

Mental Illness and Domestic Violence: Implications for Family Law Litigation

By Denice Wolf Markham

Many studies have shown the nexus between domestic violence victimization and mental health problems. Experts believe that between 60 percent and 90 percent of battered women have significant mental health issues.¹ Eighty-one percent of women who have been treated for psychiatric disorders report histories of abuse.² Between 30 percent and 90 percent of battered women in Chicago-area domestic violence programs have mental health diagnoses.³ Although no study has documented this, the experience of many providers tells us that a large number of the women seeking legal assistance have mental health difficulties, including depression, posttraumatic stress disorder, substance abuse issues, or other diagnoses which have a serious impact on their family law cases.

In an era in which providers of legal services are mindful of shrinking resources and the duty to use those resources wisely to help the most people, why should poverty law specialists take on the case of a mentally ill battered woman? These cases can consume huge amounts of attorney time. They almost always necessitate expert evaluation and testimony, involve the collaboration of

attorneys with other agencies, and frequently have very difficult facts. However, work on behalf of this client population advances the mission of legal aid agencies to assist those in most need, address social issues through legal representation, and seek justice. The rewards of helping a battered woman challenged by mental health issues prove her credibility, secure custody of her children, and win a chance at freedom from fear can be enormous.

Although the facts of these cases are often initially adverse, fairness and equity are usually on the side of the battered woman, especially in custody matters. The children may also be victims of the father's abuse while the battered woman provides them with a home, care, and love.

Representing these clients can enhance a reform agenda: the stigma of mental illness and society's prejudice regarding mental health conditions are at the heart of courts' denial of custody to these mothers. Further, in cases in which the domestic violence caused or worsened the client's mental health condition, our work on these cases holds the abuser accountable for the full extent of the damage the abuser has done to the family, and prevents uneducated courts from

¹ Carole Warshaw, *Women and Violence*, in *PSYCHOLOGICAL ASPECTS OF WOMEN'S HEALTH CARE* 483 (Nada L. Stotland et al. eds., 2001).

² *Id.*

³ Carole Warshaw et al., *REPORT ON MENTAL HEALTH ISSUES AND SERVICE NEEDS IN CHICAGO AREA DOMESTIC VIOLENCE PROGRAMS* (2003), available at www.dvmphi.org.

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rewarding the reprehensible conduct of this bad actor.

Here I give some background in the issues facing this client population, discuss confidentiality, privilege, and strategies for dealing with treatment and evaluative evidence in preparing the case, and offer ideas for systemic advocacy with regard to mental illness in the family law system. Much of my analysis of these topics is based on the experience of lawyers working at Life Span, a Chicago domestic violence organization that provides both legal services and counseling to victims. Life Span has developed an expertise in working with this client population.

I. Some Background

An understanding of basic mental illness diagnoses and the causal relationship between the client's mental illness and the battering she has suffered can greatly enhance a lawyer's representation of battered women with mental health issues. Some information about the history of the mental health and domestic violence fields will also benefit legal practitioners working in this area.

A. Conflicts Between Mental Health and Domestic Violence Systems

Clients with mental illness usually are involved with a number of service providers. They may have sought help from shelters or domestic violence counselors, may have been hospitalized and received mental health treatment, or experienced some other intervention. The lawyer handling these cases will probably have relationships with some of these providers as the lawyer develops facts, gathers evidence, and prepares witnesses. Working in this area, I have been struck by the conflicts and contradictions between these two systems, each not understanding or trusting the other. To avoid any adverse effects of these conflicts on the case, and to facilitate the lawyer's interactions and relationships with these professionals, some understanding of these different systems is warranted.

Domestic violence service providers

are typically grass-roots organizations guided by the political thesis that battered women are victims of a patriarchal society which blames women for the violence perpetrated by men. The suggestion that a battered woman is "crazy" is directly contrary to this thesis and is viewed as detrimental to these providers' goal of abuser accountability. Some battered women's shelters have strict rules regarding residents with mental illness, not allowing them to control their medications, or refusing to allow women taking medication to live at the shelter. Ignorance of mental health diagnoses and treatment contribute to reluctance on the part of some service providers to deal with these issues.

Mental health service providers can lack an understanding of domestic violence in the lives of their clients. Criticisms of the mental health system include inappropriate reliance on medication to the exclusion of other treatments and using couples therapy to "treat" domestic violence. Mental health practitioners may view a battered woman's coping strategies as symptoms, pathologizing what is an appropriate response to battering. An additional problem with this system is a profound lack of resources for battered women who do not have serious mental illness. Community mental health centers often limit their services to patients with serious mental illnesses, such as schizophrenia.

Further, abusers typically control insurance and use that power to control treatment, endangering the victim.⁴

In preparing a case for a mentally ill battered woman, the lawyer must take into account the disparate approaches of each system to the lawyer's client, mindful of their effect on both written evidence and testimony. The lawyer must learn to integrate these different points of view and interpret the evidence to the advantage of the client. Educating those who rely on the work of these providers in making decisions—judges, other lawyers (especially those representing the child), and custody evaluators—about these conflicts can contribute to an accurate analysis of custody issues.

⁴ Gabriella Moroney et al., *Mental Health and Domestic Violence: Collaborative Initiatives, Service Models, and Curricula* (Sept. 2002), at www.dvmphi.org.

B. Mental Health Diagnoses 101

A familiarity with basic mental health terminology and diagnoses is necessary to represent this population of battered women. Victims who have been hospitalized, sought treatment for mental illness, or been evaluated in connection with custody litigation may have one or more diagnoses which may profoundly affect their requests for relief in family law cases. Understanding the basic symptomatology and having a framework for thinking about and analyzing these issues will allow the lawyer to develop a legal strategy for dealing with them in the context of the family law case.

Battered women suffering mental health consequences may be diagnosed with a number of illnesses, including depression, anxiety, panic disorders, or posttraumatic stress disorder.⁵ The last develops as a response to a traumatic event or events, such as battering. Symptoms are generally divided into three types: intrusive, often flashbacks or nightmares; avoidance, including inability to remember an event or lack of emotion; and increased arousal, manifested as startle reactions, inability to concentrate, and insomnia.⁶

The effects of posttraumatic stress disorder on a battered woman as a party in a legal action are important for lawyers to consider, as symptoms may directly affect the attorney-client relationship. The client may have difficulty making decisions and find it hard to trust others. These problems can compromise her ability to seek help and to cooperate with those trying to help her.⁷ She may withhold information about her abuse, her mental health history, or other important details because of her lack of trust or her inability to

remember. Although the client may have obtained a protective order or be in a shelter, posttraumatic stress disorder makes it difficult to see the battering as a past event.⁸ Those with experience in domestic violence law recognize the probable correctness of her assessment of imminent danger, but mental health professionals may see the insistence on the immediacy of her fear and trauma as a symptom of her mental illness.

Depression has long been recognized as one of the more common psychic injuries of battering. Experts estimate that between 37 percent and 63 percent of battered women experience depression.⁹ The symptoms of this disease include depressed mood, lack of interest in everyday activities, indecisiveness, inability to concentrate, fatigue, insomnia, feelings of worthlessness, or thoughts of death or suicide.¹⁰ To expect some of these symptoms to be present in a woman who has experienced even one episode of domestic violence is almost common sense. In women with a history of serious abuse, problems with depression are even more likely to occur.¹¹

Substance abuse also plagues many battered women. As many as one third of victims suffer from alcoholism.¹² Use of illegal drugs is also common.¹³ Substance abuse may be the woman's attempt to medicate herself in order to deal with the ongoing abuse or the consequences of the trauma. Another common scenario is the use of drugs or alcohol as part of the abuse. In these cases the abuser forces the victim to become dependent on these substances as a means of control and as a way to destroy her functionality and self-esteem. The abuser then uses the fact

⁵ Warshaw, *supra* note 1, at 480. "Posttraumatic stress disorder" is abbreviated commonly as "PTSD" in professional literature and discussion.

⁶ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 427-29 (4th ed. 1994).

⁷ Warshaw, *supra* note 1, at 450.

⁸ *Id.*

⁹ *Id.* at 451.

¹⁰ AM. PSYCHIATRIC ASS'N, *supra* note 6, at 327.

¹¹ Warshaw, *supra* note 1, at 451.

¹² *Id.*

¹³ *Id.*

of her addiction against her should she seek help.

C. The Causal Relationship Between Mental Illness and Domestic Violence

In many cases a convincing argument can be made that mental illness and domestic violence are causally related. Although this relationship is most apparent in those victims suffering from post-traumatic stress disorder, a causal link to other mental illnesses can also be made.¹⁴

Trauma theory is a recent construct particularly useful in analyzing the relationship between mental illness and domestic violence in a case and can help the lawyer develop a theory of the case that will insulate the client from negative inferences regarding mental illness on the part of the judge, the attorney for the child, evaluators, and other decision makers in the litigation. A basic premise of trauma theory is that the symptoms of mental illness that a battered woman manifests can be understood as survival strategies, developed as a reaction to her experience.

When trauma theory is employed, a battered woman's extreme caution and fearfulness are not a symptom of paranoia but a rational response to what she has experienced. One of the goals of this analysis is to contribute to a decision maker's understanding that the battered woman is acting as a reasonable person given the abuse she has survived.

Her distrust of others is not pathological but learned from her victimization at the hands of someone she loves. Her lack of emotion is a way of protecting herself from the psychic trauma of abuse. Viewed in the framework of trauma theory, a battered woman's symptoms can become examples of her strength in cop-

ing with what has happened to her and as reasonable attempts to survive in a violent relationship.

Domestic violence can also exacerbate a victim's already existing mental health condition.¹⁵ These battered women may have extensive mental health backgrounds and treatment records about which the batterer is familiar. The batterer may use the victim's illness as a way to control her, telling her that no one will believe her account of the abuse because she is crazy. In these cases the abuser may be overly involved in her treatment. The abuser may force her to be hospitalized or use threats of involuntary commitment to terrorize her. He may control her medication, overmedicating her or inducing symptoms by withholding medication. The abuser uses the victim's mental health status as a basis for emotional and psychological abuse.

In both situations—where mental illness is a direct result of abuse and where domestic violence is exacerbating a mental health condition—victims often will improve and symptoms will abate or disappear once the domestic violence is addressed.

II. Preparing for Family Law Litigation

In most states the well-known standard for determining custody is the best interests of the child.¹⁶ Statutes typically list a number of factors to consider in making this determination; one factor is the mental and physical health of the potential custodians.¹⁷ Courts examine the parent's level of functioning, compliance with treatment, and support systems in assigning relative importance to the mental illness in the potential custodian.¹⁸ The relationship of the child and the parent is crucial, as it is in any custody case.

¹⁴ Warshaw, *supra* note 1, at 454; see also Mary Ann Dutton et al., *Posttraumatic Stress Disorder Among Battered Women: Analysis of Legal Implications*, in 12 BEHAV. SCI. & L. 215, 226 (1994).

¹⁵ Warshaw, *supra* note 1, at 454

¹⁶ E.g., 750 ILL. COMP. STAT. 5/602 (2000).

¹⁷ E.g., *id.* 5/602(5).

¹⁸ E.g., *People ex rel. Bukovic v. Smith*, 423 N.E.2d 1302 (Ill. 1981); *In re Horbatenko*, 531 N.E.2d 1011 (Ill. 1988) (Clearinghouse No. 44,095).

A. Investigating the Case

Investigation and fact development in cases of domestic violence and mental illness are of paramount importance. The issue of mental illness can arise in many different ways: the abuser may make an allegation in pleadings or by other means, the client's referral source or the client may raise the issue, or the lawyer or paralegal may question the client on this topic. At Life Span inquiry about physical and mental illness, treatment, and medications is part of every intake.

1. Obtaining Records and Other Communications

Clients with an extensive history of hospitalizations and treatment may have difficulty remembering every treatment provider, just as some clients may be unable to remember serious incidents of abuse. Minimizing what has happened to them is a way of coping with trauma. The deep shame and guilt that clients may feel, both about the abuse and the resulting mental health consequences, may have an impact on their ability to recount their history accurately. These clients are not lying or withholding information capriciously; they cannot remember all that has happened to them in sequential order, with dates and times. That the lawyer be fully informed about the client's mental health history is crucial. Often the lawyer must rely on the lawyer's own investigation and fact gathering to fill in the gaps of the history that the client relates. This investigation always requires obtaining confidential and privileged records from treatment and service providers and institutions.

Confidentiality is a particularly thorny issue in domestic violence law, and many domestic violence advocates see protecting client's mental health treatment, counseling, and other records as a way of protecting their clients from victim blaming. States' domestic violence statutes often contain a section on the confidentiality of

communications between counselors or advocates and their clients.¹⁹ In Illinois counselors who disclose confidential information without written permission from the client are subject to criminal prosecution.²⁰ Obtaining records from domestic violence agencies always requires a written release of information from the client. At this step in case preparation, lawyers should work to engage the domestic violence counselor as an ally to achieve a common goal for the client. Domestic violence service providers have had ample experience with lawyers who do not understand domestic violence and have hurt, rather than helped, past clients. One of the initial tasks that the lawyer will have in building a beneficial relationship with a domestic violence counselor is easing the counselor's concerns about the purpose of asking for the records. The counselor can help the lawyer understand the history of the violence and can give detail and other information. Developing a good relationship with the counselor now may help when the time comes to decide who will make a knowledgeable and persuasive witness on the client's behalf.

The patient's attorney will probably be able to secure mental health treatment records through the release of information, or the client may be able to accomplish this herself. However, most states stringently protect mental health records from disclosure, and the abuser's attorney may not be able to obtain them through the regular course of fact gathering. Familiarity with the state statute dealing with confidentiality and privilege is imperative for the attorney to obtain the necessary information. For example, Illinois's Mental Health and Developmental Disabilities Confidentiality Act sets out detailed procedures for obtaining treatment records and other information, including the requirement that a judge review the records to determine relevance, at which time the court issues an

¹⁹ E.g., Illinois Domestic Violence Act, 750 ILL. COMP. STAT. 60/227. See also Stephen E. Doyne et al., *Custody Disputes Involving Domestic Violence: Making Children's Needs a Priority*, in DOMESTIC VIOLENCE LAW 340 (Nancy K. Lemon ed., 2001).

²⁰ 750 ILL. COMP. STAT. 60/227.

order for the record's release.²¹ Some treatment providers will seek review and an order from the court no matter who (including the patient) is seeking the release of the file.

An interview with the therapists and doctors working with the client can be an efficient and enlightening way to investigate the mental health aspects of the case, but these practitioners may be reluctant to discuss the case with the attorney. Time spent developing a collaborative relationship with mental health providers, just as with domestic violence professionals, is time well spent. Treators have their own duties to their client; such duties include maintaining the therapeutic relationship, which could be damaged by the dissemination of sensitive information or opinions. Under some state laws, treaters may have the power to decline to release information if they believe that it is not in the best interests of their client, regardless of the client's wishes or instructions.²² This refusal may place the client's attorney in the position of seeking a court order for her own client's records.

2. Contents of the Records

Mental health records can have a wealth of information and observations which will help the client prove the elements of her case beyond the issue of the mental illness and treatment itself. After all, the victim's attorney is not trying to prove the fact of the mental illness. The attorney can glean from the records corroboration of the client's victimization, the client's cooperation with treatment, the clinician's observations of the quality of the client's relationships with others, any assessment of her ability to be a parent, and other bits of evidence helpful to her case.

The records will also have information that is *not* helpful to the case and might be damaging to the client. Knowing the downside of the case is just as important as mastering the positive theories of the action, and the attorney must be alert for negative information, or information which may be interpreted in a manner

harmful to the client. Discussing these pieces of information with the treater can help the lawyer develop a strategy for minimizing the effects of the information on the case and explain them away. Statements of the patient's belief in her own culpability in the abuse, contradictory statements, and the patient's doubts about her ability to be a good parent are all examples of potentially damaging information in the file. The lawyer and the treatment provider can develop together an explanation for why a victim of domestic violence might express these feelings.

In all likelihood one set of records from a treatment provider will lead the attorney to other treaters or institutions with which the client has had a relationship. Get all the records from all the providers you find. Knowing what is in the client's mental health files is the only way to analyze accurately and plan for usage and management of the information and the issue of mental illness in the client's case.

B. Maximizing the Client's Strengths

As in all litigation, the manner in which the case is handled, including what evidence and strategies are employed, is the client's ultimate decision. In cases as difficult and time-consuming as these, client involvement may seem a burden. However, engaging the client in this process and having her input on decisions about the strategy for obtaining information and deciding how to use it promotes her cooperation in the litigation. The client's feeling of self-determination and ownership of the strategies used in the litigation will contribute to her success as a litigant in her own case.

Assessing the case's legal merits continues throughout the attorney's representation of the client. In cases where custody is an issue, the attorney should have a good understanding of the best-interests standard in the state and fit the facts of the client's case into the standard as the attorney investigates and develops the facts. This is an excellent time to think

²¹ Mental Health and Developmental Disabilities Confidentiality Act, 740 ILL. COMP. STAT. 110/1-110/15 (2000).

²² *E.g., id.*

about the case's weaknesses and try to address them.

In our experience, some concerns and factors can be addressed or improved upon while waiting for a case to ripen for trial. Again, if the attorney has a relationship with the other professionals involved with the client, all can work together to strengthen the client's case and chances for a successful outcome. The professionals should work together to encourage the client to take steps to enhance her own credibility. If the client feels that she is part of a team, she will be more motivated to cooperate with recommendations of the service providers involved in her case. For example, if the client is currently in treatment, the professionals can communicate the importance of compliance with treatment, further motivating the client to attend all appointments and regularly take any medication that is prescribed. The attorney can ask that the treatment provider monitor this aspect of the case and document the client's progress in the provider's file. This documentation can ensure that the client is following the strategy; the documentation is also excellent evidence should the case go to hearing or trial.

Other recommendations can serve this dual purpose of strengthening the client's case and supplying evidence for trial. Attending parenting classes and support groups is a common recommendation. Professionals working with the battered woman may suggest that the child would benefit from intervention such as counseling or art therapy. These resources can be difficult to find, but the local domestic violence agency may be able to assist the children.

A viable support network for the client and her child is positive in any custody case, but it is crucial for the battered woman with mental health issues. Family, friends, neighbors, and church can be the all-important backup that a potential custodian needs. This support system is usually a work in progress for any single parent, and the client can continue to build and develop it while the case is pending.

C. Searching for a Custody Evaluator

Finding a competent custody evaluator for domestic violence cases is always

a challenge. In most states the evaluation process is not standardized but could encompass the following: interviews with parties, review of mental health and medical records, review of criminal records of parties including police reports, and interviews with people—such as neighbors, other family members, teachers, and doctors—collateral to the case. The evaluator may perform and interpret various psychological tests. Custody evaluations that prove valuable to the court must include observations of the parties and the child or children. The evaluation itself is usually written and contains a recommendation for custody and visitation. Many contain recommendations for further treatment or other therapeutic processes such as parenting classes, anger management classes, and therapy for parents or children. In contested custody cases, the evaluator will act as an expert witness, will testify at the hearing or trial, and will be subject to cross-examination.

To assume that a mental health professional will understand domestic violence is a mistake, and to think that the professional will have a grasp of the interrelationship between domestic violence and mental illness is a greater mistake. Finding someone who is knowledgeable about these issues, or is educable, can be a tremendous asset to the case.

In our work at Life Span we have had some negative experiences with evaluators' failure to understand domestic violence and its manifestations in the mother and her relationship with her child. Clients realistically concerned for their children's physical and emotional safety when with the abuser were seen as enmeshed, overidentified, and overinvolved with their children. Evaluators routinely did not recognize these characteristics as arising from real and legitimate fear and the desire to protect as a result of domestic violence. Rather, evaluators often saw them as evidence of poor parenting skills. In some cases, clients were blamed for the effects of violence, and abusers were absent in this determination of responsibility. Through experience and networking, Life Span lawyers have found a few psychologists who are sympathetic to our clients' point of view and who

have been willing to explore the nexus between domestic violence and mental illness for themselves. In suggesting that each case would benefit from such an evaluator, I understand how difficult obtaining such an expert will be for any attorney beginning to represent this population of clients.

III. Developing a Strategy for Handling Mental Health Issues in the Case

The knowledge that the attorney has gained in the investigation and fact development phase of case preparation will form the basis for decisions about how to handle the domestic violence and mental health issues in the legal action.

A. Pleadings

In our experience at Life Span, if a client has had treatment for a mental illness and the abuser knows this, the abuser will try to use it to prove that (1) she is not a credible witness and (2) she should not be awarded custody of the children. Since the opposing party, in all likelihood, will raise the issue, we have found that acknowledging the mental health issues affirmatively in the battered woman's case is a successful strategy. This straightforward treatment of the issue helps dispel the stigma that the opposing side wants to use to its advantage either subtly or overtly. To say that the battered woman can use her mental illness in a positive way may be too strong a statement, but acknowledging the issue in her own petition for divorce, custody, or a protective order allows her to avoid a defensive posture. The battered woman's indication in her court papers that she is taking ownership of the issue of her mental health status tends to deflate any attempt by the opponent to overwhelm the case with this issue.

The client can underscore her appropriateness as a custodial parent at the same time that she raises the mental illness issue in any petition seeking an award of custody. Again, the strategy in treating the issue this way is to refuse to give credence to the stigma of mental illness. We have adapted the following sam-

ple statements for use in many cases at Life Span:

- "Petitioner has been diagnosed with depression, is currently in treatment, and is in compliance with all treatment recommendations."
- "For all of the child's life, petitioner has had the primary responsibility of caring for the parties' daughter, Mary."
- "Mary is a thriving and well-adjusted child with a close relationship to petitioner."
- "That Petitioner be awarded sole custody is in Mary's best interests."

Life Span lawyers also use pleadings to raise the issue of causality in the mental illness–domestic violence interrelation. We accomplish this as simply as possible, with a minimum of conclusory language. To describe a causal relationship between the client's mental state and the domestic violence, an allegation might be worded as follows: "Petitioner is afraid to leave her house due to her fears that the respondent is following her." This sentence, used in the context of a pleading in a case in which mental illness is an issue, is a good deal more complicated than it appears because it is an allegation incorporating the idea of trauma theory. The abuser might raise an issue of the client's paranoia and its impact on her daily life, making it impossible for her to meet her parental responsibilities. The client's lawyer is describing the issue as a result of the abuser's stalking of the client. This allegation places the focus on the abuser's intimidating conduct rather than on the victim's legitimate response.

Simple factual sentences can also relate the idea of causality in cases in which a mental health condition is exacerbated by abuse. Here the allegation might read: "Petitioner's depression deepened after the respondent began abusing her." In cases in which the mental illness was relieved once the client was protected from violence, the pleading might say: "Once petitioner entered the domestic violence shelter, her depression lifted." The use of the word "depression" is important here; the term is

both technical and in the vocabulary of the average person. “Posttraumatic stress disorder” cannot be used in the same way.

In these three examples the lawyer puts forth the theory of the case and the nexus between domestic violence and mental health issues without any technical or theoretical language which might alarm either the opposing side or the court. In fact, these factual statements lend themselves to a variety of uses in the case and can be proven through a client’s as well as an expert’s or treatment provider’s testimony.

B. Using Treatment Evidence in the Case—an Example

The best strategy for using treatment evidence is to use it to establish the mental health issue as your issue and to remain the master of the evidence. In this section I will use a case example from Life Span files to illustrate how treatment evidence can be used both to prove your case and to negate the power that the opponent hopes the mental illness will have in his case.

Mary and John were married and had an 18-month-old daughter, Ann. Mary was a stay-at-home mother and John was a patrolman in their local police department. John was abusive and had been hitting Mary with increasing frequency since her pregnancy. He prohibited her from speaking with her family and did not allow her to leave the house unless he accompanied her. Before the marriage, Mary had a history of depression and had taken antidepressants. As the domestic violence in her marriage to John progressed, Mary again became depressed. Although she took good care of Ann, she was often too debilitated by her illness to engage in any other activity. She was sad, listless, and did not take care of herself. She rarely ate a full meal and lost weight. John often told her that she was crazy, but he would not allow her to contact her doctor for help. He told her that no one would believe her story of abuse because she was crazy. John knew that he might lose his job if the police department had evidence that he was a batterer.

One evening John beat Mary severely, pulling her hair, hitting her in the torso

and thighs, grabbing her by the upper arms and shoving her to the ground and into the wall. After the beating John went out, locking Mary and Ann in the house with a dead-bolt lock and taking the key. Mary decided that she had had enough and called her family to come and get her. When her father and brother arrived, they could not get in the house. They called the police from their cell phone, and John and a few of his colleagues arrived together some minutes later.

John explained what had happened to the other officers: Mary was depressed, but she would not get help for herself. Earlier that evening she had tried to jump out of the window, and he had had to restrain her. Sobbing, Mary recounted the facts to the officers, who expressed disbelief. Mary’s relatives demanded that the officers do something to protect Mary, so, in consultation with John, they decided to take Mary to the mental health ward of the nearby hospital.

At the hospital the nurses and doctors performed a general examination to determine Mary’s physical health. They noted in the file that Mary appeared to have many fresh injuries to her body, legs, and arms. They documented the injuries on a body chart in the file. The nurse asked Mary what had happened to her, and Mary told her that her husband had beaten her earlier that night. Mary was tearful and asked repeatedly about her daughter and who was caring for her. The nurse wrote an account of the conversation in the file, noting Mary’s concern for her daughter. When Mary sat up in bed, the nurse saw clumps of hair on her pillow; the hair was falling out as a result of John’s abuse. The nurse wrote these observations in the file.

Mary was admitted voluntarily for treatment of depression. She was interviewed by nurses, social workers, and doctors several times during her two-week hospitalization. Each time Mary told the story of her victimization and related that her husband beat and isolated her. She denied ever trying to commit suicide and explained that her husband lied to cover up the true origin of her injuries. The file contained the following notations from medical personnel about Mary’s

statements: “Repeats that throughout the relationship he has been intermittently abusive—physically, including punching, pulling hair, and kicking her & verbally abusive as well.” Later the nurse noted that “husband has only set of keys to the house & locks her in with the baby when he goes to work or goes out for any reason.” The nurse identified the issues in the case as “psychiatric symptoms; domestic violence.” During her stay, nurses updated her file as her injuries developed; the nurses noted increased bruising and swelling as the days wore on.

As part of Mary’s treatment, the same practitioners interviewed John. The social worker’s notes include this sentence: “ I asked him about physical fighting between pt. He denies, though states that at times he has pushed her aside. Also admits to ‘having to restrain her.’” During a social work meeting at which both Mary and John were present, Mary described John’s abusive conduct. The social worker’s notes of the meeting reflected that John “did not deny or become overtly anxious when discussing. He states that these occurrences have been recent.” John also “expressed his wish to restrict her contact with her family.”

Mary was discharged from the hospital with antidepressant medication. She went home with John and resumed their life together, hoping that John would change his behavior toward her. Mary had twice weekly appointments with the social worker at the hospital and took her medicine as prescribed. She lived with John for two months until John beat her again. Taking baby Ann with her, she fled to her sister’s home. She contacted Life Span for help. We took her case to file for an order of protection under the Illinois Domestic Violence Act.

In the meetings with her attorney, Mary was straightforward about her mental health issues and recent lengthy hospitalization. She was skeptical that she would be able to keep her baby and was sure that a judge would not believe her story of abuse. The lawyer interviewed Mary at length and observed her with her daughter. She asked Mary to go to the hospital and get a copy of her treatment records. The lawyer reviewed the records that Mary

brought to her later that week and found many statements that could be helpful. The lawyer met with Mary and explained that she wanted to file papers that told the judge about Mary’s illness and her treatment. The lawyer explained the issues related to the use of privileged information. With Mary in agreement with this strategy, the lawyer prepared a petition for a protective order, also asking for temporary custody of Ann. The pleading included an account of Mary’s recent problems with depression and described the condition as one that arose after a history of abuse. The petition alleged that Mary was in treatment and taking her medication, fully functional and taking care of her daughter. John’s lawyer filed an answer that raised doubts about Mary’s ability to be truthful. The answer described Mary as suicidal and unable to care for Ann. John also filed his own petition for custody.

This case went to hearing within a week of its filing at John’s insistence. He was concerned that the petition would damage his career as a police officer, and he was confident that the case would be quickly resolved in his favor. In preparation for the hearing, Life Span lawyers held a conference with Mary and the practitioners who had treated her at the hospital. They went over the files and agreed that their testimony could only help Mary prove her case. The lawyer subpoenaed the nurse and social worker, along with their complete files.

The Life Span attorneys offered the following evidence: Mary testified about the abuse and about her relationship with Ann. She talked about her depression and her treatment compliance. She told the judge that she felt much better since she moved in with her sister. Her lawyer was surprised at how well Mary stood up under cross-examination; she was a little shaky but remained consistent. Mary’s sister testified about her observations about Mary’s parenting abilities, and how glad she was to have her sister back after years of John hanging up the phone when she called. Mary’s dad testified about the night he went to help Mary and found her dead-bolted in the house.

We then called the nurse as a witness. She testified about Mary’s injuries

and her statements concerning how she became injured. She showed the court her body chart and her documentation of the progression of Mary's injuries. She testified as to Mary's concern about Ann. She testified about Mary's consistency and candor during the several conversations she had with Mary about the history of abuse. When the psychiatric social worker testified, she talked about Mary's physical condition and her consistent statements about the battering. She talked about John's demeanor, his admissions about the pushing and other violence, as well as his unwillingness to let Mary see her family. She explained to the judge that depression can be a result of abuse and is a very treatable condition. She also testified that Mary had kept her appointments since leaving the hospital, was compliant with medication, and the depression had lessened considerably. The social worker had observed Mary and Ann together many times in her office and found their interactions appropriate. We used the nurse to supply a foundation for the treatment records and entered them into evidence.

John testified on his own behalf. His testimony was a series of denials and assertions that Mary was crazy and could not be believed. From his work as a police officer, he knew that the victim's credibility is often an issue in domestic violence cases and that many police and judges believe that women fabricate allegations. He thought Mary's mental illness would heighten the judge's reluctance to believe her. He talked about trying to restrain Mary and fearing for Ann's safety in her care, even though Mary had always been Ann's caretaker. John's lawyers called the officers who had taken Mary to the hospital; the officers' testimony described her as weeping and incoherent.

The judge granted Mary the order of protection and gave her temporary custody of her daughter. He required Mary and the baby to live with her sister during the pendency of the case and to follow the instructions of her social worker. He ordered John to enroll in domestic violence counseling and reported his conduct to the police department. The judge ordered the parties to participate in an evaluation for custody purposes. This case pended for more than



a year while the evaluation was completed. Mary was the recommended custodian, and the case settled.

In Mary's case the lawyers used the mental health evidence for a number of purposes. First, it bolstered her credibility on the abuse issues and helped prove that domestic violence occurred. Mary's consistency in telling her story to a number of people in a situation in which she was likely to be truthful, and the fact that those people believed her, helped prove her reliability. Second, the mental health evidence was presented as part of Mary's case and Mary remained in control of the issue. The professional testimony was part of Mary's case in chief and in her favor. Mary's testimony drew a relationship between her husband's abuse and her state of mind and feelings. As a whole, this strategy prevented John from exaggerating the prob-

lem, inflating its importance, or characterizing her illness as debilitating.

Mary was able to present evidence that she was an appropriate parent for Ann. She testified about her caretaking abilities, as did her sister. The nurse and social worker presented evidence about Mary's concern for her daughter, her compliance with treatment, and her appropriate interactions with Ann. Although the judge put some safeguards in place for Ann as part of the temporary order, the client and her lawyers clearly established that she, and not her abusive husband, was a better parent for Ann.

C. Some Caution in Using Treatment Evidence

Many lawyers are tremendously reluctant to use treatment evidence in a hearing or trial, perhaps in part because of the many unknowns of using this kind of evidence. The lawyer should become familiar with some of the issues involved and the applicable law of the state as a way of making this valuable evidence a useful part of the case.

1. Waiving the Privilege by Introducing Mental Health Treatment Evidence

Once the client introduces the mental health treatment evidence as part of her case, it is no longer protected by privilege. The opponent can make use of any documentation in the file for his own purposes—to prove his case elements, to damage the battered woman, or to discredit her theory of the case. Therefore, when deciding to go forward with a treatment file as part of the battered woman's evidence, the woman's lawyer must know everything that is contained in the file and make the determination that the information is more helpful than harmful.

2. The Dangers of Cross-Examination

Obviously any witness the lawyer offers must be vetted for cross-examination issues. Testifying in court can be frightening for battered women, and, for those suffering the traumatic mental health effects of battering, the prospect of cross-examination can be terrifying. Witnesses,

including the health professionals, must be thoroughly prepared. For example, many treatment files contain ambiguous or contradictory statements, and the lawyer should assist the treatee in formulating an explanation for this common occurrence. The witness' demeanor, tone, and attitude are important, and the lawyer should direct the presentation. Although the witness is a professional, the witness may not, without thorough preparation, give the forceful, straightforward testimony that the lawyer is seeking. Life Span lawyers routinely prepare a difficult cross to administer to their own witnesses.

3. Formerly Privileged Information May Be Used in Other Proceedings

In Illinois and in jurisdictions across the country, battered women find themselves challenged in a number of different forums. A battered woman seeking civil remedies in a family law case may also participate in the criminal prosecution of the domestic violence crime or be brought into juvenile court on charges of child endangerment, abuse, or neglect. When the privilege protecting mental health records is waived in one proceeding, such as an order-of-protection hearing, that same evidence could be used in another proceeding under very different circumstances. For example, a treatment file detailing a long history of abuse may be very helpful in establishing a case for a protective order in civil court but may be damning in a juvenile court proceeding charging the victim with failure to protect her children from witnessing abuse in the home. This possibility must be included in any calculus about the relative helpfulness and harmfulness of information contained in the files.

4. Waiving the Privilege by Making Mental Illness an Issue in the Case

Some lawyers have theorized that once the battered woman raises the issue of her own mental health, she makes it an issue in the case and thereby precludes her ability to assert a privilege over her mental health records even when she has not introduced any of these records in

support of her case. This idea is analogous to the issues of illness and injury in a tort action; when a plaintiff sues for damages for a tortious injury, the plaintiff's medical condition is a central issue in the case—it is the subject of the lawsuit. The plaintiff in that circumstance cannot successfully protect relevant medical information as privileged. However, in custody litigation, Illinois courts hold that the issue in a custody matter is “best interests,” not the parents' medical status, and that parents retain the ability to assert that their medical and health records are privileged.²³ Before raising any mental health issue, lawyers must research this point in the case law of their own state.

IV. Systemic Advocacy

Representing mentally ill battered women individually can affect the manner in which the court system handles these issues, and each case that a legal services provider takes contributes to reforms in the system. Judges, lawyers, mediators, custody evaluators, and child's representatives can all be educated by thorough and thoughtful representation of the battered woman.

Forging relationships with service providers in other disciplines affecting your client also has a reform effect, and creating these relationships benefits other clients within this special population even if they do not have the benefit of informed legal representation.

In Illinois a ground-breaking project focuses on systemic reform of these issues and is a highly successful model for other jurisdictions. The Domestic Violence and Mental Health Policy Initiative, headed by Dr. Carole Warshaw, brings together service providers from domestic violence and mental health to discuss common issues and create ways to collaborate.²⁴ Building relationships can overcome the stigma and mistrust between these fields. This effort also offers opportunities for cross-

training and creates a process for reciprocal referrals.

V. Conclusion

Mental illness is a factor in a significant number of battered women's lives and should not be a bar to successful custody bids on their behalf. Providers of legal services can and should take these cases.

Lawyers undertaking this work can enhance their ability to obtain good family law outcomes by understanding the relationship between mental illness and domestic violence. A willingness to confront prejudice and stigma about mental illness in our courts and in our society by thoughtful mastery of this issue as part of the victim's case is a crucial part of this approach. Building relationships with domestic violence and mental health service providers will assist greatly in this effort on both an individual and a systemic level. A custody evaluator with an understanding of both battering and mental illness is a necessary component of successful litigation, and recruiting such a professional is an important initial step in representing this client population.

Court systems and their personnel, including judges and lawyers, especially those representing children, need education on these topics, both from experience in working on individual cases and in a comprehensive manner.

Battered women whose abuse has affected them through mental illness are underserved by the legal services profession, which often considers these cases too difficult and time-consuming to undertake. Strategies that result in significant victories for battered women and their children are within the reach of any interested poverty law practitioner. This work can be wholly rewarding, both on an individual basis and as a means of addressing the prejudice our society holds toward the mentally ill and those victimized by violence in the home.

²³ Jonathon D. Nye, *Disclosure and Privilege of Mental Health and Substance Abuse Records and Information*, in 23 ILL. FAM. L. REP. 94 (2000).

²⁴ For information about the Domestic Violence and Mental Health Policy Initiative, see www.dvmhpi.org.