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Pisa, 6 January 2009

Technical opinion from a psychiatrist on the case against Mr. Carlo Parlanti  
Case #2002026651 Ventura County Superior Court, State of California (USA)

**Foreword**

Having examined the main trial documents and proceedings of this case, I have found several elements of interest: both in the manner in which allegations were produced by the Accuser and in the actual content of the Accuser's statements: These elements, in my opinion, raise a reasonable doubt as to the truthfulness of the events reported.

I do not simply and generically doubt that the alleged events are false or unlikely; rather, the reasonable doubt raised by an examination of the documentation suggests a behaviour pattern occurring in individuals affected by specific psychic disorders, conditions especially well-known to psychiatric experts acting as forensic consultants.

The aim of this "technical opinion" is to bring to the attention of the Court the possibility that the Accuser may have been affected by a mental disorder at the time of her statements alleging the abuse and during the following period, a condition that may jeopardize the truthfulness of her allegations.

1. Abnormalities and inconsistencies in the Accuser's behaviour

In this specific case, the objectively abnormal aspects in the submission of the allegations are, in my opinion, the following:

- a) the delay with which the Accuser recalls the event (2 weeks later); the further delay (2005, during preliminary investigations) with which, after allegations have been submitted, she attempts to prove the existence of bodily injuries dating from the events themselves.
- b) The fact that injuries to sexual organs - the main focus of the allegations - were not reported in such a way as to require an inspection during the first medical examination by Dr. Manchester (according to the anamnesis, the event was described as an attempt to penetrate the vagina with a hand, as far as possible); the injury is recorded in that examination as "*painful, but improving*" and is not included in the final diagnosis. Ms. White wrote to Dr. Manchester, before her interview with the Authorities (22 July 2004), mentioning dental injuries (that do not appear on her medical file) and stressing once again the genital trauma, describing the various consequences of the injury, and stating that she had at the time given him an exact description of the abuse and the injuries suffered (*the full act*). From the documentation, however, this does not appear to be the case.
- c) The fact that the severe injuries (presumed concussion with loss of brain fluid and presumed perineal-pelvic trauma, which not only did not improve but got worse) were never investigated, and therefore no objective documentation of them exists.

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- d) The numerous contradictory or inconsistent statements by the Accuser, explained away by claiming to suffer from amnesia, or confused memory, or temporal disorientation (for example, as to the exact date of the abuse). At the same time, however, she spontaneously reports all details of the abuse and violent acts and the time of day at which they occurred.
- e) Despite the fact that the Accuser had already in the past alleged being the victim of abuse and violence, on this occasion she justifies the delay before denouncing the events by claiming that she did not trust the Authorities (despite the fact that she had already phoned several people to tell them that she had been the victim of abuse). According to her own account, even once she was free to do so, she did not immediately ask for help or ask to be taken to the hospital.
- f) Her apparent disorganization, after being subjected to abuse, stands in stark contrast with the fact that she took photographs to document the external signs of violence on her body. Further, her active efforts at documenting her external injuries (bruises on her face) conflict with the fact that she did not demand that the physicians examine the injuries caused by the abuse (genital, rectal, cranial lesions).
- g) The delay, of years, with which she submitted the self-produced photographic documentation; the photos were allegedly taken immediately after the abuse, but which were judged as not being datable to that period with any certainty. I shall not presume to go into a technical evaluation as to the date of those photos; yet, these images elicit immediate doubts as to their authenticity if they are compared to photo exhibits that have been dated with certainty. This consideration, alongside the delay with which the Accuser produced these photographs, undoubtedly makes the submitted evidence abnormal.

Generally speaking, one gains the impression that the submission of evidence (statements and photos) is inconsistent with the type and extent of the alleged injuries; that the Accuser is aware of the inconclusiveness of her allegations but is intent on proving the dangerousness of the defendant rather than directly upholding her accusations against him for the specific abuses.

## ***2. Basic Elements of Psychiatric Medicine***

There are basically two psychiatric syndromes in which "false accusations" are made by persons who at the time of the allegations are not in a state of confusion, or in a state of psychomotor agitation, or of manifest alienation: paranoia or factitious disorder (also known as pathological falsification or feigning). Alternatively, one might also suspect that a false allegation might be a conscious means to obtain material gain, with no intrinsic psychopathological process involved.

Hypothesis a): Delusion (paranoia)

An accuser would be convinced of having suffered the abuse and violence based on a delusional representation, i.e. a complex of thoughts, automatically recorded as memories, that have suddenly re-emerged and been accepted as authentic without any need for verification. The structure of the delusion

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is preceded by a stage in which the person perceives that there is something that she cannot properly focus on, characterized by confused or fragmentary mental images and an unstable emotive link; suddenly, all this is translated into a primary delusional nucleus (for example, having been physically abused by person X) and the first elements thus acquire meaning through a sort of "revelation". The person can thus convince herself that the "fog" through which the false memory appears is linked specifically to the trauma she has suffered, or to the manipulations to which she was subjected by her persecutors.

The primary conviction, with its connected false memories, is followed by the organization of other elements of memory and the automatic correction of minor inconsistencies. Any gaps, contradictions or evidence to the contrary is thus classified as the result of falsifications perpetrated by others, or as irrelevant since it cannot undermine the subjective conviction of the main assumption (the truth of the fact).

An element suggesting that the Accuser (in the case against Carlo Parlanti) may have been affected by such a form of mental alteration is the fact that she thought the Defendant was tapping her phone conversations, her emails, her fax.

This hypothesis, however, appears less likely because the Accuser behaves as a person who is perfectly aware of the need for evidence in support of her allegations, especially after her accusations caused the Defendant to be arrested and tried. A paranoid person, on the contrary, would have gathered all available pieces of evidence as precisely as possible from the very beginning, although typically the evidence gathered is not substantial and only consists of subjective, inconclusive elements, or those considered interesting from a deductive point of view (and only if there is an assumption that the allegations are true). The paranoid person believes, against all evidence, that sufficient elements to confirm her allegations exist, and if she searches for further evidence, she does so by personal investigation or by asking third parties to "speak up"; but she would not voluntarily produce evidence, nor it is likely that she may forget. As relates to evidence that is not convincing (such as the photographs), a paranoid person would tend to believe that it was forged specifically in order to boycott her, and would not produce it except in order to advance this parallel allegation, since she would recognize its objective inconsistency *vis-à-vis* the thesis she is attempting to prove to everyone.

Hypothesis b): simulation

The Accuser would have produced false evidence for specific or general practical purposes (for example, to be awarded damages). A mere simulation generally does not rely on "improbable" evidence, which then becomes difficult to demonstrate or can be quashed, but rather on fairly detailed and likely allegations. that are credible, if possible backed up by evidence, even evidence that has been forged for the purpose. A person who simulates may not be able to predict developments and small inconsistencies; but, from the beginning, she would produce simple accusations backed up by the essential evidence, which does not at all appear to be the case here.

Hypothesis c): factitious disorder – according to DSM IV TR – also known as Munchausen syndrome,

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or more generally falsification disorder, or fantastic pseudology.

This disorder consists in producing fictitious elements functional to the construction of a "case" relating to the person, capable of arousing compassion, admiration or attention. The original description involves subjects associating "unlikely" stories and the account of severe symptoms, often voluntarily producing on themselves the signs of alleged diseases, to the extent of subjecting themselves to risky and useless medical and surgical interventions.

The accuser's behaviour revolves around a central idea of getting her own back (in the absence of related crimes) or of eliciting consensus or admiration for herself. To this end, she produces, in an uncontrolled manner, allegations and accusations, attempting to make them credible by enhancing their scope and their features, regardless of the risk of jeopardizing the overall credibility and of the lack of documentary evidence. For this purpose, she may deliberately falsify evidence or induce others to make statements in support of the alleged facts, shedding positive light on her person, or discrediting her adversary. Usually, evidence to contradict the claims is soon found, or the falsification is uncovered; at which point, the person will try to fill the gaps or correct the errors by producing new allegations. Typically the overall allegation will become more complex, introducing the involvement of third parties, recalling similar facts having occurred at a different time. Basically, the accuser believes her behaviour is justified because she believes that her hostility towards the accused is justified, for personal reasons. In these cases the ability to lie is striking, since lying occurs without any embarrassment or difficulty, despite all the evident inconsistencies and abnormalities contained in the allegations (revelations occurring at different times, crucial evidence only emerging much later, contradictory evidence, need to fill certain gaps by claiming amnesia). The explanation lies in the presence of a form of emotional dissociation enabling these persons to testify a fictitious reality, which they experience as both "fantastic" and "which they can bear witness to", according to a rationale in which the facts are false but at the same time represent the fantastic translation of their real emotional reality (hostility, idea of having been wronged, feelings of vengeance, jealousy, etc., frustration for having been rejected, envy, etc.).

Subjects affected by factitious disorder frequently present dissociative type symptoms: a state of consciousness that does not correspond in a stable way to precise parameters of memory, identity and temporal continuity, so that they can relatively (and dangerously) easily assume different positions and attitudes from those of other people and the environment.

Subjects affected by factitious disorder are characterized by an unstable mood, typically swinging between phases of elevated mood and energy, and phases of panic, despair and frustration. Their attitude to others is totalizing, so they tend to alternate between idealization and devotion to partners and friends, on the one hand, and disparagement, demonization and vindictiveness on the other. In their professional and working life, these subjects can alternate involvement and commitment to phases of inaction and inability to take decisions. The subjects affected by this syndrome often appear convincing, due to the assuredness with which they uphold their basic thesis and their ability to manipulate their listeners, since they display no anxiety when lying and have a chameleon-like ability to dramatize unlikely and improbable allegations.

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### 3. Psychiatric History of the Accuser

Relevant elements in addressing a psychiatric history of Ms. White, unrelated to the case against Carlo Parlanti:

Ms. White has a positive psychiatric history for Major Depression. Her psychiatrist officially reported this diagnosis in an affidavit (223-228203-95 Judicial District Tarrant County Texas), stating that this cerebral condition interferes with memory and attention levels, in other words with cognitive functions that condition a person's state of consciousness.

Ms. Whites, albeit for other indications, takes psychotropic drugs. The effects of such drugs, especially if associated with alcohol, can alter psychic functions in a transitory or continuous manner, especially in persons with a predisposition.

E. Thayer's document, Investigation report – Nov. 16, 2005 – contains Mr. Brandon's statement on Ms. White's behaviour in her job, a behaviour pattern consistent with neuropsychological alterations (attention and memory) and with anxiety and mood disorders.

#### Conclusions

Based on the behavioural abnormalities and the inconsistency of allegations - inconsistency due to both absence of objective evidence and conflicting documentary evidence;

Based on the presence of elements suggesting mental disorder in the Accuser's present and past history;

Based on an expert knowledge of psychic disorders producing similar behaviour patterns;

I consider that it would be sensible, and indeed crucial, to verify the psychic status of the Accuser and, further, to evaluate the abnormalities in the entire set of allegations underpinning the Court case in the light of this aspect; and that this should be done in a systematic and consequential manner on each successive occasion.