By consequence, is comprehensive argument why court/DHS 1) MUST have EXPERT health providers dictating best interest decisions when parental/custody are being interfered 2) that court/DHS ARE UNEQUIVOCALLY BEING RECKLESS AND CAUSING HARM if they make any decisions infringing on custody or health treatment of a family

Is the Child's Therapist Part of the Problem?

What Judges, Attorneys, and Mental Health Professionals Need to Know About Court-related Treatment for Children

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I. Introduction

The emotional distress associated with divorce and the legal proceedings that surround it often result in a decision to involve children in psychotherapy. It is essential that these children receive appropriate, unbiased treatment from therapists that possess the requisite expertise to work in the context of a court case. Clinicians who undertake court-related treatment without adequate expertise run the risk of exacerbating, rather than improving, the life situations of these children. In this article, we describe the appropriate role of a child's therapist in a forensic context, and the differences between court-related treatment and traditional psychotherapy. We also suggest criteria for evaluating the performance and expertise of

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children's therapists, critical evaluation of declarations, and determining when a change of therapists is necessary. We offer some practice tips for attorneys.

The growing research base regarding risks to children of high conflict divorce,[1] children's suggestibility,[2] and the coping skills that children need for successful adjustment[3] underscores the importance of children receiving appropriate, unbiased treatment from therapists that possess the requisite expertise to work in the context of a court case.[4] The treating therapist may have frequent, regular contact with a child over an extended period of time. Such treatment often has a profound effect both on a child's adjustment and on the progress of a case.

see UCHeath "Adjustment Disorders" and chronic pathology of untreated/unresolved AD. PTSD/ Trauma-Response/ Anxiety disorder is a separate but addictive and compounding disorder

Standards and guidelines for child custody evaluations have been developed based on the professional literature,[5] and have been established by several professional organizations and, in some areas, state statutes and court rules.[6] Only a few authors have written about the distinctions

1. *See, generally,* ELIZABETH M. ELLIS, DIVORCE WARS: INTERVENTIONS WITH FAMILIES IN CONFLICT (2000); CARLA B. GARRITY & MITCHELL A. BARIS, CAUGHT IN THE MIDDLE: PROTECTING THE CHILDREN OF HIGH-CONFLICT DIVORCE (1994); JANET R. JOHNSTON & VIVIENNE ROSEBY, IN THE NAME OF THE CHILD: A DEVELOPMENTAL APPROACH TO UNDERSTANDING AND HELPING CHILDREN OF CONFLICTED AND VIOLENT DIVORCE (1997).

2. *See, e.g.,* STEPHEN J. CECI & MAGGIE BRUCK, JEOPARDY IN THE COURTROOM: A SCIENTIFIC ANALYSIS OF CHILDREN'S TESTIMONY (1995); Lyn R. Greenberg, *Ethical Issues in Child Custody and Dependency Cases: Enduring Principles and Emerging Challenges*. 1 J. CHILD CUSTODY (forthcoming 2003); KATHRYN KUEHNLE, ASSESSING ALLEGATIONS OF CHILD SEXUAL ABUSE (1996); Kathryn Kuehnle, Lyn R. Greenberg, & Michael C. Gottlieb, *Incorporating the Principles of Scientifically Based Child Interviews into Family Law Cases*, 1 J. CHILD CUSTODY (forthcoming 2003).

3. *See, e.g.,* 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); Lynne M. Cooper, Phillip R. Shaver, & Nancy L. Collins, *Attachment Styles, Emotion Regulation, and Adjustment in Adolescence*, 74 J. PERSONALITY & SOC. PSYCHOL. 1380 (1998); Judy Dunn et al., *Family Lives and Friendships: The Perspectives of Children in Step-parent, Single-parent, and Nonstep Families*, 15 J. FAM. PSYCHOL. 272 (2001); Laura Fields, & Ronald J. Prinz, *Coping and Adjustment During Childhood and Adolescence*, 17 CLINICAL PSYCHOL. REV. 937 (1997); JOHNSTON & ROSEBY, *supra* note 1; Joan B. Kelly & Robert E. Emery, *Children's Adjustment Following Divorce: Risk and Resilience Perspectives*, FAM. REL. (forthcoming 2003); KUEHNLE, *supra* note 2; Kuehnle, Greenberg, & Gottlieb, *supra* note 2; 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).

4. *See* Greenberg, *supra* note 2; Lyn R. Greenberg & Jonathan W. Gould, *The Treating Expert: A Hybrid Role with Firm Boundaries*, 32 PROF. PSYCHOL. RES. & PRAC. 469 (2001).

5. *See, e.g.,* ROBERT M. GALATZER-LEVY & LOUIS KRAUS, THE SCIENTIFIC BASIS OF CHILD CUSTODY DECISIONS (1999); JONATHAN W. GOULD, CONDUCTING SCIENTIFICALLY CRAFTED CHILD CUSTODY EVALUATIONS (1998); PHILIP M. STAHL, COMPLEX ISSUES IN CHILD CUSTODY EVALUATIONS (1999).

6. *See,* Cal. R. Ct. 5.220, reproduced in Appendix.

between treatment and evaluation roles[7] and even fewer about forensically-informed treatment.[8] Currently, there are no professional practice guidelines or standards governing the role of a therapist conducting treatment in the context of a court case, such as a contested custody dispute or dependency case. There is, however, an emerging professional consensus on the appropriate role of a treating therapist working with court-involved children and families.[9]

We believe that the emerging literature is sufficient to identify central issues which distinguish appropriate court-related treatment from traditional psychotherapy. We further propose that therapists providing treatment in the context of a court case should be ethically bound to exhibit a level of competence and expertise comparable to that expected of a child custody evaluator.[10] While the *treating expert's* role is distinct from that of the *forensic expert,* (*e.g.*, psychological examiner or child custody evaluator), *effective treatment with children of separating and divorcing families can occur only when the therapist is knowledgeable about the myriad of forensic mental health and legal issues that often are imposed upon the therapist, the children, their parents, and the treatment itself during contested custodial disputes.*

In this article, we suggest criteria which may be useful in evaluating different aspects of the treating expert's role. In some circumstances, a judicial officer's or attorney's first contact with a child's therapist may occur after the therapist has expressed an opinion, provided a letter or declaration at the request of a parent, or in more serious cases, has filed a report of suspected child abuse. Attorneys, mental health professionals, and ultimately judicial officers may need to determine: (1) whether a child's therapist has sufficient expertise regarding divorce-related issues to effectively assist the child; (2) whether a therapist has retained sufficient professional objectivity to avoid biasing treatment; and (3) the quality and credibility of a treating therapist's data, reports, and/or opinions. The professional practice criteria that we suggest may also be useful in guiding a

7. *See, e.g.,* Greenberg & Gould, *supra* note 4; Lyn R. Greenberg et al., *Effective Intervention with High-conflict Families: How Judges Can Promote and Recognize Competent Treatment in Family Court*, J. CENTER FAM. CHILD. & CTS. (forthcoming 2003); Stuart A. Greenberg & Daniel W. Shuman, *Irreconcilable Conflict Between Therapeutic and Forensic Roles*, 28 PROF. PSYCHOL. RES. & PRAC. 50 (1997).

8. *See, e.g.*, Greenberg & Gould, *supra* note 4; Greenberg et al., *supra* note 7; Greenberg & Shuman, *supra* note 7; D. Vigil, & L. Kenney-Markan, *The Parameters of Forensically Informed Treatment* (1995) (unpublished manuscript, available from authors).

9. *See, e.g.*, Greenberg & Gould, *supra* note 4; Greenberg et al., *supra* note 7; Greenberg & Shuman, *supra* note 7; Vigil & Kenney-Markan, *supra* note 8.

10. Am. Psychol. Ass'n Bd. of Prof. Affairs, Committee on Prof. Prac., *Guidelines for Child Custody Evaluations in Divorce Proceedings*, 47 AM. PSYCHOL. 1597 (1994).

therapist's course of treatment and professional practice, as well as an attorney's approach to dealing with treating professionals.

II. Treatment in the Context of the Court

Traditionally, psychotherapy has been viewed as a voluntary process initiated by the client for the purpose of making changes in his/her life. The basic elements of almost all therapies include establishing a positive rapport between the client and the therapist, encouraging the free expression of the client's feelings and thoughts, and assisting the client to function better in the client's chosen areas of change. When children and families are not involved with the courts, treatment is often based upon the belief that the client is motivated to provide *accurate* information to the therapist because this will enhance the therapist's ability to assist the client. While therapeutic approaches differ in their use of confrontation, many therapists are trained to accept, support and advocate for their clients' needs. Therapists often work within their clients' perceptions of the outside world rather than attempting to determine the factual accuracy of those perceptions through collateral contacts and other information gathering methods. This orientation promotes a supportive atmosphere, but may also lead therapists to be reluctant to actively challenge a client's assumptions, interpretations or dysfunctional behaviors.

Many of the assumptions which underlie traditional psychotherapy cannot be extended to treatment in a forensic case, particularly if the treatment involves a child. In treatment which has been ordered by the court or motivated by the client's involvement in litigation, some or all of the traditional elements of voluntary participation may not apply. Adults may be directed into treatment or ordered to obtain and cooperate with treatment for their children. The choice of therapists or the issues to be addressed in treatment may also be ordered or restricted by the court. In some cases, parents' visitation or custodial rights are restricted until they demonstrate certain behavioral changes (*e.g.*, resolving issues related to domestic or child abuse, abstaining from substance abuse or supporting the child's relationship with the other parent). Even if parents are not ordered to retain a therapist, treatment may be a mechanism through which the client chooses to address the issues of concern to the court. The order governing treatment may explicitly require the therapist to report progress to the court or its agent (*e.g.*, a forensic evaluator or child protective services), or the parent may simply expect that the therapist will be providing treatment information to be considered by the court. Thus, a parent's behavior change (or encouragement of particular behavior in their child) may be motivated to advance a particular outcome in the custody dispute or to

convince a third party that treatment is no longer necessary. This motivation stands in sharp contrast to the motivation of the voluntary client whose interest is in feeling better and making effective self change rather than satisfying the expectations of the court. In cases with a high level of parental conflict, however, a stipulation or court order governing treatment may be an essential component of effective intervention. Some authors[11] have proposed models for court-ordered intervention in conflicted cases, while others[12] have suggested guidelines for structuring effective orders for children or family treatment.

Particularly in court-ordered treatment, ongoing litigation also impacts the confidentiality of the treatment process. In traditional clinical treatment, the psychotherapist-patient privilege can usually be broken only with the express written permission of the adult client or the child's parents. A therapist conducting court-related treatment may be expected to provide information to a child custody evaluator, counsel, guardian *ad litem*, child protective services, an attorney appointed to represent the child and/or directly to the court. This diminished confidentiality may directly impact the amount or type of information provided to the therapist.[13]

No, GAL exists. This is a big problem.

Whenever a child at the center of a custody case is in treatment, the therapist must be cognizant of the potential impact of the dispute and ongoing litigation on the treatment process. Parents embroiled in a legal struggle are often under considerable stress that may impact their ability to understand or act upon what is in their child's best interests. Adults who are intent on achieving a particular adult-oriented outcome may alter their interaction with the treating professional in order to achieve this goal. Parents may present information that favors only one side. They may distort or omit information, intentionally or otherwise. Their goal to prevail in the legal conflict may co-exist with, or override, their ability to support their children's independent needs and progress. We define children's *independent needs and progress* in terms of the child's ability to master common developmental tasks such as learning healthy coping skills, establishing emotional independence, and engaging in independent, healthy relationships with a variety of others. Many high-conflict parents do not view these two issues as distinct. Each parent's preferred outcome becomes synonymous with his or her view of what is best for the child.

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11. *See, e.g.*, Janet R. Johnston, Marjorie Gans Walters, & Steven Friedlander, *Therapeutic Work with Alienated Children and Their Families*, 39 FAM. CT. REV. 316 (2001); Matthew J. Sullivan & Joan B. Kelly, *Legal and Psychological Management of Cases with an Alienated Child*, 39 FAM. CT. REV. 299 (2001).
12. *See, e.g.*, Greenberg et al., *supra* note 7.
13. David Nowell & Jean Spruill, *If It's Not Absolutely Confidential, Will Information Be Disclosed?*, 24 PROF. PSYCHOL. RES. & PRAC. 367 (1993).

These parents believe that prevailing in litigation is the best goal for treatment because they honestly view that as in the child's best interests.

The challenge for the forensically-informed therapist[14] is to be aware that the information being brought into the treatment session could be intentionally or unintentionally distorted. Statements made by a parent or child may include inaccurate observations, selective attention to events that support one parent's view, perceptions distorted by the parent's emotional investment in the outcome, and/or deliberate distortion of information. A child's perceptions and statements may be altered by external influences such as suggestive questioning, exposure to the parental conflict, or exposure to a parent's emotional needs. Any of these influences may be intended to directly or indirectly guide the therapist toward a viewpoint that supports one parent's litigation position over the other. The forensically-informed therapist understands the larger social, legal and family context and recognizes the potential impact of these often conflicting systems on treatment. It is essential that the therapist learns to think *forensically* as well as clinically by critically evaluating all incoming information in light of the dynamics of the custody conflict.

We use the term "forensic thinking" to represent the need to understand the larger, competing systemic factors which affect treatment in the context of the court. Forensic thinking requires knowledge of relevant research regarding children's adjustment to divorce, domestic violence, alienation dynamics, child abuse, children's suggestibility, the impact of parental conflict on children, child development and the coping skills children need to adjust successfully as they mature. The therapist must also be able to apply that research to the case at hand, maintain professional objectivity and a balanced perspective, support and advocate for the child's *developmental* needs, and, as necessary, provide high-quality reports and testimony within the boundaries of the therapeutic role. It is essential that the therapist critically evaluate the nature, source, and representativeness of the information being brought into the sessions. This requires that the therapist generate and actively explore a variety of possibilities (*i.e.*, alternative hypotheses) regarding the nature and causes of a child's difficulties.

- trauma response, "trauma-informed assessment"
- critical illness, loss of parent trauma
- residual trauma-response from past other parent trauma
- parent trauma response
- pathogenic influence: false "victimization" [good/evil framing], false trauma reenactment, false shared persecutory delusion/paranoia
- Adjustment Disorder; losing home, severe illness in only parent, experiencing a trauma response in that parent

For example, suppose a five-year-old child is reported to be crying during transitions to visits. If a child exhibits such behavior or expresses concerns about a parent, it is important that the therapist consider a variety of possible explanations for the child's statements and behavior. The therapist needs to consider the child's explanation, each parent's observations and views, surrounding circumstances, and the child's developmental stage. The timing of an allegation may also be important, particularly if there is

14. Vigil & Kenney-Markan, *supra* note 8.

an upcoming hearing or other event in which the reported event might be relevant in determining a legal outcome or a parenting decision. Possible hypotheses include, but are not limited to:

(1) developmental issues which cause transitions or visits to be difficult for the child; or PTSD/Trauma-response disorder (NCTSN et al)

(2) the circumstances of the visit exchange are stressful;

(3) the child experienced an unpleasant event with one of the parents, which the child perceived correctly and remembered accurately; 3b) accurate recall, but disregulated trauma response (NCTSN et al)

(4) the child has a distressing memory or perception associated with one of the parents, which he or she only partially heard, saw, or understood;

(5) the child is recalling some memory associated with one of the parents and has also heard extensive adult discussion about the alleged event;

(6) the child has experienced an event or events which have been mischaracterized or misinterpreted due to age or developmental factors;

(7) another person (the custodial parent, older sibling, or misled professional) has suggested or communicated to the child that the other parent is unsafe or exhibits emotional distress when the child has contact with that parent;

(8) the child is currently having difficulty in his/her relationship with one parent, and the other parent is communicating that avoidance is an appropriate response to this problem (rather than resolving the issue with the parent involved);

(9) the child is insecure about his or her relationship with a parent or feels responsible for caring for that parent emotionally;

(10) the child has been externally influenced (by a parent, older sibling, or other significant adult) to report a false unpleasant event; and/or

(11) the child is angry at a parent for some other event and the allegation is an attempt to retaliate or get the parent's attention. The latter possibility is most likely to be relevant in the case of an older child who may have been taught (often by observing their parents' behavior) that avoidance and/or retaliation are appropriate ways to deal with emotional issues.

The therapist who does not consider all of these possibilities, but rather limits his/her consideration to a subset of these interpretations (*e.g.*, assuming that the child's account is literally accurate or, conversely, that it is entirely the product of the custody conflict) runs the risk of introduc-

ing a systematic bias into the child's treatment. Such a therapist is likely to limit his or her explorations in a manner consistent with this limited interpretation of events, and to seek or value only that information that is consistent with the therapist's pre-existing orientation or viewpoint. The concept of professional objectivity does not suggest that a therapist should be unconcerned about a client, or should not support the needs or interests of that client. We believe, however, that a child's therapist must *actively* strive to remain objective by maintaining focus on a variety of possible interpretations for a child's statements or behavior, and actively seeking information that may support one possibility or another.

III. Professional Objectivity and Balance

The forensically-informed therapist makes every effort to maintain a balanced perspective and to support the child's appropriate relationship with both parents. This includes respecting both parents' rights to consent to treatment, to communicate with the therapist about their child's needs, and to receive information from the therapist about the child's progress (unless a court orders otherwise). Even when a parent's consent is not legally required, it is important that the therapist make an active effort to understand each parent's concerns and motivations, to assist the child in addressing issues with both parents and to assist the parents in responding to the child's needs.

The orientation to include both parents in the child's treatment is consistent with custody orders which require both parents' involvement in decisions about the child's medical and psychological care. This orientation is also supported by studies on children's adjustment to divorce, which indicate that children who are able to maintain quality relationships with both parents often have better outcomes than children who do not have contact with both parents.[15]

The two most important criteria of objective and balanced treatment are: (1) the therapist's ability to focus on and understand the family situation in which the child lives, including the impact of the family's involvement with the legal system; and (2) the therapist's ability to identify, formulate and actively explore rival, different and plausible interpretations of the child's behavior, statements, problems and needs. These *treatment hypotheses* are different from those employed by the child custody evaluator. An evalua-

15. *See, e.g.*, Paul R. Amato & Joan G. Gilbreth, *Nonresident Fathers and Children's Well-being: A Meta-analysis*, 61 J. MARRIAGE & FAM. 557 (1999); Kelly & Emery, *supra* note 3; Joan B. Kelly & Michael Lamb, *Developmental Issues in Relocation Cases Involving Young Children: When, Whether and How?*, J. FAM. PSYCHOL. (forthcoming 2003); Mary F. Whiteside & Betsy Jane Becker, *Parental Factors and the Young Child's Postdivorce Adjustment: A Meta-analysis with Implications for Parenting Arrangements*, 14 J. FAM. PSYCHOL. 5 (2000).

tor investigates each possible alternative to assist the court in making decisions about psycholegal issues, such as whether the child is in danger in either parent's household and what custody arrangement would best support the needs of the child. The focus of the *treating expert*[16] is on intervention rather than investigation. To conduct balanced and effective treatment, however, the therapist must also formulate rival, plausible hypotheses to determine the child's treatment needs and implement appropriate interventions. With respect to the hypothetical five-year-old described above, these hypotheses would include, but not be limited to, the child's developmental level, circumstances during the visit transition, the child's exposure to the parental conflict, problems in the relationship between the child and either parent, other complicating emotional or coping difficulties, *etc*.

Merriam-Webster's dictionary online[17] defines bias as "systematic error introduced into sampling or testing by selecting or encouraging one outcome or answer over others." Most human beings have biases, based on their own personal experience, and these can be particularly powerful (and often unrecognized) when dealing with the welfare of a child. We would argue that the forensically-sophisticated child's therapist has an obligation to maintain procedures and thought processes specifically designed to control (or at least illuminate) potential sources of bias. These would include: (1) actively considering a variety of possible interpretations of a child's situation and needs; and (2) engaging in deliberate efforts to explore these various possibilities. This includes making active attempts to access information consistent with a variety of points of view.

If a therapist becomes overly aligned with one litigating parent and only considers that parent's viewpoint, the result is biased treatment and often an escalation of the parental conflict. Janet Johnston and Vivienne Roseby coined the term *tribal warfare*[18] to refer to a custody conflict in which people outside the immediate family system take sides and participate in the conflict. Therapists are not immune from being drawn into the *tribal warfare* between families, particularly if they become overly aligned with one parent and consider only that parent's point of view.

It is never in the best interest of the child for a therapist to take any position that does not support the child's independent needs and relationships, or to express an opinion that exceeds the therapist's knowledge and

16. *See* Greenberg & Shuman, *supra* note 7, at 51. The authors coined the term "treating expert" to refer to appropriately-limited expert testimony by a treating therapist. Greenberg & Gould, *supra* note 4, further described the role of the treating expert in child custody and child protection cases. *See also* Greenberg et al., *supra* note 7.

17. *See* <http://www.m-w.com/home.htm>.

18. JOHNSTON & ROSEBY, *supra* note 1.

role in the case. This is not to say that a therapist should not request changes in parents' behavior, nor that the therapist should be precluded from expressing an opinion that a parent may not agree with. In fact, an important part of the job of the child's therapist is to request changes in the child's environment to support the child's needs. It is important, however, that the therapist's interventions and opinions be based on the *child's* needs and coping abilities rather than on parental concerns that may be inconsistent with the child's needs. Moreover, therapists should generally be evenhanded in providing information to both parents. Each parent should have an opportunity to consider the therapist's opinion, ask questions, and/or provide additional information.

Biased therapists may escalate conflict by providing treatment information to the court at the request of one parent without obtaining a balanced understanding of both sides of an issue. In the extreme, a biased therapist may present unbalanced information to the court by minimizing or ignoring bias in the information available. Some therapists even express opinions about parent-child relationships that they have not observed. We believe that offering opinions to the court based upon an inadequate foundation of information, especially when the testimony crosses the line from treatment opinions into forensic judgments (*e.g.*, opinions about custodial placement and conclusive opinions about allegations of abuse), is a violation of the professional standards governing most therapists. Biased therapists often do not recognize the need to formulate and explore alternative hypotheses about a child's behaviors. A judicial officer may assign significant weight to a therapist's testimony based on the expectation that the therapist is providing a balanced understanding of the family system, resulting in decisions that are seriously harmful to children and families.

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Even if the child's therapist never testifies or communicates to the court, a biased therapist may reinforce a distorted view of the child's experience and each parent's contribution to his or her life. This is likely to undermine the child's emotional independence and ability to develop the coping skills needed for successful adjustment. Biased treatment may reinforce dysfunctional coping skills and seriously contaminate the information available to other decision makers such as a child custody evaluator or judicial officer. In such instances, a change of therapists may support unbiased treatment for the child.

adult, judge, caseworker, school official

While it is often ideal for a child's therapist to have equal contact with a child's parents, this is not always possible. Distance between parents' residences, work schedules, and other practical considerations may make it impossible for one of the parents to transport the child to treatment. No matter what the real-world obstacles to frequent involvement in treatment,

it is important that the therapist remain aware of the importance of each parent's involvement in the child's life, and actively seek information and contact with both parents.

The therapist may also need to request information from other adults who are frequently involved with the child and/or have information about the child's functioning that may be relevant to treatment. The scope of these contacts is limited to obtaining information about the child's functioning in other settings, such as school or day care, and coordinating treatment with others who may be able to support the child's treatment. This is in contrast to the more wide-ranging collateral interviews which are part of a forensic evaluation.

IV. Knowledge and Use of the Research

The expanding research base 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 skills and development has taught us much about children's needs and responses when they are at the center of a family conflict. Much of this research is directly relevant to a child's treatment. The treating expert must be familiar with research in these areas, and must be able to apply the appropriate research to the case at hand.

A. Children's Suggestibility

Therapists providing court-related treatment must be aware of the breadth of research on children's suggestibility. Research has shown that children's memories, perceptions and verbal statements may be affected by many variables, including their developmental abilities, interview conditions and the emotional reactions of others. Children's memories and interpretations of events are particularly vulnerable to influence if the incident discussed has some resonance or familiarity within the child's memory. Children often respond to biased questioning, or to an interviewer with a strong opinion or emotional agenda, by producing exactly that information for which the adult appears to be looking.[19] Other studies suggest that, in addition to undermining treatment, such biased questioning may impact children's responses to later interviews (*e.g.*, during a

19. Kathy Pezdek, Kimberly Finger, & Danelle Hodge, *Planting False Childhood Memories: The Role of Event Plausibility*, 8 PSYCHOL. SCI. 437 (1997); Kathy Pezdek & Chantal Roe, *The Suggestibility of Children's Memory for Being Touched: Planting, Erasing, and Changing Memories*, 21 LAW & HUM. BEH. 95 (1997); William C. Thompson, K. Alison Clarke-Stewart, & Stephen J. Lepore, *What Did the Janitor Do? Suggestive Interviewing and the Accuracy of Children's Accounts*, 21 LAW & HUM. BEH. 405 (1997).

child custody evaluation), even if the later interviews are conducted in an unbiased manner.[20]

Therapists' clinical hypotheses and treatment goals should reflect current knowledge on children's suggestibility. The therapist must consider research from a variety of perspectives, including studies that highlight the strengths in children's memories, research regarding the impact of trauma, and studies demonstrating the potential impact of external influences on children's perceptions and interpretations of events. Treatment goals should be structured to enhance the child's ability to critically evaluate information and rely on his or her independent experiences in making decisions about relationships.

- trauma response exceeds coping capacity

B. Children's Coping and Development

Children's treatment should be designed with an understanding of each child's level of development, and with procedures that will assist children in developing the coping skills they will need to function successfully as they mature. Children who learn to use active coping skills (*e.g.*, engaging with others and asking for help) have better outcomes than those who continue to rely on more primitive coping methods, such as avoidance or suppression of emotions. Children also adjust better to parental separation, remarriage, and other transitions when they are able to participate in active decision-making in both homes, and when they are able to establish healthy and supportive relationships with peers.[21] Even when children learn to use active problem solving skills in school and apply them in social situations, they often continue to rely on dysfunctional approaches to family problems.[22] For this reason, it is essential that therapists actively support children in developing active coping responses to family issues.

Children of divorce are often required to adapt to a two-household family structure in which they may spend less time with both parents and experience several life style changes. Post-divorce family systems are often characterized by both children and parents experiencing greater stress, depression, internal and interpersonal conflict, changes in familiar routines and perceived loneliness. Parents may be more preoccupied with their own emotional issues and less effective, consistent and attentive to their children.[23] As a result, children must learn to communicate their

20. Studies are summarized in CECI & BRUCK, *supra* note 2, and DEBRA A. POOLE & MICHAEL E. LAMB, INVESTIGATIVE INTERVIEWS OF CHILDREN: A GUIDE FOR HELPING PROFESSIONALS (1998).

21. Dunn et al., *supra* note 3; Kelly & Emery, *supra* note 3.

22. Fields & Prinz, *supra* note 3.

23. ROBERT E. EMERY, MARRIAGE, DIVORCE, AND CHILDREN'S ADJUSTMENT (2nd ed. 1999); E. MAVIS HETHERINGTON & JOHN KELLY, FOR BETTER OR WORSE: DIVORCE RECONSIDERED

needs clearly and effectively, so that they are more likely to gain the attention and understanding of adults or older siblings. In most cases, this requires that the children communicate verbally, and that the therapist assist parents in recognizing and responding appropriately to their children's needs, including setting appropriate limits. These active relationship skills are also essential to children's abilities to form healthy relationships with peers and to form healthy intimate relationships as they mature.

C. Impact of Parental Conflict.

Children have better outcomes following parental separation when they can develop and/or maintain quality relationships with both parents, particularly when they are not placed in the middle of parental conflict. Long-term exposure to parental conflict may cause significant harm to children who may need protection or supervised contact when conflict is intractable or a parent is severely impaired.[24] The interrelationships among these variables are extremely complex.[25] Children may be both directly and indirectly impacted by parental conflict. They may model parental conflict, fail to learn appropriate social or coping skills, and experience on-going emotional or physiological distress.

The impact of conflict is diminished when parents are able to resolve their disputes using low-conflict approaches such as negotiation and compromise, even if the children do not witness that resolution. Children appear more adversely affected when parents engage in high conflict tactics and are unable to resolve disputes constructively.[26] High marital conflict also indirectly affects child adjustment by impacting parent-child relationships and children's access to non-custodial parents.[27] Maternal satisfaction about the father visiting has been found to be a stronger predictor of child adjustment than parental conflict.[28] Some researchers suggest that

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(2002); Kelly & Emery, *supra* note 3.

24. 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); Kelly & Emery, *supra* note 3; Vivienne Roseby & Janet R. Johnston, *Children of Armageddon: Common Developmental Threats in High-conflict Divorcing Families*, 7 CHILD & ADOLESCENT PSYCHIATRIC CLINICS OF N. AM. 295 (1998).

25. Amato & Gilbreth, *supra* note 15; Robert Bauserman, *Child Adjustment in Joint-custody Versus Sole-custody Arrangements: A Meta-analytic Review*, 16 J. FAM. PSYCHOL. 91 (2002).

26. MARK E. CUMMINGS & PATRICK DAVIES, CHILDREN AND MARITAL CONFLICT: THE IMPACT OF FAMILY DISPUTE AND RESOLUTION (1994); Kelly & Emery, *supra* note 3; Roseby & Johnston, *supra* note 24.

27. CUMMINGS & DAVIES, *supra* note 26; Robert E. Emery et al., *Child Custody Mediation and Litigation: Custody, Contact, and Coparenting 12 Years after Initial Dispute Resolution*, 69 J. CONSULTING & CLINICAL PSYCHOL. 323 (2001); Kelly, *supra* note 24; Kelly & Emery, *supra* note 3.

28. Kelly, *supra* note 24; Valarie King & Holly E. Heard, *Nonresident Father Visitation*,

well-defined parental responsibility schedules, including overnights, should be established as soon as possible after separation. These arrangements should promote strong attachment between the child and both parents, and are better for the child when they are consistently adhered to over time.[29] The child's therapist may have an essential role in helping the child resolve issues with each parent, and in helping the parents be more responsive to the child's needs so that the child can function successfully in the household.

One of the most important determinants of the impact of parental conflict on children is the degree to which children are placed in the middle of the conflict by their parents. Janet Johnston noted that in families with continuing, extreme, and often violent conflict after divorce, children with more frequent transitions and face-to-face custody changes had poorer adjustment than children in sole custody situations.[30] Joan Kelly notes, however, that it is unknown what level of conflict is damaging to children in shared custody arrangements, particularly if transitions are structured to minimize or eliminate the need for face-to-face contact between parents (*e.g.*, using neutral locations such as school or day care).[31] Adolescents who are caught in the middle of their parents' divorce are more poorly adjusted than adolescents whose parents continue to have conflict, but do not involve their children.[32] Children's therapists may have an important role in helping families to devise and implement specific plans that will decrease children's exposure to conflict.

Conflict, and the child's exposure to conflict, can be direct and obvious or it can be subtle and covert. A child caught in the middle of the parents' dispute may be asked to carry hostile messages to the other parent or spy on the other parent. Such a child could be both directly and indirectly exposed to adult emotional issues. Examples of subtle and inappropriate parent behavior include: (a) responding to most of a child's statements, but failing to respond to positive statements about the other parent; (b) showing overt distress when the child takes a toy to the other parent's

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Parental Conflict, and Mother's Satisfaction: What's Best for Child Well-being?, 61 J. MARRIAGE & FAM. 385 (1999).

29. Kelly, *supra* note 24; Joan B. Kelly & Michael E. Lamb, *Using Child Development Research to Make Appropriate Custody and Access Decisions for Young Children*, 38 FAM. & CONCILIATION CTS. REV. 297 (2000).

30. Janet R. Johnston, *Children's Adjustment in Sole Custody Compared to Joint Custody Families and Principles for Custody Decision Making*, 33 FAM. & CONCILIATION CTS. REV. 415 (1995).

31. Kelly, *supra* note 24; Kelly & Emery, *supra* note 3.

32. CHRISTY M. BUCHANAN, ELEANOR M. MACCOBY, & SANFORD M. DORNBUSCH, ADOLESCENTS AFTER DIVORCE 230 (1996); Christy M. Buchanan, Eleanor E. Maccoby, & Sanford M. Dornbusch, *Caught Between Parents: Adolescents' Experience in Divorced Homes*, 62 CHILD DEV. 1008 (1991).

home; (c) anxiously questioning a child about his/her time with the other parent; and (d) 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.

These subtle behaviors convey important messages to the child about the parent's inability to tolerate the other parent-child relationship and the degree to which the child may discuss his experiences and feelings about the other parent. Children who are exposed to these behaviors may learn to keep things to themselves, often relying on problematic coping skills such as suppressing their emotions, developing somatic symptoms, and avoidance. They may also feel compelled to choose between their parents and/or others they love, and may produce statements which they believe will ease the distress of the parent who is unable to tolerate the other parent-child relationship.

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

Such subtle experiences may be quite insidious in their effect. Children's therapists need to be alert for signs that a child is being exposed to the parental conflict in both overt and subtle ways, and should assist children in identifying the behaviors that distress them. It is also important to call the parents' attention to the harm that these behaviors can cause to their children, and design interventions to address these issues. Such interventions may include referring a parent for services (*e.g.*, individual treatment, conflict reduction or parenting classes, etc.) and/or structured conjoint sessions to assist the child in resolving issues with other family members. Parent education services help many parents to reduce inappropriate attitudes and behaviors toward the other parent, although more individualized interventions may be necessary with higher-conflict families.

The research results suggest that children's therapists should promote the development and maintenance of strong parent-child attachments, healthy relationships, adaptive coping skills and regular contact with both parents, with minimal exposure to parental conflict. It also suggests that therapists need to be savvy to the subtle influences of parental conflict and the ways in which children are often used as pawns in the end game of litigation victory.

V. Supporting What Children Need — Which Is Not Always What They Want

The custody evaluation literature frequently includes discussion of the role that children's expressed wishes should play in the custody evaluator's recommendations. However, forensically-inexperienced therapists who adhere to a traditional treatment model of supporting and advocating for their clients may report the child's "feelings" without considering the influence that the larger family context may have on the information and feelings provided by the child in treatment. In particular, therapists may not adequately consider the effects of external influences or developmental issues that may have an impact on the child's statements or behavior.

....or trauma

We submit that the therapist's role is to support the child's *developmental needs*, including the need to develop adaptive coping skills. As described above, it is essential that therapists critically examine information that is presented to them, and assist children in relying on their own perceptions in establishing and developing relationships. Therapists can model such behavior by gently challenging inconsistencies in children's statements in treatment, and conveying an expectation that children resolve problems directly rather than simply avoiding them. Most adults recognize that children should not be permitted to avoid other situations that they find challenging (*e.g.*, a teacher with whom the child is having difficulty), but should be motivated, and at times required, to resolve interpersonal problems directly (*e.g.*, by talking to the teacher about the problem rather than avoiding school). However, litigating parents often attempt to stand this axiom on its head by advocating that the child be permitted to avoid contact with a parent with whom the child is having difficulty. Too often, therapists acquiesce to this double-standard rather than structuring a treatment intervention which will assist the child in resolving issues directly with the involved parent.

Key

**Not child welfare system workers or crisis responders or school officials or typical bottom level LCSWs/ LPCs when the idea of child endangermen t breezes into their minds

This is not to suggest that the therapist should not consider a child's feelings when making recommendations to parents or structuring treatment. Treatment should communicate an expectation that parents support their children in mastering developmental tasks and learning effective coping skills, including the skill of asserting independent feelings and needs. When a parent is engaging in behavior that is distressing a child or undermining a child's need for emotional independence, the therapist may need to request a behavior change from the parent. The therapist may suggest a parenting class or treatment, collaborate with a parent's therapist, or conduct structured conjoint sessions to assist the child in directly addressing his/her concerns with the parent. Such interventions may be effective even with an impaired parent, if the format is sufficiently structured to support

the child while limiting the parent's problematic behavior. This is also supportive of the child's developmental needs to establish emotional independence and to learn appropriate coping skills. Parents who might not be responsive to complaints from another adult will sometimes respond when the request comes directly from their child, particularly in the presence of a therapist who assists the parent in hearing the child's message.

Of course, it is not always possible for children's concerns to be resolved using therapeutic interventions such as those described above. When a parent's behavior is dangerous or presents a risk to a child and the parent is unwilling to address that behavior, it may be necessary for the therapist to articulate the impact of the parent's behavior on the child to other professionals or the court. The therapist may also request that a child-custody evaluation be ordered to revisit the custody or visitation issues.

VI. Considerations in Sharing (or Requesting) Treatment Information

Therapists working with court-involved children and families are more likely to be asked to provide treatment information to a third party than are therapists providing traditional community treatment. As a result, therapists providing treatment in a forensic context need to pay special attention to the issues of informed consent and the potential impact of disclosing, or declining to disclose, information about the scope, nature and progress of treatment.

Since therapists often work with children and families for a period of time, they may have important information regarding the needs, perspective, and functioning of the child. In most cases, information from the child's treatment will reach the court through the report of the child custody evaluator. However, therapists may be subpoenaed to testify or requested to provide a report or declaration/affidavit regarding the child's progress in treatment, the progress of conjoint or reunification therapy, and any number of related issues.

Therapists may have 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 opinions do not conform with what the parent was hoping to hear. These issues can be managed by informing children and parents of the conditions under which the therapist may share, or be ordered to share, treatment information. This type of discussion is part of the informed consent process for parents, and should occur with children (in a manner appropriate to the child's age) at both the onset of treatment and when situations arise in which it may be necessary to disclose treatment information. Often, children are more concerned about the reactions

of the adults around them than about the sharing of information *per se*. Children may, in fact, be relieved when the therapist discloses information which the child has been unable to express himself/herself. 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/her environment. Otherwise, the disclosure of treatment information may seriously damage the child's trust in the therapy process.

The complex issues involved with sharing treatment information have led to differing opinions among therapists. Some therapists have chosen to recuse themselves entirely from the court process or even from speaking to the child custody evaluator. This philosophy is sometimes referred to as "safe haven" therapy.[33] Therapists who engage in safe haven therapy ask that the parents stipulate to limits on the therapist's role in providing information to any third party. Stipulations may include written agreements that the therapist will not testify in a custody trial or speak to a psychological evaluator. Some authors have even proposed that therapists be barred from the courtroom altogether.[34] Therapists who advocate this stance emphasize that, in order to provide a safe environment for a child or adult to explore emotional issues, privilege must be maintained, and that both the therapist and treatment information must be excluded from the resolution of the child custody case.

The alternate perspective is that a child's therapist may have information which would be difficult for the evaluator or judicial officer to obtain otherwise, and which may be important to an evaluator or judicial officer's analysis of a case. In some cases, this information may be essential for the protection of the child. Therapeutic information may be particularly important when cases involve a high level of conflict, allegations of maltreatment, or other circumstances in which information about the child's reality or functioning are critical issues in the court's decision making. Examples of such situations include when: (1) a case has been going on for an extended period of time; (2) the child's overt behavior has changed over time; (3) there is an allegation of abuse which is several years old; (4) the therapist has observed the child under more than one custody arrangement; (5) the child has been exposed to the parental conflict for an extended period of time; or (6) other information relevant to the custody

33. Carol Silbergeld, *A Clinical Perspective*, address before the 19th Annual Child Custody Colloquium (January 15, 1997).

34. Daniel W. Shuman et al., *An Immodest Proposal: Should Treating Mental Health Professionals Be Barred from Testifying About Their Patients?*, 16 BEH. SCI. & LAW 509 (1998).

evaluation has become evident in treatment.[35] In some situations, a therapist may be permitted to safeguard some treatment information and limit reports to information that is relevant to the matter before the court.[36] Issues such as whether a treating therapist should provide treatment information, who should receive that information, and how such information should be structured and limited, are subjects of considerable controversy. One aspect of the controversy involves role boundaries. Too often, therapists stray beyond the boundaries of their roles as treating therapists and into the arena of psycholegal opinions and recommendations. Psycholegal opinions include recommendations about custody arrangements, parental capacity, and conclusive opinions about allegations of maltreatment. As mentioned above, these issues are more appropriately addressed by the forensic evaluator, who has a broader information base than that available to the therapist.

VII. The Treating Expert — Role Boundaries and Suggested Guidelines of Expertise

A. The Treating Expert

We have emphasized the expertise needed by therapists in forensic cases. We have also noted the differences between the role of the *treating expert* and the role of the *forensic expert* or *forensic evaluator*. Historically, discussions of expert testimony have been largely limited to contrasting the role of the fact witness with that of the expert witness. Testimony from a fact witness is often limited to first-hand observations and facts. Testimony from an expert witness allows for statements of opinions as well as statements of fact which address the psychological aspects of the legal issues before the court. There are two types of expert witnesses, the treating expert and the forensic expert.[37] While the distinction between treating and forensic experts is accepted by much of the forensic mental health community, the qualifications and limitations of the treating expert's role remains largely undefined in the professional literature. In this section, we make an attempt to arrive at such a conceptualization, which may be useful for those involved in such court matters as divorce, custody and dependency.

B. Distinguishing Treating Expert from the Forensic Expert

The essential goal of a forensic evaluator is to gather information to answer specific psycholegal questions about a family's functioning. The focus of the forensic assessment is driven by the needs of the court. The

35. Greenberg & Gould, *supra* note 4; Greenberg et al., *supra* note 7.
36. *See, e.g., In re* Mark L.,114 Cal. Rptr. 2d 499 (Ct. App. 2001).
37. Greenberg & Shuman, *supra* note 7; Greenberg & Gould, *supra* note 4.

expectation is that the judicial officer will use aspects of the evaluator's recommendations in determining a solution for the family. The psychologist performing this evaluation is appointed as a *forensic expert*, and is authorized to offer opinions on psycholegal issues such as parental capacity and the best custody arrangement for the child.[38]

In contrast to the broad scope with which an evaluator views a family, the treating psychologist's focus is narrower, more intimate, and more longitudinal. This perspective adds power to the therapist's ability to track behavior and help a child or family master developmental challenges. As a result, treating psychologists may be well qualified to render 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 related issues. Much of this information may be an important part of the data considered by the child custody evaluator. Nevertheless, the treating therapist does not have the evaluation perspective or breadth of information which is inherent in the forensic expert's role. As a result, it is not appropriate for the treating therapist to render opinions on psycholegal issues such as parental capacity and custodial arrangements. Such opinions are the province of the child custody evaluator and ultimately the court.

C. Reliability and Validity of the Treating Expert's Opinion

Not all expert testimony is created equal. There is likely to be at least as wide a variation in the quality of therapist testimony and opinion as is present in the testimony of child custody evaluators or other forensic experts. Daniel Shuman has written with both Stuart Greenberg[39] and Bruce Sales[40] on criteria for assessing the quality of expert opinion testimony.[41] Shuman and Greenberg, referencing established ethical standards in psychology, have argued that an expert's adherence to those standards should have a bearing on both the admissibility and the weight of the expert's opinion.[42] Shuman and Sales note that forensic opinion testimony can range on a continuum from opinions based totally on scientific research to entirely clinical opinions (*i.e.*, statements based only on the personal opinion of the expert, and ignoring or contradicting relevant sci-

38. GOULD, *supra* note 5; Greenberg & Shuman, *supra* note 7.

39. Daniel W. Shuman & Stuart Greenberg, *The Role of Ethical Norms in the Admissibility of Expert Testimony*, JUDGES J. 5-9, 42 (Winter, 1998).

40. Daniel W. Shuman & Bruce D. Sales, *The Admissibility of Expert Testimony Based upon Clinical Judgment and Scientific Research*, 4 PSYCHOL., PUB. POL'Y & LAW 1226 (1998).

41. Shuman & Greenberg, *supra* note 39; Shuman & Sales, *supra* note 40.

42. Shuman & Greenberg, *supra* note 39.

entific research).[43] The midrange would include opinions which are based on scientific research but extrapolate beyond established results and clinical opinions, which are based on the expert's personal experience but also acknowledge relevant research results or result from research-based data-gathering techniques.

There are important differences between treatment and evaluation roles and the type of appropriate expert testimony that can be offered from each role.[44] It seems evident, however, that the quality of treating expert reports and testimony can be evaluated by criteria that are somewhat parallel to those proposed for forensic experts.

A treating expert's opinion should be based on systematic methods of gathering and tracking treatment data, a thorough knowledge of relevant research, treatment methods which support the child's developmental needs, and interventions based on research about children's adjustment and coping needs rather than ideologically or emotionally-driven ideas of what is best for children. Many methods used by therapists have not yet been empirically validated, and much of what therapists do is based on their experience and clinical theory. As described above, however, much research is available that should inform the treatment process.[45] Therapists who continue to use methods that are contradicted by current research should be prepared to justify doing so. At a minimum, therapists who express opinions based only on their clinical experience should clearly delineate these statements from opinions that include consideration of available research.[46]

While it is beyond the role of the treating expert to express an opinion on a psycholegal issue, therapists are often asked questions which are designed to support or refute a legal position. The treating therapist must resist the temptation to assist the court by providing opinions which go beyond his or her role, competence, and the scope of his or her data. The therapist may respectfully decline to express an inappropriate opinion by referencing the type of data or assessment which would be required to provide a valid answer to the pending question, contrasting this with the data available to the therapist.

VIII. When Should A Child's Therapist Be Removed?

The stakes are high in child custody and dependency cases. Unbiased, developmentally-sensitive treatment by a forensically-trained therapist can be an enormously positive force in a child's life. Conversely, the

43. Shuman & Sales, *supra* note 40.
44. Greenberg & Shuman, *supra* note 7.
45. Greenberg, *supra* note 2; Greenberg & Gould, *supra* note 4.
46. *See* Shuman & Sales, *supra* note 40, for an extensive discussion of the relative value of clinical judgment and scientific testimony.

power of the therapist's role carries with it an enormous potential to do harm. Therapists who bias treatment or jump to conclusions can seriously undermine a child's development and contaminate the data considered by the child custody evaluator.

The question of whether to remove a child's therapist presents complicated issues. As described above, bias in children's treatment may cause serious harm to children and families. It is important to note, however, that the fact that a parent becomes angry at a therapist does not necessarily mean that the therapist is conducting inappropriate treatment.

Some parents may refuse to support the child's treatment, particularly if the therapist has been unwilling to support that parent's position in the custody conflict. An angry parent may also refuse to support treatment in the hope the judicial officer will remove the child's therapist and replace the therapist with someone more supportive of the parent's position.

Removing a child's therapist in this circumstance may be very damaging to the child. Removal of an independent therapist may send the message that the parent's anger and/or manipulation of the system are given greater weight in decision-making than respect for 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.

These risks are significant in cases with a high level of conflict. Children at the center of a contested dispute may be subjected to repeated disruptions in their access to significant relationships. Such children may become quite confused because of the divergent viewpoints of each parent. A litigating parent may be unable or unwilling to tolerate the presence in the child's life of anyone who does not support that parent's position. If the parent is successful at banning one person after another (including the other parent) from the child's life, the child's universe of social relationships becomes progressively more restricted. If the child is exposed only to relationships that support one parent's viewpoint, the pressure to adopt that parent's belief system may become overwhelming. If the therapist is supporting the child's independent perceptions (which often do not conform to either contesting parent), the loss of that therapist may be a serious blow to the child's developing emotional independence.

In seeking to determine the usefulness of the therapist's role with the child, the essential issues are whether the therapist has taken steps to understand the systemic family context, maintain a balanced perspective on the child's problems and needs, explore multiple hypotheses, and support the child's *independent* perceptions and needs. If the therapist has maintained such an approach but a parent refuses to support treatment, it

may be more supportive to the child to appoint a separate conjoint therapist than to remove the child's individual therapist.

Conversely, the continuation of biased treatment may cause serious damage to a child. A biased therapist may escalate the "tribal warfare"[47] of high conflict family systems by overly-aligning with one parent and against the other parent. As described above, biased treatment undermines children's development and presents a substantial risk of presenting unreliable information to the court. The harmful effects of biased treatment may also be exacerbated over time by progressively undermining children's coping abilities and creating a self-fulfilling prophecy of behavioral symptoms and invalid statements. Long-term biased treatment may also undermine children's independent memories and their ability to perceive relationships accurately. Under these circumstances, it may be most supportive to the child to terminate the biased treatment and arrange a therapeutic transition to another therapist. Such transitions can often be accomplished over a few weeks' time if both the therapist and the parents paint the transition in a positive light and provide reassurance to the child. This may require both coordination with the new therapist and a specific stipulation or court order that specifies the procedures to be used in transitioning treatment.

IX. Practice Tips for Attorneys Dealing with Children's Therapists

A. Tips for Parent's Attorneys

1. Children's therapy is more likely to be effective with both parents' involvement. *Whenever possible*, advise parents not to initiate children's treatment unilaterally.
2. Select therapists who are knowledgeable about high-conflict divorce. Request resumes from therapists that your clients are considering retaining, and/or request recommendations from others in the community. Where there is adequate funding available, it is often wise to select therapists based on qualifications, rather than membership in insurance panels which reimburse therapists at reduced rates. Many of the most highly qualified therapists do not accept managed care or other insurance contracts.
3. Avoid therapists who do not have established procedures, or whose protocols do not involve evenhanded communication with parents.
4. If you are a parent's attorney, and you or your client suspect that a child's therapist is engaging in inappropriate practice:

...the court and DHS trained in trauma and trauma response, adolescent development, suggestibility and alienation dynamics, trauma and engagement resistant treatment modalities, family systems, life span consequence/ dysfunction, detection of disease underpinnings

47. JOHNSTON & ROSEBY, *supra* note 1, at 6-11.

a. Attempt to determine the basis for the concern (*i.e.*, whether the therapist *is* conducting biased treatment, exceeding his or her role, or supporting children in avoiding problems rather than learning to deal with them)
b. Advise your client to attempt to open or improve communication with the therapist
c. Request a conference call with the therapist and opposing counsel. (The therapist will likely require a release from the parents to participate in such a call.)

5. If you are a parent's attorney and are confronted with a declaration that reflects negatively on your client:
   a. Attempt to determine whether the therapist had sufficient basis on which to express his or her opinion (*e.g.*, whether the therapist has expressed an opinion regarding a parent-child relationship that he or she has not observed);
   b. Attempt to determine whether the therapist has expressed an opinion that is beyond the scope of the therapist's role (*e.g.*, if the therapist has expressed an opinion about the best custody arrangement for the child);
   c. Attempt to ascertain whether the therapist's statements are based on confidential communication and, if so, whether the therapist had authority to release these statements.

B. Tips for Minors' Counsel

1. Ascertain who holds the child's privilege. If it is a high-conflict case and the statutory authority is unclear, ensure that the order governing the child's treatment establishes that privilege is held by the minor's counsel.
2. If you are appointed to represent a child who is already in therapy:
   a. Interview the therapist regarding treatment provided to the child. Ask the therapist specific questions regarding the child's progress, possibilities that the therapist has considered in assessing the child's needs (listen for evidence of bias), and treatment methods being used to help the child cope actively with stress and problems. The therapist should be able to list a variety of hypotheses that he or she has explored or intends to explore regarding the child's symptoms and needs, how those

possibilities were assessed, and the therapist's specific treatment plans and interventions.

b. Do not assume that the child's therapist is doing a poor job if the child resists therapy or states that he or she doesn't want to attend. Particularly in high-conflict cases, children may have become accustomed to avoiding problems and may resist attempts by the therapist to help them cope more effectively. A child at the center of a high-conflict custody dispute may also echo one or both parents' expressed views regarding their treatment.

c. Remember that part of the therapist's job is to support the child's developmental needs. This includes challenging both children and parents to cope more effectively, including using active methods to resolve problems. This may or may not always be consistent with the child's expressed view.

3. If you believe that the therapist has engaged in egregious conduct or is conducting biased treatment:

a. Consider requesting an evaluation limited to the purpose of determining the appropriateness of the child's treatment

b. Consider requesting that the child's therapist be replaced. This may require expert testimony to educate the court about children's suggestibility or the harmful effects of long-term, inappropriate treatment.

X. Conclusions

Decisions and interventions made by psychologists can have long-lasting effects on the lives of children and families. It has been argued elsewhere that forensic psychologists must demonstrate the highest level of professional practice and competence. Although there is some controversy on this point, most authors agree that the development of standards and guidelines for child custody evaluations have helped raise the level of professional practice. We believe that development of standards for court-related treatment and effective practices by attorneys could be similarly useful in raising the quality of services.

Therapists help divorcing families every day. Not every case needs, nor can every family afford, a forensic psychologist to provide treatment. We contend, however, that just as complex medical problems may require specialist care, complex dependency and custody cases require therapists with forensic training, demonstrating the highest level of professional practice.

APPENDIX

Cal. R. Ct. 5.220[48]

(a) [Authority] This rule is adopted under article VI, section 6 of the California Constitution and Family Code sections 211 and 3110.5.

(b) [Purpose] As required by Family Code section 3110.5, this rule establishes education, experience, and training requirements for child custody evaluators who are appointed only under Family Code section 3111, Evidence Code section 730, or Code of Civil Procedure section 2032. Additional training requirements for these child custody evaluators are contained in rule 1257.7.

(c) [Definitions] For purposes of this rule:

(1) A "child custody evaluator" is a court-appointed investigator as defined in Family Code section 3110.

(2) A "child custody evaluation" is an expert investigation and analysis of the health, safety, welfare, and best interest of a child with regard to disputed custody and visitation issues.

(3) A "full evaluation, investigation, or assessment" is a comprehensive examination of the health, safety, welfare, and best interest of the child.

(4) A "partial evaluation, investigation, or assessment" is an examination of the health, safety, welfare, and best interest of the child that is limited by court order in either time or scope.

(5) The terms "evaluation," "investigation," and "assessment" are synonymous.

(6) "Best interest of the child" is described in Family Code section 3011.

(d) [Requirements for evaluators' qualifications: education, experience, and training] Persons appointed as child custody evaluators must:

(1) Effective January 1, 2004, complete a total of 40 hours of initial training and education as described in subdivision (e). At least 20 of the 40 hours of education and training required by this rule must be completed by January 1, 2003;

48. *See* <http://www.courtinfo.ca.gov/rules/titlefive/1180-1280.15.doc-277.htm#TopOfPage>.

(2) Comply with the training requirements described in rule 1257.7;
(3) Fulfill the experience requirements described in subdivision (f); and
(4) Meet the continuing education, experience, and training requirements described in subdivision (g).

(e) [Education and training requirements] Only education acquired after January 1, 2000 that meets the requirements for training and education providers described in subdivision (n), meets the requirements of this rule. Ten of the hours required by this rule may be earned through self-study that is supervised by a training provider who meets the requirements described in subdivision (n). Serving as the instructor in a course meeting the requirements described in subdivision (n) in one or more of the subjects listed in paragraphs (1) through (21) below can be substituted for completion of the requisite number of hours specified in subdivision (d) on an hour-per-hour basis, but each subject taught may be counted only once. The hours required by this rule must include, but are not limited to, all of the following subjects:

(1) The psychological and developmental needs of children, especially as those needs relate to decisions about child custody and visitation;
(2) Family dynamics, including, but not limited to, parent-child relationships, blended families, and extended family relationships;
(3) The effects of separation, divorce, domestic violence, child sexual abuse, child physical or emotional abuse or neglect, substance abuse, and interparental conflict on the psychological and developmental needs of children and adults;
(4) The assessment of child sexual abuse issues required by Family Code section 3110.5(b)(2)(A)-(F) and Family Code section 3118; local procedures for handling child sexual abuse cases; and the effect that court procedures may have on the evaluation process when there are allegations of child sexual abuse;
(5) The significance of culture and religion in the lives of the parties;
(6) Safety issues that may arise during the evaluation process and their potential effects on all participants in the evaluation;

(7) When and how to interview or assess adults, infants, and children; gather information from collateral sources; collect and assess relevant data; and recognize the limits of data sources' reliability and validity;
(8) The importance of addressing issues such as general mental health, medication use, and learning or physical disabilities;
(9) The importance of staying current with relevant literature and research;
(10) How to apply comparable interview, assessment, and testing procedures that meet generally accepted clinical, forensic, scientific, diagnostic, or medical standards to all parties;
(11) When to consult with or involve additional experts or other appropriate persons;
(12) How to inform each adult party of the purpose, nature, and method of the evaluation;
(13) How to assess parenting capacity and construct effective parenting plans;
(14) Ethical requirements associated with the child custody evaluator's professional license and rule 1257.3;
(15) The legal context within which child custody and visitation issues are decided and additional legal and ethical standards to consider when serving as a child custody evaluator;
(16) The importance of understanding relevant distinctions among the roles of evaluator, mediator, and therapist;
(17) How to write reports and recommendations, where appropriate;
(18) Mandatory reporting requirements and limitations on confidentiality;
(19) How to prepare for and give court testimony;
(20) How to maintain professional neutrality and objectivity when conducting child custody evaluations; and
(21) The importance of assessing the health, safety, welfare, and best interest of the child or children involved in the proceedings.

(f) [Experience requirements] Persons appointed as child custody evaluators must satisfy initial experience requirements by:
(1) Completing or supervising three court-appointed partial or full child custody evaluations including a written

or an oral report between January 1, 2000, and July 1, 2003; or

(2) Conducting six child custody evaluations in consultation with another professional who meets the education, experience, and training requirements of this rule.

(g) [Continuing education and training] Effective January 1, 2004, persons appointed as child custody evaluators must annually attend 8 hours of update training covering subjects described in subdivision (e) after completing the initial 40 hours of training. This requirement is in addition to the annual update training described in rule 1257.7.

(h) [Ongoing clinical consultation] When conducting evaluations, persons appointed as child custody evaluators should, where appropriate, seek guidance from professionals who meet the requirements of this rule.

(i) [Court employees] Effective January 1, 2004, court-connected evaluators may conduct evaluations if they have already completed at least 20 hours of the training required in subdivision (d) of this rule and meet all of the qualifications established by this rule within 12 months after completing the 20-hour requirement. During the period in which a court-connected evaluator does not yet meet the requirements of this rule, a court-connected professional who meets the requirements of the rule must supervise the court-connected evaluator's work.

(j) [Alternative appointment criteria] If the court appoints a child custody evaluator under Family Code section 3110.5(d), the court must require that the evaluator:

(1) Possess a master's or doctoral degree in psychology, social work, marriage and family counseling, or another behavioral science substantially related to working with families; and

(2) Have completed the education, experience, and training requirements in subdivisions (e) and (g) of this rule.

(k) [Licensing requirements] On or after January 1, 2005, persons appointed as child custody evaluators must meet the criteria set forth in Family Code section 3110.5(c)(1)-(5).

(l) [Responsibility of the courts] Each court:

(1) On or before January 1, 2004, must develop local court rules to implement this rule that:

(A) Provide for acceptance of and response to complaints about an evaluator's performance, and

(B) Establish a process for informing the public about how to find qualified evaluators in that jurisdiction;

(2) Effective January 1, 2004, must use the Judicial Council form Order Appointing Child Custody Evaluator (FL-327) to appoint a private child custody evaluator or a court-connected evaluation service. Form FL-327 may be supplemented with local court forms;

(3) Must provide the Judicial Council with a copy of any local court forms used to implement this rule; and,

(4) As feasible and appropriate, may confer with education and training providers to develop and deliver curricula of comparable quality and relevance to child custody evaluations for both court-connected and private child custody evaluators.

(m) [Child custody evaluator] A person appointed as a child custody evaluator must:

(1) Effective January 1, 2004, complete and file with the court Judicial Council form Declaration of Child Custody Evaluator Regarding Qualifications (FL-326). This form must be filed no later than 10 court days after receipt of notification of the appointment and before any work on the child custody evaluation has begun, unless the person is a court-connected employee who is required to file annually with the court Judicial Council form Declaration of Child Custody Evaluator Regarding Qualifications (FL-326);

(2) At the beginning of the child custody evaluation, inform each adult party of the purpose, nature, and method of the evaluation, and provide information about the evaluator's education, experience, and training;

(3) Use interview, assessment, and testing procedures that are consistent with generally accepted clinical, forensic, scientific, diagnostic, or medical standards;

(4) Have a license in good standing if licensed at the time of appointment, except as described in Family Code section 3110.5(d);

(5) Be knowledgeable about relevant resources and service providers; and

(6) Prior to undertaking the evaluation or at the first practical moment, inform the court, counsel, and parties of possible or actual multiple roles or conflicts of interest.

(n) [Training and education providers] Eligible providers may include educational institutions, professional associations, professional continuing education groups, public or private for-profit or not-for-profit groups, court-connected groups, and the Administrative Office of the Courts. Eligible providers must:

(1) Ensure that the training instructors or consultants delivering the training and education programs either meet the requirements of this rule or are experts in the subject matter;

(2) Monitor and evaluate the quality of courses, curricula, training, instructors, and consultants;

(3) Emphasize the importance of focusing the child custody evaluation on the health, safety, welfare, and best interest of the child;

(4) Distribute a certificate of completion to each person who has attended the training. The certificate will document the number of hours of training offered, the number of hours the person attended, the dates of the training, and the name of the training provider; and

(5) Meet the approval requirements described in subdivision (o).

(o) [Eligible training] Effective July 1, 2003, eligible training and education programs must be approved by the Administrative Director of the Courts. Training and education taken between January 1, 2000, and July 1, 2003, may be applied toward the requirements of this rule if it addresses the subjects listed in subdivision (e), and is either certified for continuing education credit by a professional provider group or offered as part of a related postgraduate degree or licensing program. (Ad eff. 1/1/02).