

## **Prudent Therapy in High Conflict Cases: With and Without Allegations of Intimate Partner Violence or Child Abuse**

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*Many therapists see large numbers of people who are going through the process of divorce, but they do not receive training about the special issues that emerge in many divorcing families, particularly those who are engaged in high levels of conflict. Therapists in these cases may be faced with situations where there are allegations of abuse or domestic violence or other allegations are swirling within high conflict complex cases, in which the therapist is drawn toward advocacy or into action that is inadvertently detrimental to the family or puts the therapist at risk. This article describes some of these professional risks and recommends best practices in these complicated clinical cases.*

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Psychotherapy is often necessary and useful for families involved in the high-stress processes of divorce and child custody disputes. Many mental health professionals (MHPs) find that a substantial percentage of their therapy caseloads consist of people who are contemplating or going through divorce. The crisis of divorce often leads people to look for a therapist and, in some cases, the psychological work done by the person in the aftermath of a divorce leads to successful reorganization of their functioning (Amato, 2010; Hetherington, Bridges, & Insabella, 1998; Hetherington & Kelly, 2003). Therapists are often very helpful when they work with individuals' distress, anxiety, depression, and other symptoms and when they help their clients think through the decisions they need to make. There are some situations in which

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the therapist can make unwise statements or interventions that may damage the client and the family. These situations may arise when there are allegations of domestic violence, child abuse, or “parental alienation” when the divorce is litigated and the focus of the parent’s therapy becomes entangled with helping win the legal dispute. Therapists can make unwise statements or take unwise actions when they lose objectivity, fail to consider the limitations in the information they have, and fail to operate within the limitations of the therapist role.

In this article, we discuss some of the challenges that may arise in individual therapy with adults going through divorce when there are unconfirmed allegations of domestic violence or child physical or sexual abuse, whether or not the cases have been court-ordered and whether or not they are directly or indirectly court involved. That is, there may be allegations that are under investigation by another agency or individual during the time the therapy is being conducted, or there may be allegations that have been investigated and found to be either unsubstantiated or unfounded. The focus of this article is to aid therapists who have *not* identified themselves as forensically trained and oriented but who, nevertheless, find themselves in these cases. Basic graduate school training and most internships in clinical psychotherapy provide little or no guidance for therapists to follow when they are faced with these complex cases with allegations of abuse and violence. Such cases present powerful subtle and overt demands for the therapist to take sides and to provide advocacy for the client or to provide information for the court. Therapists do best to maintain their independence in the face of such pressures, a stance that depends on the therapist having the knowledge that allows him or her to do this.

Even when court involvement is known from the beginning of the treatment, therapists need training and information about best practices. Readers are directed to the full special issue of the *Journal of Child Custody*, March 2012, for information on recent developments and specific strategies for effective therapies and interventions that are court ordered or that are organized as court involved from the beginning. Readers are also directed to the AFCC task force report, *Guidelines for Court-Involved Therapy*, 2010 (Fidnick, Koch, Greenberg, & Sullivan, 2010). Still other articles in this issue focus on treatment of children in cases that have court involvement.

The basic exhortation from ancient times is resoundingly relevant in these cases: First, do no harm (attributed to Hippocrates, 400 B.C.E.). Therapists in these cases need to have a grounded, clear-eyed analysis of their role, their professional responsibilities to everyone in the family, the limits and boundaries of their knowledge, and their allowable range of action.

## THE ENTRY INTO PSYCHOTHERAPY

There are many paths into psychotherapy. Parents may seek treatment for themselves, on their own initiative, to help them deal with the distress they

are feeling around the time of divorce. Parents may seek treatment for the traumatic effects of domestic violence or for direction and help with dealing with a controlling and/or violent partner. Parents sometimes bring up concerns about a child to their own therapist with the hope that the child's symptoms will lead the therapist to report child abuse (allegedly by the other parent). Parents sometimes will seek out therapists who specialize in trauma treatments of various kinds to treat traumas they believe they have suffered. The various paths into therapy may be obvious and known at the beginning, or covert and only evident later in the therapeutic process. The client may be unable to articulate all of his or her reasons for seeking treatment. The motivations and intentions may lead to complications for which the prudent therapist needs to be prepared.

Parents sometimes seek treatment for general worries about their children or for specific worries about abuse and neglect at the hands of the other parent. They may hope to get emotional support for their own primacy as parent or even to get testimony from the therapist in their favor and against the other parent. As suggested, the hopes and intentions of the person who contacts the therapist may not be immediately apparent, and the alleged trauma may not have been substantiated by any independent investigation at the point that the therapist is contacted (Greenberg, Gould, Gould-Saltman, & Stahl, 2003; Kuehnle & Connell, 2010). While we agree with Kuehnle and Connell (2010) that specific treatment for trauma should not be done unless and until there is a legal determination about the alleged trauma, in many cases a client is symptomatic and may nonetheless benefit from a course of treatment that is symptom specific, in which the therapist maintains an objective and neutral stance with regard to the allegations themselves.

The source of a referral may come from someone other than the client. Other professionals who are involved with the family, attorneys, teachers, pediatricians, or even the court, may direct adults to psychotherapy. Teachers and physicians may make a recommendation based on concern about the symptoms or deep distress in a parent. Attorneys may instruct their clients to begin therapy to improve their resilience and capacity to parent well during the period of conflict and litigation. It is also true that attorneys may send their clients to psychotherapy with the goal (often unspoken) of positioning the client to appear more favorable in the eyes of the court, for example, to deflect accusations of domestic violence or "alienation" of the children. Some attorneys send their clients to meet with a therapist with an expectation that the therapist will provide positive feedback to the courts about the client's parenting.

Courts sometimes order treatment of parents as a condition of continued parent-child contact, with or without clear direction about feedback to the court. Courts sometimes recommend focused treatment such as anger management, family therapy, or reunification therapy. Court-involved therapy is discussed elsewhere in this special issue. In this article we focus on people who come into treatment presenting with more general clinical issues in

addition to concerns or allegations of possible child abuse or domestic violence.

The way in which a person comes to the therapist's office may provide varying amounts of clinical information about the relationship the individual has with the legal system. If the adult sought treatment voluntarily but as part of a legal case that is not initially disclosed, a "nonforensic" therapist may find himself or herself dealing with issues related to the court at some later point. The choice to accept "forensic cases" belongs to the therapist, but no therapist can guarantee that their practices will remain free of such cases.

Some psychotherapists refuse to accept children or adults into treatment if they believe there *might* be litigation in the future. And there are others who will withdraw and make a transfer to another therapist, when and if high conflict and litigation occur. Our contention is that mental health professionals do not need to fear such situations, but they do need information, training, and supervision or consultation to manage these situations well. At the extremes, both therapists who are overconfident and do not seek out consultation and information before acting in high-conflict divorce cases and those who are frightened away from acting in any capacity in high-conflict cases may make things worse for the clients. They can exacerbate the situation by interfering with appropriate investigations, contaminating the information that might be available to the family or the court, contributing to polarization, or aggravating the parent's inability to tolerate ambivalence or uncertainty. By withdrawing from the treatment, the therapist may inadvertently convey the impression that the family's situation is so bad no one can help them. Both groups of therapists do not serve their clients well and may be helped by a closer discussion of the issues in these cases.

### UNDERSTANDING THE STATUS OF THE CASE

Although the intake process is important in all psychotherapy cases, it is crucial in forensic cases. When contacted by a person seeking psychotherapy, most MHPs will direct the initial interview to find out what the current problems are and to get some history of the individual and the problem. The MHP in the clinical role of psychotherapist will take the patient's description of the problem and the history at face value (Greenberg & Gould 2001; Greenberg, Gottlieb, & Gould-Saltman, 2008; Guenther & Otto, 2010; Shuman & Greenberg, 1997).

When the problems and issues concern divorce, children, and child custody, there are additional facts that a therapist needs to know. The first is the status of the legal case. The individual may not know this very clearly, as he or she may be confused and overwhelmed with the legal process. The therapist can help organize the client's thinking and improve the services he or she provides if he or she learns where the person is along the path from marriage,

separation, divorce, and movement toward final settlement and orders. Note that this does not imply the provision of legal advice, which is never appropriate. Simple questions from the therapist about what the client has been told and about what papers they have signed or seen may help the client organize his or her own questions about what is happening in the legal process. Clients should be directed back to their attorneys to ask for clarification of legal questions.

The limits of confidentiality must be discussed as part of an informed consent in all types of therapy whether the therapy is court ordered or not. These discussions of confidentiality should occur at the beginning of therapy as well as intermittently throughout the course of treatment. Informed consent is a process, not a one-time event. These discussions must include the pros and cons of the therapist testifying if served with a subpoena as well as disclosures that might have the potential to weaken or even waive the client's privileges. Fuller discussion of confidentiality and informed consent are beyond the scope of this article. These issues are covered thoroughly in the Dwyer article on informed consent and the Perlman article on tips for clinicians (Dwyer, 2012; Perlman, 2012).

It is our view that that the MHP functions in the best practice if the therapeutic and forensic roles in a given case are kept totally separate—in every way. This is consistent with Specialty Guidelines for Forensic Psychologists, 4.02.01, Therapeutic–Forensic Role Conflicts (2011). It is required by American Psychological Association (APA, 2010) ethical standards, most competence standards, and state licensing laws. Thus, it is helpful to anticipate with the client whether the therapist and/or treatment records might be subpoenaed, what will happen if the therapist and/or treatment records are in fact subpoenaed, and how the therapist would handle a query from the parent's attorney, a child custody evaluator, a mediator, and/or a case manager or parenting coordinator. This should all be discussed ahead of time, preferably long before information about the client's therapy is sought, and they should be memorialized in treatment notes.

Sometimes parents ask individual therapists to write a letter to the court or to attorneys, stating their opinion of the emotional health of a child who has been observed informally in the waiting room. Sometimes these requests come to therapists who have not observed the child but have only heard the parent's description of symptoms and statements. Embedded in these requests is usually a parent's stance (if not a direct statement) about the ultimate custody arrangement the child needs. It is always an error to offer an opinion about custodial arrangements without having evaluated both parents and all children. In some situations and some jurisdictions, it may be an error that is considered malpractice or a violation of licensing laws. While state law and guidelines govern the area of child custody evaluations, the prohibition against opining on the children's custody arrangements and schedules apply to MHPs in other roles, not only to formal child custody evaluators.

When one parent in a highly conflicted custody dispute brings a child's problems to a therapist, he or she may also provide information about negative qualities of the other parent, making an effort to convince the therapist of the deficiencies and possible malfeasance of the other party. It can be difficult for therapists to keep in mind that they cannot judge the accuracy of the information they are given, and they cannot know the truthfulness or accuracy of the parent with whom they are engaged. In addition, the therapist cannot know how accurately the client is hearing and understanding the therapist's statements. Parents may hear what they wish to hear and may misquote the therapist. Therapists cannot control such distortions, of course, but when therapists limit their statements to facts that are known, they can minimize the risk.

Further, prudent adult therapists advise clients ahead of time not to bring the children with them to their therapists. This advice is given for many reasons amongst which is that it is easier to be clear that you, as the parent's treating therapist, have not seen the child professionally when you in fact have never met the child, even in the waiting room. There is also a risk of creating more distress or confusion for the child when he or she is involved, even peripherally, in the parent's treatment.

The authors know well, from clinical experience, that the parents' stories can be compelling, especially in the absence of balanced, corrective information from the other side, which is not available outside the forensic assessment process. The compelling story may sway the therapist into believing the account is true. No matter how compelling the client is, the prudent therapist does not move out of a neutral and independent position by concluding that the client's information is true. (APA Ethical Principle 2.01: Practice within the boundaries of competence clearly speaks to the need for the therapist to speak only about people and capacities about which they have direct knowledge.)

#### FORESIGHT REGARDING UPCOMING PROBLEMS

At the beginning of any treatment, an experienced therapist may be able to foresee issues that are likely to arise in the course of therapy. For example, a client who immediately idealizes the new MHP, while devaluing a former therapist, may well come to be angry and devaluing of the current therapy relationship at some point in the future.

Likewise, in contentious divorces, the therapist also may see impending problems that are not apparent to the client and feel drawn toward helping to prepare the client for litigation. For example, a mother of preschool-aged children may describe a critical and controlling husband with an uncooperative stance relative to shared or cooperative parenting. While she is talking about her hopes for a collaborative settlement, the MHP may well begin to be concerned that her estranged husband may react to the situation by mounting an attack on her parenting. Similarly, a father who has had a traditional role of

breadwinner with involvement with his children in the evenings and on weekends may talk about collaborative settlements, while the MHP begins to be concerned that he will be described as uninvolved and marginal. In both these cases, it is important that the therapist not contribute to escalation of the conflict by defining or predicting problems. Unwarranted statements of warning can increase the level of suspicion between the parties. On a clinical level, the therapist is presenting himself or herself as an expert, predicting the future, taking a position of knowledge and power in relation to the client. On a practical level, such comments from the therapist present a one-sided analysis of the situation that may push the client toward black-and-white thinking, increasing his or her bias. The therapist would best serve his or her patient by helping him or her see the situation from many perspectives including seeing the world through the ex's eyes. Additionally the therapist better serves his or her patient by helping him or her respond, as opposed to react, to a given situation.

Unlike inappropriate warnings about the legal process or about the other parent, predictions about known reasons for disruption in the child's behavior when their schedules change, when the primary caretaker returns to work, or when there is a move can be very helpful. When such predictions include a range of hypothesized causes based on the research, the therapist can help the parent to see the child's behavior as a more normal reaction to the situation rather than as an indication that something is terribly wrong. Such discussions also contribute to expanding the parent's ability to imagine the internal experience of the child.

For example, it is known (Drozd & Olesen, 2004; Johnston & Roseby, 2009; Lee & Olesen, 2001) that many children of all ages show distress at the time of transitions between the parents. Such symptoms do not necessarily indicate serious problems with parenting at one home or the other but may be a fairly normal reaction to confusing and unwanted transitions. Providing such information to the parent may help forestall more detrimental interpretations of the child's behavior.

Another potential pitfall for the therapist is the temptation to offer diagnoses of the other parent and to give advice about the legal strategy of the client. The pull toward diagnosis can be powerful as the seemingly outrageous behavior of the soon-to-be ex-spouse is described. The pull to support the client by "helping them understand" a disorder in the other parent can be significant. Rather than diagnosing the other parent, the therapist should help the client remember and honor the many sides of the person they were married to. This does not mean ignoring the negative aspects or the reasons for the separation and divorce, but it does mean helping the person avoid the black-and-white thinking that so often makes divorce disputes so toxic. Such extreme negative characterizations undermine the client's respect for his or her own decisions, undermine confidence in the spouse's parenting, and may make it less likely that solutions to the conflict will be found. Again,

recognizing and validating the typical behavioral reactions to divorce may help the client to accept his or her own behaviors and, more importantly perhaps, to accept the behaviors of the former spouse as reactions within the expected range, not necessarily proof of malevolence or disturbance. Further, the prudent therapist working with a client who is involved in a divorce serves his or her client best in assessing for and addressing general clinical issues in the client some of which may have preceded the marital separation. Doing such is simply good practice.

#### WHEN THE COURT IS DIRECTLY INVOLVED

When the court becomes involved with the family in an ongoing therapy case, there may be a host of new stresses on the therapist. In an ongoing therapy with an adult, when there is a new issue of court involvement, the therapist needs to maintain a clinical focus on the client, rather than be drawn into discussions of the new situation. In many cases of high-conflict divorce, the client may request advocacy from the therapist. The client may ask that the therapist speak with the children, investigate the children's point of view, speak with his or her attorney, or write a letter to the court on his or her behalf. Any action by the therapist except mandated reporting of child abuse is a clinical and a professional error. It constitutes a clinical error because the therapists, by taking action, will have moved from the position of helping clients recognize and understand their own feelings and motives and helping them organize and regulate their reactions to the world around them, to a position of defining the external world and providing guidance about people and events the therapists do not have firsthand knowledge of. Advocacy by the therapist is also a professional error because the MHP has created a dual role of consultant about the legal situation alongside the role of therapist. The therapist risks malpractice or a licensing complaint if he or she intervenes by writing a letter opining about the recommended custody schedule or by providing a diagnosis of the other party without having evaluated that person (Fidnick et al., 2010).

Another area of risk arises when the court itself requests information from the therapist, regardless of the client's rights to confidentiality or the therapeutic role. Such pressure may be complicated when the client is not represented by an attorney for therapy records. A client's counsel can argue against the court's request or against an overreaching demand from the other parent's attorney. The therapist may need to consult with a legal and professional expert about the requirements and limitations of subpoenas and court orders (which are quite different). Most malpractice carriers provide consultation services for these purposes.

At other times, a misguided attorney may request a letter from the therapist certifying the client's good mental health and ability to parent. There may be a place for such a letter (for example, as collateral information

provided to a custody evaluator, when the evaluator initiates the request), a narrowly written description of what the therapist knows firsthand about the client (e.g., number of appointments attended, frequency of current therapy, and whether there has been reasonable progress towards treatment goals). The actual request, however, is often for a more expansive communication including opinions about parenting capacity, which cannot be known by a parent's individual therapist. At worst, an attorney may request an opinion or recommendation about custody schedules. Again, complying with such a request interrupts the treatment of the individual and opens the therapist to accusations of professional misconduct or malpractice.

It should be noted that the privilege to not disclose any information from psychotherapy belongs to the client and not the therapist. There are many complex issues that can arise around these questions, which are beyond the scope of this article. Nevertheless, therapists who are not forensically trained should know that every subpoena needs a response, but the response does not necessarily have to include providing the information that is demanded. Consultation with an expert in the treatment of people involved in the legal system is essential when a therapist receives a subpoena. The reader is referred to the Perlman article in this issue (Perlman, 2012).

#### BECOMING PART OF THE PROBLEM

At times in high-conflict divorce, the professionals involved may “play out” the roles of members of the families they serve. For example, a professional may take on highly emotional “rescuing” positions for one parent, out of proportion to the actual professional role he or she is in. Judges, attorneys, and MHPs may become irrational or may become blinded from seeing multiple hypotheses, explanations, or perspectives, and consequentially reenact the parental conflict in hostile or emotional interactions with other professionals. Such reenactment by the professionals of the parental dynamics compounds the conflict (Greenberg, Gould, Schnider, Gould-Saltman, & Martindale, 2003)

Such reactions can be considered examples of countertransference. Therapists should be aware of the extensive literature on countertransference (Martindale & Gould, 2007; Pickar, 2007) and should be vigilant about their own cognitive and emotional reactions to these difficult family situations. When the therapist's ability to understand the client is clouded by his or her own emotional reactions, the therapist is responsible for recognizing and working out those personal responses. This is best done when the clinician seeks a consultation that will enhance the ability to set and explore multiple hypotheses with an open mind. In other words, professionals can inoculate themselves from stepping into the fray by grounding themselves as scientist-practitioners.

## ALLEGATIONS OF DOMESTIC VIOLENCE

With alleged victims of intimate partner violence, there are delicate tensions to negotiate. On the one hand, a genuine victim needs to feel supported and believed in order to feel safe with the therapist and to be open in treatment. On the other hand, when there has been no investigation or finding around the allegations, the conscientious therapist maintains some neutrality and an open mind and holds multiple hypotheses about the events described.

Therapists can demonstrate empathy and understanding by providing and demonstrating knowledge of the effects of trauma and of the dynamics of domestic violence events to the client. Sensitive discussions between the therapist and the client about the tension between providing support and providing advocacy can create a foundation for effective therapy. Support is within the role of therapy. A therapist who has a good understanding of the dynamics of intimate partner violence can convey support. When the client can feel confident that her therapist really understands her situation and the dynamics, often she is better able to tolerate the therapist's lack of strong advocacy in (or about) the legal system.

## ALLEGATIONS OF CHILD ABUSE

When a parent introduces allegations of child abuse into his or her therapy, there are many increased stresses on the therapist. Sometimes the matter has been raised and is being investigated by the agencies or individuals who are qualified in that jurisdiction to conduct such an investigation. The parent's therapist, in this case, can help the client by holding multiple hypotheses himself or herself and encouraging the parent to continue to hold multiple hypotheses about the possibility of child abuse. It is invaluable for the therapist to help the client to tolerate the uncertainty and anxiety of waiting for a decision from the investigating authorities, to help him or her maintain composure, and to avoid increasing the child's anxiety or confusion. The therapist can also help the parent avoid behavior that may contribute to suspicion about his or her motives or behavior in the allegation.

In other situations, allegations may have been investigated and found to be unsubstantiated. As a therapist for the alleging parent, the MHP needs to help the parent stay realistic, manage his or her feelings of fear and anger, and keep clear boundaries between his or her own thoughts and feelings about the other parent and from his or her child's thoughts and feelings about the child's other parent. The therapist can and should provide information and psychoeducation about obstructionist gatekeeping while avoiding the pull to tell the parent what to do or to advise them about strategy for self-presentation in the court or in a child custody evaluation. (Gatekeeping is defined as beliefs and behaviors of one parent that endeavored to facilitate or limit the other parent's involvement

with children [Ganong, Coleman, & McCaulley, 2012].) Therapy should focus on ways to help clients manage stress, recognize past experiences that may be resonant in the present (for example, the parent's own history of abuse), and understand all the feelings he or she has. The therapist may "hold a mirror up" to the parent, allowing for more self-reflection and broader considerations of whether his or her actions are helping or harming the child.

As was discussed earlier, the therapist needs to help the parent deepen his or her ability to imagine his or her child's internal experience, with consideration of all the multiple things that may be going on in the child's mind. This process of "mentalizing" is particularly important when there are questions of child abuse. Mentalizing is a psychological concept that describes the ability to understand the mental state (including motives, emotions, and beliefs) of oneself and others and to interpret behavior in terms of the intentional mental states (Lieberman, Van Horn, & Ippen, 2005). Mentalizing is an important aspect of parenting and can also help parents recognize and avoid their own black-and-white thinking.

Other times there may be unfounded allegations, yet the client remains worried about the child's safety when with the other parent. As previously described with respect to domestic violence allegations, it is essential that the parent's therapist be vigilant to avoid blurring the distinctions between the forensic expert and the parent's therapist. The therapist cannot argue against the client's concerns but still must work with the client to broaden the possible hypotheses he or she can tolerate. The therapist must also help the client work with the reality of the situation as it is, rather than joining in with or arguing against the parent's recriminations against "the system" or engaging in discussions of "what might have and should have been." Again, helping a client determine what they can control and what they cannot control is a crucial function of therapy.

In all of these situations, we recommend that the therapist review the list of hypotheses put forward by Kuehnle (1996). Although these hypotheses were written specifically to apply to investigations of child sexual abuse, they can be adapted to a more general concern about child abuse. These hypotheses describe levels of credibility and certainty about past abuse and levels of risk of future abuse, allowing the clinician to consider each hypothesis independently and in detail. The hypotheses include considerations of the interactions among factors affecting willingness to disclose abuse, credibility, and truth. Consideration of these hypotheses may help therapists to maintain and teach clients to think more clearly.

## COORDINATION WITH OTHER PROFESSIONALS

In some, if not most, cases it may be appropriate to secure permissions and maintain communication with the child's therapist. Information about the

child's concerns and behaviors may be helpful in working with the parent, for example by helping to reduce polarization. Information from the parent's observations of the child may be helpful to the child's therapist in understanding the play or communications from the child. It is also comforting in many cases for the adult client to feel the therapist is interested in his child's well being.

One concern about such contact between the parent's and the child's therapists is the potential implication that the parent's confidentiality has been breached by the contact. This could be an issue, for example, where the child's therapy has been court ordered and there is a requirement for the child's therapist to report to the court. The parent's confidentiality could be construed to be waived if the contact with the child's therapist is not very carefully structured as part of the parent's treatment.

With permission, it can be very helpful to maintain communication with a family therapist who is involved with both parents and with the children. Both therapies may be improved by information and perspective from the other. Particularly in high-conflict families, coordination between and among therapists can help everyone maintain perspective beyond the more narrow views of the particular individual client. This is feasible only when both parents have given explicit consent for such communication. If only one side's therapist has input into family therapy and gets information from it, there is a great risk that the family therapy will not remain neutral and objective. Again, it is crucial to know or even to define the status of the parent's confidentiality if the therapist is in contact with the other MHPs. It may be best for both parents to consider the addition of an addendum to the original Informed Consent covering the issue of contact between therapists working with different members of the family.

It is rarely a good idea for an adult's therapist to be in contact with the attorney for that parent. Many attorneys will take a conversation and quote the therapist in written documents to the court, without ever checking with the therapist about accuracy or context. The pressure for advocacy is likely to be increased to the extent that there is direct contact between attorney and therapist, and there will certainly be the appearance of bias and advocacy. If therapists believe they should provide some information to the attorneys, it is best for that information to be in writing so there is no possibility of distortion or misquotation.

When a child custody evaluator asks the therapist for information, the therapist must be careful to avoid disturbing or destroying the therapy via the evaluator's account of the therapist's statements. There are two ways the therapist can best protect himself or herself from being misquoted. The therapist can provide the information in written form in response to the evaluator's questions, or the therapist can ask for the evaluator to show him or her the written summary of what has been said before it is included in the report. Additionally the prudent therapist prepares the parent ahead of time for what

the therapist is going to say to the child custody evaluator. The client should be explicitly cautioned that the child custody evaluator may ask questions that go beyond what the parent expects or wants the therapist to say; otherwise the client may feel betrayed. This is one of the times that it is crucial for the prudent therapist and the client parent to revisit the informed consent. Said another way, this is an example of how informed consent is a process and not a single event that occurs only at the beginning of treatment.

There are certainly times when the forensically informed therapist, who is in a clinical role in a given case, may find himself or herself tempted to slide into a forensic role. The wise therapist keeps the roles separate and understands the therapeutic value for the client of keeping clear boundaries. Again, self-reflection and solid consultation are strong measures to take against drifting into another role.

## CONCLUSION

In the minefield of high conflict and litigated divorce, the clinical therapist for adults in these families needs to be prepared to function appropriately and competently in the treatment they provide. The therapist's commitment to maintaining a neutral and professional position with the client is the basis for competent treatment. This article has laid out some considerations for the therapist who is confronted with the potential conflicts and stresses that are inherent in these cases. As the take-away message from this article, we list some Do's, Don'ts, and Cautions.

### List of Cautions

- Look out for confirmatory bias, looking at facts that fit your opinion rather than looking at a wide range of information.
- Pay attention to possible unspoken motives of the client and his/her attorney.
- Look out for the compelling draw toward becoming part of the drama.
- Look out for black-and-white, all-or-nothing thinking in yourself and in your client. (Should you find yourself thinking in an all-or-nothing manner, consider ways to offset bias, including: keeping an open mind throughout the therapeutic process; creating and updating multiple hypotheses for your own use; carefully collecting/recording all data, including data that supports competing hypotheses; and engaging in professional consultations throughout the process of the therapy.)

### List of Do's

- Ask how the client is dealing with sleep and work and in relationships with children, family, and friends.

- Ask about spiritual or religious or community support systems.
- Ask about the involvement of the client's family of origin in the current situation.
- Assess how the client is managing stress of separation, divorce and/or high-conflict post divorce.
- Ask about possible use/misuse/abuse of or dependence on substances (alcohol, prescription medications, street drugs).
- Ask about the support system the parent is using for advice. Help the parent widen the sources of advice and information, if necessary.
- Assess for suicidal ideation, fantasies, and plans.
- Assess for ideas, fantasies, and plans for aggression toward others.
- Ask about access to weapons for your client and the other parent.
- Inform the client early in the treatment as to what you will and will not do in their case.
- Get signed releases to speak with the family therapist and child therapist.
- Contact the child and family therapists when necessary to gain broader perspective and avoid "splitting" among the professionals.
- Work to help your client move past all-or-nothing thinking.

#### List of Don'ts

- Don't become a consultant for the client's attorney.
- Don't become an advocate for your client or for the child.
- Don't make suggestions about custody or access. (You have not evaluated the whole family as would be necessary.)
- Don't share your personal stories with the client.
- Don't diagnose the other parent, especially if you have never met him or her.
- Don't mix forensic and clinical roles. (If you don't know the difference, read the articles referenced here.)
- Don't go beyond the limits of your expertise, training, and supervised experience.
- Don't give legal advice.
- Don't write a declaration or a letter or an affidavit on behalf of your client without careful thought and consultation.
- Don't treat abuse unless there has been a finding of abuse.

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