SPECIAL ISSUE: PARENT-CHILD CONTACT PROBLEMS: CONCEPTS, CONTROVERSIES, & CONUNDRUMS

INTERVENTIONS

TRAUMA-INFORMED INTERVENTIONS IN PARENT–CHILD CONTACT CASES

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Parent–child contact problems may arise in the context of high conflict separation/divorce dynamics between parents. In cases where there are parent–child contact problems and children resist or refuse contact with one of their parents, there may also be incidents of child maltreatment, intimate partner violence, or compromised parenting that can be experienced by a parent or child as traumatic. The circumstances around separation and/or post-divorce often result in intense stress for families. In this paper we distinguish between the stressful circumstances that may arise as a result of high interparental conflict and pulls for alignment from a parent, and the real or perceived trauma as a factor which contributes to resistance or refusal of a child to have contact with a parent. Interventions to address both trauma responses and the resist-refuse dynamics are differentiated and discussed. After screening and assessment, the intent is to treat trauma responses with short-term, evidence-based therapy, either before or concurrent with co-parent and family intervention.

Key Points for the Family Court Community:

- Parent-child contact problems may have many causes. When children resist contact with a parent the multiple factors including trauma, that result in this problem must be explored.
- Assessing the impact and symptoms of interparental conflict and trauma on children and coparents, including emotional dysregulation resulting in feelings of being overwhelmed or needing to avoid is necessary to proceed with a family intervention
- For family intervention to be successful It is necessary for each family member to be able to manage distressing emotions without feeling overwhelmed or numb and to be able to process information accurately. These issues may result in one of the treatment components that can occur before or at the same time as the family intervention.
- Delaying contact with a parent generally results in more negative characterization, anxiety and polarization and is generally not recommended. Instead safe, structured contact to begin the process of desensitization should occur once the parent and child have basic skills of coping with and managing distressing thoughts and feelings.

Keywords: *Alienation; Divorce; High-Conflict; Parent–Child Contact Problems; Parent–Child Relationship; Resist-Refuse; Stress; Trauma.*

I. WHAT IS TRAUMA?

The role of trauma should be considered in any strained parent–child relationship as it can precede the resist-refuse dynamic and/or the intense conflict between the parents and within the family system. Or, the circumstances themselves can exacerbate or elicit a trauma or a stress response in the child or in one or both parents. Thus, a multifactorial systematic assessment of the many issues that may contribute to these strained parent–child relationships is essential. These factors may include developmental influences, temperament, anxious parent–child relationships, alignments with

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FAMILY COURT REVIEW, Vol. 58 No. 2, April 2020 470–487

a parent, gatekeeping behaviors, compromised parenting behaviors, exposure to high conflict or intimate partner violence between parents, and/or abuse or neglect.

Cases where a child resists or refuses contact with a parent are challenging for the court, clinicians, and attorneys. Often these cases require enormous resources. The common cross-allegations of alienation from one parent against abuse, violence or compromised parent from the other typically result in polarization of the family and the systems around them. Often the court and clinicians try to determine the cause of the trauma response and/or the veracity of the reported symptoms in an effort to find an unequivocal solution to the problem. The literature often describes these parent–child problems in binary terms—it is abuse/violence or alienation (Drozd & Olesen, 2004, 2010; Fidler & Ward, 2017; Kelly & Johnston, 2001). In fact, however, many of these cases are multifactorial (Johnston & Sullivan, 2020) or hybrid (Friedlander & Walters, 2010) and require attention to traumatic experiences as well as to alienating behaviors.

Trauma is an event outside of normal experience. It is exposure to an actual or threatened death, serious injury, or sexual violence via directly experiencing or witnessing a traumatic event or learning that a traumatic event occurred to someone close, that causes a natural emotional reaction. Trauma can be a response to a single incident (acute), repeated over time (chronic), or the result of varied, repetitive, and prolonged exposure to traumatic events that are often invasive and interpersonal in nature (complex). "Trauma" as used herein includes both the objectively traumatic event that fits Criterion A in the Diagnostic and Statistics Manual V (DSM V)[1], as well as traumatic experiences in which symptoms of trauma are present without meeting the specific criteria set forth in DSM V Criterion A.

Acute trauma involving a single traumatic incident can include exposure to a serious incident of intimate partner or community violence; an experience of being severely injured by a vehicle, acquaintance, stranger, parent or caregiver, or other accident; or molestation. Chronic trauma is repeated and prolonged, such as exposure to repeated acts of domestic violence or abuse. Chronic trauma can also result from multiple acute traumas, occurring one after the other. Complex trauma is exposure to *varied and repeated* traumatic events or experiences that often occur during childhood (or adolescence) and are due to the action, or inaction, of a caregiver. One example of complex trauma would be a child who was exposed to domestic violence *and* abuse and/or neglect during 4 years of their childhood (varied and repeated traumatic events from caregivers). Some examples of chronic trauma would be trauma that results from years of workplace sexual abuse or years of physical abuse by a romantic partner. The differences between chronic and complex trauma, however, can often be minimal. The main differentiation is that complex trauma involves varied and repeated invasive trauma by someone close to the victim that often begins in childhood or adolescence, whereas chronic trauma involves either a single type of repeated trauma or exposure to multiple incidents of acute trauma that occur one after the other. The frequency and severity of the incidents leading to chronic and complex trauma symptomology may vary.

Any trauma has potential physiological effects, including neurobiological and neurohormonal changes. Generally, however, one finds long lasting sequelae in complex and chronic trauma, as opposed to a single incident trauma. These changes are associated with impairments in memory, learning, mood modulation, as well as heightened sensitivity to stressors, and chronic activation of physiological stress responses with increased frequency/intensity of experienced fear and anxiety. According to Van der Kolk (2005):

> Isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma, such as are captured in the PTSD diagnosis. In contrast, complex childhood trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole. Developmental trauma sets the stage for unfocussed and irrelevant responses to subsequent stress…. (p. 403).

Developmental trauma, as described by van der Kolk, is complex trauma that occurs from significant and severe chronic traumatic events, experienced in childhood and adolescence, that have been perpetrated by a caregiver or individual that is expected to be a source of "security, protection, and stability" (Lawson & Quinn, 2013). The stress can be emotional, physical, sexual, or secondary

(such as witnessing family violence), and can also include medical trauma and traumatic loss or grief. At the same time, a single severe traumatic event may also affect development. Developmental trauma then, can be acute, complex, or chronic in that it affects developmental processes.

When complex trauma refers to the symptoms associated with traumatic experiences, research has had difficulty identifying the symptom profile of complex trauma. It is generally believed, however, that complex trauma differs from acute trauma (exposure to a single traumatic event). Deficits linked to complex trauma can involve deficiencies in interpersonal relationships and attachment, emotional and behavioral regulation, cognition and attention, psychological stability (experiencing issues related to depression, anxiety, and dissociation), and biological changes that negatively impact physical health. Additionally, symptoms may include dissociation, alterations in self-perception and/or worldview, self-harm, and addiction (Kliethermes, Schacht, & Drewry, 2014; Lawson & Quinn, 2013).

II. DEVELOPMENTAL IMPACT OF TRAUMA ON CHILDREN

Children with complex trauma often mistrust others. For many people, as the number of traumatic events they are exposed to increases, so does the number and intricacy of complex trauma symptoms. Continuing exposure to trauma creates in the individual a constant state of anxiety, hypervigilance, and the feeling that the world is unsafe and disordered (Lawson & Quinn, 2013).

During elementary and middle school the child's world grows to include, not just the family, but also the school, community, and peers. At this point, children are continuing to develop their sense of self and others as they also continue to develop their worldview. Trauma at this stage may interfere with peer relationships, school success, and sense of self. If trauma exposure occurred earlier than in elementary and middle school (e.g., in early childhood), then such early trauma interferes with the child's ability to relate interpersonally and to trust peers, parents, and other adults. Additionally, the child may have impaired self-efficacy, self-regulation, attention, and frustration tolerance. Such children are often rigid in terms of interpersonal relationships, experiencing deficits in critical thinking and problem-solving. They also may not be curious children, since they are more concerned with safety and security than they are in exploring their world. They may gravitate towards staying close to their secure base, as opposed to venturing out into the world (Lawson & Quinn, 2013). Clearly, this becomes even more complicated for the child whose caregiver is both a source of security, at times, as well as the perpetrator of the trauma. It is these children, with complex trauma experienced at the hands of their caregivers, who are more prone to develop a disorganized attachment style.

Trauma experienced in adolescence can cause deficits in affect and behavioral regulation, judgment, development, and coping skills. To cope with chronic and/or complex trauma, a youth may disconnect from their peers and isolate themselves and engage in over-control, as well as engage in alcohol and drug use, self-harm, and risky sexual behavior. If the trauma had been occurring since childhood, the continuing chronic trauma leads to an increased lack of sense of self and increased dissociation in order to manage (Lawson & Quinn, 2013). Gaps in one stage of development can complicate the next stage of development, leaving the child vulnerable as they negotiate new challenges while they grow.

A. STRESS OF HIGH CONFLICT BETWEEN PARENTS

Enduring and intense conflict between parents, especially when the parents use the children in their conflict, is one of the two most significant factors that negatively affect the adjustment of children post-separation and/or divorce (Goodman, Bonds, Sandler, & Braver, 2004; Grych, 2005; Kelly & Emery, 2003). Children are often significantly affected by denigration of one parent by the other parent (Buehler et al., 1997; Cummings, Goeke-Morey, & Papp, 2001; Deutsch & Pruett, 2009; Grych, 2005; Grych, Harold, & Miles, 2003) or destructive conflict, including using children to carry hostile communications, asking them to keep secrets, or exposing them to verbal or

physical aggression (Cummings et al., 2001), as opposed to encapsulated conflict where children are not exposed or used.

The second factor that most affects children's adjustment after separation or divorce is the quality of parenting. The extent to which parenting quality is affected by interparental conflict has been discussed (Krishnakumar & Buehler, 2008; Lamela, Figueiredo, Bastos, & Feinberg, 2016; Sandler et al., 2012), but is inconclusive. While it appears high conflict between parents and poorer quality of parenting are correlated, it is unclear whether other variables intervene, or whether baseline levels of quality of parenting change in the face of high conflict between parents post separation.

It is also unclear how chronic stress, as we often see in families where enduring high conflict between parents exists, interfaces with symptoms of complex trauma. Complex trauma symptoms will often consist of symptoms commonly associated with PTSD, depression, insecure attachment, and dissociation. Symptoms of complex trauma also consist of developmental disruptions and traumatic stress reactions, such as chronic hyperarousal that interferes with the development of one's regulation of emotions (Kliethermes et al., 2014). In some children who resist or refuse contact with a parent we see a symptom profile of chronic hyperarousal and deficits in judgment and coping skills. Assessment of how the chronic interparental conflict has affected the children is just as important as the screening for, and if necessary, the assessment of the child's exposure to specific traumas (e.g., child abuse, neglect, exposure to serious intimate partner violence).

In addition, the change to the family system, as a result of the separation or divorce, may result in the cessation of contact due to allegations or findings of neglect or abuse by government agencies or courts. The usually sudden termination of contact with a parent is most likely experienced by the child as a traumatic experience for the children and both parents. It is often marked as an acute event (contact is stopped) from which the family can either denigrate, discredit the worthiness of the alleged perpetrating parent, and focus on the alleged damage, or, manage the absence by organizing resources to help mobilize coping efforts and support resilience among the family members. The ability of each parent to take responsibility for their behavior and the resulting impact on the family is reflective of each parent's coping style. The extent that the family system approaches this loss of contact with a parent in a functional way will determine in large part whether the family can manage the conflict that may result, particularly if renewed contact with the children is ordered. How a family manages disruptions in contact, and rehabilitation efforts and successes, is predictive of children's short- and long-term adjustment. The narrative of the family members can invite hope and resolution, or the narrative can result in persistent conflict that does not serve the best interests of the children.

B. SCREENING AND ASSESSMENT OF TRAUMA

Screening of objective trauma events and other traumatic experiences should precede intervention and treatment. Screening for trauma is required in all cases, whereas assessment is called for in only those cases where there has been a positive screen. Screening involves throwing out a large net to see if there is any possibility of trauma. The result of an assessment is that something is categorized as possible trauma or not. By definition, screenings include false positives; meaning, that some things are picked up as possible trauma, when in the end, they are not traumatic. Screening may be followed by an in-depth assessment that involves a close look at the events and their effects to determine if, in fact, they meet the criteria for trauma. A screening of each member of the family for trauma should be done in every case where parent–child contact problems are suspected or found. If the initial screen of a family member shows they have experienced, what may be for some, a traumatic event, the assessment that follows ascertains whether there remain any unresolved trauma-related symptoms, and if so, the nature and effect of those symptoms.

Potentially traumatic events that should be screened for include a wide range of incidents, including: natural or human made disaster, war/terrorism/political violence, forced displacement, system-induced trauma, trafficking/sexual exploitation, bullying and/or witnessed suicide, serious/

accidental injury, illness/medical trauma, community violence, as well as bearing witness to domestic violence, and school violence/school emergency. All of these events are most likely outside the range of normal experience and thus may be experienced as potentially traumatic or not. Screenings are to be done to rule in or rule out physical assault, physical abuse, neglect, psychological maltreatment/emotional abuse, sexual abuse, sexual assault, and, interference with caregiving. Screenings also include a look at kidnapping/abduction, bereavement, and/or long-term separation, (Gerrity & Folcarelli, 2018; National Child Traumatic Stress Network).

If the screening indicates the likelihood of aggressive behaviors by a caregiver or parent(s), the nature of those aggressive behaviors is to be considered as well—whether the aggression has been physical, sexual, economic, psychological, and/or coercively controlling. Whereas the first three kinds of aggression may be more readily visible and measurable, psychological and/or coercive controlling behaviors are just as significant, especially with regard to long-term effects. If the screening indicates there has been intimidation, isolation, denigration, control, or subordination of a partner resulting in fear, disempowerment, entrapment, and/or trauma, then a specific assessment of coercive control and the effects of it upon the victim(s), parenting, and co-parenting needs to be conducted.

Some of the symptoms that may be present and may or may not be related to a traumatic event include depressive or dissociative symptoms, anxiety symptoms, anger, sleep disturbances, sexual concerns, intrusive experiences, past and present mental disorders, substance abuse, and/or risks for self-harm, suicide, and violence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Any given event may be experienced as traumatic by one parent or child, but not by another. Sometimes an event is stressful in a way that the person can manage and utilize to develop new coping skills, and even feel empowered in managing the stress. However, that same event may be experienced as more than stressful, and in fact traumatic, by one person and not another—dependent upon trauma history, the immediacy (or not) of interventions, and the resiliency of the person who experiences the event (Drozd, Saini, & Deutsch, 2018; Saini, Drozd, & Deutsch, 2018).

The effects of experiencing a stressor or trauma are dependent upon many variables—including whether the trauma was acute, chronic, or complex. The context in which the trauma(s) occurred is especially critical to assess. Context includes frequency, recency, severity, directionality, pattern, intention, circumstance, and consequence (APA, 2017; Association of Family and Conciliation Courts, 2016; Austin & Drozd, 2012). If a family member has been in therapy, an assessment of the effectiveness of that therapy is also important. This includes the factors of the therapeutic relationship, responsiveness, and treatment method (Norcross & Wampold, 2019).

Clearly, the effect of the events experienced is the most salient part of the assessment. Factors to elicit include the age of the onset of the trauma, whether there has been a single trauma or multiple ones, and the type of the trauma. Additionally, the assessment is best when it takes into account whether there have been co-occurring traumas, especially in childhood. The strength of the effect of traumas experienced in childhood, adolescence, and adulthood are likely dependent upon the adult or child's role in the event (self, family, friend), their age at the time of the event, and the details of the trauma. Childhood trauma, especially multiple traumas that occur at the ages in which structures in the brain are still forming, can result in an individual being more vulnerable to symptoms as an adult when exposed to additional trauma (Felitti et al., 2019; Pynoos, 2016).

Treating trauma when there have been no symptoms of trauma can be more damaging than helpful (Kuehnle & Connell, 2009; Olesen & Drozd, 2012). Screening measures to consider include: (1) Juvenile Victimization Questionnaire (Finkelhor, Turner, Hamby, & Ormrod, 2011); (2) Traumatic Events Screening Inventory (Ford & Rogers, 1997); and (3) Trauma Symptom Checklist for Children (Briere, 1996). The UCLA PTSD Reaction Index for DSM-5 (Steinberg, Brymer, Decker, & Pynoos, 2004) may serve as both a screening and an assessment tool.

Screening for trauma and then, if the screen is positive, an assessment of the nature and effect of any trauma, is the precursor of treatments and interventions that follow. Unlike screening that considers the potential presence of trauma, a comprehensive trauma assessment determines the nature

and extent of the trauma and its potential impact on coping, parent–child relationships, and parenting plan considerations. Upon the completion of a screening for trauma and an assessment, if indicated, the clinician will need to integrate their conclusions, which may include child abuse and neglect and/or the witnessing of intimate partner violence, into the overall picture of a family that may very well include chronic interparental conflict. Trauma and conflict do not exist in isolation as they may have a synergistic effect upon the family, and in particular, upon the vulnerable and developing child.

III. HYPOTHESES

As data is collected in the screening, and in any subsequent assessments for trauma that follows a positive screen, hypotheses are formed. The questions before the clinician include: "Has the child been a victim of child abuse and/or witnessed abuse? If so, what is the nature of the abuse? What was the effect of the abuse on the primary and secondary victims whether they are the child and/or a parent?" Hypotheses that may be formed (ones similar to those that follow and that are also found in Figure 1) are:

Abuse has occurred

1. Child is credible and has been a victim of child abuse and/or witnessed abuse.
2. Child has been a victim of child abuse and/or witnessed abuse, but due to misguided loyalty will not disclose the abuse.

Abuse has not occurred

3. Child has not been a victim of child abuse and/or witnessed abuse; however, a hypervigilant parent inaccurately believes that their child has been a victim of child abuse.
4. Child has not been a victim of child abuse and/or witnessed abuse, but a parent is using the allegation of child abuse to manipulate the court system during child custody litigation.
5. Child is credible and has not been a victim of child abuse and/or witnessed abuse, but child has become alienated from the identified parent perpetrator and has misperceived and mischaracterized innocent/ambiguous interactions.

Uncertainty and Unknown

6. It is unknown, and unlikely to be known with certainty, whether the child has been a victim of child abuse and/or witnessed abuse, given that the data has been compromised over time.

The original idea about using a conceptualization that includes multiple hypotheses comes from the seminal work of Kathryn Kuehnle (1996), who urged those working with this population to utilize a systematic approach to evaluations involving complex issues like abuse, family violence, high conflict parenting, and alienation. The sixth hypothesis was developed in consideration of the possibility that the data may have been tainted and that ultimately, after careful consideration, those doing the trauma assessment may conclude that the answer to the question, "Has the child been a victim of abuse and/or witnessed abuse?" is: "It is not known and will not be known for certain whether the child has been a victim of child abuse and/or witnessed abuse." For some, in cases where the evaluator, clinicians, social service agencies, and the courts find that there is not enough data to support any one of the other five hypotheses, this is a reality that families are left with to find a way to move forward (Drozd, Olesen, & Saini, 2013).

Each case needs to be looked at to determine what is best for the child or children involved. Sometimes, even with confirmation of abuse, it may be in a child's best interest to have reunification with the resisted parent. Further, some children who are abused do not resist the parent who abused

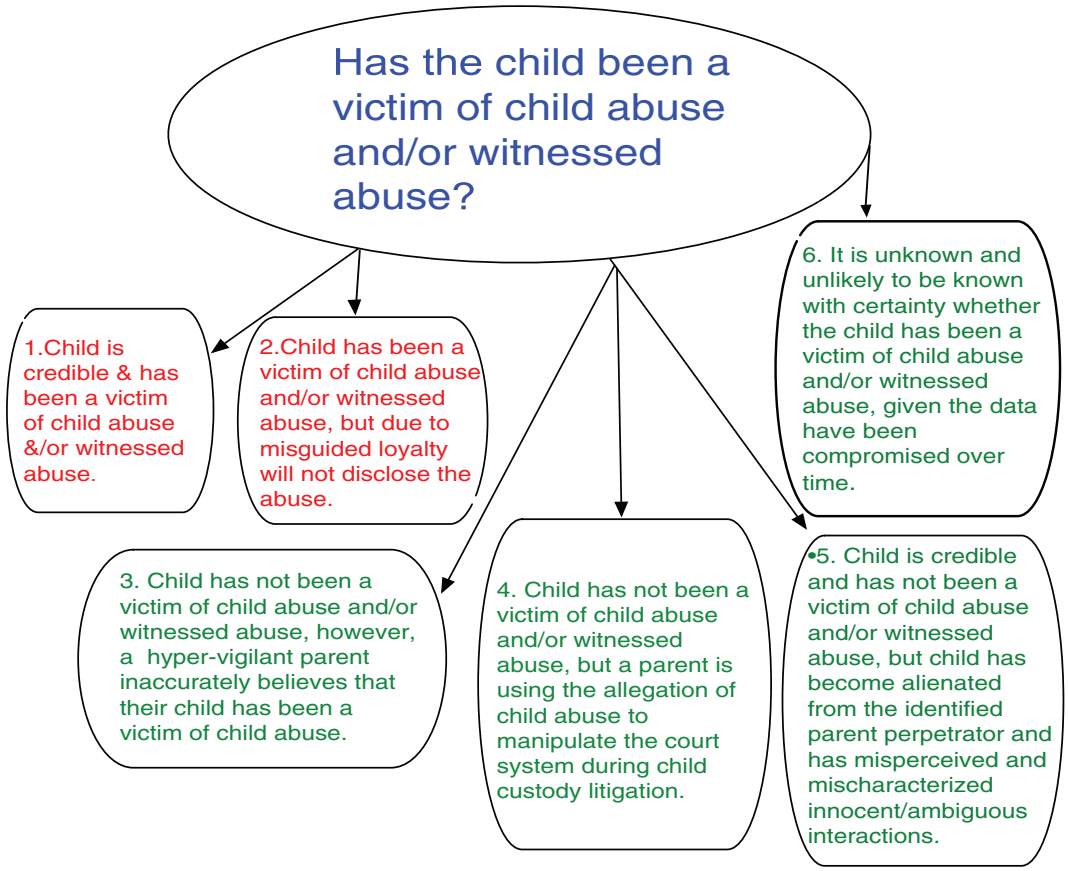

Figure 1 Abuse hypotheses.

them. They may also identify with that parent and/or need to be protected. Clearly, some children who are abused resist the parent who abused them, and they need to be protected.

Assessments that take the systematic approach suggested by Kuehnle (1996) and Drozd et al. (2013) are less vulnerable to preventable error and bias. With this approach, interventions that follow data collection and the development of, and testing of hypotheses, are more likely to effect change in families.

A. INTERVENTION APPROACHES

After screening, and if needed a trauma assessment, a clinical assessment is necessary to understand the multiple factors contributing to the nature and severity of the parent–child contact problem. The intervention should be tailored to meet the needs of the family. First and foremost, clinical and legal professionals must consider the physical safety of the family members, including threats of kidnapping, abduction, or physical harm. The initial emphasis is on physical safety because emotional and psychological safety can be more relative terms, tied into the perceptions of each family member. Emotional safety is also critical to consider given that the impact of emotional or psychological abuse can be for some victims as profound, if not more profound, as physical abuse.

Assessment of psychological safety requires information about the active emotional abuse of the other parent or child, including: intrusive psychological parenting that is harmful, intimidation, coercive control, repeated unsubstantiated allegations of sexual, physical, or emotional abuse, and

severe untreated mental illness or substance abuse in a parent that results in unpredictable behaviors (Fidler & Ward, 2017). Based on the safety assessment, a determination must be made as to whether the intervention should include: (1) the whole family (Fidler, Deutsch, & Polak, 2019; Greenberg, Schnider, & Jackson, 2019; Ward, Deutsch, & Sullivan, 2017); (2) trauma treatment, e.g., https://www.apa.org/ptsd-guideline/treatments/; Drozd, Saini, & Vellucci-Cook, (2019); and/or (3) parenting treatment (Sullivan, Deutsch, & Ward, 2017), as well as the order in which the intervention(s) should occur. Sometimes these treatments can occur simultaneously, while in other situations they will occur sequentially. As noted, when a parent or child has difficulty regulating emotions and accurately processing information, trauma treatment must precede a family intervention.

One of the difficulties of situations where children resist or refuse contact with a parent is that the family is often torn apart and polarized, the interparental conflict has been ongoing, and the children have been in the middle of the conflict, often for years, including prior to the parents' separation. Evaluating what has transpired through these years is difficult and the injuries and responses get lost, rigidified, or exaggerated. In every situation in which litigation or conflict is polarizing, where there are allegations of abuse, neglect, intimate partner violence, mental illness, harmful parenting, and/or child resistance to contact with a parent, early intervention should occur. Yet, it is rarely achieved, resulting in more entrenchment in rigidly held views and anxiety about any changes in family connections.

Calls for differentiated case management, assuming that conflict-ridden families require more and different services and closer judicial supervision (Birnbaum & Bala, 2010; Schepard, 2004), have been made, but only few have been heeded in North American jurisdictions. It has been shown, though, that effective screening for conflict, domestic violence, child abuse or neglect, substance abuse, mental health issues, and/or poor communication between parents that leads to differentiated and appropriate services can reduce return rates to court and custody and access motions (Cyr, Poitras, & Godbout, 2020; Pruett & Durell, 2009; Salem, Kulak, & Deutsch, 2007). Waiting to see how the cases unfold does the families a tremendous disservice. Generally, time is not on the side of cases that include resist-refuse dynamics. In fact, it is not uncommon for children to suffer and for the family members to become more entrenched in conflict and resistance the longer that time elapses (Walters & Friedlander, 2016). When there has been some trauma or abuse that is not severe, it may be in the child's best interest to reintegrate with a parent, particularly if that parent can take responsibility for their actions and the impact it has had on the child, offer an apology that includes repentance and restitution, promise to not do it again, or demonstrate changed behavior.

The sequencing of interventions for a family in which a child resists or refuses contact with a parent depends on the results of the assessment. Successful treatment, regardless of the presence or form of the stress or trauma experienced by the family members, requires a safe, organized or structured environment, with supportive relationship(s), focused on opportunities to learn and build coping skills. Traditional individual child therapy or parent therapy, alone, is not helpful in these cases (Walters & Friedlander, 2016). Rather, a model is needed that supports a child's developmental skills through daily activities and behavior by building healthy pro-social skills and emotional independence, with a focus on identifying and managing independent feelings, establishing boundaries, separating self and others perceptions and emotions, while helping parents build developmentally appropriate parenting skills to support the child's growth (Greenberg, Doi Fick, & Schnider, 2012; Greenberg, Schnider, & Jackson, 2019). A trauma-informed approach builds on these coping skills by incorporating strategies for managing distressing thoughts, feelings, and behaviors, and learning how to process trauma-related memories. This type of individual work with the child should be combined with the work of each parent, the co-parents, and the family.

IV. TREATMENT OF TRAUMA RESPONSES

When a child or parent has acute trauma symptoms, as soon as safety can be assured, an immediate short-term course of therapy to address the cognitive, emotional, and physical trauma

symptoms is recommended. Evidence-informed and evidence-based treatments can be found at APA (https://www.apa.org/ptsd-guideline/treatments/recommendations-summary-table.pdf), National Child Traumatic Stress Network (NCTSN) (www.nctsn.org), SAMHSA (www.samhsa.gov), effectivechildtherapy.org; and Drozd, Saini, and Vellucci-Cook (2019).

The symptoms that particularly interfere with family intervention include each family member's emotional dysregulation—an inability to manage distressing emotions without feeling overwhelmed or numb. Avoidance is another symptom, often part of a cycle of anxiety, where the feared stimulus is avoided and the avoidance leads to an increased anxious response, which leads to more avoidance. Soon the anxiety increases, and the avoided stimulus is seen as more dangerous or toxic, thus increasing avoidance, and perpetuating more anxiety, along with exaggerated and/or distorted perceptions and interpretations.

The hallmark symptoms of hyperarousal or hypervigilance can result in faulty assessments of danger. Hyperarousal or hypervigilance can be the physiological response to trauma as changes occur in the functioning of the limbic system resulting in variable releases of cortisol (McEwen, 2007; Teicher, 2002). In turn, this can interfere with the ability of the person to accurately assess the immediacy or likelihood of danger and can result in over-reactivity or seeing danger in that which is safe. Along with that, people who have been exposed to trauma often describe triggers, or sensory experiences that they have when even very remotely reminded of the trauma. As an example, take the co-parent who hears the other parent raise their voice in a manner that sets off a similar physiological reaction to the one experienced when the co-parent was previously verbally abusive. The result could be the same in the here-and-now as the co-parent experiences the other parent being verbally abusive, perhaps, when objectively speaking, that did not occur; yet, the brain responds as if it did.

The cognitive changes that occur in response to trauma can have the greatest impact on both how a child or parent understands an experience or communication through inaccurate perception, interpretation, and attribution, and how misperceptions, misinterpretations, and misattributions affect communications and relationships with others. Intrusive thoughts and memories are confusing and frightening in that, when something reminds one of the traumatic event, one may have a strong reaction and believe it is happening in the present. Further, that which has been categorized as safe and normal may in fact be unsafe and abnormal. Metaphorically speaking, it is as if the wires have been crossed whereas, in reality, they are related to the release of stress hormones that may contribute to misperceptions and misinterpretations. Misperceptions and misinterpretations become common in response to trauma. It is not uncommon to misinterpret something that even very remotely reminds someone of the trauma as being dangerous, when in fact there is no danger present in the here-and-now.

The short-term treatment includes learning coping skills and developing a repertoire of tools to facilitate tolerating distressing emotions, with an intentional focus on the modulation of emotions, including strategies such as: mindfulness and deep breathing; identifying triggers, connecting the trigger to the reaction, and managing emotions when faced with a triggering stimulus; assessing whether this is a current threat or a reaction from the past; and changing associations of misunderstood danger and maladaptive thoughts, feelings, and behaviors (Cohen & Mannarino, 2015). The goal of this treatment is to modify the dysregulation that affects the physiological elements of the acute trauma reaction. Regulation and modulation of emotions is necessary to reason and relate to others effectively.

This short-term treatment for the parent and/or child does not preclude, and may very well include, contact with the other parent. Pending a careful clinical assessment, contact should not necessarily automatically stop when allegations have been made. Real life *in vivo* experiences of safe contact and the self-efficacy that can come as the result of one using newly learned coping skills can provide information to move the individual therapy into the effective processing of emotions and management of anxiety. Family interventions use principles of emotional modulation including movement, exposure therapy, and systematic desensitization so that the family members can have accurate perceptions, interpretations, and attributions about each other and the experiences that they

share; this, in addition to being able to identify, modulate, and process their emotions in a safe setting.

In most cases, individual work and safe structured contact between a resisted parent and child are best when concurrent and synchronized. Holding off on contact results in increased anxiety and rigidly held, polarized perceptions and memories (Greenberg & Schnider, 2020). Except in those cases where the risks to the child's functioning include self-harm or significant decompensation in functioning, seeing a rejected parent will be stressful, but not intolerable with the proper supports in place. As time is rarely on the side of the process of reconnection, safe structured contact to begin the process of desensitization and making sense of competing narratives should begin as soon as the **acute** symptoms of emotional dysregulation can be managed.

V. COMPONENTS OF FAMILY INTERVENTION

Building treatment components begins with a screening for trauma. Depending on the results of the screening, there is a careful assessment that will include trauma if present in the screening, or a no trauma assessment of the family and formulation that leads to an appropriate treatment plan (Fidler & Ward, 2017; Greenberg & Lebow, 2016; Lebow, 2019; Saini, 2019). The nature and depth of the assessment will vary based on the context and circumstances of the family. Beginning with a timeline of the familial relationships, significant rupturing events, and previous successful and unsuccessful interventions is a useful tool for understanding the scope of the assessment. The treatment plan must build competencies that can be measured. The competencies require change on the part of each family member individually, in the relationships between the co-parents, and in the relationships between each parent and child. Many of these families externalize or locate the problems in the family in others within the family (rather than within themselves). One of the first steps in treatment of the family is to elicit from the co-parents broad goals for their children, such as good emotional adjustment and physical health, to create a shared foundation for working together to provide the best short- and long-term outcomes for their children. Referring back to these shared hopes for their children when treatment is stuck can sometimes move change forward again. These cases often involve a great deal of blame and rigidly held beliefs. It is helpful to motivate each family member to change by considering some role, however small, they may have in the family problem now, or how they may influence the future. The use of motivational interviewing (Miller & Rollnick, 2012) is a helpful evidence-based treatment throughout the intervention.

These cases need the involvement of the court to enhance accountability. Using a structured form for accountability provides the link between the clinical intervention and the court. This paper includes Changes in Resist/Refuse Dynamics Checklist (CRDC) (Drozd, Saini, Walters, Fidler, & Deutsch, 2020) as a tool for clinical and legal use to assess changes in the child and parent (see Figure 2). The behavioral, emotional, and cognitive indices of change for each child and parent have implications for changes in the family relationships. The CRDC is designed to provide the professionals much needed measures of accountability for the progress that is being made and where it may be stymied in these complex cases.

Within the family work, psychoeducation focuses on the emotional, cognitive, social, and long-term physical and emotional health implications that parental conflicts, disputes, and alienating and counter rejecting behaviors have on the child (Fidler et al., 2019). Psychoeducation on appropriate developmental expectations and consequences, authoritative (as opposed to permissive and authoritarian) discipline techniques, appropriate level of parental involvement, appropriate boundaries, and emotional regulation can all be addressed. This psychoeducational focus is appropriate for both parents and should include co-parenting work that separately or together builds a clear structure and holding environment for the child. This kind of psychoeducation and skill building is appropriate even when traumatic symptoms are assessed or reported by either parent.

CHANGES IN RESIST-REFUSE DYNAMICS CHECKLIST (CRDC)

Leslie Drozd, Ph.D., Michael Saini, Ph.D., Marjorie Gans Walters, Ph.D., Barbara Jo Fidler, Ph.D., & Robin Deutsch, Ph.D., ABPP

Rejected/Resisted Parent's (RP's) Name _____
Favored Parent's (FP's) Name _____
Child's Name, Age, & DOB (Please Use One Form Per Child.)_____
Name of Rater: _____Rater is (Circle one.): Family Therapist/ Parent Coordinator/Case Manager /Judge
Date Form Filled Out:_____

A. FOR THE CHILD

(i) Behavioral Indices For The Child (Rejected Parent).					(RP)
	N	R	S	O	VO
1. Child greets the parent in a friendly manner (e.g. at minimum child says hello).					
2. Child has ongoing contact with parent without signs of resistance.					
3. Child can comfortably sit in a room with parent.					
4. Child participates in activities with parent (e.g. plays games, goes places like movies, builds with Legos, etc.).					
5. Child engages in spontaneous conversations with parent.					
6. Child engages in respectful conversations with parent.					
7. Child seeks/maintains relationships with the parent's extended family.					
8. Child does homework with parent.					
9. Child accepts reasonable limit setting by parent.					
10. While with the parent, child freely talks about their experiences while in the other parent's care.					
11. While with the parent, child speaks positively about the other parent.					
12. Child seeks out the parent's advice with specific problems or issues.					

(i) Behavioral Indices For The Child (Favored Parent).					(FP)
	N	R	S	O	VO
1. Child greets the parent in a friendly manner (e.g. at minimum child says hello).					
2. Child has ongoing contact with parent without signs of resistance.					
3. Child can comfortably sit in a room with parent.					
4. Child participates in activities with parent (e.g. plays games, goes places like movies, builds with Legos, etc.).					
5. Child engages in spontaneous conversations with parent.					
6. Child engages in respectful conversations with parent.					
7. Child seeks/maintains relationships with the parent's extended family.					
8. Child does homework with parent.					
9. Child accepts reasonable limit setting by parent.					
10. While with the parent, child freely talks about their experiences while in the other parent's care.					
11. While with the parent, child speaks positively about the other parent.					
12. Child seeks out the parent's advice with specific problems or issues.					

(ii) Emotional Indices For The Child (Rejected Parent).					(RP)
	N	R	S	O	VO
1. Child spontaneously displays affection towards parent in front of other parent.					
2. Child is comfortable being engaged in activity with parent at same time they are in front of other parent.					
3. Child is comfortable sharing feelings with the parent (e.g. worries, needs, fears, etc.).					
4. Child approaches parent for comfort.					
5. Child displays affection towards parent (e.g. sitting appropriately close-by, age-appropriate hugging, cuddling).					

(ii) Emotional Indices For The Child (Favored Parent).					(FP)
	N	R	S	O	VO
1. Child spontaneously displays affection towards parent in front of other parent.					
2. Child is comfortable being engaged in activity with parent at same time they are in front of other parent.					
3. Child is comfortable sharing feelings with the parent (e.g. worries, needs, fears, etc.).					
4. Child approaches parent for comfort.					
5. Child displays affection towards parent (e.g. sitting appropriately close-by, age-appropriate hugging, cuddling).					

Ratings: N=Never, R=Rarely S=Seldom, O=Occasionally, VO=Very Often.

Figure 2 Changes in resist-refuse dynamics checklist (CRDC).

(ii) Cognitive Indices For The Child (Rejected Parent).					(RP)
	N	R	S	O	VO
1. Child has some age-related capacity to see the "good" and the "bad" in parent.					
2. Child demonstrates age-appropriate capacity for seeing different perspectives as new situations arise, both within th the family and within the child's social relationships.					

(iii) Cognitive Indices For The Child (Favored Parent).					(FP)
	N	R	S	O	VO
1. Child has some age-related capacity to see the "good" and the "bad" in parent.					
2. Child demonstrates age-appropriate capacity for seeing different perspectives as new situations arise, both within the family and within the child's social relationships.					

B. ABOUT EACH PARENT

(i) Behavioral Indices About Each Parent (Rejected Parent).					(RP)
	N	R	S	O	VO
1. Parent supports the child's relationship with other parent.					
2. Parent consistently maintains positive support for other parent's involvement in child's life.					
3. Parent demonstrates ability to understand/accept the child without blaming.					
4. Parent expresses hope that the child will have the best possible relationship with other parent.					
5. Parent does not tell or convey indirectly to the child any negative views of other parent.					
6. Parent takes responsibility for his/her role in causing disruption of the child's relationship with other parent.					
7. Parent includes other parent in child's life (e.g., medical, academic, social).					
8. Parent complies with the court-ordered parenting plan.					
9. Parent can be at the same activity with other parent.					
10. Parent communicates directly with other parent, rather than expecting child to carry messages back & forth.					
11. Parent communicates respectfully with other parent.					
12. Parent greets other parent cordially during transitions in front of child.					
13. Parent demonstrates good emotional boundaries with child.					
14. Parent supports the child's activities by ensuring child attends the activity.					
15. Parent supports child's social relationships with peers.					
16. Parent redirects child to discuss any complaints/commentary/concerns about other parent with that parent.					
17. Parent demonstrates reasonable progress towards treatment goals.					
18. Parent demonstrates in observable actions the ability to not expose their child to their own negative beliefs & fears about the other parent.					

(i) Behavioral Indices About Each Parent (Favored Parent).					(FP)
	N	R	S	O	VO
1. Parent supports the child's relationship with other parent.					
2. Parent consistently maintains positive support for other parent's involvement in child's life.					
3. Parent demonstrates ability to understand/accept the child without blaming.					
4. Parent expresses hope that the child will have the best possible relationship with other parent.					
5. Parent does not tell or convey indirectly to the child any negative views of other parent.					
6. Parent takes responsibility for his/her role in causing disruption of the child's relationship with other parent.					
7. Parent includes other parent in child's life (e.g., medical, academic, social).					
8. Parent complies with the court-ordered parenting plan.					
9. Parent can be at the same activity with other parent.					
10. Parent communicates directly with other parent, rather than expecting child to carry messages back & forth.					
11. Parent communicates respectfully with other parent.					
12. Parent greets other parent cordially during transitions in front of child.					
13. Parent demonstrates good emotional boundaries with child.					
14. Parent supports the child's activities by ensuring child attends the activity.					
15. Parent supports child's social relationships with peers.					
16. Parent redirects child to discuss any complaints/commentary/concerns about other parent with that parent.					
17. Parent demonstrates reasonable progress towards treatment goals.					

Ratings: N=Never, R=Rarely S=Seldom, O=Occasionally, VO=Very Often.

Figure 2 Continued

18. Parent demonstrates the ability to <u>not</u> expose their child to their own negative beliefs & fears about the other parent.					
(ii) Emotional Indices About Each Parent (Rejected Parent).					**(RP)**
	N	**R**	**S**	**O**	**VO**
1. Parent demonstrates the ability to emotionally regulate.					
2. Parent demonstrates flexibility in their emotional responses.					
3. Parent is able to differentiate their emotions from their child's feelings.					
4. Parent demonstrates sensitivity & empathy regarding their child's experiences.					
5. Parent supports other parent's autonomy with the child.					
(ii) Emotional Indices About Each Parent (Favored Parent).					**(FP)**
	N	**R**	**S**	**O**	**VO**
1. Parent demonstrates the ability to emotionally regulate.					
2. Parent demonstrates flexibility in their emotional responses.					
3. Parent is able to differentiate their emotions from their child's feelings.					
4. Parent demonstrates sensitivity & empathy regarding their child's experiences.					
5. Parent supports other parent's autonomy with the child.					
(iii) Cognitive Indices About Each Parent (Rejected Parent).					**(RP)**
	N	**R**	**S**	**O**	**VO**
1. Parent accepts that the child wants to have contact with both parents (without raising the past and reverting to blaming the child's prior hostility/rejection on the other parent).					
2. Parent accepts that relationship with other parent is important for child and does <u>not</u> revert to past beliefs.					
3. Parent demonstrates an ability to separate his/her own negative thoughts and feelings about the other parent from the child's needs to have a relationship with other parent (e.g. statements such as "your other parent left us" are absent).					
(iii) Cognitive Indices About Each Parent (Favored Parent).					**(FP)**
	N	**R**	**S**	**O**	**VO**
1. Parent accepts that the child wants to have contact with both parents (without raising the past and reverting to blaming the child's prior hostility/rejection on the other parent).					
2. Parent accepts that relationship with other parent is important for child and does <u>not</u> revert to past beliefs.					
3. Parent demonstrates an ability to separate his/her own negative thoughts and feelings about the other parent from the child's needs to have a relationship with other parent (e.g. statements such as "your other parent left us" are absent).					

Overview of the Checklist.

The Changes In Resist-Refuse Dynamics Checklist (CRDC) is a checklist designed to give professionals guidelines through which to observe, assess, and understand the behavioral, emotional and cognitive changes that need to occur to resolve these parent-child contact problems.

- It is important to note that the CDRC should not replace a comprehensive screening of violence.
- The CDRC is not a diagnostic tool.
- The CDRC may work best when combined with other tools for assessment.
- The CDRC should only be used by trained professionals.
- The CDRC may not be appropriate for use with all cases.

Instructions for completing the CDRC.

Please fill in the names of the Rejected/Resisted Parent's (RP) and the Favored Parent (FP) in the chart below. For each item below, please indicate in the last three months whether the item has occurred N=Never, R=Rarely S=Seldom, O=Occasionally, VO=Very Often. There are no wrong answers. Please complete this to the best of your knowledge. If you don't know, please leave your answer blank.

Dimensions of the CDRC.

The CDRC has two sections: (1) the child; and (2) the parent. Each section is divided into behavioral, emotional and cognitive indices. In turn, each section is sub-divided into a part for the favored parent and a part for the rejected parent to fill out.

Scoring the CDRC.

This rating form is designed to be filled out by a professional who has observed (or heard testimony about) the parent-child interactions. This form is <u>not designed to be scored</u>.

Application of the CDRC.

The use of the CDRC is for trained professionals (i.e., therapists, attorneys and judges). Should a professional wish for a parent to fill out the form, it will need to be adapted and personalized. The professional may use this checklist to set treatment goals and to facilitate a discussion with each parent about their measures of progress with their child(ren). For example, this might be filled out at the start, at various stages during, and at the end of therapy.

Figure 2 Continued

The loss of the spousal relationship is a significant stressor. For some, this major stressor results in intrusive thoughts about the breakup of the relationship, avoidance behaviors, and significant symptoms of anxiety. Those who have a history of past trauma may be more vulnerable to these symptoms. A positive coping response to trauma is to find personal meaning, a sense of purpose, and a personal mission. At times, in families in which a child resists or refuses contact with the rejected parent, it is common to see the favored parent forging a personal mission to hurt, excise, or ward off their co-parent from having any kind of relationship with the children. The potential for this resulting in immense harm to the child is tremendous as the child has also experienced significant family change, often accompanied by changes in relationships, neighborhood, and school. Multiple changes, coupled with multiple major losses, are likely to negatively affect the child's adjustment.

When both parents are in a room together and can actually converse with one another, they may each reexamine their extreme beliefs about the other parent. Getting them to shift from all good/all bad, all or nothing, black and white thinking is the first step in that perceptual shift. It is important to provide information to both parents and shine a light on the responsibility they both share for their child's well-being. Education that addresses the potential physiological impact of chronic toxic stress and trauma on the one hand, and resiliency building factors on the other hand, can be very powerful for parents as they consider the short- and long-term impacts of their behaviors on their children's development. Due to the fact that parents are often so focused on externalizing responsibility for the family's difficulties, exercises which develop perspective-taking by standing in the shoes of their child and co-parent can broaden their views. Most parents blame one another for any conflict the child experiences. Showing video clips of children and young adults talking about what it feels like to be caught in the middle of their parents' conflict, how they dreaded holidays and special occasions as those special events would engender conflict between their parents, and stating what it is that they need and wish from their parents, assists parents in staying focused on their children. Likewise, education about the toxic effect conflict has on children's long-term health, brain development, and building of resilience can be powerfully demonstrated through video clips and education about Adverse Childhood Experiences (https://developingchild.harvard.edu; Felitti et al., 1998; https://www.nctsn.org).

Stress is a part of the process of the family adapting to a new family reorganization and structure after separation or divorce (Minuchin, 1974; Pardeck, 1989). When parents separate or divorce, the family members may cope in a variety of ways. Each member's coping resources affect the other, so the family system is reacting to individual, systemic responses and exchanges. Addressing the alliances within the family from a systemic perspective and focusing on safety and solutions is part of the integrative clinical framework necessary to create change for these families (Lebow, 2019). Further, tapping into, working off of, and enhancing resiliency factors is a cornerstone of the work to be done.

As resistance/refusal can be thought of as parenting time phobia, systematic desensitization in the context of parent contact resistance/refusal can be conducted similarly to the approach used for other fears and/or phobias (Wolpe & Lazarus, 1966). Desensitization work is used with the child as well as other members of the family (such as each parent) in the context of family therapy (and also in the individual therapy work of the participating individuals). Thus, the child: (1) creates a fear/anxiety hierarchy regarding alone time spent with the non-preferred parent (in terms of different possible scenarios and activities, etc.); (2) learns relaxation techniques; (3) engages in imaginal desensitization in individual therapy (the child, as well as any participating family member in their own individual therapy work) using relaxation techniques; and (4) engages in desensitization and reunification in family therapy (the exposure to the hierarchy may initially be through reciprocal letter writing, to phone calls and video calls, and then to actual contact) using relaxation techniques (Garber, 2015).

Recent preliminary research has shown that significant healthy changes in family systems where a child is resisting contact with a parent can occur as changes are made in the co-parenting relationship. For example, co-parents who attended Overcoming Barriers Camp and intensive interventions report they are better able to: (1) understand the impact on the child of the strained parent–child

relationship of the child's relationship with both parents; (2) take responsibility for their own contribution to the strained parent–child relationship problems; (3) regulate their emotions; (4) understand effective coping strategies; and (5) protect the child from the conflict (Saini, 2019).

When working with co-parents, one can use the same techniques described above, ultimately moving from emails to facilitated phone calls to video calls, and then to actual contact using relaxation techniques. In cases where traumatic events occurred and one or both parents are exhibiting post-trauma symptoms, the parent's individual therapist may be present to both provide support to the parent, and to see firsthand how the individual was able to draw up their coping skills in the reality of the other parent's presentation.

Co-parents often need to reframe the narrative they have about the separation/divorce, as well as the role and responsibility each parent has in the breakup of the family, by helping them take each other's perspective and the perspective of the child, and support a new narrative that helps the child see that the parents can focus on their well-being, have mutual aspirations for them, and can communicate and cooperate in developing a new family structure/plan in which the children are no longer triangulated. This narrative co-construction helps the family move forward with a new agreed upon or court ordered schedule and removes the children from the overwhelming conflict (Blow & Daniel, 2002; Moran, Sullivan, & Sullivan 2015; Saltzman, Pynoos, Lester, Layne, & Beardslee, 2013).

An apology is often part of the family work needed to repair and build relationships. It may be a necessary step to rebuild trust and requires a parent to take responsibility for their actions, show remorse, make restitution, and repent. Whereas forgiveness may be a desired outcome, it is not a requirement. Apologies may be from parent to parent, parent to child, or from both parents to child. Apologies model and foster empathy and can aid in the capacity for self-regulation (Ruckstaetter, Sells, Neymeyer, & Zink, 2017). Apologies can reduce levels of frustration, thereby allowing people to move beyond resentment and anger (Saini, Deutsch, & Drozd, 2019). Effective apologies do not rely on excuses and are not defensive. Further, effective apologies involve not just words—but rather actions that lead to remediation and trust. Apologies must be sincere and are ideally delivered face-to-face. Sometimes the way to open the door to a face-to-face apology is with an initial letter offering the apology, and requesting an actual meeting to offer restitution. In addition, where appropriate, parent apologies to each other, and to children, can be included in the jointly delivered new family narrative to the children.

Cohen and Mannarino (1996) found that parents' emotional reactions to trauma were the second-strongest predictor of treatment outcome next to treatment type. Thus, the family could have the best screening, the best assessment, solid evidence-based treatment for trauma—all while the child recovers from any symptoms of trauma they may have experienced and as they heal from the loss of the family as they once knew it; however, if the child still has strong resistance to a parent one has to look as to whether the trauma and/or parent alienating behaviors remain alive in the home.

If trauma and/or parent alienating behaviors remain, they may very well impair the child from moving forward on a normal developmental trajectory in which they can accurately assess each parent's strengths and vulnerabilities and mobilize developmentally appropriate coping skills. The clinical-legal team structure can assist in this process by holding family members accountable and by assessing the efforts of each family member (see CRDC), but if the trauma and the parent alienating behaviors remain in the air, no matter how hard the clinical-legal team works, the success of the work lies at the feet of each member of the family. Each member needs to take responsibility and embrace the goals of, and hopes for, recovery, repair, and resilience. As they do, they will be able to function as a family that puts their child's best interest first while they make the past their steppingstone to the future.

ENDNOTE

1. The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): Direct exposure. Witnessing the trauma. Learning that a relative or close friend was exposed to a trauma.

REFERENCES

American Psychological Association. (2017). *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults*. Washington, DC: Author. Retrieved from https://www.apa.org/ptsd-guideline/treatments/recommendations-summary-table.pdf

Association of Family and Conciliation Courts. (2016). *Guidelines for examining intimate partner violence: A supplement to the AFCC model standards of practice for child custody evaluation*. Madison, WI: Author.

Austin, W. G., & Drozd, L. M. (2012). Intimate partner violence and child custody evaluation, part I: Theoretical framework, forensic model, and assessment issues. *Journal of Child Custody*, 9(4), 250–309.

Birnbaum, R., & Bala, N. (2010). Toward the differentiation of high conflict families: An analysis of social science research and Canadian case law. *Family Court Review*, 48(3), 403–416.

Blow, K., & Daniel, G. (2002). Frozen narratives? Post-divorce processes and contact disputes. *Journal of Family Therapy*, 23, 85–103.

Briere, J. (1996). *Trauma Symptom Checklist, PAR* [Measurement instrument]. Retrieved from https://www.parinc.com/Products/Pkey/461.

Buehler, C., Anthony, C., Krishnakumar, A., Stone, G., Gerard, J., & Pemberton, S. (1997). Interparental conflict and youth problem behaviors: A meta-analysis. *Journal of Child and Family Studies*, 6(2), 233–247.

Cohen, J. A., & Mannarino, A. P. (1996). "A treatment outcome study for sexually abused preschool children: Initial findings": *Errata. Journal of the American Academy of Child & Adolescent Psychiatry*, 35(6), 835. https://doi.org/10.1097/00004583-199606000-00030

Cohen, J., & Mannarino, A. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics of North America*, 24(3), 557–570.

Cummings, E. M., Goeke-Morey, M. C., & Papp, L. M. (2001). Couple conflict, children, and families: It's not just you and me, babe. In A. Booth, A. C. Crouter, & M. Clements (Eds.), *Couples in conflict* (pp. 117–147). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Cyr, F., Poitras, K., & Godbout, E. (2020). An interdisciplinary case management protocol for child resistance or refusal dynamics. *Family Court Review*, 58(2), 560–575.

Deutsch, R. M., & Pruett, M. K. (2009). Child adjustment and high conflict divorce. In R. M. Galatzer-Levy & L. Kraus (Eds.), *The scientific basis of child custody decisions* (2nd ed., pp. 353–375). New York, NY: John Wiley & Sons.

Drozd, L., & Olesen, N. (2004). Is it abuse, alienation, and/or estrangement? *Journal of Child Custody*, 1(3), 65–106.

Drozd, L., & Olesen, N. (2010). Abuse and alienation are real: A response to Meier's critique of the decision tree. *Journal of Child Custody*, 7(4), 253–265.

Drozd, L., Olesen, N., & Saini, M. (2013). *Parenting plan & child custody evaluations: Using decision trees to increase evaluator competence & avoid preventable errors*. Sarasota, FL: Professional Resource Prep.

Drozd, L., Saini, M., & Deutsch, R. M. (2018). *Assessment and intervention in resist/refuse cases: A trauma-informed approach*. [Presentation] Presentation at AFCC 55th Annual Conference, Washington, DC.

Drozd, L., Saini, M., & Vellucci-Cook, K. (2019). Trauma and child custody disputes: Screening, assessment and interventions. In L. R. Greenberg, B. J. Fidler, & M. A. Saini (Eds.), *Evidence-informed interventions for court-involved families: Promoting coping and healthy child development*. New York, NY: Oxford University Press.

Drozd, L., Saini, M., Walters, M. Fidler, B., & Deutsch R. M. (2020). Changes in Resist-Refuse Dynamics Checklist (CRDC).

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (2019). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 56(6), 774–786.

Fidler, B. J., Deutsch, R. M., & Polak, S. (2019). "How am I supposed to treat these cases?" Working with families struggling with entrenched parent–child contact problems. In L. Greenberg, B. Fidler, & M. Saini (Eds.), *Evidence-informed interventions for court-involved families* (pp. 227–259). New York, NY: Oxford University Press.

Fidler, B. J., & Ward, P. (2017). Clinical decision-making in parent-child contact problem cases: Tailoring the intervention to the family's needs. In A. Judge & R. M. Deutsch (Eds.), *Overcoming parent-child contact problems: Family-based interventions for resistance, rejection, alienation* (pp. 13–62). New York, NY: Oxford University Press.

Finkelhor, D., Turner, H. A., Hamby, S. L., & Ormrod, R. K. (2011). Poly-victimization: Children's exposure of multiple types of violence, crime, and abuse. OJJDP Juvenile Justice Bulletin, NCJ235504, 1-12.

Ford, J. D., & Rogers, K. (1997, November). *Empirically based assessment of trauma and PTSD with children and adolescents*. [Presentation]. Paper presented at the annual convention of the International Society for Traumatic Stress Studies, Montreal, Quebec, Canada.

Friedlander, S., & Walters, M. G. (2010). When a child rejects a parent: Tailoring the intervention to fit the problem. *Family Court Review*, 48(1), 97–110.

Garber, B. D. (2015). Cognitive-behavioral methods in high-conflict divorce: Systematic desensitization adapted to parent-child reunification interventions. *Family Court Review*, 53(1), 96–112.

Gerrity, E., & Folcarelli, C. (2018). *Child traumatic stress: What every policymaker should know.* Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.

Goodman, M., Bonds, D., Sandler, I., & Braver, S. (2004). Parent psychoeducational programs and reducing the negative effects of interparental conflict following divorce. *Family Court Review*, 42(2), 263–279.

Greenberg, L. R., Doi Fick, L., & Schnider, R. (2012). Keeping the developmental frame: Child-centered conjoint therapy. *Journal of Child Custody*, 9(1–2), 39–68. https://doi.org/10.1080/15379418.2012.652568

Greenberg, L. R., & Lebow, J. (2016). Putting it all together: Effective intervention planning for children and families. In L. Drozd, M. Saini, & N. Olesen (Eds.), *Parenting plan evaluations: Applied research for the family court* (pp. 555–584). New York, NY: Oxford University Press.

Greenberg, L. R. & Schnider, R. A. (2020). We're Still Taking X-Rays but the Patient is Dying: What Keeps Us From Intervening More Quickly in Resist-Refuse Cases? *Family Court Review*, 58(2), 488–506.

Greenberg, L. R., Schnider, R., & Jackson, J. (2019). Early intervention with resistance/refusal dynamics and hybrid cases. In L. Greenberg, B. Fidler, & M. Saini (Eds.), *Evidence-informed interventions for court-involved families* (pp. 189–226). New York, NY: Oxford University Press.

Grych, J. H. (2005). Interparental conflict as a risk factor for child maladjustment: Implications for the development of prevention programs. *Family Court Review*, 43(1), 97–108.

Grych, J. H., Harold, G. T., & Miles, C. J. (2003). A prospective investigation of appraisals as mediators of the link between interparental conflict and child adjustment. *Child Development*, 74(4), 1176–1193. https://doi.org/10.1111/1467-8624.00600

Johnston, J. & Sullivan, M. (2020). Parental Alienation: In Search of Common Ground For a More Differentiated Theory. *Family Court Review*, 58(2), 270–292.

Kelly, J. B., & Emery, R. E. (2003). Children's adjustment following divorce: Risk and resilience perspectives. *Family Relations: An Interdisciplinary Journal of Applied Family Studies*, 52(4), 352–362.

Kelly, J. B., & Johnston, J. R. (2001). The alienated child: A reformulation of parental alienation syndrome. *Family Court Review*, 39(3), 249–266.

Kliethermes, M., Schacht, M., & Drewry, K. (2014). Complex trauma. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 339–361.

Krishnakumar, A., & Buehler, C. (2008). Interparental conflict and parenting behaviors: A meta-analytic review. *Family Relationships*, 49(1), 25–44. https://doi.org/10.1111/j.1741-3729.2000.00025.x

Kuehnle, K. (1996). *Assessing allegations of child sexual abuse*. Sarasota, FL: Professional Resource Press.

Kuehnle, K., & Connell, M. (2009). *The evaluation of child sexual abuse allegations: A comprehensive guide to assessment and testimony.* New York, NY: Wiley.

Lamela, D., Figueiredo, B., Bastos, A., & Feinberg, M. (2016). Typologies of post-divorce coparenting and parental well-being, parenting quality and children's psychological adjustment. *Child Psychiatry & Human Development*, 47(5), 716–728. https://doi.org/10.1007/s10578-015-0604-5

Lawson, D., & Quinn, J. (2013). Complex trauma in children and adolescents: Evidence-based practice in clinical settings. *Journal of Clinical Psychology*, 69(5), 497–509.

Lebow, J. (2019). Specialized child and family interventions. In L. Greenberg, B. Fidler, & M. Saini (Eds.), *Evidence-informed interventions for court-involved families* (pp. 57–79). New York, NY: Oxford University Press.

McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: Central role of the brain. *Physiological Reviews*, 87(3), 873–904. https://doi.org/10.1152/physrev.00041.2006

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. New York, NY: Guilford Press.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Moran, J.A., Sullivan, T., & Sullivan, M. (2015). Overcoming the Co-Parenting Trap: Essential skills what a child resists a parent. Natick, MA: Overcoming Barriers.

National Child Traumatic Stress Network (NCTSN). (2003). Effective Treatment for Youth Trauma, 1-3. Retrieved from www.nctsn.org.

Norcross, J. C., & Wampold, B. E. (2019). Relationships and responsiveness in the psychological treatment of trauma: The tragedy of the APA clinical practice guideline. *Psychotherapy*, 56(3), 391–399. https://doi.org/10.1037/pst0000228

Olesen, N. W., & Drozd, L. M. (2012). Prudent therapy in high conflict cases: With and without allegations of intimate partner violence or child abuse. *Journal of Child Custody*, 9(1–2), 69–84. https://doi.org/10.1080/15379418.2012.652570

Pardeck, J. T. (1989). The Minuchin family stress model: A guide for assessing and treating the impact of marital disruption on children and families. *International Journal of Adolescence and Youth*, 1(4), 367–377. https://doi.org/10.1080/02673843.1989.9747650

Pruett, M. K., & Durell, M. (2009, May). *Connecticut judicial branch court support services division family civil intake screen and services evaluation: Final outcomes report*. Retrieved from https://www.afccnet.org/Portals/0/PublicDocuments/CEFCP/ConnecticutFinalReport.pdf?ver=2013-08-21-072318-000.

Pynoos, R. (2016). Collecting trauma data about children: Operationalizing the concept of trauma in children. In K. Marton (Ed.), *National academies of sciences, engineering, and medicine. Measuring trauma: Workshop summary* (pp. 29–39). Washington, DC: National Academies Press (US).

Ruckstaetter, J., Sells, J., Neymeyer, M. D., & Zink, D. (2017). Parental apologies, empathy, shame, guilt and attachment: A path analysis. *Journal of Counselling & Development*, 95(4), 389–400. https://doi.org/10.1002/jcad.12154

Saini, M. A. (2019). Strengthening coparenting relationships to improve strained parent-child relationships: A follow-up study of parents' experiences of attending the overcoming Barriers Program. *Family Court Review*, 57(2), 217–230.

Saini, M. A., Deutsch, R. M., & Drozd, L. (2019, February). *Therapeutic apologies in the context of strained parent-child relationships*. [Presentation] Paper presented at AFCC California Chapter Annual Conference, Costa Mesa, CA.

Saini, M. A., Drozd, L., & Deutsch, R. M. (2018). A trauma-informed approach for the assessment and intervention of resist/refusal cases. *Family News & Views*, A Publication of AFCC-New York, 2(2), 1–7.

Salem, P., Kulak, D., & Deutsch, R. M. (2007). Triaging family court services: The Connecticut judicial branch's family civil intake screen. *Pace Law Review,* 27(4), 741–783.

Saltzman, W. R., Pynoos, R. S., Lester, P., Layne, C. M., & Beardslee, W. R. (2013). Enhancing family resilience through family narrative co-construction. *Clinical Child and Family Psychology Review*, 16(3), 294–310.

Sandler, I., Wolchik, S., Winslow, E., Mahrer, N., Moran, J., & Weinstock, D. (2012). Quality of maternal and paternal parenting following separation and divorce. In K. Kuehnle & L. Drozd (Eds.), *Parenting plan evaluations: Applied research for the family court* (pp. 85–117). New York, NY: Oxford University Press.

Schepard, A. (2004). *Children, courts, and custody.* New York, NY: Cambridge University Press.

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports*, 6(2), 96–100.

Substance Abuse and Mental Health Services Administration [SAMHSA] (2015). Behavioral health trends in the united states: Results from the 2014 national survey on drug use and health [WWW document]. Retrieved from www.samhsa.gov/.

Sullivan, M. J., Deutsch, R. M., & Ward, P. (2017). Coparenting, parenting and child-focused family interventions. In A. Judge & R. M. Deutsch (Eds.), *Overcoming parent-child contact problems: Family-based interventions for resistance, rejection, alienation* (pp. 222–242). New York, NY: Oxford University Press.

Teicher, M. H. (2002). Scars that won't heal: The neurobiology of child abuse. *Scientific American*, 286(3), 68–75.

Van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35(5), 401–408.

Walters, M. G. & Friedlander, S. (2016). When a child rejects a parent: Working with the intractable resist/refuse dynamic. *Family Court Review*, 54(3), 424–445.

Ward, P., Deutsch, R. M., & Sullivan, M. J. (2017). Overview of the overcoming barriers approach. In A. Judge & R. M. Deutsch (Eds.), *Overcoming parent-child contact problems: Family-based interventions for resistance, rejection, alienation* (pp. 107–130). New York, NY: Oxford University Press.

Wolpe, J., & Lazarus, A. A. (1966). *Behavior therapy techniques: A guide to the treatment of neuroses*. Elmsford, NY: Pergamon Press.

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