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February 17, 2021

DECLARATION OF DR. PAUL SIMPSON

I, Paul Simpson, Ed.D., declare under penalty of perjury:

1. I am Dr. Paul Simpson, a psychologist specializing in forensic and clinical psychology. I received my doctorate from Northern Arizona University in 1990 and have been a licensed psychologist in the State of Arizona since 1991. I have testified and/or consulted as an expert in approximately 400+ state and federal trials and over 50 courts-martial for the U.S. Airforce, Army, Marines, and Navy. In 1997 I authored a book on memory and suggestibility. I am an instructor for the State Bar of Arizona and have provided trainings on numerous topics, including thirteen presentations on the topic of Eyewitness Memory and twice regarding Alcohol Blackouts and Sexual Assault. For the past five years I have been an instructor for the U.S. Air Force's JAG school at Maxwell AB. This training has been part of their Advanced Sexual Assault Litigation Course (ASALC). In addition, I have provided psychology professionals training regarding sexual compulsions / sexual offense in over 300 cities in all 50 states over a span of 13 years.

2. Through my education, training, and military justice experience, I have become knowledgeable about the numerous impacts and manifestations that mental illness can have on the human body and related cognitive functioning. I have developed scientifically grounded, evidence-based expertise on numerous forensic topics.

3. I have discussed the case of United States v. A1C Jones with his defense counsel, and they have informed me of the charges and allegations in this case.

4. Defense counsel has asked for my opinion on whether a diagnosis of Borderline Personality Disorder for the complaining witness in this case would have strong bearing on her credibility in terms of being able to perceive, recall and accurately speak about allegations of assault. As is explained in the remainder of this document, scientific research reveals that Borderline Personality Disorder is a serious and chronic psychological disorder that can compromise a patient's ability to accurately perceive and recall reality. The condition also has a clear correlation with propensity to engage in "Pseudologia" (pathological lying) and its correlate in false allegations of sexual assault.

5. Research shows an individual with borderline personality may place him/herself in riskier situations and may, therefore, have an increased risk of actual sexual assault. Conversely, an individual with borderline personality disorder may also suffer from certain key cognitive distortions that lead to false reports.

6. Defense counsel has also asked me to opine on whether an exploration of the complaining witnesses' treatment records for verification of the diagnosis of Borderline Personality Disorder would be important in providing a robust defense of their client. The Writer does not presume to supplant the authority of the Court. Speaking only as a forensic psychologist, it is my opinion that identification of Borderline Personality Disorder would be absolutely critical to providing an appropriate defense and the ability to teach the trier-of-fact about how this condition might impact a report of sexual assault.

Executed this 17th day of February 2021.

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Paul Simpson, Ed.D.

I. What is "Borderline Personality Disorder"?

Borderline personality disorder (BPD) is a mental illness characterized by a long-term pattern of unstable relationships, distorted sense of self, and strong emotional reactions. It typically is first identified in young adulthood and remains pervasive throughout the course of a person's lifetime. Unlike other psychological "*states*" (i.e., depression, anxiety) it does not wax-and-wane over time. It is a "*trait*" that remains constant with little change. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5, 2013) is published by the American Psychiatric Association. In the United States it is the considered to be an authoritative reference for diagnosing mental illness. The DSM-5 describes nine common characteristics of BPD (with minor text modifications).

Borderline Personality Disorder Diagnostic Criteria 301.83 (F60.3)

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 five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.
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 two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., 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 (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, 2013), American Psychiatric Association, pp. 663

Please see Appendix A for the complete DSM-5 text regarding BPD.

Motivations for Intentional False Reporting

We now turn our attention to another fundamental question – *"Why would someone intentionally make a false report of sexual assault?"* The authors of the research article, *Pathways to false allegations of sexual assault*, note;

> *Humans do lie, and their lies can be difficult to detect. Often, humans lie because of what they perceive as the favorable consequences for lying; for sexual assault these consequences could be*
>
> 1. *the severe negative consequences that the alleged perpetrator experiences,*
> 2. *secondary gain from victim status,*
> 3. *excusing behaviors or characteristics of the alleged victim (e.g., sexual activity, pregnancy, sexually transmitted diseases), and*
> 4. *financial gain.*

Engle, Jessica., O'Donohue, William. *Pathways to false allegations of sexual assault*. Journal of Forensic Psychology Practice, Vol 12(2), Mar, 2012. p. 103.

Research shows that intentional false accusations can reflect a variety of motives. Here is a summary of the findings from studies in the previous section of this paper.

- Kanin's (1994) categorized false accusations into three motivations:
  - Alibis (50%)

- Revenge (30%)
- Attention-seeking (20%).

- The *Bavarian Police Study of False Rape Allegations* (2000) identified motivations related to:
  - Conflicts/problems in family or partnerships (20.7%)
  - Hiding sexual relationships (12.9%)
  - Puberty crisis cover / first sexual experience (10.7%)
  - Attracting compassion and attention (11.4%)
  - Justification for misconduct (10%)
  - Shame / embarrassment (3.6%)
  - Fear of pregnancy (1.4%)
  - Countersuing / revenge (7.5%)
  - Cerebral organic disturbance / alcoholism / drug dependency / psych disease (22.1%)
  - Motive not discernible (2.1%)

- The *FBI Law Enforcement Bulletin* (2012) identifies motivations that include:
  - Mental illness / depression
  - Attention / Sympathy
  - Financial / profit
  - Alibi
  - Revenge

- Zutter did a recent review on this issue (*Motives for filing a false allegation of rape*, 2018). Motivations included:
  - Material gain
  - Alibi
  - Revenge
  - Sympathy
  - Attention
  - Disturbed mental state
  - Relabeling
  - Regret
  - 20% of complainants didn't know why they filed false allegations.

III. Borderline Personality Disorder and False Allegations of Sexual Assault

Our final area of exploration is the intersection between BPD and false allegations. Engle and O'Donohue (2012) make the following observations. Note that at the time of their study the earlier edition of the DSM is referenced (DSM-IV-TR).

> The DSM-IV-TR (American Psychiatric Association, 2000) includes nine diagnostic criteria for this disorder, which for simplicity can be narrowed down to four domains (Lieb et al., 2004). The first domain is affective disturbance that includes intense emotions, rapidly shifting emotions, and mood reactivity. The second domain is disturbed cognition that includes three levels of symptomatology: troubling but non-psychotic problems including dissociation (discussed above) and intense feelings of being bad (relevant to this pathway); quasi-psychotic and psychotic-like symptoms of delusions and hallucinations (further discussed below) that are somewhat reality-based; and psychotic symptoms of delusions and hallucinations. The third domain is impulsivity, either physically destructive to the self or generalized impulsivity. The fourth domain involves the existence of unstable

and erratic relationships, in which the borderline individual struggles to avoid either real or imagined abandonment.

When parsing these domains, it can be more clearly seen how BPD may serve as a pathway for false allegations of sexual assault. The first domain (Leib et al., 2004) includes the diagnostic criterion of quickly switching from idealization to devaluation of relationship (American Psychiatric Association, 2000). The instability of relationships experienced by an individual with BPD may be rooted in the tendency to quickly switch from idealizing significant others or lovers to devaluing them (American Psychiatric Association, 2000). This sudden change in conceptualization of a partner is often caused by feeling that the partner is not caring enough or giving enough or by suspicion of abandonment. The rapid shifting between idealizing and demonization may bring about a change in perspective such that a relationship that was viewed idealistically in the past is now seen through the devalued lens of abuse or mistreatment. Past events then may become construed as "abuse" and may lead a person with BPD to believe he or she is a victim of sexual assault.

As Kanin (1994) found in his longitudinal study, two of the three major motivations to file a false allegation of rape were attention-seeking and revenge. The switch from idealization to devaluation of the relationship and/or relationship partner (American Psychiatric Association, 2000) may spur a desire for revenge for any past behaviors that are, in the devaluation phase, newly construed as mistreatment. In addition an individual with BPD who is feeling fear of abandonment may seek frantically to achieve the attention that is craved from the partner who is perceived to be neglectful (American Psychiatric Association, 2000). The impulsive nature of a person with BPD may also lead them to act on these motivations for attention or revenge by filing a false allegation of sexual assault before carefully considering the consequences. Also, there is some evidence that individuals with BPD engage in behaviors that are viewed as "manipulative" (Linehan, 1993). Manipulative behaviors are often outside the conscious awareness of the individual and are learned through positive reinforcement, as manipulation frequently results in positive outcomes for the manipulator. Thus, an individual with BPD may use a sexual assault allegation as a way of impacting a third party for some desired outcome.

The second domain (Lieb et al., 2004), consisting of symptoms of reality-based delusions and hallucinations, may lead to false beliefs of sexual assault, and clinical experience suggests that sexuality is a common theme in delusions and hallucinations. The DSM-IV-TR (American Psychiatric Association 2000, p. 299) defines delusions as "erroneous beliefs that usually involve misinterpretations of perceptions or experiences." Hallucinations involve sensory experiences that do not appear to be externally caused.

Thus, individuals with BPD may represent a "perfect storm" of symptoms in which an impulsive, emotionally dysregulated individual who is demonizing someone and has loose contact with reality and who is attention and revenge makes a false allegation of sexual assault. However, when considering this pathway, it is important to keep in mind that individuals with BPD are more likely to have experienced sexual or physical assault (Lieb, et al., 2004) due to the same characteristics of the disorder. Thus, it is important to fairly and adequately weigh the evidence presented in an allegation of sexual assault.

Engle, Jessica., O'Donohue, William. *Pathways to false allegations of sexual assault*.
Journal of Forensic Psychology Practice, Vol 12(2), Mar, 2012. pp. 109-111.

APPENDIX A: DSM-5 Definition of Borderline Personality Disorder

Diagnostic Criteria 301.83 (F60.3)
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 five (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 two areas that are potentially self-damaging (e.g., 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 (e.g., 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 (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Diagnostic Features
The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5.

Individuals with borderline personality disorder have a pattern of unstable and intense relationships (Criterion 2). They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, or is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternatively be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). There are sudden and dramatic shifts in selfimage, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to that of a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations.

Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with this disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Completed suicide occurs in 8%–10% of such individuals, and self-mutilative acts (e.g., cutting or burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help.

These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that the individual assumes increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil.

Individuals with borderline personality disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with borderline personality disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction.

These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Individuals with borderline personality disorder may be troubled by chronic feelings of emptiness (Criterion 7). Easily bored, they may constantly seek something to do.

Individuals with this disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

Associated Features Supporting Diagnosis

Individuals with borderline personality disorder may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going; destroying a good relationship just when it is clear that the relationship could last). Some individuals develop psychotic-like symptoms (e.g., hallucinations, body-image distortions, ideas of reference, hypnagogic phenomena) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships.

Premature death from suicide may occur in individuals with this disorder, especially in those with co-occurring depressive disorders or substance use disorders. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and separation or divorce are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss are more common in the childhood histories of those with borderline personality disorder. Common co-occurring disorders include depressive and bipolar disorders, substance use disorders, eating disorders (notably bulimia nervosa), posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. Borderline personality disorder also frequently co-occurs with the other personality disorders.

Prevalence

The median population prevalence of borderline personality disorder is estimated to be 1.6% but may be as high as 5.9%. The prevalence of borderline personality disorder is about 6% in primary care settings, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients. The prevalence of borderline personality disorder may decrease in older age groups.

Development and Course

There is considerable variability in the course of borderline personality disorder. The most common pattern is one of chronic instability in early adulthood, with episodes of serious affective and impulsive dyscontrol and high levels of use of health and mental health resources. The impairment from the disorder and the risk of suicide are greatest in the young-adult years and gradually wane with advancing age. Although the tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong, individuals who engage in therapeutic intervention often show improvement beginning sometime during the first year. During their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning. Follow- up studies of individuals identified through outpatient mental health clinics indicate that after about 10 years, as many as half of the individuals no longer have a pattern of behavior that meets full criteria for borderline personality disorder.

Risk and Prognostic Factors

Genetic and physiological. Borderline personality disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for substance use disorders, antisocial personality disorder, and depressive or bipolar disorders.

Culture-Related Diagnostic Issues

The pattern of behavior seen in borderline personality disorder has been identified in many settings around the world. Adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display behaviors that misleadingly give the impression of borderline personality disorder. Such situations are characterized by emotional instability, "existential" dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers.

Gender-Related Diagnostic Issues

Borderline personality disorder is diagnosed predominantly (about 75%) in females.

Differential Diagnosis

Depressive and bipolar disorders. Borderline personality disorder often co-occurs with depressive or bipolar disorders, and when criteria for both are met, both may be diagnosed. Because the cross-sectional presentation of borderline personality disorder can be mimicked by an episode of depressive or bipolar disorder, the clinician should avoid giving an additional diagnosis

of borderline personality disorder based only on cross-sectional presentation without having documented that the pattern of behavior had an early onset and a longstanding course.

Other personality disorders. Other personality disorders may be confused with borderline personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to borderline personality disorder, all can be diagnosed. Although histrionic personality disorder can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, borderline personality disorder is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness. Paranoid ideas or illusions may be present in both borderline personality disorder and schizotypal personality disorder, but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in borderline personality disorder. Although paranoid personality disorder and narcissistic personality disorder may also be characterized by an angry reaction to minor stimuli, the relative stability of self-image, as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns, distinguishes these disorders from borderline personality disorder. Although antisocial personality disorder and borderline personality disorder are both characterized by manipulative behavior, individuals with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification, whereas the goal in borderline personality disorder is directed more toward gaining the concern of caretakers. Both dependent personality disorder and borderline personality disorder are characterized by fear of abandonment; however, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline personality disorder can further be distinguished from dependent personality disorder by the typical pattern of unstable and intense relationships.

Personality change due to another medical condition. Borderline personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Borderline personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Identity problems. Borderline personality disorder should be distinguished from an identity problem, which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder.

DSM 5 (2013), American Psychiatric Association, pp. 663-666

APPENDIX B:
Research Articles on BPD and False Allegations of Sexual Assault

Pseudologia fantastica in the borderline patient.
Snyder, Scott.
The American Journal of Psychiatry, Vol 143(10), Oct, 1986. pp. 1287-1289.
Abstract:

Describes 4 cases of pseudologia fantastica, or pathological lying, that was associated with borderline personality disorder (BPD) in an 18-, 26-, and 35-yr-old female and in an 18-yr-old male. Clinical, forensic, and treatment implications of this disorder are discussed. Cases illustrate the association between pathological lying and narcissistic gratification, poor self-esteem, and a fragile sense of self in BPD patients.

Review of A Developmental Model of Borderline Personality Disorder.
Berger, Joseph
American Journal of Psychotherapy, Vol 58(2), 2004. pp. 253-255.
Abstract:

Reviews the book 'A Developmental Model of Borderline Personality Disorder' by Patricia Hoffman Judd and Thomas H. Mc Glashan (see record 2003-06987-000). The main portion of the book consists of four long, detailed case histories of patients who were hospitalized and treated at the Chestnut Lodge hospital between 1950 and 1975. These chapters are introduced with a brief history of Chestnut Lodge, and a summary of McGlashan's retrospective review of all patients treated at Chestnut Lodge in those years. The book concludes with two chapters; one discusses treatment aspects and the other explains many of the symptomatic and behavioral features of these patients as they relate to the developmental model outlined in the first chapter. The authors conclude that borderline personality disorder (BPD) arises in a vulnerable individual because of a combination of that vulnerability and an excess of environmental stressors, most prominent of which is maternal deprivation and/or maltreatment or abuse. The authors recommend that BPD patients should preferably be treated by a team. I also agree that contrary to the traditional analytic abstinence-rejection approach, gifts from patients should be accepted 'graciously and with appreciation'- unless overdone. **The authors also urge therapists to be aware that these patients often make false accusations**.

Pathways to false allegations of sexual harassment.
O'donohue, William and Bowers, Adrian H.
Journal of Investigative Psychology and Offender Profiling, Vol 3(1), Jan, 2006. pp. 47-74.
Abstract:

A sexual harassment allegation is either true or false. Whether specific allegations are true or false is important to questions of epidemiology, clinical diagnosis and treatment, administrative and legal proceedings, as well as the welfare of actual victims and innocent alleged perpetrators. It is naive and harmful to operate with the heuristic: 'All claims are true'. However, the truth of many allegations is very difficult to determine, particularly as is often the case when there are no witnesses, no conclusive hard evidence, and the presence of a situation where both parties have divergent accounts of the alleged occurrence. There has been little theoretical or empirical work on what would cause a person to make a false allegation of sexual harassment. This paper gives an overview of the intricacies associated with sexual harassment investigations and enumerates 14 possible pathways to false allegations: lying; borderline personality disorder, histrionic personality disorder, psychosis, gender prejudice, substance abuse, dementia, false memories, false interpretations, biased interviews, sociopathy, personality disorders not otherwise specified, investigative mistakes, and mistakes in determination of the degree of harassment.

Pathways to false allegations of sexual assault.
Engle, Jessica and O'Donohue, William.
Journal of Forensic Psychology Practice, Vol 12(2), Mar, 2012. pp. 97-123.
Abstract:

Not all allegations of sexual assault are true. Unfortunately, there has been little work on understanding the prevalence of false allegations or pathways to these. This paper proposes 11 pathways to false allegations of sexual assault: (a) lying, (b) implied consent, (c) false memories, (d) intoxication, (e) antisocial personality disorder, (f) borderline personality disorder, (g) histrionic personality disorder, (h) delirium, (i) psychotic disorders, (j) dissociation, and (k) intellectual disability. These pathways originate in the psychological diatheses of the individual. Further research is needed into the frequency of these pathways, ways to accurately detect these, and whether other pathways exist.

Die schrittweise interaktive Entstehung einer Fehlbeschuldigung sexuellen Missbrauchs.
Translated Title: The stepwise interactive creation of false accusations of sexual abuse.
Kröber, Hans-Ludwig.
Forensische Psychiatrie, Psychologie, Kriminologie, Vol 7(4), Nov, 2013. pp. 240-249.
Abstract:
False accusations of sexual abuse and also violent sexual misconduct by persons in a close relationship often have a long history of development by which the alleged victim increasingly involves other persons who are then used to substantiate the authenticity and truth of the claims, even before allegations are made. Using three cases as examples this article describes the approaches used which are found particularly in emotionally unstable borderline type personalities. When a mental disorder or personality disorder of the alleged victim is suspected, the volitional competence to testify should be tested. This applies not only for borderline personality disorders (which is occasionally reclassified as posttraumatic disorder) but also when symptoms of a puberty crisis, an adolescence crisis or another relevant crisis, such as a posttraumatic disorder are present.