The National Center for the Prosecution of Violence Against Women

THE voice

Helping Prosecutors Give Victims a Voice

American Prosecutors Research Institute
The Research and Development Division of NDAA
Volume 1, Number 10

The Prosecutor's Guide to Mental Health Disorders

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Editor's note: *This article was written to assist prosecutors who may not typically handle cases involving victims with mental health disorders. This article is not primarily intended to provide courtroom tips; please contact the National Center for the Prosecution of Violence Against Women for resources relating to trial practice.*

Sexual assault and domestic violence prosecutors commonly encounter victims with mental health disorders due to the tendency of predators to seek out vulnerable victims.[4] These victims are affected not only by the crime itself, but often by the additional challenges they face throughout the pretrial and trial process. Defense attorneys regularly re-victimize these victims by seeking their mental health records or by arguing that they are incompetent or not credible because of their disorder. Oftentimes, these arguments are baseless. Prosecutors with an understanding of mental health disorders can successfully combat these defense tactics and ensure that victims who suffer from mental health disorders are not misrepresented. This article discusses common mental health disorders and their significance to prosecutors. First, the article discusses the specific disorders; then it explains the differing impact of mental health disorders on competence and credibility. This article is followed by a chart, which reviews all of the disorders mentioned in the article and summarizes the disorders' symptoms, prevalence, course, and potential impact on witness credibility.

OVERVIEW OF COMMON DISORDERS

The prosecutor should become familiar with the mental health disorders that most commonly affect victims. The first group of disorders—Mood, Anxiety, and Adjustment Disorders—are the most common disorders. A victim afflicted with one of these disorders should be able to survive a challenge to her[5] competence, as these disorders generally do not affect an individual's ability to process and recall events. The second group of disorders—Cognitive, Dissociative, Psychotic, and Personality Disorders—may create competency issues, as they can affect one's ability to learn new information and remember previously learned information.[6]

Mood Disorders, Anxiety Disorders, and Adjustment Disorders

Mood Disorders, Anxiety Disorders, and Adjustment Disorders are relatively common in the general population, and prosecutors are likely to encounter vic-tims with these disorders. It is very important that prosecutors understand that these disorders do not, in themselves, provide motivation for a victim to lie or otherwise impede a victim's ability to recall and accurately relay events. Prosecutors should be able to easily overcome any defense challenges to competence or credibility.

Mood Disorders

Mood disorders can be divided into the Depressive Disorders and Bipolar

continued ➢

Disorders. Depressive Disorders include Major Depressive Disorder and Dysthymic Disorder. A victim with Major Depressive Disorder may appear sad, hopeless, and discouraged, and may have impaired ability to make decisions. Thoughts of death and suicide attempts are not uncommon. In the most rare and severe cases, psychotic features will be associated with an individual's depression.[7] Dysthymic Disorders can be thought of as a less severe Depressive Disorder. The life-time risk for women to have a Depressive Disorder is 10% to 25%, with 5% to 9% experiencing a major depressive episode at any one time. Overwhelmingly, a victim with a Depressive Disorder will be competent to testify and will not have significant memory problems. The victim's motivation to participate in the legal process may appear to wax and wane, and it is important to remember this may be part of her psychiatric disorder and can be expected.

The Bipolar Disorders involve the presence of Manic Episodes or Hypomanic Episodes, usually alternating with Major Depressive episodes. A victim experiencing a Manic Episode may appear to act in an irrational manner. She may stay awake for days on end, be very distractible, have incessant speech and/or pressured speech, and have flights of ideas with racing thoughts. Hypomanic Episodes are a less severe version of mania and do not significantly interfere with the person's ability to function. If a victim is currently experiencing a manic episode, she should be evaluated and treated psychiatrically before taking the stand. Individuals diagnosed with Bipolar Disorders may have, as part of their symptom presentation, a history of engaging in high-risk behaviors such as frequent sexual contacts. Prosecutors should be aware of this possibility.

Depressive and Manic Episodes can occur following psychosocial stressors. Thus, an assault and the resultant legal process can trigger one of these episodes in a person with a Mood Disorder, possibly causing the victim to be difficult to understand, have poor judgment, experience psychomotor retardation,[8] or become depressed. For the reasons set forth in the preceding paragraphs, prosecutors should easily be able to overcome defense challenges to a victim's competence and credibility by introducing an expert, if necessary, to explain the typical effects of these disorders. In addition, prosecutors who work with mental health professionals can lessen the impact of the legal process on the victim and present the victim's testimony in the best possible light.

Anxiety Disorders

Anxiety Disorders include but are not limited to: Panic Disorders, Phobias, Obsessive-Compulsive Disorder, Acute Stress Disorder, and Posttraumatic Stress Disorder (PTSD). In general, victims with these disorders may experience such feelings as accelerated heart rate, shaking, shortness of breath, nausea, lightheadedness, and fear of going crazy.

One of the most common diagnoses of victims of violence is PTSD. A victim with PTSD may experience those symptoms listed above, but may also be unable to recall important aspects of events relating to her assault. One of the hallmarks of the PTSD diagnosis is re-experiencing a traumatic event, as well as persistent efforts to avoid memories of the experience due to the distress these memories cause. This is not an Amnestic Disorder,[9] nor does it imply that the witness would create memories. In other words, someone suffering from PTSD is not necessarily more likely to imagine false memories. Prosecutors should be patient interviewing victims with PTSD and allow for extra time. Since neither "re-experiencing" nor memory loss constitutes either a hallucination or Amnestic Disorder, and, since both are hallmark symptoms of PTSD, they can be easily and readily explained to a jury by any mental health professional without the need to investigate the witness's mental health history.

Prosecutors who attempt to show that a victim suffers from PTSD due to a crime should recognize that this strategy may open the door to the defense argument that some other traumatic event caused the victim's PTSD. Further, if the prosecutor introduces evidence of PTSD at trial, the defense may be entitled to obtain the victim's mental health records.

For the reasons set forth in the preceding paragraphs, prosecutors should easily be able to overcome defense challenges to a victim's competence and credibility by introducing an expert, if necessary, to explain the typical effects of Anxiety Disorders.

Adjustment Disorders

Adjustment Disorders involve a generally short-term psychological response to a stressor or stressors that result in the development of clinically significant emotional or behavioral symptoms. An Adjustment Disorder is a common response to the trauma of an assault. A victim may experience decreased performance at work or school and temporary changes in social relationships. Adjustment Disorders may be associated with suicide attempts, substance use, and somatic complaints. This class of diagnosis is considered to be of "minor" psychiatric significance compared to other disorders, and while there may be some concern about the victim's lowered motivation to participate in the judicial process (as she may be in a depressed state), the prosecutor should be able to show that the witness is competent and that the disorder does not impact credibility. As with PTSD, the prosecutor should be cautious about introducing evidence of an Adjustment Disorder as a way of showing that the crime occurred because it may open the door and enable the defense to obtain the victim's mental health records.

Cognitive Disorders, Psychotic Disorders, Dissociative Disorders, and Personality Disorders

In contrast to the disorders discussed above, the following disorders may have a significant impact on victim competence as a witness and credibility before a jury.

Cognitive Disorders

The diagnoses which should cause the most concern to prosecutors are Cognitive Disorders, which, by definition, affect the witness's ability to accurately process and recall events. Thus, Cognitive Disorders may affect the witness's competence, despite her desire to tell the truth. The Cognitive Disorders that will be of the most concern for prosecutors are the Amnestic Disorders, which are characterized by memory impairment in the absence of other significant accompanying cognitive impairments. Amnestic Disorders related to head injuries can affect people in any age group. Alcohol-induced Amnestic Disorder is most common in people over the age of 40 who have used alcohol heavily for prolonged timeframes. Transient Global Amnesia usually appears in people over age 50.[10] Symptoms may include impaired ability to learn new information and/or inability to recall previously learned information. While an amnestic individual may have memory loss for a particular time period, the disorder will not affect recall of other time periods. Consequently, if the witness has retrograde amnesia (inability to recall events prior to the onset of amnesia) that occurred when she was 20 years old, her memory for events at age 21 should not be affected regardless of her current age.

The prosecutor's chief task in working with a victim with a Cognitive Disorder will be to determine, with the aid of a qualified expert, whether the victim can recall the events about which she will testify. A diagnosis of a form of amnesia need not affect witness competence, provided that the amnesia does not encompass the time during which the relevant events took place, and there are no co-existing disorders which would otherwise affect her competence. It is unlikely that a prosecutor will be able to keep these disorders out of evidence at the trial because they do impact the victim's ability to recall the events at issue.

Psychotic Disorders

The next group of disorders that impact victim competence and credibility are schizophrenia and other psychotic disorders. The term "psychotic" has come to mean a combination of certain symptoms which include delusions, disorganized speech, unpredictable agitation, and hallucinations. A victim suffering from such a disorder may express a variety of unusual or odd beliefs such as magical thinking[11] or sensing the presence of an unseen person. Her speech may be generally understandable but digressive, vague, or abstract. All of these behaviors may make it hard for the prosecutor to interact with a victim and she will often appear unstable. Further, the victim's diminished communication skills may hinder her ability to construct coherent ideas or testimony. With proper psychiatric care and medication, victims with schizophrenia and other psychotic disorders can typically function normally and meet the standards for witness competence. In such cases, the prosecutor should engage a qualified mental health professional to present expert testimony on the victim's disorder and current functioning. Prosecutors should recognize, however, that if they choose to present this type of testimony, the defense probably will obtain access to the victim's mental health records.

Dissociative Disorders

Dissociative Disorders are clinical disorders which cause a disruption in the functions of consciousness, memory, identity, or perception. They include, for example, Dissociative Identity Disorder, formerly called Multiple Personality Disorder. A victim with a Dissociative Disorder may have the inability to recall important personal information, experience confusion about her personal identity or even assume a new identity. In addition to interfering with social and occupational functioning, such a disorder will also make it difficult for victims to interact with the legal system. Victims with Dissociative Disorders, however, are very rare. Further, the victim is likely to be under the active care of a mental health professional, who will be the best judge of her ability to testify competently. When the victim's treating mental health professional determines that she is able to testify, the prosecutor should be prepared to engage a qualified expert to present testimony on the victim's disorder and current functioning.

Personality Disorders

In addition to the clinical disorders discussed above, Personality Disorders can have a major impact on witness credibility. The DSM-IV-TR defines a Personality Disorder as an enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset that can be traced back at least to adolescence or early adulthood, is stable over time, and leads to distress or impairment.[12]

Personality Disorders are grouped into three clusters: A, B, and C. Cluster A disorders include Paranoid, Schizoid, and Schizotypal Disorders, any of which may result in the victim/witness being viewed on the stand as mentally unstable. Prosecutors should recognize that a victim diagnosed with a Paranoid Disorder may distrust and be suspicious of you and your motives. She may express her suspiciousness and hostility by overt argumentativeness or hostile aloofness. The prosecutor's two greatest challenges

with this victim will be to gain her trust so that she will fully disclose the events of the assault and to prevent her from becoming argumentative and angry on the stand.

People with Schizoid and Schizotypal Disorders may show some eccentricities of behavior that could mirror schizophrenia, but they do not meet the clinical diagnosis for schizophrenia. These Personality Disorders are marked by impaired interpersonal skills, disturbed thought patterns, and unusual behavior or physical appearance. Schizophrenia, on the other hand, is characterized by impairments in the perception and expression of reality. Psychotic individuals may experience delusions and auditory hallucinations, whereas Schizoid and Schizotypal individuals are in contact with reality, but may have odd and/or disturbing behaviors.

For the prosecutor's purposes, Schizoid and Schizotypal Disorders are relatively similar. Individuals with these disorders can demonstrate a pattern of detachment from social relationships and will not likely be cooperative when dealing with the legal system. Such a victim's expressed range of emotions is restricted, giving the appearance that she does not care about what is happening in her life. The prosecutor's greatest challenge with a victim afflicted with a Schizoid or Schizotypal Disorder will be convincing the jury of the emotional impact that the crime has had on the victim.

Cluster B disorders include Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. A jury will tend to view these individuals on the witness stand as highly emotional and self-absorbed. Antisocial Personality Disorder is a pervasive pattern of disregard for, and violation of, the rights of others. In the overwhelming majority of cases, this is a Personality Disorder associated with the assailant and not the victim. However, in the rare case where a victim presents with this disorder, she may likely show a lack of empathy; inflated, arrogant self-appraisal; superficial charm; and depressed mood. An individual with Antisocial Personality Disorder can be described as a psychopath/ sociopath who, as a predator, uses manipulation, charm, and violence to control others and to satisfy her own selfish needs. This person may take what she wants in a cold-blooded manner, doing as she pleases, all the while violating social norms without the slightest sense of regret.[13] The prosecutor's challenge with this individual is to get the jury to look past her seeming attitude of self-absorption.

This same task holds true with Narcissistic Personality Disorder. This disorder is characterized by a pattern of grandiosity, need for admiration, and lack of empathy. Those affected by Narcissistic Personality Disorder routinely overestimate their abilities and inflate their accomplishments, believe they are superior to others, and require excessive admiration. Even though they want to portray themselves in the best light possible, they will not change their behavior even when it causes problems or emotional distress to others. Though they appear to have high self-esteem, they are very sensitive to injury from criticism. Criticism will haunt them and leave them feeling humiliated, degraded, and empty, so if the prosecutor criticizes them, they may become even more difficult to work with.

Borderline Personality Disorder is a pattern of instability in relationships, self-image, and emotion. The prosecutor's relationship with victims afflicted with this disorder will often be one of love/hate, since such victims are prone to sudden and dramatic shifts in their view of others and display impulsivity in areas that are potentially self-damaging.

Histrionic Personality Disorder involves excessive emotionality and attention-seeking behavior. People with this disorder usually are able to function at a high level and can be successful; however, their disorder may affect their relationships. The prosecutor should be aware that their style of speech is excessively impressionistic and lacking in detail, so it may be hard to elicit the truth from them. They also have a high degree of suggestibility, so the prosecutor should take precautions in wording questions to reduce this risk. Both Borderline and Histrionic Personality Disordered victims are likely to have an extensive history of highly volatile sexual relationships. The prosecutor will be challenged when attempting to keep these victims emotionally stable throughout interviews and testimony, and when trying to get a detailed history.

Cluster C disorders include Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. Individuals with Cluster C disorders will often be seen by the jury as odd or pathetic. Avoidant Personality Disorder involves social inhibitions, feelings of inadequacy, and hypersensitivity to negative evaluation. This victim wants friends, but is so afraid of rejection that she avoids any but the safest contact. She may miss appointments and be hesitant to interact with the prosecutor for fear of being ridiculed. The prosecutor's challenge is to establish himself/herself as a "safe" person and then to support the victim so that she is able to testify. Prosecutors should be prepared to spend extensive time in an empty courtroom with repeated practice of both direct and cross examination in order to make the victim comfortable.

Dependent Personality Disorder involves an excessive need to be taken care of that leads to submissive and clinging behavior. She likely has difficulty making everyday decisions, and, therefore may allow the prosecutor (or someone else) to take responsibility for most major areas of her life. The victim may belittle her abilities, referring to herself as stupid and incompetent. Prosecutors must make sure to reinforce that this is not true and must also be vigilant to ensure that the assailant does not try to move back into the role of decision-maker for the victim.

Obsessive-Compulsive Personality Disorder is a preoccupation with

orderliness, perfectionism, and mental and interpersonal control. Individuals with this disorder try to maintain a sense of control through attention to rules, trivial details, or procedures, to the extent that the major point of the activity is lost. They also may place excessive demands on the prosecutor as their point of contact in the criminal justice system. Victims with this type of disorder also may become upset and angry in situations in which they are not able to maintain control over their environment. The challenge with these victims will not be in the courtroom; rather, it will be the intense emotional energy on the prosecutor's part to set limits and to deal with their insistent demands on the prosecutor's time. As opposed to individuals with Cluster A or B Personality Disorders, who most likely will become argumentative, stubborn, and refuse to cooperate when questioned by the opposing counsel, those with Cluster C Personality Disorders may be easily bullied and crumble under the pressure of cross-examination.

Victims diagnosed with Personality Disorders should be evaluated by a mental health professional. Since these disorders are long-term and relatively stable over time, the victim's personality will not change significantly. The disorder, therefore, will be an issue that needs to be addressed in almost every meeting the prosecutor has with the victim. The prosecutor also will likely need a mental health expert to testify at trial to educate the jury on the nature of the victim's Personality Disorder and the impact of the disorder on the victim's behavior.

IMPACT ON VICTIM COMPETENCE AND CREDIBILITY

The first defense challenge prosecutors are likely to face is the allegation that a victim with a mental health disorder is not competent to testify. A victim with a mental illness who will testify in court must, like any witness, be deemed competent by the court to offer testimony. Historically, the insane or mentally ill were among categories of people excluded from offering testimony for fear that they would knowingly or unknowingly provide inaccurate testimony.[14] Today, however, all witnesses are generally presumed competent to testify.[15] "This presumption of competence includes witnesses who are mentally ill so long as the witness has first-hand knowledge of the facts and can understand the obligation to tell the truth."[16] To be competent, a witness must be capable of communicating relevant material and understand the obligation to do so.[17] Competence to be a witness is determined by the trial court after such examination as the court deems appropriate, and the court's exercise of discretion in this matter is to be reversed only for clear error.[18] Moreover, inconsistent statements do not make a witness incompetent to testify.[19] When faced with a challenge to competence, prosecutors should examine it in light of these standards.

Demonstrating that the witness is competent to testify will not always be enough to keep the witness' mental health disorder out of court. The defense will probably next attempt to introduce evidence of the disorder as a way of showing that the witness is not credible. While mentally ill witnesses are not incompetent to testify, they may be cross-examined to determine whether such impairment affects their capacity either at the time of the event or at trial to perceive, recollect, and narrate.[20] Although the mental disorder may not make a witness incompetent, a history of mental disorders may go to the weight of the testimony.[21] Prosecutors who understand the nature of mental illness and its impact on credibility will be better able to protect victims from having their testimony confused and diluted by a defense attorney and, thus, misconstrued by jurors. In addition, prosecutors who understand the disorders will be better able to work with victims and present their testimony clearly during direct examination at trial.

SUMMARY

When dealing with a victim with a mental health disorder, prosecutors must first identify the disorder. If the victim has a Mood Disorder, Anxiety Disorder, or Adjustment Disorder, it is unlikely that the prosecutor will need to access the victim's mental health records. The prosecutor should oppose defense attempts to secure the victim's mental health records, as typically, nothing about these disorders causes a victim to have difficulty remembering events or relating testimony in a truthful way.

If the victim suffers from a Cognitive, Dissociative, Psychotic, or Personality Disorder, the prosecutor's job is more challenging. The prosecutor must determine if the illness impacts the victim's ability to recall events or testify truthfully. If it does, the defense will probably be able to raise the issue at trial. Prosecutors should check the law in their jurisdiction because the victim's records may be privileged; i.e., neither the prosecution nor the defense may be entitled to access them. Prosecutors may wish to work with civil attorneys who can protect victims from unsubstantiated defense challenges. ■

QUICK REFERENCE GUIDE FOR COMMON MENTAL HEALTH DISORDERS

Disorder	Symtoms	Prevalence	Course	Impact on Witness Credibility
MAJOR DEPRESSIVE DISORDER	Depressed mood; diminished interest in activities; weight loss; insomnia or hypersomnia; feelings of worthlessness	10%–25% for women and 5%–12% for men	Mean age of onset is mid-20s; usually develops over days to weeks; duration is variable; in most cases complete remission of symptoms occurs	Low
MANIC EPISODE	Distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week	0.4%–1.6% in adults	Mean age of onset is early 20s; usually begins suddenly, with a rapid escalation of symptoms over a few days; episodes last from a few weeks to several months	Medium to high if untreated
ANXIETY	Intense fear; sweating; chest pain; nausea; feeling of dizziness; fear of dying (may include lower level descriptions, e.g., worry, etc.)	3% in adults	Many individuals may feel anxious or nervous all their lives; onset usually occurs in childhood or adolescence	Low
ADJUSTMENT	Distress in excess of what would be expected from exposure to a stressor; nervousness; fear of separation from attachment figure	2%–8% in children and adolescents and the elderly	Usually begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor	None, unless there is shock associated with adjustment disorder
AMNESTIC	Memory impairment in ability to learn new information or inability to recall previously learned information	Varies depending on how it is diagnosed	Age of onset and subsequent course is dependent on pathological process	Variable
SCHIZOPHRENIA	Delusions; hallucinations; disorganized speech; disorganized or catatonic behavior	0.5%–1.5% in adults	Median age of onset is mid-20s for men and late 20s for women; onset may be abrupt or insidious	High
DISSOCIATIVE	Disruption in integrated functions of consciousness, memory, identity or perception	< 1% in adults In recent years there has been an increase in number of cases[22]	Can be present in any age group; duration of amnesia may be minutes to years	Variable
DELIRIUM	Impaired ability to remember and to focus; disorientation; speech and language impairment; delusions; hallucinations; irritability	0.4% in adults ages 18 and older 1.1% in those 55 and older	Develops over hours to days; may resolve in a few hours to days, or symptoms may persist for weeks to months	High while in delirious state
DEMENTIA	Impaired ability to learn new material; forgetting previously learned material; disturbances in executive functioning (i.e., the brain's ability to absorb and interpret information); impaired ability to carry out motor activities; failure to recognize or identify objects	3.0% of adults with severe cognitive impairment	May be progressive, static, or remitting; level of disability depends on severity of individual's cognitive impairment and available social support	High

Personality Disorder	Symtoms	Prevalence	Course	Impact on Witness Credibility
PARANOID	Distrust and suspiciousness of others; bearing grudges; reluctance to confide in others	0.5%–2.5% of the general population	Brief episodes may last minutes to hours; could be premorbid antecedent of delusional disorder or schizophrenia	High
SCHIZOID	Detachment from social relationships; restricted range of expression of emotions; lacks close friends; takes pleasure in few activities	3.1% of the general population; more prevalent in males	May be first apparent in childhood and adolescence	High
ANTISOCIAL	Disregard for, and violation of, the rights of others; impulsivity; lack of remorse; irresponsibility; irritability; aggressiveness	3% males; 1% females	Chronic course, but may become less evident or remit as person gets older	Medium
BORDERLINE	Instability of interpersonal relationships, self-image, and affects; chronic feelings of emptiness; recurrent suicidal behavior; identity disturbances; intense anger	2% of the general population	Variability in course; during the 30s and 40s individuals attain greater stability in their relationships and vocational functioning	Medium
HISTRIONIC	Excessive emotionality and attention seeking; suggestible; self-dramatization; rapidly shifting emotions; considers relationships more intimate than they actually are	2–3% of the general population	Usually able to function at a high level and can be successful socially and at work	Medium
NARCISSISTIC	Grandiosity; need for admiration; lacking in empathy; has sense of entitlement	1% of general population 2–16% in clinical population	Unusual for them to seek treatment; may be exacerbated by the onset of aging	Low
AVOIDANT	Social inhibition; feelings of inadequacy; hypersensitivity; views self as socially inept; reluctant to take personal risks	0.5–1.0% of general population 10% of outpatients in mental health clinics	Usually starts in infancy and may increase in severity during adolescence and early adulthood	Low to Medium
DEPENDENT	Excessive need to be taken care of that leads to submissive and clinging behavior; difficulty making everyday decisions	.5% of the general population but frequently reported in mental health clinics	May be lifelong	Low to Medium
OBSESSIVE-COMPULSIVE	Preoccupation with orderliness, perfectionism, and mental and interpersonal control; rigid; stubborn; reluctant to delegate tasks	1% in general population 3–10% in mental health clinics	May be lifelong	Low

FOOTNOTES

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[4] New Jersey Office of the Attorney General, Justice for All: Prosecuting Crimes Committed Against Persons with Disabilities, p. 1 (2006), stating, "Children and adults with disabilities experience violence and abuse at least twice as often as their non-disabled peers."

[5] *See* U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Intimate Partner Violence in the U.S. (1993-2004), http://www.ojp.usdoj.gov/bjs/intimate/offender.htm. In 2004, 96.9% of victims of intimate partner violence were female where the offender was male. *See also* U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Intimate Partner Violence in the U.S. (1993-2004), http://www.ojp.usdoj.gov/bjs/intimate/table/vomen.htm (indicating that in 75.3% of cases in 2004, offenders of intimate partner violence were male, regardless of the victim's gender). For this reason, the author will use "she" when referring to the victim and "he" when referring to the perpetrator or defendant. For additional information about this survey, please contact Chuck Rainville at NDAA's Office of Research and Evaluation.

[6] For more detailed and comprehensive information regarding mental health disorders, see American Psychiatric Organization, Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision, 2000).

[7] When this occurs, it is relatively easily treated via medication, but it is usually indistinguishable from psychotic disorders to the nonprofessional.

[8] *See* Encyclopedia of Mental Disorders (Ellen Thackery ed., 2006), *at* http://health.enotes.com/childrens-health-encyclopedia/depressive-disorders/. Psychomotor retardation is "slowed mental and physical processes characteristic of a bipolar depressive episode."

[9] *See Id.* At http://health.enotes.com/mental-disorders-encyclopedia/amnestic-disorders/. "The [A]mnestic [D]isorders are a group of disorders that involve loss of memories previously established, loss of the ability to create new memories, or loss of the ability learn new information. As defined by the mental health professional's handbook, the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (2000) … the [A]mnestic [D]isorders result from two basic causes: general medical conditions that produce memory disturbances; and exposure to a chemical (drug of abuse, medication, or environmental toxin). An [A]mnestic [D]isorder whose cause cannot be definitively established may be given the diagnosis of [A]mnestic [D]isorder and not otherwise specified."

[10] *See Id.*

[11] Magical thinking is a belief system in which thoughts, words, or actions assume unrealistic power (e.g., "using a tinfoil hat will prevent others from stealing my thoughts" or "counting to ten repeatedly will prevent bad things from happening to me").

[12] *See* Diagnostic and Statistical Manual of Mental Disorders, p. 685 (4th ed., text revision, 2000).

[13] The prosecutor should note that, depending on the situation, an individual with Antisocial Personality Disorder may become a victim when her intent was to be the aggressor. For example, individuals with this disorder may create a situation in which they target another individual, only to find themselves the victim of that individual's aggression.

[14] Susan Crump, *Would You Trust This Patient?* The Forensic Echo 2(6) *at* http://echo.forensicpanel.com/1998/5/1/wouldyou.html.

[15] *See* Fed. R. Evid. 601.

[16] *Id.*, citing United States v. Gutman, 725 F.2d 417, 420 (7th Cir., 1984).

[17] United States v. Saenz, 747 F.2d 930 (5th Cir. 1984), *reh'g denied en banc*, 752 F.2d 646 (5th Cir. 1985), *cert. denied*, Solis v. United States, 473 U.S. 906 (1985).

[18] United States v. Odom, 736 F.2d 104 (4th Cir. 1984).

[19] Hill v. McHenry, 211 F. Supp. 2d 1267 (D. Kan. 2002).

[20] *Id.*

[21] United States v. Phibbs, 999 F.2d 1053, 38 Fed.R.Evid. Serv. 881 (6th Cir. 1993); United States v. Skorniak, 59 F.3d 750, 42 Fed.R.Evid.Serv. 996 (8th Cir. 1995).

[22] *Id.* at 521. "This increase has been subject to very different interpretations. Some believe that greater awareness of the diagnosis among mental health professionals has resulted in the identification of cases that were not previously diagnosed. In contrast, others believe that the syndrome has been overdiagnosed in individuals who are highly suggestible."

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This article was supported by Grant No. 2004-WT-AX-K047, awarded by the Office on Violence Against Women, Office of Justice Programs, United States Department of Justice. This information is offered for educational purposes only and is not legal advice. The points of view, opinions, findings, conclusions, and recommendations expressed in this publication are those of the author and do not necessarily reflect the official position of the Office on Violence Against Women, the U.S. Department of Justice, or the National District Attorneys Association and the American Prosecutors Research Institute.