Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

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Table of Contents

PREAMBLE

The Guidelines for Court-Involved Therapy have been formulated to assist members of the Association of Family and Conciliation Courts (AFCC) and others who provide treatment to court-involved children and families. The Guidelines are also intended to assist those who rely on mental health services or on the opinions of mental health professionals in promoting effective treatment and assessing the quality of treatment services. The Guidelines are also intended to assist the Courts to develop clear and effective Court orders and parenting plans that may be necessary for treatment to be effective.

AFCC does not intend these Guidelines to define mandatory practice. They are a best-practice guide for therapists, attorneys, other professionals and judicial officers when there is a need for therapeutic interventions with court-involved children or parents. While available resources and local jurisdictional expectations may influence the types of therapeutic services provided by a Court-Involved Therapist (CIT), the purpose of these guidelines is to educate, highlight common concerns, and to apply relevant ethical and professional guidelines, standards, and research in handling court-involved families.

INTRODUCTION

For the purposes of these guidelines, court-involved therapists are mental health professionals who provide therapeutic services to family members involved in child custody or juvenile dependency Court processes. Family and juvenile Court cases involving therapeutic services introduce unique factors and dynamics that require consideration in the treatment process. Both the treatment process and information provided to the therapist are likely to be influenced by the family's involvement in a legal process. While appropriate treatment can offer considerable benefit to children and families, inappropriate treatment may escalate family conflict and cause significant damage.

The Guidelines for Court-Involved Therapy are the product of the Court-Involved Therapist Task Force, appointed by AFCC President Robin Deutsch in 2009. Task force members were: Hon. Linda S. Fidnick, Co-Chair; Matthew Sullivan, Ph.D., Co-Chair; Lyn R. Greenberg, Ph.D., Reporter; Paul Berman, Ph.D.; Christopher Barrows, J.D.; Hon. R. John Harper; Hon. Anita Josey-Herring; Mindy Mitnick, M.Ed., M.A.; and Hon. Gail Perlman.

DEFINITIONS

A. Definitions Regarding Professional Roles

Community Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is not involved with the legal system at any time during the treatment.

Court-Involved Therapist (CIT): Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is, at any time during the treatment, involved with the legal system.

Court-Appointed Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because the particular psychotherapist was ordered by a judge to provide treatment. The Court order designates the specific psychotherapist and may describe the expected treatment.

Court-Ordered Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because it was ordered by a judge. The Court order does not designate a specific therapist and may describe the expected treatment.

B. Definitions Regarding Experts

Expert: The word expert generally refers to a person with specialized knowledge of a particular subject matter.

In the legal context, the word "expert" refers to a witness who has been specifically qualified by the Court in a particular case to provide opinion evidence within a circumscribed subject matter determined by the Court. To qualify an expert, the Court first reviews evidence of the witness's expertise of that subject matter, unless the admissibility of the professional's opinion as an expert has been previously stipulated to by the parties or established by the Court.

(a) Treating Expert: A mental health professional, who currently serves or has served as the therapist for a parent, child, couple or family involved with the legal system. If the therapist is qualified by the Court as an expert, testimony should be limited to the therapist's particular area of expertise and issues directly relevant to the treatment role. To the degree permitted by the Court in a specific case, the treating expert can provide expert opinion regarding a parent or child's psychological functioning over time, progress, relationship dynamics, coping skills, development, co-parenting progress, or need for further treatment, as appropriate to the therapist's role. In contrast to the forensic expert, the treating expert does not have the information base or objectivity necessary to make psycho-legal recommendations, such as specifying parenting plans, legal custody, or decision-making authority.

(b) Mental Health Forensic Expert: A mental health professional hired by a party or appointed by a Court to answer a legal question through the application of psychological methods. A mental health forensic expert, for example, may perform a custody evaluation, a psychological evaluation to answer a particular question formulated by the Court, a competency evaluation, an evaluation to assist the Court in the decision-making process regarding custody and/or access. Their testimony might include psycho-legal issues such as recommendations about parenting plans, legal custody or decision-making authority.

C. General Definitions

Client/Patient: A parent, child, couple or family receiving psychotherapeutic treatment from any of the mental health professionals defined in this section

Collateral: A person, not a client or patient, who has information bearing on the client or patient and whom a mental health professional, in any role defined in this section, interviews to obtain information or engages directly in the client or patient's treatment.

Confidentiality: An ethical duty, also established by statute, rules or case law in some jurisdictions, owed by a mental health professional to a client/patient, subject to some exceptions, to maintain the client/patient's privacy by not revealing information received from the client/patient.

Privilege: A legal right, conferred by statute in many jurisdictions and limited by exceptions, held by a mental health professional's client/patient to prevent the mental health professional from disclosing confidential information in a legal proceeding. Some jurisdictions have a formal process for determining whether or not and under what circumstances the privilege will be waived by or on behalf of the client/patient to allow testimony by the mental health professional in a court-related matter. (Issues regarding privilege and confidentiality are described in Guideline 7.)

Conflict of Interest: A situation in which personal, professional, legal or other interests or relationships have the potential to compromise or bias the mental health professional's judgment, effectiveness or objectivity. A conflict of interest may also occur in some jurisdictions based on the establishment of an appearance of conflict standard rather than an actual conflict.

Informed Consent:

(a) A client/patient's decision to consent to a proposed treatment or a proposed release of confidential information by a mental health professional, after the client/patient has received reasonably full and accurate information from the mental health professional as to the risks, benefits and likely consequences of the decision to consent.

(b) The term is used colloquially by mental health professionals to mean the *process* by which a client/patient receives the information needed to make an informed decision. The process usually includes discussion and a written agreement between the mental health professional and the client/patient as to the information provided and the client's understanding of it. (See Guideline 6.)

GUIDELINE 1: ASSESSING LEVELS OF COURT INVOLVEMENT

1.1 A CIT should assess the degree to which legal processes will impact the treatment and consider issues that may impact the client or parent's functioning in treatment, and the implications of treatment interventions on the legal processes

(a) The CIT should be aware that cases may have different degrees of Court involvement, and may also change in their degree of Court involvement over time.

(b) The CIT should obtain information about how the decision to enter therapy was made, who was involved in the decision, and what outcomes are expected from the treatment or the therapist by parents, other professionals, or the Court.

(c) The CIT should consider the variety of mechanisms through which court-involved families can enter treatment, and the implications of each of those circumstances:

(1) A parent involved in a Court case recognizes his/her own or child's distress and seeks treatment.
(2) A parent seeks therapy for him/herself or a child, in hopes of improving his/her own position in the Court case and securing the therapist's direct or indirect participation (report to a custody evaluator, etc.).
(3) Parents are ordered to obtain therapy for themselves or a child, but select from community practitioners with no specific agenda, reporting expectation or requirement.
(4) The Court orders therapy to address particular issues, such as child distress, high-conflict dynamics, reunification, etc. The order may include some degree of reporting requirement, or contingencies allowing reporting.

(d) The CIT should consider the potential impact of Court involvement on adults' functioning in treatment. The stress of Court involvement and the importance of the outcome to those involved can generate conscious or unconscious distortion of information and changes in the clients' or parents' expectations of the therapist.

(e) The CIT should consider the impact of his/her natural working alliance with the client. This may lead the therapist to align with the client's position in the legal dispute, thus impairing the CIT's ability to prepare the client to cope with likely outcomes and stresses in the legal process. While a client may equate his or her best interests with prevailing in the legal dispute, CITs must remain cognizant that their role is to promote successful psychological

functioning in the client, not to serve as an advocate or a forensic expert or produce a particular outcome in the legal process.

1.2. Special considerations for court-involved roles with children

(a) Children's behavior and statements may vary markedly based on the circumstances of treatment.

(b) The CIT has an enhanced obligation to consider multiple treatment hypotheses and be knowledgeable about children's developmental tasks and needs.

(c) The CIT should use particular caution to ensure that he/she has adequate data on which to base any opinions or assessments, and to form and express such opinions only within confines of the therapeutic role and available information, while remaining cognizant of the impact of Court involvement on the family and on treatment information.

(d) The CIT must, whenever possible, obtain each parent's perspective in the treatment process and maintain professional objectivity when interpreting statements and behaviors of children. The CIT should use particular caution in interpreting statements, play or drawings that appear to express positions on adult issues to avoid inaccurate or incomplete assessment of a child's developmental needs, expressed thoughts and feelings.

(e) The CIT should be aware of the potential impact of parental needs and expectations on treatment involving children or adolescents. The CIT should be particularly aware that:

  (1) A parent may have a genuine desire to obtain treatment or provide it to a child, but may also have expectations that the therapy will support the parent's own goals in the legal conflict.
  (2) A child or adolescent who is expressing a "position" regarding a contested issue in the legal conflict may have external influences on their perceptions, or that negatively impact their coping skills.

(f) While it is common in traditional treatment for one parent to be more involved in child treatment than the other, this therapy structure creates a risk in court-involved treatment. A CIT should consider *both* parent-child relationships and each parent's perspective in court-involved treatment.

GUIDELINE 2: PROFESSIONAL RESPONSIBILITIES

2.1 A CIT should establish and maintain appropriate role boundaries

(a) A CIT should inform potential clients, and others who may be relying on the therapist's opinion or services, of the nature of the services that can be offered by the therapist and the limits thereof. This includes providing thorough informed consent to clients/parents and appropriate information to others who may rely on the therapist's information. (See Guideline 6 and Guideline 10.)

(b) A CIT should resist pressure from anyone to provide services beyond or antithetical to the therapeutic role, as defined by recognized professional and ethical standards or guidelines.

(c) A CIT should explain to clients any decisions to decline to provide certain services. If others (e.g., the Court guardian *ad litem*, minor's counsel or agency) have requested services that the CIT considers inappropriate, the CIT should also explain decisions to decline these requests, to the degree that information provided is not privileged or privilege has been waived.

(d) A CIT should be prepared to modify elements of the therapeutic process, if appropriate, and to explain the necessity for the modification.

(e) A CIT should apprise the Court of any conflicts between the Court's expectations and the ethical and professional obligations, or role limitations, of the therapist.

2.2 A CIT should demonstrate respect for parties, families, the legal process and its participants

(a) A CIT should communicate respect for the legal system to clients, collaterals, and others who may rely on the therapist's work, information or opinions.

(b) A CIT should provide a thorough informed consent processes to parents, and age-appropriate explanations to children, as described in Guideline 6.

(c) A CIT should communicate, within the limits of any applicable privilege, regarding the limits and responsibilities of the therapist's role.

(d) A CIT should respect each parent's rights, as defined by relevant orders or law, regarding knowledge of, consenting to, and/or participating in a child's treatment.

(e) A CIT should be knowledgeable about appropriate expectations for developmentally acceptable behavior in children while respecting their independent feelings, perceptions, and developmental needs.

(f) A CIT should communicate with counsel in a balanced manner when in a neutral role and authorized to do so.

2.3 A CIT should provide clear, non-technical communication of observations and opinions to adult clients, parents of child clients, and other professionals when appropriate and permitted by applicable privilege

2.4 A CIT should maintain professional objectivity

(a) A CIT should actively seek information that will provide the most thorough understanding of his/her client's circumstances and issues, while remaining within the limits of the therapist's assigned therapeutic role in the case.

(b) When children are involved in treatment, a CIT has an enhanced obligation to consider multiple hypotheses, seek information and involvement from both parents and avoid the biasing effects of one-sided or limited information.

(c) A CIT should make efforts to consider and assess treatment issues from the perspective of each involved individual. This does not preclude maintaining a strong therapeutic alliance with a parent client/patient in individual therapy, but may require exploring with the client how others may perceive the issues.

(d) To the degree possible in the given therapeutic role, the CIT should remain aware of the information emerging in the legal process in order to assist the client in coping with it.

2.5 The CIT should manage relationships responsibly

(a) A CIT should recognize that the therapeutic relationship may change as a family's involvement with the Court changes or as the therapist communicates to other professionals, collaterals or the Court.

(b) If a parent or family who has not previously been court-involved becomes involved in a legal process and asks the therapist to continue services, the CIT should discuss with the relevant individuals and/or family members the potential effect of Court involvement on the therapy. This should include discussion of potential requests for release of therapeutic information to others including a child custody evaluator, parenting coordinator, other professionals, or the Court.

(c) If a CIT who has not previously been involved with a client's ongoing litigation is asked to provide information or have other involvement in the legal process, the CIT should notify the client and/or the client's legal representative of such requests. If the CIT believes the release of information

will adversely impact the client, the CIT should seek legal advice and notify the Court.

(d) The CIT should clearly document informed consent on the above issues.

2.6 A CIT should maintain accountability

(a) The therapist in a child-centered role should recognize that active intervention may result in the dissatisfaction of one or both parents, but should nevertheless maintain focus on the welfare of the child client.

(b) If disputes arise regarding interpretation of Court orders governing treatment, the CIT should seek direction or clarification from the Court, or an authorized Court representative in the case.

(c) The CIT should recognize that others in the legal system (e.g., custody evaluator, parenting coordinator, child's counsel or the Court) may have a role in monitoring or reviewing the therapeutic process.

(d) The CIT should recognize that his/her judgments, interventions, reports, testimony and opinions may have a profound impact on outcomes for children and families. The CIT should remain objective at all times, should use caution in forming and expressing opinions, and should use particular caution in drawing conclusions from limited observations or sources of information.

(e) A CIT should recognize that the dynamics of a court-involved case may create conflicts or disagreements with litigating parents or lead to demands that the therapist withdraw from the case. The CIT should recognize that therapeutic confrontation of a parent or a child, or a refusal to accede to the wishes of a parent or child, may frustrate that individual's desires, but does not necessarily constitute a conflict of interest. Such therapeutic confrontation may be therapeutically appropriate or even essential. In such a situation, withdrawing from the case or abandoning the intervention, unless terminated by the client, may be antithetical to the interest of the child or family.

GUIDELINE 3: COMPETENCE

3.1 A CIT has a responsibility to develop and maintain specialized competence sufficient for the roles they undertake

3.2 Gaining and maintaining competence

(a) A CIT has a responsibility to obtain education and training, and to maintain current knowledge, in areas including, but not limited to:

(1) Characteristics of divorcing/separated families and children

(2) Family systems and other systems in which court-involved families interact
(3) The impact of high interparental conflict on post-separation custody arrangements
(4) Effective interventions with divorcing or separated families
(5) Adaptations of traditional therapeutic approaches that may be Necessary to work with divorcing or separated families
(6) characteristics and needs of special populations who may be Involved in treatment
(7) Ethical issues and applicable local legal standards

(b) A CIT should utilize continuing education and professional development resources to maintain current knowledge of issues relevant to court-involved treatment.

(c) A CIT may also gain some of the required knowledge through experience and consultation with colleagues; however, clinical experience should not be a substitute for knowledge of the underlying science, relevant research, legal issues and standards of practice.

3.3 Areas of competence

(a) The CIT should maintain knowledge and familiarity with current research related to psychological issues in areas including, but not limited to:

(1) Child development and coping, including developmental tasks
(2) Child interviewing and suggestibility
(3) Children's decision-making ability, including appropriate means of understanding children's abilities and interpreting expressed preferences or opinions
(4) Factors in divorcing families that increase risk to children, or promote resilience in children
(5) Domestic violence
(6) Child abuse and child welfare
(7) High conflict dynamics, including risks to children from exposure to parental conflict, parental undermining, alienation and estrangement
(8) Treatment approaches, including both traditional methods and adaptations for divorcing or separated families
(9) Parenting and behavioral interventions
(10) Special needs issues, including medical issues, psychiatric diagnoses, substance abuse, learning or educational problems, developmental delays, etc.
(11) Ethnic, cultural, and sexual orientation differences among families

(b) The CIT should maintain knowledge and familiarity with legal information and issues related to court-involved therapy, including, but not limited to:

(1) Statutes and local Court rules in the therapist's jurisdiction
(2) Case precedents relevant to court-involved treatment
(3) Interactions and potential conflicts between governing mental health practice and family Court expectations or family law statues
(4) Ethical and professional guidelines and standards applicable to the role of the CIT, obtaining ethics consultation as appropriate
(5) Circumstances under which it may be necessary or appropriate for the therapist to consult an attorney

(c) The CIT should seek appropriate consultations when issues arise that are outside of the CIT's expertise.

3.4 Understanding of professional roles and resources

(a) The CIT should be familiar with the roles of other professionals with whom the CIT may interface while providing therapy in a case.

(b) The CIT should understand the roles of the child custody evaluator and the parenting coordinator, and the impact that the appointment of such professionals may have on both the process of therapy and the privacy of therapeutic information.

(c) The CIT should understand the roles of the minor's counsel or guardian *ad litem*, and should be aware of the laws governing confidentiality of treatment information when one of these professionals is appointed.

3.5 Representation of competence, state of professional knowledge

(a) The CIT should accurately represent his/her areas of competence, advise clients/parents if an issue arises that is beyond the CIT's knowledge and expertise, and initiate consultation and/or referral, when appropriate.

(b) The CIT should understand the limits of scientific knowledge and use caution to avoid overstating the certainty or parameters of professional opinions. (See Guideline 10.)

3.6 Consideration of impact of personal beliefs and experiences

(a) The CIT should remain familiar with current research on the impact of personal bias, personal beliefs and cultural and value differences, factors that may contribute to bias, and efforts that may be undertaken to contain or manage potentially biasing conditions in the CIT's work.

(b) The CIT should recognize and acknowledge that powerful issues may arise in court-related cases that generate personal reactions in the therapist or others, and take steps to counterbalance exposure to information or otherwise manage these issues.

(c) The CIT should obtain appropriate consultation to assist in maintaining professional objectivity.

GUIDELINE 4: MULTIPLE RELATIONSHIPS

4.1 The CIT should avoid serving simultaneously in multiple roles, particularly if these create a conflict of interest. For example, the CIT should not serve simultaneously as therapist and evaluator or as therapist and friend. Similarly, the CIT is strongly discouraged from performing different roles sequentially, as, for example, a therapist who becomes an evaluator or a therapist who becomes a parenting coordinator.

4.2 The CIT should disclose to all relevant parties any multiple relationships that cannot be avoided and the potential negative impact of such multiple roles.

(a) The CIT who discovers that he/she is performing multiple roles in a case should promptly seek to resolve any conflicts in a manner that is least harmful to the client and family. The CIT should clarify the expectations of each role and seek to avoid or minimize the negative impact of assuming multiple roles.

(b) The CIT should recognize that relationships with clients are not time limited and that prior relationships, or the anticipation of future relationships, may have an adverse effect on the CIT's ability to be objective.

(c) The CIT should attempt to avoid conflicts of interest and should address them as soon as they arise, or the potential for conflict becomes known, by:

(1) Identifying a real or apparent conflict of interest as soon as it becomes known to the CIT
(2) Refusing to assume a therapeutic role if personal, professional, legal, financial or other interests or relationships could reasonably be expected to impair objectivity, competence or effectiveness in the provision of services
(3) Communicating with the client or potential client or counsel, and, if necessary, with the Court, about the existence of the conflict.
(4) Recognizing that the appearance of a conflict of interest, as well as an actual conflict of interest, can diminish public trust and confidence both in the therapeutic service and in the Court
(5) Differentiating between conflicts that require declining to assume or

withdrawing from the therapeutic role, as opposed to multiple or sequential roles that may be undertaken with waivers from the client or parent

(6) Recognizing the risks of undertaking conflicting roles, even if the client or parent signs a waiver

(7) Clearly documenting the disclosure of any waived conflict, the client's ability to understand it, and the client's waiver. The client must receive a clear explanation of the conflict, and it may also be necessary to provide such explanations to other professionals or agencies relying on the therapist's work or information

GUIDELINE 5: FEE ARRANGEMENTS

5.1 The CIT should establish a clear written fee agreement with the responsible parties prior to commencing the treatment relationship

(a) A CIT may send a written fee agreement to the parties and/or client(s) prior to commencing treatment.

(b) If the case is not court-involved, a CIT may discuss the terms and fee requirements of treatment directly with the parties and/or client. This discussion should be documented in the CIT's record.

(c) If the case is already court-involved, or likely to be, a CIT may send the fee and consent agreements to counsel.

5.2 The CIT should provide written documentation to each responsible party

(a) Documentation should include a description of the treatment services to be provided, including all of the elements of informed consent described in Guideline 6.

(b) A CIT should provide a fee agreement that contains, at a minimum:

(1) A description of all services and charges

(2) Expectations regarding payment, including, if applicable:
   (i) fees associated with missed or cancelled sessions,
   (ii) costs/fees generated by one parent,
   (iii) consequences of non-payment, including its potential impact on continued provision of services,
   (iv) the use of collection agencies or other legal measures that may be taken to collect the fee (see attached sample agreement).

(3) Policies with regard to insurance reimbursement, if any. This should include issues such as identifying the person responsible for submitting the insurance form, payment for covered and non-covered

services, responsibility for submitting treatment plans (if required by the insurer) and the consequences of using insurance.

(4) Policies regarding advance payments, if any, for treatment services and the use of those payments

(5) A procedure for handling of disputes regarding payment

(c) If the therapy is court-ordered, the CIT should provide to the Court all information required to engage the CIT so that the Court can issue an appropriate and comprehensive order. The written fee agreement may be incorporated into the Court order that initiates the therapy. The therapist should request that the Court specify the party responsible for the payment or the specific apportionment between the parents or parties. In the event that the Court order fails to address the issue of fees adequately, the therapist should take appropriate steps to obtain clarification from the Court before providing services. Arrangements should be sufficiently clear to prevent or resolve most fee-related disputes, and for a future judicial officer or reviewer to be able to resolve any such disputes submitted to the Court.

(d) If treatment is terminated or suspended due to non-payment, the CIT should conduct the termination or suspension in accordance with the order, fee agreement and ethical principles.

(e) The CIT should maintain complete and accurate written records of all amounts billed and all amounts paid.

GUIDELINE 6: INFORMED CONSENT

6.1 At the outset of therapy, the CIT should provide a thorough informed consent process to adult clients and parents or legal guardians if the therapy involves the child

(a) A CIT has a professional obligation to inform the client of the limits of confidentiality and privilege at the outset of the therapeutic relationship, to promote informed decision-making throughout treatment and to document such explanations in the CIT's record. The CIT should clarify that these cautions do not constitute legal advice, and that the CIT will obey the Court's orders regarding treatment information.

(b) The informed consent should use language that is understandable and includes, at a minimum, information about the nature and anticipated course of the therapy, risks and benefits of the therapy, fees, the potential involvement of other individuals in the therapy, and a discussion of confidentiality.

(c) The CIT should be aware of state laws that impact confidentiality and access to records and these should be incorporated in the informed consent.

(d) Clients or their counsel should have an opportunity to ask questions, obtain answers, and discuss their concerns. These discussions should be documented in the CIT's record.

6.2 If a child is to be involved in treatment, there are special considerations

(a) A CIT should generally avoid accepting a child into treatment without notifying or consulting with both parents.

(b) A CIT should request copies of Court orders or custody judgments documenting each parent's right/authority to make decisions regarding treatment and delineation of each parent's access to treatment information.

(c) In rare and urgent cases, such as when there is strong reason to suspect a risk to a child's safety, a CIT may accept a child in treatment at the request of one parent. This should only occur if that parent has clear legal authority to consent and pending efforts to either notify the other parent or obtain permission from the Court; however, the CIT should be aware that such a decision may increase risk to the child, and to the CIT.

(d) A CIT should explain the nature and purpose of the treatment to a child in age-appropriate language. It may be necessary to revisit these issues as treatment proceeds.

(e) A CIT should discuss the limits of parental involvement and confidentiality with the parents or guardians of a child or adolescent involved in treatment.

6.3 When a CIT becomes involved in treatment at the request of a third party such as the Court, an attorney, or a social service agency, the CIT should be especially attentive to informed consent issues

(a) The CIT should identify to the client the name of the person or agency that requested the services and the potential impact this may have on the treatment.

(b) If an adult client or parent does not sign the informed consent, or otherwise has significant disagreements with the treatment process, the CIT should defer commencement of services and refer the client back to the third party agency or the Court for clarification.

(c) If the CIT has been appointed by the Court to provide treatment to one or more adults and an adult refuses to sign consent documents, the CIT should defer commencement of services until consent is obtained or the Court takes action to resolve the issue.

(d) If a CIT is asked by anyone to provide treatment to a child and one parent supports treatment while the other refuses consent, the therapist should refer the parties back to the Court for resolution of the dispute between the parents, and then proceed as the Court directs.

(e) If the court-ordered treatment is to proceed, it is recommended that the CIT require a treatment order, specifying the nature of the services to be provided and the parameters of treatment, before proceeding with treatment.

6.4 When more than one individual participates in the therapy, the CIT should clarify with each person the nature of the relationship between the participants and between each participant and the therapist. The CIT should also clarify his/her roles and responsibilities, the anticipated use of information provided by each person, and the extent and limits of confidentiality and privilege

6.5 On a case-specific basis, the CIT should explain to the client the manner in which treatment information will be handled. Issues to be clarified may include, but are not limited to:

(a) Whether the consent of one or both parents will be required to release information from conjoint, co-parenting or marital therapy

(b) Whether information will be released to a custody evaluator, parenting coordinator, the Court, or any other individual, and the extent of the information to be released

(c) Whether, and how, the CIT will communicate to the Court in the event that one or both parents do not cooperate with court-ordered treatment

(d) What will happen if the CIT is subpoenaed to give testimony in a court-related matter

(e) What information can be released to insurance companies, the Court, the other parent, or other entities to enable the CIT to collect his/her fees.

6.6 The parent/client should be encouraged to consult with counsel before signing a therapy/informed consent agreement, if the parent or client is represented

6.7 If the CIT's level of Court involvement changes or requests are made to change the CIT's role, the CIT should inform the client of the risks, benefits and impact of any potential changes in treatment

(a) The CIT should obtain consultation before contemplating a change in his/her role that might create a conflict of interest or alter therapeutic alliances.

(b) If the CIT becomes aware of potentially conflicting roles, he/she should take reasonable steps to immediately disclose, clarify and discuss the potential conflicts and any potential adverse impact. The CIT should make best efforts to minimize any negative impact, including withdrawing from the case, if appropriate.

(c) If the parties consent to a change in the CIT's role, the CIT should document the revised informed consent process.

6.8 The CIT should be sensitive to the possibility of being asked to provide feedback to third parties or to testify as a witness. The CIT should inform the client of this potential at the beginning of the informed consent process and as necessary thereafter.

(a) The CIT should take reasonable steps to clarify the limits of the therapeutic role, the potential scope of information to be released, and the potential implications of the release of information or the testimony for the client (see Guideline 7). In no case should the CIT attempt to provide legal advice to the client.

GUIDELINE 7: PRIVACY, CONFIDENTIALITY AND PRIVILEGE

7.1 The CIT should understand the principal issues that arise in court-related therapy in regard to client/patient confidentiality and privilege.

(a) The CIT should be aware that laws and standards vary markedly among jurisdictions, and there may be conflicts in the law within a single jurisdiction. Issues that may vary among (and within) jurisdictions include, but are not limited to:

(1) The identified client
(2) Assertion and waiver of the client's privilege
(3) Under what circumstances the mental health professional can or must disclose confidential information

(b) The CIT should be aware that ethical, clinical, and legal issues related to confidentiality/privilege may differ depending on whether a parent, child, couple or family is in treatment.

(c) The CIT should be aware of clinical issues related to disclosure of confidential information. (See Guideline 8.7.)

7.2 The impact of litigation on decisions regarding use of treatment information.

(a) The CIT should also be aware that a client or parent's legal case may be affected by the client's decision to release or decline to release treatment information. The CIT should encourage the client/parent to seek appropriate legal consultation before making this decision.

(b) The CIT should consider the impact of the Court context on a client's decisions about the use of treatment information and should take precautions accordingly.

(c) The CIT should consider that situational pressures may affect the client or parent's judgment or authority on the issue of waiving the privilege regarding treatment information. These pressures may include requests from the Court or other professionals with influence on the legal proceedings (e.g., a custody evaluator or parenting coordinator) that the parent waive his/her own, or the child's privilege as to the treatment relationship.

(d) The CIT should be aware that in some jurisdictions or situations, parents may not hold the right to waive or assert the child's privilege in court-involved treatment or treatment of the child. In some jurisdictions, a CIT has the option or duty to resist disclosure of information, or seek direction from the Court, if the CIT determines that disclosure of the information risks the welfare of the child. The CIT should be familiar with the appropriate procedures for his/her jurisdiction.

7.3 A CIT should recognize the limits of his/her expertise and, when in doubt as to whether information requested about treatment can be released, seek legal advice or request direction from the Court

7.4 Ongoing obligation to inform clients

(a) A CIT should revisit the discussion of confidentiality with the client as circumstances change, or as issues arise in therapy that may result in the disclosure of treatment information.

(b) If therapy is court-ordered and there is dispute regarding privacy, confidentiality and privilege, the CIT should seek clarification from the Court prior to commencing services. If a dispute arises as to the interpretation of the Court order after services have begun, the CIT should seek direction from the Court before releasing information.

7.5 Special issues in children's treatment

(a) A CIT should be familiar with general provisions governing confidentiality of children's treatment information in his/her jurisdiction, including:

(1) Who holds the child's privilege and how a child's privilege can be waived or asserted
(2) Under what circumstances a child or adolescent may have a role in this decision
(3) How the CIT should respond if he/she receives conflicting instructions from the parents
(4) How the CIT should respond if he/she believes that disclosure of treatment information poses a substantial risk of harm to the child

(b) At the outset of a child's treatment, the CIT should clarify the provisions of the order or therapy agreement regarding the child's treatment information. These issues include, but are not limited to:

(1) How information about a child's progress will be shared with parents
(2) Whether the consent of one or both parents will be required to release information about the child's progress
(3) The role that the child's thoughts and feelings will play in determining what information is shared, and how it is shared
(4) Circumstances in which the CIT may be required to release information to the parent or other professionals
(5) Circumstances that might require further discussion, clarification or modification of the order or agreement as the treatment progresses

(c) A CIT should prepare the child client for the release of treatment information, address the child's feelings about the issue, and assist the child in coping with any stressors that may result.

(d) The CIT should adapt explanations to the developmental and situational needs of each child.

(1) When working with a child client, the CIT should clarify the limits of confidentiality in developmentally appropriate language
(2) A CIT should not make blanket promises to a child that treatment information will be confidential

7.6 Considerations for therapists covered under the Health Insurance Portability and Accountability Act (HIPAA)

If the CIT is a HIPAA-covered entity, he/she must be aware of his/her obligations under the Act, and the how those obligations may change if the client or family

becomes involved with the Court. When requirements under HIPAA appear to be in conflict with other laws or Court orders, the CIT should obtain legal consultation.

7.7 Responding to requests for treatment information from third parties

(a) The CIT should request a copy of the release signed by the client, former client, parent, or other authorized person. The CIT should not communicate with a third party without an appropriate release or order of the Court authorizing disclosure.

(b) Prior to providing client information to a third party, the CIT should attempt to inform the client or former client about the request for release of information.

(c) The CIT should inform the client or former client of the nature of the information that may be released to a third party if the client waives the privilege. If appropriate, the CIT should also refer the client or former client to his/her attorney to assist the client in making this decision.

(d) A release does not supersede a Court order; therefore, prior to releasing information to a third party, a CIT should consult any agreement or Court order that governs the treatment.

7.8 Responding to a subpoena

(a) A CIT should be aware of differences between subpoenas and Court orders.

(b) A CIT who has received a subpoena should consider consulting an attorney familiar with both legal issues in the jurisdiction related to mental health law and the requirements of the Court in which the family is involved. Procedures, requirements, and the CIT's options will vary depending on the jurisdiction, whether the case is being heard in a family Court or juvenile dependency Court, and many other issues.

(c) A CIT should not automatically respond to a subpoena by disclosing written or oral information.

(d) A CIT should not ignore a subpoena.

(e) The CIT may wish to consider the additional guidance provided in Appendix A regarding specific steps that may be helpful in responding to a subpoena.

7.9 Responding to a Court order for release of treatment information

(a) If the CIT is ordered by the Court to release information, particularly over the

objection of one of the parties, the CIT should request a written order specifying the parameters of information to be released.

(b) If there are outstanding legal questions regarding what information can be released (such as whether the CIT can release information from other agencies or child protective services), the CIT may wish to obtain the assistance of an attorney who can bring these issues to attention of the Court and obtain clarification or direction.

7.10 Appealing a Court order

There are some circumstances in which a CIT may believe that disclosing information may violate ethical or professional practice guidelines applicable to mental health practice. In such a case, the CIT may wish to consult an attorney familiar with the laws of mental health privilege/confidentiality in that jurisdiction.

GUIDELINE 8: METHODS AND PROCEDURES

8.1 The CIT should adhere to the methods and procedures generally accepted in his/her particular discipline. In addition, the CIT should maintain methods and procedures consistent with being involved in situations, which may include litigation, testimony, and the reporting of various matters to Court, parties, or their attorneys.

8.2 Obtaining necessary information if the therapy is court-ordered

(a) The CIT should attempt to obtain all information necessary to conduct the court-ordered therapy and should discuss the goals of the court-ordered therapy with the client.

(b) As appropriate to the specific case, the CIT should request information that may be necessary for effective treatment. This may include permission to speak to a prior therapist or other involved professionals, copies of prior Court orders, therapy records, and reports from child custody evaluators, child protective services, or a guardian *ad litem.*

(c) The CIT should obtain necessary information, including copies of relevant Court orders, to confirm that his/her role is clearly defined and consistent with the therapeutic role and the CIT's expertise.

(d) If the CIT is unable to obtain information from the parties or counsel that is necessary to conduct treatment, the CIT may apply to the Court for further direction if the CIT has obtained appropriate releases. Application to the Court should be preceded by proper notice to the parties and counsel.

8.3 Therapeutic role and process

(a) The CIT has a responsibility to identify both the intended clients and any others intended to be the beneficiaries of the intervention.

(b) When the intended beneficiary of the intervention is an individual client, the primary focus of the therapist is the client's welfare and treatment is implemented for the benefit of the client. Therapists with different treatment orientations may identify different treatment goals, but all focus on improving client's functioning.

(c) In other cases, a relationship or family unit may be the identified client or may be the participants in counseling, but the goal may be to reduce conflict or promote behavior change for the benefit of the child (e.g., co-parenting or conjoint/reunification therapy).

(d) The CIT should clearly identify the goals, procedures and beneficiaries based on any relevant orders and in collaboration with the client(s) and other professionals as appropriate, and should clearly communicate this information to participants in the therapy.

8.4 The CIT should understand that the information provided by the client during the course of the treatment is based upon the client's experience and perspective, which may sometimes be distorted or lacking balance and comprehensiveness

(a) The CIT should strive to maintain professional objectivity, and to remain aware of the impact of the therapeutic alliance on the therapist's information and perspective.

(b) The CIT should actively consider alternative hypotheses regarding the information (i.e., data) he/she is receiving in the treatment.

(c) The CIT should strive to be aware of societal and personal biases and continuously monitor his/her actions for evidence of potential bias. Awareness of research and focus on the treatment data inform the CIT and help limit the potential for bias. The CIT should consider withdrawing from a case when he/she is unable to manage a known bias and/or is unable to maintain objectivity.

(d) The CIT should be aware that the treatment may be influenced by the client or family's involvement in legal processes, and that the legal process may be influenced by the actions of the therapist.

(e) The CIT must constantly guard against/protect his or her work from threats to professional objectivity and role boundaries.

8.5 Selecting appropriate treatment methods

(a) A CIT should not exceed the bounds of his/her professional competence in his/her diagnosis, treatment planning and treatment of clients.

(b) A CIT should use methods or interventions that are generally accepted within the professional communities and literature, and should apply methods or interventions appropriate to the situations and characteristics of court-involved families.

(c) A CIT should be able to justify and explain the choice of methods based upon the current state of professional knowledge and research.

(d) The CIT should select treatment methods or approaches that minimize the potential for biased or inappropriate interpretations of client's statements and behaviors or perceptions of others' behavior. This may include deliberate balance in asking questions, challenging assumptions, and supplementing behavioral observations with other methods of inquiry.

(e) A CIT should exercise caution in forming opinions or structuring therapy based on limited or one-sided information.

(f) A CIT should maintain current knowledge about the validity (or lack of validity) of using specific behaviors as a basis for diagnosis or treatment, and should employ treatment methods that allow the therapist to gather information from a variety of methods and observations.

8.6 Critical examination of information

(a) A CIT should critically examine information received from a client before formulating or offering a clinical opinion. This is especially important in light of the possibility that a therapeutic alliance may produce a bias toward the client.

(b) A CIT should recognize that loss of therapeutic objectivity may harm a child or family, whether or not the therapist reports or testifies about the therapy. Therapists should avoid inappropriate bias by actively considering, and exploring, rival hypotheses about a client's difficulties.

8.7 A CIT should consider the clinical implications of actions taken when the CIT is asked to release treatment information, and should endeavor to minimize risks in these areas

(a) The therapist should be aware that an adult client requesting the release of information may not fully attend to, or understand, the risks and benefits of such a decision. This may lead to distress in the client or damage to the therapeutic alliance, if the client is surprised by the therapist's information or opinion.

(b) The therapist should assist the client in understanding:

(1) The risks and benefits of releasing information
(2) The nature of the information in the client's records
(3) The CIT's obligation to provide complete answers when questioned under oath and to avoid misleading other professionals or the Court
(4) Other potential factors that may lead to distress in the client or damage to the therapeutic relationship due to the release of information

(c) When a child is involved in treatment and the CIT is asked to release treatment information, the CIT should consider and address issues to minimize disruption of treatment and avoid distress in the child. Issues to consider may include:

(1) Appreciation of the parent's right to information and any concerns that he or she may have about the child or the therapy
(2) Protection of the child's treatment progress and privacy
(3) Potential for disruption of the therapeutic relationship if the parent feels excluded or resorts to litigation in order to obtain information
(4) Possibilities for negotiating the parent's involvement and managing the sharing of information without violation of the child's privacy, wholesale release of treatment information, or litigation

(d) The CIT should consider and address the various clinical possibilities in children's expressed preferences about disclosure of information. The CIT should consider the potential implications of whatever action the CIT takes, and should utilize available therapeutic options for dealing with the child's information. Issues to consider and address may include:

(1) Treatment goals related to the children's resolving of issues with parents
(2) A child's realistic or unrealistic fears about the parent's response to the information
(3) The child's own emotional issues or difficulty in expressing feelings directly

(4) Whether the child will ultimately be empowered or protected by having the CIT share information on the child's behalf
(5) Whether the child needs protective measures to prevent harm resulting from the sharing of therapeutic information
(6) Whether information can be disclosed in a therapeutic rather than legal setting

(e) The CIT should prepare both adult and child clients for the sharing of information and endeavor to anticipate any problems the client may experience as a result.

8.8 A CIT should seek appropriate advice

When in doubt about an appropriate course of action, the CIT should consider seeking legal advice or professional consultation. Such advice may protect both the clients/participants in therapy and the CIT.

GUIDELINE 9: DOCUMENTATION

9.1 A CIT should create documentation so that the Court can understand the treatment process, progress and financial arrangements

9.2 A CIT should establish and maintain a system of record keeping that is consistent with applicable law, rules, and regulations and that safeguards applicable privacy, confidentiality, and legal privilege. A CIT should create and maintain records reasonably contemporaneously with the provision of services.

(a) In deciding what to include in the record, the CIT may determine what is necessary in order to:

(1) Provide competent care
(2) Assist collaborating professionals in delivery of care
(3) Provide documentation required for reimbursement or required administratively under contracts or laws
(4) Effectively document any decision making, especially in high-risk situations
(5) Allow the CIT to effectively answer a legal or regulatory complaint

(b) If a client, parent or third party requests limited record keeping as a condition of treatment the CIT should explain that record keeping must meet professional standards.

9.3 Records should be organized and sufficiently detailed

A CIT should maintain records that facilitate the provision of future services by the CIT and by other professionals, ensure accuracy of billing and payments, and ensure compliance with ethical requirements and laws. Records should be sufficiently detailed, legible and readily available for reproduction upon receipt of appropriate releases or Court orders.

9.4 Confidentiality and security of records

A CIT should make all reasonable efforts to maintain confidentiality in creating, storing, accessing, transferring and disposing of records under his/her control. A CIT should maintain active control of records, provide appropriate training to any support staff, and take reasonable care to prevent the loss or destruction of records.

9.5 Ethical and statutory requirements

(a) A CIT should be cognizant of and follow relevant ethical and statutory requirements regarding maintaining records.

9.6 Communicate and clarify recordkeeping with the client and/or parents

(a) When the client is a child, the CIT should request any orders establishing who has the authority to consent to release of records. A minor may have the legal prerogative to consent to treatment, but the parent may nevertheless seek access to the records. A CIT should verify parents' statements of having the sole authority to consent to or block release of records by requesting relevant documents.

(b) When the CIT has multiple clients, such as when a parent participates in therapy with the child, the CIT should clarify as part of the informed consent procedure how the records are kept and who can authorize their release.

(c) A CIT should clarify any costs associated with providing copies of records and follow relevant statutes regarding fee arrangements. A CIT should not refuse to release records needed for emergency treatment because a client has not paid for services.

(d) Even when clients are participating in therapy pursuant to a Court order, the CIT should clarify policies, procedures and fees associated with the release of records and confidentiality.

GUIDELINE 10: PROFESSIONAL COMMUNICATION

Communication from a CIT to another therapist, the client, parents, counsel, or the Court carries with it an obligation to ensure that the communication is authorized, clear, and accurate. A CIT should recognize the adversarial nature of the legal system and the potential impact of the therapist's observations and opinions.

10.1 Authorization to communicate

A CIT should take reasonable steps to ensure that he/she is authorized to communicate with a third party, as described in Guideline 7.

10.2 Accuracy in communication

(a) In communication with others, a CIT should take reasonable steps to ensure that he/she is accurate in communicating:

(1) The nature of the service provided
(2) His or her opinions on diagnosis, prognosis, and/or progress in treatment
(3) His or her opinions on appropriate actions that would support the therapy
(4) His or her understanding of the role the therapist has with the family and in the Court process
(5) Reports or observations of parents' or children's behavior

(b) The CIT should make reasonable efforts to ensure that information regarding his or her services, including treatment, reports and testimony is communicated in language that can be understood by consumers and minimizes potential for misuse of the therapist's information.

10.3 Communicating limits and distinctions

A CIT should communicate the bases and limitations of observations and opinions.

(a) In all communications, especially in reports or testimony, the CIT should distinguish between observations, verbatim statements, inferences derived from his or her sources of information and conclusions or assessments reached.

(b) A CIT should articulate the limits of any communications. A CIT should decline to communicate opinions, recommendations, or information requested:

(1) When there is insufficient data on which to form a reliable opinion
(2) When there is no authorization to do so
(3) When the opinion requested is inconsistent with the role of the CIT

(c) Where the information available to the CIT might support more than one therapeutic assessment or opinion, the CIT should present and acknowledge the alternate possibilities and any treatment data or research supporting them.

(d) When necessary and appropriate, a CIT should be prepared to explain the limits of the CIT's role and the reasons it is inappropriate to give testimony or opinions in violation of that role.

10.4 Appropriate parties to include in communication

A CIT should carefully consider who should be aware of and involved in each professional communication.

(a) The CIT should consider whether one or both counsel, a guardian *ad litem*, child's counsel, other CITs, or parenting coordinator should be included in the communication.

(b) The CIT should respond with caution if an adult client's attorney requests a treatment report, particularly if the request comes through the client. The CIT should discuss with the client the potential content and implications of such a report, as discussed in Guidelines 7 and 8. With an appropriate release, the CIT may also wish to consider consulting with the adult client's attorney to ensure that the attorney is aware of the potential content and implications of a report from the therapist.

(c) The CIT in a neutral role, such as that of child's therapist, co-parenting therapist or conjoint/reunification therapist, should avoid unilateral communication with either parent's attorney in order to avoid appearance of bias and to contain the potential for actual bias.

10.5 Testimony

(a) A CIT should recognize the limits of his/her knowledge, and the potential impact that testifying in Court may have on the client and on treatment. Prior to testifying, a CIT should thoroughly discuss these issues with adult clients, and should engage in age-appropriate preparation of child clients.

(b) A CIT should comply with any limits on the scope of his/her testimony, which have been specified by a judicial officer in conjunction with any applicable ethical code.

(c) A CIT should anticipate that clients, attorneys, and the Court may ask the CIT to testify beyond the limits of his or her knowledge and role. The CIT should respectfully decline to provide information or opinions that exceed the treatment role or the CIT's knowledge base.

(d) A CIT should seek to clarify any conflicts between the testimony requested by the Court or counsel and any limitations imposed by professional ethics codes or licensing regulations.

(e) When the CIT is designated as an Expert Witness by the Court he or she may offer relevant clinical opinions within the role of the treating expert.

(1) The CIT may offer opinions on issues such as diagnosis, changes or behaviors observed in treatment, treatment plan, prognosis, coping and developmental abilities, conditions necessary for effective treatment, etc.
(2) The CIT should not render opinions on psycho-legal issues (e.g., parental capacity, child custody, validity of an abuse allegation, joint or sole custody), as these are beyond the scope of the treatment role and properly the province of other professionals and the Court

APPENDIX A

RESPONDING TO A SUBPOENA

This material is intended to supplement the information in Guidelines 7 and 8.7 regarding privilege and confidentiality issues, and the clinical management of requests for treatment records or information.

1. A subpoena is not a Court order. It is a formal request from an attorney to summon a witness or require a witness to bring documents to a hearing. The hearing might be a deposition (oral testimony taken under oath in preparation for a formal trial or to preserve the evidence) or a trial itself.

2. A CIT should never ignore a subpoena.

3. A CIT should not assume that a subpoena requires him or her to automatically disclose all requested information

4. Some jurisdictions have detailed statutes regarding psychotherapist privilege. These may include specific statutorily-mandated steps the CIT can take in response to receipt of a subpoena. In other jurisdictions, a CIT may want to obtain legal advice from an attorney familiar with (1) the privacy law in that jurisdiction; (2) the requirements specific to family court cases or the laws governing the CIT's role; and (3) the ethical obligations of mental health professionals. It is important for each CIT to know the state of the law in his or her jurisdiction on this issue and for the CIT to provide his/her counsel with any specific orders governing the CIT's role in the particular case.

5. The requirements for responding to a subpoena may be different in a juvenile or dependency court, a family court, a general civil court and a criminal court. When obtaining legal counsel with regard to a subpoena, the CIT should know which type of court is the setting for the case that generated the subpoena and should provide legal counsel with all relevant orders and documents.

6. If a CIT receives a subpoena regarding an adult client's treatment, he or she should make and document best efforts to notify the client or former client that the subpoena was served. The CIT should let the client know the scope of the information sought in the subpoena and that the client has a right to consult counsel to determine how best to respond to the subpoena.

7. If the subpoena was sent by the client's attorney, the CIT may, with the written consent of the client, cooperate with the attorney.

8. If the subpoena was sent by opposing counsel, the CIT may, with the written consent of the client, cooperate with the client's attorney to design a strategy for response to the subpoena.

9. In working with the client's attorney, it is important for the CIT to learn what the attorney hopes to gain from the CIT's involvement in (or exclusion from) the case, the issues being litigated, and the information and/or opinions that the lawyer will ask the CIT to reveal. The CIT should also attempt to learn what the opposing side is trying to achieve and whether and in what way the opposing lawyer may attempt to discredit the CIT's information and/or opinions.

10. Upon receipt of the subpoena, the CIT should carefully review his or her own records regarding the client and be prepared to discuss with the client and his or her attorney the following:

    A. Whether the record contains outdated material;
    B. Whether the record contains highly personal material;
    C. Whether the record contains information that could help the client achieve the goals described by the client's attorney;
    D. Whether the record contains information that could harm the client's goals.

11. If the subpoena was sent by the opposing attorney, the CIT should discuss with the client's attorney whether or not it would be useful to attempt to negotiate with opposing attorney to limit the scope of the subpoena, e.g., to redact outdated material, the names of third parties not important to the litigation or highly personal information.

12. The CIT should discuss with the client's attorney whether or not it would be wise to bring a Motion to Quash the subpoena, i.e., a request of the Court that the CIT be relieved of the obligation to provide testimony or produce records. The Motion to Quash must be grounded in some legally-cognizable rationale. For example, the material known to the CIT may not be relevant to the litigation. Or the opposition might be able to obtain the information known by the CIT from other sources, which would be less invasive to the client than obtaining information from the CIT. Or in some jurisdictions it will be possible to argue that, even though the CIT has information bearing on the case, it is more important that the client's privacy be maintained than that the information be disclosed.

13. If a child is the CIT's client and the child's records are subpoenaed, the CIT should consider whether or not the potential consequences to the child warrant opposing release of the information, requesting that an independent advocate be appointed, or warning the involved parties about risks to the child from release of the information. The CIT should be familiar with the procedures in his or her jurisdiction that are used to protect or consider the child's treatment information. In most jurisdictions, under ordinary circumstances, the parents or the person with legal custody of the child or the legal guardian has the power to determine whether or not to allow a child's private information to be released. However, if the parents are themselves in conflict in the litigation, the jurisdiction may have a special process for determining the child's privacy rights (as the parents are in a conflict of interest position about the child's privacy rights). Some jurisdictions will have a procedure by which a specially appointed person will decide,

after learning more about the litigation and the effects on the child, whether to waive or to assert the child's privilege. In some jurisdictions the decision of that appointee is decisive; in other jurisdictions, the person's decision is a recommendation to the Court, which has the final say.

14. If the CIT is asked to give information or an opinion about the effect on the child client of release of treatment information, the CIT should be prepared to explain the potential impact on the child of releasing the information and, conversely, the potential impact of withholding the information and the risks and benefits of each. Relevant factors might include the child's wishes, the impact of the decision on the child's ability to trust therapy and the CIT following a disclosure, the child's needs or ability to have his or her voice heard in the litigation, and whether or not there are other, less intrusive sources for obtaining the information.

15. The CIT should be aware that ultimate decisions regarding release of treatment information may not be the province of the therapist. Properly informed adults, and their attorneys, may have the right to control their treatment information. Those charged with protecting the child, such a minor's counsel, Guardian Ad Litem or the Court, may need to weigh and determine the best means of protecting the child's interests.

For supplemental information, please see the following documents:

Sample client-therapist contract:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/Client-therapistcontract.pdf

Sample order for counseling:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/OrderforCounseling.pdf

Sample stipulation and order for counseling:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/StipulationandorderforCounseling.pdf

Suggested references:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/Suggestedreferences.pdf

Differential Approach for Assessing and Intervening with Strained Parent-Child Relationships after Divorce - © Fidler, Bala & Saini, 2013

Assessment: Level of Severity	Mild	Moderate	Severe
1. Parental conduct 2. Protection vs the probability of harm 3. Rigidity of child's perceptions/behavior towards his/her parents 4. Frequency of parent-child contact 5. Duration of strained relationships 6. History of parents' rigidity 7. Responsiveness to education/treatment as suggested 8. Compliance with court, orders, parenting plans,nd treatment agreements	1. Minimal interference/ badmouthing 2.Parent values child's relationship with other parent but occasionally displays misguided protective behavior 3. Child values relationship with both parents, but displays discomfort (not extended to extended family) 4. Minor interruptions of parent-child contact (e.g. late, missed visits, short-lived transition difficulties in presence of FP) 5. Situational and infrequent relationship strain (eg. due to affinity, alignment, expected and time-limited upset over parents' separation) 6. Generally flexible but can be rigid 7. Responsive to treatment/education to improve parent-child relationships 8. Compliant with parenting plan, treatment agreement and court orders	1. Episodic interference / badmouthing 2. Parent's overprotection (unwittingly or intentionally) undermines the child's relationship with the other parent 3. Child displays more resistance than at mild level, although reactions are mixed, confused or inconsistent (eg., before or during transitions, while with resisted parent) 4. Contact is sporadic, infrequent and/or delayed 5. Pattern of missed opportunities for parent-child contact; child takes longer to settle in after transitions than at mild level and may become unsettled closer to return time to FP 6. Generally rigid but some instances of flexibility 7. Attends treatment but sporadic and/or with minimal success 8. Inconsistent compliance with parenting plan, treatment agreement and court orders	1. Psychologically abusive alienating behaviors related to mental health issues (eg. paranoia) 2. Identifies actions as protecting (rights of) child, despite repeated investigations or evidence that demonstrates that the risk of future harm is improbable, or make malicious allegations knowing they are unfounded 3. Rigid / extreme child reaction to rejected parent (eg., threats to run away, of harm to self or others, acting out or aggressive behavior) 4. No or very infrequent contact between child and RP 5. Chronic parent-child disruptions 6. Inflexible position taking 7. Refusal of treatment / Previous attempts for treatment unsuccessful 8. Noncompliance with parenting plan, treatment agreement or court orders
Legal Interventions: From court support, monitoring to intervening	Detailed parenting plan, including specified parenting time with RP, and primary residence care with FP Early case conference Court management and monitoring Referral to parenting education or counselling with experienced therapist Warning of sanctions for noncompliance of parenting plan and orders	Highly detailed parenting plan (specified court ordered parenting time for child with RP) Court monitoring Continuity with one judge Warning of sanctions or custody reversal Sanctions for noncompliance (contempt of court, opportunity to purge contempt) Consideration for joint custody to ensure involvement of the rejected parent in child-related decision making Consideration for extended periods of contact over holidays with rejected parent (eg, summer school break) Consideration for equal parenting time Court appointment of a therapist experienced in alienation	Strong sanctions for noncompliance implemented Possibility of transfer of custody to RP with one of more of the following monitored by court: -interim interruption of contact (at least 3 months) with FP, or indefinitely until behaviour change demonstrated - monitored or supervised contact with FP - use of transitional site to prepare for transfer of custody to RP -eventual return to FP if there is an absence of parental alienating behaviors demonstrated
Client Interventions: Map interventions to client needs	Preventative parent education Psychoeducational groups for children Family therapy (members seen in various combinations) Therapist reporting back to court when there is noncompliance with parenting plan, orders or treatment agreement	Court ordered family therapy (members seen in various combinations) to repair relationships & implement court ordered parenting time with rejected parent Additional therapy for child, rejected or favored parent Intensive residential family intervention (may be with one family or group therapy), with both parents and children, combining therapy and psychoeducation (e.g., family camp program, weekend workshop) Therapist reporting back to court for noncompliance with parenting plan, orders or treatment agreement Parenting Coordinator (case manager / monitor interventions)	Custody reversal (as above) accompanied by reintegration intervention with child and RP, followed by intervention/therapy to reunify FP Parent education and individual therapy for FP with a view to reunification with child Therapist reporting back to court when there is noncompliance with parenting plan, orders or treatment agreement Parenting Coordinator (case manager / monitor of interventions)

PARENTING PLAN CHECKLIST FOR HIGH CONFLICT FAMILIES

Barbara Jo Fidler, Ph.D., C.Psych., Acc.FM.

Lawyers, mediators, assessors/evaluators and parenting coordinators may wish to structure their Parenting Plans for high-conflict families using the following headings. Examples of the specific areas that would typically fall under each heading are provided.

PARENTING GUIDELINES AND PRINCIPLES

- Various parenting guidelines, principles and aspirations relating to good parenting, promoting children's relationships with the other parent, supporting the parenting plan, not denigrating the other parent, not involving the children in conflict, respecting the other parent's privacy, not raising issues at transition times when children are present, etc.
- Relevant and appropriate child-rearing practices (e.g., degree of consistency regarding various routines such as bedtime, napping, dietary restrictions, homework, etc.).

PARENTAL COMMUNICATION

- Rules of engagement for the parents' communication and behaviour in and out of the children's presence.
- Detail regarding the parents' communication: how, when, where, how frequently, the required response time, etc.

REGULAR PARENTING TIME SCHEDULES

- Clearly delineated parenting time with each parent
- When does parenting time start and stop?
- What happens to the parenting time schedule when a child is ill?
- Who calls the school when a child is ill?
- When is time with the other parent forfeited because of illness?
- Exact pickup and drop-off days and times
- Rules for parental behaviour at transitions (i.e., no discussion of anything beyond cordial niceties)
- Location of transition?
- Who does the transportation?
- Punctuality rules

CHANGES TO PARENTING TIME SCHEDULES

- Rules relating to how the need for temporary changes to the parenting time will be addressed and resolved in the event of a dispute.
- How are temporary changes/requests handled?
- What is the agreed-upon response time for requests for changes?
- What is the policy regarding "make-up" time with the child/ren?

- Is there a right of first refusal? If so, what is the threshold of time allowed (e.g., four hours, eight hours, one overnight or more?)

HOLIDAYS, SPECIAL DAYS AND VACATIONS

- Specify *all* holidays clearly defined as to beginning and end of period, location of transitions, who provides transportation, etc.
- Agreement that these days take precedence over usual schedule
- How are summer vacation dates determined? Who gets first choice? How much notice is given?
- Is there a rule that the one-week holiday (seven days) must include a usually scheduled weekend?
- If not, what happens to the usual weekend rotation?
- Does the statutory day add to the seven days to make eight days?
- What happens to the usual schedule when the holiday schedule ends?
    - Does the usual rotation continue or change?
    - Does one parent get three weekends in row, or do the parents split one week and resume the usual alternation of weekends?
- What about professional development school days?
- Children's birthday parties:
    - Who pays?
    - Who attends?
    - How are the gifts divided?

CHILDREN'S CONTACT WITH NON-RESIDENT PARENT

- Is there unlimited telephone contact between the child and the non-resident parent, or are there rules (e.g., frequency of calls in a week, time of day, who initiates the call, etc.)?

EXTRACURRICULAR ACTIVITIES

- How are extracurricular activities decided upon?
- Is consent or notice only required when such activities overlap the other parent's time?
- Can both parents (and family members) attend all activities, only some (e.g., special final events), or none?

CHILDREN'S CLOTHING & BELONGINGS

- What are the rules around clothing: washing; returning; number of changes provided to the parent who pays child support; loss; breakage?
- Which are Section 7 expenses, and which come out of child support?

DAY-TO-DAY DECISIONS

- Who takes children to routine medical/dental appointments?
- Can both parents attend such appointments?
- What, how and when will child-related information be shared?
- Who is the librarian of documents: health card; immunization; etc.?
- Which parent attends at parent–teacher meetings?
- Which parent accompanies the child/ren on field trips?
- Which parent is responsible for the children's haircuts?

MAJOR DECISIONS (CHILDREN'S HEALTH/WELFARE, HEALTH, EDUCATION, & RELIGION)

- Precise protocol for how these are decided
- Exchange of information
- Details regarding the children's religious observance, if any (e.g., attendance at church, Sunday school, rituals, etc.)

TRAVEL

- Notice? Consent?
- Notarized letter (rules regarding response time; number of days in advance of travel; who pays)
- What is in the itinerary?
- Who holds the passports?
- Phone calls with the non-resident parent during travel with the resident parent?

RESIDENTIAL MOVES

- Number of days of notice required
- Geographic boundaries/limits, or distance from each other.

JURISDICTIONAL MOVES

- Agreed to mutually; otherwise by court order

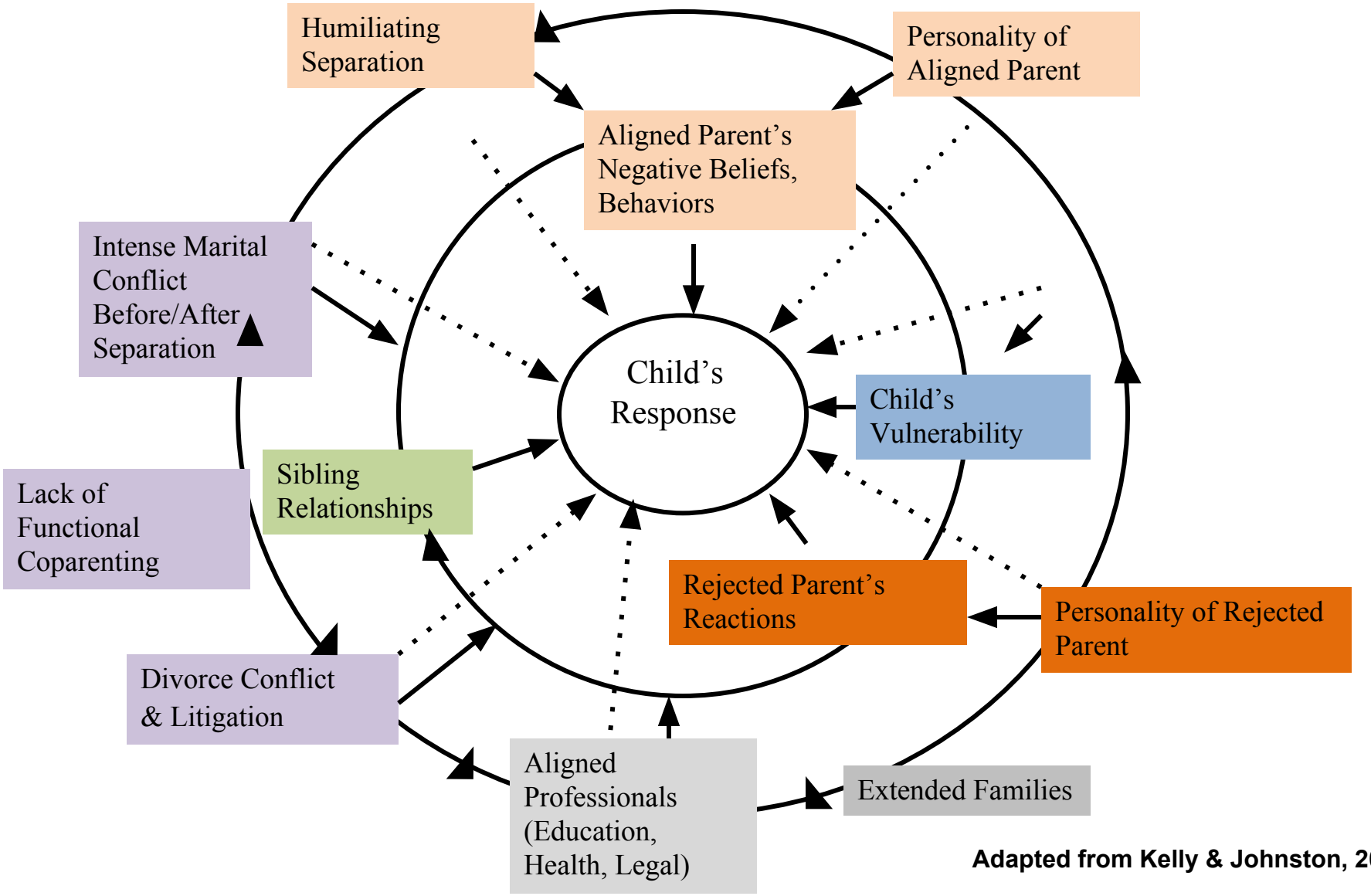
CHANGE OF NAME

- Identify restrictions as per relevant/local law

FUTURE DISPUTE RESOLUTION

- Identify future dispute resolution mechanism/method (i.e., mediation, parenting coordination, mediation/arbitration, etc.)
- Identify professional to provide services
- Identify how fees will be paid

Factors contributing to & sustaining parent-child contact problems



Adapted from Kelly & Johnston, 2001

PARENTING PLAN CHECKLIST FOR HIGH CONFLICT FAMILIES

Barbara Jo Fidler, Ph.D., C.Psych., Acc.FM.

Lawyers, mediators, assessors/evaluators and parenting coordinators may wish to structure their Parenting Plans for high-conflict families using the following headings. Examples of the specific areas that would typically fall under each heading are provided.

PARENTING GUIDELINES AND PRINCIPLES

- Various parenting guidelines, principles and aspirations relating to good parenting, promoting children's relationships with the other parent, supporting the parenting plan, not denigrating the other parent, not involving the children in conflict, respecting the other parent's privacy, not raising issues at transition times when children are present, etc.
- Relevant and appropriate child-rearing practices (e.g., degree of consistency regarding various routines such as bedtime, napping, dietary restrictions, homework, etc.).

PARENTAL COMMUNICATION

- Rules of engagement for the parents' communication and behaviour in and out of the children's presence.
- Detail regarding the parents' communication: how, when, where, how frequently, the required response time, etc.

REGULAR PARENTING TIME SCHEDULES

- Clearly delineated parenting time with each parent
- When does parenting time start and stop?
- What happens to the parenting time schedule when a child is ill?
- Who calls the school when a child is ill?
- When is time with the other parent forfeited because of illness?
- Exact pickup and drop-off days and times
- Rules for parental behaviour at transitions (i.e., no discussion of anything beyond cordial niceties)
- Location of transition?
- Who does the transportation?
- Punctuality rules

CHANGES TO PARENTING TIME SCHEDULES

- Rules relating to how the need for temporary changes to the parenting time will be addressed and resolved in the event of a dispute.
- How are temporary changes/requests handled?
- What is the agreed-upon response time for requests for changes?
- What is the policy regarding "make-up" time with the child/ren?

- Is there a right of first refusal? If so, what is the threshold of time allowed (e.g., four hours, eight hours, one overnight or more?)

HOLIDAYS, SPECIAL DAYS AND VACATIONS

- Specify *all* holidays clearly defined as to beginning and end of period, location of transitions, who provides transportation, etc.
- Agreement that these days take precedence over usual schedule
- How are summer vacation dates determined? Who gets first choice? How much notice is given?
- Is there a rule that the one-week holiday (seven days) must include a usually scheduled weekend?
- If not, what happens to the usual weekend rotation?
- Does the statutory day add to the seven days to make eight days?
- What happens to the usual schedule when the holiday schedule ends?
    - Does the usual rotation continue or change?
    - Does one parent get three weekends in row, or do the parents split one week and resume the usual alternation of weekends?
- What about professional development school days?
- Children's birthday parties:
    - Who pays?
    - Who attends?
    - How are the gifts divided?

CHILDREN'S CONTACT WITH NON-RESIDENT PARENT

- Is there unlimited telephone contact between the child and the non-resident parent, or are there rules (e.g., frequency of calls in a week, time of day, who initiates the call, etc.)?

EXTRACURRICULAR ACTIVITIES

- How are extracurricular activities decided upon?
- Is consent or notice only required when such activities overlap the other parent's time?
- Can both parents (and family members) attend all activities, only some (e.g., special final events), or none?

CHILDREN'S CLOTHING & BELONGINGS

- What are the rules around clothing: washing; returning; number of changes provided to the parent who pays child support; loss; breakage?
- Which are Section 7 expenses, and which come out of child support?

DAY-TO-DAY DECISIONS

- Who takes children to routine medical/dental appointments?
- Can both parents attend such appointments?
- What, how and when will child-related information be shared?
- Who is the librarian of documents: health card; immunization; etc.?
- Which parent attends at parent–teacher meetings?
- Which parent accompanies the child/ren on field trips?
- Which parent is responsible for the children's haircuts?

MAJOR DECISIONS (CHILDREN'S HEALTH/WELFARE, HEALTH, EDUCATION, & RELIGION)

- Precise protocol for how these are decided
- Exchange of information
- Details regarding the children's religious observance, if any (e.g., attendance at church, Sunday school, rituals, etc.)

TRAVEL

- Notice? Consent?
- Notarized letter (rules regarding response time; number of days in advance of travel; who pays)
- What is in the itinerary?
- Who holds the passports?
- Phone calls with the non-resident parent during travel with the resident parent?

RESIDENTIAL MOVES

- Number of days of notice required
- Geographic boundaries/limits, or distance from each other.

JURISDICTIONAL MOVES

- Agreed to mutually; otherwise by court order

CHANGE OF NAME

- Identify restrictions as per relevant/local law

FUTURE DISPUTE RESOLUTION

- Identify future dispute resolution mechanism/method (i.e., mediation, parenting coordination, mediation/arbitration, etc.)
- Identify professional to provide services
- Identify how fees will be paid

FAMILY THERAPY INTERVENTION AGREEMENT

Between: [insert names of parents]

Court File Number: _____

OBJECTIVES

1. The parents agree the objective of the family therapy intervention is not to determine IF it is in the child(ren)'s best interests to have contact with one of the parents. Rather, the parents agree it is in the child(ren)'s best interests to have meaningful relationships with *both* parents. The family therapy intervention is intended to help the child(ren) have healthy and meaningful relationships with both parents.

2. To meet the goals listed below, the parents agree to engage the services of [insert therapist(s)' name(s)] (may be one or more therapists; also referred to as "the therapist(s)" in this Agreement). Each parent shall contact the therapist(s) no later than _____ to provide consent to proceed with the clinical intake and engage in the informed consent process. Once both parents have contacted the therapist(s), intake questionnaires will be sent to each parent to complete. The parents agree to complete the intake questionnaires within 7 days of receiving them. Once both sets of completed intake questionnaires and any supporting documentation (e.g., relevant court orders, custody/access report, other relevant reports, etc.) have been received, appointments will be scheduled.

3. The family therapy intervention provided for in this Agreement has been court ordered, in the [insert name of court].

4. Any other particulars of this matter can be addressed in the court order, in this Informed Consent Agreement, by way of attachment, or future correspondence.
5. The role of the therapist(s) is to assist with the family therapy intervention and not as a custody assessor, arbitrator, parenting coordinator, or consultant for litigation.

6. The goals of the therapy may include to:
   a. foster overall healthy child adjustment;

b. facilitate the implementation of the previously agreed-to or court-ordered parenting time schedule, dated _____;
c. restore, develop, or facilitate adequate parenting and coparenting functioning and skills;
d. assist the parents to resolve relevant parent–child conflicts;
e. develop family communication skills and effective approaches to problem-solving;
f. assist the parents to fully understand the child(ren)'s needs for healthy relationships with both parents and the negative repercussions for the child(ren) of a severed or compromised relationship with a parent in their young lives and as adults;
g. restore or facilitate contact between [insert rejected parent's name] and [insert child(ren)'s name(s), age(s), and date(s) of birth];
h. assist the parents and their child(ren) to identify and separate each child's needs and views from each parent's needs and views;
i. work with each family member to establish more appropriate parent–parent and parent–child roles and boundaries;
j. correct the child(ren)'s distortions and replace these with more realistic perceptions reflecting the child's actual experience with both parents;
k. assist the child(ren) to differentiate self from others and exercise age-appropriate autonomy;
l. assist each parent to distinguish valid concerns from overly negative, critical, and generalized views relating to the other parent;
m. other (specify)_____.

7. While the parents may have different views about the causes or reasons for their child(ren)'s reluctance or refusal to have contact with _____, they agree not only to the objectives defined above but also that they each need to be part of the solution to meet those objectives.

PROCESS

8. The parents agree to the involvement of the entire family, in various combinations, as directed by the therapist(s). The process will include meetings with each parent and the child(ren) individually and jointly. The process may include meetings with other family members as deemed necessary by the therapist(s)

9. The therapist(s) will *not* be making decisions regarding the child(ren)'s parenting time with each parent (access) or legal decision-making (custody) as this is outside the therapist's role. Rather, as the therapist(s) they will be assisting to implement the previously agreed-to or court-ordered Parenting Plan. Notwithstanding, the parents agree the therapist(s) may determine the parenting time for the purposes of the therapy, the nature of transitions between the parents, rules of parental communication or engagement, location and pacing of the parent–child contact consistent with the court-ordered Parenting Plan, etc. The therapist(s) may make recommendations deemed helpful to the child(ren) in implementing the court orders or the current agreed-to Parenting Plan.

10. The therapist(s) may provide a report to the parents, lawyers, or the court describing the parents' and child(ren)'s progress and cooperation, including any obstacles preventing the therapy from beginning or continuing. This may include specific statements and behaviors, which the therapist(s) deems necessary to adequately support other content or statements in the report. Recommendations may be provided regarding additional services or counselling where deemed appropriate. Any opinions or recommendations reported will be limited in scope to matters for which the therapist(s) has obtained sufficient information.

11. The parents will provide all records, documentation, and information requested by the therapist(s) as soon as possible upon request.

12. The therapist(s) may choose to contact other previous or current professionals involved with the family members to receive and obtain information to better meet the aforementioned treatment goals. Toward this end, the parents will sign all consent forms requested by the therapist(s) permitting the exchange of information between the relevant professionals.

13. The therapist(s) may make recommendations for the involvement of additional professionals (e.g., individual therapist for parent or child, educational specialist, coach for parent education).

14. The therapist(s) may make recommendations for the termination of other therapist(s) who may be currently involved with the family members.

RESPONSIBILITY OF THE PARENTS

15. The parents agree to fully cooperate, support, and wholeheartedly participate in the family therapy intervention. This includes, but is not limited to: (1) responding to the therapist(s) within 24 hours unless determined otherwise by the therapist once the parent requests a temporary change (applicable when situations arise that would make this impossible or unreasonable, such as vacation, illness, work travel, etc.); (2) paying for services in a timely manner in accordance with the fee agreement executed by the parents; (3) ensuring the child(ren) is transported to and from scheduled therapy appointments in a timely manner, and even if the appointment does not involve that parent or if it involves the other parent; and (4) exercising parental authority to require the child(ren) to attend and cooperate with the therapy. If requested by the therapist, a parent shall bring the child when it is not that parent's parenting time, picking up and returning the child to their school, daycare or other location as per the therapist's instructions.

16. The parents are advised the court may consider the good-faith efforts and the parents' demonstrated behavior during the therapy as a factor in determining any decisions about the child(ren)'s best interests, including legal custody (decision-making) or access (parenting time).

17. The parents have been advised the therapy requires each parent to make changes in their own behavior and parenting to support their child(ren)'s needs. The therapist(s) may request specific changes in such areas as setting appropriate limits for the child(ren), encouraging the child(ren) to express feelings and solve problems appropriately, listening to the child(ren)'s concerns and actively supporting the child(ren)'s independent relationships, and shielding the child(ren) from parental conflict. The parents agree to make reasonable efforts to cooperate with the requests made by the therapist(s) in these and any other relevant areas. If either parent disagrees with requests or recommendations made by the therapist(s), the parent will discuss those concerns privately with the therapist(s), and will not allow the child(ren) to witness or overhear the concerns.

18. Both parents will overtly support the therapy and the therapist(s) to the child(ren). This includes respecting the child(ren)'s right *not* to discuss the therapy with their parents and not asking the child(ren) for information about the sessions.

19. The parents will refrain from scheduling new after-school activities, lessons, or events during the scheduled therapy appointments. Reasonable efforts will be made to schedule appointments so the child(ren) does not miss school or their currently scheduled extracurricular activities. However, this may not always be possible.

20. Given the risks of information being taken out of context or being incomplete, the parents agree they and their lawyers will *not* restate, summarize, or paraphrase in court documents any feedback or statements provided by the therapist(s) during the therapy. If necessary, a report may be requested, permitting the therapist(s) to communicate about the therapy to the court as per this Agreement and the court order.

21. There shall be no audio or visual recording of the therapy, unless agreed to in writing by the therapist(s). Unauthorized recording of any kind may be sufficient basis for the therapist(s) to terminate the treatment and provide a report explaining the reasons.

22. Both parents acknowledge they have had an opportunity to review this Agreement and to ask any questions they may have concerning the therapist(s') approach to the therapy and other available alternatives.

DURATION OF SERVICES

23. The therapy shall continue for a minimum of ___ months, with reevaluation of the need for continued services based on the progress in meeting the goals listed above (#6). Neither parent may unilaterally withdraw from this Agreement prior to the completion of the term identified. However, with their joint consent in writing, both parents may terminate this Agreement.

OR

The therapy shall continue until the therapist(s) indicates the goals listed in #6 have been met, that no further progress is possible at this time, or that appointment of a different therapist is necessary.

OR

In the event either parent wishes to terminate the therapy, they will provide 15 days' written notice to the therapist(s) and the other parent. The parents will attempt, with the assistance of their lawyers, to agree on an alternate to

replace _____. If the parents are unable to agree within 30 days, an alternate will be appointed by [insert "the court" or the specific name of the Arbitrator or Parenting Coordinator for determination in a summary fashion].

24. With four (4) weeks' notice in writing, the therapist(s) may resign if they determine this to be in the best interests of the child(ren), in which case a referral may be made to another therapist if the therapist(s) deems this to be appropriate.

CONFIDENTIALITY

25. While the therapist(s) is bound to maintain confidentiality and not permitted to disclose information to anyone who is not involved in the process, the parents understand the process may involve the therapist(s) and the other relevant professionals (previous or current) sharing information (e.g., custody assessor, parent's or child's therapist, teacher, parenting coordinator, etc.).

26. The therapist(s) may use discretion to disclose information obtained from the participants in the therapy to the other participants in the therapy.

27. The therapist(s) shall be free to disclose all information, documentation, and correspondence generated by the process with the lawyer for each parent (and child's lawyer and CAS lawyer, where present) and with the court, and may speak with the lawyers ex parte. This signed Agreement serves as the parents' informed consent for the therapist(s), _____, to obtain information from the court, counsel, and both parents AND for them to provide information received from all sources verbally or in a report to the court, counsel, and the other parent.

28. The parents understand the therapist(s) is required to report to the appropriate child protection service or agency if the therapist has a reasonable suspicion a child is being physically, sexually, or emotionally abused or neglected. In addition, the therapist(s) is obliged to notify the proper authorities if the therapist has a "reasonable suspicion" a client may harm himself or herself, or the other parent.

ELECTRONIC PROVISION OF SERVICES

29. Electronic provision of services including use of email, telephone, video contacts (eg., VSee) and text messaging (rarely) may be provided by FMF therapist and staff personnel and requires your consent. Scheduling is done by email usually and may also be done by telephone.

30. Email may be used in the delivery of some services to augment or follow up on face-to-face or telephone sessions. In these cases we may provide updates, invoices, account statements, summaries, draft parenting plans or memoranda, educational resources or exchange information. Based on the nature of the service provided, these email communications may include information not only about others including your child(ren) or the other parent.

31. When consenting to the provision of services by telephone or electronically, it is important to appreciate both the risks and benefits, including insufficiency, misunderstandings due to lack of visual clues and context, and failures in technology. In the event of a technology failure when using VSee (audio or visual), your therapist will call you by telephone at the number you provide for back up at the time of scheduling.

32. While efforts are made to protect privacy when providing services by telephone or electronically, the same degree of confidentiality provided during in-person office sessions is not possible. The limitations include the possibility of interceptions of communications while these are occurring. Every effort needs to be made from both the therapist's and your end to minimize any interruptions during video or telephone contacts (e.g., turning off cell phones, locking the door, etc.). Towards this end, you agree to make these efforts and further, to advise the therapist you are communicating with at the time if someone comes into the room you are in, or is within earshot.

33. The benefits of using electronic communications and telephone may include appropriateness, avoiding the need to travel a distance, taking less time off work, having possible access to services continuing while the therapist is away, having the option to receive services when you are away or for convenience or comfort. Alternatives to the provision of electronic or telephone services include in-person services only or local services from an appropriately trained and available health service provider of the same or different discipline.

34. Please keep in mind that other individuals (your spouse, new partner, child, adolescent, others living in your home) may be able to access information, sensitive or otherwise, communicated electronically or by telephone between you and the therapist in your own home or work place. As noted, the information shared may be about others, not only you. Any communications provided by the therapist or administrative assistant are intended for you and not for others, unless agreed to otherwise. By signing this informed consent form you are confirming to the therapist you have taken reasonable steps to secure your own electronic devices you choose to use to communicate with the therapist (mobile phones, iPads, computers, etc.). This would include having a confidential password and adequate firewalls. You further agree not to allow others (e.g., your children of any age, new partner or spouse, parent, friend, relative, etc.) access to any communications sent to you from the therapist or administrative assistant, unless an agreement is reached in advance that the particular communication is appropriate to share with others. (Please see separate *Privacy Policy* for more information on privacy.)

35. Emergencies. We ask for you to identify a contact we can reach by telephone and email for use in an emergency that may arise during an office or telephone contact, or during any electronically facilitated contact. If you do not attend for a scheduled meeting of any kind, we will attempt to call you twice. If we do not hear back in what is deemed to be a reasonable period of time, we will contact the person you have identified as your emergency contact.

36. Licensure. [Insert names of therapists and where they are licensed to practice.] Unless they are licensed in that jurisdiction, it is illegal for a social worker or psychologist to practice in a location you may be in at the time the service is delivered, even if you are a resident of Ontario, unless the therapist obtains permission from that state or province or the required form of licensure in advance of the delivery of service. In many cases, it is possible for permission or a temporary license to be obtained. By signing this agreement you agree to advise the therapist for each telephone or video contact if you are no longer in Ontario.

FEES

37. Fees shall be charged for all professional services performed pursuant to the terms of this Agreement, including administrative matters (record-keeping, long-distance telephone charges, photocopying, courier charges, postage, and

disbursements), document and correspondence review, writing memos to the file, reports, preparation between sessions, voice mail, email correspondence, in-person sessions with family members and collateral sources, and telephone calls. Fees may be charged retroactively for any services rendered prior to the receipt of the initial retainer. Disbursements shall be paid to professionals who require remuneration for their participation, and for any agency/hospital/police reports.

38. The hourly rate for services is $_____.00 per hour (no HST applicable). The fees shall be shared equally unless otherwise agreed to by the parents or ordered by the court at the time this Agreement is executed. If not shared equally, the mother shall pay _____% and the father shall pay _____% of the hourly rate.

39. Each parent will provide an initial retainer of 10 hours of services no later than their first meeting with the therapist(s). At all times each parent shall maintain a retainer of at least two hours in the account of the therapist, who shall advise in advance when a further retainer is required. A monthly statement of account will be provided to the parents. If the above terms are not satisfied, the therapist(s) may choose to postpone all services until the retainer terms are satisfied. Nonpayment of fees shall be grounds for the resignation of the therapist(s).

40. Appointments cancelled without at least 48 (forty-eight) business hours' advance notice may be charged at full fee independent of the reason for the cancellation (i.e., Monday and Tuesday appointments must be canceled by 5:00 p.m. on the previous Friday to avoid the possibility of this charge). The parents will each be responsible for bills arising from their own cancellation with insufficient notice or failure to attend a scheduled appointment.

41. A parent may request a report for any return to court. The parent who makes this request will be responsible for paying fully for the report in advance by retainer at the hourly rate of $275.00 (plus HST), or otherwise as ordered by the court.

42. The parents agree all testimony or appearance at court of any kind provided by the therapist(s) shall be considered expert testimony. Fees related to preparation for or attendance at court (e.g., trial, settlement conference, discoveries) are billed at between $_____.00 and $_____.00 per hour (plus HST) for each therapist, depending on the therapist's rate, and shall be paid for by

the parent calling the therapist/expert. Fees for attendance at court, testifying in court, or discoveries are billed by a minimum half-day rate of $_____.00. Any court-related fees (i.e., preparation time, attendance, and travel) shall be provided in advance by retainer by the parent requesting the therapist's attendance at court. A separate contract for these services (detailing cancellation policy, etc.) may apply and be provided at the time of any request.

INDEPENDENT LEGAL ADVICE

43. Each of the parents confirms they have received independent legal advice prior to executing this Agreement, or is aware they have a right to do so.

44. Both parents:
    a. understand their rights and obligations under this Agreement and the nature and consequences of the Agreement;
    b. acknowledge they have received and reviewed the therapist's Privacy Policy;
    c. acknowledge they are not under any undue influence or duress; and
    d. acknowledge they are signing this Agreement voluntarily.

RISKS & LIMITATIONS

45. Informed consent requires disclosure of potential risks and limitations. By signing the Agreement, the parents acknowledge the therapist(s) cannot guarantee physical safety during the family therapy intervention. The parents further acknowledge the therapist cannot guarantee against bad faith or abuse of process by any participant. The parents understand there is no guarantee the family and coparenting functioning and the parent–child contact problem will be resolved during family therapy. The parents acknowledge they may not be fully satisfied with the outcome of the services provided.

INFORMED CONSENT

46. Having read the above, I hereby consent to:
    a. willingly continuing with this family therapy intervention process;
    b. informing my legal counsel, or if representing myself, advising the court and the other parent in writing to let them know I choose to withdraw from the therapy;

c. advising the therapist(s) in writing if I choose to withdraw consent for this therapy;
d. all information and communication provided by me being done so on a 'with prejudice' (not confidential) basis and for this information to be used in court if required;
e. the therapist(s) seeking full and active participation from me and other family members as she deems necessary.

47. I understand:
    a. what is expected of me and the relative risks of the information being used in court or this legal matter;
    b. the nature of this therapy, fees associated, cancellation policy (48 hours), mutual responsibilities, confidentiality issues and limitations, benefits, and risks, the consequences of non-action, the option to refuse or withdraw, and the elements of the "with prejudice" nature of this therapy;
    c. the signing of this Agreement/Informed Consent by me is further acknowledgment of informed consent as it dictates the professional activities the therapist(s) will be conducting.

TO EVIDENCE THEIR AGREEMENT, THE PARENTS HAVE SIGNED THIS AGREEMENT BEFORE A WITNESS.

Signature _____ Date_____

Print Name _____ _____

Date of Birth

Witness Signature_____ Date _____

Print Name _____

Signature _____ Date_____

Print Name _____ _____

Date of Birth

Witness Signature _____ Date _____

Print Name _____

Family Court Review

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ARTICLE: **CHILDREN RESISTING** POSTSEPARATION **CONTACT** WITH A **PARENT:** CONCEPTS, CONTROVERSIES, AND CONUNDRUMS

NAME: Barbara Jo Fidler and Nicholas Bala

BIO: Barbara Jo Fidler, Ph.D., Toronto Canada is a clinical-developmental psychologist who provides training, consultation, parenting coordination, mediation, therapy and expert testimony. She has specialized in child and divorce-related matters, including high-conflict parenting, custody evaluations, and **parent**-child **contact** problems. Dr. Fidler is a frequent presenter to the judiciary, family bar and mental health professionals on high conflict families and related topics. She has published in the areas of separation/divorce, parenting plans and residential schedules, **parent**-child **contact** problems and parenting coordination.

Nicholas Bala, LLM has been a law professor at Queen's University in Canada since 1980, and was a visiting professor at Duke. Much of his research work has been interdisciplinary, and it has addressed such issues as: best interests of **children:** and alienation; family violence; the legal definition of marriage and the family, including polygamy; child abuse and child witnesses; child welfare law; and juvenile justice. Prof. Bala written or co-authored 15 books and more than 130 articles and book chapters, and his work is frequently cited by the courts, including the Supreme Court of Canada.

Correspondence: drbarbarafidler@sympatico.ca

LEXISNEXIS SUMMARY:
... The international handbook of parental alienation syndrome: Conceptual, clinical and legal considerations (pp. 163-178).....With more research and experience, legal and mental health practitioners have noted that pure or "clean" cases of child alienation and realistic estrangement (those that only include alienating behavior on the part of the favored **parent** or abuse/neglect on the part of the rejected prent, respectively) are less common than the mixed or "hybrid" cases, which have varying degrees of enmeshment and boundary diffusion between the aligned **parent** and the child and some degree of ineptness by the rejected **parent,** making proper "diagnosis" and intervention planning extremely challenging (Friedlander & Walters, 2010) .....THE CHILD In addition to the aligned **parent** exhibiting degrees of alienating behaviour, manifestations of alienation in a child are varied and depend on many factors, including the degree of alienation itself--mild, moderate or severe .....Clawar and Rivlin (1991) identify 8 different processes involved in severe alienation: (1) theme for the rationalization of rejection; (2) sense of support and connection to alienating **parent** is fostered; (3) feeling of sympathy for the alienating **parent** is fostered; (4) child's loyalty is tested by child's behavior/attitude; (5) reinforcement by seeking out behaviors of the rejected **parent** that reinforce the alienation; (6) maintenance of alienation: subtle reminders; (7) child shows support for beliefs of alienating **parent;** and (8) child's compliance tested: rewarded or not admonished for inappropriate behavior..... The literature consistently reports that alienated **children** are at risk for emotional distress and adjustment difficulties and further, at greater risk than **children** from litigating families who are not alienated (e.g., Burrill, 2006a; Cartwright, 1993; Clawar & Rivlin, 1991; Dunne & Hedrick, 1994; Gardner, 1992a, 2006; Garrity & Baris, 1994; Kelly & Johnston, 2001; Kopetski, 1998a, 1998b, Johnston, 2003; Johnston & Roseby, 1997; Johnston, Walters, & Olesen, 2005c; Lampel, 1996; Lee & Olesen, 2001; Lowenstein, 2006; Lund, 1995; Racusin & Copans, 1994; Rand, 1997a, 1997b; Rand, Rand, & Kopetski, 2005; Stahl, 1999; Stoltz & Ney, 2002; Turkat 1994, 1999; Waldron & Joanis, 1996; Walsh & Bone, 1997; Wallerstein & Blakeslee, 1989; Ward & Harvey, 1993; Warshak, 2010a).....Others are less inclined to offer this advice, in part because of the research indicating that: (1) **children** of divorce generally do best when they have good relationships with two involved and effective **parents** (Kelly, 2007); (2) in retrospect, young adults who experienced parental separation wished they had more time with their noncustodial **parents** (Fabricius & Hall, 2000; Finley & Schwartz, 2007; Laumann-Billings & Emery, 2000); (3) fathers play an important role in child development and adjustment (Parke, 2004; Schwartz & Finley, 2009); and (4) alienated **children** and adults alienated as **children** report that despite their protests otherwise, they secretly longed for more **contact** with their rejected **parent** and wished someone would have insisted they have **contact** (Baker, 2005b, 2007; Clawar & Rivlin, 1991) ..... The model proposed keeps the role of the

family therapist (or **parent**-child **contact** facilitator) distinct from that of the parenting coordinator or mediator/arbitrator (Fidler, Bala, Birnbaum, & Kavassalis, 2008; Johnston, Walters, & Friedlander, 2001, Sullivan, 2004; Friedlander & Walters, 2010) ..... Goals of Therapy Therapy and counseling for the mild and some moderate cases, has been described by many (Carter, Haave, & Vandersteen, 2006; Drozd & Olesen, 2009; Fidler, Bala, Birnbaum, & Kavassalis, 2008; Friedlander & Walters, 2010; Johnston & Goldman, 2010; Johnston, Roseby, & Kuehnle, 2009; Johnston, Walters, & Friedlander, 2001) ..... It is important to recognize that this lack of research on the effect of these interventions to remedy alienation exist in a context of a growing body of research about the long-term harmful effects of alienating parental conduct on **children** (e.g., Baker), but only very limited research on effects (or outcomes) of judicial decision-making related to court interventions in custody and access in general ..... Still, there is actually more literature and research (in this issue and elsewhere) on the effects of custody reversal than on other interventions that are typically recommended or ordered, such as **parent** education programs, family-focussed or reunification therapy, parenting coordination, supervised visitation, a finding of contempt of court, or a judicial decision not to deal with alienation because of a concern about the trauma of a change in custody or the limitations of the rejected **parent**..... With prevention in mind, Andre and Baker (2009) have developed the I Don't Want to Choose book and workbook, part of a newly developed school-based curriculum for groups of middle school **children whose parents** are separated or divorced, that are designed to teach **children** to resist pressure to choose between their **parents.** (2) Education and standards for professionals .... Journal of Family Psychology, 14, 671-687.

HIGHLIGHT: This article provides an overview of the key concepts, themes, issues, and possible mental health and legal interventions related to **children's** postseparation resistance to having **contact** with one **parent.** We maintain that the too often strongly gendered polemic on alienation and abuse is polarizing and needs to be replaced with a more nuanced and balanced discussion that recognizes the complexity of the issues so that the needs of **children** and families can be better met. This article reviews the historical development of the concept of alienation; discusses the causes, dynamics, and differentiation of various types of **parent** child **contact** problems; and summarizes the literature on the impact of alienation on **children.** These are complex cases. A significant portion of the cases in which alienation is alleged are not in fact alienation cases; for those where alienation is present, interventions will vary depending on the degree of the alienation. More severe alienation cases are unlikely to be responsive to therapeutic or psycho-educational interventions in the absence of either a temporary interruption of **contact** between the child and the alienating **parent** or a more permanent custody reversal. We conclude with a summary of recommendations for practice and policy, including the need for early identification and intervention to prevent the development of severe cases, interdisciplinary collaboration and further development and research of interventions.

TEXT:

[*10] INTRODUCTION

Alienation cases have received much public and professional attention in the last year, particularly in Canada, with many reported cases (Bala, Hunt, & McCarney, 2010) and media attention [n1] . As with so many issues in family law, there are polarized, strongly gendered narratives of alienation. Some men's rights activists claim that mothers alienate **children** from their fathers to seek revenge for separation, some making false and malicious allegations of abuse. [n2] These groups may further assert that the courts are gender-biased against fathers in dealing with child custody matters generally and especially when addressing alienation. [n3] Some feminists dismiss all, or most, alienation claims as fabricated by male perpetrators of intimate partner violence, often also abusive fathers, to exert control over the victimized mother and maintain **contact with children,** who justifiably resist or refuse **contact** with them, this being an adaptive and positive coping mechanism. [n4]

While there is some validity to both of these narratives, each has significant mythical elements, and furthermore, in our view, neither is especially helpful for improving the lives of **children.** The reality of these cases is often highly complex and not captured by either of these relatively simplistic explanations.

Clinical experience and research have shown that abusive men may alienate their **children** from their victim mothers (Johnston, Walters, & Olesen, 2005b). These men may allege attempted alienation by the victim as a smokescreen to their own abusive behavior, **[*11]** or claim that it is the mother's behavior that has alienated the **children.** Rightly, mothers whose partners are abusive attempt to protect their **children.** *And*, not "but," there are indeed other women consciously, or unconsciously, motivated by vengeance or due to personality disorders or mental illness who may alienate their **children** from fathers with whom the child had at least an adequate relationship and in many cases a good and loving relationship. A subset of these women may make repeated false allegations of abuse, some intentionally and more unintentionally, truly believing and even after thorough investigations not being able to be reassured that the abuse did not occur. The existence of alienation is not equivalent to a denial of child abuse or intimate partner violence. What is concerning is that the feminist advocates who, in the name of helping women, deny that alienation exists, do a great disservice to not only the many mothers who are unjustifiably alienated from their **children,** and often by abusive men, but more importantly do a disservice to the **children.** [n5] Similarly, fathers' rights and "parental alienation *syndrome"* groups do a disservice to **children** and rejected **parents** if they portray all rejected **parents** as "victims" and resist scrutiny of the conduct of these **parents.**

These narrow and polarizing perspectives mirror the inflexible all or none thinking observed by alienated **children and their parents.** This is not an either/or proposition; there are abused **children** and there are alienated **children.** Professionals need to move

beyond extreme and simplistic analyses. It can be very challenging for professionals to properly understand the dynamics of an individual family where allegations of alienation are present and for judges, lawyers, and mental health professionals to make decisions or offer opinions that truly promote the best interests of the **children.**

There are no reliable statistics on the prevalence of alienation. Even in high-conflict separations where it is common for each **parent** to express negative sentiments about the other **parent** to the child, most **children** continue to long for and seek **contact** with both **parents** (Wallerstein & Kelly, 1980; Hetherington, Cox, & Cox, 1985; Johnston, Walters, & Olesen, 2005b; Warshak & Santrock, 1983). Further, while alienating behaviors are common, not all **children** exposed to such behaviors become alienated (Johnston, Walters, & Olesen, 2005c). Writers note that even abused **children** are likely to want to maintain a relationship with their abusive **parents.**

A minority, between 11 and 15 percent, of **children** from community samples of divorcing families have been found to reject or resist **contact** with one **parent** while remaining aligned with the other **parent** (Johnston, 1993, 2003; Johnston, Walters, & Olesen, 2005b; Racusin & Copans, 1994; Wallerstein & Kelly, 1980). Estimates of alienation are higher in custody-disputing samples, with some studies reporting about one-fifth (Kopetski, 1998a, 1998b; Johnston, 1993, 2003; Johnston, Walters, & Olesen, 2005c), and others reporting as high as 40 percent of **children** exhibiting an alignment with one **parent** (Johnston & Campbell, 1988; Lampel, 1996). In one study of highly conflicted custody-disputing families, Johnston and her colleagues reported about one-fifth (20 to 27 percent) had alienation issues, but only about 6 percent were found to be extremely or severely rejecting of a **parent.**

Research consistently indicates that boys and girls experience alienation about equally, but that adolescents are more likely to become alienated from a **parent** than younger **children** (Kelly & Johnston, 2001). Both mothers and fathers can be alienated from their **children** (Bala, Hunt, & McCarney, 2010), although most successful alienation is perpetrated by the **parent** with custody or primary care of **children** (most commonly the mother), as it is difficult (though not impossible) for a **parent** with limited **contact** with a child to alienate a child from the primary caregiver.

[*12] KEY CONCEPTS, THEMES, AND ISSUES

DEVELOPMENT: CONTEXT AND CONTROVERSY

Although the concept of "alienation" is a relatively new psychological term, it is not a new phenomenon. In 1949, psychoanalyst Wilhelm Reich (Reich, 1949) wrote in his book, *Character Analysis*, that certain personality types amongst divorced **parents** defend themselves from narcissist injury by fighting for custody of the child and defaming the partner in an effort to rob the other **parent** of the pleasure of the child. In 1980, Wallerstein and Kelly (1980) referred to an "unholy alliance between a narcissistically enraged **parent** and a particularly vulnerable older child or adolescent, who together waged battle in efforts to hurt and punish the other **parent.**" Johnston and Roseby (1997) noted that these "unholy alliances" are a later manifestation of a failed separation--individuation process in vulnerable **children** exposed to dysfunctional family relationships during their early years.

In 1985, the late American psychiatrist, Richard Gardner, introduced the term "parental alienation syndrome" (PAS), defining it as:

> The parental alienation syndrome (PAS) is a disorder that arises primarily in the context of child custody disputes. Its primary manifestation is the child's campaign of denigration against a **parent,** a campaign that has no justification. It results from the *combination* of a programming (brainwashing) **parent's** indoctrination and the child's own contribution to the vilification of the target **parent.** When true parental abuse and/or neglect are present, the child's animosity may be justified, and so the parental alienation syndrome explanation for the child's hostility is not applicable (p. 61).

Gardner placed particular emphasis on three contributing factors: "parental 'brainwashing,' situational factors and the child's own contributions." The diagnosis of PAS is dependent on eight primary factors identified in the child: (1) campaign of denigration; (2) weak, frivolous or absurd rationalizations for the deprecation; (3) lack of ambivalence; (4) the "independent thinker" phenomenon (child claims these are their own, and not the alienating **parent's** beliefs); (5) reflexive support of the alienating **parent** in the parental conflict; (6) child's absence of guilt over cruelty to, or exploitation of, the alienated **parent;** (7) presence of borrowed scenarios; and (8) spread of rejection to extended family and friends of the alienated **parent.**

Gardner advised that PAS is determined by the extent to which the efforts of the alienating **parent** have been successfully manifest *in the child*, and not by the **parent's** efforts alone. The eight symptoms are likely to appear in moderate and severe cases of PAS, while some, but not all, of them may occur in the milder forms.

Douglas Darnall (1997, 1998) differentiated PAS from Parental Alienation (PA), noting that PAS focuses on the *child's* reaction while PA, his preferred term, focuses on the *alienating **parent's*** behavior. Unlike others who criticize Gardner's apparent emphasis on

the conduct of the alienating **parent's** role in the child's resistance or refusal, at the exclusion of other factors, Baker and Darnall (2006) argue that Gardner tended to focus on the child, while they stress the alienating **parent's** behavior in their conceptualizations.

Warshak (2001) identified three components that must be present for a *bona fide* identification of parental alienation: (1) a persistent, not occasional, rejection or denigration of a **parent** that reaches the level of a campaign; (2) an unjustified (unreasonable) or **[*13]** irrational rejection by the child; and (3) rejection by a child that is a *partial* result of the alienating **parent's** influence. Initially, Warshak (2003a, 2006) suggested that the concept of "pathological alienation" might bridge the evident differences in the literature. He defines this as "a disturbance in which **children,** usually in the context of sharing a **parent's** negative attitudes, suffer unreasonable aversion to a person, or persons, with whom they formerly enjoyed normal relations or with whom they would normally develop affectionate relations" (2006, p. 361). This definition considers not only the role of the child, but explicitly identifies the role of the alienating **parent,** a necessary component of the problem. Importantly, Warshak's definition further identifies two critical aspects: (1) a *change* from a previously good relationship where the child shared a warm and healthy attachment, or would have been expected to develop a good relationship and (2) the possibility that the aversion may also be *applied to others* (such as other family members), and not only to **parents.** This recognition that a child once had a secure attachment to the now rejected **parent,** notwithstanding personality or parenting flaws, is of particular relevance for accurate assessment and when remedies are considered, a point to which we return later. More recently, Warshak (2010b) questions using a label that includes "pathological," because of its association with the medical model. [n6]

ALIENATION AS A DIAGNOSIS--PAS?

Gardner's work was historically important, while also being controversial, both then and now. For example, many writers have abandoned the term "syndrome." While some mental health professionals support the validity of a PAS diagnosis (Brody, 2006; Burrill, 2006b; Katz, 2003; Kopetski, 2006; Leving, 2006; Lorandos, 2006; Rand, 1997a, 1997b; Rand, Rand, & Kopetski, 2005; Walsh & Bone, 1997), others have argued that having a diagnosis of PAS is not useful, is not valid clinically, and does not meet the criteria for a syndrome from an evidentiary perspective (Bruch, 2001; Emery, 2005; Faller, 1998; Hoult, 2006; Johnston & Kelly, 2004; Walker, Brantley, & Rigsbee, 2004b; Williams, 2001; Zirogiannis, 2001).

Criticisms include the observation that PAS is not included in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV TM).* Gardner's reply (2002b, 2004) explains that submissions were never made for PAS to be included, thus the committees did not have occasion to reject it. He adds that in the 1980s, when he began noticing and writing about PAS, it would have been premature to consider PAS for *DSM-IV* because there were too few articles in the literature to warrant a submission for inclusion to the committees that started meeting in the early 1990s. Years ago, Gardner predicted that the committees for *DSM-V* were likely to consider a submission for inclusion given that there were well over 100 articles at that time on PAS, including 18 by Gardner in peer-review journals, 66 by others, and 51 on the phenomena of pathological alienation (list available from www.rgardner.com and www.warshak.com). There are many more articles since then. Gardner's prediction has come true and the *DSM* committees are now considering PAS as a diagnosis for inclusion in the next edition, scheduled to be released in 2012. However, as Warshak (2006) notes, *DSM* specifically cautions against its use in forensic settings (pp xxiii-xxiv). Warshak (2001) and others argue against the use the term "parental alienation *syndrome"* in reports and testimony, instead recommending inclusion of statements made by **parents and children,** and descriptions of family dynamics and behaviors.

[*14] DIFFERENTIATING PARENT-CHILD CONTACT PROBLEMS

A child may resist or reject a **parent** for many reasons. Research and writing has resulted in the development of a more nuanced and better understanding of **parent**--child **contact** problems. Kelly and Johnston (2001) conclude that Gardner's formulation placed too much emphasis on the conduct of the alienating **parent,** with insufficient consideration to the many other equally significant contributing factors, including the role of the rejected **parent.** In an effort to focus on the child, they refer to the "alienated child" who "freely and persistently expresses unreasonable negative feelings and beliefs (such as anger, hatred, rejection, and/or fear) toward a **parent** that are disproportionate to their actual experience of that **parent.**"

Kelly and Johnston (2001) [n7] provide a reformulated systems-based and multifactor model to explain why some **children** resist **contact** or reject a **parent** and remain aligned with the other **parent.** The identified factors include: (1) the alienating behavior and motivation of the aligned **parent;** (2) the rejected **parent's** inept parenting and counter-rejecting behavior (before or after the rejection); (3) domestic violence/abuse and child abuse/neglect; (4) chronic litigation that typically includes "tribal warfare" (involvement of family, friends and new partners); (5) sibling dynamics and pressures; (6) a vulnerable child (dependent, anxious, fearful, emotionally troubled and with poor coping and reality testing); and (7) developmental factors (e.g., age-appropriate separation anxiety, response to separation or conflict consistent with the cognitive development of **children** aged 8 to 15 years).

Consistent with the work of Gardner (1992a) and others (e.g., Warshak, 2002), the Kelly and Johnston model emphasizes the need to differentiate the truly alienated child, consequent to a **parent's** pernicious influence, from the child who resists or refuses **contact** with a **parent** for reasons not primarily due to an alienating **parent's** overt, or covert, campaign against the other **parent.** In this model, because a child's rejection of one **parent** can occur in the absence of an alienating **parent,** the behavior of the favored

parent *may* not be the most important factor, and may not even be significant. Further, even when the alienating **parent's** conduct is a contributing factor, Kelly and Johnston note that the other factors are as equally important to consider. Kelly and Johnston's reformulated model, and subsequent developments of this model (Drozd & Olesen, 2004; Friedlander & Walters, 2010), require the various types of rejection or resistance (e.g., stage of development, response to the parental separation or high conflict, child abuse/ neglect or violence) to be differentiated based on the reasonableness of the child's reaction (Gardner 2002b; Warshak, 2000, 2001).

As aptly elucidated by Kelly and Johnston and others, **children** can refuse or resist **contact** with one **parent** for many reasons. A child while maintaining **contact** with both **parents,** may have an *affinity* toward one **parent** because of temperament, gender, age, familiarity, greater time spent with that **parent,** or shared interests. For example, a toddler may experience normal separation anxiety or a preference for the **parent** of the opposite gender, while an older child may prefer the **parent** of the same gender. This normal and developmentally expected ebb and flow of preferences (affinity) and gender identification occurs in both divorced and nondivorced families, and is not the result of an alienation process. When it occurs in divorcing families, however, affinities and gender identifications can be concerning to both **parents;** the preferred **parent** incorrectly concludes the other **parent** has erred in some significant way, and the resisted **parent,** feeling threatened, may incorrectly conclude that the other **parent** is trying to alienate the child.

[*15] *Alignments* between the child and the preferred **parent** may develop before, during or after the separation because of the nonpreferred **parent's** minimal involvement in parenting, inexperience or poor parenting, even if these shortcomings do *not* reach the level of abuse or neglect. Alignments may develop before the separation when **parents** invite their **children** to take their sides; these alignments may transition to alienation during or after the separation. Also, alignments may develop for divorce-specific reasons, such as when a child becomes angry or upset with a **parent** who leaves the family; leaves the left **parent** feeling hurt, upset, or angry; or starts a new relationship. Further, **children** may form alignments in response to ongoing or emergent parental conflict, such as that related to financial disputes or a desire to relocate. These divorce and parental conflict-related alignments, which may not be unjustified initially, may, if not remedied early on, develop into alienation where the child's reaction becomes disproportionate to the reality of their experience with the rejected **parent.**

As **children** mature cognitively, they move from egocentric and concrete reasoning to being able to consider the perspective of others. While younger **children** can take the perspective of the **parent** they are with at the time, they are unable, at least initially, to consider discrepant perspectives simultaneously. Accordingly, loyalty conflicts initially manifest with a child demonstrating a shifting allegiance (Johnston & Roseby, 1997). As **children** mature cognitively, they acquire the capacity for reflexive thought ("I know that you know that I know") and can then partially begin to retain more than one perspective at a time. When a child experiences contradictory parental perspectives, cognitive dissonance and true loyalty conflicts may emerge. To cope with persistent and contradictory information, distress and confusion, the child may move from shifting allegiances with each change in care to an alignment with one **parent,** accompanied by either a resistance or refusal to spend time with the other **parent.** To rationalize this behavior, the child tends to see the situation in black-and-white terms, believing that one **parent** is all (or mostly) good while the other is all (or mostly) bad. This "reasoning" can become fixed and inflexible and grow to have a life of its own; it persists without the evident influence of the aligned **parent.**

"Child alienation" needs to be differentiated from a "realistic estrangement," where the child's resistance or refusal may result from the trauma of witnessing domestic violence or from experiencing physical abuse, sexual abuse, or significantly inept or neglectful parenting by the rejected **parent.** It is truly abusive behavior or extremely compromised parenting that differentiates alienation from a realistic estrangement. In these cases, **children** may exhibit symptoms of post-traumatic stress disorder rather than a disproportionate or unjustified reaction to their actual experience with the rejected **parent.** Reacting with anger, fear or a need to retaliate, the aligned **parent** may attempt to protect the child from harm. Treatment and judicial remedies will necessarily be different in these two circumstances, both involving a **parent**--child **contact** problem.

With more research and experience, legal and mental health practitioners have noted that pure or "clean" cases of child alienation and realistic estrangement (those that *only* include alienating behavior on the part of the favored **parent** or abuse/neglect on the part of the rejected prent, respectively) are less common than the mixed or "hybrid" cases, which have varying degrees of enmeshment and boundary diffusion between the aligned **parent** and the child and some degree of ineptness by the rejected **parent,** making proper "diagnosis" and intervention planning extremely challenging (Friedlander & Walters, 2010). In some instances of realistic estrangement the aligned **parent's** reactions may be disproportionate to the circumstances and even emotionally harmful to the child (Friedlander & Walters, **[*16]** 2010; Johnston, Roseby, & Kuehnle, 2009). The protective response of the aligned **parent** in *both* child alienation and realistic estrangement can look like alienating behavior.

In cases where the rejected **parent** has been abusive or violent with the other **parent,** or neglectful, abusive or significantly inept with the child, the more correct "diagnosis" is realistic estrangement, justified *primarily,* though not always exclusively, by the rejected **parent's** behavior. The child's reaction to the rejected **parent** is relatively independent and occurs irrespective of the preferred **parent's** attitudes and behavior. In alienation, the child's resistance or rejection is *primarily,* though not always exclusively, the result of the alienating **parent's** conduct, conscious or unconscious, subtle or obvious, direct or indirect. This **parent** may be malicious and vindictive, feel above the law, be deliberate in their actions, or have a mental illness that may be marked with

disordered thinking or paranoia, suggesting their behavior is unintentional. In cases of realistic estrangement, protective and other reactive behavior by the preferred **parent** can be mild, moderate or severe, as can the level of the estrangement (the child's reaction) itself.

While pure or clean cases may be less common than mixed cases, some cases may be more pure or clean than others. When attempting to differentiate alienation from realistic estrangement, it is important to recognize that lapses in good parenting are common and expected; there are no perfect **parents.** Incidents of poor parenting by the rejected **parent** may occur in some and even most cases of child alienation, although not necessarily all cases. In other cases, rejected **parents** are good or perfectly appropriate **parents,** both before and after the alienation surfaces (Baker & Fine, 2008; Johnston, Roseby, & Kuehnle, 2009). Here, the child enjoyed a good relationship with the **parent,** with any deficits in the **parent's** personality or behavior being insufficient to cause a rift. What started out as a known parenting flaw may come to be seen as a contributing factor to the child alienation. It is also possible that once accepted parenting behavior changes for the worse postseparation because that **parent** is parenting in a different context and without the other **parent** as a support or buffer, resulting in rejection of that **parent.** When poor parenting is present in child alienation, it does not rise to the level of neglect, emotional abuse or physical abuse; if it did rise to this level, the identification should not be alienation but estrangement. It is *primarily,* although not exclusively, the disproportionate reaction *of the child* in combination with the aligned **parent's** alienating behavior, intentional or unintentional, that makes it child alienation.

While a best practice assessment will assist the justice system in the differentiation and weight put on all of the contributing factors and on the analysis and ultimate categorization of **parent**--child **contact** problems, classification is not an exact science, but rather involves both art and science (Gould & Martindale, 2007). What is key in child alienation and helpful in making these sometimes fine distinctions, is *how* the aligned **parent** responds to inevitable instances of poor parenting by the rejected **parent;** that is, not only what the alienating **parent** does, but also what this **parent** does *not* do. In child alienation, the aligned **parent** puts a spin on the rejected **parent's** flaws, which are exaggerated and repeated. "Legends" develop and the child is influenced to believe the rejected **parent** is unworthy and in some cases abusive. The child develops an anxious and phobic-like response. Like other phobias, the continued avoidance of the anxiety-provoking circumstances (parental conflict, loyalty bind), or feared object (the rejected **parent)**, known as "anticipatory anxiety", reinforces the child's avoidance and rejection. The child's resistance or refusal is reinforced by the aligned **parent's** approval and extra attention. Further, a mutually escalating cycle of fear and anxiety develop between the child and alienating **parent;** the more upset the child is, the more protective and concerned the **parent** is, which in turn **[*17]** escalates the child's reactions, and so on. [n8] Learning theory demonstrates that the correction (extinction) of the avoidance is extremely difficult and requires exposure and systematic desensitization to the avoided circumstance or feared object.

Further, in alienation the child's relationship with the rejected **parent** is not supported by the alienating **parent;** the child is not encouraged to see both the good and not so good in the other **parent.** Nor is the child required to sort out and resolve the difficulties or conflicts, as the aligned **parent** would likely expect of the child in other situations, such as when the child complains about a friend, teacher or coach, giving the child the distinct impression that the child's relationships with other people are more important than having a relationship with their other **parent.** When difficulties occur between the aligned **parent** and the child (or with a relative of that **parent), the parent** is likely to expect and require the child to sort out those difficulties, not avoid them or sever ties with the people with whom the child experienced the conflict. Instead, the alienating **parent** exploits the rejected **parent's** common foibles and shortcomings, and purports to "leave the decision" about whether to have **contact** or even making efforts to resolve conflicts, to the child, thereby sending a strong message that the relationship is not that important. Interestingly, it is not uncommon for this **parent** who is noncommittal or lenient when it comes to the child seeing the other **parent,** to assert firm expectations and sometimes be intrusive and overly controlling when it comes to the child's behavior in other respects, such as homework, being polite with relatives and neighbors, chores, extracurricular activities and lesson and so on. Good parenting includes not only listening and validating a child's feelings, but also helping them to see things from another person's perspective, resolving not avoiding conflicts, having expectations, and modeling compassion, empathy and forgiveness; practices that are not part of the truly alienating **parent's** repertoire when it comes to the rejected **parent.**

There is a further necessary distinction that is not attended to sufficiently by some writers--between inappropriate and counterproductive behavior on the part of the rejected **parent,** behavior that is *reactive* to the situation and the child's resistance or rejection, and behavior on the part of the rejected **parent** that pre-dates the alienation and thus is *causal.* We discuss commonly observed reactive behaviors of the rejected **parent** below.

THE CHILD

In addition to the aligned **parent** exhibiting degrees of alienating behaviour, manifestations of alienation in a child are varied and depend on many factors, including the degree of alienation itself--mild, moderate or severe. [n9] **Children** will exhibit all or none thinking, idealizing the favored **parent** and devaluing the rejected **parent.** They will likely deny having ever experienced any good times with the rejected **parent** when this is clearly not the case; if shown video or photographs depicting otherwise, they will claim the images have been doctored or they were just pretending. Often, complaints are presented in a litany, some of these being trivial, false or irrational. The child's tone and description of the relationship with an alienated **parent** is often brittle, repetitive, has an artificial, rehearsed quality, and is lacking in detail. The child's words are often adult-like. The child's reaction of hatred or disdain is

unjustified and disproportionate to the deed. The negative feelings are expressed with little if any ambivalence. They can be rude and disrespectful, even violent, without guilt. Feelings and hatred often include the extended family or friends of the **parent,** even when the child has had little or no **contact** with them for some time. The hatred may even extend to pets of the rejected **parent.**

[*18] The child's words are often incongruent with his or her affect. While claiming to be fearful, an alienated child, often and easily without a typical fear reaction, shows anger for abandonment, the separation, and for the rejected **parent** not being a responsible **parent** or for hurting the favored **parent.** Younger siblings often mimic what they have heard their older sibling say and are unable to elaborate on the details of the events they are alleging. **Children** are likely to deny any hope for reconciliation or having been influenced by, or concerned for, the favored **parent.** Some alienated **children** are precocious and appear pseudo-responsible or adult-like, while others may be vulnerable, dependent, and have special needs.

THE FAVORED PARENT

Psychopathology and personality disorders are present in a significant proportion of high-conflict **parents** litigating over custody or access (Johnston, 1993; Feinberg & Greene, 1997, Friedman, 2004; Siegel & Langford, 1998). These **parents** may be rigidly defended and moralistic, perceive themselves to be flawless and virtuous, externalize responsibility onto others and lack insight into their own behavior and the impact of their behavior has on others (Bagby, Nicholson, Buis, Radovanovic, & Fidler, 1999; Bathurst, Gottfried, & Gottfried, 1997; Siegel, 1996). Psychological disturbance, including histrionic, paranoid, and narcissistic personality disorders or characteristics, psychosis, suicidal behavior and substance abuse are common among alienating **parents** (Baker, 2006; Clawar & Rivlin, 1991; Gardner, 1992b; Hoppe & Kenney, 1994; Kopetski, 1998a, 1998b; Johnston & Campbell, 1988; Johnston, Walters, & Olesen, 2005a; Lampel, 1996; Siegel & Langford, 1998; Rand, 1997a; Racusin & Copans, 1994; Turkat, 1994, 1999; Warshak, 2010a).

Janet Johnston and her colleagues compared **parents,** some of whom were alienating, participating in custody evaluations with data from two nonpatient samples of separated **parents** (Johnston, Walters, & Olesen, 2005a). They found that custody litigants were significantly different from the nonpatient samples on numerous variables, most notably their lack of resilience to separation and their experiences of loss. Sometimes an alienating **parent,** typically a father, is also a perpetrator of intimate partner violence or child abuse, and the child, through a process of identification with the aggressor, becomes alienated from the victim **parent** (Drozd, Kuehnle, & Walker, 2004; Drozd & Olesen, 2004; Johnston, Walters, & Olesen, 2005b).

Alienating behavior can be conceptualized on at least two dimensions: level of severity (mild, moderate or severe behaviors) and intentionality (conscious, malicious and direct, or more unconscious, manipulative and indirect). [n10] Responsiveness to intervention and the court are important, related aspects of these dimensions. It is common for family and friends of the alienating **parent** to exert control and manipulation as well.

Clawar and Rivlin (1991) identify 8 different processes involved in severe alienation: (1) theme for the rationalization of rejection; (2) sense of support and connection to alienating **parent** is fostered; (3) feeling of sympathy for the alienating **parent** is fostered; (4) child's loyalty is tested by child's behavior/attitude; (5) reinforcement by seeking out behaviors of the rejected **parent** that reinforce the alienation; (6) maintenance of alienation: subtle reminders; (7) child shows support for beliefs of alienating **parent;** and (8) child's compliance tested: rewarded or not admonished for inappropriate behavior.

Darnall (1998) identifies three types of alienators: (1) *naive alienators* are passive about the relationship with the other **parent** and occasionally say or do something to alienate or **[*19]** reinforce alienation; (2) *active alienators* know what they are doing is wrong but, in an effort to cope with hurt and anger, alienate as a result of emotional vulnerability or poor impulse control; and (3) *obsessed alienators* feeling justified: this **parent** wants to hurt the target **parent** and destroy the child's relationship with that **parent,** rarely showing self-control or insight.

Baker (2005a) identifies five general strategies alienating **parents** use to turn **children** against the other **parent** and the extended family (some or all may be used), with levels of severity and explicitness ranging within each of these categories. In another study, Baker and Darnall (2006) identify as many as 1,300 actions, categorized into 66 strategies. These strategies are summarized into seven groups, plus a catch-all miscellaneous group:

(1) Badmouthing (e.g., qualities, portrayed as dangerous, mean, abandoning; using the rejected **parent's** first name with the child instead of "Mom or "Dad", etc.);
(2) Limiting/interfering with parenting time (e.g., moving away, arranging activities during scheduled time with rejected **parent,** calling during **contact;** giving child "choice" about whether to have **contact,** etc.);
(3) Limiting/interfering with mail or phone **contact** (blocking, intercepting, or monitoring calls and mail, etc.);
(4) Limiting/interfering with symbolic **contact** (limiting mentioning, no photographs, having child call someone else "Mom" or "Dad"; changing child's name, etc.);
(5) Interfering with information (e.g., refusing to communicate, using child as messenger not giving important school and medical information, etc.);

(6) Emotional manipulation (e.g., withdrawing love, inducing guild, interrogating child, forcing child to choose/express loyalty or reject, rewarding for rejection, etc.);
(7) Unhealthy alliance (e.g., fostering dependency, child having to spy, keep secrets, etc.); and
(8) Miscellaneous (e.g., badmouthing to friends, teachers, doctors, interfering with child's counseling, creating conflict between child and rejected **parent,** etc.)

The alienated child becomes highly attuned to the aligned **parent's** neediness and dependency on the child for love and acceptance. Quickly, the child comes to know that it is impossible to show love for both **parents;** showing love for and receiving love from the rejected **parent** is tantamount to betraying the alienating **parent.** A child's loyal behavior is rewarded with warmth, attention love and even material goods. Disloyal behavior is negatively reinforced with punishing looks, anger, withdrawal and abandonment, a risk the child cannot take having already "lost" one loving and loved **parent.**

THE REJECTED PARENT

As previously mentioned, an important and often times omitted distinction needs to be made between the initial or *primary causes* of the alienation and the rejected **parent's** *reaction to provocative behavior* (Gardner, 1992a; Turkat, 1994; Warshak, 2003a). A rejected **parent's** reactive behavior may maintain or reinforce the alienation, and to this extent may be lacking in child-focus and in some cases, even harmful. If properly classified as alienation, this response will not rise to the level of neglect or emotional or physical abuse, in which case an identification of realistic estrangement is indicated.

[*20] Rejected **parents** often react with passivity and withdrawal in an effort to cope with the parental conflict that may pre-date the separation. They may wish to give the child "space" to have his or her feelings and to come around. These reactions may reinforce the allegations made against them by the alienating **parent** and the child, including abandonment, disinterest and poor parenting (Baker, 2006; Gardner, 2002c; Kelly & Johnston, 2001; Kopetski, 1998a, 1998b; Vassiliou & Cartwright, 2001). However, not giving the child some space is sometimes criticized as insensitive and pushy. Some rejected **parents** may lack appropriate degrees of empathy and be counter-rejecting, punitive and angry with their child, much like a knee-jerk reaction to being treated very poorly and disrespectfully by their child. The rejected **parent** may be easily offended and ironically react like their alienated child, with aggressive and disrespectful behavior. Some rejected **parents** vacillate between passivity and confrontational behavior (Baker, 2006; Kopetski, 1998b; Kelly & Johnston, 2001; Warshak, 2010a), which can be very confusing for their child.

Rejected **parents** may act in self-centered and immature ways, with little or no insight into how their own behavior is contributing to the ongoing problem and affecting the child. They may have difficulty separating their child's needs and feelings from the motivations and behaviors of the alienating **parent,** quickly concluding--and inappropriately voicing--that the child is simply mimicking what they have heard or been told. Sometimes, a rejected **parent** may on the surface appear more disturbed than the alienating **parent;** if the rejected **parent** does not capitulate, the conflict escalates (Kopetski, 1998a; Lee & Olesen, 2001). Few rejected **parents** have the benefit of being adequately prepared in advance to deal constructively with at least some of the extreme behaviors manifest by the alienated child. [n11]

IMPACT OF ALIENATION

EFFECTS OF ALIENATION ON CHILDREN

Understanding the short- and long-term effects of alienation on **children** is crucial when considering if, when and how there should be intervention. The literature consistently reports that alienated **children** are at risk for emotional distress and adjustment difficulties and further, at greater risk than **children** from litigating families who are not alienated (e.g., Burrill, 2006a; Cartwright, 1993; Clawar & Rivlin, 1991; Dunne & Hedrick, 1994; Gardner, 1992a, 2006; Garrity & Baris, 1994; Kelly & Johnston, 2001; Kopetski, 1998a, 1998b, Johnston, 2003; Johnston & Roseby, 1997; Johnston, Walters, & Olesen, 2005c; Lampel, 1996; Lee & Olesen, 2001; Lowenstein, 2006; Lund, 1995; Racusin & Copans, 1994; Rand, 1997a, 1997b; Rand, Rand, & Kopetski, 2005; Stahl, 1999; Stoltz & Ney, 2002; Turkat 1994, 1999; Waldron & Joanis, 1996; Walsh & Bone, 1997; Wallerstein & Blakeslee, 1989; Ward & Harvey, 1993; Warshak, 2010a). Clinical observations, case reviews and both qualitative and empirical studies uniformly indicate that alienated **children** may exhibit: (1) poor reality testing; (2) illogical cognitive operations; (3) simplistic and rigid information processing; (4) inaccurate or distorted interpersonal perceptions; (5) disturbed and compromised interpersonal functioning; (6) self-hatred; (7) low self esteem (internalize negative parts of rejected **parent,** self doubt about own perceptions, self blame for rejecting **parent** or abandoning siblings, mistrust, feel unworthy or unloved, feel abandoned) or inflated self-esteem or omnipotence; (8) pseudo-maturity; (9) gender-identity **[*21]** problems; (10) poor differentiation of self (enmeshment); (11) aggression and conduct disorders; (12) disregard for social norms and authority; (13) poor impulse control; (14) emotional constriction, passivity, or dependency; and (15) lack of remorse or guilt.

High levels of parental conflict and severe alienation may be identified by child protection agencies as emotional abuse warranting the child is in need of protection when the child exhibits serious symptoms, such as anxiety, depression, withdrawal, self-destructive or aggressive behavior or delayed development (Fidler, Bala, Birnbaum, & Kavassalis, 2008). However, it is common for

these agencies not to intervene, as they consider that the family assessment and court process are adequate to address the protection concerns, or because the agency concludes that the child is not being "abused" or "neglected" as defined by statute.

EFFECTS OF ALIENATION ON ADULT CHILDREN

Amy Baker's results from her qualitative retrospective study of adults alienated as **children** are sobering (2005a, 2005b, 2007). Many of these adults suffered from low self-esteem, having internalized the negative characterization by the alienating **parent** of their rejected **parent.** Self-hatred, self-blame and guilt for abandoning younger siblings were noted. Seventy percent disclosed suffering significant episodes of depression. Approximately one-third of the sample reported having had serious problems with drugs or alcohol during adolescence, using such substances to cope with painful feelings arising from loss and parental conflict.

The respondents in Baker's study reported that their own experiences and memories did not match the picture painted by their alienating **parent,** which caused them to experience self-doubt about their own perceptions and feelings about themselves and others. They had difficulty trusting that anyone would ever love them; two-thirds had been divorced once and one quarter more than once. Consistent with case studies and clinical literature, Baker's respondents reported that they became angry and resentful about being emotionally manipulated and controlled; eventually this negatively affected their relationship with the alienating **parent.** About half of Baker's sample reported that they had become alienated from their own **children.**

Relevant to the controversy over how much weight to give **children's** preferences, whether or not we should heed their wishes, and if they mean what they say, Baker reported that while most of the adults distinctly recalled *claiming* during childhood that they hated or feared their rejected **parent** and on some level did have negative feelings, they did not want that **parent** to walk away from them and secretly hoped someone would realize that they did not mean what they said. Similarly, Clawar and Rivlin (1991) reported that 80 percent of alienated **children** wanted the alienation detected and stopped. Baker's results further indicated that for more than half of those alienated, their relationships remained severed for more than 22 years, while for all of them the alienation lasted at least 6 years.

Baker's research provides an important contribution. Like all of the research in this field, the results need to be treated cautiously given the qualitative and retrospective nature of her study. Her group of adult respondents may have been among the more severely alienated as **children.** A comparison group of adult **children** of divorce who did not experience parental alienation was not included and not all of the **children** shared all of the reported reactions. While noting the limitations of her study, Baker concludes that the voices and felt experiences of these adult **children** deserve to be heard and provide a good foundation for future well-designed research.

[*22] Janet Johnston and Judith Goldman (2010) provide 15- to 20-year follow-up data from two sources; one-third of their 90 custody-disputing families initially referred by the courts and provided with confidential, [n12] family-focused counseling, and the treatment records of 42 **children** from 39 litigating families who received counseling for nearly an average of 10 years. Referrals were made specifically to address the child's resistance or refusal to visit, or for other more general reasons relating to the parental conflict; these groups were not studied separately. Data included the young adults' retrospective reports from clinical interviews and ratings of the clinical files, both conducted by the first author, who was also the **children's** therapist years prior. [n13] In addition, the young adults completed standardized measures of their emotional functioning, relationships and the quality of their **parent**-child relationships over the years.

Preliminary and speculative hypotheses are offered with respect to outcomes and the adult **children's** attitudes and feelings about their experiences in the judicial system. Johnston and Goldman observed that the range of resistance and rejection and outcomes varied depending on many factors, including the family dynamics and parental behaviors, the causes of the resistance or rejection, the age of onset, and the chronicity of the family dysfunction. Their article in this issue elaborates on these variations.

In summary, they observed that retrospectively the adult **children** had strong negative views and feelings when they were forced to participate with different therapists for reunification therapy, while those who had a single supportive long-term therapist found the experience beneficial. Nearly all of the youth between the ages of 18 and 21 years initiated **contact** with their rejected **parents,** having achieved their emancipation milestones. The outcomes, in terms of sustainability of the **contact** and relationship, were mixed. Interestingly, even though many were required by the court to attend counseling when they were **children,** the young adults reported that they initiated repairing their relationships with their **parents** voluntarily and without the help of their counselors. Johnston and Goldman (2010) suggest a "strategy of voluntary supportive counseling and/or backing off and allowing the youth to mature and time to heal the breach" instead of forcing adolescents to participate in counseling. They conclude that teenagers who feel empowered and that their autonomy is respected are better able to distance themselves from the parental and family conflicts and consequently more likely to initiate **contact** with the rejected **parent.** Despite the young adults' reported dissatisfaction with being forced to attend counseling and their reported belief that they initiated reconciliation without the help of the counselor, it is impossible to know on the basis of these data the extent to which maturity, the forced counseling, or some other factor or combination of factors, were responsible for the youth's decision to initiate **contact** with their rejected **parent.** The previously

summarized findings of Baker, and Clawar and Rivlin, noting that young adults and **children** wished someone would have recognized they did not mean what they said are important considerations when identifying an appropriate intervention.

Johnston and Goldman (2010) report that better long-term outcomes were found when the predominantly negative feelings for one **parent** developed during adolescence (12 to 15 years), when primarily in reaction to the recent divorce, compared to earlier in childhood. The adolescent's resistance or rejection was a developmentally expected coping mechanism. The finding that poorer outcomes were found when the reactions began in earlier childhood lends support to the importance of early identification, intervention and prevention for this younger age group. Further, in this follow-up study highly successful outcomes occurred for a minority and were more likely with early intervention and prevention when alienation was first alleged.

[*23] In speaking about their poorest outcomes, where the child's rejection is primarily due to "serious parenting deficits" (presumably primarily realistic estrangement), Johnston and Goldman (2010) advise that these **children** should be permitted to "get on with life" with the assistance of a supportive therapist where voluntary, rather than persisting with court orders for reunification. They further note that, in cases of severe alienation where the aligned **parent** is mentally ill, has a serious personality disorder or is noncompliant with orders and therapy, a custody reversal, perhaps with the child residing with a third-party temporarily, may be warranted, providing the rejected **parent** has sufficient parenting capacity.

REMEDIES

SPONTANEOUS REUNIFICATION

Writers have followed cases and observed spontaneous reconciliations, or degrees of this (Johnston & Goldman, 2010; Darnall & Steinberg, 2008a, 2008b; Rand & Rand, 2006; Vassiliou & Cartwright, 2001). Maturation, independence, emancipation and life cycle trigger events, such as graduation, a rift in the relationship with the custodial **parent,** death or serious illness of a family member have been identified by these writers and clinicians as precipitants for a reconciliation, sometimes years later.

In severe alienation cases, some legal and mental health professionals advise rejected **parents** to give up on trying to enforce visitation, believing this is the least detrimental alternative for the child, in part expecting that the child's exposure to parental conflict and badmouthing will abate. [n14] It remains unclear, though, the extent to which the adolescent who is cut off from the rejected **parent** will be protected from interparental conflict or badmouthing. Others are less inclined to offer this advice, in part because of the research indicating that: (1) **children** of divorce generally do best when they have good relationships with two involved and effective **parents** (Kelly, 2007); (2) in retrospect, young adults who experienced parental separation wished they had more time with their noncustodial **parents** (Fabricius & Hall, 2000; Finley & Schwartz, 2007; Laumann-Billings & Emery, 2000); (3) fathers play an important role in child development and adjustment (Parke, 2004; Schwartz & Finley, 2009); and (4) alienated **children** and adults alienated as **children** report that despite their protests otherwise, they secretly longed for more **contact** with their rejected **parent** and wished someone would have insisted they have **contact** (Baker, 2005b, 2007; Clawar & Rivlin, 1991). Even if the **parent** chooses to walk away, and notwithstanding a child's claims of hate or fear for the rejected **parent,** the child is likely to feel some sense of abandonment, in effect rejected by the **parent.** Such feelings may be mitigated if a "proper goodbye for now" between the child and rejected **parent** can be orchestrated in some way. However, in many severe cases even this is not possible, in which case efforts should be made for an indirect goodbye, such as a lawyer or mental health professional reading, in the absence of the rejected **parent,** a carefully crafted letter expressing love and offering an "open door."

Darnall and Steinberg (2008a, 2008b) studied 27 **children** and young adults who experienced varying degrees of spontaneous reunification without "any significant intervention from the court or mental health professional" (2008b, p. 254). They report that a crisis in life can create an opportunity for reconciliation between an adult child and **parent.** Four scenarios are identified, after years of no **contact** with a rejected **parent,** where the adult **[*24]** child initiated **contact:** (1) "Hurting Stalemate" (e.g., a mutual crisis for the **parents** when they realize they are in a "no win" situation, such as a child being criminally charged); (2) "Recent Catastrophe" (e.g., a terminal illness of a close family member; (3) "Impending Catastrophe" or "Deteriorating Position" (e.g., each **parent** realizes that failure to act will lead to serious crisis for their child, such as depression or suicide); and (4) "Enticing Opportunity" (e.g., a child needing money).

In light of these reported results, it is important in cases where efforts to enforce **contact** are abandoned, in the absence of a finding of violence or child abuse, that the courts require a custodial **parent** to provide regular information updates to the rejected noncustodial **parent,** preferably through a third party, to more easily facilitate and monitor compliance with the order. Without this information, there will be even less opportunity to rely on life-changing events as a catalyst for reconciliation. However, with this information, it may be easier for a child to initiate **contact** with the rejected **parent** years later, knowing that **parent** remained interested and informed, even if only from a distance.

A review of Darnall and Steinberg's case examples is instructive in our growing understanding of what may be instrumental in effecting change. They state that the courts and mental health professionals played no "significant role" in the reunifications. However, some of their case examples suggest otherwise, depending on how one defines "significant." All of their reports of

spontaneous reunification, irrespective of the specific category of crisis, had one or more of the following in common: (1) the favored **parent** had eventually come to support the reunification in some way, either for his or her own self-interest or by following the child's lead; (2) the court became involved, in effect threatening a crisis for the **parents,** such as, a third party caring for the child; (3) the alienated child was influenced by siblings who had continued to have **contact** with the rejected **parent;** or (4) the child had found a way to appease the favored **parent** by claiming it was the court who made the reunification happen or by showing that the favored **parent** would benefit (e.g., not have to pay for college). A follow-up found that one-third (9/27) of the individuals continued to sustain the reunification, leaving two-thirds who did not. These data indicate that some cases involved pure spontaneous reunification while others involved some court involvement, and that the majority of reunifications were not sustained.

As indicated by the above studies summarized, there are different views on whether **children** should be required or pressured to reestablish a relationship with the rejected **parent.** Further, the existing data on spontaneous reconciliation and the sustainability of the **contact** and relationship are preliminary and mixed. What is clear is that these cases are often extremely complex, and the intervention or lack of it must be determined on a case by case basis; rules and presumptions are insufficient to address the variability across cases.

MODALITIES, MODELS, AND GOALS OF COUNSELING INTERVENTION

The specific clinical or educational intervention and the extent of court involvement will depend on the nature (alienation, realistic estrangement, mixed case, degree of intentionality) *and* the level or extent (mild, moderate or severe; responsiveness to intervention and court) of the **parent**-child **contact** problem. Interventions involving education, counseling or psychotherapy tend to be suitable for *mild and some moderate cases*, which we propose may include the relatively pure or clean alienation or realistic estrangement cases or the mixed cases, which have elements of realistic estrangement, enmeshment, and alienation. [n15] **[*25]** Included in these mixed cases may be those where the child, while **resisting** due to an affinity, age, gender or divorce-related alignment continues to have **contact with the parent** to some degree. For many cases, it is difficult to know at the outset which of these cases may become severe if left on its own without court or clinical intervention. The screening or clinical assessment must include a way to conclude or at best hypothesize (correctly or incorrectly), based on all of the obtained information to date, that the aligned and rejected **parents** are likely to be responsive to some direction or education and in turn compliant with therapy and court orders. All severe and some moderate cases of alienation, which we elaborate on later, are likely to require a different and more intrusive approach if the relationship with the rejected **parent** is not to be abandoned and the alienation is to be successfully corrected. [n16]

Various models, protocols and strategies for the less severe cases have been presented at professional conferences and written about in reputable journals. The articles in this special issue expand on a few of these important interventions. [n17] Here, we briefly summarize important principles and considerations with respect to the structural components of these interventions.

Family Systems Approach to Therapy

Alienation is a systemic and family problem where disruptions in family structure, boundaries and roles are evident (McHale & Sullivan, 2008; Minuchin, 1974). While there may be strong disagreement amongst the family members and the various professionals as to the causes and development of the alienation, *both* **parents** have responsibility for the solution.

A *family-systems approach* is required in mild and some moderate cases (Everett, 2006; Cartwright, 2006; Friedlander & Walters, 2010; Lowenstein, 1998; Gardner, 1998a, 2001b; Johnston, 2005b; Johnston & Roseby, 1997; Johnston, Roseby, & Kuehnle, 2009; Johnston, Walters, & Friedlander, 2001, Sullivan & Kelly, 2001). This approach involves the participation of the entire family in various combinations (sometimes including individual sessions for child or **parents)**, will always involve both **parents** and may include relatives such as stepparents, stepsiblings, and grandparents as well as any third-party professionals such as treating physicians and therapists. [n18] Frequently, legal and mental health professionals may have the mistaken view that individual therapy alone for the child (or one or both of the **parents)** is indicated. Individual therapy for the child by either the same or a different therapist working as a member of a team, without the inclusion of other family members, is likely to deter the effectiveness of the intervention and may further entrench the alienation.

Treatment Model Structure

Various intervention models ranging from the involvement of a single professional to a team of two or more professionals coordinated by court order may be used. As previously noted, since for many cases it is difficult to know in the earlier stages which of these may become severe and require more intrusive measures, there should be a detailed written service agreement for the intervention or counseling, preferably giving effect to a separation agreement or a court order for services (Drozd & Olesen, 2009; Friedlander & Walters, 2010; Johnston & Goldman, 2010; Johnston, Walters, & Friedlander, 2001). A separate **[*26]** treatment agreement or contract is usually necessary to augment a court order that frequently, at least in our jurisdiction, does not include sufficient terms and explanations (Fidler, Bala, Birnbaum, & Kavassalis, 2008). [n19] When using a single-family therapist model, another professional, such as an arbitrator or parenting coordinator is desirable for monitoring and decision-making within a defined and limited scope. In the absence of this professional, these functions should fall to the court, as the therapist should not assume this

role. In more complex cases, a team approach is likely to be preferable, where the child and possibly each **parent** have their own therapist. An additional therapist for **parents** together may be desirable, or this role can be assumed by a parenting coordinator or arbitrator, who would also assume the role of case manager, team leader, and decision-maker. In both the single- and multiprofessional (team) models, open and unrestricted communication between all of the professionals involved *and* the court is a key component, and must be agreed to or court ordered prior to therapy beginning (Friedlander & Walters, 2010; Johnston, Walters, & Friedlander, 2001; Sullivan & Kelly, 2001).

In some of the more challenging cases at the moderate level, it is very difficult, if not impossible, for one therapist to achieve the desired objectives and meet all of the various, complex and often competing needs of the different family members, let alone assume additional roles, such as arbitrator, which is likely to compromise the practitioner's effectiveness and neutrality in the eyes of the family. Similar to the problems inherent in an individual **parent's** or child's therapist offering recommendations in a custody case (Greenberg & Gould, 2001; Greenberg & Shuman, 1997), assuming the dual roles of therapist and decision maker poses serious ethical and practical issues (Greenberg, Gould, Schnider, Gould-Saltman, & Martindale, 2003; Kirkland & Kirkland, 2006, Ontario Psychological Association, 1998; Sullivan, 2004). The model proposed keeps the role of the family therapist (or **parent**-child **contact** facilitator) distinct from that of the parenting coordinator or mediator/arbitrator (Fidler, Bala, Birnbaum, & Kavassalis, 2008; Johnston, Walters, & Friedlander, 2001, Sullivan, 2004; Friedlander & Walters, 2010). If the child or **parent** understands that the therapist can also change or determine the parenting time schedule, the therapeutic efforts to implement the parenting time or repair the family relationships to the point that parenting time can resume will be seriously compromised. If seen in the role of an assessor or evaluator, the therapist is unlikely to ever be able to move beyond answering the question that asks *if* it is in the child's best interests to have **contact** with the rejected **parent.** Any counseling must have already determined that it *is* indeed in the child's best interests to have **contact,** based on a previous comprehensive clinical assessment or finding of the court.

Naturally, the family's financial means and the availability of clinical resources are an important constraint on any treatment plan. The therapeutic and psycho-educational models proposed here and by others (Friedlander & Walters, 2010; Jaffe, Ashbourne, & Mamo, 2010; Johnston & Goldman, 2010) are all expensive. The significant costs of these various models preclude many families from receiving these services, a problem that requires the attention of government and policy makers.

Goals of Therapy

Therapy and counseling for the mild and some moderate cases, has been described by many (Carter, Haave, & Vandersteen, 2006; Drozd & Olesen, 2009; Fidler, Bala, Birnbaum, & Kavassalis, 2008; Friedlander & Walters, 2010; Johnston & Goldman, 2010; Johnston, Roseby, & Kuehnle, 2009; Johnston, Walters, & Friedlander, 2001). While it is often **[*27]** referred to as reintegration or reconciliation counseling by judges, lawyers and some mental health practitioners, it is important to recognize that the goals of this therapy may include not only reunification with the rejected **parent,** but also facilitating global healthy child adjustment and coping mechanisms. This includes correcting the child's distorted and polarized views and replacing them with more realistic views of each **parent,** improving the child's healthy relationships with *both* **parents,** addressing divorce-related stress, boundaries and age-appropriate autonomy and restoring adequate parenting, co-parenting and **parent**--child roles.

A similar approach is practiced by a team of psychologists in Edmonton, Canada, called Family Restructuring Therapy (Carter, Haave, & Vandersteen, 2006, 2008, 2009). In July 2009, Robin Deutsch, Matt Sullivan, and Peggie Ward completed the second year of their innovative 5-day family camp, Overcoming Barriers Family Camp where *both* **parents, the children,** and stepparents participate (Deutsch, Sullivan, & Ward, 2008; Deutsch, Sullivan, Ward, Carey, & Blane, 2009). The camp program is described in detail in this issue (Sullivan, Ward, & Deutsch, 2010).

Bill Eddy (2009) has developed an early intervention, short-term and highly structured cognitive-behavioral program, New Ways for Families, for high-conflict family court cases, including those involving allegations of alienation. At the time of first appearances in court, many **parents** are simply not ready to engage meaningfully to resolve their disputes. The program's intention is to assist **parents** early on with communication and conflict-resolution skill development that will hopefully enable them to make better use of services to develop their **post-separation** parenting plans and arrangements. [n20]

As noted, one of the many goals of a therapeutic and educational approach is to facilitate the child's relationship and **contact** with the rejected **parent.** The therapist may be required to assist the family to implement a previously agreed to or court ordered parenting time schedule, preferably detailed and unambiguous. This schedule may be final, interim or incremental, with increasing time for the child with the rejected **parent.** In other cases, initially a child's **contact** with a rejected **parent** may be limited to the therapy sessions ("therapeutic access") for a specified period, after which, with the benefit of a report from the therapist, [n21] the family will return to the court or their arbitrator for further determinations of the parenting time schedule. [n22]

It is important to distinguish therapeutically facilitated parenting time from supervised access or visitation. The latter may be appropriate for the mild or moderate cases of purer or primarily realistic estrangement. However, once any risk of harm has been ruled out, it is important that the reunification of the child with a rejected **parent** not be referred to as "supervised access", and that it not take place at a supervised access center identified as such, as this is likely to reinforce the child's irrational fears and to that extent do

more harm than good (Johnston, 2005a, 2006).

THE COURT'S EARLY AND VIGILANT INVOLVEMENT

Professionals vary in the extent to which they support the court's involvement (and the degree of this) in alienation cases, ranging from rarely to never involved (Bruch, 2001; Walker, Brantley, & Rigsbee, 2004a), to sometimes limited for the more severe cases (Jaffe, Ashbourne, & Mamo, 2010), to often including what may appear to be the more milder types initially to prevent the problem from getting worse (Fidler, Bala, Birnbaum, & Kavassalis, 2008; Friedlander & Walters, 2010; Rand, 1997b). Most experienced legal and mental health professionals emphasize the need for the court's early and vigilant **[*28]** involvement. Formalizing the **parents'** consent to treatment in a court order is often prudent, because as previously noted, it is difficult to know in advance which cases may become severe, and usually, the longer the alienation lasts, the worse it gets and more difficult it becomes to remedy, even if there is reconciliation many years later. Further, without a court order, standards of practice and privacy legislation permit clients to revoke their consent for treatment for any reason at any time. The need for court involvement, then, applies not only to custody reversal, but also to other interventions typically recommended and used in alienation cases, such as individual and family therapy, reintegration therapy, parenting coordination, and some **parent** education programs (Warshak, 2010b). Given the consensus for early identification, triage and appropriate intervention, as noted in all of the articles in this issue, we believe that there is a very important role for the court, even for what may appear to be a mild case at the time.

Some argue that therapeutic change is necessarily dependent on voluntary participation; that forcing therapy is an oxymoron, as orders are poor motivators to change attitudes and feelings (Bruch, 2001; Darnall & Steinberg, 2008a; Wallerstein, Lewis, & Blakeslee, 2000). This argument has some intuitive appeal, and ultimately no one can be forced to engage meaningfully in therapy. However, clinical experience and the studies summarized in this issue suggest that in many alienation cases, education, coaching, and encouragement or threats of a judge can be prime motivators for change, including engagement in therapy. The fear of loss can be very motivating. Severe problems call for more interventionist solutions if long lasting and meaningful change (second order), not only surface or superficial change (first order) change, is to come about (Watzlawick, Weakland, & Fisch, 1974). Studies on short term, systemic therapies, such as structural, strategic, solution-focused, and cognitive-behavioral approaches, indicate that a behavioral change can occur without insight, and further, that a change in behavior can precipitate a shift in attitudes and emotions.

As discussed below and elaborated by Justice Martinson in this issue (2010), case management--one specialist family law judge for one family--is especially valuable for cases where alienation is alleged. Judicial continuity allows the judge to gain an appreciation of the complex nature of the case and to set clear expectations for the **parents** (and in some cases the **children)**. Although contempt of court orders, reversal of custody and temporary suspension of **contact** with an alienating **parent** are important options in the judicial toolbox for dealing with alienation, they should be last resorts. The primary judicial role, in all but the most intractable cases, should be educational--an authoritative figure making clear to both **parents** how their behavior is affecting their **children.** The exhortations of a judge--setting out clear expectations and consequences for failures to comply--can move many **parents and children,** who may also be interviewed by the judge (Warshak, 2010b), to alter their behaviors, especially if combined with directions for educational or therapeutic interventions (Brownstone, 2008; Darnall & Steinberg, 2008a). Only the most personality-disordered **parents** are likely to defy a judge who has set out clear expectations and consequences. When this occurs, it may be necessary to resort to remedies more suitable for the severe cases of alienation.

Another option, short of reversing custody, is for the court to order a prolonged period of residence with the rejected **parent,** such as during the summer or an extended vacation, coupled with counseling and *temporarily* restricted or suspended **contact** with the alienating **parent.** This arrangement, which in the long run provides less disruption and greater continuity of care, may be more appropriate than reversing custody permanently, while also affording the child and rejected **parent** the uninterrupted time and space needed to repair and rebuild their relationship (see, e.g., *Pettenuzzo-Deschene,* 2007).

[*29] CUSTODY REVERSAL: ONE OPTION FOR SEVERE CASES

Custody reversal is *one* option for severe cases of alienation. In our view, the question is not whether or not there should ever be a custody reversal, but rather, in which circumstances is it the most appropriate remedy and how and under what legal conditions it should be implemented. In more severe cases, it may be the least detrimental option for the child. Several important questions surface when considering for a specific case the option of reversing custody to the rejected **parent** while suspending, at least temporarily, the child's **contact** with the favored **parent:** Is the alienation emotionally abusive? Is custody reversal likely to cause more harm than good? That is, do the short or long term benefits of placing the child with the once loved, now rejected **parent** outweigh the risks (trauma or harm) of temporarily separating the child from the alienating **parent?** Stated differently, which risk is greater: Separation from an unhealthy or enmeshed relationship or remaining in that relationship? What are the capacities of the rejected **parent?** More general questions also arise, such as whether older **children** have sufficient maturity to make decisions about attending counseling or severing ties with a rejected **parent,** and most broadly, does custody reversal work?

The negative short-term and long-term effects of alienation, including intrusive parenting have been well documented (e.g., Baker, 2007; Barber, 2002; Johnston, 2005a; Johnston, Roseby, & Kuehnle, 2009; Johnston, Walters, & Olesen, 2005c). While there

is general recognition that a reversal of custody may be warranted in severe cases (Drozd & Olesen, 2009; Gardner, 1998a; Johnston & Goldman, 2010; Johnston, Roseby, & Kuehnle, 2009; Sullivan & Kelly, 2001; Warshak, 2010b), debate continues with respect to identifying which cases are in fact severe enough. There may also be differing opinions regarding whether a case is severe or mixed, or with respect to cases that started with elements of less significant realistic estrangement but developed into disproportionate reactions on the part of the child because of alienating behavior by an overprotective or hyper-vigilant aligned **parent** who unintentionally or intentionally was not responsive to redirection and intervention.

Severe cases have been noted to have clinical pathology in the **parents or children** according to the *DSM-IV*, typically on Axis I and II (Clawar & Rivlin, 1991; Gardner, 1992b; Johnston & Goldman, 2010; Johnston, Roseby, & Kuehnle, 2009; Johnston, Walters, & Olesen, 2005c). The alienating **parent** may be psychotic, sociopathic or severely character-disordered, often involving either malicious or strongly believed allegations of abuse by the rejected **parent** that have not been substantiated after repeated investigations. In this subset of severe cases, alienating **parents** may be paranoid and there may be evidence of a *folie a deux* or Munchausen's by Proxy Contemporary Type (Rand, 1993). Also, severe cases may include the alienating **parent** having serious parenting deficits, such as being extremely overprotective or intrusive, having a substance abuse problem, or there may be a credible risk of child abduction (Johnston, Roseby, & Kuehnle, 2009). While some may be skeptical (Jaffe, Ashbourne, & Mamo, 2010), others have indicated that these severe cases are tantamount to significant emotional abuse (Johnston, 2005a; Gardner, 1998b; Rand, 1997a, 1997b; Sullivan & Kelly, 2001; Warshak, 2003a) and are unlikely to be remedied with education and therapy.

Perspectives For and Against Custody Reversal

Bruch (2001) and Wallerstein, Lewis, and Blakeslee (2000) maintain that **children** who are rejecting or strongly **resisting** a **parent** will "come around" eventually, and further assert **[*30]** there is no evidence that ordering **contact** or expensive treatment is effective. [n23] In addition, these writers have questioned the benefits to **children** involved in high conflict parental separation of having relationships with both **parents.** These writers argue that enforced parenting time, treatment, and custody reversal are counterproductive, in that they will only serve to reinforce the child's hatred for the rejected **parent,** adding further stress to the already vulnerable child. Further concerns include that a custody reversal may place the child at risk for running away or self-destructive behavior (Jaffe, Ashbourne, & Mamo, 2010; Johnston, Roseby, & Kuehnle, 2009). Opponents to custody reversal argue that an abrupt and lengthy, even if temporary, separation from a primary attachment figure (referred to by some as a "parentectomy", even when, and especially when, the attachment and relationship are enmeshed or pathological, places the child at greater risk than losing **contact** with a rejected **parent** and half the family (Garber, 2004; Jaffe, Ashbourne, & Mamo, 2010).

Mental health and legal professionals are faced with what British Columbia Supreme Court Justice Bruce Preston referred to as the "stark dilemma" *(A.A. v S.N.A.*, 2007). Do the long-term benefits of having a relationship with the rejected and healthier **parent** outweigh the shorter-term risks, such as the emotional costs or the potential for the child's destructive behavior associated with temporarily separating the child from the favored **parent?** If irrational alienation is determined to be emotionally abusive, then the answer to the stark dilemma should be clear or clearer. Some professionals are very cautious about custody reversal and are likely to argue that any alienating conduct in a specific case is not abusive. Other professionals may be more likely in specific cases to maintain that court intervention is justified to protect a child from the unrelenting emotional abuse of the alienation, just as it is in child-protection cases, even when **parents** may not be conscious of their attempts to turn the child against other **parent.** The importance of focusing on the long-term welfare of **children,** notwithstanding the short-term risks, was recognized by the British Columbia Court of Appeals in its 2007 judgment in the previously mentioned case of *A.A. v S.N.A.*, where the court, reversing the trial decision, ordered that custody of a 10-year-old girl be transferred from her alienating mother to her rejected father, with a suspension of access to the mother and maternal grandmother, including telephone access, until otherwise recommended by the court-appointed professional, or by a court order (see Martinson, 2010, in this issue for further elaboration).

For proponents, a significant concern in addition to the child not having a relationship with the rejected **parent** and often the entire extended family, is the alienating **parents'** intrusive and overprotective parenting and the exploitation, indoctrination, induction of fear and hatred and, in some cases, paranoia, in **children.** Important distinctions need to be made between the *strength* and *quality* of an attachment; a strong bond does not necessary mean it is healthy. In fact, strong bonds may be indicative of unhealthy and insecure attachments, as demonstrated by an abusive **parent** and their fearful child or by an over-protective or intrusive **parent** and their parentified or placating child. Writers also note that attachment is but one element of the **parent**--child relationship (Arredondo & Edwards, 2000; Byrne, O'Connor, Marvin, & Whelan, 2005) and a child's adjustment. Other factors include the **parent's** own attachment, the ability to meet the child's instrumental needs, parenting capacity and style (authoritarian, authoritative or permissive), teaching and role modeling and are predictive of a child's adjustment. Consequently, many factors, not only the quality or strength of the attachment with the aligned or alienating **parent,** must be considered when making recommendations or determinations in child custody disputes (Birnbaum, Fidler, & Kavassalis, 2008). There may also be subtle gender issues at play here. Would those who object to a child being separated from an alienating, and thus **[*31]** emotionally abusive custodial mother, have the same objection when it is the custodial father who is emotionally abusive and alienating the child against the mother, thereby requiring a separation from the father?

Proponents of custody reversal may, in specific cases, conclude that an alienating **parent's** parenting is not only compromised but emotionally abusive, and consequently, the risks associated with not separating the child from the aligned **parent** are far greater than any potential risks of changing custody, providing the rejected **parent** is an at least adequate **parent** and the child once had a secure attachment and a reasonably good relationship with that **parent.** While most opponents of custody reversal acknowledge it is preferable for a child to have good relationships with both **parents** and their extended families, they are likely to argue that despite alienating conduct by the "primary" caregiver, severing ties with a rejected "non-primary" **parent** and the extended family is preferable to separating the child from the alienating primary **parent.** Each perspective calls for a different or opposite least detrimental solution.

There is an assumption that in severe cases, all or most **children** are likely to be traumatized or go into crisis when separated from the alienating **parent,** who in many cases is likely to be the custodial mother. We do not have controlled empirical studies for this particular population comparing alienated **children** who were separated and those who were not separated from their favored **parent** and placed with their previously loved **parent.** Examination of the child protection literature may be instructive. Preliminary research from retrospective studies and clinical anecdotes reported by many seasoned clinicians suggest that for at least some **children,** a separation from the favored **parent** is liberating because the child is able to resume what was a deep attachment to the **parent** they have not been free to love in the presence of the favored **parent.** Amy Baker's research (supported by that of Clawar & Rivlin, 1991) indicating that many **children** secretly wished that someone called their bluff and insisted they have a relationship with the **parent** they claimed to fear or hate, is an important consideration when making these extremely difficult decisions. In the case where a child threatens self-harm in contemplation of a move from the custodial to the rejected **parent,** it is often difficult, if not impossible, to ferret out the cause for the child's distress be it the potential move or the ill effects of the alienation process. Further, it must be borne in mind that **children** left with a severely alienating **parent** are likely to experience emotional trauma and also may eventually engage in self-harm.

Further, legal and mental health proponents of custody reversal (e.g., child representatives, evaluators, therapists, mediators and parenting coordinators) note that they have repeatedly observed that once out of the orbit of the preferred **parent,** an alienated child can transform reasonably, sometimes very quickly, from refusing or staunchly **resisting** the rejected **parent,** to being able to show and receive love from that **parent.** This transformation is often met by an equally swift shift back to the alienated position as soon as (or even before in anticipation) the child returns to the favored **parent.** The child's need and ability to vacillate between denying and accepting parts of themselves so quickly and visibly is difficult to believe unless one has actually observed it directly, and suggests a compromised adjustment and development of self.

Assessors and the courts need to consider carefully what poses the greatest risk to a *particular* child in a *particular* set of family circumstances, noting the likely short *and* long-term detrimental effects of living in a distorted reality where the child is not free to be who they are and emotionally autonomous. For some, the least detrimental long-term option is to place the child with the **parent** more likely to promote overall healthy psychological development and adjustment, including but not limited to a healthy relationship **[*32]** with the other **parent.** For others, the reverse is the case. It is important to recognize that a healthy relationship is not without challenges or complaints; there is no perfect **parent**-child relationship. Rather, a functional relationship will include the ability to accept and integrate both good and bad qualities coupled with flexible thinking, the capacity for multiple perspective-taking, good communication and problem-solving skills, and so on, all of which are indices of mature interpersonal skills and relationships.

Ethical issues related to coercion, **children's** rights and civil liberties are important and debated considerations. As previously mentioned, these concerns are relevant not only to custody reversal, but to all of the interventions typically recommended and used in alienation cases, such as family-focused therapy, parenting coordination, some **parent** education programs, Overcoming Barriers Family Camp or the Family Bridges workshop (Warshak, 2010b). [n24] It appears then, that the issue may be less about coercion per se and more about the nature and degree of the coercion, and further, for which cases it is appropriate. One needs to ask not only about the ethical issues of intervening when **children** protest, but also about the ethical issues when intervention is not provided to protect **children** from abusive parenting (Warshak, 2010b). We concur with Warshak, who elaborates on the ethical issues and notes that it will be up to the individual professional to determine "where they stand when it comes to the ethics of recommending or providing services to **children** who are referred against their will."

When to heed and not heed a child's wishes is another area of considerable discussion and debate. For example, Bruch (2001) and Wallerstein and Tanke (1996) assert that a child's stated wishes deserve careful consideration and should be respected in many cases. Some of these same writers have vociferously object to the court's involvement in mandating treatment, parenting time enforcement and custody reversal (see also Jaffe, Ashbourne, & Mamo, 2010; Faller, 1998; Walker, Brantley, & Rigsbee, 2004a, 2004b), while failing to discuss or giving lip service to the many studies of **children** and adult **children** of divorce, some of whom may have been alienated, reporting a longing to have had more time with their non-custodial fathers (see, e.g., Ahrons & Tanner, 2003; Hetherington & Kelly, 2002; Fabricius, 2003; Fabricius & Hall, 2000; Laumann-Billings & Emery, 2000; Parkinson, Cashmore, & Single, 2005; Parkinson & Smyth, 2004; Schwartz & Finley, 2009).

Proponents of custody reversal in severe cases of alienation note that while **children's** feelings and ideas are indeed important to consider, they are not determinative. A child's wishes and preferences must be independent to be given weight. Parental influence is, and ought to be, integral to parenting; however, there is good and bad influence. **Children** should always have a feeling of "being heard" while making it clear to them that they do not have the responsibility for making decisions (Warshak, 2003b). This is the case for adolescents, not only **children,** given that the adolescent brain and executive functioning (e.g., coordinating information, judgment, planning, weighing alternatives, analysis, cognitive flexibility, problem solving, etc), are developing rapidly in important ways. The adolescent brain is in effect "under construction", hence the greater risk-taking behavior, poor judgment and problems with impulse control often observed in adolescence. To make informed decisions, one has to be able to anticipate and understand the future consequences of different options. It is not until the early 20's that the brain completes the maturation process. By law, younger adolescents are not permitted to vote, consume alcohol, drive without a license, or be truant. Typically, good enough **parents** do not permit their **children** and adolescents to refuse to go to school or receive medical treatment. Logically then, proponents maintain that **children** should not be permitted to make a life-changing decision such as severing ties with one **parent** or their grandparents and other relatives. Rather, **[*33]** **parents** should require, not force, their **children** to work towards resolving the conflicts with the other **parent** and resuming **contact,** unless there is a determination that such **contact** is not in the child's best interests. [n25]

Another important consideration is the efficacy of treatment with severe cases. Qualitative case studies and experienced clinicians supporting recommendations and orders to reverse custody maintain that therapy, as the primary intervention, simply does not work in severe and even in some moderate alienation cases (Clawar & Rivlin, 1991; Dunne & Hedrick, 1994; Kopetski, 1998a, 1998b, 2006; Lampel, 1996; Lowenstein, 2006; Lund, 1995; Gardner, 2001a; Rand, 1997b; Rand, Rand, & Kopetski, 2005). [n26] This is not unexpected given that by definition, severe cases involve significant **parent** psychopathology and character disorders, which may include paranoia, severe mental illness, disordered thinking, lack of insight capacity and sociopathy. Moreover, therapy may even make matters worse (Rand, 1997b) to the extent that the alienated child and favored **parent** choose to dig in their heels and prove their point, thereby further entrenching their distorted views (Fidler, Bala, Birnbaum, & Kavassalis, 2008).

In severe cases, where a child refuses **contact** with a **parent,** a program such as Family Bridges: A Workshop for Troubled and Alienated **Parent**-Child Relationships may assist the family to adjust to transition and court order (Rand & Warshak, 2008; Warshak, 2010b). This program was developed in the early 1990s by psychologist Dr. Randy Rand in the context of child abduction, and then later expanded for cases of severe alienation by Drs. Richard Warshak and Deidre Rand. Family Bridges provides psycho-education, not therapy and is facilitated by two professionals who work initially with the **children** and the rejected **parent;** followed by the favored **parent** should he or she agree to participate in a subsequent workshop or aftercare treatment. See Richard Warshak's article in this issue for a comprehensive description of Family Bridges and the results of preliminary outcome research.

In other cases, transfer to a transitional site may be indicated before the rejected **parent** and child are united for further intervention (Gardner, 1998c, 2001b; Gottlieb, 2006; Johnston & Goldman, 2010). The child is separated from both **parents** for a short time before reintegrating with the rejected **parent.** Sites vary in degree of structure and control required, ranging from placement with a friend or relative to a treatment center, hospital or foster home. Once the child is successfully reunited with the rejected **parent,** a gradual reintroduction of the alienating **parent,** sometimes temporarily supervised, is carefully monitored to ensure that the alienation does not resume.

Research on Enforced Parenting Time and Custody Reversal

To date, there has been little well-controlled research on outcomes, either positive or negative, of ordering parenting time or reversing custody in alienation cases. It is important to recognize that this lack of research on the effect of these interventions to remedy alienation exist in a context of a growing body of research about the long-term harmful effects of alienating parental conduct on **children** (e.g., Baker), but only very limited research on effects (or outcomes) of judicial decision-making related to court interventions in custody and access in general. Still, there is actually more literature and research (in this issue and elsewhere) on the effects of custody reversal than on other interventions that are typically recommended or ordered, such as **parent** education programs, family-focussed or reunification therapy, parenting coordination, supervised visitation, a finding of contempt of court, or a judicial decision not to deal with alienation because of a concern about the trauma of a change in custody or the limitations of the rejected **parent.**

[*34] Experienced clinicians and those reporting on their qualitative research using case studies have reported on the benefits of changing custody or enforced parenting time in severe alienation cases (Clawar & Rivlin, 1991; Dunne & Hedrick, 1994; Gardner, 2001a; Lampel, 1996; Rand, Rand, & Kopetski, 2005; Warshak, 2010b). For example, Clawar and Rivlin (1991) reported an improvement in 90 percent of cases in **children's** relationships with rejected **parents** and in other areas of their functioning in 400 cases where an increase in the child's **contact with the parent** was court ordered, half of these orders over the objection of the **children.** They further reported that **children** interviewed after the imposed parenting time expressed relief, saying they could not have reestablished the relationship on their own, indicating the need to be able to save face and lay blame for seeing the **parent** on someone else. In another study, Lampel (1996) reported improvement in 18 cases where there was a change in custody. In a case analysis of 26 cases, 16 of these meeting Gardner's criteria for severe PAS, Dunne and Hedrick (1994) reported that alienation was

eliminated in four of the 26 **children,** for three of whom the court ordered a custody reversal and restricted **contact** with the alienating **parent.** In the remaining 22 cases, where there was no change in custody, improvements were not forthcoming with therapy alone.

Gardner (2001b) conducted a qualitative follow-up of 99 **children** from 52 families he had previously diagnosed with PAS. He concluded:

> The court chose to either restrict the **children's** access to the alienator or change custody in 22 of the **children.** There was a significant reduction or even elimination of PAS symptomatology in all 22 of these cases. This represents a 100 percent success rate. The court chose not to transfer custody or reduce access to the alienator in 77 cases. In these cases there was an increase in PAS symptomatology in 70 (90.9 percent). In only 7 cases (9.1 percent) of the nontransferred was there spontaneous improvement. Custodial change and/or reduction of the alienator's access to the **children** was found to be associated with a reduction in PAS symptomatology (§ 2(df=1)=68.28, $p < .001$) (Gardner 2001b, p. 39).

He reported a spontaneous reconciliation in four cases and no reduction in PAS symptoms in the seven **children** (nine percent) for whom **contact** with the rejected **parent** was not increased. However, in all of the 22 instances in which custody was changed or the alienating **parent's contact** was restricted, PAS was eliminated or reduced. Limitations to Gardner's follow-up include that the same individual who formulated the hypotheses and diagnoses (Gardner) also conducted the follow-up interviews, and only the rejected **parents** and not either the **children** or the alienating **parents** were interviewed.

Rand, Rand, and Kopetski (2005) reported similar findings in their follow-up study of the 45 **children** from 25 families Kopetski had studied over 20 years starting in 1976. A range of moderate to severe PAS characterized these cases. Alienation was interrupted by judicial action for 20 **children** from 12 families where there was enforced visitation or a change of custody. For those in the treatment group where there were orders for therapy and gradually increased access, alienation remained uninterrupted and in some cases became worse. Those in the first group maintained better relationships with both **parents** unless the alienating **parent** was too disturbed. This group included those who experienced both enforced **contact** and custody reversal, and consequently, it remains unclear the extent to which each of these factors was successful in alleviating the alienation. The authors note that these follow-up results are consistent with other previously mentioned studies reporting on various interventions. They conclude that an assessor's recommendations and subsequent court decisions can make a difference between interrupted and completed alienation in more severe cases.

[*35] Proponents and opponents of custody reversal agree that it is preferable for **children** to have good relationships with both **parents.** In addition, they agree that it is preferable to implement interventions such as education, coaching, counseling, and court monitoring early to prevent the escalation of **parent**-child **contact** problems and the need for custody reversal. Further, with few exceptions, commentators agree that in the severest of cases, which may present as such at the outset or later after various efforts to intervene have failed, custody reversal may be the least detrimental alternative for the child.

RECOMMENDATIONS FOR PRACTICE AND POLICY

Although a detailed discussion of the practice and policy prescriptions relating to alienation cases is beyond the scope of this paper, here we sketch ideas and directions that merit support.

(1) *Prevention.* Psycho-educational programs are helpful before people decide to have **children** together and when raising **children,** and are especially valuable if they find themselves having relationship difficulties or are in the very early stages of separation. These programs can assist **parents** to develop effective communication, problem solving and conflict resolution skills, and effective parenting and co-parenting, including learning about the importance for their **children** of maintaining positive relationships with both **parents** and about the harm of alienation. Programs explaining the various methods of non-adversarial dispute resolution and the negative effects of parental hostility and litigation are imperative. While such programs may not prevent the most severe cases of alienation from occurring, they have positive value for many **parents and children.**

More general and divorce-specific psycho-educational programs for **children** in schools relating to communication and conflict resolution are also needed. [n27] With prevention in mind, Andre and Baker (2009) have developed the *I Don't Want to Choose* book and workbook, part of a newly developed school-based curriculum for groups of middle school **children whose parents** are separated or divorced, that are designed to teach **children** to resist pressure to choose between their **parents.** [n28]

(2) *Education and standards for professionals.* Mental health professionals, lawyers and judges in the family justice system require initial and then continuing education and training in the specialized areas of high conflict cases (including the systemic problems related to "negative advocates," family relationships, domestic violence and alienation) (Fidler, Bala, Birnbaum, & Kavassalis, 2008; Martinson, 2010). In some cases, lawyers and mental health

professionals become inappropriately enmeshed with their clients, ultimately doing the **children** and the clients a disservice; education and training can help to deal with this. Cross-disciplinary training and collaboration are imperative (Beck, Holtzworth-Munroe, D'Onofrio, Fee, & Hill, 2009). Further development of best practice guidelines specifically for the various roles [n29] and services connected with high conflict cases (e.g., mediation, consultation, coaching, education, assessments, **parent**-child **contact** problem family therapy, reintegration therapy or therapeutic access, parenting coordination, expert testimony, etc.) will be helpful.

(3) *Early identification, screening, triage, and expedited process.* While there is debate on some important issues regarding responses to **children resisting** or **[*36]** refusing **contact** with one **parent,** there is near unanimous agreement amongst experienced legal and mental health practitioners that there is a need for early identification and screening of high conflict cases, including recognition and responses to intimate partner violence. Effective early identification of high conflict cases will be assisted by the development of validated instruments (Birnbaum & Saini, 2007). In cases where there are alienation allegations, early assessment by a court appointed mental health professional with specialized knowledge is highly desirable; alienation generally becomes more difficult to address with the passage of time, as **children and parents** are more likely to become entrenched in their positions, further exacerbated by the litigation over parenting and financial matters. Later, ineffective interventions are not only a waste of resources, but can result in escalating polarization (Schepard, 2004).

If **parents** are able to agree that there are problems with a child's relationship with one **parent** and that it is indeed in the child's best interests to have **contact** with both **parents,** the parties themselves may consider moving immediately to counseling, accompanied by a detailed contract agreement or consent order, with a view to repairing the family relationships. A voluntary response is almost always best for all involved and most likely to be effective; the fact that the parties agree to take some action is itself an important predictor of positive outcomes. If therapy is undertaken, a clinical assessment for the purposes of the therapy is needed, as in any therapy case, during which a treatment/intervention plan should be developed. If the **parents** do not accept the plan, they are free to return to court. The therapist may choose to recommend a court-ordered comprehensive assessment if appropriate and mandatory reporting of abuse would be required thereby addressing cases suspected to involve pure or even primarily realistic estrangement at the outset.

If a court ordered assessment or evaluation is required by a court appointed assessor, the assessment (Bala, Fidler, Goldberg, & Houston, 2007) and settlement process and trial (Martinson, 2010), if necessary, should be expedited. We recommend that assessments in these cases should be completed as quickly as possible and in no more than six to eight weeks. Assessors should be canvassed in advance as to their expected completion date. In addition, consideration needs to be given to how, when, and where to best disseminate the evaluation findings or report to the **parents** to prevent misuse, including the ill-advised and premature involvement of the **children** leading to an exacerbation of the alienation and what can become the child's phobic reaction to the recommendations for therapy or custody reversal, with or without an intervention to assist with this transition, as the case may require. Initially, and before it is clear if there is going to be a settlement on the basis of the recommendations, it may be best for evaluation reports to be shared with the **parents** under the supervision of the court and their lawyers, with the evaluator providing guidance in understanding the report and recommendations as well as how to discuss these with the **children. The parents** should be required by the court not to share the report or its contents with the **children** until a time when it is appropriate to do so and even then, the conditions for doing this need to be clarified (Trussler, 2008).

Delays and ineffective intervention are likely to entrench the alienation, making it more difficult to remedy. Sometimes, the attempted solution becomes the problem. Those determining the intervention should carefully consider any previous **[*37]** efforts that were unsuccessful so that similar approaches are not repeated, thereby reinforcing the alienation and the child's negative reaction to the failed efforts.

(4) *Detailed and unambiguous parenting plan orders.* A detailed parenting plan and treatment order, where relevant, including but not limited to parenting time arrangements need to accompany any clinical interventions. In high conflict cases, detailed and comprehensive parenting plans, including all aspects of parenting arrangements (parenting time, location and manner of transitions, decision making, parental communication and sharing of information, and so on), will assist towards disengagement and parallel co-parenting, thereby protecting **children** from the damaging effects of unremitting parental conflict (Birnbaum, Fidler, & Kavassalis, 2008, Chapter 6).

(5) *Early and vigilant case management by one judge.* The best resolution of mild and moderate alienation cases is often through judicial exhortation and encouragement towards counseling and settlement. This requires early identification of high conflict cases and judicial case management at the pre-resolution, resolution and enforcement stages (Martinson, 2010). Litigating **parents** need to know from the start that there will be accountability for their behavior and that there will be clear consequences for failing to comply with court orders or for undermining the child's relationship with the other **parent;** this requires judicial case management. In some cases when court monitored counseling is ordered or recommended, the judge may also need to include a warning that if there is noncompliance, the court may consider specific sanctions or a custody reversal.

(6) *Effective enforcement of all court orders.* Recognizing that many alienating **parents** have personality disorders or

have exhibited characteristics consistent with these disorders, the judiciary must follow through on their orders with appropriate responses to failure to comply (Bala, Hunt, & McCarney, 2010; Epstein, 2007; Kelly, 2010; Martinson, 2010). Not doing so only reinforces the **parent's** narcissism and disregard for authority and rules, characteristics also frequently observed in alienated **children.** In more severe, intractable cases, there may need to be a change in custody and temporary suspension of, or supervised **contact** with, the alienating **parent.**

(7) *Improving professional collaboration.* The need for collaboration is clear. Legal and mental health professionals need to remain truly open-minded to each other's ideas and especially those that are inconsistent with their own. Think tanks or discussions within an atmosphere of mutual respect and space to disagree without rebuke are needed. This improved collaboration is imperative if the needs of **children** are to be properly identified and addressed. Given the systemic nature of this problem, the efforts and models used by mental health professionals cannot stand in isolation from those used by the legal and judicial system (Beck, Holtzworth-Munroe, D'Onofrio, Fee, & Hill, 2009). Improved interventions require both better collaboration in the research and the development of interdisciplinary professional standards of practice and local task forces to coordinate service provision. [n30]

(8) *Judicial control after a trial.* In some cases, judicial control must continue after a trial, by having the trial judge remain seized with a case and review previous orders. A change in custody may occur with or without therapy or another type of intervention. When these do occur, progress reports are needed to assist the court.

[*38] (9) *Further development of clinical and educational programs and interventions.* Notwithstanding the more recent media attention, alienation is not a new phenomenon and professionals have been struggling with these difficult cases for decades. In recognizing what has not worked and where there is a need for further research, we have gained significantly in knowledge over the past years. Recently, there has been a renewed interest in alienation in legal and mental health writings and presentations at professional conferences. Further development of treatment models and strategies are necessary, these containing efficacy evaluation research.

(10) *Better access to services.* Resources are limited. A small percent of the divorcing population uses a disproportionate amount of court-connected resources. While some families may benefit from multiple services and professionals, often too many are involved and working, albeit unintentionally, at cross purposes. We need to consider a triaged, as opposed to tiered, approach [n31] in an effort to prevent waste and coordinate and expedite positive resolutions for these complex and varied high-conflict families (Salem, 2009), including those where **parent**-child **contact** problems, irrespective of sole or primary cause, are present. Services are expensive and not available in many areas. Efforts need to hone the best service for the particular family and to make these readily and equally available to all families in need.

(11) *More and better research.* Well-designed, methodologically sound research into the efficacy of all of the different legal, educational, and clinical responses to mild, moderate and severe alienation is needed to know these remedies and interventions "do no harm," but also to be confident that they have positive effects. Given the complexity of the causes and dynamics of resistance to **parent contact,** conducting such research poses significant fiscal, practical and ethical challenges. [n32] Family life and high-conflict families in particular are complex; the dynamic interplay of many factors will impact our understanding of what works and what does not work. Large samples are needed to capture the complexity of these situations, but such numbers are not typically available. Results from any one study need replication. Without a large sample, longitudinal designs and random assignment, we can never be certain that the effects are due to the intervention and not due to some other factors. Ethical, not only fiscal, realities prohibit these approaches, especially more recently given the economic times. Further, we are in a catch-22 to the extent that **children** and families need to participate in these options for us to study their relative efficacy. Cross-sectional retrospective studies, qualitative research, and case analyses are more realistic to expect; these studies can be informative and instructive, especially when similarities are found across them. At best, data from these studies need to be treated as preliminary and upon which to develop hypotheses for further research and for our work with individual families.

While research is vitally important, legal and mental health practitioners cannot wait for science to catch up to their ongoing cases, as recommendations and decisions need to be made pending the outcome of good research. For example, it is already clear that therapy and education, at least the methods and programs currently available, are ineffective for the severe cases of alienation. In addition, there is good research available on the impact of separation, high conflict, and intimate partner violence on **children** and adolescents and on related matters that can inform our work in alienation cases.

> **[*39]** Further, even when more and better designed research is available, decisions for any individual child and family cannot be based on aggregate data. Consequently, using the research available and our experience as legal and mental health practitioners, a careful investigation and risk-benefit analysis of each case is required, as would be the case even if good research were available. Once a case is before the courts, not intervening and leaving the child alienated and in the care of a disturbed **parent**--that is a decision to take no action--is also a decision that needs to be researched and justified. In some more severe cases, the best interests of the child require very

significant interventions like custody reversal, Family Bridges or Overcoming Barriers Family Camp.

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Legal Topics:

For related research and practice materials, see the following legal topics:
Criminal Law & ProcedureCriminal OffensesCrimes Against PersonsDomestic OffensesChildrenElementsCriminal Law & ProcedureTrialsExamination of WitnessesChild WitnessesFamily LawFamily Protection & WelfareGeneral Overview

FOOTNOTES:

n1 *See, e.g.*, Sarah Hampson, *Courts Can Rescue Kids From an Alienating* ***Parent,*** THE GLOBE AND MAIL, Jan. 29, 2009.

n2 *See, e.g.*, Barbara Kay, *Brainwashing the Kids to Spite the Ex*, NATIONAL POST, Jan. 30, 2009; Kathryn Blaze Carlson, *Custody Judges Rule on Vengeance: Courts Criticized for Recognizing "Parental Alienation,"* NATIONAL POST, Mar. 28, 2009.

n3 *See, e.g.*, Kirk Makin, *Gender Bias Evident in Alienation Case*, THE GLOBE AND MAIL, March 28, 2009, reporting on a study by Toronto lawyer Gene Colman, presented at the Canadian Symposium For Parental Alienation Syndrome Mar. 27-29, 2009, Toronto.

n4 Carol Bruch, *Parental Alienation Syndrome and Parental Alienation: Getting It Wrong in Child Custody* Cases (2001), 35 FAM. L.Q. 527; Jennifer Hoult, *The Evidentiary Admissibility of Parental Alienation Syndrome: Science, Law, and Policy* (2006), 26 CHILD RTS. L.J. 1; Joan Meier, *A Historical Perspective on Parental Alienation Syndrome and Parental Alienation* (July-December 2009), 6 J. CHILD CUSTODY. 232.

n5 See Gardner (2002a) for further elaboration.

n6 The term "irrational" alienation has been used more recently to replace the use of "pathological" (Fidler, Bala, Birnbaum & Kavassalis, 2008; Warshak, 2010a). Concerns have been expressed by contributors in this issue about including "irrational" in the term describing alienation. While by definition "irrational" means "illogical" or "unreasonable" and thus define what is meant by alienation as it is differentiated from realistic estrangement, we have chosen not to include "irrational" in a label and instead refer to "child alienation" or "alienation" as defined in this article.

n7 See Gardner's commentary (2004) and Johnston and Kelly's rejoinder (2004).

n8 Separated high conflict **parents** often have no direct **contact** with each other and rely on second hand information, including from their child, to form opinions about each other. See Campbell (2005) for further elaboration on the role of ambiguity and attribution theory in the development of anxiety and negative stereotypes that are highly resistant to change.

n9 See Fidler, Bala, Birnbaum, and Kavassalis (2008) for an extensive list of behaviors exhibited by the alienated child, alienating **parent** and the rejected **parent** (Table 15, pp249-252).

n10 See table referred to in footnote 9 for an extensive list of behaviors exhibited by the alienating **parent** (Table 15, pp249-252).

n11 See article by Baker and Andre (2008), "Beyond the High Road: Responding to 17 Parental Alienation Strategies without Compromising Your Morals or Harming Your Child" for an excellent guide for rejected **parents.**

n12 Reporting to the court was limited to whether or not the family attended the counselling.

n13 This is a common methodology in conducting qualitative research (see, e.g., articles by Friedlander and Walters and Warshak in this issue).

n14 Warshak (2010b) identifies this as Option 4 and provides a thorough discussion of the advantages and disadvantages. See Jaffe, Ashbourne, and Mamo (2010) and Johnston and Goldman (2010) for further discussion of the option in certain circumstances, including those related to alienation and realistic estrangement.

n15 See Friedlander and Walters (2010) for further elaboration of these various dynamics.

n16 Severe realistic estrangement may require the child to initially receive treatment for post-traumatic stress, potentially followed by family counseling, including reintegration therapy or supervised or therapeutic access, where appropriate, while severe alienation due to a disproportionate or unjustified reaction on the part of the child may require a custody reversal with or without an approach like Family Bridges: A Workshop for Troubled and Alienated **Parent**-Child Relationships (Warshak, 2010b), summarized further on.

n17 In addition, techniques and strategies for working with each child, the rejected **parent** and the favored **parent,** as well as those for working with the family as a whole or in dyads and triads are beyond the scope of the paper. (See, e.g., Baker & Fine, 2008; Carey, Sullivan, & Ward, 2007; Carter, Haave, & Vandersteen, 2006, 2008, 2009; Coates et al., 2004; De Vries & Niemi, 2007; Sullivan, Ward, & Deutsch, 2010; Deutsch, Sullivan, Ward, Carey, & Blane, 2009; Drozd & Olesen, 2009; Eddy, 2009; Everett, 2006; Fidler, Chodos, Nelson, & Vanbetlehem, 2009; Freeman, Abel, Cowper-Smith, & Stein, 2004; Gardner, 1999, 2001c; Johnston, 2005a, 2005b; Johnston, Roseby, & Kuehnle, 2009; Johnston, Walters, & Friedlander, 2001; Sullivan & Kelly, 2001; Ward & Harvey, 1993).

n18 The Multi-Modal Family Intervention (MMI) originally developed in 2001 by Johnston, Walters and Friedlander and expanded in this issue by Friedlander and Walters is a family-focused intervention based on systemic theory and includes individual psychotherapy, family therapy, case management and education, and coaching all under the umbrella of the family court.

n19 For further elaboration, see Table 16, p261 for a checklist of components recommended for inclusion in orders and contracts for therapeutic intervention. A revised sample *Family Treatment and Intervention Agreement* used when there are **parent**-child **contact** problems may be obtained from the first author.

n20 The program involves six weeks of individual and confidential **parent** counseling, following by a further six weeks of non-confidential, **parent**-child counseling. Using a **Parent** Workbook, the individual **parent** counseling sessions focus on learning and strengthening three key skills, namely, flexible thinking, managed emotions and moderate behaviors. During the **Parent**-Child Counseling, each **parent** meets with the child three times and teaches the child the three skills that the **parent** learned during the individual **parent** sessions, also relying on a workbook to guide them through the process. The expectation is that after the counseling, some families will be able to resolve their parenting arrangements on their own or through some form of alternative dispute resolution. If not, the **parents** may return to court and the **parent**-child counselor will provide a report to the court on the **parent**-child sessions. For further information and materials visit www.highconflictinstitute.com or **contact** newways@highconflictinstitute.com.

n21 Note that any report from a therapist will tend to be descriptive and observational in nature about the process, the behaviors of the participants and the progress of therapy, and *not* provide recommendations for parenting time or legal custody given that a comprehensive custody evaluation was not completed.

n22 Depending on the degree of the child's reaction and alienation, individual sessions may help the child prepare for eventual sessions with a rejected **parent.** For example, the court order may require that the child attend three individual sessions, followed by three months of therapeutic access coupled with individual or **parent**-child sessions with the aligned **parent.** Subsequently, the therapist's office may be used as a transitional site where the therapist meets with both **parents** and the child in various combinations, before and after the child's **contact** with the rejected **parent.** Sometimes someone other than the aligned **parent** may be designated to bring the child to the therapist's office. Next, sessions may occur before and after the parenting time, but not necessarily on the same day, still permitting the therapist to monitor and assess the family's progress and provide expedient intervention where required. Considerable advance planning and logistics are required to implement this model. The ultimate goal would be for the detailed, court-ordered parenting time to occur without the need for the therapist's involvement.

n23 To support her claim, Bruch cites a newspaper report and telephone conversation with Judith Wallerstein on her follow-up of 25 young adults (Wallerstein, Lewis, & Blakeslee, 2000). Also, see Warshak (2003a, endnote 29 in 2010b) for a citation to Wallerstein's work that supports an alternative position.

n24 See article in this issue for further elaboration of the ethical issues related to all approaches used in alienation cases, ranging from mild to severe.

n25 See *S.V. v. C.T.I.,* [2009] O.J. No. 816, per Reilly J. where the judge makes the important distinction between a **parent** "forcing" and "requiring" certain behavior from a child, including such conduct as attending school and visiting with a non-custodial **parent.**

n26 See next section for a summary of the research to date.

n27 See Pollet (2009) for survey of programs for **parents and children** in the United States and a discussion of the related research and issues. For programs in Canada, see paper prepared by Pauline O'Connor for the Department of Justice, *Voice and Support: Programs for **Children** Experiencing Parental Separation and Divorce,* available at www.justice.ga.ca.

n28 The 17+ week activity-based program promotes discussion of common family situations (e.g., one **parent** looking sad, hurt, or angry when a child departs for parenting time with the other **parent,** one **parent** confiding in the child or denigrating the other **parent,** and so on) and accompanying problem solving approaches to loyalty conflicts, specifically, critical thinking, considering options, listening to one's hear, and getting support from within and from others.

n29 For example, in June 2008, AFCC convened a multidisciplinary task force to provide best practice guidelines the role of court-involved therapy (AFCC Newsletter, Spring 2009).

n30 See the July 2009 *Family Court Review,* Volume 47(3) for several articles which discuss models for multidisciplinary training and collaboration.

n31 A triaged approach involves a screening and identification process that is then linked to a particular intervention, such as education, therapy, mediation or assessment, while a tiered approach tends to start with the least intrusive intervention, which in the case of failure, will then be augmented with another intervention, such as assessment followed by mediation.

n32 See the article by Kelly and Ramsey (2009) and the reply by Austin (2009) both in *Family Court Review* for an important discussion of these issues with respect to custody evaluations. Much of the same can be said for research applied to the problem of and remedies for alienation.

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Evidence-Informed Interventions for Court-Involved Families: Promoting Healthy Coping and Development

Lyn R. Greenberg, Ph.D., ABPP
Forensic and Clinical Psychology
Board Certified, Couple and Family Psychology
11340 W. Olympic Blvd., Suite 265
Los Angeles, CA 90064
Tel: (310) 399-3684
Fax: (310) 988-2706
lyn@lyngreenbergphd.com
www.lyngreenbergphd.com

Barbara J. Fidler, Ph.D., C.Psych., Acc.FM
Family Solutions
1709 Bathurst Street
Toronto, ON M5P 3K2
Tel: (416) 481-2046
Fax: (416) 481-5957
Email: drbarbarafidler@sympatico.ca

Michael A. Saini, Ph.D., M.S.W., R.S.W.
Factor-Inwentash Faculty of Social Work, University of Toronto
246 Bloor Street West
Toronto, ON, M5S 1A1
Tel: 416-946-50277 Fax: 905-836-9455
Email: michael.saini@utoronto.ca

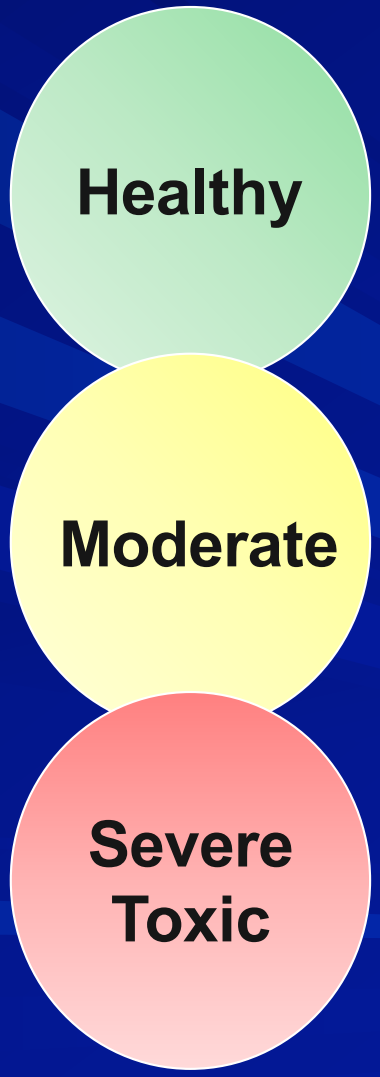
Evidence-Informed Interventions for Court-Involved Families: Promoting Healthy Coping and Development

Table of Contents

Part C – Special Issues in Intervention with Children and Families

Chapter 16: Concluding Thoughts and Future Directions
Confirmed authors: Lyn R. Greenberg, Ph.D., ABPP, Barbara J. Fidler, Ph.D., C.Psych., Acc.FM, Michael Saini, Ph.D., M.S.W., R.S.W., Hon. Robert Schnider (Ret.), Ashley-Lauren Reyes, M.A.

Levels of Stress, Potential Outcomes



Avoidance
Regression

Mastery

Unhealthy Stress
Responses

Support
Resolution
Resilience

Long-term dysfunction
Risks to physical and
mental health

Interventions,
Treatment, Recovery,
Resilience

Inspired by Drozd and Saini, 2018

National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices

The fact sheets linked from this page offer descriptive summaries of some of the clinical treatments, mental health interventions, and other trauma-informed service approaches that the National Child Traumatic Stress Network (NCTSN) and its various centers have developed and/or implemented as a means of promoting the Network's mission of raising the standard of care for traumatized youth and families.

This list does not present a comprehensive list of all relevant interventions developed and available for treating child traumatic stress. Nor do the fact sheets themselves offer a rigorous review of the evidence supporting each intervention. The NCTSN does not intend for this website to serve as a public notice or advertising space for interventions that its sites are not implementing.

Individuals who wish to know the evidence supporting an intervention may search online databases such as the National Registry of Evidence-Based Programs and Practices (NREPP) and the California Evidence-Based Clearinghouse for Child Welfare (CEBC). These websites offer a rigorous review of interventions—and the evidence supporting them—for a variety of child and adolescent mental health problems. Those searching for an intervention to best match the needs of the populations they serve are encouraged to consider other interventions than those summarized here.

ORDER Order NCTSN documents and other products where you see this icon—and have them delivered anywhere in the United States.

Page Contents:

How the Fact Sheets Were Developed

These fact sheets were developed as part of the NCTSN Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project, a joint venture undertaken by the NCTSN and the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. The aim of this project was to summarize various types of clinical and research evidence pertaining to trauma-informed interventions, especially as these interventions relate to diverse cultural groups (as defined by such factors as race, ethnicity, sexual orientation, socioeconomic status, spirituality, disability, and geography).

Produced in close consultation with the developer of each treatment or service approach and replacing a set of fact sheets developed by the NCTSN in 2005, these documents include more up-to-date information and more culturally-relevant features. The fact sheets not updated for the NCTSN Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project remain in their original form.

Back to Top

How to Use the Fact Sheets

In recognition of the diverse needs of the child and adolescent populations served by NCTSN sites across the country, the interventions and treatments listed below span a continuum of evidence-based and evidence-supported interventions ranging from rigorously evaluated interventions to promising practices and newly-emerging practices. Readers are encouraged to review and consider these practices from a variety of perspectives including the following:

1. Consider not only the levels and types of evidence that support the use of the intervention in general, but also its appropriateness for a given community and target population. For example, does it address the types of trauma and losses that are prevalent within that population? Does it address their typical consequences, such as mental distress, functional impairment, risky behavior, or developmental disruption?
2. More generally, the needs, values, available resources, demographic characteristics, and informed preferences of a provider's service population also influence the type of intervention needed. Factors to consider include these:
   - Local culture and values of the clientele and the surrounding community
   - Developmental factors, including age, cognitive, and social domains
   - Socioeconomic factors
   - Logistical and other barriers to help-seeking
   - Availability of individual/family/community strength-based resources that can be therapeutically leveraged
   - Setting in which services are offered (school, residential, clinic, home)
3. Also consider such factors as training requirements, feasibility of adoption and implementation, and potential for sustainability. Readers should gather additional information on adoption readiness through discussions with the treatment developers and other sites that have implemented the practices.
4. The NCTSN has developed a position statement on Prerequisite Clinical Competencies for Implementing Effective, Trauma-informed Intervention—that agency leaders, clinicians, trainers, and others can use to guide optimal service provision to children and families affected by trauma—delineating the clinical knowledge and skills recommended prior to training in or implementing an evidence-based treatment (EBT) both within and outside of the NCTSN. A variety of NCTSN tools may be available to help build these foundational competencies, including the Core

Curriculum on Childhood Trauma.

5. Many existing trauma-focused interventions overlap in their content and approaches. These areas of overlap are termed core components. Core components can be conceptualized as intervention objectives (what the therapist intends to achieve by intervening) or practice elements (actions the therapist undertakes toward achieving the intervention objective). Providers should consider: (1) Whether a given intervention targets or includes the desired intervention objectives (outcomes valued by the clients), and (2) whether the practice elements used in the intervention can be realistically implemented by the therapist (e.g., specific skills-acquisition activities, homework, role-play, games). Taken together, agencies/clinicians should evaluate both intervention objectives and practice elements in terms of their "fit" with the specific needs and preferences of the population the agency serves.):

Back to Top

Core Components of Interventions

- Motivational interviewing (to engage clients)
- Risk screening (to identify high-risk clients)
- Triage to different levels and types of intervention (to match clients to the interventions that will most likely benefit them/they need)
- Systematic assessment, case conceptualization, and treatment planning (to tailor intervention to the needs, strengths, circumstances, and wishes of individual clients)
- Engagement/addressing barriers to service-seeking (to ensure clients receive an adequate dosage of treatment in order to make sufficient therapeutic gains)
- Psychoeducation about trauma reminders and loss reminders (to strengthen coping skills)
- Psychoeducation about posttraumatic stress reactions and grief reactions (to strengthen coping skills)
- Teaching emotional regulation skills (to strengthen coping skills)
- Maintaining adaptive routines (to promote positive adjustment at home and at school)
- Parenting skills and behavior management (to improve parent-child relationships and to improve child behavior)
- Constructing a trauma narrative (to reduce posttraumatic stress reactions)
- Teaching safety skills (to promote safety)
- Advocacy on behalf of the client (to improve client support and functioning at school, in the juvenile justice system, and so forth)
- Teaching relapse prevention skills (to maintain treatment gains over time)
- Monitor client progress/response during treatment (to detect and correct insufficient therapeutic gains in timely ways)
- Evaluate treatment effectiveness (to ensure that treatment produces changes that matter to clients and other stakeholders, such as the court system)

In contrast, interventions that do not include needed core components may be inappropriate for the population or may require substantial adaptation.

Back to Top

Intervention Descriptions

Click on each intervention fact sheet, culture specific sheet or training guideline to download detailed information on the intervention as well as where to obtain additional information. Interventions are listed in alphabetical order.

Name of Intervention	Targeted Populations	Modality	Culture-Specific Fact Sheet	Training Guidelines
Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP) (2012) (PDF)	8-21; both males and females; for youth experiencing a wide range of traumas	individual	Yes	--
Alternatives for Families - A Cognitive Behavioral Therapy (AF-CBT) (2012) (PDF)	School-age children; for youth experiencing a wide range of traumas	individual, family	Yes	--
Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP) (2012) (PDF)	0-18; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes	Yes
Attachment and Biobehavioral Catch-up (ABC) (2012) (PDF)	Birth – 24 months; both males and females; for low-income families who have experienced neglect, abuse, domestic violence, placement instability	individual, family	No	Yes
Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth (2012) (PDF)	2-21; both males and females; for children, caregivers, and systems that have experienced a wide range of traumas	individual, family, systems	Yes	Yes
An Elementary School Intervention for Childhood Trauma (Bounce Back) (2017) (PDF)	5-11;both males and females; for use in schools for youth experiencing a wide range of traumas	individual, group, family	No	--

Child Adult Relationship Enhancement (CARE) (2008) (PDF)	Children of all ages and their caregivers; both males and females	family, systems	Yes	--
Child and Family Traumatic Stress Intervention (CFTSI) (2012) (PDF)	7-18; both males and females; for parents and children who may have complex trauma histories	individual, family, systems	No	--
Child Development-Community Policing Program (2007) (PDF)	0-18+; both males and females; for children and families in the aftermath of crime and violence.	individual, family, systems	No	--
Child-Parent Psychotherapy (CPP) (2012) (PDF)	0-6; both males and females; for youth who have experienced a wide range of traumas and parents with chronic trauma	individual, family, systems	Yes	--
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (2012) (PDF)	10-15; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes	Yes
Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT) (2015) (PDF)	4-17; both male and female; for families with a history of physical abuse and inappropriate physical discipline/coercive parenting strategies	individual, group, family	Yes	--
COPE - Community Outreach Program - Esperanza (2007) (PDF)	4-18; both males and females; for traumatized children who are presenting with behavior or social-emotional problems	individual, family	No	--
Culturally Modified Trauma-Focused Treatment (CM-TFT) (2008) (PDF)	4-18; both males and females; Latino/Hispanic; for youth who have experienced a wide range of traumas	individual, family	Yes	--
Early Pathways (EP) (2017) (PDF)	Child abuse and neglect, sexual abuse, intimate partner abuse, community violence, multiple and prolonged traumatic events, and complex trauma	family	No	--
Family Advocate Program (2005) (PDF)	18-70; both males and females; for youth who present with anxiety, depression, PTSD symptoms, and/or traumatic loss	family	No	--
Forensically-Sensitive Therapy (2005) (PDF)	4-17; predominantly female; for youth presenting problems ranging from anxiety and depression to risk-taking behaviors and functional impairment. Program is designed for a mental health clinic.	individual, family	No	--
Group Treatment for Children Affected by Domestic Violence (2007) (PDF)	5-no upper limit; both males and females; for children and their nonoffending parents who have been exposed to DV	group, family, systems	No	--
Honoring Children, Making Relatives (2007) (PDF)	3-7; both males and females; for American Indian and Alaska Native children	individual, family	No	--
Honoring Children, Mending the Circle (2007) (PDF)	3-18; both males and females; for American Indian and Alaska Native children	individual	No	--
Honoring Children, Respectful Ways (2007) (PDF)	3-12; both males and females; for American Indian and Alaska Native children	individual	No	--
Integrative Treatment of Complex Trauma for	2-21; both males and females; for Hispanic-American, African-	individual, family, systems	Yes	Yes

Adolescents (ITCT-A) (2008) (PDF)	American, Caucasian, Asian-American; for youth who may have complex trauma histories			
Integrative Treatment of Complex Trauma for Adolescents (ITCT-C) (2017) (PDF)	2-21; both males and females; for Hispanic-American, African-American, Caucasian, Asian-American; for youth who may have complex trauma histories	individual, family, systems	No	--
International Family Adult and Child Enhancement Services (IFACES) (2012) (PDF)	6-12; both males and females; for refugee and immigrant children who have experienced trauma as a result of war or displacement	individual	Yes	--
Let's Connect (LC) (2016) (PDF)	3-15; both males and females; for children who have experienced a wide range of traumas	individual, family	Yes	--
Parent-Child Interaction Therapy (PCIT) (2008) (PDF)	2-12; both males and females	individual, family, systems	Yes	Yes
Problematic Sexual Behavior-Cognitive-Behavioral Therapy for School-Age Children (PSB-CBT-S) (2016) (PDF)	7-12; both males and females; for children with problematic sexual behavior may or may not have a history of trauma	individual, family, systems	Yes	No
Psychological First Aid (PFA) (2012) (PDF)	0-120; both males and females; for individuals immediately following disasters, terrorism, and other emergencies	individual	Yes	--
Real Life Heroes (RLH) (2012) (PDF)	6-12, plus adolescents (13-19) with delays in social, emotional or cognitive functioning; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes	Yes
Risk Reduction through Family Therapy (RRTF) (2015) (PDF)	13-18, both males and females; for adolescents and family; primary trauma type is childhood sexual abuse/sexual assault	family	No	--
Safe Harbor Program (2007) (PDF)	6-21; both males and females; provided in schools for children and adolescents exposed to trauma and violence who may present with a range of problems and symptoms	individual, group, family, systems	No	--
Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART) (2012) (PDF)	3-11; both males and females; to date the model has been effectively used with primarily African-American children; majority of families are low income	individual, family, systems	No	Yes
Sanctuary Model (2008) (PDF)	4-no upper limit; both males and females; evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community to help people heal from trauma	systems	Yes	Yes
Skills for Psychological Recovery (SPR) (2012) (PDF)	5-120; both males and females	individual, family	Yes	--
Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST) (2005) (PDF)	12-21; for females who have experienced sexual/physical abuse and a range of additional traumas, including community violence,	individual, group	No	Yes

	domestic violence, and sexual assault			
Southeast Asian Teen Village (2005) (PDF)	adolescents; females, Southeast Asian (mostly Hmong)	group	No	--
Streetwork Project (2007) (PDF)	13-23; both males and females; harm reduction program good with a wide variety of ethnic/racial groups, religious group, and the LGBTQ community	individual, group, systems	No	--
Strengthening Family Coping Resources (SFCR) (2008) (PDF)	0-no upper limit; both males and females; for families experiencing economic hardship	family	No	Yes
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (2012) (PDF)	12-21; both males and females; for adolescents with Complex Trauma, e.g. adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault).	group	Yes	--
Support for Students Exposed to Trauma: School Support for Child hood Trauma (SSET) (2017) (PDF)	10-16; both males and females; for use in schools for youth experiencing a wide range of traumas	individual	No	--
Trauma Adapted Family Connections (TA-FC) (2012) (PDF)	0-18; both males and females; who reside in the household; families experiencing complex development trauma, at risk of neglect	individual, family, group	No	--
Trauma Affect Regulation: Guide for Education and Therapy (TARGET) (2012) (PDF)	10-18+; both males and females; for children and caregivers experiencing traumatic stress; very frequently with single parents or with families whose children have limited contact with biological parents (e.g., foster kids, residential placements), and diversity of religious affiliations	individual, group, family, systems	Yes	Yes
Trauma and Grief Component Therapy for Adolescents (TGCT-A) (2015) (PDF)	12-20; both males and females; for trauma-exposed or traumatically bereaved older children and adolescents	individual, group, family, systems	Yes	--
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (2012) (PDF)	3-21; both males and females; for children with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers	individual, family	Yes	Yes
Trauma-Focused Coping in Schools (TFC) (AKA: Multimodality Trauma Treatment Trauma-Focused Coping-MMTT) (2012) (PDF)	6-18; both males and females; for children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control	individual, group	Yes	--
Trauma-Informed Organizational Self-Assessment (2008) (PDF)	6-19; both males and females; for children who have experienced a wide range of traumas	individual,family, systems	Yes	--
Trauma Systems Therapy (TST) (2016) (PDF)	6-19; both males and females; for youth who have experienced a wide range of traumas	systems	Yes	--
Trauma Systems Therapy for	10-18; both males and	systems	Yes	--

Refugees (TST-R) (2016) (PDF)	females; newly arriving, recently resettled, and established refugee youth and communities		

Back to Top

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LYN R. GREENBERG, PH.D., ABPP
Forensic and Clinical Psychology
Board Certified, Couple and Family Psychology
11340 W. Olympic Blvd., Suite 265
Los Angeles, CA 90064
310/399-3684 * fax 310/988-2706
lyn@lyngreenbergphd.com * http://lyngreenbergphd.com/

Elements of Systematic Intervention Planning

➢ **Identifying goals (focus on developmental tasks and behaviors)**

- **Treatment goals for children**
  - What does each child need to learn/master
    - Individually?
    - In family relationships?
    - In other systems, settings, activities?
  - What behaviors will demonstrate progress?

- **Treatment goals for parents**
  - What does each parent need to master
    - To shield the child from conflict?
    - To use effective parenting skills and authority, so the child can progress developmentally
    - To support the child's independent relationships?
    - To manage daily routines and support normal activities for the child?
    - To create a safe and stable household?
    - To accurately understand the child's feelings, including expressions of distress?
    - To solve family problems effectively?
  - What behaviors will demonstrate progress?

➢ **Identifying resources required**

- What activities or services can promote the desired changes?
- Can the child participate in community or normative activities?
  - If so, what activities will best promote treatment goals?
  - If not, what interventions are required to enable the child to participate?
  - What structures are needed to shield the child from conflict during activities?
- Are psychoeducational resources available?
- How do available services fit with parents' schedules and daily stressors?

- How can the family be assisted in integrating and applying information and experiences from various settings?
- Is specialized treatment or a treatment team required?
- Is it workable to combine some specialized services with community activities/resources?

- **Underlying structure**
  - Detail in safety orders – establishing safety while promoting healthy relationships and activities
  - Reducing conflict in parenting transitions
  - Structures for children's activities and events
    - Procedures for selecting and supporting activities
    - Support for children's autonomy and parent-child relationships
    - Priorities among activities, and between activities and therapeutic interventions
    - A process to adapt procedures as needs change

- **Structuring psychological interventions**
  - Consider each element in model orders and specialized treatment models
  - Selection of therapists
    - Sufficient qualifications, at least in the coordinating therapist
    - Explain the differences to the court
    - Realistic understanding of resources, and about the choices parents make about using their resources
    - Consider combining specialized and non-specialized services, with coordination
  - Structure for coordinating therapeutic information
  - Balancing privacy and accountability
  - Clear path from the therapeutic approach to the desired change
  - Establishing accountability
    - Cooperation with treatment
    - Payment
    - Supportive transitions to and from services
    - Shielding the child from conflict
    - Use of parental authority to promote child's cooperation
    - Specific behavioral changes
  - Is a parenting coordinator needed?
    - If so – what skills or background should this person have?
    - How should the rule be structured?
    - What if the parents won't stipulate?

- **Anticipating and addressing sabotage and resistance**
  - If interventions haven't worked in the past, what has gone wrong?
  - If past interventions were inappropriately selected or poorly structured, differentiate the new intervention plan from what has been tried in the past
  - If family members have frustrated or undermined progress, how?
  - Who is likely to disagree with the recommended plan?
    - How might resistance be manifest?
    - Which parts of the recommendations will cause anxiety in the child?
  - Establish procedures with clear expectations and enough detail to prevent obvious sources of sabotage
  - If recommending a specialized provider, consider recommending that person be involved in crafting the treatment order

- **Measurement of progress and feedback mechanisms**

Attorney for Petitioner

Attorney for Respondent

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

In re the Marriage of:	)	Case No.
Petitioner:	)	STIPULATION AND ORDER FOR
	)	COUNSELING AND/OR PARENT
and	)	EDUCATION
Respondent:	)	

1. IT IS HEREBY STIPULATED by and between the parties, (insert names)_____ joined by their respective attorneys of record, to the appointment of Lyn R. Greenberg, Ph.D. (CA Lic. Psychologist, #PSY11436) to conduct counseling/psychotherapy with themselves and/or the minor child(ren) of the parties (insert names and birth dates of minor children): _____

2. OTHER PARTICIPANTS IN COUNSELING

Both parents will participate in counseling if requested by Dr. Greenberg. Dr. Greenberg may request the involvement of other household or family members as she deems appropriate. The parents acknowledge that, when a child is involved in counseling, the child is considered to be Dr. Greenberg's client/patient. Parents are adjunct/collateral participants in counseling directed toward the welfare of the child.

3. DURATION OF COUNSELING

The parties and/or minor child(ren) and/or others will participate in counseling for at least ____ months, not to exceed one year unless the parties stipulate otherwise or the court so orders. The frequency, duration and structure of sessions will be adjusted as Dr. Greenberg deems appropriate. Dr. Greenberg will determine the order of appointments and who should be present at each. As consistent with other orders in this matter, and if a child is involved in treatment then the parties agree to deviate from their usual parenting time arrangements as appropriate to allow both parties to participate in transporting the minor child to and from treatment.

4. COOPERATION WITH TREATMENT

Both parties are ordered to cooperate with Dr. Greenberg, including, but not limited to, (1) paying for services in a timely manner in accordance with the fee agreement executed by the parties with the Dr. Greenberg, (2) ensuring that the minor child(ren) are transported to and from scheduled appointments in a timely manner; and (3) exercising parental authority to require that the minor child(ren) attend(s) and cooperate(s) with treatment.

The parties have been advised that successful psychotherapy for children often requires

that parents make changes in their own behavior and parenting, to support their children's needs. Dr. Greenberg may request specific changes in such areas as setting appropriate limits for children, encouraging children to express feelings and solve problems appropriately, listening to children's concerns, actively supporting children's independent relationships, and shielding the children from parental conflict. The parties agree to make reasonable efforts to cooperate with Dr. Greenberg's requests in these areas. If either parent disagrees with requests or recommendations made by Dr. Greenberg, the parent will discuss those concerns privately with Dr. Greenberg, and will not allow the child to witness or overhear such concerns. Both parties acknowledge that they have had an opportunity to review this stipulation and Dr. Greenberg's consent agreement, and to ask any questions they may have concerning Dr. Greenberg's approach to treatment and other alternatives that may be available. The structure, frequency, duration, and participants in therapy sessions will be determined by Dr. Greenberg. Dr Greenberg will not make recommendations as to custody or parenting plans, nor determinations regarding the child's best interests, as these are outside the therapists' role. She may make recommendations to the parties regarding changes in the parent-child relationships that may be helpful to the children in implementing the Court's orders. When children are not directly involved, but therapy is conducted for the benefit of the children parents may need to consider similar behavior changes.

5. GOALS OF COUNSELING

The goals of counseling shall be following (check all boxes and describe specific issues):

[ ] Facilitate communication between the parties regarding their minor child(ren)'s needs:_____

_____

[ ] Reduce conflict regarding parenting time schedules_____

_____

_____

[ ] Improve the quality of parenting skills of (Petitioner/Respondent/both parents),

_____

_____

[ ] Address emotional/behavioral problems of child(ren)

_____

[ ] Facilitate the relationship between child(ren) and

[ ] Petitioner [ ] Respondent [ ] both parents

[ ] Conjoint/family therapy for

[ ] both parents

[ ] both parents and the child(ren)

6. CONFIDENTIALITY

Except as authorized below, Dr. Greenberg will keep confidential all information obtained in counseling except when mandated by law to report suspected child abuse and where a person appears to be a danger to him/herself or others. If a child is in treatment, Dr. Greenberg will require written authorizations from both parents to release any information not required by law or addressed in this stipulation/order. Any authorizations to release and receive information, as noted below, represent additional and full waivers of any privileges that may apply to information provided to Dr. Greenberg. References to "any applicable privilege" herein do not represent a legal determination by the therapist that a particular privilege applies in this case. Such a determination would be the province of the Court if a dispute arises. The

stipulation signed herein describes the intended conduct of the therapist with respect to these issues, all of which may be subordinate to the orders or findings of the trial court. The parties understand that the therapist is not an attorney and that he/she is required to obey the order of the court and/or to bring to the attention of the court any possible conflicts between the court's orders and professional practice standards applicable to psychologists. By signing this stipulation, both parents acknowledge that they have had an opportunity to review this stipulation with counsel. Both parents agree to attempt to resolve any disputes over sharing of information with Dr. Greenberg before taking legal action. If Dr. Greenberg is required to by subpoena or ethical obligations to participate in a legal matter, the parties agree to reimburse Dr. Greenberg for reasonable expenses including attorneys fees.

The parents also understand that, if Dr. Greenberg is permitted by waiver or required by law or court order to provide information to anyone, including counsel, a child custody evaluator and/or the Court, the information released may include information that might otherwise be considered to be protected under the Health Insurance Portability and Accountability Act (HIPAA).

Should any dispute arise as to whether a communication is privileged, Dr. Greenberg will refer the issue to the court for resolution, and will refrain from disclosing the information in dispute until directed by the Court. Dr. Greenberg will obey any order from the trial court regarding release of treatment information provided by the parents or children. The parties agree to hold Dr. Greenberg harmless regarding any release of information provided based on good-faith adherence to a waiver or Court order, and for any delay resulting from a good faith decision by Dr. Greenberg to seek direction from the Court before releasing information.

7. METADATA

The parties agree that, to the extent Dr. Greenberg is formally (e.g., pursuant to

subpoena) or informally requested/required to produce her records, Dr. Greenberg may provide records in paper form or on a flash drive. In either event, Dr. Greenberg will not be required to produce electronic copies of her books and records or provide "metadata" relating to her books and records. Dr. Greenberg's production of documents from her computer will be limited to items Dr. Greenberg can print out. The parties will not have access to Dr. Greenberg's personal devices. Dr. Greenberg will only provide records if all privilege issues have been resolved.

8. DIRECT COMMUNICATIONS TO THE COURT

If either party returns to court regarding custody or visitation issues, Dr. Greenberg:

_____ will provide no information to the court, absent additional order and waivers

_____will provide a letter to the Court describing the parties' and children's progress and cooperation in treatment. This may include specific statements and behaviors which Dr. Greenberg deems necessary to adequately support other content or statements in her letter.

_____will describe the type of additional services and/or treatment, if any, that would be helpful for the children or family

_____ will describe on other interventions that would be helpful to the children and family

Authorization to provide a letter to the Court on any of these issues represents a full waiver of any applicable privilege regarding this counseling/therapy, such a waiver also applies to any testimony that Dr. Greenberg is required to provide about her letter. Any letter provided by Dr. Greenberg will only address issues related to the counseling or therapy. Such a letter does not substitute for a child custody evaluation, and Dr. Greenberg will not make any custody

recommendations. Procedures in therapy are not equivalent to those provided in a child custody evaluation.

Dr. Greenberg is authorized to notify the court, with copies of the communication to counsel, if she is unable to proceed with court-ordered treatment due to non-cooperation of any party, including non-payment of fees, or if significant obstacles are being encountered to treatment.

The parties and counsel agree that all testimony provided by Dr. Greenberg, in any matter related to this family, shall be considered expert testimony, paid for at Dr. Greenberg's regular fee, under the terms of Dr. Greenberg's fee agreement. . No letter or testimony will be provided by Dr. Greenberg without payment seven days in advance, from the parent or counsel desiring such report or testimony, or from the party responsible for paying for treatment. Absent receipt of such payment, Dr. Greenberg will be under no obligation to provide communications, testimony, or services of any kind.

9. INFORMATION TO CUSTODY EVALUATORS

If either party returns to court regarding custody or visitation issues and a custody evaluation is ordered, the parties may be asked to waive privilege so that Dr. Greenberg can provide information to the child custody evaluator. If such waivers are provided, the content of information provided to the evaluator will be at Dr. Greenberg's discretion. Both parents agree to execute any additional releases that may be necessary or convenient to document waiver of privilege. If a child is in treatment, Dr. Greenberg must receive releases from both parents or an order of the Court to disclose treatment information.

10. COMMUNICATION WITH OTHER PROFESSIONALS

To coordinate treatment, it may be helpful for Dr. Greenberg to communicate with other

professionals (therapists, teachers, doctors, etc.). The parties hereby waive all applicable privilege to allow Dr. Greenberg to receive information from and provide any and all treatment information to the professionals listed below:

_____

_____

_____

The parties agree to execute any additional releases that may be necessary or convenient to allow such communication. If Dr. Greenberg believes that communication with any other professionals would be helpful to treatment, additional releases may be requested from the parties. If Dr. Greenberg requests communication with the parties' individual treating therapists, the parties may provide a one-way release, preserving the confidentiality of their individual treatment information, if appropriate.

11. If Dr. Greenberg is ordered or requested to provide treatment information in a manner that she believes raises risks to the welfare of the children, Dr. Greenberg is authorized to provide this information to the Court, as well as to request any interventions (e.g.. appointment of minor's counsel) that she believes would mitigate this risk.

12. [ ] A review hearing is hereby set for _____, for the following purposes:

_____

_____

13. FEES

The cost of the counseling shall be paid as follows:

_____ Petitioner; _____ Respondent; _____ ½ by each party in accordance with the terms of Dr. Greenberg's fee agreement.

Dr. Greenberg's individual meetings with each parent will be paid for by:

_____ the parent attending the session

_____½ by each party;

_____petitioner;

_____respondent.

Outside-session services (including but not limited to conference calls, correspondence, and telephone calls), as described in Dr. Greenberg's consent agreement, will be paid as follows: _____

_____

Each parent is to provide payment to Dr. Greenberg within ten days of receiving any invoice or request for payment from Dr. Greenberg.

Each parent and counsel acknowledge that they have had an opportunity to review Dr. Greenberg's fee/consent agreement and this stipulation, and to consult with counsel concerning it. The parents agree to abide by the terms of this agreement and Dr. Greenberg's fee/consent agreement, and agree to abide by the terms of those documents. Each parent and counsel acknowledge that treatment services may be suspended if fees are not paid, and that Dr. Greenberg has no responsibility to provide letters, testimony or other services if fees are not paid. If treatment services are suspended due to nonpayment of fees by either party, Dr. Greenberg is authorized to disclose this information to both parents, counsel and the Court.

A facsimile or photocopy of this stipulation/order shall be considered as valid as the original. This Stipulation and Order may be signed in counterparts.

IT IS SO STIPULATED.

DATED: _____ _____
Petitioner

DATED: _____ _____
Respondent

DATED: _____ _____
Attorney for Minor (if applicable)

AGREED AS TO CONTENT AND FORM:

DATED: _____ _____
Attorney for Petitioner

DATED: _____ _____
Attorney for Respondent

ORDER

IT IS SO ORDERED.

DATED: _____

_____
JUDGE OF THE SUPERIOR COURT

We're Still Taking X-Rays but the Patient is Dying: What Keeps Us From Intervening More Quickly in Resist-Refuse Cases?

Lyn R. Greenberg, PhD, ABPP and Hon. Robert Schnider

Abstract

Professionals frequently lament the fact that the dynamics of resist-refuse cases are often entrenched before the family receives effective intervention. Dysfunctional behavior patterns can become entrenched, with severe impairment of children's ability to function. Assessment is a critical component in the process of assisting families, but can come to so dominate the process that the situation is unrecoverable once the assessment is completed and meaningful interventions begin. The authors will describe commonly encountered obstacles to early intervention in resist-refuse cases, ranging from systemic stressors to the persistence of inaccurate beliefs and information and practices that undermine accountability. Practical strategies, including a broader conceptual model, integrating assessment into intervention, encouraging lawyers and courts to take earlier action, and suggestions for future professional development will be addressed.

Keywords: Resist-Refuse Dynamics, Court-Involved Therapy, Child Custody, Early Intervention

We're Still Taking X-Rays but the Patient is Dying: What Keeps Us From Intervening More Quickly in Resist-Refuse Cases?

Resist-refuse dynamics present complex challenges to professionals (Fidler, Deutsch, & Polak, 2019; Greenberg, Doi Fick, & Schnider, 2016; Greenberg, Schnider, & Jackson, 2019; Walters & Friedlander, 2016). It is common for professionals who provide services in these cases to lament that the family did not receive [1]specialized services more quickly, that so much time and money was wasted on investigations that did not yield clear results, or on relitigation of every decision, recommendation or allegation. The problems faced by children at the center of conflict, particularly if they have entrenched dysfunctional behavior, can seriously impair their functioning. While risk assessment is essential, the poor outcomes in many of these cases suggest that it may be worthwhile to revisit common approaches to addressing these issues. In this article, we explore some of the obstacles to early intervention in resist-refuse cases and

[1] Walters & Friedlander (2016) describe the "(intractable) Resist/Refuse Dynamic (RRD) as a complex set of interacting factors, family dynamics, personality characteristics and vulnerabilities, conscious and unconscious motivations, and other idiosyncratic factors that combine to contribute to the unjustified rejection of a parent. In our discussion of early intervention in these cases, we refer to resist-refuse dynamics as the full complex of factors that may contribute to a child resisting parenting transitions. At the early intervention stage, it may be premature to draw conclusions about the contributing factors, or the degree to which the child's reaction is "justified." The dynamic may include all of the factors mentioned by Walters & Friedlander (2016), as well as other transient, developmental and systemic factors.

propose potential solutions, amplifying some of our discussion with comparisons to what occurs in medical care.

Medical professionals often encounter patients who are already acutely ill. They may not have regular physicians, or access to the patient's medical history may be incomplete or inconsistent. (Divorcing families may also carry their conflict into this arena.) The common perception of the "medical model" is that physicians do a complete diagnostic workup and arrive at a definite diagnosis before prescribing any treatment. While an intellectually appealing idea, the reality is much more complex. Lab tests, complete history and radiologic studies may ultimately be important in arriving at a diagnosis, but not all problems can be identified immediately and it may be critical to stop the patient's bleeding or support respiratory function even if a complete diagnosis cannot be established immediately. The physician must balance achieving diagnostic certainty against managing immediate risks. The patient's response to initial attempts at treatment, as well as the added information from diagnostic procedures, may ultimately clarify the best course of treatment. Moreover, physicians frequently must weigh the value of potential information to be gained from the diagnostic procedure against the potential risks of the diagnostic procedure. Among those risks is the waste of time, resources and the strength of the patient of undergoing excessive diagnostic procedures that either do not yield precise results or do not change the options for managing the patient's condition.

Similarly, practitioners who work with RRD families frequently encounter situations in which families have undergone extensive and repeated evaluations, depleting the family's resources and leading to months of additional litigation as dissatisfied parents challenge the results and any recommendations for therapy or other services are not implemented.

The Appeal of One More Xray – Adjusting the Framework

Certainty is appealing. The allegations expressed in RRD cases are often extreme and mutually exclusive, while the reality is generally much more complex. Judicial officers are often asked to order services that support one parent's perspective over the other, such as allegations of unjustified restrictive gatekeeping (Saini, Drozd, & Olesen, 2017) vs. allegations of poor parenting or intimate partner violence. Judges understandably want the best possible assurance that the services they are ordering are appropriate for the actual problem(s), and they may mistakenly believe that delaying services avoids any risk of harm. They hope that one more investigation, trial, or evaluation will provide definitive answers, without the process costing the family more in time, stress or financial resources than the value of the information obtained.

To be sure, risk assessment is an essential part of both evaluation and treatment, and all providers should be constantly alert for risk factors or behavioral patterns that could endanger a child or parent. Parenting plan evaluations, or evaluations to assess potential danger to a child, may serve a vital function. Often, a well-conducted evaluation or child protective services investigation will reveal those risks. In other cases, the dynamics placing a child at risk are much more subtle and complex. Findings in those cases are rarely as clean or definitive as a broken bone observed on an x-ray. Over time, the alert clinician may become aware of risks to a child's safety, which may or may not be the same as prior allegations, and should promptly report any reasonable suspicion to child protection authorities. In many cases, however, the literal "truth" of past allegations may be difficult or impossible to determine. In some cases, and where resources permit, some forms of intervention can begin while a custody evaluation is still ongoing. This is often possible when the interventions being considered are those that support a child's general developmental needs, such as shielding school or recreational activities from

conflict or therapeutic interventions that address the healthy coping abilities that all children need. Such options are described in greater detail below. Early intervention may both stem risks to the child and provide important information for both the custody assessment and treatment/intervention planning.

Over time, clinicians may be able to detect and intervene with unhealthy family dynamics that do not constitute child abuse but nevertheless have a profound and destructive impact on children's ability to cope and develop. Moreover, children and families are in a constant state of change, based on both children's developmental issues and, in some cases, the family's reaction to prolonged conflict or litigation. Children at the center of conflict often fail to master essential developmental skills. Avoiding problems, rather than solving them, becomes a habit. Patterns of poor parenting, undermining of a parent-child relationship, and failure to require children to adopt healthy patterns of conduct interact to create a complex of increasingly severe emotional risks to the child. Linear conceptualizations of cause and effect may continue to appeal to parents who are "stuck" on establishing blame, but they are unlikely to accurately reflect the complexity of the problem. Well-conducted custody evaluations generally reflect this, and often provide therapeutic recommendations consistent with the complexity of the problems.

When Does Assessment Get Out of Control?

All of the aforementioned assessment issues exist against a backdrop of the issues that judges must consider when deciding what kinds of services they can order and what they should order. Since any order for services will require the parents to spend money that they might prefer to be spending elsewhere, it is likely that a parent's need or desire will be delayed or unfulfilled. Neither party may be particularly welcoming of services that address a variety of possible causes of a child's problems, or that may require changes in the behavior of both parents. One or both

may be committed to the view that the other parent is evil, self-focused, and uninterested in the welfare of the child. The critical focus on the child's developmental needs may get lost in the search for "fault."

Since no evaluation is ever perfect, parents may become focused on obtaining the flawless investigation that is expected to yield the conclusion they desire. Judicial officers, and even evaluators, may lack the training to recognize the abilities and services children will need, even if an absolute conclusion about the "cause" of the problem is elusive. Family therapists know that dysfunctional behavior must be analyzed not just in terms of cause, but in terms of the forces in the child's environment that are maintaining the behavior. Caught up in the search for cause, professionals may lose sight of concepts that are readily recognized when they take a step back from the legal struggle. When the search for a prior cause becomes more important than helping the child manage stress and coping effectively, it is likely that the emphasis has been misplaced.

Moreover, when the court requires the parents to focus on the child's needs and cooperate with a therapist, the parents' cooperation and behavior may yield important information about the nature of the family's problems. For example, some parents are willing to spend thousands of dollars on repeated evaluations but claim they are unable to afford quality therapy. Some of them can respond to psychoeducation or therapeutic services designed to help them focus on the child's current pain and change their behavior to relieve that pain and strengthen the child. Others cannot or will not change their behavior, and if the therapist's requests are appropriate, those responses are also revealing. The results of these efforts may better inform any ongoing evaluation, the work of a parenting coordinator, or the decisions to be made by the court.

As noted above, physicians considering diagnostic procedures must evaluate whether the results will materially affect the available options for treating the patient, and whether the risk of harm to the patient may outweigh the value of the results. The medical model does not completely fit the court-involved family, because of the complex systemic factors that may cause family dysfunction. Nevertheless, such a risk-benefit analysis may be a useful framework to consider when deciding what services to request or order.

To be of any value, risk assessment must be bidirectional – in other words, the decision-maker should consider both the risk of ordering services and the risks of doing nothing. For example, a judicial officer considering ordering family therapy may be concerned that the therapists approved by the parents' insurance carrier will not have the requisite expertise to work in a family law case and will unwittingly cause harm, and that the parents will be unable or unwilling to expend resources for someone with more training. Conversely, doing nothing while a child's behavior continues to worsen, a parent-child relationship is destroyed, and no meaningful efforts are undertaken to teach or expect the child to resolve interpersonal problems can do serious damage. Amid the increasing professional literature on emotional and even medical risks to children at the center of conflict, and about the coping and emotional abilities they need to adjust successfully, it is unsurprising that children and families who do not receive effective help fare poorly.

Obstacles to Early Intervention

Twenty-twenty hindsight is easy. When faced with a case that has tragically gone wrong, with a child or adolescent who has been severely damaged, and with intractably bitter or battling parents, one can often readily identify missed opportunities to intervene. But at the time that such decisions are being made, other concerns may crowd out consideration of the interventions

that would have been likely to prevent poor outcomes. In this section, we review the obstacles that may arise from various professional perspectives, and some of the common misunderstandings, information and training gaps, systemic obstacles and cognitive errors that impede more effective service planning. .

Issues Arising From the Parents

Divorce often represents a financial and emotional earthquake for one or both parents, as well as for the children. Parents are often told, sometimes correctly, that resolving their own emotional issues and resolving the separation peaceably offers the best chance for successful adjustment in the children. Children may resist parenting transitions based on developmental issues or the emotional turmoil around them. In some families, these difficulties resolve as the parents calm down, or the parents receive advice to expect this. As a result, relatively easy interventions that may protect the children, such as enrolling a young child in preschool, are overlooked, delayed, or bogged down in conflict between the parties. In a minority of families, one or both parents are so heavily invested in blame or conflict that the possibility of a solution is threatening to them. Advocates, family members, attorneys or therapists may advise them to resist compromise – often based on the one-sided perspective or distorted perception of a parent.

Financial issues represent a constant stressor during a divorce, which may be the worst financial crisis a family has ever faced. Financial disputes may have precipitated the divorce, but even when this is not the case, the divorce creates new financial stressors for the family. Parents are faced with attorneys' fees, court costs and forensic experts, and the same amount of income must now support two households. Since financial instability may be a major stressor to families after parental separation, an argument can be made that securing the family's financial future also protects the child's needs. Of course, some parents who are willing to spend extensively to

litigate blame will claim to be unable to afford therapy or other services, or may argue for delays and additional investigation before services are provided. Even well intentioned parents may not have the education to know that certain services, such as preschool enrollment or procedures that protect the child from conflict at joint events, may protect children even while other allegations are being investigated. (Many professionals do not know this, do not consider it.) For a parent who is invested in ensuring that the situation does not improve, a demand for x-ray after x-ray can delay intervention for months or years.

Professional Obstacles and Training Issues.

Many professionals of all disciplines lack the professional training or experience to deal effectively with RRD cases, especially in the early stages (Bala & Slabach, 2019; Fidler, Deutsch, & Polak, 2019; Greenberg, Doi Fick, & Schnider, 2016; Greenberg, Schnider, & Jackson, 2019). Conflicts among professional roles may also lead to missed opportunities for intervention. Specialized providers are not available in all locations, and parents may initially turn to professionals who come at lower cost but do not have the requisite training to handle these cases. In this section, we review some of the obstacles and offer some suggestions for training and practical solutions.

Judicial officers. To varying degrees (depending on jurisdiction), judges have the authority to order interventions for families – by ordering services or investigations, or by reallocating parenting time or legal custody. In making those decisions, judges are in effect ordering the parties to follow certain priorities in how they spend their money, time and energy. The narratives presented to judges are often polarized and mutually exclusive – i.e. disruption of the parent-child relationship is a result of *either* "abuse" or "alienation" – rarely reflecting the complexity of poor parenting, exposure to conflict, developmental issues, parent and child

vulnerabilities that more often underlie these cases. Judges are rarely presented with clear, grounded information about the child's behavior and how it compares with developmental norms. They may not be informed about the risks of allowing dysfunctional behavior to continue or the types of services that can strengthen the child even if the court has not yet made a finding about the causes of the family's problems. The idea of "one more x-ray" is also appealing for them – they are tempted to either order an evaluation or hear more evidence, to discern what the "real" problem is, before ordering services so that they can allocate the limited family dollars to the *most* effective form of service. They may believe that doing nothing is the same as "doing no harm."

The best custody evaluations identify these complex issues, but it is also common for investigations, evaluations or hearings to follow the polarized thinking of the parents. As noted above, many professionals have observed the impacts of poor quality therapy and worry that therapists who are covered under the family's insurance plan will not have the training or sophistication to provide appropriate treatment.. Sometimes these concerns are justified, but viable options are often overlooked.

Judges sometimes receive general education about child development as part of their judicial training, but this information may be difficult to apply in RRD cases unless it is presented in those terms. Judges need clear, in-context information about the impact of the parenting conflict on the abilities children should be learning, whether they are moving forward or regressing, and whether the parents' requests or actions support or inhibit the child's development. They also need clear information about treatment options and the basic elements – such as the involvement of both parents and a detailed, unambiguous court order – necessary for any chance of success. This training, and any associated "cheat sheets" or other tools, must be

provided to judicial officers in clear, non-technical language. Judges should also insist on such clarity from lawyers and experts.

Resources such as the *Gatekeeping Bench Book* (Austin, Fieldstone, & Pruett, 2013) are useful to judicial officers in understanding terminology and making determinations about some of the factors present in a case. Pruett, Cowan, Cowan, & Diamond (2012) developed programs for enhancing facilitative gatekeeping, or parents encouragement of the other parent's involvement, which present a useful model for prevention and early intervention when a parent is unnecessarily inhibiting contact but not intentionally undermining the other parent-child relationship. Additionally, for judicial officers' continuing education, self-study CD's or webinars could be available outlining the importance of early intervention, treatment options, and ways of crafting effective orders for protecting children and establishing effective services. The AFCC Judicial Webinar series addresses some of these issues, although more specific programs on early intervention may be helpful.

It may also be useful to teach judges to ask certain types of questions when presented with allegations about a child's resistance to contact with the other parent. A question as simple as, "what have you tried to fix this problem?" may put the onus on parents to explain what attempts they have made and justify any resistance to services or settings that may help. It may also be useful to inquire about any anticipated harm from a request being made by a parent. It may be easy to cite potential harms of a parent is requesting a reversal of custody. Justifying opposition to preschool, or to *appropriately structured* family therapy, would likely be more difficult.

Lawyers. Lawyers may see some of their responsibilities as more important than, or even inconsistent with, early intervention to protect children. Since legal codes of ethics require

lawyers to advance their clients' interests, how lawyers define that obligation may determine whether the well-being of the child is included in their consideration (Bala & Slabach, 2019).

Financial demands arise in this setting as well. Lawyers may feel that the client's resources need to be conserved for what seem to be more pressing issues, such as financial disputes, and they may be less familiar with the questions to ask to determine what mental health referrals might be worthy of consideration. They may prioritize focusing on more specific and familiar, even quantifiable issues, such as division of property and support. Even when the disputes involve the children, the focus is often on "time share" and decision-making rather than on the details of the child's current developmental status or emotional condition and what each parent is doing about it.

Lawyers may also face pressures to resist cooperation and compromise, even if the lawyer believes such steps would be best for the children, the adult client and the case. Many parents, particularly when they are emotionally distressed or angry, expect their lawyers to advocate their desires. Parents may have unrealistic expectations of what litigation can accomplish, and about the implications for their children if conflict continues. The lawyer may fear a professional complaint or being fired by the client for not being "tough enough", or later being sued by a former client if the lawyer's cooperation is second-guessed by another lawyer or the client is unhappy with the result. Lawyers may also fear that if they refer a client to an individual therapist who maintains an objective focus rather than endorsing a parent's skewed viewpoint, it may harm the parent's relationship with the lawyer. Lawyers and therapists for parents often do not communicate frequently enough, so each may be counting on the other to "reality check" a difficult client. In actuality, it is the combination of both professionals is often

most helpful in encouraging parents to change behaviors that could lead to poor results in the legal process as well as harm to children. (See Campbell, 2020 for elaboration.)

Lawyers can have an enormously important role in obtaining prompt intervention, if they are sufficiently knowledgeable to present the right information and effective proposals to the court. When judicial officers are asked what the most effective strategy would be for getting them to issue specific and effective orders, they frequently respond that lawyers should bring those orders to them (Bala & Slabach, 2019). Lawyers also need training on how to select appropriate therapists, inquire about their training, craft effective orders, recognize when treatment is going off course, understand therapists' ethical obligations and collaborate effectively with their adult clients' therapists. Many resources are available to assist them in these areas[2].

Lawyers need to know enough about children's developmental needs, or obtain enough consultation, to request orders that are relevant to easing the child's distress. They may be more effective in getting action from judges if they present reasonable, developmentally appropriate solutions with little risk of harm. For example, a proposal for a child attend preschool, or resume an after school activity, may carry more weight if it is framed in terms of the child's developmental needs, rather than simply as a means to facilitate a parenting transition.

Mental health professionals. Some obstacles to early intervention can arise from mental health professionals (MHPs) involved in the case. Therapists may not have adequate

[2] See for example, Association of Family and Conciliation Courts' Guidelines for Court Involved Therapy (Association of Family and Conciliation Courts, 2011) and the American Psychological Association's Ethical code (American Psychological Association, 2017).

training for working with court-involved clients; those who become overly aligned with a parent's view may fail to remain objective and inadvertently escalate conflict. Poorly planned and/or uncoordinated treatment may exacerbate conflict rather than resolving it.

Traditionally, MHPs are taught to align with their clients' interests, which is often interpreted as being identical to advocating the parent's or child's expressed view. Viewed from another perspective, a core purpose of therapy is to assist clients (whether parents or children), to cope in a healthier way with the actual stressors in their lives. For all members of a separating family this includes adjusting to a change in the family structure. For parents, it may include learning to conduct themselves in a way that does not expose the children to conflict, accepting that the other parent will have a role in the children's lives, understanding the expectations of the legal system, and changing their behavior as necessary to meet those expectations. Just as parents may fire attorneys who appear to be too conciliatory, some will have difficulty tolerating a therapist who explores alternative interpretations of events, confronts dysfunctional behavior, or recommends changes in the client's own behavior rather than just blaming the other parent. That being said, a therapist who fails to address these issues and unequivocally supports the parent's perspective may be doing the parent no favors, as the parent will ultimately encounter a professional whose role is to be neutral and objective rather than the parent's advocate. Many such parents have been shocked by the results of an evaluation or court hearing, because they have never been exposed to a more realistic interpretation of events or better problem-solving approaches.

Therapeutic confrontation, reframing and motivational interviewing (Iannos & Antcliff, 2013) are part of many therapists' skill sets, as many therapy clients enter treatment because of pressure from an another person or setting (employer, spouse, legal situation, etc.) to change

their behavior. Therapists, who are unwilling to use those tools, may need to recognize their limitations for dealing with custody-disputing parents. Other therapists simply fail to recognize that their work with a custody-disputing parent is a situation in which they need to apply those skills, as their clients appear to be entering therapy voluntarily and are seeking a supportive ally in their struggle against the other parent.

The "pull" to align with a client's expressed wishes is particularly strong when the therapeutic data is coming directly from a child. Therapists working with these children need to be familiar with research on children's adjustment to divorce, developmental issues, and the types of interactions that can influence children's statements and perceptions. The *Association of Family and Conciliation Courts' Guidelines for Court-Involved Therapy* (2011) outline essential areas of knowledge for treating children at the center of custody disputes, and MHP professional organizations continue to undertake training efforts for non-specialized therapists.

It has been the first author's observation that enhancing competence among children's therapists and family therapists may include reminding them of what they already know. A surprising number of therapists who would never support avoidance or regressive behavior on the part of a child toward school or other environments, nevertheless fall under the influence of conflict and support such behavior in children of divorce. Therapists also need to be cognizant of historical therapeutic models that are unlikely to work, and reject cases that are set up to fail (Fidler, Deutsch, & Polak, 2019; Greenberg, Doi Fick, & Schnider, 2016; Greenberg, Schnider, & Jackson, 2019). For example, lawyers and judges often recommend "reunification therapy" that is limited to the rejected parent and child, or individual child therapy that does not include both parents and the family system. Both of these models are unlikely to be effective and may unwittingly escalate conflict (Fidler, Deutsch, & Polak, 2019). Therapists should have clear

informed consent procedures, templates for consents and orders that include the elements necessary for the intervention to succeed. This is discussed in further detail below.

Some custody evaluators, parenting coordinators and forensic experts also inadvertently create obstacles to effective intervention. Professionals who are poorly informed about available options for services, or who fail to maintain a systemic and developmental perspective, may overlook options to support the child's emotional independence. While many evaluations end with recommendations for treatment or other services, too many evaluators offer poorly defined treatment plans that are inconsistent with current knowledge. Other experts make negative judgments about family members' potential to progress based on their response to treatment that was inappropriately structured or not well adapted to the parents' situation. Just as physicians do, informed MHPs can make reasonable inferences from available research and create evidence-informed intervention plans. Medical interventions rarely come with guarantees, but it is generally not suggested that children should not receive health care unless there is certainty about the outcome. Experts discussing the risks of intervention, without addressing the risks of doing nothing, are not providing helpful information to the court.

Broader Systemic Obstacles

The Remarkable Persistence of Inaccurate Information, Bad Ideas, and Ineffective Procedures

When there is too little information exchange between professionals with different bases of information, new information may not reach seasoned professionals. Overwhelmed and frustrated professionals may repeat to each other outdated concepts and generalizations that *seem* true, but are actually inconsistent with current research and, in some cases, long-established professional knowledge outside their subspecialty. In addition to the fallacy that every element

of blame must be established before services can begin, common outdated beliefs and practices include the following:

The assumption that change must be voluntary. This is sometimes expressed by stated beliefs that parents must acquire insight, that the primary goal is to change parents' beliefs, or that there is no point in requiring services unless the parents have internal motivation for change. This is contradicted by studies that show the effectiveness of behavioral therapies for dysfunctional family dynamics and even for families in which abuse has occurred, as well as the effectiveness of behavioral parent training especially when problems are caught and addressed early (Greenberg, 2019; Greenberg, Schnider, & Jackson, 2019; Lutzker & Merrick, 2009, Lutzker & Edwards, 2009; Pedro-Carroll, Sandler, & Wolchik, 2005; Reed et al., 2013). It also contradicts the common experience that many adult clients attempt psychotherapy with some kind of external motivation (such as pressure from a job or spouse) and it is common for children to enter psychotherapy based on the perception of others (parents, teachers) that it is needed. Many only later recognize the benefits themselves, after seeing the benefits of adopting new strategies.

The consequence of expecting "insight" is that it moves the focus of interventions from the behaviors that need to change to a vague expectation that parents change their opinions or beliefs. Particularly for parents who are still litigating, this can be a difficult or impossible goal. Often, parents' feelings and attitudes do not change until they disengage from the legal struggle, try new methods of coparenting, see changes in their coparent, feel financial deprivation from the costs of litigating, or see positive results from new strategies. From the perspective of their emotional development, children cannot wait for parents to "achieve insight" to experience relief from the impacts of conflict, and it certainly isn't in their interest to get no help until most of the

family's resources are exhausted Many parents can certainly benefit from personal therapy, but specific changes in behavior – for example, setting limits with children, shielding them from the parental conflict, improving parenting skills, and making positive statements to support parenting transitions – can be taught (and set as behavioral expectations) without parents needing to change their opinions of one another.

Absence of accountability, poor therapeutic structure. Another traditional concept is that mental health services can only work if they are completely confidential. In high conflict cases, however, protection of the children and effective treatment often requires some form of external accountability, at least with respect to the parents' cooperation. Resist-refuse cases frequently include parents who are so entrenched in their disparate views that they are resistant to even the most reasonable steps to limit the impact of conflict on their child – such as setting appointments, promoting children's cooperation, or setting procedures to limit conflict at organized events. Since children are not in control of their environments, protecting them requires that parents cooperate with qualified child-centered professionals and comply with court orders for therapy, parent education or other services.

Early intervention often requires judicial officers to order parents take concrete steps they do not want to take, and hold them accountable if they do not comply. Professionals and parents often lament that parents who refuse to cooperate often face few consequences or no consequences at all. In some cases, the court will consider a parent's noncompliance during a trial months or even years later, or by a custody evaluator/assessor during a long investigation process. But by the time that occurs, the child may be seriously dysfunctional and face a long road to healthier behavior. Frustrated parents may also begin to exhibit the effects of prolonged stress with more dysfunctional behavior.

Obstacles to accountability include large judicial caseloads that make prompt follow up difficult, poorly defined expectations for cooperation, difficulty proving intent or malicious intent, and a shortage of resources for other professionals, such as children's (best interest) lawyers, who might be able to promote cooperation. As noted above, a particularly common error occurs when the court orders therapy only for child or for the rejected parent and child, with no expectation of involvement, cooperation or support of the therapeutic process by the preferred parent. Poorly planned interventions are unlikely to succeed, but failed treatment can add to professional pessimism that anything can be effective. Lawyers representing uncooperative clients may oppose any order that would be specific enough for their clients to be held accountable, and judicial officers may lack the training, confidence or time to craft and enforce sufficiently detailed orders or recognize that RRD is rarely a one-sided phenomenon.

Loss of developmental focus, linear thinking. The legal world is largely linear and often reductionistic. Judges are asked to make discrete decisions and findings of fact, often between alternatives presented by the parents and framed from the parents' perspective. Even when parents present their wishes using language about the best interests of the child, their perceptions of children's behavior are often colored by their own emotional needs and legal positions. Some issues, such as financial disputes, can be framed in discrete terms, and judges are often asked to make decisions about parenting plans or decision-making authority that parents perceive as global "wins" or "losses."

Children's lives are much less linear. A true understanding of a child's life requires constant recognition that much of a child's development takes place outside of the court context. Children are engaged in a variety of systems – including school, recreational activities, extended family, sibling, peer relationships, and in some cases medical or special education systems. Each

setting both imposes demands on the family and offers the child the opportunity to obtain independent emotional support, outside of the parents' issues or legal struggles. In fact, children are least likely to suffer harm from trauma when they have interpersonal resources and supportive adults who can help them resolve the experience (National Scientific Council on the Developing Child, 2015). Programs such as Head Start Trauma Smart provide coping-focused therapeutic, educational and recreational activities to help children master the abilities they need to achieve healthy development, regardless of whether a "definite finding" can be made about the allegations between their parents (Austin & Greenberg, 2019; Blaustein & Kinniburgh, 2010; Fidler, Deutsch, & Polak, 2019; Greenberg, 2019; Greenberg, Schnider, & Jackson, 2019). While specific, content-focused trauma treatments should not occur unless there has been a definitive finding of trauma (Deutsch, Drozd, & Akijo, 2020; Drozd, Saini, & Vellucci-Cook, 2019), many of the abilities that underlie successful adjustment can be taught and promoted both in appropriate therapy and in children's daily activities. One of the most tragic losses to children occurs when every activity or aspect of their lives becomes another canvas for parental conflict or for parents "proving" the correctness of their own perspectives (Johnston, Roseby, & Kuehnle, 2009). It is critical that MHPs and other professionals consider, and constantly remind themselves, that children's lives do not or at least should not- entirely revolve around us and the legal struggle.

Judicial officers typically respond to the issues brought to them by the parties. If no one has helped the parties to think broadly enough about their children's well being, critical information that could help the child develop, or facilitate a parent-child relationship, may never be considered. Judicial decision-making is based on evidence presented in the courtroom, and judges lack the knowledge and authority to undertake independent evaluation of the

psychological issues. Judges can "develop their own evidence" by asking their own questions, but they need to know what questions to ask and a witness who can answer those questions has to be put forward by one of the parties.

Politicization, Extreme Rhetoric

When children resist contact with a parent, their behavior is often distressing to one or both parents, and to observers. There are legitimate criticisms that the early conceptualizations of this phenomena (such as Gardner, 1989), overemphasized blaming the preferred parent for the child's behavior and ignored real risk factors like intimate partner violence. Conversely, other authors have exhibited complete denial that children's perceptions, feelings or behavior can be influenced by parents or other adults who are invested in interfering with or destroying the other parent-child relationship. Over the past 25 years, scholars, researchers and clinicians have identified many issues relevant to RRD, including but not limited to enhanced knowledge about children's development, the extent of their vulnerability to external influence, the impacts of trauma, interpersonal violence and parental conflict, and the parenting practices and deficits that may be involved in these families. The *Family Court Review* has devoted several special issues to this topic, and most current literature emphasizes the complexity of these family dynamics.. Unfortunately, the analysis of these cases often remains highly polarized, occurring against a background of gender politics, selective presentation of information and scholar-advocacy bias (Sandler et al., 2016). Advocates at both extremes have distorted the literature, engaged in personal attacks, and accused professionals who disagree of condoning abuse or ignoring dangers to children.

Some advocates and advocacy groups have also targeted judicial officers, children's lawyers, guardians at litem and mental health professionals, who often cannot defend themselves

because case information is confidential by law, or because of a professional obligation to protect children from public airing of their family's struggles. In some jurisdictions, agenda-driven legislation is also common. Some advocates blur the distinction between one-sided descriptions of RRD cases and the more complex, nuanced, research-informed models that have been developed in recent years. These tactics drive polarization and encourage an oversimplified, us vs them approach – exactly the opposite of what children caught in complex family dynamics need. In addition to their genuine desire to avoid doing harm to a child, judicial officers may be as vulnerable as anyone else to either oversimplified rhetoric or the bullying tactics adopted by some advocates. Doing nothing, or acceding to a request to delay any action until after another evaluation or hearing (more x-rays), can appear to be less professionally risky than taking action.

Is That the Child's Voice You're Hearing?

In most jurisdictions, courts are required to consider children's views in some way, deciding the weight to be assigned to the child's views based, in part, on the child's ability to form and express their independent views. In many respects, the expectation that children's perceptions and feelings be considered is a positive one, based on a desire to afford dignity and respect to a child impacted by a legal proceeding. *How* we listen to children, and whether our approach truly empowers the child, is more complex.

This issue may be particularly fraught in RRD cases, specifically because one parent is alleged to have consciously or unconsciously influenced or manipulated the child's perceptions or feelings. Parents engaged in high conflict behavior often do not model or teach children healthy skills for resolving problems. Children may become accustomed to avoiding problems rather than resolving them, or reliant on unhealthy coping responses such as becoming the

emotional caretaker of a needy parent, regressing to behavior characteristic of younger children, withdrawing from independent relationships, avoiding all emotion, and refusing to engage with others to resolve conflict. Children may be unable to tolerate conflicting feelings, refuse to engage with anyone who is involved with the rejected parent, and fail to develop essential problem solving abilities such as weighing competing possibilities. Such children, and especially adolescents, can appear mature, definitive, and emphatic when asked the questions they expect about their views and preferences or "positions" in the custody conflict. It takes an astute, qualified interviewer to explore beyond the expected questions and detect the delays in emotional development that compromise a child or adolescent's ability to form a reasonable opinion. Judges may not have the time or training to fully explore the bases of child's perceptions and feelings, what efforts have been attempted to resolve problems with a parent, and how the child is functioning emotionally.

It is important to remember that when children and adolescents express opinions that are not based on their own experiences and healthy coping abilities, they are *not* empowered. Healthy children develop decision-making skills gradually, starting with smaller decisions and progressing to more important ones. Healthy children can discuss the advantages and disadvantages of various plans, and can tolerate gentle exploration of their expressed preferences. When children do not have those abilities, but their expressed preferences are relied on for the parenting plan anyway, there is considerable risk of ongoing emotional harm to the child – particularly if they are asked to make the lifer altering decision about whether to see a parent. In some jurisdictions, there is a formal or informal presumption that a child who has reached a certain age can express a meaningful preference that should be given considerable weight by the court. In those cases, children may be directly or indirectly pressured to resist both

therapy and contact with the rejected parent until they reach the age at which their preferences will be weighted heavily by the judge. Many children have been heard to say that they need not cooperate with therapy or the parenting plan because when they reach a certain age, the judge will let them decide their own parenting plan. Judges and other professionals who set limits with these dynamics, or with the parents who enable them, may find themselves accused of not listening to the child or even of "violating the child's rights." Unfortunately, those may be the very professionals who are being most attentive to the various aspects of the child's perceptions and functioning.

Tools and Potential Solutions

Entrenched RRD cases are complex, and it can often seem overwhelming to consider the level of systemic changes that may be involved in promoting earlier and better intervention for children. Children at the center of conflict could benefit greatly from a more wholistic view of their lives, and earlier and better case management. Systemic change can emerge from a variety of sources, ranging from broad actions to reduce judicial caseloads to practical steps to promote better results for individual families. We do not purport to have perfect answers, but in this section we offer suggestions for overcoming obstacles on both a systemic and individual case level.

Countering the Myths

In much of the material above, we have described questionable or inaccurate assumptions about children and families that have had a disturbingly long life span in the family court system. Inaccurate assumptions persist about the nature of effective intervention, how families change, how to recognize children in trouble, the possibilities for earlier intervention, and how much assessment is needed before any services can be provided to stem the "emotional bleeding" that

can so severely handicap children emotionally. Countering inaccurate information can occur through better training as described above, but may also require constant alertness and energy from every professional involved in a case, and a willingness to confront outdated "truisms" and myths. Structures and practical tools for viewing these families differently may help.

Developmental Focus

In many jurisdictions, initial court documents filed by parents focus primarily on outlining the ultimate result that a party desires, both financially and in terms of parenting plan and authority. The documents may make claims about each parent's sensitivity to the child or parenting abilities, but often offer little information about the child's actual developmental status, daily routines, upcoming parenting decisions about developmentally appropriate opportunities, and any areas outside of the parental conflict that may pose risks to the child. Since parental conflict impacts children on a daily basis, failure to attend to these issues may leave unaddressed the most destructive impacts of the parenting conflict.

On a systemic basis, gathering information differently may be a key to focusing attention on these issues. A surprising amount of revealing information is generated when questions are asked that go beyond allegations that a young child is "not ready" to spend overnights with the other parent, or that a child who should be using language is regressing to tears and acting-out behavior at the time of parenting transitions. Such developmental inquiry is unlikely to be possible in the setting of a hearing, but could be part of standard inquiry at other "entry points" into the legal system, whether that be mediation, consultation with a lawyer, or completion of a form asking those questions.

Absent such systemic-level change, inquiry about a child's daily life, activities, and the attempts being made to promote developmental progress should be an early area of focus when

dealing with an RRD case. With young children, for example, it is frequently proposed that parenting transitions be at a neutral location when parent-to-parent transitions are not working well, or the child is demonstrating regressive behavior such as tearfulness. The issue often missed is that preschoolers, particularly those who have been exposed to trauma or exposed to protracted parental conflict, *need to be mastering language and active coping skills.* These abilities are central to successful adjustment, and parents focused on their own conflict may not be attending to them well. A child who is enrolled in preschool gets active, consistent, developmentally appropriate support for healthy coping abilities, including resolving conflicts and expressing their feelings with words. These healthy abilities are promoted on a daily basis, without reference to the parental conflict unless parents are interfering in that setting. School and recreational activities serve many of the same functions for older children (Austin & Greenberg, 2019; Blaustein & Kinniburgh, 2010; Drozd, Saini, & Vellucci-Cook, 2019; Greenberg, 2019), who also need to master healthy coping abilities in order to achieve healthy adjustment (Davies, Martin, Sturge-Apple, Ripple, & Cicchetti, 2016; Pedro-Carroll, Sandler, & Wolchik, 2005).

If the "job" of children is to master these healthy abilities, the primary responsibility of parents is to create and protect the opportunities for these to occur. This may be a useful lens through which to view RRD cases, given that once cases progress to severe entrenchment, the child's resistance can often extend well past the resisted parent to any coach, teacher, parent, friend, or extended family member who still engages with the resisted parent (Warshak, 2001). Protecting children's ability to form independent relationships, and not have all areas of life infected by the parental conflict, can be conceived of as a fundamental responsibility of parenting, and a reasonable expectation of both parents. Counsel and mental health professionals

working with parents should attend to these issues. Is a preschool-aged child getting an opportunity for that independent, supportive experience separate and apart from the parental conflict? How are parents behaving at school and recreational events? How do parents respond to requests that they support these opportunities? Have specific, reasonable requests for behaviors that protect the child from conflict been refused?

Greenberg, Doi Fick, and Schnider (2016), and Greenberg, Schnider, and Jackson (2019) have presented a detailed framework for developmentally-focused early intervention in RRD cases. But an initial step is for counsel to inquire about these issues, to make proposals for child-protective opportunities and protocols, and be able to present a record of the response to these suggestions and requests. This requires that both parents be able to focus beyond the issue of parenting time to the child's broader emotional health. In many cases, expanding children's access to neutral environments may make it possible to arrange more effective parenting transitions, both because this negates the need for both parents' presence and because the child's time in the neutral environment will likely have reinforced healthier behavior. If the child's access to such experiences is undermined, unreasonably restricted to one parent's sphere of influence, or supported only for its role in enabling parenting transitions, that should raise concerns. While these developmentally focused approaches may be less inherently satisfying to angry parents than securing a court decision blaming the other parent, they are also more likely to be helpful to the child.

Templates and More Effective Orders

As stated above, the time pressures of a courtroom crowded with cases gives both the judicial officer and counsel less time to think about the nuances of cases and carefully draft an order that covers many of the issues unique to each case. This is an area where lawyers, MHPs

and judges can have a positive impact. Each professional group can help create a standard order that addresses the issues that commonly arise with a "check the box" format to adopt those areas that are relevant to the individual case. One critical issue to address is the amount of information that can be released by the therapists and who can receive that information (court, lawyers, parents, evaluators, other related MHPs). Again, training for judges and lawyers is helpful here. "Safe harbor" models, in which absolutely no information can be released by the therapist, may have conceptual appeal when the judge's hope is that therapy alone will resolve the issues. Unfortunately such structures are typically ineffective in RRD cases and may even escalate conflict, particularly if the therapist over identifies or uncritically accepts the client's or child's "expressed view" with no "reality check" from engagement with other therapists or a neutral professional such as a parenting coordinator. Greenberg and Sullivan (2012) and Greenberg, Schnider, and Jackson (2019) describe tiered forms of information sharing that allow essential information to reach the court while encouraging some level of discretion on behalf of the child. Direct reporting can be limited to procedural issues (attendance, general statements about participation, lateness or no show), or based on specific circumstances such as a parent relitigating or not cooperating with the therapists.

Payment issues should be clearly addressed, including who pays what amount and when, and the procedure and consequence if one party fails to pay as ordered. In some jurisdictions, the court may denominate payment of fees to the therapist as a form of child support, if properly structured and permitted in the jurisdiction. Other procedural areas would include who is required to participate, the timing or number of sessions and how dates are set – typically, therapists should be given considerable discretion in scheduling and structuring sessions, including requesting that parents deviate from the parenting schedule if necessary for

each parent to participate in transporting the child. Sample forms for stipulations and orders can be found in the *AFCC Guidelines for Court-Involved Therapy* (2011), Bala and Slabach (2019), Fidler, Deutsch, and Polak (2019), and Greenberg, Schnider, and Jackson (2019).

Judicial orders can include provisions that aid in enforcement of the orders and minimize returns to court for modifications and determinations about contempt. These would include both "carrots" and "sticks." Typical "carrots" would include automatic step ups in parenting timeif certain goals are met (e.g. complete80% of the ordered therapy and the monitor then goes away). This would be coupled with an order that allows a direct report from the therapist about session attendance. A typical "stick" is the opposite. Fail to complete the therapy and no change occurs in the parenting plan. For ethical reasons, MHPs typically do not include such provisions in their standard orders. But forms could include a general prompt for enforcement mechanisms, and lawyers can certainly advocate for them.

Parents can be incredibly creative in finding ways to frustrate orders to address RRD dynamics, which is another reason why it can be extremely important for therapists to develop standard forms for stipulations (elsewhere referred to as "orders on consent") or court orders and collaborate with counsel in framing the order for a specific case. Conference calls between the therapist and all counsel, or in some jurisdictions including counsel and the court, may help to identify problems, prevent some, and deal expeditiously with the problems that are likely to arise. Standard orders are likely to be more comprehensive in identifying potential problems, and may include suggested language for goals and consequences or a "check off" of issues that the judge can identify.

An increasingly critical issue is the need for the court order to include behavioral expectations, such as requiring parents to exercise their parental authority to promote the child's

cooperation with treatment and parenting transitions. (Getting the child to the office parking lot, or the waiting room, is insufficient.) Since there are common problems that occur repeatedly in these cases, templates can be created of common behavioral expectations and then augmented by the mental health professional, attorneys and the court. Deutsch, Drozd, and Ajiko (this issue) have developed a tool, specific to issues of parent-child engagement that can be used to both guide behavioral expectations and assess the effectiveness of treatment. This can be paired with behavioral expectations for both parent cooperation and child mastery of healthy coping abilities.

Many courts have standard orders directing parents not to disparage one another in front of the child. We believe that this language is often insufficient, and could be strengthened to include an affirmative obligation to shield the child from conflict, not allow the child to see legal documents, and refrain from discussion of the legal matter, serving the other parent with papers, or other hostile acts during parenting transitions and at the child's school or other neutral settings. Specialized message boards for parents, such as OurFamilyWizard and Coparenter, provide a forum for documenting cooperation, or lack thereof, on issues such as following a therapist's recommendations to reduce conflict at school events.

Many parenting programs already include specific suggestions for parents as to how to support children's parenting transitions and relationships with the other parent, and a reasonably informed mental health professional can look at the problem parenting or child behaviors being reported and suggest positive, adaptive behavior changes. Greenberg, Doi Fick, and Schnider (2012, 2016) included some examples of this type of instruction. Some additional possible templates, which may of course require adaptation to the situation, are attached as appendix A.

One sample describes guidelines for parenting transitions of young children, while the other relates to protection of school and other settings from conflict.. In the event of a safety risk

or restrictions on a parent's involvement, it may be necessary to modify the examples to require compliance with a monitor during a parenting transition or some other specific circumstance. If the parent is subject to some restrictions but does not represent a danger to the other parent or child at public events such as school activities, these templates may serve as a tool for allowing the parent to continue to fulfill some aspects of the parental role and have healthy engagement with the child. This makes it easier for the court to more carefully craft restraining orders to limit only the parenting conduct that is at issue in the case. For example, if a parent cannot attend the school activity, modifications may include having someone provide a video of the event, followed by a congratulatory phone or Skype call between parent and child. These may be critical initial steps to support therapeutic progress.

There is no perfect order, and it is realistic to expect some parents to frustrate the most carefully constructed language. In addition, there may be some behavioral expectations that, for legal reasons, cannot be included in a court order. For that reason, it is critical that Court's use another powerful tool in their arsenal – articulation of findings and expectations that frame the context of the order

The Critical Role of the Court's Findings and "Expectations"

Not everything can be included in a court order**.** For example, it may be legally problematic to require a parent to refrain from exhibiting tears or a sad expression when the child transitions to the other parent, even though such behaviors powerfully impact children. For this reason, it's critical that judicial officers use the other powerful tools available to them, such as the ability make on-the-record findings or articulate the Court's expectations and the behaviors that the Court wants to see improve. The Court can articulate the importance of ensuring smooth

and peaceful transitions, protecting the child's ability to enjoy independent activities, setting limits with the child to ensure appropriate behavior, cooperating with a therapist, etc.

This is more than just use of a "bully pulpit." By grounding these expectations in what would normally be expected of parents (such as ensuring school attendance, completion of homework, that the child get enough rest, that physicians' instructions be complied with, etc.), the Court conveys an important message about the connection between these issues, normal child development, and the Court's considerations about the child's best interests. Judicial officers can directly tell parents that their level of cooperation on these issues, and the observed results for the child, may be a factor in the Court's later decisions. This latter point is important because some parents may comply with the specific language of guidelines such as those attached, while simultaneously undermining the intent of those instructions by finding other ways to expose a child to the parent's emotional distress or conveying contradictory messages to the child while outside of public view. No order, or statement of judicial expectations is foolproof, but judicial officers' statements of the results they expect to see can be very powerful

Conclusion

The risks to children from chronic exposure to parental conflict including entrenched RRD cases are well established. It is common to hear professionals express frustration that a family received quality intervention too late to resolve the problem, restore a threatened parent-child relationship, or salvage the child's emotional functioning. Many of the causes of such delay are systemic and rooted in the polarization of high conflict child custody cases, as well as the surrounding political climates. The appeal of the endless x-ray is considerable, particularly if the parents have the means and motivation to support repeated investigation over problem solving.

Many types of interventions that can stabilize or assist the child – coping-focused therapy, involvement in preschool, orders restraining the parents' conduct at school events – come with minimal risk and offer essential developmental support to the child. If all professionals are aware of effective services and the risks of delay, the family's responses to those services may provide an enormous amount of useful information – either improving the family's situation or providing the behavioral basis for further orders.

Appendix A

Suggested Elements For Transitions and School Involvement

The suggestions listed in the following pages are for consideration only and are not intended to substitute for the necessary adaptation to a particular case. Where realistic safety concerns exist, or the Court is taking precautions while an assessment is being conducted, additional elements may be necessary such as involvement of a monitor or parenting transition supervisor. Trained and experienced mental health professionals may be of assistance in adapting general principles such as these to specific case situations.

These types of instructions are most effective when accompanied by findings or an articulation of expectations from the court about the kinds of conditions which help and hurt children and the potential role of those conditions and the parents' compliance in future decisions by the Court.

Transition of Young Child Between Parents

(Sample Expectations)

1. The (receiving parent) will drive to the location of the pickup. The parent will park at the curb, wait in the car and unlock the door.
2. The (transitioning/sending parent) will walk out to the other parent's car with the child, place the child in the back seat of the other parent's car, fasten the child's seatbelt, place the child's backpack or bag us supplies in the car, and close and lock the car door.
3. The (transitioning parent), will either wave or say hi to the receiving parent. The other parent will respond in kind. Neither parent will discuss issues in the parenting conflict, make any references to lawyers or the court case, exchange hostile glances or hand gestures, serve the other parent with legal papers, or engage in any other action to disturb the peacefulness of the transition for the child. The transitioning parent will set clear limits with any regressive or noncompliant behaviors demonstrated by the child.
4. Upon fastening the child's seat belt, the transitioning parent will say, "Goodbye, (child's name). Have a good time with (the other parent). I will see you when you get back." The transitioning parent will then immediately walk away from the car.
5. Upon completion of this procedure, the receiving parent will drive away.
6. If the transitioning parent has essential information to pass on to the receiving parent, the transitioning parent will post a message via (approved parenting message board) not less than 2 hours before the transition time. Urgent information may be conveyed by text.
7. Absent extraordinary circumstances, the transitioning parent will ensure that the child is clean and rested prior to the parenting transitions. The transitioning parent shall avoid scheduling play dates or other activities in such a manner that they must be interrupted to

facilitate the parenting transition. In the exceptional circumstance of an external activity such as a birthday party for another child, parents shall provide prompt notice of the invitation to the other party and confer regarding the feasibility of allowing the receiving parent to pick up the child at that location.

Shielding the Child From Conflict at School and Neutral Activities

(Sample Instructions)

It is the expectation of this Court that parents engage their best efforts to protect the child's independent, developmentally important activities from the impact of the parenting conflict. Each parent has an independent obligation to actively shield the child from such conflict, including making all efforts to prevent the child's exposure to legal documents, direct or indirect references to the custody conflict, direct or indirect expressions of hostility between the parents.

1. Except when both parents are present for an externally organized event (school recital, play, athletic contest, etc.), neither parent shall be present at the time that the other parent picks up the child. (This can be modified to specifically restrict the days that either parent can be at the school or volunteer for school events. If one parent only has parenting time on the weekends, a provision specifically allowing that parent to volunteer for school events may be necessary.)
2. (Parent A) shall remain _____ feet from parent B during all school events.
3. If the parents encounter one another at a school event and the child is present, each parent shall say hello to the other. Neither parent will discuss any aspect of the parenting conflict in the child's presence, serve one another with papers, or make reference to lawyers, hearings, or any other aspect of the legal conflict. The parents shall also wave or politely greet any other adult who is present for the activity, as a model of socially appropriate behavior for the child.

4. After the practice or other independent event, the child may briefly approach the non-custodial parent to say hello. That parent will then direct the child back to the parent who has parenting time that day.
5. After the practice or other independent event, the non-custodial parent may briefly approach the child to praise the child's performance or efforts, then redirecting the child back to the parent who has parenting time.
6. Each parent will exercise appropriate parental authority to require that the child exhibit polite and socially appropriate behavior at all times, including the child's behavior toward both parents, extended family, friends and other adults.
7. Both parents will consistently encourage the child to remain with peers and follow all rules related to the activity. Unless the child is injured, neither parent shall support the child withdrawing from the activity to be with the parent.
8. Both parents will be polite to school and athletic personnel and refrain from mentioning any aspect of the custody conflict.
9. It is the responsibility of the transitioning parent to ensure that all supplies and equipment necessary for school or a neutral activity are transferred to the receiving parent. It is recommended that the parents each purchase a uniform for the child's independent activity. If essential but non-duplicated items (soccer shoes, costumes for a play, homework, etc.) are left behind with the parent who does not have custody and the items will be needed the same day, it is that parent's responsibility to ensure that the items are left at the school office not less than two hours before they are needed. The parent will not remain at the school for the parenting transition. If the items will not be needed the same day or the school will not permit them to be left at the school, the

parent will make arrangements to leave the items at a mutually agreed location for direct pickup by the other parent.

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#16

AFCC-CA NEWSLETTER

Merlyn N. Hernandez, CFLS
Executive Editor AFCC
California Newsletter

AFCC-CA President's Message

Michele Brown, CFLS
President of AFCC-CA

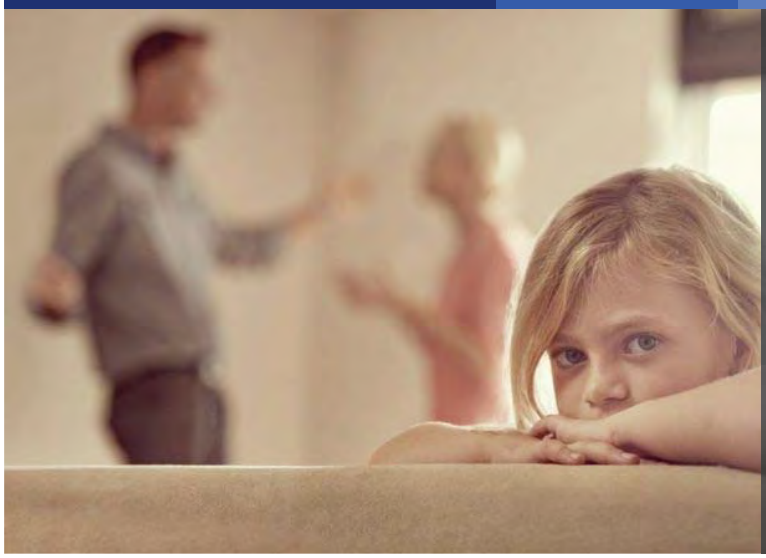
Fellow AFCC- CA members.

It is a great honor for me to be elected as President of the California Chapter of AFCC. We have an exciting two years ahead of us and I want to give you a glimpse of some of the coming attractions, introduce you to the fantastic board members that AFCC-CA members have supporting us in creating a dynamic Chapter, and congratulate the AFCC-CA 2018 conference committee for a conference that was second to none.

It is a privilege for me to introduce you to your 2018-2019 Board of Directors and Officers for AFCC-CA. We have a well-rounded board comprised of Judicial Officers, Mental Health professionals and lawyers.

The Officers of the Board have already demonstrated great leadership skills and I am proud to introduce you to them. We are extremely fortunate to have the Honorable Mark A. Juhas, Family Law Judge in Los Angeles Superior Court and a frequent speaker at AFCC-CA and AFCC- National conferences, ACFLS Spring Seminar and the Family Law Section of the CLA, as President Elect. Judge Juhas takes ideas and turns them into action. He is also an active member of the legislation committee. Frank Davis, Ph.D., a dedicated child custody evaluator from Berkeley, is our energetic Vice-President, full of ideas to bring AFCC-CA into the 21st century and has been leading our mentor committee. Our new Secretary, Shane Ford, is a well-respected Certified Family Law Specialist and fellow in the American Academy of Matrimonial Lawyers, from the San Francisco Bay area, who did a phenomenal job as co-chair of the AFCC-CA 2018 conference. Check out Shane's impeccable minutes on our website to see what projects your Board members are working on this year. Diane Wasznicky, past president of AFCC-CA and past president of the Association of Certified Family Law Specialists (ACFLS), is a well-respected Certified Family Law Specialist from the Sacramento area, and she is our Treasurer and chair of the Legislation committee. Immediate Past President, Mike Kretzmer, Certified Family Law Specialist and fellow in the American Academy of Matrimonial Lawyers from the Los Angeles area, has been a great source of answers to my myriad of questions—and I know he will continue to be a sounding board for me for the next two years. This group of amazing individuals rounds out the Officers for AFCC-CA.

The Officers rely heavily on the incredibly talented and hard-working board members of AFCC-CA. The Honorable Harvey A.



Managing Special Needs Issues in Child Custody Disputes Practical Strategies in Changing Times

Lyn R. Greenberg, Ph.D., ABPP
Hon. Robert Schnider (Ret.)

Disputes regarding children with special needs are becoming increasingly common in child custody cases. Disagreements about the child's care and needs may be presented to the court as urgent matters or in fragmented form, with the suggestion that one parent must be marginalized in order for the child to receive necessary services. In other cases, parental conflict may risk harming the child by delaying services that are time sensitive or urgently needed. External providers unfamiliar with the court may become aligned with one parent based on partial information, complicating attempts to understand the problem and reach decisions.

At the height of conflict, decisions are often presented in simplistic terms. One parent is presented as advocating for the child's needs, while the other is presented as being "in denial." When a child has a heart condition or a severe developmental disorder, issues may be clearer and easier to resolve. When diagnoses are less clear and symptoms more subject to interpretation, differences between parents are often more complex. Given court's limited resources and time stressors, it is frequently tempting for the court to give one parent full or primary authority over selecting and arranging services for the child. Such arrangements can have the appeal of simplicity, efficiency, and apparent reduction of conflict, but create risks of marginalizing a parent, reducing consistency in the child's environment and treatment, increasing resentment and denying the child of emotional and parenting resources that both parents can provide. In some cases, conflict is simply relocated to other venues or to the family's daily life.

We propose here some methods for management of these cases that may promote parental cooperation and more prompt intervention for the child, manage conflict, or help differentiate between cases in which coparenting is possible and situations in which one parent must be given authority. This information may be useful for selecting professionals and services and/or presenting to the court indications that shared decision making isn't possible.

Defining Terms and Categories.
Children with special needs include those with developmental, medical, social, psychological, and behavioral issues which require special services or adaptations in the child's family, social, or educational life. These comprise a dizzying array of conditions with a wide range of severity and impact on the child. Children with more serious problems may require intensive, costly interventions, advocacy for services, and other attention from parents that increase family stress and lead to an increased risk of family disruption and divorce. Children with milder conditions may function fairly well until the stress of the parents' separation, at which time the child's symptoms, or parental reports of symptoms, may increase. Some parents are relatively united about care for the child until they separate, while in other families, disputes about the child's condition and needs predate or even precipitate the divorce. All of these dynamics exist against the common background of mistrust and conflict that characterize separating families.

Special needs children may receive services from a variety of other professionals who are often unfamiliar with the dynamics of divorce. Impressions about the child may be formed based on incomplete or one-sided information from parents who race one another to be the first to talk with the professional. Parents may label one another as overreacting, infantilizing the child, using the child's alleged diagnosis to marginalize the other parent, incompetence, denial of the child's needs, or co-opting professionals before the other parent can have input. Language used by external professionals may translate poorly to the family court. For example, a teacher's recommendation that a child "have consistency" may be presented to the court as a recommendation that the

Special Needs cont. from page 4)

child reside in only one home, when what the child actually needs is consistent rules or homework procedures. Sometimes that requires a single home during the school week, while in other cases consistency is enhanced by giving each parent a break from parenting demands.

Similarly, orders that give one parent primary authority, with a requirement that the other parent be consulted, do not always work out as intended by the Court – particularly if there is no one to enforce the requirement of consultation or to ensure that it is meaningful. The result may be poorer quality decisions, marginalization of a parent, poor cooperation with treatment plans, and placing the child at the center of conflict.

How Much Do They Need to Agree? Pickar and Kaufman (2015) have developed a risk assessment model for determining parenting plans, particularly when the child's special needs are severe or create acute risks to the child's safety. They have also discussed how the dynamics of parental gatekeeping may manifest in these families *(Kaufman & Pickar, 2017)*. In their work and that of others, it is often suggested that parents must reach a "functional level of agreement" about the child's diagnosis and needs (*Kaufman and Pickar,* 2015, p. 196) in order for coparenting to be possible, and that this should indeed be a primary goal in early coparenting efforts. This may be a high hurdle for parents to overcome in the early stages of the divorce, when they agree on little and mistrust is high. If disagreement exists, a critical decision must be made as to whether to focus on an evaluation to establish a diagnosis that then guides treatment planning, or whether a focus on areas of agreement and functional cooperation may be more productive.

Certainly we agree that where safety risks are high (a child who runs away, engages in self-injuries behavior, or is at risk of suicide), a high degree of parental cooperation may be necessary. Many special needs children, however, exhibit milder behaviors subject to a variety of interpretations. In these cases, prioritizing one parent's perspective over the other may not be helpful to the child. The areas and criteria for agreement deserve closer scrutiny. Some of the strategies listed below are best implemented by a parenting coordinator, but the combination of a skilled family therapist and a supportive minor's counsel may also allow for either improvement for the child or clarified information to present to the court.

"Diagnosis" vs. Behavior. Some of the conditions that are the subject of the most parental controversy raise diagnostic disagreement outside of the family court as well. It is important to recognize that from the perspective of managing the child's problems, precise agreement on diagnosis isn't always possible or necessary. In exploring these issues, behavioral descriptions are more useful and more understandable to both parents and the court. For example, a child who is exhibiting hyperactivity, learning and behavioral challenges may have been impacted by a biological condition, an increase in school demands, distress about the parental separation, or all of these issues. Parents may be in dispute as to whether the child has Attention-Deficit-Hyperactivity-Disorder (ADHD), and whether the child could benefit from medication, but may be able to agree that the child is exhibiting learning difficulties, poor social skills, poor compliance with rules, or other problems. With help, they may be able to agree on initial behavior management strategies, such as procedures suggested by a teacher, as a way of both assisting the child and clarifying treatment needs. Similarly, parents who agree (or have been told) that their child is medically obese may disagree about the cause of the problem but be willing to follow a physician's or therapist's initial guidance for managing the condition. The same may be true of children who appear to fall somewhere on the autism spectrum, as parents may be able to initially commit to specific behavioral plans while discussion of the "labeling dispute" continues.

Parents may need professional assistance in disengaging from the diagnostic dispute, at least temporarily, to focus on problem behaviors. A family therapist consulting with the child's pediatrician can be effective in this area. It has been our experience that when parents are able to cooperate with early interventions, disagreements on other issues may narrow. For example, if both parents follow a behavioral plan but the child continues to struggle, parents may be more accepting of considering other interventions, such as medication or therapy. Experiencing success through cooperation may help parents be more open to considering one another's opinions about the child's diagnosis and treatment needs.

Selection of Treatment Providers, Assessment Processes. Few actions generate more suspicion in a parent than being excluded from consultation with a treatment provider. In some families, one parent may have assumed the primary role in such appointments before the separation and seeks services more out of habit than a desire to exclude. Some parents have historically been unavailable or passive about obtaining services. Some parents have personal issues that lead them to resist services for the child, including a personal history of the same problems that have been identified in the child. When these are issues in dispute, it is often critical to establish a structure for dealing with doctors, therapists, teachers and other professionals. Court orders requiring consultation between parents may be insufficient to promote both parents' information reaching the professionals. It may be necessary to establish a precise structure for consulting other professionals that

Special Needs cont. from page 4)

includes both parents' input and observations, with the parents bringing their perceptions back to a coparenting counselor, family therapist or parenting coordinator, who would also be able to contact the physician, teacher or other providers directly. A reality of these children's lives is that many providers may be involved, so the central mental health professional may need the ability to establish a collaborative team. In some cases, minor's counsel may be necessary to seek orders that will direct an evenhanded and orderly process and document parental communication through venues such as Our Family Wizard. Much information may also be gained by observing what happens when the structure is established. Do both parents attend meetings at the school? Do they follow through on speaking with doctors, attending parenting classes, communicating with one another, or participating in other interventions for the child?

Enhancing Parenting Abilities, Providing for Respite. In some families, one parent is clearly more knowledgeable and adept than the other parent in working with the special needs child. Kaufman and Pickar (2017)provide an excellent description of how these differences may impact on coparenting. Some of these differences reflect marked differences in parenting abilities, while a closer look at other families may reveal parents who each have attributes to offer the child but react in unproductive ways to their different orientations and knowledge. One parent may need to learn specific skills for managing the child's behavior, while the other may need to support independence and avoid micromanaging.

In many cases both parents are struggling, more than they are willing to admit to themselves or each other. Even children with less severe special needs may place high demands on parents' energy and emotional resources. (Pickar and Kaufman, in process.) Exhausted parents are rarely consistent or effective. Many providers and experts, outside of the family law system, strongly suggest that parents take opportunities for rest and respite while the child is in an organized activity or in someone else's care.

When parents are overwhelmed, it is easy to become consumed with managing therapeutic appointments and not consider the child's needs or abilities in terms of social and recreational development. Many special needs children, especially those with mild or moderate impairments, are fully capable of participating in structured peer activities and recreation. They may find strengths in some activities that bolster self-esteem and help the child establish critical and social abilities. Moreover, while one parent may have strengths in communicating with medical personnel, the other may have, or be able to develop, skills in finding recreation programs that will adapt to the child's needs and support the child's overall goals. While such activities may be of critical importance, they are easy to overlook when parents are fighting over other services. In addition to providing important resources for the child, these activities may provide important opportunities for respite and coparenting, or to address subtle "gatekeeping" issues that may impact the child. (Pickar and Kaufman, 2017; Austin and Greenberg, in process.)

The "art" for the parenting coordinator, coparenting counselor or family therapist is to encourage parents to develop a partnership and schedule that allows them to provide respite for one another and cooperate on issues such as taking children to therapy, activities or other appointments. Establishing a structure that involves each parent in the therapeutic regime, such as alternating in taking the child to appointments, may allow the therapist to have a more realistic appraisal of the family situation and help each parent to be more effective with the child. When conflict emerges that cannot be resolved without the court's assistance, it becomes important to clearly convey to the parents, and perhaps ultimately the court, the connection between the disputed issues and the child's developmental needs. The parenting coordinator or family therapist may also serve a critical function in ensuring the providers communicate and are not working at cross purposes. If sufficiently qualified minor's counsel are available, they may be helpful in bringing information to the court and promoting accountability.

How Much Can We Lead Them to Water? It is well established in psychology that experience with positive change can lead to changes in one's beliefs, which in turn can lead to more positive change. Even if parents do not change their beliefs, there are beneficial effects to reducing the child's exposure to conflict. But many conflicting parents will not take the first steps toward positive change, or place themselves in the position to experience what can work, without the external motivations associated with a legal process.

While parents must stipulate to a parenting coordinator, judges and jurisdictions differ widely on their interpretation of what other services the court can order. There is general agreement that the court can order counseling under Cal Fam Code §3190 for the purpose of improving communication and reducing conflict. Judges differ widely in their interpretation of that language, although in the second author's experience, most take an expansive view of the types of counseling they may order. They may also differ in their understanding of the scope of professionals' roles. This creates some hazards for MHPs, underscoring the importance of a careful informed consent process. MHPs must determine the scope of services and cooperation necessary to be effective. MHPs can articulate those expectations in draft

Special Needs cont. from page 4)

order or informed consent documents, which they should request be incorporated into any order regarding their services. While a full discussion of informed consent is beyond the scope of this article, it is useful to consider the provision of consent documents as a "conversation" between the potential provider, counsel and the court. Parties (or the court) can reject part of the language requested by the MHP, who must then determine whether he/she can ethically provide services within the scope of the modified document. This can seem a tedious and time consuming process, but is essential risk management. In addition, progress is more likely if everyone is clear on the terms of engagement and expectations. Sample order language is appended to the *AFCC Guidelines for Court Involved Therapy* (Association of Family and Conciliation Courts, 2010).

Judges can, of course, also motivate change through various formal and informal methods. More informally a judge can use the "bully pulpit" admonishing the parties of the negative consequences of their behavior, e.g. "If you continue this way you are going to destroy this child and bankrupt yourselves." While this can occasionally produce the desired results, more direct methods are more effective.

The court can establish goals for the child, setting expectations that the parents should meet when the case returns for a review. An example would be the completion and turning in of all homework assignments, by the child. Even more powerful is establishing expectations for parental behavior. The court can find that the time share or legal custody orders are specifically based on the court's expectation that each party will, for example, consult with the other prior to medical appointments or administering medication or enrolling in a group. Putting that finding on the record makes it clear that the failure to comply could be seen as a change of circumstances justifying a modification of the orders to the detriment of the party who did not comply.

Finally there are financial levers. A court can order that the parties split the AGREED costs of certain expenses, but if one party incurs the expense without obtaining agreement they would be fully responsible for that cost.

The recently concluded AFCC California Chapter Conference featured a Special Institute on this topic, *"Managing Special Needs Issues in the Context of Child Custody Disputes: Practical Strategies, Early Intervention" (Greenberg, Lopez, Gould-Saltman, 2018).* The interdisciplinary panel provided therapeutic and case management strategies, as well as suggestions for stipulations and orders governing services. Judges, attorneys, and mental health professionals in attendance discussed both the potential of this approach and difficulties that may be encountered in our current legal climate. In particularly high conflict cases, it may be difficult to find providers willing to care for these vulnerable children. Methods for reducing chaos, structuring information gathering, and maintaining community care and involvement for children were also discussed. Conditions in which minor's counsel may be helpful were also discussed.

While obstacles may be encountered to this or any other intervention, the potential for benefit is particularly high for children with special needs. These children may need prompt services and experience immediate benefit if parents can learn to cooperate with medical, educational and therapeutic professionals and engage logical decision-making to steps to help their child. Additional therapeutic applications can be found in Greenberg, Doi Fick and Schnider (2012, 2016).

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Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

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Approved by the AFCC Board of Directors
October 2010

Table of Contents

PREAMBLE

The Guidelines for Court-Involved Therapy have been formulated to assist members of the Association of Family and Conciliation Courts (AFCC) and others who provide treatment to court-involved children and families. The Guidelines are also intended to assist those who rely on mental health services or on the opinions of mental health professionals in promoting effective treatment and assessing the quality of treatment services. The Guidelines are also intended to assist the Courts to develop clear and effective Court orders and parenting plans that may be necessary for treatment to be effective.

AFCC does not intend these Guidelines to define mandatory practice. They are a best-practice guide for therapists, attorneys, other professionals and judicial officers when there is a need for therapeutic interventions with court-involved children or parents. While available resources and local jurisdictional expectations may influence the types of therapeutic services provided by a Court-Involved Therapist (CIT), the purpose of these guidelines is to educate, highlight common concerns, and to apply relevant ethical and professional guidelines, standards, and research in handling court-involved families.

INTRODUCTION

For the purposes of these guidelines, court-involved therapists are mental health professionals who provide therapeutic services to family members involved in child custody or juvenile dependency Court processes. Family and juvenile Court cases involving therapeutic services introduce unique factors and dynamics that require consideration in the treatment process. Both the treatment process and information provided to the therapist are likely to be influenced by the family's involvement in a legal process. While appropriate treatment can offer considerable benefit to children and families, inappropriate treatment may escalate family conflict and cause significant damage.

The Guidelines for Court-Involved Therapy are the product of the Court-Involved Therapist Task Force, appointed by AFCC President Robin Deutsch in 2009. Task force members were: Hon. Linda S. Fidnick, Co-Chair; Matthew Sullivan, Ph.D., Co-Chair; Lyn R. Greenberg, Ph.D., Reporter; Paul Berman, Ph.D.; Christopher Barrows, J.D.; Hon. R. John Harper; Hon. Anita Josey-Herring; Mindy Mitnick, M.Ed., M.A.; and Hon. Gail Perlman.

DEFINITIONS

A. Definitions Regarding Professional Roles

Community Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is not involved with the legal system at any time during the treatment.

Court-Involved Therapist (CIT): Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is, at any time during the treatment, involved with the legal system.

Court-Appointed Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because the particular psychotherapist was ordered by a judge to provide treatment. The Court order designates the specific psychotherapist and may describe the expected treatment.

Court-Ordered Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because it was ordered by a judge. The Court order does not designate a specific therapist and may describe the expected treatment.

B. Definitions Regarding Experts

Expert: The word expert generally refers to a person with specialized knowledge of a particular subject matter.

In the legal context, the word "expert" refers to a witness who has been specifically qualified by the Court in a particular case to provide opinion evidence within a circumscribed subject matter determined by the Court. To qualify an expert, the Court first reviews evidence of the witness's expertise of that subject matter, unless the admissibility of the professional's opinion as an expert has been previously stipulated to by the parties or established by the Court.

(a) Treating Expert: A mental health professional, who currently serves or has served as the therapist for a parent, child, couple or family involved with the legal system. If the therapist is qualified by the Court as an expert, testimony should be limited to the therapist's particular area of expertise and issues directly relevant to the treatment role. To the degree permitted by the Court in a specific case, the treating expert can provide expert opinion regarding a parent or child's psychological functioning over time, progress, relationship dynamics, coping skills, development, co-parenting progress, or need for further treatment, as appropriate to the therapist's role. In contrast to the forensic expert, the treating expert does not have the information base or objectivity necessary to make psycho-legal recommendations, such as specifying parenting plans, legal custody, or decision-making authority.

(b) Mental Health Forensic Expert: A mental health professional hired by a party or appointed by a Court to answer a legal question through the application of psychological methods. A mental health forensic expert, for example, may perform a custody evaluation, a psychological evaluation to answer a particular question formulated by the Court, a competency evaluation, an evaluation to assist the Court in the decision-making process regarding custody and/or access. Their testimony might include psycho-legal issues such as recommendations about parenting plans, legal custody or decision-making authority.

C. General Definitions

Client/Patient: A parent, child, couple or family receiving psychotherapeutic treatment from any of the mental health professionals defined in this section

Collateral: A person, not a client or patient, who has information bearing on the client or patient and whom a mental health professional, in any role defined in this section, interviews to obtain information or engages directly in the client or patient's treatment.

Confidentiality: An ethical duty, also established by statute, rules or case law in some jurisdictions, owed by a mental health professional to a client/patient, subject to some exceptions, to maintain the client/patient's privacy by not revealing information received from the client/patient.

Privilege: A legal right, conferred by statute in many jurisdictions and limited by exceptions, held by a mental health professional's client/patient to prevent the mental health professional from disclosing confidential information in a legal proceeding. Some jurisdictions have a formal process for determining whether or not and under what circumstances the privilege will be waived by or on behalf of the client/patient to allow testimony by the mental health professional in a court-related matter. (Issues regarding privilege and confidentiality are described in Guideline 7.)

Conflict of Interest: A situation in which personal, professional, legal or other interests or relationships have the potential to compromise or bias the mental health professional's judgment, effectiveness or objectivity. A conflict of interest may also occur in some jurisdictions based on the establishment of an appearance of conflict standard rather than an actual conflict.

Informed Consent:

(a) A client/patient's decision to consent to a proposed treatment or a proposed release of confidential information by a mental health professional, after the client/patient has received reasonably full and accurate information from the mental health professional as to the risks, benefits and likely consequences of the decision to consent.

(b) The term is used colloquially by mental health professionals to mean the *process* by which a client/patient receives the information needed to make an informed decision. The process usually includes discussion and a written agreement between the mental health professional and the client/patient as to the information provided and the client's understanding of it. (See Guideline 6.)

GUIDELINE 1: ASSESSING LEVELS OF COURT INVOLVEMENT

1.1 A CIT should assess the degree to which legal processes will impact the treatment and consider issues that may impact the client or parent's functioning in treatment, and the implications of treatment interventions on the legal processes

(a) The CIT should be aware that cases may have different degrees of Court involvement, and may also change in their degree of Court involvement over time.

(b) The CIT should obtain information about how the decision to enter therapy was made, who was involved in the decision, and what outcomes are expected from the treatment or the therapist by parents, other professionals, or the Court.

(c) The CIT should consider the variety of mechanisms through which court-involved families can enter treatment, and the implications of each of those circumstances:

(1) A parent involved in a Court case recognizes his/her own or child's distress and seeks treatment.
(2) A parent seeks therapy for him/herself or a child, in hopes of improving his/her own position in the Court case and securing the therapist's direct or indirect participation (report to a custody evaluator, etc.).
(3) Parents are ordered to obtain therapy for themselves or a child, but select from community practitioners with no specific agenda, reporting expectation or requirement.
(4) The Court orders therapy to address particular issues, such as child distress, high-conflict dynamics, reunification, etc. The order may include some degree of reporting requirement, or contingencies allowing reporting.

(d) The CIT should consider the potential impact of Court involvement on adults' functioning in treatment. The stress of Court involvement and the importance of the outcome to those involved can generate conscious or unconscious distortion of information and changes in the clients' or parents' expectations of the therapist.

(e) The CIT should consider the impact of his/her natural working alliance with the client. This may lead the therapist to align with the client's position in the legal dispute, thus impairing the CIT's ability to prepare the client to cope with likely outcomes and stresses in the legal process. While a client may equate his or her best interests with prevailing in the legal dispute, CITs must remain cognizant that their role is to promote successful psychological

functioning in the client, not to serve as an advocate or a forensic expert or produce a particular outcome in the legal process.

1.2. Special considerations for court-involved roles with children

(a) Children's behavior and statements may vary markedly based on the circumstances of treatment.

(b) The CIT has an enhanced obligation to consider multiple treatment hypotheses and be knowledgeable about children's developmental tasks and needs.

(c) The CIT should use particular caution to ensure that he/she has adequate data on which to base any opinions or assessments, and to form and express such opinions only within confines of the therapeutic role and available information, while remaining cognizant of the impact of Court involvement on the family and on treatment information.

(d) The CIT must, whenever possible, obtain each parent's perspective in the treatment process and maintain professional objectivity when interpreting statements and behaviors of children. The CIT should use particular caution in interpreting statements, play or drawings that appear to express positions on adult issues to avoid inaccurate or incomplete assessment of a child's developmental needs, expressed thoughts and feelings.

(e) The CIT should be aware of the potential impact of parental needs and expectations on treatment involving children or adolescents. The CIT should be particularly aware that:

  (1) A parent may have a genuine desire to obtain treatment or provide it to a child, but may also have expectations that the therapy will support the parent's own goals in the legal conflict.
  (2) A child or adolescent who is expressing a "position" regarding a contested issue in the legal conflict may have external influences on their perceptions, or that negatively impact their coping skills.

(f) While it is common in traditional treatment for one parent to be more involved in child treatment than the other, this therapy structure creates a risk in court-involved treatment. A CIT should consider *both* parent-child relationships and each parent's perspective in court-involved treatment.

GUIDELINE 2: PROFESSIONAL RESPONSIBILITIES

2.1 A CIT should establish and maintain appropriate role boundaries

(a) A CIT should inform potential clients, and others who may be relying on the therapist's opinion or services, of the nature of the services that can be offered by the therapist and the limits thereof. This includes providing thorough informed consent to clients/parents and appropriate information to others who may rely on the therapist's information. (See Guideline 6 and Guideline 10.)

(b) A CIT should resist pressure from anyone to provide services beyond or antithetical to the therapeutic role, as defined by recognized professional and ethical standards or guidelines.

(c) A CIT should explain to clients any decisions to decline to provide certain services. If others (e.g., the Court guardian *ad litem*, minor's counsel or agency) have requested services that the CIT considers inappropriate, the CIT should also explain decisions to decline these requests, to the degree that information provided is not privileged or privilege has been waived.

(d) A CIT should be prepared to modify elements of the therapeutic process, if appropriate, and to explain the necessity for the modification.

(e) A CIT should apprise the Court of any conflicts between the Court's expectations and the ethical and professional obligations, or role limitations, of the therapist.

2.2 A CIT should demonstrate respect for parties, families, the legal process and its participants

(a) A CIT should communicate respect for the legal system to clients, collaterals, and others who may rely on the therapist's work, information or opinions.

(b) A CIT should provide a thorough informed consent processes to parents, and age-appropriate explanations to children, as described in Guideline 6.

(c) A CIT should communicate, within the limits of any applicable privilege, regarding the limits and responsibilities of the therapist's role.

(d) A CIT should respect each parent's rights, as defined by relevant orders or law, regarding knowledge of, consenting to, and/or participating in a child's treatment.

(e) A CIT should be knowledgeable about appropriate expectations for developmentally acceptable behavior in children while respecting their independent feelings, perceptions, and developmental needs.

(f) A CIT should communicate with counsel in a balanced manner when in a neutral role and authorized to do so.

2.3 A CIT should provide clear, non-technical communication of observations and opinions to adult clients, parents of child clients, and other professionals when appropriate and permitted by applicable privilege

2.4 A CIT should maintain professional objectivity

(a) A CIT should actively seek information that will provide the most thorough understanding of his/her client's circumstances and issues, while remaining within the limits of the therapist's assigned therapeutic role in the case.

(b) When children are involved in treatment, a CIT has an enhanced obligation to consider multiple hypotheses, seek information and involvement from both parents and avoid the biasing effects of one-sided or limited information.

(c) A CIT should make efforts to consider and assess treatment issues from the perspective of each involved individual. This does not preclude maintaining a strong therapeutic alliance with a parent client/patient in individual therapy, but may require exploring with the client how others may perceive the issues.

(d) To the degree possible in the given therapeutic role, the CIT should remain aware of the information emerging in the legal process in order to assist the client in coping with it.

2.5 The CIT should manage relationships responsibly

(a) A CIT should recognize that the therapeutic relationship may change as a family's involvement with the Court changes or as the therapist communicates to other professionals, collaterals or the Court.

(b) If a parent or family who has not previously been court-involved becomes involved in a legal process and asks the therapist to continue services, the CIT should discuss with the relevant individuals and/or family members the potential effect of Court involvement on the therapy. This should include discussion of potential requests for release of therapeutic information to others including a child custody evaluator, parenting coordinator, other professionals, or the Court.

(c) If a CIT who has not previously been involved with a client's ongoing litigation is asked to provide information or have other involvement in the legal process, the CIT should notify the client and/or the client's legal representative of such requests. If the CIT believes the release of information

will adversely impact the client, the CIT should seek legal advice and notify the Court.

(d) The CIT should clearly document informed consent on the above issues.

2.6 A CIT should maintain accountability

(a) The therapist in a child-centered role should recognize that active intervention may result in the dissatisfaction of one or both parents, but should nevertheless maintain focus on the welfare of the child client.

(b) If disputes arise regarding interpretation of Court orders governing treatment, the CIT should seek direction or clarification from the Court, or an authorized Court representative in the case.

(c) The CIT should recognize that others in the legal system (e.g., custody evaluator, parenting coordinator, child's counsel or the Court) may have a role in monitoring or reviewing the therapeutic process.

(d) The CIT should recognize that his/her judgments, interventions, reports, testimony and opinions may have a profound impact on outcomes for children and families. The CIT should remain objective at all times, should use caution in forming and expressing opinions, and should use particular caution in drawing conclusions from limited observations or sources of information.

(e) A CIT should recognize that the dynamics of a court-involved case may create conflicts or disagreements with litigating parents or lead to demands that the therapist withdraw from the case. The CIT should recognize that therapeutic confrontation of a parent or a child, or a refusal to accede to the wishes of a parent or child, may frustrate that individual's desires, but does not necessarily constitute a conflict of interest. Such therapeutic confrontation may be therapeutically appropriate or even essential. In such a situation, withdrawing from the case or abandoning the intervention, unless terminated by the client, may be antithetical to the interest of the child or family.

GUIDELINE 3: COMPETENCE

3.1 A CIT has a responsibility to develop and maintain specialized competence sufficient for the roles they undertake

3.2 Gaining and maintaining competence

(a) A CIT has a responsibility to obtain education and training, and to maintain current knowledge, in areas including, but not limited to:

(1) Characteristics of divorcing/separated families and children

(2) Family systems and other systems in which court-involved families interact
(3) The impact of high interparental conflict on post-separation custody arrangements
(4) Effective interventions with divorcing or separated families
(5) Adaptations of traditional therapeutic approaches that may be Necessary to work with divorcing or separated families
(6) characteristics and needs of special populations who may be Involved in treatment
(7) Ethical issues and applicable local legal standards

(b) A CIT should utilize continuing education and professional development resources to maintain current knowledge of issues relevant to court-involved treatment.

(c) A CIT may also gain some of the required knowledge through experience and consultation with colleagues; however, clinical experience should not be a substitute for knowledge of the underlying science, relevant research, legal issues and standards of practice.

3.3 Areas of competence

(a) The CIT should maintain knowledge and familiarity with current research related to psychological issues in areas including, but not limited to:

(1) Child development and coping, including developmental tasks
(2) Child interviewing and suggestibility
(3) Children's decision-making ability, including appropriate means of understanding children's abilities and interpreting expressed preferences or opinions
(4) Factors in divorcing families that increase risk to children, or promote resilience in children
(5) Domestic violence
(6) Child abuse and child welfare
(7) High conflict dynamics, including risks to children from exposure to parental conflict, parental undermining, alienation and estrangement
(8) Treatment approaches, including both traditional methods and adaptations for divorcing or separated families
(9) Parenting and behavioral interventions
(10) Special needs issues, including medical issues, psychiatric diagnoses, substance abuse, learning or educational problems, developmental delays, etc.
(11) Ethnic, cultural, and sexual orientation differences among families

(b) The CIT should maintain knowledge and familiarity with legal information and issues related to court-involved therapy, including, but not limited to:

(1) Statutes and local Court rules in the therapist's jurisdiction
(2) Case precedents relevant to court-involved treatment
(3) Interactions and potential conflicts between governing mental health practice and family Court expectations or family law statues
(4) Ethical and professional guidelines and standards applicable to the role of the CIT, obtaining ethics consultation as appropriate
(5) Circumstances under which it may be necessary or appropriate for the therapist to consult an attorney

(c) The CIT should seek appropriate consultations when issues arise that are outside of the CIT's expertise.

3.4 Understanding of professional roles and resources

(a) The CIT should be familiar with the roles of other professionals with whom the CIT may interface while providing therapy in a case.

(b) The CIT should understand the roles of the child custody evaluator and the parenting coordinator, and the impact that the appointment of such professionals may have on both the process of therapy and the privacy of therapeutic information.

(c) The CIT should understand the roles of the minor's counsel or guardian *ad litem*, and should be aware of the laws governing confidentiality of treatment information when one of these professionals is appointed.

3.5 Representation of competence, state of professional knowledge

(a) The CIT should accurately represent his/her areas of competence, advise clients/parents if an issue arises that is beyond the CIT's knowledge and expertise, and initiate consultation and/or referral, when appropriate.

(b) The CIT should understand the limits of scientific knowledge and use caution to avoid overstating the certainty or parameters of professional opinions. (See Guideline 10.)

3.6 Consideration of impact of personal beliefs and experiences

(a) The CIT should remain familiar with current research on the impact of personal bias, personal beliefs and cultural and value differences, factors that may contribute to bias, and efforts that may be undertaken to contain or manage potentially biasing conditions in the CIT's work.

(b) The CIT should recognize and acknowledge that powerful issues may arise in court-related cases that generate personal reactions in the therapist or others, and take steps to counterbalance exposure to information or otherwise manage these issues.

(c) The CIT should obtain appropriate consultation to assist in maintaining professional objectivity.

GUIDELINE 4: MULTIPLE RELATIONSHIPS

4.1 The CIT should avoid serving simultaneously in multiple roles, particularly if these create a conflict of interest. For example, the CIT should not serve simultaneously as therapist and evaluator or as therapist and friend. Similarly, the CIT is strongly discouraged from performing different roles sequentially, as, for example, a therapist who becomes an evaluator or a therapist who becomes a parenting coordinator.

4.2 The CIT should disclose to all relevant parties any multiple relationships that cannot be avoided and the potential negative impact of such multiple roles.

(a) The CIT who discovers that he/she is performing multiple roles in a case should promptly seek to resolve any conflicts in a manner that is least harmful to the client and family. The CIT should clarify the expectations of each role and seek to avoid or minimize the negative impact of assuming multiple roles.

(b) The CIT should recognize that relationships with clients are not time limited and that prior relationships, or the anticipation of future relationships, may have an adverse effect on the CIT's ability to be objective.

(c) The CIT should attempt to avoid conflicts of interest and should address them as soon as they arise, or the potential for conflict becomes known, by:

(1) Identifying a real or apparent conflict of interest as soon as it becomes known to the CIT
(2) Refusing to assume a therapeutic role if personal, professional, legal, financial or other interests or relationships could reasonably be expected to impair objectivity, competence or effectiveness in the provision of services
(3) Communicating with the client or potential client or counsel, and, if necessary, with the Court, about the existence of the conflict.
(4) Recognizing that the appearance of a conflict of interest, as well as an actual conflict of interest, can diminish public trust and confidence both in the therapeutic service and in the Court
(5) Differentiating between conflicts that require declining to assume or

withdrawing from the therapeutic role, as opposed to multiple or sequential roles that may be undertaken with waivers from the client or parent

(6) Recognizing the risks of undertaking conflicting roles, even if the client or parent signs a waiver

(7) Clearly documenting the disclosure of any waived conflict, the client's ability to understand it, and the client's waiver. The client must receive a clear explanation of the conflict, and it may also be necessary to provide such explanations to other professionals or agencies relying on the therapist's work or information

GUIDELINE 5: FEE ARRANGEMENTS

5.1 The CIT should establish a clear written fee agreement with the responsible parties prior to commencing the treatment relationship

(a) A CIT may send a written fee agreement to the parties and/or client(s) prior to commencing treatment.

(b) If the case is not court-involved, a CIT may discuss the terms and fee requirements of treatment directly with the parties and/or client. This discussion should be documented in the CIT's record.

(c) If the case is already court-involved, or likely to be, a CIT may send the fee and consent agreements to counsel.

5.2 The CIT should provide written documentation to each responsible party

(a) Documentation should include a description of the treatment services to be provided, including all of the elements of informed consent described in Guideline 6.

(b) A CIT should provide a fee agreement that contains, at a minimum:

(1) A description of all services and charges

(2) Expectations regarding payment, including, if applicable:
   (i) fees associated with missed or cancelled sessions,
   (ii) costs/fees generated by one parent,
   (iii) consequences of non-payment, including its potential impact on continued provision of services,
   (iv) the use of collection agencies or other legal measures that may be taken to collect the fee (see attached sample agreement).

(3) Policies with regard to insurance reimbursement, if any. This should include issues such as identifying the person responsible for submitting the insurance form, payment for covered and non-covered

services, responsibility for submitting treatment plans (if required by the insurer) and the consequences of using insurance.

(4) Policies regarding advance payments, if any, for treatment services and the use of those payments

(5) A procedure for handling of disputes regarding payment

(c) If the therapy is court-ordered, the CIT should provide to the Court all information required to engage the CIT so that the Court can issue an appropriate and comprehensive order. The written fee agreement may be incorporated into the Court order that initiates the therapy. The therapist should request that the Court specify the party responsible for the payment or the specific apportionment between the parents or parties. In the event that the Court order fails to address the issue of fees adequately, the therapist should take appropriate steps to obtain clarification from the Court before providing services. Arrangements should be sufficiently clear to prevent or resolve most fee-related disputes, and for a future judicial officer or reviewer to be able to resolve any such disputes submitted to the Court.

(d) If treatment is terminated or suspended due to non-payment, the CIT should conduct the termination or suspension in accordance with the order, fee agreement and ethical principles.

(e) The CIT should maintain complete and accurate written records of all amounts billed and all amounts paid.

GUIDELINE 6: INFORMED CONSENT

6.1 At the outset of therapy, the CIT should provide a thorough informed consent process to adult clients and parents or legal guardians if the therapy involves the child

(a) A CIT has a professional obligation to inform the client of the limits of confidentiality and privilege at the outset of the therapeutic relationship, to promote informed decision-making throughout treatment and to document such explanations in the CIT's record. The CIT should clarify that these cautions do not constitute legal advice, and that the CIT will obey the Court's orders regarding treatment information.

(b) The informed consent should use language that is understandable and includes, at a minimum, information about the nature and anticipated course of the therapy, risks and benefits of the therapy, fees, the potential involvement of other individuals in the therapy, and a discussion of confidentiality.

(c) The CIT should be aware of state laws that impact confidentiality and access to records and these should be incorporated in the informed consent.

(d) Clients or their counsel should have an opportunity to ask questions, obtain answers, and discuss their concerns. These discussions should be documented in the CIT's record.

6.2 If a child is to be involved in treatment, there are special considerations

(a) A CIT should generally avoid accepting a child into treatment without notifying or consulting with both parents.

(b) A CIT should request copies of Court orders or custody judgments documenting each parent's right/authority to make decisions regarding treatment and delineation of each parent's access to treatment information.

(c) In rare and urgent cases, such as when there is strong reason to suspect a risk to a child's safety, a CIT may accept a child in treatment at the request of one parent. This should only occur if that parent has clear legal authority to consent and pending efforts to either notify the other parent or obtain permission from the Court; however, the CIT should be aware that such a decision may increase risk to the child, and to the CIT.

(d) A CIT should explain the nature and purpose of the treatment to a child in age-appropriate language. It may be necessary to revisit these issues as treatment proceeds.

(e) A CIT should discuss the limits of parental involvement and confidentiality with the parents or guardians of a child or adolescent involved in treatment.

6.3 When a CIT becomes involved in treatment at the request of a third party such as the Court, an attorney, or a social service agency, the CIT should be especially attentive to informed consent issues

(a) The CIT should identify to the client the name of the person or agency that requested the services and the potential impact this may have on the treatment.

(b) If an adult client or parent does not sign the informed consent, or otherwise has significant disagreements with the treatment process, the CIT should defer commencement of services and refer the client back to the third party agency or the Court for clarification.

(c) If the CIT has been appointed by the Court to provide treatment to one or more adults and an adult refuses to sign consent documents, the CIT should defer commencement of services until consent is obtained or the Court takes action to resolve the issue.

(d) If a CIT is asked by anyone to provide treatment to a child and one parent supports treatment while the other refuses consent, the therapist should refer the parties back to the Court for resolution of the dispute between the parents, and then proceed as the Court directs.

(e) If the court-ordered treatment is to proceed, it is recommended that the CIT require a treatment order, specifying the nature of the services to be provided and the parameters of treatment, before proceeding with treatment.

6.4 When more than one individual participates in the therapy, the CIT should clarify with each person the nature of the relationship between the participants and between each participant and the therapist. The CIT should also clarify his/her roles and responsibilities, the anticipated use of information provided by each person, and the extent and limits of confidentiality and privilege

6.5 On a case-specific basis, the CIT should explain to the client the manner in which treatment information will be handled. Issues to be clarified may include, but are not limited to:

(a) Whether the consent of one or both parents will be required to release information from conjoint, co-parenting or marital therapy

(b) Whether information will be released to a custody evaluator, parenting coordinator, the Court, or any other individual, and the extent of the information to be released

(c) Whether, and how, the CIT will communicate to the Court in the event that one or both parents do not cooperate with court-ordered treatment

(d) What will happen if the CIT is subpoenaed to give testimony in a court-related matter

(e) What information can be released to insurance companies, the Court, the other parent, or other entities to enable the CIT to collect his/her fees.

6.6 The parent/client should be encouraged to consult with counsel before signing a therapy/informed consent agreement, if the parent or client is represented

6.7 If the CIT's level of Court involvement changes or requests are made to change the CIT's role, the CIT should inform the client of the risks, benefits and impact of any potential changes in treatment

(a) The CIT should obtain consultation before contemplating a change in his/her role that might create a conflict of interest or alter therapeutic alliances.

(b) If the CIT becomes aware of potentially conflicting roles, he/she should take reasonable steps to immediately disclose, clarify and discuss the potential conflicts and any potential adverse impact. The CIT should make best efforts to minimize any negative impact, including withdrawing from the case, if appropriate.

(c) If the parties consent to a change in the CIT's role, the CIT should document the revised informed consent process.

6.8 The CIT should be sensitive to the possibility of being asked to provide feedback to third parties or to testify as a witness. The CIT should inform the client of this potential at the beginning of the informed consent process and as necessary thereafter.

(a) The CIT should take reasonable steps to clarify the limits of the therapeutic role, the potential scope of information to be released, and the potential implications of the release of information or the testimony for the client (see Guideline 7). In no case should the CIT attempt to provide legal advice to the client.

GUIDELINE 7: PRIVACY, CONFIDENTIALITY AND PRIVILEGE

7.1 The CIT should understand the principal issues that arise in court-related therapy in regard to client/patient confidentiality and privilege.

(a) The CIT should be aware that laws and standards vary markedly among jurisdictions, and there may be conflicts in the law within a single jurisdiction. Issues that may vary among (and within) jurisdictions include, but are not limited to:

(1) The identified client
(2) Assertion and waiver of the client's privilege
(3) Under what circumstances the mental health professional can or must disclose confidential information

(b) The CIT should be aware that ethical, clinical, and legal issues related to confidentiality/privilege may differ depending on whether a parent, child, couple or family is in treatment.

(c) The CIT should be aware of clinical issues related to disclosure of confidential information. (See Guideline 8.7.)

7.2 The impact of litigation on decisions regarding use of treatment information.

(a) The CIT should also be aware that a client or parent's legal case may be affected by the client's decision to release or decline to release treatment information. The CIT should encourage the client/parent to seek appropriate legal consultation before making this decision.

(b) The CIT should consider the impact of the Court context on a client's decisions about the use of treatment information and should take precautions accordingly.

(c) The CIT should consider that situational pressures may affect the client or parent's judgment or authority on the issue of waiving the privilege regarding treatment information. These pressures may include requests from the Court or other professionals with influence on the legal proceedings (e.g., a custody evaluator or parenting coordinator) that the parent waive his/her own, or the child's privilege as to the treatment relationship.

(d) The CIT should be aware that in some jurisdictions or situations, parents may not hold the right to waive or assert the child's privilege in court-involved treatment or treatment of the child. In some jurisdictions, a CIT has the option or duty to resist disclosure of information, or seek direction from the Court, if the CIT determines that disclosure of the information risks the welfare of the child. The CIT should be familiar with the appropriate procedures for his/her jurisdiction.

7.3 A CIT should recognize the limits of his/her expertise and, when in doubt as to whether information requested about treatment can be released, seek legal advice or request direction from the Court

7.4 Ongoing obligation to inform clients

(a) A CIT should revisit the discussion of confidentiality with the client as circumstances change, or as issues arise in therapy that may result in the disclosure of treatment information.

(b) If therapy is court-ordered and there is dispute regarding privacy, confidentiality and privilege, the CIT should seek clarification from the Court prior to commencing services. If a dispute arises as to the interpretation of the Court order after services have begun, the CIT should seek direction from the Court before releasing information.

7.5 Special issues in children's treatment

(a) A CIT should be familiar with general provisions governing confidentiality of children's treatment information in his/her jurisdiction, including:

(1) Who holds the child's privilege and how a child's privilege can be waived or asserted
(2) Under what circumstances a child or adolescent may have a role in this decision
(3) How the CIT should respond if he/she receives conflicting instructions from the parents
(4) How the CIT should respond if he/she believes that disclosure of treatment information poses a substantial risk of harm to the child

(b) At the outset of a child's treatment, the CIT should clarify the provisions of the order or therapy agreement regarding the child's treatment information. These issues include, but are not limited to:

(1) How information about a child's progress will be shared with parents
(2) Whether the consent of one or both parents will be required to release information about the child's progress
(3) The role that the child's thoughts and feelings will play in determining what information is shared, and how it is shared
(4) Circumstances in which the CIT may be required to release information to the parent or other professionals
(5) Circumstances that might require further discussion, clarification or modification of the order or agreement as the treatment progresses

(c) A CIT should prepare the child client for the release of treatment information, address the child's feelings about the issue, and assist the child in coping with any stressors that may result.

(d) The CIT should adapt explanations to the developmental and situational needs of each child.

(1) When working with a child client, the CIT should clarify the limits of confidentiality in developmentally appropriate language
(2) A CIT should not make blanket promises to a child that treatment information will be confidential

7.6 Considerations for therapists covered under the Health Insurance Portability and Accountability Act (HIPAA)

If the CIT is a HIPAA-covered entity, he/she must be aware of his/her obligations under the Act, and the how those obligations may change if the client or family

becomes involved with the Court. When requirements under HIPAA appear to be in conflict with other laws or Court orders, the CIT should obtain legal consultation.

7.7 Responding to requests for treatment information from third parties

(a) The CIT should request a copy of the release signed by the client, former client, parent, or other authorized person. The CIT should not communicate with a third party without an appropriate release or order of the Court authorizing disclosure.

(b) Prior to providing client information to a third party, the CIT should attempt to inform the client or former client about the request for release of information.

(c) The CIT should inform the client or former client of the nature of the information that may be released to a third party if the client waives the privilege. If appropriate, the CIT should also refer the client or former client to his/her attorney to assist the client in making this decision.

(d) A release does not supersede a Court order; therefore, prior to releasing information to a third party, a CIT should consult any agreement or Court order that governs the treatment.

7.8 Responding to a subpoena

(a) A CIT should be aware of differences between subpoenas and Court orders.

(b) A CIT who has received a subpoena should consider consulting an attorney familiar with both legal issues in the jurisdiction related to mental health law and the requirements of the Court in which the family is involved. Procedures, requirements, and the CIT's options will vary depending on the jurisdiction, whether the case is being heard in a family Court or juvenile dependency Court, and many other issues.

(c) A CIT should not automatically respond to a subpoena by disclosing written or oral information.

(d) A CIT should not ignore a subpoena.

(e) The CIT may wish to consider the additional guidance provided in Appendix A regarding specific steps that may be helpful in responding to a subpoena.

7.9 Responding to a Court order for release of treatment information

(a) If the CIT is ordered by the Court to release information, particularly over the

objection of one of the parties, the CIT should request a written order specifying the parameters of information to be released.

(b) If there are outstanding legal questions regarding what information can be released (such as whether the CIT can release information from other agencies or child protective services), the CIT may wish to obtain the assistance of an attorney who can bring these issues to attention of the Court and obtain clarification or direction.

7.10 Appealing a Court order

There are some circumstances in which a CIT may believe that disclosing information may violate ethical or professional practice guidelines applicable to mental health practice. In such a case, the CIT may wish to consult an attorney familiar with the laws of mental health privilege/confidentiality in that jurisdiction.

GUIDELINE 8: METHODS AND PROCEDURES

8.1 The CIT should adhere to the methods and procedures generally accepted in his/her particular discipline. In addition, the CIT should maintain methods and procedures consistent with being involved in situations, which may include litigation, testimony, and the reporting of various matters to Court, parties, or their attorneys.

8.2 Obtaining necessary information if the therapy is court-ordered

(a) The CIT should attempt to obtain all information necessary to conduct the court-ordered therapy and should discuss the goals of the court-ordered therapy with the client.

(b) As appropriate to the specific case, the CIT should request information that may be necessary for effective treatment. This may include permission to speak to a prior therapist or other involved professionals, copies of prior Court orders, therapy records, and reports from child custody evaluators, child protective services, or a guardian *ad litem.*

(c) The CIT should obtain necessary information, including copies of relevant Court orders, to confirm that his/her role is clearly defined and consistent with the therapeutic role and the CIT's expertise.

(d) If the CIT is unable to obtain information from the parties or counsel that is necessary to conduct treatment, the CIT may apply to the Court for further direction if the CIT has obtained appropriate releases. Application to the Court should be preceded by proper notice to the parties and counsel.

8.3 Therapeutic role and process

(a) The CIT has a responsibility to identify both the intended clients and any others intended to be the beneficiaries of the intervention.

(b) When the intended beneficiary of the intervention is an individual client, the primary focus of the therapist is the client's welfare and treatment is implemented for the benefit of the client. Therapists with different treatment orientations may identify different treatment goals, but all focus on improving client's functioning.

(c) In other cases, a relationship or family unit may be the identified client or may be the participants in counseling, but the goal may be to reduce conflict or promote behavior change for the benefit of the child (e.g., co-parenting or conjoint/reunification therapy).

(d) The CIT should clearly identify the goals, procedures and beneficiaries based on any relevant orders and in collaboration with the client(s) and other professionals as appropriate, and should clearly communicate this information to participants in the therapy.

8.4 The CIT should understand that the information provided by the client during the course of the treatment is based upon the client's experience and perspective, which may sometimes be distorted or lacking balance and comprehensiveness

(a) The CIT should strive to maintain professional objectivity, and to remain aware of the impact of the therapeutic alliance on the therapist's information and perspective.

(b) The CIT should actively consider alternative hypotheses regarding the information (i.e., data) he/she is receiving in the treatment.

(c) The CIT should strive to be aware of societal and personal biases and continuously monitor his/her actions for evidence of potential bias. Awareness of research and focus on the treatment data inform the CIT and help limit the potential for bias. The CIT should consider withdrawing from a case when he/she is unable to manage a known bias and/or is unable to maintain objectivity.

(d) The CIT should be aware that the treatment may be influenced by the client or family's involvement in legal processes, and that the legal process may be influenced by the actions of the therapist.

(e) The CIT must constantly guard against/protect his or her work from threats to professional objectivity and role boundaries.

8.5 Selecting appropriate treatment methods

(a) A CIT should not exceed the bounds of his/her professional competence in his/her diagnosis, treatment planning and treatment of clients.

(b) A CIT should use methods or interventions that are generally accepted within the professional communities and literature, and should apply methods or interventions appropriate to the situations and characteristics of court-involved families.

(c) A CIT should be able to justify and explain the choice of methods based upon the current state of professional knowledge and research.

(d) The CIT should select treatment methods or approaches that minimize the potential for biased or inappropriate interpretations of client's statements and behaviors or perceptions of others' behavior. This may include deliberate balance in asking questions, challenging assumptions, and supplementing behavioral observations with other methods of inquiry.

(e) A CIT should exercise caution in forming opinions or structuring therapy based on limited or one-sided information.

(f) A CIT should maintain current knowledge about the validity (or lack of validity) of using specific behaviors as a basis for diagnosis or treatment, and should employ treatment methods that allow the therapist to gather information from a variety of methods and observations.

8.6 Critical examination of information

(a) A CIT should critically examine information received from a client before formulating or offering a clinical opinion. This is especially important in light of the possibility that a therapeutic alliance may produce a bias toward the client.

(b) A CIT should recognize that loss of therapeutic objectivity may harm a child or family, whether or not the therapist reports or testifies about the therapy. Therapists should avoid inappropriate bias by actively considering, and exploring, rival hypotheses about a client's difficulties.

8.7 A CIT should consider the clinical implications of actions taken when the CIT is asked to release treatment information, and should endeavor to minimize risks in these areas

(a) The therapist should be aware that an adult client requesting the release of information may not fully attend to, or understand, the risks and benefits of such a decision. This may lead to distress in the client or damage to the therapeutic alliance, if the client is surprised by the therapist's information or opinion.

(b) The therapist should assist the client in understanding:

(1) The risks and benefits of releasing information
(2) The nature of the information in the client's records
(3) The CIT's obligation to provide complete answers when questioned under oath and to avoid misleading other professionals or the Court
(4) Other potential factors that may lead to distress in the client or damage to the therapeutic relationship due to the release of information

(c) When a child is involved in treatment and the CIT is asked to release treatment information, the CIT should consider and address issues to minimize disruption of treatment and avoid distress in the child. Issues to consider may include:

(1) Appreciation of the parent's right to information and any concerns that he or she may have about the child or the therapy
(2) Protection of the child's treatment progress and privacy
(3) Potential for disruption of the therapeutic relationship if the parent feels excluded or resorts to litigation in order to obtain information
(4) Possibilities for negotiating the parent's involvement and managing the sharing of information without violation of the child's privacy, wholesale release of treatment information, or litigation

(d) The CIT should consider and address the various clinical possibilities in children's expressed preferences about disclosure of information. The CIT should consider the potential implications of whatever action the CIT takes, and should utilize available therapeutic options for dealing with the child's information. Issues to consider and address may include:

(1) Treatment goals related to the children's resolving of issues with parents
(2) A child's realistic or unrealistic fears about the parent's response to the information
(3) The child's own emotional issues or difficulty in expressing feelings directly

(4) Whether the child will ultimately be empowered or protected by having the CIT share information on the child's behalf
(5) Whether the child needs protective measures to prevent harm resulting from the sharing of therapeutic information
(6) Whether information can be disclosed in a therapeutic rather than legal setting

(e) The CIT should prepare both adult and child clients for the sharing of information and endeavor to anticipate any problems the client may experience as a result.

8.8 A CIT should seek appropriate advice

When in doubt about an appropriate course of action, the CIT should consider seeking legal advice or professional consultation. Such advice may protect both the clients/participants in therapy and the CIT.

GUIDELINE 9: DOCUMENTATION

9.1 A CIT should create documentation so that the Court can understand the treatment process, progress and financial arrangements

9.2 A CIT should establish and maintain a system of record keeping that is consistent with applicable law, rules, and regulations and that safeguards applicable privacy, confidentiality, and legal privilege. A CIT should create and maintain records reasonably contemporaneously with the provision of services.

(a) In deciding what to include in the record, the CIT may determine what is necessary in order to:

(1) Provide competent care
(2) Assist collaborating professionals in delivery of care
(3) Provide documentation required for reimbursement or required administratively under contracts or laws
(4) Effectively document any decision making, especially in high-risk situations
(5) Allow the CIT to effectively answer a legal or regulatory complaint

(b) If a client, parent or third party requests limited record keeping as a condition of treatment the CIT should explain that record keeping must meet professional standards.

9.3 Records should be organized and sufficiently detailed

A CIT should maintain records that facilitate the provision of future services by the CIT and by other professionals, ensure accuracy of billing and payments, and ensure compliance with ethical requirements and laws. Records should be sufficiently detailed, legible and readily available for reproduction upon receipt of appropriate releases or Court orders.

9.4 Confidentiality and security of records

A CIT should make all reasonable efforts to maintain confidentiality in creating, storing, accessing, transferring and disposing of records under his/her control. A CIT should maintain active control of records, provide appropriate training to any support staff, and take reasonable care to prevent the loss or destruction of records.

9.5 Ethical and statutory requirements

(a) A CIT should be cognizant of and follow relevant ethical and statutory requirements regarding maintaining records.

9.6 Communicate and clarify recordkeeping with the client and/or parents

(a) When the client is a child, the CIT should request any orders establishing who has the authority to consent to release of records. A minor may have the legal prerogative to consent to treatment, but the parent may nevertheless seek access to the records. A CIT should verify parents' statements of having the sole authority to consent to or block release of records by requesting relevant documents.

(b) When the CIT has multiple clients, such as when a parent participates in therapy with the child, the CIT should clarify as part of the informed consent procedure how the records are kept and who can authorize their release.

(c) A CIT should clarify any costs associated with providing copies of records and follow relevant statutes regarding fee arrangements. A CIT should not refuse to release records needed for emergency treatment because a client has not paid for services.

(d) Even when clients are participating in therapy pursuant to a Court order, the CIT should clarify policies, procedures and fees associated with the release of records and confidentiality.

GUIDELINE 10: PROFESSIONAL COMMUNICATION

Communication from a CIT to another therapist, the client, parents, counsel, or the Court carries with it an obligation to ensure that the communication is authorized, clear, and accurate. A CIT should recognize the adversarial nature of the legal system and the potential impact of the therapist's observations and opinions.

10.1 Authorization to communicate

A CIT should take reasonable steps to ensure that he/she is authorized to communicate with a third party, as described in Guideline 7.

10.2 Accuracy in communication

(a) In communication with others, a CIT should take reasonable steps to ensure that he/she is accurate in communicating:

(1) The nature of the service provided
(2) His or her opinions on diagnosis, prognosis, and/or progress in treatment
(3) His or her opinions on appropriate actions that would support the therapy
(4) His or her understanding of the role the therapist has with the family and in the Court process
(5) Reports or observations of parents' or children's behavior

(b) The CIT should make reasonable efforts to ensure that information regarding his or her services, including treatment, reports and testimony is communicated in language that can be understood by consumers and minimizes potential for misuse of the therapist's information.

10.3 Communicating limits and distinctions

A CIT should communicate the bases and limitations of observations and opinions.

(a) In all communications, especially in reports or testimony, the CIT should distinguish between observations, verbatim statements, inferences derived from his or her sources of information and conclusions or assessments reached.

(b) A CIT should articulate the limits of any communications. A CIT should decline to communicate opinions, recommendations, or information requested:

(1) When there is insufficient data on which to form a reliable opinion
(2) When there is no authorization to do so
(3) When the opinion requested is inconsistent with the role of the CIT

(c) Where the information available to the CIT might support more than one therapeutic assessment or opinion, the CIT should present and acknowledge the alternate possibilities and any treatment data or research supporting them.

(d) When necessary and appropriate, a CIT should be prepared to explain the limits of the CIT's role and the reasons it is inappropriate to give testimony or opinions in violation of that role.

10.4 Appropriate parties to include in communication

A CIT should carefully consider who should be aware of and involved in each professional communication.

(a) The CIT should consider whether one or both counsel, a guardian *ad litem*, child's counsel, other CITs, or parenting coordinator should be included in the communication.

(b) The CIT should respond with caution if an adult client's attorney requests a treatment report, particularly if the request comes through the client. The CIT should discuss with the client the potential content and implications of such a report, as discussed in Guidelines 7 and 8. With an appropriate release, the CIT may also wish to consider consulting with the adult client's attorney to ensure that the attorney is aware of the potential content and implications of a report from the therapist.

(c) The CIT in a neutral role, such as that of child's therapist, co-parenting therapist or conjoint/reunification therapist, should avoid unilateral communication with either parent's attorney in order to avoid appearance of bias and to contain the potential for actual bias.

10.5 Testimony

(a) A CIT should recognize the limits of his/her knowledge, and the potential impact that testifying in Court may have on the client and on treatment. Prior to testifying, a CIT should thoroughly discuss these issues with adult clients, and should engage in age-appropriate preparation of child clients.

(b) A CIT should comply with any limits on the scope of his/her testimony, which have been specified by a judicial officer in conjunction with any applicable ethical code.

(c) A CIT should anticipate that clients, attorneys, and the Court may ask the CIT to testify beyond the limits of his or her knowledge and role. The CIT should respectfully decline to provide information or opinions that exceed the treatment role or the CIT's knowledge base.

(d) A CIT should seek to clarify any conflicts between the testimony requested by the Court or counsel and any limitations imposed by professional ethics codes or licensing regulations.

(e) When the CIT is designated as an Expert Witness by the Court he or she may offer relevant clinical opinions within the role of the treating expert.

(1) The CIT may offer opinions on issues such as diagnosis, changes or behaviors observed in treatment, treatment plan, prognosis, coping and developmental abilities, conditions necessary for effective treatment, etc.
(2) The CIT should not render opinions on psycho-legal issues (e.g., parental capacity, child custody, validity of an abuse allegation, joint or sole custody), as these are beyond the scope of the treatment role and properly the province of other professionals and the Court

APPENDIX A

RESPONDING TO A SUBPOENA

This material is intended to supplement the information in Guidelines 7 and 8.7 regarding privilege and confidentiality issues, and the clinical management of requests for treatment records or information.

1. A subpoena is not a Court order. It is a formal request from an attorney to summon a witness or require a witness to bring documents to a hearing. The hearing might be a deposition (oral testimony taken under oath in preparation for a formal trial or to preserve the evidence) or a trial itself.

2. A CIT should never ignore a subpoena.

3. A CIT should not assume that a subpoena requires him or her to automatically disclose all requested information

4. Some jurisdictions have detailed statutes regarding psychotherapist privilege. These may include specific statutorily-mandated steps the CIT can take in response to receipt of a subpoena. In other jurisdictions, a CIT may want to obtain legal advice from an attorney familiar with (1) the privacy law in that jurisdiction; (2) the requirements specific to family court cases or the laws governing the CIT's role; and (3) the ethical obligations of mental health professionals. It is important for each CIT to know the state of the law in his or her jurisdiction on this issue and for the CIT to provide his/her counsel with any specific orders governing the CIT's role in the particular case.

5. The requirements for responding to a subpoena may be different in a juvenile or dependency court, a family court, a general civil court and a criminal court. When obtaining legal counsel with regard to a subpoena, the CIT should know which type of court is the setting for the case that generated the subpoena and should provide legal counsel with all relevant orders and documents.

6. If a CIT receives a subpoena regarding an adult client's treatment, he or she should make and document best efforts to notify the client or former client that the subpoena was served. The CIT should let the client know the scope of the information sought in the subpoena and that the client has a right to consult counsel to determine how best to respond to the subpoena.

7. If the subpoena was sent by the client's attorney, the CIT may, with the written consent of the client, cooperate with the attorney.

8. If the subpoena was sent by opposing counsel, the CIT may, with the written consent of the client, cooperate with the client's attorney to design a strategy for response to the subpoena.

9. In working with the client's attorney, it is important for the CIT to learn what the attorney hopes to gain from the CIT's involvement in (or exclusion from) the case, the issues being litigated, and the information and/or opinions that the lawyer will ask the CIT to reveal. The CIT should also attempt to learn what the opposing side is trying to achieve and whether and in what way the opposing lawyer may attempt to discredit the CIT's information and/or opinions.

10. Upon receipt of the subpoena, the CIT should carefully review his or her own records regarding the client and be prepared to discuss with the client and his or her attorney the following:

    A. Whether the record contains outdated material;
    B. Whether the record contains highly personal material;
    C. Whether the record contains information that could help the client achieve the goals described by the client's attorney;
    D. Whether the record contains information that could harm the client's goals.

11. If the subpoena was sent by the opposing attorney, the CIT should discuss with the client's attorney whether or not it would be useful to attempt to negotiate with opposing attorney to limit the scope of the subpoena, e.g., to redact outdated material, the names of third parties not important to the litigation or highly personal information.

12. The CIT should discuss with the client's attorney whether or not it would be wise to bring a Motion to Quash the subpoena, i.e., a request of the Court that the CIT be relieved of the obligation to provide testimony or produce records. The Motion to Quash must be grounded in some legally-cognizable rationale. For example, the material known to the CIT may not be relevant to the litigation. Or the opposition might be able to obtain the information known by the CIT from other sources, which would be less invasive to the client than obtaining information from the CIT. Or in some jurisdictions it will be possible to argue that, even though the CIT has information bearing on the case, it is more important that the client's privacy be maintained than that the information be disclosed.

13. If a child is the CIT's client and the child's records are subpoenaed, the CIT should consider whether or not the potential consequences to the child warrant opposing release of the information, requesting that an independent advocate be appointed, or warning the involved parties about risks to the child from release of the information. The CIT should be familiar with the procedures in his or her jurisdiction that are used to protect or consider the child's treatment information. In most jurisdictions, under ordinary circumstances, the parents or the person with legal custody of the child or the legal guardian has the power to determine whether or not to allow a child's private information to be released. However, if the parents are themselves in conflict in the litigation, the jurisdiction may have a special process for determining the child's privacy rights (as the parents are in a conflict of interest position about the child's privacy rights). Some jurisdictions will have a procedure by which a specially appointed person will decide,

after learning more about the litigation and the effects on the child, whether to waive or to assert the child's privilege. In some jurisdictions the decision of that appointee is decisive; in other jurisdictions, the person's decision is a recommendation to the Court, which has the final say.

14. If the CIT is asked to give information or an opinion about the effect on the child client of release of treatment information, the CIT should be prepared to explain the potential impact on the child of releasing the information and, conversely, the potential impact of withholding the information and the risks and benefits of each. Relevant factors might include the child's wishes, the impact of the decision on the child's ability to trust therapy and the CIT following a disclosure, the child's needs or ability to have his or her voice heard in the litigation, and whether or not there are other, less intrusive sources for obtaining the information.

15. The CIT should be aware that ultimate decisions regarding release of treatment information may not be the province of the therapist. Properly informed adults, and their attorneys, may have the right to control their treatment information. Those charged with protecting the child, such a minor's counsel, Guardian Ad Litem or the Court, may need to weigh and determine the best means of protecting the child's interests.

For supplemental information, please see the following documents:

Sample client-therapist contract:
http://www.afccnet.org/pdfs/Client-therapist%20contract.pdf

Sample stipulation and order for counseling:
http://www.afccnet.org/pdfs/Stipulation%20and%20order%20for%20Counseling.pdf

Sample order for counseling:
http://www.afccnet.org/pdfs/Order%20for%20Counseling.pdf

Suggested references:
http://www.afccnet.org/pdfs/Suggested%20references.pdf

Attorney for Petitioner

Attorney for Respondent

In re the Marriage of:	)	Case No.
Petitioner:	)	STIPULATION AND ORDER FOR
	)	COUNSELING AND/OR PARENT
and	)	EDUCATION
Respondent:	)	

1. IT IS HEREBY STIPULATED by and between the parties, (insert names)_____ _____ joined by their respective attorneys of record, to the appointment of XXX to conduct counseling/psychotherapy with themselves and/or the minor child(ren) of the parties (insert names and birth dates of minor children): _____ _____

2. OTHER PARTICIPANTS IN COUNSELING

Both parents will participate in counseling if requested by XX. XX may request the involvement of other household or family members as she deems appropriate. The parents acknowledge that, when a child is involved in counseling, the child is considered to be XX client/patient. Parents are adjunct/collateral participants in counseling directed toward the welfare of the child.

3. DURATION OF COUNSELING

The parties and/or minor child(ren) and/or others will participate in counseling for at least ____ months, not to exceed one year unless the parties stipulate otherwise or the court so orders. The frequency, duration and structure of sessions will be adjusted as XX deems appropriate. XX will determine the order of appointments and who should be present at each. As consistent with other orders in this matter, and if a child is involved in treatment then the parties agree to deviate from their usual parenting time arrangements as appropriate to allow both parties to participate in transporting the minor child to and from treatment.

4. COOPERATION WITH TREATMENT

Both parties are ordered to cooperate with XX, including, but not limited to, (1) paying for services in a timely manner in accordance with the fee agreement executed by the parties with the XX, (2) ensuring that the minor child(ren) are transported to and from scheduled appointments in a timely manner; and (3) exercising parental authority to require that the minor child(ren) attend(s) and cooperate(s) with treatment.

The parties have been advised that successful psychotherapy for children often requires

that parents make changes in their own behavior and parenting, to support their children's needs. XX may request specific changes in such areas as setting appropriate limits for children, encouraging children to express feelings and solve problems appropriately, listening to children's concerns, actively supporting children's independent relationships, and shielding the children from parental conflict. The parties agree to make reasonable efforts to cooperate with XX requests in these areas. If either parent disagrees with requests or recommendations made by XX, the parent will discuss those concerns privately with XX, and will not allow the child to witness or overhear such concerns. Both parties acknowledge that they have had an opportunity to review this stipulation and Dr. XX consent agreement, and to ask any questions they may have concerning Dr. XX approach to treatment and other alternatives that may be available. The structure, frequency, duration, and participants in therapy sessions will be determined by Dr. XX.

Dr XX will not make recommendations as to custody or parenting plans, nor determinations regarding the child's best interests, as these are outside the therapists' role. She may make recommendations to the parties regarding changes in the parent-child relationships that may be helpful to the children in implementing the Court's orders. When children are not directly involved, but therapy is conducted for the benefit of the children parents may need to consider similar behavior changes.

5. GOALS OF COUNSELING

The goals of counseling shall be following (check all boxes and describe specific issues):

[ ] Facilitate communication between the parties regarding their minor child(ren)'s needs:_____

_____

[ ] Reduce conflict regarding parenting time schedules_____

_____

_____

[ ] Improve the quality of parenting skills of (Petitioner/Respondent/both parents),

_____

_____

[ ] Address emotional/behavioral problems of child(ren)

_____

[ ] Facilitate the relationship between child(ren) and

[ ] Petitioner [ ] Respondent [ ] both parents

[ ] Conjoint/family therapy for

[ ] both parents

[ ] both parents and the child(ren)

6. CONFIDENTIALITY

Except as authorized below, Dr. XX will keep confidential all information obtained in counseling except when mandated by law to report suspected child abuse and where a person appears to be a danger to him/herself or others. If a child is in treatment, Dr. XX will require written authorizations from both parents to release any information not required by law or addressed in this stipulation/order. Any authorizations to release and receive information, as noted below, represent additional and full waivers of any privileges that may apply to information provided to Dr. XX. References to "any applicable privilege" herein do not represent a legal determination by the therapist that a particular privilege applies in this case. Such a determination would be the province of the Court if a dispute arises. The

stipulation signed herein describes the intended conduct of the therapist with respect to these issues, all of which may be subordinate to the orders or findings of the trial court. The parties understand that the therapist is not an attorney and that he/she is required to obey the order of the court and/or to bring to the attention of the court any possible conflicts between the court's orders and professional practice standards applicable to psychologists. By signing this stipulation, both parents acknowledge that they have had an opportunity to review this stipulation with counsel. Both parents agree to attempt to resolve any disputes over sharing of information with Dr. XX before taking legal action. If Dr. XX is required to by subpoena or ethical obligations to participate in a legal matter, the parties agree to reimburse Dr. XX for reasonable expenses including attorneys fees.

The parents also understand that, if Dr. XX is permitted by waiver or required by law or court order to provide information to anyone, including counsel, a child custody evaluator and/or the Court, the information released may include information that might otherwise be considered to be protected under the Health Insurance Portability and Accountability Act (HIPAA).

Should any dispute arise as to whether a communication is privileged, Dr. XX will refer the issue to the court for resolution, and will refrain from disclosing the information in dispute until directed by the Court. XX will obey any order from the trial court regarding release of treatment information provided by the parents or children. The parties agree to hold Dr. XX harmless regarding any release of information provided based on good-faith adherence to a waiver or Court order, and for any delay resulting from a good faith decision by Dr. XX to seek direction from the Court before releasing information.

7. METADATA

The parties agree that, to the extent Dr. XX is formally (e.g., pursuant to

subpoena) or informally requested/required to produce her records, Dr. XX may provide records in paper form or on a flash drive. In either event, Dr. XXwill not be required to produce electronic copies of her books and records or provide "metadata" relating to her books and records. Dr. XX production of documents from her computer will be limited to items Dr. XX can print out. The parties will not have access to Dr. XX personal devices. Dr. XX will only provide records if all privilege issues have been resolved.

8. DIRECT COMMUNICATIONS TO THE COURT

If either party returns to court regarding custody or visitation issues, Dr. XX :

_____ will provide no information to the court, absent additional order and waivers

_____will provide a letter to the Court describing the parties' and children's progress and cooperation in treatment. This may include specific statements and behaviors which Dr. XX deems necessary to adequately support other content or statements in her letter.

_____will describe the type of additional services and/or treatment, if any, that would be helpful for the children or family

_____ will describe on other interventions that would be helpful to the children and family

Authorization to provide a letter to the Court on any of these issues represents a full waiver of any applicable privilege regarding this counseling/therapy, such a waiver also applies to any testimony that Dr. XX is required to provide about her letter. Any letter provided by Dr. XX will only address issues related to the counseling or therapy. Such a letter does not substitute for a child custody evaluation, and Dr. XX will not make any custody

recommendations. Procedures in therapy are not equivalent to those provided in a child custody evaluation.

Dr. XX is authorized to notify the court, with copies of the communication to counsel, if she is unable to proceed with court-ordered treatment due to non-cooperation of any party, including non-payment of fees, or if significant obstacles are being encountered to treatment.

The parties and counsel agree that all testimony provided by Dr. XX, in any matter related to this family, shall be considered expert testimony, paid for at Dr. XX regular fee, under the terms of Dr. XX fee agreement. . No letter or testimony will be provided by Dr. XX without payment seven days in advance, from the parent or counsel desiring such report or testimony, or from the party responsible for paying for treatment. Absent receipt of such payment, Dr. XX will be under no obligation to provide communications, testimony, or services of any kind.

9. INFORMATION TO CUSTODY EVALUATORS

If either party returns to court regarding custody or visitation issues and a custody evaluation is ordered, the parties may be asked to waive privilege so that Dr. XX can provide information to the child custody evaluator. If such waivers are provided, the content of information provided to the evaluator will be at Dr. XX discretion. Both parents agree to execute any additional releases that may be necessary or convenient to document waiver of privilege. If a child is in treatment, Dr. XX must receive releases from both parents or an order of the Court to disclose treatment information.

10. COMMUNICATION WITH OTHER PROFESSIONALS

To coordinate treatment, it may be helpful for Dr. XX to communicate with other

professionals (therapists, teachers, doctors, etc.). The parties hereby waive all applicable privilege to allow Dr. XX to receive information from and provide any and all treatment information to the professionals listed below:

_____

_____

_____

The parties agree to execute any additional releases that may be necessary or convenient to allow such communication. If Dr. XX believes that communication with any other professionals would be helpful to treatment, additional releases may be requested from the parties. If Dr. XX requests communication with the parties' individual treating therapists, the parties may provide a one-way release, preserving the confidentiality of their individual treatment information, if appropriate.

11. If Dr. XXis ordered or requested to provide treatment information in a manner that she believes raises risks to the welfare of the children, Dr. XX is authorized to provide this information to the Court, as well as to request any interventions (e.g.. appointment of minor's counsel) that she believes would mitigate this risk.

12. [ ] A review hearing is hereby set for _____, for the following purposes:

_____

_____

13. FEES

The cost of the counseling shall be paid as follows:

_____ Petitioner; _____ Respondent; _____ ½ by each party in accordance with the terms of Dr. XX fee agreement.

Dr. XX individual meetings with each parent will be paid for by:

_____ the parent attending the session

_____½ by each party;

_____petitioner;

_____respondent.

Outside-session services (including but not limited to conference calls, correspondence, and telephone calls), as described in Dr. XX consent agreement, will be paid as follows: _____

_____

Each parent is to provide payment to Dr. XX within ten days of receiving any invoice or request for payment from Dr XX.

Each parent and counsel acknowledge that they have had an opportunity to review Dr. XX fee/consent agreement and this stipulation, and to consult with counsel concerning it. The parents agree to abide by the terms of this agreement and Dr. XX fee/consent agreement, and agree to abide by the terms of those documents. Each parent and counsel acknowledge that treatment services may be suspended if fees are not paid, and that Dr. XX has no responsibility to provide letters, testimony or other services if fees are not paid. If treatment services are suspended due to nonpayment of fees by either party, Dr. XX is authorized to disclose this information to both parents, counsel and the Court.

A facsimile or photocopy of this stipulation/order shall be considered as valid as the original. This Stipulation and Order may be signed in counterparts.

IT IS SO STIPULATED.

DATED: _____

_____

Petitioner

DATED: _____

_____

Respondent

DATED: _____

_____

Attorney for Minor (if applicable)

AGREED AS TO CONTENT AND FORM:

DATED: _____

_____

Attorney for Petitioner

DATED: _____

_____

Attorney for Respondent

ORDER

IT IS SO ORDERED.

DATED: _____

JUDGE OF THE SUPERIOR COURT

PARENTING PLAN CHECKLIST FOR HIGH CONFLICT FAMILIES

Barbara Jo Fidler, Ph.D., C.Psych., Acc.FM.

Lawyers, mediators, assessors/evaluators and parenting coordinators may wish to structure their Parenting Plans for high-conflict families using the following headings. Examples of the specific areas that would typically fall under each heading are provided.

PARENTING GUIDELINES AND PRINCIPLES

- Various parenting guidelines, principles and aspirations relating to good parenting, promoting children's relationships with the other parent, supporting the parenting plan, not denigrating the other parent, not involving the children in conflict, respecting the other parent's privacy, not raising issues at transition times when children are present, etc.
- Relevant and appropriate child-rearing practices (e.g., degree of consistency regarding various routines such as bedtime, napping, dietary restrictions, homework, etc.).

PARENTAL COMMUNICATION

- Rules of engagement for the parents' communication and behaviour in and out of the children's presence.
- Detail regarding the parents' communication: how, when, where, how frequently, the required response time, etc.

REGULAR PARENTING TIME SCHEDULES

- Clearly delineated parenting time with each parent
- When does parenting time start and stop?
- What happens to the parenting time schedule when a child is ill?
- Who calls the school when a child is ill?
- When is time with the other parent forfeited because of illness?
- Exact pickup and drop-off days and times
- Rules for parental behaviour at transitions (i.e., no discussion of anything beyond cordial niceties)
- Location of transition?
- Who does the transportation?
- Punctuality rules

CHANGES TO PARENTING TIME SCHEDULES

- Rules relating to how the need for temporary changes to the parenting time will be addressed and resolved in the event of a dispute.
- How are temporary changes/requests handled?
- What is the agreed-upon response time for requests for changes?
- What is the policy regarding "make-up" time with the child/ren?

- Is there a right of first refusal? If so, what is the threshold of time allowed (e.g., four hours, eight hours, one overnight or more?)

HOLIDAYS, SPECIAL DAYS AND VACATIONS

- Specify *all* holidays clearly defined as to beginning and end of period, location of transitions, who provides transportation, etc.
- Agreement that these days take precedence over usual schedule
- How are summer vacation dates determined? Who gets first choice? How much notice is given?
- Is there a rule that the one-week holiday (seven days) must include a usually scheduled weekend?
- If not, what happens to the usual weekend rotation?
- Does the statutory day add to the seven days to make eight days?
- What happens to the usual schedule when the holiday schedule ends?
    - Does the usual rotation continue or change?
    - Does one parent get three weekends in row, or do the parents split one week and resume the usual alternation of weekends?
- What about professional development school days?
- Children's birthday parties:
    - Who pays?
    - Who attends?
    - How are the gifts divided?

CHILDREN'S CONTACT WITH NON-RESIDENT PARENT

- Is there unlimited telephone contact between the child and the non-resident parent, or are there rules (e.g., frequency of calls in a week, time of day, who initiates the call, etc.)?

EXTRACURRICULAR ACTIVITIES

- How are extracurricular activities decided upon?
- Is consent or notice only required when such activities overlap the other parent's time?
- Can both parents (and family members) attend all activities, only some (e.g., special final events), or none?

CHILDREN'S CLOTHING & BELONGINGS

- What are the rules around clothing: washing; returning; number of changes provided to the parent who pays child support; loss; breakage?
- Which are Section 7 expenses, and which come out of child support?

DAY-TO-DAY DECISIONS

- Who takes children to routine medical/dental appointments?
- Can both parents attend such appointments?
- What, how and when will child-related information be shared?
- Who is the librarian of documents: health card; immunization; etc.?
- Which parent attends at parent–teacher meetings?
- Which parent accompanies the child/ren on field trips?
- Which parent is responsible for the children's haircuts?

MAJOR DECISIONS (CHILDREN'S HEALTH/WELFARE, HEALTH, EDUCATION, & RELIGION)

- Precise protocol for how these are decided
- Exchange of information
- Details regarding the children's religious observance, if any (e.g., attendance at church, Sunday school, rituals, etc.)

TRAVEL

- Notice? Consent?
- Notarized letter (rules regarding response time; number of days in advance of travel; who pays)
- What is in the itinerary?
- Who holds the passports?
- Phone calls with the non-resident parent during travel with the resident parent?

RESIDENTIAL MOVES

- Number of days of notice required
- Geographic boundaries/limits, or distance from each other.

JURISDICTIONAL MOVES

- Agreed to mutually; otherwise by court order

CHANGE OF NAME

- Identify restrictions as per relevant/local law

FUTURE DISPUTE RESOLUTION

- Identify future dispute resolution mechanism/method (i.e., mediation, parenting coordination, mediation/arbitration, etc.)
- Identify professional to provide services
- Identify how fees will be paid

We're Still Taking X-Rays but the Patient is Dying: What Keeps Us From Intervening More Quickly in Resist-Refuse Cases?

Lyn R. Greenberg, PhD, ABPP and Hon. Robert Schnider

Abstract

Professionals frequently lament the fact that the dynamics of resist-refuse cases are often entrenched before the family receives effective intervention. Dysfunctional behavior patterns can become entrenched, with severe impairment of children's ability to function. Assessment is a critical component in the process of assisting families, but can come to so dominate the process that the situation is unrecoverable once the assessment is completed and meaningful interventions begin. The authors will describe commonly encountered obstacles to early intervention in resist-refuse cases, ranging from systemic stressors to the persistence of inaccurate beliefs and information and practices that undermine accountability. Practical strategies, including a broader conceptual model, integrating assessment into intervention, encouraging lawyers and courts to take earlier action, and suggestions for future professional development will be addressed.

Keywords: Resist-Refuse Dynamics, Court-Involved Therapy, Child Custody, Early Intervention

We're Still Taking X-Rays but the Patient is Dying: What Keeps Us From Intervening More Quickly in Resist-Refuse Cases?

Resist-refuse dynamics present complex challenges to professionals (Fidler, Deutsch, & Polak, 2019; Greenberg, Doi Fick, & Schnider, 2016; Greenberg, Schnider, & Jackson, 2019; Walters & Friedlander, 2016). It is common for professionals who provide services in these cases to lament that the family did not receive [1]specialized services more quickly, that so much time and money was wasted on investigations that did not yield clear results, or on relitigation of every decision, recommendation or allegation. The problems faced by children at the center of conflict, particularly if they have entrenched dysfunctional behavior, can seriously impair their functioning. While risk assessment is essential, the poor outcomes in many of these cases suggest that it may be worthwhile to revisit common approaches to addressing these issues. In this article, we explore some of the obstacles to early intervention in resist-refuse cases and

[1] Walters & Friedlander (2016) describe the "(intractable) Resist/Refuse Dynamic (RRD) as a complex set of interacting factors, family dynamics, personality characteristics and vulnerabilities, conscious and unconscious motivations, and other idiosyncratic factors that combine to contribute to the unjustified rejection of a parent. In our discussion of early intervention in these cases, we refer to resist-refuse dynamics as the full complex of factors that may contribute to a child resisting parenting transitions. At the early intervention stage, it may be premature to draw conclusions about the contributing factors, or the degree to which the child's reaction is "justified." The dynamic may include all of the factors mentioned by Walters & Friedlander (2016), as well as other transient, developmental and systemic factors.

propose potential solutions, amplifying some of our discussion with comparisons to what occurs in medical care.

Medical professionals often encounter patients who are already acutely ill. They may not have regular physicians, or access to the patient's medical history may be incomplete or inconsistent. (Divorcing families may also carry their conflict into this arena.) The common perception of the "medical model" is that physicians do a complete diagnostic workup and arrive at a definite diagnosis before prescribing any treatment. While an intellectually appealing idea, the reality is much more complex. Lab tests, complete history and radiologic studies may ultimately be important in arriving at a diagnosis, but not all problems can be identified immediately and it may be critical to stop the patient's bleeding or support respiratory function even if a complete diagnosis cannot be established immediately. The physician must balance achieving diagnostic certainty against managing immediate risks. The patient's response to initial attempts at treatment, as well as the added information from diagnostic procedures, may ultimately clarify the best course of treatment. Moreover, physicians frequently must weigh the value of potential information to be gained from the diagnostic procedure against the potential risks of the diagnostic procedure. Among those risks is the waste of time, resources and the strength of the patient of undergoing excessive diagnostic procedures that either do not yield precise results or do not change the options for managing the patient's condition.

Similarly, practitioners who work with RRD families frequently encounter situations in which families have undergone extensive and repeated evaluations, depleting the family's resources and leading to months of additional litigation as dissatisfied parents challenge the results and any recommendations for therapy or other services are not implemented.

The Appeal of One More Xray – Adjusting the Framework

Certainty is appealing. The allegations expressed in RRD cases are often extreme and mutually exclusive, while the reality is generally much more complex. Judicial officers are often asked to order services that support one parent's perspective over the other, such as allegations of unjustified restrictive gatekeeping (Saini, Drozd, & Olesen, 2017) vs. allegations of poor parenting or intimate partner violence. Judges understandably want the best possible assurance that the services they are ordering are appropriate for the actual problem(s), and they may mistakenly believe that delaying services avoids any risk of harm. They hope that one more investigation, trial, or evaluation will provide definitive answers, without the process costing the family more in time, stress or financial resources than the value of the information obtained.

To be sure, risk assessment is an essential part of both evaluation and treatment, and all providers should be constantly alert for risk factors or behavioral patterns that could endanger a child or parent. Parenting plan evaluations, or evaluations to assess potential danger to a child, may serve a vital function. Often, a well-conducted evaluation or child protective services investigation will reveal those risks. In other cases, the dynamics placing a child at risk are much more subtle and complex. Findings in those cases are rarely as clean or definitive as a broken bone observed on an x-ray. Over time, the alert clinician may become aware of risks to a child's safety, which may or may not be the same as prior allegations, and should promptly report any reasonable suspicion to child protection authorities. In many cases, however, the literal "truth" of past allegations may be difficult or impossible to determine. In some cases, and where resources permit, some forms of intervention can begin while a custody evaluation is still ongoing. This is often possible when the interventions being considered are those that support a child's general developmental needs, such as shielding school or recreational activities from

conflict or therapeutic interventions that address the healthy coping abilities that all children need. Such options are described in greater detail below. Early intervention may both stem risks to the child and provide important information for both the custody assessment and treatment/intervention planning.

Over time, clinicians may be able to detect and intervene with unhealthy family dynamics that do not constitute child abuse but nevertheless have a profound and destructive impact on children's ability to cope and develop. Moreover, children and families are in a constant state of change, based on both children's developmental issues and, in some cases, the family's reaction to prolonged conflict or litigation. Children at the center of conflict often fail to master essential developmental skills. Avoiding problems, rather than solving them, becomes a habit. Patterns of poor parenting, undermining of a parent-child relationship, and failure to require children to adopt healthy patterns of conduct interact to create a complex of increasingly severe emotional risks to the child. Linear conceptualizations of cause and effect may continue to appeal to parents who are "stuck" on establishing blame, but they are unlikely to accurately reflect the complexity of the problem. Well-conducted custody evaluations generally reflect this, and often provide therapeutic recommendations consistent with the complexity of the problems.

When Does Assessment Get Out of Control?

All of the aforementioned assessment issues exist against a backdrop of the issues that judges must consider when deciding what kinds of services they can order and what they should order. Since any order for services will require the parents to spend money that they might prefer to be spending elsewhere, it is likely that a parent's need or desire will be delayed or unfulfilled. Neither party may be particularly welcoming of services that address a variety of possible causes of a child's problems, or that may require changes in the behavior of both parents. One or both

may be committed to the view that the other parent is evil, self-focused, and uninterested in the welfare of the child. The critical focus on the child's developmental needs may get lost in the search for "fault."

Since no evaluation is ever perfect, parents may become focused on obtaining the flawless investigation that is expected to yield the conclusion they desire. Judicial officers, and even evaluators, may lack the training to recognize the abilities and services children will need, even if an absolute conclusion about the "cause" of the problem is elusive. Family therapists know that dysfunctional behavior must be analyzed not just in terms of cause, but in terms of the forces in the child's environment that are maintaining the behavior. Caught up in the search for cause, professionals may lose sight of concepts that are readily recognized when they take a step back from the legal struggle. When the search for a prior cause becomes more important than helping the child manage stress and coping effectively, it is likely that the emphasis has been misplaced.

Moreover, when the court requires the parents to focus on the child's needs and cooperate with a therapist, the parents' cooperation and behavior may yield important information about the nature of the family's problems. For example, some parents are willing to spend thousands of dollars on repeated evaluations but claim they are unable to afford quality therapy. Some of them can respond to psychoeducation or therapeutic services designed to help them focus on the child's current pain and change their behavior to relieve that pain and strengthen the child. Others cannot or will not change their behavior, and if the therapist's requests are appropriate, those responses are also revealing. The results of these efforts may better inform any ongoing evaluation, the work of a parenting coordinator, or the decisions to be made by the court.

As noted above, physicians considering diagnostic procedures must evaluate whether the results will materially affect the available options for treating the patient, and whether the risk of harm to the patient may outweigh the value of the results. The medical model does not completely fit the court-involved family, because of the complex systemic factors that may cause family dysfunction. Nevertheless, such a risk-benefit analysis may be a useful framework to consider when deciding what services to request or order.

To be of any value, risk assessment must be bidirectional – in other words, the decision-maker should consider both the risk of ordering services and the risks of doing nothing. For example, a judicial officer considering ordering family therapy may be concerned that the therapists approved by the parents' insurance carrier will not have the requisite expertise to work in a family law case and will unwittingly cause harm, and that the parents will be unable or unwilling to expend resources for someone with more training. Conversely, doing nothing while a child's behavior continues to worsen, a parent-child relationship is destroyed, and no meaningful efforts are undertaken to teach or expect the child to resolve interpersonal problems can do serious damage. Amid the increasing professional literature on emotional and even medical risks to children at the center of conflict, and about the coping and emotional abilities they need to adjust successfully, it is unsurprising that children and families who do not receive effective help fare poorly.

Obstacles to Early Intervention

Twenty-twenty hindsight is easy. When faced with a case that has tragically gone wrong, with a child or adolescent who has been severely damaged, and with intractably bitter or battling parents, one can often readily identify missed opportunities to intervene. But at the time that such decisions are being made, other concerns may crowd out consideration of the interventions

that would have been likely to prevent poor outcomes. In this section, we review the obstacles that may arise from various professional perspectives, and some of the common misunderstandings, information and training gaps, systemic obstacles and cognitive errors that impede more effective service planning. .

Issues Arising From the Parents

Divorce often represents a financial and emotional earthquake for one or both parents, as well as for the children. Parents are often told, sometimes correctly, that resolving their own emotional issues and resolving the separation peaceably offers the best chance for successful adjustment in the children. Children may resist parenting transitions based on developmental issues or the emotional turmoil around them. In some families, these difficulties resolve as the parents calm down, or the parents receive advice to expect this. As a result, relatively easy interventions that may protect the children, such as enrolling a young child in preschool, are overlooked, delayed, or bogged down in conflict between the parties. In a minority of families, one or both parents are so heavily invested in blame or conflict that the possibility of a solution is threatening to them. Advocates, family members, attorneys or therapists may advise them to resist compromise – often based on the one-sided perspective or distorted perception of a parent.

Financial issues represent a constant stressor during a divorce, which may be the worst financial crisis a family has ever faced. Financial disputes may have precipitated the divorce, but even when this is not the case, the divorce creates new financial stressors for the family. Parents are faced with attorneys' fees, court costs and forensic experts, and the same amount of income must now support two households. Since financial instability may be a major stressor to families after parental separation, an argument can be made that securing the family's financial future also protects the child's needs. Of course, some parents who are willing to spend extensively to

litigate blame will claim to be unable to afford therapy or other services, or may argue for delays and additional investigation before services are provided. Even well intentioned parents may not have the education to know that certain services, such as preschool enrollment or procedures that protect the child from conflict at joint events, may protect children even while other allegations are being investigated. (Many professionals do not know this, do not consider it.) For a parent who is invested in ensuring that the situation does not improve, a demand for x-ray after x-ray can delay intervention for months or years.

Professional Obstacles and Training Issues.

Many professionals of all disciplines lack the professional training or experience to deal effectively with RRD cases, especially in the early stages (Bala & Slabach, 2019; Fidler, Deutsch, & Polak, 2019; Greenberg, Doi Fick, & Schnider, 2016; Greenberg, Schnider, & Jackson, 2019). Conflicts among professional roles may also lead to missed opportunities for intervention. Specialized providers are not available in all locations, and parents may initially turn to professionals who come at lower cost but do not have the requisite training to handle these cases. In this section, we review some of the obstacles and offer some suggestions for training and practical solutions.

Judicial officers. To varying degrees (depending on jurisdiction), judges have the authority to order interventions for families – by ordering services or investigations, or by reallocating parenting time or legal custody. In making those decisions, judges are in effect ordering the parties to follow certain priorities in how they spend their money, time and energy. The narratives presented to judges are often polarized and mutually exclusive – i.e. disruption of the parent-child relationship is a result of *either* "abuse" or "alienation" – rarely reflecting the complexity of poor parenting, exposure to conflict, developmental issues, parent and child

vulnerabilities that more often underlie these cases. Judges are rarely presented with clear, grounded information about the child's behavior and how it compares with developmental norms. They may not be informed about the risks of allowing dysfunctional behavior to continue or the types of services that can strengthen the child even if the court has not yet made a finding about the causes of the family's problems. The idea of "one more x-ray" is also appealing for them – they are tempted to either order an evaluation or hear more evidence, to discern what the "real" problem is, before ordering services so that they can allocate the limited family dollars to the *most* effective form of service. They may believe that doing nothing is the same as "doing no harm."

The best custody evaluations identify these complex issues, but it is also common for investigations, evaluations or hearings to follow the polarized thinking of the parents. As noted above, many professionals have observed the impacts of poor quality therapy and worry that therapists who are covered under the family's insurance plan will not have the training or sophistication to provide appropriate treatment.. Sometimes these concerns are justified, but viable options are often overlooked.

Judges sometimes receive general education about child development as part of their judicial training, but this information may be difficult to apply in RRD cases unless it is presented in those terms. Judges need clear, in-context information about the impact of the parenting conflict on the abilities children should be learning, whether they are moving forward or regressing, and whether the parents' requests or actions support or inhibit the child's development. They also need clear information about treatment options and the basic elements – such as the involvement of both parents and a detailed, unambiguous court order – necessary for any chance of success. This training, and any associated "cheat sheets" or other tools, must be

provided to judicial officers in clear, non-technical language. Judges should also insist on such clarity from lawyers and experts.

Resources such as the *Gatekeeping Bench Book* (Austin, Fieldstone, & Pruett, 2013) are useful to judicial officers in understanding terminology and making determinations about some of the factors present in a case. Pruett, Cowan, Cowan, & Diamond (2012) developed programs for enhancing facilitative gatekeeping, or parents encouragement of the other parent's involvement, which present a useful model for prevention and early intervention when a parent is unnecessarily inhibiting contact but not intentionally undermining the other parent-child relationship. Additionally, for judicial officers' continuing education, self-study CD's or webinars could be available outlining the importance of early intervention, treatment options, and ways of crafting effective orders for protecting children and establishing effective services. The AFCC Judicial Webinar series addresses some of these issues, although more specific programs on early intervention may be helpful.

It may also be useful to teach judges to ask certain types of questions when presented with allegations about a child's resistance to contact with the other parent. A question as simple as, "what have you tried to fix this problem?" may put the onus on parents to explain what attempts they have made and justify any resistance to services or settings that may help. It may also be useful to inquire about any anticipated harm from a request being made by a parent. It may be easy to cite potential harms of a parent is requesting a reversal of custody. Justifying opposition to preschool, or to *appropriately structured* family therapy, would likely be more difficult.

Lawyers. Lawyers may see some of their responsibilities as more important than, or even inconsistent with, early intervention to protect children. Since legal codes of ethics require

lawyers to advance their clients' interests, how lawyers define that obligation may determine whether the well-being of the child is included in their consideration (Bala & Slabach, 2019).

Financial demands arise in this setting as well. Lawyers may feel that the client's resources need to be conserved for what seem to be more pressing issues, such as financial disputes, and they may be less familiar with the questions to ask to determine what mental health referrals might be worthy of consideration. They may prioritize focusing on more specific and familiar, even quantifiable issues, such as division of property and support. Even when the disputes involve the children, the focus is often on "time share" and decision-making rather than on the details of the child's current developmental status or emotional condition and what each parent is doing about it.

Lawyers may also face pressures to resist cooperation and compromise, even if the lawyer believes such steps would be best for the children, the adult client and the case. Many parents, particularly when they are emotionally distressed or angry, expect their lawyers to advocate their desires. Parents may have unrealistic expectations of what litigation can accomplish, and about the implications for their children if conflict continues. The lawyer may fear a professional complaint or being fired by the client for not being "tough enough", or later being sued by a former client if the lawyer's cooperation is second-guessed by another lawyer or the client is unhappy with the result. Lawyers may also fear that if they refer a client to an individual therapist who maintains an objective focus rather than endorsing a parent's skewed viewpoint, it may harm the parent's relationship with the lawyer. Lawyers and therapists for parents often do not communicate frequently enough, so each may be counting on the other to "reality check" a difficult client. In actuality, it is the combination of both professionals is often

most helpful in encouraging parents to change behaviors that could lead to poor results in the legal process as well as harm to children. (See Campbell, 2020 for elaboration.)

Lawyers can have an enormously important role in obtaining prompt intervention, if they are sufficiently knowledgeable to present the right information and effective proposals to the court. When judicial officers are asked what the most effective strategy would be for getting them to issue specific and effective orders, they frequently respond that lawyers should bring those orders to them (Bala & Slabach, 2019). Lawyers also need training on how to select appropriate therapists, inquire about their training, craft effective orders, recognize when treatment is going off course, understand therapists' ethical obligations and collaborate effectively with their adult clients' therapists. Many resources are available to assist them in these areas[2].

Lawyers need to know enough about children's developmental needs, or obtain enough consultation, to request orders that are relevant to easing the child's distress. They may be more effective in getting action from judges if they present reasonable, developmentally appropriate solutions with little risk of harm. For example, a proposal for a child attend preschool, or resume an after school activity, may carry more weight if it is framed in terms of the child's developmental needs, rather than simply as a means to facilitate a parenting transition.

Mental health professionals. Some obstacles to early intervention can arise from mental health professionals (MHPs) involved in the case. Therapists may not have adequate

[2] See for example, Association of Family and Conciliation Courts' Guidelines for Court Involved Therapy (Association of Family and Conciliation Courts, 2011) and the American Psychological Association's Ethical code (American Psychological Association, 2017).

training for working with court-involved clients; those who become overly aligned with a parent's view may fail to remain objective and inadvertently escalate conflict. Poorly planned and/or uncoordinated treatment may exacerbate conflict rather than resolving it.

Traditionally, MHPs are taught to align with their clients' interests, which is often interpreted as being identical to advocating the parent's or child's expressed view. Viewed from another perspective, a core purpose of therapy is to assist clients (whether parents or children), to cope in a healthier way with the actual stressors in their lives. For all members of a separating family this includes adjusting to a change in the family structure. For parents, it may include learning to conduct themselves in a way that does not expose the children to conflict, accepting that the other parent will have a role in the children's lives, understanding the expectations of the legal system, and changing their behavior as necessary to meet those expectations. Just as parents may fire attorneys who appear to be too conciliatory, some will have difficulty tolerating a therapist who explores alternative interpretations of events, confronts dysfunctional behavior, or recommends changes in the client's own behavior rather than just blaming the other parent. That being said, a therapist who fails to address these issues and unequivocally supports the parent's perspective may be doing the parent no favors, as the parent will ultimately encounter a professional whose role is to be neutral and objective rather than the parent's advocate. Many such parents have been shocked by the results of an evaluation or court hearing, because they have never been exposed to a more realistic interpretation of events or better problem-solving approaches.

Therapeutic confrontation, reframing and motivational interviewing (Iannos & Antcliff, 2013) are part of many therapists' skill sets, as many therapy clients enter treatment because of pressure from an another person or setting (employer, spouse, legal situation, etc.) to change

their behavior. Therapists, who are unwilling to use those tools, may need to recognize their limitations for dealing with custody-disputing parents. Other therapists simply fail to recognize that their work with a custody-disputing parent is a situation in which they need to apply those skills, as their clients appear to be entering therapy voluntarily and are seeking a supportive ally in their struggle against the other parent.

The "pull" to align with a client's expressed wishes is particularly strong when the therapeutic data is coming directly from a child. Therapists working with these children need to be familiar with research on children's adjustment to divorce, developmental issues, and the types of interactions that can influence children's statements and perceptions. The *Association of Family and Conciliation Courts' Guidelines for Court-Involved Therapy* (2011) outline essential areas of knowledge for treating children at the center of custody disputes, and MHP professional organizations continue to undertake training efforts for non-specialized therapists.

It has been the first author's observation that enhancing competence among children's therapists and family therapists may include reminding them of what they already know. A surprising number of therapists who would never support avoidance or regressive behavior on the part of a child toward school or other environments, nevertheless fall under the influence of conflict and support such behavior in children of divorce. Therapists also need to be cognizant of historical therapeutic models that are unlikely to work, and reject cases that are set up to fail (Fidler, Deutsch, & Polak, 2019; Greenberg, Doi Fick, & Schnider, 2016; Greenberg, Schnider, & Jackson, 2019). For example, lawyers and judges often recommend "reunification therapy" that is limited to the rejected parent and child, or individual child therapy that does not include both parents and the family system. Both of these models are unlikely to be effective and may unwittingly escalate conflict (Fidler, Deutsch, & Polak, 2019). Therapists should have clear

informed consent procedures, templates for consents and orders that include the elements necessary for the intervention to succeed. This is discussed in further detail below.

Some custody evaluators, parenting coordinators and forensic experts also inadvertently create obstacles to effective intervention. Professionals who are poorly informed about available options for services, or who fail to maintain a systemic and developmental perspective, may overlook options to support the child's emotional independence. While many evaluations end with recommendations for treatment or other services, too many evaluators offer poorly defined treatment plans that are inconsistent with current knowledge. Other experts make negative judgments about family members' potential to progress based on their response to treatment that was inappropriately structured or not well adapted to the parents' situation. Just as physicians do, informed MHPs can make reasonable inferences from available research and create evidence-informed intervention plans. Medical interventions rarely come with guarantees, but it is generally not suggested that children should not receive health care unless there is certainty about the outcome. Experts discussing the risks of intervention, without addressing the risks of doing nothing, are not providing helpful information to the court.

Broader Systemic Obstacles

The Remarkable Persistence of Inaccurate Information, Bad Ideas, and Ineffective Procedures

When there is too little information exchange between professionals with different bases of information, new information may not reach seasoned professionals. Overwhelmed and frustrated professionals may repeat to each other outdated concepts and generalizations that *seem* true, but are actually inconsistent with current research and, in some cases, long-established professional knowledge outside their subspecialty. In addition to the fallacy that every element

of blame must be established before services can begin, common outdated beliefs and practices include the following:

The assumption that change must be voluntary. This is sometimes expressed by stated beliefs that parents must acquire insight, that the primary goal is to change parents' beliefs, or that there is no point in requiring services unless the parents have internal motivation for change. This is contradicted by studies that show the effectiveness of behavioral therapies for dysfunctional family dynamics and even for families in which abuse has occurred, as well as the effectiveness of behavioral parent training especially when problems are caught and addressed early (Greenberg, 2019; Greenberg, Schnider, & Jackson, 2019; Lutzker & Merrick, 2009, Lutzker & Edwards, 2009; Pedro-Carroll, Sandler, & Wolchik, 2005; Reed et al., 2013). It also contradicts the common experience that many adult clients attempt psychotherapy with some kind of external motivation (such as pressure from a job or spouse) and it is common for children to enter psychotherapy based on the perception of others (parents, teachers) that it is needed. Many only later recognize the benefits themselves, after seeing the benefits of adopting new strategies.

The consequence of expecting "insight" is that it moves the focus of interventions from the behaviors that need to change to a vague expectation that parents change their opinions or beliefs. Particularly for parents who are still litigating, this can be a difficult or impossible goal. Often, parents' feelings and attitudes do not change until they disengage from the legal struggle, try new methods of coparenting, see changes in their coparent, feel financial deprivation from the costs of litigating, or see positive results from new strategies. From the perspective of their emotional development, children cannot wait for parents to "achieve insight" to experience relief from the impacts of conflict, and it certainly isn't in their interest to get no help until most of the

family's resources are exhausted Many parents can certainly benefit from personal therapy, but specific changes in behavior – for example, setting limits with children, shielding them from the parental conflict, improving parenting skills, and making positive statements to support parenting transitions – can be taught (and set as behavioral expectations) without parents needing to change their opinions of one another.

Absence of accountability, poor therapeutic structure. Another traditional concept is that mental health services can only work if they are completely confidential. In high conflict cases, however, protection of the children and effective treatment often requires some form of external accountability, at least with respect to the parents' cooperation. Resist-refuse cases frequently include parents who are so entrenched in their disparate views that they are resistant to even the most reasonable steps to limit the impact of conflict on their child – such as setting appointments, promoting children's cooperation, or setting procedures to limit conflict at organized events. Since children are not in control of their environments, protecting them requires that parents cooperate with qualified child-centered professionals and comply with court orders for therapy, parent education or other services.

Early intervention often requires judicial officers to order parents take concrete steps they do not want to take, and hold them accountable if they do not comply. Professionals and parents often lament that parents who refuse to cooperate often face few consequences or no consequences at all. In some cases, the court will consider a parent's noncompliance during a trial months or even years later, or by a custody evaluator/assessor during a long investigation process. But by the time that occurs, the child may be seriously dysfunctional and face a long road to healthier behavior. Frustrated parents may also begin to exhibit the effects of prolonged stress with more dysfunctional behavior.

Obstacles to accountability include large judicial caseloads that make prompt follow up difficult, poorly defined expectations for cooperation, difficulty proving intent or malicious intent, and a shortage of resources for other professionals, such as children's (best interest) lawyers, who might be able to promote cooperation. As noted above, a particularly common error occurs when the court orders therapy only for child or for the rejected parent and child, with no expectation of involvement, cooperation or support of the therapeutic process by the preferred parent. Poorly planned interventions are unlikely to succeed, but failed treatment can add to professional pessimism that anything can be effective. Lawyers representing uncooperative clients may oppose any order that would be specific enough for their clients to be held accountable, and judicial officers may lack the training, confidence or time to craft and enforce sufficiently detailed orders or recognize that RRD is rarely a one-sided phenomenon.

Loss of developmental focus, linear thinking. The legal world is largely linear and often reductionistic. Judges are asked to make discrete decisions and findings of fact, often between alternatives presented by the parents and framed from the parents' perspective. Even when parents present their wishes using language about the best interests of the child, their perceptions of children's behavior are often colored by their own emotional needs and legal positions. Some issues, such as financial disputes, can be framed in discrete terms, and judges are often asked to make decisions about parenting plans or decision-making authority that parents perceive as global "wins" or "losses."

Children's lives are much less linear. A true understanding of a child's life requires constant recognition that much of a child's development takes place outside of the court context. Children are engaged in a variety of systems – including school, recreational activities, extended family, sibling, peer relationships, and in some cases medical or special education systems. Each

setting both imposes demands on the family and offers the child the opportunity to obtain independent emotional support, outside of the parents' issues or legal struggles. In fact, children are least likely to suffer harm from trauma when they have interpersonal resources and supportive adults who can help them resolve the experience (National Scientific Council on the Developing Child, 2015). Programs such as Head Start Trauma Smart provide coping-focused therapeutic, educational and recreational activities to help children master the abilities they need to achieve healthy development, regardless of whether a "definite finding" can be made about the allegations between their parents (Austin & Greenberg, 2019; Blaustein & Kinniburgh, 2010; Fidler, Deutsch, & Polak, 2019; Greenberg, 2019; Greenberg, Schnider, & Jackson, 2019). While specific, content-focused trauma treatments should not occur unless there has been a definitive finding of trauma (Deutsch, Drozd, & Akijo, 2020; Drozd, Saini, & Vellucci-Cook, 2019), many of the abilities that underlie successful adjustment can be taught and promoted both in appropriate therapy and in children's daily activities. One of the most tragic losses to children occurs when every activity or aspect of their lives becomes another canvas for parental conflict or for parents "proving" the correctness of their own perspectives (Johnston, Roseby, & Kuehnle, 2009). It is critical that MHPs and other professionals consider, and constantly remind themselves, that children's lives do not or at least should not- entirely revolve around us and the legal struggle.

Judicial officers typically respond to the issues brought to them by the parties. If no one has helped the parties to think broadly enough about their children's well being, critical information that could help the child develop, or facilitate a parent-child relationship, may never be considered. Judicial decision-making is based on evidence presented in the courtroom, and judges lack the knowledge and authority to undertake independent evaluation of the

psychological issues. Judges can "develop their own evidence" by asking their own questions, but they need to know what questions to ask and a witness who can answer those questions has to be put forward by one of the parties.

Politicization, Extreme Rhetoric

When children resist contact with a parent, their behavior is often distressing to one or both parents, and to observers. There are legitimate criticisms that the early conceptualizations of this phenomena (such as Gardner, 1989), overemphasized blaming the preferred parent for the child's behavior and ignored real risk factors like intimate partner violence. Conversely, other authors have exhibited complete denial that children's perceptions, feelings or behavior can be influenced by parents or other adults who are invested in interfering with or destroying the other parent-child relationship. Over the past 25 years, scholars, researchers and clinicians have identified many issues relevant to RRD, including but not limited to enhanced knowledge about children's development, the extent of their vulnerability to external influence, the impacts of trauma, interpersonal violence and parental conflict, and the parenting practices and deficits that may be involved in these families. The *Family Court Review* has devoted several special issues to this topic, and most current literature emphasizes the complexity of these family dynamics.. Unfortunately, the analysis of these cases often remains highly polarized, occurring against a background of gender politics, selective presentation of information and scholar-advocacy bias (Sandler et al., 2016). Advocates at both extremes have distorted the literature, engaged in personal attacks, and accused professionals who disagree of condoning abuse or ignoring dangers to children.

Some advocates and advocacy groups have also targeted judicial officers, children's lawyers, guardians at litem and mental health professionals, who often cannot defend themselves

because case information is confidential by law, or because of a professional obligation to protect children from public airing of their family's struggles. In some jurisdictions, agenda-driven legislation is also common. Some advocates blur the distinction between one-sided descriptions of RRD cases and the more complex, nuanced, research-informed models that have been developed in recent years. These tactics drive polarization and encourage an oversimplified, us vs them approach – exactly the opposite of what children caught in complex family dynamics need. In addition to their genuine desire to avoid doing harm to a child, judicial officers may be as vulnerable as anyone else to either oversimplified rhetoric or the bullying tactics adopted by some advocates. Doing nothing, or acceding to a request to delay any action until after another evaluation or hearing (more x-rays), can appear to be less professionally risky than taking action.

Is That the Child's Voice You're Hearing?

In most jurisdictions, courts are required to consider children's views in some way, deciding the weight to be assigned to the child's views based, in part, on the child's ability to form and express their independent views. In many respects, the expectation that children's perceptions and feelings be considered is a positive one, based on a desire to afford dignity and respect to a child impacted by a legal proceeding. *How* we listen to children, and whether our approach truly empowers the child, is more complex.

This issue may be particularly fraught in RRD cases, specifically because one parent is alleged to have consciously or unconsciously influenced or manipulated the child's perceptions or feelings. Parents engaged in high conflict behavior often do not model or teach children healthy skills for resolving problems. Children may become accustomed to avoiding problems rather than resolving them, or reliant on unhealthy coping responses such as becoming the

emotional caretaker of a needy parent, regressing to behavior characteristic of younger children, withdrawing from independent relationships, avoiding all emotion, and refusing to engage with others to resolve conflict. Children may be unable to tolerate conflicting feelings, refuse to engage with anyone who is involved with the rejected parent, and fail to develop essential problem solving abilities such as weighing competing possibilities. Such children, and especially adolescents, can appear mature, definitive, and emphatic when asked the questions they expect about their views and preferences or "positions" in the custody conflict. It takes an astute, qualified interviewer to explore beyond the expected questions and detect the delays in emotional development that compromise a child or adolescent's ability to form a reasonable opinion. Judges may not have the time or training to fully explore the bases of child's perceptions and feelings, what efforts have been attempted to resolve problems with a parent, and how the child is functioning emotionally.

It is important to remember that when children and adolescents express opinions that are not based on their own experiences and healthy coping abilities, they are *not* empowered. Healthy children develop decision-making skills gradually, starting with smaller decisions and progressing to more important ones. Healthy children can discuss the advantages and disadvantages of various plans, and can tolerate gentle exploration of their expressed preferences. When children do not have those abilities, but their expressed preferences are relied on for the parenting plan anyway, there is considerable risk of ongoing emotional harm to the child – particularly if they are asked to make the lifer altering decision about whether to see a parent. In some jurisdictions, there is a formal or informal presumption that a child who has reached a certain age can express a meaningful preference that should be given considerable weight by the court. In those cases, children may be directly or indirectly pressured to resist both

therapy and contact with the rejected parent until they reach the age at which their preferences will be weighted heavily by the judge. Many children have been heard to say that they need not cooperate with therapy or the parenting plan because when they reach a certain age, the judge will let them decide their own parenting plan. Judges and other professionals who set limits with these dynamics, or with the parents who enable them, may find themselves accused of not listening to the child or even of "violating the child's rights." Unfortunately, those may be the very professionals who are being most attentive to the various aspects of the child's perceptions and functioning.

Tools and Potential Solutions

Entrenched RRD cases are complex, and it can often seem overwhelming to consider the level of systemic changes that may be involved in promoting earlier and better intervention for children. Children at the center of conflict could benefit greatly from a more wholistic view of their lives, and earlier and better case management. Systemic change can emerge from a variety of sources, ranging from broad actions to reduce judicial caseloads to practical steps to promote better results for individual families. We do not purport to have perfect answers, but in this section we offer suggestions for overcoming obstacles on both a systemic and individual case level.

Countering the Myths

In much of the material above, we have described questionable or inaccurate assumptions about children and families that have had a disturbingly long life span in the family court system. Inaccurate assumptions persist about the nature of effective intervention, how families change, how to recognize children in trouble, the possibilities for earlier intervention, and how much assessment is needed before any services can be provided to stem the "emotional bleeding" that

can so severely handicap children emotionally. Countering inaccurate information can occur through better training as described above, but may also require constant alertness and energy from every professional involved in a case, and a willingness to confront outdated "truisms" and myths. Structures and practical tools for viewing these families differently may help.

Developmental Focus

In many jurisdictions, initial court documents filed by parents focus primarily on outlining the ultimate result that a party desires, both financially and in terms of parenting plan and authority. The documents may make claims about each parent's sensitivity to the child or parenting abilities, but often offer little information about the child's actual developmental status, daily routines, upcoming parenting decisions about developmentally appropriate opportunities, and any areas outside of the parental conflict that may pose risks to the child. Since parental conflict impacts children on a daily basis, failure to attend to these issues may leave unaddressed the most destructive impacts of the parenting conflict.

On a systemic basis, gathering information differently may be a key to focusing attention on these issues. A surprising amount of revealing information is generated when questions are asked that go beyond allegations that a young child is "not ready" to spend overnights with the other parent, or that a child who should be using language is regressing to tears and acting-out behavior at the time of parenting transitions. Such developmental inquiry is unlikely to be possible in the setting of a hearing, but could be part of standard inquiry at other "entry points" into the legal system, whether that be mediation, consultation with a lawyer, or completion of a form asking those questions.

Absent such systemic-level change, inquiry about a child's daily life, activities, and the attempts being made to promote developmental progress should be an early area of focus when

dealing with an RRD case. With young children, for example, it is frequently proposed that parenting transitions be at a neutral location when parent-to-parent transitions are not working well, or the child is demonstrating regressive behavior such as tearfulness. The issue often missed is that preschoolers, particularly those who have been exposed to trauma or exposed to protracted parental conflict, *need to be mastering language and active coping skills.* These abilities are central to successful adjustment, and parents focused on their own conflict may not be attending to them well. A child who is enrolled in preschool gets active, consistent, developmentally appropriate support for healthy coping abilities, including resolving conflicts and expressing their feelings with words. These healthy abilities are promoted on a daily basis, without reference to the parental conflict unless parents are interfering in that setting. School and recreational activities serve many of the same functions for older children (Austin & Greenberg, 2019; Blaustein & Kinniburgh, 2010; Drozd, Saini, & Vellucci-Cook, 2019; Greenberg, 2019), who also need to master healthy coping abilities in order to achieve healthy adjustment (Davies, Martin, Sturge-Apple, Ripple, & Cicchetti, 2016; Pedro-Carroll, Sandler, & Wolchik, 2005).

If the "job" of children is to master these healthy abilities, the primary responsibility of parents is to create and protect the opportunities for these to occur. This may be a useful lens through which to view RRD cases, given that once cases progress to severe entrenchment, the child's resistance can often extend well past the resisted parent to any coach, teacher, parent, friend, or extended family member who still engages with the resisted parent (Warshak, 2001). Protecting children's ability to form independent relationships, and not have all areas of life infected by the parental conflict, can be conceived of as a fundamental responsibility of parenting, and a reasonable expectation of both parents. Counsel and mental health professionals

working with parents should attend to these issues. Is a preschool-aged child getting an opportunity for that independent, supportive experience separate and apart from the parental conflict? How are parents behaving at school and recreational events? How do parents respond to requests that they support these opportunities? Have specific, reasonable requests for behaviors that protect the child from conflict been refused?

Greenberg, Doi Fick, and Schnider (2016), and Greenberg, Schnider, and Jackson (2019) have presented a detailed framework for developmentally-focused early intervention in RRD cases. But an initial step is for counsel to inquire about these issues, to make proposals for child-protective opportunities and protocols, and be able to present a record of the response to these suggestions and requests. This requires that both parents be able to focus beyond the issue of parenting time to the child's broader emotional health. In many cases, expanding children's access to neutral environments may make it possible to arrange more effective parenting transitions, both because this negates the need for both parents' presence and because the child's time in the neutral environment will likely have reinforced healthier behavior. If the child's access to such experiences is undermined, unreasonably restricted to one parent's sphere of influence, or supported only for its role in enabling parenting transitions, that should raise concerns. While these developmentally focused approaches may be less inherently satisfying to angry parents than securing a court decision blaming the other parent, they are also more likely to be helpful to the child.

Templates and More Effective Orders

As stated above, the time pressures of a courtroom crowded with cases gives both the judicial officer and counsel less time to think about the nuances of cases and carefully draft an order that covers many of the issues unique to each case. This is an area where lawyers, MHPs

and judges can have a positive impact. Each professional group can help create a standard order that addresses the issues that commonly arise with a "check the box" format to adopt those areas that are relevant to the individual case. One critical issue to address is the amount of information that can be released by the therapists and who can receive that information (court, lawyers, parents, evaluators, other related MHPs). Again, training for judges and lawyers is helpful here. "Safe harbor" models, in which absolutely no information can be released by the therapist, may have conceptual appeal when the judge's hope is that therapy alone will resolve the issues. Unfortunately such structures are typically ineffective in RRD cases and may even escalate conflict, particularly if the therapist over identifies or uncritically accepts the client's or child's "expressed view" with no "reality check" from engagement with other therapists or a neutral professional such as a parenting coordinator. Greenberg and Sullivan (2012) and Greenberg, Schnider, and Jackson (2019) describe tiered forms of information sharing that allow essential information to reach the court while encouraging some level of discretion on behalf of the child. Direct reporting can be limited to procedural issues (attendance, general statements about participation, lateness or no show), or based on specific circumstances such as a parent relitigating or not cooperating with the therapists.

Payment issues should be clearly addressed, including who pays what amount and when, and the procedure and consequence if one party fails to pay as ordered. In some jurisdictions, the court may denominate payment of fees to the therapist as a form of child support, if properly structured and permitted in the jurisdiction. Other procedural areas would include who is required to participate, the timing or number of sessions and how dates are set – typically, therapists should be given considerable discretion in scheduling and structuring sessions, including requesting that parents deviate from the parenting schedule if necessary for

each parent to participate in transporting the child. Sample forms for stipulations and orders can be found in the *AFCC Guidelines for Court-Involved Therapy* (2011), Bala and Slabach (2019), Fidler, Deutsch, and Polak (2019), and Greenberg, Schnider, and Jackson (2019).

Judicial orders can include provisions that aid in enforcement of the orders and minimize returns to court for modifications and determinations about contempt. These would include both "carrots" and "sticks." Typical "carrots" would include automatic step ups in parenting timeif certain goals are met (e.g. complete80% of the ordered therapy and the monitor then goes away). This would be coupled with an order that allows a direct report from the therapist about session attendance. A typical "stick" is the opposite. Fail to complete the therapy and no change occurs in the parenting plan. For ethical reasons, MHPs typically do not include such provisions in their standard orders. But forms could include a general prompt for enforcement mechanisms, and lawyers can certainly advocate for them.

Parents can be incredibly creative in finding ways to frustrate orders to address RRD dynamics, which is another reason why it can be extremely important for therapists to develop standard forms for stipulations (elsewhere referred to as "orders on consent") or court orders and collaborate with counsel in framing the order for a specific case. Conference calls between the therapist and all counsel, or in some jurisdictions including counsel and the court, may help to identify problems, prevent some, and deal expeditiously with the problems that are likely to arise. Standard orders are likely to be more comprehensive in identifying potential problems, and may include suggested language for goals and consequences or a "check off" of issues that the judge can identify.

An increasingly critical issue is the need for the court order to include behavioral expectations, such as requiring parents to exercise their parental authority to promote the child's

cooperation with treatment and parenting transitions. (Getting the child to the office parking lot, or the waiting room, is insufficient.) Since there are common problems that occur repeatedly in these cases, templates can be created of common behavioral expectations and then augmented by the mental health professional, attorneys and the court. Deutsch, Drozd, and Ajiko (this issue) have developed a tool, specific to issues of parent-child engagement that can be used to both guide behavioral expectations and assess the effectiveness of treatment. This can be paired with behavioral expectations for both parent cooperation and child mastery of healthy coping abilities.

Many courts have standard orders directing parents not to disparage one another in front of the child. We believe that this language is often insufficient, and could be strengthened to include an affirmative obligation to shield the child from conflict, not allow the child to see legal documents, and refrain from discussion of the legal matter, serving the other parent with papers, or other hostile acts during parenting transitions and at the child's school or other neutral settings. Specialized message boards for parents, such as OurFamilyWizard and Coparenter, provide a forum for documenting cooperation, or lack thereof, on issues such as following a therapist's recommendations to reduce conflict at school events.

Many parenting programs already include specific suggestions for parents as to how to support children's parenting transitions and relationships with the other parent, and a reasonably informed mental health professional can look at the problem parenting or child behaviors being reported and suggest positive, adaptive behavior changes. Greenberg, Doi Fick, and Schnider (2012, 2016) included some examples of this type of instruction. Some additional possible templates, which may of course require adaptation to the situation, are attached as appendix A.

One sample describes guidelines for parenting transitions of young children, while the other relates to protection of school and other settings from conflict.. In the event of a safety risk

or restrictions on a parent's involvement, it may be necessary to modify the examples to require compliance with a monitor during a parenting transition or some other specific circumstance. If the parent is subject to some restrictions but does not represent a danger to the other parent or child at public events such as school activities, these templates may serve as a tool for allowing the parent to continue to fulfill some aspects of the parental role and have healthy engagement with the child. This makes it easier for the court to more carefully craft restraining orders to limit only the parenting conduct that is at issue in the case. For example, if a parent cannot attend the school activity, modifications may include having someone provide a video of the event, followed by a congratulatory phone or Skype call between parent and child. These may be critical initial steps to support therapeutic progress.

There is no perfect order, and it is realistic to expect some parents to frustrate the most carefully constructed language. In addition, there may be some behavioral expectations that, for legal reasons, cannot be included in a court order. For that reason, it is critical that Court's use another powerful tool in their arsenal – articulation of findings and expectations that frame the context of the order

The Critical Role of the Court's Findings and "Expectations"

Not everything can be included in a court order**.** For example, it may be legally problematic to require a parent to refrain from exhibiting tears or a sad expression when the child transitions to the other parent, even though such behaviors powerfully impact children. For this reason, it's critical that judicial officers use the other powerful tools available to them, such as the ability make on-the-record findings or articulate the Court's expectations and the behaviors that the Court wants to see improve. The Court can articulate the importance of ensuring smooth

and peaceful transitions, protecting the child's ability to enjoy independent activities, setting limits with the child to ensure appropriate behavior, cooperating with a therapist, etc.

This is more than just use of a "bully pulpit." By grounding these expectations in what would normally be expected of parents (such as ensuring school attendance, completion of homework, that the child get enough rest, that physicians' instructions be complied with, etc.), the Court conveys an important message about the connection between these issues, normal child development, and the Court's considerations about the child's best interests. Judicial officers can directly tell parents that their level of cooperation on these issues, and the observed results for the child, may be a factor in the Court's later decisions. This latter point is important because some parents may comply with the specific language of guidelines such as those attached, while simultaneously undermining the intent of those instructions by finding other ways to expose a child to the parent's emotional distress or conveying contradictory messages to the child while outside of public view. No order, or statement of judicial expectations is foolproof, but judicial officers' statements of the results they expect to see can be very powerful

Conclusion

The risks to children from chronic exposure to parental conflict including entrenched RRD cases are well established. It is common to hear professionals express frustration that a family received quality intervention too late to resolve the problem, restore a threatened parent-child relationship, or salvage the child's emotional functioning. Many of the causes of such delay are systemic and rooted in the polarization of high conflict child custody cases, as well as the surrounding political climates. The appeal of the endless x-ray is considerable, particularly if the parents have the means and motivation to support repeated investigation over problem solving.

Many types of interventions that can stabilize or assist the child – coping-focused therapy, involvement in preschool, orders restraining the parents' conduct at school events – come with minimal risk and offer essential developmental support to the child. If all professionals are aware of effective services and the risks of delay, the family's responses to those services may provide an enormous amount of useful information – either improving the family's situation or providing the behavioral basis for further orders.

Appendix A

Suggested Elements For Transitions and School Involvement

The suggestions listed in the following pages are for consideration only and are not intended to substitute for the necessary adaptation to a particular case. Where realistic safety concerns exist, or the Court is taking precautions while an assessment is being conducted, additional elements may be necessary such as involvement of a monitor or parenting transition supervisor. Trained and experienced mental health professionals may be of assistance in adapting general principles such as these to specific case situations.

These types of instructions are most effective when accompanied by findings or an articulation of expectations from the court about the kinds of conditions which help and hurt children and the potential role of those conditions and the parents' compliance in future decisions by the Court.

Transition of Young Child Between Parents

(Sample Expectations)

1. The (receiving parent) will drive to the location of the pickup. The parent will park at the curb, wait in the car and unlock the door.
2. The (transitioning/sending parent) will walk out to the other parent's car with the child, place the child in the back seat of the other parent's car, fasten the child's seatbelt, place the child's backpack or bag us supplies in the car, and close and lock the car door.
3. The (transitioning parent), will either wave or say hi to the receiving parent. The other parent will respond in kind. Neither parent will discuss issues in the parenting conflict, make any references to lawyers or the court case, exchange hostile glances or hand gestures, serve the other parent with legal papers, or engage in any other action to disturb the peacefulness of the transition for the child. The transitioning parent will set clear limits with any regressive or noncompliant behaviors demonstrated by the child.
4. Upon fastening the child's seat belt, the transitioning parent will say, "Goodbye, (child's name). Have a good time with (the other parent). I will see you when you get back." The transitioning parent will then immediately walk away from the car.
5. Upon completion of this procedure, the receiving parent will drive away.
6. If the transitioning parent has essential information to pass on to the receiving parent, the transitioning parent will post a message via (approved parenting message board) not less than 2 hours before the transition time. Urgent information may be conveyed by text.
7. Absent extraordinary circumstances, the transitioning parent will ensure that the child is clean and rested prior to the parenting transitions. The transitioning parent shall avoid scheduling play dates or other activities in such a manner that they must be interrupted to

facilitate the parenting transition. In the exceptional circumstance of an external activity such as a birthday party for another child, parents shall provide prompt notice of the invitation to the other party and confer regarding the feasibility of allowing the receiving parent to pick up the child at that location.

Shielding the Child From Conflict at School and Neutral Activities

(Sample Instructions)

It is the expectation of this Court that parents engage their best efforts to protect the child's independent, developmentally important activities from the impact of the parenting conflict. Each parent has an independent obligation to actively shield the child from such conflict, including making all efforts to prevent the child's exposure to legal documents, direct or indirect references to the custody conflict, direct or indirect expressions of hostility between the parents.

1. Except when both parents are present for an externally organized event (school recital, play, athletic contest, etc.), neither parent shall be present at the time that the other parent picks up the child. (This can be modified to specifically restrict the days that either parent can be at the school or volunteer for school events. If one parent only has parenting time on the weekends, a provision specifically allowing that parent to volunteer for school events may be necessary.)
2. (Parent A) shall remain _____ feet from parent B during all school events.
3. If the parents encounter one another at a school event and the child is present, each parent shall say hello to the other. Neither parent will discuss any aspect of the parenting conflict in the child's presence, serve one another with papers, or make reference to lawyers, hearings, or any other aspect of the legal conflict. The parents shall also wave or politely greet any other adult who is present for the activity, as a model of socially appropriate behavior for the child.

4. After the practice or other independent event, the child may briefly approach the non-custodial parent to say hello. That parent will then direct the child back to the parent who has parenting time that day.
5. After the practice or other independent event, the non-custodial parent may briefly approach the child to praise the child's performance or efforts, then redirecting the child back to the parent who has parenting time.
6. Each parent will exercise appropriate parental authority to require that the child exhibit polite and socially appropriate behavior at all times, including the child's behavior toward both parents, extended family, friends and other adults.
7. Both parents will consistently encourage the child to remain with peers and follow all rules related to the activity. Unless the child is injured, neither parent shall support the child withdrawing from the activity to be with the parent.
8. Both parents will be polite to school and athletic personnel and refrain from mentioning any aspect of the custody conflict.
9. It is the responsibility of the transitioning parent to ensure that all supplies and equipment necessary for school or a neutral activity are transferred to the receiving parent. It is recommended that the parents each purchase a uniform for the child's independent activity. If essential but non-duplicated items (soccer shoes, costumes for a play, homework, etc.) are left behind with the parent who does not have custody and the items will be needed the same day, it is that parent's responsibility to ensure that the items are left at the school office not less than two hours before they are needed. The parent will not remain at the school for the parenting transition. If the items will not be needed the same day or the school will not permit them to be left at the school, the

parent will make arrangements to leave the items at a mutually agreed location for direct pickup by the other parent.

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STEP UP PARENTING TIME PLANS TO ACCOMPANY FAMILY THERAPY & REPORTING IN PARENT CHILD CONTACT CASES [1,2]

Barbara Jo Fidler, Ph.D., C.Psych., Acc.FM.
Toronto, Ontario

Children are often dealing with multiple issues regarding their feelings toward an resisted rejected parent. Difficulty adjusting to contact with a parent, or a lack of interest in a relationship with a parent, is not a reason, in and of itself, to delay reunification. Indeed, often the stepped resumption of contact with a parent, combined with appropriate mental health interventions, is needed to address the child contact problems.

Challenges are encountered if the therapist is put in the position of either recommending or determining the parenting time or related adjustments. These challenges are likely especially likely if the therapist is expected to determine the pacing of implementing the court ordered parenting time schedule that may not be realistic or possible when the parents commence therapy.

Assigning this responsibility to the therapist puts them in an improper dual role. Further, it contradicts the premise upon which the family therapy is proceeding, namely that the court has determined or the parents have agreed it IS in the child's best interests to have contact with the rejected parent irrespective of the nature and intensity of the contact problem. The therapy process is NOT to determine if it is in the child's best interests to have contact with a parent, but rather to implement contact and restore family relationships, including that between parents and children, and between parents as co-parents. When it cannot be stipulated that it is in the child's best interest to resume and/or repair contact with a parent, a different process be it legal or clinical, must occur before therapy can proceed.

Accordingly, in parent-child contact problem cases, a court order for family therapy needs to specify a **clear** plan to move a parent from whatever level of parent time they are currently having to whatever level of contact the court sets, or the parents can agree to in a consent order. In addition to the need for a detailed and unambiguous court order for the therapy, a specific and unambiguous parenting time schedule needs to be inserted into the treatment agreement (see 5b of separate handout, Family Therapy Agreement).

In some cases, the current status quo or court ordered parenting time schedule will suffice, with the expectation that it is to be implemented as ordered while the family

[1] See separate handouts: Checklist for court order and sample Family Therapy Agreement.

[2] With permission, this handout has been adapted from material prepared by Dr. Aaron Robb April 18, 2014 for: 2014 Innovations --- Breaking Boundaries in Custody Litigation A Systematic Approach to Reunification Therapy June 12-13, Dallas/Addison, Texas, University of Texas School of Law.

therapy is ongoing. At the very least, the intention would be for the therapist to work towards implementing the court ordered parenting time. To address this problem, "stepped plans", a term used by Texas psychologist Dr. Aaron Robb, may be indicated.

Although the therapist does not have the authority or responsibility to determine the parenting time, in accordance with their mandatory reporting obligation, the therapist would be obliged to report any reasonable suspicions of child abuse or neglect (sexual, physical, emotional harm), which would in effect introduce potential concerns about the advisability of the current parenting time continuing until the CAS has investigate.

Different types of contact may be included in stepped plans:

1. Supervised Contact: Supervision provided by a professional or nonprofessional (family member, friend, other).

2. Monitored Contact: Provided by a third party who remains nearby in the same location. However, when there are concerns about possible emotional or physical abuse of the children, the sharing of inappropriate adult information with the children, or other interactions where a closer level of scrutiny is needed (i.e., supervision), monitored contact is not appropriate.

3. Therapeutically Facilitated Contact: There may be cases where starting unsupervised, supervised or monitored contact may not be advisable as a starting point and a therapy-oriented approach is more appropriate. In these cases, all parent-child contact occurs during the therapy as part of the therapy. This could occur in the therapist's office, a parent's home, or in the community with the therapist.

4. Parent-Child Contact Without 1, 2, or 3 as above: This would be as per the court order and terms in 5b of the Family Therapy Agreement.

A. Examples of Step Up Plans From Supervised to the Court Ordered Parenting Time

The following are fairly standard stair steps plans:

Plan #1

Level 1:	Supervised contact for 2 hours every Saturday
Level 2:	Supervised contact for 4 hours every Saturday
Level 3:	Monitored contact from 9:00 a.m. to 6:00 p.m. on the first, third, and fifth Saturdays
Level 4:	Remove monitor, continue with Level 3 schedule

Level 5: First, third, and fifth weekends from Saturdays at 9:00 a.m. to Sundays at 6:00 p.m.
Level 6: First, third, and fifth weekends from Fridays after school to Sundays at 6:00 p.m.
Level 7: Interim or final endpoint court ordered parenting time schedule

A variation on this plan when supervised or monitored contact might not be needed would be to start with Level 2 (without supervisor), progressing to Level 3 (without monitor), and then progressing through levels 5, 6, and 7.

Plan #2

Level 1: 8 hours total supervised contact on the first, third and fifth weekends
Level 2: Add an unsupervised 3-hour meal parenting time (lunch/dinner) on the second and fourth weekends
Level 3: Change to 4 hours supervised and 4 hours unsupervised contact on the first, third, and fifth weekends
Level 4: Unsupervised parenting time 9:00 a.m. to 5:00 p.m. Saturdays and Sundays on the first, third, and fifth weekends. End meal parenting times on second and fourth weekends.
Level 5: Unsupervised parenting time from 9:00 a.m. Saturdays to 5:00 p.m. Sundays on the first, third, and fifth weekends. Add weeknight unsupervised dinner parenting time on Thursdays.
Level 6: Interim or final endpoint Court-ordered parenting time

A variation on this plan when supervised contact might not be needed would be to start with Level 4 and move forward from there.

Plan #3 - - - Contact with therapist only initially

Level 1: Therapeutically-facilitated contact of child and parent. Following initial intake and assessment, the family therapist will schedule [# of sessions] weekly joint sessions with the RP and the child, to which the FP parent will transport the child. Individual sessions with each parent or the child at the discretion of the therapist should be included at each level of this plan.
Level 2: The RP and the child will have a 3 hour unsupervised meal time parenting time following a parent-child therapy session where they will discuss plans for the parenting time. The RP and the child will return to the therapist's office at the end of the parenting time to meet with the FP to process how their contact with the RP went. The child will leave with the FP at the end of the session.
Level 3: RP will have 8 hours of unsupervised contact, with contact starting and ending at the therapist's office.
Level 4: RP will have 6 hours unsupervised contact, with FP dropping the child

off at the home of RP or another location identified by the therapist at the start of the parenting time and the parenting time ending at the therapist's office to process how interaction went. FP will pick the child up at the end of the session.

Level 5: While continuing weekly family therapy, RP will have unsupervised parenting time from 9:00 a.m. Saturdays to 5:00 p.m. Sundays on the first, third, and fifth weekends.

Level 6: Interim or final endpoint Court ordered parenting time

Various iterations of this plan, adjusting the number of steps and the rate of increased time per step, should be obvious. The initial goals are to allow monitoring of interactions and a safe space to process any interactions. Debriefing with all family members, including the FP is essential. Individual contact can also be used to process outside of the joint sessions.

Plan #4

Level 1: While the child and parent are participating in individual sessions with the family therapist or a separate individual therapist for each, parenting time occurs under therapeutic supervision with a neutral/unaffiliated provider. This avoids both dual-role violations for therapists and preserves the neutrality of the therapeutic supervisor.

Level 2: Convert therapeutic supervision to standard supervised contact. Continue individual therapy throughout remaining levels as needed.

Level 3: Remove supervision constraints under one of the previously noted plans.

This plan focuses on more intensive services at the beginning of contact and may be suitable where concerns are less about parent-child relationships and more about parenting competency and/or safety. Feedback from therapists after Level 1 may be less interaction focused and more in regards to each person's individual issues.

Additional provisions can be tied to the various levels, such as holiday parenting time if a parent is on a particular level (i.e. an overnight near Christmas on Example 2, Level 5, or a few days over spring break on Example 1, Level 6) if those are viewed as appropriate to the case. Additionally parents always have the option, however unlikely, to agree to such arrangements on their own as the case progresses. As a caution, any such variations should be agreed between the parents in writing (hardcopy, e-mail, Our Family Wizard, etc.), and copies should be provided to the treatment team.

B. Moving Between Steps

As noted, the predetermined court order or agreement specifies that the therapist managing the reunification process is not to make decisions about parenting time or custody. The therapist, is however, expected to report back on behavioral progress of the parents and child, which then serve as "trigger conditions". It cannot be overstated that the therapist job is to assess and implement, not determine or even recommend parenting time.
Requirements to move up to next step can identify any or all:

1. # of weeks at each level
2. #of weeks in individual and/or family therapy
3. participation and/or completion in other interventions (e.g., parenting education such as individual, group or on-line, with a specification as to what needs to be included in the curriculum such as: the impact on children of parental conflict, information about the differentiation of various parent-child contact problems and the impact on children, reducing parental alienating behaviours, basic parenting skill development, etc.)
4. period of time having abstained from drugs or alcohol

Steps may also go down to decrease the amount of parenting time, again pursuant to the court ordered plan.

In the case of noncompliance, relapse, or other behavioural problems, one possible consequence is that instead of plateauing at the current parenting time plan, the rejected parent returns to an earlier level. This might mean returning to the step immediately previous to the current step, starting over from the beginning, or somewhere in between

Example: Should the treatment team determine the RP is not in compliance, this parent will return to the prior parenting time level for [# of weeks]. At the end of this time, compliance shall be reassessed and the RP either advances to the next level if compliant, or again moves to the next lower parenting time level if noncompliant and reassessed again in [# of weeks], repeating this process until the RP returns to compliance. (*This is a broad judgment call, but acknowledges that some parents may simply not engage as needed in order to meet the best interests of their children.*)

Example: Should the RP test positive for illegal drugs at any drug screen, they shall return to Level 1 of the previously outlined parenting plan. (*This is an automatic trigger needing no judgment at all, just a report from the drug testing agency.*)

C. Reporting: Frequency, What to Include & to Whom

Reporting is intended to promote accountability and compliance; while the report may be used in Court, these reports may not end up in court. The reports must provide the information needed by the court and lawyers, while remaining sensitive to preserving some confidentiality.

Frequency of Reports

1. *Time based* – Every X weeks, monthly, or quarterly. Reporting does not have to be on a fixed basis, but as parents progress through various levels, the need for reports may be lessened. The case that may need weekly summaries in the beginning, and might transition to monthly reports as time progresses. It is important to check with the reporting professional to insure they are able to make reports on the schedule the case requires.

2. *Condition based* – Reports may be limited to when critical milestones are reached. Once a parent completes a particular task the mental health professional certifies that to the lawyers and/or court.

3. *Combinations* – It is highly recommended that there be some form of routine reporting so that contemporaneous assessments of progress are documented. Setting a maximum period that will pass before a report is needed may allow several condition-based reports to be generated, but prevents total silence if there is a lull in services or plateau in progress for some reason.

Options of What to Include in the Report:

1. *Therapy*

    - summary of education and interventions completed
    - summary of homework completed
    - frequency of attendance
    - assessments of compliance with treatment plans
    - willingness and responsiveness to behaving differently, examples of specific behavioural changes
    - whether shortcomings are a reflection of a need to build additional abilities or a lack of willingness to use the skills they are being taught,
    - level of insight
    - ability to express healthy insight to the child in question, etc.

2. *Psychiatric care*

    - compliance with medication checks
    - assessment of client understanding of the importance of medication management
    - client willingness to adhere to a medication regimen
    - participation in Intensive Outpatient or Partial Hospitalization Programs

3. *Substance Abuse*

    - results of physiological testing (clean, positive for particular substances, or not responded to and treated as a failed test)
    - feedback from sponsors, attendance at community support groups or Supportive Outpatient Programs, behaviours indicative of increased relapse risk, etc.

4. *Pain management* --- viewed as a subset of substance abuse, therapy, or psychiatric issues. Untreated or undertreated pain can manifest negatively in many ways. Additionally parents may also develop tolerance and drug-seeking behaviors. In addition to 3. Above:

    - results of monitoring that the parent has alerted their various treatment provider (such as their primary care provider) to the pain management plan
    - has advised regarding treatment issues
    - is (or is not) complying with that plan

5. *Basic parenting skills* – this entails parents demonstrating anything from the ability to change a diaper to more complex skills such as offering choices and consequences.

    - summarizing observed parenting, improvements, set backs, no change

6. *Additional Group or Individualized Educational Programs or Courses*

    - Inclusion of list of parenting education parent obtained outside of the therapy (e.g., books read, videos watched, on line or in person course, etc.). Parent can be asked to keep a homework log summarizing all of the material provided that they completed outside the therapy sessions that were then discussed in the therapy.
    - obtaining certificates of completion
    - records of homework

7. *Participation in supervised/monitored contact* (addresses self-sabotaging approach)

    - obtaining record of participation of resisted/rejected parent (RP)
    - has the favoured parent (FP) brought the child and on time
    - obtaining observations notes, positives and negatives, taken by supervisor (summarizing problems/issues, if any, are occurring during supervised parenting times)

Reporting To Whom

Regular exchange of information between members of the treatment team, including informal reports status updates will be a requirement and noted in the court order and family therapy agreement. The following represent more formal reports:

1. *Status reports to the court*. See above. Copies should be sent to parents and counsel.

2. *Letters to the counsel*. While there is a minimal additional expense in keeping the lawyer involved, depending on the nature of the case and level of involvement of the lawyers, reports are an easy way to routinely document progress. Any formal communications by or between the treatment team (treatment plans, billing statements, etc.) should also normally be copied to all lawyers to insure transparency is maintained.

3. *Directly to the parents*. This is the most direct way of documenting progress, and may be done via formal written communication, or more informal methods such as e-mail or using a communication software platform, such as Our Family Wizard. They should normally receive copies of letters to the court and counsel.

Sample Coparenting Agreement for when the child complains about the coparent. Exerpted from Overcoming the Coparenting Trap (Moran, Sullivan and Sullivan 2015)

To minimize the critical comments by a parent or a child, each parent read the following statement and rules to the children:

It is our divorce. You should not feel responsible for it, hear about it, worry about our emotions, or put with either of us getting upset and not behaving well.

Here are our rules:

- Neither Mom nor Dad is allowed to make critical statements about one another;
- If you hear us make a critical statement about one another, please point out that we are breaking the rule, and you may tell the other parent what you heard said, if you wish.
- You are not allowed to read court documents, read our text messages or emails to one another, or overhear our conversations with other adults about divorce-related matters. It is your responsibility as well as ours to ensure that you are not exposed to such matters.
- If one of us seems angry or upset about the divorce, please don't ask us to talk about it; instead, give us time and space. We are competent adults and can take care of our own business although sometimes we need a "time out" to settle our emotions.
- If you have a complaint about either of us, bring it directly to the one you have the complaint about rather than the other parent. Everyone has to learn to address relationship problems. We know it can be tough for a kid to be direct with a parent; we will help you along if you start the talk. But going forward, if you complain to me about Mom/Dad, I will listen politely, and ask you to bring the issue to

Mom/Dad; I won't jump in for you.

- However, if you tell one of us that you have an issue with your other parent and are not comfortable to talk to your other parent directly, we can all meet together, and I will do my best to help you talk about your issue without talking for you. [Note: if the child has a counselor, the parent should direct the child to share their concerns and issues with the counselor.]