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A Systematic Approach to Reunification Therapy

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Preface:

As Dr. Warshak's previous paper clearly indicates, a number of the cases involving reunification work are related to issues of irrational or unjustified alienation. However, there are also cases where children before the court are refusing to see one of their parents, and the reasons behind that refusal may or may not be related to irrational or unjustified alienation. We have all seen cases where a parent has engaged in certain behavior that has caused their children to desire to cease contact with a parent, and we have also seen cases where a child is refusing to see a parent for reasons unrelated to the issue of alienation. In turn, this brief paper will address the specific issues of reunification as a whole, as well as the factors to be considered in drafting orders for reunification counseling or therapeutic intervention.

A Brief Overview of the Issue of Reunification:

Reunification cases appear to be a newer or more frequent phenomena facing Judges, lawyers, and mental health professionals. These cases involve either an alienated parent and child or an estranged parent and child, and the question before the court is how to rectify and resolve the issues within that relationship. In the cases of extreme alienation, Richard Warshak has done a great deal of research that is quite helpful in understanding the significance of these cases, and he has proposed that in the worst of these types of cases, a change in physical possession may be warranted. However, in cases that are not quite that extreme, the question then becomes how to fix the relationship at hand, and to date, there is very limited research on this topic outside of Dr. Warshak's work.

Ms Bradshaw Schmidt's practice group, NTXFIT (North Texas Families in Transition Professionals), has been actively discussing and addressing this issue for some time and had been in the process of determining some appropriate policies, procedures, and sample court orders for managing this issue. The actual specifics were still in their infancy as of the date that this section of the paper was originally published, but here are the important factors that had been determined as of the fall of 2013:

1. *the court needs to determine if reunification is an "if" or a "when" scenario* - this specifically means that the court needs to instruct the mental health professional (who is often identified as the reunification counselor) whether or not the court is trying to determine "if" reunification will occur between the parent and the child or "when" reunification will occur between the parent and the child. Should the court determine that the question is "if," a child custody evaluation or guardian ad litem may be necessary.
2. *the parents need to be told what the court's determination is surrounding if and when* - it is important that the parents understand what the court's ruling is so that both parents are on the same page with the child within the reunification process. This also helps in the counselor's ability to notify the court when one parent is not in compliance with the court's determination.
3. *the court needs to determine what the final goal for reunification is* - if the court determines that the question about reunification is when, the next step is what the final goal needs to be. In other words, if the ultimate goal is for a child to transition to standard possession with that parent, the reunification counselor needs to know that. Often reunification counselors are ordered to begin counseling with the estranged or alienated parent and child, and they are told to initiate a stair step visitation schedule. However, that schedule is not clearly defined or a long-term goal is not established, and counselors cannot make parenting plan recommendations or rulings per the current standard of practice; so, they need the court's guidance on what the court wants to see happen.

4. *both parents need to be involved in the process* - it is preferred that a child in a reunification situation see both parents involved and supportive of the process. In addition, without both parents involvement in that process, it is difficult to determine if one of the parents is sabotaging the process. (NOTE: This does not apply to cases involving severe alienation where the child has been placed with the rejected parent. Those cases do not require involvement of the favored parent to be successful, and in extreme cases of abduction, the favored parent may be in jail or prohibited from having contact with the child per the court's order.)
5. *the counselor needs to be able to communicate any issues of non-compliance with the court* - the process truly benefits from a reunification counselor being able to report to both attorneys and the court when either parent is non-compliant with the process and with the court's rulings. Without this component, reunification counseling can flounder and be ineffective, which only makes the ultimate goal that much more difficult to achieve.

Based upon even these few initial factors, one can easily see that cases involving reunification create a unique set of circumstances that differ from family to family. This ultimately makes the drafting of orders quite difficult as well, which is the reason that the following portion of the paper drafted by Aaron Robb, PhD, takes a more systemic approach to dealing with these families. It is hoped that these factors will be helpful to the attorneys and the Judges in drafting more effective orders for these families in the future; while providing the mental health professionals with effective practice tips that they can implement in their work with these unique families.

A Systematic Approach to Reunification Therapy:

This section of the paper, written by Aaron Robb, PhD, is intended to be a guide to structuring orders for reunification plans and the various services that are often associated with those plans. Any case where there has been a break in parent-child contact, or where there has been damage to the parent-child relationship, will have unique challenges – an attempt to create a “paint by numbers” approach to drafting orders in such cases is bound to fail. Rather, we hope to offer an “a la carte menu” of options and a broad road map to navigating this process. Please do not think this will always be a linear progression; there are often unpredictable outcomes even when everyone is acting with the best of intentions. At the same time, please do not confuse expected setbacks with a derailment of the process – mistakes are not failure, and no one can expect perfection in any human endeavor.

- The Challenge for Therapists in Making Recommendations About Parent-Child Contact

The courts have acknowledged that in some circumstances the appointment of a neutral third party in complex cases may be necessary because the court is not in the best position to determine when a parent may be capable of transitioning to more standard access. The Court of Appeals has held that in these cases the court's order must be very specific as to: (1) identify the third party, (2) provide dates and other guidelines for the transition program, (3) provide dates when the standard possession order should begin, and (4) provide dates by which the third party should report to the court if these matters could not be accomplished as ordered.¹ Courts can also order specific services as conditions of parent-child contact.²

¹ In the Interest of J.S.P., 04-07-481-CV, 2008; Hale v. Hale 04-05-00314-CV, 2006

² In the Interest of D.A., a Child, 307 S.W.3d 556, 2010

Counselors and psychotherapists can provide a wealth of behavioral health information to attorneys and the courts; however they are also often drawn into inappropriately making recommendations regarding conservatorship, possession, and access issues. The Family Code already recognizes that before making conservatorship, possession, and access recommendations evaluators must satisfy a lengthy list of requirements, and parenting facilitators are specifically forbidden from making such recommendations. Many therapists also recognize that making such recommendations may damage the therapeutic relationship with their clients. Recognized best practice for counselors and psychotherapists, whose information gathering is targeted at treatment issues, is to refrain from offering psycho-legal opinions regarding possession and access issues. This is enshrined in Texas' licensing codes for psychologists, and in national ethical guidelines such as those promulgated by the American Association of Marriage and Family Therapists.

By focusing therapists' recommendations in reunification therapy on measurable behavioral issues and assessment of interpersonal functioning, courts can avoid asking therapists to cross into ethical grey areas. At the same time, this focus allows for structuring proper triggers to increase contact between parents and children as the parent-child relationship improves. We adopt such an approach throughout this document and demonstrate multiple ways such recommendations can be structured.

- Using This Guide

This guide is broken down into four sections. Part 1 ("Creating a Good Order") addresses issues in identifying problems and the corresponding interventions to correct those problems. Part 2 ("Initial Assessment Process") details initial issues for mental health professionals as the critical first steps are taken. Part 3 ("Example Stair Step Parenting Time Plans") discusses various options for structuring parenting time plans based on issues specific to the case. Part 4 ("Movement Between Steps") addresses the various trigger conditions that mental health professionals can report back on and how those can be best targeted to the assessment of behaviors and interpersonal functioning.

Throughout this guide you will see critical topics to be addressed in the court order included in boxes. The intent is to bridge the difference between philosophical underpinnings and practical drafting tips and tools.

- *Related activities from the mental health professionals involved are included at the end of these sections in italics. Clear documentation is often critical in cases that are already fraught with emotional reasoning and "he-said/she-said" recriminations.*

Part 1: Creating a Good Order

In order to change a situation, the first step is to identify what deficiencies in family functioning exist and then to select the intervention professional or professionals to treat them. Such deficiencies may be identified in formal forensic assessments, such as a child custody evaluation or individual psychological evaluation, or treatment needs may be clear to all involved. Without specific direction from the court at the beginning of the process, interventions risk becoming mired in the parties' conflicting goals.

Once this foundation is established, the professionals involved begin work with the family (discussed further in the next section), refining these goals, and updating treatment plans.

Treatment plans allow for tracking the progress of the family as they work on various goals and demonstrate growing insight and skills.

- What prompts the referral for reunification services and how should services be structured to address those issues?

When drafting an order, identify and clearly outline the attitudes and behaviors that need remediation, i.e. what needs to change to reach the end goal?

It is also important to note that treatment providers in a case may range from a single therapist conducting parent-child relational therapy (often referred to as a “reunification therapist”) to a comprehensive treatment team of therapists and psychiatrists for parents and children, visitation supervisors, and a parenting facilitator. Different issues require different approaches, but when there are multiple professionals involved it may be helpful to designate a team lead or a case manager to coordinate treatment team decisions and make final judgment calls.

If there are forensic evaluations or other reports detailing the family’s case history, those should be provided to the treatment providers to assist them in understanding the context of the family’s current situation and what has brought the family to this point.

- *Treatment plans based on the identified issues should be provided to all parties and shared amongst the treatment team (if there is one) with updates on a regular basis. It may also be appropriate for these updates to be provided to attorneys of record and the court. Therapists must be clear on who reports to who, and how often, as outlined in the order (see examples in Part 4, below).*

While we encourage much latitude be provided to the professionals in setting the format of sessions, the order should be clear enough that everyone is aware of expectations.

- Format & fee issues

Orders should specify that the parent-child therapist may meet with the parties or the children jointly or separately, as needed. Any child therapists involved should also be provided leeway to schedule parent consultations as needed, or to require that each of the parents bring the child on whatever frequency is therapeutically appropriate.

The order should also address how much of the costs for services each of the parents should be responsible financially for, and how payment arrangements may be impacted by the format of sessions (i.e. each parent pays when they take the child, a 50/50 split on all fees, one parent pays 100%, etc.).

- *Billing statements should be copied to all sides in a case in order to foster transparency regarding all services, unless there is a clear therapeutic rationale stated as to why this would be contraindicated.*

The order also needs a clear plan to move a parent from whatever level of contact they are currently at to whatever level of contact the court sets as the desired endpoint (presumptively, but

not always, the Standard Possession Order), and this should be clearly spelled out in the order. Often these plans detail discrete levels of access, or steps towards the endpoint, and thus are referred to as “stair step schedules.” More on this is included in Part 3, below, including examples of these schedules. Sometimes movement between the steps, forward or backward, is automatic, based on various conditions (i.e. a clean drug test); while at other times transitions might only occur after an assessment of progress on some factor or combination of factors (i.e. active participation in a Supportive Outpatient Program). Part 4 of this document lists various examples of structuring conditions for adjusting parenting time arrangements.

Part 2: Initial Assessment Process

It is important to begin with realizing that there are many reasons why a parent and child may have suffered a rupture in their relationship. Understanding current functioning in the context of historical issues for the family is critical in figuring out how to move forward. Please note, one of the critical pre-conditions for reunification therapy is an acknowledgement by the court that says clearly there is no longer a question of *if* parent-child contact will happen, but *how* such contact will happen. Treatment professionals must reinforce this acknowledgement. The additional barriers raised when contact with a parent is perceived as optional can often be insurmountable. Children generally desire more contact only as the parent-relationship improves. Waiting until a child is “ready” for contact is a paradoxical approach, as without contact the relationship only becomes more strained and easier to discard.

That said, not all parents are capable of taking the steps needed to address the “how” question due to problems with substance abuse, domestic violence, untreated mental illness, and other challenges that interfere with healthy functioning to the point that those issues must be the primary focus of treatment in order for the parent-child relationship to move forward. For a detailed discussion regarding typology of cases where children are resistant to contact with a parent please see Friedlander & Walters’ “When a child rejects a parent: Tailoring the intervention to fit the problem” in Family Court Review (2010, volume 48, issue 1).

In the examples below, the phrases “estranged parent” or “rejected parent” are used to refer to the parent who is working on reunification with the child. In rare cases, such as following severe alienation, reunification work may be taking place between a child and an enmeshed or favored parent where the court has temporarily halted the child’s contact with that parent. In such cases, rather than repairing the relationship to establish a healthy connection, the goals may be more appropriately conceptualized as establishing healthy boundaries for the parent and child so that each may have an individual identity and the child may have individual relationships with both parents.

- Assessment of the readiness and willingness of the estranged parent to be a resource for the child.

When a parent is impaired because of substance abuse, untreated mental illness, or other individual functioning issues, a reunification therapist may have to recommend that these issues be brought under control as the first step to moving a reunification plan forward. A parent who frightens a child by interacting while impaired (i.e. drunk, high, paranoid, delusional, etc.) only further damages the relationship, which is the opposite of the goal of reunification therapy.

Likewise, a parent who lacks insight as to how their past issues of domestic violence, abusive

parenting practices, and other problems impact upon their child may do more harm than good in pushing forward. In this same vein, the parent who focuses more on blaming others than loving their child may only further damage their relationship with the child.

- *The report back by the therapist should identify if additional services are needed for reunification to proceed, whether that work can be done concurrently or if it is a prerequisite for further reunification work, and what the treatment goal should be to reach that point.*

Professional Tip: Many therapists encourage letter-writing, sharing of pictures and videos, and other methods of communication that can be screened by the therapist. The therapist can work with the parent on maximizing healthy expressions and minimizing harmful ones. This can be a difficult emotional process as parents begin to understand more about the children's developmental needs and learn how they can focus on being a support for their children.

- Assess the readiness and willingness of the non-estranged or favored parent to support reunification.

Often the non-estranged parent contributes to the dynamics of the interaction between the estranged parent and the child, and the goal is for this to be a positive contribution rather than another drain on the child's emotional supports. To be clear, a parent who is engaged in alienating behaviors (intentional or otherwise) may sabotage the process in ways that are impossible to overcome. In such cases, the court may need to reconsider the child's living arrangements and look for more radical solutions to negate the toxic influence of the non-estranged parent on the child before repair of the estranged parent-child relationship is possible.

- *The report back by the therapist should identify whether the non-estranged parent is serving as a resource to help the child with reunification or if they are adding additional barriers to reunification. If they are creating/maintaining barriers, the therapist should also identify if there exists any apparent therapeutic or psycho-educational remedies to reduce those barriers.*

Professional Tip: The barrier-creating parents are often in need of having their past positive efforts in solo parenting acknowledged. They also often need education on the beneficial effects of letting the child have a genuine relationship with their other parent. Even when the relationship with the estranged parent may not necessarily be as healthy or as positive as the non-estranged parent might hope, it allows the child to begin resolving related issues sooner, rather than later, in their process of identify formation.

- Assess the capacity and functioning of the child.

There will be emotional challenges during reunification. A child in need of inpatient hospitalization or residential treatment may be too emotionally fragile to move forward with reunification at that point. Likewise, there are going to be some children who are more resilient than others, and progress will vary in speed from one child to another, even with children in the same family. The question here is one of pacing. While parents may disagree over what is "too slow" or "too fast," we must keep the focus on the child in question.

- *The report back by the therapist should address any individual needs of the child and how services for the child can be integrated to facilitate the reunification process.*

Professional Tip: Children are often dealing with multiple issues regarding their feelings toward an estranged parent. Difficulty adjusting to contact with a parent, or a lack of interest in a relationship with a parent, is not a reason, in and of itself, to delay reunification. Often that is precisely the reason for services in the first place.

Part 3: Example Stair Step Parenting Time Plans

At the outset of any parenting time plan, it is important to clearly define the terms used in the order so that everyone is clear what is being addressed.

Supervised visitation refers to contact between a non-custodial parent and one or more children in the presence of a third person responsible for observing and seeking to ensure the safety of those involved.³ The supervisor, whether a neutral professional or a family member, should maintain direct line of sight and be within earshot so they can promptly intervene if a parent behaves inappropriately and needs to be redirected.

Monitored visitation refers to parent-child contact where a third party is nearby. Monitored visits may be an appropriate level of service when the main concern might be a parent departing the designated visitation location, or the availability of the third party to intervene if there is an obvious conflict between parent and child. Stages of a case where there is concern about possible emotional or physical abuse of the children, the sharing of inappropriate adult information with the children, or other interactions where a close level of scrutiny is needed are not appropriate for monitored visitation.⁴

Therapeutically supervised visitation refers to supervised visitation overseen by a licensed mental health professional with the goal to not only supervise but improve parent-child interactions. It is primarily supervised visitation, as the first concern is protecting the children involved, rather than any particular therapeutic goal.

- Example stair step plan #1

Level 1: Supervised visitation for 2 hours every Saturday

Level 2: Supervised visitation for 4 hours every Saturday

Level 3: Monitored visitation from 9:00 a.m. to 6:00 p.m. on the first, third, and fifth Saturdays

Level 4: Remove monitor, continue with Level 3 schedule

³ From the Supervised Visitation Network “Questions Parents Ask” – www.svnetwork.net/questions-parents-ask.sp

⁴ Adapted from Forensic Counseling Services’ “Differences between ‘monitored’ and ‘supervised’ visitation” – www.texas counseling.org

Level 5: First, third, and fifth weekends from Saturdays at 9:00 a.m. to Sundays at 6:00 p.m.

Level 6: First, third, and fifth weekends from Fridays after school to Sundays at 6:00 p.m.

Level 7: Standard Possession Order

A variation on this plan when supervised or monitored visitation might not be needed would be to start with Level 2 (sans supervisor), progressing to Level 3 (sans monitor), and then progressing through levels 5, 6, and 7.

- Example stair step plan #2

Level 1: 8 hours total supervised visitation on the first, third and fifth weekends

Level 2: Add an unsupervised three hour meal visit (lunch/dinner) on the second and fourth weekends

Level 3: Change to 4 hours supervised and 4 hours unsupervised visitation on the first, third, and fifth weekends

Level 4: Unsupervised access 9:00 a.m. to 5:00 p.m. Saturdays and Sundays on the first, third, and fifth weekends. End meal visits on second and fourth weekends.

Level 5: Unsupervised access from 9:00 a.m. Saturdays to 5:00 p.m. Sundays on the first, third, and fifth weekends. Add weeknight unsupervised dinner visit on Thursdays.

Level 6: Standard possession order

A variation on this plan when supervised visitation might not be needed would be to start with Level 4 and move forward from there.

These first two plans are fairly standard examples of progression from supervised visitation to a Standard Possession Order. There may be cases where starting with supervised contact may not be advisable as a starting point and a more therapy-oriented approach is more appropriate. Depending on the needs of the case and the age of the child, this might involve filial therapy techniques, parent-child interaction therapy, or other modalities. Issues of therapeutic approach should be discussed with possible therapists prior to naming them in an order to insure a good match for the child and the family.

- Example stair step plan #3

Level 1: Therapeutic reintroduction of child and parent. Following initial assessment, the parent-child therapist will schedule [# of sessions] weekly joint sessions with Parent A and the child, to which Parent B will transport the child. Individual sessions with each party or the child at the discretion of the therapist should be included at each level of this plan.

Level 2: Parent A and the child will have a 3 hour unsupervised meal time visit following a parent-child therapy session where they will discuss plans for the visit. Parent A and the child will return to the therapist's office at the end of the visit to process how their interaction went with Parent B picking the child up at the end of the session.

Level 3: Parent A will have 8 hours of unsupervised visitation, with visitation starting and ending at the therapist's office.

Level 4: Parent A will have 6 hours unsupervised visitation, with Parent B dropping the child off at the home of Parent A or another location identified by the therapist at the start of the visit and the visit ending at the therapist's office to process how interaction went. Parent B will pick the child up at the end of the session.

Level 5: While continuing weekly parent-child therapy, Parent A will have unsupervised access from 9:00 a.m. Saturdays to 5:00 p.m. Sundays on the first, third, and fifth weekends.

Level 6: Standard Possession Order

Various iterations of this plan, adjusting the number of steps and the rate of increased time per step, should be obvious. The initial goals are to allow monitoring of interactions and a safe space to process any interactions. Individual contact can also be used to process outside of the joint sessions.

- Example stair step plan #4

Level 1: While the child in question and parent are participating in individual therapy, contact occurs under therapeutic supervision with a neutral/unaffiliated provider. This avoids both dual-role violations for therapists and preserves the neutrality of the therapeutic supervisor.

Level 2: Convert therapeutic supervision to standard supervised visitation. Continue individual therapy throughout remaining levels as needed.

Level 3: Remove supervision constraints under one of the previously noted plans

This plan focuses on more intensive services at the beginning of contact and may be suitable where concerns are less about parent-child relationships and more about parenting competency and/or safety. Feedback from therapists after Level 1 may be less interaction focused and more in regards to each person's individual issues.

Additional provisions can be tied to the various levels, such as holiday parenting time if a parent is on a particular level (i.e. an overnight near Christmas on Example 2, Level 5, or a few days over spring break on Example 1, Level 6) if those are viewed as appropriate to the case. Additionally parents always have the option, however unlikely, to agree to such arrangements on their own as the case progresses. As a caution, any such variations should be agreed between the parents in writing (hardcopy, e-mail, Our Family Wizard, etc.), and copies should be provided to the treatment team.

Part 4: Moving Between Steps

The question of “when do you move from one step to another” in a stair step plan is a critical issue. Thankfully having such a predetermined plan in place allows the mental health professional managing the reunification process freedom from having to make decisions regarding possession or access. Rather, with the steps set a mental health professional can report back on behavioral progress of the parents which then serve as “trigger conditions.” This is more than a fig leaf or a proxy, but a way for the mental health professionals to assess what they were trained and licensed to assess, behaviors and interpersonal functioning. As with many areas in life, these are behaviors that have consequences, but the mental health professionals are neither responsible for the parents behaviors or the resulting consequences, only assessing what those behaviors are.

- Moving up levels

Parents may have insight-oriented requirements, skill-related requirements, participation-related requirements,⁵ time-related requirements, or some combination of all of these as preconditions for moving up to the next parenting time level in the stair step plan.

Example: After Parent A has completed [# of weeks] at Level 1 they shall move to Level 2. (*An automatic transition.*)

Example: After Parent A has completed [# of weeks] at Level 1 and participated in [# of sessions] of therapy with the child in question they shall move to Level 2. (*Requiring the therapist to report back on therapy participation.*)

Example: Once Parent A is able to demonstrate basic infant caregiving skills and has completed the ‘Bottles and Blocks’ parenting class they shall move to Level 2. (*Requiring a professional to report back on an assessment of caregiving skills and verify class completion.*)

Example: Once Parent A is able to demonstrate insight into how their alcoholism has negatively impacted the child in question and is willing and able to express that to the child in a healthy and supportive manner they shall move to Level 4. (*This is a more advanced insight and skill related assessment. Sometimes insight alone is insufficient, and parents must build that insight into tools they can use with their children.*)

- Steps also go down

In the case of noncompliance, relapse, or other behavioral problems, one possible consequence is that instead of plateauing at the current parenting time plan the parent returns to an earlier level. This might mean returning to the step immediately previous to the current step, starting over from the beginning, or somewhere in between.

Example: Should the treatment team determine Parent A is not in compliance, Parent A will

⁵ To be clear, there is a difference between attending a service (being a warm body in a seat) and actively participating in services.

return to the prior access level for [# of weeks]. At the end of this time, compliance shall be reassessed and Parent A either advanced to the next level if compliant, or again move to the next lower access level if noncompliant and reassessed again in [# of weeks], repeating this process until Parent A returns to compliance. (*This is a broad judgment call, but acknowledges that some parents may simply not engage as needed in order to meet the best interests of their children.*)

Example: Should Parent A test positive for illegal drugs at any drug screen, they shall return to Level 1 of the previously outlined parenting plan. (*This is an automatic trigger needing no judgment at all, just a report from the testing agency.*)

The range of possible trigger issues is as wide as the scope of problems that lead to reunification therapy. The following examples of issues that therapists might report back on is not intended to be comprehensive, although it does touch on major issues seen in routine work with these families.

- Therapy – This entails not just attendance, but active participation and work toward resolution of issues. It may be hard for parents to accept the identified issues, or they may pay lip service to making changes in their words or actions, but be unable to implement behavioral changes.
 - *Report back can include frequency of attendance, assessments of compliance with treatment plans, whether shortcomings are a reflection of a need to build additional abilities or a lack of willingness to use the skills they are being taught, level of insight, ability to express healthy insight to the child in question, etc.*
- Psychiatric care – Talk therapy and psychoeducational approaches are not always sufficient when clients suffer from serious mental illness, crippling anxiety, or other difficulties that are generally treated in conjunction with medication management. Additionally parents may have other physiological issues (i.e. thyroid dysfunction) that would need to be properly assessed and medically managed as part of the process.
 - *Report back can include compliance with medication checks, assessment of client understanding of the importance of medication management, client willingness to adhere to a medication regimen, participation in Intensive Outpatient or Partial Hospitalization Programs, etc.*
- Substance abuse issues – In addition to individual therapy, this may entail drug screens, ETG testing, Scram and other device monitoring, support group attendance, relapse prevention planning, avoiding past triggers for use, changing social support structures, and a host of other interventions.
 - *In addition to basic therapy issues noted above, trigger reports to the family and treatment team regarding substance abuse might be based on the results of physiological testing (clean, positive for particular substances, or not responded to and treated as a failed test), feedback from sponsors, attendance at community support groups or Supportive Outpatient Programs, behaviors indicative of increased relapse risk, etc.*

- Pain management – This issue is sometimes viewed as a subset of substance abuse, therapy, or psychiatric issues, but pain management is sufficiently unique to merit mention on its own. Untreated or undertreated pain can manifest negatively in many ways. Additionally parents may also develop tolerance and drug-seeking behaviors.
 - *In addition to the previously noted report back triggers, pain management issues may include monitoring that the parent has alerted their various treatment providers (such as their primary care provider) to the pain management plan, has advised regarding treatment issues, and is complying with that plan.*
- Basic parenting skills – This entails parents demonstrating anything from the ability to change a diaper to more complex skills such as offering choices and consequences.
 - *Report back may be tied to class completion, such as “Baby and Me” or “Love and Logic” seminars, or more individualized assessment of the parent’s skills in practice with the child in question.*
- Participation in supervised visitation – it may sound like something Yogi Berra would have said, but sometimes showing up is the first step towards getting to know someone. Often parents are erratic in their contact with children, a self-sabotaging approach to reunification at best.
 - *Has the parent shown up for supervised visits (and is the other parent bringing the child as ordered)? What problems/issues, if any, are occurring during supervised visits?*

Finally, the frequency of reporting and where the person’s reports should be sent should also be addressed.

- Reporting frequency
 - Time based** – Every X weeks, monthly, or quarterly. Reporting does not have to be on a fixed basis, but as parents progress through various levels, the need for reports may be lessened. The case that may have needed weekly summaries in the beginning might transition to monthly reports as time progresses. It is important to check with the reporting professional to insure that they are able to make reports on the schedule the case requires.
 - Condition based** – Once a parent completes a particular task the mental health professional certifies that to the group.
 - Combinations** – It is highly recommended that there be some form of routine reporting so that contemporaneous assessments of progress are documented. Setting a maximum period that will pass before a report is needed may allow several condition-based reports to be generated but prevents total silence if there is a lull in services or plateau in progress for some reason.
- Reporting to whom?
 - Status reports to the court** – These reports may only be necessary in exceptional services,

or when critical milestones are reached.

Letters to the attorneys – While there is a minimal additional expense in keeping the attorneys in the loop, depending on the nature of the case and level of involvement of the attorneys, reports are an easy way to routinely document progress. Any formal communications by or between the treatment team (treatment plans, billing statements, etc.) should likely also be copied to both attorneys to insure transparency is maintained.

Directly to the parties – This is obviously the most direct way of documenting progress, and may be done via formal written communication, or more informal methods such as e-mail or Our Family Wizard.

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Aaron Robb, Ph.D. April 18th, 2014

Additional resources for mental health professionals working with reunification therapy:

Beyond Divorce Casualties: Reunifying the Alienated Family by Douglas Darnall (Taylor Trade Publishing).

Best Practice Guide: Emotional Harm and Parent-Child Contact Problems in High Conflict Separations by Barbara Jo Fidler, Nicholas Bala, and Howard Hurwitz (Created for the High Conflict Forum (Toronto) in conjunction with Jewish Family & Child).

Divorce Poison: How to Protect Your Family from Bad-Mouthing and Brainwashing by Richard A. Warshak, PhD (HarperCollins Publishers)

Family Bridges: Using Insights from Social Science to Reconnect Parents and Alienated Children by Richard A. Warshak, PhD. Published January 2010 in Volume 48, Issue 1 of the Family Court Review, Pages 48-80.

Family Restructuring Therapy: Interventions with High Conflict Separations and Divorces by Stephen Carter (HCI Press).