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Dr. Welner

Thanks very much. I appreciate the opportunity to speak with you today. Recognizing the manner in which I am speaking, perhaps apologizing for the psychiatric profession, let me point out that we all have a responsibility for upholding standards. As to the relevance of The Forensic Panel[1] to this topic, the only peer-reviewed forensic consultation practice in the United States, it is very much my belief that peer oversight is healthy to the medical profession, and that standardization is key for the behavioral sciences, as it is for the gathering of DNA evidence, or the gathering of forensic science evidence. I don't see, as a forensic psychiatrist, my science as being any less exact than other medical specialties. Those of you who are in the audience who have had the opportunity to encounter forensic psychiatry should have the same demands of rigor.

Before we start out, if people could raise their hands, how many in this room are judges, so I get a sense of your frame of reference? OK. So, we have approximately six judges. Am I to presume that you work in Family Courts, Civil Courts and Criminal Courts? Have I missed any of the Courts?

Audience Member

Supreme Court.

Dr. Welner

Supreme Court? OK. So, you're covering a gamut of cases. Correct? So, how many in this room are psychiatrists and psychologists? OK. How many are attorneys? OK. How many are

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1. THE FORENSIC PANEL, *at* http://www.forensicpanel.com.

students? OK. Of course, we have the two highly regarded interns up there.

So, with that, I want to present to you the experiences that I have had working on a variety of cases of the interface between the antisocial and battered female defendant. It is actually quite appropriate to put the black female defendant on our first slide, someone very well represented in forensic circles, and yet a subpopulation for which research in forensic populations is so lagging, that it leads to diagnostic uncertainties because we are not sophisticated about the psychosocial challenges that are unique to them.

Let's begin with a frame reference for a talk on the overlap of illness and criminality. What distinguishes forensic psychiatry from clinical psychiatry, which the other professionals here and I practice in our offices? Well, if you come into my clinical office with a complaint, I take what you say at face value. There is a presumption of trust. If you come into my office as a litigant, whether I have been consulting with your or opposing counsel, there is a presumption of skepticism. That's not to say that a forensic psychiatrist is disrespectful of a person's concerns, but we must be aware that we are part of the adversarial process, and therefore the pressures of the adversarial process are playing themselves out in our offices. This unique dynamic imposes a burden, an investigative burden. In forensic psychiatry, we never stop asking questions. We truly have an opportunity to take all of this expertise that we've learned from our medical training, from behavioral science training, and we must put on an investigator's cap.

We explore as the evidence dictates and probe avenues unique to the case. Let's consider this example: I'm working on a case now. A park ranger was killed in Hawaii. This happened, of course, on the beach, so you know I'm doing a crime scene visit for that. This is a case, by virtue of the facts, that requires I understand how dogs react to certain types of confrontation. Yes, dogs. There was a gun and dog bit the ranger before he was shot by his assailant. Unusual, peculiar, but you learn, probe, investigate and we have to reconstruct. That's really part of every single forensic exam. You have three requirements: 1) **probing evidence as the evidence dictates,** regardless of whether it is a criminal case, or a family court

case; 2) searching by necessity; and 3) the requirement of truth, and that's what leads us to the questions of diagnosis.

Item two, **searching by necessity,** confronts adversarial concealment. That's not just concealment by opposing counsel. I'm well aware that the attorneys who come and retain me for a case, may be invested in giving me information that **they** feel I should see.

For those of you who are psychiatrists and psychologists who wish to do an ethical, unmanipulated exam, I'd like to share something you may find effective to tell attorneys before they retain you. I recommend you introduce yourself with these points also: "There are a couple of things you need to know before you bring your case here. First of all, I'm not a hired gun, so if you don't have a lot of confidence in your case, then you're probably better off going somewhere else because I don't want us to have any problem when I come back to you and tell you, you have nothing and then I have to worry about the bill." You will save yourself a lot of aggravation. The other thing you have to tell them is: "I need to see everything. And I need the latitude to be able to tell you that I need to talk to somebody without having some long discussion. I'm a busy person. And if I say it matters, I need to follow-up on it, let me go look." So, you have to make that clear with the person who retains you otherwise you are going to get bogged down with things that lengthen your examination and then, of course, you'll run into "I need the report in twelve hours," and you have a list of things to do that you couldn't possibly accomplish. Of course, at times, you will run into a reluctance of cooperation, so you have to learn socially how to work with attorneys as well as people you're examining in order elicit this kind of information and access to sources.

I just testified on a case yesterday involving a collateral witness. The witness was a woman who had been kidnapped, approximately twenty years earlier. Could you imagine going through this, and then you get some strange call from some forensic psychiatrist a thousand miles away that says, "Tell me about the day you got kidnapped and stuffed in a trunk." Of course, she's not going to want to talk about that, especially when her son told her, "Mommy, if that doctor from New York calls, just hang-up the phone on him." Fortunately, I kept her

on the phone for an hour. I got the whole story. But, you've got to train yourself of how to work with witnesses, just as, for example, very good police officers, very good interviewers of assault victims do, so that people will tell them their story. You normally need that from impartial witnesses and from corroborating witnesses too, in case people have an agenda, and they will pollute or contaminate your cases. When I have to get information from jailhouse informants, I really need to get corroborating witnesses as well.

So, that brings us to item three, **the requirement of truth**. Of course, the ramifications are that if you get a diagnosis wrong, it may result in implications for capital sentencing. It may result in an enormous financial penalty to somebody who does not deserve it, or on the contrary, someone who does deserve a penalty who is not penalized. For those of you who are involved in custody cases, your diagnosis of a parent change the course of the child's life. So, one of the things that I want you to come away with today is an appreciation for a constant that we use in medicine called "differential diagnosis."

Differential Diagnosis

I never get a sense that the court appreciates this. When you go to medical school, or you go to psychiatric training, we are weaned onto differential diagnosis. That is, you get a variety of different symptoms, a variety of history, and there are a number of diagnostic possibilities on the table. It's not one of those jokes that psychiatrists can never make a decision. Rather, it speaks to the strength of psychiatry, that we keep an open mind, just as the best judges would do, and say "OK, it's possible that it can be this or it's possible it can be that, let me learn this, and then I will be able to shrink the realm of possibilities, which I should be considering, as a possible diagnosis."

So, when you see in a report something that says "R/O" (Rule Out), it doesn't mean that it exists. It does mean that it is part of a differential diagnosis and should be considered. It doesn't mean that, as we will go on to explore, it can't be resolved and you should therefore demand resolution. One should start with a healthy, broadening diagnosis, and then shrink based on the amount of information that becomes available in

order to have a more crystallized sense of possibilities. Now, of course controversy persists about the standards of diagnosis and whether the DSM-IV TR[2] is adequate for the courts, but we will not resolve that today. Let me just say that DSM (Diagnostic Statistical Manual) is a diagnostic standard manual that at least exists for us as psychiatrists to practice with.

So, if we use and give a diagnosis, it should correspond to our generally accepted standards that the field provides through the DSM. However, standards do not just apply to diagnosis. There are standards for other aspects and facts of psychology. What's a "delusion," for example? You will hear all kinds of terminology thrown around in cases, for example, that someone is "delusional" or "psychotic" and these are, of course, terms of specific definition. Any technological, sophisticated scientific term would be, just as there are precise definitions for diagnosis. So, you should expect accountability for precise use of terminology, not just about the diagnosis, in whether it was present, but if the symptom truly is what it is represented to be.

We operate under a variety of forces which potentially compromise and contaminate the examination. There are the pressures of certain types of cases. Anytime you work within a high-profile case, you experience some of the forces that may be at work. For example, I did work as a consultant on the Matthew Shepard homicide in Wyoming.[3] If they make a play out of a case,[4] that is a clear indication of how much political pressure can be attached, whether it's the Penry case,[5] retardation, or the death penalty in the Supreme Court. That death penalty case[6] certainly had enough pressure on it that only a couple of weeks ago, I was down in Texas testifying before a state legislature. Cases with the death penalty introduce political pressures that can cause bias. An examiner has to be very careful not to get sucked into that in arriving at conclusions.

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2. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR (4th ed., text rev. 2002) [hereinafter DSM-IV-TR].

3. *See* James Brooke, *Beaten Gay Student Dies, Spurring Tears, Outrage*, SEATTLE POST-INTELLIGENCER, Oct. 13, 1998, at A1.

4. Sandra C. Dillard, *Hate Crime Sparks Play: Show Will Open at Denver Venue*, DENV. POST, Nov. 11, 1999, at B1.

5. *See* Penry v. State, 691 S.W.2d 636 (Tex. Crim. App. 1985).

6. *See id.*

There is also the problem of notoriety. I'll always remember the call that I got from the defense attorney for Andrea Yates[7] when he was shopping for an appropriate expert for his psychiatric exam. He said to me, "I got all these calls from people from all over the country, who offered to work on this case for free." He, of course, was trying to impress me when we were discussing the fees. I said, "Well, ok, why don't you hire them?"

There is something about the opportunity to get your face on television that seems to attract people even in a dignified profession such as psychiatry, just as it does in law. You can bet that when a case is going to be on television or in the newspapers, some expert witnesses will succumb to the pressures to present an opinion that is scientifically without merit—the power of fifteen minutes of fame.

Then, of course, there is the notion of sanctioned dishonesty. People are out and out paid or have other pressures in order to come up with an opinion. More commonly, we've heard of this problem in custody and visitation cases. A painful example of this in a criminal case of recent memory is the Vincent Gigante case.[8] Not only was the head of the Genovese crime family examined by a number of people who overlooked certain kinds of standards that would of otherwise been used, but these people went on to appear on *60 Minutes* and portray Vincent Gigante as the political prisoner of our time. These experts were people who have taught generations of forensic psychiatrists. That's why they were trotted out for *60 Minutes*. Of course, you might say, "well, **you** try saying no to Vincent Gigante," and that's a very good point.

Independent of mob cases, there are cases where financial pressures can cause someone to overlook the embellishments of the man walking around Greenwich Village in a bathrobe.[9] "Professional malingering" is something you don't often hear discussed.

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7. Lisa Teachey et al., *A Somber Reunion / Family Visits Yates in Jail / Woman Held in Drowning of 5 Kids Gets Attorney*, HOUS. CHRON., June 23, 2001, at A1.

8. United States v Gigante, 166 F.3d 75 (2d Cir. 1999).

9. Larry McShane, *Curtain Comes Down on the 'Oddfather': For 30 years, Mob Boss Vincent Gigante Feigned Dementia to Avoid Prison Now Authorities Say They Have Evidence Proving His Sanity*, L.A. TIMES, Mar. 23, 2003, at A18.

Malingering means faking. Detecting a faking examinee is one thing, but it's professional malingering when an expert fakes the condition. That really creates a problem.

In principle, I really believe that both sides should have an opportunity to review the notes of my examination. That shouldn't be a problem. I don't write the report in my head. I sit down and write a twenty-page report. That's because I've done interviewing, and I've done a variety of different things. If opposing counsel retains a psychiatrist, he ought to have an opportunity to review my work. If you judges out there have an opportunity to navigate the way things are done in your court, then you should demand that notes be made available to both sides because forensic assessment should really be about honesty. We also learn from each other as psychiatrists. We have an opportunity to see someone else's work and, at face value, determine why he may have come to a different impression and why his ideas bear serious consideration.

There's also a question of missing raw data. When psychological tests are administered and conclusions are offered, it's not mumbo jumbo. These are standardized psychological tests, standardized because of the way in which they should be administered. They produce raw data that can and should be interpreted. Sometimes this raw data is held back with the testing psychologist declaring, "I can only release this to psychologists who are qualified." Well, ok, go get a qualified psychologist and let's go see the raw data.

Without scrutiny, this is the kind of outrageous chicanery that goes on. I'll give you one example that comes to mind. A death penalty case that I was working on in New Jersey, where the defendant was given a test called the PAI (Personality Assessment Inventory),[10] which is a validated test for forensic use of assessing personality. The rape-murder defendant was assessed through this test as someone who has no anti-social features. However, if you review his history, he had been arrested 8,000 times and never went to work or school for more than weeks at a time. With these and more anti-social features, he certainly meets the criteria. What gives? How on earth did this

10. LESLEY C. MOREY, PERSONALITY ASSESSMENT INVENTORY—PROFESSIONAL MANUAL (1991).

person not show up with anti-social features on a test like the PAI? There's just no way of knowing. So what happens? After what seems to have been a tooth extraction of opposing counsel's witness, I finally get access to this raw data and come to find out that the tester didn't administer the section that dealt with the anti-social personality! Now that's how you get a test to only show what you want it to—without anyone knowing! The scheme worked. What a country. But this kind of thing goes on. Without the raw data, you'd never know that this scheme ever existed. If you simply don't administer the selected part, then the person, of course, is going to show up with an incorrect diagnosis. Both sides have to have the opportunity for oversight of this kind of professional malingering.

Another possibility for inaccuracy is when there are unavailable informants. People may have a lot to offer, but for one reason or another, they can't be "accessed." That is as contrived as manipulated psychological testing.

There is also always the possibility of overreliance on the examiner's self-report. Forensic testing really has to take into consideration the possibility of malingering, the possibility of exaggeration, and the possibility of under-reporting. There are only a few psychological tests that control whether the examinee has responded and participated in the exam in an honest manner. When the tests simply reflect self-reports and the subject is a litigant, he may have an interest in dramatizing his symptoms. How is the self-interest to be verified in the Beck inventory[11]—a test administered in common psychiatric practice? In clinical settings, there is a presumption of trust. A Beck inventory is done all the time.

But again, a Beck inventory is a litigant's best friend in a forensic context because it is a self-report instrument and can be manipulated to overembellish. Sure, I'm extremely upset! Sure, I never sleep a day! Sure, I haven't eaten in six weeks! (Of course, you're going to score in the high 30's).[12] Psychological testing imposes a challenge to forensic examiners, who must be aware of the possibility of malingering in a number of tests. A few, though not many, have been standardized in this regard.

11. *See* AARON T. BECK & R.A. STEER, MANUAL FOR REVISED BECK DEPRESSION INVENTORY (Psychological Corp. ed., 1988).

12. *See id.*

Let's look at what isn't said in the reports that you read and the testimony you use. There are symptoms that are not necessarily considered for other possibilities. When one questions the presence of voices, some mock psychology in saying, "oh, just say you hear voices." There has been a lot of research about how to take history about hallucinations.[13] You hear it in the left ear? You hear it in the right ear? What do you do to make it go away? When does it get worse? When does it get better? What do the voices tell you to do? How do you cope with and respond to these commands? So, there's a whole series of questions that should be asked about hallucinations. Now, does that absolutely enable one to tell whether a complaint of hallucinations is legitimate? Not completely. However, what I am saying is that you, attorneys, judges, behavioral science colleagues and students who are coming up, should have that thirst for additional information. That's the way it should be. It's a lot more than just "voices." Or is it really "voices?" That's the kind of quality of information that you deserve in your cases. Assumptions are some of the things in The Forensic Panel that we look for in each other's reports. We make sure certain words are taken out. If anyone writes, "seems" the report doesn't go out the door. If you don't know, you don't know. If you can't get more history, don't write about it. So, when you see something in a report, for instance the word "seems," it's basically another word for saying the examiner didn't get enough information. So, you can't make assumptions because it isn't an inexact science. It's only inexact when you don't have enough history. If you don't have enough history, then you have to say you don't have enough. That's what I mean when I encourage you to consider what's missing from a report.

Then, one must consider if there are questions missing from the interview. On one case that I'm working on now for a defense attorney, I offered some questions to his investigator about a murder defendant. Actually, this is a case up in Westchester County, and the investigator was only given those questions that the defense attorney knows are going yield answers that are not necessarily incriminating and will not reflect poorly on his client. So, this kind of thing happens. OK, the question

13. Philip J. Resnick, *Malingered Psychosis*, *in* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION 47 (Richard Roger ed., 2d ed. 1997).

gets asked. Some questions get asked. So, you have a complete set of notes, but there are areas that are avoided in the interview, which clearly would be of diagnostic significance. Or, things that are missing in the report, that are in notes.

I remember another case, out in Nebraska, of a gentleman who killed his wife, and would have killed his family if he had not gotten too tired from killing his wife. He was exhausted, so the kids survived. We tried to untangle the motive of this person, who was a professional man, who went to church every Sunday, and then all of a sudden he destroys his family. Well, it turns out that for over twenty years he lived a double life as a homosexual. Somehow this didn't end up in the defense report. How did that happen? Have we fought tooth and nail just to get a hold of the examiner's notes that are incomplete? The notes from the psychiatric interview contain information that somehow, magically did not appear in the examination notes.

What I like to do when I get the notes is actually speak to the examiner because another little trick is writing notes that are so illegible, that even if someone gets the notes, you never know what was actually discussed. This is not hair splitting. These are little games that go on, and what they do is effect the integrity of the case, and that reflects poorly on psychiatry. Justice is one thing, but when proof does get compromised, it makes our whole profession look bad. When there is a Vincent Gigante case, America laughs at all of us, whether we're working on the case or not. So, I think it is a matter of a professional and personal responsibility.

With that, let's talk about post-traumatic stress disorder (PTS). We'll do it a little bit later regarding whether or not there is any post-traumatic stress disorder present when people go into an examination. While there may be a whole range of diagnosis, PTS may not be present, but the person might be quite ill and there may be some other peculiar conditions. What is in the differential? And then, of course, what happens if you presume someone is malingering—a little too soon?

I had one fantastic case, involving a disability insurance claim, where the claimant was malingering, but the claimant was just as sick. He just happened to be histrionic, theatrical and over-played his sickness. But, he was sick and he was malingering. So, sometimes, in the zeal to get at the idea of faking

it, the whole "Ah Ha!" eclipses recognition that malingering is but a shroud that covers something else. Does it cover criminality, a dark secret, or merely other illness? So as examiners, we have to determine why it is that a person is malingering and what is beneath the shroud.

Diagnostic Tricks

First of all, I would like to encourage you that whenever you see anything NOS, to feel that you haven't gotten your money's worth. NOS means not otherwise specified. In my professional opinion it is a code word for saying, "I haven't had enough information to complete my examination," or "I haven't had enough time to complete my examination," or "I don't want to tell you what I really think because it would be damaging." So, in the DSM-IV-TR I can parse words, but when it says, "not otherwise specified," it basically connotes that an examinee's presentation has some of the criteria, but not all of them. My best representation to you is that, whenever I see it, I see it in the best case scenario, as **incomplete**. It represents an **incomplete conclusion**. In the worst case scenario, it represents a scam of an examiner parsing words. If you feel you're stuck with a "NOS," go back and get more information. Because something's out there, and if you feel that it meets the criteria of several conditions, name those with a differential rather than say I will not specify.

And of course, during the process, some diagnoses mitigate and some diagnoses aggravate. A person is likely to be more sympathetic if there is a medical contributor, if the diagnosis is causing him to be viewed as an accessory to some sort of a problem, rather than a prime mover, to perhaps be vulnerable to provocation, to have acted out of character. Of course, there are other diagnoses that aggravate—of perversion, the diagnoses that are associated with criminality. You call someone a psychopath in a forensic examination, and that's really like putting the mark of Cain on his or her forehead. And yet, at the same time, the caution with which psychiatry approaches psychopathy is unfortunate. I find that even people who might have interest in doing so are reserved because they recognize how damning a diagnosis it is. So, they will hop around the subject and the court doesn't realize what it is actually dealing with,

but uses words like "an impulsive character with anti-social features."

Then, on the other hand, a diagnosis can be given for the purpose of damning. Calling someone a sociopath when the criteria haven't fully been fulfilled aggravates the perception of the person because it reflects a certain criminology.

With that said, battered woman syndrome may be missed because of the presence of antisocial symptoms that many battered women have. So, you apply what you have already learned here today. As long as we are precise, probe as the evidence dictates, search by necessity, and establish the truth of the matter by diligent interviewing, we can tease overlapping sympathetic and unsympathetic syndromes apart.

There are specific criteria that are native to battered women syndrome, such as the isolation and emotional dependence.[14] There are the dynamics between the batterer and the victim, for example, the long-term power differentials. It doesn't matter if an incident of abuse has just happened. The victim idealizes the aggressor and denies the danger. Not every battered woman walks into your examination room, or into your courtroom, with dark circles under her eyes from having been battered around the face. She may not have been struck for about six months or about four months. But, clearly, the victim does have the emotional trauma symptoms, and a variety of anxiety or depressive symptoms may be present. Certain psychosexual dysfunction, and substance abuse, is common to battered women.[15]

In battered woman relationships, the batterer has specific qualities. With proper probing and investigation, the dynamics of the relationship, the impact on the victim, as well as the temperament and quality of the batterer, can be properly elicited. There are, however, some problems that contribute to some fuzziness in the diagnosis. When we are conducting these types of examinations, it can sometimes be difficult to distinguish what is a bad relationship from a relationship that is in fact

14. Mary Ann Douglas, *The Battered Woman's Syndrome*, *in* DOMESTIC VIOLENCE ON TRIAL: PSYCHOLOGICAL AND LEGAL DIMENSIONS OF FAMILY VIOLENCE 39-54 (Daniel Jay Sonkin ed., 2d ed. 1987).

15. Walter J. Gleason, *Mental Disorders in Battered Women: An Empirical Study*, 8 VIOLENCE AND VICTIMS 53 (1993).

abusive. What is the cracked eggshell of dependence? Someone who comes into a relationship exceptionally dependent to begin with ultimately becomes that much more controlled. What we envision from battered women syndrome is a very controlling individual who subjugates a non-dominant partner. What happens when a dynamic assumes itself, even before any abuse takes place? Teasing out past abuse and a subjective sense of emotional abuse is essential.

Emotional abuse is a part of the battered women syndrome.[16] But, what is the accuracy of the perception of a person who is emotionally abused? Then, there is a financial and material dependence that obviously is very common in marriages and other significant relationships. When does that become a dependence on the pathological order of battered women syndrome?

The displacement of powerlessness is always possible. Somebody who encounters abuse in another sphere of her life may find it more appropriate to displace the perception of abuse within the relationship, especially if it's a divorce action or a family court action.

While the criteria are more specific for battered women syndrome, the psychological testing for it and the results are not. So, it is a history-driven diagnosis. One of the problems with battered women syndrome is that in some of the research on these populations there has shown to be a high prevalence of anti-social behavior.[17] So, now what do you do? You're dealing with, in certain instances, a victim who may be quite the character. You'll note that in order to earn a diagnosis of anti-social personality, you have to have a long history of a variety of different problematic behaviors. The plot thickens as the anti-social personality is made up of the history of past conduct disorder plus continued problems.

16. Donald G. Dutton & Susan Painter, *The Battered Woman Syndrome: Effects of Severity and Intermittency of Abuse*, 63 AM. J. ORTHOPSYCHIATRY 614 (1993).

17. Amber O. Rollstin & Jeffery M. Kern, *Correlates of Battered Women's Psychological Distress: Severity of Abuse and Duration of the Postabuse Period*, 82 PSYCHOL. REP. 387 (1998).

Psychopathy is anti-social personality plus personal features of manipulative, egocentricity, and parasitism.[18] That was the history of Eileen Wuornos.[19] She was not just a serial killer, but diagnostically and biographically, a psychopath. A lot had been written about her. She was certainly such a compelling individual in her presentation that she had a number of people feeling that she had never even committed these murders, even right up until the time when she abandoned her death row fight. She admitted, however, that she killed her victims, even challenging that she was perfectly sane in accepting her death sentence.[20]

Male and female psychopaths have slightly different presentations. Female sociopathy is not rare, although it may be more readily concealed in women than it is in men. In women, antisocial personality is often accompanied by significant psychiatric disorders, such as depression and post-traumatic stress disorder.[21] Therefore, the prevailing ideas that people who have antisocial personality disorder, do not otherwise have anything wrong with them, or anything that can be addressed in treatment, is in fact a myth.

Another myth is based on what inferences can be drawn from married couples. Is it impossible for married people to be antisocial? No. Women with an antisocial history are often married, or have been married. You hear of cases where there are children being killed, and you may presume that because the woman is married there is no possibility that antisocial behavior enters the equation. However, that is not necessarily the case, particularly if the baby is not killed as a newborn or within the first day of being born.

I want to also give you an understanding generally of why personality disorder is significant in a legal sense. Taking away criteria for a moment, which you already know you need to fo-

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18. *See* ROBERT D. HARE, THE HARE PSYCHOPATHY CHECKLIST—REVISED (2d ed. 2003).

19. *See* Wournos v. State, 644 So.2d 1012 (Fla. 1994).

20. Jeff Brazil, *Aileen Wuornos' Confession: 'Highway Hooker' Recounts 7 Killings—Wuornos Talks Freely of Victims in Just-Released Confession Video*, ORLANDO SENTINEL, Dec. 12, 1991, at A1.

21. Michael Welner, Who's Battering? Sorting Out Aggression in the Female Defendant, The Law, Family and Violence: A Multidisciplinary Symposium, at Duquesne University School of Law (Nov. 9, 2002).

cus on, sometimes there is overlap in dramatic and erratic personality types: borderline, narcissistic, anti-social and to some degree dependent. How do we resolve the significance of personality disorders?

Consider the event that you are dealing with and a trigger for what caused the event to happen. These personality disorders are associated with hot buttons, or what prompts someone to do something which brings them to the attention of the court. For someone who is anti-social, it's exploitative and opportunistic:[22] the opportunity to get money, the opportunity to get property, to take advantage. OK, so that's a trigger point.

For the borderline, it's separation and attachment. It's the idea of abandonment.[23] It's so disabling, that it turns the presentable Glenn Close, into the borderline personality disordered woman in *Fatal Attraction*.[24]

For the narcissist, it's a person whose been dismissed, disrespected, or demeaned.[25] That person feels the need to counterattack in a violent way, in a controlling way, in a dominating way and in an explosive way. There is overlap between borderline and anti-social personality disorder. There is co-existence of antisocial personality disorder with post-traumatic stress disorder. So, focus on the trigger points of the event in question, then you can sort out what's diagnostically relevant.

Finally, I'd like to alert you to disorders that don't get diagnosed as often because they are not as easy to find, to pick up. Dissociative disorders,[26] when they occur, develop in those who have been particularly traumatized in the past. Because the traumas can be so unspeakable, the symptoms may be peculiar ways of coping which do not come to the attention of the examiner.

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22. DSM-IV-TR, *supra* note 2.

23. *Id.*

24. (Paramount Pictures 1987).

25. DSM-IV-TR, *supra* note 2.

26. Alfonso Martinez-Taboas & Guillermo Bernal, *Dissociation, Psychopathology, and Abusive Experiences in a Nonclinical Latino University Student Group*, 6 CULTURAL DIVERSITY & ETHNIC MINORITY PSYCHOL. 32 (2000).

The person with a dissociative history has a history of being tortured.[27] If you don't see a tortuous history, then you should have some suspicion about a dissociative disorder. Finally, the man of the day, Jason Blair.[28] Of course because the New York Times is in the process of doing an investigation, he has been labeled as having bipolar disorder.[29] But, you know something, when the snow has finally fallen and we have our twelve inches of snow, they'll be calling him a psychopath. I don't want to sound presumptuous, but there's certainly been a lot written about a person who does not manifest the symptoms of bipolar disorder, yet has the capacity to lie so brazenly that he could convince you, as he is peeing down your back, that it is indeed raining. It is not just lying, but the quality of lying and the capacity to create enormous chaos. I mean, this is the *New York Times* for God's sake. The capacity to create enormous chaos is the kind of institutional destruction of what psychopaths could do.

There is also the example of Mark Whitacre, who is the Archer-Daniels Midland executive later implicated in a scheme in which he wore a wire in meetings with executive colleagues. They thought he was the greatest thing since sliced bread and his company ended up with billions of dollars in fines for a lysine price-fixing scam in which he entangled the very company the promoted his meteoric rise through the executive ranks. Thanks for nothing. He too called himself a bipolar.[30]

The key take home points are that: a) there are a number of conditions that overlap and/or masquerade; b) diagnoses that reflect well or poorly may co-exist simultaneously; and c) assessing for malingering can only be done by thorough inquiry, but is only part of what an examination requires—for every examinee has a real story whether it is attached to a diagnosis or not.

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27. Dorothy Otnow Lewis et al., *Objective Documentation of Child Abuse and Dissociation in 12 Murderers with Dissociative Identity Disorder*, 154 AM. J. PSYCHIATRY 1703, 1703-04 (1997).

28. Keith J. Kelly & Todd Venezia, *Blair Says 'Sorry' As His Ex-Bosses Fall*, N.Y. POST, June 6, 2003, at 4.

29. Conor O'Clery, *All the News That's Not Fit to Print Brings Down Top Editors at the 'New York Times'*, IRISH TIMES, June 7, 2003, at 11.

30. William R. Wineke, *A Chilling Tale of Corporate Greed the ADM Price-Fixing Scandal Makes for an Eye-Opening Read*, WIS. ST. J., July 8, 2001, at F3.

Thank you very much for your attention and interest. I'll answer your questions at the panel discussion, or by email if you prefer.