, *State v. Clafin*,²³³ the State's expert testified that it was her experience that forty-three percent of child molestation cases were reported to have been committed by "father figures."²³⁴ The Court of Appeals opined that "[a]n opinion that the defendant statistically is more likely to have committed the crime because of his membership in a group—in this case, his paternalistic relationship to the victims—is inadmissible."²³⁵

Similarly, sometimes a defendant's results on tests such as the MMPI have been put forth as diagnostic of being a child sexual abuser, but it is well agreed that such "profiles" are not forensically useful.²³⁶ Thus, it appears that in Washington, given the presumption of innocence for criminal defendants, defendants must be convicted on the basis of what they did, not who they are.

227. *State v. Steward*, 34 Wash. App. 221, 660 P.2d 278 (1983).

228. *Id.* at 223, 660 P.2d at 279.

229. *Id.* at 224, 660 P.2d at 280.

230. *State v. Maule*, 35 Wash. App. 287, 667 P.2d 96 (1983).

231. *Id.* at 289, 667 P.2d at 97.

232. *Id.* at 289, 667 P.2d at 99.

233. *State v. Clafin*, 38 Wash. App. 847, 690 P.2d 1186 (1984).

234. *Id.* at 852, 690 P.2d 1190.

235. *Id.*

236. *See United States v. Banks*, 36 M.J. 150 (C.M.A. 1992). *See generally* Brian J. Bigelow, Ph.D., *On the Assessment of Children in Suspected Child Sexual Abuse in Light of Daubert and Frye: Limitations of Profiles and Interviews as Scientifically Grounded Evidence*, 46 J. FORENSIC SCI. 573, 574 (2000).

C. Syndromes Suggesting No Abuse Has Occurred

Some syndromes are introduced to suggest that the victim lacks credibility, and that therefore the alleged abuse and/or battering likely did not occur. These syndromes are usually proposed by the defense, and they are used in an attempt to show the child victim is mistaken or is mis-remembering the incident. Personal examination by the expert of the victim may or may not be involved.

1. Parental Alienation Syndrome

The term Parental Alienation Syndrome (PAS) was coined by the late psychiatrist Richard Gardner.²³⁷ As Gardner conceived of it, this syndrome arises in the context of child-custody disputes, when one parent (the alienating parent) induces a program of denigration against the other parent (the alienated or target parent), which the child then adopts. This syndrome results when the children are programmed by the alienating parent. As Gardner conceived of it, when actual sexual abuse is present, then the PAS concept is not applicable.²³⁸ Thus, when the PAS concept is utilized in court, the argument is being made that since symptoms of PAS are present, the likelihood that sexual abuse has occurred is low.

The primary symptoms of PAS, according to Gardner, are (1) a campaign of denigration by one parent against the other, in which the child is empowered to mimic and parrot the denigrating messages, (2) the child is given weak, frivolous and absurd rationalizations for the deprecation, (3) a lack of ambivalence on the part of the child is present (the alienated or target parent is viewed as the incarnation of all evil), (4) the child claims that his or her dislike and hatred of the alienated or target parent is all his or her idea, the so-called “independent thinker” phenomenon, (5) the child reflexively supports the alienating parent in the parental conflict, (6) the child has no guilt over his cruelty to and/or exploitation of the alienated parent, (7) the child uses “borrowed scenarios,” using words that are generally not found in the vocabulary of children of that age, and (8) animosity is spread to the extended family and friends of the alienated parent.²³⁹

237. RICHARD A. GARDNER, M.D., *THE PARENTAL ALIENATION SYNDROME AND THE DIFFERENTIATION BETWEEN FABRICATED AND GENUINE CHILD SEX ABUSE* xix (1987); RICHARD A. GARDNER, M.D., *THE PARENTAL ALIENATION SYNDROME: A GUIDE FOR MENTAL HEALTH AND LEGAL PROFESSIONALS* (1992).

238. Richard A. Gardner, M.D., *The Empowerment of Children in the Development of Parental Alienation Syndrome*, 20 AM. J. FORENSIC PSYCHOL. 5, 5–29 (2002).

239. *Id.* at 5–29.

Gardner believed that false sex-abuse accusations emerge in about ten percent of PAS cases.²⁴⁰ Thus, if a child in a child custody dispute makes sex-abuse allegations while showing PAS symptoms, Gardner believed the likelihood that sexual abuse has occurred is very low. He believed that CPS evaluators often empower such children to put their innocent parents in jail by using anatomical dolls and suggestive questioning to confirm pre-existing biases, and by claiming that “children never lie” about sexual abuse. He also believed that therapists often contribute to the pathological empowerment of PAS children, especially when hired by the alienating parent.²⁴¹

There has been criticism of how the PAS concept has been used in court, both in the child-custody context and in the criminal court context when one parent is accused of sexually abusing the child. One article concludes that the hypothesized etiologic agent of an alienating parent and a receptive child renders an unfalsifiable theory that is tautological.²⁴² These critics argue that since there is no “commonly recognized, or empirically verified pathogenesis, course, familial pattern or treatment selection” in PAS, it cannot be considered to be diagnostic.²⁴³ The same authors believe that indiscriminate use of the PAS concept has led to widespread confusion and misunderstanding in judicial, legal, and psychological circles, and state that some jurisdictions have decided not to allow expert testimony about PAS. The authors feel PAS has often been misapplied to many diverse phenomena occurring in child-custody disputes. These phenomena include normal separation anxiety, the child’s inability to deal with high-conflict transitions between leaving parents, visitation resistance derived from a child’s concern about one parent’s parenting style, and visitation resistance arising from concern about leaving an emotionally fragile parent alone.

Washington appellate courts have apparently not yet dealt with “parental alienation syndrome” in a criminal context, but a recent Washington Court of Appeals case addressed PAS in a child custody context.²⁴⁴ In that case, the husband admitted he had physically assaulted his wife during their marriage.²⁴⁵ A psychologist testified in front of the trial court that the husband should undergo a domestic

240. For a discussion of the relationship between PAS and false sex abuse allegations, see RICHARD A. GARDNER, M.D., *PSYCHOTHERAPY WITH SEX-ABUSE VICTIMS: TRUE, FALSE, AND HYSTERICAL* 238–44 (1996).

241. Gardner, *supra* note 238, at 23–26.

242. Joan B. Kelly & Janet R. Johnston, *The Alienated Child: A Reformulation of Parental Alienation Syndrome*, 39 *FAM. CT. REV.* 249 (2001).

243. *Id.* at 249.

244. *In re Marriage of Shen*, No.47362-0-1, 2002 WL 1011545, at *1 (Wash. App. 2002).

245. *Id.*

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violence treatment program before having any contact with his eleven-year-old daughter.²⁴⁶ In contrast, the psychiatrist testified that the husband did not pose any threat to the eleven year-old.²⁴⁷ The trial court then ordered that another psychiatrist evaluate the parties and make recommendations as to visitation, and that psychiatrist concluded that the child suffered from parental alienation syndrome and opined there was no risk of harm to the child.²⁴⁸ The trial court agreed in ordering a parenting plan that did not restrict visitation.²⁴⁹ On appeal, the wife argued that the trial court had erred both in not requiring the husband to participate in domestic violence counseling and in finding he did not pose a threat to the child.²⁵⁰ The Court of Appeals affirmed, finding that the parenting plan was not “manifestly unreasonable,” and by inference condoning the expert’s use of the PAS construct.²⁵¹

In another child custody case, *In re Swyers*,²⁵² the trial court had granted custody of a three-year-old girl to her mother with extensive visitation rights to the father.²⁵³ The mother accused the father of sexual abuse,²⁵⁴ and the trial court entered a temporary order that allowed for only supervised visitation and also restrained either parent from taking the child out of the state.²⁵⁵ Shortly thereafter, the mother took the child to Florida and hid her from the father;²⁵⁶ consequently, the father was made the primary residential parent after he was able to locate the child in Florida and bring her back to Washington.²⁵⁷ A guardian ad litem was appointed in the case.²⁵⁸ The mother petitioned again that she be made the primary residential parent. The guardian ad litem did not support the petition, stating in a report that the mother was showing “a continuing pattern . . . to sabotage his [the father’s] ability to father his daughter.”²⁵⁹ The trial court entered a finding that the mother was undermining the father’s role as primary parent, stating that, “‘parental alienation syndrome’ is prevalent and is a major issue in this case.”²⁶⁰ When the father requested attorney’s fees, the trial court

246. *Id.*

247. *Id.*

248. *Id.* at *2.

249. *Id.*

250. *Id.* at *3.

251. *Id.* at *4–5.

252. *In re Swyers*, No.18754-3-III, 2001 WL 85178, at *1 (Wash. App. 2001).

253. *Id.*

254. *Id.*

255. *Id.*

256. *Id.*

257. *Id.*

258. *Id.*

259. *Id.* at *2.

260. *Id.*

granted him a substantial amount, and the mother appealed.²⁶¹ The Court of Appeals (Division III) affirmed the award of attorney's fees, citing intransigence on the part of the mother and specifically citing with approval the trial court's finding of parental alienation syndrome.²⁶²

2. False Memory Syndrome

A related notion of PAS is known as "false memory syndrome." This concept arises in cases in which the child is accusing someone of sexual abuse, but the accusations are likely not true. False memory syndrome is thought to occur because of leading and suggestive questions asked of children by family members, CPS workers, therapists, police, and prosecutors.²⁶³

The concept of false memory syndrome is only partially developed. The symptoms of the syndrome have not been delineated, except the claim that a child's memories were "tainted" by improperly leading and suggestive questioning. There is considerable empirical authority for the proposition that false memories can be implanted by leading and suggestive questioning, especially in children.²⁶⁴ *In Dependency of A.E.P.*,²⁶⁵ the Washington Supreme Court discussed two ways that alleged taint caused by leading or suggestive questioning can be addressed, either in terms of the child's competency to be a witness, or in terms of "reliability" of hearsay statements made by the child.²⁶⁶ At the trial court level, *A.E.P.* actually involved testimony by a psychologist, Stuart Greenberg, Ph.D., who suggested the child's statements that her father had sexually abused her were unreliable because of suggestive and improper interviewing.²⁶⁷ Dr. Greenberg did not testify to the existence of any syndrome and had not personally

261. *Id.* at *3.

262. *Id.* at *4.

263. The False Memory Syndrome Foundation, an advocacy organization founded by Peter and Pameal Freyd for people who believe they have been falsely accused of child sexual abuse, has been instrumental in helping alleged falsely accused parents sue their children's therapists for allegedly implanting false memories of childhood sexual abuse.

264. Debra A. Poole & D. Stephen Lindsay, *Interviewing Pre-Schoolers: Effects of Non-Suggestive Techniques, Parental Coaching, and Leading Questions on Reports of Non-Experienced Events*, 60 J. EXPERIMENTAL CHILD PSYCHOL. 129, 147-50 (1995); Sena Garven et al., *More Than Suggestion: The Effects of Interviewing Techniques from the McMartin Preschool Case*, 83 J. APPLIED PSYCHOL. 347, 354-57 (1998).

265. *Matter of Dependency of A.E.P.*, 135 Wash. 2d 208, 956 P.2d 297 (Wash. 1998).

266. *Id.* at 227-228, 956 P.2d at 306-07. For more information regarding the test for reliability of such hearsay statements, see *State v. Ryan*, 103 Wash. 2d 165, 691 P.2d 197 (1984).

267. *Dependency of A.E.P.*, 135 Wash. 2d at 220, 956 P.2d at 302-03.

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evaluated the child.²⁶⁸ Upon appeal, the Washington Supreme Court found that the child had been incompetent to testify.²⁶⁹

In a case involving one of the notorious Wenatchee child sex abuse prosecutions,²⁷⁰ Division III reversed the trial court's decision not to authorize funds for expert testimony regarding false memory syndrome, which would have purported to explain how Detective Perez's interviewing methods could have led to inaccurate testimony.²⁷¹ In the offer of proof, the defense told the trial court that it needed funds for a "false memory syndrome" expert because "the syndrome explains how improper questioning can cause a child to honestly believe she has been molested when, in fact, she has not."²⁷² Division III stated, "Expert testimony on why a child may make untruthful, inculpatory statements went to the crux of . . . the defense. We therefore hold that the trial court abused its discretion when it denied . . . the funds to secure expert testimony on false memory syndrome. On retrial, the superior court shall authorize appointment of such an expert." The prosecution appealed that finding to the Washington Supreme Court, and the Washington Supreme Court asked Division III to revise its findings in light of *A.E.P.* Division III did so and again required the trial court to authorize funds for an expert on false memory syndrome.²⁷³ It does not appear that the court intended the expert to personally evaluate the child, but the two *Carol M.D.* cases suggest that the expert might nonetheless be allowed to testify to the presence of "false memory syndrome" if the expert found it existed in a given case.

There is considerable research evidence indicating that an adult's memories of actual events can be altered by feeding them misleading information. For example, if a group of people watching a simulated crime or accident are later given erroneous information about the details, many will later incorporate the false details into their description

268. *Id.* at 219–220, 956 P.2d at 302–03.

269. *Id.* at 234, 956 P.2d at 309. For more information regarding the test for competency of a child witness, see *State v. Allen*, 70 Wash. 2d 690, 424 P.2d 1021 (1967).

270. The Wenatchee child-sex-ring investigations generated a great deal of controversy. At least 60 adults were arrested on 29,726 charges of child sex abuse involving 43 children. The sex-abuse investigations have since been heavily criticized by the courts. All 18 people convicted in the investigations now have been freed, with their cases overturned or by agreeing to plead to lesser charges to get out of prison. Mike Barber, *Victim of Wenatchee Sex-Abuse Investigators Bears No Ill Will*, SEATTLE POST-INTELLIGENCER (Aug. 10, 2001), http://seattlepi.nwsourc.com/local/34703_wena10.shtml (last visited Nov. 6, 2003). The individuals accused subsequently launched a series of high-profile lawsuits. *Id.*

271. *State v. Carol M.D.*, 89 Wash. App. 77, 89–90, 948 P.2d 837, 844 (1997).

272. *Id.*

273. *State v. Carol M.D.*, 97 Wash. App. 355, 358, 983 P.2d 1165, 1166 (1999) (withdrawing separate portion of earlier opinion and adhering to all other matters, including payment of expert).

of the event.²⁷⁴ Furthermore, it is possible to implant entirely false memories, causing people to believe an event happened, when it never actually happened, such as being lost in a shopping mall for an extended period of time, being rescued by a lifeguard, or surviving a vicious animal attack.²⁷⁵ After being shown false advertising copy about a visit to Disneyland and meeting Bugs Bunny there, a substantial number of the subjects remembered meeting Bugs Bunny at Disneyland, an impossibility, as Bugs Bunny is a Warner Brothers character.²⁷⁶ There is no doubt that law enforcement authorities can unwittingly plant false memories through leading and suggestive interrogations. Indeed, incorrect identification by a witness is the leading cause of false convictions, and suggestive and/or leading line-ups and photo spreads cause a significant number of those false identifications.²⁷⁷ The U.S. Supreme Court has established guidelines to evaluate the harm caused by such suggestive procedures.²⁷⁸ In addition, social scientists have done extensive research on line-ups and photo spreads, and offer suggestions as to how to make them more accurate.²⁷⁹

Memory distortions may also contribute to the failure to convict a guilty person, if accurate eyewitness memories are undermined.²⁸⁰ Unfortunately, there is no way to tell altered, distorted, or completely false memories from true memories, making it impossible to evaluate an eyewitness in an attempt to uncover whether the memories are “true” or “false.” Thus, expert testimony about “false memory syndrome” is usually given without the expert having conducted a personal evaluation of the witness. Therefore, the use of the term “syndrome” does not appear to be justified.

274. See Elizabeth F. Loftus & Edith Greene, *Warning: Even Memory for Faces May Be Contagious*, 4 LAW & HUM. BEHAV. 323 (1980); Elizabeth F. Loftus & Hunter G. Hoffman, *Misinformation and Memory: The Creation of New Memories*, 118 J. EXP. PSYCHOL. 100, 100 (1989).

275. Elizabeth F. Loftus, *Our Changeable Memories: Legal and Practical Implications*, 4 NATURE REVIEWS Mar. 2003, at 232, available at <http://faculty.washington.edu/eloftus/Articles/2003Nature.pdf> (last visited November 5, 2003).

276. *Id.*

277. See generally, C. RONALD HUFF ET AL., CONVICTED BUT INNOCENT: WRONGFUL CONVICTION AND PUBLIC POLICY (1996); Wayne T. Westling, *The Case for Expert Witness Assistance to the Jury in Eyewitness Identification Cases*, 71 OR. L. REV. 93 (1992).

278. Neil v. Biggers, 409 U.S. 188, 199–200 (1972).

279. See Gary L. Wells et al., *Eyewitness identification Procedures: Recommendations for Line-ups and Photo Spreads*, 22 LAW & HUM. BEHAV. 603 (1998).

280. See generally Fredric D. Woocher, Note, Did Your Eyes Deceive You? Expert Psychological Testimony on the Unreliability of Eyewitness Testimony, 29 STANFORD L. REV. 969, 1026–28 (1977).

V. BATTERED PERSON'S SYNDROME

"Battered Woman Syndrome," a term originally coined by Lenore Walker,²⁸¹ is often used to describe the cyclical nature of violence in domestic relationships. Walker's theory suggests that battering relationships often show a cyclical pattern with three main phases: (1) a period of tension building, (2) the acute battering incident or explosion, and (3) a period of loving contrition.²⁸² This conceptualization follows from learning theory, which points to positive reinforcement in the third phase, often described as the "honeymoon period."²⁸³ The social learning theory of "learned helplessness" provides a way of understanding why battered women stay with their abusive males.²⁸⁴ Walker believes that the cyclical nature of the violence psychologically traps the woman in the relationship.²⁸⁵ The battered woman feels there is nothing she can do to stop the beatings, and she falls into a state of depression and learned helplessness.²⁸⁶ The batterer makes it clear by his threats and actions that if she attempts to leave, she will be subjected to even greater abuse.

Given the cyclical pattern of abuse, women who have been repeatedly battered develop an ability to recognize the different phases of the cycle. Battered woman syndrome has most frequently been used in court to explain why a woman attacked her abuser in a non-confrontational situation—the explanation is that the woman recognized that the non-confrontational situation was merely a temporary lull in the cycle of abuse, and that the woman was in a state of "anticipatory fear" of the violence she knew would soon resume.²⁸⁷ While someone outside the situation might view her actions as unreasonable, the abused woman possesses a unique perspective that recognizes the impending nature of the violence. The battered woman has a heightened ability to recognize the cues that precede the battering incidents, often referred to

281. See LENORE E.A. WALKER, *THE BATTERED WOMAN*, xv (1979) [hereinafter WALKER, *THE BATTERED WOMAN*]; LENORE E.A. WALKER, *THE BATTERED WOMAN SYNDROME* (Springer series, Focus on Women, v.6, 1984) [hereinafter WALKER, *THE BATTERED WOMAN SYNDROME*]; LENORE E.A. WALKER, *ABUSED WOMEN AND SURVIVOR THERAPY: A PRACTICAL GUIDE FOR THE PSYCHOTHERAPIST* (1994).

282. WALKER, *THE BATTERED WOMAN*, *supra* note 281, at 55–70.

283. See Lenore E.A. Walker, *Assessment of Abusive Spousal Relationships*, in *HANDBOOK OF RELATIONAL DIAGNOSIS AND DYSFUNCTIONAL FAMILY PATTERNS* 338 (F. Kaslow ed., 1996); WALKER, *THE BATTERED WOMAN* at 55, WALKER, *THE BATTERED WOMAN SYNDROME* at 95.

284. This theory was first discovered in an experimental animal laboratory by Seligman, and then applied to battered women by Walker. See MARTIN E.P. SELIGMAN, *HELPLESSNESS: ON DEPRESSION, DEVELOPMENT AND DEATH* 21–44 (Richard C. Atkinson et al., eds., 1975).

285. WALKER, *THE BATTERED WOMAN*, *supra* note 281, at 68–69.

286. *Id.* at 42–54.

287. 2 DAVID L. FAIGMAN ET AL., *MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY* 3 (2000).

as “hypervigilance.” Thus, apparently trivial actions on the part of the batterer may incite lethal assaults by the abused woman, as the woman perceives her situation differently than a “reasonable” stranger to the situation would. Additionally, abused women may perceive that the battering is escalating in severity over time, so it may be “reasonable” for a battered woman to believe that upcoming encounters may be more deadly than those that have already transpired.

A. Washington Allows Defense Experts to Testify about Battered Person’s Syndrome in Self-Defense Cases.

A number of obstacles were present when lawyers and mental health experts first attempted to use battered woman’s syndrome as a defense to homicide in cases in which the woman had killed her batterer. First, up until relatively recently, the law of self-defense had been based exclusively on the so-called “objective” standard. Juries were asked to determine whether what the defendant did was what a “reasonable person” would have done when faced with the same or similar circumstances. All individuals were expected to live up to this “reasonableness” standard without taking into account past histories. Under this objective standard, self-defense was not allowed unless the threat experienced by the defendant was “immediate.” In other words, the threat had to occur simultaneously with the act of self-defense. A defendant could not claim self-defense based solely on threats or violence that had occurred at some time in the past. Rather, there had to be a necessity established for the self-defense, and the response had to be proportional to the threat presented.²⁸⁸

In the 1970s and 1980s, virtually all jurisdictions began allowing juries to take into account the particular mental make-up of a battered woman in deciding whether her actions had been reasonable. Several states, including Ohio, Massachusetts, Maryland, Missouri, and Wyoming provided for admission of the battered woman syndrome through legislation.²⁸⁹

In Washington’s first important case involving battered woman syndrome, *State v. Wanrow*,²⁹⁰ the defendant Yvonne Wanrow was convicted of second degree murder and first degree assault.²⁹¹ Some months earlier, Ms. Hooper’s seven-year-old daughter had developed a

288. See Brett C. Trowbridge, *Self Defense as a Mental Defense*, 19 AM. J. FORENSIC PSYCHOL. 63, 63 (2001).

289. 2 DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 2, n.2 (2000).

290. *State v. Wanrow*, 88 Wash. 2d 221, 559 P.2d 548 (1997).

291. *Id.* at 224, 559 P.2d at 550.

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sexually transmitted disease.²⁹² Ms. Hooper had not been able to determine who had molested her daughter, but on the night of the shooting Ms. Hooper discovered it was the decedent who had allegedly violated her daughter.²⁹³ Ms. Hooper called the police who said the decedent could not be arrested until Monday morning.²⁹⁴ Ms. Hooper called Ms. Wanrow and asked her to come over and stay the night in the Hooper house.²⁹⁵ Ms. Wanrow arrived with a handgun in her purse.²⁹⁶ Ms. Wanrow's sister and brother-in-law also arrived for "added protection," and unknown to the women in the house, Ms. Wanrow's brother-in-law went to the decedent's house with a baseball bat accusing the decedent of being a child molester.²⁹⁷ The decedent then suggested that he and the brother-in-law go over to the Hooper house "to straighten everything out."²⁹⁸ When the decedent, a large man who was visibly intoxicated, entered the residence, he was told to leave, but he declined to do so.²⁹⁹ He approached a young boy and said "My what a cute little boy!"³⁰⁰ Ms. Wanrow, a 5-foot 4-inch woman who at that time had a broken leg and was using crutches, went to the front door looking for her brother-in-law to enlist his assistance.³⁰¹ Not seeing him, she turned around, and saw the decedent directly behind her.³⁰² She later testified she was "gravely startled" by this situation, and she shot and killed him in what amounted to a reflex action.³⁰³

In instructing the jury about the law of self-defense, the trial court directed the jury "to consider only those acts and circumstances occurring at or immediately before the killing."³⁰⁴ After the instruction was given, Ms. Wanrow was convicted. Upon appeal, the Washington Supreme Court felt the jury instruction was defective, stating that the instructions should allow jurors to "put themselves in the place of the appellant, get the point of view she had at the time of the tragedy, and view the conduct of the [deceased] with all its pertinent sidelights as the appellant was warranted in viewing it. In no other way could the jury safely say what a reasonable prudent [person] similarly situated would

292. *Id.*

293. *Id.*

294. *Id.* at 225, 559 P.2d at 550.

295. *Id.* at 225, 559 P.2d at 551.

296. *Id.*

297. *Id.* at 225-26, 559 P.2d at 551.

298. *Id.* at 226, 559 P.2d at 551.

299. *Id.*

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.*

304. *Id.* at 234, 559 P.2d at 555.

have done.”³⁰⁵ Thus, the so-called “objective” standard for self-defense began to have a “subjective” component.

In the next crucial Washington case, *State v. Allery*,³⁰⁶ the defendant, who had been married for five years, experienced a consistent pattern of physical abuse at the hands of her husband. He often pistol whipped her, assaulted her with knives, and beat her with his fists.³⁰⁷ On one occasion, she was hospitalized when her husband struck her in the head with a tire iron.³⁰⁸ Because the beatings had been increasing in intensity and severity, she filed for divorce and served her husband with a restraining order.³⁰⁹ Late one night when she entered her house, she was surprised to find her husband waiting there for her. According to her testimony, he threatened to kill her.³¹⁰ After she unsuccessfully tried to escape out a window, she fired one shot at him with a shotgun, killing him.³¹¹

The trial court refused to give the self-defense instructions offered by the defense.³¹² The trial court offered only the following instruction on self-defense:

Homicide is justifiable when committed in the lawful defense of the slayer when the slayer, even though mistaken, has reasonable ground to believe the person slain intends to inflict death or great bodily harm and there appears to the slayer to be imminent danger of such harm being accomplished. The slayer may employ such force and means as a reasonably prudent person would use under the same or similar conditions as they appeared to the slayer at the time.³¹³

The defense offered the expert testimony of Karil Klingbeil, who was prepared to explain battered woman syndrome to the jury. However, after extensive voir dire conducted out of the presence of the jury, the trial judge decided not to allow the testimony.³¹⁴ Klingbeil would have testified that in her opinion, Allery displayed the behavioral and emotional characteristics of a battered woman.³¹⁵ The defense counsel was specific in explaining the purpose of the proposed testimony. It was offered to (1) explain the mentality and behavior of

305. *Id.* at 235–36, 559 P.2d at 556.

306. *State v. Allery*, 101 Wash. 2d 591, 682 P.2d 312 (1984).

307. *Id.* at 592, 682 P.2d at 313.

308. *Id.* at 592–93, 682 P.2d at 313.

309. *Id.* at 593, 682 P.2d at 313.

310. *Id.* at 593, 682 P.2d at 313.

311. *Id.* at 593, 682 P.2d at 313–14.

312. *Id.* at 594, 682 P.2d at 314.

313. *Id.* at 593, 682 P.2d at 314.

314. *Id.* at 595, 682 P.2d at 315.

315. *Id.*

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battered women generally, (2) to provide a basis from which the jury could understand why the defendant perceived herself in imminent danger at the time of the shooting, and (3) to explain why a battered woman remains in a relationship that is physically dangerous.³¹⁶

The defendant was convicted of second-degree murder.³¹⁷ However, the Washington Supreme Court reversed on appeal.³¹⁸ The court cited *Wanrow* in holding that the self-defense instruction did “not make the subjective self-defense standard manifestly apparent to the average juror,”³¹⁹ adding that “[t]he instruction is inadequate because it does not instruct the jury to consider the conditions as they appeared to the slayer, taking into consideration all of the facts and circumstances known to the slayer at the time and prior to the incident.”³²⁰ The court concluded that “[t]he jury should have been instructed to consider the self-defense issue from the defendant’s perspective in light of all she knew and had experienced with the victim.”³²¹

As to the admissibility of expert testimony about the battered woman syndrome, the Washington Supreme Court cited ER 702, which provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence, or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.³²²

The Court recited the rule’s three-part test regarding the admissibility of expert testimony in Washington: (1) whether the witness qualifies as an expert, (2) whether the opinion is based on an explanatory theory generally accepted in the scientific community (i.e. the *Frye* test, as explained above), and (3) whether the expert testimony would be helpful to the trier of fact.³²³

The qualifications of Klingbeil were well established and were not at issue in the case.³²⁴ Klingbeil testified in voir dire that the battered woman syndrome was a “recognized phenomenon in the psychiatric

316. *Id.* at 596, 682 P.2d at 315.

317. *Id.* at 592, 682 P.2d at 313.

318. *Id.* at 599, 682 P.2d at 317.

319. *Id.* at 594, 682 P.2d at 314 (citing *State v. Wanrow*, 88 Wash. 2d 221, 235–36, 559 P.2d 548, 556 (1977)).

320. *Id.* at 595, 682 P.2d at 314–15.

321. *Id.*, 682 P.2d at 315. Other jurisdictions have also adopted a quasi-subjective test which allows the jury to consider what the reasonable battered woman similarly situated to the defendant would have perceived. *See, e.g.*, *State v. Hundley*, 693 P.2d 475 (Kan. 1985).

322. WASH. R. EVID.702.

323. *Allery*, 101 Wash. 2d at 596, 682 P.2d at 315.

324. *Id.*

profession and was defined as a technical term of art in professional diagnostic textbooks.”³²⁵ Klingbeil had testified in voir dire that:

[t]he battered woman syndrome is comprised of three distinct phases. In the first phase, tension mounts between the woman and her partner and minor abuse occurs. More serious violence follows and the woman experiences a sense of powerlessness to do anything to stop her husband. Psychologists describe a phenomenon known as “learned helplessness,” a condition in which the woman is psychologically locked into her situation due to economic dependence on the man, an abiding attachment to him, and the failure of the legal system to adequately respond to the problem. Finally, there is a temporary lull in the physical abuse inflicted on the battered woman, and she forgives her assailant, hoping that the abuse will not reoccur.³²⁶

The court ruled:

We join with these courts which hold expert testimony on the battered woman syndrome admissible. We find that expert testimony explaining why a person suffering from the battered woman syndrome would not leave her mate, would not inform police or friends, and would fear increased aggression against herself would be helpful to a jury in understanding a phenomenon not within the competence of an ordinary lay person. Where the psychologist is qualified to testify about the battered woman syndrome, and the defendant establishes her identity as a battered woman, expert testimony on the battered woman syndrome is admissible. This evidence may have a substantial bearing on the woman’s perceptions and behavior at the time of the killing and is central to her claim of self-defense.³²⁷

Notice that under this ruling the expert is allowed to personally evaluate the defendant and give an opinion as to whether the defendant should properly be diagnosed as suffering from battered woman syndrome. Some jurisdictions, however, do not allow an expert to testify whether a particular person suffers from the syndrome.³²⁸

325. *Id.*

326. *Id.* at 596–97, 682 P.2d at 315.

327. *Id.* at 597, 682 P.2d at 316 (citations omitted).

328. *See State v. Ritt*, 599 N.W.2d 802 (Minn. 1999). In denying such testimony, the court stated:

Testimony on battered woman syndrome is limited to a description of the syndrome’s general nature and the expert is not allowed to testify whether a particular defendant or witness suffers from the syndrome because the expert testimony may be perceived as evidence on the ultimate issue of guilt or innocence . . . or as an “unwarranted ‘stamp of scientific legitimacy’ to the testimony.”

Id. at 811.

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Since its emergence in the late 1970s, expert testimony on battered woman syndrome in self-defense cases has been admitted in some form in every state.³²⁹ However, some evidence of self-defense is usually required before the expert testimony may be admitted. For example, a Wyoming case upheld a trial court's exclusion of battered woman syndrome expert testimony because the underlying facts did not support a chain of self-defense.³³⁰ In addition, most jurisdictions require the courts to pay for expert witnesses on battered woman's syndrome in appropriate cases with indigent defendants.³³¹

In another Washington case, *State v. Kelly*,³³² the issue arose as to whether the state could offer a woman's prior aggressive acts in a battered woman syndrome self-defense case to show that she was not always helpless, passive, and dependent as her expert witness claimed.³³³ In *Kelly*, the defendant shot and killed her husband.³³⁴ At trial, she contended her husband had physically beaten her during the marriage, and at the time of the shooting she feared another episode of abuse.³³⁵

The defense called an expert witness, who had personally examined her and diagnosed her as suffering from battered woman syndrome.³³⁶ In rebuttal, the State made an offer of proof from two witnesses, one who said the woman had threatened him, and another who said she had observed the defendant pounding on the back door of the defendant's home with a shovel while her husband, Mr. Kelly, was inside.³³⁷ Defense counsel made a motion to exclude the testimony of both rebuttal witnesses, but the trial judge denied it, stating that the character evidence would rebut the expert testimony regarding "isolation" and "learned helplessness." Subsequently, the jury convicted the defendant of second degree murder.³³⁸

Upon appeal, the Washington Supreme Court opined that the expert's testimony had not been character evidence, as Washington does not permit proof of character by opinion testimony.³³⁹ The court stated,

329. See Janet Parrish, *Trend Analysis: Expert Testimony on Battering and its Effects in Criminal Cases*, at <http://www.ojp.usdoj.gov/ocpa/94Guides/Trials/Trend/> (last visited November 1, 2003).

330. *Duran v. State*, 990 P.2d 1005, 1009 (Wyo. 1999). See also *Lentz v. State*, 604 So.2d 243, 246-47 (Miss. 1992) and *People v. Yaklich*, 833 P.2d 758, 761 (Colo. Ct. App. 1991).

331. See, e.g., *Dunn v. Roberts*, 963 F.2d 308, 313-14 (10th Cir. 1992).

332. *State v. Kelly*, 102 Wash. 2d 188, 685 P.2d 564 (1984).

333. *Id.* at 190, 685 P.2d at 567.

334. *Id.*

335. *Id.*

336. *Id.*

337. *Id.* at 190-91, 685 P.2d at 567.

338. *Id.* at 191, 685 P.2d at 567.

339. *Id.* at 194-95, 685 P.2d at 569.

“Mrs. Kelly did not introduce expert testimony to show that at the time she shot her husband, she acted in conformity with behavioral characteristics which were said to comprise the ‘battered woman syndrome.’ Rather, the expert testimony was offered to aid the jury in understanding the reasonableness of Mrs. Kelly’s apprehension of imminent death or bodily injury.”³⁴⁰ As a result, the Washington Supreme Court reversed the decision and remanded for a new trial.³⁴¹

Thus, in Washington, it appears that the State may not rebut battered woman syndrome evidence by using lay witnesses to attest to specific incidents in which the defendant acted aggressively in the past, even if those behaviors were directed at the batterer himself. On the other hand, experts in Washington can most likely testify to such prior acts as foundation for an opinion as to whether the defendant actually suffers from PTSD or battered woman syndrome.

The next important development in Washington in this context was the extension of battered woman syndrome to the diagnosis of battered children in *State v. Janes*.³⁴² In that case, Janes’s stepfather sporadically beat Janes, a seventeen-year-old boy, over a ten-year period.³⁴³ Janes had also witnessed violence against his mother and brother.³⁴⁴ One night, after waiting in the home with his stepfather’s guns for several hours, smoking marijuana and drinking whiskey, the boy shot and killed his stepfather when he walked in the door.³⁴⁵

At trial, in support of a self-defense instruction, the defense called a child psychiatrist, Dr. Christopher Varley, who gave an offer of proof. His testimony diagnosed Janes as suffering from PTSD based on his personal evaluation of him.³⁴⁶ This diagnosis was later repeated before the jury. Varley testified that PTSD impaired Janes’ ability to premeditate.³⁴⁷ He also stated that in his opinion, Janes feared imminent harm on the day in question, even though Janes himself had denied fearing imminent harm that day.³⁴⁸

The trial judge allowed Varley’s testimony, but denied the request for a self-defense instruction.³⁴⁹ The trial judge concluded the circumstances showing threat were too remote and insufficiently

340. *Id.* at 195–96, 685 P.2d at 569.

341. *Id.* at 201, 685 P.2d at 573.

342. *State v. Janes*, 121 Wash. 2d 220, 850 P.2d 495 (1993).

343. *Janes*, 121 Wash. 2d at 223, 850 P.2d at 496.

344. *Id.*

345. *Id.* at 224–25, 850 P.2d at 496–97.

346. *Id.* at 226–27, 850 P.2d at 497–98.

347. *Id.* at 227, 850 P.2d at 498.

348. *Id.*

349. *Id.* at 227–28, 850 P.2d at 498.

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aggressive to justify a self-defense instruction.³⁵⁰ The trial judge did allow a diminished capacity instruction and additional testimony on diminished capacity from psychologist Bruce Olsen, Ph.D., who had also diagnosed Janes with PTSD.³⁵¹ In rebuttal, the State called Dr. Carl Redick, a Western State Hospital psychologist, who testified Janes suffered from long-term substance abuse, not PTSD, and that he had the capacity to premeditate.³⁵² The jury found Janes not guilty of first degree murder, but guilty of second degree murder.³⁵³

The Washington Supreme Court reversed and remanded the case to the trial court to determine whether a self-defense instruction and expert testimony were appropriate.³⁵⁴ The court enunciated the principle that expert testimony regarding the “battered child syndrome” was admissible in appropriate cases to aid in the proof of self-defense.³⁵⁵ The court reasoned that battered child syndrome met the *Frye* test of scientific admissibility, ruling it had achieved general acceptance in the scientific community.³⁵⁶ The court stated, “We conclude that the battered child syndrome is the functional and legal equivalent of the battered woman syndrome, and find it admissible under the *Frye* test.”³⁵⁷ The court also ruled that admission of expert testimony regarding battered child syndrome would have been “helpful” to the jury under ER 702 because “[e]xpert testimony regarding the syndrome helps the jury to understand the reasonableness of the defendant’s perceptions.”³⁵⁸

Citing *Wanrow*, the Washington Supreme Court once again alluded to a subjective element in self-defense cases, such that the jury could grasp what a reasonably prudent person similarly situated would have done.³⁵⁹ The court reasoned that the requirement that the danger of great bodily harm perceived by the defendant needed to be “imminent” did not mean that it had to be immediate.³⁶⁰ The fact that the “triggering behavior” is separated in time from an episode of abuse does not negate the reasonableness of a defendant’s perception of imminent harm if in the past these two types of conduct have been

350. *Id.* at 228, 850 P.2d at 498.

351. *Id.* at 228–30, 850 P.2d at 498–500.

352. *Id.* at 231, 850 P.2d at 500.

353. *Id.*

354. *Id.* at 242, 850 P.2d at 506.

355. *Id.* at 232–236, 850 P.2d at 501–03.

356. *Id.*

357. *Id.* at 235, 850 P.2d at 503.

358. *Id.* at 236, 850 P.2d at 503.

359. *Id.* at 238, 850 P.2d at 504.

360. *Id.* at 241–42, 850 P.2d at 506.

“inevitably linked.”³⁶¹ The court further stated that in an abusive situation the fact “[t]hat the triggering behavior and the abusive episode are divided by time does not necessarily negate the reasonableness of the defendant’s perception of imminent harm.”³⁶²

There remains a split among jurisdictions that recognize a battered child syndrome defense. Many jurisdictions recognize the defense,³⁶³ but others do not.³⁶⁴

B. Washington Allows General Testimony Regarding Battered Woman’s Syndrome if the Defense has Attacked the Credibility of the Victim.

In a Washington Supreme Court case, *State v. Ciskie*,³⁶⁵ the defendant was charged with four counts of rape. The expert testimony of Karil Klingbeil was offered by the State after defense counsel had attacked the alleged victim’s credibility by describing the State’s case as “carefully rehearsed” and by claiming that all sexual intercourse had been consensual.³⁶⁶

The trial court ruled that Klingbeil could testify, but restricted the testimony in several ways.³⁶⁷ Klingbeil was allowed to testify that the victim had PTSD, based on her personal evaluation of the victim. Klingbeil stated that the trauma which could have caused PTSD could have been any unusual stressful event, not necessarily a rape or an assault, and the trial court did not allow the State to question Klingbeil as to what she believed the trauma had been in the present victim’s case.³⁶⁸ Rather, she was only allowed to testify in response to a hypothetical that a victim’s delay in reporting the rapes was characteristic of a woman suffering from battered woman’s syndrome.³⁶⁹

The Washington Supreme Court upheld the convictions,³⁷⁰ but stated that if Klingbeil had been allowed to give her assessment of the victim’s credibility, her testimony could have been overly prejudicial.³⁷¹ The Washington Supreme Court went on to state that,

361. *Id.*, 850 P.2d at 506.

362. *Id.* at 241, 850 P.2d at 506.

363. *See, e.g.*, *State v. Nemeth*, 694 N.E.2d 1332, 1336 (Ohio 1998).

364. *See, e.g.*, *State v. Gachot*, 609 So.2d 269 (La. Ct. App. 1992).

365. *State v. Ciskie*, 110 Wash. 2d 263, 751 P.2d 1165 (1988).

366. *Id.* at 269, 751 P.2d at 1168–69.

367. For example, Klingbeil could not use the term rape trauma syndrome and could not offer an opinion as to whether the victim was raped. *Id.* at 272, 751 P.2d at 1170.

368. *Id.* at 280, 751 P.2d at 1174.

369. *Id.* at 278–79, 751 P.2d at 1173.

370. *Id.* at 279, 751 P.2d at 1173.

371. *Id.* at 279, 751 P.2d at 1174.

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“With the benefit of hindsight, it would perhaps have been preferable to bar the diagnosis portion of the testimony altogether, to avoid the danger of the jury’s inferring a diagnosis of rape,” but concluded that undue prejudice had not occurred, stating the trial judge had done “an admirable job of limiting the expert’s testimony to that which would be of maximum benefit to the jury.”³⁷² In his dissent, Justice Dore complained that the testimony had been overly prejudicial, stating, “The testimony, in effect, put the defendant on trial for being a batterer.”³⁷³

Thus, in Washington cases in which the defense has attacked the credibility of the alleged victim and syndrome testimony is deemed relevant, a properly qualified expert witness is allowed to testify for the State about the general characteristics of those suffering from battered woman syndrome or PTSD. However, the expert should not be allowed to make a diagnostic statement that the victim in that particular case suffers from battered woman syndrome or PTSD. Some states also allow testimony about characteristics of battered women if the defense “opens the door.”³⁷⁴ However, testimony about the general characteristics of abusers is generally not allowed.³⁷⁵

C. Washington Allows Expert Testimony Regarding Battered Woman’s Syndrome in Cases of Duress

Battered woman syndrome can also be used in Washington in cases of alleged duress. In *State v. Riker*,³⁷⁶ the defendant raised the defense of duress to charges of delivery and possession of cocaine.³⁷⁷ She claimed that a police informant, Mr. Burke, coerced her into the crime with verbal threats,³⁷⁸ and she contended that her history as a battered woman in other relationships should have been made known to the jury.³⁷⁹ The defendant Riker offered the testimony of Karil Klingbeil on the subject,³⁸⁰ but the trial court disallowed the expert’s testimony.³⁸¹ On appeal, the Washington Supreme Court affirmed the trial court’s conviction.³⁸²

372. *Id.* at 280, 751 P.2d at 1174.

373. *Id.* at 286, 751 P.2d at 1177 (Dore, J., dissenting).

374. *See State v. Kelly*, 478 A.2d 364, 375 (N.J. 1984); *Parrish v. State*, 514 S.E.2d 458, 463 (Ga. Ct. App. 1999).

375. *See Parrish*, 514 S.E.2d at 463; *Ryan v. State*, 988 P.2d 46, 55 (Wyo. 1999).

376. *State v. Riker*, 123 Wash. 2d 351, 869 P.2d 43 (1994).

377. *Id.* at 353, 869 P.2d at 45.

378. *Id.*

379. *Id.*

380. In the case, Klingbeil had personally evaluated the defendant and had diagnosed her as suffering from battered woman syndrome based on her past history of abusive relationships.

381. *Riker*, 123 Wash. 2d at 357, 869 P.2d at 47.

382. *Id.* at 370, 869 P.2d at 53.

Riker testified that Burke had once forced her sister to give Riker some rings in exchange for \$20 to buy cocaine, had once pushed her sister against the wall, and had threatened to harm her sister if Riker did not obtain cocaine for him.³⁸³ Riker further testified that Burke had never hit her,³⁸⁴ but also testified regarding her own past history of abusive relationships to support her duress defense, stating her fear of Burke.³⁸⁵ During her offer of proof, Klingbeil admitted that the use of the battered woman syndrome in a case where there was not an intimate relationship between the batterer and the victim was “novel.”³⁸⁶

The Washington Supreme Court ruled that it had been proper for the trial court to exclude Klingbeil’s testimony because the defendant’s actions had occurred “outside of a battering relationship,”³⁸⁷ and in the court’s opinion there was not scientific acceptance (i.e. the *Frye* test was not met) of battered woman syndrome when applied to behavior that occurred outside the context of a battering relationship.³⁸⁸ In the court’s opinion, there was not “a reliable method of applying the theory to the facts of the case.”³⁸⁹ In his dissent, Justice Utter thought the proposed use of the expert testimony was no different than in *Allery*,³⁹⁰ i.e., to explain “to the jury the concepts of learned helplessness and how a battered person assesses danger,”³⁹¹ and he stated in his opinion the expert testimony should have been allowed because “[t]he fact that Riker and Burke were never involved in a battering relationship or an intimate relationship of any kind is immaterial.”³⁹²

However, in another duress case, *State v. Williams*,³⁹³ the defendant and the batterer did have a long-term history of battering within an intimate relationship.³⁹⁴ In that case, the Washington Supreme Court upheld the use of the battered woman syndrome even in a case in which the duress was not “immediate.”³⁹⁵ The defendant claimed she had committed welfare fraud because she was forced to do so by her abusive live-in boyfriend.³⁹⁶ At trial, Williams testified she and her children would have suffered severe abuse or even death if she

383. *Id.* at 356, 869 P.2d at 46.

384. *Id.*

385. *Id.* at 357, 869 P.2d at 46.

386. *Id.*

387. *Id.* at 359, 869 P.2d at 47.

388. *Id.* at 359–364, 869 P.2d at 47–50.

389. *Id.* at 363, 869 P.2d at 50.

390. 101 Wash. 2d 591, 682 P.2d 312 (1984).

391. *Riker*, 123 Wash. 2d at 371–72, 869 P.2d at 54.

392. *Id.* at 372, 869 P.2d at 54.

393. *State v. Williams*, 132 Wash. 2d 248, 937 P.2d 1052 (1997).

394. *Id.* at 251–52, 937 P.2d at 1054–55.

395. *Id.* at 258–60, 937 P.2d at 1058.

396. *Id.* at 253, 937 P.2d at 1055.

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disobeyed him.³⁹⁷ A defense expert testified that she suffered from battered woman syndrome, stating that a batterer need not be present to exert control over his victim, and opining that the welfare fraud had not been “willful” as required by the statute.³⁹⁸ The defense proposed a jury instruction on duress, but the trial court declined to give it, declaring that the threats to Williams were not sufficiently immediate because the boyfriend was away at sea most of the time.³⁹⁹ Consequently, Williams was convicted.⁴⁰⁰

On appeal, the Washington Supreme Court reversed the trial court, stating, “The duress statute does not require that it actually be possible for the harm to be immediate. Rather, it directs the inquiry at the defendant’s *belief*, and whether such a belief is reasonable.”⁴⁰¹

D. Washington Allows Expert Testimony Regarding Battered Woman’s Syndrome to Justify a More Lenient Sentence.

Use of the battered woman syndrome has also been upheld to support giving a woman a sentence less than the standard range. In one case, the defendant was originally charged with second degree murder and manslaughter.⁴⁰² She contended she acted in self-defense and suffered from battered woman syndrome.⁴⁰³ The jury found that she lacked the requisite intent for second degree murder, but had not acted in self-defense, and she was convicted of first degree manslaughter.⁴⁰⁴ Because she had no prior criminal history, her presumptive sentencing range was 31 to 41 months, but the trial court sentenced her under an “exceptional” sentence of only 30 days of total confinement, 30 days of partial confinement, and 240 hours of community service, with an additional year of community supervision.⁴⁰⁵ The court’s justification for such a lenient sentence was that her ability “to appreciate the wrongfulness of her conduct or to conform her conduct to the requirements of the law was significantly impaired because she is a battered woman.”⁴⁰⁶ The Washington Supreme Court upheld the sentence, stating that there were adequate reasons supported by the

397. *Id.*

398. *Id.*

399. *Id.* at 258–59, 937 P.2d at 1058.

400. *Id.* at 253, 937 P.2d at 1055.

401. *Id.* (emphasis added). For a discussion of how various jurisdictions handle battered woman syndrome testimony in a duress context, see 2 DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY, 21–25 (2000).

402. *State v. Pascal*, 108 Wash. 2d 125, 736 P.2d 1065 (1987).

403. *Id.* at 129, 736 P.2d at 1068.

404. *Id.*

405. *Id.*

406. *Id.* at 129–30, 736 P.2d at 1068.

record for imposing a more lenient sentence, and that it was not “clearly too lenient.”⁴⁰⁷ The Ninth Circuit has allowed such syndrome evidence in sentencing under some circumstances.⁴⁰⁸

VI. LIMITATIONS OF SYNDROME EVIDENCE

As previously discussed, appellate courts in reviewing the admission of expert testimony regarding trauma-related syndromes evaluate the scientific evidence to determine if a given syndrome meets the *Frye* test of “general acceptance” in the related field. They ask whether there is evidence of universal or near-universal symptoms resulting from each type of trauma, and whether those symptoms also often occur among those who have not experienced the trauma. They also ask whether those symptoms could be attributable to some other trauma not relevant to the case.

A. Rape Trauma Syndrome

The questions above, when applied to the concept of rape trauma syndrome, lead us to an important inquiry: Can psychologists determine whether it is more or less likely that a rape occurred merely on the basis of a woman’s description of her psychological symptoms?

One problem is that information about symptoms is usually gathered by self-reporting mechanisms, whether received by interview or psychological testing. Obviously, any expert proposing to state that a person’s symptoms are (or were) consistent with having been raped should have corroborating information beyond the simple self-reports of the alleged victim, since malingering is a distinct possibility, and some studies have shown that trauma-related symptoms can be faked.⁴⁰⁹

Another problem is that some non-victims experience PTSD symptoms. Studies consistently show that victims of sexual assault report more symptoms of PTSD than do non-victims.⁴¹⁰ However, there is usually considerable overlap between the two groups, which makes it very difficult to state with any certainty what a “typical” rape victim’s symptoms would be. For example, in a study of female college students who were victims of molestation, attempted rape, coerced rape, and forcible rape, 34% of the women in the victimized groups met the cut-off for PTSD on the Crime Related PTSD Scale, but 22% of the

407. *Id.* at 139, 736 P.2d at 1073.

408. *See* U.S. v. Johnson, 956 F.2d 894, 899–900 (9th Cir. 1992).

409. Judith A. Lyons et al., *The Potential for Faking on the Mississippi Scale for Combat Related PTSD*, 7 J. TRAUMATIC STRESS 441, 444–45 (1994).

410. 2 DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 123, n.27 (2000).

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non-victims also were categorized as having PTSD.⁴¹¹ Based on this study, it would be consistent with being raped that a person showed PTSD, but it would also be consistent with being raped that a person did not meet the criteria for PTSD. Similarly, meeting the criteria for PTSD would be consistent with having been raped, but would also be consistent with not having been raped!

The same problem seems to exist for the other symptoms that frequently occur after rape. Numerous studies have assessed the prevalence of depression between victims versus non-victims. These studies have consistently shown a higher rate of depression and/or depressive symptoms among victims than non-victims, but there is always considerable overlap between the two groups. For example, in a sample of victims from a rape crisis center, 38% of the victims met the diagnostic criteria for major depressive disorder at six months post rape, but 16% of a matched comparison group also met the criteria for that disorder.⁴¹² Another study found major depressive disorder in 48% of raped women, but found that 27% of women who had not been raped also had major depressive disorder.⁴¹³ Thus, it would be “consistent” with having been raped that the alleged victim either is depressed or is not depressed, and either diagnosis would also be consistent with not having been raped.

Similarly, although anxiety is a common symptom among those who have been raped, it is also a common symptom among those who have not been raped. One study found that 82% of victims showed generalized anxiety disorder, but 32% of non-victims also suffered from the same disorder.⁴¹⁴ It is clear that comorbidity is also a problem because PTSD symptoms overlap with the diagnostic criteria for several other clinical disorders, including depression, panic disorder, phobias, obsessive-compulsive disorder, and alcohol and drug abuse.

Thus, it appears that a person who has been raped may show no symptoms, may show PTSD symptoms, may be depressed, anxious, or may show any combination of these symptoms. Similarly, a person who has not been raped may show no symptoms, or any combination of these symptoms. Any person’s behavior after an alleged rape could thus be “consistent” with either having been raped or not having been raped. The well-documented research on the effects of rape tells us much about

411. *Id.*

412. Ellen Frank & Barbara Pazak Anderson, *Psychiatric Disorders in Rape Victims: Past History and Current Symptomatology*, 28 COMP. PSYCHIATRY 77, 80 (1987).

413. 2 DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 126 (2002).

414. Ellen Frank & Barbara Pazak Anderson, *Psychiatric Disorders in Rape Victims: Past History and Current Symptomatology*, 28 COMP. PSYCHIATRY 77, 80 (1987).

what the range of effects can be across cases. However, this research tells us very little about any individual case, since there is no group of symptoms that is unique to having been raped. At the same time, it is clear that a person who has been raped is more likely to show symptoms of emotional distress than a person who has not been raped, with an average 21% increase in the prevalence of psychological distress in rape victims as compared to non-victims.⁴¹⁵

From this point of view, the Washington Supreme Court appears to be correct in its assertion that rape trauma evidence is not sufficiently "reliable" to be used as it was in *Black* in which the expert stated, "there is a specific profile of a rape victim, and (she) fits in."⁴¹⁶

B. Child Abuse Syndromes

The same type of questions must be asked about the scientific validity of child abuse syndromes, especially when introduced by experts to show that sexual abuse has occurred. Are there valid "syndromes" that can be reliably distinguished between children who have been sexually abused and those who have not? The evidence suggests that there are not.

Susan McLeer and her colleagues examined sexually abused children they found at an outpatient child psychiatry unit and discovered that 49% met DSM-III-R criteria for PTSD with others exhibiting at least some PTSD symptoms.⁴¹⁷ In a follow up study, McLeer and her colleagues compared sexually abused children from a clinical setting with non-abused children from a clinical setting and diagnosed 42% of the sexually abused children with PTSD as opposed to only 9% with PTSD in the control group.⁴¹⁸ The most frequent diagnosis in both groups was attention deficit hyperactivity disorder.⁴¹⁹ McLeer and her colleagues did another study in which the sexually abused children were not drawn from a clinical setting; 36% of this group met criteria for PTSD, and the majority had some PTSD symptoms.⁴²⁰ In another study, about half of the sexually abused children who were referred to a child witness preparation program exhibited some PTSD

415. Terri L. Weaver & George A. Clum, *Psychological Distress Associated with Interpersonal Violence: A Meta-Analysis*, 15 CLINICAL PSYCHOL. REV. 115, 126 (1995).

416. *Black*, 109 Wash. 2d at 339, 745 P.2d at 14.

417. Susan V. McLeer, M.D. et al., *Post Traumatic Stress Disorder in Sexually Abused Children*, 27 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 650, 652 (1988).

418. Susan V. McLeer, M.D. et al., *Psychiatric Disorders in Sexually Abused Children*, 33 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 313, 316 (1994).

419. *Id.*

420. Susan V. McLeer, M.D. et al., *Non-Clinically Referred Sexually Abused Children*, 37 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1132 (1998).

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symptomatology. Girls (as opposed to boys) and older children were more likely to qualify for PTSD diagnoses, as were children whose abuse occurred over a longer period of time, and those who were subjected to threats and/or coercion.⁴²¹

Another study compared sexually abused children with physically abused children and non-abused controls referred to a foster care agency.⁴²² Sixty-four percent of the sexually abused children showed PTSD, as compared to 42% of the physically abused children, and 18% of the controls.⁴²³

Most researchers have concluded that sexual abuse leads to higher rates of PTSD than other forms of abuse.⁴²⁴ However, studies do not show that PTSD is a near universal after-effect of sexual abuse, with the above studies all showing almost half of the sexually abused children not meeting the criteria for PTSD.

Major depression appears to be common among sexually abused children. In a study of one hundred consecutive admissions to an inpatient child psychiatric unit, 77% of the sexually abused children were diagnosed with major depression (using the Diagnostic Interview of Children and Adolescents), whereas only 33% of the physically abused children and 10% of the non-abused controls were diagnosed with major depression. However, there were only 13 sexually abused children, a sample perhaps too small from which to make any definitive conclusions.⁴²⁵

There is some evidence that sexually abused children have on average depressed IQ scores.⁴²⁶ Obviously, however, depressed IQ scores could in no way be considered diagnostic of child sexual abuse. Another way to approach the problem is to look exclusively at children who have been abused. One study looked at children with sexually transmitted diseases. Half of the children showed behavioral symptoms, but half of them did not.⁴²⁷

421. David A. Wolfe et al., *Factors Associated with the Development of Posttraumatic Stress Disorder Among Child Victims of Sexual Abuse*, 18 CHILD ABUSE & NEGLECT 37, 43 (1994).

422. Allison E. Dubner & Robert W. Motta, *Sexually and Physically Abused Foster Care Children and Post Traumatic Stress Disorder*, 67 J. CONSULTING & CLINICAL PSYCHOL. 367, 371-72 (1999).

423. *Id.*

424. See, e.g., Sue Boney-McCoy & David Finkelhor, *Psychosocial Sequelae of Violent Victimization in a National Youth Sample*, 63 J. CONSULTING & CLINICAL PSYCHOL. 726, 733-35 (1995).

425. Richard Livingston, M.D., *Sexually and Physically Abused Children*, 26 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 413, 414 (1987).

426. Normand J. Carrey et al., *Physiological and Cognitive Correlates of Child Abuse*, 34 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1067, 1067-73 (1995).

427. Louanne Lawson & Mark Chaffin, *False Negatives in Sexual Abuse Disclosure Interviews*, 7 J. INTERPERSONAL VIOLENCE 532, 540 (1992).

These studies are based on children admitted to hospitals for treatment, or children whose abuse has been officially reported to the authorities, so they are not generalizable to sexually abused children generally. Rind and his colleagues did a meta-analysis of the literature on the effects of child sexual abuse, relying on college students' data and survey data instead of clinical or legal samples.⁴²⁸ Their conclusion was that victims of childhood sexual abuse rarely experience more adverse psychological symptoms later in life than people who were not sexually abused.⁴²⁹ These studies are controversial, but have not yet been replicated scientifically.

Indeed, studies on non-clinical populations appearing since the Rind, et al., meta-analysis have uncovered adverse consequences of childhood sexual abuse.⁴³⁰ Findings from the Adverse Childhood Experiences (ACE) study (performed in a non-clinical setting) show that adults who report a history of childhood sexual abuse are about three times more likely to have attempted suicide at least once during their lives.⁴³¹ Furthermore, adults who report a history of childhood sexual abuse are also statistically more likely to report that they are suffering from alcoholism, drug abuse, depression, smoking, promiscuity, sexually transmitted disease, and obesity, as well as a number of medical conditions such as cancer, ischemic heart disease, and liver disease.⁴³²

In summary, "findings suggest the absence of any specific syndrome in children who have been sexually abused and no single traumatizing process."⁴³³ The notion that there is any one "syndrome" or pattern of symptoms specific to child sexual abuse does not appear to hold up to scientific scrutiny. Even the commonly believed idea that sexually abused children exhibit more sexual behavior problems does

428. Bruce Rind and Philip Tromovitch, *A Meta-Analytic Examination of Assumed Properties of Child Sexual Abuse Using College Samples*, 124 PSYCHOL. BULL. 22 (1998); Bruce Rind & Philip Tromovitch, *A Meta-Analytic Review of Findings from National Samples of Psychological Correlates of Child Sexual Abuse*, 34 J. SEXUAL RES. 237 (1997).

429. *Id.*

430. Kenneth S. Kendler, M.D. et al., *Child Sexual Abuse and Adult Psychiatric and Substance Disorders in Women: An Epidemiological and Cotwin Control Analysis*, 57 ARCH. GEN. PSYCHIATRY 953, 953-59 (2000); Elliot C. Nelson et al., *Association between Self-Reported Childhood Sexual Abuse and Adverse Psychosocial Stressors: Results from a Twin Study*, 59 ARCH. GEN. PSYCHIATRY 139, 139-45 (2002).

431. Shanta R. Dube, M.P.H. et al., *Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Spans: Findings from the Adverse Childhood Experiences Study*, 286 JAMA 3089, 3093 (Dec. 26, 2001).

432. Vincent J. Felitti, M.D., F.A.C.P. et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTATIVE MED. 245, 252-53 (1998).

433. Kathleen A. Kendall-Tackett et al., *Impact of Sexual Abuse on Children: A Review and Synthesis of Recent Empirical Studies*, 113 PSYCHOL. BULL. 164, 164 (1996).

not appear to hold up. A multi-disciplinary team investigated the diagnostic utility of sexual behavior problems in diagnosing child sexual abuse using the Child Sexual Behavior Inventory (CSBI), and sexually abused children were found to be no more likely to have high CSBI scores than non-sexually abused children.⁴³⁴ For many years, many people believed that a child's style of play with anatomically correct dolls could corroborate sexual abuse, but there is now general agreement that such use of the dolls is improper.⁴³⁵ Various structured interview approaches have been put forth as methods to determine the truth or falsity of children's statements about alleged sexual abuse, most notably Yuille's statement validity analysis, but there is little research to support the notion that statement validity analysis content analysis can reliably differentiate between true and false allegations.⁴³⁶

C. Battered Person Syndromes

Expert testimony regarding the concepts of battered woman syndrome and battered child syndrome are usually admissible by a person claiming self-defense. However, we have not yet determined whether scientific literature bears out the claim that these syndromes can reliably distinguish between people who have been battered and those who have not. To do so, we must first remember what the central symptoms of battered woman syndrome purportedly are. Then we can look for studies showing that most or all individuals who have been battered show those symptoms, and that those symptoms are not common among individuals who have not been battered.

1. Battered Woman's Syndrome

Use of the concept of the "battered woman syndrome" has been an improvement over traditional approaches to dealing with women claiming self-defense. It has helped overcome sex-bias in the law of self-defense, as the objective standard of the "reasonable person" has been replaced by the more subjective standard of what a reasonable woman with the defendant's history and mental make-up would do. However, adoption of the battered woman syndrome concept brought with it its own set of problems. Critics recognized that battered woman

434. Kerry M. Drach et al., *The Diagnostic Utility of Sexual Behavior Problems in Diagnosing Sexual Abuse in a Forensic Child Abuse Evaluation Clinic*, 25 CHILD ABUSE & NEGLECT 489, 500-01 (2001).

435. Gerald P. Koocher et al., *Psychological Science and the Use of Anatomically Detailed Dolls in Child Sexual Assessments*, 118 PSYCHOL. BULL. 2, 199, 218 (1995).

436. C.L. Ruby & John C. Brigham, *The Usefulness of the Criterion-Based Content and Analysis Technique in Distinguishing Between Truth and Fabricated Allegations*, 3 PSYCHOL., PUB. POL'Y & L. 4, 705, 717-18 (1997).

syndrome perpetuated some of the same stereotypic images of battered women that feminists had fought to overcome.⁴³⁷ The rationale for admission of testimony about battered woman syndrome was a woman's weakness, dependency, and passivity, and the testimony was "presented, interpreted, and heard as victimization."⁴³⁸

The assertion that "learned helplessness" was a common symptom among battered women has been heavily criticized.⁴³⁹ In her original study, Walker compared the responses of women who were still in battering relationships to women who had left a battering relationship. Walker concluded that the results were compatible with learned helplessness theory, but Walker presented no statistical tests of differences between the groups.⁴⁴⁰ Walker did not compare women in battering relationships to women who were not in battering relationships or to women who had left men in non-abusive relationships. A number of researchers have argued that the passive characterization of battered women conveyed through the learned helplessness theory is flawed, and they have presented data in support of their position. One study, which was conducted by means of a questionnaire in a national women's magazine, found that women use a wide range of strategies in their attempts to end violence.⁴⁴¹ Although the notion of learned helplessness applied to a subset of the women surveyed, the vast majority of the women surveyed engaged in a variety of positive responses in an attempt to end abuse.⁴⁴² From interviews conducted with battered women, another study found that women employ a wide range of behaviors that are inconsistent with the concept of learned helplessness.⁴⁴³ One group documented thirty-one common strategies women use to try to end abuse.⁴⁴⁴ Indeed, women frequently attempt to leave battering relationships, although attempts at separation are often very dangerous.⁴⁴⁵ Women who remain in battering relationships may do so because of economic dependence upon the batterer, not because of

437. See Elizabeth M. Schneider, *Describing and Changing: Women's Self-Defense Work and the Problem of Expert Testimony on Battering*, 9 WOMEN'S RTS. L. REP. 195, 220-21 (1986).

438. *Id.* at 200.

439. See, e.g. Paula Finley Mangum, *Reconceptualizing Battered Woman Syndrome Evidence: Prosecution Use of Expert Testimony on Battering*, 19 B.C. THIRD WORLD L.J. 593, 606-07 (1999).

440. WALKER, THE BATTERED WOMAN SYNDROME, *supra* note 281, at xiii.

441. LEE H. BOWKER, ENDING THE VIOLENCE 19-33 (1986).

442. Richard J. Gelles, Ph.D., & Murray A. Straus, Ph.D., INTIMATE VIOLENCE, 156 (1988).

443. R. Emerson Dobash & Russell P. Dobash, *The Nature and Antecedents of Violent Events*, 24 BRIT. J. CRIMINOLOGY 269 (1984).

444. Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 SMU L. REV. 2117, 2136 (1993).

445. Emma Morton et al., *Partner Homicide Suicide Involving Female Homicide Victims: A Population Based Study in North Carolina*, 13 VIOLENCE & VICTIMS 91, 103 (1998).

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learned helplessness.⁴⁴⁶ Women also stay in battering relationships because social services and police agencies provide limited assistance to battered women attempting to end abuse.⁴⁴⁷

The other central tenet of the battered woman's syndrome, the "cycle of violence" concept, has been heavily criticized. Walker's theory suggests that battering relationships often show a cyclical pattern with three main phases: (1) a period of tension building, (2) the acute battering incident or explosion, and (3) a period of loving contrition.⁴⁴⁸ Walker's original study involved interviews with predominately white, middle-class women drawn from Walker's clinical practice or volunteers.⁴⁴⁹ She later did a more extensive interview study of 400 battered women, using a 200-page questionnaire.⁴⁵⁰ Open ended questions were asked as to whether the abuser's behavior prior to the beatings was "irritable, provocative, aggressive, hostile, threatening," and whether the abuser's behavior following the abusive incident was "nice, loving, contrite."⁴⁵¹ The women rated each of these adjectives on a five-point scale. No data were presented regarding the percentage of cases in which all three phases of the cycle occurred. There was evidence of a tension-building phase in about two-thirds of the cases, and there was evidence of loving contrition after the abusive incident in fifty-eight percent of the cases.⁴⁵² Based on this data, Walker concluded there was support for the cycle of violence theory, although close to half the cases did not conform to the three-stage cycle of violence concept.

Numerous commentators have called into question the validity of Walker's conclusions.⁴⁵³ The methodology of the study itself has also been criticized because of its frequent use of leading questions.⁴⁵⁴ Various researchers have studied to what extent the three-stage cycle of

446. WALKER, *THE BATTERED WOMAN*, *supra* note 281, at 127-144.

447. Judith S. Gordon, *Community Services for Abused Women: A Review of Perceived Usefulness and Efficacy*, 11 J. FAM. VIOLENCE 315, 318-28 (1996).

448. See WALKER, *THE BATTERED WOMAN*, *supra* note 281, WALKER, *THE BATTERED WOMAN SYNDROME*, *supra* note 281.

449. WALKER, *THE BATTERED WOMAN*, *supra* note 281, ix-xviii (1979).

450. WALKER, *THE BATTERED WOMAN SYNDROME*, *supra* note 281, 226-27 (1984).

451. 2 DAVID L. FAIGMAN ET AL., *MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY* 43 (2002). For a description of the methodology of the study from Walker's perspective, see WALKER, *THE BATTERED WOMAN SYNDROME*, *supra* note 281, at 225-232.

452. 2 DAVID L. FAIGMAN ET AL., *MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY* 43 (2002).

453. See, e.g., Marilyn McMahon, *Battered Women and Bad Science: The Limited Validity and Utility of the Battered Woman Syndrome*, 6 PSYCHIATRY, PSYCHOL. & L. 23 (1999).

454. David L. Faigman, *The Battered Woman Syndrome and Self-Defense: A Legal and Empirical Dissent*, 73 VA. L. REV. 619, 637 (1986).

violence concept fits the data, and have concluded that a wide variety of patterns exist, with more variability than postulated by Walker.⁴⁵⁵ Mary Ann Dutton, a highly respected domestic violence researcher, has concluded that there is no characteristic cycle of violence.⁴⁵⁶ In her later work, Walker indicated that not all relationships follow the three-stage cycle of violence pattern and that variations in the pattern can be found.⁴⁵⁷

If neither the learned helplessness theory nor the cycle of violence theory is truly diagnostic of battering, then it seems clear that diagnosing battered woman syndrome using these symptoms is not a valid way to determine whether a woman has truly been battered. It is apparent that many women in battering relationships will not show those symptoms, whereas women who have not been battered may show such symptoms. Nonetheless, the American Psychological Association (APA) has endorsed the validity of battered woman syndrome in amicus briefs it has filed in homicide cases by battered women.⁴⁵⁸

The issue of diagnostic accuracy becomes relevant when a court allows an expert to offer an opinion about whether an individual actually suffers from battered woman syndrome (or battered child syndrome), as is allowed in Washington homicide cases where the defendant is claiming self-defense.⁴⁵⁹ Some courts feel that matters of diagnostic accuracy are not germane to the relevancy of the testimony, but only to the weight such testimony should be given. However, even under this argument, the weight given to the testimony should depend upon the extent to which battered woman syndrome has a demonstrated body of unique symptoms, and thus, diagnostic reliability.⁴⁶⁰

It seems clear that if the defense presents expert testimony that battered woman syndrome does have unique symptoms and that the defendant suffers from them, then the prosecution will also be allowed to present expert testimony that battered woman syndrome is not an accurate diagnostic category, and/or that the defendant does not suffer from battered woman syndrome. If a defense expert has examined and

455. "Taken in their entirety, these studies indicate that the cycle does not characterize all battering relationships and that the pattern is not necessarily an invariable cycle with three clear and distinct phases." 2 DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 45 (2002).

456. *See id.*

457. *See id.* (citing Lenore E.A. Walker, *Psychology and Law Symposium: Women and the Law*, 20 PEPP. L. REV. 1170, 1181-85 (1993)).

458. Reported in 9 WOMEN'S RTS. L. REP 245, 253-57 (1986).

459. *See State v. Allery*, 101 Wash. 2d 591, 682 P.2d 312 (1984); *State v. Janes*, 121 Wash. 2d 220, 850 P.2d 495 (1993).

460. *See Regina A. Schuller & Neil Vidmar, Battered Woman Evidence in the Courtroom*, 16 LAW & HUM. BEHAV. 273, 278-79 (1992).

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diagnosed the defendant, then the court will almost certainly allow an expert for the prosecution to examine and diagnose the defendant. If the defendant does not show symptoms of learned helplessness and cycle of violence, the prosecution's expert may testify that she does not suffer from battered woman syndrome, lending support for the contention that she did not fear imminent harm, and thus is guilty of murder. This unseemly "battle of the experts" would likely open up many areas of the defendant's personal history for discussion in court. Furthermore, such conflicting testimony could be prejudicial to the defendant, especially if she were battered and did fear imminent harm, but she did not show symptoms of learned helplessness and the cycle of violence. In other words, the diagnostic inaccuracy of the battered woman syndrome concept could result in the conviction of a woman who truly did fear imminent harm, since prosecution experts could argue that the defendant was not a battered woman because she did not have the symptoms of battered woman syndrome.

If the courts treat battered woman syndrome as a standard to which all battered women must conform, those battered women whose symptoms do not conform to battered woman syndrome will be prejudiced.⁴⁶¹ The less similar the defendant's symptoms are to the prototypical battered woman as described by Walker, the greater the prejudice will be.

These concerns seem to lead to the conclusion that experts should not personally evaluate and diagnose the defendant, or if they do, the experts should restrict their diagnoses to PTSD or other DSM-IV-TR diagnoses that have general acceptance among psychologists and psychiatrists and well-defined, scientifically proven diagnostic criteria. Courts should allow experts to testify only as to what symptoms are common among battered women, without making the additional leap that the defendant has a syndrome that proves she was battered, or proves that she thought she was facing imminent harm. As long as a defense expert has not personally evaluated the defendant, there would be no justification for a prosecution expert to personally examine her, and a prosecution expert would be limited to testifying as to whether the defendant's symptoms were symptoms commonly reported by battered women. Consequently, the diagnosis of battered woman syndrome (or any other diagnosis such as PTSD) could not be unfairly used to the prejudice of either side.

Not all women who have been battered suffer from PTSD. Studies indicate that battered women are at risk for developing PTSD; estimates

461. See Phyllis L. Crocker, *The Meaning of Equality for Battered Women Who Kill Men in Self-Defense*, 8 HARV. WOMEN'S L.J. 121, 144 (1985).

range from 31% to 81%, and most studies show that the severity of the violence experienced is positively related to the presence of PTSD and PTSD symptomatology.⁴⁶² Golding did a meta-analysis, reviewing the literature on the prevalence of mental health problems among women who have been physically abused by an intimate male partner. Among the eleven studies that assessed PTSD, 63.8% of the women showed PTSD. Across the eighteen studies that included measures of depression, 47.6% of the women suffered depression. Among the ten studies that measured assessments of alcohol abuse, 18.5% of the women showed alcohol abuse. Finally, among the thirteen studies that included suicidality, the prevalence was 17.9%.⁴⁶³ Thus, it would be incorrect for an expert to testify that since a given defendant did not suffer from PTSD (or did not suffer from depression, suicidality, or alcohol abuse) she must not have been a battered woman. In other words, no one diagnosis or syndrome is diagnostic of battering.

2. Battered Child Syndrome

The term “battered child syndrome” is confusing, because it has been used in at least two different contexts with very different meanings. A pediatrician coined the phrase in 1962 as a way of describing the injuries very young children receive when they have been physically abused, such as subdural hematomas, fractures of long bones, and multiple soft tissue injuries.⁴⁶⁴ This syndrome is admissible in Washington and in most other jurisdictions when it is introduced by the State through a physician expert witness in an attempt to prove that the child’s injuries were intentional rather than accidental.⁴⁶⁵ This article does not concern itself with this use of the concept of battered child syndrome. This article does concern itself, however, with battered child syndrome evidence, usually introduced by a defense expert to show how learned helplessness and the cycle of violence can cause a child to kill his abuser in circumstances that might otherwise not appear reasonable. In *Janes*,⁴⁶⁶ for example, the Washington Supreme Court acknowledged parallels between women and children who kill their abusers after years of family violence. Some scholars have suggested the use of the term

462. 2 DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 58 (2002).

463. Jacqueline M. Golding, *Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta-Analysis*, 14 J. FAM. VIOLENCE 99 (1999).

464. C. Henry Kempe, M.D. et al., *The Battered Child Syndrome*, 181 JAMA 17, 105 (1962).

465. See *State v. Norlin*, 134 Wash. 2d 570, 585, 951 P.2d 1131, 1138 (1998) (J. Talmadge, concurring, cites favorably to *State v. Mulder*, 22 Wash. App 513, 516–16, 629 P.2d 462, 463–464 (1981)); *State v. Toennis*, 52 Wash. App. 176, 185, 158 P.2d 539, 545 (1988).

466. *Janes*, 121 Wash. 2d 220, 235, 850 P.2d 495, 502 (1993).

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“battered person syndrome”⁴⁶⁷ to encompass both battered woman syndrome and battered child syndrome.⁴⁶⁸

The term “battered child syndrome” has not been widely adopted within the scientific community. The term has most frequently been used by Paul Mones,⁴⁶⁹ a defense attorney, to explain acts of parricide by adolescent boys. Mones’ observations have been gleaned from his experience with parricide cases, and he uses the theory of “self-preservation” to explain parricide.⁴⁷⁰ Scientific information about perpetrators of parricide is fairly limited. Child abuse frequently precedes parricides, but “reliable estimates of the prevalence of child maltreatment in parricides” is not possible because “studies have lumped together mild and severe physical abuse, sexual abuse, verbal abuse, psychological abuse, and in some cases physical and psychological neglect.”⁴⁷¹

A number of scientific studies have examined the prevalence of PTSD, as well as other psychiatric disorders, in abused children. In a study focusing exclusively on physical abuse, physically abused adolescents were compared with matched controls on the PTSD module of the Structured Clinical Interview for Diagnosis.⁴⁷² The authors concluded that PTSD was not evident in higher proportions in the physically abused group.⁴⁷³ In a much larger study comparing physically abused children with non-abused children, a wide range of psychopathology was reported among the abused group.⁴⁷⁴ However, researchers concluded that there is no specific syndrome or diagnosis associated with physical abuse.⁴⁷⁵ In a study of severely maltreated children, 40% of the children evaluated met the criteria for PTSD. Two years later, 33% of these children still retained the diagnosis.⁴⁷⁶ A review of the literature on physical abuse concluded that approximately 8% of physically abused children and adolescents have current

467. Georgia extends the theory to men in *Freeman v. State*, 496 S.E.2d 716, 718 (Ga. 1998).

468. Steven R. Hicks, *Admissibility of Expert Testimony on the Psychology of the Battered Child*, 11 LAW & PSYCHOL. REV. 103, 106 (1987).

469. Paul Mones, *When the Innocent Strike Back: Abused Children Who Kill Their Parents*, 8 J. INTERPERSONAL VIOLENCE 297 (1993).

470. *Id.* at 297–99.

471. Marc Hillbrand et al., *Parricides: Characteristics of Offenders and Victims, Legal Factors, and Treatment Issues*, 4 AGGRESSION & VIOLENT BEHAV. 179, 182 (1998).

472. David Pelcovitz, Ph.D. et al., *Post-Traumatic Stress Disorder in Physically Abused Adolescents*, 33 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 305 (1994).

473. *Id.* at 309.

474. Alan J. Flisher, Ph.D., *Characteristics of Physically Abused Children and Adolescents*, 36 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 123 (1997).

475. *Id.* at 127.

476. Richard Famularo et al., *Persistence of Pediatric Post Traumatic Stress Disorder After Two Years*, 20 CHILD ABUSE & NEGLECT 1245, 1247 (1996).

diagnoses of major depressive disorder, and at least 30% “have lifetime disruptive disorder diagnoses.”⁴⁷⁷ Taken together, these research findings are not supportive of any diagnosis or syndrome as diagnostic of physical abuse among children. Therefore, the term battered child syndrome does not appear to be an accepted scientific term.

VII. BASE RATE CONSIDERATIONS

Even assuming that syndromes or profiles such as rape trauma syndrome, child abuse syndrome, battered woman syndrome, and PTSD could be shown to be scientifically sound, testimony about such syndromes could be inherently misleading due to base rate differences. Melton offers a hypothetical example.⁴⁷⁸ Suppose a syndrome or profile could be devised that was so powerful that it could identify 90% of women who had been raped, 90% of children who had been sexually abused, or 90% of women who had been battered. Assume that 5% of women in the general population have been raped, that 5% of children in the general population have been sexually abused, and that 5% of the women in the general population have been severely battered. If an individual fits the profile, what is the probability that the person has actually been abused? If 1,000 people were examined, the profile would correctly identify 90% of those who had been raped, abused, or battered. Assuming that 50 individuals (5%) have been raped, sexually abused, or battered, the profile would correctly identify 45 individuals (true-positives). However, the profile would also identify 10% of those who had not been raped, sexually abused, or battered as having been raped (false-positives). Out of 950 who had not been raped, sexually abused, or battered, the profile would incorrectly identify 95 (10%) as having been raped (false-positives). The profile would identify a total of 130 individuals (45 true-positives and 95 false-positives) as having been raped, sexually abused, or battered. Only 45 of the individuals identified by the profile (35%) would actually have been raped, sexually abused, or battered. However, upon hearing that an alleged victim met the profile, a judge or jury would probably not realize that, because of the base rates, the probability that the alleged victim had actually been raped, sexually abused, or battered was low.

477. Sandra J. Kaplan et al., *Child and Adolescent Abuse and Neglect Research: A Review of the Past Ten Years*, 38 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1214, 1217 (1999).

478. GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 195 (1997).

VIII. CONCLUSION

The scientific evidence suggests that rape trauma syndrome, the various child abuse syndromes, and battered woman syndrome are terms that were originally coined to help with clinical and therapeutic issues. These terms are still very helpful in clinical contexts to help understand the trauma process; however, they are not useful forensically, as they are not diagnostic of rape, child abuse, or battering. Furthermore, these terms do not have well-defined, scientifically proven symptoms. Therefore, they are not generally accepted among the community of psychologists and psychiatrists, and they are not included in the DSM-IV-TR. Traumatized individuals may show many types of psychological reactions,⁴⁷⁹ including learned helplessness and the cycle of violence, anxiety, depression, substance abuse, accommodation, PTSD, or any combination of these symptoms. Additionally, it is not uncommon for traumatized individuals to show no adverse psychological reactions at all.⁴⁸⁰ All people who suffer a given trauma do not show specific behaviors unique to that trauma.⁴⁸¹

Testimony from an expert describing in general what the common symptoms of traumatization are will be helpful to the trier of fact under ER 702 if scientific studies are cited and opposing counsel is allowed to provide contrary scientific authority before admissibility is determined. However, testimony that certain symptoms are merely “consistent with” trauma (as opposed to “common to” trauma) is meaningless, since almost any post-trauma symptom or behavior *could* occur; therefore, such testimony is of limited probative value and should not be allowed.

Courts that allow mental health professionals to personally evaluate traumatized individuals and to make diagnostic statements about them in front of the trier of fact have reached incorrect conclusions about the scientific acceptability and scientific validity of these concepts. Washington has made the correct decision by excluding rape trauma syndrome and the various child abuse syndromes as profiles that are not generally accepted in the scientific community. However, by ruling that battered woman syndrome and battered child syndrome are accepted diagnostic terms within the scientific community, Washington courts have erred. There is no commonly agreed upon set of symptoms for battered woman syndrome or battered child syndrome. Additionally, there is no set of symptoms that is universal or near-

479. See also DSM-IV-TR, *supra* note 4, at 465. See generally Patricia A. Frazier, *Rape Trauma Syndrome: The Scientific Status of Research on Rape Trauma Syndrome*, in 2 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 117–143 (2002).

480. See *infra*, pp. 506–17.

481. *Id.*

universal and unique or near-unique to battering. Thus, the use of the term “battered syndrome” unfairly prejudices the trier of fact against the alleged batterer, since the term itself unfairly suggests there is a syndrome that is diagnostic of battering. If courts do allow mental health professionals to personally evaluate allegedly traumatized individuals, and to make diagnostic statements about them in front of the trier of fact, the courts should restrict the professionals from testifying about any diagnoses not included in DSM-IV-TR. In certain cases, DSM-IV-TR’s diagnoses of PTSD, acute stress disorder, major depression, generalized anxiety disorder, etc., may be appropriate, as these diagnoses do not presume to be able to determine whether abuse has actually occurred. Furthermore, diagnoses included in the DSM-IV-TR are scientifically derived, well defined, and accepted in the scientific community.

The danger involved in allowing mental health professionals to make any diagnostic statement (including PTSD and other DSM-IV-TR diagnoses) about an alleged victim of abuse in a criminal case is that experts for opposing counsel will almost certainly be allowed to evaluate the individual, and to delve into all aspects of that person’s history, including sexual experiences, prior traumas, mental health treatment records, etc. Such “battles of the experts” can traumatize the alleged victim, erroneously shift the focus of the criminal case to issues that are only peripherally relevant to the charges involved, and undermine shield statutes that nearly all jurisdictions have enacted.

The better approach is *not* to allow mental health experts to personally evaluate the alleged victim of abuse. Courts should only allow general mental health testimony about what symptoms traumatized individuals commonly have after the other side has “opened the door” by claiming that the alleged victim’s post-trauma behavior was inconsistent with the behavior of victimized persons. Courts should not allow testimony about common reactions to trauma unless an expert can point to specific studies in scientific literature demonstrating the validity of those claims. Experts should not be allowed to testify as to what constitutes common reactions to trauma based solely on their own experience, since such impressions cannot be challenged or rebutted by scientific means because they are not objective, systematic, or scientific. Furthermore, mental health professionals may be able to claim in their experience they have seen a number of *alleged* victims, but they will not have been able to systematically compare “true-victims” with “false-victims.” Finally, the *Frye* standard should control in Washington, and unsupported statements about what an expert has commonly seen in his or her practice should *not* be allowed.