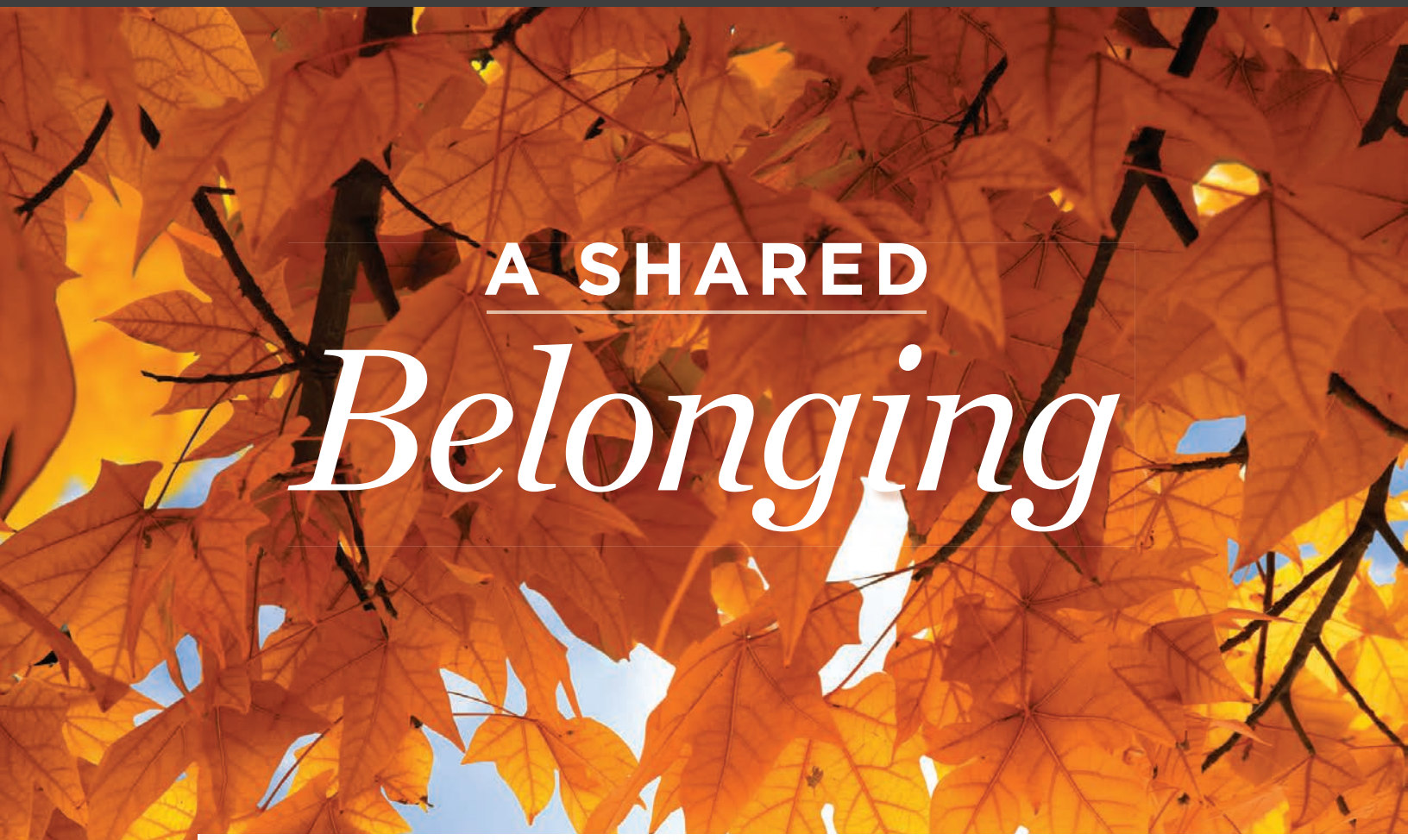
Bulletin of
the Society for
Couple & Family
Psychology
43

TFP
The Family Psychologist

CELEBRATING THE DIVERSITY OF ALL COUPLES AND FAMILIES

VOLUME 32, NO. 3



A SHARED *Belonging*

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2016 Board of Directors

EDITORIAL POLICY THE FAMILY PSYCHOLOGIST

The Family Psychologist is a triannual publication devoted to news and issues in the delivery of services to individuals, couples and families. Articles pertaining to family psychology and policy are invited.

Authors or publishers may send books for potential review directly to the editors of The Reference Corner.

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Full Page	$125
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SUBMISSION DEADLINES

Deadline	Issue	Pub.Date
February 15	Spring	Mar/April
June 15	Summer	July/August
September 15	Fall/Winter	November

TFP 2016 Editorial Staff

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Lyn R. Greenberg, Ph.D., ABPP

Diagnostic Language and Litigating Parents: When is it Useful?

FFP's who testify, or who communicate in any way to either the court or the parents have a choice in what language to employ. Whether in the therapeutic setting or in communications to the court, the language we use or endorse may impact the progress of the case and the outcome for the child.

My ex has a personality disorder.

The language of personality disorder has become common in both litigation contexts and in the popular press. A brief google search under such terms as "personality disorder" and "divorce" will yield a plethora of popular press articles, often written by authors who describe themselves as "divorce coaches" or "parent advocates" and reference their own divorces as a context or example. One can easily find sites referencing either Narcissistic Personality Disorder or Borderline Personality Disorder as the most common problem in family court, often divided by gender. Increasingly, parents are appearing at court-ordered coparenting or parent education programs and announcing to the therapist that the other parent has one of these personality disorders or a "high conflict personality" (Eddy, 2012). Some are even citing "brain studies" that supposedly support this conclusion, notwithstanding increasing concern in the scientific and radiologic communities about the quality of studies and overgeneralization of their findings. Many of the articles suggest the need to educate judges to make these diagnoses themselves and abandon expectations of peaceful coparenting.

To be sure, many FFP's have encountered parents who have enduring patterns of coping or functioning that seem resistant to change and compromise children's functioning or treatment. Some parents have had high quality treatment, parent education or other interventions and remain unwilling or unable to change. Some exhibit behaviors that directly expose children to the custody conflict or inhibit children's ability to learn healthy coping behaviors and adjust successfully. Some chronically blame others for their behavior and violate court orders. Many are reinforced by the suggestion that the other parent has an incurable condition that makes coparenting impossible, thus absolving the "diagnosing" parent of any responsibility for changing his/her own behavior.

Families involved in the court system are typically families in crisis. Parenting effectiveness, as well as other comping mechanisms, may be impacted for as long as two years after the separation. When an ambiguous event occurs, it is not uncommon for each parent to adopt only the most ominous interpretation of the other parent's behavior. While each litigant may assume that the other parent's problems are fixed and incurable, our training tells us that most human behavior arises from a more complex set of variables.

Behavior may result from dispositional traits or situational events. Parents may be predisposed to perceive events as threatening while in the throes of a custody conflict, but this tendency may be less pronounced or more modifiable in a different context. Does that parent have a personality disorder? Do we have the database to professionally suggest that the parent has a fixed personality style that will forever undermine coparenting and the children's adjustment?

Sometimes we do have that data, if a parent has been repeatedly offered high quality intervention and has failed to change. This often requires highly specific court orders, interventions specifically directed toward parenting or coparenting behavior, and a mechanism for accountability. These are interventions that are often suggested for high conflict families, just as parents are routinely advised to get their own therapeutic support, keep communications respectful and business-like, and learn skills for de-escalating conflict. The diagnostic label is not necessary either for that advice or for the careful treatment planning and data-gathering that will illustrate whether a parent can change. When a co-parent is genuinely mentally ill, the healthier parent is often taught ways of protecting the children, and parallel parenting rather than active coparenting may be advised. As FFPs, we may serve an enormously useful role by identifying the behavior that needs to change and the impact of the parent's behavior on the children. We can assist in the creation of tight court orders, procedures to protect the children when both parents attend a school event, etc. We can assist children with coping skills for dealing with less-than-perfect parents. Some of these interventions are described by Greenberg, Doi Fick, and Schnider (2016) and by Lebow and Black (2012).

Is the diagnostic language useful? Many professionals, including the authors of the DSM-V, have raised concerns about the dangers of diagnostic language in the context of litigation (American Psychiatric Association, 2013, p. 25). Introduction of this language in a litigation context may escalate conflict. Many parents have not received appropriate intervention before they reach the FFP's office. Custody orders are not specific enough, parent education has not targeted the right behaviors, attorneys or unqualified therapists have escalated conflict rather than creating a structure for raising the children. In those cases, it may be risky to speculate that the parent cannot benefit or cooperate until he/she has had an opportunity to do so. An FFP may face particular scrutiny if he/she has offered or endorsed diagnostic language without sufficient data about the parent's actual behavior. To make such a diagnosis relevant for family court, the psychologist must also be able to document an impact of the alleged diagnosis on parenting behavior. It is particularly hazardous, and in most cases unethical, for the therapist treating one parent to offer a diagnosis of the other. Even if the therapist never testifies in court, the choice of language may influence the perceptions and conduct of the alleging parent. Some professionals have even publicly suggested that if one believes that one's coparent has a personality disorder, one should never admit error or take responsibility for anything (Gilbert, 2013). Obviously, such behavior is not productive for coparenting and may harm the interests of both the children and the alleging parent if the "accused" parent is not, in fact, intractable.

This diagnostic language may also have consequences for intervention with the family. If the "accused" parent is focused on defending him/herself against this allegedly incurable diagnosis, or hurling contrary diagnostic language against the other parent, relatively less energy may be available for addressing the actual parenting behaviors that can help or harm children.

When is diagnostic language useful?

FFPs often encounter parents who have struggled with psychological issues that can be independently assessed, considered in recommended parenting plans, treated, or considered in context. Parents who have struggled with bipolar illness, depression, anxiety, or emotional upheaval related to the separation may impact their children when the problem is acute but improve markedly with treatment. FFPs may be able to respond to misconceptions about the impact of a psychological issue on parenting, explain any real risks to the children, and advise as to the kinds of treatment that may mitigate risks. If a parent has an objectively diagnosed, enduring illness or limitation, children can be taught coping abilities to deal with the parent's limitations. Even in these situations, the most productive

focus is often on the actions that a parent can take to protect or support the children, and holding the parent accountable for his/her decisions. For some parents, this may mean complying with a medication or psychotherapy plan. For others, it may mean compliance with substance abuse treatment. A useful therapeutic focus may be to address management of the condition, just as one might counsel a parent on how to manage a medical condition so that it doesn't cause risks or distress to the children. If the parent had a condition that is now resolved, such as a historical depression, the FFP may be able to present information to the family or the court about the incidence of the condition in the general population and the relevance, if any, of such a history to current parenting.

FFPs considering using or endorsing diagnostic language may want to consider the following issues: is the diagnosis arising from the psychologist's independent assessment, or is it coming from a litigant's agenda? Is there a reliable association between the diagnosis and parenting? Is the FFP in an appropriate role to issue or endorse such a diagnosis, and does the FFP have sufficient data to do so? Has the FFP observed, or obtained data, suggesting that the parent is actually engaged in problematic behavior? Will use of diagnostic language clarify or amplify something for the family or the court, or will it inflame the situation? Can the issues and recommended interventions be described behaviorally? Careful consideration of these and related ethical issues will enhance the FFP's usefulness to the family and/or the legal system.

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