1

2

Degrees of Court Involvement

- *Court involved* treatment may be any therapy with impact on, or being impacted by, ongoing legal processes;
- *Court-ordered* therapy may be a situation in which a parent is ordered to obtain treatment, or provide treatment to a child, perhaps to address specific issues. This therapy may or may not involve permeable privilege or reporting requirement.
- In *court appointed* treatment a specific therapist is appointed to address specific treatment goals, which may be identified by the Court or an evaluator.

Degree of Court involvement can change over time

3

Implications of Court-involvement

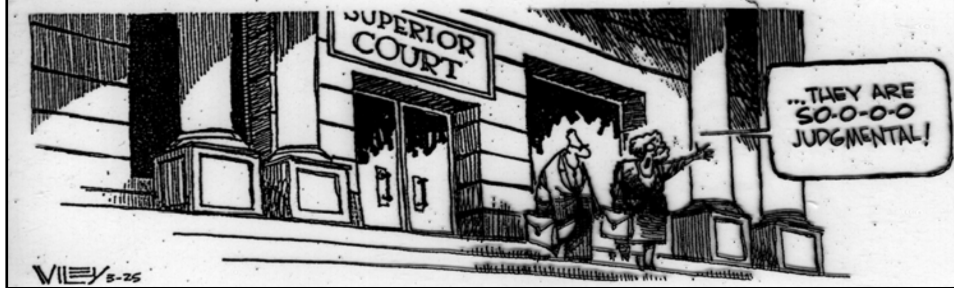
- Legal processes impact treatment
  - Impact the client's attitudes, motivations, behavior
    - Informational distortions are common
  - Impact the MHP's position (advocacy?)
  - Impact on the legal process – information that is shared in the process

This is a unique treatment context that requires consciousness of these impacts and specialized procedures and techniques

4

Clinical Interventions in the Legal Adversarial Process

- Everyone is right in their narrative and they'll prove it
- It's tough to work with parents, but litigants are impossible



5

Historical Assumptions

6

- Treatment only works if it is:
  - Completely confidential
  - Voluntary
  - Insight-oriented
  - Not in the context of a child custody dispute
- Anything else isn't therapy

6

7

High-Conflict Cases

- Exposure of child to conflict
- Poor parental communication
- Poor compliance with court orders
- Disputes over minor issues, may include frequent court hearings

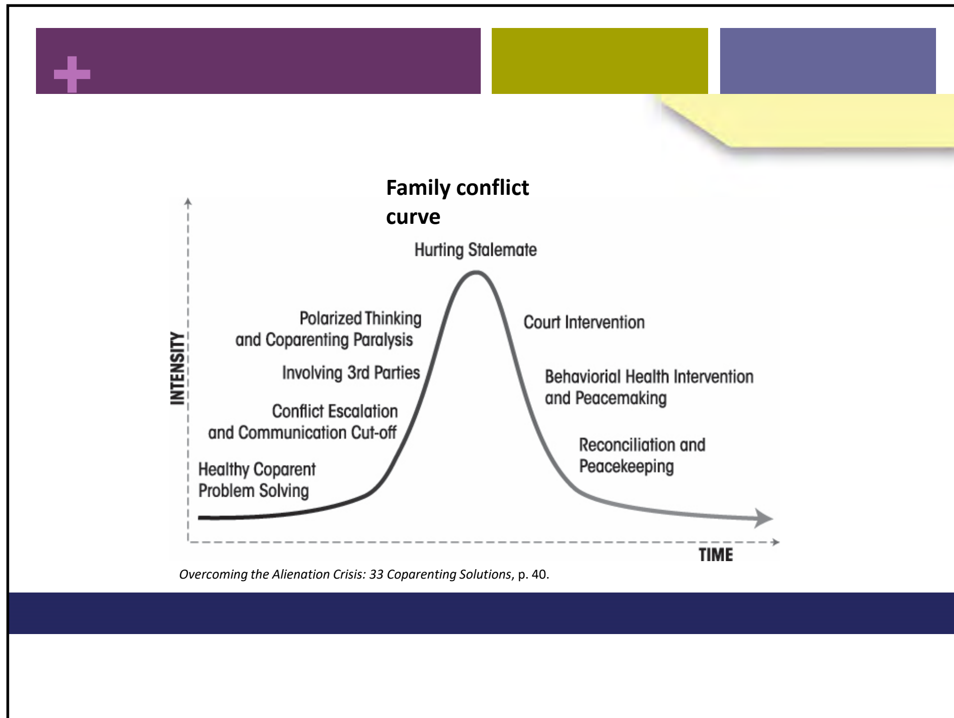
7

8

High-Conflict Cases

- Control battles
- Undermining of other parent or other nonaligned adults
- Poor ability to separate adults' needs from children's needs

8



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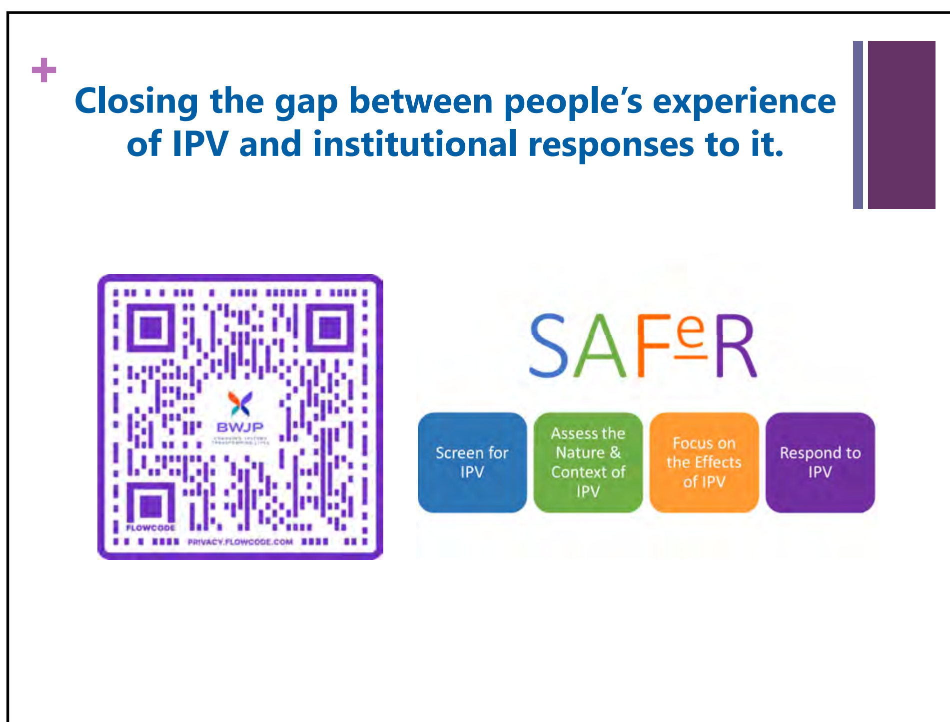
10

High-Conflict Cases

- Parental conflict may pre-date the separation and Court Involvement
- May include situational or common couple violence
- Distinguish from patterns of sustained battering or abuse

10

Closing the gap between people's experience of IPV and institutional responses to it.



11

Other contributing factors…

12

- Parents may not have had healthy coping skills prior to separation
- May not have had access to adequate treatment
- May have been directed by advocates or others toward high conflict solutions
- Own betrayal of trust in other parent may be generalized to the child

12

13

Concerns may be realistic…

- Undermining of parental relationships rarely takes place in a vacuum
- Multiple factors often contribute
- Education may or may not help
- History of poor treatment or inadequate intervention
- Underlying personality factors

13

14

Motivation for problem solving may be compromised if

- The other parent-child relationship is undervalued (or vilified)
- Requirements for problem solving feel overwhelming
- Parent has limited coping ability
- Child has adopted dysfunctional behavior
- Parent doesn’t recognize broader importance

14

Poor candidates for therapy..

- Active substance abuse
- Untreated mental illness
- Inadequate enforcement of orders
- Untreated anger issues
- Poor treatment compliance

Adjusting our work to the Court-Involved Population

- Orders/findings usually focus on the impact of the conflict on the children, and/or serious emotional/behavior problems
- The target is behavior
  - Children need more rapid relief
  - Not everyone can achieve insight first
  - We don’t need to convince them to like each other, just to change behavior that impacts the child
  - Insight can follow behavior change; may require acquisition of specific skills

"I don't want/need to make any changes"

- Involuntary Clients
- Litigants
- Personality vulnerability

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Involuntary clients

- Typical techniques are not going to work
  - Most basic treatment assumes clients cooperative and eager
- Don't assume compliance, buy-in
  - take measures for accountability, coercive – linkage to Court authority - case management critical
- Changing the playing field of motivations
  - Court orders – threat of less desirable outcomes
  - Interventions as motivation

    example - OCB camp - intake to camp

18

19

Types of Treatment that may be subject to Court orders

- Child treatment
- Conjoint therapy
- Coparenting therapy
- Parent therapy
- Significant jurisdictional differences, differences among judicial officers about legal authority to order treatment

19

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Coordination of multiple treatments

- Orders are essential to provide:
  - Expectations of communication between therapists
  - Guidance on roles as the relate to goals
  - Specification of confidentiality
  - Linkage to the court as treatment relates to issues before the Court
  - Coordination function

  - Sullivan, (2020) Collaborative teams. In L. Greenberg, B. Fidler, & M. Saini (Eds.), *Evidence Informed Interventions for Court-Involved Families: Promoting Healthy Coping and Development*. Oxford, NY: Oxford University Pre

20

Constructing Effective Treatment Agreements/Orders

21

- The "one–liner" is a set up for disaster:
  - See sample treatment service agreement/Court order
- What should be specified:
  - The treatment modality
  - Specific professional referrals
  - A protocol to explore availability, "interview", select
  - Specifying intake protocol
    - Including providing case information – obtaining relevant documentation – evals, pleadings, court orders

21

Treatment orders (cont.)

22

- Scheduling (balanced involvement)
- Fees, insurance
- Ongoing compliance
- Expectations of information derived from treatment
- Termination mechanisms
- Enough flexibility for a qualified therapist to conduct effective treatment

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Avoiding Landmines

- Court involvement may raise ethical and clinical issues beyond those which occur in general clinical treatment
- Enhanced procedures may be required in areas such as informed consent, maintaining professional objectivity and expressing the limitations of clinical opinions
- Court-involved cases are often presented with a sense of urgency and requests that therapists bypass or rush ethical or clinical procedures
- Just because a therapist is Court-ordered doesn't necessarily mean that therapist should accept that appointment
- The therapist should be proactive in recognizing and addressing potential ethical and clinical issues

23

Video Demonstration

- PC interview with an existing Child Therapist on a case

24

Therapists who avoid trouble

- Appreciate the need for specialized competence, such as knowledge of relevant research when working with Court-involved cases
- Maintain careful procedures
- Constantly challenge their own assumptions about the client and his/her situation
  - 'I know my client is litigating, but (s)he would never lie or distort information''

25

Avoiding Trouble

- Avoid drawing conclusions based on one-sided information
  - Critically evaluate information
- Adhere carefully to the boundaries of the therapeutic role and available information.
- Do not substitute your own judgement for that of the Court

26

Violations of Ethical and Professional Standards

- Adequate information to support any opinions expressed
- Limitations of therapeutic/treatment opinion
  - No custody recommendations or "best interest" findings
  - No opinions about individuals you have not treated
  - No opinions about relationships (parenting/marital/coparenting) if doing individual treatment
  - Opinions about progress, coping skills, involvement in treatment are appropriate if based on adequate data

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Brief Summary of AFCC-CIT Guidelines

- G-3 Competence:
  - Legal and psychological topic areas to have sufficient education and training
- G-4 Multiple Relationships
  - Conflicts of interest
- G-5 Fee arrangements
  - High conflict dynamics play out with $$$

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Guidelines (continued)

- G-6 Informed Consent
  - Enhancements essential; don't re-invent the wheel
- G-7 Privacy, confidentiality and Privilege
  - How to handle treatment information vis-à-vis other professionals and the Court

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Guidelines (continued)

- G-8 Methods and Procedures
- Need to be adapted to the legal context, defensible if challenged, resistant to the powerful impacts of biased or distorted information, and sensitive to the potential impact of therapeutic intervention on the outcome of the case.

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Guidelines (continued)

- G-9 Documentation
  - Record-keeping that protects both client and professional
- G-10 Professional Communication
  - What to communicate, to whom and how

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Summary of Advice for Court-Involved Therapists

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of research on divorcing/separating families and their children,
as well as issues such as child abuse, domestic violence, alienation and high conflict dynamics, children's suggestibility and interviewing, and child development.
Such knowledge is essential to court-involved therapeutic roles,
and is just as important for court-involved therapists as for other experts. Even therapists who work only with adults should develop and maintain sufficient knowledge of child-related research to address parenting issues.

33

Detailed informed consent is more important when the client or family is involved in a legal process.
Provide detailed informed consent documents;
make every effort to ensure that your clients,
or the parents of a potential child client,
understand the nature of the services to which they are consenting, any limits on confidentiality,
and the clients' or parents' responsibilities toward the process (including financial arrangements).

It may be necessary to revisit IC, if court-involvement changes --- DOCUMENT

34

3. When treating children, know the legal custody situation.

A parent with apparent authority to consent to treatment may not have actual authority, or may be required by court order to consult with the other parent about treatment decisions. Request a copy of any custody order establishing and clarifying parents' rights to involve their children in mental health treatment, and any decision-making process that the parents are to follow. If no such order exists, assume the parents have joint legal authority.
While it may be legal for one parent to consent to treatment without consulting the other parent, treatment effectiveness may be sabotaged if one parent is excluded.

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4. Maintain professional objectivity and multiple working Hypotheses about case dynamics and treatment needs.

Remember that the information you are getting may be one-sided or incomplete.
Use caution in forming or communicating therapeutic opinion based on one-sided information.

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5. Know the limits of your role and work within them.

Provide clinical feedback as appropriate to treatment and clinical opinions when properly requested.
Support your client's therapeutic progress, but avoid Becoming engaged as a legal advocate or expert.

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6. Use methods supported by available research.

Avoid methods, or interpretations of therapeutic information, that would not be consistent with research on issues such as child interviewing, child development, parental conflict, or the use/misuse of play or other behaviors as diagnostic indicators.

38

If you are working with a parent, be sure that the parent has authorized release of treatment information and has been informed of the potential consequences of such disclosure. If working with a child, clarify the expectations regarding confidentiality, and who has authority to waive or assert the child's privilege.

39

Attempt to obtain information from both parents and to engage both in treatment if possible and appropriate. Avoid unilateral communications with either parent's counsel.
Remember that a biased approach to treatment may also be perceived by the child.

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FAMILY THERAPY PROGRAM AGREEMENT

Between: ________________________ and __________________________
(father) (mother)

OBJECTIVES

1. Both parents have agreed that it is in the children's best interests to have positive and meaningful relationships with both parents. To meet this goal they have agreed to engage the services of Matthew J. Sullivan, Ph.D. to work with all members of the family toward this outcome.

2. While the parents may have different views about the cause and reason for the children's behaviors, expressed attitudes, their interparental conflict and many other identified problems in their shared custody situation, they agree not only on the objectives defined in #1, but also that they each need to be a part of the solution to meet those objectives. Both parents understand they will be engaged in the therapeutic work necessary to support the children's healthy adjustment to a shared parenting arrangement.

3. The parents have agreed to the involvement of the entire family, in various combinations, as directed by Dr. Sullivan. The process will include meetings between the therapist and each of the parents and the children individually and jointly as directed by the therapist. The process may include interviews and/or meetings with other family members as deemed necessary by the therapist.

ROLE AND AUTHORITY OF THE THERAPIST

4. The therapist will not be making decisions regarding the children's time with each parent and/or legal decision-making. Rather, the therapist will be assisting to implement the previously agreed to and/or court ordered parenting plan. Notwithstanding, we agree that the therapist may make recommendations to the parents, and the Court's evaluators to the extent that the therapist has obtained sufficient information. The parents understand and agree to the provisions of the stipulation and order re: appointment of family therapist filed with the Court on September 8, 2010.

5. Both parents agree and understand that, in the best interest of their children, the scope of the therapist's role is to include the following:

a) work with each parent and their children toward the goal of identifying and separating each child's needs and views from each parent's needs and views;
b) assist the parents to fully understand the needs of each of the children and the negative repercussions for the children of high conflict shared custody arrangements
c) work with each family member to help them form more appropriate parent-parent and parent-child roles and boundaries;
d) help each parent to distinguish valid concerns from overly negative, critical and generalized views relating to the other parent;
e) assist parents to resolve relevant parent-child conflicts;

g) provide consultation to the parents and coach and educate them about ways to better communicate regarding the children, and about ways to better communicate with each other.

6. The therapist may choose to contact any other professionals involved with the family to both give and receive information to better meet the aforementioned objectives and goals of the therapy. Toward this end, the parents will sign all releases of information required to implement the process. The parents shall provide all records, documentation, and information requested by the therapist as soon as possible upon request.

RESPONSIBILITY OF THE PARENTS

8. Both parents will overtly support the therapy and the therapist to the children. This includes respecting the children's right *not* to discuss their sessions with the therapist. To this end the parents will not ask the child(ren) for information about their therapy sessions or parenting time with the other parent.

9. During any scheduled appointments between the child and the therapist, between one parent and the therapist or during the other parent's parenting time, the parents will refrain from scheduling desirable activities in which the child(ren) may feel they miss out or have been excluded from.

DURATION OF SERVICES

10. The therapy shall continue as specified in the Stipulation and Order re: appointment of family therapist.

11. Neither parent may unilaterally withdraw from this Agreement prior to the completion of the term identified in # 10. With their joint consent in writing, both parents may terminate this Agreement. The therapist may resign any time she determines the resignation to be in the best interests of the child(ren) and will make a referral to another therapist after giving 4 weeks notice.

CONFIDENTIALITY

12. The parents understand that the process is not confidential. The therapist may use his discretion to exchange information as necessary between parents, between the parents and the children and between the children. The therapist shall be free to disclose all information, documentation and correspondence generated by the process provided in the stipulation and order re: appointment of family therapist. The therapist may at his discretion exchange information with other relevant professionals currently or previously involved but may not speak with the lawyers ex-parte.

13. The parents understand that the therapist is required to report to the appropriate child welfare authority if she has a reasonable suspicion that a child(ren) is being abused and/or neglected. In addition, the therapist is obliged to notify the proper authorities if she has a "reasonable suspicion" that a client may harm himself or herself or the other parent.

FEES

14. Pursuant to paragraph 11. of the Stipulation and Order re: appointment of family therapist, the Mother shall advance a retainer of $3000.00. This will provide 20 hours of treatment at a rate of $300.00per hour. Fees are applied to all time expended in any/all professional activities, including administrative matters. This includes time spent in reviewing documents and correspondence, writing memos to the file, writing reports, voice-mail, e-mail, meetings, and contacts/telephone calls with the parents, their counsel and other professionals involved.

15. Fees related to preparation for court are billed at $300.00 hour. Fees for testifying in court are billed by minimum half-day rate of $1750.00 Court-related fees (i.e., preparation time, attendance and travel) shall be by retainer in advance of any services rendered by the parent requesting the therapist's attendance at court. A separate contract for these services (detailing cancellation policy etc.) will apply and be provided at the time of any request. Fees related to preparation for and attendance at court will be billed at $350.00 per hour
at the time the request is made for these services.

At all times Dr. Sullivan shall maintain a retainer of at least $1200.00 (four hours) and shall advise in advance when a further retainer is required. A statement of account will be provided to the parents on a monthly basis. If the above terms are not satisfied, Dr. Sullivan will postpone all services until the retainer terms are met. Non-payment of fees shall be grounds
for the resignation of Dr. Matthew Sullivan.

18. Appointments cancelled without at least 48 (forty-eight) hours advance notice may be charged at full fee independent of the reason for the cancellation. Monday appointments must be cancelled by 5:00 p.m. on the previous Friday. The parents will each be responsible for bills arising from his/her own cancellation with insufficient notice and/or failure to attend a scheduled appointment.

DATE: ________________________

____
Father

DATE: ________________________

____
Mother

Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

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Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

Approved by the AFCC Board of Directors
"October 2010

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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

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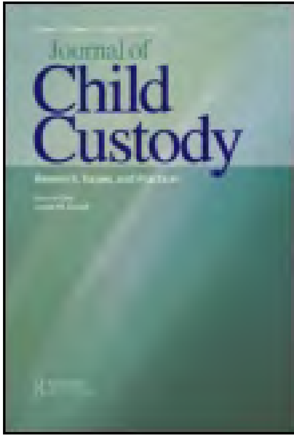

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Parenting Coordinator and Therapist Collaboration in High-Conflict Shared Custody Cases

Lyn R. Greenberg [a] & Matthew J. Sullivan [b]

[a] Independent Practice, Forensic and Clinical Psychology, Los Angeles, California

[b] Independent Practice, Palo Alto, California

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Parenting Coordinator and Therapist Collaboration in High-Conflict Shared Custody Cases

LYN R. GREENBERG
Independent Practice, Forensic and Clinical Psychology, Los Angeles, California

MATTHEW J. SULLIVAN
Independent Practice, Palo Alto, California

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The complexity of many high-conflict shared custody cases creates enormous and often overwhelming challenges to a therapist and/ or parenting coordinator (PC) independently involved in such situations. Unfortunately, having both therapeutic and PC roles involved in a case does not assure effective work with these families. This article describes the distinctions between these roles, their synergies, and challenges faced when attempting to provide coordinated interventions in high conflict cases. Essential elements of collaborative team functioning are presented, and numerous strategies to address common issues that confront professionals working on these cases are provided.

KEYWORDS *high-conflict divorce, court-involved therapy, parenting coordination*

High-conflict custody cases often have multiple mental health interventions being implemented to assist families, both pre-decree and after custody orders have been issued by the court. These interventions can include therapy for individual child(ren) or parents, and sometimes for combinations of family members (co-parents, parent–child dyads, etc.). These cases may have a parenting coordinator (PC) appointed by the court or private consent agreement to assist the parents in implementing their parenting plan/custody order (Boyan & Termini, 2004; Coates, Deutsch, Starnes, Sullivan, & Sydlik, 2004; Kirkland & Sullivan, 2008). The multiple functions of the PC role,

Address correspondence to Lyn R. Greenberg, Ph.D., 12041 Wilshire Boulevard, Suite 303, Los Angeles, CA 90025. E-mail: lyn@lyngreenbergphd.com

including dispute resolution and coordination of professional involvement, are particularly well suited to support the family's ongoing needs (AFCC, 2006; Hayes, 2010).

Structured professional collaboration, led by a PC, is often essential to guide the efforts of a child therapist or a more extensive therapeutic team (Coates et al., 2004; Sullivan & Kelly, 2001), which can include the parents' therapists, parenting coaches, and other specialized professionals (behavior specialists, psychiatrists, reunification therapists, etc.). A PC-led treatment team approach is particularly important when some level of decision-making related to the implementation of a parenting plan will be required, based on the progress of mental health interventions. Coordination among the treatment team, which maintains clear role boundaries between professionals, is essential to support effective mental health interventions in these cases. Team collaboration may be needed to manage the negative impact of interparental conflict on any treatment modality, to provide mechanisms for setting and reviewing progress toward treatment goals, and to address predictable tensions arising among professionals who are working in high conflict shared custody situations.

Treating therapists may intend to collaborate with one another when a PC is not involved but may be constrained by privilege issues, alliances, and the limits of the therapeutic role. Few professional partnerships are as powerful as that between the skilled PC and the sophisticated child therapist. When treating professionals for the parents are also engaged, a management system can be created that enhances parental roles, promotes good decision making for children, and can create and maintain a healthy atmosphere for the child's development without incurring the time, costs, stress, or emotional consequences of litigation.

This article explores the roles, structures, and predictable issues that arise in cases where a PC and a treating mental health professional work with a high-conflict family, in which the parents share custody of the children. It will focus on particular aspects of the professional collaboration from many perspectives, highlighting the challenge and complexity of structuring and implementing effective intervention with these families.

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SYNERGIES AND DIFFERENTIATION OF ROLES

It has often been observed that child custody evaluators have a more comprehensive view of a family's situation than can be obtained by a therapist working with either the parents or the child (Greenberg & Gould, 2001; Greenberg, Gould, Schnider, Gould-Saltman, & Martindale, 2003). Child custody evaluators take a time-limited, objective, broad-based view of the family and use the information gathered to make recommendations to the court. The role of the child custody evaluator is temporary, and many evaluations

of high-conflict families result in recommendations for both psychotherapy and an Alternative Dispute Resolution (ADR) process for making ongoing decisions about the child. A PC can be part of the post-decree plan; in addition to having an ADR role, a PC can help the parents coordinate therapeutic intervention and, within the confines of the stipulation, make decisions about the implementation of the parenting plan/custody order that are beyond the role of the treating professional(s) involved with the family (Fidnick, Koch, Greenberg, & Sullivan, 2011; Greenberg & Gould, 2001).

Therapists often have detailed, intimate, and longitudinal information about parents and children. If the therapist is practicing within appropriate boundaries, the therapist does not have responsibility for decisions on psycho-legal issues such as parenting time schedules and major decisions involving the child's health, education, and activities (AFCC, 2011; Fidnick et al., 2011). Because they have involvement with families over time, and because they don't make parenting, co-parenting or psycho-legal decisions, they are able to focus their work on the day-to-day experiences and relationships that form the tapestries of children's lives. For example, the therapist does not recommend which soccer team a child will join, but may help the child to express his feelings about the issue, assist the parents in listening, and assist the child in adjusting to whatever decision is made. Therapists may have a role in educating parents about children's needs and in assisting children in learning to communicate more effectively with parents. They may assist with the daily struggles over homework, friendships, activities, and management of children's behavior, and can provide therapeutic suggestions to parents on those issues. Ideally, therapists help children to master the coping skills they will need to adjust successfully as adults, and they assist parents in distinguishing between their own needs and those of the children. They may also counsel and support family members in dealing with their frustrations when legal processes or decisions disappoint them (Greenberg, Gould, & Gould-Saltman, 2002; Greenberg, Gould, Gould-Saltman, & Stahl, 2003).

Many parents are able to progress beyond the point of acute conflict and profit from therapy, education, or the passage of time to make joint decisions that support their children's healthy development. For a small but significant minority, however, functional joint decision-making remains elusive. Absent a dispute resolution alternative, these parents may return to court repeatedly and continue to expose children to the costs and detrimental effects of prolonged parental conflict (Baris et al., 2001; Johnston & Campbell, 1988; Sullivan, 2008). In these families, uncoordinated individual parent or child therapy may exacerbate the conflict. This is a particular danger if the adults' therapists support the parents' biases and fail to consider alternative perspectives, or if the child's therapist fails to consider the impact of parental conflict on the child. With the appropriate legal authority, a PC can assume responsibility for making decisions about the child within the PC process when

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parents cannot agree. If the case moves back into the legal system, the PC can assist the court in making those decisions. The PC is able to obtain longitudinal information from a variety of sources—including therapeutic information—to consider in making decisions related to the implementation of the parenting plan. In addition, if appropriately qualified, the PC may assume a powerful, ongoing role in coordinating mental health treatment for the family. For example, the PC can intervene to redirect problem therapy, assist less experienced therapists, and provide objective information to counteract the biasing impact of therapeutic alliances. If the parameters of the order permit it and problems with inappropriate treatment remain unresolved, the PC may be able to terminate problem treatment or make a recommendation that the court do so. The PC can use information from the therapeutic team to work with parents to make better child-focused decisions. Ultimately, this may enable parents to negotiate the resolution of child-focused disputes that may arise, rather than bringing all co-parenting conflicts to the PC.

Treatment of high conflict families requires working with clients who, at least initially, do not necessarily see a need for personal change. As noted elsewhere in this volume (Greenberg, Doi Fick, & Schnider, 2012), treatment may be the result of court orders or evaluations that identify treatment goals with which one or both parents do not agree. Both parents and children may fear the changes encouraged by the treatment team or directed by the court order or parenting plan, and may, therefore, be motivated to undermine or refuse to cooperate with a recommended treatment. The involvement of a PC may be able to resolve, or at least manage, many of these problems, as the PC occupies a neutral role and can often exercise decision-making authority. The PC may be able to issue orders that require parents to cooperate with treatment and protect the children's treatment from interference due to the parental conflict. This may be an essential issue in the management of high-conflict cases, because the child's chance of healthy development may depend on at least some changes in parental behavior (Johnston, Roseby, & Kuehnle, 2009). Children's therapists must be able to request such changes, either directly with the parents or indirectly, by supporting children in asserting themselves or relaying concerns to the PC (Johnston & Roseby, 1997; Johnston, Walters, & Friedlander, 2001; Sullivan & Kelly, 2001).

PC's may serve an essential function in conveying and reinforcing requests for changes in parenting behavior. The PC may underscore the importance of these issues by identifying for the parent the connection between changes in parental behavior and the parent achieving his/her desired outcome on issues related to the implementation of the parenting plan, such as increases in parenting time (Sullivan & Kelly, 2001). Where parents appear to be severely emotionally limited or unwilling to modify their behavior, children need to learn to adapt to such limits and seek emotional sustenance in other relationships (Friedlander & Walters, 2010; Greenberg

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et al., 2012). In these severe cases, the PC may have an essential role in protecting the privacy and security of the child's treatment and diverting the parents' conflict elsewhere.

The PCs may enter a case in a number of ways, and these may alter the options available for forging a cohesive intervention team. In some cases, a PC may be appointed post-judgment under a circumstance that requires the creation of a new therapeutic team. This scenario may give the PC considerable discretion in selecting particular therapists and structuring the team and intervention plan. Parents may agree that the child needs therapy, but disagree as to how the therapist should be selected or attempt to bias the potential therapists by prematurely sharing one-sided information. In other cases, parents and/or children have already been working with therapists long before the PC is appointed. The existing therapy may be appropriate, or problematic dynamics may already exist that the PC will need to address. In another subset of cases, conflict regarding a child's treatment may have precipitated the appointment of the PC. The PC may, therefore, be immediately faced with allegations by a parent against the therapist and with difficult choices about the future of that treatment. The PCs may also encounter situations in which polarization among the "team" of mental health professionals mirrors that of the family. This is a common dynamic between individual parent's therapists that has some potential of being improved if the parents' therapists have some ability to work collaboratively on the case (Sullivan & Kelly, 2001).

SETTING UP COLLABORATIVE TEAMS

Whether the appointment of a PC precedes or follows the engagement of other therapists,the rules and structure of the treatment team must be well articulated, understood, and followed by all of the professionals. This is primarily the responsibility of the PC. Clear boundaries, with open lines of communication and appreciation of the others' responsibilities, may prevent misunderstandings and the fractures of collaboration that may lead professional relationships to mirror the conflict of the family. The team of PC and therapists needs to have a clear hierarchy—the PC is ultimately in charge and exercises global responsibility for implementing both the parenting plan and the treatment interventions that impact the welfare of the child. Conversely, it may be difficult for PC to manage interparental conflict if he/she is not supported by solid, coordinated treatment. Therapists must appreciate the limitations of their roles. PCs must appreciate the impact of power dynamics and convey an appropriate level of respect for each therapist's obligations and contribution to the intervention team. Each team member has an important role in enhancing the effectiveness of the other.

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Selection of the Child's Therapist

When the PC is involved in selecting the child's therapist, he/she should establish a balanced structure for the parents' involvement in the selection process. The PC can recommend potential therapists who have sufficient expertise to work with children at the center of parental disputes (AFCC, 2011; Fidnick et al., 2011) and can provide a detailed protocol for selection of the therapists, preferably in consultation with the candidate therapists.

Parents can mutually identify issues to be considered in the selection process (such as the availability, the therapist's approach, and costs), and the PC can direct the process, including the timeframe by which certain tasks are to be accomplished. Parents can be directed to consider potential therapists either separately or jointly. Each approach has pitfalls. If parents are permitted to interview the potential therapists individually, each may attempt to align the potential therapist by providing partial or distorted information. An individual parent may also subtly intimidate a potential therapist by making intimations of legal or ethical risks, or by painting a threatening picture of the other parent. Joint interviews by parents have all of the risks in attendance when conflicting parents interact with other professionals, in that the conflict may overwhelm the exchange of useful information. Conversely, joint interviews are more protective of the therapist, who may otherwise be accused by either parent of having been biased by individual interaction with the other.

While parents should have some involvement in the selection of the therapist, professional risks may be created for the child's therapist who meets with either parent in the absence of a stipulation appointing the therapist to treat the child. In addition to the potential for bias and distortion of information, the therapist who participates in such a meeting may be construed as having provided clinical services without consent. An alternate approach is to have the parents participate in a conference call with each potential therapist, perhaps with the PC also on the call, so that they can ask essential questions about the therapist's availability and approach. Such calls should be brief, and all professionals should avoid contributing to a parent's perception that professional services can, or should, be provided at no cost. Many therapists will provide a brief, joint conference call without charge, particularly if the PC is present to structure the interaction and help the candidate therapist to bring it to a timely conclusion. The parents can then separately rank the candidate therapists, with the PC making the final selection based on the results of the ranking. Each professional's appreciation of the other's liability risks, and the joint communication to the parent that professional time is a valuable resource, promote a basis of trust between the professionals that is an essential element of making a treatment team function effectively.

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Case Example. ***Protocol for the selection of a therapist (provided by a PC to the parents)*:** Each parent will rank each of the following three available child therapists (list names and numbers), based on whatever independent research and brief interview they elect to undertake and that is consistent with each therapist's referral and intake protocols. They will submit their ranking to the PC, not copied to the other parent, by (date). Each parent may "veto" one of the three therapists. The PC will then select the therapist based on the ranking. Both parents will complete the informed consent and fee agreement and a release of information for the therapist to share information with the PC by (date). The therapist will direct which parent should bring the child in for the initial intake meeting and what the structure of parent involvement in the child's therapy shall be.

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This protocol assures that a child therapist will be selected, commence work with the child, have initial input from the PC, and establish an appropriate structure for parent involvement and their collaborative work with the PC.

It is crucial to deal with the potential impact of financial resources and insurance considerations early in the process. Where family means are limited or insurance reimbursement is expected to pay for therapy, parents should be directed to obtain information about the terms of their insurance plans and the services that are and are not covered. Some insurance companies exclude court-ordered services entirely; others have "preferred providers" who may not have sufficient specialization to work in court-involved roles. Other insurance plans will provide payment for sessions but will exclude all outside-session services, such as phone calls, emails, team meetings, and communications with the PC. High-conflict parents may be heavy consumers of such services and may direct such requests toward professionals whom they believe are not likely to charge for them. Professionals who have clinical responsibility for a case (such as children's therapists and pediatricians) may face liability risks if they do not respond to calls that are presented by the parents as "emergencies." This contributes to the high rate of burnout among therapists in these cases and to decisions by these therapists to decline court-involved cases.

An effective way to manage these risks is to require that both parents maintain an advance payment on account with the therapist to cover the costs of coordination with the PC and other outside-session services. Parents should also be prepared for the possibility that the best therapists may not accept direct insurance payments, particularly if insurance companies have imposed contracts that deny the therapist reimbursement for some services. In such situations, the PC should specify and monitor which parent has responsibility for submitting claims to insurance carriers, a protocol for how insurance reimbursement is documented, how non-covered costs are allocated, and how parents should reimburse one another, if necessary.

Both the PC and the therapist can empathize with parents' frustrations about obstacles created by insurance carriers, and even parents with financial

means may be tempted to simply select a therapist who is on the insurance company's panel. This may reflect a lack of information about differences in expertise among therapists, but may also reflect the same high-conflict dynamics that exist in other areas. Parents who do not want to change their own behavior may be reluctant to engage a highly qualified therapist or may choose to reserve financial resources for the possibility of re-engaging the legal conflict.

Whenever possible, the PC should establish the minimal qualifications for any therapist who is considered to treat the child (Fidnick et al., 2011). In most cases, the selection of a qualified child therapist will be much more cost effective than dealing with the problems created by inadequate therapy (Greenberg, 2009; Greenberg, Gould, Gould-Saltman, et al., 2003; Greenberg, Gould, Schnider, et al., 2003). It also sends a message to the parents about the importance of providing for the child psychological resources that offer sufficient expertise to stem the enormous risks that parental conflict creates for children. The issue of containing costs may also provide opportunities for the PC to point out to the parents the connection between their behavioral choices and the costs they incur. When parents do not have the resources to afford high-quality treatment, the qualified PC's guidance to the therapist will be particularly important.

ESTABLISHING TREATMENT PARAMETERS

Once the parents execute a waiver to allow an exchange of information, the PC and child therapist should confer and jointly establish the treatment structure. It is best that this occur at the onset of their joint involvement in a case. This should include some discussion of treatment goals, both for the individual child and as part of the overall goals established by the PC for the family system. In most cases, it is most effective for the PC to provide input (relevant court documents, assessment reports, etc.) and to brief the therapist about the substantive and procedural aspects of the case prior to the therapist initiating work with the child. Conversely, in cases that have involved allegations of collusion among professionals, the therapist may elect to conduct a limited number of initial sessions (such as intake sessions with the parents and one or two sessions with the child) before obtaining input from any other professional. The PC should assess whether the therapist has sufficient expertise to exercise such discretion, as bias may be created when information is limited. Experienced professionals can jointly agree on the point at which information exchange should begin. When the therapist is less experienced, it may be appropriate for the PC to direct the timing.

The PC and therapist should establish parameters regarding scheduling of therapy sessions (with as much balanced parental involvement as possible), how the therapist's fees are paid, who transports the child to sessions,

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transition procedures, and other protocols that will assist the therapist in providing effective treatment. A therapist who is experienced with court-involved cases may have established rules and protocols in these areas, which can be adjusted with the PC as consistent with any particular aspects of the case. Thorough communication about this type of issue may be essential, as the therapist has the responsibility to structure interventions with the child, and the PC is in an ideal position to promote or require the parents' cooperation. When the therapist does not have the experience or the expertise to have such structured procedures, the PC may be able to assist the therapist in establishing them.

The PC and the therapist should discuss the structure and parameters for parents' involvement in the children's treatment. Absent exceptional circumstances, most children's therapists need the flexibility to invite a parent into the child's session, or to meet briefly with the parent alone, to handle an immediate or urgent issue. Such circumstances may include opportunities to capitalize on the child's progress, if the child expresses a willingness to express feelings to a parent and the parent has the ability to support this. Even a parent who is opposed to the therapy should be instructed to cooperate with such interventions, just as parents are expected to engage politely with one another when the child is present. General treatment updates to parents may occur via email, periodic sessions or phone calls with parents, or joint communications with parents. Sensitive, ongoing issues may be best handled through the PC or treatment team, particularly if one of the parents mistrusts the therapist. In some cases, the needs or behavior of the parents may require separate structures.

Coordination with the PC regarding these issues both promotes problem resolution and protects the therapist, who may otherwise be accused of bias or improper conduct. This underscores the importance of selecting a therapist in whom the PC has confidence, or engaging in whatever coordination is necessary to build such mutual trust. The PC should be able to trust the therapist to maintain reasonable procedures and to promptly alert the PC if a clinical situation requires an unusual response. Conversely, the therapist should be able to rely on the PC to support the child's treatment and reasonable decisions by a therapist, who must spontaneously deal with crises or difficult dynamics created by parents who have their own agendas about the child's treatment. With such coordination, the PC may be able to establish expectations about the parents' conduct when involved with the child's therapy, thus allowing the child's treatment to be more successful.

THE PC JOINING A THERAPIST ON THE CASE

When a PC joins a case with ongoing child treatment, the issues can be particularly delicate. The PC may encounter a therapist who is genuinely

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concerned for the child and who has engaged in generally appropriate treatment, particularly if the therapist has some training or knowledge of high-conflict divorce. Even specialized therapists, however, may be outmatched by the combination of acutely symptomatic behavior in the child and the high-conflict dynamics that exist while parents are actively litigating. The therapist can request or recommend changes in parent behavior but cannot and should not provide recommendations about custody or other psycho-legal issues. One or both parents may be angry or mistrustful of the therapist, for reasons ranging from an error by the therapist to a therapist's appropriate refusal to make a custody recommendation or support an allegation by one parent against the other. At the height of parental conflict, children may be acutely symptomatic. It is their ongoing treatment providers who must address those symptoms, often with insufficient tools, until the court case reaches a conclusion. Parents may have acted out by withholding payments, undermining children's participation, requesting inappropriate information or interventions from the therapist, or making excessive demands on the therapist's time with last-minute communications or purported emergencies.

When a PC arrives on a case with ongoing treatment, a therapist who feels embattled may initially respond with distress and concern. Effective therapists who have experience with skilled PCs will likely view the PC's arrival with relief, as the PC may be able to address issues that are beyond the therapist's role.

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> Case Example. ***Parenting versus co-parenting issues*:** The child therapist emailed the PC because the father of her child client met with the therapist for a few minutes prior to the child's session to ask the therapist's opinion about whether a sports-focused summer camp would be better for his child than a music-oriented summer camp. The therapist was concerned that this was a current issue in dispute between the parents, and that providing any feedback might compromise her relationship with either parent. The PC had directed the therapist to refer the parents to the PC for any co-parenting issues, explaining that the PC was now responsible for these issues and that directing them to the PC would help keep the child's therapy "out of the middle" of parenting plan disputes. The therapist did assure the father that she regularly spoke with the child about all of his activities and that the therapist would also regularly confer with the PC. The PC aided this process by seeking information from the therapist about feelings that the child had expressed over time about his activities, and the impact of the parental conflict about activities on the child.

This example highlights how the therapist can work with the PC in establishing protocols that transfer to the PC some of the role of managing and resolving issues that the therapist has been pressured or required to

address before the PC became involved. Such a transition should occur on an orderly basis, in a manner that supports the PC's responsibility to manage conflict while not undermining the therapist's role with the child or either parent. The therapist must remain cognizant of the fact that his/her knowledge of the case is intimate and detailed but limited in scope. The PC must make decisions to address disputed issues in the implementation of the court-ordered parenting plan or the broader goals of the family, such as progress in rebuilding parent–child relationships. The PC should respect the fact that the therapist has been on the case longer and may have more information about patterns of parent or child behavior over time. It is not uncommon for parents to revisit issues with the newly-appointed PC that have long been subjects of parental dispute, and about which the child has expressed clear and appropriate feelings. If the PC fails to seek such information, the unintentional message to the child may be that his feelings no longer matter and that all conflicts can be revisited because there is a new person in the parents' lives.

It is often appropriate for the therapist to explore the child's feelings about issues that are the subject of conflict, although it is often more appropriate to do this over time than at the very moment when the dispute is most acute. Effective therapists should routinely explore children's feelings about their daily activities so that the therapist can develop a baseline of information about the child's daily experiences. If the therapist has done this, he/she already has relevant information to provide to the PC about the issues presented by the parents. In other situations, cautious inquiry from the therapist may assist the child in expressing current feelings, which the therapist can discuss with the PC. This allows the child to have an appropriate voice in decisions that affect him, while decreasing pressure on the child to align with either parent. The therapist may need to coordinate with the PC about the proper time and manner to support the child in expressing his independent feelings to the parents. The PC may have direct knowledge of the parents' status and likely reactions, and this will impact the timing of clinical interventions. Clinical judgment and prompt coordination between the PC and the therapist are necessary in these situations, as the correct intervention may vary based on a variety of issues. The goals are both to support the role differentiation between the PC and the therapist and to continue to support the child's expression of independent feelings, which ultimately can be communicated directly to the parents.

Therapists must respect the PC's responsibility to ask questions about the bases for any interventions or clinical opinions expressed by the therapist; in the process, the PC may alert the therapist to information or possibilities that the therapist has not considered. As the PC is the overall manager of the case, the child's therapist who refuses to cooperate with such inquiries may be demonstrating that he or she no longer has sufficient objectivity to continue providing treatment.

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Some PCs choose to begin their work from the perspective that parenting coordination is an opportunity for the parents to make a fresh start. They may initially limit their inquiries to the therapist so that they can explore the case independently. This is a defensible and reasonable approach when a PC joins a case and may ultimately be protective to both the parenting coordination process and the child's therapy. Nevertheless, and despite the fact that the PC occupies a neutral role, the PC who chooses to limit the information he/she considers is vulnerable to the same sources of bias that occur when a therapist has limited information. In the hypothetical example previously described, if the child has accomplished the difficult task of telling his parents how he feels about sports or music camp and either the therapist or the child is caught off guard by the re-emergence of the issue, the result may be an undermining of the child's trust in therapy.

As the PC is assuming a position of authority over a therapist who may have previously operated alone, he/she should be sensitive to the therapist's concerns about distortions that may be presented to the PC by the parents or by other professionals on the case. PCs should be cautious about forming opinions about a child's treatment—past or present—without considering information from the therapist. In some cases, particularly if a therapist's conduct has been inappropriate, the PC may have to intervene to redirect treatment or to consider removing the therapist from a case. Therapists may need to consider whether they can continue to be effective, in light of decisions by the court, their relationship with a PC on the case or the dynamics of the case. Even a therapist who expects to transition off of a case may be justifiably concerned about issues such as professional reputation, or the PC's opinion of the therapist, if the PC does not consider the therapist's information about the child's treatment or the parents' allegations. In a community with a shortage of adequately skilled professionals who work with high-conflict shared custody situations, demonstrations of appropriate professional respect may enhance both current and future intervention teams. Specific suggestions for dealing with allegations against therapists will be discussed in detail below.

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EXPANDING THE TREATMENT TEAM

Both treatment interventions and parenting coordination are much more likely to effect change if information can be shared among the PC, the child's therapist, and the treatment providers working with the parents. This can be a complex issue, in that it must balance the privacy concerns of the parent's treatment relationship and the benefits to opening that therapy to new information sources that can enhance the parent's treatment. The collaboration can have enormous potential benefits in that the PC and the other therapists can potentially provide information to the parent's therapist that will improve

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the effectiveness and objectivity of the parent's therapy. The PC who has access to all therapists working with the family can help coordinate treatment and manage the inevitable conflicts that may occur among therapists who have strong alliances with their respective clients (Deutsch, Coates, & Fieldstone, 2008).

Some high-conflict parents have enormous difficulty tolerating any perspectives that diverge from their own, and they may select therapists who overly align with the parent or who are reluctant to engage in any therapeutic confrontation. In such situations, the parent may disengage from his/her therapist if he/she knows that the therapist will be sharing information or even that the therapist will be receiving counterbalanced information from the PC. The PC should work with the parent to understand the benefits of team collaboration in these cases, and to ease resistance to opening their personal therapy to the PC process. This may be supported by a provision in their appointment order or services agreement requiring a waiver to exchange information with parent therapists. If a parent refuses to allow his/her therapist to share information with the PC and other therapists involved in the case, it may be possible for the PC to provide "one-way" information to the parent's therapist about the goals of the treatment team or information that would counterbalance the parent's perspective. This may increase the effectiveness of the parent's therapeutic work while preserving the privacy of that relationship.

In some situations, the parent's individual treatment may need to be separated from the role of the professional who will intervene with the parent about parenting and co-parenting issues. The addition of a parenting coach to the treatment team, if resources permit, may allow such issues to be addressed without involving the individual therapist. Nevertheless, parents who have serious emotional difficulties may be unable to effect necessary changes if the parent's individual therapist is excluded from information that may impact treatment goals. Ultimately, a parent's failure to change behavior may lead to consequences in the parenting plan.

> Case Example. ***Increasing the effectiveness of parent therapy:*** During a conference call that included the mother's therapist, the child's therapist, and the PC, the mother's therapist was surprised to hear from the PC that the mother was engaging in "alienating" behaviors toward the father, which included sharing with the child's teacher negative and distorted information about the father's new spouse. An ugly incident at the child's soccer game, where the mother yelled and swore at the stepmother, was addressed. The child's therapist provided information about the discomfort and anxiety the child was experiencing, and reported concerns about the increasingly negative and vague reports by the child about her experience at the father's home. The combination of specific feedback to the mother's therapist about problematic conduct on the mother's part (which the mother had not shared with her therapist), feedback from the

child's therapist about the deleterious emotional impact on the child of the mother's conduct, and the concern that the PC raised about the implications of the mother's behavior for the shared custody situation, gave the mother's therapist powerful material to bring back to her work with the mother.

COLLABORATIVE TEAM FUNCTIONING

Once the necessary parameters are in place to support the sharing of information between the professionals involved in the case, the intervention team can begin the work of setting comprehensive goals for the family and specific goals for parents and children. Goals for the family are often linked to issues specified by the court, such as modifying the timeshare as a child develops, repairing or reunifying a child's relationship with a rejected parent, managing the educational or health "special needs" of a child, and protecting a child from the chronic and intense high conflict of co-parents. Professional discussion and consensus about these goals is the essential first step for the collaborative team. Gaining consensus and buy-in to team goals may require considerable discussion and debate, as professional involvement in these highly polarized situations has often had the impact of polarizing the perspectives of professionals involved. This may be a particular issue for parents' therapists. Effective professional collaboration requires that the problematic loyalties and alliances to individual clients be replaced with a primary loyalty to the professional team and its goals and objectives. While this may initially seem like a conflict of interest for parents' therapists, each parent's treatment is ultimately likely to be more effective if the therapists have sufficient information and objectivity to assist the parents in reaching the goals established by the court and defined by the PC (Greenberg, 2009; Sullivan & Kelly, 2001).

The team must reach consensus on the goals for the family, which the PC is ultimately responsible to define and promote, and on the responsibility of each team member to work toward those goals. Absent such a working agreement, professional intervention will likely continue to reinforce the dynamics that drive the conflict rather than to assist with management and resolution of it.

Once individual and team intervention goals are defined, the collaborative work is supported by regular connections to review progress, address issues that arise in the work, and set new goals as the work with the family proceeds. These connections can include full team "meetings" as well as dyadic connections between particular professionals who may need to share information particular to their client's treatment.

The time and expense of effective collaboration between team members can be considerable and prohibitive. The use of conference calls or email, rather than face-to-face meetings, can increase the ease of connection and

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make collaboration possible. Collaborative team functioning is enhanced by procedures such as the following: (a) PCs providing written summaries of team meetings/conference calls, specifying each professional's objectives and responsibility during the next period of time in their individual work; (b) the team strategizing about how each member will "frame" feedback from the team meetings to their clients, in order to protect and enrich the ongoing work of each professional; (c) therapists sending brief, periodic updates of their work by email to the PC; (d) the PC copying relevant team members on summary letters, agreements, decisions, and monitored email communications between parents from their work with the family; and (e) developing strategies for the PC to obtain input from team members relevant to co-parenting issues such that the therapist's work with their clients is not compromised.

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THERAPY AT THE CENTER OF CONTROVERSY

PCs are often required to respond to controversies about the performance of a therapist who has been appointed or designated to serve a neutral role, such as a child's therapist or a conjoint/reunification therapist. On occasion, controversy regarding the performance of a therapist may be the issue that prompts the appointment of the PC. This situation is particularly delicate in that the PC may be immediately required to assess the performance of a therapist who is already embattled and may have more, or different, knowledge about the case than the newly appointed PC does.

It can be tempting for a PC to remove a therapist who is disliked by one of the parents, on the theory that the therapist no longer has the trust of that parent and therefore cannot work effectively with the child(ren). While there are some occasions when this is necessary, the authors would argue that decisions about the removal of a therapist should be primarily based on the conduct of the therapist and on an assessment as to whether an effective treatment plan can continue for the child. Removing a therapist who has conducted appropriate treatment may send some damaging messages, both to the child and to the parents. In a high-conflict case, the child will likely have been exposed to the complaining parent's perspective about the therapist. If the child has been able to maintain a positive relationship with the therapist despite the parent's complaints, removal of the therapist may send the child the message that the parent's negative feelings and perceptions of the therapist are more important than the child's independent experience or feelings (Greenberg, Gould, Gould-Saltman, et al., 2003; Greenberg et al., 2002).

Many high-conflict parents have established patterns in which relationships are separated into two categories: those who support a particular parent's agenda and those who do not (Sullivan & Kelly, 2001). Neutrality may not be an acceptable option to these parents. As a result, children may have

experienced the serial removal of many relationships from their lives or the requirement that they have two separate sets of social networks, one group aligned with each parent. These children may have experienced the prior removal of therapists, teachers, and other adults who became aligned with one parent or who were independently supporting the child and attempting to engage with both parents. In such circumstances, the removal of the child's therapist due to a parent's demands may send the message to the child that no relationship is secure unless the person avoids angering the powerful parent. The result of this destructive pattern may impact how the child engages with the next therapist, and lead to an erosion of the security, independence, and autonomy of their other relationships. Of course, removal of a child's therapist may also send a destructive message to the angry parent, reinforcing behavior that disrupts the child's relationships.

There are occasions, of course, when the PC or the therapist will determine that a therapeutic transition would be the outcome that would best support (or would be least detrimental to) the child. On other occasions, a transition may be necessary for the protection of the therapist. In either case, the PC can mitigate negative results for the child by coordinating the transition, supervising the "messaging" to the child about the reason for the change, selecting a highly qualified therapist to assume responsibility for treatment, and insisting on a clear and detailed court order to support that therapist.

Assessing the Quality of Treatment

The vast majority of therapists treating divorced children do not have specialty training in the area. Cost and insurance coverage may have been the primary determinants in selecting the therapist, and the therapist may have entered the case without being aware of the importance of balancing parents' involvement or using enhanced procedures for informed consent. As training opportunities improve, more therapists will be aware of the hazards to avoid when undertaking treatment of court-involved families.

Before the involvement of the PC, the child's therapist may have been facing an overwhelming array of demands from the parents and symptoms in the child. One or both parents may have attempted to involve the therapist in litigation, and the therapist may have been required to share information with a child custody evaluator—all without the protective parameters for information sharing previously described.

As noted elsewhere in this volume (Greenberg et al., 2012), it is not uncommon for a child's therapist to bias treatment by engaging with only one parent or to accept a child into treatment without the other parent's consent. The parent who first contacts the therapist may tell the therapist that the other parent will not support treatment or that the child will not feel "safe" if the other parent knows about the therapy. The therapist may be told that the

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presenting parent has sole custody or that the presenting parent will not authorize the therapist to contact the other parent. The wise therapist will decline to provide services when such demands are presented and will insist on seeing any custody order purported to give sole decision-making authority for the child's mental health care to the presenting parent.

If only one parent brings the child to therapy, and particularly if the child is instructed to keep the therapy secret from the other parent, it is likely that the child's statements in therapy will be consistent with the allegations of the therapy-involved parent. The child's statements may appear to be independent and quite credible, creating a self-reinforcing cycle in which the therapist does not believe it necessary to consider information from the other parent. These dynamics are exacerbated when the excluded parent learns about the treatment and demands information about the therapy, or asserts his or her joint custodial rights and directs the therapist to stop treatment. To the naive therapist, these behaviors may appear to confirm the aligned parent's negative description of the excluded parent, further exacerbating the conflict. Of course, it is important to differentiate between the therapist who colludes with excluding a parent and the therapist who attempts to engage both parents but is rebuffed.

Another common mistake occurs when a therapist fails to differentiate between supporting a child's developmental needs and supporting all of a child's expressed wishes or "position statements" about adult issues in the custody conflict. Children who have been heavily exposed to adult conflict may present with emphatic, adult-like statements and tantrums or other regressive behavior, accompanied by demands for changes in the parenting plan, with no ability to describe the actual problems occurring with a parent. Other children can describe difficulties with the less-preferred parent but regress or resist any efforts by the therapist to promote engagement and healthy problem solving. Either set of behaviors should alert a child's therapist that he/she may not be getting the full story, and the therapist should explore a variety of hypotheses about the child's statements and behavior (AFCC, 2011; Fidnick et al., 2011; Greenberg, Gould, Gould-Saltman, et al., 2003; Johnston et al., 2001).

The PC evaluating the child's therapy should inquire in detail about the therapist's approach to assessing the child's symptoms and statements. A heavily aligned therapist, or one who is feeling defensive, may present the PC with conclusions rather than a description of the process. The PC should ask the therapist to describe the initial presentation of statements and behaviors, the possibilities the therapist considered, and the steps the therapist took to assess and intervene. Sometimes, the PC will suggest possibilities that the therapist has not considered, and this provides an opportunity for the PC to explore the therapist's openness to new information. Some therapists who have been exposed to one-sided information are quite startled to see how differently the child behaves when accompanied by the other parent. A

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therapist who can be open to new information may be able to engage with both parents and rebalance the treatment, thus preserving the child's therapy relationship while conducting more objective and appropriate treatment.

The PC should also consider the possibility that the inexperienced therapist, operating without the support of a PC and treatment team, was overwhelmed by the child's behavior and did not know how to intervene effectively. Some therapists initially attempt to limit the child's behavior but are unable to gain the cooperation of one or both parents in setting such limits. The therapist may recognize that the child's behavior is unhealthy or inappropriate but be confronted with parents who are more invested in the meaning of the child's behavior for the adult's position in the custody litigation. Such parents will resist the therapist's suggestions that the parent set, or enforce, more consistent and clear limits (Greenberg et al., 2012).

Careful inquiry from the PC may reveal that the therapist is in need of some support and direction but is able to provide independent support to the child. The PC can reduce the therapist's isolation by involving the therapist in the treatment team, providing information that the therapist has not had access to, and providing consultation and direction about effective ways to intervene with the child. The PC may also be able to reduce the mistrust of a parent who has been excluded by advising the parent of the therapist's strengths and openness to engaging with the parent. If the therapist attempted to engage the parent but was rebuffed, the PC may direct the parent to cooperate with the therapist and may serve as a more functional communication link, providing the therapist with information from the estranged parent and his/her therapist. The PC may also need to engage both parents' therapists to redirect the parents' expectations about the child's therapy, differentiating the child's needs from the parents' desires. As previously described, the PC can provide a structure for discussing treatment progress that provides essential information to the parents while protecting the child's treatment. The PC may also issue orders that adjust the structure of the therapy in question. For example, both individual child treatment and conjoint/reunification therapy are generally more effective if both parents are involved. The PC may issue orders to allow, or require, involvement by both parents.

A parent who is unable to engage with the child's therapist may be able to receive essential information from his/her own therapist or from the PC, but should be directed whenever possible to maintain the basic responsibilities of transporting the child and engaging respectfully with the therapist. By establishing these requirements, the PC provides the child with the message that the child can have a relationship with someone the parent dislikes. This may be a healthy step toward giving the child permission to engage with both parents and extended families on both sides, and ultimately progress toward building an independent social world.

In some circumstances, the PC's inquiry may reveal that the therapist has become so aligned with one parent that he/she cannot continue effectively.

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As described elsewhere in this volume (Greenberg et al., 2012), a therapist who reinforces unhealthy behavior in the child or undermines conjoint/ reunification therapy may ultimately be hindering the child's development.

Children may be powerfully influenced by adults' behaviors about contested issues. Their statements, memories, and perceptions may be influenced by their developmental abilities, the decisions made by adults as to which questions to ask and which possibilities to consider, and the emotional reactions of adults to their behavior (Friedlander & Walters, 2010; Kuehnle & Connell, 2010; Pedzek, Finger, & Hodge, 1997). Biased therapy can approximate long-term suggestive interviewing, leading children to produce exactly the statements for which the adult appears to be looking. If the child's therapist is limiting his/her inquiries only to possibilities that support one parent's agenda, the therapist may be undermining the child's independent perceptions rather than helping the child to cope effectively and express his independent memories. In these circumstances, the continuation of unhealthy therapy may be as destructive to the child as the disruption of healthy relationships (Greenberg, Gould, Gould-Saltman, et al., 2003)

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> Case Example. ***Problematic child therapy:*** The PC initiated an inquiry to the therapist after the father alleged that the therapist was biased against him and reluctant to consider his information. The therapist confirmed that she had had limited contact with the father because she felt that he was destructive to the child. The therapist advised the PC that both the child and the mother had consistently reported that the child cried during transitions to the father's care. She specifically cited an incident in which the father had allegedly been too rough with the child in the bathtub, as reported by the child's mother and confirmed by the child. The therapist reported that the child was increasingly distressed since the court had ordered the PC's appointment and movement toward having the child spend more time with the father.
>
> The PC inquired as to the hypotheses that the therapist had considered in assessing the child's symptoms. What developmental issues had she considered? Had she sought the father's observations? Did she inquire about bathing procedures? How had she discussed with the child the pending changes in the parenting plan? The PC also advised the therapist that an extensive custody evaluation had been completed in the case and that the child had been observed to be relaxed and age-appropriate with the father. The PC also advised the therapist that a nanny was present when the child was bathed and had reported no distress. The therapist responded that the nanny was on the father's payroll, that she believed the child, and that she felt that the child had a right to decide whether to spend more time with the father. She felt that the father was insensitive for refusing to listen to the child's feelings, and she had advised the mother to appeal the court's decisions. She resisted the PC's suggestions that she consider the father's information, set limits with the child, or focus on helping the child to cope with the reality of the adult decisions that had

been made. The PC provided the therapist with additional information relevant to the case, as well as relevant material about high-conflict cases, children's vulnerability to external influence, and court-involved therapy. The therapist continued to insist that she knew the child better than anyone and did not support the planned direction of the case.

If a therapist demonstrates an inability to remain objective or to modify procedures that are sending unhealthy messages to the child, it may be necessary for the PC to direct that a change occur. If the therapist has engaged in unethical conduct, such as expressing opinions about the parenting plan or providing diagnostic opinions about a parent whom the therapist has never met, a therapeutic transition is likely necessary.

If a transition is necessary and the therapist is sufficiently cooperative, the PC can work with the therapist on a plan for a therapeutic transition. Therapists who are cooperative with the transition should have a role in determining the process. The higher the level of tension, the more likely it is that transition sessions should be limited with some structural guidance from the PC. If the therapist is hostile to the PC or is likely to exacerbate the conflict, the PC may have to abruptly terminate the therapy and personally undertake the work of telling the child about the change.

In some circumstances, a therapist may be sufficiently cooperative to meet with the child and PC at the PC's office to allow the child to say goodbye. If this is not possible, the child's new therapist may have to assist the child in some procedure such as sending a note or a picture to the former therapist to acknowledge the relationship and the transition. The PC should direct the parents as to how to discuss the change with the child. If tensions are high, instructions regarding specific dialogue may be necessary, or the PC may need to meet with the parents and the child to address the therapeutic transition. The message to the child, from all adults, should acknowledge the importance of the prior relationship while expressing confidence and support for the child's new therapy. Parents may be referred to situations where such a transition has happened effectively, such as when children say goodbye to a kindergarten teacher and move on to the first grade. The PC should recognize that the parent who supports the child's therapy may view this transition as a loss and may attempt to seek emotional support from the former therapist or even to maintain contact between that therapist and the child. Limiting orders and the involvement of the rest of the treatment team may be necessary to secure the least disruptive transition.

CONCLUSION

The complexity of many high-conflict shared custody cases creates enormous and often overwhelming challenges to a therapist and/or PC independently involved in such situations. Many community therapists are well intentioned but lack specialized knowledge about working with high-conflict families.

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This increases the risk that therapy will exacerbate family conflict and cause harm rather than benefit to the child or family. The addition of a PC to the intervention team can provide a powerful and effective addition to therapeutic interventions. Each professional brings a unique and complementary set of skills to these cases that can enhance the work of the others and manage the common challenges these families present. The collaborative team approach is often the only way to effectively work with high-conflict families, if resources support professional intervention and support. The assignment of collaborative teams does not assure effective intervention, and the involvement of multiple professionals creates challenges and obstacles to working with these families.

In this article, the authors have attempted to identify common issues that arise for professionals in these cases and have offered suggestions for the management of these issues. Structuring collaborative work includes selecting specialized professionals to work on these cases, having an appropriate court order and service agreements to support individual roles and team functioning, and executing releases necessary to permit the ongoing sharing of treatment/PC information. Other specific protocols for team functioning are essential to effective intervention. Without conscious and deliberate methods and procedures in place, the challenges of these high-conflict situations are often more than a match for even highly skilled professionals. This increases the rate of professional burnout and frustration and increases professional risk to the well-intentioned professionals who undertake these cases. Conversely, a powerful synergy can be created when PCs and therapists can establish structures that support the PC's overall responsibility to manage the case and the therapist's role in helping parents and children to effectively meet the established goals for the family. Collaborative teams may also maximize the effective use of resources, as professionals with higher levels of expertise assist the less experienced team members in intervening effectively. The result may be a more positive outcome for the individual family and a benefit to the community, as more skilled professionals become available to assist distressed families.

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