CATCHING THEM BEFORE TOO MUCH DAMAGE IS DONE: EARLY INTERVENTION WITH RESISTANCE-REFUSAL DYNAMICS

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Children often need help before their parents are ready to stop fighting. Children at the center of high-conflict disputes, particularly those who resist contact with a parent, face extraordinary risks of maladjustment. Years of investigation and litigation may precede any meaningful attempt at intervention, based on the questionable belief that all elements of causality (or blame) must be established before any effective treatment can occur. Children's functioning may continue to deteriorate during this time, undermining their future adjustment and reducing the chance of successful intervention later. We illustrate the application of the coping-focused, multisystemic Child Centered Conjoint Therapy model to assisting these families. Methods to assist children without compromising external investigations are discussed.

Key Points for the Family Court Community:

- Children at the center of conflict often exhibit dysfunction early, failing to master developmental tasks or developing other symptoms.
- Trained professionals can identify problem behaviors and intervene early, before problems become entrenched.
- It is not always necessary to conclusively assign blame or the causes of dysfunction in order to assist the child.
- Early intervention allows better integration with the child's natural world and activities.
- With disciplined procedures, effective treatment can occur without tainting or interfering with external investigations or evaluations.

Keywords: *Child Abuse; Child-Centered Conjoint Therapy; Court-Involved Therapy; Domestic Violence; High-Conflict Divorce; Resistance–Refusal Dynamics; Reunification; and Visitation Resistance.*

ADJUSTING OUR THINKING TO FOCUS ON COPING

The risks to children at the center of conflict have been well established in the professional literature, but there is less agreement as to the best way to support or assist families before too much damage is done to children's development. Children at the center of conflict exhibit dysfunctional patterns early, failing to master essential developmental skills or demonstrating regressive or inappropriate behavior (Kelly, 2012). Older children may begin to alter their behavior based on their perception of parents' needs, rather than developing independent relationship skills. Younger children are extremely vulnerable to anxiety or anger in adults or older siblings, and may demonstrate regressive behavior, anxiety, or resistance to parenting transitions. All of these behaviors can be caused by a variety of factors, but are also associated with difficulties in future adjustment. Some children can maintain developmentally appropriate behavior in neutral settings, at least early on, but demonstrate more difficulty when exposed directly to the parenting conflict or subjected to it for a longer period of time. Although behaviorally focused therapies exist in many areas of psychology, the process of litigation may prioritize blame over assisting the child. As described below, the Child-Centered Conjoint Therapy (CCCT) model is designed to provide immediate assistance by supporting essential developmental skills. Even while parents argue about the root cause of the problem, a skilled family therapist or therapeutic team can focus on preventing deterioration and giving the child some opportunity and permission for normative experiences while other issues in the case are pending.

As described by Greenberg and Lebow (2016), there is an expanding research base underscoring the importance of children's development of effective coping abilities, as well as a greater

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appreciation of the variety of venues for supporting these abilities. Other studies underscore common elements in successful outcomes for children of divorce (Dunn, Davies, O'Connor, & Sturgess, 2001; Pedro-Carroll, 2005; Pedro-Carroll, Sandler, & Wolchik, 2005; Sandler, Tein, Mehta, Wolchik, & Ayers, 2000). These include both coping abilities and coping efficacy, as well as access to the normal peer and developmental activities that other children enjoy (Pedro-Carroll, 2005). Coping abilities include, but are not limited to, the ability to differentiate one's own feelings from someone else's, appropriately express independent needs and feelings, regulate emotions, manage distress, recognize danger, know the difference between anxiety or discomfort and danger, ask for help, and form healthy relationships with others.

Critical among these abilities is that the child *actively* engages with others, in an appropriate way, to get his/her needs met. Coping efficacy reflects the child's confidence that, if s/he uses healthy coping skills, someone in the environment will respond. Pedro-Carroll (2005) notes the importance of children having a realistic appraisal of control, recognizing what they can and cannot change and which decisions are ultimately made by adults. Both the general developmental literature and outcome investigations with children of divorce underscore the importance of children having access to the activities that other children enjoy (Johnston, Roseby, & Kuehnle, 2009, pp. 152–153). This is also consistent with literature from other disciplines recognizing the importance of various activities to children's development and management of difficulties in both adults and children (Austin, 2013; Austin, 1982; Moran, Sullivan, & Sullivan, 2015).

For the child's adjustment, these issues are considerably more important than the subjects, such as exact timeshare, that often preoccupy adults. With early intervention, many children can have a respite from dysfunctional family dynamics, develop or maintain healthy social and relationship-building skills, learn healthy coping abilities, and benefit from safer venues for resolving conflict or maintaining connections with a parent.

THE Child-Centered Conjont Therapy (CCCT) MODEL

CCCT (Greenberg, Doi Fick, & Schnider, 2012; Greenberg et al., 2008; Greenberg & Doi Fick, 2005; Greenberg, Gould, Gould-Saltman, & Stahl, 2003) is an adaptive, coping-focused, multisystemic approach useful for children of preschool age and above. Adapted interventions can be done with even younger children, with focus on the parenting behaviors that support development. As described below, the therapist maintains discretion as to who is involved in each session. CCCT is focused on developmental tasks that a child needs to achieve in order to function successfully in future relationships. Drawing on research from developmental and family psychology, recreation therapy, and other disciplines, the approach is designed to consider the full tapestry of a child's activities and relationships as resources for both supporting healthy development and resolving parent–child contact problems. Family discussion of emotionally loaded history may be an ultimate component, but the intervention rarely begins there; rather, the focus is on establishing healthy, pro-social behavior in the child, as well as protection and support for the child's emotional independence. The model is designed to be coordinated by a highly skilled family therapist, or a designated child's therapist, who maintains a systemic approach but a clear focus on the child's independent needs and involves family members as appropriate.

The model is designed to give the therapist flexibility with who attends sessions and the interventions used. Initially, "family therapy" may consist of separate sessions with the therapist serving as a conduit for communication, or conjoint sessions focused on daily issues and skill building. The model provides an opportunity for parents to implement and practice the skills they were taught in psycho-educational settings. Other elements of the intervention may include establishing detailed protocols for management of the child's activities, engaging with other professionals and community resources, and promoting normalization of the child's behavior and experiences. Parent–child relationship issues are addressed in a variety of venues. The model is not limited to within-session

contact and may include interfacing with other systems, phone call or e-mail boosters, or other services. The focus of the model on daily activities and behavior makes it easily adaptable to young children.

Interventions are highly structured. They focus on basic components of emotional development such as identifying and expressing independent feelings, promoting safety and security, establishing boundaries, identifying and making distinctions among family members' perceptions and emotions, encouraging discussion about specific behaviors and problems while shielding the child from the parental conflict, establishing healthy routines, and altering both parents' and children's behavior to promote healthy adjustment in the child. Parents are taught to apply healthier parenting skills and held accountable if they persist in parenting patterns that undermine or cause continued distress to the child or violate therapeutic agreements or court orders. All of these issues can be addressed while focusing on daily issues and coping skills, without interfering with external investigations. Mechanisms for establishing and maintaining accountability are discussed in greater detail below.

As described elsewhere (Greenberg, Doi Fick, & Schnider, 2012; Greenberg et al., 2008; Greenberg & Doi Fick, 2005; Greenberg et al., 2003), the CCCT model was developed with careful attention to relevant ethical codes and professional practice guidelines (American Psychological Association, 2002). Although it preceded the Association of Family and Conciliation Courts (AFCC) Guidelines for Court-Involved Therapy, the procedures in the model are consistent with the Guidelines and designed to limit bias and remain consistent with relevant research. As the model is developmentally based and adaptive, we have found it to be applicable to a variety of issues faced by court-involved families.

Our focus in this article is on the application of the CCCT model to families in which a child resists or refuses contact with a parent, resists transitions between parents, or demonstrates regressive behavior that either or both parents associate with parenting transitions. Our use of the term "resistance-refusal dynamics" is a generic one, referring to a variety of families in which such phenomena are observed. A number of authors have addressed families in which children resist contact with a parent, with or without a reasonable basis for their objections (Fidler, Bala, & Saini, 2012; Kelly & Johnston, 2001; Friedlander & Walters, 2010; Warshak, 2001; Drozd & Olesen, 2004; Garber, 2011). Various authors have described treatment or psychoeducation approaches for families in which these patterns have become established, generally focused on children aged 8 and above (Sullivan, Ward, & Deutsch, 2010; Sullivan & Kelly, 2001; Warshak, 2001; Friedlander & Walters, 2010). Prior to this age, most children do not independently produce hostile narratives about a parent. Nevertheless, as described below, a variety of developmentally regressive and unhealthy coping behaviors may be evident in much younger children. In most children, these issues are more likely to be more amenable to intervention when addressed early. Our focus in this article is on application of CCCT to early intervention with these challenging families.

ADDRESSING A HOLE IN THE CONTINUUM—THE CASE FOR EARLY INTERVENTION

CCCT is designed to assist families who often go unserved or who receive attention too late. Many of these are families who did not sufficiently benefit from group classes for separating parents or from general parenting classes. Some parents resolve global issues (such as general timeshare) through mediation or settlement, but continue to expose their children to instability and conflict regarding daily routines, activities, parenting transitions, rules, and other issues of daily life. While their children remain at psychological risk, these families may not receive further services unless they return to court to resolve a dispute or their children demonstrate emotional or behavioral problems. If the children's behavior violates school rules or laws, it may be treated as a disciplinary issue without addressing the family dynamics causing or maintaining the problem. Older children may be less responsive to treatment or fail to elicit the sympathy of authority figures. This underscores an additional risk of failing to intervene when children are in distress.

In contrast to traditional verbal approaches to therapy, the clear targets in CCCT are coping skills and behavior. As others have written (Sullivan, 2008), parents in the highest-conflict families are more likely to exhibit long-term patterns of acting-out behavior and relationship difficulties (Fidler & Bala, 2010; Sullivan, 2008; Sullivan et al., 2010), and model dysfunctional behavior for their children. 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 (and children) may have violated court orders and normal rules of conduct for extended periods of time without really experiencing any specific consequences for their behavior. For these reasons, professionals may believe that these families cannot benefit from therapeutic help (Johnston, Walters, & Olesen, 2005; Walters & Friedlander, 2010). 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).

The work of Pruett, Cowan, Cowan, and Diamond (2012) underscores both the complexity of this population and the potential benefits of attending to their problems early. Pruett et al. (2012) have developed and demonstrated the effectiveness of time-limited, psychoeducational group interventions aimed at increasing father involvement, reducing restrictive gatekeeping, and facilitating parental cooperation (Austin, 2012). While they describe their intervention as a primary prevention strategy, it offers more services than more limited court-based parenting programs. Chief among them is the engagement of case managers who assist families struggling with other daily issues.

Children who resist contact with a parent may be more likely to come to the attention of the court, as the excluded parent may seek orders to enforce the parenting plan, provide counseling, a child custody evaluation, or an order for some of the more specialized milieu programs that address disrupted relationships. Many of these families are also poorly served, as they may initially be referred to therapy that is not adequately structured or specialized for this situation. Outmoded and often demonstrably ineffective treatment approaches, such as counseling that is limited to the rejected parent and child, are often among the first to be attempted. (This is a common structure when courts order "reunification therapy," but a one-sided approach is rarely successful and may exacerbate the problem.) Traditionally, therapy has often focused exclusively or excessively on issues in the parenting conflict, without adequate attention to the rest of the child's life or other developmental needs. Parents who are in dispute as to the cause of the disrupted relationship may choose to litigate this issue or request extensive evaluations, with children receiving little effective help or intervention for months or years.

When a child has not mastered age-appropriate developmental abilities, this may be quickly apparent to a trained observer. Thus, these types of issues can be addressed with very young children and their parents, and can begin long before a dynamic of restrictive gatekeeping, estrangement, or avoidance becomes truly entrenched in the child. Mastery of these abilities is critical to the child's future, transcending immediate issues in the family conflict. If resistance-refusal dynamics become entrenched, however, the older child or adolescent may begin to exhibit regressed or dysfunctional behavior in front of peers, such as crying, tantrums or rudeness to a parent. The adolescent may then become increasingly socially marginalized, as both peers and other parents react to the inappropriateness of the child's or adolescent's behavior. This, in turn, robs the adolescent of the emotional resources and healthy relationships that s/he may need to achieve successful adjustment and independent relationships.

A core concept in the CCCT model is the recognition that resistance-refusal dynamics, like all of the problems in court-involved families, occur against a broader systemic and developmental background. In addition to the stresses of family conflict, children may have emotional, medical, educational, or behavioral issues that need prompt intervention to avoid a lifetime of disability or dysfunction. In some children, these vulnerabilities exist before the parents separate and are a factor in the separation. In others, these conditions arise independently after the separation or become more visible as stress increases. For example, a child may receive a diagnosis of attention deficit/hyperactivity disorder or a learning disability, which was at a subclinical level while the child was in the early grades but became more disabling as the child entered third grade and the parents separated. Obesity in children may reach a level of clinical concern as a child gets older or in response to a

sudden, marked weight gain or other deterioration. Other children have medical conditions that are unrelated to the parenting conflict but are either neglected or become a focus of conflict once the parents separate. Parents who blame one another for the child's difficulties may fail to focus on assisting the child, advocating for the child's educational needs, cooperating with medical or mental health treatment, or establishing other resources for the child. The child's condition may then deteriorate, and depression or a sense of helplessness may compound the original problems. All of these conditions may reflect a combination of developmental, genetic, psychological, and environmental factors and may need or be responsive to a variety of kinds of intervention.

While judicial determination of some allegations (such as allegations of abuse or danger to the child) must precede therapy *regarding those issues*, families exhibiting resistance-refusal dynamics often present a host of other deficits and problems. Many have trouble maintaining an emotionally stable or healthy environment, access to peer activities and healthy relationships, or the other developmental experiences children need for healthy adjustment. These issues can be addressed without compromising external investigations or evaluations, and addressing them may be crucial for the ultimate health of the family and children. Allowing dysfunctional behaviors to become entrenched through years of litigation and investigation may seriously impair children's functioning, diminishing the chance that any intervention will be successful when a conclusion is finally reached.

Even if it is determined that there is a traumatic history to be resolved, the interventions described herein will provide tools necessary to address those issues. Toward that end, a protective structure is established for therapeutic sessions; children are expected to treat parents with the respect accorded to any adult. Parents are not required to agree with their children's perceptions but are prohibited from any behavior that could be perceived as intimidating or denying children's feelings. Practicing on noncontested or daily issues, both are taught skills for discussing and resolving problems. Specialized resources and parenting materials can also be reviewed and practiced with parents separately, so that expectations are more realistic and time with the child more productive. Moran, Sullivan, and Sullivan (2015) have provided a very useful handbook for parents addressing some of these issues. In the therapeutic context, we have provided these rules to parents in advance and requested that therapists practice with their clients using examples of distressing things that the children might say. These can be tailored to the case, often gleaned from legal documents or the parents' experiences with the child.

REQUIRING DEVELOPMENTALLY APPROPRIATE PARENTING AND DEALING WITH CONFLICTING EXPECTATIONS

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. For example, a 4-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. If the child is capable of walking into his preschool, a birthday party, or his karate class, he is capable of walking into the therapist's office or getting into the other parent's car. These parent–child interactions will provide data regarding the quality of the parenting and the child's responsiveness to each parent's style, which can then form the basis for further intervention.

Particularly in the initial stages, this process may require constantly refocusing the parents on what they can do to help the child, rather than assigning blame for the problem. 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.

This can become an escalating cycle if either parent, or the child, resists opportunities to improve the relationship between the child and the nonpreferred parent. Avoidance is a powerful, if extremely unhealthy coping strategy and in court-involved families there may be an even greater impetus to resist change. Parents may perceive threats to their legal positions or an unwelcome focus on both parents' contribution to problems. Children may have become accustomed to avoiding problems rather than dealing with them and may never have developed the active coping skills that are so critical to development. At least one parent may be indulging the child's regressive or acting-out behavior. The child may be avoiding dealing with his/her 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, it is not uncommon for them to initially attempt to avoid the work, and uncertainty, of change.

The therapist may be able to defuse this issue by focusing on the routines, rules, and structure of each household, exploring this issue with each parent and with the child. Often, children can speak more freely and descriptively about these issues than about the contested issues that are the focus of litigation, and these daily issues are often developmentally critical. Parents are quick to blame one another for children's problems or even for minor variations in behavior. The therapist should work with each parent to realistically review his/her observations while making parenting suggestions to alter the child's behavior and promote healthy development. 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 issues common to conflicted households prior to considering anxiety or trauma as a cause of the child's behavior. For example, the therapist should explore differences in the routines and rules between households, sources of fatigue, practical stressors surrounding bed and mealtimes, or other variables that may lead to tantrum behavior or other distress in the child. In the process, parents may learn to consider a variety of possible explanations for their children's behavior, rather than immediately blaming the other parent. It is also important for parents and children to learn that parents may have different rules or practices on some issues (Smart, 2002), just as different teachers have different rules.

It is helpful to explore messages the child perceives from either parent about the meanings of important concepts 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 around parenting transitions or disputed issues? Does the household differentiate between feelings of anger and inappropriate behavior? Careful and systematic exploration often reveals the enormous cognitive and emotional binds impacting children.

Initial procedures can be adopted around school events or organized activities, where the activity is largely under the direction of a third adult. Organized or externally based activities lend themselves to common expectations. If the less-preferred parent has some deficits, this is an opportunity for him/her to demonstrate that s/he can rise to the occasion, follow others' rules, and avoid embarrassing the child. Activities can also be selected and structured to support the strengths of each parent–child relationship (Austin, 1982, 2013; Moran et al., 2015) with behavioral expectations adjusted according to the parents' and child's abilities. If the preferred parent truly is not undermining the other parent–child relationship, s/he can demonstrate this by supporting these activities, setting clear limits with the child, and intervening promptly if the child demonstrates inappropriate behavior toward the other parent—just as the preferred parent would do if the child behaved that way toward any other adult. The child gains practice in being polite to someone that s/he may not like at the moment, a common skill taught to children, and avoids being marginalized by peers. If the child grumpily acknowledges that the rejected parent "didn't embarrass me *this* time," therapeutic movement has occurred and can be built upon.

A child's conflicted loyalty or a parent's attitude toward the other parent may distort the information that the child provides about his/her time with the other parent. Ultimately, the most successful therapy process will help the child to feel freer to tell each parent about positive time with the other parent, and to express in an appropriate way the child's concerns about each parent. Many parents fall short of these goals, but by establishing behavioral rules that promote these abilities in the child and allow engagement in all aspects of the child's life, communication patterns can be established

that carve out a safer space, at least in external environments, for the child's healthy development. Even if the parent does not share the goal or wish to cooperate, the parent's own attorney, therapist, or consultants may advise that it is both better for the child and better for the parent's ultimate legal position to cooperate with providing some normalcy for the child. Other methods for promoting parental cooperation are detailed below.

This model requires contracting with parents, providing written notes, or confirming by e-mail 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 and orders with the parent, explore the parent's reactions, and document clearly. 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 parents. 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. Ultimately, the therapist may need to rely on the court's underlying orders to promote cooperation in treatment. Components of effective therapy orders/stipulations are extensively discussed in Greenberg, Doi Fick, and Schnider (2012) and the AFCC Guidelines (2011).

ILLUSTRATIVE CASE EXAMPLES

Joe Brown and Patti White are the parents of Janie, age $4\frac{1}{2}$, who is a pre-kindergarten student. They have each presented a video showing the following: Janie was clutched in Mother's arms while Mother carried her to Father's waiting car. Mother's face was close to Janie's as she cried and Mother said, "I know it's scary, Janie, but Daddy is here to pick you up." Father cheerfully greeted Janie but said nothing to Mother, other than, "put her down please Patti." Janie began to cry as Mother said to Father, "I told you she's too scared to go with you. She knows you're still a dangerous alcoholic. Why doesn't anyone listen to me." Father responded with hostility, "You're alienating her. She's fine when she's not around you. This is why I should have custody." The parents continued to execute the exchange for 15 minutes in the same manner while Janie's distress escalated. This occurred 1 day before Father was scheduled to take Janie to perform in a program at her school. Janie is substantially overweight and has delays in gross motor skills, issues which are impeding her participation with peers. Her pediatrician has urged the parents to address these issues immediately by increasing Janie's physical activity and promoting healthier food choices. He suggests structured but noncompetitive programs such as a local kiddie gym. Mother has reluctantly chosen a program, although she believes this issue can wait because Janie is so distressed and dislikes physical activity. Father has chosen a different kiddie gym program with which he thinks Mother should comply. Mother cites this as another reason for Janie's distress at parenting transitions. Father has filed an ex parte motion seeking to have his parenting time extended so that he always transitions Janie to and from school. Mother wants Father's parenting time monitored. Each is seeking sole custody and a custody evaluation has been ordered.

This is a complex scenario, but not really more complex than what we often see in our daily professional practice. Children often present with multiple and overlapping issues that pose risks to their future development, particularly if exacerbated by stress or neglected due to the parenting conflict. While the parents pursue their disagreement about the causes of the problems, the child's deterioration continues. Without intervention, children in these situations may have seriously entrenched problems by the time evaluations or litigation is concluded. Effective intervention is possible without interfering with a custody evaluation, although the family therapist may also generate data that will be useful to understanding the problems.

In this case, the therapist might provide highly structured procedures to facilitate any parenting transitions involving both parents, although it may reduce stress to use natural transitions at neutral settings. For any parenting exchanges that involve both parents, Father may be instructed to wait in the car while Mother facilitates the transition. The level of detail can seem excruciating to the normal observer. For example, Mother might be instructed to (1) help Janie into her car seat; (2) buckle Janie

in; (3) say, "Bye, Janie, have a good time with Dad, and I will see you when you get back"; (4) smile, wave, close the car door, and walk away. Father would be instructed to leave the curb without hesitation while engaging Janie in cheerful conversation. Similar procedures will likely be needed to encourage each parent to support (or at least not undermine) Janie's activities with the other parent. Treatment goals include promoting Janie's independent skills, avoiding more developmental delay, and allowing as many issues as possible to be addressed in community settings with help to strengthen her peer relationships. An early focus on the medical recommendations and Janie's developmental needs may help parents to build some habits for separating medical issues from the conflict, but this is certainly not guaranteed. Either way, the early intervention may delay the need for more medical services and promote success for Janie.

The selection of Janie's activities may gradually include her desires and preferences, particularly if she has a protected space for describing her likes and dislikes, which activities her friends are in, and other child-centered concerns. All of this takes place in the context of developmentally appropriate limits and structure—that is, Janie does not have the choice to avoid exercise entirely, refuse to transition to either parent, or indulge in regressive behavior. Through counseling procedures such as those described below, she could earn the right to have some voice in selecting the activities she participates in. Such procedures also send reassuring messages to children that they do not have to choose between their parents. At best, this provides support for healthier behavior by both parents and support for Janie. At worst, it provides a record of developmentally focused suggestions, which can be used to hold a parent accountable if s/he refuses to cooperate and Janie's behavior worsens.

A developmentally based rapid intervention does not require the parent to agree with the court's order or to change his/her opinion of the other parent; it is intended to bring immediate relief to the child. An anxious parent might also be reminded that specific, conflict-reducing procedures will also help professionals to "see the real problem." Thus, both of Janie's parents can be assured that the therapist is remaining alert for signs of problems in the other parent's relationship with Janie so that assistance can be offered. Each parent's attorney might remind them of the potential consequences of refusing to cooperate with common-sense suggestions such as reducing Janie's distress and supporting recommended activities. Teachers may be helpful in reinforcing "big girl" behavior in Janie, modeling effective behavior for the parents, and giving Janie access to healthy relationships. By reinforcing appropriate behavior across Janie's settings and activities, Janie may be strengthened even if the parents remain in conflict.

Content may emerge in counseling sessions that does not entirely support either parent's perceptions but rather the complexity of Janie's distress, which can then be addressed in a structured way by the family therapist. The parents can also be referred for appropriate services as their deficits become clearer. Rapid change can be promoted with an emphasis on Janie's medical risks, coordination with medical professionals, and the need for cooperation from both parents with uncomfortable behavioral changes.

As the multisystemic plan is created and implemented, the therapist may be able to identify strengths and deficits that inform future service planning. For example, while some parents fail to set limits as part of the parental conflict, others have more general difficulty establishing routines and setting limits with their children. This difficulty may be temporary, if the crisis of divorce forces changes in the household and temporarily overwhelms the parent. Other parents need more general assistance (i.e., a parenting skills class) to better manage their children's behavior. In some cases, the children's behavior has become difficult to manage due to their independent issues, not arising from either parent or the divorce. Parents are often not alert to these factors; therapists should have a systematic process for considering them.

CLINICAL INTERVENTIONS

BUILDING A LANGUAGE OF FEELINGS

Many children and parents in conflicted families are unable to identify or articulate their independent feelings (Johnston , Walters, & Friedlander 2001), or to separate their own feelings from those

of others. Developmentally, these are critical abilities. Many materials are available that expose children to depictions of feelings in daily experiences, matching them to common feeling words. These materials are often used in early childhood education and are not focused on divorce or parenting conflict. The therapist may review these materials with children and ask children to identify occasions when they have had similar feelings. As children describe events about their daily lives, the therapist can help them use the materials to find pictures or words that match their experience. These can later be used in discussions with parents, on content that starts with the mundane and builds in complexity.

Many children of conflicted parents struggle with powerfully ambivalent feelings that either they or their parents are unable to identify or tolerate. It is helpful to both parent and child to use concrete terms to define confusing or conflicting emotional experiences. Nonloaded examples can also be used to teach these skills, and neutral source materials are available for that purpose (often from education outlets). Age-appropriate language with a young child, for example, might include, "I'm having two feelings at the same time. I'm happy to go to Disneyland but sorry to miss my friend's birthday party." With appropriate parental and therapeutic support, this may be expanded to family-centered content, such as, "I'm happy to go camping with Daddy but sad that Mommy will be alone." It should be noted that the ability to tolerate ambivalence is often severely impaired in children of conflict, which impairs their ability to tolerate complex emotions and form healthy relationships. One often finds that children have failed to master emotional abilities characteristic of much younger children, making exploration of these issues a challenging and delicate aspect of therapy.

The focus is on assisting the child to build an independent vocabulary of emotions that hopefully can be shared with parents. Practicing with daily activities, the parent's task is 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 or works with the child to find a more comfortable routine or practice. Even when parents cannot accept ambivalence or achieve higher-level change, children can discuss the issues in their individual sessions, and the skills practiced will be useful to the child in coping with the parents' conflict and in building other relationships.

A TRAUMA-SENSITIVE BUT NONSUGGESTIVE APPROACH

Many high-conflict families arrive amid allegations of trauma, and children may make statements or exhibit behavioral signs that *may* represent trauma. Children may be traumatized by specific events with parents, chronic conflict, perceived threats of abandonment, and/or external events. These issues are often the subject of external investigations and thus may not be specifically discussed in therapy until those investigations are concluded. Nevertheless, this model is designed to be both trauma sensitive and nonsuggestive, as the interventions help build a foundation of coping and communication abilities that will help children address any traumatic issues.

The "language of feelings" intervention supports these abilities, with the therapist maintaining therapeutic objectivity by systematically eliciting the child's perceptions on a variety of nonloaded issues and how various feeling words apply to them (Greenberg et al., 2003; Kent & Doi Fick, 2001). Traumatic memories may be expressed by the child, but are more likely to be understood correctly if grounded in basic skills and everyday experience. Therapeutic knowledge about the effects of trauma 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. These biases may then influence children's perceptions. It is critical to remember that symptoms can have multiple meanings, and if trauma exists, it may be more complex than either parent's perception. Systematic exploration of possibilities is essential. Therapists may need more advanced training to manage these complex cases, and disciplined procedures are also essential. The AFCC Guidelines (2011) outline some of the essential areas of training, which must be combined with a therapist's willingness to constantly question one's own assumptions and explore alternate possibilities.

Children who resist contact with a parent may be unusually direct about raising allegations of trauma with an appointed family therapist or with the nonpreferred parent. To avoid tainting external investigations, therapists may need to acknowledge the importance of the child's feelings but gently redirect the topic to another time or to the professional who has been designated to investigate the allegations. For example, a therapist might say, "That sounds like really important stuff to talk about. But you know, the court has set some rules about what we do, and it sounds like the judge wants (the social worker or evaluator) to be the ones to talk to you about that for now. That doesn't mean we can never talk about it, but for right now it would be good to just get to know each other and give me a chance to catch up on all of the papers they sent me."

The therapist can explore whether there is anything making the child feel unsafe "right now" because the therapist might be able to help with those issues. This could lead to useful discussion of how to make any ordered visitation manageable for the child and also permit the therapist to explore the reasonableness of any fears expressed by the child. Is either parent making inappropriate comments to the child? Is either of them discussing the allegations? Is the child expressing unrealistic fears, such as a concern that a parent's presence at a school concert will somehow cause the child to be unable to sing at the performance? How could the parent do that?

This exploration enables the therapist to focus on techniques that assist the child with stress management and empower the child to enjoy his/her own school performance regardless of what his parents are doing or saying. Along the way, the therapist is reinforcing healthy coping abilities such as a realistic appraisal of control, enhancing the child's independent ability to manage his emotions, and assisting the child to derive support from age appropriate activities. If the child resists discussing any subject other than the allegations, this behavior is noteworthy and hazardous to the child's functioning. The therapist should help the child to engage with child-centered elements of his/her life. The therapist can request healthy messages from both parents that support the child in focusing on activities outside of the parenting conflict and should assist the child with skills for doing so. If the therapist is unable to gain cooperation in this endeavor, it is noteworthy information to be considered in any assessment of the child and family.

In this hypothetical situation, an initial protocol may require the disfavored parent to sit farther away from the child and have no interaction with the child other than a friendly wave and an opportunity to praise the child's performance via subsequent message or at a therapy session. To the degree that the preferred parent is conveying anxiety to the child, such protective structures may reassure both parent and child or demonstrate that the parent's or child's expressed concerns are not realistic. The restricted parent has an opportunity to demonstrate his/her ability to cooperate (or not). As a general rule, these interventions are easier with younger children who may be impacted by adult anxiety or anger, but can be helped to overcome their anxiety with structure and the support of independent adults. (Preschool teachers are often particularly adept at this.) It is often necessary to review the proposed activity in detail with both the preferred parent and the child, discussing each step in the proposed activity, a realistic appraisal of risks and benefits, and specific steps or protocols to manage any anxiety the child expresses. This is best done separately with the parent and child, as their feelings may not be the same.

This approach also allows time to establish an adequate foundation in communication before more emotionally loaded content is discussed. Parents can be taught specific language that empathizes with the child's feelings, avoids denying their memories, and commits to plans for the future that address concerns such as management of anger. Specific discussion of past allegations may need to be delayed, but the child's feelings or fears can be addressed in planning for the child's expected time with the parent. The same skills can be reinforced in discussion of the outside activities that parents are attending and in discussions with the preferred parent.

The preferred parent's task is to support the child in exercising healthy coping skills, including using language to express independent feelings and participating in independent activities as permitted/ordered by the court. This may require setting limits with regressive behavior.

The goal of all of these interventions is to support active coping and continued mastery of developmental skills, so that any trauma that does exist will not be so disabling to the child. When

avoidance becomes entrenched, the child's behavior may more closely resemble a tantrum and should be dealt with as such. Some form of parent accountability, as described below, may be necessary for such interventions to be successful. Detailed, specific plans facilitate this, as specific behaviors are suggested for each parent that the parent either will or will not comply with.

It is worth noting that current research on treatment of trauma emphasizes the use of cognitive-behavioral approaches and other methods that reduce arousal or hyper-reactivity (Silverman et al., 2008) and promote effective coping abilities. This orientation is consistent with the plans suggested above. Careful selection of activities (Austin, 2013) may reinforce these abilities in children (Silverman et al., 2008). Activities such as martial arts, yoga, or other activities that focus on self-control, mindfulness, calming oneself, and breathing may be supportive to any future efforts to treat trauma, without presupposing any conclusions on the issue. Where issues of self-control have been raised, these activities may provide an opportunity for both parent and child to learn and demonstrate skills that address these issues.

Families can also develop signal words that are unusual in everyday conversation but provide a way for a child to tell a parent that s/he 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 use of these words did not alter the parent's behavior or conversation. The child will require explicit permission from parents to allow this intervention to be successful, and therapists can observe whether parents are willing or able to do this credibly. Sessions can focus on whether the tool is being used appropriately or simply to avoid unpleasant tasks—again, a foundation for future work.

We underscore here that these hypothetical interventions are only examples*;* they must be adjusted to the clinical situation at hand and often require that the therapist have advanced training. They are not intended to in any way deny the importance of traumatic events; rather, they are intended to provide options for supporting the child's emotional survival and development without tainting external investigations.

Once the court has made its findings, therapists may need to revisit the process of helping children resolve traumatic memories, discordant perceptions of events, or fears about future contact with their parents. A brief, age-appropriate explanation of the court's findings can begin the shift to comply with adult decisions. Specific procedures for this process are beyond the scope of this article but are described in Greenberg, Doi Fick, and Schnider (2012) and will also be addressed in a future publication.

THE IMPORTANCE OF ACCOUNTABILITY

Effective intervention often requires a backdrop of accountability. In some cases this accountability is indirect, such as when a child custody evaluation is underway and the parents expect that the evaluator will ultimately seek information from the therapist. The court may create the context for treatment by issuing orders about the behavioral changes it wants to see, such as peaceable exchanges, improvement in the child's behavior, the child's access to extracurricular activities with appropriate conduct by parents, attention to a child's educational or medical needs, adherence to the parenting plan, and so on. A therapeutic plan may be a necessary element of those goals (Greenberg et al, 2008). Family court professionals disagree about how specific the court can be in ordering interventions, and jurisdictional differences abound. The involvement of a parenting coordinator and collaborative team is ideal (Greenberg & Sullivan, 2012). Whatever the form of accountability, it is essential that the court clearly convey the expectation that parents cooperate.

Therapists should assist families in establishing 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 promote compliance and reduce stress on the child. For example, if the

parenting plan includes telephonic or Web visits, the therapist should obtain detailed information about how these occur and recommend detailed protocols, including eliminating distractions (Walters & Friedlander, 2010). Detailed follow-up is essential. For example, with appropriate discussion and consent, Web visits can be recorded and reviewed with parents and children. Such recordings may provide a wealth of information and discussion material for the child and parents, reinforcing both appropriate behavior and the ability of the child and parents to discuss their different perceptions of events. Parents' strengths and deficiencies often emerge during these discussions, giving the therapist an opportunity to make appropriate interventions or referrals.

MANAGEMENT OF THERAPEUTIC INFORMATION

Accountability may also be promoted by clarity about the information that therapists may be permitted or required to disclose. Jurisdictions differ markedly in their treatment of these issues, and a full exploration of this issue is beyond the scope of this article. The AFCC Guidelines address this issue in detail, both in the main document and in sample materials, orders, and consents in the appendices. For purposes of the present article, however, it is important to note that the issue need not be binary. As we have emphasized throughout this article, part of the focus in CCCT is for children to learn to express feelings appropriately and for parents to learn to better understand their children's needs. Thus, to the degree that it is safe to do so, parents should be learning more about their children throughout the therapy process. Some therapeutic finesse is required in making these decisions when they are part of a clinical intervention, as parents and children build the skills necessary to listen to one another.

With higher-conflict families or if problems become more entrenched, interventions without accountability are less likely to succeed. Courts (and parents) may have a variety of options available to them, but therapists must also honestly assess whether the structure being established for treatment is adequate to the task they are expected to accomplish. Failed therapy also has consequences for children. It is also important to consider the situations in which children *want* certain information to reach their parents or others with the ability to protect them. When, for example, a therapist will be speaking to an evaluator, children can be given an opportunity to select information that should be shared, as well as to express any concerns they may have about the reaction of their parents when information is disclosed. This also provides the therapist with an opportunity to equip the child with coping skills for these situations.

Each of us has had cases in which (1) no reporting was permitted; (2) disclosure was limited to certain circumstances, such as renewed litigation or the request of a child custody evaluator; (3) we have been required to testify; or (4) reports were limited to overall descriptions of the coping abilities being focused on and/or parents' cooperation and a variety of other scenarios. We have had situations in which parents threaten to file new litigation and demand reports from us, only to change course once we advise them of what we would have to say in such a report. We generally request permission to use our discretion in sharing information with parents or in the type of information shared about the child's statements, to promote treatment goals and avoid surprises.

While it is often assumed that sharing of therapeutic information necessarily involves a breach of trust, we have found that this is often not the case if the issue is managed appropriately. Balancing privacy and accountability is a difficult issue in these cases and is best viewed as an issue to be managed, on an ongoing basis, as part of the therapy.

CLEAR UNDERLYING ORDERS HELP

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, detailed orders addressing 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 work with a therapist to develop detailed protocols for such events. Such structures can also be applied to other parenting activities such as assisting with homework, attending parent–teacher conferences and other common parenting activities. This creates a structure that is less demeaning for the restricted parent and underscores the complexity of the parental role and the variety of ways that parents can support their children. In therapy, therapists can assist parents with skills for asking the child relevant questions and responding to a child's cues and behavior. Interventions that reduce the parent's isolation from the child will facilitate the normal conversations that underlie most important relationships. This is often an essential element of resolving resistance-refusal dynamics.

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 such 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.

Creative use of available options is essential. If a parent cannot attend a school or athletic event, can the other parent be expected to post a video of the event online for the other parent to see? A parent who cannot attend a joint parent–teacher conference may need help asserting his/her need for a separate opportunity to talk to the teacher. Specificity in orders may be necessary to obtain the cooperation necessary for these interventions to succeed, and this is an instance in which managed sharing of therapeutic information may help. For example, a therapist may send an email to both parents summarizing his suggestions for ensuring that a restricted or distant parent can view his son's basketball game online, including the suggestion that the nonrestricted parent videotape the game and make it available on a specified web site, and that the restricted or distant parent view the game within 48 hours and communicate with the child about it. This would not require that the therapist disclose any of the child's statements. Either parent could then use the e-mail as an exhibit, along with whatever verification exists that the other parent did or did not comply. (Web sites such as Our Family Wizard are already set up for this purpose.)

Specificity is also important on issues such as transportation for therapy and activities, parenting transitions, 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 prevent similar 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 may be providing a broader range of therapeutic services than is the case in traditional treatment and that this intervention, while more expensive than "bargain basement" therapy, is hugely less expensive than extensive evaluations or litigation. Detailed discussion of therapy consents and orders can be found in Greenberg, Doi Fick, and Schnider (2012) and the AFCC Guidelines for Court-Involved Therap*y*.

Legal professionals disagree about what courts can directly order parents to do versus encouraging their cooperation or signing stipulations arrived at through mediation or other processes. The time pressures on judicial officers may also result in them settling what are perceived to be the "big" issues and leaving the therapist to sort out the rest. While a full exploration of the obstacles and possibilities is beyond the scope of this article, we would observe that a number of commonly used tools, legal strategies, and standard orders could be adapted to address many of the types of accountability required by this model. Forms can be developed that list common elements seen in conflicting families, so that mediators, attorneys or hearing officers can check and/or modify relevant orders for each

family. Many of the elements in these orders may appear to be minutiae to the busy hearing officer and may ultimately need modification as therapy progresses. The involvement of a parenting coordinator and collaborative team (Greenberg & Sullivan, 2012) is an ideal and sometimes necessary solution, but not available to all families.

CONCLUSION

CCCT is a systemic, coping-focused, trauma-sensitive model targeting court-involved families. The model is most effective when supported by expectations of parental cooperation, mechanisms for accountability, parenting structures, and specific orders that allow therapeutic intervention to impact children's everyday experiences. In this article, our focus has been on application of the model to resistance-refusal dynamics or the deteriorations in the child's emotional development that precede them. The interventions are designed to facilitate the child's healthy engagement in daily activities and independent relationships, promoting the coping and emotional abilities critical to successful adjustment. Specific behavioral interventions target immediate solutions, with hope that internalized change *may* follow, but the child will be exposed to or learn different coping responses regardless. 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 financial challenges facing family courts, and the risks of delayed intervention, underscore the need for interventions that promote immediate relief to children and families while hopefully reducing the need for ongoing litigation. Just as critically, CCCT is designed to address the variety of systems and activities that interact with families. In families, many activities happen simultaneously. Emotional challenges and developmental tasks do not necessarily arise in a carefully defined sequence. Both challenges and opportunities arise for children as part of the family's daily life, impacted by the parental conflict and other factors related to the litigation. If intervention occurs early enough, available community resources and professionals (i.e., school events, recreational activities, and other professionals involved with the child) may still be available to the child and supportive to treatment. This enhances the relevance of therapy to the child's daily life and may ultimately both enhance benefits and reduce costs.

CCCT will not be effective with every family. Therapy procedures and goals must be adapted to the individual family. Parents who represent a danger to their children may always be limited in their time with the child, and appropriately so. Other parents will never be able to truly tolerate a child's engagement with the other parent. The aim is to promote sufficient emotional and coping abilities to support the child in resolving issues to the degree possible with parents, while engaging in healthy relationships outside of the family.

An additional strength of the model is the focus on concrete and behavioral issues that are understandable 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. Some of the relevant data will also emerge in nonprivileged settings, such as the child's activities, which may allow relevant information to emerge without compromising the child's privacy.

CCCT should be considered an evidence-informed model. While there has been clinical success with its methods and it is based in the social science literature, controlled studies of its effectiveness as a unit have not been possible.

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