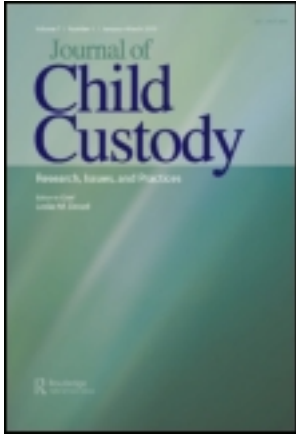


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On: 14 March 2012, At: 15:22

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Child Custody

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wjcc20>

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Available online: 12 Mar 2012

To cite this article: Lyn R. Greenberg & Matthew J. Sullivan (2012): Parenting Coordinator and Therapist Collaboration in High-Conflict Shared Custody Cases, *Journal of Child Custody*, 9:1-2, 85-107

To link to this article: <http://dx.doi.org/10.1080/15379418.2012.652571>

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

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

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

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

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

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

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

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

SYNERGIES AND DIFFERENTIATION OF ROLES

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

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

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

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

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

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

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

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

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

SETTING UP COLLABORATIVE TEAMS

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

Selection of the Child's Therapist

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

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

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

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

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

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

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

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

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

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

ESTABLISHING TREATMENT PARAMETERS

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

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

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

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

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

THE PC JOINING A THERAPIST ON THE CASE

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

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

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

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

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

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

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

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

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

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

EXPANDING THE TREATMENT TEAM

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

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

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

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

Case Example. ***Increasing the effectiveness of parent therapy:***

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

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

COLLABORATIVE TEAM FUNCTIONING

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

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

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

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

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

THErapy AT THE CENTER OF CONTROVERSY

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

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

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

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

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

Assessing the Quality of Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Example. ***Problematic child therapy:*** The PC initiated an inquiry to the therapist after the father alleged that the therapist was biased against him and reluctant to consider his information. The therapist confirmed that she had had limited contact with the father because she felt that he was destructive to the child. The therapist advised the PC that both the child and the mother had consistently reported that the child cried during transitions to the father's care. She specifically cited an incident in which the father had allegedly been too rough with the child in the bathtub, as reported by the child's mother and confirmed by the child. The therapist reported that the child was increasingly distressed since the court had ordered the PC's appointment and movement toward having the child spend more time with the father.

The PC inquired as to the hypotheses that the therapist had considered in assessing the child's symptoms. What developmental issues had she considered? Had she sought the father's observations? Did she inquire about bathing procedures? How had she discussed with the child the pending changes in the parenting plan? The PC also advised the therapist that an extensive custody evaluation had been completed in the case and that the child had been observed to be relaxed and age-appropriate with the father. The PC also advised the therapist that a nanny was present when the child was bathed and had reported no distress. The therapist responded that the nanny was on the father's payroll, that she believed the child, and that she felt that the child had a right to decide whether to spend more time with the father. She felt that the father was insensitive for refusing to listen to the child's feelings, and she had advised the mother to appeal the court's decisions. She resisted the PC's suggestions that she consider the father's information, set limits with the child, or focus on helping the child to cope with the reality of the adult decisions that had

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

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

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

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

CONCLUSION

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

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

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

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