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Distinguishing among mental health services relevant to family law process

By: **Benjamin D. Garber, Ph.D.**

In an alternate reality, psychologists have developed a reliable and valid test for determining the ideal future allocation of high conflict parents' parenting rights and responsibilities. The test is quick, cheap and has been shown to guarantee the children's optimal social, emotional, cognitive, and occupational outcomes.

In this same fantasy world, psychologists also have a reliable instrument with which to determine with certainty whether to terminate a parent's rights, whether to allow a parent to relocate out of state with his or her kids, whether a parent will be neglectful or abusive, and what combination of eight numbers will win the next lottery.

In the real world—the world in which our courts are dramatically overburdened, our child protective service professionals struggle with an impossible job, and parents sometimes act as if destroying one another is more important than caring for their children- psychologists have no such magical tools. Unfortunately, this doesn't stop some courts from ordering them.

The fit between the family courts' needs and forensic mental health professionals' arsenal is far from perfect. This article offers a basic description of a number of services that are sometimes relevant to the questions that come before the family courts. This overview is offered in the hope that a fuller understanding of the nature and limitations of these processes might help our family courts to more efficiently and effectively serve our children's best interests.

Rather than simply present a glossary of mental health services, the discussion to follow is organized around each of seven (non-mutually exclusive) questions that commonly arise in the context of family law litigation.

1. "Is this parent crazy?" Hopefully, we all know that "crazy" is a pejorative, generic term with no place in psychology and no meaning in the family courts. The question arises, nonetheless, particularly when high conflict litigants begin to throw around labels such as "borderline personality disorder" and "bipolar illness" and "multiple personality disorder."

Psychiatry has catalogued the various forms of "mental illness" in a volume known as the Diagnostic and Statistical Manual (DSM). The current DSM is in its fourth iteration (thus, DSM-IV) published in 1994. The DSM-5 (not anticipated to use the Roman numeral!) is due out in 2013. Psychology and its allied mental health professional guilds (e.g., clinical social work, pastoral care, licensed clinical mental health counselors) have endorsed the DSM terminology, at least in part to comply with billing practices imposed by managed health care.

Psychology is very good at using standardized measurement instruments to answer very specific questions about an individual's social, emotional, and cognitive functioning. For example, psychometric testing can be very useful in the criminal courts when questions about offender mental capacity are at issue.

In family law, however, the questions that psychologists can answer using standardized individual psychometric instruments seldom have direct and demonstrable bearing on the issues before the court. There is no valid reason, for example, to grant residential or decision making authority to the parent who has fewer or lesser diagnoses, higher or lower intelligence, more or less conventional inkblot responses, or a particular constellation of MMPI scores. Of course, there are exceptions to this rule – individuals whose profound psychopathology bears on parenting and co-parenting capacity- but

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these individuals' idiosyncrasies are generally so pronounced and longstanding that that formal testing is redundant.

As a practical matter, ordering one or both parents to complete individual psychological testing incurs great expense and typically consumes many weeks only to introduce diagnoses and formulations which themselves then become the subject of intense and expensive litigation. In some cases, the testing psychologist must be deposed and called to testify. Opposing experts are hired to argue fine points of test selection, administration and interpretation. Pointless debates comparing his versus her pathologies ensue when none of this has any necessary relevance to serving the best interests of the child.

The questions litigated in our family courts, the theme throughout the family law literature, the motive underlying this author's practice and indeed throughout this article is "fit." How does the psychological and behavioral "fit" between parent and child serve the child's needs? Fit is not about labeling an individual parent's psychopathology. It is about that parent's real life ability and willingness to read and respond to each child's unique needs. At issue are relationships, not personalities.

2. "Is this adult a good enough parent?" This question arises in termination of parental rights (TPR), foster and adoptive care cases, among others. This question seeks to qualify, if not to quantify, an individual adult's abstract and generic capacity to read and respond to children's needs generically. Psychology can provide this service in the form of a parenting capacity evaluation.

A parenting capacity evaluation sets a very low threshold for success. It typically examines an adult's understanding of developmental differences, his or her capacities for empathy, communication and impulse control, among other relevant qualities. It may include indicators of potential for abuse and/or neglect. It cannot, however, address the adult's capacity to read and respond to his or her own child's unique needs. As such, a parenting capacity evaluation of Parent A can only be compared to a parenting capacity evaluation of Parent B at the broadest, most generic, either-or level. Demonstrating that one parent has limited or no parenting capacity can be valuable to TPR litigation, but finding that both of a pair of divorcing parents have at least basic parenting capacity usually yields little or nothing of value to the larger questions before the court.

3. "Should Parent A be ordered to engage in psychotherapy?" Our family courts quite frequently order individual adult litigants to enroll in "psychotherapy" or "counseling," usually with no definition of the intended therapy's goal, identification of the legal patient or client and therefore without any clarification as to the confidentiality –or lack thereof- of the service. In short, an order such as, "Mr. Smith will engage in outpatient psychotherapy" may be intended as an opportunity for growth and change, but more often is a waste of time, money and effort and can be, at worst, a set-up for both the litigant and the therapist who accepts the case.

Whereas some medical interventions will succeed or fail in their intended purpose regardless of the patient's wishes, psychotherapy is a mutual process requiring patient or client trust, investment and commitment. In the absence of these critical ingredients, the court may be able to order the horse to water, but it cannot make him drink.

The dilemma of the adult litigant who sits silently in a therapist's office for an hour a week in order to comply with a court order is compounded by attendant ambiguities associated with confidentiality. Many mental health professionals (including this author) would define the legal patient and the holder of confidentiality in a court ordered psychotherapy as the court, not the adult sitting on the couch. Many such therapies proceed ignorant of this detail, only to cause both therapist and the participating adult ("clinical patient") grave distress when the court demands access to relevant records. Other, more savvy therapists proactively alert the participating adult to this detail, thereby fulfilling relevant ethical expectations but simultaneously closing the door on any hope of a genuine and therapeutic relationship.^[1]

Does this mean that the court should not order parent-litigants to engage in psychotherapy? Perhaps. Questions about one or the other parent's behavior are better addressed through standardized psychological assessment (see item #1, above) as opposed to psychotherapy. However, should the court determine that a parent-litigant might benefit from psychotherapy such that the child's best interests might better be served (e.g., with the goal of better controlling an addiction or overcoming a crippling anxiety), the relevant order must be clear and detailed, addressing the presumed purpose of the intervention, the background to be provided to the therapist, who is to be

identified as the legal patient, and the associated limitations of confidentiality. For example:

“Mr. Smith will enroll in psychotherapy with a state licensed mental health professional within four weeks of the date of this order. The psychotherapy is intended to assist Mr. Smith in redirecting his anger so as to minimize the children’s experience of same. The psychotherapist, once identified, will be provided with a copy of this order and the Guardian ad litem’s report. Mr. Smith is to be identified as the legal patient or client receiving this service and will thereby enjoy the customary protections and limitations of confidentiality. Mr. Smith will, however, provide this court with the therapist’s name and credentials at the outset of the therapy and thereafter with a monthly, notarized statement from the therapist identifying (1) the dates of his attendance and (2) whether he is compliant with the therapist’s recommendations. The therapist may only divulge the content and progress of the therapy to the court with Mr. Smith’s informed consent. The therapist will furthermore provide (3) a notarized statement if and when the therapist determines that the psychotherapy should be terminated.”

4. “Should a minor child embroiled in his or her parents’ high conflict litigation be ordered to enroll in psychotherapy?” The relevant empirical literature demonstrates that children can be okay in the long run despite exposure to horrific trauma and conflict if they have a single, constant emotional anchor through it all (Masten et al., 1999; Rutter, 1979). Psychotherapy can provide such a “port in the storm” for children.

However, the practical, procedural and legal downsides of ordering a court-embroiled child into psychotherapy can be considerable. These include managed care’s emphasis on short-term, solution-focused interventions and formal diagnosis, unintended but implicit confirmation of the child’s belief that he or she is “crazy” and thereby the cause of the family problem, and the parents’ intrusion into and manipulation of the therapy despite the 2005 Berg ruling.^[2] Also relevant is the psychotherapist community’s unfortunate but longstanding general aversion to court-related matters of any kind.

Further complicating this consideration are questions of confidentiality. Once again, in lieu of orders to the contrary, there is a strong argument in favor of identifying the court as the legal “patient” and not the individual, regardless of age. This may not seem like as much of a dilemma when a minor child is sitting on the couch, but the legality is confounded both by the therapist’s wish to respect the child’s privacy in the process of building a trusting relationship and by protections guaranteed adolescents under federal law.^[3]

On balance, a child with demonstrable social, emotional, and/or behavioral difficulties should at least be evaluated by his or her pediatrician and/or school, if not directly by a child-centered mental health professional. This is best accomplished with both parents’ active support but may, in some instances, require court-order. The evaluating professional should then provide both parents with specific written recommendations appropriate to the child’s needs, if any, including whether enrolling in psychotherapy might serve his or her best interests. If subsequent services are recommended and the parents are stalemated, the court can consider one of at least two options.

First, some courts will allocate decision making authority in all mental health matters exclusively to one parent. This can resolve the legal issue, but is unlikely to resolve the associated clinical dilemma. Specifically, even without legal authority, the disenfranchised parent can undermine the child’s therapy (Garber 2004b).

In the alternative, the court can craft an order carefully tailored to the child’s needs and maturity. For example,

“Mr. Smith and Ms. Jones will immediately enroll Billy in outpatient psychotherapy consistent with the pediatrician’s recommendations. Each parent will identify three potential therapists for this purpose. Each parent will have the freedom to interview any or all of the six candidates within four weeks of the date of this order, such meetings to be conducted at each parent’s expense and exclusive of Billy’s mental health insurance benefits. The parents will meet on [date] with [mediator] for the purpose of selecting a therapist from among these six. In lieu of a mediated agreement, the court will select one among the six identified therapists. The parents will

provide the selected therapist with this order and the Guardian ad litem's report. The parents will comply with Billy's therapist's requests as to their contribution to the process, the frequency of meetings, and completion of any 'homework' with or for their son. The parents will equally divide all out of pocket expenses incurred. The parents will respect the privacy of this process and fully support Billy in trusting and making use of this service. The parents will request that the therapist provide them with a summary of this therapy, noting in particular each parent's support and the dates of all services provided, allowing the therapist to exercise his or her discretion in respecting the child's privacy in the interest of serving the child's best interests. The therapist and the therapy will not otherwise be drawn into the litigation for any purpose barring the therapist's expressed concerns for any person's safety."

5. "How should these two adults' future parenting rights and responsibilities be allocated?" This may be the most difficult question posed to the court when high conflict parents separate or divorce. It is *not* a question that any mental health professional can address for two critically important reasons. First, the governing best interests of the child standard (as set forth, for example, in section 402 of the United States' Uniform Marriage and Divorce Act [1973/1975][4]) includes consideration of criteria that a mental health professional is unlikely to be qualified to address (e.g., physical health, financial and educational matters). As a result, many mental health professionals will be careful to address instead the best *psychological* interests of the child (Miller, 2002).

Second, a mental health professional who presumes to determine how adults' future parenting rights and responsibilities should be allocated is usurping the court's authority and, in so doing, is arguably breaching relevant ethics.[5] Indeed, the matter of whether evaluating psychologists can and should do more than provide objective description has been hotly debated (e.g., Tippins and Wittman, 2005).

Given these caveats, psychology may be able to answer the question, "How do these two adults' respective parenting strengths and weaknesses serve the particular needs of their child?" and, "How best will this child's social, emotional and cognitive needs best be met?" The process, formerly known as a custody evaluation, is now referred to as a child-centered family evaluation (CCFE).[6] This is a comprehensive evaluation of each parent and child, the quality of the relationship between each parent and each child, the quality of the co-parents' relationship (e.g., consistency of parenting practices, mutual support, capacity for child-centered, proactive communication), and consideration of the psychological factors relevant to these relationships. CCFE is also the most reliable and valid means presently available with which to answer the most incendiary issues in the field such as "Is Parent A alienating the children from Parent B?" and "Is Parent A adultifying, parentifying or infantilizing one or more of the children?" (Garber, 2011).

6. "Should these parents be ordered to engage in co-parenting services?" Co-parenting is an adult intervention intended to facilitate the participant-parents' mutual communication, cooperation and the consistency of their respective parenting practices. These services are not a form of psychotherapy as they are not focused on understanding, expressing or changing emotions. Indeed, participants in co-parenting services are routinely advised to simultaneously maintain their own psychotherapy so as to have an opportunity to manage the emotions that are inevitably stirred up in the course of participating in co-parenting services (Garber, 2004a).

Co-parenting services are, instead, a business-like, agenda-driven form of ADR built upon empirical evidence that children's needs are best served when their caregivers are able to communicate, cooperate and establish a high degree of consistency. As such, court-ordered co-parenting services can be of significant benefit to mildly to moderately conflicted co-parents when there is no threat of domestic violence.

High conflict co-parents, on the other hand, routinely need more than child-centered mediation. In the absence of arbitration authority, parties' long-standing investment in proving their partner to be the bad parent (and thereby proving themselves to be the good parent) will continue to trump any child-centered goals and cripple the process. These parents are more likely to benefit by engaging a parent coordinator.

Parent coordination (PC) is a relatively new form of ADR endorsed by the Association of Family and Conciliation Courts, recognized by the American Psychological Association and written into a number of others states' legislation. Although it is not yet formally

acknowledged in New Hampshire, some courts will appoint parent coordinators on a case by case basis with parties' mutual consent.^[7]

Parent coordinators meet with parties to resolve co-parenting differences within the limits of the existing parenting plan. The process, like co-parenting services, is child-centered and agenda driven. The difference, however, is that in any instance in which education and mediation prove insufficient, the parent coordinator can arbitrate such that his or her decision stands unless and until a court orders otherwise.

7. "Should this parent be ordered to participate in a parent training class?" Yes. Above and beyond the Child Impact Seminar, parent-litigants should take every opportunity to learn more about child and family development and healthy parenting practices. The cost of such services is routinely far less than any therapy, spans a fixed period of time and offers the benefit of other parent-participants' perspectives, experiences and hard-won wisdom. Apart from the cost, there is no downside to this order. Indeed, parents should voluntarily sign up for parenting education opportunities, confident that even if the court doesn't acknowledge this proactive effort, certainly their children will benefit in the process.

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Endnotes

[1] Readers are strongly urged to review the guidelines for court-involved therapy published by the Association of Family and Conciliation Courts (2010) available at www.afccnet.org/Portals/0/PublicDocuments/Guidelines/GuidelinesforCourtInvolvedTherapyAFCC.pdf

[2] Berg v Berg (NH Supreme Court, 2005). This ruling is published at www.courts.state.nh.us/supreme/opinions/2005/berg112.htm. See also the New Hampshire Board of Mental Health Practice's statement on this ruling at www.nh.gov/mhpb/berg.html.

[3] See Behnke and Warner's excellent and concise discussion of these and related issues "Confidentiality in the treatment of adolescents" at www.apa.org/monitor/mar02/confidentiality.aspx

[4] See www.uniformdivorce.com/UMDA.pdf for example for the full text

[5] For example, the American Psychological Association's 2010 revised Code of Conduct, standard 2.01 Boundaries of Competence; see www.apa.org/ethics/code/index.aspx for the full ethics standards.

[6] See healthyparent.com/CCFE.html to learn more.

[7] See www.PCANH.org



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