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Background, Education and Practice

Beth has been helping families for more than 30 years as a judge, lawyer and social worker. In 2005, Beth joined GoransonBain as a partner. Prior to returning to the practice of law, Beth served as the Judge of the 303rd Family District Court and as the Associate Judge of the 301st Family District Court. Before her 8 years of judicial service, Beth was a partner at the law firm of Gardere & Wynne, L.L.P. where she practiced family law. Prior to entering the legal profession, Beth worked with children in crisis and was recognized as a child abuse expert. Beth’s practice is limited to the area of family law. Her practice includes all aspects of family law including complex property issues and child-related matters. Beth specializes in handling cases involving issues of substance abuse, mental illness, domestic violence and abuse of children. Beth often serves as a mediator and practices Collaborative Law.

Beth has been selected as one of the Best Lawyers in America in Family Law and Family Law Mediation by Best Lawyers of America, named “Best Lawyers in Dallas” by D Magazine; “Best Women Lawyers in Dallas 2010” by D Magazine, and Texas Super Lawyer by Texas Monthly. Beth contributes her time to several advisory boards that deal with domestic violence in families and children in need. She has authored numerous papers and has been a frequent speaker on family law issues.
INTRODUCTION

Most hotly contested custody cases involve at least one party with a personality disorder or mental illness. The disordered party is driving the litigation train and everyone else is in for a bumpy ride. Unfortunately, the personality disorder or mental illness is often not recognized by the attorneys and/or judge involved in the case. By failing to be able to identify a personality disorder or mental illness, attorneys and judges contribute to perpetuating high conflict cases and litigation. The end result is irreparable damage to families.

To effectively represent and defend against the client with the personality disorder or mental illness, attorneys and judges need to recognize and understand the personality traits that comprise the personality disorders and mental illnesses seen in the family law court. This article will describe the personality disorders and mental illness most frequently seen in the family law courts and discuss how to represent and defend against clients with these disorders. The mental illness addressed in this article is Bipolar Disorder and the personality disorders discussed are: borderline, narcissist, obsessive compulsive, histrionic, dependant, paranoid and antisocial.

OVERVIEW – PERSONALITY DISORDERS AND MENTAL ILLNESS IN THE FAMILY LAW COURT:

Personality Disorders and Mental Illness: A personality disorder is a clinical term that is used to describe individuals who have personality traits that have become exaggerated, rigidified and inflexible to the point that there is a significant impairment on the person’s daily functioning. Major mental illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, and post traumatic stress disorder. The existence of the personality disorder or mental illness most often leads to significant problems in the individual’s work and personal lives. On the surface, the client with the mental illness or personality disorder may look no different from anyone else. However, after you spend time with this client and observe them in a crisis, the issues in their ability to function will begin to surface.

The Personality Traits of the Client with Personality Disorders and Mental Illness Wreak Havoc in the Family Law Court: Intense conflicts will eventually arise in the marriages of those individuals with personality disorders and mental illnesses. As such, clients with personality disorders or mental illness are the ones most likely to be involved in protracted custody litigation. The divorce process will be a very conflictual process due to the party with the personality disorder or mental illness engaging in the following types of behavior:

- They “dig in” and maintain rigid attitudes and perceptions throughout the family law process.
- They are not likely to change in the short term—if ever. If your client is suffering from a personality disorder or mental illness, you are likely to see the traits and behaviors for the duration of your professional relationship.
- Viewing their world as generally adversarial, so they often see all people as either allies or enemies in it.
- Their thinking is often dominated by cognitive distortions, such as: all-or-nothing thinking, emotional reasoning, personalization of benign events, minimization of the positive and maximization of the negative.
- They may form very inaccurate beliefs about the other person, but cling rigidly to those beliefs when they are challenged -- because being challenged is usually perceived as a threat.
- They are more likely to make false statements.
- Lying may be justified in their eyes -- possibly to bring a reconciliation or as a punishment. They will lie under oath.
- They are often preoccupied with other people's behavior while avoiding any examination of their own behavior.
- They claim the other party has characteristics which are really their own.
- They have an intensity that convinces professionals involved in the case (both mental health professionals and attorneys) that what they say is true.

Guidelines to Follow in Representing The Client with a Personality Disorder or Mental Illness: In representing a client with a personality disorder or mental illness, the following are some guidelines to follow:

- Do not expect the client with a personality disorder or mental illness to agree with your independent assessment of the situation.
Focus on working with the client and not trying to change them. If you try and change the client’s viewpoint, they will most likely become highly defensive, not trust you, or fire you.

Try and educate the client that others involved in the family law process, such as their spouse, children, the judge, friends and mental health professionals, may have a different view.

Do not focus on what is right or wrong. Instead focus on what is in the best interests of the children.

Communicate to the client that you understand how they feel and are perceiving the situation. This communication helps take the sting out of their reactions about being wrong.

Do not hesitate to compel your client to get the appropriate professional help. By not doing so, you may exacerbate the conflict in the case and prolong the litigation.

The Role of the Family Law Court Process in the Custody Litigation: For the party with a personality disorder or mental illness, all the world is a stage -- including court. They are highly skilled at and invested in the adversarial process. They see the judge as fulfilling the role of the all-powerful person who will punish or control the other spouse for them. They will perceive that the focus of the court process is to fix blame and they will use or attempt to use their attorney to champion their cause. Even the mental health professionals involved in the case are often manipulated by the party with a disorder or mental illness. The mental health professional does not have sufficient protection from being sued so they have a tendency to only describe personality traits and do not take firm positions against the disordered party for fear of being sued. The end result is that rather than being protective, the family court process can be very unpredictable and inadvertently encourages false allegations, aggressive and sometimes violent behavior, and intense blaming of the parent that does not have a personality disorder or mental illness. Many clients have been unable to protect themselves and their children from abuse by the parent and spouse with a personality disorder or mental illness. Instead, they have found themselves experiencing restraining orders, supervised visitation, financial sanctions and even incarceration, because the courts are often more persuaded by the intense emotions and blaming behavior of the party with the personality disorder or mental illness.

The court must realize that the parties are often not equally at fault. A non-offending spouse may truly need the court's assistance in dealing with the offender. The court should not be neutralized by mutual allegations without looking deeper. Otherwise, because of their personality style, the most offending party is often able to continue their offender behavior -- either by matching the other's true allegations for a neutral outcome, or by being the most skilled at briefly looking good and thereby receiving the court's endorsement. The court is in a unique position to motivate needed change in personal behavior. In highly contested cases, counseling or consequences should be ordered. Professionals and parties must work together to fully diagnose and treat each person's underlying problems, rather than allowing the parties (and their advocates) to become absorbed in an endless adversarial process. Because their largest issues are internal, they will never be resolved in court.

**BIPOLAR DISORDER – I AM GREAT, SMART AND CAN DO ANYTHING – I WANT TO DIE**

**DSM IV CRITERIA:** The DSM IV criteria for Bipolar Disorder is as set forth below:

**Bipolar I Disorder**–The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episodes. Episodes of Substance-Induced Mood Disorder (due to the direct effects of a medication, or other somatic treatments for depression, a drug of abuse, or toxin exposure) or of Mood Disorder due to a General Medical Condition do not count toward a diagnosis of Bipolar I Disorder. In addition, the episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

**Bipolar II Disorder**–The essential feature of Bipolar II Disorder is a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. Hypomanic Episodes should not be confused with the several days of euthymia that may follow remission of a Major Depressive Episode. Episodes of Substance-Induced Mood Disorder (due to the direct effects of a medication, or other somatic treatments for depression, a drug of abuse, or toxin exposure) or of Mood Disorder due to a General Medical Condition do not count toward a diagnosis of...
Bipolar I Disorder. In addition, the episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophrreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood;
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others);
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains;
- Insomnia or hypersomnia nearly every day;
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down);
- Fatigue or loss of energy nearly every day;
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick);
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others);
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self-esteem or grandiosity;
- Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
- More talkative than usual or pressure to keep talking.
- Flight of ideas or subjective experience that thoughts are racing.
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli).
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
THE MENTALLY INCOMPETENT PARTY

CHAPTER 45

• Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The symptoms do not meet criteria for a Mixed Episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatments) or a general medical condition (e.g., hyperthyroidism).

THE DIFFERENT FACES OF BIPOLAR DISORDER: To summarize the DSM IV criteria, Bipolar Disorder has three different faces are described as follows:

• Bipolar I Disorder (mania or a mixed episode) – The classic manic-depressive form of the illness, characterized by at least one manic episode or mixed episode. Usually—but not always—Bipolar I Disorder also involves at least one episode of depression.

• Bipolar II Disorder (hypomania and depression) – In Bipolar II disorder, the person doesn’t experience full-blown manic episodes. Instead, the illness involves episodes of hypomania and severe depression.

• Cyclothymia (hypomania and mild depression) – Cyclothymia is a milder form of Bipolar Disorder. It consists of cyclical mood swings. However, the symptoms are less severe than full-blown mania or depression.

DESCRIPTION AND SYMPTOMS: Bipolar Disorder (also known as manic depression) causes serious shifts in mood, energy, and thinking. There will be extreme highs of mania to the extreme lows of depression. More than just a fleeting good or bad mood, the cycles of Bipolar Disorder last for days, weeks, or months. Unlike ordinary mood swings, the mood changes of Bipolar Disorder are so intense that they interfere with an individual’s ability to function.

In the manic phase, the individual has feelings of heightened energy, creativity, and euphoria. People experiencing a manic episode often talk a mile a minute, sleep very little, and are hyperactive. They may also feel like they’re all-powerful, invincible, or destined for greatness. But while mania feels good at first, it has a tendency to spiral out of control. Eventually, a person in a manic episode will engage in reckless behavior such as spending excessive sums of money, impulsively quit a job, charge up huge amounts on credit cards, inappropriate sexual activity, or making foolish business investments. They may also become angry, irritable, and aggressive. They will pick fights and lash out when others don’t go along with their plans. They will blame anyone who criticizes their behavior. In the manic phase, the person will feel rested after sleeping two hours. If the disorder goes untreated, some people even become delusional or start hearing voices.

Certain symptoms are more common in bipolar depression than in regular depression. For example, bipolar depression is more likely to involve irritability, guilt, unpredictable mood swings, and feelings of restlessness. In the depressive phase, individuals tend to move and speak slowly, sleep a lot, gain weight, be too tired to get out of bed and full of self-loathing and hopelessness over being unemployed and in debt. In addition, they are more likely to develop psychotic depression—a condition in which they’ve lost contact with reality—and to experience major disability in work and social functioning.

It is important to understand that the Bipolar Disorder can look very different from person to person. The symptoms vary widely in their pattern, severity, and frequency. Some people are more prone to either mania or depression, while others alternate equally between the two types of episodes. Some have frequent mood disruptions during their life, while others experience only a few over a lifetime.

BIPOLARS WE HAVE KNOWN, LOVED OR FEARED: The following individuals have or may have Bipolar Disorder: Patty Duke, Carrie Fisher, Britney Spears, Linda Hamilton, Connie Fisher, Jim Carrey, Drew Carrey, Ted Turner, and Marilyn Monroe.

CAUSES: The exact cause of Bipolar Disorder is not positively known. However, many experts believe that multiple factors are involved which act together to cause this mental illness. Bipolar Disorder may result from a chemical imbalance within the brain.
The brain's functions are controlled by chemicals called neurotransmitters and an imbalance in the levels of one of these neurotransmitters may cause Bipolar Disorder. When levels of a certain chemical or chemicals are too high, mania occurs and when levels drop below normal levels, a person may experience depression. There is also a significant genetic component to Bipolar Disorder. Family members are at risk if another family member has Bipolar Disorder. Also, recent life events and interpersonal relationships often trigger the onsets and recurrences of bipolar mood episodes. For example, a stressful life event is often the trigger of a bipolar episode. Thus, Bipolar Disorder does not occur just because of one gene, rather, the cause of Bipolar Disorder is likely a combination of multiple genetic and environmental factors.

COURSE: Bipolar Disorder generally occurs in late adolescence or young adulthood. However, the first symptoms of Bipolar Disorder can occur in pre-adolescence. If Bipolar Disorder manifests itself in childhood, the child will have a mix of mania and depression symptoms with rapid and severe cycling between moods producing chronic irritability. The younger the age of onset of Bipolar Disorder, the more likely it is that there is a significant family history of the disorder. The course of Bipolar Disorder is dependent on a number of factors, such as the severity of the illness, the age of onset, co-morbid conditions, frequency of episodes, cycle pattern and the presence or absence of “rapid cycling”. Early onset of Bipolar Disorder most commonly starts with a depressive episode and there may be many episodes of depression before the first manic episode. Regardless when the onset of the disorder occurs, there is a significant time-lag between the onset and the time the person receives their first treatment.

PREVALENCE: Approximately 1 in 83 people in United States suffer from Bipolar Disorder. The prevalence of Bipolar Disorders in the United States is almost three times greater than previously reported.

MALE V. FEMALE: There appears to be no distinction in the incidence of bipolar depression among men and women. Both sexes experience typical onset of the condition around age 20. However, the first episode in males tends to be manic and the first episode in females tends to be depressive. In men, the episodes of mania and depression are of approximately equal duration, whereas depression tends to dominate in women. Furthermore, rapid cycling is most likely to occur in women and women may be more likely than men to be hospitalized for manic episodes.

CO-MORBIDITY: Other psychiatric and medical conditions are greatly increased in individuals with Bipolar Disorder. These co-morbid conditions can make the course of the illness more difficult to treat and manage. The two most common co-morbid conditions are anxiety disorder and substance abuse; the National Comorbidity Study in 1999 reported a prevalence of 93% for anxiety disorder and of 64% for substance abuse in patients with Bipolar I Disorder. Individuals with Bipolar Disorder who also have a history of substance abuse have a more complicated disease course than those with no history of substance abuse. Co-morbidity of medical and psychiatric disorders is more common in women than men. Co-morbidity, particularly thyroid disease, migraine, obesity, and anxiety disorders occur more frequently in women than men. Both men and women with the Bipolar Disorder have high rates of co-morbidity with alcohol and other substance use disorders.

BIPOLAR DISORDER AND SUICIDE: The depressive phase of Bipolar Disorder is often very severe, and suicide is a major risk factor. In fact, people suffering from Bipolar Disorder are more likely to attempt suicide than those suffering from regular depression. Furthermore, their suicide attempts tend to be more lethal. The risk of suicide is even higher in people with Bipolar Disorder who have frequent depressive episodes, mixed episodes, a history of alcohol or drug abuse, a family history of suicide, or an early onset of the disease.

DIAGNOSIS AND TREATMENT: There is currently no definitive medical test for diagnosing Bipolar Disorder. Furthermore, there are a number of physical conditions and quite a few psychiatric disorders which present symptoms that can be confused with those of Bipolar Disorder (such as borderline personality disorder discussed below). And just to complicate the issue even more, there are a great many psychiatric disorders can occur in tandem with Bipolar Disorder. In reaching a diagnosis of Bipolar Disorder, the evaluator will conduct a medical history and physical exam, a complete psychiatric history, a family history of medical and psychiatric symptoms and an evaluation of the individual’s current symptoms.
The lag time between the onset of a bipolar episode and treatment may predict a poorer response to treatment. Medication is the cornerstone of treatment for Bipolar Disorder. Most individuals need the medication to regulate their moods and avoid relapse. The medication functions by directly manipulating brain and body chemistries. Unfortunately, 50 percent of individuals diagnosed with Bipolar Disorder do not take the prescribed medications. The manic-side energy and impaired judgment will provide powerful incentives to your client to skip medication. The client will prefer to stay in the mania high. Further, not only does the medication level out the extreme highs, each drug has an array of side effects from weight gain to cognitive dulling. Most people with bipolar depression are not helped by antidepressants. In fact, there is a risk that antidepressants can make Bipolar Disorder worse–triggering mania or hypomania, causing rapid cycling between mood states, or interfering with other mood stabilizing drugs. Prescribing tolerable drugs in tolerable dosages for each case is a psychiatric high-wire act. Talk therapies are not generally appropriate as primary means of Bipolar Disorder treatment, although they can be quite helpful and even essential as adjunctive treatments.

AFFECT ON MARRIAGE AND PARENTING:
The daily interactions of Bipolar Disorder can be a threat to any social relationship, including marriage. Individuals with Bipolar Disorder have trouble containing their emotions and are often irritable and unpredictable due to their mood swings. Living with someone having Bipolar Disorder is very stressful and the marital relationship is filled with misunderstandings and conflicts. Reckless behavior like abuse of alcohol or drugs, accidents from excessive risk taking, financial burden from over-spending, inability to remain gainfully employed and sexual infidelities have the potential to unravel even the most loving of relationships. Family members often struggle with feelings of guilt, fear, anger, and helplessness. Ultimately, the strain can cause serious relationship problems. As such, it is not difficult to link Bipolar Disorder and divorce. Divorce occurs in almost 90 percent of marriages in which one partner is suffering from Bipolar Disorder.

It is very common for an individual to have never been diagnosed with Bipolar Disorder until shortly before or after the divorce action is filed. This fact is often true because the person may have been suffering from a milder case of Bipolar Disorder and thus the mood swings were not as pronounced. However, upon the occurrence of a stressful event or the filing of the divorce, a full blown episode of mania is triggered and the extreme mood swings and dramatic shifts between manic and depressive occur. The stressful event may be the cause of the divorce or may be the divorce itself.

REPRESENTING AND DEFENDING AGAINST THE CLIENT WITH BIPOLAR DISORDER:
Bipolar Disorder does not have to be fatal to being a good parent. There's a big difference between being a parent with Bipolar Disorder which is stable verses unstable. If a parent is managing their Bipolar Disorder, then it does not compromise the child's best interests to be in the care of that parent. Thus, a parent suffering from Bipolar Disorder is well-served to be candid about their condition. In most cases, the parent's openness will cause the judge to consider the mental health issue in a light most favorable to the candid parent.

How to Identify if your Client is in a Manic Episode: As noted above, the events leading up to the filing of the divorce or the filing of the divorce itself, may have triggered a manic episode in your client. As a result, during your representation, you may notice that the client is exhibiting behaviors that don’t seem “normal” – something is just not right to you. If so, then assess the client’s behavior by reviewing the following behaviors that indicate whether the client is in a manic episode:

- Spending excessive amounts of money;
- Purchasing or attempting to purchase items that he/she clearly cannot afford (i.e. multiple million dollar real estate);
- Purchasing a particular item over and over (i.e. shoes, make-up, artwork, snakebite kit);
- Has recently received tickets for speeding and/or reckless driving;
- Has recently had several fender benders;
- Is having or has had several extra-marital affairs;
- Is drinking to excess;
- Is using illegal drugs;
- Not sleeping at night and less need for sleep;
- Increased energy levels or activity;
- A euphoric mood that is excessive and very excitable attitude towards everything;
- Severe irritability and aggression that has resulted in a loss of a job or a falling out with a good friend or family member;
- Provocative and intrusive behavior;
- Poor judgment and lack of concentration;
- Racing thoughts and talking too much;
- Rapid speech;
- Driving around aimlessly.

**What Actions to Take if You Believe that the Client is Suffering from Bipolar Disorder:** If you are going to be successful in representing the client with Bipolar Disorder, then you must ensure that your client is properly diagnosed and treated. Accordingly, if you believe that your client is suffering from Bipolar Disorder you may consider taking some of the following steps:

- Ask your client for permission to talk to other family members or friends to help you assess the behavior that your client is exhibiting.
- Get your client evaluated. If the client is in a manic or depressive state, they will most likely not want to go for treatment. Insist that they do so.
- Ask the client for permission to provide the evaluator with information about the client’s behavior. This information may come from you and/or from other family or friends. If the client is the only person that provides the evaluator with information to make an assessment, the client may not be completely honest in self-reporting their symptoms.
- Ask for permission to go with the client to the evaluator and/or their therapist. Talk to the therapist about what behaviors you have observed.

**What the Client Needs to do to be Successful:** The most critical element to being successful in overcoming the disorder and being a good parent is for your client to acknowledge the diagnosis of the disorder and to pursue the proper treatment. This may sound easier than it really is due to the characteristics of the disorder itself. The client needs to:

- Get educated. They need to learn as much as they can about Bipolar Disorder. The more they know, the better he/she will be at assisting their own recovery.
- Avoid high-stress situations. Stress can trigger a manic and/or depressive episode so the client needs to learn to avoid stressful situations.
- Learn to manage stress. If the client is going through a divorce, then they need to find an avenue to deal with the stress and stabilize their mood. Healthy sleeping, eating, and exercising habits can help stabilize moods. Keeping a regular sleep schedule is particularly important.
- Seek support. The client has a much better chance of succeeding if they have a support group that they can turn to for help and encouragement. In addition, the support group should be given permission to report to the treatment provider if they believe that the client is exhibiting signs of a manic or depressive episode.
- Monitor their moods. The client needs to keep track of the symptoms and watch for signs that the moods are swinging out of control so they can stop the problem before it starts.
- Get treatment. The client with Bipolar Disorder will be the most successful if they are properly medicated and gain insight into their behavior and its affect on others. This treatment may include medication and therapy.

**What Actions to Take if Your Client has a Diagnosis of Bipolar Disorder:**

- Let them know you can only represent them if they get treatment and stay on medications.
- Request that the client give their treatment providers permission to contact you if the provider believes that the client is not taking the medication as prescribed, is not obtaining treatment, is exhibiting signs of a manic or depressive episode, and/or appears to be a threat or danger to themselves or others.
- Emphasize the importance of medication and making sure all prescriptions are being taken as directed.
- The other spouse and the court may be concerned that your client is not taking the prescribed medication. To address this concern, arrange for the client’s doctor to test their lithium level on a periodic basis to prove that the medication is being taken.
- Encourage the client to speak to the doctor about any bothersome side effects. Side effects can be very unpleasant if the dose of the medication is too low or too
high, but a change in medication or dosage may solve the problem.

- Remind the client that abruptly stopping medication is dangerous.
- Help the client form a support group to monitor their behavior and if they are on their medication.

**How to Defend Against the Opposing Party with Bipolar Disorder:** If the opposing spouse suffers from Bipolar Disorder, you may want to take the following action:

- Get a restraining order if needed to stop any reckless spending by the opposing party.
- Freeze financial accounts if there is a possibility that the spouse may dissipate assets.
- Request the opposing party’s medical records.
- Obtain a protective order if there is family violence involving your client or the children and safety issues are present.
- If there is concern that the opposing party is not taking the medication as prescribed, request that the Court test the opposing party on a periodic basis to determine if the medication is being taken.
- If the opposing party appears to be self medicating, then request drug and/or alcohol testing.
- Often, the party with Bipolar Disorder will not provide accurate or complete information to the treatment provider. If so, the treatment provider may not properly diagnosis or treat the opposing party. Accordingly, request that your client have the opportunity to provide the opposing party’s treatment provider with information regarding their behavior.
- Your client’s comfort level with the Bipolar Disordered spouse being able to provide proper care for the children will be low. If the opposing party contends that they are successfully managing the Bipolar Disorder, request that your client have the opportunity to sit down with the treatment provider so that they can hear for themselves how their spouse is progressing. If both parties and the attorneys attend such a session, then everyone can hear the same description at the same time.
- In a settlement with someone who has Bipolar Disorder, it is better to take money up-front than to get it over the years. By doing so, your client can ensure that they receive their share of the estate. If the money is to be paid in the future, there is too much of a risk that the opposing party will not spend the money in a manic episode.

**BORDERLINE PERSONALITY – I HATE YOU – DON’T LEAVE ME**

**DSM IV CRITERIA:** The DSM IV describes borderline personality disorder (BPD) as 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:

- Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5;
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation;
- Identity disturbance: markedly and persistently unstable self-image or sense of self;
- 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;
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior;
- 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);
- Chronic feelings of emptiness;
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights);
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

The name BPD is confusing and imparts no relevant or descriptive information. When the term “Borderline Personality” was coined in the 1950s,
patients didn't fit other diagnostic categories. Today, the Treatment and Research Advancements National Association for Personality Disorders is campaigning to change the name and designation of BPD in the DSM V which will be out in 2013. There is also discussion about changing BPD, an Axis II diagnosis (personality disorders and mental retardation), to an Axis I diagnosis (clinical disorders).

DESCRIPTION AND SYMPTOMS: The central feature of BPD is instability, affecting individuals in many sectors of their lives. The BPD individual demonstrates a wide range of impulsive behaviors, particularly those that are self destructive. BPD is characterized by wide mood swings, intense anger even at benign events, and idealization followed by devaluation. The BPD individual’s emotional life is a rollercoaster and his/her interpersonal relationships are particularly unstable. Typically, the BPD person has serious problems with boundaries. They become quickly involved in relationships with people, and then quickly become disappointed with them. They make great demands on other people, and easily become frightened of being abandoned by them. People with BPD may even experience brief periods in which they separate from reality and have a psychotic episode.

BORDERLINES WE HAVE KNOWN, LOVED OR FEARED: The following celebrities have or may have BPD: Princess Diana, Heather Mills, Courtney Love, Lindsey Lohan, Amy Winehouse, and Angelina Jolie. Examples of BPD are a predatory Glenn Close in "Fatal Attraction" and Jessica Walter who played in "Play Misty for Me".

CAUSES: BPD has no known causes. However, if as a child, someone was sexually abused, had a disrupted family life or had abandonment issues, they may be more likely to suffer BPD.

COURSE: BPD is an illness of young people, and usually begins in adolescence or youth. BPD is usually chronic, and severe problems often continue to be present for many years. The level of long term improvement in persons with BPD varies a great deal. A minority will develop a successful career, marry happily, and recover completely. In the majority of cases, both impulsivity and emotional instability decline over time, and the patient is eventually able to function at a reasonable level. The borderline pathology tends to "burn out" in middle age, and most patients function significantly better by the ages of thirty-five to forty. Nearly 3/4 of the individuals with BPD attempt suicide or display self-mutilating behaviors like cutting themselves with razors or burning themselves. The risk of suicide is greatest during young adulthood and seems to diminish with age. Only about 10% of suicide attempts are successful.

PREVALENCE: BPD is probably the most prevalent personality disorder. A 2008 study of nearly 35,000 adults in the Journal of Clinical Psychiatry found that 5.9% — which would translate into 18 million Americans — had been given a BPD diagnosis. In 2000, the American Psychiatric Association believed that only 2% had BPD.

MALE V. FEMALE: BPD has long been regarded as an illness disproportionately affecting women. There are about three times more women than men diagnosed with BPD.

CO-MORBIDITY: Nearly 90% of those with BPD are also diagnosed with another personality disorder or major mental illness, including Bipolar Disorder. They are also prone to eating disorders. Despite the psychotic features that might exist, there is no correlation between BPD and schizophrenia.

DIAGNOSIS AND TREATMENT: Clinicians who are trained to diagnose and treat those with BPD will watch for “extreme” and frequent ups and downs, inordinately harsh self-judgment and behavior that is best described as being a “drama queen”. The symptoms of BPD are most often confused with Bipolar Disorder. John Gunderson, a psychoanalyst specializing in BPD gives the following criteria in order of importance in diagnosing BPD:

- Intense unstable relationships in which the BPD always ends up getting hurt. Gunderson admits that this symptom is somewhat general but considers it so central to BPD that he says he would hesitate to diagnose a patient as BPD without its presence.
- Repetitive self destructive behavior, often designed to prompt rescue.
- Chronic fear of abandonment and panic when forced to be alone.
- Distorted thoughts/perceptions, particularly in terms of relationships and interactions with others.
- Hypersensitivity, meaning an unusual sensitivity to nonverbal communications. Gunderson notes that this can be confused with distortion if practitioners are not careful.
- Impulsive behaviors that often embarrass the borderline later.
• Poor social adaption: in a way, borderlines tend not to know or understand the rules regarding performance in job and academic settings.

Persons with BPD are among the most difficult to treat. These individuals are here one day and gone the next – physically, emotionally, behaviorally or attitudinally. The individual that suffers from BPD is not likely to feel that he/she needs help. For those who seek treatment, group therapy has been effective in altering some of the behavior. Medications can also help with BPD. Unfortunately, because the BPD individual typically doesn’t see a problem with themselves, they don’t follow instructions and don’t cooperate with treatment or trust the people who are trying to help. In the end, “curing” BPD is rare, although when given appropriate treatment, a large percentage may assume "some type of functional role with modest health-care utilization, but it takes years to get there.

AFFECT ON MARRIAGE AND PARENTING:
In a word, BPD is "traumatic" for family members. A spouse or parent with BPD can appear quite functional in their interactions with others - highly competent, focused, and driven to be successful - but there's intense inner chaos that tends to be projected only onto close family members. It is particularly difficult to deal with the family member’s suicidal threats, attempts and hospitalizations. Women with BPD tend to choose narcissistic men as their spouses. In these marriages, the narcissistic husband initially finds his BPD wife attractive, but later becomes abusive or abandoning.

REPRESENTING AND DEFENDING AGAINST THE BPD CLIENT: High-conflict divorces and custody suits are common in a case involving a BPD. When the case involves the custody of children, many times there are elements of domestic violence, false allegations of domestic violence or sexual abuse, distortion campaigns, and parental alienation. Further, the individual with BPD will often seek out new relationships during the divorce process to ameliorate the pain of anxiety and separation.

How to Identify if a Party has BPD: Because individuals with BPD seldom recognize that they have any problems, it is rare that the person has already been diagnosed as BPD. The following list of behaviors can help you determine if your client or his/her spouse is suffering from BPD. The more criteria that are present, the more likely it is that the individual is a BPD:

• Does the party impulsively engage in a pattern of self-destructive or even addictive behavior involving alcohol, drugs, sex, etc.?
• Does the party only feel "good" when he or she feels "right"?
• Is the party being victimized or is your client victimizing the other party?
• Has the party set about destroying every aspect of the other party’s life that is important to them:
  o By falsely accusing the other spouse of criminal or immoral behavior;
  o By disrupting the other spouse’s ability to earn a living;
  o By threatening to sever the other spouse’s relationship with the children;
  o By wasting all of the wealth and savings;
  o By compromising the other spouse’s standing in your community and among his/her peers;
  o By making the other spouse’s life a living hell at home when no one "sees" what is going on behind closed doors;
  o By alienating the children from the other spouse;
  o By physically attacking the other spouse in the hopes of intimidating you or provoking you to retaliate;
  o By creating 10 times as many problems as any human could solve;
  o By driving a wedge between the other spouse and his/her friends and family?
• Is the person having an affair-perhaps with the other spouse’s best friend in spite?
• Does the spouse treat the children like objects rather than people?
• Does the spouse demonize the other spouse to others?
• Does the spouse blame the other spouse for everything that is wrong in his or her life?
• Does the spouse frequently manifest an inappropriate rage and resentment toward the other spouse?
• Does the spouse project onto the other spouse his or her shortcomings (e.g., you lie, are unfaithful, aren’t good enough, don’t try hard enough, are not trustworthy)?
• Does the spouse seem to lack the capacity to see his or her imperfections?
• Does the spouse sincerely believe he or she is always right?
• Does the spouse suddenly deny what she or he said or did as soon as it becomes apparent that the earlier statement or act will no longer produce the result he or she wants?
• Does the spouse have sexual identity issues or "misuse" sex or have a hedonistic attitude toward sex;
• Is the spouse’s behavior intended to subjugate others to her or his will?

Behaviors to Expect from BPD Clients: Clients with BPD will engage in the following types of behavior:

• Tell you to start something and then deny that they told you to do it.
• Be manipulative or appear to be manipulative because of inconsistent behavior.
• Love you when you make them look good; but if you drop the ball for a second, they will be all over you.
• Idealize you and experience great disappointment when their unconscious hopes are not fully realized.
• Give you profuse compliments.
• Experience any efforts you make to set limits as rejection and may act out in an impulsive way.
• Likely to sue you and/or assert a sexual harassment claim.

How to Manage the BPD Client: In representing the BPD client, you will need to:

• Be very matter-of-fact about your role and function and try not to give extra attention.
• Set limits early in the relationship.
• Be wary of their profuse compliments.
• Be aware they either make extra demands on your time and energy or ignore you.
• Request discipline, and insist on compliance and promptness with appointments and with information you request from them.
• Monitor telephone calls with your staff regarding feelings of anxiety and abandonment.
• Advise your staff not to over-react to the client’s accounts of his/her personal crisis.
• Don’t always trust the BPD client’s motives because they are emotional rather than rational.
• Try not to overreact to their swift and extreme moods.
• Try to represent a factor of practical stability in their chaotic functioning.
• Avoid personal relationships with them. If you threaten to withdraw they can do serious harm.
• You need to be stable. Reinforce good behavior and set firm, gentle limits.
• Give constructive criticism in a positive context.

Help Your Client to Understand Their BPD Spouse: A number of books are available that can provide your client with some guidance as to how to deal with the BPD spouse and the effects of the disorder on children. The books include: "Stop Walking on Eggshells; Coping When Somebody You Care About Has Borderline Personality Disorder" and "Stop Walking on Eggshells Workbook: Practical Strategies for Living with Someone Who Has Borderline Personality Disorder" both by Paul T. Mason and Randi Kreiger; "Understanding the Borderline Mother: Helping Her Children Transcend the Tense, Unpredictable, and Volatile Relationship" by Dr. Christine Ann Lawson; and "The Borderline Personality: Vision and Healings" by Dr. Nathan Schwartz-Salant.

How to Defend Against the Opposing Party with BPD: It is not only difficult to diagnosis this disorder but it is also difficult to defend against it. So, it is important that you and your client gather information and documents to help the judge or evaluator determine that the spouse is indeed suffering from BPD. If you believe that the opposing spouse suffers from BPD:

• Prepare your client for the possibility of false allegations. You need to guide your client to protect themselves from false allegations. Your client should not be alone with the BPD spouse and they should not have telephone...
conversations that are not recorded or witnessed by a third party.

- Caution your client to be on the defensive and offensive at the same time and to be aware of not putting themselves in harm’s way.
- Counsel your client to not take the bait of the BPD spouse. Your client needs to remain above the fray and have clean hands at all times. You don’t want the judge and/or evaluator to believe that your client is engaging in “mutual combat” with their spouse.
- Ask your client to outline the BPD spouse’s behavior that best identifies them as a BPD, such as self-destructive behavior; false allegations; wasting of assets; sexual affairs, etc. The client needs to be as specific as possible. You need to know dates, locations, times and the names of the persons that can provide information on each of these behaviors.
- Work with your client on the sources from which you can gather documents to reveal the lies and distortions of fact.
- During this process, don’t reveal to the opposing attorney that you believe that their client is suffering from BPD – this revelation may impede your ability to gather much needed evidence.
- Ask the opposing counsel for releases so you can get documents directly from a source – if the opposing attorney does not yet know what you are looking for, they may be more likely to provide you with the releases.
- Send a request for production of documents to gather documents from the opposing party.
- Identify and interview witnesses that can provide information on the BPD spouse’s behavior. Get the witnesses to provide you with a written statement about the facts they know.
- If the parties are involved in a custody evaluation, you will want to outline the behaviors for the evaluator and then provide the evaluator with the documents and witness statements to support your position.
- Prepare your client for their interaction with the custody evaluator. Stress to them to not “slam” the other spouse and to not pronounce that they have diagnosed their spouse as BPD. The client needs to stick to just the undisputable facts.
- If your client is testifying at a hearing or in trial, again make sure that your client does not “slam” the other spouse and sticks to just the facts. If your client stoops to bad mouthing the other parent, they will lose credibility. And more importantly, the judge will not be able to ascertain that both parties are not equally to blame for the conflict or who is telling the truth.

NARCISSISTIC PERSONALITY – WOULD YOU LIKE TO BASK IN MY LIGHT? I THOUGHT SO.

DSM IV CRITERIA: The DSM IV describes the narcissistic personality disorder (NPD) as a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and presents in a variety of contexts, as indicated by five (or more) of the following:

- Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements);
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love;
- Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions);
- Requires excessive admiration;
- Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations;
- Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends;
- Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others;
- Is often envious of others or believes that others are envious of him or her;
- Shows arrogant, haughty behaviors or attitudes.

DESCRIPTION AND SYMPTOMS: The interpersonal relationships of persons with NPD are typically impaired due to their lack of empathy, disregard for others, exploitativeness, sense of entitlement, and constant need for attention (called “Narcissistic Supply”). Individuals with NPD typically fall into two categories. The NPD individual may be "cerebral" and derive their Narcissistic Supply from their intelligence or academic achievements. Or,
the NPD individual may be "somatic" and derive their Narcissistic Supply from their physique, exercise, physical or sexual prowess and romantic or physical "conquests". The NPD may be either overbearing or charming and seductive. The NPD assumes that everyone else will accept their point of view and they will not hesitate to use gross or subtle coercion to achieve their goals. The individual with NPD will tend to blame others for any relationship or business problems and attempt to avoid looking at their own contribution. Individuals with NPD feel injured, humiliated and empty when criticized. They often react with disdain, rage, and defiance to any slight, real or imagined.

NPD symptoms may include:

- Believing that you're better than others;
- Fantasizing about power, success and attractiveness;
- Exaggerating your achievements or talents;
- Expecting constant praise and admiration;
- Believing that you're special and acting accordingly;
- Failing to recognize other people's emotions and feelings;
- Expecting others to go along with your ideas and plans;
- Taking advantage of others;
- Expressing disdain for those you feel are inferior;
- Being jealous of others;
- Believing that others are jealous of you;
- Trouble keeping healthy relationships;
- Setting unrealistic goals;
- Being easily hurt and rejected;
- Having a fragile self-esteem;
- Appearing as tough-minded or unemotional.

NARCISSISTS WE HAVE KNOWN, LOVED OR FEARED: Many of the most famous narcissists have been convicted of committing murder. They include O.J. Simpson, Ted Bundy, and Scott Peterson.

CAUSES: It is commonly attributed to childhood abuse and trauma inflicted by parents, authority figures, or even peers.

COURSE: The onset of pathological narcissism begins in infancy, childhood and early adolescence. The course is variable and often prolonged. There appears to be no good data on the course of NPD.

PREVALENCE: Between 0.5-1% of the general population are diagnosed with NPD.

MALE V. FEMALE: Overwhelmingly, most narcissists are men. The percentage may be as high as 75%.

CO-MORBIDITY: NPD is often diagnosed with other personality disorders, such as the HPD, BPD, paranoid, and antisocial personality disorder.

DIAGNOSIS AND TREATMENT: The prognosis for an adult suffering from NPD is poor, though his adaptation to life and to others can improve with treatment. The common treatment for patients with NPD is talk therapy. Talk therapy is used to modify the narcissist's antisocial, interpersonally exploitative, and dysfunctional behaviors, often with some success. Medication is prescribed to control and ameliorate attendant conditions such as mood disorders.

AFFECT ON MARRIAGE AND PARENTING: When the narcissist reveals his true colors, it is usually far too late. His victims are unable to separate from him. They are frustrated by this acquired helplessness and angry at themselves for having failed to see through the narcissist earlier on. A spouse and parent with NPD often treats their spouse and child the same – idealizes them at first and then devalues them in favor of alternative, safer and more subservient, sources. Such treatment is traumatic and can have long-lasting emotional effects. The inability of the parent with NPD to acknowledge and abide by the personal boundaries set by others puts the child at heightened risk of abuse – verbal, emotional, physical, and, often, sexual. The narcissist’s possessiveness and negative emotions, such as rage and envy – hinder the individual’s ability to act as a proper parent. The NPD individual’s propensities for reckless behaviour, substance abuse, and sexual deviance may also endanger the child's welfare, or even his or her life.

REPRESENTING AND DEFENDING AGAINST THE NPD CLIENT: The party with the NPD has a sense of entitlement that is endless and the other party will be maligned and disparaged. In the mind of the narcissist, the other party is worthless and deserves nothing. The narcissist will be vindictive and often stalks and harasses the other party. The narcissist makes a divorce the battleground and their spouse the enemy. There are two primary ways of coping with the vindictive narcissist in a custody case. The first method is to frighten them by exposing their lies and embarrassing them. If sufficiently deterred – the
narcissist may disengage and give up everything they were fighting for and sometimes make amends. The other method is to neutralize the narcissist by offering them continued Narcissistic Supply until the war is over.

Behaviors to Expect from NPD Clients: Clients with NPD will engage in the following types of behavior:

- Difficulty in understanding a different point of view.
- Will take any experience of defeat as humiliating and may express and want retaliation.
- React negatively to anything they perceive as criticism.
- Can have a sense of entitlement that has to be fed and handled.
- Prone to exaggerate the facts.
- Dislike any reality testing.
- May want to manipulate and exploit others.
- May be difficult to get along with.
- Can litigate or be violent when they feel slighted.

How to Manage Clients with NPD: In working with the NPD client:

- Ask them to use their “good intelligence” to understand another person’s point of view or need.
- Acknowledge their minor accomplishments, even if they are routine.
- Try to avoid or minimize the concept of win-lose in the divorce process.
- Be aware of the vulnerability and poor sense of self-worth that lies underneath their confident surface.
- Minimize the extent to which you can achieve their idealized and expected goals.
- Require facts and corroborating evidence in order to verify their exaggerations.
- Set out the limitations of family law and make sure they understand you.
- Use confrontation sensitively, be very specific and gentle.
- Don’t argue with them.
- Flatter their idea but explain why it might not produce the result wanted.
- Firing them needs to be done delicately.

Preparing Your Client for Dealing with the NPD in a Court of Law: The following are some pointers for the client dealing with the NPD spouse in the family law court:

- Take an assertive approach.
- Quickly provide credible factual information to the court.
- Try to be as perfect as possible in every way during the court process. You don’t want to give the NPD spouse something to legitimately use against you.
- Prepare for the lies. Have an answer. You may have the truth on your side, but your spouse has no empathy and will destroy you with lies.
- Expose the false statements and serious misbehaviors of the NPD party with credible evidence.
- Do not be emotional during the court process. Emotions in family court can be seen as a sign of a psychological problem.
- Find a way to make sure your narcissist is getting something out of the negotiations that they want. They have to feel they are winning. If they feel like they are losing, the litigation will continue and be used as revenge.

How to Defend Against the Opposing Party with NPD:

Expose the Lies of the Narcissist: It is possible to "break" a narcissist, even a well-trained and prepared one if you and your client are prepared. Narcissists are superhuman in their capacity to distort reality by offering highly "plausible" alternative scenarios, which fit most of the facts. It is essential to be equipped with absolutely unequivocal, first rate, thoroughly authenticated and vouched for information. The following actions can be used to expose the lies of the narcissist:

- Ask your client to outline the narcissist’s lies and distortions of fact for you. The client needs to be as specific as possible. You need to know dates, locations, times and the names of the persons that can provide information on each lie.
- Take each lie and look for how the lie leads to another and another. Because the narcissist has been lying for years, they are not likely to have taken the steps to conceal their lies or realize that one lie begets another lie.
As you are gathering and outlining the lies, be careful how much you reveal to the opposing attorney. Often the opposing attorney will not realize that their client is a full-blown narcissist and lying and distorting the facts until much later. You will have a better opportunity to collect the evidence you need to expose the narcissist’s lies if the opposing attorney has not yet discovered that their client is liar.

Work with your client on the sources from which you can gather documents to reveal the lies and distortions of fact.

Ask the opposing counsel for releases so you can get documents directly from a source – if the opposing attorney does not yet know what you are looking for, they may be more likely to provide you with the releases.

Send a request for production of documents to gather documents from the narcissist.

Draft interrogatories that you know the narcissist will not be able to resist providing untruthful answers to and for which you have evidence to demonstrate that the answer is a lie.

Draft a request for admissions that you also know the narcissist will not be able to resist providing untruthful answers to and for which you have evidence to demonstrate that the answer is a lie.

Identify and interview witnesses that can demonstrate the narcissist is lying. Get the witnesses to provide you with a written statement about the facts they know.

If the parties are involved in a custody evaluation, you will want to outline the lies for the evaluator and then provide the evaluator with the documents to reveal the lies. Also, provide the evaluator with the witness statements.

Provoke the Narcissist: The narcissist reacts with narcissistic rage, hatred, aggression, or violence to an infringement of what he perceives to be his entitlement. Any insinuation or hint that the narcissist is not special will often result in the narcissist losing control and exposing their true colors. The narcissist finds the following devastating:

- Any statement or fact, which seems to contradict their inflated perception of their grandiose self.
- Any criticism, disagreement, exposure of fake achievements, belittling of "talents and skills"
- Any description of the narcissist as average and common, indistinguishable from many others.
- Any hint that the narcissist is weak, needy, dependent, deficient, slow, not intelligent, naive, gullible, susceptible, not in the know, manipulated, and/or a victim.

The narcissist may lose control if you state to them:

- That he does not deserve the best treatment.
- That his needs are not everyone's priority.
- That he is boring, that his requirements can be catered to by an average practitioner (medical doctor, accountant, lawyer, psychiatrist).
- That he and his motives are transparent and can be easily gauged, that he will do what he is told.
- That his temper tantrums will not be tolerated.
- That no special concessions will be made to accommodate his inflated sense of self.
- That, like everyone else, he is subject to court procedures, etc.

OBSESSIVE-COMPULSIVE PERSONALITY—DON’T BREAK THE RULES

DSM IV CRITERIA: The DSM IV describes obsessive compulsive personality disorder (OCPD) as a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost;
- Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met);
- Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity);
- Is over-conscientious, scrupulous, and inflexible about matters of morality, ethics, or
values (not accounted for by cultural or religious identification);
• Is unable to discard worn-out or worthless objects even when they have no sentimental value;
• Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things;
• Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes;
• Shows rigidity and stubbornness.

DESCRIPTION AND SYMPTOMS: The primary characteristics of OCPD are rigid adherence to rules and regulations and an overwhelming need for orderliness, perfectionism, and control. People living with OCPD are inflexible, perfectionists and unwilling to yield responsibilities to others. They are reliable, dependable, orderly, and methodical, but their inflexibility makes them unable to adapt to change. Because they are cautious and weigh all aspects of a problem, they have difficulty making decisions. They take their responsibilities seriously, but because they cannot tolerate mistakes or imperfection, they often have trouble completing tasks. People with OCPD are often high achievers, especially in the sciences and other intellectually demanding fields that require order and attention to detail. However, their responsibilities make them so anxious that they can rarely enjoy their successes. They are uncomfortable with their feelings, with relationships, and with situations in which they lack control, must rely on others or events that are unpredictable.

CAUSES: Family dynamics and parenting styles most often explain the origin of OCPD. As a child, the OCPD person was often consistently punished for negative behavior, failure, and rule-breaking and at the same time, he/she did not receive any praise for success and compliance. Their parents put pressure on them as a child to get control of themselves and to behave like little adults, rather than as an independent and individual person. In an effort to be good and to gain their parents’ approval, the child became trapped in an internal struggle to gain control of his/her own "bad" or "dangerous" impulses, desires, and feelings. The child then develops into an adult who is inwardly and perhaps even unconsciously, angry, and outwardly very driven to achieve respect and approval.

COURSE: It usually begins in early adulthood and has a chronic course.

PREVALENCE: OCPD, is one of the more prevalent personality disorders in the United States. Approximately sixteen million adult Americans meet the diagnostic criteria for OCPD—that's 7.9 percent of the general population.

MALE V. FEMALE: OCPD is twice as common in males as females.

CO-MORBIDITY: People with OCPD are susceptible to major depressive episodes, due to stress, tension, and social rejection. Depression is often triggered by just the everyday physical and cognitive limitations that come with aging that are difficult for the OCPD individual to handle. Anxiety disorders, social phobia, specific phobias, mood disorders, and eating disorders often co-occur with OCPD.

DIFFERENCE BETWEEN OCPD AND OCD: The term OCPD implies a relationship with obsessive compulsive disorder (OCD) – this is not true. OCD is not a less severe version of OCD. While OCD and OCPD share some symptoms, the two disorders are unrelated. OCD has certain important differences from OCD. People with OCD are often aware that their obsessions are abnormal, but are compelled to perform them anyway. People with OCPD, however, believe their need for strict order and rules is perfectly normal. OCD often interferes with the OCD individual’s success in social and work environments. While people with OCPD certainly have difficulties with social relationships, they usually tend to perform well in work environments.

DIAGNOSIS AND TREATMENT OF OCPD: OCPD is diagnosed based on the individual’s symptoms and personal history. In arriving at a diagnosis of OCPD, it is important to rule out other medical conditions that can mimic OCPD, including:

- antisocial personality disorder
- chronic substance abuse
- narcissistic personality disorder
- obsessive compulsive disorder (OCD)
- schizoid personality disorder
- underlying medical conditions

The overall prognosis for OCPD is better than for many other personality disorders. Because the OCPD individual defers to authority and rigid self-control, they are less likely to abuse medication or cease treatment. On the other hand, the hidden rebelliousness of OCPD may lead to a subconscious rejection of treatment. Selective serotonin reuptake
inhibitors may help reduce the compulsive behavior in the OCPD individual.

**OCPD'S AFFECT ON THE MARRIAGE AND CHILDREN:** The OCPD spouse and parent are often domineering and rude. They will attempt to hold family members accountable for conforming to rules and unrealistic expectations, resulting in constant conflicts over personal control and independence. Further, the OCPD spouse and parent do not have the capacity to comprehend the emotional needs of their spouse and children. Financially, the OCPD individual tends to be thrifty to the point of miserliness, hoarding money for some imagined future catastrophe. This behavior often creates financial arguments in the family. The person with OCPD also does not recognize their internal conflict between conforming and their subconscious rebellion. This conflict often manifests itself as psycho-physiological conditions, including stress-induced muscle tension, anxiety, and impotence and cause further stress in the family.

**REPRESENTING AND DEFENDING AGAINST THE OCPD CLIENT:**

**Behaviors to Expect from OCPD Clients:** Clients with OCPD will engage in the following types of behavior:

- Will be over-controlled in their decision making.
- Will be over-controlled in their relationship with you.
- Will believe that they understand better or more than you do and will expect you to agree with them.
- Will lose the big picture.
- Will believe that they have to depend on themselves to get things done.
- Will expect perfection from themselves and you.
- Will believe that any flaw or defect of performance may lead to a catastrophe.
- Will need to be in complete control of their emotions.
- Will believe that you should do it their way.
- Will believe that any flaw, defect or mistake you make is intolerable.
- Will become very defensive and may appear paranoid if you challenge them.

**How to Manage the Client with OCPD:** In representing the OCPD client:

- Critique with care and use constructive criticism. If you are too critical the client will be overcome with anxiety.
- Don’t try to get them to be emotionally expressive – this is pointless.
- Because the OCPD client can pay an inordinate amount of attention to rules, schedules and procedures, they will lose sight of the big picture. Therefore, at times, it will be necessary to interrupt their insistence on details while praising them for their diligence. Provide the client with a regular explanation of the “bigger picture”. If you do so, then you help the client avoid excessive anger.
- When you confront their controlling behaviors, you will need to clarify your authority in the handling of the case. At the same time show the client appreciation and respect for his/her abilities in compiling the documents and for making suggestions.
- You will need to constantly underscore that other people may have views different from their views and that these differing views may be valid and applicable to their case even though it does not make sense to them.
- If the OCPD client cannot entertain differing views and such views keep them stressed and anxious, then you need to get the client to a therapist to address the issue.
- From the outset of your relationship with the OCPD client, be consistent and insistent that although you respect what they are thinking, you are the expert and expect his/her acknowledgement to this fact.

**How to Defend Against the Opposing Party with OCPD:** The suggestions made in the section on BPD disorder can be adapted and used when defending against the opposing party with OCPD.

**HISTRIONIC PERSONALITY—PAY ATTENTION TO ME – I'M SO PRETTY.**

**DSM IV CRITERIA:** The DSM IV lists eight symptoms that form the diagnostic criteria for histrionic personality disorder (HPD):

- Center of attention: Patients with HPD experience discomfort when they are not the center of attention.
- Sexually seductive: Patients with HPD display inappropriate sexually seductive or provocative behaviors towards others.
• Shifting emotions: The expression of emotions of patients with HPD tends to be shallow and to shift rapidly.
• Physical appearance: Individuals with HPD consistently employ physical appearance to gain attention for themselves.
• Speech style: The speech style of patients with HPD lacks detail. Individuals with HPD tend to generalize, and when these individuals speak, they aim to please and impress.
• Dramatic behaviors: Patients with HPD display self-dramatization and exaggerate their emotions.
• Suggestibility: Other individuals or circumstances can easily influence patients with HPD.
• Overestimation of intimacy: Patients with HPD overestimate the level of intimacy in a relationship.

DESCRIPTION AND SYMPTOMS: The individual with HPD displays an enduring pattern of attention-seeking and excessively dramatic behaviors. Individuals with HPD are charming, energetic, manipulative, seductive, impulsive, erratic, and demanding. They conspicuously seek attention, are dramatic and excessively emotional. The HPD’s lively and expressive manner results in easily established but often superficial and transient relationships. Their expression of emotions often seems exaggerated, childish, and contrived to evoke sympathy or attention. People with a HPD are prone to sexually provocative behavior or to sexualizing nonsexual relationships. Some individuals with HPD also are hypochondriacal and exaggerate their physical problems to get the attention they need. The HPD individual expresses a strong need to be the center of attention. Individuals with HPD exaggerate, throw temper tantrums, and cry if they are not the center of attention. Individuals with HPD are naive, gullible, have a low frustration threshold, and strong dependency needs. Further, HPD has a unique position among the personality disorders in that it is the only personality disorder explicitly connected to a patient's physical appearance – the individual with HPD is overly concerned with appearance.

CAUSES: The cause of HPD is unknown, but childhood events such as deaths in the immediate family, illnesses within the immediate family which present constant anxiety, divorce of parents and genetics may be involved. Individuals who have experienced pervasive trauma during childhood have been shown to be at a greater risk for developing HPD as well as for developing other personality disorders.

COURSE: The pattern of craving attention and displaying dramatic behavior for an individual with HPD begins by early adulthood. The personality characteristics of individuals with HPD are long-lasting. Symptoms can last a lifetime, but as individuals with HPD age, they display fewer symptoms. Some research suggests that the difference between older and younger individuals may be attributed to the fact that older individuals have less energy.

PREVALENCE: The prevalence of HPD in the general population is estimated to be approximately 2%-3%.

MALE V. FEMALE: Clinicians tend to diagnose HPD more frequently in females. The research suggests that the connection between HPD and physical appearance holds for women rather than for men. Also, researchers have found that HPD appears primarily in men and women with above-average physical appearances.

CO-MORBIDITY: HPD has been associated with alcoholism and with higher rates of somatization disorder, conversion disorder, and major depressive disorder. Personality disorders such as BPD, NPD, antisocial, and dependent can occur with HPD.

DIAGNOSIS AND TREATMENT: A diagnosis of HPD can usually be made by the person's appearance, behavior, and history. However, there is no test to confirm this diagnosis. Because the criteria are subjective, some people may be wrongly diagnosed as having the disorder while others with the disorder may not be diagnosed. Treatment is often prompted by depression associated with the ending of a romantic relationship. The diagnosis of HPD is complicated because it may seem like many other disorders, and also because it commonly occurs simultaneously with other personality disorders.

Medication does little to affect HPD, but may be helpful with symptoms such as depression. Psychotherapy may also be of benefit. HPD may require several years of therapy and may affect individuals throughout their lives. Some professionals believe that psychoanalytic therapy is a treatment of choice for HPD because it assists patients to become aware of their own feelings. Individuals with HPD utilize medical services frequently, but they usually do not stay in psychotherapeutic treatment long enough to make changes. They tend to set vague goals and to move toward something more exciting.
AFFECT ON MARRIAGE AND PARENTING:
Deep cracks that develop in one’s personality due to suffering from HPD make it difficult to become a good spouse or parent. The HPD individual tends to have clashes with family members on minor issues. There is a high rate of separations, affairs and divorce in the cases of HPD. When the client with HPD appears in the family court, they may have similarities to BPD but with less anger and more chaos.

REPRESENTING AND DEFENDING AGAINST THE HPD CLIENT:

Behaviors to Expect from Clients with HPD:
Clients with HPD will engage in the following types of behavior:

- They will want and sometimes demand frequent reminders they are valued and appreciated.
- They will make dramatic presentations about the way that they have been wronged by their spouse and will assume the role of a victim who needs to be rescued.
- They will telephone on the spur of the moment when unforeseen events happen regarding a spouse or children.
- They will tend to exaggerate the importance of selective interactions and will try to convince you of the accuracy of their perceptions, most of which are based on unconscious emotional storminess.
- They will not provide you with details and specifics.
- They will most likely be late and sloppy.
- They will be generally happy but if they get distressed they will make everyone miserable.
- They will at first seem receptive and agreeable to requests to bring in organized data necessary for the case and then will not follow through.
- They will need enormous reassurance that they can go through old files, cabinets, accounts, and letters and search their memory to retrieve data and organize it.
- They will be seductive when avoiding their responsibility of thinking and behaving logically. If they are having an affair or abusing substances, they may deny this in spite of evidence to the contrary and even show indifference to the importance of this information.
- An overriding characteristic is repression. They can unconsciously make believe that something does not exist or is not important, and not only believe it, but act accordingly.

How to Manage Clients with HPD: In working with the HPD client:

- Their exaggerated and theatrical descriptions of specific incidents should be acknowledged, however, be sure to check out the information they provide.
- Ask for verifiable data that can corroborate their hunches, feelings and intuition.
- When you request specific information, they need to be told what documents to get, how to organize them and why they are important.
- Give them personal attention and validation they want up to a point, but insist that they produce needed information and attend to the data they would rather ignore.
- Give them gentle reality based guidance by providing as much detail as you can, but not so much that they depend on you for every direction.

How to Defend Against the Opposing Party with HPD: The suggestions made in the section on BPD disorder can be adapted and used when defending against the opposing party with HPD.

DEPENDENT PERSONALITY – TAKE CARE OF ME – IF YOU DON’T I WILL FIND SOMEONE WHO WILL

DSM IV CRITERIA: The DSM IV states that five of the following criteria should be present for a diagnosis of dependent personality disorder (DPD):

- Difficulty making decisions, even minor ones, without guidance and reassurance from others;
- Requiring others to take responsibility for major decisions and responsibilities beyond what would be age-appropriate (e.g., letting a parent choose a college without offering any input on the decision);
- Difficulty disagreeing with others due to an unreasonable fear of alienation;
- Unable to initiate or complete projects or tasks due to a belief that he or she is either inept or that the appearance of success would lead a support person(s) to abandon him or her;
• Takes on unreasonably unpleasant tasks or sacrifices things in order to win the approval of others;
• Unable to spend time alone due to a lack of self-reliance and an unreasonable fear of being unable to care for oneself;
• Inability to remain independent of a close relationship as manifested by seeking a substitute support relationship immediately after one ends (e.g., a teenager who feels she must have a boyfriend constantly to validate her self-worth);
• Unrealistic preoccupation with the thought of being left to care for oneself.

DESCRIPTION AND SYMPTOMS: DPD is characterized by a pervasive psychological dependence on other people. People with DPD routinely surrender major decisions and responsibilities to others and permit the needs of those they depend on to supersede their own. They lack self-confidence and feel intensely insecure about their ability to take care of themselves. They often protest that they cannot make decisions and do not know what to do or how to do it. These individuals will decline to be ambitious and believe that they lack abilities, virtues and attractiveness.

Individuals with DPD see other people as much more capable to shoulder life's responsibilities, to navigate a complex world, and to deal with the competitions of life. They see other people as powerful, competent, and capable of providing a sense of security and support to them. Individuals with DPD avoid situations that require them to accept responsibility for themselves; they look to others to take the lead and provide continuous support. DPD’s judgment of others is distorted by their inclination to see others as they wish they were rather than as they are. These individuals are fixated in the past. They maintain youthful impressions; they retain unsophisticated ideas and childlike views of the people toward whom they remain totally submissive. Individuals with DPD view strong caretakers, in particular, in an idealized manner; they believe they will be all right as long as the strong figure upon whom they depend is accessible. Complications of this disorder may include depression, alcohol and drug abuse, and susceptibility to physical, emotional and sexual abuse.

CAUSES: DPD is more common in those who have suffered from chronic illness in childhood. A specific stressful life event as a child may result in DPD if the child’s dependent behavior in response to the event becomes chronic and significantly interferes with day-to-day functioning and/or causes the child significant distress. Chronic physical illness or separation anxiety disorder in childhood or adolescence may predispose the individual to develop this disorder.

COURSE: DPD usually begins in early adulthood, and has a chronic course. Dependent behavior is very common in childhood, but most adolescents grow out of this behavior. Unfortunately, for some, this dependent behavior persists and intensifies into adulthood.

PREVALENCE: Overall prevalence is approximately one to two percent of the general population.

MALE V. FEMALE: This disorder is more frequent in females.

CO-MORBIDITY: DPD frequently occurs in tandem with other personality-based mental illness, such as BPD and HPD. It is also believed that those diagnosed with DPD are at an increased risk of mood and anxiety disorders.

DIAGNOSIS AND TREATMENT: The following questions may be used in assessing individuals for DPD:

- Some people enjoy making decisions. Others prefer to have someone they trust guide them. Which do you prefer?
- Do you seek advice for everyday decisions? (Are the decisions you make understood by the practitioner?)
- Do you find yourself in situations where other people have made decisions about important areas in your life, e.g. what job to take?, Symptoms you have they do not understand?
- Is it hard for you to express a different opinion with someone you are close to? What do you think might happen if you did?
- Do you often pretend to agree with others even if you do not? Why? Could it get you into trouble if you disagree?
- Do you often need help to get started on a project?
- Do you ever volunteer to do unpleasant things for others so they will take care of you when you need it?
- Are you uncomfortable when you are alone? Are you afraid you will not be able to take care of yourself?
- Have you found that you are desperate to get into another relationship right away when a
close relationship ends? Even if the new relationship might not be the best person for you?

- Do you worry about important people in your life leaving you?

The primary treatment for DPD is psychotherapy, with an emphasis on learning to cope with anxiety, developing assertiveness, and improving decision-making skills. Group therapy can also be helpful. In cases where parents or other adult caregivers seem to be facilitating the behavior, therapy for them is also appropriate.

**AFFECT ON MARRIAGE AND PARENTING:** Individuals with DPD see relationships with significant others as necessary for survival. Because they are unable to function independently; they have to be in supportive relationships to be able to manage their lives. Spouses with DPD typically depend on the other spouse to decide where they should live, what kind of job they should have and which neighbors to befriend. They may go to great lengths to stay in a marriage. Not only will individuals with DPD subordinate their needs to those of their spouse, they will meet unreasonable demands and submit to abuse and intimidation to avoid isolation and abandonment. As a result, they will often marry a more aggressive spouse, sometimes with a personality disorder.

They will try hard to please their spouse. At the same time, their clinging behavior can make the marriage relationship difficult to establish and maintain. When the marriage ends, a person with DPD will feel desperate and unable to take care of herself/himself. When a marriage is ending, individuals with DPD may urgently seek another relationship to provide the care and support they need. Parents with DPD may become co-dependent on their children and develop an unhealthy dependence on them. The result may be a very dysfunctional parent-child relationship leaving the child feeling responsible for the DPD parent.

**Behaviors to Expect from Clients with HPD:**

Clients with DPD will engage in the following types of behavior:

- Will turn to you to lead and direct them.
- Will not take much initiative.
- Will have clouded thinking and may have difficulty finding words to express themselves.
- Will go to great lengths not to alienate or risk your disapproval.
- Will disagree with you inside themselves but not verbally in an outward way, only to sabotage your suggestions later on.
- Will not disagree, refuse, nor question directly due to fear of rejection, not resentment nor indifference.
- Will have difficulty completing the tasks you give them independently.
- Will have an affair while the divorce is pending.

**How to Manage the DPD Client:** In working with the DPD client:

- Need to take an authoritative and directive role.
- Encourage them to be more assertive and verbal, but do not expect great changes.
- Make certain that they understand your recommendations, and check to see if they agree.
- Set up situations in which they can participate in their case.
- Review their work and give generous and frequent acknowledgement and support where appropriate.
- Do periodic check-ins to make certain that they are not feeling overwhelmed by your requests.
- Encourage them to finish the divorce before entering into another relationship or at a minimum to keep the children from being exposed to their new relationship.

**How to Manage the DPD Client’s Passive Aggressive Behavior:** Individuals with DPD have particular trouble expressing anger or resentment in a direct manner because they fear rejection and disapproval. If your DPD client has accumulated anger that is buried, they may develop passive aggressive traits. If so, then they will express anger or resentment indirectly in a way that would be hard to “blame them”. They will act this way to all the people in their lives – including you. The passive aggressive DPD client can be very difficult to deal with because they smile, nod their head and appear to be cooperating but later show their lack of compliance in
various ways. The following are a few examples of such behavior:

- They may be late for appointments, claiming that they forgot.
- They may “need” to leave an appointment early or interrupt with a distraction.
- They may be late or slow in paying bills.
- They may bring up information late in the legal process and claim that they had told you this before.
- They may sabotage the children’s visitation schedule by being late, not showing up, and not calling to cancel.
- They may not pay the court ordered child support.

Despite the DPD client’s reasonable explanation for such behavior, there is most certainly anger underneath it. In working with passive aggressive clients:

- Set definite limitations on appointment times and follow through on all agreements.
- Give them written schedules and copies of agreements.
- Keep a copy of everything and monitor compliance.
- Confront them when they sabotage visitation or fail to pay child support.
- Be firm but caring towards them.

How to Defend Against the DPD Opposing Party:

The suggestions made in the section on BPD disorder can be adapted and used when defending against the DPD opposing party.

PARANOID PERSONALITY—I AM WATCHING MY BACK AT ALL TIMES

DSM IV CRITERIA: The DSM IV describes paranoid personality disorder (PPD) to be a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her;
- Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates;
- Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her;
- Reads hidden demeaning or threatening meanings into benign remarks or events;
- Persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights;
- Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack;
- Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

DESCRIPTION AND SYMPTOMS: People with PPD are distrustful and suspicious of others. They are generally cold and distant in their relationships. Based on little or no evidence, they suspect that others are out to harm them and usually find hostile or malicious motives behind other people's actions. Thus, people with PPD may take actions that they feel are justifiable retaliation but that others find baffling. This behavior often leads to rejection by others, which seems to justify their original feelings.

As a general rule, individuals with PPD remain in touch with reality and don't have any of the hallucinations or delusions seen in patients with psychoses. Nevertheless, their suspicions that others are intent on harming or exploiting them are so pervasive and intense that people with PPD often become very isolated. They avoid normal social interactions. And, because they feel so insecure in what is a very threatening world for them, patients with PPD are capable of becoming violent. Paranoid suspicions carry over into all realms of life. Those burdened with PPD are frequently convinced that their sexual partners are unfaithful. They may misinterpret compliments offered by employers or coworkers as hidden criticisms or attempts to get them to work harder. Because they persistently question the motivations and trustworthiness of others, individuals with PPD are not inclined to share intimacies. They fear such information might be used against them. As a result, they become hostile and unfriendly, argumentative or aloof. Their unpleasantness often draws negative responses from those around them. They have little insight into the effects of their attitude and behavior on their generally unsuccessful interactions with others. People with PPD are likely to place all the blame on others.

CAUSES: No one knows what causes PPD, although it is thought that familial and genetic factors may influence the development of the disorder in some
cases. There seem to be more cases of PPD in families that have one or more members who suffer from such psychotic disorders as schizophrenia or delusional disorder. Some therapists believe that the behavior that characterizes PPD might be learned. They suggest that such behavior might be traced back to childhood experiences. According to this view, children who are exposed to adult anger and rage with no way to predict the outbursts and no way to escape or control them develop paranoid ways of thinking in an effort to cope with the stress. PPD would emerge when this type of thinking becomes part of the individual's personality as adulthood approaches.

**COURSE:** PPD begins by early adulthood and is present in a variety of contexts. The long-term projection for people with PPD is bleak. Most patients experience predominant symptoms of the disorder for the duration of their lifetime and require consistent therapy.

**PREVALENCE:** Between 0.5% and 2.5% of the general population of the United States may have PPD. A significant percentage of institutionalized psychiatric patients, between 10% and 30%, might have symptoms that qualify for a diagnosis of PPD.

**MALE V. FEMALE:** The disorder appears to be more common in men than in women.

**DIAGNOSIS AND TREATMENT:** The PPD diagnosis is usually made on the basis of the doctor's interview with the patient or a diagnostic questionnaire. In addition, input from people who know the patient may be requested.

Psychotherapy is the most promising method of treatment for PPD. It is extremely difficult to establish a secure relationship with the therapist due to the dramatic skepticism of individuals with PPD. People with PPD rarely initiate treatment and often terminate it prematurely. Medications are usually contraindicated for PPD because they can arouse unnecessary suspicion that will usually result in noncompliance and treatment dropout. Medications which are prescribed for specific conditions should be done so for the briefest time period possible to bring the condition under management.

**AFFECT ON MARRIAGE AND PARENTING:** The PPD is a disaster for relationships. The PPD spouse can vacillate between being warm, concerned, loving and attentive to being abusive, suspicious, projecting, accusing, blaming, critical, demanding, belittling and downright cruel. The warmth and concern of a PPD cannot counterbalance the damage and hurt that can be inflicted upon significant others.

**REPRESENTING AND DEFENDING AGAINST THE PPD CLIENT:** The PPD client may be the most litigious personality disorder. They cannot acquiesce and they will feel powerless in the court system. For the PPD individual, the trauma of the divorce will exacerbate and reinforce their suspiciousness. It is not uncommon for the party with PPD to contend that their spouse has been planning the divorce for a long time and that others have been colluding with them. The PPD client will deny any personal or retaliatory intent against their spouse and will act self righteous and contend their spouse is the one that needs to be stopped. The PPD parent will be the parent first to raise the alienation issue in the custody case and the parent first to alienate the children. Because the PPD client cannot recognize their behaviors, they will put polarizing pressure on the child.

**Behaviors to Expect from Clients with PPD:** Clients with PPD will engage in the following types of behavior:

- Will be reluctant to provide information about themselves.
- Will not react well to surprises, they need to know what is going to happen and when.
- May not trust you very much but will trust you more if you tell them the truth, even if they do not like the truth.
- Will often demand that you appeal the Court’s ruling or ask for reconsideration.
- Will feel powerless in the system.
- Will ask suspicious questions of you.
- Will give angry stares or odd expressions, particularly in the courtroom.

**How to Manage the Client with PPD:** In working with the PPD client:

- Encourage them to share information and explain the importance of it.
- Provide them with information on a regular basis to reassure that there is no conspiracy. This is especially true if you go in chambers with opposing counsel and the Judge to discuss the case.
- Do not surprise them with information, let them know what is going to happen in court and what information is going to be used.
• Never cover up significant information. Admit a mistake, acknowledge an oversight and own up to a misunderstanding.
• Keep accurate notes.
• At the end of a meeting with the client, ask the client to summarize what they heard and understood.
• Acknowledge any kernel of truth found in their otherwise paranoid beliefs and challenge their exaggerations that do not seem to fit with reality.
• Recommend treatment and help them get it.
• Be honest in pointing out which conclusions seem logical and reasonable and which do not seem substantiated by the evidence from other sources.
• Be careful not to humiliate them.

How to Defend Against the PPD Opposing Party:
The suggestions made in the section on BPD disorder can be adapted and used when defending against the PPD opposing party.

ANTISOCIAL PERSONALITY—I DON’T CARE ABOUT ANYONE BUT ME

DSM IV CRITERIA: The DSM IV describes the antisocial personality disorder (ASP) as a pervasive pattern of disregarding and violating the rights of others. Diagnostic criteria for this disorder state that this pattern must include at least three of the following specific signs and symptoms:

• Lack of conforming to laws, as evidenced by repeatedly committing crimes;
• Repeated deceitfulness in relationships with others, such as lying, using false names, or conning others for profit or pleasure;
• Failure to think or plan ahead (impulsivity);
• Tendency to irritability, anger, and aggression, as shown by repeatedly assaulting others or getting into frequent physical fights;
• Disregard for personal safety or the safety of others;
• Persistent lack of taking responsibility, such as failing to establish a pattern of good work habits or keeping financial obligations;
• A lack of feeling guilty about wrong-doing.

Other important characteristics of this disorder include that it is not diagnosed in children (individuals younger than 18 years of age), but the affected person must have shown symptoms of this diagnosis at least since 15 years of age. Additionally, it cannot be diagnosed if the person only shows symptoms of antisocial personality disorder at the same time they are suffering from schizophrenia or when having a manic episode.

DESCRIPTION AND SYMPTOMS: ASP is one of the most violent and aggressive of the various personality disorders. Also known as psychopathic personality or sociopathic personality disorder, ASP describes a complete disregard for the rights, feelings, or safety of others. People with an ASP show callous disregard for the rights and feelings of others. Dishonesty and deceit permeate their relationships. People with an ASP act out their conflicts impulsively and irresponsibly. They tolerate frustration poorly, and sometimes they are hostile or violent. Often they do not anticipate the negative consequences of their antisocial behaviors and, despite the problems or harm they cause others, do not feel remorse or guilt. Rather, they glibly rationalize their behavior or blame it on others. Frustration and punishment do not motivate them to modify their behaviors or improve their judgment and foresight but, rather, usually confirm their harshly unsentimental view of the world. People with an antisocial personality are prone to alcoholism, drug addiction, sexual deviation, promiscuity, and imprisonment. They are likely to fail at their jobs and move from one area to another. People with an antisocial personality have a shorter life expectancy than the general population.

CAUSES: The exact cause of ASP is unknown. However, they often have a family history of antisocial behavior, substance abuse and divorce. As children, many were emotionally neglected and physically abused.

COURSE: ASP is a lifelong personality disorder that begins before age 15. The disorder is chronic, though it tends to be worse early in its course. The disorder peaks during the late teens and early 20s. The disorder tends to diminish or stabilize with age. In their 40s and 50s, about half the people with ASP are either improved or in remission. Age 35 is the average age that improvement is likely to be seen in terms of a reduction in dangerous and destructive behavior.

PREVALENCE: ASP appears in 3.6 percent of the adult US population, or approximately 7.6 million people. Sociopaths and psychopaths make up a high percentage of inmates in United States prisons.

MALE V. FEMALE: The condition appears to be more common in men than women. An estimated eighty percent of male inmates have antisocial
personality disorder. Female sociopaths are thought to make up 65 percent of the population in women's prisons.

**DIAGNOSIS AND TREATMENT:** ASP is not as difficult to diagnose as some personality disorders. Many cases of ASP only come to medical attention when the person seeks medical attention by a court of law. In such cases, the psychopath can be expected to resist both diagnosis and treatment. For a diagnosis of ASP, a childhood diagnosis of conduct disorder is required (or evidence that the person met the diagnostic criteria for conduct disorder as a child).

Like many other personality disorders, ASP has symptoms that can be explained by the presence of other conditions, and these conditions must be ruled out during diagnosis. Such conditions include manic episodes and schizophrenia, as well as other personality disorders, including:

- Narcissistic personality disorder;
- Histrionic personality disorder;
- Borderline personality disorder;
- Paranoid personality disorder.

Therapy has been used to treat ASP, with limited success. Group therapy at the outset is not recommended, given the sociopath's preferences for confrontational and manipulative interaction. Intensive, long-term, inpatient treatment has been shown to be successful if the patient is cooperative. Ultimately, time appears to be the best treatment for ASP. Medications are not generally advised, as the sociopath will either not take the medication, or, in many cases, abuse it.

**AFFECT ON MARRIAGE AND PARENTING:** The poor impulse control, lack of patience, and uncaring attitude, cause individuals with ASP to have trouble staying in relationships such as marriage. Spouses with ASP are experts at manipulation and hidden agendas. Despite their behavior on the surface, there is likely a self-serving goal underneath. The ASP spouse is not concerned with how their spouse feels about anything, but they are concerned about their feelings and their situation. The ASP spouse will feel entitled to torment their family due to the divorce process. Among all the personality disorders, persons with ASP are more likely to abuse and neglect. They will often hold property hostage as they deal in the divorce. They will also make a variety of threats, the most common being “I’ll quit my job so you’ll not receive child support!” or “I’ll move away where the court can’t find me!” The ASP individual is typically not a good parent – there will be little emotional attachment and a lack of bonding with the children.

**REPRESENTING AND DEFENDING AGAINST THE ASP CLIENT:**

**Behaviors to Expect from the Client with ASP:** Clients with ASP will engage in the following types of behavior:

- They will be self-centered with little regard for anyone or their feelings.
- They can be very charming and quite manipulative.
- They are skilled in being very chameleon-like and can shift in attitude and behavior as the situation demands.
- They can withhold, exaggerate, distort, and lie about information with absolutely no regret.
- They will do the absolute minimum in any situation – they will take a shortcut and not learn from their experience.

**How to Manage the Client with ASP:** In working with the ASP client:

- Do not expect optimal cooperation.
- Inform the client that withholding, lying or exaggerating information that other people may have will lead not only to embarrassment for them but to an unsatisfactory resolution.
- Examine their generalized statements and be aware that if they avoid giving requested concrete examples and data, they may be manipulating or lying.
- Look for inconsistencies between their own self-descriptions and other people's reports of them, documents, or any objective data.
- Set firm standards for working together and do not waiver.
- They need to understand the long term consequences because they only respond to consequences.
- They need to be taught that by doing something in the right manner, there may be more advantages.
- Outline their responsibilities and monitor to see whether they follow through with agreements made.
- Make sure they are fulfilling their financial obligations to you.
- You may need to withdraw quickly.
How to Defend Against the ASP Opposing Party:
The suggestions made in the section on NPD and BPD disorder can be adapted and used when defending against the ASD opposing party. In addition, if your client is divorcing an ASP spouse:

- Be on guard if your client’s ASP spouse offers to do something nice for your client. For example, if the ASP spouse offers to pay your client’s telephone bill, the ASP spouse may actually be looking for a ticket to your client’s finances, their calls, and a reason to call, visit, scream, and discuss each and every phone call your client makes for the next few years.
- Don’t let your client negotiate with the ASP spouse. There is an imbalance of power and your client cannot negotiate with the ASP spouse on any kind of equal footing.
- When confronted with any threat, assume a neutral position and don’t threaten back.
- Be prepared for the ASP spouse to engage in a variety of different manipulations. They may buy a new car during divorce negotiations, hoping the debt will lower his child support; undermine your client’s authority with the children or blame your client for the divorce; call your client’s family and friends to give his side of the story; report a miraculous religious conversion; or develop an incurable medical condition. Expect anything.
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