WHEN A CHILD REJECTS A PARENT: WORKING WITH THE INTRACTABLE RESIST/REFUSE DYNAMIC

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A subgroup of intractable families, in which a child refuses postseparation contact with a parent, perplexes and frustrates professionals who work with them. This article discusses the underlying forces that drive the family's intractability, as well as guidelines for working with the family. The guidelines include specific court orders developed from the very beginning of the case that elaborate the court's stance about goals and expectations for the family, along with specialized individual and family therapies that are undertaken within a framework of planned collaboration with the court. The collaborative team of legal and mental health professionals works in an innovative and active way to structure, support, and monitor the family's progress in resolving the resist/refuse dynamic.

Key Points for the Family Court Community:

- A small group of families in which a child resists or refuses to spend time with a parent are especially resistant to intervention. Their dynamic emerges as intractable when it is apparent that it is being fueled by a significant mental health component, vulnerability, or rigidity within one or more family members.
- The work with intractable families often raises serious and challenging dilemmas, such as determining the risks to the child of losing contact with a parent, whether the child's voice is separate and distinct from that of the parents, and if emotional abuse is present, such that the option of a change in custody is raised.
- The clinical interventions that are utilized with intractable families are specialized and nontraditional and require participation of the entire family.
- Helping intractable families requires a concerted, collaborative effort and an innovative partnership between legal and mental health practitioners.
- Essential from the outset, this collaboration requires small adjustments to the familiar paradigms within which each professional is accustomed to work, including a new perspective on confidentiality.
- The court also is a participant in the collaboration, as it has a crucial role to play in structuring, overseeing, and monitoring the clinical interventions and resolving impasses as they are reached.

Keywords: *Child Rejection of a Parent; Court-Ordered Therapy; Favored Parent; Multi Modal Family Intervention; Parental Alienation; Reconnection Therapy; Reintegration Therapy; Rejected Parent; Resist/Refuse Dynamic; Reunification; and Reunification Therapy.*

INTRODUCTION

In the 6 years since the last *Family Court Review* Special Issue on children who refuse contact with a parent (January 2010), many families have participated in interventions aimed at unraveling and resolving this complex problem—the Resist/Refuse Dynamic (RRD). The RRD refers to a complex set of interacting factors, family dynamics, personality characteristics and vulnerabilities, conscious and unconscious motivations, and other idiosyncratic factors that combine to contribute to the unjustified rejection of a parent.[1]

While it has always been clear that RRD families pose a daunting challenge in their resistance to change, an especially intractable subgroup of these families is gaining the attention of legal and mental health professionals.[2] These "stuck" families typically reach an impasse early in treatment. While some of these have previously been labeled as "severe" cases of alienation, it is currently apparent that, in addition to severe alienation, other factors often underlie and contribute to the family's intractability.

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In this article we identify the characteristics of the intractable family and outline some intervention options that can address their entrenched, potently resistive nature. These families require a carefully framed, focused, and directive approach, implemented by a collaborative team of mental health and legal professionals. Effective intervention requires periodic, preplanned communication with the court. This refinement and extension of the Multi-Modal Family Intervention model (MMFI; Johnston, Walters, & Friedlander, 2001; Friedlander & Walters, 2010) is tailored specifically for intractable and severe cases. The suggested framework can also be used for less severe cases to accelerate progress and to ensure that the necessary supportive structure is in place if needed.

Intractable cases often leave professionals feeling increasingly helpless. In response, some mental health and legal professionals develop an aversive reaction to working with them, and avoid them. Others, who lose patience with these families, resort to using drastic measures to resolve the impasse.[3] Professionals are more likely to employ misguided efforts to help when they have a limited understanding of intractable cases and even more limited resources available toward which they can direct these families. This paper is addressed as much to the bench and bar as it is to mental health professionals.

UNDERSTANDING INTRACTABLE RRD FAMILIES

Intractability within RRD families can originate in one or both parents or the child, either alone or in concert with one or both parents. Often, the intractability is fueled by a mental health component within one or more family members that makes them vulnerable to the polarizing RRD dynamic, including not being able to successfully cope with and move beyond the stress, loss, and even trauma involved in the separation and divorce process, and/or becoming unduly influenced by another family member (e.g., a child by a parent or a sibling, a parent by a new spouse, or a grandparent).

THE CHILD'S VULNERABILITIES

Kelly and Johnston (2001) have discussed the many pathways through which an "alienated child" arrives at the point of refusing to have contact with an adequate rejected parent. Among those factors are vulnerabilities of the child—physical, cognitive and emotional—that are too great to accommodate the stresses of a divorce. A child's rigid rejecting stance may reflect, in part, having resources that are too limited or inadequate for navigating shared time with warring parents, particularly when conflicts arise unpredictably during transitions between homes. A young or developmentally limited child's postdivorce alignment with a parent can simplify the child's dilemma about "who is right and who is wrong" and "what is fair and what is unfair." Younger children may also be less able to resist the loyalty pull of the favored parent, especially when it is rooted in that parent's neediness, or the allure of modeling an older sibling's stance toward the rejected parent.

In custody disputes, there has been a rise of the number of children with special needs—those with specific learning disorders and cognitive impairment, chronic developmental disorders, physical disabilities, serious medical conditions, and severe psychiatric and behavioral disorders (Pickar & Kaufman, 2015, p. 113). Being ill equipped to handle ongoing interparental conflict, these children may be especially vulnerable to rejecting a parent as a means of solving an otherwise overwhelming problem.

Specific emotional vulnerabilities among children who reject a parent have been recognized by Johnston, Walters, and Olesen (2005a). These emotional vulnerabilities include consistent use of coping styles that involve avoidance and diminished ability to have realistic, mutual, empathic relationships with others (Johnston, Walters, & Olesen, 2005b). These vulnerabilities may not be evident in the children's daily lives, however, as the child may otherwise appear to be independent and competent, even an academic and social "star." The consequences of internalizing their distress and disregarding their unresolved grief about the loss of their intact family may emerge sometime later, and the consequences can be profound.

Although the child's avoidance-based rejection of a parent has an adaptive component, as it partially removes the child from being in the center of a difficult situation, the child also pays a price. Aligning with a parent often reinforces the ongoing use of black and white thinking—seeing that parent as "all good," and the other parent as "all bad;" and avoiding the person with whom you have difficulties thwarts attempts to develop a more adaptive, problem-solving strategy such as seeking to discuss and work out those difficulties. Seen from this perspective, a child's active engagement in the favored parent's campaign against an ex-spouse can usurp the child's mastery of age-appropriate coping skills, such as developing complex thinking and communication skills to resolve difficulties, and thus, over time, impede the child's developmental progress and ability to keep pace with the skill levels of age-peers in these areas. The gap in emotional maturity may then also affect the ability to maintain good peer relationships.

PARENTAL INTRACTABILITY

Many intractable parents have significant mental health problems, a common component of which is an externalization of their own problems and insistence that the family's problems are generated entirely by the other parent. Individual psychopathology, immaturity, and emotional neediness also impede the intractable parent's ability to consider alternative perspectives. Distortions in perceptions and negative thinking affect how a parent can effectively solve problems. Emotional dysregulation can lead to impulsive actions, overreactions, and the creation of drama for the children and ex-spouse. Most importantly, all of these problems impair the parent's ability to maintain a clear, consistent focus on the child's needs and well being.

PARENTAL INTRACTABILITY RELATED TO AN ENCAPSULATED DELUSION

In some RRD families, a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief. It is different from a psychotic delusional disorder in that it does not compromise intellectual, cognitive, social, or emotional functioning. Thus, despite harboring the encapsulated delusion, the intractable parent may *appear* to be an excellent parent and high-functioning adult.

When alienation is the predominant factor in the RRD, the theme of the favored parent's fixed delusion often is that the rejected parent is sexually, physically, and/or emotionally abusing the child.[4] The child may come to share the parent's encapsulated delusion and to regard the beliefs as his/her own (cf. Childress, 2013). When estrangement is a significant factor in the RRD, rigid rejected parents may have a fixed belief that the favored parent, whom they view as totally responsible for the child's rejection, is emotionally harming the child through overly permissive parenting that can only be corrected by the rejected parent's morally superior parenting style. This belief can also rise to the level of an encapsulated delusion for some rejected parents.

THE FAVORED PARENT'S INTRACTABILITY AND ENMESHMENT

Although not a factor in all RRD cases, parent–child enmeshment (cf. Minuchin, 1974) is also recognized as an especially significant mental health issue within the dysfunctional family dynamics of some RRD families (Fidler, Bala, & Saini, 2013; Friedlander & Walters, 2010; Garber, 2011). Enmeshment refers to diffusion in the psychological boundary between the parent and child, which includes intrusive parenting and lack of respect for boundaries and the psychological separateness of the child. Within enmeshed parent–child relationships, the thoughts, feelings and beliefs of the child and the parent become increasingly indistinguishable.

There is increasing awareness of the deleterious effects of parent–child enmeshment (Garber, 2011; Peris & Emery, 2005). Johnston (1990) noted role diffusion in the context of high conflict divorce. Garber (2011) delineated different kinds of "role corrosions," specifically adultification, in which the parent uses the child as a confidante; parentification, in which the parent uses the child as a parent figure; and infantalization. In all of these role changes, the child's strivings for age-appropriate functioning are thwarted in order to meet the parent's needs. The child may be home-schooled, kept socially isolated, and/or prevented from participating in age-appropriate activities. Garber (2011, p. 327) states that in some extreme, seldom seen cases, the infantilizing parent creates or maintains a child's illness in a manner consistent with a formal diagnosis of Factitious Disorder Imposed on Another.

THE REJECTED PARENT'S INTRACTABILITY AND RIGIDITY

In some complex, hybrid cases, the rejected parent often has a significant part in fortifying the RRD.[5] These rejected parents may have already found the child's rejection and allegations against them to be a critical blow to their parental identity, to their idealization of their parental role based on a belief that they are the only good role model for the child. In addition, they must then bear the social stigma of being rejected by their own child, of not finding redress or protection through court proceedings, as well as experiencing the loss of contact with the child, all of which makes the experience almost unbearable.

It can be particularly problematic when the rejected parent relies on the use of narcissistic defenses, or there are indications of deeper problems stemming from an underlying narcissistic personality structure. Intractable rejected parents commonly have an adamant and self-righteous conviction that their moral fiber and values are superior to those of the favored parent. They regard the guidance they provide in parenting as an antidote to the poor parenting and role modeling that the child gets from the favored parent. Sometimes the degree to which they compensate for perceived shortcomings of the favored parent results in even more extreme behaviors than they normally would engage in, which further exacerbates their problem with the child. Upholding morally superior values and promulgating the only acceptable rules of life for their child can lead the rejected parent to dismiss the possibility of compromise, which they see as "giving in" to the child's wishes. This rigidity can be especially hard for teenagers who require increasing independence at this stage of their development.

DILEMMAS PRESENTED BY INTRACTABLE RRD FAMILIES

Working to modify the intractable dynamic of RRD families raises both thorny questions and agonizing dilemmas concerning how to protect the child from experiencing the loss of one or the other of their parents.

LISTENING TO THE CHILDS'S VOICE

Nowhere can the call to hear the child's voice be more resounding than when the favored parent advocates for respecting the child's feelings and wishes. However, listening to the child is far from a straightforward issue (see Parkinson & Cashmore, 2008; Warshak, 2003). Giving children who are rejecting a parent a public forum in which to take sides about the interparental dispute can be problematic, as this serves to solidify their position. Also, there is a crucial difference between listening to the child's voice by inviting their input and listening to their opinion, and allowing the child to have a say in the decision that is made. Grappling with the general question of how much input a child should have in custodial decision-making requires careful consideration of whether a child or adolescent is capable of grasping the realities and long-term repercussions of limiting or eliminating contact

with an adequate parent. Discussion of legal issues surrounding these questions includes compelling arguments against giving the child's voice prominence in these cases (Dale, 2014; Rosen, 2013; Weir, 2011) especially because, as Warshak (2003) has underscored, in these cases it is often not the child's voice we are hearing.

FACING THE STARK DILEMMA

Warshak (2010) called attention to the central dilemma of these more extreme cases—the relative risks and benefits of a child being left with a favored parent who is actively undermining and devaluing the child's relationship with the other parent, as opposed to moving the child into the care of the rejected, but mentally healthier and adequate parent. Many professionals previously believed that disrupting the emotional bond between a favored parent and a child through a change of custody would be more damaging to the child than losing a less close rejected parent. Emerging research on attachment has led to a refined understanding of the parent–child bond. A secure attachment is now seen as anchored in both the emotional closeness within the parent–child relationship, as well as in the child's comfort venturing beyond that realm to explore the larger world, as facilitated by the parent who supports and encourages separation-individuation (for discussions of attachment theory and research, see Main, Hesse, & Hesse, 2011; Marvin, Cooper, Hoffman, & Powell, 2002). There has been a shift in looking at the criterion for resolving the stark dilemma from which parent is most bonded to the child, to evaluating whether the favored parent's behaviors, which interfere with healthy development and age-appropriate separation, qualify as harmful or abusive to the child.

DETERMINING THE PRESENCE OF ABUSE

If the favored parent's clinging, controlling or intrusive behaviors significantly impede the child's development, they may be emotionally abusive, in which case changing custody to the rejected parent would be a demonstrably viable option that may be protective of the child.

Recent research about emotional abuse provides a perspective about whether alienating behaviors, that is, the prolonged undermining of a child's relationship with the other adequate parent, may be recognized as abusive. These studies include consideration of intrusive and controlling parenting and studies of role reversal in which the parent implicitly or explicitly requires the child to serve the parent's needs (see Chase, 1999; Kerig, 2005; Barber & Harmon, 2002). In some intractable cases the favored parent's alienating behavior is intrusive and controlling. And, in some cases this parent seeks to have the child serve their own needs, including the need for confirmation of being the "exceptional, superior" parent—an internal image that is central to the favored parent's identity. A parent–child relationship that serves primarily the favored parent's needs is often evident when characterized by psychological enmeshment that seriously interferes with the child's healthy development.

In general, severely alienating behavior may be understood as emotional abuse, particularly when done consciously, with malicious intent, and when it clearly places the parent's needs over those of the child. However, there is no clear delineation of when and where that line into abuse is crossed. The determination of whether the favored parent's behavior constitutes abuse may require an independent evaluation by a mental health professional with a specialization in divorce and alienation.

RISKING LOSS OF THE CHILD'S RELATIONSHIP WITH THE REJECTED PARENT

While the broader goal of interventions with RRD families involves restoring family functioning to include appropriate parent–child and co-parental relationships, the difficult process of rebuilding and protecting the child's relationship with the rejected parent may not go smoothly, sometimes because the rejected parent does not behave in ways that nurture the rebuilding of the relationship. Some rejected parents within intractable families have an underlying rigidity in their psychological

makeup, have unreasonable expectations about how the child should respond to them, and experience difficulty recognizing how they may have significantly contributed to the problem. As a result, they may inadvertently push the child away, and, in their anger, even strike back in subtle ways, and ultimately, may counterreject the child. When an intractable or rigid rejected parent chooses to walk away from the child and family after having concluded that the situation is impossible, the child still experiences the loss of a parent.

AVOIDING TIME DELAYS THAT WORSEN THE RESIST/REFUSE DYNAMIC

Time is a major enemy in RRD cases. The dynamic becomes increasingly entrenched the longer it remains unaddressed and the longer the period of no contact between the rejected parent and the child. The excruciatingly slow pace at which the court system moves also delays efforts to resolve the problem and may be exacerbated by a prolonged evaluation, and as well as litigation over intervention. In fact, delay has often been employed as a legal tactic in such cases, especially in cases of older adolescents, as the court is less inclined to intervene as the adolescent gets older, and once the adolescent turns eighteen the court no longer has jurisdiction.

For the nonintractable RRD cases the damaging effect of time can be mitigated through educational efforts aimed at prevention, identification of at-risk cases early in the legal process, and early intervention. However, as it is not usually clear in the beginning whether a family will become intractable, having a more sharply focused awareness of the potential for intractability can lead to early implementation of court orders that include the structures necessary for effective treatment. Having these structures already in place can expedite the process of holding family members accountable for their part in unraveling and resolving the RRD. This, in itself, creates momentum for change.

CREATING EFFECTIVE OVERSIGHT AND MONITORING BOTH DURING AND AFTER AN INTERVENTION

Intractable cases require more than the initial interventions that help family members recognize the various underlying issues and aspects of their behaviors that must be changed. Ongoing oversight and monitoring of the progress that each family member achieves creates accountability and counteracts the natural resistance to change. Real, meaningful, and sustainable change is much less likely without ongoing oversight and monitoring.

A current dilemma in achieving oversight, and thus accountability for change, is how to put mechanisms in place that allow a mental health professional to communicate about each family member's behavior and progress with an appropriate authority. Choosing the appropriate authority is also part of the dilemma. The professionals who have the authority to respond to intractability issues are the judge and the parent coordinator who assumes oversight and can communicate with the judge. However, in some states a parent coordinator cannot be appointed and needs to be stipulated, a step unlikely to be taken by a parent who wishes to avoid accountability and retain their own decision-making authority. Without a parent coordinator, the court is the remaining option for oversight and monitoring of the intractable case. Yet there are many counties and states in which the law does not support this role for the court.[6] This dilemma calls for innovative thinking and a different level of involvement and collaboration on the part of the legal and mental health professionals, as well as working through the ethical and professional issues that are precipitated by addressing this dilemma.

INTERVENTIONS TO PREVENT AND ADDRESS INTRACTABILITY

The components of the intervention presented here include nontraditional individual and family psychotherapies for the child, the favored parent and the rejected parent, as well as the enhanced, collaborative teamwork among the mental health and legal professionals that can, when optimally

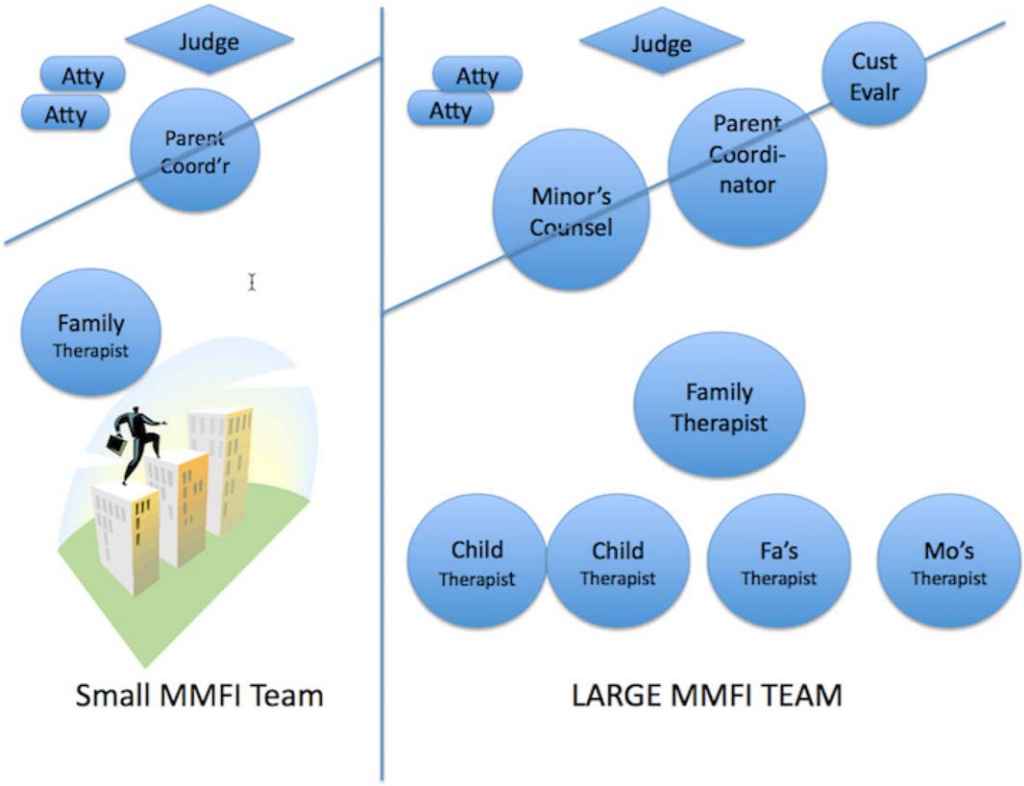

Figure 1 Composition of Intervention Teams for the Intractable RRD Family.

implemented, contribute to more successful outcomes. The MMFI involves the use of a family therapist and/or multiple individual therapists[7] as well as a professional with decision-making authority or authority to communicate to the court. There can be a small or a large professional team working with the family, as shown in Figure 1. A large team involves more mental health and legal professionals who have potential access to the judge.

Regardless of the size of the team, if there is no professional who has access to both the judge and the therapist(s), such as a parent coordinator, or a custody evaluator, and in some cases a minor's counsel, then the therapist(s) who work with the family is isolated from the rest of the team. While this separation is necessary for many other court cases, in court-ordered interventions for intractable RRD families, it may hinder therapeutic progress as well as effectively informed judicial decision making. Creating thoughtfully designed links between the legal and mental health realms, in order to facilitate teamwork and to move through impasses typical of intractable RRD families, is an extension and elaboration of the MMFI model. It is discusssed in the section on collaboration below.

NONTRADITIONAL, SPECIALIZED CLINICAL INTERVENTIONS

Specialized Individual Psychotherapy to Help and Support the Child

It is understandable that a child who aligns with a favored parent may strongly resist treatment interventions, because the interventions can stir up the underlying anxiety and fears that motivated the alignment, thereby threatening to disrupt the child's emotional equilibrium. Some children sense

that having to spend time with the rejected parent might lead to experiencing renewed loyalty conflicts, which could then lead to internal destabilization and disorganization. The more emotionally vulnerable the child, the more threatening the changes can seem and the more intransigent the child's stance may become.

To be effective, the individual child work should *not* follow the model of traditional child psychotherapy. A modified, specialized individual psychotherapy for the child, implemented concurrently with family therapy when possible, helps to stabilize the child's internal world as well as strengthen and augment the child's coping abilities.

The therapist should have training and experience in working with RRD cases. The therapy will include education, coaching, and skill building (see the case examples in Walters & Friedlander, 2010). The therapist must demonstrate understanding of the child's difficult position as well as establish their usefulness by teaching skills that enable the child to manage the situation and to resume the process of separation-individuation, as developmentally appropriate. In other words, there is support for the child to move forward developmentally, socially, and emotionally and to be less focused on the need to be allied with and supportive of the favored parent in the interparental battle. Progress in the separation-individuation process enables the child to become more sensitive to feelings and beliefs that are different from those of the favored parent and to feel less responsible for the emotional well being of the favored parent. Often the therapist is the only adult who has an opportunity to offer new input to the child. The new skills and self-knowledge gained in therapy helps these children discover and better maintain the integrity of their own beliefs about their experience with the rejected parent and resist the influence of an alienating favored parent.[8]

Individual work with the child may also address some of the child's difficulties with the rejected parent, such as distorted underlying beliefs about the rejected parent, while also gaining and accepting a realistic understanding about the rejected parent's limitations. Particularly if an intractable rejected parent decides to walk away and counterreject the child, the child needs help in dealing with the associated experience of loss and guilt.

Specialized Individual Psychotherapy for the Intractable Favored Parent

Addressing the intractability and the mental health issues of the favored parent is typically more challenging for professionals than is working with other family members. Because the intractable favored parent may make convincing public statements of support and understanding that the child benefits from having a restored, healthy relationship with the rejected parent, the stubborn, unyielding quality of the favored parent's beliefs and behavior, and the subtle, indirect, and often nonverbal and insidious ways these beliefs are conveyed to the child, may not be revealed until later in the intervention process. As the RRD starts to shift and the child's stance softens, the favored parent's lack of cooperation, resistance, and pushback tends to escalate. At the point that the favored parent's stance is finally fully identifiable as intractable, there may be few avenues open for redress. True intractability on the part of the favored parent may require a change in custody to the rejected parent, as noted above.

The nontraditional, individual therapeutic work with a favored parent focuses on intensive modification of the favored parent's behavior and recognition of the favored parent's distorted and inaccurate beliefs about the rejected parent, such as those involved in an encapsulated delusion. A directive, and sometimes confrontive approach is required. A solely, or mainly supportive approach is neither therapeutic nor appropriate, as it reinforces the recalcitrance, and becomes part of the problem. The mental health practitioner who is uncomfortable with a more directive approach is not a good choice for the favored parent's individual therapist. As they become aware of it, the parent coordinator and the custody evaluator both have the authority and the responsibility to call attention to such an inappropriate and counterproductive therapy with the favored parent and, if necessary, to recommend a change of therapist.

In some intractable RRD cases, enmeshment of the favored parent with the child surfaces as the principal source of the impasse. Enmeshment cases, based on the parent's emotional neediness, are often more difficult to address as the parent and child are less conscious of the problem and highly invested in maintaining the status quo. Any change can be experienced as threatening the stability of the favored parent in particular, and the family equilibrium in general. Nevertheless, these issues can be addressed within individual therapy that focuses on personal growth and maturation. In this therapy the parent will learn how to pursue a life and interests separate from the child, supported by education regarding how damaging it is to the child to have their healthy development thwarted. The goal is to help the favored parent to develop the capacity to have his/her own emotional needs met outside of the parent–child relationship, as well as to recognize how the child's needs and emotional life can differ from their own, and can best be met outside of the parent–child relationship, for example, in peer relationships. As noted above, the child's individual therapy would involve a parallel separation-individuation process, focusing on emotional growth and development that enables the child to have greater involvement with peers and in activities that do not include the enmeshed parent. The enmeshed parent and child may also meet together to address changes in the dynamics of their relationship.

Specialized Psychotherapy/Coaching for the Intractable Rejected Parent

Rejected parents generally benefit from the support, specialized guidance and coaching of a therapist who is experienced in working with the RRD family. The parenting information they receive and the broadened understanding about the child's situation often help them to maintain patience and stamina in the face of their child's rejection, as well as modify their parenting and approach to the child when reengagement occurs. Often, if available, a therapeutic support group for rejected parents is a very helpful source of advice and comfort.

However, one of the hallmarks of an intractable rejected parent is the inability to ally and collaborate with the therapist/coach or other professionals with whom they are working. When an individual therapist/coach or family therapist explains to an intractable rejected parent that modifying their parenting or other behavior is necessary to alleviate their child's rejection, their very rigidity prevents them from modifying their ideas and behaviors to avoid further damage to the parent–child relationship. Asking the rejected parent to look more pointedly at their role and complicity in creating the RRD, may lead to the rejected parent seeing the therapist as having become allied with the favored parent, or it might result in the parent simply dismissing that therapist as not very knowledgeable or understanding.

Meanwhile, the rejected parent's behavior, while not technically reaching the level of abuse, may be truly unpleasant, further polarizing, and unreasonable, which together make it very difficult for the child to manage. The intractable rejected parent's behavior continues to reinforce the child's resistance to having contact, and the ensuing spiral downward can be devastating. The child may devise ways not to see the rejected parent, or the professionals involved may have to design a timeout or institute other limits on their contact.

Although rare, this process can also lead to the rejected parent counter rejecting the child and walking away. While not always possible, a therapist can mitigate the loss by formulating a plan to provide closure, for the rejected parent to say goodbye, to clarify that the breach in their relationship may be temporary, and for the child and rejected parent to begin grieving the loss of their time together. A time may be designated for them to meet again at some point in the future to determine if it is possible and desirable to resume contact.

COLLABORATIVE WORK AMONG THE TEAM OF MENTAL HEALTH AND LEGAL PROFESSIONALS

In this extension of the MMFI, collaboration and communication among mental health and legal professionals is an essential part of the proposed model for working with intractable RRD families.

Operating in conjunction with one another, these two sets of professionals can support the strong, optimally effective treatment that intractable RRD families demand, have greater impact on an RRD family than either can have separately, and can mobilize the necessary actions to effect change more quickly than they would through regular court processes.[9]

Structuring the Collaboration: Formulating the Court Orders/Stipulation Supporting the Therapeutic Interventions[10]

The court orders articulate the authority of the state and are a permanent record of the court's findings, which can be invoked as often as necessary. Having the therapeutic interventions for intractable RRD families ordered by the court is essential for creating a potentially effective treatment because the court's authority serves to counteract the resistance inherent in the RRD family. Discussion here will focus on the court order for family therapy, although some of the same principles can apply to the individual therapies as discussed above especially when the individual therapist is the sole mental health practitioner.

As the keystone of the intervention, the court order specifies: (1) the goals for the intervention; (2) the court's expectation that *all* family members shall participate and cooperate; (3) the necessary structure for the implementation of the intervention; and (4) the court's role in monitoring the family's progress, thereby creating and insuring accountability of each family member to work towards those goals.

The specificity of the orders helps the family to experience the therapist as a neutral professional whose role it is to carry out the orders of the court, in the service of the best interests of the child. Inclusion of the requirement for participation and consequences for failure to cooperate in the detailed orders decrease the likelihood that either parent will undermine the treatment efforts or render them ineffective. Thus the orders help insure that the therapy moves forward.

Writing the Court Order

Collaboration among the professionals occurs from the very beginning when, together, they prepare the court order for family therapy. After the attorneys and the court agree upon a specific family therapist, and then, before the agreed-upon therapist has contact with the family, the attorneys, the therapist, and also the court—when the judge is amenable—collaborate in crafting the basic court order.[11]

It is particularly important that there is agreement upon the major goal of the intervention, that is, that the family work be directed to restoring family functioning so that the child can attain and maintain the best possible relationship with both parents and that this statement be put into the court order or stipulation. The parents also sign the therapist's treatment agreement, which reiterates the court's statement about the treatment goals, providing yet another chance for them to affirm their understanding, acceptance, and willingness to work toward these court-specified outcomes. Having this written, shared understanding that the parents and children are court ordered to engage and participate in therapy can be profoundly helpful to overcome the initial resistance of both the favored parent and the child.

Providing for Court Oversight

The court order should include details such as the dates when the court will be reviewing the progress of the family within the intervention, a provision that neither parent has the power to unilaterally terminate the treatment, as well as a statement that there will be consequences and sanctions—financial or related to the parent's time with the child—for a parent's failure to meet the court's expectations. The latter addition is especially important and helpful in intractable cases. The court order may also state the expectations for the child or adolescent to participate in the intervention,

noting the consequences for the parents if they do not insure the child or adolescent's compliance (see Appendix A for examples of such orders).

The accountability component within the order is found in the provision that sets review hearings to take place at certain intervals in order for the court to monitor the family's progress. Usually the court expects to receive written or oral feedback from the family therapist or parenting coordinator shortly before the previously set court review hearings. The feedback focuses on whether progress is being made in the treatment and whether there are any issues that need legal attention or intervention. If the family therapist or parenting coordinator states that the intervention is going well and the family's issues are being handled clinically, the hearing date will be cancelled. If family issues have come up that suggest a need for commentary or ruling by the judge, then the scheduled hearing will go through and the legal professionals will address the issues. But sometimes a telephone case conference between the family therapist and attorneys can resolve minor issues, obviating the need for a hearing while resolving issues that impede progress. For example, a family therapist might use a telephone case conference with attorneys to address a potential clinical impasse by having the collaborative team help a parent to accept the authority of the parent coordinator, or having the collaborative team re-affirm the court's expectation of cooperation and compliance with the treatment intervention.[12]

"CUSTOMIZED CONFIDENTIALITY" IN COMMUNICATION BETWEEN LEGAL AND MENTAL HEALTH PROFESSIONALS

In working with RRD families, it is necessary that the communication among therapists and legal professionals and the court be more open than it has been traditionally, but it must still protect the privacy of the therapy as well as the attorney–client privilege and work product. The mental health professionals divulge only whether the family member has been attending and whether there are any obstacles to that family member's cooperative engagement in the clinical work. The attorney does not divulge anything involved in the attorney–client privilege. The judge does not opine on any issues unless in the context of a formal hearing. Yet, each professional has greater access to the other professionals in the case, can ask questions, and can listen to responses that are allowed within the new framework.

ATTENDING TO ETHICAL AND OTHER DILEMMAS FOR EACH PROFESSIONAL WITHIN THE COLLABORATIVE PARADIGM

We recognize that the proposed paradigm stretches the current limits on how legal and mental health professionals communicate and collaborate with one another and thus it may be challenging to implement. Conflict arises from interpretations of the ethics and guidelines of the individual professions concerning work with divorcing parents. Yet, some legal and mental health professionals, who also recognize the need and potential benefits of rethinking of these ethical and practice issues, have already suggested, and sometimes even instituted minor modifications similar to these (e.g., Greenberg & Sullivan, 2012; Greenberg, Doi Fick, & Schnider, 2012; Lebow & Black, 2012; Guidelines for Court-Involved Therapy, 2011).

The unifying principle for the collaborative work is that each professional has a specific part to play in working towards the agreed-upon goals of the intervention, which are, in turn, based on the already determined or agreed upon best interests of the child. Each professional acts, at least partly, in concert with the unified team working on behalf of the client family. Preliminary commentary about implications for ethical and practical guidelines that inform each professional's role are included in this discussion, although a full discussion of these issues is outside the scope of this paper.

The Judge's Role

The judge's participation as a member of the collaborative team may vary according to the level of involvement preferred by the judge, as well as the interest and expertise of the judge. It can range

from the judge essentially serving as the team leader and case manager,[13] to the judge being an active participant, to the judge remaining distant from the process and focused only on exercising judicial authority by making rulings.

Judge's Authority. Because RRD families pose such difficult dilemmas, with the two sides being highly polarized, they are usually less amenable to mediated solutions and have been more likely to rely on the courtroom to air and settle their battles. The judge's role is unique in carrying authority that other professional roles do not enjoy, which places the judge in an advantageous position to help intractable RRD families. The judge's authority and power are used strategically and proactively, rather than reactively when there is a crisis. Preset case management conferences or hearings are valuable platforms for the judge to ensure that each family member is doing his/her part to reach the court-ordered goals. The judge can also provide timely support when greater authority is needed to address a problem that clinical treatment has not resolved. Because of the tendency of the intractable family to use the court with some frequency, the already calendared case conferences or hearings employed in this model may result in more timely and efficient resolution of some of their difficulties. Case management for intractable families can be optimized by having one judge consistently on the same case.

The Judge's Need for Information. The judge has access to information necessary for working with intractable RRD families through the court order, discussed above, which specifies that there will be communication—albeit within due process requirements[14]—between the family therapist and the court. Being better informed helps the judge gain a deeper understanding of the case. The information augments the judge's ability to make difficult decisions, particularly those that involve modifying the favored parent's or rejected parent's physical and legal custody, determining whether issuing sanctions might be helpful at a particular time, and when grappling with dilemmas which might put the child at risk of losing significant contact with one or the other parent that would effect a major change of that relationship.

Within the team of professionals working with intractable RRD cases, many cases may not have minor's counsel, a custody evaluator or a parenting coordinator, the professionals who traditionally have the most access to the judge, as shown in Figure 1, because many families cannot afford to work with a larger therapeutic and legal team. In that situation the judge does not receive the needed information. Figure 2 illustrates all the possible lines of communication that could be opened among the professional team members, albeit with "customized confidentiality." Opening the two newer avenues of communication, between the family therapist and the judge, and between the family therapist and the attorneys, is important as it enables the needs of the family with an intractable RRD to be more fully and efficiently addressed. The family therapist's communication can take place in hearings or case conferences with the judge, and within telephone conferences with the attorneys. Within each situation, the therapist's shared information is very carefully selected for its maximum benefit to the family, and it is balanced so as not to jeopardize the neutral stance of the therapist. Care is taken by the family therapist to proactively address with his/her clients possible distrust and fear that having this communication might engender.

Judge's Role with Adolescents. Some parents in RRD families argue strongly for their adolescent to have an opportunity to express his/her feelings and wishes directly to the judge, because these cases are notorious for demanding that the child's voice be heard and the child's preference be followed. In turn, many courts are increasingly open to hearing the adolescent's voice either directly or indirectly. In many jurisdictions around the world, the judge must do so.[15] While this presents new challenges to the judicial officer who may have limited experience having an adolescent in the courtroom or in chambers, it may also present an opportunity to be especially helpful to both the adolescent and the RRD family.

In many RRD families, a major contributing factor to the intractability is the chronic failure of the co-parental dyad to effectively parent their child, and especially of the favored parent to exercise appropriate parental authority. In such cases, the judge may speak directly to the adolescent, in front of the parents, explaining what the adolescent is expected to do, why it is deemed to be in his/her

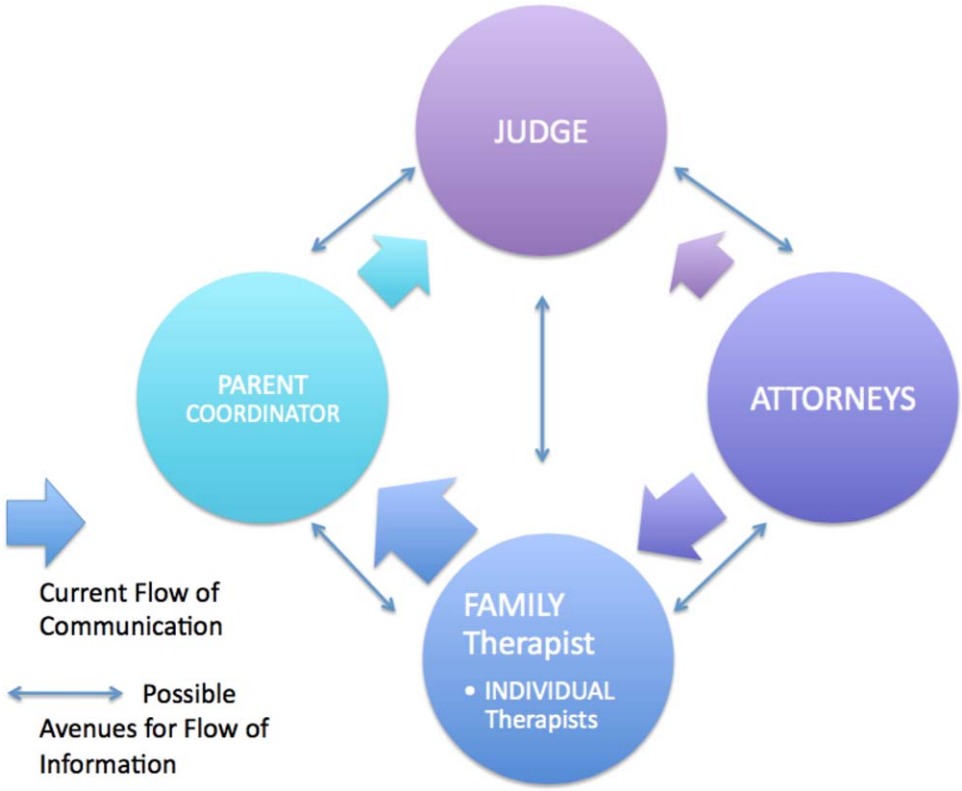

Figure 2 The Flow of Information to the Judge and Among Professionals [Color figure can be viewed in the online issue, which is available at wileyonlinelibrary.com.]

best interests, and that it is his/her parents' responsibility to insure that they do as expected.[16] The judge's statement of what the adolescent must do carries the authority of the court and reminds the favored parent of the responsibility to ensure that the adolescent complies. It may include consequences for that parent if the adolescent fails to do so. These actions by the court bolster the legitimacy and power of the intervention in the eyes of the family. They give comfort and support to the rejected parent, and they delegitimize the attitudes and conduct of the favored parent. In the process, the over-empowered adolescent, who may rarely have experienced limits on his/her behavior, may learn an invaluable lesson. Thus, if the favored parent fails to exercise appropriate parental authority, the judge can exercise the power of the state to further the adolescent's best interests. In this way, the judge not only demonstrates appropriate authority, but also serves as a member of the professional team by requiring cooperation with the therapeutic interventions.

The Role of the Mental Health Professional

The mental health provider selectively communicates with the legal team at different times, in order to formulate the court order for the intervention, to implement the intervention, to address an impasse in the treatment, as well as to provide periodic progress reports to the court. While many mental health professionals are accustomed to communicating with other therapists who are treating different family members, most mental health professionals are not used to working closely with attorneys or the court. Many feel apprehensive and intimidated about interacting with the legal

community, put off by the confrontational style they anticipate experiencing within the adversarial system and uncertain how to draw boundaries to avoid unintended legal entanglements.

Addressing Client Confidentiality

Mental health professionals have also hesitated to collaborate with legal professionals because of concern that a compromise in patient confidentiality would result in a breach of trust that would damage the therapeutic alliance. However, clinicians working with high-conflict divorcing families and RRD families have become increasingly accepting of modifying strict adherence to absolute confidentiality. Recognition that clinical work with high-conflict divorce and RRD families requires different parameters about confidentiality from traditional psychotherapy was spearheaded by Greenberg and other cited earlier in this section. The court order for the intervention with RRD families can specify that the mental health professional's treatment progress report to the court need only include information about whether the family members are attending, cooperating, and meaningfully engaged in the treatment, with little or no specific or substantive detail. In the providers' treatment agreement there should be an explanation that the parent's informed consent for communication to the court about these issues is not required because the waiver of confidentiality is already specified in the court order.

Understanding Ex Parte Communication

Mental health professionals who are not familiar working with the court should realize that there is a difference between an ex parte communication with one of the attorneys or judge, which is usually not allowed, and a communication that includes both attorneys, which is possible. Direct communication with the judge is allowed under certain circumstances that must be agreed upon beforehand. Thus, there are limits on private two-way conversations. In telephone conference calls, the attorneys or therapist may have to just listen to what the other has to say; they may respond by giving limited information.

The possibility of having a specified ex parte communication between the therapist and just one attorney, or the judge, can be explored at a time that the need arises, regarding a specific incident or issue, to determine if an exception should be made. For example, a therapist might propose having ex parte communication with both attorneys separately, each conversation being exclusively about that attorney's parent–client, or child–client, in order to address issues related to a treatment impasse. Proactively, the possibility for ex parte communication can be discussed in the initial conference call between the attorneys and the potential treating therapist before the intervention begins, and if an agreement is made, it can be specified within the court order or within a written agreement with the mental health professional and the attorneys.

Apart from the scheduled contacts, there are times when the therapist may find it helpful to reach out to the legal professionals for support or assistance. Having all attorneys present in a telephone conference call does not create problems in the same way that having ex parte communication does. This communication can be useful to address and understand minor legal and nonlegal issues. This process can streamline the time and the expense for everyone of pursuing litigation to enforce compliance with the treatment intervention, especially if what is needed is clarification of the intent of the court order.

The Attorney's Role

The attorney's customary duty includes counseling—advising, coaching, educating, possibly providing a mental health professional coach, and so on—with the goals of helping the client put his/her best foot forward for the judge. Attorneys need to maintain their clients' confidence in them, just as mental health professionals need to maintain a solid treatment alliance with their client. There is

attorney–client privilege as well as the work product doctrine that protects attorney–client communication. Yet, in working with intractable RRD families, attorneys also need to be fully on board with the goals of the intervention.

Ethical Dilemmas. Attorneys are ethically required to follow the directives of their clients. In their traditional practice, attorneys are unwavering, strong advocates for their client, in an adversarial role with the other side. In interventions with many high conflict divorce families and most RRD families, attorneys are also asked to modify their approach somewhat, and work within a collaborative team in working towards the agreed-upon goals of the intervention, which are, in turn, based on the agreed-upon and/or independently determined best interests of the child. Helping a client to understand what is in the child's best interest may be a difficult process for both the attorney and the client. A relevant question is whether within this collaborative approach the attorney can still adequately represent and address the attorney–client's best interest, when the attorney also addresses the child's best interest.

It is helpful if the question of the child's well-being has been addressed through a child custody evaluation and recommendations and/or court orders have outlined expectations aimed a supporting the child's well-being. Then attorneys can actually support their clients by helping them follow the court order, which allows the attorney to follow the ethical guidelines of advocating in his/her client's best interest. If, through an approved ex parte communication or other means, an attorney learns about noncooperation or other difficulties of the parent–client, that attorney has the opportunity to discuss with his/her client the probable dangers and consequences of his/her problematic behavior, especially if it violates the agreed-upon court order. Such a discussion about the client's shortcomings should take place privately, and be considered as falling under the attorney–client work product that is privileged. Another example lies in the work an attorney does with an intractable favored or rejected parent when the attorney has to encourage that parent–client to face his/her role in creating and resolving the RRD, instead of just supporting his or her client's position. Advocating for the client's best interest in these cases may mean explaining to the client that the relationship with his/her child may be lost to him/her unless s/he cooperates with the therapeutic intervention.

Through joint telephone conferences with the mental health professional and the other attorney, and permitted ex parte communications, as well as in case management conferences, the attorney has an opportunity to develop a broader understanding of his/her client's case. Many attorneys appreciate having a psychological perspective about their client, and have often tried to gain access to that perspective by hiring a mental health professional consultant who works solely on their client's side. But the feedback of such a consultant who works only on one side is limited by not knowing how the client operates within the therapeutic work and within the larger system.

There is a danger that if the attorney steps too far out of the traditional mold an RRD client may become dissatisfied, and may choose to fire the attorney. Indeed, the polarizing dynamic that is implicit in RRD cases increases the likelihood that an attorney or therapist will be viewed as aligning with one or the other side. Sometimes it takes sequentially two or three attorneys or therapists who convey the same message to the client before the client understands the benefits of the message, that is, how taking certain necessary steps would actually benefit the parent, the child, and the family. In those most difficult cases, the best solution may lie in the judge simply issuing an order about what the parent needs to do.

The Role of the Parent Coordinator[17]

The parent coordinator, who is empowered with some decision-making and recommending authority, typically serves as the overseer of the various therapies involved in the intervention, as well as the link between the treatment providers and the court.[18] Of all the professionals on the collaborative team, the parent coordinator frequently has the most experience and acumen in threading his/her way through the tangle of ethical dilemmas that might compromise confidentiality or trust that family members have with their treatment providers, while at the same time providing needed information to the court. The parent coordinator uses discretion about how much information

obtained from the therapists is shared with the court. Many parent coordinators also have the added experience of using their authority and decision-making power in a balanced way, thus maintaining staying power in their status as a useful resource for the family. When there is no available parent coordinator, the family therapist may assume some limited components of that role, as explained above, by providing some information to the court through the telephone conferences with the attorneys, or, within case management conferences, directly to the judge.[19]

DISCUSSION AND CONCLUSION

The intractability of families with a RRD is often rooted in particularly challenging personality or mental health problems of either or both the favored and rejected parents, and may also involve a child with physical, cognitive or emotional vulnerabilities. These internal, individual difficulties are often exacerbated by the stress, and sometimes even trauma, of the separation and divorce process. The difficulties are then unwittingly reinforced by extended family and friends, as well as by legal professionals adhering to an adversarial system that fortifies resistance to change, and also by therapists victimized by the polarizing forces of these cases. An initial poor response to interventions offered to help these families can result in their becoming stuck in impenetrable impasses. The passage of time then allows further entrenchment of these impasses.

While intractable RRD families engender frustration in mental health and legal professionals, it appears likely that the mental health interventions and legal strategies currently being offered to the families frustrates them as well. Presently, there is a mismatch between the needs of these families and the resources available to serve them. Current clinical and legal paradigms may not go far enough in what they offer, are lacking in duration or depth of the intervention, have limited accessibility, take painstakingly long times to be implemented, and, importantly, are out of reach to most families in their affordability. Moreover, many less skilled or less experienced practitioners, within both legal and mental health fields, prematurely align with one parent, and diagnose the other parent without ever having met them, causing further polarization and delay, thereby adding to the difficulties in resolving the problem. Not having a broad enough grasp on the complex nature of the family's problem, these professionals are unable to offer family members the understanding that each of the many factors that contribute to the RRD need to be addressed in order for it to resolve.

Indeed, there are many shortcomings to the interventions that are currently offered. Many mental health interventions are not court-ordered, and if they are, oftentimes they are labeled as "reunification therapy" and considered as a process only involving the rejected parent and child, under the mistaken belief that they must simply learn to relate to each other better. These interventions are not clear about the need for all family members to be involved, or that the broader goals for the intervention include shifting the RRD. Many therapists do not have enough specialized training in divorce issues, in alienation, and in estrangement specifically in the RRD, to understand the problems of this intractable group. Many therapists find that working with high conflict divorcing families is stressful, unsatisfying, and quickly become disinterested. They then pass up opportunities for training, and if they have an RRD family whom they take on, they are unprepared and treat the family members within a more traditional, but inappropriate clinical paradigm. Some therapists who take on these cases work in isolation and do not understand the benefit of forming a therapeutic team involving a parent coordinator, or a family therapist working alongside individual therapists, which can make the intervention more effective.

Recognition of many of these problems motivated the development of intensive, relatively short-term interventions. While potentially effective in addressing the complex issues, these three to five day interventions do not ensure an "aftercare" program that provides continuity and help for these families to carry back into their lives and consolidate at home what they learned during the intensive intervention. Furthermore, there is no guarantee that the local aftercare professionals will be appropriately trained, experienced, and well-equipped to deal with these families.

Clearly, adversarial paradigms, which work well in other court venues, do not work as well in family court, and are especially detrimental for intractable RRD families, as the need to blame the other side for the rejecting behavior of the child, so central to their dynamic, can be exacerbated. Legal professionals have the challenge of keeping the needs of the child in the forefront while also dealing with advising and representing their client. The judge needs sufficient information from the attorneys and the mental health professionals in order to make well-considered judgments that can help the family move forward, even if those judgments involve painful dilemmas.

The more extreme the intractability is, the greater the need for collaboration among legal and mental health professionals. Without patient work that includes perceiving and addressing the needs of the whole family, especially the untenable situation for the child, and without continued communication among professionals and involvement of the court, the impasses may become too entrenched to resolve.

This article proposes some guidelines for mental health and legal professionals to use with intractable RRD families that may meet some of their needs more efficiently and thoroughly than do current practices. These guidelines include:

1. The use of specialized clinical interventions which include: (a) modified, nontraditional individual psychotherapies for intractable RRD family members; or (b) a specific type of family therapy that also incorporates and utilizes the foci and modifications proposed for the individual psychotherapies; and (c) possible use of both (a) and (b).
2. Teamwork among the legal and mental health professionals, which includes: (a) ongoing collaboration between the legal and mental health professionals throughout the duration of the clinical intervention; and (b) communication of the team with the court that allows for oversight and monitoring of the family members' progress, which supports the clinical interventions by adding a component of structured accountability.

In practice, it is valuable to follow these guidelines from the outset of the work with an RRD family, because by the time the case reveals itself to be intractable, it would be too late to modify the intervention and institute the necessary provisions to address the intractability.

The challenges of intractable RRD families push on the role boundaries of professionals who work with families of divorce. Efforts to help intractable RRD families underscore the need for a paradigm shift in the way the various professionals conceptualize their roles in order to create collaborative teamwork that is aimed at benefiting the family's well being. This shift is similar to and compatible with some of the modifications that already have been called for in the larger family court system, such as the need for therapeutic jurisprudence (Babb, 2014).

The authors acknowledge some of the limitations within their proposal for an extension of the MMFI approach. First, it is fairly new, and although the model has worked well insofar as it has been employed, there has been no research that evaluates its effectiveness. While there is a frustrating absence of good research and empirical data to direct interventions, there remains the pressing need to help these families. While waiting for direction from empirical evidence, interventions are guided by many factors, including clinical experience.

Some parts of the proposed changes have already been put into practice by professionals who keep up with the literature within their fields of specialization, who adapt to new approaches when working with their clients, and who have already developed trusting interdisciplinary relationships with colleagues through experiences in working with problematic families. These professionals have made shifts in their perceptions about what the work with RRD families requires through experiencing the advantages of modified therapies and collaborative teamwork with these families. Recognizing and formalizing their efforts in this direction has led, in part, to the authors' formulation of the guidelines proposed within this article.

APPENDIX A: SAMPLE STATEMENTS FOR COURT ORDERS WITH RRD FAMILIES

Note: This is not a model for a complete court order or stipulation. Instead, these statements are examples of how support for the family intervention may be woven into a stipulation or court order. It is expected that these statements would be modified to meet the needs of a particular family and/or court. These statements reference *Mother* as the rejected parent and *son* as the child who is rejecting Mother, but could just as easily be written to reference *Father* and *daughter*, or some other variation.

1. Mother and Father shall promptly facilitate receiving the services of Dr. X (family therapist). All family members shall participate in the family therapy with Dr. X, and cooperate fully with the services of Dr. X.

2. The Court expects that Mother and Father shall engage with Dr. X in good faith and in a manner that reflects their mutual commitment to the specified goal of the family therapy, that their son has healthy, positive relationships with *both* parents and members of both households.

3. Dr. X will assist *son* with the goal of re-establishing and developing the best possible relationship with Mother.

4. The Court expects that Mother and Father shall cooperate promptly with scheduling and follow-through with all appointments ordered by the court and/or requested by Dr. X., provide releases and background information as Dr. X requests. Father will transport son to and from appointments with Dr. X.

5. The Court will be monitoring the participation and anticipated progress of Mother, Father, and son. To the extent that Dr. X determines that siblings or other family members are necessary or important to achieving the goals of the family therapy, the Court shall also monitor their participation.

6. The Court will set Case Management Conferences (CMCs) or potential hearing dates every 60 days for this case, until an ending time determined by the Court. Fifteen days before each set date, Dr. X will provide a brief report in writing to the attorneys and the court. The attorneys can cancel the CMC or hearing date upon agreement. Further CMC or hearing dates are scheduled for _____, _____, _____.

7. Dr. X is encouraged to write to the Court directly, copied simultaneously to the various lawyers for the parents and the children, in the event that Dr. X encounters difficulty with securing the cooperation of the parents, and concludes that the Court's assistance is necessary to meet the goals of the family therapy as set forth here and in _____.

8. If Dr. X does not feel s/he can continue as the family therapist for any reason, the parties shall attempt to agree upon a qualified, substitute therapist. If the parties are unable to agree, each party shall submit one or more recommendations and the court shall appoint the family therapist. Neither party may unilaterally terminate the services of the family therapist without an order of this court.

9. Dr. X's fees shall be shared in the following way:

Mother pays _____%, Father pays _____%.

Dr. X shall be paid in a timely manner according to his/her Treatment Agreement. Nonpayment of fees shall be construed by the Court as a form of non-cooperation with Dr. X's treatment. The Court shall reserve jurisdiction to modify the fee sharing arrangement in the event that the court makes a finding that a parent is not cooperating with this order.

Judge's Participation and Compliance Agreement, for use with an adolescent**

I, _____, understand that the Judge has the power to make decisions about whether my mom or dad has legal or physical custody of me. I know that I have a right to tell the Judge what my opinion is and that the Judge makes this decision based on what s/he believes to be in my best interests.

As part of this court case, I understand that the Judge will give my dad legal and physical custody of me. As a condition of that custody, the Judge has ordered my dad to schedule, and make sure that I attend and participate in family therapy with Dr. X for the purpose of my having the best possible relationship I can have with my mom. I understand that Dr. X will listen to my concerns and ensure that contact with my mom is consistent with my best interests.

Therefore, I agree to do the following things:

1. Attend all therapeutic sessions and appointments that my parent schedules for me.
2. Communicate and cooperate with Dr. X.
3. Participate in contacting and communicating with my other parent as recommended by Dr. X, even when it is uncomfortable for me, and
4. Follow through with the parenting timeshare schedule.

Dated: _____ _____

Signature of Adolescent

Dated: _____ _____

Signature of Minor's Counsel

**This agreement is written on Court stationery (e.g. In the Superior Court of the State of . . . for the County of . . . in the matter of:, Case Number. . ., labeled as Participation and Compliance Agreement For . . .name of child), and once signed, it is filed with the Court stamped with the date filed.

NOTES

1. Discussion of RRD families in this article specifically does *not* include families in which a child rejects a parent because of recognized, clearly established abuse or intimate partner violence by that parent. Abuse cases pose problems and challenges very different from those of the RRD. Confusion may have occurred because interventions for both types of cases have misleadingly been labeled as "reunification therapy."

2. The discussion in this article is based primarily on the author's experience with the Multi-Modal Family Intervention (MMFI), a child-centered, multi-tiered intervention that involves all family members, and utilizes a collaborative team of professionals with different roles and levels of authority.

3. A recent example, given great attention by the media, occurred in Michigan when a family court judge ordered the rejecting children to a juvenile detention facility after they refused the judge's suggestion of trying to have lunch with their father (Abbey-Lambertz, 2016).

4. Some favored parents cannot be dissuaded of their belief about sexual abuse by the rejected parent despite repeated disconfirmation by investigations of the Department of Human Services (called Child Protective Services or Department of Child Family Services in different jurisdictions), the findings and conclusions of a custody evaluation, or information available from evidentiary court proceedings. Some favored parents take their story from one venue to another, even moving to a different city so that the case can be retried. A favored parent may resurrect a previously disproved allegation years later, placing a rejected parent, who had been previously cleared of the allegations, once again in a defensive position.

5. In fact, these cases are especially vulnerable to intractability since each parent points to real, legitimate behavior on the part of the other parent that actually contributes to the problem, which then buttresses their resistance to recognizing their own contributions.

6. There are also limitations on the court, both financial and time, which limit the availability of the judge to perform this role.

7. In the discussion concerning different therapies for the parents and children, note that when it is not financially feasible or otherwise desirable to have several ongoing individual psychotherapies, some of the components that are described in the sections about the individual therapies can be incorporated into the family therapy by the family therapist.

8. One goal of the child therapy is to correct inaccurate beliefs about the rejected parent, replacing those with beliefs based on their own experiences, past and current. Although in some cases this process may start spontaneously as children regain ongoing contact with the rejected parent, most children need ongoing help to work through this process. An assumption that children at a certain age spontaneously review and revise their beliefs about their parents on their own has not been substantiated. Johnston and Goldman (2010) did find that many adult children were sufficiently curious about their previously rejected parent to seek contact with them. However, this contact was not always sustained, nor did it necessarily result in revisions in their beliefs about the rejected parent.

9. Examples of how the collaborative work can facilitate the intervention include:

(1) *Protecting the child*. The parenting coordinator mitigates the impact of the child's exposure to and influence of the alienating behaviors of the favored parent. The court can issue court orders addressing enmeshment of a child with a parent, directing that the child be removed from home schooling; be required to sleep in their own bed; and be enrolled in age-appropriate activities. The enmeshed parent can be ordered to schedule sleepovers for the child; to enroll the child in 'sleep-away' summer camp; and to limit their volunteer time in the child's school.

(2) *Working with the favored parent*. The favored parent's attorney can explain there are long-term consequences of the alienating behaviors for the client's relationship with their child that may involve the potential loss of custodial time and even a change of custody. The court can impose sanctions and consequences on the favored parent such as reducing the favored parent's time with the child, or requiring supervision of the time the favored parent has with the child, or, if this is not effective, the court can impose a period of no contact between the favored parent and the child. If the favored parent's alienating behaviors recur even after a period of no contact, or even a change of custody, a brief re-evaluation by a skilled custody evaluator may be helpful in order to determine the best course of action.

(3) *Effecting a change of custody*. This very serious decision cannot be undertaken without the judge having convincing and persuasive supporting information gleaned from members of the collaborative team that it would be in the best interests of the child. The change creates a family crisis that requires immediate, well-orchestrated help from the mental health practitioners for the parents and the children. A program that offers a start in that direction is the Family Bridges program (Warshak, 2010). The aim of this program is to give the child a chance to see the rejected parent in a new light, while removed from the source of the alienation and misinformation about that parent. In the wake of a change in custody, the Family Bridges program suggests that the favored parent not have contact with the child for a specified period of time, such as ninety days. Although difficult to enforce, restrictions on the child's contact with the favored parent can be monitored by the collaborative team in various ways, and violations of the restriction can have the pre-set consequence of prolonging the period of time for restriction of contact.

10. The authors understand that not all jurisdictions/states have statutory or case law providing for court-ordered therapeutic interventions. Further we understand that in some jurisdictions where there is no statutory or case law authority to order therapy, some judges and attorneys question whether the court has authority to accept and enforce agreements for therapy. Some states, however, such as California, give the courts clear authority to do both (cf. FL 3190 et. Seq.). Where no statutory authority exists for the judge to order therapy, the burden is on the custody evaluator to recommend specific terms, and on the attorneys to negotiate and stipulate to an acceptable therapeutic intervention.

11. The court order may be stipulated or adjudicated depending upon the jurisdiction.

12. The latter can be helpful with an adolescent who is resistant to following the court orders to have some therapeutic contact with the rejected parent. A meeting could be held in the judge's chambers, with minor's counsel and the family therapist present, for the adolescent to hear the judge's reasons for making the order firsthand.

13. More active judges assume the role of a hands-on case manager who is fully committed to seeing the case through the process of implementing the court orders. They prefer to use less formal case management conferences instead of formal hearings. At the case conference the judge, attorneys, and mental health professionals sit around a table to work on issues together rather than having two sides argue the facts and law as would occur in a typically adversarial hearing.

14. This does not mean that in order to receive the information, a motion and hearing is required. It simply means that anything the judge sees or hears must be copied or must include the attorneys for all parties. A clearly defined procedure agreed to by all parties is required.

15. For example, in 2011, California's Legislature amended the statute governing child testimony (Cal. Fam. Code §3042 (2011). At the direction of the legislature, California's Judicial Council adopted Cal. Rules of Court, rule 5.250. Together, these new laws create a presumption in favor of the Court hearing the views of children age fourteen and up, and set forth a variety of ways in which those views may be communicated to the court.

16. Some family court judges address the adolescent within the courtroom, with both parents present, as well as their lawyers, all of whom are "witnesses" to what is said (personal communication, California Superior Court Commissioner Marjorie Slabach (ret.), August, 2015).

17. The authors are aware that in many states parenting coordinators can only become involved in a case through stipulation, and not through a court-order. The expense involved in working with a parenting coordinator is another factor that bars them from being utilized more frequently.

18. With a hands-on judge who presides over the case management conferences, the judge assumes the role of the leader of the team of professionals.

19. Of course, the family therapist avoids offering recommendations or opinions, which only the empowered parent coordinator can do, and is careful to preserve the integrity of the clinical role and to maintain therapeutic neutrality.

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