Lies, Personality Disorders and Expert Evidence: New Developments in the Law

Farrell v The Queen (1998) 155 ALR 652 per Gaudron, McHugh, Kirby, Hayne and Callinan JJ

Ian Freckelton
Barrister-at-Law, Victoria, NSW, Qld, SA, Tas, NT and ACT; Department of Law and Legal Studies, La Trobe University; Medical Faculty, Monash University; Member, Mental Health Review Board of Victoria

Terese Henning
Law Faculty, University of Tasmania

The High Court decision in *Farrell v The Queen*[1] has determined that psychiatric and psychological evidence is admissible about the effect of mental conditions outside the realm of ordinary experience upon witness reliability. The practical effect of the decision is to give a fillip in sexual assault trials in particular to the defence tactic of calling expert evidence to suggest that because a complainant suffers from a personality disorder she or he may not be worthy of a jury's trust. The authors argue that while the decision is not surprising from a legal point of view, it may have many important repercussions for the conduct of sexual assault trials — to the detriment of complainants.

In general, expert evidence about a witness' credibility is not admissible. This is so whether the evidence sought to be adduced is to suggest that a witness is likely to be telling the truth, or whether the evidence is to impugn the likely truth-telling of a witness. The rule against "oath-helping" evidence is responsible for the first and the common knowledge rule[2] for the second. Underlying both rules is the notion that the assessment of credibility is archetypally the function of the trier of fact, be it judge or jury. However, there is an exception which in Australia had been little tested until the important decision of the High Court in *Farrell v The Queen*[3]. In England it had been enunciated by the House of Lords as follows: "when a witness through physical (in which I include mental) disease or abnormality is not capable of giving a true or reliable account to the jury, it must surely be allowable for medical evidence to reveal this

Correspondence to: Dr I Freckelton, c/o Barristers' Clerk Howells, Owen Dixon Chambers, 205 William St, Melbourne VIC 3000, Australia. Email: I.Freckelton@latrobe.edu.au

vital hidden fact to them."[4] However, the decision in *Farrell* prizes open a good deal further the door to expert evidence about the credibility of witnesses. It does so in the context of persons with personality and substance abuse disorders, which are psychiatric diagnoses, not within the traditional rubric of the designation of "mental illness". This casenote explores the far-reaching ramifications of the High Court's decision and highlights what it is likely to mean for complainants in sexual assault prosecutions who have either borderline or histrionic personality disorders.

The Facts

The appellant in *Farrell v The Queen* was an Anglican priest convicted at trial of rape, aggravated sexual assault and assault in Hobart, Tasmania. According to him, he attended a hotel for some time and came upon the complainant who had been drinking heavily and had fallen over on the footpath outside the hotel. He took him to his house in a car, looked after him for a time and then drove him to a point near the complainant's house, leaving him there still very drunk. The complainant, by contrast, said that he was bound, sexually assaulted and beaten by two men. He said that he was eventually taken from the house where he was attacked, with a pillowcase over his head and his hands tied behind his back. He swore that he managed to attract the attention of his brother at his house who cut the necktie that bound his hands. The complainant reported the assault promptly to police and was medically examined. Genetic testing discovered semen in his anal cavity but it was unable either to implicate or exonerate the appellant.

Some weeks before the incident, the appellant had complained to police of having been assaulted in his own home by two men whom he had met at the same hotel. In photographs of his house, a tie very similar to that with which the complainant claimed to have been bound on the second occasion could be seen.

The complainant, a man of 34 at the time of the incident, had a troubled history, including having been admitted to hospital more than once for alcohol and benzodiazepine abuse. It was suggested that he had tried to commit suicide on more than one occasion. According to hospital records, he had previously been diagnosed as having a borderline personality disorder or an anti-social personality disorder.

The appellant was convicted at trial of one count of assault, one count of aggravated sexual assault and four counts of rape, being found not guilty on a number of other counts. Four of the verdicts of guilty were by majority. He appealed against conviction to the Tasmanian Court of Criminal Appeal, did not succeed, and then appealed to the High Court. There were three appeal points before the High Court: (1) that the trial judge erred in admitting into evidence the photograph of the necktie, (2) that the verdicts were unreasonable, having regard to a careful examination of the evidence, and (3) that the trial judge's rulings and directions on the expert evidence from a Tasmanian psychiatrist, Dr Sale, occasioned a mistrial. The first two appeal points failed but the final one succeeded by a majority decision.

The Expert Evidence at Trial

Evidence was called on behalf of the appellant at his trial about the reliability of the complainant. The trial judge permitted a substantial amount of the psychiatric evidence to be admitted, but ruled inadmissible evidence that the complainant may have manifested a factitious disorder. Dr Sale, the psychiatrist called on behalf of the appellant, was permitted to testify that the complainant was suffering from a mental disorder which he described as "alcohol dependence and polysubstance abuse", as well as a "personality disorder".[5] He had not examined the appellant but based his views on hospital and medical records relating to the appellant. Dr Sale described a personality disorder as "perhaps more like a disability than an illness ... where an individual has a characteristic way of behaving, of responding to situations, of doing things that is mal-adaptive and causes distress or dysfunction either to themselves and/or others."[6] He made reference to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM") and said that in his view the complainant suffered from anti-social personality disorder and probably from borderline personality disorder within the compass of the DSM definition. Dr Sale said that a person with a borderline personality disorder "characteristically

has stormy relationships and stormy moods — and they are usually impulsive and they are frequently suicidal or threaten suicide".[7] Similarly, he said that a person with an anti-social personality disorder "is a person who habitually deviates from cultural norms regarding social behaviour such that they frequently have an extensive criminal record, they frequently have a poor occupational record, they tend to exploit or to con others, they are often regarded as deceitful."[8] He said that a borderline personality disorder would not have any effect upon memory or reporting but that an anti-social personality disorder, while not actually affecting the structure of a person's memory "may have an impact on what they report." The most important aspect of his evidence was that he expressed the opinion to the jury that persons suffering from an anti-social personality disorder "are inherently less truthful than the average person."[9]

Dr Sale also testified that the ingestion of large amounts of benzodiazepines could affect memory and that "a very common side effect of benzodiazepine use and abuse would be periods of amnesia during the time when the levels are at the peak levels in the person's body."[10] He made reference to the propensity of benzodiazepine addicts to lie to their doctors in order to obtain supplies on prescription. He also opined that persons with a history of alcohol abuse could also have impaired memories.

With respect to the excluded evidence of the factitious disorder, Dr Sale explained on the voire dire to decide the admissibility of his evidence that persons manifesting the disorder present at hospitals with false and exaggerated complaints of illness, that the apparent purpose of these complaints is attention-seeking and not financial or some other external gain. He also described the most extreme form of factitious disorder, Munchausen syndrome, which, he explained applied "to individuals who present repeatedly to hospitals usually gaining admission, [whose] complaints are often of a dramatic nature, [and who] often present as apparent emergencies. ... They often tell unnecessarily elaborate stories about why they are there, more than is needed to gain admission. ... They often use aliases to gain admission to hospital because after a while they become recognised at various hospitals. "[11] Once in hospital their behaviour does not conform to that of a normal patient, "in that they don't seem to be seeking to alleviate their complaints and their behaviour is often disruptive and demanding."[12] It was his opinion that although the complainant did not exhibit a full Munchausen disorder because he had not made use of aliases, his other behaviour brought him close to it. He pointed particularly to the complainant's repeated hospitalisations which were precipitated by dramatic, almost theatrical complaints with repetitive themes of self-injury and sexual victimisation. This evidence had been rejected by the trial judge, a rejection maintained by the Tasmanian Court of Criminal Appeal on three grounds: first, Dr Sale had been unable to express any firm opinion that the complainant actually suffered from factitious disorder; second, in any event, the disorder was not shown to be one which deprived him of the capacity to recollect or to recount the truth; and third, the complainant's tendency to lie and his bizarre past behaviour had been amply exposed to the jury through cross-examination of the complainant and the production of his medical records.[13]

The trial judge directed the jury to scrutinise the complainant's evidence with extra care because there was "a real risk that his evidence might be unreliable and [they] must be careful to take into account that risk, extra in his case, over and above ordinary witnesses, when ... considering his evidence."[14] However, in charging the jury, the trial judge stressed that the jury should be careful in assessing the complainant's reliability, but not because of the evidence of Dr Sale:

> juries only need evidence from psychiatrists when they have got information and opinions about people's mental health that ordinary folk like you and I would not be able to form, that's when we need psychiatric help, and Dr Sale didn't have any of those opinions about this man. He knew what we all know, that he's alcoholic ... and that he's addicted to these prescription drugs ..., he's got a turbulent history ..., he's had hallucinations and we all know that if someone with that sort of background tells you something happened you need to scrutinise it with extra care.[15]

He returned to the same theme later in his charge, telling the jurors that sometimes ordinary human experience is not sufficient to understand the evidence and that it was in such circumstances that expert evidence, such as medical testimony, becomes relevant. However, he then

commented: "that is why Dr Sale's opinion really does not count for anything because he did not get to the stage of diagnosing an actual medical condition which would be on [sic beyond] your experience and mine"[16]

The appellant's main argument before the High Court was that the trial judge's direction effectively removed Dr Sale's evidence from the jury and that in doing so the trial judge wrongly denied to the appellant the benefit of the weight which Dr Sale's diagnosis of the complainant and opinions about his credibility gave to the appellant's contention that the complainant should not be believed

The High Court Decision as to the Expert Evidence

The High Court by a majority of three to two (Gaudron, Kirby and Callinan JJ) held that the appellant had been wrongly deprived of the chance of an acquittal that was fairly open to him because the case against him depended on the jury's acceptance of the complainant's evidence. McHugh and Hayne JJ in dissent held that, in spite of the flaws in what the trial judge said to the jury about the psychiatrist's evidence, his direction did not disadvantage the appellant because the trial judge's warning brought the dangers of acting on the complainant's evidence home to the jury authoritatively and vividly. This meant that he was not deprived of a fair chance of acquittal. Justices Kirby and Callinan were also of the view that the expert evidence of established psychiatric conditions should have been allowed in full and that such evidence had been erroneously rejected. Justices Gaudron, Hayne and McHugh, however, rejected this ground of appeal, but, unfortunately, did not address it in their reasons for judgment.

The most important aspect of the decision from the point of view of its ongoing significance as precedent resides in the law as enunciated by the majority of the High Court in relation to the admissibility of expert evidence about witnesses' credibility. The Court unanimously held that expert evidence as to a condition which may affect a witness' ability to give reliable evidence is admissible, provided that the expert evidence extends beyond the experience of ordinary persons. Justice Kirby held that while expert evidence on the ultimate credibility of a witness is not admissible, expert evidence on psychological and physical conditions which may lead to certain behaviour relevant to credibility, is admissible. However, this is only so if (a) the evidence is given by an expert within an established field of knowledge relevant to the witness' expertise; (b) the testimony goes beyond the ordinary experience of the trier of fact; and (c) the trier of fact, if a jury, is provided with a firm warning that the expert cannot determine matters of credibility and that such matters are the ultimate obligation of the jury to determine.[17]

Justice Kirby's judgment on the subject is the most substantial. He found that the trial judge had been right to approach with caution any attempt to adduce evidence which could have the effect of usurping the role of the jury in assessing the complainant's credibility. He confirmed this function to be preeminently that of the jury, and held that the function could not be assumed by expert witnesses "offering their opinion on the accuracy, consistency and believability" of a witness' testimony.[18] However, he acknowledged the study of human behaviour, including psychology, to be "an accepted scientific discipline" and confirmed it to be appropriate for expert evidence to be admitted "where established patterns of human behaviour have been studied, analysed and scientifically described." As an example of such information, His Honour cited battered woman's syndrome. He held that such evidence was admissible, not to usurp the role of the fact-finder, and noted that principle and a recognition of the imperfections of science deny such a consequence, apparently referring to the existence of exceptions to such patterns as can be discerned by social science research about matters such as credibility.

Justice Kirby held that in the case before the Court "it would have been quite wrong to cast a person such as the complainant into a limbo of unbelievable witnesses simply because, in the past, he had manifested psychological conditions which are often, or sometimes, associated with mendacity."[19] However, he held that if a psychiatrist could provide evidence that the complainant was manifesting symptoms of an established psychological condition, it would be wrong to deprive jurors of evidence about what such a condition entailed: "Such testimony goes beyond the ordinary experience of the trier of fact. It is not mere analysis of statistical probability. It is

not tendered to suggest that a witness, capable of telling the truth, would choose not to do so. It does not involve an invitation to the decision-maker to abandon its duty itself to determine the credibility of the witness. It is rather the provision by an expert witness of an opinion resting upon established research within that expert's scientific discipline."[20]

Justice Callinan reached the same ultimate conclusion as Kirby J. He held that the trial judge should have permitted the psychiatrist to give evidence of the possible existence of a disability or disorder which told upon the complainant's capacity to give reliable evidence, that had he done so he would then have been obliged to inform the jury of the way in which they could use the evidence. He rejected the argument that because Dr Sale was unable to depose to the actual existence of a disorder, his evidence could not be led to establish its possible existence. He noted a statement by Brennan J in *Bromley v The Queen*[21] that "if the nature, severity and significance of [a complainant's] mental disorder is deposed to by persons qualified to do so, that may bring home to the jury more vividly and more authoritatively than a judicial warning on the danger of acting upon the witness' evidence without corroboration." However, he found it to have limited application as precedent, in part because it was made in the context of disposing of an application for special leave to appeal to the High Court. He found assistance in the decision of the Canadian Supreme Court in *R v Marquard*[22] where McLachlin J (with whom Iacobucci and Major JJ agreed) acknowledged that there were circumstances in which expert evidence in relation to a witness' credibility is appropriate – in particular, where the evidence is about psychological and physical factors which may lead to certain behaviour relevant to credibility, and where it goes beyond the ordinary experience of the trier of fact. Justice Callinan found that the trial judge's direction was based upon an erroneous rejection of evidence and was factually wrong because Dr Sale had, in fact, given evidence of the consequences of actual disorders or disabilities arising from drug and alcohol abuse and personality disorders. This evidence was relevant to the capacity to give reliable evidence and should have resulted in the trial judge appropriately summing up its relevance to the jury. Here, though, he found that the trial judge had wrongly negated its impact by the way in which he had portrayed it to the jury.

Justice Gaudron found that Dr Sale's evidence fell somewhat short of evidence of the complainant's impaired capacity to give accurate evidence. Rather, she found that it simply raised the possibility of his being impaired on account of alcohol and substance abuse, and it "raised the probability of greater unreliability of the complainant's evidence on account of his anti-social personality disorder than in the case of persons who do not suffer from that disorder."[23] She found no reason to exclude expert evidence, although it does not disclose an impaired capacity in a witness, if it discloses the existence of a disability the likely consequences of which bear on the reliability of the witness' evidence and extend beyond the experience of ordinary persons. She distinguished between Dr Sale's evidence about the possible effects of alcohol and substance abuse, which she found not to be beyond the experience of ordinary persons, and his evidence about the complainant's personality disorder — a distinct disability, one feature of which was that persons with that disability 'are inherently less truthful than the average person'. That is not, in my view, a matter within the experience of ordinary persons and, thus, Dr Sale's evidence was, to that extent, relevant and admissible."[24]

Ramifications of the Decision

The decision of the High Court in *Farrell* is consistent with a number of decisions in England and Australia which have permitted expert opinion evidence from mental health professionals about witnesses' credibility when such witnesses are said to be suffering from a mental condition that affects their capacity to tell the truth or to recount a version of events with accuracy or reliability. However, Justices Gaudron and Kirby have not limited the admission of this evidence to cases where the mental condition affects witnesses' *capacity* to give reliable evidence. They permit evidence of mental disability to be given wherever it impacts upon the reliability of a witness's testimony provided that that disability and its consequences are outside the experience of ordinary people. Justice Gaudron stated:

> In the present case, the evidence of Dr Sale fell somewhat short of evidence of the complainant's impaired capacity to give accurate evidence. It simply raised the possibility of his being impaired in that way on account of alcohol and substance abuse. It also raised the possibility of greater unreliability of the complainant's evidence on account of his anti-social personality disorder than in the case of persons who do not suffer from that disorder. In principle, however, there is no reason why expert evidence should be excluded, although it does not disclose a witness's impaired capacity, if, nevertheless, it discloses the existence of a disability the likely consequences of which bear upon the reliability of that witness's evidence and extend beyond the experience of ordinary humans.[25]

Her Honour jettisoned a more cautious approach which focused on witnesses' capacity to give reliable evidence, partly in reliance upon a statement of Lord Pearce in *R v Toohey*[26] that "medical evidence is admissible to show that a witness suffers from some disease or defect or abnormality of mind that affects the reliability of his evidence." Interestingly, elsewhere in this judgment His Lordship had based the admissiblity of this evidence on its relevance to the witness's capacity to give a true and reliable account.

Justice Kirby's view is contained in his statement, quoted above, that expert evidence on psychological and physical conditions which may lead to certain behaviour relevant to credibility is admissible provided that it meets the three criteria of a.) being given by an expert from an established field of knowledge within the witness's expertise; b.) being beyond the ordinary experience of the trier of fact; and c.) being subject to an appropriate warning concerning the fact finder's obligations.

Justice Hayne did not express any view on this matter. However, he clearly accepted the relevance and admissibility of Dr Sale's evidence about the complainant's psychiatric condition and acknowledged that the trial judge's direction on the point was inadequate, albeit not sufficiently inadequate to warrant the appeal being upheld. This could be interpreted in one of two ways: either he considered the psychiatric conditions suffered by the complainant to be likely to affect his capacity to give reliable evidence, or he did not assess the admissibility of evidence about them according to their effect upon people's capacity for veracity.

Usually a more restrictive approach has been adopted which has tended to confine expert evidence about credibility to conditions affecting witnesses' capacity for truthfulness or reliability.[27] The approach of Kirby and Gaudron JJ is more than semantically different from this position. Clearly where a witness's capacity for reliability is affected by a mental or physical condition, the possibility for individual control is either lacking or reduced. For example, the witness may not be able to distinguish reality from fantasy or their mind may produce a distorted or uncomprehending view of the world. Schizophrenic disorders and advanced Alzheimer's disease appear to fit descriptors such as these. In contrast, if a mental condition affects sufferers' reliability without necessarily bearing upon their capacity for reliability, questions of individual control become more complex. The point is, however, that in this situation, while the witnesses' reliability may be affected, their ability to be reliable may not. A variety of personality disorders and the factitious disorders described by Dr Sale may produce this result.

The more conservative formulation promulgated in cases like *Bromley*[28] was favoured by Callinan J. His Honour stated that he would have agreed with statements of the Supreme Court of Canada in *R v Marquard*[29] that expert evidence on "human conduct and the psychological and physical factors which may lead to certain behaviour relevant to credibility is admissible..."[30] had they been limited to the possible existence of a disorder or disability affecting the capacity of a witness to give reliable evidence. Later in his judgment Callinan J stated: "...the trial judge ... should have permitted the psychiatrist to give the evidence ... of the possible existence of a disability or disorder as it bore upon the the complainant's capacity to give reliable evidence."[31] However, Callinan J. then adopted an expansive view of the kind of disorders that may affect a person's capacity to give reliable evidence. While he did not identify with precision (that is, by name) the identity of such disorders, he did indicate that the excluded evidence relating to factitious disorder and Munchausen syndrome should have been admitted. He also clearly accepted the admissibility of evidence concerning the potential effect of

personality disorders. In *Farrell*, then, 'capacity' has either been read out of consideration or read so broadly as to provide no real barrier to admissibility. The path is now swept clearer and the door opened wider to the admission of psychiatric evidence on the issue of credibility than a closer adherence to the traditional approach would have permitted.

The virtue of the more restrictive, traditional approach is that, by limiting the scope of expert evidence relevant to credibility, it reduces the risk that criminal trials will become "trial by psychiatrists".[32] Justices Kirby and Gaudron attempt to counter this risk by stressing the twin criteria for admissibility: that the evidence fall within an established field of knowledge relevant to the witness's expertise and that that knowledge fall outside the ordinary experience of the trier of fact. The strength of the broader approach is that it maximises the availability of relevant evidence to the trier of fact. This is of particular significance in those cases where the verdict depends upon an assessment of witnesses' veracity. This is the case in the vast majority of sexual offences trials. Justice Kirby has also attempted to maintain the assessment of credibility within the exclusive province of the jury by imposing the requirement that trial judges firmly warn juries that the expert "cannot determine matters of credibility and that such matters are the ultimate obligation of the jury to determine."[33] It is questionable, however, whether such a direction is likely to be effective. Since the evidence is considered to be necessary to provide the jury with "a more vivid and authoritative"[34] account than can be achieved by a judicial warning alone, and given that the deficiency of the trial judge's direction resided in its cancellation of that heightened authority, how can it be reasonable for a jury to reject that evidence? The level of significance and authority accorded the expert evidence renders any instruction that it might be ignored or rejected difficult to understand and implement. This in turn raises the possibility that the jury's evaluation of witnesses' credibility may be too heavily influenced by the expert opinion.

The majority's decision in *Farrell* appears to have been flagged by the English Court of Criminal Appeal decision in *Ward*[35]. In that case it was held that:

> ...the expert evidence of a psychiatrist or psychologist may properly be admitted if it is to the effect that a defendant is suffering from a condition not properly described as mental illness, but from a personality disorder so severe as properly to be categorised as mental disorder. ... In our view such evidence is admissible on the issue whether what a defendant has said in a confession was reliable and therefore likely to have been true.[36]

This decision is notably different from that in *Farrell* in one respect, however. It confines the admission of evidence of personality disorders to those that are of such severity as to properly be categorised as mental disorders. The majority in *Farrell* did not impose this limitation. In fact, in *Farrell* the issue of severity and gradations of severity in mental disorders were not an operative concern. As much as anything this is evident from the array of terminology employed in the judgments. Justice Gaudron spoke of "mental disorder"[37] and "disability".[38] Justice Kirby consistently used the term, "psychological condition"[39] while Justice Hayne spoke of "mental disability', "mental disorders" and "psychiatric condition"[40]. Justice Callinan used the terms, "disorder" and "disability" interchangeably.[41] This would be a trivial matter were it not for the fact *Farrell* has created a degree of uncertainty about which disorders, disabilities, conditions or whatever will enable the reception of expert evidence about credibility. Particular statements in the judgment of Kirby J demonstrate the problem. His Honour stressed that it would be wrong to cast any person "into a limbo of unbelievable witnesses simply because, in the past, he had manifested psychological conditions which are often, or sometimes, associated with mendacity."[42] He, nevertheless, concluded that if expert evidence established that the witness manifested symptoms of "an established psychological condition"[43], it would be wrong to deprive the trier of fact of evidence of the implications of that condition. This begs the question: how can the first statement realistically have any operative effect in view of the second? If it is wrong to deprive the trier of fact of this type of evidence in the circumstances stated, when will a witness who suffers from a psychological condition recognized as affecting veracity, ever not be cast "into a limbo of unbelievable witnesses"? Clearly Kirby J countenanced the existence of some

psychological conditions associated with mendacity which may not entail the admission of expert evidence for the benefit of the jury. However, we have no hints as to their identification.

Where the mental impairment is an organic brain injury or where a person suffers a schizophrenic disorder, the reasons for the trier of fact needing expert guidance are clear enough. However, the situation is considerably murkier where the disorder concerned is a substance abuse disorder or a personality disorder. The admissibility of expert evidence about a witness' credibility when the witness is a substance abuser remains unclear in the wake of *Farrell*. Justices Gaudron[44] and Callinan[45] found that the possibility of impaired memory due to alcohol and drug abuse is within the experience of ordinary persons, so expert evidence on the subject is not admissible. Justice Hayne, with whom Justice McHugh agreed, did not distinguish between the personality and substance abuse disorders suffered by the complainant.[46] Nor did Justice Kirby[47]. This leaves the admissibility of expert evidence about the deleterious impact of significant substance abuse upon a witnesses' reliability unsatisfactorily unclear. It is not unusual for a key witness in a prosecution to be alcoholic or to have a history of substantial use of opiates, amphetamines or benzodiazepines. However, the impact of that dependency upon witnesses' memories and cognition varies dramatically between those whose mental state is relatively unaffected to those whose cognitive faculties have been profoundly damaged. Expert evidence on the subject has the potential to enable informed evaluation of the reliance that can be placed upon such witnesses' evidence. The decision of the High Court is likely to facilitate the admissibility of such evidence, although the status of such mental health opinions still is uncertain.

Personality disorders have come over the past decade to exercise the minds of Australia's courts and tribunals to an increasing extent. In Victoria, the most extensive decision of that state's Mental Health Review Board affirmed the preponderance of psychiatric opinion on the subject – that a distinction should be drawn between mental illness and personality disorders.[48] That was later enshrined in Victoria's *Mental Health Act* 1986[49]. The distinction also exists in legislation in a number of other jurisdictions. Generally, persons with personality disorders are sentenced as though they were ordinary members of the community[50], although in *Harland-White v The Queen*, the Victorian Court of Appeal held that at its extreme end an anti-social personality disorder may be equated for sentencing purposes to a mental illness. Persons with an anti-social personality disorder and also a borderline personality disorder figure in a significant percentage of cases involving sexual and non-sexual violence — both as complainants and as accused persons. A key issue in such cases is their reliability as witnesses.[51]

A number of different terms are used in relation to the best-known of the personality disorders — anti-social personality disorder, which is the term employed by the American Psychiatric Association's 4th edition of the Diagnostic and Statistical Manual of Mental Disorders, dissocial personality disorder, the term used by the World Health Association's 10th edition of the International Classification of Mental and Behavioural Disorders, psychopathy, and sociopathy, the latter two of which are the more traditional descriptors of the disorder.[52] They share most diagnostic features in common[53]

A propensity to lie is a diagnostic indicator for anti-social personality disorder and has been described as one of its core components[54]. The tendency of the psychopath/sociopath/person with an anti-social personality disorder to mislead and to manipulate has been described repeatedly by researchers[55], Hare for instance arguing that such persons have a poor integration of the factual and emotional components of their speech, words not having the same emotional colouring as they do for ordinary members of the community: "for the psychopath, lying is just a matter of moving words around".[56] This is a subcategory of the relative absence of empathy toward others experienced by the psychopath. Doren has gone as far as to warn mental health professionals about the extent to which psychopaths may engage in mendacity:

> [T]herapists need to expect (1) their psychopathic clients to lie, (2) that the lies will usually be simple but may be incredibly intricate, (3) that you as therapists will not be able most of the time to demonstrate that your clients are lying, (4) that you do not need to trust your clients for them to trust you or for you to perform successful therapy, and (5) that your clients' lying simply represents a

> symptom of his psychopathology and not a sign of your incompetence.[57]

Importantly, though, depending on the exact criteria employed for diagnosing anti-social personality disorder or psychopathy, the incidence of the disorder within the general population is not minor — 3% in males and 1% in females according to DSM-IV[58] — and has been suggested to be much higher amongst sentenced prisoners.[59]

Similarly, lying or inaccurate provision of information is characteristic of persons with a borderline personality disorder. Ford summarises key characteristics of the disorder as follows:

> The behavior of the borderline person is often characterized by impulsive behavior, including self-destructive acts. There may be problems with alcohol, drugs, shopping sprees, or promiscuity[60]. Moods are intense and may change abruptly. Relationships are tenuous, with the other person initially idealized and later devalued. Envy and overtly jealous behavior are frequently seen, and these people may construct elaborate fantasies of a wish-fulfilling nature that they communicate to others as fact. Other common fabrications are about how they have suffered or been abused in the past. For example, the lie of one woman with borderline personality disorder included the story that she had been captured and tortured.[61] Lies or misrepresentations concerning sexual abuse and rape may also occur.[62] There is an undercurrent of pervasive anger interrupted only be periodic eruptions of rage.[63]

However, while instability and impulsiveness are integral to the disorder, lying and manipulation do not figure amongst the disorder's DSM indicators.[64] The incidence of borderline personality disorder is substantial within the general population.[65] In particular, its diagnosis is dramatically represented amongst persons who have been sexually assaulted when young[66]. Stone et al in 1987 documented histories of childhood incest in 36% and 41% of recently hospitalised female patients diagnosed with borderline personality disorder in New York and Brisbane respectively. Herman and Van der Kolk have attributed the higher incidence of the disorder in females to the incidence of sexual assault upon girls and argued that the early experiences of violence occurring within a developing child's system of attachments may produce both psychological and psychophysiological disorders.[67]

The decision of the High Court in *Farrell* will result in a common defence tactic to adduce psychiatric or psychological evidence about the unreliability of evidence given by persons with anti-social personality disorder or borderline personality disorder. Further, the decisions of Kirby and Callinan JJ have paved the way for evidence of factitious disorders to be adduced. This development is of particular concern in sexual assault prosecutions where complainants already have a particularly difficult passage through the criminal justice system, often being treated as though they, and not the accused, are the person on trial.[68] The potential for expert evidence that reviews available mental health and general medical records of a witness will focus attention upon the protection provided in Victoria and New South Wales upon the access that can be gained by defence lawyers to counselling records[69]. It will add fuel to the calls for such records to be immune from subpoenas in sexual assault trials. Counselling records are already being trawled, in those jurisdictions where they are not immune from subpoena, for material to use in attacks upon complainants' credibility.[70] These records may document complainants' drug and alcohol use, their mental health history and any problems in their past.[71] The decision in *Farrell* is likely to make them even more attractive to defence counsel. Apart from issues relating to the confidential nature of such records, there are also questions concerning their reliability. The point has been made that medical and counselling records are not made as part of the criminal investigation process. [72] Patients and counselling clients do not normally see them, review them or check their accuracy. In cases like *Farrell*, expert psychiatric evidence will almost inevitably be based upon medical or counselling records made by others. The psychiatrist will not usually have had the benefit of examining the complainant personally. Complainants are, of course, under no obligation to make themselves available to defence experts for that purpose. This means that the expert's opinion of the complainant's mental health is, of necessity, based upon hearsay material. In *Farrell* the records upon which the psychiatrist based his opinion covered a period of 13 years and included diagnoses made and opinions expressed

by nurses, doctors and welfare offices. None of the people who had made the original diagnoses or recorded the other items in the files were called to testify. The accuracy of their perceptions and of what they recorded could not, therefore, be tested in any depth during the trial. This deficiency may be critical in cases where the defence seeks to adduce evidence of diagnoses like Munchausen syndrome or factitious disorder. Such diagnoses depend on assessments of whether a person is lying, attention-seeking, exaggerating for effect, dramatising and being disruptive and demanding. As Wright J noted in the Court of Criminal Appeal, if the material upon which such a diagnosis is made is equivocal or if the alleged sufferer's statements cannot be shown to be false, then the foundation for the diagnosis is gone.[73] In such situations, if the original diagnostician does not testify, while cross-examination may alert the jury to more obvious defiencies in the foundational material and expert testimony as well as to the second-hand nature of the expert's diagnosis, the probability of hidden flaws in the original diagnoses being discovered or revealed to the trier of fact is remote. For this reason the Canadian Supreme Court has mandated trial judges to caution juries that the weight attributable to expert opinions which are factually based on a "melange of admissible and inadmissible evidence ... is directly related to the amount and quality of admissible evidence on which it relies."[74] Such a caution would be equally appropriate in cases like *Farrell* where the factual basis of the expert's opinion consists of admissible evidence but where the accuracy and reliability of that evidence cannot be fully tested or scutinised for the benefit of the jury. While the High Court was not called upon to consider this issue in *Farrell*, concerns about the foundation of the expert's opinion clearly exercised the minds of the trial judge and Wright J in the Court of Criminal Appeal and influenced their decisions to exclude much of the expert evidence that the defence attempted to adduce.

The view expressed by the psychiatrist in *Farrell* was that the complainant suffered from an anti-social personality disorder and probably from a borderline personality disorder, although all the diagnostic criteria for the latter were not met. His crucial evidence, namely that persons suffering from anti-social personality disorder are "inherently less truthful than the average person", appears generally to be consistent with the preponderance of recent psychiatric writing on the subject and also with the criteria for diagnosis of an anti-social personality disorder under DSM-IV. Notably, though, a person can be diagnosed with the disorder, without satisfying the "deceitfulness" indicator for the disorder so long as sufficient other criteria are met. In other words, deceitfulness is not a prerequisite for the diagnosis.

The psychiatrist's evidence, as given in *Farrell*, was supportive of the appellant's case by being suggestive that the complainant's assertions may not be reliable. It came invested with the authority of emanating from an experienced mental health expert. Similar evidence could frequently be adduced to detract from the credibility of persons who have been sexually assaulted where the criteria for a histrionic personality disorder[75], a factitious disorder or a borderline personality disorder are satisfied.[76] All these disorders manifest in ways which bear upon their sufferers' truthfulness. The principal result of the decision in *Farrell* will be the more frequent calling of expert mental health witnesses to warn of the hazards of accepting uncritically the assertions of persons with a range of psychiatric disorders. How far does this possibility extend? For example, is the same tactic open to the Crown to challenge the credibility of an accused who gives evidence? It is likely that courts would adopt a restrictive approach to such evidence. In addition, where an accused is concerned, there is a variety of protective rules and devices that defence counsel and trial judges can deploy to exclude such evidence. Principally, the so-called propensity evidence or similar fact evidence rules, where they still exist, would operate to control such evidence. Alternatively, trial judges might excercise their discretion to exclude the evidence on the basis that its probative weight is outweighed by its prejudicial effect for the accused. Could the decision of the High Court in *Farrell* operate in reverse; that is, could it provide a basis for admitting psychiatric evidence to rehabilitate or support the credibility of a witness? In a number of Australian jurisdictions, the Crown has attempted to lead evidence supportive of the credibility of child complainants in sexual assault cases in the form of expert testimony concerning the child sexual

abuse accommodation syndrome.[77] In no reported case to date has this evidence ultimately been permitted. The courts have relied upon a number of grounds to reject it but a common thread running through all the cases has been the determination that this syndrome does not yet constitute an established body of knowledge or area of expertise outside to ordinary experience of the trier of fact. The decision in *Farrell* offers little to help overcome this obstacle. The preconditions it sets down for the admission of expert evidence on the issue of credibility maintain the centrality of the requirements that the evidence relate to an established field of knowledge and that it extend beyond the ordinary experience of the trier of fact. Justice Kirby's statement that "where established patterns of human behaviour have been studied, analysed and scientifically described, it is appropriate that evidence about them should be available to the decision-maker"[78] may offer a meagre glimmer of hope that the tide of rejection may yet turn. Nevertheless, this still requires that those who seek to adduce evidence of the child sexual abuse accommodation sydrome establish that it relates to an established pattern of human behaviour in the terms described. Accordingly, it is the authors' view that *Farrell* will impact on future cases primarily by increasing the opportunity for defendants to adduce expert testimony to undermine the credibility of complainants diagnosed as suffering a psychiatric condition associated with mendacity.

Endnotes

1 (1998) 155 ALR 652.
2 See I Freckelton, "The Common Knowledge Rule" in I Freckelton and H Selby (ed), *Expert Evidence*, 5 vol looseleaf service, LBC Information Services, Sydney, 1993–.
3 (1998) 155 ALR 652.
4 *R v Toohey* [1965] AC 595 at 608.
5 *Farrell v The Queen* (1998) 155 ALR 652 at 664.
6 Ibid at 664.
7 Ibid at 666.
8 Ibid at 666.
9 Ibid at 666
10 Ibid at 665.
11 Ibid at 673.
12 Ibid at 673.
13 *Farrell v The Queen*, unreported, Tasmanian Court of Criminal Appeal, 7 June 1996, per Cox CJ at 14–15; per Wright J at 1.
14 (1998) 155 ALR 652 at 656.
15 Ibid at 666–7.
16 Ibid at 667.
17 Ibid at 661–2.
18 Ibid at 660.
19 Ibid at 661.
20 Ibid at 661.
21 (1986) 161 CLR 315 at 325; 67 ALR 12 at 17.
22 (1993) 85 CCC (3d) 193 at 228–9.
23 *Farrell v The Queen* (1998) 153 ALR 652 at 655.
24 Ibid at 656.
25 (1998) 155 ALR 652 at 655
26 *R v Toohey* [1965] AC 595 at 608
27 *Bromley v The Queen* [1986] 161 CLR 314; *Murphy v The Queen* [1988–1989] 167 CLR 94; *MacKenney* (1981) 76 Cr App R 271 at 276 (Court of Appeal, England); *R v Taylor* (1986) 31 CCC (3d)1 at 6.
28 *Bromley v The Queen* [1986] 161 CLR 314.
29 *R v Marquard* (1993) 85 CCC (3d) 193 at 228–229.
30 I (1998) 155 ALR 652 at 678–679.
31 Ibid at 679.
32 *R v Turner* [1975] 1 QB 834 at 842. This concern has been alluded to in a number of cases: *R v Toohey* [1965] AC 595 at 608; *R v Ward* [1993] 2 All ER 577 at 640; *R v Marquard* (1993) 85 CCC (3d) 193 at 228–229; *Runjanjic & Kontinnen v The Queen* (1991) 53 A Crim R 362 at 369.
33 *R v Farrell* (1998) 153 ALR 652 at 661–2.
34 Ibid at 662.
35 *R v Ward* [1993] 2 All ER 577.
36 Ibid at 641.
37 (1998) 155 ALR 652 at 655.
38 Ibid at 655 & 656.
39 Ibid at 661.
40 Ibid at 668 & 669.
41 Ibid at 678, 679 & 682.
42 Ibid at 661.
43 Ibid.
44 Ibid at 656.
45 Ibid at 677.
46 See in particular 669.
47 See, for instance, at 661–2.
48 *In the Appeal of GW* (1990) 1 MHRBD (Vic) 147.
49 See also *Mental Health Act* 1990 (NSW), s11; *Mental Health Act* 1996 (WA), s4(2).

50 See, for instance, *Burchielli v The Queen*, unreported, Victorian Court of Criminal Appeal, 10 June 1977; *R v Steels* (1987) 24 A Crim R 201 at 204; *Hatherley v The Queen*, unreported, Victorian Court of Criminal Appeal, 6 May 1986.

51 It should be noted, though, that under DSM-IV there are 10 different personality disorders. Histrionic personality disorder also figures from time to time as a forensically significant mental disorder.

52 For a recent analysis of the descriptors and the terms, see I Freckelton, "Psychopathy and the Law" in Proceedings of the Dangerousness Conference, Institute of Public Affairs, Melbourne (in press, 1998).

53 The DSM-IV diagnostic criteria for antisocial personality disorder are: "A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by 3 (or more) of the following: (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest; (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure; (3) impulsivity or failure to plan ahead; (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults; (5) reckless disregard for safety of self or others; (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations; (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another. B. The individual is at least age 18 years. C. There is evidence of Conduct Disorder with onset before age 15 years. D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode." (emphasis added)

54 R Rogers, KL Dion and E Lynett, "Diagnostic Validity of Antisocial Disorder: a Prototypical Analysis" (1992) 16 *Law and Human Behavior* 677.

55 See especially R Hare, *Without Conscience: the Disturbing World of the Psychopaths Among Us*, Pocket Books, New York, 1993.

56 See RD Hare, AE Forth and SD Hart, "The Psychopath as Prototype for Pathological Lying and Deception" in JC Yuille, *Credibility Assessment*, Kluwer, Dordrecht, 1989 at p. 34. Hare, *Without Conscience*, op cit supra, colourfully sums up his analysis: "lying, deceiving, and manipulation are natural talents for psychopaths. ... Given their glibness and the facility with which they lie, it is not surprising that psychopaths successfully cheat, bilk, defraud, con, and manipulate people and have not the slightest compunction about doing so.": pp. 40–49.

57 DM Doren, *Understanding and Treating the Psyhopath*, Jason Aronson Inc, Northvale, New Jersey, 1996, at p. 207.

58 At p. 648.

59 See, for instance, B Harry, "Criminals' Explanation of their Criminal Behavior I: The Contribution of Criminologic Variables" (1992) 37 *Journal of Forensic Science* 1327; B Harry, "Criminals' Explanation of their Criminal Behavior II: a Possible Role for Psychopathy" (1992) 37 *Journal of Forensic Science* 1334.

60 See DSM-IV.

61 CV Ford, "The Munchausen Syndrome: a Report of Four New Cases and a Review of psychodynamic Considerations" (1973) 4 *Psychiatr Med* 31.

62 MD Feldman, CV Ford and T Stone, "Deceiving Others, Deceiving Oneself: Three Cases of Factitious Rape" (1994) 87 *South Med J* 736.

63 CV Ford, *Lies! Lies!! Lies!!! The Psychology of Deceit*, American Psychiatric Press, Washington DC, 1996 at p. 118.

64 Under DSM-IV (at p. 654) the diagnostic criteria for the disorder are: "A. A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by 5 (or more) of the following: (1) frantic efforts to avoid real or imagined abandonment. Note: do not include suicidal or self-mutilating behavior covered in Criterion 5; (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; (3) identity disturbance markedly and persistently unstable self-image or sense of self; (4) impulsivity in at least 2 areas that are potentially self-damaging (eg spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in criterion 5; (5) recurrent suicidal behavior, gestures or threats, or self-mutilating behavior; (6) affective instability due to a marked reactivity of mood (eg intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days); (7) chronic feelings of emptiness; (8) inappropriate, intense anger or difficulty controlling anger (eg frequent displays of temper, constant anger, recurrent physical fights); (9) transient, stress related paranoid ideation or severe dissociative symptoms."

65 2% in the general population; 10% in patients seen in outpatient mental health facilities; and 20% among psychiatric inpatients according to DSM IV at p. 652. Kernberg estimated that 11 to 15% of the general population exhibit the symptoms of broderline personality disorder, with 10 to 25% of these actually manifesting the disorder: O Kernberg, "The Structural Diagnosis of Borderline Personality Organization" in P Hartocollis, *Borderline Personality Disorders: The Concept, the Syndrome, the Patient*, International Universities Press, New Yourk, 1977, at p. 118.

66 See, for instance, DG Dutton, The Batterer: A Psychological Profile, Basic Books, New York, 1995, at p. 140ff. See SN Ogata, KR Silk, S Goodrick, N Lohr, D Westen and E Hill, "Childhood and Sexual Abuse in Adult Patients with Borderline Personality Disorder" (1989) 147(8) American Journal of Psychiatry 1008; MC Zanarini, JG Gunderson, MF Marino, EO Schwartz and FR Frankenburg, "Childhood Experience of Borderline Patients" (1989) 30 *Comprehensive Psychiatry* 18; B Van der Kolk, "The Complexity of Adaptation to Trauma" in B Van der Kolk, AC McFarlane and L Weisaeth, *Traumatic Stress: the Effects of Overwhelming Experience on Mind, Body and Society*, Guilford Press, New York, 1996.

67 J Herman and B Van der Kolk, "Traumatic Antecedents of Borderline Personality Disorder" in B Van der Kolk (ed), *Psychological Trauma, American Psychiatric Press*, Washington DC, 1987; see also J Herman, D Russell and K Trocki, "Long-Term Effects of Incestuous Abuse in Childhood" (1986) 143 *American Journal of Psychiatry* 1293; J Herman, *Trauma and Recovery*, Pandora, London, 1994, at p. 125–6.

68 See generally P Easteal, *Balancing the Scales: Rape, Law Reform and Australian Culture*, Federation Press, Sydney, 1998.

69 See s.126H of the *Evidence Act* 1995 (NSW) and *the Evidence (Confidential Communications) Bill* 1998 (Vic); A Cossins, "Tipping the Scales in Her Favour: The Need to Protect Counselling Records in Sexual Assault Trials" and I Freckelton, "Sexual Offence Prosecutions: a Barrister's Perspective" in P Easteal (ed), op cit supra, at pp. 94–106, and pp. 156–7.

70 A Cossins "Tipping the Scales in Her Favour: The Need To Protect Counselling Records in Sexual Assault Trials" In P Easteal (ed), *Balancing the Scales: Rape Law Reform and the Australian Culture*, Federation Press, Sydney, 1998.

71 Ibid.

72 Ibid.

73 *Farrell v The Queen*, unreported, Tasmanian Court of Criminal Appeal, 7 June 1996, at per Wright J at 1.

74 *Lavallee v The Queen* (1990) 55 CCC (3d) 97 at 131.

75 See CV Ford, *Lies! Lies!! Lies!!! The Psychology of Deceit*, American Psychiatric Association, Washington DC, 1996, pp. 110–116. The DSM-IV criteria for the disorder are: "A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by 5 or more of the following: (1) is uncomfortable in situations in which he or she is not the center of attention; (2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior; (3) displays rapidly shifting and shallow expression of emotions; (4) consistently uses physical appearance to draw attention to self; (5) has a style of speech that is excessively impressionistic or lacking in detail; (6) shows self-dramatization, theatricality, and exaggerated expression of emotion; (7) is suggestible, ie easily influenced by others or circumstances; (8) considers relationships to be more intimate than they actually are." (at p. 657–8) Note also Narcissistic Personality Disorder at p.661.

76 However, under DSM-IV at p. 654 the diagnostic criteria for Borderline Personality Disorder do not specifically incorporate a propensity to lie criterion or indicium.

77 *C v R* (1993) 70 A Crim R 378; *Ingles v R*, Unreported, Tasmanian Court of Criminal Appeal, 4 May 1993; *R v J* (1994) 75 A Crim R 522; *F v R* (1995) 83 A Crim R 502 and see I Freckelton "Child Sexual Abuse Accommodation Syndrome: The Travails of Counterintuitive Evidence in Australia and New Zealand" (1997) 15 *Behavioral Sciences and the Law*, 247.

78 (1998) 155 ALR 652 at 661.