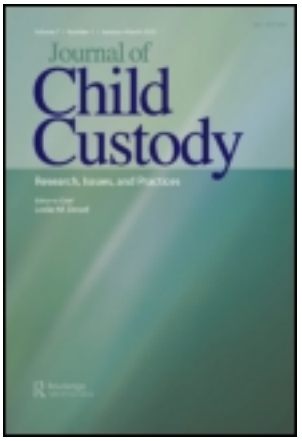

Journal of Child Custody
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wjcc20

Keeping the Developmental Frame: Child-Centered Conjoint Therapy

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Available online: 12 Mar 2012

To cite this article: Lyn R. Greenberg, Lynda Doi Fick & Hon. Robert Schnider (Ret.) (2012): Keeping the Developmental Frame: Child-Centered Conjoint Therapy, Journal of Child Custody, 9:1-2, 39-68

To link to this article: http://dx.doi.org/10.1080/15379418.2012.652568

Journal of Child Custody, 9:39–68, 2012

ISSN: 1537-9418 print/1537-940X online
DOI: 10.1080/15379418.2012.652568

Routledge
Taylor & Francis Group

Keeping the Developmental Frame: Child-Centered Conjoint Therapy

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Children at the center of high-conflict parenting disputes face a variety of emotional risks, emanating from both difficult historical experiences and the ongoing family conflict. Chief among these risks is that children's developmental progress will be compromised or distorted, such that children fail to master the essential developmental tasks and coping skills that they need to function in society and future relationships. In this article, the authors present a model of "child centered conjoint therapy" which can be used in both designated family therapy and as an approach to adapting children's treatment. CCCT is based on the core concept that the child's development, and his/her ability to master healthy coping abilities, must be the primary focus in all therapeutic intervention. This highly structured approach focuses on specific symptoms, behaviors, and skills, as well as the redirection of relationships and emotional healing necessary for children to adjust successfully. The authors also address common problems, obstacles, and the backdrop of support from a PC or the court, which may be necessary for therapy to succeed.

KEYWORDS conjoint therapy, child abuse, court-involved therapy, high-conflict divorce, domestic violence, reunification

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Professionals in both family law and juvenile dependency courts frequently struggle to find the best treatment approach to help children adjust after parental separation and traumatic family experiences. Tension may exist, or appear to exist, around preserving child safety, promoting healthy coping skills, rebuilding relationships where possible, and equipping children with the abilities to overcome traumatic experiences as they grow and develop.

In this article, the authors present a tentative model for child-centered conjoint therapy (CCCT). The model is based on relevant research and drawn from over thirty years of combined experience in treating children, advocating for children, and executing judicial management of high-conflict cases. The model can be applied by court-involved therapists appointed to treat a family, but can also be used when a therapist is appointed to treat the child and ultimately engage the parents. CCCT focuses on the developmental tasks that a child needs to achieve in order to function successfully in future relationships. Interventions are highly structured. They focus on validating the child's independent feelings, promoting feelings of safety and security, establishing boundaries, identifying and making distinctions among family members' perceptions and emotions, encouraging discussion about specific behaviors and problems, and altering both parents' and children's behavior to promote healthy adjustment in the child.

Understanding the Need

Children at the center of adult conflict face a variety of developmental and emotional risks. In many of these cases, a child's perceptions have been influenced by his/her conflicted loyalty between two primary identity figures, the parents. Children who are in the midst of high-conflict situations have often been exposed to radically different perceptions of reality, which occur in an emotionally loaded context because of the child's love for, and dependency on, each parent. They may have been presented with parents' extreme views of relationships and with accounts of events that are not consistent with the child's experience. These dynamics make it more difficult for them to deal with emotional complexity and to form other healthy relationships (Johnston, Lee, Olesen, & Walters, 2005; Johnston, Roseby, & Kuehnle, 2009).

Children who have been exposed to domestic violence are often emotionally conflicted. They may have been exposed to abuse or violence and high-conflict dynamics. As a result, these children are less able to cope with situations, articulate their emotions, or make distinctions between their independent perceptions and external influences. In many instances, they cannot consistently rely on their parents as resources for trust, physical safety, or emotional well-being. They may feel responsible for soothing or providing empathy for a parent's physical or emotional injuries (Johnston, Lee, et al., 2005).

There is a growing research base regarding risks to children of high conflict divorce, children's suggestibility, and the coping skills that children need for successful adjustment. This research underscores the importance of children receiving appropriate, unbiased treatment from therapists who possess the requisite expertise to work in the context of a court case (Association of Family and Conciliation Courts [AFCC] Task Force on Court-Involved Therapy, 2011; Greenberg & Gould, 2001; Greenberg, Gould, Gould-Saltman, & Stahl, 2003). The specific characteristics of these families, and risks faced by these children, also argue for treatment procedures adapted to this population and directed to those behaviors that promote autonomy, minimize risks, and promote resilience for these children (Fidnick, Koch, Greenberg, & Sullivan, 2011; Greenberg et al., 2003; Kent & Doi Fick, 2001).

Risks of delay and unwarranted assumptions

Each of the aforementioned risk factors is best addressed promptly, before unhealthy behavior becomes entrenched. Nevertheless, it is common for children to experience extended delays in receiving treatment. This may occur because of stresses on court or family resources, disputes as to the nature of the child's needs, or the belief that all issues must be resolved by the court before the child can receive any help.

Kuehnle and Connell (2010) and Olesen and Drozd (2012) have argued that therapists must take precautions to maintain objectivity and avoid tainting children's statements when allegations of abuse are ongoing and unresolved. Other authors (Hewitt, 1999) present approaches that appear to assume the truth of the allegations whether or not they have been substantiated by the court, and to engage with the child and family on that basis. Most professionals have encountered circumstances in which a therapist has formed premature conclusions and biased treatment as a result, with devastating consequences for children and families. Withholding treatment, however, raises the risk that unhealthy behavior will become entrenched and irresolvable (Sullivan & Kelly, 2001).

Impact on children's dialogue

A child's dialogue may become the center of controversy when well-meaning adults want to understand a child's needs, but the child's perceptions or statements may have been affected by the family conflict. In some cases, adults may focus so heavily on a child's statements that this eclipses all other consideration of the child's development or ability to function. Adults may question or attend to children based on the adult's perceptions, assumptions, or needs. This may apply to a professional seeking a clear answer to a complex family dilemma, as well as to a litigating parent.

These authors support paying careful attention to children's *feelings and developmental needs* while considering the family's *stressors and context,* as will clearly be demonstrated in the following sections. In intact or lower conflict families, the wishes or feelings of a child may be considered in a family's decisions, but the child is less likely to be burdened with the responsibility for adult decisions that may strongly impact the child's future. These issues become more problematic as conflict in the family increases. When a child's statements are viewed without consideration of his/her overall functioning, the child is unlikely to be empowered and is more likely to be caught in entrenched, unhealthy relationships and conflict behavior (Johnston, Walters, & Olesen, 2005; Kelly & Johnston, 2001). The child's memories and perceptions may be so heavily influenced by others' concerns that he/she will have difficulty differentiating between his/her own memories and others' perceptions (Kuehnle, Greenberg, & Gottlieb, 2004; Pedzek, Finger, & Hodge, 1997; Pedzek & Roe, 1997; Thompson, Clarke-Stewart, & Lepore, 1997). Unfortunately, the child's dialogue may reflect the parents' communications but be trumpeted as the child's own wishes and experiences.

The child may be unable to rely on his/her own experiences or feelings, perceiving and distorting events as an extension of the parent's beliefs (Fidler & Bala, 2010; Walters & Friedlander, 2010a). These behaviors may persist and impact the child's adjustment far into the future (Johnston et al., 2009). These issues require intervention by therapists with sufficient expertise to understand the relevant research and to assist the child in differentiating, and expressing, his own complex and independent feelings. This is a critical goal for the child as an individual, separate and apart from whether "reunification," per se, is successful. In addition, this focus enhances the child's chance of maintaining or rebuilding important relationships. The generation of accurately complex, independent therapeutic data may also allow children to have healthy participation in decisions that affect their lives.

It is our belief that skilled therapists can maintain objectivity and a balanced perspective and can provide treatment to children that enhances the child's independent development rather than focusing on adults' concerns and allegations. In the authors' experience, the highest conflict families present a wealth of psychological issues, many of which can be addressed without compromising the court's process or the parties' rights. Failing to do so may leave the child in limbo for years, relying on unhealthy coping skills and with treatment paralyzed by each successive adult allegation or event in the litigation. The child's development and functioning may be permanently impaired as a result. Conversely, when a therapist addresses issues that reflect daily patterns or that are not at the center of litigation, the process creates the groundwork and healthier interactions necessary to address more contested issues (Greenberg, 2009). Specific procedures are described in greater detail in the following sections.

Target populations

This model of psychotherapy can be useful in a variety of cases that present difficult intervention dilemmas to the court. The scope of intervention may change depending on the child's condition, safety precautions or limitations required, and the progress of treatment. In cases with ongoing allegations of abuse, or allegations that have not yet been resolved by the court, intervention may start with less contested issues and proceed toward issues more central to the conflict, after they have been resolved by the court.

The CCCT model can be useful in cases involving:

- unconstrained or inconclusive allegations of sexual or physical abuse;
- allegations of situational violence, some types of maltreatment, or poor or abusive parenting;
- high-conflict dynamics between parents or other significant adults;
- conflict about the child's needs or expressed preferences;
- extended parental absence, estrangement, or a history of marginal or inconsistent involvement between parent and child; and
- a child that is reportedly resistant or avoidant to contact with a parent.

In many cases, more than one of these dynamics exists simultaneously or sequentially. Furthermore, children or adults can present with the belief that a relationship is simply disposable and that the child has no need either to interact with the parent or to deal with his/her own feelings. Often, however, the child's needs are far more complex. Past disruptions in the relationship, and child's resistance to rebuilding the connection, may reflect a variety of situational or emotional issues. Failure to address these issues may make it difficult for the child to learn the skills necessary for successful social and emotional functioning (Fields & Prinz, 1997; Sullivan & Kelly, 2001). In some cases, the conjoint process will demonstrate that the less preferred parent is unable or unwilling to make a sustained commitment to the child, or that the child can only engage in a limited way with the parent. Even in such circumstances, however, the therapy process provides a way for the child to address emotional issues and move forward with healthy coping skills for future relationships. Options may also be created for future parent–child contact as the child matures and/or the family situation changes (Friedlander & Walters, 2010).

Conjoint therapy is contraindicated when active violence, child abuse, or substance abuse is occurring. In cases where the court has made a finding of severe abuse and parent behavior is intractable, therapy may be limited to helping the child resolve feelings rather than promoting a full reunification of the relationship (Kent & Doi Fick, 2001).

Not all conjoint therapy will be successful, and children may not be fully able to reconcile their feelings about a parent or about the parent's actions.

Nevertheless, with an adequately supportive and safe structure, the CCCT model can help the child make the necessary distinctions between his/her own and others' feelings, reduce the child's feelings of guilt or self-blame, and help the child achieve an understanding of the parent–child relationship that will not impair the child's future functioning (Greenberg, Doi Fick, & Levanas, 2008; Levanas, Greenberg, Drozd, & Rosen, 2004; Kent & Doi Fick, 2001). Most importantly, the CCCT model will allow the child to learn the skills that will promote success in future relationships and the ability to function successfully in the future.

Adjusting assumptions and treatment models

Effective treatment with vulnerable families, whether in family law or dependency cases, may require adjustments of traditional models and assumptions regarding therapy (Greenberg & Gould, 2001; Greenberg et al., 2003; Lebow & Black, 2012; Lebow & Rekhart, 2007; Olesen & Drozd, 2012). Such assumptions may operate at multiple levels, since court-involved therapists are typically dealing with other professionals who are highly educated and verbally oriented (i.e., attorneys and judicial officers). These individuals are more likely to have been exposed to models of therapy that are voluntary, self-motivated, strictly confidential, and oriented toward assisting the therapy client in attaining some level of insight.

Highly symptomatic families often use very different coping and behavioral patterns than the professionals who interact with them. As others have written (Sullivan, 2008), parents in the highest conflict families, or those who have come to the attention of the dependency court, are more likely to exhibit long-term patterns of acting-out behavior and difficult relationships with others (Fidler & Bala, 2010; Sullivan, 2008; Sullivan, Ward, & Deutsch, 2010). Litigation processes and long delays between court hearings further compound the difficulty in connecting behavior to consequences, even when all parties clearly understand the court orders. Thus, parents may have refused cooperation or violated court orders for extended periods of time without really experiencing any consequences for their behavior. For these reasons, professionals may believe that these families cannot benefit from therapeutic help (Johnston, Walters, & Olesen, 2005; Walters & Friedlander, 2010a). Conversely, as others have noted, even seriously dysfunctional families can be helped if treatment methods are adapted to fit this population (Gershater-Molko, Lutzker, & Wesch, 2002).

Early resistance is common

Traditional models of psychotherapy are often inapplicable or impractical in these cases. Many models of psychotherapy are based on the assumption that the therapist and the client(s) agree on the goals of the intervention. In

contrast, many court-involved therapy cases begin with a treatment goal from the court that is uncomfortable for one or both parents, or for the child. In some cases, this may reflect a parent's sustained desire or need to continue dysfunctional patterns, undermine the child's relationship with the other parent, or secure a perceived advantage in the custody conflict. Many cases, however, reflect more complicated dynamics. Children who are heavily exposed to parents' needs may produce statements or behaviors that mirror the parent's needs rather than the child's experience. The child may also decide that his/her emotional survival depends on taking sides with the more powerful parent. Parents may not recognize the problems this creates for their child, or they may believe that all of the child's problems are caused by the "unreasonable" expectations of the court or the other parent. The child may have adopted unhealthy coping patterns exhibited by their parents, or they may have entrenched habits of avoiding, rather than resolving, uncomfortable emotions and interpersonal problems.

Given these dynamics, it may be unrealistic to expect that these families will voluntarily enter treatment, let alone share the goals of the other parent, the therapist, or the court. As a result, this type of court-involved treatment requires more focused methods and a higher level of structure and accountability than traditional psychotherapy or treatment sought by higher functioning parents (Doi Fick, Figoten, Williams, & Pichivai, 2010).

KEEPING THE DEVELOPMENTAL FRAME – WHAT SKILLS WILL THIS CHILD NEED TO HAVE A FUTURE?

The CCCT model is based on the concept that the child's development, and the skills that he/she must master to become a functioning adult, must be the core focus in all therapeutic intervention. In most cases, children will function most successfully if: (a) they are able to engage with each parent in a manner that is realistic and consistent with the children's independent experience; (b) they are able to separate their own experience from others' perceptions; (c) they are able to articulate and assert their independent thoughts and feelings; (d) they are able to engage in healthy relationships and resolve interpersonal problems through direct communication and engagement with others; and (e) they can learn to use active coping skills rather than avoidance, acting-out behavior, or internalized symptoms to cope with emotional issues (Contreras, Kerns, Weimer, Gentzler, & Tomich, 2000).

The overwhelming research on the importance of these skills (Contreras et al., 2000; Cooper, Shaver, & Collins, 1998; Dunn, Davies, O'Connor, & Sturgess, 2001; Fields & Prinz, 1997; Johnston & Roseby, 1997; Kelly & Emery, 2003) and the real-life implications if children fail to learn them, may ultimately serve as a reason for parents to appreciate the value of treatment and to cooperate with the therapist (Johnston, Walters, & Friedlander,

2001). Initially, however, the therapist may encounter enormous passive or active resistance from parents and children, particularly if this has been a successful tactic for parents in the past. The therapist may need to interrupt parents' concentration on legal struggles to refocus on children's current distress and on risks to the child's future functioning. A parent may fear that progress in therapy poses a threat to his/her legal position such as resulting in more parenting time for the other parent, reduction of child support, or an unwelcome focus on both parents' contribution to problems. Children may have become accustomed to avoiding problems rather than dealing with them, having at least one parent indulge regressive or acting-out behavior, or avoiding dealing with their own feelings by taking sides or producing statements that each parent wants to hear (Fidler & Bala, 2010). Although both parents and children may ultimately find that better coping skills make life easier, their initial reaction is likely to be an attempt to avoid the work, and uncertainty, of change.

Legal Underpinnings, Importance of Structure, and Judicial Support

Effective therapeutic intervention often requires a backdrop of support by the court, which creates the context for treatment and may include a beginning definition of the goals of treatment. Legal controversies exist about the court's authority to order treatment, and practices vary among jurisdictions. In some states, a specific finding from the court (e.g., that conflict is impacting the child) may provide the authority for the court to order counseling. In other situations, therapy may be a necessary element of a broader plan, such as an attempt to rebuild a parent–child relationship or an attempt to provide an opportunity for a parent to modify dysfunctional behavior before the court is forced to consider stronger measures to protect the child (Greenberg et al., 2008).

In a dependency proceeding, individual treatment may be ordered for the children at the outset of the case and for the parents if the allegations are sustained. In a family court proceeding, treatment may be ordered at various stages of the process and investigations, or repeated allegations may occur over extended periods of time. In very high-conflict cases, the family may move back and forth between court systems, with either the same or different therapeutic teams and very dissimilar expectations in the legal setting. Both settings, however, typically include the legal expectation that each parent have an opportunity for contact and for a relationship with the child, and that disrupted relationships be reunified/rebuilt to the extent that it is safe and possible. For example, family preservation is addressed in the Adoptions and Safe Family Act, 1997 and Santosky v. Kramer (1981). In California Family Code sec. 3020(b), the legislature states that it is

> . . . The public policy of this state to assure that children have frequent and continuing contact with both parents . . . . After the parental relationship ends.

Whether the therapist is appointed/designated to treat the child, or to conduct child-focused intervention with the family, therapy is most effective when the parents have a clear directive from the court to cooperate with treatment and the therapist has the flexibility to structure treatment. Success is most likely when the therapist is involved with both parent–child relationships and when some mechanism for accountability is included in the treatment order.

Respecting the limits of the role

In an atmosphere of limited resources, it is often tempting to vest the therapist with the power to make recommendations on psycho-legal issues, such as the best schedule for progress in reunification or parenting plans. This can be fatal to the treatment process, and the therapist may be in jeopardy of licensing board actions or ethical complaints. Therapists may have considerable information, particularly about the extent of families' cooperation and about the child's developmental progress, that may help the court or other professionals—such as an evaluator or a parenting coordinator—to act or make recommendations for the benefit of the child. Nevertheless, therapeutic information is usually limited in scope and may be affected by the therapist's need to maintain a working alliance with members of the family. While it may be appealing to the decision maker (and to some therapists) to have the therapist make psycho-legal recommendations, this practice creates considerable and unnecessary risk to both the therapist and the treatment process. Therapists must balance the requirement for accountability with the family's need for discretion, privacy, and a reasonably safe place for the child to experiment with new coping skills. While sharing information is a clinically sensitive issue that can be used to keep parents accountable, it is inconsistent with the therapeutic role for the therapist to make psycho-legal recommendations, and it is generally considered improper for them to do so (AFCC Task Force on Court-Involved Therapy, 2011; American Psychological Association, 2002).

Clear underlying orders aid treatment

Ultimately, there is considerable power in the therapist being able to say, "The judge decided; I'm just here to make it work." It is therefore useful to have clear orders underlying therapy, including an order that details the court's expectations on issues such as parenting time, review hearings, and the extent of each parent's participation in the child's life as therapy progresses (Martinson, 2010). While children's safety must always be the first priority, we have found that it is useful, when safe, to have underlying orders that allow both parents to have access to common childhood experiences such as attendance at athletic events, school performances, and other

child-focused activities. For example, the court may consider ordering that a monitored parent may attend athletic and school events, allowing the parent to greet the child but avoid engaging with the other parent, and directing the parents to cooperate with the therapist to develop detailed protocols for such events. This creates a structure that is less demeaning for the restricted parent, allows the child to benefit from a parent's attendance and praise of the child's efforts, and provides less loaded material that the parent can discuss with the child in treatment. Such experiences also allow the child to view the parent in the context of activities that are outside of the allegations or parenting conflict. Of course, such a structure cannot be utilized where the court has determined that there is danger in such areas as stalking, violence, or child abduction. Nevertheless, progress in therapy is likely to be enhanced by maintaining parental roles as much as possible without endangering the child.

Specific orders are also important on issues such as transportation, limits and specifics in restraining orders, telephone access, and the responsibility of the parents to cooperate with the therapist and exercise their parental authority to promote the child's cooperation. Orders can be drafted that specifically address conflicts that have arisen in the past for each specific family (e.g., late exchanges, conflict at public events, missed telephone calls). Financial arrangements should reflect the reality that therapists in these situations may be providing a broader range of therapeutic services than is the case in traditional treatment. Therapists should not begin treatment without clarity as to who is responsible for payment for all services, including reviewing documents (and whether the review of documents by the therapist can be requested or required), making telephone calls, giving any required reports or testimony, reviewing email correspondence, and so forth.

It is often helpful to involve the therapist in crafting a stipulation that will allow therapy to be most effective. Detailed suggestions regarding the content of orders and consents can be found elsewhere in this issue (Dwyer, 2012) as well as in the AFCC Guidelines for Court-Involved Therapists (AFCC Task Force on Court-Involved Therapy, 2011). The family or the court may initially find the detailed stipulation or consent cumbersome, but consideration of these issues at the beginning of treatment can create considerable savings in time and money as treatment progresses (Greenberg & Sullivan, 2012; Johnston et al., 2001; Sullivan & Kelly, 2001). Such transparency also minimizes the opportunity for parents and attorneys to create procedural hurdles intended to stall treatment progress. In addition, detailed stipulations and consents meet the requirements of informed consent that govern the practice of psychotherapy.

Handling of treatment information

As described elsewhere in this issue, the expected limits of therapeutic privacy should be addressed in detail by the parents, counsel, and therapist before

treatment begins (AFCC Task Force on Court-Involved Therapy, 2011; Dwyer, 2012; Greenberg & Sullivan, 2012; Perlman, 2012). Decisions regarding this issue are often viewed in extreme terms, with the suggestion that either no treatment information be released, or that all therapy details be available. It is the authors' experience, however, that more nuanced solutions are often more helpful. Some jurisdictions may require status conferences or other kinds of periodic feedback about treatment progress. In other jurisdictions, the therapy may be structured such that the therapist does not share treatment information unless one of the parents re-initiates litigation. In those cases, the therapist may be authorized or ordered to share information with the court via a report or a discussion with a case manager or other court-appointed professional.

Some cases require a more regular feedback mechanism, and in such cases it may be helpful to involve a parenting coordinator, special master, guardian at litem, case manager, or child's attorney, as long as close cooperation is maintained. Many of these cases require closer judicial case management and regular review hearings to assess therapeutic progress and to make decisions about changes to the parenting plan. Continuity in judicial management of the case may be invaluable (Sullivan & Kelly, 2001).

In some jurisdictions, the court may elect to identify the child, rather than the family, as the therapist's client, with the parents involved as adjuncts to the child's treatment. This may allow the therapist to alert the court when he/she encounters problems with parental cooperation, without being required to disclose communications from the child. The methods described in this article can be applicable whether the child or the family is the identified client, as the child's needs are emphasized as central throughout. These distinctions are crucial to the therapist's other clinical and ethical responsibilities. In many cases, it is helpful for the court to specify that the therapy is based on the child's needs. It is also helpful for the court to include direction to the therapist to alert the court if the therapist encounters problems with parent cooperation (Weinstock, personal communication, August 5, 2011). This may be important in creating appropriate expectations for each participant. Since circumstances can change, however, it is generally unwise for a therapist to promise complete secrecy to a child (AFCC Task Force on Court-Involved Therapy, 2011).

In summary, therapy is most likely to be successful if court orders include:

- expectation of cooperation by both parents, including specific expectations of parent behavior;
- court's concerns and treatment goals, reasons for the referral;
- contingencies in the event of re-litigation;
- payment arrangements for all treatment-related services;
- parameters for extended family involvement, contact with other professionals, etc.;

- provisions for accountability;
- privilege/confidentiality expectations, circumstances in which treatment information may be disclosed;
- separate custody/visitation orders as backdrop for treatment, including orders about parental attendance at the child's activities and about cooperation with the therapist in setting procedures;
- parameters for information to be provided to the therapist;
- discretion for the therapist to set arrangements and procedures for treatment; and
- consequences for failure to comply with treatment orders.

Therapists have a responsibility to review proposed orders and to decline assignments that violate professional responsibilities or ethical standards. Often, therapists can provide suggestions that will make the order both ethically defensible and clinically effective. Vagueness in court orders or consents creates extraordinary danger for therapists, and a parent who is resistant to change may use the lack of specificity to paralyze treatment. It may be advisable for therapists to have standard stipulation forms or consents that they can provide to counsel or the court. Some judicial officers also have standard forms with sufficient detail (Lewis, Kibler-Sanchez, & Wasznicky, 2009). Sample orders and consents also can be found as an appendix to the AFCC Guidelines for Court-Involved Therapists (2011).

TREATMENT METHODS

Although the therapist adapts methods to specific issues and the individual family situation, CCCT is focused on a set of core consistent messages, all aimed at promoting the child's developmental progress. While it is not possible to address every area or symptom to which these methods apply, the reader will likely notice some common elements in the description of treatment methods in the following sections. Therapy is cognitively based and targets the parties' behavior, patterns of communication, and problem-solving abilities (Greenberg, 2009).

Initial Procedures

The therapist should have some flexibility in the methods used to begin treatment, provided that information is obtained from both parents and there is a clear, consistent message that therapy will be focused on the child's needs. The therapist may conduct initial meetings with parents (separately or conjointly) before or after meeting the child individually. The therapist may review historical data such as an evaluation report, as consistent with the court's direction. If historical data is reviewed, the therapist should explain

to the parties that this review is only for the purpose of assisting the therapist in structuring a treatment plan. It is not the therapist's role to conduct an forensic evaluation, make findings of fact, or make psycholegal recommendations (Weinstock, personal communication, August 5, 2011). While such information may be relevant to treatment planning, data will also be obtained over the course of treatment that may complement or expand upon the findings of an evaluator or the contents of other documents. The therapist may need to revisit these role distinctions periodically with the parents, as circumstances arise.

Throughout the course of treatment, the therapist periodically meets individually with the child, and for a portion of each conjoint session, to assess the child's level of comfort or to allow the therapist to address a child's distress. This structure maintains a commitment to the child that the therapist is available to help, while not excessively delaying the requirement that the child learn active and direct communication skills. Interventions with the child are adjusted individually based on the child's developmental abilities and the identified case stressors.

Gaining Parental Cooperation

The process of promoting parent cooperation begins with the treatment order or consent and the intake sessions with the parents. Obtaining each parent's perception and concerns is essential to facilitating change, creating parental involvement and trust in the therapeutic process, and understanding the different stressors in each household.

During the intake session, the therapist explains the parents' roles in helping the child develop age-appropriate behavior and skills. Parents must encourage children to use these skills, and they must enforce expectations of appropriate behavior. They also should encourage the child's independent expression of emotions and work with the child to practice problem-solving techniques. In the parent interview, the therapist has an opportunity to suggest adjunctive services if indicated, such as parenting classes or individual therapy. Later, it may be beneficial to revisit these issues if a parent becomes resistant to change or experiences a sense of loss when the child's behavior shifts. Sessions can be tailored to consider child safety issues (e.g., monitored contact, parent driving issues) while still allowing parents to alternate bringing the child to appointments, if court orders permit.

Protective Structure, Accepting Different Perspectives

The child's perceptions serve as the starting point for addressing issues. Parents are not required to directly admit to events that they do not agree with or do not recall, but they are not permitted to attempt to alter, criticize, or discount the child's memories or feelings. A parent may tell a child that he/she does not recall an incident and then ask the child to explain more to gain a more

thorough understanding of the child's perceptions. Sessions are structured to explore the child's independent memories or to seek out the child's reactions to sensitive discussions with a parent. Children need to know that their perceptions are accepted and taken seriously but may not be literal memories. A treatment goal is to help parents (and ultimately children) acknowledge that each person may have different perceptions about the same incident (Smart, 2002). These perceptions are frequently influenced by a person's wants, hopes, fears, or other agenda. During chaos or family violence, a person's sight may have been blocked, or the language an adult used may have implied specific behavior that may have occurred differently than perceived. While acknowledging a difference of perception may not lead to the "truth of the matter," it may add insight about each individual's perceptions and suggest some future solutions for the family (Doi Fick, Greenberg, Perlman, & Barrows, 2010).

Parents need to learn to recognize the sources of children's perceptions. For example, a parent who reports that his/her child eavesdrops is likely aware that listening through doors or from around corners alters what is heard. If the parent allows the child to continue this behavior or fails to keep adult material away from the child, the parent may be passively giving permission for such behavior and the misinterpretations that may result. Conversely, parents need to learn to recognize and address their own contributions to the child's memories and distress. For example, parents may be in dispute about whether an alleged incident of domestic violence occurred and about the nature of that incident. Both parents may minimize or distort the extent of the child's awareness of the event. The child may only remember being in bed in the next room, unable to block out the sounds of the parents yelling and other loud, frightening noises. The child's memory of the event may include both accurate perceptions and beliefs resulting from each parent inculcating the child with the parent's narrative about the event (Johnston et al., 2009).

Children may draw distorted conclusions about events based on their stage of development or because of unhealthy behaviors they have adopted. The therapist can assist the parent in identifying and addressing these behaviors. The game "telephone" demonstrates how words are altered when passed from one person to the next, and children are often familiar with this game from their school experiences. Children at the center of conflict often fail to apply knowledge from other social relationships to issues in their families. The therapist can create exercises to help the child apply independent knowledge to family situations.

ADDRESSING POOR PARENTING AND EXPECTATIONS OF DEVELOPMENTALLY APPROPRIATE BEHAVIOR

Therapy is structured to require children to exhibit behavior that would normally be expected of a child the same age, in any setting where the child is

expected to follow rules and treat others with respect. This may require giving directions to parents as to the best ways to promote the child's cooperation. Therapists should instruct parents to exercise parenting skills designed to enhance the child's independence, and to practice skill-building techniques used in the course of treatment. For example, a 3-year-old is expected to walk into the session rather than be carried by an adult, unless the child needs physical assistance from the parent. These parent–child interactions will provide data regarding the quality of the parenting and the child's responses to each parent's style. Therapists should also teach parents to make careful observations and consider a variety of possibilities before placing blame on the other parent. Patterns of poor parenting may arise from a variety of sources, some of which are addressed in the following section.

Promoting Healthy Parenting Routines

When a parent is concerned about the child's time with the other parent, he/she may express alarm and believe that a child's behavior has changed following contact with the other parent. Parents often overreact to minor fluctuations that the parent would not notice if the visit had not occurred. In other cases, real environmental issues may contribute to the child's behavior. Routines, structures, and schedules may be different between households. One parent may have greater developmental knowledge, or greater sensitivity, than the other. One may be better at setting limits. After a parenting transition, the receiving parent may be particularly attentive to changes in the child's behavior. It is not uncommon for receiving parents to both interpret and respond differently when the child exhibits difficult behavior after spending time with the other parent. For example, a parent who would otherwise recognize the need to set a limit with a child's tantrum may instead "diagnose" the child's tantrum as reflecting a problem with the other parent. The parent may have a legitimate concern about the other household but may also be defensive about difficulties he/she is having and will avoid potential scrutiny. Some parents need to believe that all problems emanate from the other household. Others will initially adopt this focus but can be assisted with better parenting skills and communication, or they may be reassured about normal variations in children's behavior.

A common complaint is that the child is having difficulty transitioning between the parents. Rather than reinforcing undesired behavior, the therapist can instruct a parent to follow specific steps for the exchange. This type of rapid intervention does not require the parent to agree with the court's order or to change his/her opinion of the other parent, but it is intended to bring immediate relief to the child. For example, the receiving parent may be instructed to wait in the car while the other parent facilitates the transition. The transitioning parent may be instructed to pick the child up, place the child in the car seat, buckle the child in, and place a stuffed bear in the

child's arms. The departing parent may be instructed to say to the child: "Bye, Jane, have a good time with Mom, and I will see you when you get back." The parent is instructed to smile, wave, and close the vehicle door. The receiving parent is encouraged to politely thank the other parent, welcome the child, and leave the curb without hesitation. Other specific protocols may be appropriate based on the issues of each individual case.

The therapist should clarify the similarities and differences between each home regarding household routine, structure, rewards, and consequences. For example, differences in bedtimes or routines may impact a variety of emotional issues, educational success, and the child's behavior. The therapist should work with each parent to realistically review his/her observations while making parenting suggestions to alter the child's behavior. For example, if a child functions poorly at school after an overnight in the other parent's home, or if a young child becomes more irritable or fussy the next day, it may be prudent to rule out environmental factors. Parents may need some education or assistance in responding to these issues. An evenhanded approach on these issues is helpful, particularly if one parent has felt overly criticized by the other. It is essential that the therapist explore these common issues with parents, prior to suggesting that anxiety or trauma may be a cause of the child's behavior. In the process, parents may learn to consider a greater variety of possible explanations for their children's behavior. It is also important for parents and children to learn that parents may have different rules or practices on some issues (Smart, 2002).

Therapists can also help parents use technology to promote healthy routines. For some families, replacing telephone calls with web visits is more suitable to the child's developmental stage. The therapist will likely need to establish rules for the web visits (Walters & Friedlander, 2010b), which would include eliminating distractions to the child. Therapists may also need to assist parents with other ways to facilitate rebuilding the parent–child relationship. For example, a parent who cannot attend a school or athletic event may be able to view a videotape of the event so that he/she can intelligently discuss it with the child. A parent who cannot attend a parent–teacher conference in person might be able to attend telephonically or have a brief phone conference privately with the teacher at a later time. A therapist can assist parents with skills for asking the child relevant questions and responding to a child's cues. Interventions that reduce the parent's isolation from the child will also facilitate the normal conversations that underlie most important relationships.

Therapists should assist families to establish specific behaviors or dialogue to comply with court orders, addressing nonverbal and indirect as well as direct behaviors. As Fidler and Bala (2010) and others have noted, high-conflict parents are often characterized by what they do *not* do, as well as by what they do. The therapist may need to establish therapeutic contracts outlining specific, active procedures to reduce stress to the child. It is helpful

for the therapist to conduct feedback sessions with parents to help reinforce patterns of change, or to assess whether modifications to a plan are needed. This also provides an opportunity to assess obstacles in the treatment plan, which may necessitate referring a parent to adjunct services (i.e., individual therapy, parenting classes).

Building a Language of Feelings

The English language includes hundreds of words that express and describe emotions, but many children in these families are unable to identify or articulate their independent feelings (Johnston et al., 2001). Therapists have tools at their disposal including age-appropriate books, charts, flash cards, and photographs that demonstrate the use of language to convey emotions with appropriate application. Throughout the sessions, the therapist assists the child in building an expanded vocabulary for emotions and provides a list for the parent and child to use. The child may initially use art or play materials to express emotions, but the goal of the intervention is to teach the child to use words that other people can recognize and respond to. A bright 3-year-old once stated that her brain felt like "crackers in the soup," which generated specific adjectives: confused, trapped, tricked, and pulled. These words were added to the "feeling word" list and shared with a parent at the following session. The parent's task was to empathize with the child's perceptions, acknowledge an understanding of these emotions, and praise the child for self-expression. A bonus occurs when a parent apologizes to the child for contributing to the child's stress. Parents can also acknowledge responsibility by committing to plans to encourage the child's expression of feelings and alter dynamics in the future. If families can use these words during contact outside of therapy, it may warn a parent of a child's building stress and provide an opportunity for a parent to choose a different course of action or conversation.

Children can be taught to recognize complex and conflicting emotions through materials that have no connection whatsoever to the allegations in the case. They need parental and therapeutic support to identify and express these issues in the context of family interactions. The defining vocabulary can equal the child's developmental level with explanations like, "I'm having two feelings at the same time. I'm happy to go to Disneyland with Daddy but sad that Mommy will be alone." This illustrates the child's conflicted emotions caused by high-conflict parental relationships.

Families can also develop "signal words" that are unusual in everyday conversation but provide a way for a child to tell a parent that he/she is becoming distressed or overwhelmed. (Some children choose words with literal connotations of chaos or disruption, such as "volcano" or "earthquake".) A therapeutic contract between parent and child would allow the child to notify the therapist if declarations of emotional stress did not alter the

parent's behavior or conversation. The child will require explicit permission from parents to allow this intervention to be successful.

Therapeutic objectivity is essential during this process, with the therapist systematically exploring materials and eliciting the child's perceptions about how various feeling words apply to the child's actual experience or memories (Greenberg & Gould, 2001; Greenberg et al., 2003; Kent & Doi Fick, 2001). Adults can be powerfully persuasive to children. Therapeutic knowledge about the effects of traumatic events can be a source of bias for the therapist, who may unwittingly make assumptions about what has happened to the child and how the child has responded to it. A therapist may find it helpful to explore messages with the child that he/she has received from either parent about the meanings of important words and the acceptability of the child's feelings. Is there a special definition of "truth" in one household or the other? How do parents respond to the child's various feelings, in everyday interactions as well as in issues related to the litigation? Does the household differentiate between feelings of anger and inappropriate behavior? Careful and systematic exploration often reveals the enormous cognitive and emotional binds that children experience when they are at the center of parental conflict or when they are attempting to describe a traumatic event involving a loved one.

Redirecting Unhealthy Child Behavior

When children have had extended exposure to unhealthy family dynamics, they may adopt behaviors that are extremely unhealthy or that pose risks to the child's future. Children can exhibit stunning variability in their behavior, based both on emotional issues and on the reactions of adults around them.

Children can be severely impacted by trauma, but they can also demonstrate and develop sources of strength and resilience. When a child has had an overwhelming experience, sensitivity to the child's reactions must be coupled with a gentle but consistent message that the child can cope and move on with life. When a parent (or therapist) focuses only on the child's vulnerabilities or emotional wounds, the child may be encouraged to view himself/herself this way. Parents who are responding to their own anxieties may assume that the child has identical feelings or may believe that the best way to protect the child is to support the child in avoiding difficult tasks or emotional issues. The alleged victim status of the child becomes the justification for various adult agendas about the ultimate parenting plan or the child's relationship with the other parent. The child may accept the family narrative or demonstrate expected behaviors as a way of exhibiting loyalty to that part of the family. These behaviors become self-reinforcing, as the child who buries his/her own feelings also avoids the confusion and ambivalence that may arise when comparing the family narrative to his/her own

experience. Avoidance of emotional issues becomes the child's habitual response. These coping habits can impair the child's functioning far into the future, as the child lacks the skills to build intimate relationships based on his/her own perceptions and experiences.

Children in disturbed families often adopt behaviors that have been demonstrated to them by their parents, or they adopt markedly inappropriate behaviors to avoid situations that are difficult for them. They may demonstrate regressive behaviors such as tantrums, crying, or a refusal to use basic skills such as walking or carrying their belongings. Older children may exhibit acting-out behavior such as tantrums, disrespectful treatment of adults, or destruction of a parent's property. Often these children are aware that they would not be permitted such behavior at school or in other settings, but they continue such behaviors in family relationships.

Family patterns support dysfunctional behavior when an invested parent applies "special rules" to a child's conduct that is related to the family conflict. One of the authors was confronted with a situation in which an adolescent had destroyed property at the other parent's home and freely admitted his actions. The adolescent was able to articulate the consequences he would have experienced if he had destroyed property at school or in any other setting. The parent who experienced the property destruction did not have enough time with the child to enact an effective consequence, and the other parent made excuses for the child rather than set limits. This essentially sent the message that destruction of property was appropriate or permitted as long as the child was in the other parent's home, which was strikingly inconsistent with general conduct expected in society. In this case, the therapist's task was to engage the residential parent to support the message that destruction of property is never acceptable, because it is a socially and legally unacceptable behavior. The therapist then assessed whether the parent's reluctance to set limits emanated from the parent's agenda in the custody conflict or from the parent's overall difficulty in controlling the adolescent's behavior. After limits were effectively set with the acting-out behavior, the therapist could then assist both parents and child in addressing their underlying issues.

Most children have learned rules about acceptable behavior at school, where they are not permitted to engage in name-calling, tantrum behavior, property defamation or destruction, physical aggression, or disrespectful treatment of adults. The therapeutic message to the child is that if a behavior would not be accepted at school, it is not acceptable in therapy or with either parent. A child or adolescent's anger at a parent may be entirely reasonable but must be expressed and resolved appropriately. Similarly, both parents must learn to recognize behaviors that pose risks to the child's future. Rules and limits are established that engage both parents in requiring appropriate behavior from the child. As the child masters healthier skills, he/she will likely gain independence and confidence in dealing with family issues.

Addressing Trauma, Paths of Accepting Responsibility

When applied across the full texture of parent–child relationships, the methods described previously also establish the groundwork required for children to discuss difficult or traumatic events. The therapist has an opportunity to assess each participant's coping abilities. Therapeutic agreements on daily issues provide an opportunity for the child to test the parent's sincerity or trustworthiness and emotional reactivity. One party's inability to effectively cope and discuss a trauma can undermine the process. It may be necessary to consult with the child's and/or the parent's individual therapist prior to addressing trauma conjointly. The therapeutic expectation is for the parent to give permission and encourage the child to share his/her recollections and feelings about difficult events, even if the child's memories differ from those of the parent.

The therapist assists the parties in identifying situations that trigger flashbacks or painful memories. For a child, a trigger to a traumatic memory may be a word, tone, intensity, or body language that creates discomfort or stress. The child and parents are encouraged to use the skills they have developed to discuss and overcome the effects of trauma, and to use caution in assuming that any difficult behavior reflects the impact of trauma. Parents are encouraged to use sincere praise to reinforce continued discussions. The parent may share memories that are similar to the child's. Moreover, the parent is expected to acknowledge the child's statements and to express empathy in response to the child's distress. The therapist continues to regularly meet with the child to assess the child's responses and to learn if therapeutic contracts are being followed effectively.

A parent can recognize his/her role in a child's pain or distress and can commit to handling things differently in the future, without having to admit illegal conduct or make other statements that could be used against him/her in court. A parent's apology does not need to include literal admissions of disputed events. The goal is for the parent to apologize for behaving or making decisions that led to the child's distress. The apology may focus on the emotional impact to the child with a statement such as: "I'm sorry for what I did and how I made you feel. I did not intend to hurt or scare you." Then, if a child asserts that he/she will never forgive the parent, the parent can demonstrate compassion by responding with words such as, "I understand." Privately, the therapist may also need to explore the sources of a child's statement that he/she cannot forgive a parent or move past the historical event. If a parent explains the steps he/she has taken to rectify behavior (e.g., through counseling or parenting classes), this acknowledges to the child that such behavior required change or intervention. For reassurance, the parent may remind the child of any specific measures (e.g., court orders, monitored contact) that are in place to ensure that similar events will not occur. The therapist can support a parent's request to continue to be a part of a child's life by establishing therapeutic rules for future contact around addressing

safety, managing anger, avoiding trigger events, and empowering the child to express his/her concerns.

There are some cases in which treatment occurs in the context of multiple or longstanding allegations of abuse or domestic violence. In these cases, delays in treatment may cement limitations in parent–child contact and make it difficult to rebuild relationships, even if the court does not sustain the allegations. If a safe treatment structure can be created, it may be healthier for the child to begin to rebuild some aspects of the relationship with the parent, even if legal proceedings are continuing. For some, parent–child contact is exclusive to the conjoint session. This level of restriction makes treatment more difficult, however, as there is no outside experience or common activity with the parent.

Parents who are awaiting trial may be concerned about incriminating themselves by what they say in therapy. The therapist must create a structure that respects a parent's constitutional rights without allowing the parent to behave in a manner that undermines the child's independent thoughts or feelings. The therapist provides the parent with guidelines for responding to the child's statements. This may limit spontaneity at the beginning but assists a parent in gaining comfort with the process and decreases his/her defensiveness. The child is kept safe from a parent's contradictory statements and is allowed to build confidence in self-expression. When a therapist deals with a parent about these issues, the therapist must be cognizant of the mechanisms by which a parent's communication or behavior may alter or manipulate the child's thoughts and feelings (Pedzek et al., 1997; Pedzek & Roe, 1997; Thompson et al., 1997).

Dealing With Loyalty Conflicts

Children from conflicted families often feel caught between parents' opposing needs and expectations. Parental conflict may have long predated the separation, and the child may align with one parent for a variety of reasons. Some children have a natural affinity for one parent's style, while others have aligned with one parent due to exposure to adult information or the belief that one parent is more needy or vulnerable. One parent may have better parenting skills or sensitivity to the child. In some situations, this reflects limitations in the less preferred parent. Alternatively, the less preferred parent may not have had as much time or opportunity to parent as the other parent has enjoyed. This becomes an escalating cycle if the preferred parent, or the child, resists opportunities to improve the relationship with the non-preferred parent.

The therapist attempts to separate the parent's issues from those of the child. By making distinctions in each party's perceptions, the therapist can encourage the child to be emotionally independent from each parent and work with the parents to respect emotional boundaries.

A child with conflicted loyalties will frequently distort the information he/she shares with each parent. Treatment includes working with the preferred parent to give the child permission to share rewarding or happy experiences that occurred with the other parent. The therapist encourages the child to identify and describe new awareness, positive changes, or recent memories of positive events, which may be difficult for the preferred parent to hear or accept. This intervention requires close follow-up by the therapist to ensure that the preferred parent is not undermining the child's shared experiences.

A therapist may also assist a child in expressing his/her concerns about the preferred parent's emotional needs or reactions. For example, the therapist can assist the child to inform the preferred parent that he/she is aware of how the parent feels when the child is gone and to describe the conflicted emotions he/she experiences while with the other parent. The preferred parent is encouraged to offer sincere reassurance to the child by explaining that he/she has other activities to accomplish while the child is gone. Each parent may need to learn to explicitly encourage the child to enjoy time with the other parent. By practicing this exercise, parent and child establish a pattern of communication that can be repeated prior to the other parent's visits or custodial time or during telephone calls when away.

This model requires contracting with parents, providing written notes, or confirming by email to encourage parents to be accountable for their behavior. The therapist must clearly state expectations without ambiguity. If a parent's cooperation decreases, the therapist must review contracts with the parent and explore the parent's reactions. The therapist should emphasize to the parent that the child's stress will decrease when conflicted parents change their behavior and that cooperation might even make life easier for the preferred parent. The therapist must emphasize that the parent is not just being asked to alter behavior to benefit the other parent—cooperation is important to all of the child's current and future relationships.

OBSTACLES AND COMPLICATIONS

Parental Noncompliance

The environments of children are usually controlled by the adults who care for them. Since a goal of CCCT is to enhance the child's emotional independence, a parent who refuses to cooperate may create serious emotional consequences for the child. A child who is learning new coping skills in therapy should attempt to apply them at home and should learn to tell the therapist if the new skill did not work. A parent who cannot tolerate the child's growth may also undermine the child's confidence in other areas, such as the child learning to complete parenting transitions without crying or other misbehavior. In the preceding sections, the authors have described some

of the methods used to promote parental cooperation, even with reluctant parents. When a parent fails to adhere to a treatment contract or refuses cooperation in other areas, the prudent initial procedure is to meet privately with the parent to explore the issue. A parent's non-cooperation may reflect unwillingness to change, difficulty applying or learning skills taught by the therapist, a failure to recognize signals from the child, or other issues. The child's therapist may need to intervene with the parent, coordinate with the parent's individual therapist, or refer the parent for additional services.

There is a subset of cases in which parents refuse to comply with the court's orders, in therapy or in other areas. For example, the court may have ordered the parents to follow the therapist's protocols for parenting exchanges or school athletic events, and one or both parents may have refused to comply. Where the parent is persisting in behavior that causes stress to the child, such as arguing with the other parent during the child's school events, rapid relief may be appropriate. It may be useful for the court to underscore that its decision is an order and to explain the potential consequences of refusing to comply. Alternatively, the court could issue a specific order restricting the parent's participation in the extracurricular activity until the parent cooperates with the therapist. Such interventions have been effective but may also create strain on an already overburdened court system. In these cases, it may be essential to add another professional to the team, such as a parenting coordinator, who is empowered to make daily decisions. (See Greenberg & Sullivan, 2012.) Where that is not possible, a minor's counsel may be able to bring the child's needs to the attention of the court. In rare circumstances, the therapist may find that the presenting problems cannot be effectively addressed within the therapeutic role and may suggest that either the team be broadened (see Greenberg & Sullivan, 2012) or that the family be referred back for forensic evaluation.

The therapist must keep an open mind as to the reasons for the noncompliance and must make detailed, specific requests of the parents. Specific contracts also provide records as to the therapist's attempts to secure cooperation from the parent. Since treatment contracts are designed to address behavior outside of therapy, this may be helpful in indentifying the subset of parents who will "fake" cooperation in the presence of the therapist but will make no effort to change their behavior in their daily relationships with children (Goldman & Johnston, 2009). For these families, accountability is essential. The child must know that the therapist will follow up on the therapeutic contract and address the disappointment and mistrust that the child feels when an important adult fails to keep a promise. Adjustments to the treatment plan may be necessary to avoid "setting the child up" for repeated disappointments.

Responses to "The Child's Voice"

Recent developments in research and the law have underscored the importance of allowing children appropriate levels of participation in the decisions

that affect their lives. The interventions described in this article are largely focused on creating a situation that empowers children with the ability to cope more effectively, make reasoned decisions, and communicate their feelings effectively.

Difficulties are created when parents or professionals respond too literally to statements from a child, as these may reflect the child's mood, temporary reactions, or deference to the more powerful parent. Children may appear emphatic, decisive, and well-prepared when they are discussing the issue about which they were expecting questions. They may have had long hours of exposure to adult information and language, which adds to an impression of maturity. Children of high-conflict families, however, may be *pseudo*-mature, presenting an adult-like and reasonable appearance when discussing "what they want," but dissolving into tears, regression, and acting-out behavior when the interview is broadened or when an adult asks about contradictory information or ambivalent feelings (Garber, 2011).

This can create a dilemma for the therapist and the court. The privacy and safety of the therapeutic setting may be important for the child, and may be the only place where the child can speak freely. Conversely, and sometimes simultaneously, the child may be relying on the therapist to convey information that the child is unable to express himself/herself. A full discussion of this issue is beyond the scope of this article, but the dilemma is worth noting and considering in treatment plans. In such a situation the court may or may not order limited sharing of information, or may give such control to a minor's attorney. Children and therapists can work toward safe and managed information sharing, when it is necessary to do so.

Inappropriate or Undermining Therapists

Children often benefit most when an expert therapist is appointed early in the case. In many cases, however, the expert therapist is appointed only after a prior therapy has failed or become controversial. For example, it is not uncommon for a conjoint therapist to be appointed after the child has been in individual therapy for an extended period of time and has made little or no progress toward rebuilding his/her relationship with the less preferred parent.

Certain errors are common when inexperienced therapists treat children of distressed families. The child's therapist may have engaged only with one parent, thus biasing treatment. The therapist may believe that his/her role is to support the child's literally expressed desires, rather then focusing on broader developmental goals or complying with the orders of the court. The therapist may ideologically believe that a child should not have to engage with a parent if the child does not wish to do so, that parents should be required to make specific admissions in order to see their children, or that it is appropriate to support the child's avoidance. In other cases, the therapist may be uncertain

as to how to intervene if confronted with intense opposition or dysfunctional behavior from the child. The concept of "supporting the child" is confused with acceding to the child's demands, even if the therapist would not support the child in avoiding school or any other required activities. In such cases, the therapist may align with the parent who disagrees with the court's order, and may undermine the conjoint therapy by supporting dysfunctional behavior in the child.

When the child is involved in both individual and conjoint therapy, it is essential that both therapists consult to coordinate treatment plans. The expert therapist may be able to educate the individual therapist about more appropriate ways to support the child, and about the therapists' obligation to stay consistent with the court's orders. Such a conflict in treatment may require the involvement of another professional, such as a parenting coordinator. In severe cases, it may be necessary for the conjoint therapist to document the refusal of the individual therapist to cooperate and to bring those behaviors to the attention of the parents, coordinating professionals, or the court. In such cases, it may ultimately be healthier for the child to terminate an unhealthy treatment process if it is reinforcing dysfunctional behavior. These issues are discussed in greater detail elsewhere in this issue (Greenberg & Sullivan, 2012).

Attempts to intimidate or remove an appropriate therapist

The converse problem occurs when a therapist conducts appropriate treatment but one or both parents disagree with the therapist. For some highly conflicted parents, neutrality in a child's therapist is intolerable. Such parents have an intense need to have all professionals align with them, both emotionally and in terms of the parent's agenda in the custody conflict. They may apply similarly rigid rules to a child's other relationships, rejecting friends, teachers, coaches, and extended family members who are perceived to be too friendly with the other parent (Sullivan & Kelly, 2001).

A parent may become angry at a therapist for requesting a change in the parent's behavior, setting limits with the child, or expressing anything other than unquestioning support for the parent's agenda. The parent may expose the child to his/her anger at the therapist, undermine the child's trust or cooperation with therapy, and make attempts in the legal arena to have the therapist removed.

It is often tempting for decision makers to remove a child's therapist if one parent does not support the therapy. In most cases, however, it is unwise to remove a child's therapist, or child-centered conjoint therapist, based only on the anger of a parent. Such decisions send a message to the child that the parent's anger is more important than the child's needs and that no relationship is permanent if a parent becomes angry. Moreover, it is the authors' view that therapy can only be effective if the therapist is free to request changes in behavior from a parent and to encourage changes in the child. Therapists

cannot implement these interventions if they fear being removed, or disrupting the child's treatment, because they made statements or requests that a parent disagrees with. Judicial support of treatment is essential in these cases. The addition of a parenting coordinator or minor's counsel may produce a much better result for the child than the removal of an appropriate therapist. (See Greenberg and Sullivan, 2012, for a more detailed discussion of these issues.)

CONCLUSION

Child-centered conjoint therapy is a nontraditional model targeting court-involved families. The model is most effective when supported by specific orders, expectations of parental cooperation, mechanisms for accountability, and parenting structures that allow therapeutic intervention to impact children's everyday experiences with parents. The interventions are designed to assist parents to create rapid behavioral and cognitive changes for their children, and for themselves, and to maximize healthy parent–child relationships. Specific behavioral interventions target immediate solutions with the hope that internalized change will follow. Parents and children are taught skills to strengthen the child's independent growth and assist each parent's adjustment and ability to cope with stress and trauma. Even if parents never achieve what a therapist would describe as "insight," the changes in behavior can provide the opportunity for children to have a healthier future.

The economic fluctuation in court-related resources calls for interventions that promote immediate relief to children and their families, while reducing the need for ongoing litigation. Some families present with complex issues and require treatment over an extended period of time, while others can more quickly adopt changes presented in concrete and behavioral terms. The model is designed to intervene in the family dynamics quickly, to support progress in parenting time and relationships, as consistent with the court's orders. Ultimately, families are encouraged to apply their new skills and may eventually need to consult the therapist less frequently.

The CCCT model cannot be effective with every family. As previously described, the stepwise progression of treatment goals and therapy content allows the therapist to make adjustments based on the demonstrated abilities of the parent and child. For some, only limited resumption of contact may be feasible. For others, it may be possible to achieve a more complete resolution of emotional issues and greater involvement of the parent in the child's life.

An additional strength of the model is the focus on concrete and behavioral issues that can be clearly explained to those outside the mental health professions. Thus, if the family does return to litigation or a custody evaluation is ordered, the therapist may be able to provide specific data that will assist decision makers in making necessary modifications to parenting plans.

The CCCT method should be considered a model in development. While there has been clinical success with its methods, and it is based in the social science literature, controlled studies of its effectiveness have not been possible. As more about the factors that promote children's resilience and families' abilities to resolve problems are discovered, greater refinements will be possible.

ACKNOWLEDGMENTS

The writers would like to thank David Weinstock, J.D., Ph.D.; Ernesto Rey, J.D.; Diane Hull, J.D.; Judge Thomas Trent Lewis; and Christina Caburnay for their invaluable assistance in the preparation of this article.

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