RESIST, REFUSE & RESOLVE

Turning the Corner on PCCP Conflict

Panel Discussion – 1:45-2:45 p.m.

Panel members

Caitlin Burgess

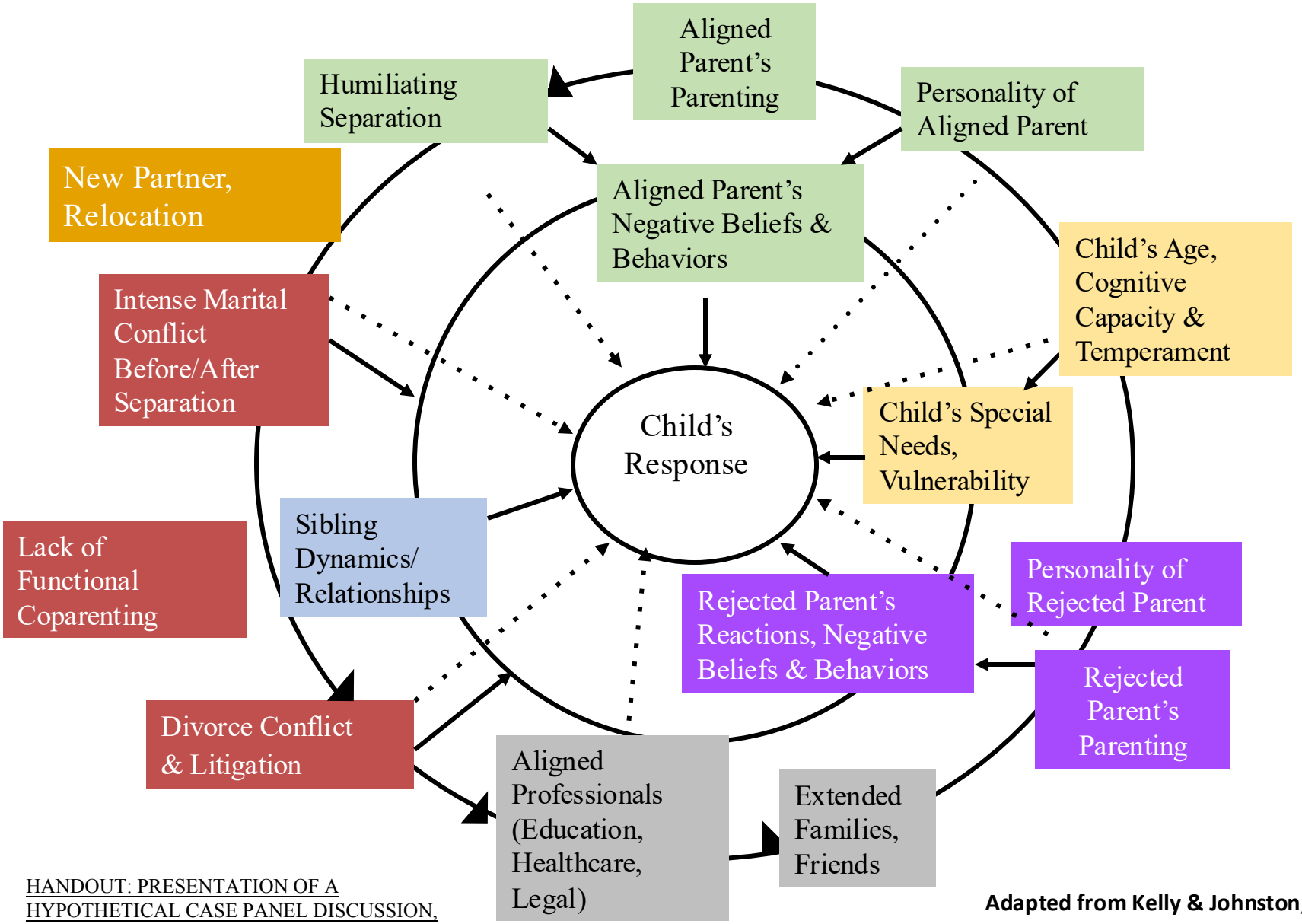
David Goldman

Allyson Henry

Jennifer Keilin

Caroline Plummer

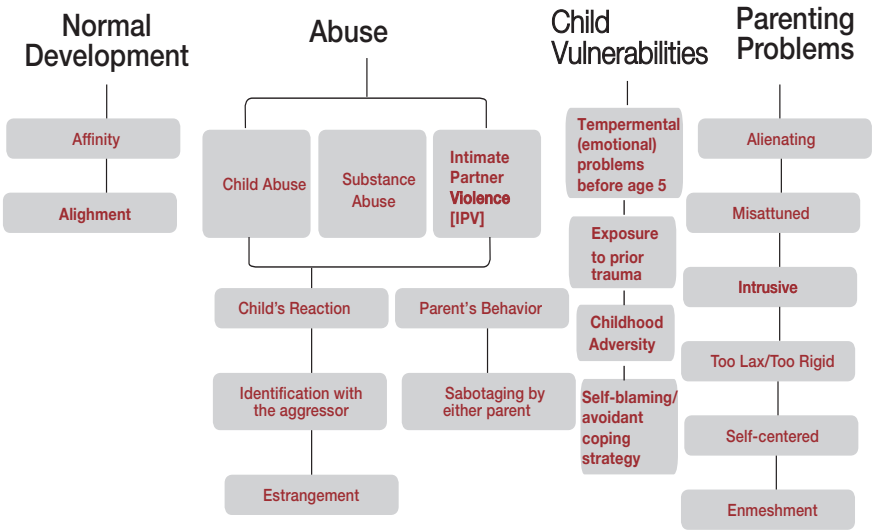
Factors contributing to & sustaining parent-child contact problems



HANDOUT: PRESENTATION OF A HYPOTHETICAL CASE PANEL DISCUSSION, WA AFCC, 4/25/2025

Adapted from Kelly & Johnston, 2001

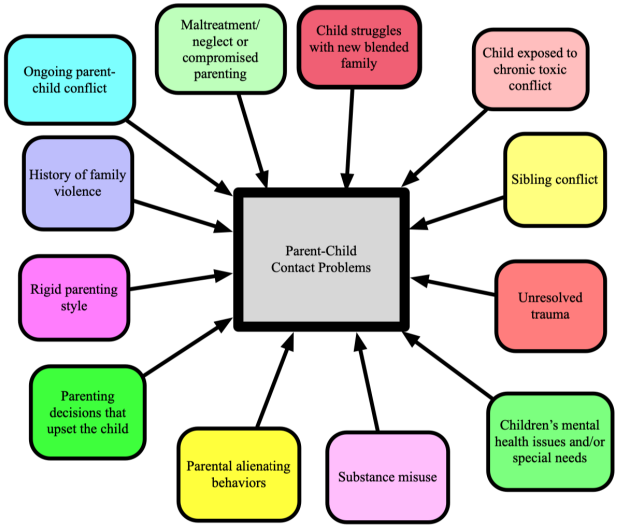
RRD/PCCP Decision Trees



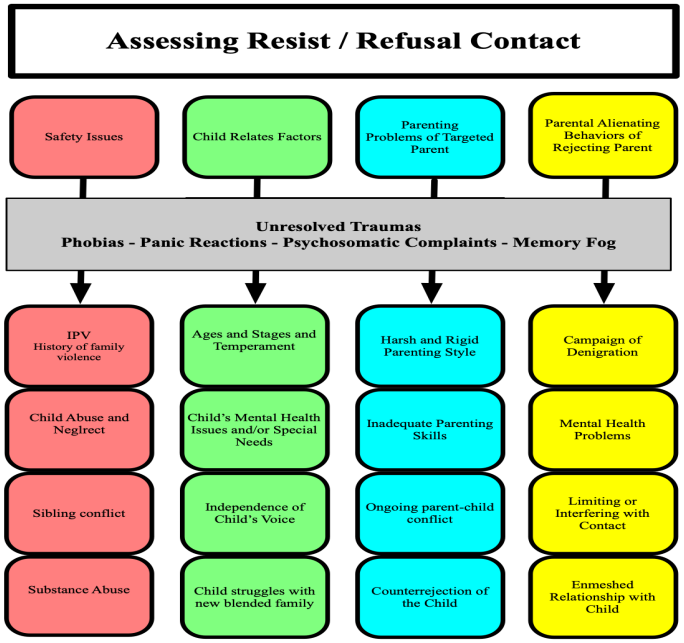
Drozd, L., Olesen, N., & Saini, M. (2013) (updated 2018 with suggestions by Deutsch, R., 2018)

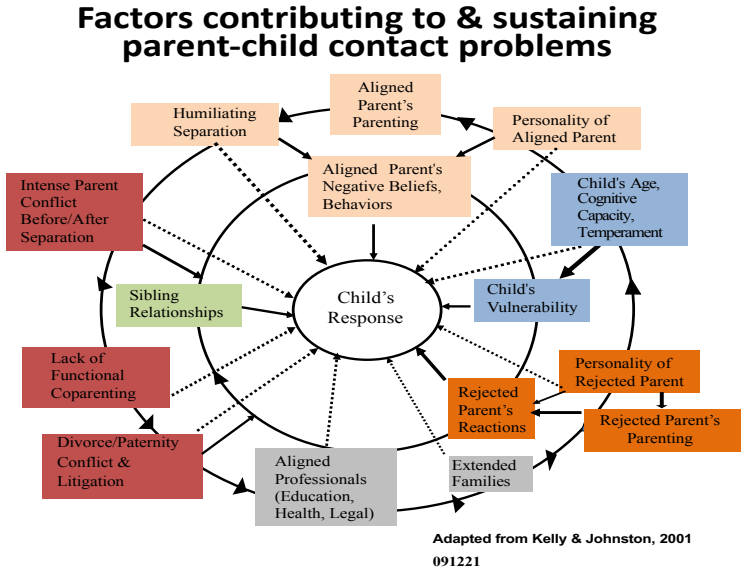
Parenting Plan & Child Custody Evaluations: Using Decision Trees to Increase Evaluator Competence & Avoid Preventable Errors.

Multi-Factor Theory of Parent-Child Contact Problems (PCCP)



Deutsch, Drozd, & Saini, 2021





Differential Approach for Assessing and Intervening with Strained Parent-Child Relationships after Divorce - © Fidler, Bala & Saini, 2013

Assessment: Level of Severity	Mild	Moderate	Severe
1. Parental conduct 2. Protection vs the probability of harm 3. Rigidity of child's perceptions/behavior towards his/her parents 4. Frequency of parent-child contact 5. Duration of strained relationships 6. History of parents' rigidity 7. Responsiveness to education/treatment as suggested 8. Compliance with court, orders, parenting plans,nd treatment agreements	1. Minimal interference/ badmouthing 2.Parent values child's relationship with other parent but occasionally displays misguided protective behavior 3. Child values relationship with both parents, but displays discomfort (not extended to extended family) 4. Minor interruptions of parent-child contact (e.g. late, missed visits, short-lived transition difficulties in presence of FP) 5. Situational and infrequent relationship strain (eg. due to affinity, alignment, expected and time-limited upset over parents' separation) 6. Generally flexible but can be rigid 7. Responsive to treatment/education to improve parent-child relationships 8. Compliant with parenting plan, treatment agreement and court orders	1. Episodic interference / badmouthing 2. Parent's overprotection (unwittingly or intentionally) undermines the child's relationship with the other parent 3. Child displays more resistance than at mild level, although reactions are mixed, confused or inconsistent (eg., before or during transitions, while with resisted parent) 4. Contact is sporadic, infrequent and/or delayed 5. Pattern of missed opportunities for parent-child contact; child takes longer to settle in after transitions than at mild level and may become unsettled closer to return time to FP 6. Generally rigid but some instances of flexibility 7. Attends treatment but sporadic and/or with minimal success 8. Inconsistent compliance with parenting plan, treatment agreement and court orders	1. Psychologically abusive alienating behaviors related to mental health issues (eg. paranoia) 2. Identifies actions as protecting (rights of) child, despite repeated investigations or evidence that demonstrates that the risk of future harm is improbable, or make malicious allegations knowing they are unfounded 3. Rigid / extreme child reaction to rejected parent (eg., threats to run away, of harm to self or others, acting out or aggressive behavior) 4. No or very infrequent contact between child and RP 5. Chronic parent-child disruptions 6. Inflexible position taking 7. Refusal of treatment / Previous attempts for treatment unsuccessful 8. Noncompliance with parenting plan, treatment agreement or court orders
Legal Interventions: From court support, monitoring to intervening	Detailed parenting plan, including specified parenting time with RP, and primary residence care with FP Early case conference Court management and monitoring Referral to parenting education or counselling with experienced therapist Warning of sanctions for noncompliance of parenting plan and orders	Highly detailed parenting plan (specified court ordered parenting time for child with RP) Court monitoring Continuity with one judge Warning of sanctions or custody reversal Sanctions for noncompliance (contempt of court, opportunity to purge contempt) Consideration for joint custody to ensure involvement of the rejected parent in child-related decision making Consideration for extended periods of contact over holidays with rejected parent (eg, summer school break) Consideration for equal parenting time Court appointment of a therapist experienced in alienation	Strong sanctions for noncompliance implemented Possibility of transfer of custody to RP with one of more of the following monitored by court: -interim interruption of contact (at least 3 months) with FP, or indefinitely until behaviour change demonstrated - monitored or supervised contact with FP - use of transitional site to prepare for transfer of custody to RP -eventual return to FP if there is an absence of parental alienating behaviors demonstrated
Client Interventions: Map interventions to client needs	Preventative parent education Psychoeducational groups for children Family therapy (members seen in various combinations) Therapist reporting back to court when there is noncompliance with parenting plan, orders or treatment agreement	Court ordered family therapy (members seen in various combinations) to repair relationships & implement court ordered parenting time with rejected parent Additional therapy for child, rejected or favored parent Intensive residential family intervention (may be with one family or group therapy), with both parents and children, combining therapy and psychoeducation (e.g., family camp program, weekend workshop) Therapist reporting back to court for noncompliance with parenting plan, orders or treatment agreement Parenting Coordinator (case manager / monitor interventions)	Custody reversal (as above) accompanied by reintegration intervention with child and RP, followed by intervention/therapy to reunify FP Parent education and individual therapy for FP with a view to reunification with child Therapist reporting back to court when there is noncompliance with parenting plan, orders or treatment agreement Parenting Coordinator (case manager / monitor of interventions)

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Basis for determination of accepting or declining a family client for Family Therapy for a Parent-Child Contact Problem

Parent Names or Superior Court Case Title _____

Superior Court Case Number: _____

Date of completion of this document: _____

The information below is NOT an evaluation of any individual or family system. The information below describes the decision-making process for this clinician regarding the consideration of therapy that addresses a parent-child contact problem including a goal of increasing contact with a parent. The description below reflects information provided to this clinician but does not address or affirm the accuracy or completeness of the information provided to this clinician. This document is a work-in-progress and may be updated with new information or additional treatment.

Criteria for Clinical Contraindications/Possible Rule-Outs For Family Therapy for PCCP – Outpatient Cases. (Adapted from Deutsch, 2023)[1]	Y/N
Parent(s) demonstrated unwillingness to participate in intervention, despite contrary statements to others, such as the court, lawyers, therapists, child protection agency.	
Parent(s) unable to stipulate that it is in the child(ren)'s best interests to have parenting time with other parent.	
Parent's ability to exercise parental authority to require children to attend therapy	
Threats/risk to safety (including abduction) of parent, child, or therapist	
Active substance use disorder in any family member.	
Diagnosed psychotic disorder, active untreated substance abuse, and/or diagnosed and untreated mental illness (e.g., bipolar, depression).	
Severe personality disorders (e.g., antisocial, paranoid, obsessive compulsive).	
Immediate threat of intimate partner violence and/or a history of intimate partner violence with control-coercive dynamics.	

[1] *Overcoming Parent-Child Contact Problems: Family Interventions 2023.* Robin M. Deutsch, PhD, ABPP, et al. Willam James College.[Class Handout]

Immediate threat of child maltreatment, neglect, or severely compromised parenting.	
Noncompliance during administrative or clinical intake consultation.	
Demonstrated, repeated disregard/noncompliance with previous court orders.	
No interim or permanent parenting time schedule in place by court order (or stipulation) to be implement as one of the goals of the therapy (i.e., may not be occurring at the time family seeks assistance).	
Children under the age of 8 years of age, who will attend the therapy (exceptions per the discretion of the therapist).	
Previous efforts at same or similar intervention have failed.	
Restrictions on therapist's access to information, contact with collateral sources.	
Active child protection agency investigation (if there is a requirement by the court or agency to wait for the outcome before initiating treatment).	
Presence of individual connected with family who is likely to sabotage intervention efficacy before, during or afterwards (e.g., stepparent, new partner, grandparent, other relative).	
ANALYSIS OF RULE-OUT CRITERIA:	

Criteria Informing Acceptance or Denial of Referral[2] (Adapted from Garber, 2021)			
1	Age of the (youngest) child	Divide by 10	
2	Duration of separation of the (youngest) child	# continuous months separated / age in months x 10	
3	Parent(s) objecting to child(ren) having relationship with other parent	1 / parent	
4	Parent(s) with substantiated history of violence in any context as an adult.	1 / parent	

[2] Garber, B. 2021. Mending Fences: A collaborative, cognitive-behavioral reunification protocol serving the best interests of the post-divorce. Polarized child. Unhooked Books. Arizona.

5	Parent(s) with substantiated history of violence within this family as an adult.	1 / parent	
6	Parent(s) with substantiated history of abuse or neglect with any child.	2 / parent	
7	Parent(s) with substantiated history of exposing the child to negative words, actions, or expressed emotions about the other parent.	1 / parent	
8	Child freely, persistently, and vehemently refuses contact with Parent B (1-3 re magnitude, longevity, and emotion of objection)	1-3	
9	Parents are unable to communicate with each other proactively and constructively.	1 if yes	
10	Parents have different parenting practices	1 if yes	
11	Child diagnosed with serious mental, physical, or educational impairment.	1 if yes	
12	Parent with substantiated (past or present) substance use disorder or behavioral dependency.	1 / parent	
13	Child already participated in one or more failed "reunification" (or similar) therapies.	1 if yes	
14	Either parent has a child by another partner who is resisting/refusing contact with parent.	1 if yes	
		TOTAL:	

0-9	10-18	19-27	28+
Self-correcting and/or conventional therapy?	Consider for Acceptance	Denial of Referral (possibly accept following treatment/stabilization)	Denial of Referral

ANALYSIS OF ACCEPTANCE OR DENIAL CRITERIA:

CHANGES IN RESIST-REFUSE DYNAMICS CHECKLIST (CRDC)

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

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

Instructions: Please fill in the names of the Rejected/Resisted Parent's (RP) and the Favored Parent (FP) in the chart below. For each item below, please indicate in the last three months whether the item has occurred N=Never, R=Rarely S=Seldom, O=Occasionally, VO=Very Often. There are no wrong answers. Please complete this to the best of your knowledge. If you don't know, please leave your answer blank. This rating form is designed to be filled out by a professional who has observed (or heard testimony about) the parent-child interactions. This form is not designed to be scored. Should a professional wish for a parent to fill out the form, it will need to be adapted and personalized. The professional may use this checklist to set treatment goals and to facilitate a discussion with each parent about their measures of progress with their child(ren). For example, this might be filled out at the start, at various stages during, and at the end of therapy.

A. FOR THE CHILD

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

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

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

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

B. *ABOUT EACH PARENT*

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

(ii) Emotional Indices About Each Parent.	(RP)					(FP)				
	N	R	S	O	VO	N	R	S	O	VO
1. Parent articulates verbally that the child is safe in both homes.										
2. Parent articulates verbally that he or she is able to emotionally regulate & repair their own moods.										
3. Parent demonstrates verbally sensitivity/empathy regarding child's difficult position of being in the middle.										
4. Parent does not create loyalty conflicts for the child.										
5. Parent supports other parent's autonomy with the child.										

(iii) Cognitive Indices About Each Parent.	(RP)					(FP)				
	N	R	S	O	VO	N	R	S	O	VO
1. Parent accepts that the child wants to have contact with both parents (without raising the past and reverting to blaming the child's prior hostility/rejection on the other parent).										
2. Parent accepts that relationship with other parent is important for child and does not revert to past beliefs.										
3. Parent demonstrates an ability to separate his/her own negative thoughts and feelings about the other parent from the child's needs to have a relationship with other parent (e.g. statements such as "your other parent left us" are absent).										

Note: This measure of progress is not to be used with cases with current & active safety concerns related to substantiated abuse and/or neglect as the result of domestic violence, child abuse, maltreatment or neglect, untreated/unmanaged mental illness, and/or risk of abduction. For more information, please contact Leslie M. Drozd, Ph.D. (leslie@lesliedrozdphd.com).

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

[CASE CAPTION]
APPENDIX TO THE SEALED REPORT:
ANALYSIS OF RESIST/REFUSE DYNAMICS[1]

"The ultimate question is whether or not it is in the child's best interest to attempt to repair the relationship with the rejected parent, irrespective of the cause of the strained relationship, and whether the rejection is justified or unjustified. A good custody evaluation will assist the family justice system in making what is often a difficult differentiation and can weight assignment of contributing factors. An evaluator's analysis and categorization of parent-child contact problems can, in turn, inform the nature of the intervention."[2]

This Appendix includes a multi-dimensional analysis of factors which may have contributed to the current dynamics in this family, in which both children are resisting/rejecting contact with their father. This analysis includes the following sections:

- A) Analysis of factors which can contribute to visitation resistance/refusal;
- B) Assessment of the severity of the strained parent-child relationship;
- C) Recommendations for intervention, based on the family-specific analysis.

SECTION A:

FACTORS CONTRIBUTING TO THE DEVELOPMENT AND/OR MAINTENANCE OF PARENT-CHILD CONTACT PROBLEMS:[3]

A combination of multiple factors may "combine to create intolerable anguish, tension, and anger for children. One psychological resolution for the child is to diminish the feeling of being torn apart by rejecting the 'bad' parent and ceasing all contact."[4]

Contributing factors may include:
(1) ***background factors*** *(which existed prior to contact problems)*
(2) ***intervening factors*** *(which continue to exacerbate contact problems)*
(3) ***child's response*** *to these influences.*

[1] This analysis includes references and citations from relevant professional literature on these subjects. These references are provided to inform the reader about important considerations for evaluating these complex dynamics in general – but not all of this information may be relevant to any particular family.
[2] Fidler, Bala, & Saini, 2013: p. 34
[3] This section has been adapted from Kelly & Johnston (2001).
[4] Kelly & Johnston, 2001: p. 256

(1). BACKGROUND FACTORS (WHICH EXISTED PRIOR TO CONTACT PROBLEMS):

- ***Personality of the Rejected Parent (RP)*:**[5] ***(e.g. if the RP previously exhibited a harsh/rigid parenting style; lack of empathy;[6] self-centered/immature personality; history of putting own needs ahead of family; critical/demanding behaviors;[7] unable to differentiate needs of the child from needs of the FP; unable to empathize with child's legitimate complaints).***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Personality of the Favored/Aligned Parent (FP)*: *(e.g. if the FP previously exhibited vulnerability to feeling rejected/abandoned; narcissistic traits; vulnerability to black-or-white/all-or-nothing thinking; identity/boundary diffusion; fears/anxiety/hypervigilance/post-traumatic stress; perception of self as child's savior/protector; perseveration of negative beliefs about RP; feels above the law; disordered thinking/paranoia)***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Lack of Functional Co-Parenting*: *(e.g. if the parents previously exhibited lack of sharing of information about child; unable to communicate effectively regarding child's needs; view of other parent as uninvolved/incompetent/irrelevant; lack of support for other parent's role/involvement)***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Intense Marital Conflict Before Separation*: *(e.g. child exposure to conflict; child triangulated/encouraged to "take sides" in marital conflict prior to the separation)***

  Analysis for this family:

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[5] In this appendix, "Rejected Parent" may be abbreviated to "RP," and "Favored Parent" may be abbreviated to "FP."

[6] "Sometimes, rejected parents have demonstrated a harshness, lack of empathy, and rigidity in their parenting style that… does not rise to the level of emotional or physical abuse. When aligned parents allege child abuse or poor parenting, these charges resonate and conjoin with the alienated child's prior experience, leading the alienated child to reject the parent on these grounds. In the more typical divorcing family, such a parenting style might cause future difficulties in parent-child relationships, as they do in married families, when children move into adolescence and challenge the rigidity and harsh parental rules, but it would not lead to complete rejection and refusal to have contact." (Kelly & Johnston, 2001: p. 259).

[7] "Interestingly, this demanding, critical behavior on the part of the rejected parent might be a consequence of his or her perception that the aligned parent is far too permissive and nondemanding. In turn, the aligned parent counter reacts to the perceived harshness and overcompensates by becoming even more lenient or overprotective with the child." (Kelly & Johnston, 2001: p. 260).

- ***Humiliating Separation*: (*e.g. presence of marital affair/betrayal; FP feels abandoned by RP; FP experiences narcissistic injury from RP; other factors which may contribute to FP feeling 'vengeful' towards RP).***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Divorce Conflict & Litigation*: *(e.g. protracted divorce; ongoing allegations/counter-allegations; child as confidant about divorce-related issues; child exposed to denigration of either/both parents; child given choices about when to see RP).***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Extended Families*: *(e.g. child given permission/encouraged to be overtly hostile towards RP by grandparents, siblings, or other family members)***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Aligned Professionals (Education, Health, Legal)*:[8] (*e.g. parent's therapists; child therapists; lawyers; professionals advocates, etc.)***

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

(2) POST-SEPARATION FACTORS EXACERBATING CONTACT PROBLEMS:

- ***Rejected Parent's Reactions*: *(e.g. RP has ceased efforts to contact child; "given up" participating in therapy with child; withdrawal due to lack of financial resources/feeling***

[8] "One of the most unfortunate of alienating processes are the witting and unwitting contributions of family law attorneys, minor's counsel, custody evaluators, and individual therapists for parents and children. Because cases in which children refuse to visit often are accompanied by allegations of emotional or physical abuse, neglect, or parental lack of interest in the child, most often framed and litigated in highly inflammatory language, professionals tend to become polarized themselves and take absolute, rigid viewpoints supporting their clients. Once enshrined in authoritative declarations in court papers, allegations become treated as though they are objective facts. Furthermore, family members retrospectively review and revise their memories and beliefs in accord with these new 'understandings,' When therapists selected for the child have no knowledge of child alienation processes or collaborative efforts needed to assist such children and families, considerable harm can be done in supporting and consolidating the child's rage and unwarranted rejection of the parent....interdisciplinary team approaches and specific therapeutic models and techniques are crucial to keep these cases from spiraling further out of control and work toward more beneficial resolutions" (Kelly & Johnston, 2001: pp. 256-257).

helpless; passivity/withdrawal in the face of marital or legal conflict; [9, 10] *counter-rejection of child; harsh/rigid parenting style; inadequate parenting skills)*

Analysis for this family:

Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Favored Parent's Negative Beliefs, Behaviors*:**[11, 12] (*e.g. FP distrusts of RP; perceives of RP as irrelevant; believes RP is 'dangerous'; negative attitudes communicated to child/RP denigrated to child; excluding RP from child's events/activities; references to/photos of RP removed from home; RP's effort to contact child experienced as 'harassment'; erosion of child's confidence in/love for RP; FP lends 'sympathetic ear' if child says negative things about RP; FP supports child's 'right' to make decisions about contact with RP; efforts to 'protect' child mounted on multiple fronts, involving school, therapists, doctors, court, restraining orders, supervised visits, cancelling visits, etc.).*

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Child's Vulnerability*:**[13] *(e.g. age/cognitive capacity;*[14] *temperament/resilience/personality vulnerabilities; extreme oppositional behaviors; anxiety/phobias; lack of ambivalence; behavioral incongruence across settings; cognitive vulnerabilities; dependence on FP; historically aligned with FP; desire to "rescue" parent perceived as having been hurt/wronged by*

[9] "Alienated children, having been bombarded with messages that the other parent does not love them, see the withdrawal as a lack of interest and abandonment, which might further fuel their rage. Such parents need coaching to assist them in remaining connected with their children... counter-rejection is felt by the child, and reinforced by the aligned parent, as confirmation of the rejected parent's lack of interest and love, which often leads to intensified condemnation of the 'bad' parent." (Kelly & Johnston, 2001: p. 259).

[10] See also Fidler, Bala, & Saini (2013), Table 3.3, p. 68.

[11] "Both empirical research and clinical observation indicate that there is often significant pathology and anger in the parent encouraging the alienation of the child, including problems with boundaries and differentiation from the child, severe separation anxieties, impaired reality testing, and projective identifications with the child...It is not a normal parental strategy to encourage the complete rejection of the other parent. Even when there is history of child abuse, the other parent is mentally ill, or the child's safety is endangered, the average parent will seek different avenues and more rational means of protecting the child. Furthermore, such parents often recognize that their child loves that parent despite the destructive behavior." (Kelly & Johnston, 2001: p. 258).

[12] See also Fidler, Bala, & Saini (2013), Table 3.1, pp. 60-61.

[13] See also Fidler, Bala, & Saini (2013), Table 3.4, p. 70

[14] "For children to form alignments with an angry parent and correspondingly reject the other parent, they need sufficient cognitive and emotional maturity. Because expressions of moral outrage and judgments are common among alienated children, they must also have achieved the stage in their development in which moral valuations and judgments are operative. Furthermore, the rage and contempt expressed by many alienated children reflect the normative increases in anger expected in the preadolescent and adolescent youngsters. These developmental achievements coalesce to create a receptivity to alienating processes and negative parental behaviors. For these reasons, it is unusual to see children whose alienation from a parent is consolidated and hardened prior to age 7 or 8. Younger children more often forget their scripts, let go of their anger, and have inconsistencies in their presentations. They are not particularly useful allies or loyal soldiers; they fail to follow parental agendas and too often enjoy themselves with the other parent once out of range of the aligned parent... Overall, the most common age range of the alienated child is from 9 to 15, although some older adolescents and young adults also can become alienated. There appear to be no sex differences among these youngsters in propensity to become an alienated child." (Kelly & Johnston, 2001: p. 260).

RP; lack of contact with RP;[15] child feels abandoned by rejected parent[16])

Analysis for this family:

Contribution to parent-contact problems: None/Mild; Moderate; Severe

- ***Sibling Relationships*:**[17] (*e.g. child given permission/encouraged to be overtly hostile towards RP)*

  Analysis for this family:

  Contribution to parent-contact problems: None/Mild; Moderate; Severe

(3) CHILD'S RESPONSE:
(e.g. extreme disproportion of child's perception/beliefs about RP and actual history of RP behaviors and parent-child relationship; child freely expresses hatred/intense dislike of RP; demonize/vilify RP; offer trivial reasons to justify their hatred; desire to unilaterally terminate relationship with RP; allegations about RP replicate FP's allegations about RP; "scripts" about RP lacking substance/detail; no ambivalence/regret regarding disparagement of RP; child rebuffs RP's efforts to communicate; child denigrates family/pets/values etc. that are associated with RP; child idealizes FP)

Analysis for this family:

Contribution to parent-contact problems: None/Mild; Moderate; Severe

SUMMARY OF SECTION A:
FACTORS CONTRIBUTING TO RESIST-REFUSE DYNAMICS (RRD):

Personality of RP
Personality of FP
Marital conflict
Extended family
Aligned professionals
Lack of functional co-parenting

[15] "External factors contributing to increased child vulnerability include a history of infrequent or total lack of contact with the rejected parent. In these cases, the effects of the alienating behaviors of the aligned parent are exacerbated when there is no opportunity to spend significant time with the rejected parent and his or her extended family. Children are not able to test and retest the reality of that parent and his or her behavior and to compare their current observations with their own distorted memories or with the negative accounts of the aligned parent. Furthermore, because false allegations of sexual or child abuse most often result in limited and supervised visiting for many months, the presence of this supervision framework promotes children's acceptance that a parent is dangerous or hurtful. Once evidence accumulates that no abuse has occurred, damage to parent-child relationships is often quite extensive and creates formidable barriers to reconstructing the relationship between rejected parents and their children." (Kelly & Johnston, 2001: p. 262).

[16] "In high-conflict divorces, some nonresidential parents do not see their children for a number of months due to high legal conflict about access and the absence of interim orders. When this occurs, feelings of abandonment and anger often deepen and put children at risk for becoming alienated." (Kelly & Johnston, 2001: p. 260).

[17] "...younger children whose older siblings are alienated might appear to be alienated as they parrot the language and ideas of the older sibling and are kept in the mode of parental rejection by the vigilant monitoring of their sibling. They are very much at risk for developing their own consolidated alienation as their cognitive and emotional abilities mature and must be protected by well-conceived interventions." (Kelly & Johnston, 2001: p. 260).

Humiliating Separation
Divorce & Litigation
Rejected Parent's Reactions
FP's Negative Beliefs/Behavior
Child/ren's Vulnerability
Sibling Relationships
Child's Response

	Mild:	Moderate:	Significant:
PRE-SEPARATION FACTORS			
POST-SEPARATION FACTORS			
CHILD'S RESPONSE			

SECTION B:
SEVERITY OF THE STRAINED PARENT-CHILD RELATIONSHIP: [18]

"Parent-child contact problems, including alienation, generally become more difficult to assess with the passage of time, as children and parents are more likely to become entrenched in their positions, which may be further exacerbated by the litigation process. Delays or use of ineffective interventions are likely to entrench the alienation, making it more difficult to remedy." [19]

"Differentiating the severity of strained relationships is the first step in determining the most appropriate prevention or intervention strategy for families. Prevention or intervention will depend on the nature and reasons for the strained parent-child contact, the degree and frequency of parents not supporting the child's relationship with the other parent, the conduct of the parents, the duration and intensity of these negative behaviors, the impact of parental behaviors on the children, the child's level of receptivity and responsiveness to these negative behaviors, and the intentionality to prevent a relationship with the other parent." [20]

1.) PARENTAL CONDUCT (EXHIBITED BY THE FAVORED PARENT)

Mild: Minimal interference/ badmouthing
Moderate: Episodic interference / badmouthing
Severe: Psychologically abusive alienating behaviors related to mental health issues (e.g. paranoia)

Assessment for this family:

2.) PROTECTION VS. THE PROBABILITY OF HARM

[18] This section has been adapted from Fidler, Bala, & Saini (2013), Figure 4.1, pp. 94-95.
[19] Fidler, Bala, & Saini (2013), p. 90
[20] Fidler, Bala, & Saini (2013), p. 90

Mild: Favored parent values child's relationship with other parent, but occasionally displays misguided protective behavior

Moderate: Favored parent's overprotection (unwittingly or intentionally) undermines the child's relationship with the other parent

Severe: Favored parent identifies actions as protecting (rights of) child, despite repeated investigations or evidence that demonstrates that the risk of future harm is improbable, or make malicious allegations knowing they are unfounded

Assessment for this family:

3.) RIGIDITY OF CHILD'S PERCEPTIONS/BEHAVIOR TOWARDS HIS/HER PARENTS

Mild: Child values relationship with both parents, but displays discomfort (not extended to extended family)

Moderate: Child displays more resistance than at mild level, although reactions are mixed, confused or inconsistent (e.g. before or during transitions, while with resisted parent)

Severe: Rigid/extreme child reaction to rejected parent (e.g. threats to run away, of harm to self or others, acting out or aggressive behavior)

Assessment for this family:

4.) FREQUENCY OF PARENT-CHILD CONTACT

Mild Minor interruptions of parent-child contact (e.g. late, missed visits, short-lived transition difficulties in presence of FP)

Moderate: Contact is sporadic, infrequent and/or delayed

Severe: No or very infrequent contact between child and RP

Assessment for this family:

5.) DURATION OF STRAINED RELATIONSHIPS

Mild: Situational and infrequent relationship strain (e.g. due to affinity, alignment, expected and time-limited upset over parents' separation)

Moderate: Pattern of missed opportunities for parent-child contact; child takes longer to settle in after transitions than at mild level and may become unsettled closer to return time to FP

Severe: Chronic parent-child disruptions

Assessment for this family:

6.) HISTORY OF PARENTS' RIGIDITY

Mild: Generally flexible but can be rigid

Moderate: Generally rigid but some instances of flexibility

Severe: Inflexible position taking

Assessment for this family:

7.) RESPONSIVENESS TO EDUCATION/ TREATMENT AS SUGGESTED

Mild: Responsive to treatment/education to improve parent-child relationships

Moderate: Attends treatment but sporadic and/or with minimal success

Severe: Refusal of treatment/Previous attempts for treatment unsuccessful

Assessment for this family:

8.) COMPLIANCE WITH COURT, ORDERS, PARENTING PLANS, AND TREATMENT AGREEMENTS

Mild: Compliant with parenting plan, treatment agreement and court orders

Moderate: Inconsistent compliance with parenting plan, treatment agreement and court orders

Severe: Noncompliance with parenting plan, treatment agreement or court orders

Assessment for this family:

SUMMARY OF SECTION B:
SEVERITY OF THE STRAINED PARENT-CHILD RELATIONSHIP:

Parental conduct (exhibited by FP)
Protection vs. the probability of harm
Rigidity of child's perceptions/behavior towards FP
Frequency of parent-child contact
Duration of strained relationships
History of Parents' rigidity
Responsiveness to education/ treatment as suggested
Compliance with court, orders, parenting plans, and treatment agreements

Mild:	Moderate:	Severe:

Based on the available data, it is my opinion that this family is exhibiting a need for intervention at the level of [insert level here].

Accordingly, the recommendations offered in the parenting evaluation report are based upon this assessment.

(see next section for examples of clinical and legal interventions at each level)

SECTION C:
EXAMPLES OF CLINICAL & LEGAL INTERVENTION[21]

"Generally, therapeutic and educational interventions tend to be suitable for mild and some moderate cases, which may include the relatively pure alienation, or justified rejection cases, or mixed cases that have elements of both justified rejection and alienation. Included in these mixed or less severe cases may be those where the child, while resisting contact due to affinity, age, gender, or divorce-related reaction and alignment, continues to have some degree of contact with the non-favored parent."

"In the more severe cases, education or therapy alone, in the absence of a temporary interruption in contact with the favored parent, and possibly accompanying change in custody, is unlikely to reverse the alienation...Further, therapy in the more severe cases, which may include some moderate cases, may be associated with the alienation becoming more entrenched."

"Cases of severe justified rejection, where it has been determined that it is in the child's best interest to attempt to repair the child's relationship with an abusive or neglectful parent, are likely to require a different approach, including individual programs of therapy for the rejected parent....(and) quite

[21] This section has been adapted from Fidler, Bala, & Saini (2013), Figure 4.1, pp. 94-95.

possibly also require individual therapy to treat the child, who may or may not have post-traumatic stress disorder. Ongoing assessment is necessary to determine if and when family counseling and parent-child reintegration are indicated."[22]

SEVERITY LEVELS AND ASSOCIATED INTERVENTIONS:

MILD:

- ***Clinical*:**
  - Preventative parent education;
  - Psychoeducational groups for children
  - Family therapy (members seen in various combinations);
  - Therapist reporting back to court when there is noncompliance with parenting plan, orders or treatment agreement
- ***Legal*:**
  - Detailed parenting plan, including specified parenting time with RP, and primary residence care with FP
  - Early case conference
  - Court management and monitoring
  - Referral to parenting education or counseling with experienced therapist
  - Warning of sanctions for noncompliance of parenting plan and orders

MODERATE:

- ***Clinical:***
  - Court ordered family therapy (members seen in various combinations) to repair relationships & implement court ordered parenting time with rejected parent;
  - Additional therapy for child, rejected or favored parent;
  - Intensive residential family intervention (may be with one family or group therapy), with both parents and children, combining therapy and psychoeducation (e.g., family camp program, weekend workshop);
  - Parenting Coordinator reporting back to court for noncompliance with parenting plan, orders or treatment agreement

- ***Legal:***
  - Highly detailed parenting plan (specified court ordered parenting time for child with RP)
  - Court monitoring Continuity with one judge
  - Warning of sanctions or custody reversal Sanctions for noncompliance (contempt of court, opportunity to purge contempt)
  - Consideration for joint custody to ensure involvement of the rejected parent in child-related decision making
  - Consideration for extended periods of contact over holidays with rejected parent (e.g., summer school break)
  - Consideration for equal parenting time
  - Court appointment of a therapist experienced in alienation

SEVERE:

- ***Clinical***:
  - Custody reversal (as above) accompanied by reintegration intervention with child and RP, followed by intervention/therapy to reunify FP
  - Parent education and individual therapy for FP with a view to reunification with child

[22] Fidler, Bala, & Saini (2013), p. 116

    - Therapist reporting back to court when there is noncompliance with parenting plan, orders or treatment agreement
    - Parenting Coordinator (case manager / monitor of interventions)
- ***Legal***: Possible transfer of custody to RP with one of more of the following monitored by court:
    - Interim interruption of contact (at least 3 months) with FP, or indefinitely until behavior change demonstrated
    - Monitored or supervised contact with FP
    - Use of transitional site to prepare for transfer of custody to RP
    - Eventual return to FP if there is an absence of parental alienating behaviors demonstrated

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EXAMPLES OF RECOMMENDATIONS FOR RESIDENTIAL SCHEDULE AND INTERVENTIONS

RESIDENTIAL SCHEDULE:

The following recommendations provide a potential "stepped-up" plan for the children to eventually resume a "normal" residential schedule with their father. However, it is my opinion that father's visits with the children should continue to be limited and supervised, until father has demonstrated that he can comply with court orders and other expectations (see below). Accordingly, I offer the following recommendations for a multi-phase plan to increase father's residential time, over a minimum of 12 months.

Phase 1 (six months, minimum):

- I recommend that the children continue to have limited, supervised contact with their father of up to up to eight hours/visit, one day/week, for at least six months, and until the following interventions have occurred:
    - Father, mother, and both children continue family therapy (including therapeutic visits between father and the children)[1]
    - Father enrolls in a comprehensive, intensive behavioral therapy program, to target his problematic personality traits (e.g. the Dialectical Behavior Therapy program at the Evidence-Based Treatment Center of Seattle).
    - Prior to issuing any reports or treatment plans, all providers should receive a copy of this report and all appendices, and should be authorized to communicate with the PC, family therapists, prior therapists (e.g. Dr. Psychologist), and the undersigned.
    - The timing and frequency of therapy sessions (including therapeutic visits) should be determined by the therapist(s).
    - Selection of individual treatment program must be approved by the PC.

- Ideally, visits should take place every week, on the same day of the week. The purpose of this recommendation is to promote stability and predictability for the children's contact with their father.
- If there is a potential scheduling conflict with another activity, visits with father should take priority. The purpose of this recommendation is to communicate very clearly to the children that these visits with their father are important, and take precedent over other demands on their time
- While the visits are being professionally supervised, I recommend that the supervisor is determined by Tuesday of the week before the visit.

The goals of father's individual therapy include (but are not limited to):

- **Decrease behavioral and verbal impulsivity** (particularly with regard to interactions with the children, co-parenting communications with mother, and communications with all treatment providers working with this family; details of this goal should be defined by the PC and therapists, with input from mother and the children)
- **Decrease emotional reactivity** (e.g. to mother, the children, treatment providers, attorneys; details of this goal should be defined by the PC and therapists, with input from mother and the children). Father's treatment provider should consider the possibility that father's emotional reactivity could be trauma-related, and incorporate this into their treatment plan, as indicated.
- **Demonstrate consistent compliance with authority,** including court orders (and other written agreements with law enforcement, prosecutor's office, etc.), agreements made with the PC, visits supervisors, and/or therapists (including rules/expectations for email communications and therapeutic visits), therapy recommendations (including family therapy and individual therapy),

and any other agreements/expectations related to his parenting of the children, and/or his co-parenting interactions/communications with mother.

Before progressing to Phase 2, Father should complete at least one round of skills training (which take approximately 6 months), and should exhibit six months of success/stability with regard to the above-described goals.

Although it is unclear at this time whether father is willing/able to participate in the above-described interventions, it is nonetheless my opinion that an intervention of this scale is necessary to provide him with an opportunity to make significant changes, and thus improve his relationship with his children.

Additional recommendations for Phase 1:

PARENTING COORDINATOR (PC):

It is my opinion that the ongoing conflict and litigation in this matter continues to place the children at significant risk of harm. Accordingly, it is my recommendation that a parenting coordinator (PC) is appointed as soon as possible, to provide ongoing monitoring/oversight of the therapeutic "team" and ongoing case management as needed (see below), to assist this family in the implementation of their parenting plan, and to resolve minor disputes.

At this time, I recommend that the PC is authorized to perform the following specific functions (at a minimum; the PC may have other requirements that are not listed here):[2]

- The PC should be authorized to resolve any disputes that may arise related to the visitation recommendations.
- If there is any disagreement/dispute regarding the visitation supervisor, the PC should be authorized to select the agency and/or supervisor. It is recommend that an agency is used, so that there are more scheduling options, and thus decreased opportunities for the visits to fall through.
- The PC should be authorized to recommend the onset or offset of supervision at any time during Phase 1 (with input from the therapists); however, the default is that father's visits are supervised for a minimum of six months, unless otherwise determined by the PC.
- Selection of a professional supervisor must be approved by the PC.
- Select members of a family-based therapy "team" (see below), including the authority to add/remove team members as indicated;
- Collaborate with the team members, individual therapists, and the undersigned to develop concrete treatment goals for this family;
- Oversee the family-based therapy intervention (see below);
- Recommend onset or offset of individual therapy or evaluation for either parent or the children;
- Terminate the family-therapy process at any time, if indicated by lack of progress, non-compliance, or other clinical concern identified by the therapist or PC.
- Receive information regarding any behavioral concerns, and respond as indicated (e.g. implement short-term interventions; offer observations to the court for review);
- Communicate with all of the professionals working with this family, including the family therapist, parents' therapists, children's therapists, attorneys, etc.;
- Monitor the parties' compliance with treatment recommendations and/or other recommendations;
- Refer parties for additional evaluation/treatment if indicated;

[2] Please also refer to attached document "PC Parenting Plan categories" for additional potential PC functions.

- Provide communication facilitation between the parties as need (e.g. monitor OFW, provide feedback/coaching about the appropriateness/effectiveness of these communications);
- Facilitate dispute resolution with the parties to help them resolve minor disputes (e.g. scheduling, etc.);
- Serve as a communication "buffer" between the family-therapy team and the court, so that the therapists are not placed in the dual role of having to provide recommendations regarding parental access;
- Any other issues agreed upon by the parties.

I recommend Caroline Plummer, LMHC, as the PC. Ms. Plummer should be provided with the following documents:

- Parenting evaluation report
- Summary of the family history (to be provided by the undersigned)
- Summary of interviews with the children (to be provided by the undersigned)
- Analysis of current resist-refuse dynamics (to be provided by the undersigned)
- Any other relevant supporting documents requested by Ms. Plummer (to be provided by the undersigned).

The PC is <u>not</u> authorized to **change** the custodial designation of joint, sole, legal or physical custody established in the existing order, nor is the PC authorized to make decisions which substantially alter the parents' residential time-sharing arrangements, which are reserved to the court for adjudication. Furthermore, either parent may seek review by the court regarding the decisions or recommendations of the PC.

<u>THERAPEUTIC INTERVENTIONS</u>:

- *<u>Family</u>*: I recommend that this family participates in a family-based therapeutic intervention, that is intended to assist this family in developing a healthier and more future-focused family dynamic, that will maximize the health and safety of the children's relationship with their father.
    - All four family members should participate in this intervention, in whatever combinations are determined by the team members.
    - The family-based intervention should include (but is not necessarily limited to), the following:
        - Developing an apology/accountability-taking/repair process between father and the children;
        - Developing a "new narrative" about the family dynamic, which both parents will communicate consistently to the children;
        - Establishing guidelines for "fact-checking" statements made by the children prior to acting on these;
        - Help the father develop a new perspective regarding supervised visits (i.e. prioritizing his children's needs to have contact with him over his need to avoid feeling "humiliated").
        - Establishing agreements between the parents about appropriate vs. inappropriate communications with the other parent, and with the children;
        - Any other goals/areas of intervention as determined by the team.
    - The team should include at least two members, who will collaborate with the PC to determine the process for this intervention, including which therapist works with father, mother, and/or the children (separately or in various combinations).

- *Children*: If recommended by a family therapist or the PC, the children should participate in individual therapy. If either parent requests therapy for either child, this referral should go through the PC, to ensure that the child's therapist will agree to the AFCC guidelines for court-involved therapists (e.g. they should attempt to communicate equally with both parents; see attached).

- *Parents*: I recommend that both parents continue to participate in individual therapy. Specifically:
    - Mother's should continue to develop skills to support the children's relationship with their father, and to separate her own emotional responses from the children's responses.
    - Father's should participate in a comprehensive, intensive Dialectical Behavior Therapy program, as described above.
    - Father should undergo a neuropsychological assessment to determine how/whether any neuro-cognitive issues may be negatively impacting his parenting, his ability to participate in therapy, and/or his ability to comply with orders/expectations.

It should be noted that any individual therapists' understanding of this family will likely be limited - and potentially biased - by data that is received solely from their client(s); therefore:

(a) All therapists working with this family should be provided with a copy of this report and appendices, and any other materials requested by the therapists;
(b) All therapists working with this family should be authorized to communicate with each other, the PC, and the undersigned (and vice-versa);
(c) Any therapists working with either of the children should agree communicate with both parents to obtain multiple sources of data. [3]

Non-compliance:

- Non-compliance with family therapy by any family member should be considered as a "red-flag" that additional therapeutic and/or judicial intervention might be indicated.[4]
- Although both parents have contributed to the development and maintenance of the children's resist-refuse dynamics, mother is currently the parent with greater parental authority/and respect, and is therefore critical for the success of ongoing interventions. Accordingly, if the children refuse to participate in family therapy, this may be considered non-compliance on the part of mother.
- If father declines to resume supervised visits if these are recommended, should be considered as a "red-flag" that additional therapeutic and/or judicial intervention might be indicated.

Phase 2: After father has completed at least six months of a comprehensive, intensive Dialectical Behavior Therapy program, and is making observable progress towards the goals defined above (pending review and approval by the PC, including interviews with therapists and family members as indicated), the children's visits with their father may be unsupervised, up to eight hours/visit, one day/week.

Phase 3: After father has completed at least twelve months of a comprehensive, intensive Dialectical Behavior Therapy program, and he has demonstrated sustained, consistent progress towards the goals defined above (pending review and approval by the PC, including interviews with therapists and family

[3] See AFCC Guidelines for Court-Involved Therapy, at https://www.afccnet.org/Resource-Center/Practice-Guidelines
[4] Examples of such recommendations will be included in the parenting evaluation report.

members as indicated), his residential time should be increased to a schedule similar to the 2018 parenting plan (e.g. alternating Thursday-Sunday overnight).

At any time, the PC should be authorized to increase or decrease either parent's residential time as indicated by the family's progress (and with input from the therapists), within the parameter for each Phase.

Emergency Restrictions: If either parent exhibits problematic patterns of behavior at any phase (i.e. that negatively impacts their parenting), the PC should be authorized to implement emergency restrictions while the matter is vetted (e.g. resuming professional supervision; suspending visits, etc.). If indicated, the PC may recommend the appointment of a GAL to investigate these concerns (i.e. conduct a BFA).[5]

Ongoing Judicial Oversight and Intervention: Given this family's history, I recommend that the court regularly reviews their progress **at least once every six months**. The PC can provide the court with regular status reports – including recommendations for modifications to either parent's residential time - based on the family' progress (and with collateral input from therapists). It is also recommended that the same judge retains jurisdiction over this family.

Payment for professional services: All professionals working with the family should be paid through a neutral third-party professional (e.g. a court-appointed accountant or financial manager), from a specially designated account that is funded in advance. The purpose of this recommendation is to remove father from the process of directly paying professionals, as this has historically triggered strong emotional reactivity and creates associated chaos/instability for the therapeutic process, and thus for the children's well-being.

[5] For additional information about BFAs, see AFCC Guidelines for Brief Focused Assessments: https://www.afccnet.org/Resource-Center/Practice-Guidelines.

GLOSSARY OF TERMS USED IN THIS ROLE PLAY

BASC: Behavior Assessment System for Children is a comprehensive assessment tool used to evaluate the behavioral and emotional functioning of children and adolescents.

BRIEF: Behavior Rating Inventory of Executive Function is a standardized assessment tool used to evaluate executive function and self-regulation in children and adolescents, with parent, teacher, and self-report forms available.

CBT: Cognitive Behavioral Therapy is a type of psychotherapy in which negative patterns of thought about the self and the world are challenged to alter unwanted behavior patterns or treat mood disorders such as depression.

CORRECTED NARRATIVE: A story or explanation that aims to counteract or correct a false, misleading, or biased narrative or understanding of events or issues.

CRDC: Changes in Resist-Refuse Dynamic Checklist

CULTURAL EXPERT: Provides specialized knowledge about cultural norms, traditions, and social practices to aid the family providers.

DBT: Dialectical Behavioral Therapy, a type of cognitive behavioral therapy that helps individuals develop skills to manage their emotions, improve their relationships, and cope with stress.

DV: Domestic Violence, A pattern of abusive behavior in any domestic relationship that is used to gain or maintain power and control over another.

ENMESHMENT: Where family members are overly involved in each other's lives and personal relationships, to the point of blurring boundaries and hindering individual autonomy.

EVIDENCE-BASED COPING SKILLS: Strategies and techniques for managing stress and difficult emotions that are supported by scientific research and clinical expertise, ensuring they are both effective and safe.

EXPOSURE THERAPY: A type of cognitive-behavioral therapy that helps individuals overcome fears and anxieties by gradually exposing them to feared situations or objects in a safe and controlled environment, breaking the cycle of avoidance and fear.

FAMILY SYSTEMS THERAPY: Family systems therapy views the family as an interconnected system where each member's actions and behaviors influence the entire group, and problems are understood within the context of these relationships.

FAVORED PARENT: A parent for whom a child expresses a strong preference in comparison to another parent.

IEP: Individualized Education Program, is a legally binding document that outlines the specific educational needs, goals, and services for a student with a disability, ensuring they receive a tailored education.

IPV: Intimate Partner Violence is a subset of domestic violence

PC: Parenting Coordinator

PCCP: Parent-Child Contact Problems encompass a wide range of issues that can negatively impact or disrupt parent-child contact, including developmental or attachment issues, alienation, family violence, psychological or health disorders in a parent, parental gatekeeping, or unsafe/inadequate parenting.

PE: Parenting Evaluator

PSYCHOEDUCATION: Teaching mental health clients about their symptoms and mental health.

RCW 26.09.191 FACTORS/FINDINGS: restrictions that can be placed on parenting plans, particularly when a parent has a history of domestic violence or other issues that may endanger a child's well-being. These restrictions are designed to safeguard a child's physical and emotional safety.

REJECTED PARENT: A parent from whom a child has withdrawn warmth and affection and exhibits resistance and refusal in comparison to another parent.

RRD: Resist/Refuse Dynamics (subset of PCCP) 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 (Walters & Friedlander, 2016, p. 424).

RULE OUT: A systematic approach used by professionals to identify factors that increase severity that could lead to a family being ruled out for treatment.

SI: Suicidal Ideation is thoughts about or a preoccupation with killing oneself.

STEP UP PLAN: A residential schedule that increases a child's contact with a parent in a graduated manner.

TRAUMA: a distressing or traumatic event that overwhelms a person's ability to cope. Trauma can be acute, chronic, or complex. The impact of trauma can be significant and long-lasting, affecting thoughts, behaviors, and overall functioning.