Effective Intervention With High-Conflict Families:

How Judges Can Promote and Recognize Competent Treatment In Family Court

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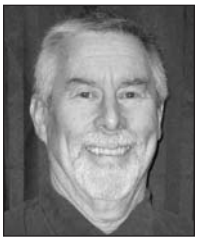

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The emotional and psychological risks to children resulting from conflicted custody disputes and the varied needs of separated families have led to the increased involvement of mental health professionals in child custody cases. The practices of mental health professionals providing court-related treatment may have a substantial impact on the reliability and relevance of their professional opinions, the effectiveness of services provided to children and families, and children's development and adjustment. This impact emphasizes the need for judicial officers and attorneys to understand the ethical and professional standards that support competent treatment and intervention services in the forensic arena.[1]

As the involvement of mental health professionals becomes more common in child custody cases, judicial officers will increasingly be called upon to determine the scope, focus, and adequacy of court-related treatment services. There are important differences among professional roles in the scope of services provided, the limitations on appropriate opinion testimony, and accepted professional practices. Individual practitioners also differ in their professional philosophies and methods. We would argue, however, that just as professional organizations have established practice standards that apply to all of their members, it is possible to identify a core set of concepts that characterize high-quality treatment services in child custody cases.

Recent publications[2] argue that the work of child custody evaluators should be consistent with current ethical standards, professional practice guidelines, clinical and scientific research and theory, and the legal standards governing the relevant jurisdiction. Several professional organizations have established guidelines and standards for child custody evaluations, but few such standards exist for treatment in the context of the court. An emerging literature is developing in this area. Greenberg and Gould, as well as Greenberg, Gould, Gould-Saltman, and Stahl,[3] have advanced the position that many of the guidelines and standards applied to custody evaluators are also relevant to the work of other psychologists providing services to court-involved families.

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The emotional and psychological risks to children of high-conflict divorce have led to the increased involvement of treating mental health professionals in child custody cases. A variety of intervention and service models have been developed to assist families in negotiating the family transition successfully and supporting children's needs. Competent mental health professionals may help children to learn effective coping skills and help parents to reduce conflict and support their children's needs. Conversely, inappropriate mental health practice can foment conflict, undermine children's development, and contaminate the data considered by the child custody evaluator or the court. This paper will provide a framework that judicial officers and counsel may find useful in structuring orders for court-related treatment and assessing the competency and appropriateness of services provided. ■

PROBLEMS AND NEEDS

This section contains three subsections describing problems involved in child custody cases. The first subsection briefly reviews the behavioral science literature pertaining to the psychological risks to children involved in contested custody cases. The second subsection discusses the need to teach children coping skills that will enable them to better handle their parents' conflicted divorce and to avoid being caught in the middle. The final subsection briefly discusses the financial barriers to effective treatment in families of divorce.

RISKS TO CHILDREN OF CONFLICTED CUSTODY DISPUTES

Children who are exposed to conflicted divorce may be at risk for a variety of psychological difficulties, both at the time of the divorce and as they grow older.[4] While the factors influencing children's adjustment are complex, children generally have better outcomes if they (1) are able to develop and maintain quality relationships with both parents, including regular contact; (2) are not exposed to severe emotional disturbance in one or both parents; (3) are not placed in the middle of the parental conflict; and (4) learn to use direct, active coping skills to resolve relationship problems. Children who rely on avoidance or suppression of emotions tend to display less satisfactory adjustment than children who are able to face their problems and emotions and to cope with them.[5] Children who are directly exposed to parental conflict, particularly if they are placed in the middle of that conflict, are particularly vulnerable to both short- and long-term emotional difficulties.[6] Children who do not learn appropriate methods of resolving relationship problems may be at risk for serious emotional difficulties as they grow older.[7]

Conflict, and the child's exposure to that conflict, can be direct and obvious or subtle and covert. Kelly notes that a child caught in the middle of the parents' dispute may witness parental arguments, be asked to carry hostile messages to the other parent, or be asked to spy on the other parent.[8] Examples of subtle and inappropriate parent behavior include (1) responding to most of a child's statements but failing to respond to positive statements about the other parent; (2) showing overt distress when the child takes a toy to the other parent's home; (3) anxiously questioning a child about his or her time with the other parent; and (4) refusing to speak to the other parent when he or she telephones to speak with the child. Such parents expose the child to the parental conflict just as much as those who engage in more overt behaviors. Both subtle and overt parental conflict conveys important messages to the child and may suggest that a parent is unable or unwilling to tolerate the child's relationship with the other parent. In extreme cases, the parent's hostility may be expanded to include extended-family members and friends who do not support the hostile parent's agenda.[9]

Children who are exposed to these behaviors may learn to keep things to themselves and to rely on problematic coping skills such as suppressing their

emotions or developing psychosomatic symptoms, avoidance, and regressive symptoms like throwing tantrums. They may feel compelled to choose between their parents or others they love and may produce statements that they believe will ease the distress of the parent who is unable to tolerate the other parent-child relationship.[10]

While in some respects subtle parental behaviors may cause less distress to a child than being in the middle of a violent argument, in other respects the subtle behavior may be just as distressing. The child who witnesses an adult argument often knows what he saw and why it upset him. A child exposed to parental conflict via more subtle behaviors may demonstrate the anxiety and conflicted feelings that come with involvement in the parental dispute without being as readily able to identify the source of those feelings.

Most children eventually achieve adequate adjustment in the years following their parents' divorce.[11] Even for children who cope effectively, however, the emotional cost is often high.[12] During and following a divorce, both children and parents often experience greater stress, depression, conflict in relationships, changes in familiar routines, and feelings of loneliness. Parents may be more preoccupied with their own emotional issues, less attentive to their children and less effective and consistent in their parenting.

As a result of the conflict they sense at home, children may feel pressured to assume more family responsibility and may feel responsible for the emotional or physical well-being of parents or siblings. They may experience disruption in their living situations, school placements, and peer relationships and become caught between their independent feelings and conflicting loyalties to their parents. Parents may directly or indirectly encourage children to avoid contact with the other parent rather than resolving issues in the parent-child relationship. Older children may feel pressured to care for one or both parents' emotional needs, in the process subordinating their independent feelings and their developmental need to establish emotional independence. These children may be at particular risk for emotional distress and problems in future relationships.[13] For all these reasons, it may be useful for the court to consider appointing a forensically sophisticated mental health professional to assist the child.[14]

When selecting a court-appointed therapist, judicial officers may wish to consider the treatment focus of the therapist as a critical factor in their decision. Not all treatment approaches are effective in helping children learn to effectively cope with their parents' divorce and subsequent conflict and distress. Recent years have seen an explosion of psychological research on children's adjustment to divorce, their ability to cope with traumatic events, and the coping skills they need for successful adjustment. There has also been increased empirical attention to the efficacy of coping-skills treatment as a focus of appropriate, cost-effective treatment for children at the center of conflicted custody disputes.

THE IMPORTANCE OF HEALTHY COPING SKILLS

While research is still emerging in many areas, numerous studies have identified essential coping abilities that children need to adjust successfully. Generally, children and adults who learn to use active and direct coping methods (e.g., asking for help, asserting their independent needs, resolving issues directly with their parents) more successfully adapt than those who rely on dysfunctional coping methods such as suppressing emotions or avoiding problem situations.[15] To establish healthy relationships as adolescents and adults, children must learn to (1) rely on their independent experiences to make decisions about relationships; (2) assert their independent feelings; and (3) effectively communicate their needs in a manner that is likely to be recognized and understood by others in their environment. Generally, this requires that children critically examine information that is presented to them and use direct, clear, verbal communication to express their needs and feelings. As described above, children need to develop these skills at a time when parents are often coping less effectively and may be modeling dysfunctional coping mechanisms or

encouraging them in their children. Therapeutic intervention stressing the development of coping skills may be essential in such families for children to achieve successful adjustment.[16]

Some psychotherapists use treatment models focused only on encouraging the child's self-expression. Such methods can range from encouraging a child to directly talk about his or her feelings to encouraging and interpreting indirect expressions such as drawings or play. Many children's therapists make play materials available to children as part of the therapy process, to help them feel more comfortable talking with the therapist.

The use of play as an "ice breaker" or adjunct to verbal therapy is a well-accepted therapeutic technique and should be differentiated from methods that rely on subjective interpretations of children's play or drawings. The latter techniques present risk even for children in intact families, as they are very vulnerable to suggestion and errors of interpretation by the therapist. The risks of such errors increase exponentially when a child is at the center of a custody conflict, as the child is increasingly likely to be exposed to parents' emotional issues, distorted perceptions, and other external information that may influence the child's perceptions. These effects may or may not be evident to the therapist, who may unwittingly compound the problem by engaging in suggestive questioning or interpretations based on one parent's concerns.

Moreover, techniques such as play therapy are likely to be less effective than other techniques in helping children learn effective coping skills following their parents' divorce. Recent research also suggests that play therapy may be even less effective for traumatized children, particularly those who have significant behavioral problems or troubled relationships.[17] Treatment approaches that focus on direct communication and active coping are more likely to promote these skills than indirect approaches such as play therapy.

FINANCIAL RESOURCES

Strained financial resources often limit the family's ability to obtain mental health services during and after divorce. Many families suffer economic hardship after divorce.[18] The costs of dividing households, litigation, increased child care, and forensic evaluations often consume family resources. Even families who have insurance for mental health services often encounter severe limitations in choice of provider and scope of service coverage. Some insurance plans disallow coverage for all court-related services, while others deny payment for the many outside-session services (e.g., telephone consultations, faxes, reports, conference calls) that are often requested of therapists in court-involved cases. Many providers share a concern that managed care or other insurance programs will not cover services the court considers necessary. As a result of these issues and reduced reimbursement rates, many of the most qualified therapists have discontinued their participation in insurance panels.

But though treatment services can be expensive, high-quality treatment may be a more cost-effective intervention than continued litigation. Indeed, with proper allocation of resources, high-quality treatment services may be within reach for many families. Many insurance programs offer an out-of-network benefit that provides some coverage for the services of providers who are not on the insurance panel. When a therapist familiar with the court context provides intervention services consistent with available research, this intervention may help parents to reduce conflict, support children's needs, and resolve disagreements without resorting to litigation.

Courts can also maximize resources by appointing a forensically sophisticated therapist to fill a child-centered role (e.g., to provide the child's treatment or child-centered conjoint or family therapy) and by allowing the therapist to confer with other therapists about the case. This coordination of treatment may promote more effective intervention and assist less-experienced therapists in understanding the court context and working to reduce parental conflict. Even when the parental conflict continues, a forensi-

cally sophisticated therapist may be able to assist children in learning healthy coping skills and adjusting successfully as they mature. If successful, therapeutic intervention may be an investment that reduces both the emotional and financial costs of the divorce. As discussed near the end of this article, a judicial officer has the authority to order treatment and make other appropriate orders.

ASSESSING THE QUALITY OF TREATMENT AND THERAPIST INFORMATION

Among the most critical decisions judicial officers face in adjudicating child custody is the appointment of a therapist for the child and the determination whether ongoing treatment should continue. Although many mental health professionals work with divorcing families, far fewer are familiar with court-related treatment. Less-experienced therapists unfamiliar with the court context also may not follow current research relevant to effective treatment of children at the center of custody disputes. Therefore, this section describes how to assess the quality of treatment for children of conflicted families of divorce.

CRITICAL EVALUATION OF DECLARATIONS

In many cases, a judicial officer's first exposure to a child's therapist is the declaration prepared by the therapist and attached to legal documents submitted by one of the parties. There is a natural temptation to give the declaration considerable weight both because of the therapist's professional status and because it refers to data coming directly from the child. The declaration, however, may not be useful to the court.

A declaration is useful to the court when the therapist has sought information from both parents, has explored multiple possibilities regarding a child's behavior, has not inappropriately aligned with one parent over the other, and has supported the child's independent needs over the agenda of either parent. Awareness of a therapist's methods is critically important in evaluating a declaration: the therapist may employ procedures that are likely to introduce bias into treatment or that are inappropriate to court-related treatment or the therapist's role. For example, a therapist who seeks information from only one parent or considers only one parent's concerns in exploring issues with the child and interpreting the child's behavior may well be providing unreliable or distorted information. If judicial officers rely on the opinions of therapists using faulty procedures, serious harm to children and families may result.

Moreover, a biased therapist may undermine a child's progress by basing treatment on the needs of the therapy-involved parent rather than on the child's independent needs. It is essential, therefore, that judicial officers critically evaluate the performance of the therapist, any testimony or documentation provided by the therapist, and the source and nature of the data contributing to the therapist's opinions on causation and treatment. While these issues are often addressed if the court orders a full child custody evaluation, the judicial officer may also need to consider them when deciding how much weight to give to a therapist's opinion or information, whether to order an evaluation, or even whether ongoing treatment should continue. In some circumstances, a judicial officer may determine that treatment is essential, but that the child should be transitioned to a different therapist. These issues are discussed in greater detail later in this article. Below are some criteria that may help judicial officers in determining the appropriateness of treatment services and the value of therapists' declarations or statements.

APPRECIATION OF THE COURT CONTEXT: THE PROBLEM WITH MERGING TRADITIONAL AND FORENSIC PRACTICE MODELS

Many psychotherapists are unprepared for the impact that ongoing custody litigation may have on treatment. Traditional psychological training often

does not include the special issues that must be considered in providing court-related treatment.[19] Historically, training in psychotherapy has focused on the building of an effective alliance with the client (or, by extension, with the parent who brings a child to treatment) and assisting the client in coping better with daily stresses or emotional issues. Implicit in this process is the assumption that the client will be motivated to provide as much accurate information to the therapist as possible to enhance the therapist's ability to assist the client. A therapist may assume that his or her client has made a voluntary choice to enter treatment and that the existence of the psychotherapist-patient privilege will promote honest sharing of information with the therapist. Many therapists believe that their role is to accept, support, and advocate for their clients' needs. This orientation promotes a supportive atmosphere but may also lead therapists to be reluctant to challenge a client's assumptions, interpretations, or dysfunctional behaviors.

Many of the assumptions that underlie traditional psychotherapy cannot be extended to treatment in a forensic case. In treatment ordered by the court or motivated by the client's involvement in litigation, some or all of the elements of voluntary participation have been removed. In this context the parent may (intentionally or otherwise) alter or distort information presented to his or her personal therapist or to the child's therapist, in the hope of persuading the therapist to support the parent's position in the custody conflict. Parents may hope or expect that the therapist will advocate the parent's position in communications with a child custody evaluator or the court. The parent's participation in treatment, or cooperation with the child's therapist, may in part be contingent on the therapist's willingness to support the parent's position. A therapist who is inexperienced with court cases may uncritically accept information provided by a client or parent, failing to consider potential sources of bias and the degree to which the information may be affected by the dynamics of the custody conflict.

Specifically, when information comes directly from a child, it can appear to be genuine and may be extraordinarily persuasive. Often, however, children's perceptions, feelings, and statements are profoundly influenced by their exposure to the custody conflict. This can occur by means of direct pressure on a child to make specific statements to the therapist, indirect or direct exposure of the child to adult information and concerns, or the child's response to a parent's emotional needs.[20] For example, children's behavior may differ markedly depending on which parent transports the child to treatment and the circumstances preceding the session (e.g., whether the child is transported directly to the therapist's office after a day at school or spends extended time in the company of a parent prior to attending the session).

It should be noted that, while it is important for a therapist to maintain an alliance with his or her client even in the context of court-ordered treatment, both parents and children may be ill served by a therapist who is reluctant to challenge dysfunctional behaviors or one-sided interpretations of another's behavior.[21] A therapist's failure to challenge such behavior in a parent may lead to negative consequences both in terms of the child's development and the parent's custody or visitation if a parent fails to address behavior problems identified by a psychological evaluator or the court.

As most parents know, children must be challenged to use age-appropriate coping skills rather than relying on regressive behavior such as crying, avoidance, or suppression of emotion. Particularly if a parent is failing to set limits with a child's inappropriate behavior, the therapist's role may be critically important in supporting a child's coping abilities.[22]

Therapists providing court-related treatment must, therefore, understand and be able to articulate the manner in which the ongoing litigation may affect the treatment process and the information provided to the therapist by a parent or child. This requires that the therapist be aware of research on children's adjustment to divorce, the impact of high-conflict dynamics on the child, and research regarding children's suggestibility and susceptibility to external

influence. It also requires that the therapist maintain professional objectivity and an awareness of potential sources of bias in treatment information.[23]

BALANCE AND THE SCIENTIFIC MINDSET

One of the hallmarks of competent court-related treatment is the therapist's ability to maintain professional objectivity and a balanced perspective. Since the information a therapist receives is often biased by the adult client's agenda or the influence of a parent on a child, the therapist must follow appropriate procedures to remain objective. When a child is in treatment, such procedures include soliciting information from both parents, involving both parents in treatment, and actively considering a variety of possible interpretations of the child's problems and needs.

Sources of Therapeutic Bias

Merriam-Webster's Collegiate Dictionary defines *bias* as "systematic error introduced into sampling or testing by selecting or encouraging one outcome or answer over others."[24] Most human beings have biases based on their own personal experiences, and these can be particularly powerful (and are often unrecognized) when one is dealing with a child's welfare. The forensically sophisticated child's therapist has an obligation to maintain thought processes and use procedures specifically designed to control (or at least illuminate) potential sources of bias. These processes and procedures would include (1) actively considering a variety of possible interpretations of a child's situation and needs and (2) using procedures, including active attempts to access information consistent with a variety of points of view, specifically designed to explore these various possibilities.

Bias can develop in a variety of ways. As discussed earlier, therapists who, in treating children, involve only one parent risk developing a bias that is shaped by that parent's perspective or by the unseen influence of the therapy-involved parent on the child. Such bias may be difficult to detect, particularly in the face of the (often emphatic) concerns of the therapy-involved parent and the symptomatic behavior of the child.

The development of biases is complex and often involves both personal and professional influences. Personal admiration for a colleague may lead a professional to consult and cite only those materials that support the colleague's position. Personal experiences with one's parents, one's spouse, or one's extended family can create perspectives on family life that evidence in the professional literature cannot alter. A practitioner may inappropriately apply professional knowledge developed through experience in a particular area of practice when he or she becomes involved in a different practice area. Similarly, experience gained in work with a particular patient population may be misapplied to an entirely different patient population, resulting in serious errors.

Certain types of bias are particularly problematic in work with high-conflict families. Some of these are general; others are case-specific. An example of a general bias is the tendency not to question statements made by children and to assume their essential accuracy without considering alternative interpretations. Case-specific biases most often occur when only one parent is involved in a child's treatment. In such situations, the unseen influence of the therapy-involved parent upon the child can affect the child's view of dynamics in the family and, as a result, the information that the child gives to the therapist. Any bias that develops may be strengthened when the therapist meets periodically with the therapy-involved parent without seeking information from the other parent or from others who may be involved with the child. Unfortunately, therapists whose perspectives have been shaped by such dynamics are often unaware that they have failed to obtain all pertinent information before formulating treatment plans. Many of these issues are discussed in greater detail below.

Effects of Bias

Therapeutic bias may have both direct and indirect effects on the child. A therapist who relies on one-

sided or distorted information, without exploring alternatives, may unwittingly collude with the therapy-involved parent's agenda by exploring only that parent's concerns and reinforcing avoidance and distorted thinking in the child.[25] It is not uncommon, for example, for a child to express concerns about what occurs during his time with one parent or the other. When only one parent is involved in the child's treatment, the presented concerns often revolve around the child's time with the non-therapy-involved parent. Such concerns may reflect actual difficulties in the child's relationship with the non-therapy-involved parent, the concerns of the therapy-involved parent, the child's anxiety about being in the middle of the parental conflict, and any number of other issues.

An inexperienced therapist may simply accept the child's statements at face value, assuming that there is difficulty in the child's relationship with the non-therapy-involved parent, without seeking that parent's view of the situation. Bias increases as the therapist asks the child questions based only on the assumption that there is a problem in the relationship with the non-therapy-involved parent, inadvertently solicits information that only supports this hypothesis, approaches the non-therapy-involved parent in a judgmental manner, formulates opinions concerning a parent-child relationship that the therapist has never observed, or reinforces avoidance by suggesting that the child should not be required to spend time with the parent. If the therapist provides such flawed information to the court and the court relies on it, the result may be damaging and long-lasting.

Even if the therapist never communicates to the court, a biased treatment process may cause serious harm to a child and family. This occurs when the therapist reinforces a distorted view of the child's world and each parent's role based on the one-sided view of the therapy-involved parent. Rather than encouraging the child to independently test his own perceptions against those of his parents and resolve issues directly, the therapist reinforces distorted thinking and poor coping skills, such as avoidance and regressive behavior. In the process, the therapist sends a subtle but powerful message that the therapist's theory, rather than the child's independent perceptions, define the child's world, and that it is acceptable for the child to run away from problem situations instead of learning to deal with them. This can seriously undermine a child's ability to cope effectively with his environment and confidently establish independent relationships, even if the therapist never submits a declaration to the court.

Containing Bias

Many sources of bias can be contained, or at least assessed, if a therapist makes active attempts to obtain information from both parents, to consider each parent's concerns, and, ideally, to observe the child after he or she has been in the company of each parent. If a parent is unwilling or unable to participate, a therapist may be able to obtain some "reality check" on the therapy-involved parent's or child's information by periodically conferring with the child's teacher or other professionals involved in the case.[26] The purpose of these contacts should be limited to obtaining information that may assist the therapist in enhancing the child's functioning. This limited scope is in contrast to the breadth of the wide-ranging collateral interviews conducted by the forensic evaluator, which are used to address broad psycholegal issues being considered by the court. Nevertheless, such contacts may be of assistance to the therapist in maintaining professional objectivity and avoiding biased treatment.[27]

The essential characteristic of the scientific mindset is the therapist's ability to articulate and consider several possible interpretations of a child's behavior, as well as a variety of possible causes of the child's difficulties. This "multiple-hypotheses" approach promotes objectivity by encouraging the therapist to actively explore interpretations of the child's behavior and areas of the child's functioning in addition to those that may be presented by the therapy-involved parent.

Although a child's expressed concerns should never be ignored, one of the hypotheses that the

therapist must consider is that the child's exposure to the custody conflict has altered his or her perceptions. Consider, for example, the common child-care activity of bathing a young child. While in nonconflict families this may be an event in which both parents normally participate, after a separation a parent may suddenly view it with anxiety. If the parent sees it this way, he or she may convey that to the child, who may then present the event with anxiety to the therapist, or even approach the bath itself with more anxiety. This may interact with other issues, such as the parent being less adept than the other parent at bathing the child and becoming even clumsier in response to the child's anxiety. A therapist who perceives the anxiety but doesn't consider these factors may assume that something inappropriate happened during the bath. While this certainly could be one possibility, another is that the child's perception of the bath changed, before or after the event, by exposure to the parent's anxiety. An open-minded therapist is more likely to accurately identify the issues involved in such a situation and to assist the child in articulating concerns to the parent involved.

A child's therapist should be able to articulate the attempts that he or she has made to maintain a balanced perspective and promote active coping, as well as identify the potential biases in treatment information that may result if such procedures are not followed. Although a parent's therapist is necessarily biased, even this therapist should be able to articulate (and, it is hoped, explore with the parent) possible interpretations of events that may not be consistent with the parent's expressed view. Otherwise, the therapist is likely to miss issues in his or her own client's functioning that may ultimately have a marked effect on the child and, potentially, the outcome of the custody conflict.

KNOWLEDGE OF THE RESEARCH

Related to the issue of the scientific mindset is the need for thorough and balanced understanding of psychological research relevant to treatment. Forensically sophisticated therapists should be thoroughly familiar with research on children's adjustment to divorce, the impact of adult conflict on children, children's suggestibility, domestic violence, child abuse, alienation dynamics, and children's coping and development. This research has taught us much about children's needs and responses when they are at the center of a family conflict. The treating expert[28] must also be able to recognize the limitations of psychological research and to apply the most appropriate research to the case at hand.[29] Few mental health professionals would deny that psychological treatment is as much "art" as science. Competent court-related treatment, however, requires that knowledge of research and theory inform clinical intervention. Clinical judgment cannot stand alone any more than scientific findings can be useful without context.

Professional objectivity also requires a balanced consideration of relevant research. Many of the psychological phenomena related to divorce are complex, and research results may often appear to be conflicting. While studies do sometimes demonstrate inconsistent results, more frequently results that appear inconsistent actually reflect differences in the procedures of the study. For example, some studies on children's suggestibility have employed procedures that emphasize the strengths of children's recollections, while others shed light on their vulnerabilities to suggestive influence. Which of these studies is most relevant to a particular case depends on the conditions to which the child has been exposed. Even a young child may be able to remember and report events accurately if he or she has not been exposed to adult information or suggestive questioning. In contrast, a child who is exposed to negative information about a parent, information about the custody conflict, or repeated questioning about time spent with the other parent may have serious difficulty differentiating between his or her independent experience and externally presented information.[30]

Particularly when there are allegations of child sexual abuse, family violence, or other forms of child maltreatment, or when parent-child relationships are undermined, the therapist's understanding and familiarity with research conducted from a variety of

perspectives are critically important. This approach stands in marked contrast to that of therapists who consider only research supporting a single perspective. Biased consideration of the research leaves therapists ill equipped to consider which research is applicable to a given case because they are not considering the full range of studies that may be relevant. These therapists may dismiss research that does not support their own perspectives without objectively considering whether the circumstances of those studies are applicable to the case at hand. Their preexisting bias may influence both their perceptions of treatment information and the therapeutic issues that they choose to address.

In contrast, the forensically informed therapist acknowledges the limitations of any research upon which he or she relies, as well as any mixed or inconsistent results that are present in the literature. The therapist should be able to describe the research that he or she believes is applicable to the case at hand and to explain why other studies with inconsistent results are less applicable. If the therapist cannot describe research that supports viewpoints other than his or her own, it is likely that a biased consideration of the literature has influenced the therapist's perspective.[31]

RESPECT FOR ROLE BOUNDARIES AND THE LIMITS OF APPROPRIATE OPINION

The essential characteristic of the treating psychologist's role, as distinguished from that of the child custody evaluator, is that the psychologist's goal is intervention. The child custody evaluator has a time-limited role and considers a broad range of information to address questions posed by the court. The treating psychologist's focus is narrower, more intimate, and more longitudinal than that of the child custody evaluator. The therapist guides interventions in support of the child's developmental needs, using treatment information to confront dysfunctional behavior, make suggestions, provide support, and persuade or exhort parents and children to cope more effectively. The process of therapy provides a depth and richness of information that may be essential to helping a child or family master developmental challenges; it is also an important part of the information considered by the child custody evaluator.

Treating psychologists should be well qualified to render expert clinical opinions on a client's diagnosis, behavior patterns observed in treatment, a child's progress toward developing healthy coping skills, changes in each parent-child relationship that would be supportive to the child, and other issues.[32] In addition, a therapist should be able to articulate the underlying basis for any opinions expressed, with sufficient specificity to allow a child custody evaluator or the court to assess the validity of his or her statements.

Consistent with the scientific mindset described earlier, the therapist should also be able to identify the limitations of opinions expressed and the treatment data underlying those opinions. Treating therapists do not have the appropriate role, focus, or information base to render opinions on psycholegal issues such as parental capacity, custody arrangements, or conclusive opinions on the validity of an abuse allegation. In light of these and other issues, a therapist who expresses a psycholegal opinion may cause harm to a child or family by providing misleading information to the court. For this reason, it is generally considered unethical for a treating therapist to offer these opinions.

WHEN SHOULD A THERAPIST BE REMOVED?

Another difficult issue arises when a party asks the court to remove a therapist who has been working with a child. This can be a complex issue, in that children at the center of custody disputes often suffer repeated disruptions in significant relationships. Some high-conflict parents have difficulty tolerating the child's relationship with anyone who does not support the parent's agenda, a position that is necessarily inconsistent with that of the child's therapist who supports a child's independent needs. An angry parent may refuse to cooperate with treatment in the

hope that the court will remove the child's therapist and replace him or her with someone who is more supportive of the parent's position. Removing a child's therapist in this circumstance may be very damaging to the child, as it may send the message that the parent's anger or manipulation of the system are given greater weight than the child's progress in treatment or working relationship with the therapist. It also undermines the child's security in relationships by conveying the message that when a parent gets angry, the child's independent relationships may disappear.

Conversely, as described earlier, the continuation of biased or inappropriate psychotherapy may cause serious harm to a child and family. Biased treatment may undermine a child's independence, foment conflict, reinforce avoidance or other dysfunctional coping mechanisms, or generate distorted information that may seriously undermine the judicial process. Moreover, the detrimental effects of inappropriate treatment are likely to increase over time as conflict becomes entrenched and biased treatment techniques undermine a child's independent perceptions.

For all these reasons it is often more harmful to continue inappropriate treatment than to allow a therapeutic transition to a more objective therapist who can support a child's independent needs. This transition can usually be accomplished within a few sessions. While such a therapeutic transition is usually better for a child than the continuation of biased or dysfunctional treatment, repeated disruptions in treatment may undermine a child's trust in the therapy process and in the security of his or her independent relationships. We suggest that the decision regarding continuation of a treatment relationship be based on the therapist's performance with respect to the criteria described above and that any change not be undertaken based on a parent's anger alone.

WHAT'S THE RIGHT INTERVENTION?

We will now address the issues considered when determining the appropriate intervention for a child and family and structuring treatment orders to promote effective treatment.

LEGAL AUTHORITY FOR ORDERING TREATMENT

California Family Code section 3190 allows the court to order parties or children into therapy in family law cases if it finds that the custody dispute poses a substantial danger to the child's best interest and that counseling is in the child's best interest.[33] Under Family Code sections 3191 and 3192, the court may order counseling for parties to facilitate communication, reduce conflict, and improve parenting skills, either together or separately, depending upon whether there is a history of child or partner abuse.[34]

Whether the court elects to order the parties to counseling will in part depend on the judicial officer's philosophy of the family court's role. According to one school of thought, the duty of the family law judicial officer is to "answer the question"—that is, when an order to show cause is brought regarding custody, it is the judicial officer's job to determine, based on the facts presented, whether the relief requested should or should not be granted. According to an alternative school of thought, when a family enters the judicial system, it is the obligation of the family law judicial officer to do more than rule on a request. The judicial officer is charged with taking, sua sponte, those steps necessary to protect the best interest of children whether or not a specific request to achieve this goal is made to the judicial officer. This more "proactive" role might include periodic reviews of the then-existing custody arrangement to ensure that it continues to meet the needs of the child or children in question. Models such as judicial case management, family-focused courts, and therapeutic jurisprudence are consistent with the latter approach.[35]

STRUCTURING TREATMENT ORDERS

The higher the level of conflict in a family, the more important it is to have a carefully structured order for child-centered treatment (i.e., children's treat-

ment or child-centered conjoint therapy). While lower-conflict families may be able to voluntarily consent to treatment and support the therapist's intervention, parents exhibiting a higher level of conflict are often unable or unwilling to follow through with treatment orders and cooperate with interventions to support their children's needs. A highly adversarial parent will often support treatment for only as long as he or she believes that the therapist is supporting that parent's agenda in the custody conflict. The child's treatment or parent-child conjoint therapy may be disrupted by an unhappy parent's unwillingness to cooperate with the intervention, pay for services, or support the child's participation. Given this possibility, therapists are often reluctant to confront damaging parental behavior out of concern that the child's treatment will be disrupted as a result. The treatment may therefore continue but its effectiveness undermined because the therapist has failed to address the parent's maladaptive behavior and its destructive effect on family interactions.

A well-structured treatment order will not always prevent these problems, as a determined parent may find a way to undermine treatment. Often, however, a detailed treatment order establishes a framework for treatment that can be used to support children's progress and hold all parties accountable for cooperating with the process.[36] Stipulations for treatment are usually negotiated between counsel, a process that promotes informed consent regarding the court's order, the therapist's expectations regarding cooperation with treatment, the financial responsibilities of the parties, limitations on privilege, and other issues. In the hands of a skilled therapist, this mechanism of accountability can also be a powerful tool to assist in persuading parents to cooperate. At a minimum, a structured treatment order provides documentation that the parents were aware of the structure of treatment before entering into the stipulation, thus reducing the possibility that they can later successfully claim to have misunderstood the court's order or intentions. While none of these conditions guarantees success in treatment, a structured treatment order often establishes minimal conditions that may make success possible.[37]

An effective treatment order establishes the essential conditions for treatment, while allowing the therapist sufficient flexibility to adjust treatment goals and methods to the needs of the family. At a minimum, an effective treatment order should address the following issues:

Participants in counseling. Most children's treatment and conjoint (family) treatment are more effective if both parents are involved in the process. Even when the established purpose of treatment is to facilitate the relationship between a child and an estranged or alienated parent, the cooperation of the other parent may be necessary for treatment to succeed. Effective treatment orders often allow the therapist discretion to require the involvement of each parent as necessary.

Scope and goals of intervention. A skilled therapist needs some flexibility to establish the structure and conditions of treatment. It is often helpful, however, to have a treatment order that clarifies the court's intent in ordering treatment. Common treatment goals, which can be established in a general check-off format in the treatment order, may include (1) improving parent-child relationships, (2) assisting children in resolving emotional or behavior problems, (3) reducing conflict regarding custody or visitation, (4) assisting parents in improving parenting skills, or (5) addressing specific behavior problems identified in a child custody evaluation or by the court. It should be noted that, while a child's therapist or conjoint therapist may need to meet periodically with each parent to facilitate treatment, such meetings are focused on the primary treatment goals in support of children's needs. To avoid potential conflicts of interest, personal therapy focused on parents' stresses and needs is usually best conducted by another therapist. Treatment is most effective, however, when there is periodic consultation among all therapists on a case.[38]

Cooperation with treatment. Most parents are able to cooperate with treatment in support of their children's needs, but highly adversarial parents are

often unable or unwilling to do so without outside intervention. While a determined parent may find a way to sabotage treatment, a court order mandating cooperation with the therapist may induce some parents to comply. Ultimately, the success of a therapeutic intervention may depend on a variety of factors, including the children's resilience, the therapist's ability to persuade parents to alter destructive behavior patterns, the actions of other professionals on the case, and the parties' interest in improving the situation. Initially, however, externally enforced compliance with treatment may be necessary to ensure that parents and children attend sessions and cooperate with even basic interventions.[39] Such a structure may provide the therapist with an opportunity to conduct initial interventions and persuade the parties to cooperate with the process. With the highest-conflict families, effective treatment may require that judicial officers be willing to back up treatment orders with contempt citations or sanctions on the uncooperative parent. Such sanctions may include financial penalties or enforcement of a court order that makes current custody arrangements conditional upon the parties' cooperation with treatment.[40]

These treatment requirements may be stated in treatment orders or specifically described by the therapist. They should include the expectation that parents exercise parental authority to ensure a basic level of cooperation by children and adolescents. While therapists are accustomed to working with resistant children and encouraging them to explore emotional issues, parents should still be expected to convey that their children exhibit the basic level of cooperation (e.g., attending sessions, answering when they are addressed by an adult) that is required in other settings (e.g., school, extracurricular activities). This expectation may forestall a common method of undermining treatment involving older children, i.e., the subtle message from a parent that demonstrating disrespect or noncompliance with the therapist is acceptable. (This is not dissimilar to the dynamic that occurs when a parent reinforces or tolerates the child's disrespectful behavior.)

Cooperation with treatment may also include requirements imposed on the interaction of a parent with an estranged child, i.e., requiring that the parent listen to the child, avoid denigrating the child's feelings or experiences, and refrain from statements that undermine the child's relationship with other significant adults. Forensically experienced therapists may develop model stipulation or order forms that specify these or other elements considered essential to effective treatment.

Financial responsibility for treatment. Many therapists with forensic experience have retainer agreements specifying fees and the types of services to which the therapist's charges may apply. Highly adversarial parents may, at least initially, be heavy consumers of a therapist's time and may request many services outside of therapy sessions, such as telephone contact, review of documents, or requests that the therapist intervene in parental disputes. Many insurance contracts exclude coverage for these types of services, so the parents' insurance may not cover fees for these services. It should be noted that the high cost of outside-session services may aid the therapeutic intervention by persuading parents to be more judicious in requests for the therapist's time and the management of conflict.

Treatment orders should specify the parties' responsibility for paying for children's sessions, parent-child conjoint sessions, the therapist's meetings with the parents, and any outside-session services such as telephone calls, review of documents, and consultation with other therapists. To facilitate continuity of treatment and enhance cooperation, many forensically experienced therapists require retainer payments against which future services will be charged. If financial responsibility is a contested issue or the parties do not honor financial responsibilities, the establishment of a trust account for treatment services may be a useful mechanism for ensuring that treatment continues. At a minimum, the order should be specific regarding when and how payments should be made. For example, it might say: "[Father] must pay the therapist's bill in full within 10 days of receiving it. [Mother] must pay

back [Father] half that amount within 10 days after [Father] pays the bill."

BALANCING PRIVACY, ACCOUNTABILITY, AND EFFECTIVENESS

Traditional psychotherapy relies on the psychotherapist-patient privilege to promote disclosure of information, and there is certainly a role for privacy even in court-related treatment. For this reason, a court or the parties' counsel may be tempted to structure orders that completely exclude treatment information from the child custody evaluator's or the court's consideration in the hope of providing a "safe haven"[41] in which a child or family can discuss concerns. This structure may be effective with low-conflict families; however, in families exhibiting a higher level of conflict, it is often necessary to establish an accountability mechanism to promote the parties' cooperation with treatment. Particularly when families have a history of poor cooperation, it may be unrealistic to expect that parents will cooperate absent a mechanism for reporting treatment progress to the child custody evaluator or the court. Moreover, the exclusion of treatment information may make it difficult to assess the therapist's performance, determine the validity of opinions or therapeutic recommendations offered by the therapist, or determine whether a change in therapists is necessary.

Treatment orders can be structured in a manner that generally maintains privacy in treatment while allowing essential information to be disclosed to other professionals. Some treatment orders allow the therapist to confer with counsel by conference call to resolve issues related to the treatment order or to communicate with counsel or the court in the event that a child is at risk. Other orders allow or require the therapist to release information to a child custody evaluator or confer with counsel by conference call to resolve issues relevant to the treatment order. Treatment orders may also allow or require the therapist to provide a progress report at the direction of the court or upon request of the parties or minor's counsel if a parent pursues further litigation of the custody dispute. When parents employ a special master or coordinator, information from the therapist may be helpful in reaching decisions that will support the child's needs. These orders allow the parties to have privacy in treatment under most circumstances while allowing the therapist to provide essential treatment information to decision makers. They may also promote cooperation, because the parties are aware that treatment information will remain private as long as they cooperate with the therapist and refrain from initiating further custody litigation.

In cases where some release of treatment information is permitted, the therapist should be required to include at least some of the specific statements or behaviors that form the basis of his or her opinion. It is difficult to imagine how an attorney could effectively cross-examine a therapist who is permitted to express global treatment opinions without any supporting data. Additionally, accountability for the use of biased procedures is removed when therapists are permitted to express opinions without providing the information that supports them. While this degree of disclosure may result in some loss of treatment privacy, the types of orders described above limit disclosure to situations in which further litigation is pursued or in which treatment information is necessary to support the needs of the child. In order to be effective, it may be necessary that the treatment order specify the types of information that may be disclosed and under what conditions.

Therapists may be able to protect some aspects of client privacy by including only information that is directly relevant to the issues being addressed by the court. The therapist may need to address either the child's feelings about the sharing of treatment information or, more often, a parent's distress when the disclosed information or expressed opinion does not conform to what the parent was hoping to hear. Informed consent procedures that explain to the child and parents the conditions under which the therapist may share—or be ordered to share—treatment information may help prepare them for this step. The stipulation and order or consent agreement

governing treatment should specify any exceptions to privilege, and parents should have an opportunity to consult with counsel before signing it. Issues related to confidentiality and the release of treatment information should also be discussed with the child, in a manner appropriate to the child's age and abilities. This should occur at both the onset of treatment and as appropriate thereafter.

The therapist should also engage the child in the process of sharing information. Children are often more concerned about the reactions of the adults around them than about the sharing of information per se. In fact, children may be relieved or empowered when the therapist discloses information that the child has been unable to express, particularly if the child is engaged in the process of identifying information that is important to share with significant adults. Whatever the child's feelings, it is essential that the therapist talk with the child about the pending release of information and assist the child with coping skills for dealing with the adults in his or her environment.[42]

CONCLUSION

Particularly when a child is in treatment, a therapist may have considerable influence on the progress and outcome of a case. As described above, a therapist may support a child in developing active coping skills or may reinforce avoidance and dysfunctional behavior. The therapist may use balanced techniques that allow the child's independent needs to emerge or may bias treatment to the degree that a child's needs are undermined. A therapist may be able to use his or her influence to persuade parents to put the children's needs first and reduce conflict or may overly align with one parent and become an active participant in the "tribal warfare" of the custody conflict.[43]

As mental health professionals become increasingly frequent providers of court-related services, they are moving to clarify the appropriate standard of practice for court-related treatment. Ultimately, however, much of the protection for consumers may come from attorneys and judges who are sufficiently familiar with these issues to structure appropriate orders and insist that therapists serving court-involved families provide an appropriate level of service.

NOTES

1. Lyn R. Greenberg & Jonathan W. Gould, *The Treating Expert: A Hybrid Role With Firm Boundaries,* 32 Prof. Psychol.: Res. & Prac. 469 (2001).

2. *See, e.g.,* Jonathan W. Gould, Conducting Scientifically Crafted Child Custody Evaluations (Sage Publ'ns 1998); Jonathan W. Gould & Lisa C. Bell, *Forensic Methods and Procedures Applied to Child Custody Evaluations: What Judges Need to Know in Determining a Competent Work Product,* 51 Juv. & Fam. Ct. J. 21 (Summer 2000); Jonathan W. Gould & Lyn R. Greenberg, *Merging Paradigms: The Marriage of Clinical Treatment With Forensic Thinking,* Int'l Acad. Fam. Psychol. Newsl., Dec. 2000, at 3–7.

3. Greenberg & Gould, *supra* note 1; Lyn R. Greenberg et al., *Is the Child's Therapist Part of The Problem? What Attorneys, Judges, and Mental Health Professionals Need to Know About Court-Related Treatment for Children,* Ass'n Fam. & Conciliation Cts. Cal. Newsl., Winter 2001, at 6–7, 24–29.

4. Robert E. Emery, Marriage, Divorce, and Children's Adjustment xii (Sage Publ'ns 2d ed. 1999); Janet R. Johnston & Vivienne Roseby, In the Name of the Child: A Developmental Approach to Understanding and Helping Children of Conflicted and Violent Divorce xiv (Free Press 1997); Paul R. Amato, *Consequences of Divorce for Adults and Children,* 62 J. Marriage & Fam. 1269 (2000); Robert Bauserman, *Child Adjustment in Joint-Custody Versus Sole-Custody Arrangements: A Meta-Analytic Review,* 16 J. Fam. Psychol. 91 (2002); Joan B. Kelly, *Marital Conflict, Divorce, and Children's Adjustment,* 7 Child & Adolescent Psychiatric Clinics N. Am. 259 (1998); Joan B. Kelly, *Children's Adjustment in Conflicted Marriage and Divorce: A Decade Review of Research,* 39 J. Am. Acad. Child & Adolescent Psychiatry 963 (2000).

5. Mark Chaffin et al., *School-Age Children's Coping With Sexual Abuse: Abuse Stresses and Symptoms Associated With Four Coping Strategies,* 21 Child Abuse & Neglect 227 (1997); M. Lynne Cooper et al., *Attachment Styles, Emo-*

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tion Regulation, and Adjustment in Adolescence, 74 J. Personality & Soc. Psychol. 1380 (1998); Laurie Fields & Ronald J. Prinz, *Coping and Adjustment During Childhood and Adolescence,* 17 Clinical Psychol. Rev. 937 (1997); Janet R. Johnston et al., *Therapeutic Work With Alienated Children and Their Families,* 39 Fam. Ct. Rev. 316 (2001); Kelly, *Children's Adjustment, supra* note 4.

6. Carla B. Garrity & Mitchell A. Baris, Caught in the Middle: Protecting the Children of High-Conflict Divorce (Lexington Books 1994); Johnston & Roseby, *supra* note 4; Kelly, *Children's Adjustment, supra* note 4; Viviene Roseby & Janet R. Johnston, High-Conflict, Violent, and Separating Families: A Group Treatment Manual for School-Age Children (Free Press 1997); Vivienne Roseby & Janet R. Johnston, *Children of Armageddon: Common Developmental Threats in High-Conflict Divorcing Families,* 7 Child & Adolescent Psychiatric Clinics N. Am. 295 (1998).

7. Roseby & Johnston, *Children of Armageddon, supra* note 6.

8. Kelly, *Children's Adjustment, supra* note 4.

9. Joan B. Kelly & Janet R. Johnston, *The Alienated Child: A Reformulation of Parental Alienation Syndrome,* 39 Fam. Ct. Rev. 249 (2001); Matthew J. Sullivan & Joan B. Kelly, *Legal and Psychological Management of Cases With an Alienated Child,* 39 Fam. Ct. Rev. 299 (2001).

10. Johnston & Roseby, *supra* note 4; Roseby & Johnston, *Children of Armageddon, supra* note 6.

11. E. Mavis Hetherington & John Kelly, For Better or for Worse: Divorce Reconsidered 7 (W.W. Norton & Co. 2002).

12. Robert E. Emery & Mary Jo Coiro, *Some Costs of Coping: Stress and Distress Among Children From Divorced Families, in* Developmental Perspectives On Trauma: Theory, Research, and Intervention 435 (Dante Cicchetti & Sheree L. Toth eds., Univ. of Rochester Press 1998).

13. *Id.;* Hetherington & Kelly, *supra* note 11.

14. A forensically sophisticated therapist is one who understands and appreciates the court context and the particular issues that arise within it.

15. Chaffin et al., *supra* note 5; Josefina M. Contreras et al., *Emotion Regulation as a Mediator of Associations Between Mother-Child Attachment and Peer Relationships in Middle Childhood,* 14 J. Fam. Psychol. 111 (2000); Emery & Coiro, *supra* note 12; Fields & Prinz, *supra* note 5; Johnston et al., *supra* note 5; Marsha G. Runtz & John R. Schallow, *Social Support and Coping Strategies as Mediators of Adult Adjustment Following Childhood Maltreatment,* 21 Child Abuse & Neglect 211 (1997).

16. Johnston & Roseby, *supra* note 4; Johnston et al., *supra* note 5; Kelly & Johnston, *supra* note 9; Sullivan & Kelly, *supra* note 9.

17. Child Physical and Sexual Abuse: Guidelines for Treatment (Final Report: December 10, 2002) (Benjamin E. Saunders et al. eds., Nat'l Crime Victims Res. & Treatment Ctr. 2002).

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20. Johnston et al., *supra* note 5.

21. Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.

22. Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.

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24. Merriam-Webster's Collegiate Dictionary 110 (10th ed. 1993).

25. Mary Lund, *A Therapist's View of Parental Alienation Syndrome,* 33 Fam. & Conciliation Cts. Rev. 308 (1995); Sullivan & Kelly, *supra* note 9.

26. Johnston et al., *supra* note 5.

27. Greenberg & Gould, *supra* note 1; Greenberg et al., *supra* note 3; Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.

28. Greenberg & Gould, *supra* note 1; Greenberg & Shuman, *supra* note 19.

29. Gould & Greenberg, *supra* note 2; Greenberg & Gould, *supra* note 1; Greenberg et al., *supra* note 3.

30. Stephen J. Ceci & Maggie Bruck, Jeopardy in the Courtroom: A Scientific Analysis of Children's Testimony (Am. Psychol. Ass'n 1995); The Recovered Memory/False Memory Debate (Kathy Pezdek & William P. Banks eds., Academic Press 1996); Kathy

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Pezdek & Chantal Roe, *The Suggestibility of Children's Memory for Being Touched: Planting, Erasing, and Changing Memories,* 21 Law & Human Behav. 95 (1997).

31. Greenberg & Gould, *supra* note 1; Greenberg et al., *supra* note 3.

32. Greenberg & Gould, *supra* note 1; Greenberg et al., *supra* note 3.

33. Section 3190 states:

> (a) The court may require parents or any other party involved in a custody or visitation dispute, and the minor child, to participate in outpatient counseling with a licensed mental health professional, or through other community programs and services that provide appropriate counseling, including, but not limited to, mental health or substance abuse services, for not more than one year, provided that the program selected has counseling available for the designated period of time, if the court finds *both* of the following:
>
> (1) The dispute between the parents, between the parent or parents and the child, between the parent or parents and another party seeking custody or visitation rights with the child, or between a party seeking custody or visitation rights and the child, poses *a substantial danger to the best interest of the child.*
>
> (2) The *counseling is in the best interest of the child.*
>
> (b) In determining whether a dispute, as described in paragraph (1) of subdivision (a), poses a substantial danger to the best interest of the child, the court shall consider, in addition to any other factors the court determines relevant, any history of domestic violence, as defined in Section 6211, within the past five years between the parents, between the parent or parents and the child, between the parent or parents and another party seeking custody or visitation rights with the child, or between a party seeking custody or visitation rights and the child.
>
> (c) Subject to Section 3192, if the court finds that the financial burden created by the order for counseling does not otherwise jeopardize a party's other financial obligations, the court shall fix the cost and shall order the entire cost of the services to be borne by the parties in the proportions the court deems reasonable.
>
> (d) The court, in its finding, shall set forth reasons why it has found both of the following:
>
> (1) The dispute poses a substantial danger to the *best interest of the child* and the counseling is in the best interest of the child.
>
> (2) The *financial burden* created by the court order for counseling *does not otherwise jeopardize a party's other financial obligations.*
>
> (e) *The court shall not order the parties to return to court upon the completion of counseling.* Any party may file a new order to show cause or motion after counseling has been completed, and the court may again order counseling consistent with this chapter.

Cal. Fam. Code § 3190 (West 1994 & Supp. 2002) (emphasis added).

34. Section 3191 states:

> The counseling pursuant to this chapter shall be specifically designed to *facilitate communication* between the parties regarding their minor child's best interest, to *reduce conflict* regarding custody or visitation, and *to improve the quality of parenting skills* of each parent.
>
> Section 3192 states:
>
> In a proceeding in which counseling is ordered pursuant to this chapter, where there has been a history of abuse by either parent against the child or by one parent against the other parent and a protective order as defined in Section 6218 is in effect, the court may order the parties to participate in counseling separately and at separate times. Each party shall bear the cost of his or her own counseling separately, unless good cause is shown for a different apportionment. The costs associated with a minor child participating in counseling shall be apportioned in accordance with Section 4062. *Id.* §§ 3191, 3192 (emphasis added).

35. Carol R. Flango, *Family-Focused Courts,* 2 J. Ctr. Fam. Child. & Cts. 99 (2000); John Leverette et al., *Judicial Case Management and the Custody and Access Assessment: Melding the Approaches,* 42 Can. J. Psychiatry 649 (1997).

36. Johnston & Roseby, *supra* note 4; Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.

37. Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9; Richard A. Warshak, Divorce Poison: Protecting the Parent-Child Bond From a Vindictive Ex 258–61 (ReganBooks 2002).

38. Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9. *See also* Cal. Fam. Code § 3191.

39. Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.

40. Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.

41. Carol Silbergeld, A Clinical Perspective (1997) (unpublished paper presented at the Los Angeles County Bar Association Nineteenth Annual Child Custody Colloquium: "Who Cares About the Children?").

NOTES 42. Greenberg & Gould, *supra* note 1; Greenberg et al., *supra* note 3.

43. Johnston & Roseby, *supra* note 4; Johnston et al., *supra* note 5; Sullivan & Kelly, *supra* note 9.