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## Risk Management in High-Conflict Divorce/Parenting Referrals: It's How You Walk Through the Fire La gestion du risque en cas de clients dirigés suite au divorce aux prises avec des relations parentales très conflictuelles : savoir naviguer entre les écueils

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### ABSTRACT

Professionals involved in counselling and psychotherapy will find themselves confronted by the problems associated with high-conflict parenting (HCP) after relationship dissolution. With these cases come unique challenges. Issues related to risk management and effective service delivery need to be considered. This article provides an introduction to professional issues related to HCP and ways to negotiate these challenging cases.

### RÉSUMÉ

Les professionnels intervenant en counseling ou en psychothérapie vont se trouver aux prises avec des problèmes liés à des relations parentales très conflictuelles suite à la rupture d'une relation. Ces cas s'accompagnent de difficultés bien particulières. Les enjeux en lien avec la gestion du risque et la prestation efficace des services doivent être pris en compte. L'article propose une introduction aux enjeux professionnels liés aux relations parentales très conflictuelles et des façons d'aborder ces cas difficiles.

After divorce or relationship dissolution, approximately 10–15% of families meet the criteria for high-conflict parenting (Department of Justice Canada, 2001; Emery, 1999). These families often seek treatment because of symptoms exhibited by their children, one parent's pursuit of professional input to advance their position in litigation, or parents' mutual desire intent to reduce conflict. Sometimes, a court directs treatment because of the parents' conflict (Amundson, 2016; Department of Justice Canada, 2001; Kourlis, Taylor, Schepard, & Pruett, 2013). These families present with complex psychological, ethical, and legal issues (Disney, Weinstein, & Oltmanns, 2012; Goodman, Bonds, Sandler, & Braver, 2004; Hayes, 2010), which must be managed in the provision of professional services. This complex and often demanding situation is rife with professional hotspots (Olesen & Drozd, 2014; Schact, 1999; Sullivan, 2004). In this article, we seek to provide guidance through this difficult terrain.

### WHAT DO WE MEAN BY HIGH CONFLICT PARENTING?

High-conflict parenting (HCP) refers to a small but robust percentage of families that fall into patterns of hostile and enduring interpersonal rancor at the point

of separation or divorce. While couples with children in intact relationships may engage in high-conflict behaviours, this article addresses HCP specific to divorce and separation. In 2000, the American Bar Association Section of Family Law and the Johnson Foundation cosponsored a conference entitled *High-Conflict Custody Cases: Reforming the System for Children* (Ramsey, 2001), which gathered an international and interdisciplinary group of judges, lawyers, and mental health professionals to discuss HCP. The participants described these families as characterized by ongoing conflict between the parents in which one or both parents display a lack of trust, high levels of strong emotion, and compulsion to engage in interpersonal confrontation in either the personal or legal domains. Parents display critical and contemptuous posturing and confrontation with one another. The parties' strong emotions are not limited to anger or aggression, but also fear, doubt, sadness, frustration, and hopelessness. To paraphrase philosopher George Santayana (Albee & Santayana, 1905), the parties often redouble their efforts [at assertion, self-righteousness, and control over the situation] when they have lost or forgotten their aim [i.e., to act in the best interests of the children]. The research on HCP (Dale, 2014; Depner, 1992; Garrity & Baris, 1994; Grych, 2005; Hetherington, 1989) identifies these characteristics of families displaying HCP:

- Lack of ability or refusal to communicate about the children and their care;
- Inability or excessive difficulty making joint decisions about the children;
- Discrepant perception about each other's parenting practices;
- Pervasive distrust and ongoing allegations about the other parent's ability to adequately care for the children;
- Unremitting hostility between adults, including verbally abusive e-mail and text messages;
- Allegations of domestic violence, physical abuse, and/or sexual abuse;
- A history of "failed" interventions through mediation, counselling, custody and access assessments, and/or trial;
- Drawn-out or frequent litigation to regulate day-to-day care and control;
- Restraining orders and/or no-contact orders.

Central to HCP is triangulation of children in the adult dynamics and dysfunction. Conflict that places children in the middle, or more importantly, gives rise to situations when children perceive themselves to be in the middle, has a poisonous and infectious effect (Dale, 2014; Fidler & Bala, 2010; Garrity & Baris, 1994; Johnston, 1993; Kuehnle & Drozd, 2012; Lampel, 1996). Ramsey (2001) stated that these children are seriously, significantly, and determinately at risk, harmed by the animosity and adversarial posturing of their parents.

According to Ramsey (2001), these children can suffer in myriad of ways. They are at greater risk for conduct problems, academic underachievement, poor self-regulation, and/or poor impulse control. Children's ability to manage their day-to-day behaviour and activities of daily living (e.g., hygiene, nutrition, clothing, social interaction), as well as their self-reliance and self-protection, is compromised (Dale, 2014; Fabricius & Luecken, 2007; Pruett, Williams, Insabella, & Little, 2003; Sandler, Miles, Cookston, & Braver, 2008; Wang & Amato, 2000).

Although the psychological literature informs us that divorce in general is a moderate risk factor for the emotional, behavioural, social, and health dimensions of children long-term (Emery, 1999; Thompson & Amato, 1999), this moderate risk is amplified by HCP. When HCP occurs, the reasonable optimism regarding children's ability to manage divorce is less warranted. The costs to children associated with HCP can emerge in emotional disorders of childhood, academic failure, drug/alcohol abuse, antisocial conduct, alienation, estrangement, and parental dissonance (Dale, 2014; Emery, 1999; Fabricius & Luecken, 2007; Pruett et al., 2003; Sandler et al., 2008; Thompson & Amato, 1999; Wang & Amato, 2000). Behind these families is often a long line of legal professionals, and also divorce coaches, child therapists, adult therapists, family therapists, mediators, parenting coordinators, evaluators, litigation support consultants, and others (see Chang, 2016). No stone has been unturned, or often unthrown, by the parents.

#### IT'S HOW YOU WALK THROUGH THE FIRE

One risk management strategy is to avoid working with these families. In the interest of self-protection, many counsellors simply state they will not work with HCP families. While it is self-evident that professionals ought not provide services for which they lack competence, the withholding or withdrawal of services in order to minimize risk to oneself can also be problematic (Canadian Counselling and Psychotherapy Association [CCPA], 2007; Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). Difficult clinical work and ethical and legal challenges associated with HCP files do not, de facto, interfere with the provision of quality services. Nonetheless, in order to "walk through the fire," counsellors and psychotherapists must actively manage risk.

#### *Recognizing High-Conflict Situations*

Identifying high-conflict families is the first step in managing risk (Baris, 2001; Department of Justice Canada, 2001; Disney et al., 2012). At the most fundamental level, HCP is manifest in (a) parental emphasis on issues related to court, (b) the conflict related to separation, (c) child custody/care, and/or (d) the child's adjustment while in the care of the other parent. It is not uncommon that a request for professional treatment related to children's distress is secondary to, or at least accompanied by, a desired legal outcome (i.e., more parenting time or decision-making with respect to the children).

Regularly, a parent will request the other parent not participate, or not even be informed about, the treatment. Often, a parent will say that the other parent "already knows," and suggests "it's okay" for the child to receive services, or that the other parent has indicated an unwillingness to be involved. A degree of skepticism is useful in this regard (Austin, 2000). The CCPA (2015) *Standards of Practice* state generally that "parents and guardians" (p. 18) should provide consent for a child's treatment, but are silent on whether both parents must consent in a high-conflict situation. However, it is prudent for a counsellor to obtain consent from both

parents before providing services to the child. In certain circumstances, lack of parental consent can be overridden by court order, but a counsellor is cautioned against overriding consent based upon the perceived necessity for treatment after hearing from only one parent. It is also prudent to ask to review the court order a parent is relying on when he or she claims “sole custody” or “primary decision-making.” If uncertain about the meaning of the document before you, do not hesitate to consult with a colleague experienced in such matters, legal counsel, or the CCPA (2015) *Standards of Practice*.

It is also not unusual to observe that the children in these families display significant symptoms, manifesting as complaints or denigration of one parent, involvement in parental issues, or pronounced anxiety, depression, and acting-out behaviours. Other times, counsellors see children presenting with an exaggerated concern for their own or a parent’s well-being (Fidler & Bala, 2010).

Often these clients (adults and children) appear to be in a state of protracted agitation. This is less reflective of specific symptoms or clinical concerns, but rather on pervasive interpersonal conflict and their focus on “case presentation.” *Case presentation* refers to the practice of laying out facts and allegations about the other parent and/or investing the children in the conflict. In the latter, one often sees a child who provides verbatim accounts of one parent’s concerns. When they give (purportedly) their own complaints, they often lack depth, focus, or specificity (Stahl, 1999).

#### *Intimate Partner Violence and/or Child Abuse and Neglect?*

While it is important to consider high-conflict and/or “case presentation,” it is vital to consider the real possibility that the presentation of the parent and the child actually reflects intimate partner violence (IPV) and/or child abuse and neglect (CAN). IPV and associated CAN co-occur with high-conflict divorce and separation in as many as 20–55% or more of contested custody cases (Jaffe, Zerweer, & Poisson, 2004; Keilitz et al., 1997). IPV can be mislabelled as HCP with serious consequences, and the clinician must differentiate between HCP and maltreatment. While it is beyond the scope of this article to discuss the connection and overlap between the characteristics of families and responses to IPV and/or CAN, it is prudent that a clinician accepting HCP referrals is competent to distinguish IPV and is aware of victim-blaming stereotypes.

A counsellor has statutory reporting obligations in cases of IPV and CAN. In HCP referrals, it is particularly important for the counsellor to undertake the duty to warn or protect responsibly. To dismiss such concerns may perpetuate harm to a child. On the other hand, uncritically taking on the role of an advocate may be embracing a falsehood. In either position, the counsellor must be aware of the ramifications, seek guidance, and support the client through due diligence and clinical attention. One option for the counsellor may be to relay allegations to the authorities without taking a position as to their credibility.

Olesen and Drozd (2012) advocate maintaining neutrality and an open mind in the face of these types of allegations. They recognize that a genuine victim

needs to feel supported and believed in the therapeutic process, and remind us that when a client feels confident that the counsellor truly understands the situation, the client is more likely to tolerate the counsellor's neutrality with respect to legal proceedings. The client who feels personally supported is more likely to understand the procedural, ethical, and legal factors that may inhibit a counsellor from advocacy in legal proceedings. If the counsellor ascertains the allegations are credible as per recognized clinical criteria, the counsellor may then decide to articulate the concerns to authorities directly, or refer the client to a lawyer, the local police domestic violence unit, child protection authorities, a women's shelter, and so on. Whatever the counsellor's take on the matter, the counsellor should document his or her actions and the rationale for the actions taken.

#### DEFINING ONE'S MANDATE

As a result of these considerations, a counsellor may feel adrift in a sea of multiple concerns, complaints, and areas for treatment. Multiple questions then arise, as they should, and it becomes clear that there are problems associated with how to structure treatment. In fact, given the conflict between the parents, it is typically difficult to structure treatment. The conflict between parents drives differences of opinion about whether therapy is required, strife over the desired therapeutic agenda, and dissent about who should participate in therapy (Dale & Gould, 2014; Schact, 1999; Sullivan, 2004). In these situations, counsellors should ask themselves:

- *Who are my clients?* Am I providing counselling to parents, children, or a conjoint service? Are the adults or the children receptive to consultation and treatment?
- *What is my job?* Is there a viable goal for counselling? How might I structure the service, and toward what end(s)?
- *Do all actual or potential participants (stakeholders) agree on the situation or my role?* Regardless of who is in the room and the way I elect to structure treatment, is there consensus or agreement on some, if not all, aspects of my work?
- *What are desired or possible outcomes?* Irrespective of my perceptions as to what might be important or what people should do, what are the dynamics of treatment and possibilities given the family before me?

Hopefully, it is clear that the ability to see the complexity in these situations is fundamental to successfully walking through the fire. Once the complexity of the matter has been identified, counsellors should turn to negotiating their role and defining their job.

#### *What Is My Job?*

With HCP clients, it is important to determine not only what you are being asked to do, but what is your authority (what you can or cannot do) as a profes-

sional counsellor. It is essential to gather specific information about the clients' reasons for seeking your services and their desired outcomes. This requires a clinician to understand

- a brief history of the course of separation and divorce;
- the current legal status in terms of custody, parenting time, and responsibilities;
- the history and circumstances of previous professional involvement, including the participation of each parent, and whether such involvement was court-ordered or voluntary;
- the outcome of any previous professional involvement;
- previous and pending legal action relative to the parent(s) or the children involved;
- the goals of the party requesting your services for the other parent's parenting or behaviour, the other parent's awareness of your potential involvement, and consent for your services (Association of Family and Conciliation Courts [AFCC], 2006; CCPA, 2007).

Though seemingly daunting, this process of enquiry is really simply acculturating yourself to the unique and specific aspects of a particular family's struggle with HCP. Acculturation is less an exercise in risk management than it is in clear and empathetic engagement with the family.

Risk management and engagement starts with foresight. The information you gather provides both the context for services and a sense of the client's receptivity to input or influence of the counsellor. For example, counsellors must impress upon clients that family law enfranchises both parents equally, and that each must provide consent before treatment can be provided. Counsellors, however, must also be aware that while each parent can pursue professional services and either may terminate services, ideally they are partners to treatment and its design. Engagement without consent is clearly a problem, but consent without engagement is a problem of another sort. Helping parents understand the risks to their children of continued conflict, and the benefits of reduced conflict, can be one way to increase client engagement. Helping parents adopt a perspective of "from this point forward," seeking to reduce conflict, rather than rehashing historic events, is another way to enhance engagement.

Professional ethics and standards of practice, of course, play a major role in defining and determining the context of the services (CCPA, 2015; Crowley & Gottlieb, 2012; Knapp et al., 2013). With HCP families, there is a need for absolute clarity regarding the clinician's role in treatment or evaluation. On any given file, counsellors could potentially provide either of these services and must determine which one of these is sought (Chang, 2016; CCPA, 2015).

Critical ethical issues arise with HCP cases in which the counsellor has not negotiated his or her role, or has not stayed within the particular definition of that role. Drawing lines is simple; operating within the lines is incredibly difficult (CCPA, 2015; Dale & Gould, 2014). What begins as treatment can easily evolve

into a request for an “opinion” regarding parenting roles and responsibilities, the desires of children, the fitness of adults, or even the suitability of a parenting schedule. The provision of any opinion is likely to find its way into a formal legal document—for example, an affidavit that places an unwitting counsellor’s opinion in evidence before the court. Clearly, without understanding the parameters associated with your professional role and what you might or ought not say, there is the possibility of ending up with a professional complaint or subpoena to attend court. The crystal-clear, pre-emptive determination of the counsellor’s role, as either treatment provider or evaluator, is fundamental to risk management (AFCC, 2006; Greenberg & Shuman, 1997).

The cross-contamination of roles (treatment provider vs. evaluator/provider of opinion) often arises from the tendency for HCP clients to convey their concerns with agitated urgency. As a result, counsellors may feel pressured toward the same state of mind. There are often passionate and disturbing allegations, if not symptoms. The implied demand is that “someone has to do something,” especially in light of the frequent claim that “no one, not mental health practitioners, lawyers, or judges, has assisted so far.” In the face of these allegations and the accompanying emotionality, a counsellor’s desire to be helpful can lead him or her to slip into providing professional services outside of ethical or even legal bounds.

For example, providing opinions about parental competency, the wishes of the children, and/or the parenting schedule while acting solely as counsellor can lead to problems, not only for the counsellor but also for all potential parties and stakeholders. Describing a parent in any way without his or her consent, sharing the complaints of one party without consent, accepting and offering the perceptions of children at face value and/or without both parents’ consent, or providing or recommending treatment or a structural change to the parenting schedule without engagement, consent, or formal assessment are just some potential problematic situations. When presented with the complexities inherent with HCP families, consider working alongside other treatment providers such as a child therapist or parent’s therapist, a bilateral custody assessor, a mediator, a consultant to counsel, and/or a parenting coordinator. In doing so, the family potentially benefits, and the risk of engaging in multiple and potentially conflictual roles is reduced.

With these concerns in mind, here are a few additional guidelines. First, if you are a treating counsellor, restrict your role to treatment. Make it clear that you can be helpful to the parent and/or the child by assisting them in coping with a difficult situation. This does not mean that there is no opportunity to provide input and direction to lawyers, custody evaluators, or even the court, but it must be done within an appropriate ethical and legal framework. Second, make every effort to recognize and enfranchise all stakeholders. There are potentially five stakeholders to consider either directly or indirectly. In order of consideration, these are children, parents, the regulatory body to whom you are responsible and its Standards of Practice (CCPA, 2015), lawyers, and courts.

## CASE EXAMPLES

Consideration of the best interest or least detrimental action relative to children is a fixed point in HCP matters. In treating children, for example, attention to the sensitivities of the parents and their engagement is necessary. If clinical attention directly or indirectly increases agitation, adversarialism, or the downloading of conflict onto children, treatment misses this fixed point of best interests. For example:

Sally<sup>1</sup> was seeking treatment for her 8-year-old son, Liam, for exacerbated signs of what she defined as separation anxiety. Sally and Liam's father, Michael, were separated but not yet divorced. Through their lawyers, Sally had requested that Michael agree to therapy for Liam. A Consent Order formalizing their agreement was granted, and Sally made all the arrangements to initiate therapy. However, the clinician was reluctant to speak with or respond to Michael, and did not have contact with him. This led to difficulties for the child, and a diminished response to treatment as reflected in the nonpresenting parent's distress associated with exclusion from consultation.

The last three stakeholders (regulatory bodies, lawyers, and the court) are indirectly enfranchised by their potential role in these matters. Standards of practice operationalize the more general and aspirational codes of ethics that define professionalism and include any specific directions to fairness and justice in matters like HCP. Counsellors must be aware of these directives and factor them into their work, as the regulatory body (e.g., CCPA or provincially legislated colleges in the counsellor's discipline), like our last two stakeholders (i.e., lawyers and judges), is "waiting in the wings," so to speak.

Lawyers and judges, often as indirect stakeholders, may have referred the clients to counselling, or their role may emerge later. It is prudent to remember that the legal system defines parties to a divorce as adversaries, and while attention to the potential needs and pressures of legal authority should be kept in mind, counsellors should seek to avoid being captured by adversarialism (Greenberg & Shuman, 1997). Counsellors need to situate their role and function in ethically informed advocacy. At times this is challenging, because the desire to be helpful and well thought of can increase a counsellor's temptation to agree to legal requests driven by the legal system (e.g., a request from lawyers for written opinions that serve their clients' positions). Adversarialism wants what it wants, and means to a desired end are considered justified. The difference between adversarialism and advocacy can be thought of as parallel to the distinction between heat (adversarialism) and light (advocacy). As an example:

A counsellor has been seeing Jack with regard to the difficulty he has been experiencing coparenting. Jack expressed a great deal of concern about the alleged conduct of Lisa, the mother, and its impact on the children. Jack demonstrated a good deal of insight and psychological mindedness. His descriptions of Lisa's behaviour were detailed, realistic, and consistent with what a counsellor would imagine could underlie the problems in the child. Jack asked the counsellor to



write a letter to his lawyer to assist in “protecting” the child. In this case, with a view to advocacy, a counsellor might write a letter that serves to educate the lawyer about useful options available (such as a bilateral parenting assessment) to determine a child’s best interests relative to Jack’s unconfirmed reports, as opposed to a more specific opinion regarding access and the parenting schedule.

Integrating the needs of all five stakeholders is the essence of advocacy, and enables the counsellor to focus clinical attention where it is required, and maintain an appropriate role within it. Support for the treatment of the child, honouring the father’s desire to address the HCP in the best possible way, respecting the other parent through modesty of communication, offering legal counsel some direction as well as articulating the sort of information a court might require for judgement, and staying well within the restraints of regulatory requirements constitute adequate clinical practice.

### **How Can I Provide Effective Care?**

The literature on ethical decision-making contains useful guidelines regarding what can go wrong, and how to stay on the side of “right” (CCPA, 2015; Crowley & Gottlieb, 2012; Knapp et al., 2013). Knapp and his colleagues (2013) caution against exercising too much or too little “protection” in walking through the fire. Their suggestions constitute a final guideline for the counsellor—the danger of too much ethical assimilation or too much personal segregation from ethics (Knapp et al., 2013).

Professionals who too rigidly emphasize ethics, standards, and guidelines over engagement run the risk of missing what these directives were designed to promote in the first place. Undue formal risk management has the potential to sterilize good clinical practice (Knapp et al., 2013)—that is, to underemphasize empathy, collaboration, coherence, or engaged rapport associated with empirically supported relationships in clinical practice (Norcross, 2002). For example:

A separated parent, referred by a friend, arrives at your office. Her child is in crisis regarding incidents at school and is refusing to attend. While making contact with and obtaining consent from the other parent is preferable, to refuse to offer services to the child until the other parent consents misses the primary presenting concern. Consent from the other parent can and should be sought as soon as possible, but not at the expense of helping relieve the child’s distress on an emergent basis.

*Segregation* refers to a marginalization of professional standards and too great an emphasis upon one’s own decision-making. With this, the counsellor may unduly value his or her personal perspective. These clinicians centralize themselves to the clinical, interpersonal, social, and legal context of HCP, and run the risk of walking into legal or ethical hotspots (Amundson, 2016). For example:

A counsellor met with a very dramatic mother and a highly agitated 7-year-old child. The child had recently refused to have contact with the father. Under the

pressure to do something, the counsellor initiated therapy, consulted with the mother's lawyer at the request of the mother, and produced an opinion that the father ought to back off from contact and seek therapy to "assist him with management of his emotions."

With this example, we see an ethical violation of the rights of the other parent arising from the desire of the counsellor to be helpful, and possibly from the professional's personal feelings about the allegations of emotional dysregulation in the father as the reason for the child's refusal. Absence of the father's consent, or a court order, to provide an opinion and the lack of any direct contact with the father, not to mention any concern for engagement, set this counsellor up to be sanctioned.

Adherence to professional standards, a keen desire to do good clinical work, and the personal commitment of each professional to be helpful lead to what the ethics acculturation model refers to as *integration* (Knapp et al., 2013): a convergence of one's experiences, clinical skill, professional concern about the context of interpersonal conflict, ethics, the relative levels of clients' distress, the legal system's tendency toward adversarialism, and the larger domain of social justice.

#### SUMMARY

The guidelines here can be collapsed into specific directives for the counsellor:

1. Keep your eyes open and look at the breadth of the situation (i.e., all the stakeholders), consider the complexity of the context and social ecology of these matters, and never hesitate to consult with peers.
2. Be skeptical about the allegations you hear, and remain engaged and committed to your role as an advocate for conflict reduction, rather than an adjunct to legally driven adversarialism.
3. Assist parents and (as much as possible) children to see the issue(s) as you see them by advocating for multiple perspectives or versions of the conflict they live with.
4. Work to reduce this conflict at the highest level, while promoting the resilience of children and adults, given that resilience and coping skills are so often taxed, and perhaps underdeveloped, in clients involved in these files.
5. Bring light, not heat, to your relationship with each parent and child, and model the calm that is elusive yet so necessary to resolution.
6. Remember that you always have time to step back, take a moment, and think. You do not need to respond to requests immediately. The urgency of clients or lawyers should not be adopted as your own.
7. Finally, resist the pull of any one stakeholder to provide for them something that you know is potentially harmful to the "fixed point" of the children's best interest, or could bring harm to, raise concern in, or aggrieve one of the other stakeholders.

Families experiencing high-conflict parenting situations seek our assistance during a significant transition in their lives. The urgency of their presentation can invite us to go beyond our normal boundaries to be helpful, but also impel us to protect ourselves. It's how we walk through the fire that helps counsellors to engage in positive and ethically prudent practice.

### Note

1. All case examples are composites, and all names are fictitious.

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