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Intensive Co-parenting Therapy: Piloting a Manualized Treatment for Divorced Families

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Intensive Co-parenting Therapy: Piloting a Manualized Treatment for Divorced Families

A dissertation submitted in partial fulfillment of the requirements for the degree of

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by

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Abstract

INTENSIVE CO-PARENTING THERAPY: PILOTING A MANUALIZED TREATMENT FOR DIVORCED FAMILIES

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

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Although resilience is the normative psychological outcome of divorce, parents and children of divorce are disproportionately represented in the mental health and legal systems. Due to the great financial and psychological costs of incessant divorce litigation, interventions that promote positive child adjustment while alleviating the costs of litigation are in high demand. Social policymakers and clinicians have responded to this demand via a number of intervention strategies; however, the implementation of many current interventions has predated supporting empirical evidence.

The present study seeks to establish the efficacy of a child-focused, intensive co-parenting therapy (ICT) intervention for divorced parents. ICT is a 14-week manualized therapy with an emphasis on communication and problem-solving training using cognitive-behavioral techniques. ICT's impact on legal outcomes (i.e., resolution of custody/visitation disputes, payment of child support, court order compliance, etc.),

communication, co-parenting and parenting (i.e., cooperation, hostility), family functioning, and child adjustment (i.e., internalizing and externalizing behavior) was assessed.

Participants were five families of divorce who had at least one child aged 11 to 17 and were court-ordered to participate in co-parenting therapy. Three of the families were African-American and two were Caucasian. A single-case research design with replication was employed. Therapeutic success was monitored by a multi-informant approach (parent, teacher, and child) according to a multiple baseline procedure. Communication and legal outcomes were monitored on a weekly basis. Co-parenting and parenting behaviors, family functioning, and child adjustment symptoms were measured at baseline, session 8, and termination.

ICT significantly impacted all outcome variables measured, although the clinical significance of that impact varied across domains. ICT had the greatest impact on legal and communication outcome variables. For example, 100% of families in the study resolved at least some portion of their custody and/or visitation disputes; 40% of families dropped their legal dispute entirely. Additionally, all families significantly increased the quality and quantity of their communication. Results in the domains of co-parenting and parenting behaviors, family functioning, and child adjustment, while noteworthy and reflective of positive outcomes, were more varied. Clinical implications of study findings are discussed as they relate to establishing ICT as a *possibly efficacious* co-parenting intervention.

Introduction

Concerns about the potentially deleterious effects of divorce on children have inundated both the popular and empirical literatures for several decades. As the divorce rate continues to rise, debate regarding the effects of divorce on child adjustment persists. While some argue that most children of divorce emerge as "reasonably competent, well-functioning individuals" (Hetherington and Stanley-Hagan, 1999), others decry that divorce scars children well into adulthood (Wallerstein, Lewis, & Blakeslee, 2000). Although resilience is the normative psychological outcome of divorce, parents and children of divorce are disproportionately represented in mental health clinics. Specifically, children and adults from divorced families are two to three times more likely to receive psychological treatment when compared to members of intact families (Howard et al., 1996; Zill, Morrison, & Coiro, 1993). Clearly, many families experience profound adjustment difficulties after divorce.

Just as divorced families are overrepresented in the mental health service system, high-conflict families of divorce place a heavy burden on the legal system. Between 20 and 30 percent of divorced families are entrenched in courtroom conflict, with two to five percent of these families being chronic litigators (Katz & Gottman, 1993). The incessant litigation of high-conflict families of divorce incurs great financial and psychological costs for both parents and children. Thus, interventions that promote positive child adjustment while alleviating the costs of litigation are in high demand. Both social

policymakers and clinicians have responded to this demand via a number of intervention strategies, including mandatory parent education workshops for divorcing parents, mediation services, parent coordination, family therapy, and co-parenting therapy. However, the implementation of many current interventions has predated supporting empirical evidence.

Targets of current interventions vary greatly. Many programs focus on educating parents about the effects of divorce on their children (Pedro-Carroll, Nakhnikian, & Montes, 2001), while others aim to help parents in reaching an amicable resolution in their legal battles (Miller & Veltkamp, 1995). Still others directly target the children of divorce, teaching active coping skills (Stolberg & Mahler, 1994). A recent study suggests that co-parenting, or the ability for estranged parents to engage in collaborative childrearing, and parenting practices are actually the necessary targets for intervention when attempting to ameliorate the negative effects of the divorce process (Ferrante, 2005).

While many have assumed that the act of divorce directly interferes with healthy child adjustment, important mediators of this relationship have been ignored (Feinberg, 2002). Co-parenting, along with general parenting competence, has consistently been identified as one of the most important contributors to post-divorce child and young adult adjustment. When the impact of co-parenting and parenting processes was examined, it was found that the process of divorce decreases co-parenting and parenting practices which, in turn, negatively impact child adjustment (Ferrante, 2005). Therefore, increasing

parents' abilities to work together after divorce and parenting competencies are important targets for both clinical practice and social policy.

Recently, there has been a call for interdisciplinary partnerships in the courts to promote evidence-based prevention initiatives for children and families of divorce (Pedro-Carroll, Sandler, & Wolchik, 2005). This interest in evidence-based interventions closely parallels the efforts of the American Psychological Association (APA) to create a schema for the classification of empirically supported psychological interventions (Chambless & Hollon, 1998). While many current interventions have been informed by the empirical divorce literature, there is also a great need for empirical evaluation of current intervention programs to ensure that these intervention efforts are in fact effective. Unfortunately, there is a tremendous disparity between how frequently intervention in divorce is discussed in the applied literature and how infrequently divorce interventions are subjected to methodologically sophisticated studies. One group of researchers noted that a literature search of over 500 articles on divorce-related therapy produced "a few" empirical studies and only "a handful" of randomized controlled trials (Emery, Kitzmann, & Waldron, 1999).

To date, no manualized co-parenting intervention program has been subjected to methodologically rigorous examination. Although clinicians appear to be providing clinical interventions for co-parents in practice (Garber, 2004), a thorough literature review did not reveal any well-defined intervention manuals. Thus, the establishment of an evidence-based co-parenting therapy is a priority. Research suggests that interventions

be cognitive-behavioral in nature with an emphasis on psychoeducation, communication skills training, and problem-solving training delivered by well-trained clinicians.

A common first methodological step in establishing the efficacy of a new intervention is the use of single-case design techniques (Kazdin, 2003; McCullough & Carr, 1987). Using the predictive confirmation structure of stage process design (McCullough & Carr, 1987), the establishment of an efficacious treatment begins with the creation of a reliable treatment manual, definition of the intended population, use of reliable and valid outcome measures, and use of appropriate data analysis. To be considered *probably efficacious*, minimum criteria state that a series of at least three or more single-case experiments must support the efficacy of a treatment in the absence of conflicting evidence (Chambless & Hollon, 1998). Thus, efficacy research of co-parenting therapy for divorced parents should begin with the implementation of a manualized treatment with a minimum of three families.

Co-parenting in Divorced Families

Co-parenting was coined to describe what researchers hypothesized to be the ideal parenting relationship after divorce. This model parent-parent relationship was characterized by mutual involvement of both parents in all decisions regarding their children (Rosenthal and Hansen, 1980). Co-parents maintain a cooperative and constructive relationship with their former partner and opt to prioritize their children's welfare over their own discord. Although they may no longer wish to be a part of each

other's lives, they understand that the child's family must remain intact and allow each other to actively participate in childrearing.

Over time, the definition of co-parenting has extended beyond that of shared parenting to include the concept that co-parents work together to support each other's parenting decisions, while maintaining healthy, yet flexible, boundaries (Maccoby, Depner, & Mnookin, 1990). Therefore, healthy co-parents strive to include each other in parenting decisions and work to compromise on these decisions. Investigators have identified three subtypes of co-parenting: *cooperative, conflicted, and disengaged* (Maccoby, et al., 1990). *Cooperative co-parents* communicate about their children regularly, have minimal levels of conflict, and praise rather than undermine their co-parent's childrearing decisions. These parents practice the ideal, healthiest subtype of co-parenting, comprising approximately 25% of all divorcing parents (Maccoby, et al., 1990; Maccoby, Buchanan, Mnookin, & Dornbusch, 1993). The second, and most detrimental (Richardson & McCabe, 2001), subtype of co-parenting has been described as *conflicted co-parenting.* These co-parents communicate about their children, but high levels of conflict, disrespect, and criticism mark this communication. Unfortunately the distribution of conflicted co-parenting matches that of cooperative co-parenting (Maccoby, et al., 1990). Most co-parents fall into the third and final category: *disengaged co-parenting.* These co-parents are involved in their children's lives but practice parallel parenting whereby they do not communicate, positively or negatively, about their children; they merely stay out of each other's way. Although this co-parenting subtype

describes most families, research has not examined *disengaged co-parenting's* link to child adjustment.

When the concept of co-parenting first entered the literature, Rosenthal and Hansen (1980) concluded that, "One of the main goals of counseling single-parent families (was) to maintain or establish a positive co-parenting relationship between the parents." Their claim was without empirical support; however, two decades of research have confirmed this hypothesis. Co-parenting is an important predictor of post-divorce child and young adult adjustment (Feinberg, 2002; Macie, 2002). Young adults who report that their parents demonstrated healthy co-parenting (low conflict, low triangulation, high respect, and high communication) are better adjusted than their peers who experienced unhealthy co-parenting in both intact and divorced families (Ferrante, 2005; Macie, 2002).

These findings are also supported within the child adjustment literature. In one notable study conducted by Camara and Resnick (1989), co-parenting cooperation and conflict style were found to be more predictive of children's adjustment than conflict regarding the spousal relationship. Thus, it is not the overall amount of conflict present that predicts children's psychological adjustment but the way in which spouses can resolve this conflict towards a cooperative co-parenting relationship. Clearly, co-parenting is a vital contributor to children's post-divorce adjustment and a necessary target for intervention.

Co-parenting Intervention Needs

Parents vary in their capacity to co-parent after divorce. Parenting style, an ability to maintain clear boundaries and self-esteem often contribute to where parents fall along the co-parenting continuum (Whiteside, 1998). It has been suggested that treatment strategies should be varied as well, such that interventions are tailored to families of divorce depending on parents' baseline ability to co-parent. Different programs, interventions, and parenting plans will be appropriate depending on the needs and resources of different families.

For example, the use of psychoeducation, such as books and educational workshops, may be most beneficial for relatively well-functioning families. While low functioning families may also benefit from these types of interventions, it has been suggested that brief, informational interventions are sufficient for families who are routinely displaying cooperative co-parenting behaviors (Whiteside, 1998). Families in the middle of the co-parenting continuum, who demonstrate a combination of cooperative and combative co-parenting practices, require skills training above and beyond court-mandated education programs and other psychoeducational materials. Skills training might focus on maintaining boundaries, communication, mediation services, and general co-parenting coaching. Services for the most dysfunctional group, high-conflict families of divorce, require the most comprehensive approach. These families need special programs supported by the courts, such as intensive therapeutic interventions, co-parenting coordination, and well-defined joint custody arrangements. Regardless of the

level of the intervention, the goal for any divorced family is to move as far to the healthy side of the co-parenting continuum as possible.

While interventions at all levels of co-parenting ability require the involvement of trained mental health or legal professionals, intensive therapeutic interventions needed to support high-conflict families of divorce require the involvement of specially trained clinicians. It is regularly acknowledged that co-parenting counselors need the following skills set: training in family therapy, child developmental theory, communication and conflict resolution, mediation techniques, adult psychopathology, familiarity with the legal system, and knowledge of the adult and child dynamics of a difficult divorce (Boyan & Termini, 2005, Whiteside, 1998). Further, multidisciplinary teams that consider both the legal and mental health needs of the family may be best suited for intensive interventions (Pedro-Carroll, et al., 2005).

Interdisciplinary partnerships in the courts designed to deliver evidence-based interventions for children and families of divorce are in high demand (Pedro-Carroll, et al., 2005). While there are currently many interventions available to families of divorce (i.e., mandatory psychoeducation workshops, mediation services, family therapy), there is a profound dearth of empirical support for these interventions. "Taken as a whole, the empirical evidence on the success of intervention with children, parents, and coparents during or following separation and divorce is far from compelling (Emery, et al., 1999, p. 339)". Efficacy and effectiveness research is needed to ensure that current intervention efforts are helpful to families of divorce (Pedro-Carroll, et al., 2005). Too frequently,

these interventions are developed—and often court-mandated—without empirical support or evaluation, especially evaluation involving random assignment or adequate comparison groups (Emery, et al., 1999; Pedro-Carroll, et al., 2005).

Additionally, current therapy efforts tend to focus on high-conflict families who have been entrenched in legal battles for several years. Many suggest that it is necessary to target intensive outreach efforts earlier in the process of separation (Pedro-Carroll, et al., 2005). Such a preventative stance would present an opportunity to provide intensive services before tensions rise and legal bills mount. Unfortunately, research has not yet examined the impact of intensive co-parenting interventions with families new to the divorce process.

Social Policy Response

Social policymakers have attempted to respond to current intervention needs for divorced families in a number of ways. First of all, there has been an increase in support for legal statutes derived from the psychological literature on the negative impact of high interparental conflict. Interparental conflict has not only been linked to poor child adjustment (Amato & Keith, 1991), but also to a variety of poor post-divorce legal outcomes (Braver, Salem, Pearson, & DeLusé, 1996). With regard to the legal aspects of divorce, interparental conflict has been linked to post-divorce litigation (Kelly, 1990), nonpayment of child support (Braver, Wolchik, Sandler, & Sheets, 1993), visitation disputes (Pearson & Anhalt, 1992), and nonvisitation by the noncustodial parent (Braver,

Wolchik, Sandler, Fogas, & Zvetina, 1991; Furstenberg, 1988). These negative legal outcomes are of great concern to the judicial system.

One way in which the court system is attempting to deal with the problems of divorce is via the implementation of better child support laws (Ellis, 2000; Ooms, 2001). Additionally, there have been efforts to increase the frequency of joint custody determinations by the courts. While mothers have historically been awarded custody more frequently than fathers, common practice now dictates that custodial decisions be made on an individual basis with no presumption that custody should be awarded based on parent gender (Bauserman, 2002; Twaite & Luchow, 1996). Recent years have seen a surge in research on the benefits of joint custody arrangements for children of divorce.

Overall, joint custody arrangements do appear to benefit children of divorce. A meta-analytic review of the literature on custody arrangements and child adjustment concluded that joint custody is advantageous for children in many cases, potentially because it facilitates ongoing positive involvement with both parents (Bauserman, 2002). Specifically, children in either joint physical or joint legal custody arrangements were found to be better adjusted than children in sole custody arrangements. Children in joint custody arrangements experienced positive family relationships, high self-esteem, and high levels of emotional and behavioral adjustment. Interestingly, the level of general adjustment of children in joint custody arrangements closely resembles that of children in intact families (Bauserman, 2002).

While the preponderance of evidence does suggest that joint custody arrangements are associated with positive child adjustment (Bauserman, 2002), custody status alone does not significantly predict child outcomes (Pruett & Hoganbruen, 1998). Parents who are awarded joint custody are more likely to have empathy, flexibility, and the abilities to maintain appropriate boundaries, separate their own needs from their children's needs, and shift from the spousal role to the co-parental role (Pruett & Hoganbruen, 1998). Therefore, cooperative co-parents are more likely to pursue and accept joint custody arrangements. Children's positive adjustment within joint custody arrangements may be due to their parents' inherent willingness to co-parent cooperatively. This revelation has led some to argue that joint custody only be awarded to parents who can cooperatively co-parent (Twaite & Luchow, 1996). Since interparental conflict mediates the relationship between custody arrangements and child adjustment, joint custody may be less helpful for high-conflict families (Twaite & Luchow, 1996).

Along with more stringent child support enforcement and increased joint custody arrangements, legislation has incorporated the psychological literature on divorce and child adjustment by directly crediting cooperative co-parenting as being in the *best interest of the child.* For example, Code of Virginia §20-124.3 cites examination of the co-parenting relationship as a major custody determinant (Best interests of the child, 2000). Specifically, "The propensity of each parent to actively support the child's contact and relationship with the other parent, the relative willingness and demonstrated ability of each parent to maintain a close and continuing relationship with the child, and the ability

of each parent to cooperate in matters affecting the child" is considered to be reflective of the child's best interests (Best interests of the child, 2000). Most other states also formally consider parents' co-parenting abilities when determining child custody (Ooms, 2001).

Finally, the legal system has stressed the importance of psychoeducation about the effects of divorce on children by promoting co-parenting education programs throughout the nation. These co-parenting education programs are designed to help divorcing parents deal with the trauma of separation and divorce for themselves and their children. Most are in a workshop format with a focus on psychoeducation and skills training. By 1995, 11 state legislatures had created laws either mandating divorce education statewide or allowing it to be mandated by various jurisdictions. Additional programs have been developed through local court rules or voluntary participation (Emery, 2001). Currently, courts in at least 40 states (The National Center for State Courts, 2004; Ooms, 2001) regularly order separating parents to attend co-parenting education programs, but only the following 14 states mandate co-parenting education across localities: Alabama, Arizona, Colorado, Connecticut, Delaware, Florida, Iowa, Massachusetts, Minnesota, New Hampshire, New Mexico, Utah, Vermont, and Virginia.

While social policymakers have made great efforts to assist families of divorce, the effectiveness of these efforts is questionable (Emery, 2001). When the impact of legislation has been examined, research methodology has been grossly inadequate. Few studies have utilized a control group at all and randomized controlled trials are

completely absent in the literature. Research that has been conducted suggests that, in general, social policies have only a very limited effect on reducing interparental conflict and increasing interparental cooperation (Emery, 2001); however, Emery (2001) argues that social policies should be judged by their indirect effects as well as their direct consequences. Although a given intervention may not produce considerable, immediate effects on reducing interparental conflict, the policy may produce incremental benefits over time. For example, social policy might contribute to shaping cultural views of conflict and the co-parenting relationship. The crude study of divorce-related social policies thus far certainly limits our understanding of their potential benefit.

Current Interventions

Currently, there are three levels of co-parenting interventions described in the literature (Blaisure & Geasler, 2000). Interventions vary in their capacity to address individual, couple, and family-of-origin concerns and skill development in communication and conflict resolution. The first level describes strictly psychoeducational interventions. These programs aim to educate parents on the effects of divorce and interparental conflict on child adjustment. For example, books on divorce and some court-mandated co-parenting education workshops would fall into this category. The second level of interventions targets emotions and skills training. Comprehensive co-parenting workshops that demonstrate communication and conflict resolution skills, as well as time-limited mediation services, may fall into this category. Finally, the third and most intensive level of intervention is comprised of focused

therapeutic interventions of five or more sessions (i.e., family therapy, co-parenting coordination, etc.). 48% of United States counties currently offer co-parenting intervention programs at one of these three intervention levels. Counties select intervention levels depending on the goals of the community and available resources. The efficacy of these various intervention strategies will be examined below.

Co-parenting Education Workshops. Co-parenting education workshops (i.e., parent education programs) are the most prevalent co-parenting intervention programs, as they have become commonplace in at least 40 states (The National Center for State Courts, 2004). In 1978 General Responsibilities as Separating Parents (GRASP), the first co-parenting education program, was created in Johnson County, Kansas. Interest in these programs evolved from both the recognition of the long-term impact of interparental conflict for families and courts and the increased rate at which parents appeared in court without attorney representation. Due to a lack of national guidelines for program content (McKenzie & Bacon, 2002), the majority of the research literature on co-parenting education programs is a "scattering" of descriptions of the content and structure of individual programs (Braver, et al., 1996).

Co-parenting education workshops nationwide tend to have the following four goals in common: (1) to provide parents with information concerning the effects of divorce and separation on children; (2) to reduce interparental conflict by improving parents' ability to communicate with each other about their children; (3) to teach parents skills and techniques that will help them to parent more effectively and cooperatively

after divorce or separation; and (4) to minimize the long-term emotional, social, and academic problems experienced by children of divorce (Ooms, 2001). Most programs are extremely time-limited; one four-hour session is the modal format (Wolchik, Sandler, Winslow, & Smith-Daniels, 2005). Due to the inclusion of both psychoeducation and skills training, the majority of co-parenting education workshops described in the literature would be considered level two interventions (Blaisure & Geasler, 2000).

Most research examining the efficacy of co-parenting education interventions has been limited to satisfaction surveys and unsophisticated pre-post intervention designs. Few studies have utilized a control group, and randomized trials are nonexistent (Emery, 2001). Parents regularly endorse high levels of satisfaction with both voluntary and court-mandated co-parenting education programs (Kramer & Washo, 1993; McKenzie & Bacon, 2002; Pedro-Carroll, et al., 2001; Shifflett & Cummings, 1999; Thoennes & Pearson, 1999; Warren & Amara, 1984). Specifically, parents find these programs to be well-organized, understandable, worthwhile, and helpful in increasing their sensitivity to their children's experience of divorce (Kramer & Washo, 1993). Even parents who initially reported resentment at having their participation court-mandated later rated the program as helpful (Stone, McKenry, & Clark, 1999).

Given the brevity of co-parenting education interventions, it is probably unreasonable to assume that they would have a large long-term impact on children and families of divorce. It is reasonable to assess the impact of program participation on parents' general knowledge and attitudes about co-parenting and divorce. Program

participation is associated with an increase in parents' general awareness about the effects of divorce and interparental conflict on children (Pedro-Carroll, et al., 2001; Thoennes & Pearson, 1999) as well as an attitude change about the importance of supporting children's healthy relationship with both parents (Pedro-Carroll, et al., 2001; Shifflett & Cummings, 1999). Another realistic outcome that might be expected as a result of program participation is parents' increased access to intensive therapeutic and legal services (McIntosh & Deacon-Wood, 2003). As a result of program participation, parents have been found to be more likely to voluntarily access additional co-parenting services (McKenzie & Bacon, 2002). "Parent education is but one program within a network of services needed to support both parents and children after separation (McKenzie & Bacon, 2002, p. 73)".

While co-parenting education programs are not associated with adverse effects (Kramer & Washo, 1993), studies that have examined long-term outcomes of program participation are not hopeful. Relitigation patterns for program participants are identical to those of non-participants (Thoennes & Pearson, 1999) when assessed four years after program completion. Further, studies that have assessed the impact of co-parenting education programs on parent and child adjustment variables (i.e., parent-child relationship quality, co-parental relationship quality) have failed to find a link between program participation and improved adjustment (Kramer & Washo, 1993).

Despite the dearth of empirical evidence in support of the widespread implementation of co-parenting education programs, the courts hold a hopeful and

positive attitude about these programs. A 1996 national survey of judges, 95% of whom routinely mandated co-parenting education program participation, revealed that judges believed that these programs were effective (Fischer, 1997). Effectiveness ratings from judges indicated beliefs that co-parenting education programs resulted in quicker resolution of custody matters and decreased litigation. Further, they felt that program participation was more than 96% effective in terms of lessening the negative effects of divorce on children and benefiting the families of participants. General feelings that these seminars benefit many and harm none cause judges to refer up to 85% of their divorce caseload to co-parenting education.

In summary, the evidence in favor of the efficacy of co-parenting education is far from convincing while the implementation of these programs is widespread. At best, program participation appears to raise parent awareness and increase parents' access to more intensive services (Wolchik, Sandler, Winslow, & Smith-Daniels, 2005). Many are concerned by the ubiquitous use of short-term psychoeducation programs as an intervention to reduce all manners of interparental conflict given the absence of supporting data (Emery, 2001). Particularly for high-conflict families, co-parenting education workshops may be a useful venue to provide comprehensive psychoeducation as a prelude to participation in an intensive co-parenting intervention.

Mediation. Mediation, also a level two intervention for families of divorce (Blaisure & Geasler, 2000), is another frequently utilized service with adequate empirical support. Mediation was conceived more than twenty years ago in the state of California

(Ooms, 2001) in an effort to increase the efficiency and family-friendliness of dispute resolution (Emery, Sbarra, & Grover, 2005). Like co-parenting education interventions, interest in mediation was motivated by research identifying interparental conflict as the major contributor to the detrimental effects of divorce on children (Emery, et al., 2005).

Mediation services are generally provided by an attorney, psychologist, or trained mediator whose aim is to assist disputing parents by facilitating constructive solutions to controversial issues (Miller & Veltkamp, 1995). In anywhere from a one- to 20-hour intervention (Emery, et al., 1999), mediators facilitate interparental communication and conflict resolution toward compromise. Typical mediation components include: (1) supervised communication; (2) development of norms for rational interaction; (3) generation of potential solutions; and (4) determination of workable and mutually acceptable agreements (Miller & Veltkamp, 1995). The focus of mediation is on negotiating a divorce settlement, not on improving family relationships (Emery, et al., 1999). Mediation strives for co-parental cooperation and models the establishment of a pleasant, businesslike relationship between parents (Emery, et al., 2005).

Most research on mediation has focused on structured, short-term mediation in a court setting (Emery, et al., 1999). Due to the existence of national standards and training programs for mediation (Ooms, 2001), it is reasonable to make comparisons across research studies. Overall, between 60 and 80 percent of couples reach agreement via mediation services (Ooms, 2001). Parents report high levels of satisfaction with

mediation, especially fathers who feel that mediation promotes a "win-win mentality" (Emery, 2001; Emery, et al., 2005).

The efficacy literature on mediation is rather sophisticated and has included a number of randomized controlled trials (Emery, 2001). Randomized trials comparing mediation to adversary settlement (routine litigation) routinely find that mediation is associated with far lower rates of relitigation compared to adversary settlement (Emery, et al., 1999; Emery, et al., 2005; Miller & Veltkamp, 1995). In fact, one study noted that only four out of 35 mediating families returned to court as compared to 26 of 36 families in the adversary litigation group (Emery, et al., 1999). Encouragingly, these results appear to be long-term. In a three-year follow-up of parents who participated in a 20-hour mediation intervention, two-thirds of high conflict families were able to keep or renegotiate their own custody agreements and stay out of court (Pruett & Hoganbruen, 1998).

Additionally, families in mediation tend to settle disputes in half the time of their peers who proceed with adversary settlement (Emery, et al., 1999). Mediation settlements also tend to be far less expensive than routine litigation (Miller & Veltkamp, 1995), especially due to greater compliance with agreements reached in mediation (Emery, et al., 1999; Miller & Veltkamp, 1995). Although not a direct focus of mediation interventions, parents who have mediated divorce settlements report having a better relationship with their ex-spouse than non-mediated couples (Miller & Veltkamp, 1995). Mediation has also been associated with positive long-term effects on parent-child

relationships, as well as children's increased contact with nonresidential parents (Emery, 2001; Emery, et al., 2005).

Mediation, compared to routine litigation, assists parents in reaching amicable agreements quickly and at lower costs than traditional courtroom litigation (Emery, 2001). Parents tend to be more satisfied with mediated agreements and are, thus, more compliant with them (Miller & Veltkamp, 1995). Some studies have even noted that mediation may indirectly lead to improved parent-child and co-parental relationships (Emery, 2001; Emery, et al., 2005). The efficacy research on mediation is by far the most "methodologically adequate research on co-parenting interventions" (Emery, et al., 1999, p. 324). This research is limited, however, by the inclusion of a nonrepresentative sample of divorced families, those with the most acrimonious divorces (Emery, et al., 1999). It is reasonable to assume that families who experience lower levels of interparental conflict might be successful with less comprehensive services than mediation.

Parent Coordination. A new co-parenting intervention that is garnering much press is that of parent coordination (Bailey, 2005). Parent coordination is a level three co-parenting intervention (Blaisure & Geasler, 2000) designed to aid dispute resolution for high-conflict families of divorce (Baris, et al., 2001). Interventions consist of approximately 10 to 16 80-minute sessions over a one or two-year period (Boyan & Termini, 2005). Parent coordination goes beyond mediation, psychotherapy, and a multitude of other family services by granting the facilitator the authority to create binding court orders. It is a nonconfidential, child-centered process for parents "for whom

mediation is inappropriate due to high levels of conflict or domestic abuse in the relationship" (Baris, et al., 2001) typically provided by a trained psychotherapist. Thus, parent coordination is intended for the most dysfunctional families of divorce.

Parent coordination was created at the Cooperative Parenting Institute (CPI) in 1994, in Atlanta, Georgia, by a group of professionals (i.e., psychologists, attorneys, social workers) with significant experience working with high-conflict families of divorce. Parent coordination resembles psychotherapy in that parent coordinators use their therapeutic skills and expertise to promote behavioral change in families of divorce; however, parent coordinators actually hold a variety of roles that transcend the traditional role of psychotherapist (Baris, et al., 2001). First, parent coordinators are evaluators. Before commencing services, parent coordinators perform thorough family assessments consisting of information gathering about the children and the co-parenting relationship. Second, parent coordinators are educators. They teach and model effective conflict resolution techniques and communication skills while informing parents about the effects of divorce and conflict on child adjustment, the workings of the legal system, and the availability of additional resources. Third, parent coordinators act as case managers, frequently facilitating communication between family members, the courts, and other professionals. Fourth, parent coordinators are interventionists. They utilize conflict management, mediation, and arbitration skills to assist families in overcoming difficult impasses, coaching parents toward conflict resolution. Finally, parent coordinators act as judges when co-parents are unable to reach an agreement. This is the major distinction

between parent coordination and traditional psychotherapy. Parent coordination is nearly always a court-ordered process, granting the psychotherapist accessibility to the family and the power to authorize court orders (Baris, et al., 2001).

Currently used in more than 20 U.S. states (Boyan & Termini, 2005), parent coordination is especially prevalent in Washington, D.C., California, and Massachusetts (Bailey, 2005). Standards for parent coordination service provision have been developed and, in 1999, the National Parent Coordinators Association (NPCA) was formed (Baris, et al., 2001). Although parent coordination first launched more than a decade ago (Baris, et al., 2001) and a book detailing its practice was recently published (Boyan & Termini, 2005) and disseminated to psychologists across the nation, no research to date has examined the utility of this intervention strategy. The lack of research examining parent coordination is particularly alarming due to its controversial practice of granting psychologists the ability to write court orders. This practice fails to consider the psychologist's ethical responsibilities (i.e., multiple roles), lack of training in the law, and the possibility that the "orders" written may intrude on the family members' rights. While there are some limits on the authority of parent coordinators (i.e., issues of custody, relocation, religion), parent coordination ignores the legal system's historical respect for family privacy and reluctance to intrude on matters of interparental conflict and co-parenting (Emery, 2001) without empirical support for doing so.

Family Therapy. Family therapy interventions address individual, couple, and family-of-origin concerns via traditional psychotherapy methods (Pruett & Hoganbruen,

1998). In cases of divorced families, family therapy tends to carry the additional goal of skill development in the domains of communication and conflict resolution (Emery et al., 1999). Family therapy would be considered a level three co-parenting intervention (Blaisure & Geasler, 2000).

While family therapy is frequently mentioned as a potential co-parenting intervention, it appears that its merits in terms of improving co-parenting have not been assessed via research. "Unfortunately, there are no empirical evaluations of family therapy for improving co-parenting following divorce (except as part of ongoing mediation and arbitration) (Emery, et al., 1999, p. 337)". Further, co-parenting programs that intervene with entire families in a cohesive way are rare (Pruett & Hoganbruen, 1998). Often, participation in traditional family therapy is avoided because it requires parents who are willing to participate in therapy and who have the resources to engage in ongoing sessions (Blaisure & Geasler, 2000). Court referrals to family therapy tend to be restricted to couples who require more attention (Blaisure & Geasler, 2000).

Co-parenting Therapy. Co-parenting therapy, as practiced and described in the literature, is a level three co-parenting intervention (Blaisure & Geasler, 2000) that specifically aims to increase cooperative co-parenting behaviors in families of divorce. Co-parenting therapists utilize predominantly cognitive-behavioral techniques to help parents establish a safe and structured environment for parenting discussions, teaching constructive problem-solving techniques, and framing issues from the perspective of the children (Whiteside, 1998). "Cognitive and behavioral techniques are much more helpful

than the psychodynamic techniques often utilized in marital therapy (Baris & Garrity, 1997, p.637)". The main goal of co-parenting therapy is to help parents separate parental interactions from their residual feelings as former spouses so that they are able to arrive at structured, behavioral solutions to define the terms of their co-parenting relationship (Baris & Garrity, 1997; Whiteside, 1998).

Because it is important that clinical interventions be tailored to the unique characteristics and resources of a given family (Whiteside, 1998), it must be recognized that co-parenting therapy is more appropriate for some families than others. Four factors tend to differentiate co-parents who continue to engage in chronic conflict and those who undergo a process of normative conflict: emotionality, personality characteristics (i.e., Axis II disorders, all-or-none thinking patterns), communication skills, and coping strategies (McIntosh & Deacon-Wood, 2003). In light of the substantial differences between the dynamics of normative and chronic conflict, intervention selection should depend on the capacities of the family (McIntosh & Deacon-Wood, 2003; Whiteside, 1998).

Three co-parenting therapy interventions have been described in the literature, but only one has been systematically evaluated. Both the Shared Parenting Support Program (SPSP; Leek, 1992) and Directed Co-parenting Intervention (DCI; Garber, 2004) are structured co-parenting programs for divorced parents. Within a family systems framework, both SPSP and DCI are cognitive-behavioral in nature and aim to increase cooperative communication and problem-solving between parents (Garber, 2004; Leek,

1992). The presumption underlying these efforts is that improved co-parenting will be associated with subsequent improvements in overall child adjustment. SPSP is designed to be administered over nine weekly sessions and then monthly sessions until termination as determined by the therapist (Leek, 1992). The typical duration of DCI is unknown (Garber, 2004). Unfortunately, neither the efficacy of SPSP nor DCI has been examined in the literature.

The only co-parenting therapy intervention that has been assessed in the literature is the Collaborative Divorce Project (CDP; Pruett, Insabella, & Gustafson, 2005) and the evidence for CDP is limited to one study. CDP is a nine to eleven month program to assist parents of children aged six and under as they begin the separation or divorce process. CDP targets children under the age of six because over half of the children who experience divorce do so by the age of six. A male-female co-parenting counseling team facilitates CDP, acting as consultants to help the family problem-solve their legal issues.

CDP begins with a two-hour divorce orientation. Next, parents participate in between two and six psychoeducational sessions similar to the co-parenting education workshops described earlier. At this point, the co-parenting counselors provide feedback to the family, identifying treatment goals. A variable number of therapeutic resolution sessions follow whereby the co-parenting team mediates resolution of parenting issues. Throughout this process, co-parenting consultation and case management is available. For families who are unable to reach an agreement, a settlement conference is scheduled between the parents, the co-parenting team, attorneys, and a judge.

Pruett et al. (2005) completed a randomized controlled trial of CDP where they randomized divorced families to either CDP or a no-treatment control group. They utilized a multi-informant approach, collecting outcome information from co-parents, attorneys, teachers, and court records. Overall, results were very promising. Parents who completed CDP reported high rates of satisfaction with the program. They reported decreased conflict, increased paternal involvement, and increased cooperation when compared to parents in the control group. Further, they had an increased understanding of the importance of contact with both parents for their child. Finally, children whose parents had participated in CDP experience higher levels of adjustment than those children whose parents were in the control group. Attorney report and court records corroborated these results, indicating that parents in CDP were more likely to be cooperative and less likely to need custody evaluations and other costly court services than their control group peers.

While the findings from the CDP study (Pruett, et al., 2005) are promising, they are limited by the inclusion of a primarily Caucasian, middle-class sample. Results from the minority co-parents who did participate in CDP suggest that CDP may actually be less helpful for minorities than for Caucasians. Additionally, future studies might include child report measures as well; the young age of children in the CDP study likely precluded the investigators from assessing outcomes from the child perspective. To date, research on the efficacy of co-parenting therapy is limited to one study. Given the

increased demand for co-parenting therapy interventions, the scarcity of efficacy research in the literature is simply unacceptable.

Essential Elements of Co-parenting Interventions

While empirical support touting the effectiveness of current co-parenting interventions is scarce, research tells us that certain behaviors predict successful co-parenting and positive child adjustment after divorce. Thus, the interventions reviewed above can provide us with helpful information in terms of understanding the essential elements of a co-parenting intervention. Because current interventions are overwhelmingly research-based, one can assume that components common across co-parenting interventions represent our best scientific knowledge of the essential elements to help parents to work together toward making child-centered decisions (Whiteside, 1998).

One core component of co-parenting interventions is psychoeducation. Current intervention efforts universally seek to educate parents about the effects of divorce and separation on child adjustment. Further, a clear understanding of the impact of interparental conflict provides parents with an understanding of the framework inherent to most co-parenting interventions. It is imperative that parents "buy in" to the assumption that children need and deserve a full relationship with both parents, as this assumption underlies all co-parenting interventions. It is hoped that education may motivate parents to work toward overcoming their differences for the sake of their child.

Since psychoeducation programs are commonly mandated at the state level, it is reasonable for a Level 3 (Blaisure & Geasler, 2000) co-parenting therapy intervention to briefly review psychoeducation with a more prominent focus on skill building. Once parents grasp the potentially negative impact their separation may have on their children, they will need to learn strategies that increase their co-parenting competencies. Research on the various dimensions of co-parenting suggests that four specific co-parenting behaviors should be targeted, including conflict, cooperation and respect, communication, and triangulation (Mullett & Stolberg, 1999; McConnell & Kerig, 2002).

Conflict. Interparental conflict is, by far, the most frequently studied co-parenting dimension. We know that interparental conflict disrupts general parenting competence; couple negativity leads to family negativity. For example, fathers have been found to give less support and encouragement to sons as a result of interparental conflict (Kitzmann, 2000). High interparental conflict predicts poor young adult adjustment as well as low intimacy with parents (Richardson & McCabe, 2001). These findings are consistent across child gender (Shaw, Emery, & Tuer, 1993) and marital status (Hetherington & Stanley-Hagan, 1999). Post-divorce interparental conflict decreases children's well-being (Amato & Keith, 1991) so much that the conflict is actually worse on children than the divorce process itself (Morrison, 1999).

Cooperation/Respect. Interparental cooperation and respect, goals for healthy co-parenting, serve as positive models for children of divorce. The co-parents who can manage to put aside their relationship differences and cooperate on childrearing matters

present a united front to their children. Positive family interactions, marked by support and respect, have been linked to decreased child externalizing behavior problems (Schoppe, Mangelsdorf, & Frosch, 2001). More broadly, high respect between parents predicts healthy psychological outcomes in young adults (Macie, 2002) and children (McConnell & Kerig, 2002).

Communication. Interparental communication, another key dimension of co-parenting, describes the frequency and way in which parents talk to each other about their children and childrearing issues. Its inclusion within the dimensions of post-divorce co-parenting is vital since the amount of communication between parents concerning their children clearly diminishes with time (Amato & Keith, 1991). In one study of parents whose children were going back and forth between households, reports of weekly communication dropped from 67% to 40% over the three years of the study (Maccoby, Buchanan, Mnookin, & Dornbusch, 1993). Other studies concur with these findings, estimating that 61% of divorced parents demonstrate low communication (Macie, 2002). Families with low co-parental communication face increased difficulty being consistent in their expectations and ability to agree on the need for parental intervention with their children. Poor communication prevents parents from being "on the same page" regarding childrearing issues and has been linked to poor child outcomes (Macie, 2002; Feinberg, 2002).

Triangulation. The least empirically examined dimension of co-parenting is that of triangulation. Triangulation occurs when intergenerational boundaries become blurred,

transforming children into allies or pawns in interparental conflict (Feinberg, 2002). Research suggests that this behavior occurs most frequently in mother-son dyads (Margolin, Gordis, & John, 2001). In this situation, mothers might inappropriately confide in their sons as if they are the "man of the house". High levels of triangulation, a behavior exhibited by approximately 56% of divorced couples in one study (Macie, 2002), lead to poor psychological adjustment in children and young adults (Macie, 2002; Feinberg, 2002).

Given that the domains of conflict, cooperation and respect, communication, and triangulation should be intervention targets, treatment must focus on teaching parents skills to improve these co-parenting behaviors. Existing co-parenting interventions employ strategies to teach two vital skills: cooperative communication and problem-solving between parents (Garber, 2004; Leek, 1992). Communication and conflict resolution therapeutic techniques, borrowed from family therapy, have been proven effective for conflicted intact families (Liddle, Santisteban, Levant, & Bray, 2001). The use of these intervention strategies with divorced families assumes that improving parents' ability to communicate with each other about their children and to reach child-focused parenting decisions will subsequently reduce interparental conflict and triangulation (Ooms, 2001).

Although many theoretical orientations incorporate communication and problem-solving techniques, it has been argued that cognitive-behavioral techniques are more helpful than the psychodynamic approach frequently utilized in marital therapy (Baris &

Garrity, 1997). Cognitive-behavioral therapy's focus on the present is especially important as co-parenting therapy is not a venue for parents to work through their past marital problems. Instead, parents entrenched in conflict need to learn to focus on the present and the needs of their child, thereby separating their role as former spouse from their new role of co-parent. The inherent structure of cognitive-behavioral therapy establishes a non-threatening and structured environment for parenting discussions, teaching constructive problem-solving techniques, and framing issues according to a child perspective.

Finally, there seems to be some agreement across the literature regarding the qualifications necessary to provide co-parenting therapy (Boyan & Termini, 2005, Whiteside, 1998). Co-parenting counselors need appropriate theoretical training, including knowledge of child developmental theory, adult psychopathology, and the adult and child dynamics of a difficult divorce. Regarding clinical training, mastery of family therapy techniques such as communication training and conflict resolution is essential. Given the high legal involvement of divorced families, co-parenting therapists also should have familiarity with the legal system and with mediation techniques as well as competence collaborating with attorneys and judges (Boyan & Termini, 2005). Despite the lack of evidence supporting current co-parenting interventions, the literature suggests that co-parenting therapy should include psychoeducation, communication, and problem-solving components delivered by a competently-trained clinician.

Evidence-Based Treatment

There is an increasing demand within the field of psychology for the establishment and dissemination of evidence-based (i.e., empirically supported) treatments (Chambless & Ollendick, 2001). The concept of evidence-based treatment derives from the tenets of the Boulder scientist-practitioner model (Committee on Training in Clinical Psychology, 1947), whereby clinical psychologists purport to inform research with clinical expertise and integrate research findings into clinical practice. Established APA guidelines for the classification of evidence-based treatments (Beutler, 1998; Chambless & Hollon, 1998) assist in the proliferation of evidence-based treatments.

The practice of evidence-based treatment is essential, particularly within the area of co-parenting interventions where few regularly implemented interventions have been systematically evaluated. The impact of clinical interventions must be measured by a variety of outcomes independent of therapist report (Kendall, 1998), especially if psychotherapy is to survive in the era of managed care (Deegear & Lawson, 2003). Further, the use of evidence-based treatments carries a number of ethical implications (Chambless & Ollendick, 2001). Clinicians should be held responsible for ensuring that the therapies that they practice do in fact produce valid and reliable outcomes. Finally, the establishment of evidence-based treatments can be useful so that effective treatments can be widely disseminated (Kendall, 1998).

As the establishment of evidence-based co-parenting interventions remains in its infancy, it is relevant to review the early stages within the development of an evidence-

based therapy (Chambless & Hollon, 1998). First, studies should utilize a treatment manual designed for a specific population. As is common to all methodological designs, the selection of reliable and valid outcome assessment measures representing the target problems and the use of appropriate statistical techniques are necessary. For a treatment to earn an initial classification of *possibly efficacious*, the effects of the therapy must be demonstrated in at least one study with a sample size of three or more (in the instance of single-case experiments). Later research must establish the superiority of the treatment across at least two independent research settings stages for a classification of *efficacious*.

Generally, researchers follow a three-stage model when establishing a new evidence-based treatment (Rounsaville & Carroll, 2001). Stage I details the process of intervention piloting, including therapy development and manual writing. The purpose of this stage is to explore the feasibility of a treatment based on its demonstration of clinically significant patient improvement and sufficient recruitment and retention with the proposed types of therapist, patients, and treatment settings. Many Stage I studies begin with fully developed treatments based on nonexperimental clinical experience (Rounsaville & Carroll, 2001, p. 136)". Methodological designs for Stage I studies vary greatly, but include the use of single-case experiments and small-scale randomized clinical trials (Rounsaville & Carroll, 2001). Stage II research consists of larger scale randomized clinical trials of treatments that have shown promise or efficacy in Stage I designs and also broadens the focus of efficacy research to assess mechanisms of action.

Finally, Stage III studies address the transportability and generalizability of evidence-based treatments.

Since the research on the efficacy of co-parenting therapy is sparse, future endeavors should begin with Stage I studies. Because Stage I research originates with the development of a psychotherapy manual, it is relevant to understand current conceptualizations of manual development. Carroll and Nuro (2002) have developed a three-stage model for psychotherapy manual development that closely parallels Rounsaville and Carroll's (2001) stage model for behavior therapies whereby the complexity of a manual increases as does the evidence for the treatment's efficacy. Stage I manual development consists of initial specification of treatment techniques, goals, and therapy format. Additionally, hypothetically active ingredients of treatment are identified. Manuals used in Stage II research progress to include highly defined guidelines that delineate the internal and external boundaries of a treatment. Finally, Stage III manuals should specifically detail guidelines for the implementation of a treatment with diverse patient populations in a range of clinical settings. Unfortunately, few Stage III manuals have been developed.

Carroll and Nuro's (2002) view of psychotherapy manual development as a series of progressive stages, with each successive stage addressing more complex clinical issues, attempts to address the criticisms that therapy manuals do not tend to be "clinician friendly" (Dobson & Hamilton, 2002; Hawley & Weisz, 2002; Jensen, 2002). It has been suggested that the inclusion of clinicians in the beginning stages of manual development

will further improve the clinical utility and external validity of manuals (Westen, 2002). To facilitate the broader use of evidence-based treatments, Chorpita (2002) has proposed that the scientist-practitioner model also be applied to treatment setting. He suggests that all stages of research be done in "real world" clinical settings rather than university settings. Overall, the establishment of an evidence-based approach that flexibly accounts for the individual characteristics of clients and therapists is a useful goal for co-parenting therapy research (Deegear & Lawson, 2003).

Single-Case Design

Although frequently mistaken as the anecdotal variety, single-case designs are increasingly utilized and respected within the field of psychology. Economic realities make a low-cost, n = 1 study an excellent way to pilot a new treatment or test out a new theory (Kazdin, 2003). In fact, single-case design is a common first step in the establishment of an evidence-based treatment (Chambless & Hollon, 1998; Kazdin, 2003). Also, psychologists are increasingly encouraged to rigorously assess changes due to treatment (Barlow, Hayes, & Nelson, 1999). Single-case designs provide a superior, true experimental method to best serve clients and ensure that therapeutic efforts are actually effective (McCullough, 2002). In fact, with the increasing requirement to systematically assess treatment change, opportunities to publish rigorous clinical work could further bridge the gap between clinical research and practice.

It is clear that single-case designs have blossomed over the years from Freud's anecdotal descriptions of patient Anna O. (Breuer & Freud, 1957) to rigorous

experiments. While single-case experiments should not be the final stage of research, they can greatly inform later stages (Kazdin, 2003). Also, single-case designs easily lend themselves to naturalistic settings, such as effectiveness trials. Increasing the use of single-case designs can improve the overall quality of mental health care by encouraging clinicians to evaluate the changes they help their clients make.

"The single-participant approach has produced solid and replicable empirical findings across a number of behavioral domains yet remains relatively obscure because of its disavowal of statistical machinery that defines psychological research in the 21st century (Moras, Telfer, & Barlow, 1993, p. 417)". Because of its avoidance of traditional statistical techniques, employment of single-case design requires a number of steps to ensure systematic evaluation of treatment. First, a specific population should be identified (McCullough, 1984b; McCullough, 2002). Next, treatment goals must be specified and a baseline assessment of these dimensions must be completed. It is especially important that intervention procedures be operationalized so reliable replications can be done (Kazdin, 2003; McCullough, 1984b). As with all research, the selection of reliable and valid measures is also highly recommended. Assessment time points must be identified and data evaluation strategies should be specified (Kazdin, 2003).

Most commonly, treatments assessed via single-case experiments follow a stage process model (SPM; McCullough, 1984a; McCullough & Carr, 1987). SPM is a "building block approach" to the process of psychotherapy whereby phases of therapy build upon and presuppose skills acquired during earlier treatment stages. SPM requires

systematic monitoring of target behavior changes across phases of treatment and at several time points during each phase. This technique is highly consistent with a multiple baseline design (Kazdin, 2003). Treatments that follow the SPM allow the investigator to look at multiple changes that occur within each stage as well as study changes that occur over the entire process of therapy.

Finally, replication is an important component in the implementation of single-case research. Replications diminish the odds that extraneous coincidence produced the study results (Gaynor, Baird, & Nelson-Gray, 1999). Also, replication allows the researcher to examine the generalizability of their findings (Gaynor et al., 1999; McCullough, 1991). The use of single-case replications addresses the major methodological criticism of single-case research, the question of external validity. This research design appears to be an appropriate first step toward the examination of the efficacy of co-parenting therapy.

Statement of the Problem

Divorced families, especially those entrenched in chronic conflict, are overrepresented in both the mental health service system and the legal system. Both clinicians and the courts have attempted to meet the needs of divorced families via a number of intervention strategies (i.e., co-parenting education workshops, mediation services, parent coordination, family therapy, co-parenting therapy); however, the implementation of and legislative support for most current interventions have preceded any actual data citing the benefits of these programs (Emery, 2001).

While targets of current interventions vary, recent work suggests that co-parenting interventions that aim to increase cooperative and collaborative childrearing may be the most appropriate target for intervention when attempting to ameliorate the negative effects of the divorce process (Feinberg, 2002; Ferrante, 2005; Macie, 2002). To date, only three manualized co-parenting interventions have been described in the literature and only one has been subjected to methodologically rigorous examination. Thus, the establishment of an evidence-based co-parenting therapy remains a priority.

Once a preliminary manual has been written for the specified population, the establishment of an evidence-based treatment begins with Stage I research to pilot a treatment's overall feasibility (Rounsaville & Carroll, 2001). Because co-parenting therapy research is in its infancy, single-case design would be an appropriate first step to determine whether treatment is probably efficacious (Chambless & Hollon, 1998). The current study seeks to establish the efficacy of a co-parenting therapy intervention utilizing a single-case design with replication. This study tests the following hypotheses:

1) Co-parenting therapy will improve legal outcomes (i.e., decreased court visits, increased payment of child support, increased visitation by noncustodial parent, compliance with court orders, etc.);

2) Co-parenting therapy will increase interparental communication;

3) Co-parenting therapy will increase co-parenting behaviors (i.e., increased cooperation and decreased hostility per child report);

4) Co-parenting therapy will increase family functioning per child and parent report;

5) Co-parenting therapy will indirectly increase child adjustment (i.e., internalizing and externalizing behavior per teacher, parent, and child report).

Method

Participants

Participants were seven divorced or separated couples who had at least one biological child between the ages of 11 and 17. All participants were court-ordered to participate in an intensive co-parenting training intervention by the Henrico County Juvenile and Domestic Relations Court. Families were excluded if either or both parents (1) abused substances; (2) had a history of child abuse, domestic violence, or other criminal involvement; or (3) experienced severe psychopathology (i.e., suicidality, homicidality, psychosis, Axis II disorders, etc.). For inclusion, parents were to have cohabitated for a minimum of two years prior to separation. Additionally, they were required to demonstrate functioning at a level that allowed for regular attendance at all scheduled therapy sessions.

A total of eleven families were referred for treatment and completed telephone screens. Of those, seven families were invited to complete an in-person screening. All seven of these families met study criteria and were enrolled in the study. Three Caucasian and four African-American families enrolled in the Intensive Co-Parenting Therapy program. Parents enrolled in the study ranged from their late 30's to mid-50's. The average ages for mothers and fathers were 42 and 44, respectively. Families were primarily middle class. On average, mothers had an annual income of $40,000 and fathers had an annual income of $63,000. All parents had at least a high school education and

most had attended at least some college (Mother Mean Years of Education = 16; Father Mean Years of Education = 14).

Overall, families in the study had children with an average age of twelve-years-old (range: 6 to 18). The average age of child research participants was thirteen-years-old, with ages ranging from eleven to sixteen. Most children in the study were middle school students. On average, families had a total of two children (range: 1 to 4).

Six of the seven families were divorced; the seventh family was never married but had lived together prior to their separation. The mean amount of time since parent separation was six and a half years, ranging from six months to fourteen years. The mean amount of time since divorce was five years with a range of one to twelve years. On average, parents had lived together for nine years (range: 5 to 13) prior to their separation. Three mothers and three fathers had been married and divorced in the past. Since the divorce of interest, one mother and three fathers had remarried.

Two families were removed from the study during treatment. One family was removed from the study after completing six sessions due to suspicion of significant mental abuse by one parent. Subsequently, the children's *guardian ad litem* was notified of this concern and the study therapist filed a complaint with Child Protective Services. It was determined that the family no longer met study inclusion criteria due to the abuse concerns and Axis II traits evidenced by the abusive parent. Another family was removed from the study after attending only one session and then failing to follow up with the study therapist. One parent in this family suffered from significant health problems which

had caused the parent to take leave from work and rendered the parent unable to attend regular weekly therapy sessions. Both families were given the opportunity to continue to be seen clinically by the study therapist within a less structured treatment design that would allow for flexible attendance and increased communication between the therapist and the court system. Both families took advantage of this opportunity and have benefited from a more flexible application of Intensive Co-parenting Therapy techniques.

Two children from Families 1 and 2 were within the target age range and participated in the study. In Families 3, 4, and 5, only one child was within the target age range to participate in the study. All analyses described below are restricted to the five families who completed treatment, including one family who completed eight of fourteen sessions and dropped their legal dispute (Family 5). This family reported that they felt they had met their treatment goals and did not need to continue in therapy. Thus, five direct replication studies are presented below.

Procedure

After completing a state-mandated four-hour co-parenting education workshop run by Dr. Laura Wert (see Appendix A for outline of psychoeducation content), seven separated/divorced couples participated in a 14-week manualized co-parenting therapy intervention. Treatment took place at a private practice office in Henrico County. Potential participants completed a phone screening with the investigator to review inclusion and exclusion criteria. Families meeting study criteria were invited to participate in the study and completed informed consent procedures with the investigator,

who also served as study therapist. The intervention included the following components (see Appendix B for a more detailed outline of session procedures):

- Sessions 1-4: Baseline assessment, goal-setting, psychoeducation
- Sessions 5-8: Communication training
- Session 9: Enhancing motivation to change, commitment to co-parenting
- Sessions 10-13: Problem-solving training
- Session 14: Wrap-up and Termination

A single-case research design with replication was employed and participants' progress was tracked according to a multiple baseline approach. At baseline, parent psychopathology was assessed, along with co-parenting, family functioning, and child adjustment measures. Co-parenting, family functioning, and child adjustment measures were readministered at two other time points, at session eight and at termination. Additional behavior change measures (i.e., frequency of communication, mode of communication, etc.) and legal outcomes (i.e., court visits, payment of child support, visitation of noncustodial parent, compliance with court orders) were monitored on a weekly basis.

Measures

The following baseline assessment measures were used for screening purposes only:

(1) *Minnesota Multiphasic Personality Inventory-2.* (MMPI-2, Butcher,

Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). The MMPI-2 is a measure of adult psychopathology and is the most widely used objective personality inventory in the world (Friedman, Lewak, Nichols, & Webb, 2001). Designed to assess a number of the major patterns of personality and emotional disorders, the MMPI-2 is used by clinicians to assist with the diagnosis of mental disorders and the selection of appropriate treatment methods.

The MMPI-2 consists of 567 true-false items written at an 8th grade reading level that tap eight Validity Scales, five Superlative Self-Presentation Subscales, 10 Clinical Scales, nine Restructured Clinical (RC) Scales, 15 Content Scales, 27 Content Component Scales, 20 Supplementary Scales, and 31 Clinical Subscales (Harris-Lingoes and Social Introversion Subscales). Since the MMPI-2 will be used primarily as a screen for adult psychopathology in co-parents and as an indicator of adult personality factors that may impact treatment, the MMPI-2's Clinical Scales will be of primary interest in this study. These scales include Hypochondriasis, Depression, Hysteria, Psychopathic Deviance, Masculinity–Femininity, Paranoia, Psychasthenia, Schizophrenia, Hypomania, and Social Introversion.

Because the MMPI-2 is the most widely researched psychological assessment tool in the world, its reliability and validity has been well-established (Friedman, et al., 2001). In fact, the MMPI-2's inclusion of eight Validity Scales within the measure provides a distinct measure of validity for each individual.

(2) *Diagnostic Interview for DSM-IV Personality Disorders.* (DIPD-IV, Zanarini,

Frankenburg, Sickel, & Yong, 1996). The DIPD-IV is a semi-structured clinical interview developed to assess the DSM-IV personality disorders in adults. The interview contains 108 sets of questions related to the diagnostic criteria for all DSM-IV Axis II personality disorders along with two research diagnoses of personality disorders (i.e., passive-aggressive and depressive personality disorders). The DIPD-IV stipulates that criteria must be present and pervasive for a minimum of two years and characteristic of the person for most of his or her adult life. The interview takes approximately 90 minutes to administer. Each diagnostic criterion is scored on the following three-point scale: 2 = present and clinical significant, 1 = present but of uncertain clinical significance, and 0 = absent or clinically insignificant. Personality disorders are then scored categorically, according to the number of criteria met as follows: 2 = yes, 1 = subthreshold (one less than required number of criteria), and 0 = no. The DIPD-IV has strong reliability and validity. Interrater reliability ranges from .79 to .91 and test-retest reliability ranges from .65 to .84. The DIPD-IV also has strong convergent validity when compared to other structured interviews for personality disorders.

(3) *Informational Questionnaire*. Participants will also complete a questionnaire indicating demographic characteristics, and family status variables. This questionnaire was written for this study as a means of collecting certain necessary information that was not captured by other measures in battery. See Appendix C for questionnaire.

Therapeutic success was monitored by a multi-informant approach. Outcome measures consisted of parent, child, and teacher report, as well as court records as follows:

(4) *The Co-parenting Behavior Questionnaire (CBQ)*. (Macie & Stolberg, 2003; Mullett & Stolberg, 1999; Schum, 2003). The CBQ is an 86-item instrument designed to assess the co-parenting interactions and parenting behaviors of divorced parents from the viewpoint of the child. This measure targets children between the ages of 10 and 17 and asks them to reflect the behavior of their parents in the past three months. The CBQ contains 12 subscales, indicating Parental Conflict, Co-parental Communication, Triangulation, Co-parental Cooperation, and each of the following parenting skills for both the mother and the father: Warmth, Parent-Child Communication, Monitoring, and Discipline. The 12 scales have good internal consistency, with alpha coefficients reported between .82 and .93. These scales also were demonstrated to have good predictive validity when correlated with measures of child behavior problems and self esteem. See Appendix D for version of CBQ used in this study.

(5) *Achenbach System of Empirically Based Assessment (ASEBA), School-Age Forms*. (Achenbach & Rescorla, 2001). Administration of the following 113-item ASEBA instruments creates an integrative measurement of child adjustment that describes the competencies, adaptive functioning, and problems of school-aged children:

- Child Behavior Checklist for Ages 6-18 (CBCL): parent report
- Teacher Report Form for Ages 6-18 (TRF): teacher report

- Youth Self-Report for Ages 11-18 (YSR): child self-report

The ASEBA is designed for assessment, treatment planning, and outcome evaluation in a number of settings and is one of the most widely researched and used behavioral rating scales. It includes both empirically-based syndrome scales and DSM-oriented scales for scoring consistent with DSM-IV categories. Ratings are transformed into raw scores, T scores, and percentiles for Total Competence, three Competence scales (Activities, Social, and School), eight Syndrome scales, six DSM-Oriented scales, Internalizing Problems, Externalizing Problems, and Total Problems. Syndrome scales include Anxious-Depressed, Withdrawn-Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior. The DSM-Oriented scales include Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit-Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems. Internalizing and Externalizing scales are derived from relevant syndrome scales while a Total Problem score reflects the sum of all items. Internalizing, Externalizing, and Total Problem scores will be used to measure therapeutic success in this study.

ASEBA instruments can be completed in approximately 15-20 minutes and consist of rating a variety of behaviors on the following scale: 0 = not true; 1 = somewhat or sometimes true; or 2 = very true or often true. There are separate scoring profiles for boys and girls ages 6 to 11 and 12 to 18. The ASEBA is a well-researched instrument with exceptionally strong reliability and validity data. The scales are supported by a solid

research base and are technically sound, both from test development and psychometric perspectives. Reliability coefficients range from .67 to .94 for various scales. Further, construct, content, and criterion-related validity evidence is extensive. T scores and percentile rank scores allow for comparisons to the normative sample to determine if a child's competencies and problems differ from what is considered typical of a child that age and gender. Computer scoring also allows for cross-informant comparisons.

(6) *Family Environment Scale (FES).* (Moos & Moos, 1994). The FES measures the social-environmental characteristics of families. The complete FES is a 90-item true-false questionnaire. For this study, only the 27-item Conflict, Cohesion, and Organization subscales were used. Because the FES is designed for respondents over the age of 11, both parents and children completed this questionnaire. The FES has been used in clinical and research work for over 25 years. It is recommended for situations in which researchers desire an omnibus assessment of the quality of family life. The utility of the FES in a divorce population is unknown. The reliability and validity of the FES have been well-established. Studies have demonstrated that the internal consistency of the FES ranges from .61 to .78. Two-month test-retest reliability ranges from .68 to .86.

(7) *Family Problem Solving Communication Index (FPSC).* (McCubbin, Thompson, & McCubbin, 1996). The FPSC is a 10-item questionnaire designed to assess a family stress and coping model from both a parent- and child-perspective. It examines family communication patterns during difficult times. The FPSC measures two forms of family communication: incendiary (i.e., conflictual and adversarial) and affirming (i.e.,

cooperative and respectful), using a 4-point rating scale (0=False, 1=Mostly False, 2=Mostly True, 3=True). The reliability of the FPSC is strong, .89. Test-retest reliability has been demonstrated to be .86. Construct and concurrent validity have been well established (McCubbin, Thompson, & McCubbin, 1996). The utility of the FPSC in a divorce population is unknown.

(8) *Legal outcomes.* Court-related data also were reviewed to determine treatment success. Data collected included frequency of court visits, payment of child support, visitation by noncustodial parent, compliance with court orders, frequency of emergency hearings, frequency of complaints to Child Protective Services, interparental legal problems unrelated to custody, and resolution of the current custody/visitation dispute. All legal outcomes were assessed orally via parent self-report on a weekly basis in the presence of both parents. Outcomes were verified via communication with the children's *guardian ad litems* and review of court orders.

(9) *Idiographic Measures.* Measures for weekly co-parenting behavior ratings varied some across participants. Because improved communication was a major treatment goal for all families, all participants reported the frequency and mode of their interparental communication. Additional idiographic measures were created to measure participants' specific treatment goals. For example, divorced couples experiencing specific difficulty keeping their communication focused on their child monitored their ability to maintain focus on their child in conversation. Families with low frequency

contact between a noncustodial parent and child monitored that contact throughout treatment. See Appendix E for a sample idiographic measure.

Analyses

Due to the nature of single-case design, sample size is insufficient for quantitative statistics. Instead, data were analyzed via visual inspection. All outcome measures were graphed and changes over the course of time were assessed. Graphs were examined for improvement in target behaviors and it was determined whether changes were related to treatment. For measures possessing normative ranges (i.e., CBQ, ASEBA measures), data were also inspected for changes in clinical significance.

Results

Results will be presented below according to the following domains of interest: legal outcomes, communication, co-parenting and parenting, family functioning, and child adjustment. Although comparisons will not be made between families, treatment outcome results from all five families will be presented cumulatively.

Legal Outcomes

Frequency of court visits. All families attended at least one court hearing prior to beginning treatment. On average, families had been to court 4 times (range from 1 to 12) before being ordered to treatment. Throughout the course of the 14-session treatment, 80% of families attended at least one prescheduled court hearing that was a continuation of the original hearing. Two families attended two such hearings during treatment. One family did not attend any additional hearings. Due to the prescheduled nature of these hearings and the probability that the hearings were scheduled at least four months prior to their occurrence, treatment was unlikely to impact the frequency of court visits.

Resolution of custody/visitation dispute. All five families resolved at least some portion of their custody and/or visitation dispute. In fact, 40% of families dropped their legal dispute entirely and did not return to court (see Figure 1). Both of these families decided upon a shared custody arrangement. Family 5 opted to retain their current shared arrangement whereby the children spent time with each parent daily and spent most overnights with the father (mother worked night shifts). Family 4 decided upon a week-

on, week-off shared custody arrangement which they drafted in sessions and filed with the courts as a consent order. The remaining 60% of families were able to create their own agreed upon holiday and visitation schedules based on their family needs rather than leave the details for the court to determine.

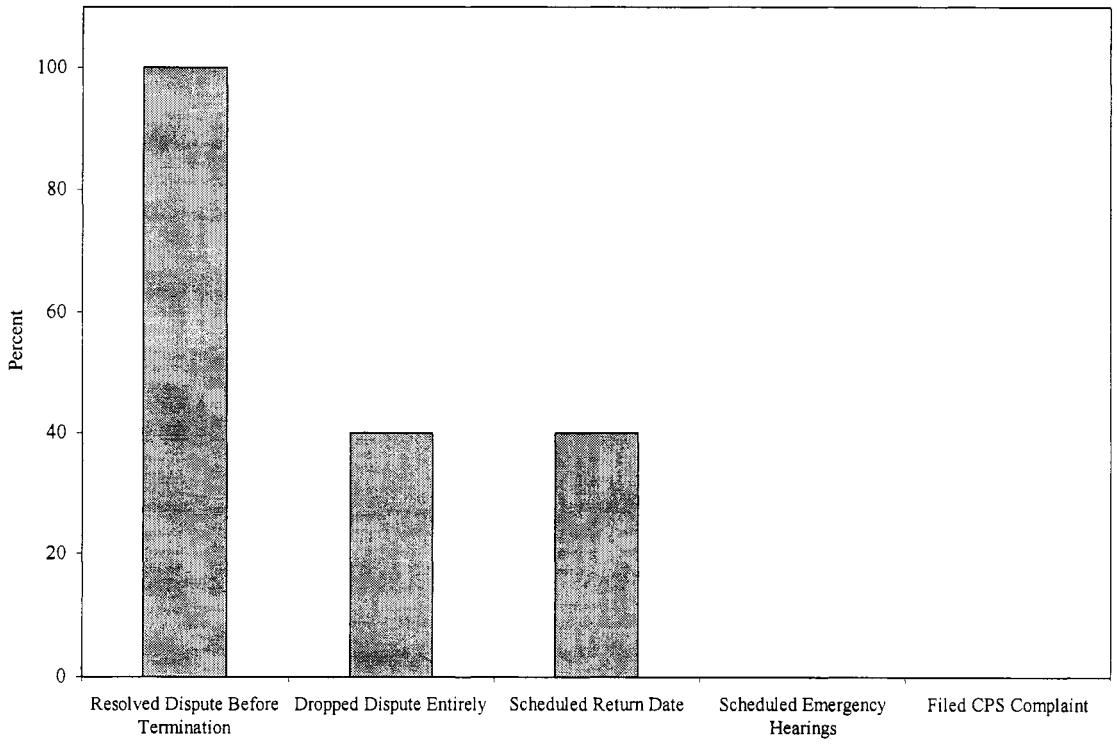

Figure 1. Legal Outcomes for Families 1-5.

Emergency hearings. None of the study participants filed for emergency hearings during treatment (see Figure 1).

Child Protective Services (CPS). None of the study parents filed CPS complaints against one another (see Figure 1). No CPS complaints were filed by other professionals

(i.e., study therapist, *guardian ad litem*, teachers, child advocate, etc.) involved in study cases.

Payment of child support. Families 1, 3, and 5 paid child support throughout treatment. Child support payments of Families 2 and 4 are displayed in Figure 2. After not paying four out of the first six weeks of therapy, Family 2 paid child support without incident from Session 7 through termination. Family 4 missed four out of five child support payments at the beginning of therapy. This family began regular payments at Session 6 and maintained support through termination, at which point the family entered an agreement to divide all costs evenly and cease formal child support.

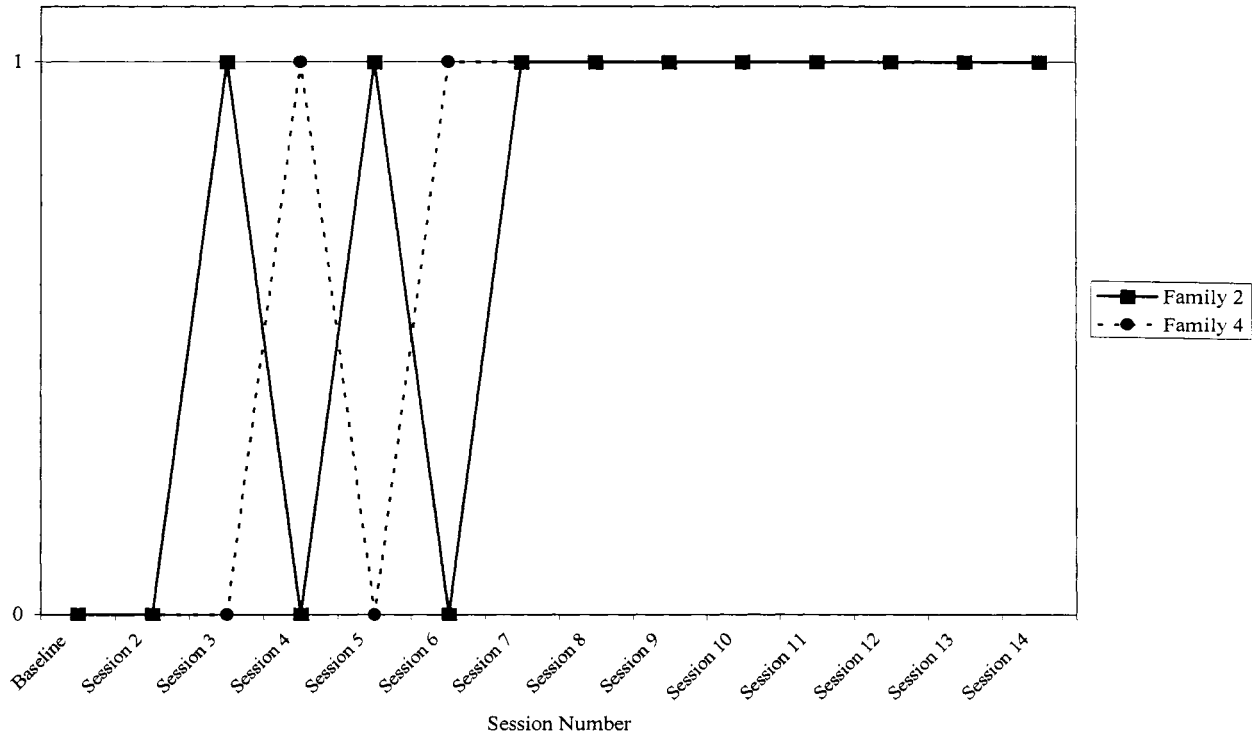

Figure 2. Child Support Payments for Families 1-5. A value of 1 indicates that support was paid. A value of 0 indicates a missed support payment. Families 1, 3, and 5 paid child support throughout treatment without incident.

Visitation by noncustodial parent. Families 1, 3, and 5 followed visitation of the children by the noncustodial parent as defined by their court order throughout treatment. Families 2 and 4 had some problems in this area and are depicted in Figure 3. The noncustodial parent in Family 2 did not have visitation as ordered on three of the first eight weeks of therapy. Visitation by the noncustodial parent followed the court order

from Session 9 through termination. After problems during the first two weeks of treatment, the noncustodial parent in Family 4 followed the visitation order from Session 3 through termination. After termination, the family went to a 50/50 shared visitation schedule.

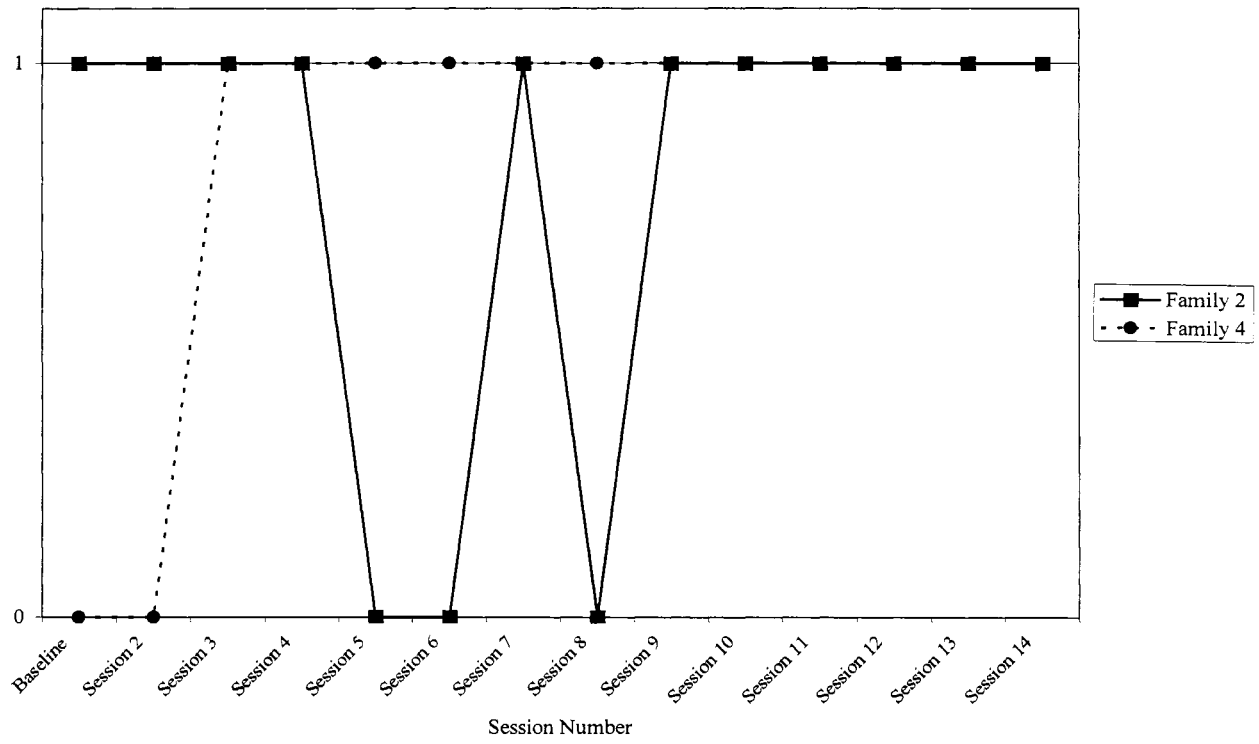

Figure 3. Noncustodial Parent Visitation for Families 1-5. A value of 1 indicates that the noncustodial parent had visitation as ordered. A value of 0 indicates that the noncustodial parent did not have visitation as ordered. Families 1, 3, and 5 had visitation as ordered throughout treatment.

Compliance with court orders. Families 1, 3, and 5 complied with the guidelines of their custody/visitation court orders throughout treatment. Court order compliance for Families 2 and 4 is illustrated in Figure 4. Family 2 failed to comply with their court order between Sessions 5 and 6. Their compliance was without incident from Session 7 through termination. Family 4 did not comply with their court order for the first two weeks of treatment. They followed their order without incident from Session 3 through termination.

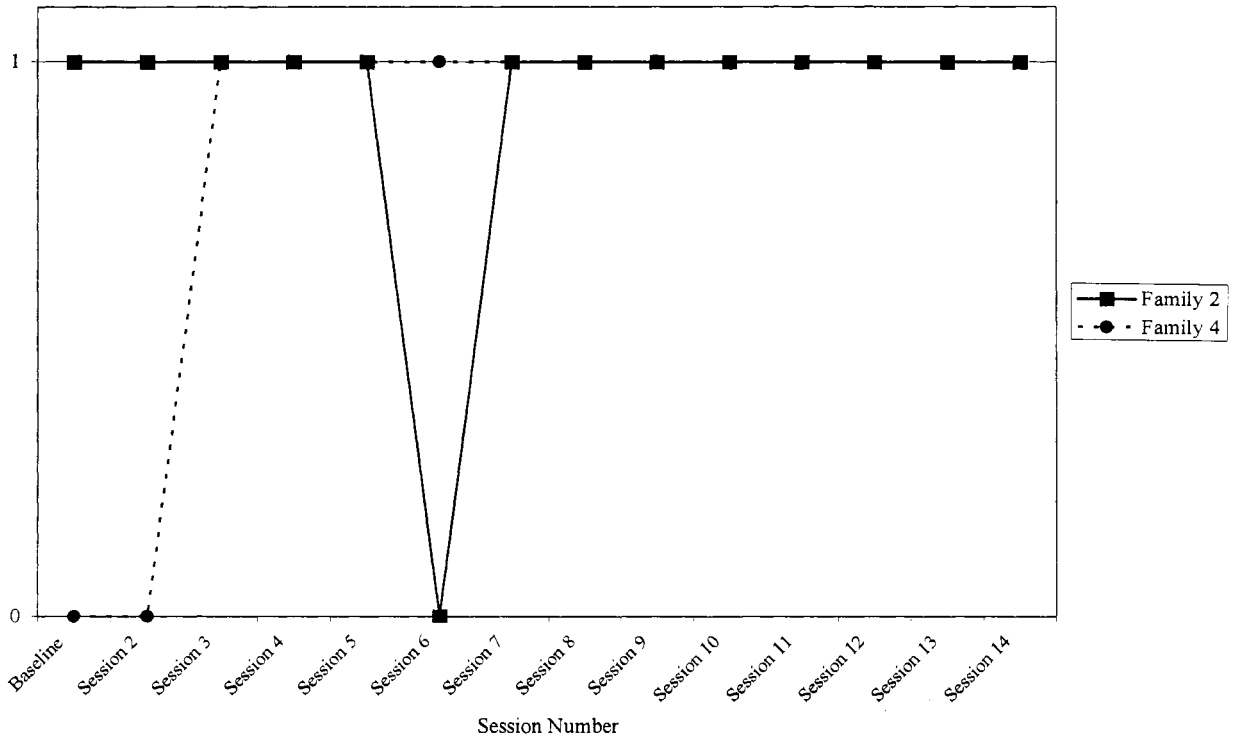

Figure 4. Court Order Compliance for Families 1-5. A value of 1 indicates compliance with the custody/visitation court order. A value of 0 indicates noncompliance. Families 1, 3, and 5 were compliant with their court orders throughout treatment.

Interparental legal problems unrelated to custody. Only one family reported legal problems that were unrelated to custody. This family had an unresolved financial dispute regarding joint assets, which remained unresolved throughout the entire course of treatment. The financial burden of this dispute caused significant hostility between the parents and had a negative impact on their ability to co-parent. The family had scheduled a court date to resolve this issue.

Legal and Physical Custody. Custody arrangements at baseline and termination were compared. Variables included Legal Custody (mother, father, or joint), Physical Custody (mother, father, or joint), and Division of Overnights. All families demonstrated a change in at least one custody variable. Four out of five families maintained joint legal custody throughout treatment. The remaining family changed from paternal legal custody to joint legal custody at termination.

In 80% of families, the noncustodial parent was granted additional visitation leading to a joint physical custody arrangement at termination. The exception was Family 1 who entered treatment with one child living with each parent. This arrangement was a temporary order in response to a family crisis. At termination, both children were placed primarily with the mother and the father was given weekend visitation. This custody arrangement mirrored the family's agreed upon arrangement that existed prior to their legal dispute. Family 4 experienced the most significant change in physical custody; the father had primary physical custody at baseline and the parents equally shared custody at termination. Family 5 maintained their custody arrangement throughout treatment.

Changes were also noted in the division of overnights the children spent with each parent over a one month period (see Figure 5). In 80% of the families, the children spent more overnights with the noncustodial parent at termination compared to baseline. On average, the noncustodial parent received an additional 4.25 overnights with the children. Again, Family 1 was an exception. The noncustodial parent spent 7 fewer overnights with the children at termination as compared to baseline.

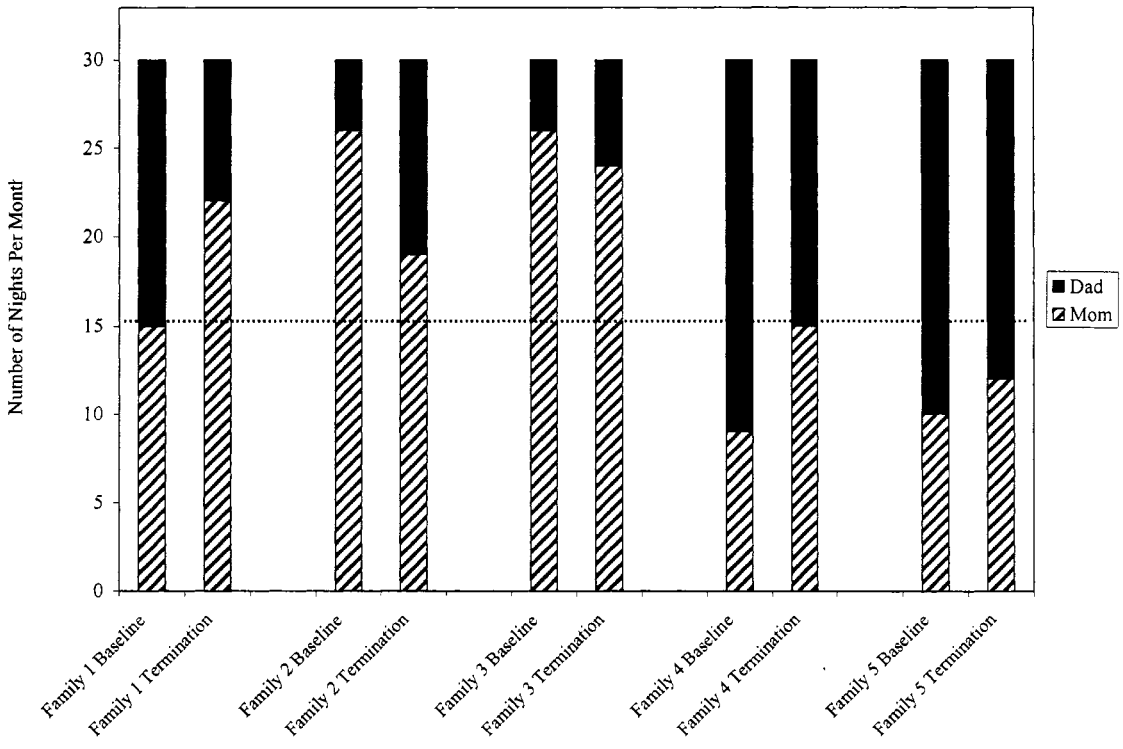

Figure 5. Division of Overnights for Families 1-5 in an average monthly period. Data were collected at baseline and termination visits. Session 8 was considered the termination time point for Family 5.

It should be noted that the division of overnights between each parent was recorded because of the court's policy of including number of overnights in child support calculations. This focus on overnights does not capture the increases in afterschool time spent with the noncustodial parents in Families 4 and 5. In both of these families, the noncustodial parent spent every weekday after school with the children.

In sum, ICT had a strong impact on legal variables. All families resolved at least some portion of their custody and/or visitation disputes, with 40% dropping their legal dispute entirely. Throughout treatment, no emergency court hearings were called and no complaints were filed with Child Protective Services. The two families who had been noncompliant with child support payments and court-ordered visitation were in complete compliance by termination. ICT did not impact the ability of one family who had additional legal problems to resolve this dispute. Finally, all families experienced custody/visitation changes. In 80% of families, the noncustodial parent was given increased visitation time between baseline and termination; an average of 4.25 additional overnights was granted between baseline and termination.

Communication

Number of weekly contacts. All families set a treatment goal to communicate at least two times per week. Thus, mean weekly contacts ≥2 will be considered to be indicative of therapeutic success.

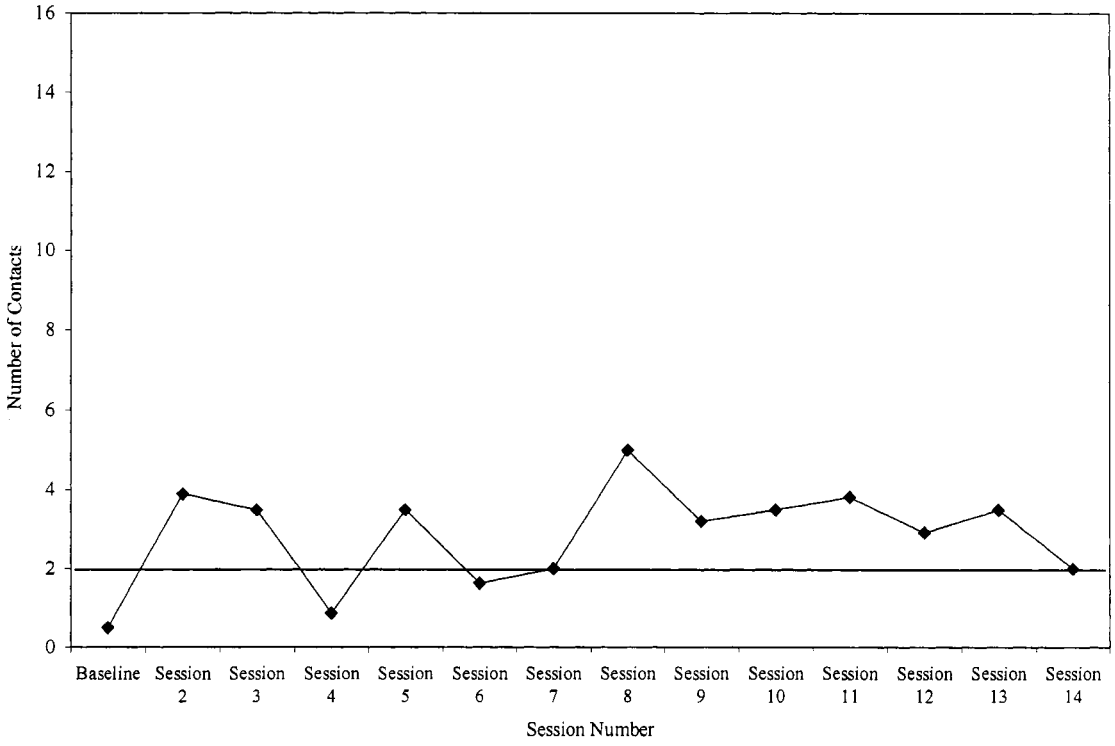

Figure 6. Family 1 – Number of Weekly Contacts.

As depicted in Figure 6, Family 1 entered treatment with a baseline communication rate of one contact every other week. They met their treatment goal of ≥2 weekly contacts from Session 7 through the end of treatment.

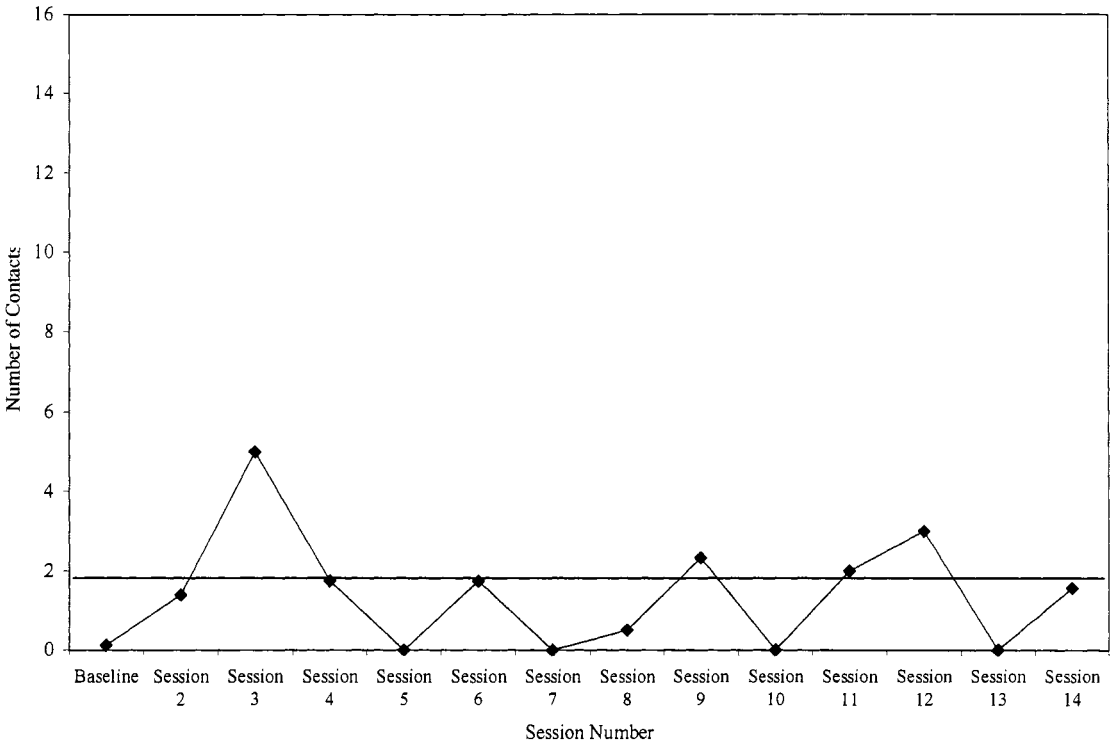

Figure 7. Family 2 – Number of Weekly Contacts.

Family 2 (see Figure 7) reported a baseline communication rate of approximately seven contacts per year. They reported a significant history of communication avoidance. During treatment, they had no contacts in the weeks prior to Sessions 5, 7, 10, and 13. On weeks when they did have contact, they generally communicated about two times but rarely surpassed this goal.

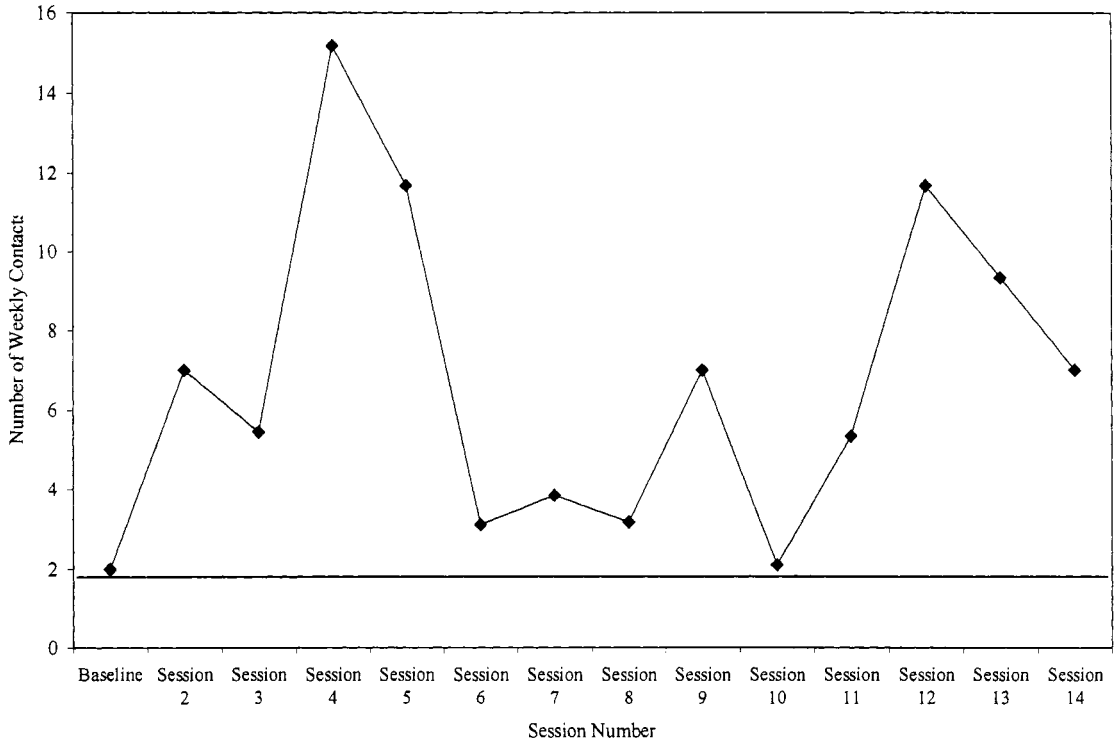

Figure 8. Family 3 – Number of Weekly Contacts.

Family 3 communicated frequently, reporting a pre-treatment communication rate of two weekly contacts (see Figure 8). Overall, they appear to have increased their frequency of communication throughout treatment, reporting ≥7 contacts prior to half of their treatment sessions. Contacts in the weeks prior to Sessions 4, 5, and 12-14 were particularly high. During the weeks prior to the final three sessions, they reported at least seven contacts.

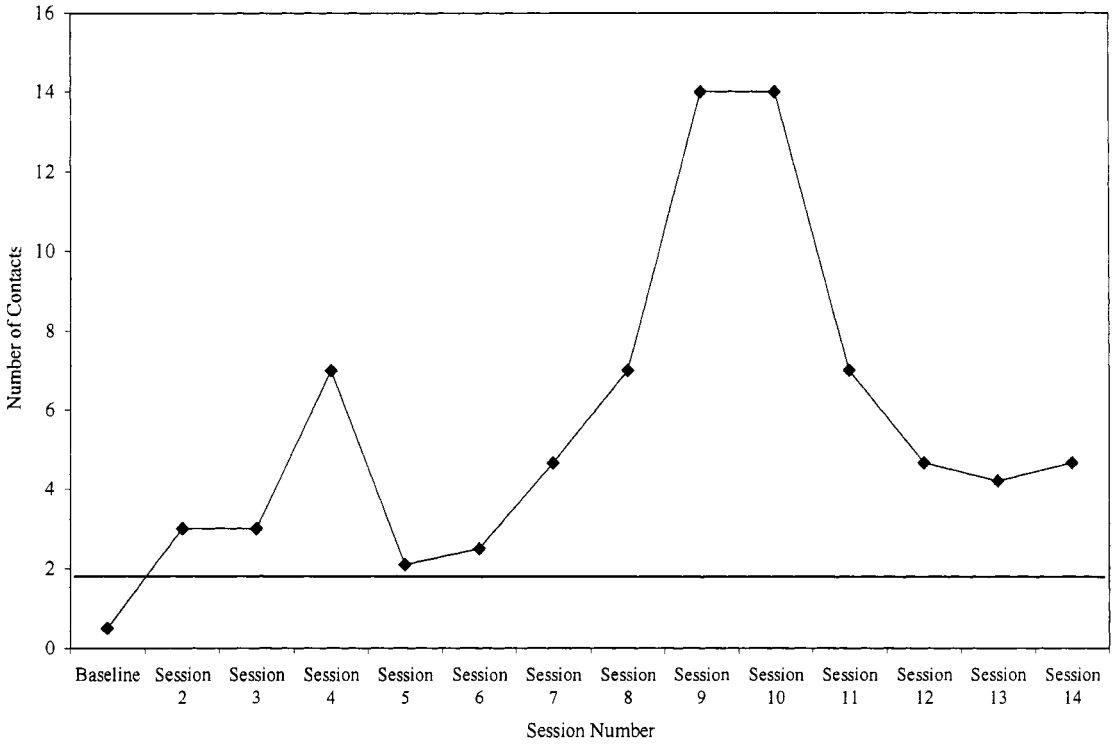

Figure 9. Family 4 – Number of Weekly Contacts.

As seen in Figure 9, Family 4 entered treatment with a baseline communication rate of one contact every other week. They exceeded their treatment goal of ≥2 weekly contacts with at least four weekly contacts from Session 7 through the end of treatment. Contacts in the weeks prior to Sessions 9 and 10 were particularly high due to a child discipline issue.

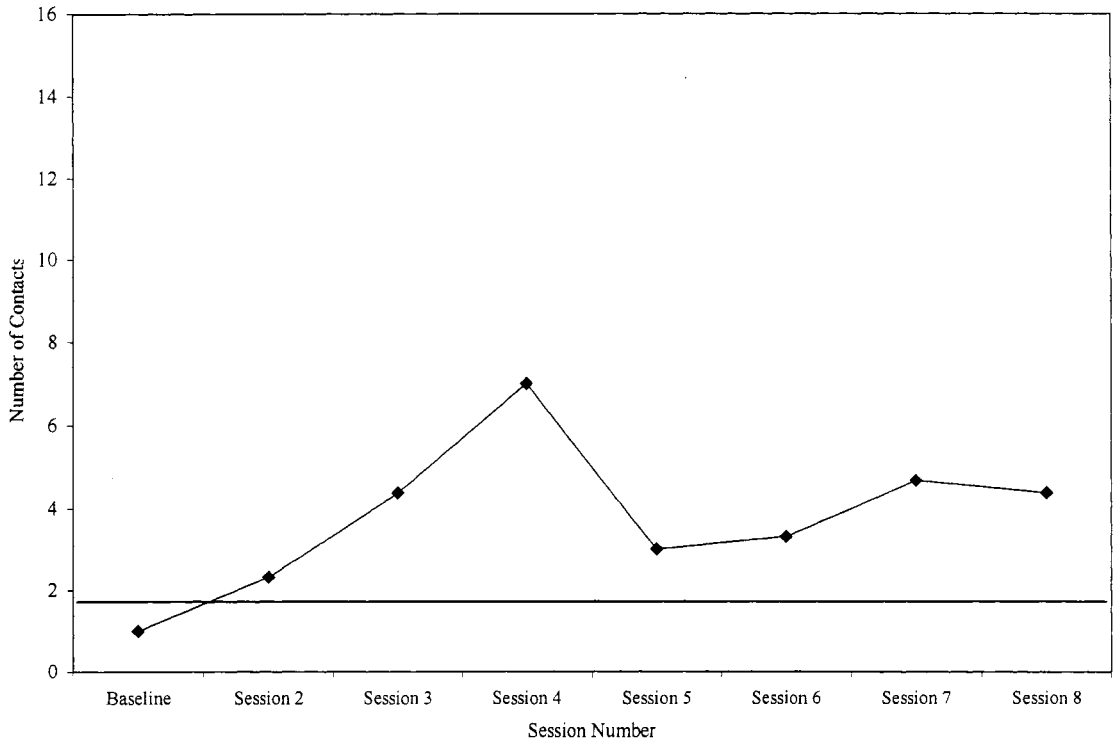

Figure 10. Family 5 – Number of Weekly Contacts.

According to Figure 10, Family 5 reported a pre-treatment communication rate of one weekly contact. They exceeded their treatment goal with ≥3 weekly contacts from Session 3 through their termination at Session 8.

Child-focused communication. All families set a goal to keep all co-parenting communication child-focused. Because clinical norms are not available for this idiographic measure, data will be described but not considered in terms of clinical significance. All communication was rated to be at least 45% child-focused with the vast

majority of contacts rated as 100% child-focused. From Session 5 through termination, 80% of contacts were reported to be 100% child-focused.

Success of communication. Success of communication was rated by both mother and father for all co-parenting contacts. Ratings were based on a 0 to 10 scale where "0" was considered "Not at all Successful", "5" was considered "Moderately Successful" and "10" was considered "Extremely Successful". Because clinical norms are not available for this idiographic measure, data will be described but not considered in terms of clinical significance.

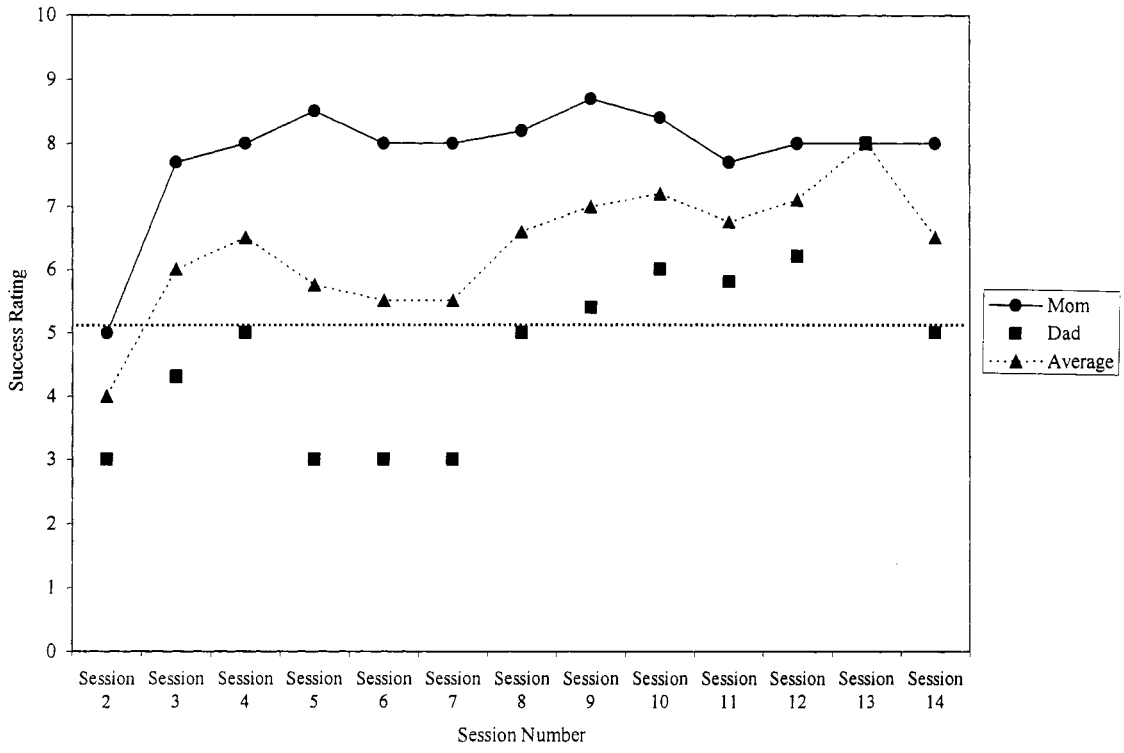

Figure 11. Family 1 – Success of Communication.

Family 1 showed an upward trend in parent ratings of communication success throughout treatment as seen in Figure 11. Across respondents, they rated their communication prior to Session 2 as a 4 as compared to a 6.5 rating upon termination. In general, the mother rated communication to be more successful than the father. She perceived that there was a great improvement in communication success over time.

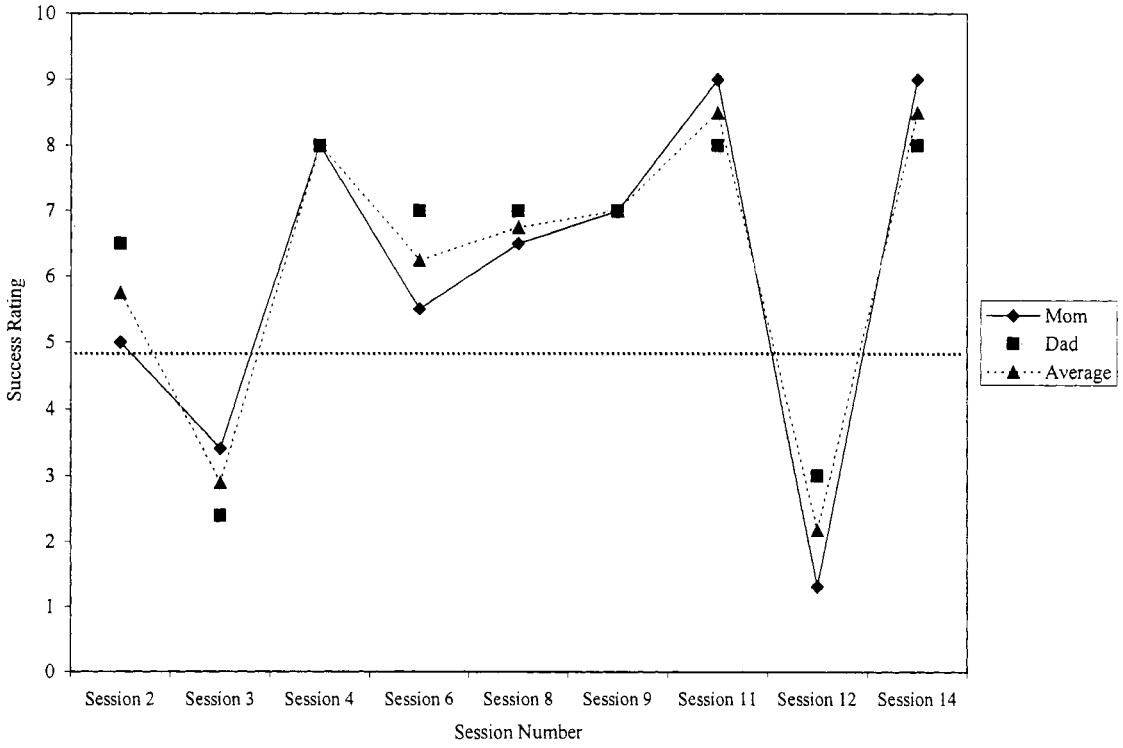

Figure 12. Family 2 – Success of Communication.

As mentioned above, Family 2 did not communicate in the weeks prior to Sessions 5, 7, 10, and 13 (see Figure 12). Overall, there appears to be an upward trend in the success ratings of both parents. Across respondents, they rated their communication

prior to Session 2 as a 5.75 as compared to an 8.5 rating upon termination. Session 12 appears to have been a particularly unsuccessful week in terms of communication with an average success rating of 2.17. This lack of success was related to a misunderstanding regarding interpretation of the visitation order. In general, mother's and father's ratings were quite similar to one another.

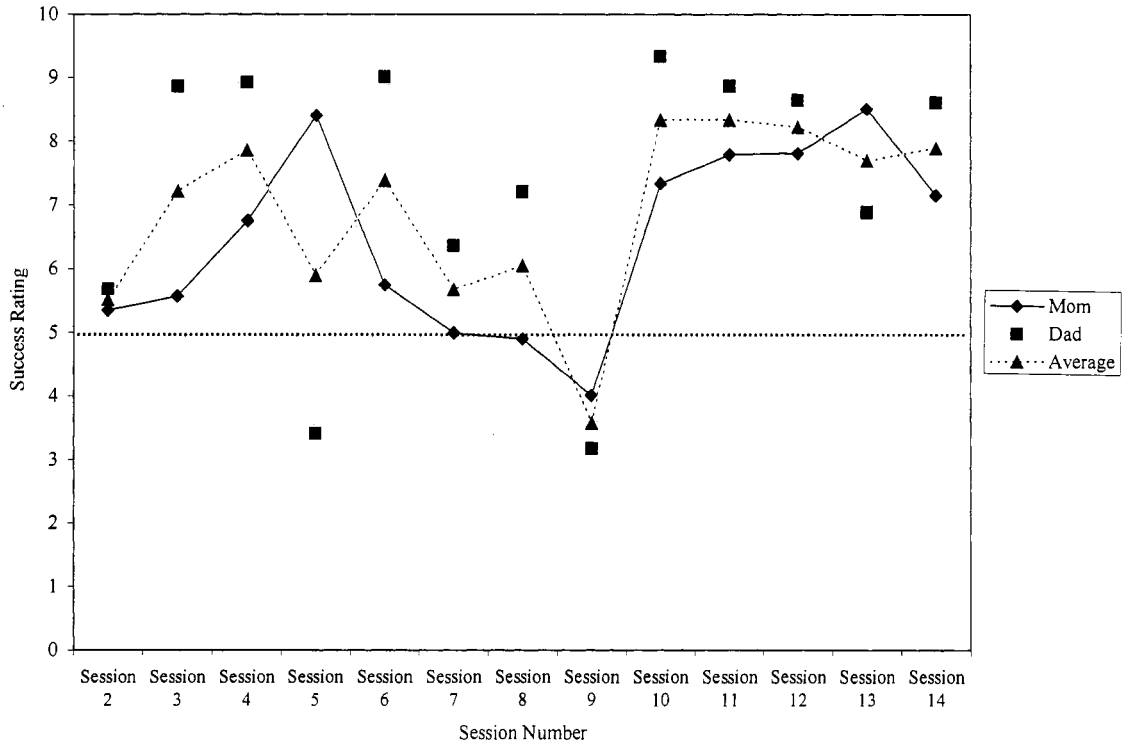

Figure 13. Family 3 – Success of Communication.

Family 3 (see Figure 13) also showed an upward trend in success ratings from the week prior to Session 2 (5.5) to termination (7.9). Communication during the weeks prior

to Sessions 5 and 9 were particularly unsuccessful. From Session 10 through termination, all success ratings were high (≥7) and appeared stable.

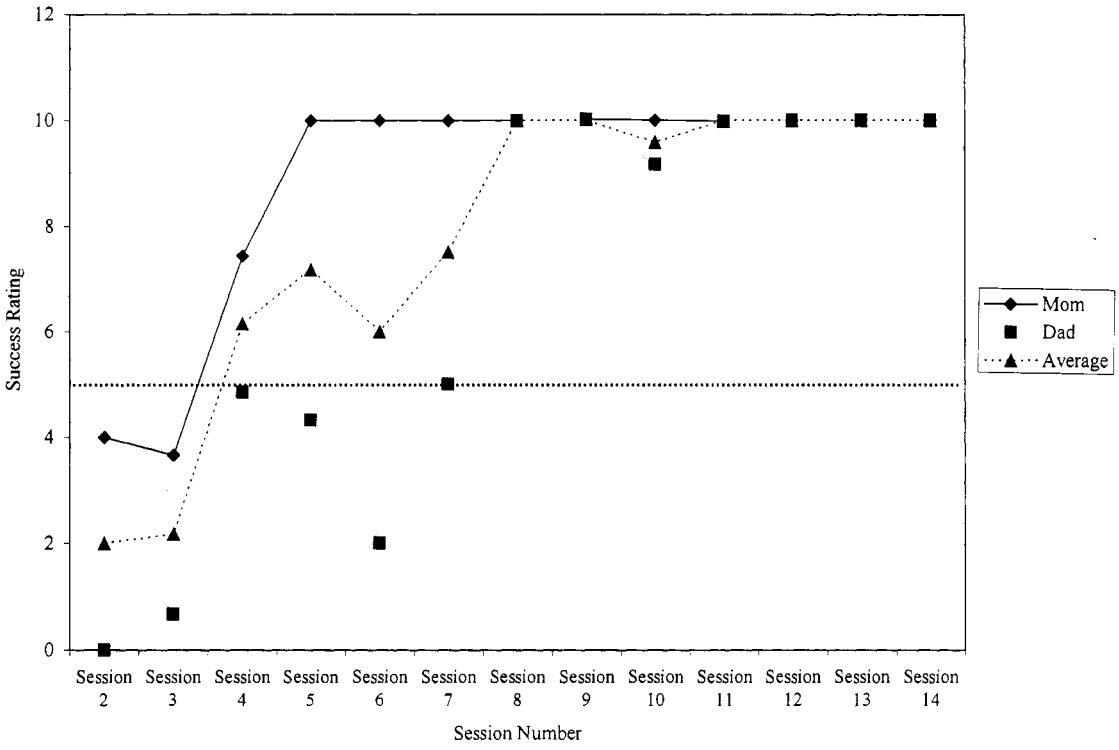

Figure 14. Family 4 – Success of Communication.

As displayed in Figure 14, Family 4 showed the greatest improvement in terms of communication success. Across respondents, they rated their communication success prior to Session 2 as a 2 as compared to a 10 rating upon termination. They rated their success as extremely successful from Session 8 through termination.

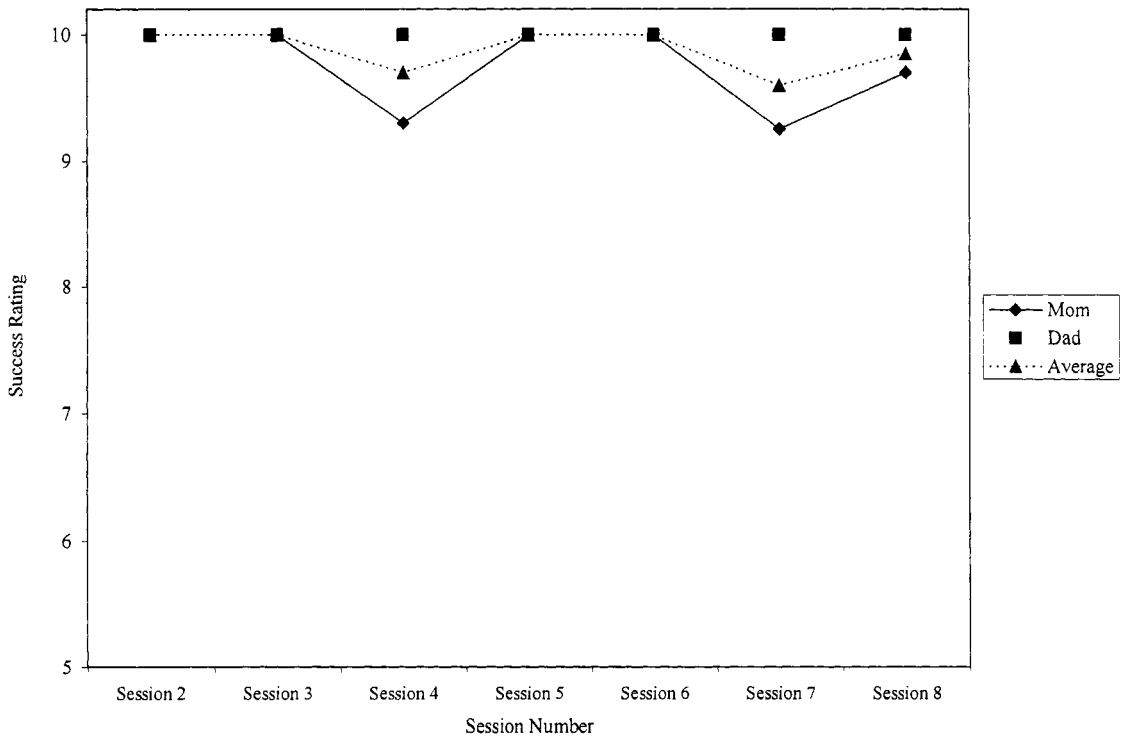

Figure 15. Family 5 – Success of Communication.

Family 5 showed no major changes across treatment sessions (see Figure 15). From the week prior to session 2 through termination, both parents rated all contacts in the extremely successful range.

Mode of communication. Telephone communication was, by far, the most common mode of communication utilized by co-parents. 76% of recorded co-parenting contacts were direct telephone conversations. The next most common mode of communication was voicemail/text message, which represented 15% of recorded contacts. 8% of contacts consisted of in-person communication. Email was used

occasionally by families; however, it was rare that both parents had email accounts that were accessed frequently enough to use email as a major communication tool.

In sum, four of the five families met their communication goal to communicate at least two times per week; three families exceeded this goal. As compared to their pre-treatment baseline, all families increased communication throughout treatment. Telephone was the most common mode of communication. Additionally, families reported an increase in their ability to keep communication child-focused. Finally, ICT strongly impacted the success of interparental communication. As treatment progressed, all families showed an upward trend in communication success ratings with a minimum of a 2.5 point gain between Session 2 and termination.

Co-Parenting and Parenting

Both co-parenting and parenting behaviors were measured by the CBQ at Sessions 1, 8, and 14. All children in the study completed this measure. All CBQ data were valid with the exception of Family 4; that child's Session 14 CBQ was invalid due to using the same response for all items without reading through the questions. T-scores at or above 65 and at or below 30 are considered to be indicative of clinical significance. Additionally, changes of $\geq$ 10 T-score points (1 standard deviation) were considered to be significant. Higher scores indicate positive co-parenting and parenting behaviors such that scores above 65 indicate positive parenting behaviors and scores below 30 indicate negative parenting behaviors.

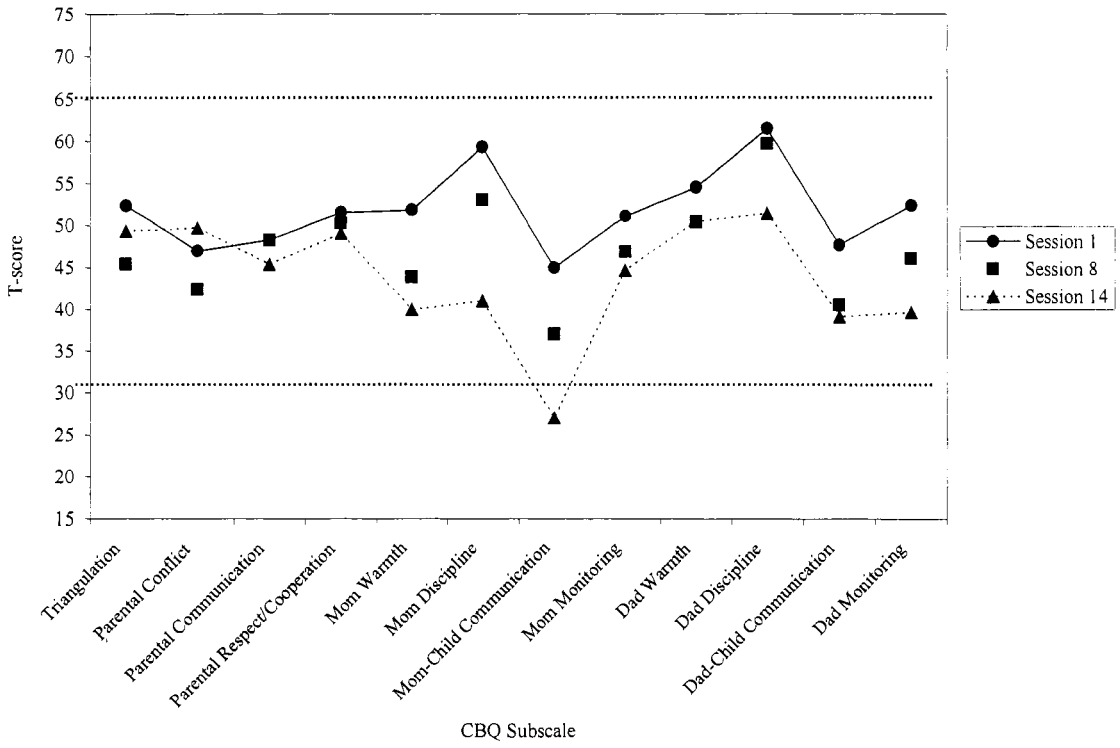

Figure 16. Family 1 – Child 1 Co-Parenting Behavior Questionnaire.

Child 1 of Family 1 indicated that most of the co-parenting and parenting behaviors measured were in the normal range (see Figure 16). As treatment progressed, significant decreases were noted in the mother's parenting behaviors in terms of warmth, discipline, and mother-child communication. In particular, the child rated mother-child communication to be at a clinically significant low at Session 14. Further, the child noted decreases in the father's parenting behaviors in terms of discipline and monitoring.

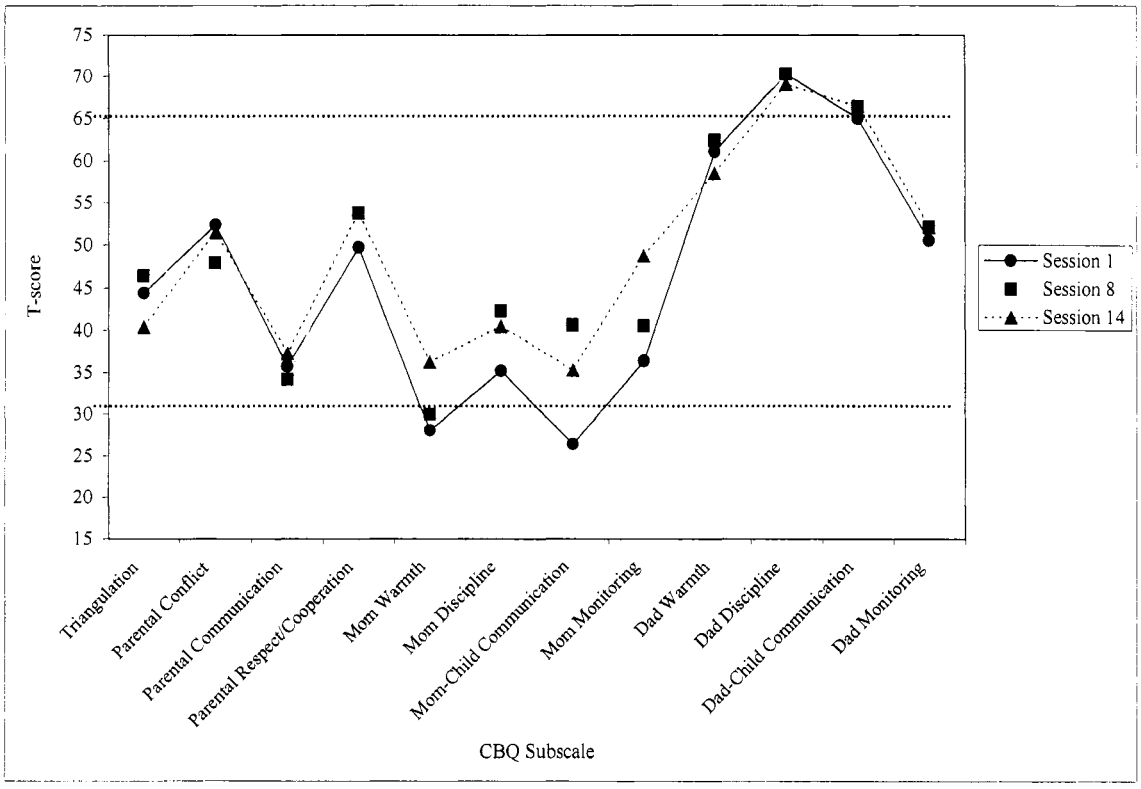

Figure 17. Family 1 – Child 2 Co-Parenting Behavior Questionnaire.

As seen in Figure 17, Child 2 of Family 1 endorsed low maternal warmth and mother-child communication at clinically significant levels at Session 1. By Session 14, significant improvements were noted in both of these domains such that ratings were in the normal range. Further, a significant increase was noted in mother's monitoring behavior. This child rated father's discipline and father-child communication to be clinically high throughout treatment. All other CBQ scales were within normal range.

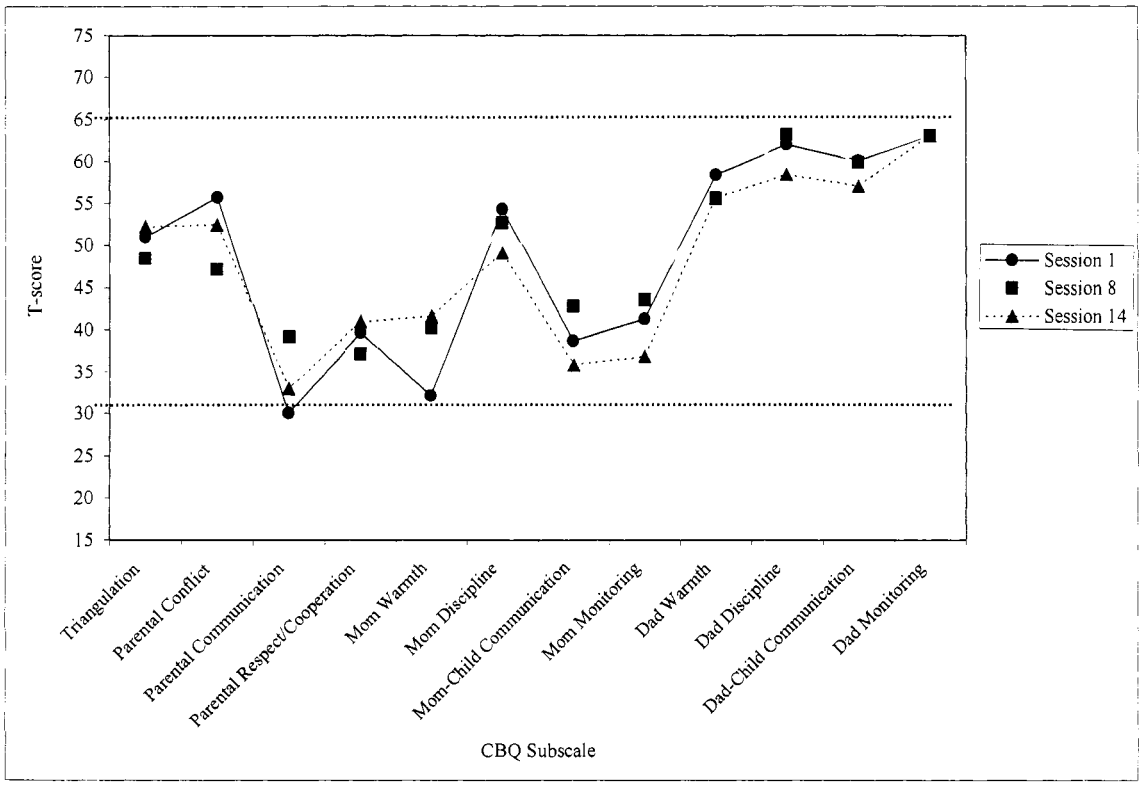

Figure 18. Family 2 – Child 1 Co-Parenting Behavior Questionnaire.

Child 1 of Family 2 endorsed significantly low levels of interparental communication at Session 1 (see Figure 18). This scale was rated within the normal range at both Sessions 8 and 14. Additionally, a significant increase in maternal warmth was noted over the course of treatment. All other CBQ scales were within normal range although the father's parenting was rated as high with slight increases.

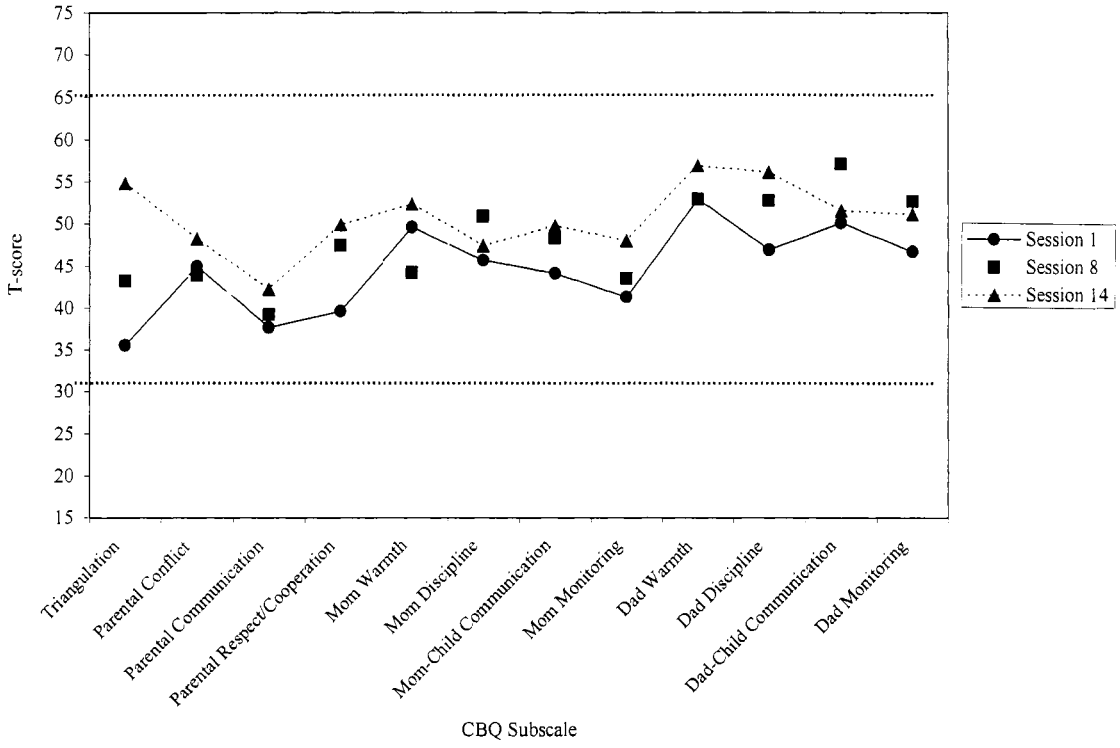

Figure 19. Family 2 – Child 2 Co-Parenting Behavior Questionnaire.

Child 2 of Family 2 rated most CBQ scales within the normal range (see Figure 19). A significant increase in triangulation was noted throughout treatment, suggesting that triangulation problems improved as treatment progressed.

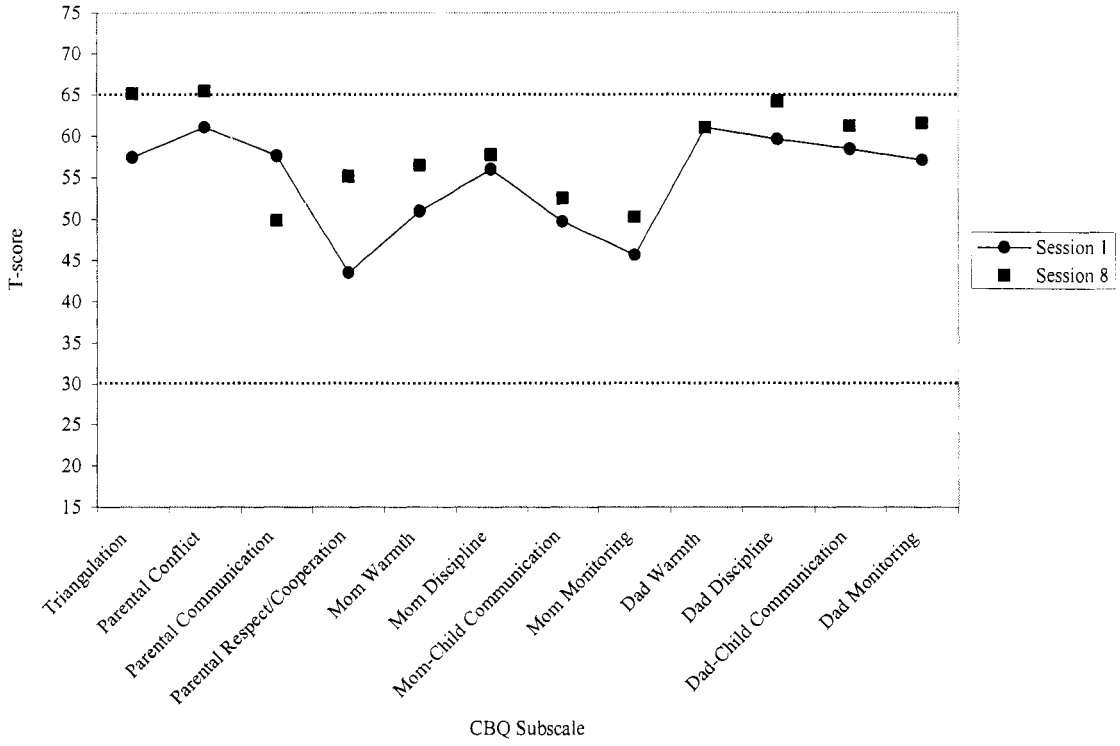

Figure 20. Family 3 – Co-Parenting Behavior Questionnaire.

As mentioned above, the child in Family 3 completed only two valid CBQs: at Session 1 and Session 8. All CBQ scales were within normal range (see Figure 20). Significant increases in triangulation, parental conflict, and parental respect/cooperation were noted between Sessions 1 and 8.

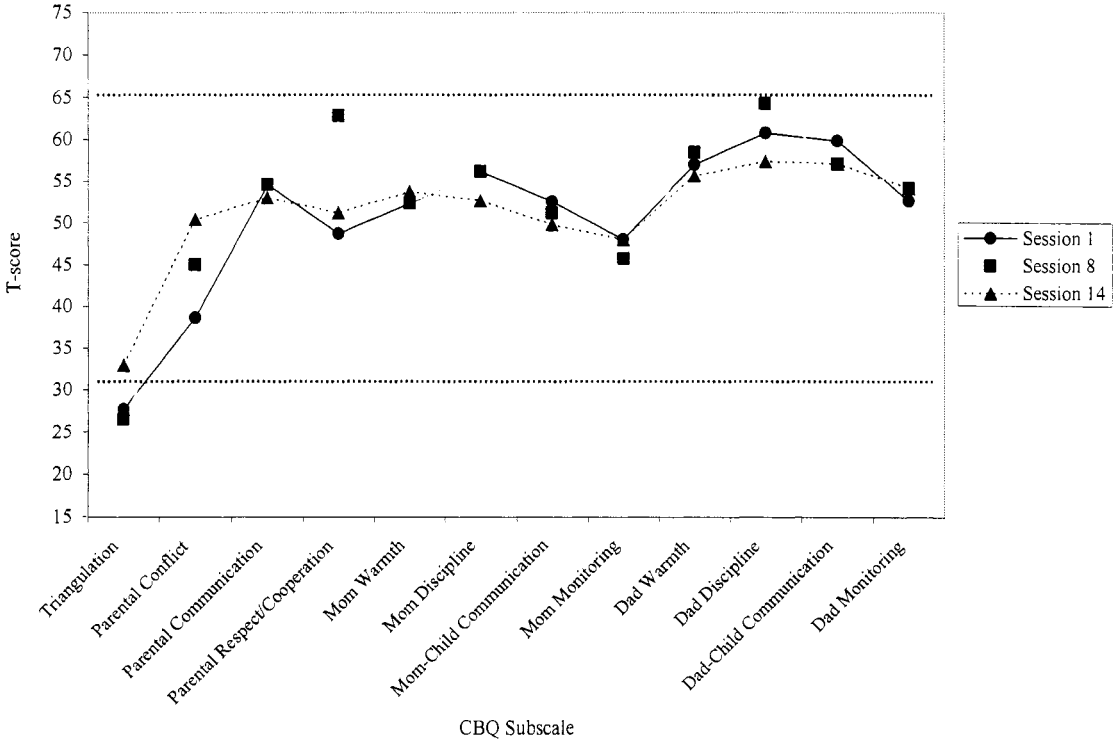

Figure 21. Family 4 – Co-Parenting Behavior Questionnaire.

The child in Family 4 indicated a clinically significantly low level of triangulation at Sessions 1 and 8 (see Figure 21), suggesting high triangulation behaviors. No changes were noted over time. Additionally, parental conflict was reported to significantly improve throughout the course of treatment. Between Sessions 1 and 8, parental respect/cooperation significantly increased; however, it returned to pre-treatment lows at Session 14. All other CBQ scales were within normal range and no changes were noted.

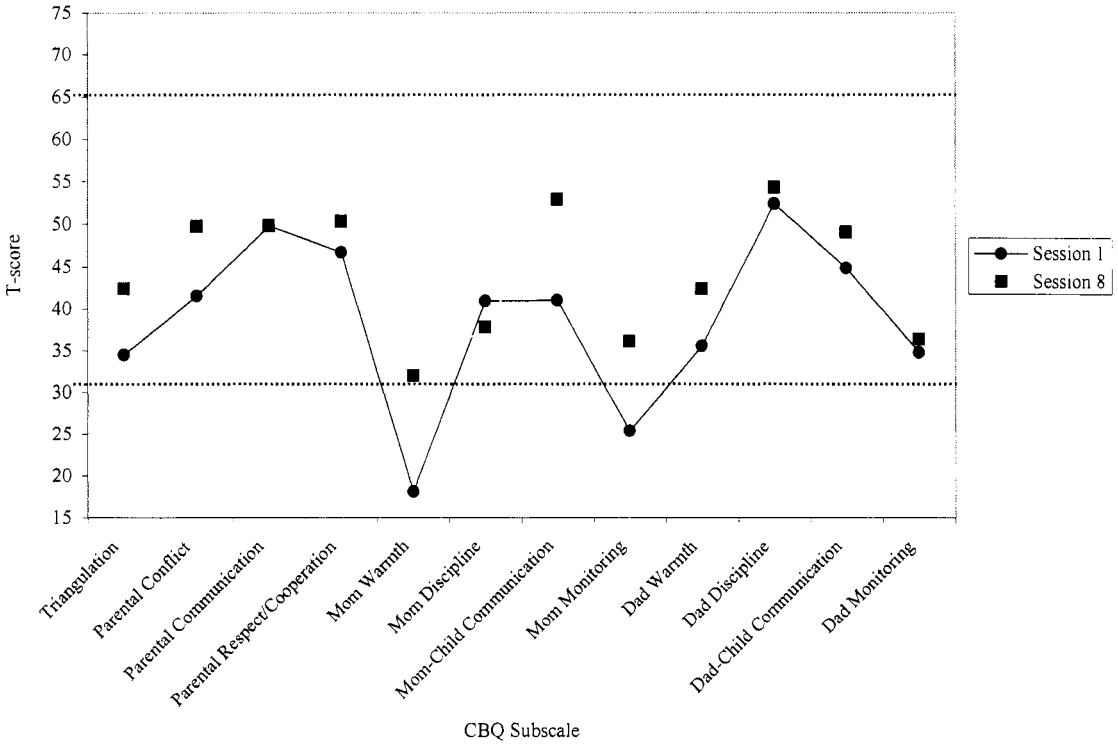

Figure 22. Family 5 – Co-Parenting Behavior Questionnaire.

Session 8 was considered the termination session for Family 5. The child in Family 5 reported significant increases in maternal warmth, monitoring, and mother-child communication between Sessions 1 and 8 (see Figure 22). In terms of clinical significance, ratings of both maternal warmth and monitoring were noted to increase from clinically low at Session 1 to the normal range at Session 8. All other CBQ scales were within normal range and no changes were noted.

Overall, most co-parenting and parenting scales on the CBQ were rated within the normal range across time points. Two families endorsed significant improvements in

parental respect/cooperation over the course of treatment. Two families indicated a significant improvement in triangulation. One family noted a significant improvement in interparental communication. Two families reported a decrease in interparental conflict over time.

Changes were also seen with regard to parenting outcomes. Specifically, three families noted significant improvements in maternal parenting behaviors such as maternal warmth, monitoring and mother-child communication. At baseline, fathers' parenting tended to be more rated as more competent than mothers' parenting. One child indicated a significant decrease in both parents' parenting behaviors over time.

Family Functioning

Family functioning measures included the FES and FPSC and were completed by both parents and children. The child in Family 4 refused to complete this assessment, but all other participants completed these measures. Measures were scored such that higher scores indicate healthier family functioning. No subscale-specific clinical cutoffs were identified in the literature. It should be noted that all study participants reported significant difficulty completing these assessments, finding the questions confusing to answer in a divorce situation. Children, in particular, had difficulty responding to items when a question elicited a different answer depending on which household was considered. They were instructed to consider both households and select the average response. Due to the reported difficulty experienced by participants when completing these measures, the validity of these administrations is questionable. In fact, the FES and

FPSC questionnaires completed by Child 1 in Family 1 were not scored due to significant missing data. This child skipped items that were difficult to understand.

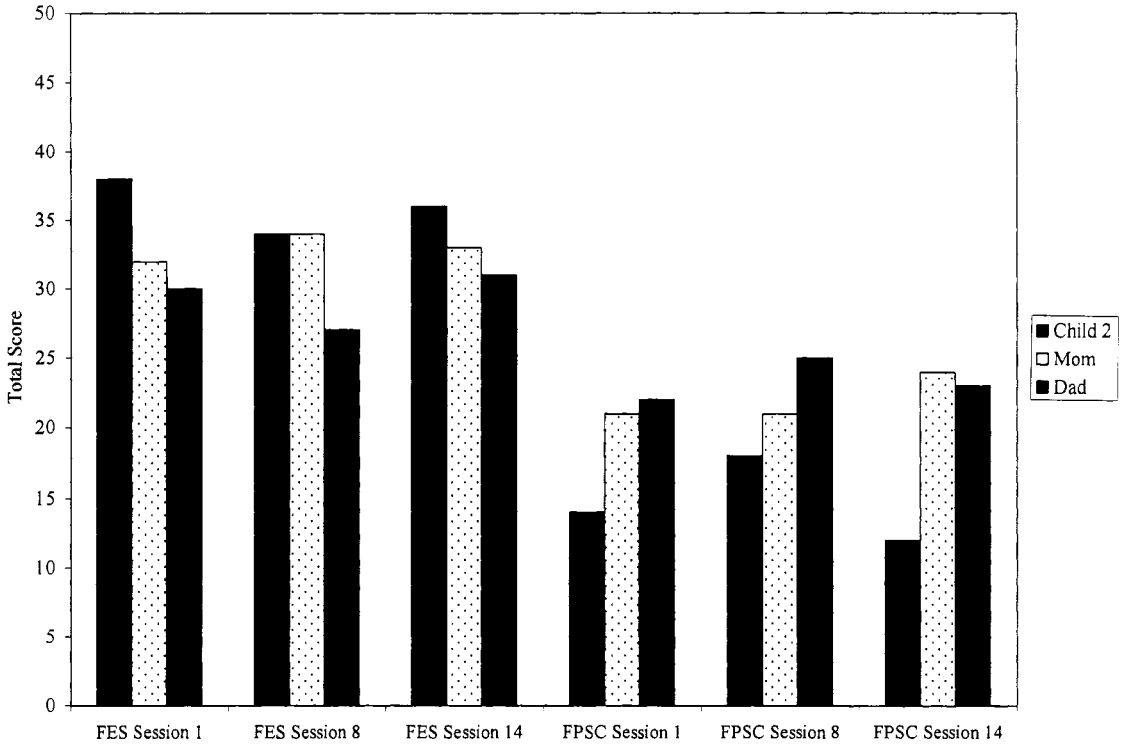

Figure 23. Family 1 – Family Functioning.

Family functioning outcomes for Family 1 are illustrated in Figure 23. Child 1 is not pictured due to invalid data. Overall, it appears that Family 1 did not note any significant changes in family functioning across Sessions 1, 8, and 14.

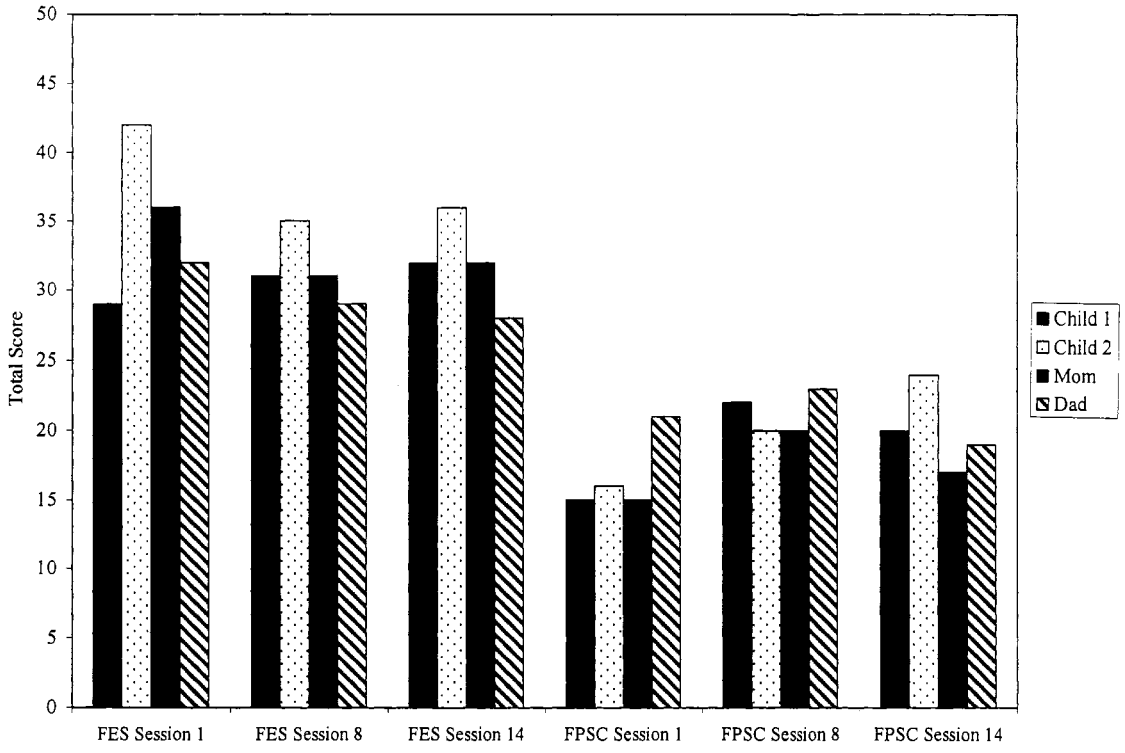

Figure 24. Family 2 – Family Functioning.

The same pattern was observed in Family 2, with the exception of Child 2 (see Figure 24). Child 2 indicated a general upward trend in family functioning, according to an 8-point increase in FPSC scores between Sessions 1 and 14. These results were different than Child 2's FES ratings which indicated a 6-pt decrease in family functioning between Sessions 1 and 14.

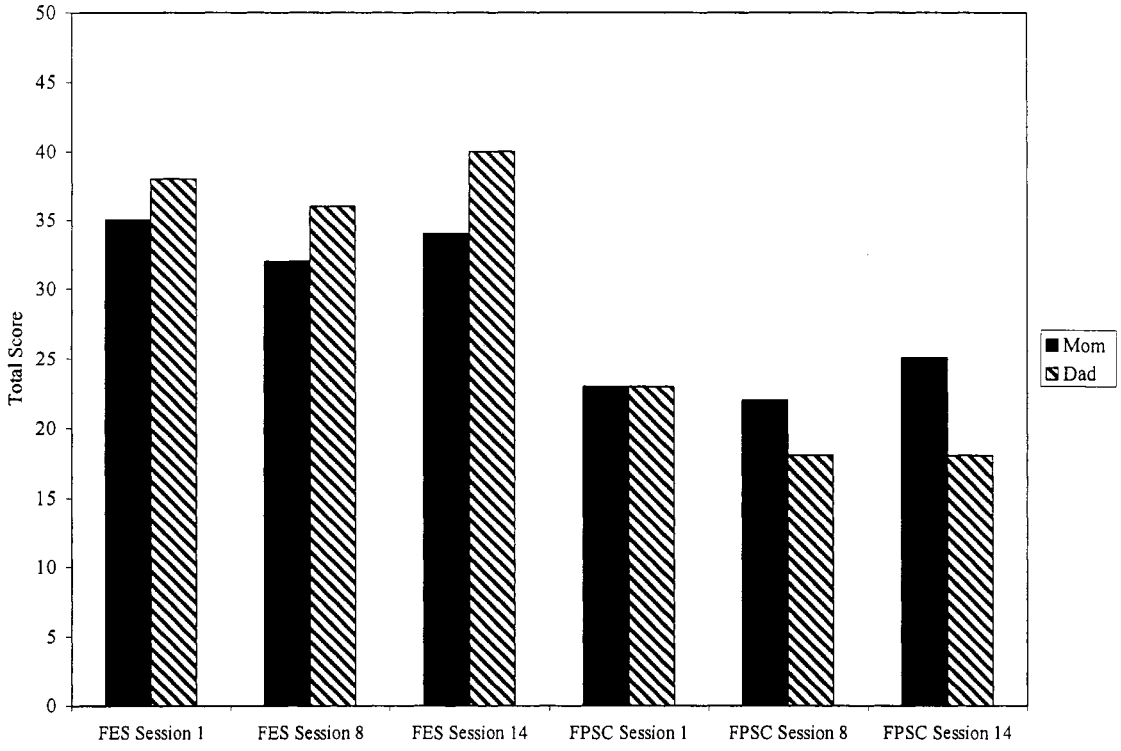

Figure 25. Family 3 – Family Functioning.

Family functioning results for Family 3 are depicted in Figure 25. The child in Family 3 refused to complete all family functioning measures. The parents in Family 3 did not note any significant changes in family functioning across Sessions 1, 8, and 14.

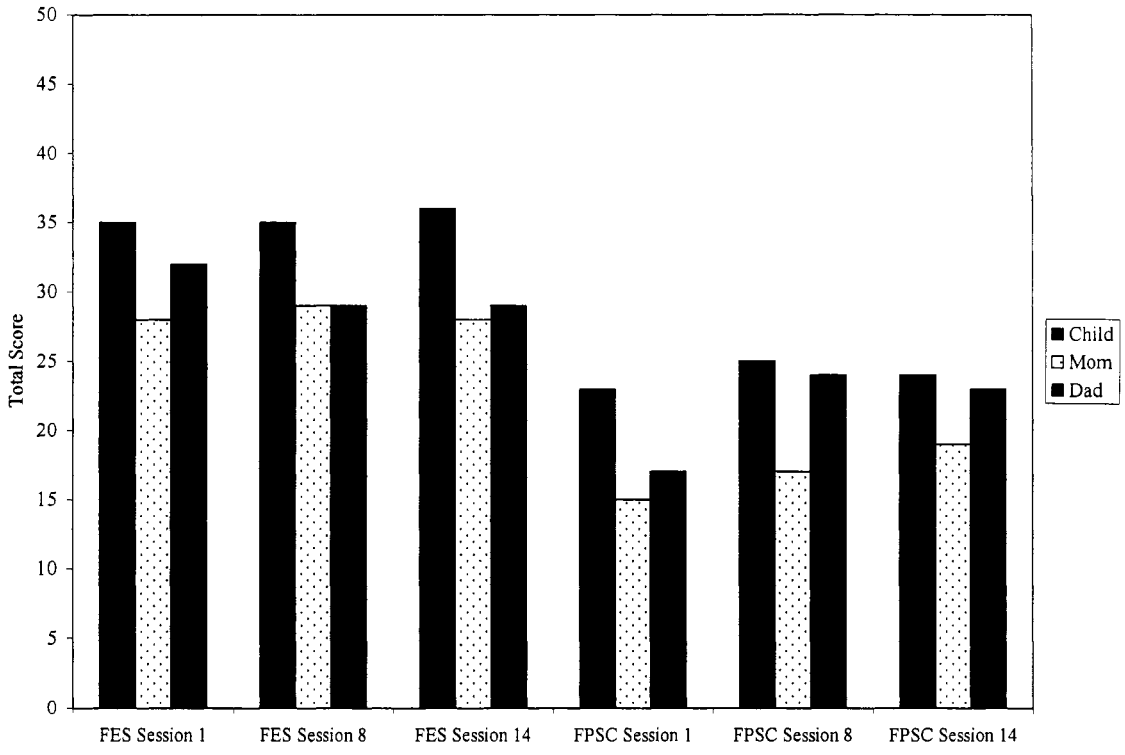

Figure 26. Family 4 – Family Functioning.

Overall, Family 4 did not note significant changes in family functioning throughout treatment (see Figure 26). According to the father's FPSC report, there may have been some increase in family functioning. He endorsed a 7-point increase in FPSC score between Sessions 1 and 8 which was generally maintained at Session 14. This finding was not replicated on the FES.

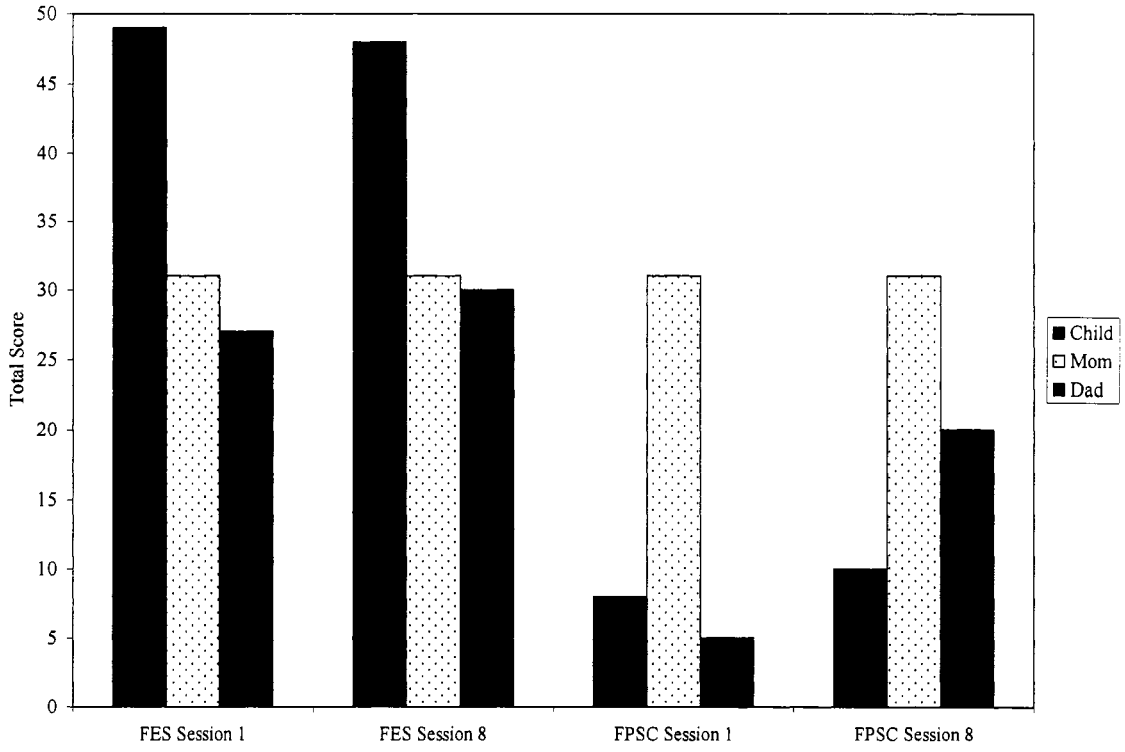

Figure 27. Family 5 – Family Functioning.

Finally, Family 5 child and mother reports did not note changes in family functioning on either the FES or FPSC. The father did report a significant increase in family functioning according to the FPSC. Between Sessions 1 and 8, a 15-point increase in FPSC scores was noted. Again, this pattern was not replicated on the FES.

In sum, ICT had little impact on family functioning as measured by the FES and FPSC. Across all five families, no changes were found in FES scores. In three of the families, one respondent within each family did indicate significant improvements in

family functioning on the FPSC. Due to the difficulty participants had completing these measures, results should be interpreted with caution.

Child Adjustment

ASEBA child adjustment measures were completed by children, parents, and teachers when available. T-scores at or above 65 are considered to be indicative of a clinically significant adjustment problem. All parents completed valid Child Behavior Checklists at Sessions 1, 8 and 14 (with the exception of Family 5 who terminated treatment at Session 8). All children in Families 1, 2, 3, and 5 completed valid Youth Self-Reports across time points. The child in Family 4 refused to complete this assessment. Unfortunately, the return rate for Teacher Report Forms was low. Families 3, 4, and 5 were missing all teacher reports. Termination teacher assessments for Families 1 and 2 were unable to be completed due to summer vacation. Additionally, Child 2 of Family 1 had only one TRF at baseline and Child 1 of Family 2 had only one TRF at Session 8.

According to all reporters, both children in Family 1 demonstrated non-clinical levels of Internalizing, Externalizing, and Total Problems across all time points (see Figures 28 and 29).

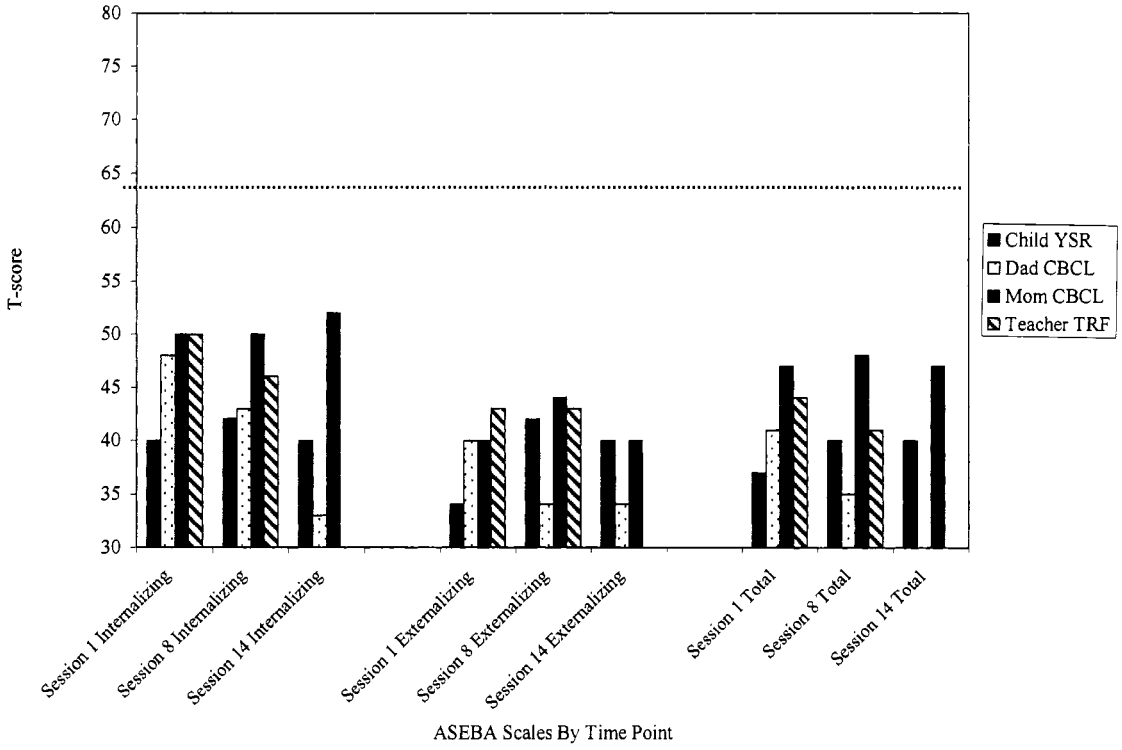

Figure 28. Family 1 – Child 1 Child Adjustment

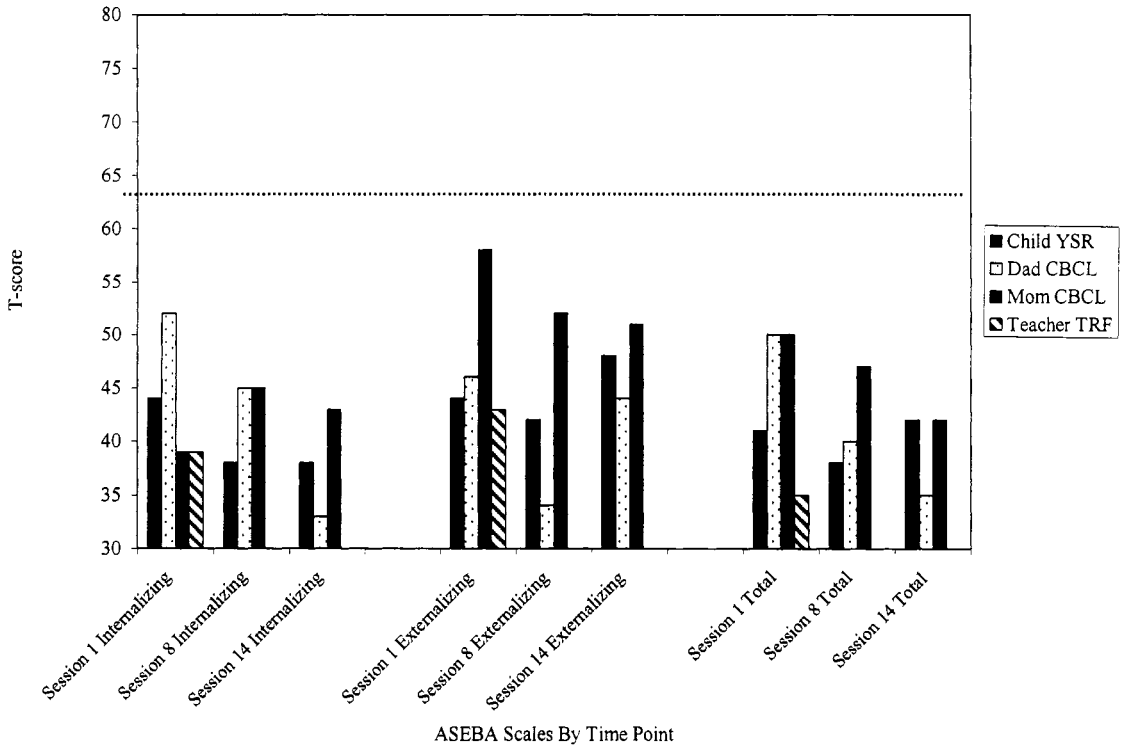

Figure 29. Family 1 – Child 2 Child Adjustment

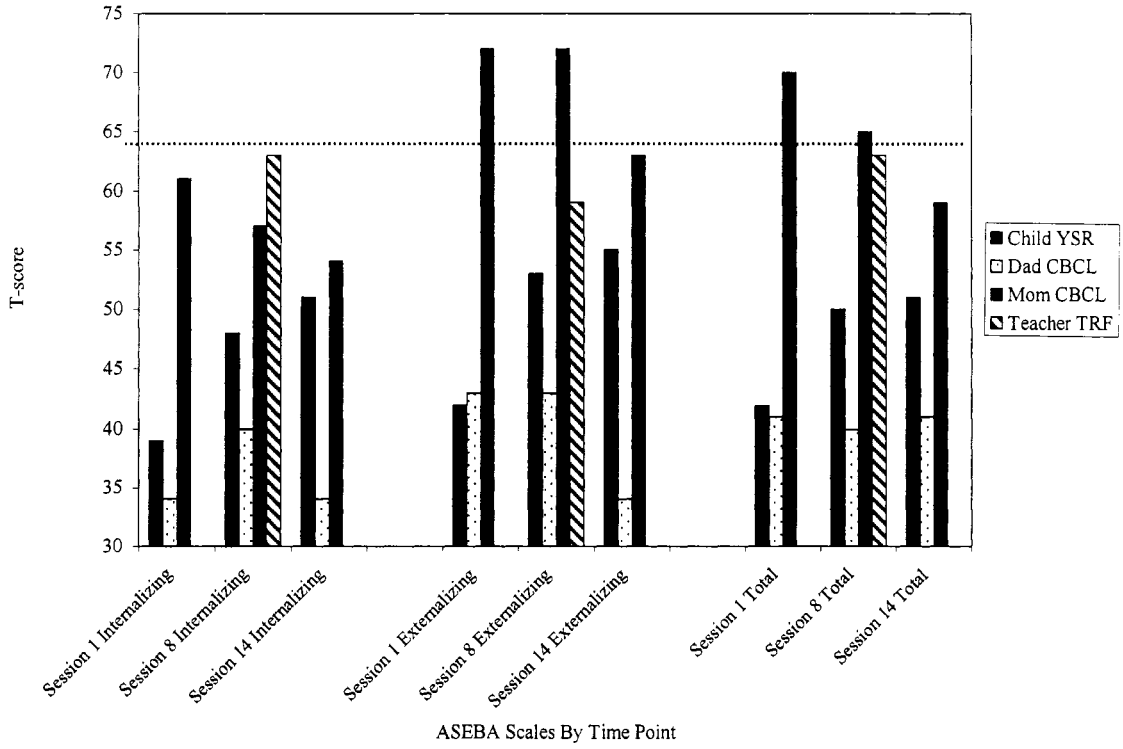

Figure 30. Family 2 – Child 1 Child Adjustment

According to the child's mother, Child 1 in Family 2 demonstrated clinical levels of Externalizing Problems at Sessions 1 and 8 (see Figure 30). At Session 14, she continued to rate these problems high (T-score = 63) but they were below clinical levels. The same pattern was seen in the mother's report of this child's Total Problems. The child, father, and teacher rated this child's Internalizing, Externalizing, and Total Problems within the normal range. This pattern of results makes sense given that the family's legal dispute originated from the high level of conflict between this child and the mother.

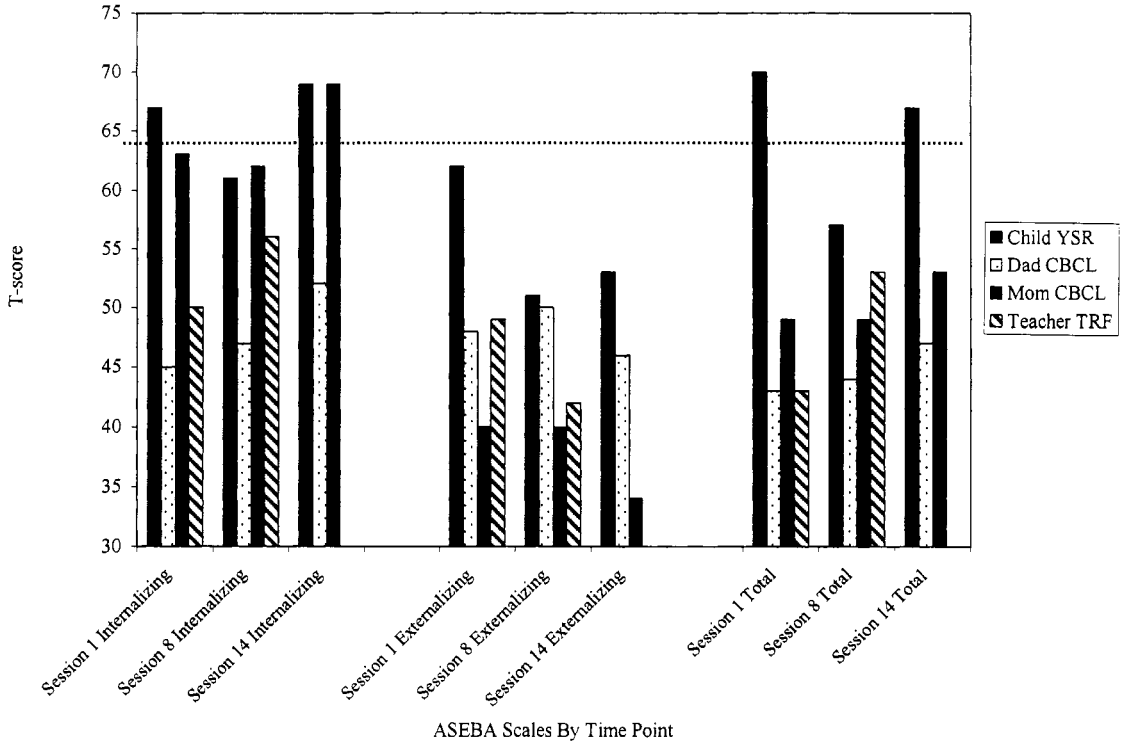

Figure 31. Family 2 – Child 2 Child Adjustment

Child 2 in Family 2 (see Figure 31) reported clinically significant levels of Internalizing Problems and Total Problems at both Sessions 1 and 14. At Session 8, this child also indicated high levels of Internalizing Problems (T-score = 61) but they were below clinical levels. Due to the child's endorsement of suicidal ideation and parasuicidal behaviors, the study therapist informed the parents and referred the child for individual treatment. It is believed that this referral increased the parents' recognition of the child's distress. Therefore, the mother reported perceptions that the child was experiencing

clinical levels of Internalizing and Total Problems at Session 14 when she had not endorsed symptoms at this level at previous time points. Although his perceptions remained below clinical levels, the father also endorsed a greater number of Internalizing Problems as treatment progressed. Overall, father and teacher reported all ASEBA scales to be in the normal range.

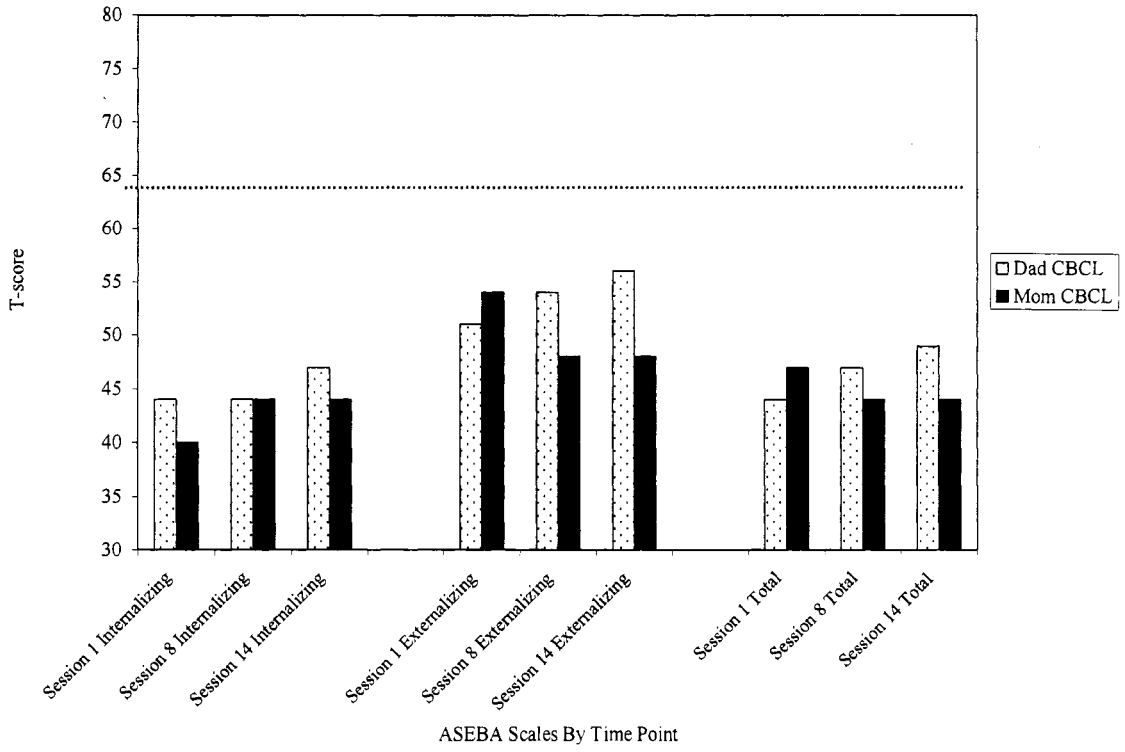

Figure 32. Family 3 Child Adjustment.

Family 3 only included parent CBCL measures of child adjustment due to the child's refusal to complete the YSR and missing TRF data (see Figure 32). According to

both parents, this child did not demonstrate clinical levels of Internalizing, Externalizing, or Total Problems across time points.

According to parent report, the child in Family 4 did not experience clinical levels of Internalizing, Externalizing, or Total Problems across time points (see Figure 33). The child's self-report, however, indicated clinical levels of Internalizing and Total Problems across all time points. No changes were noted.

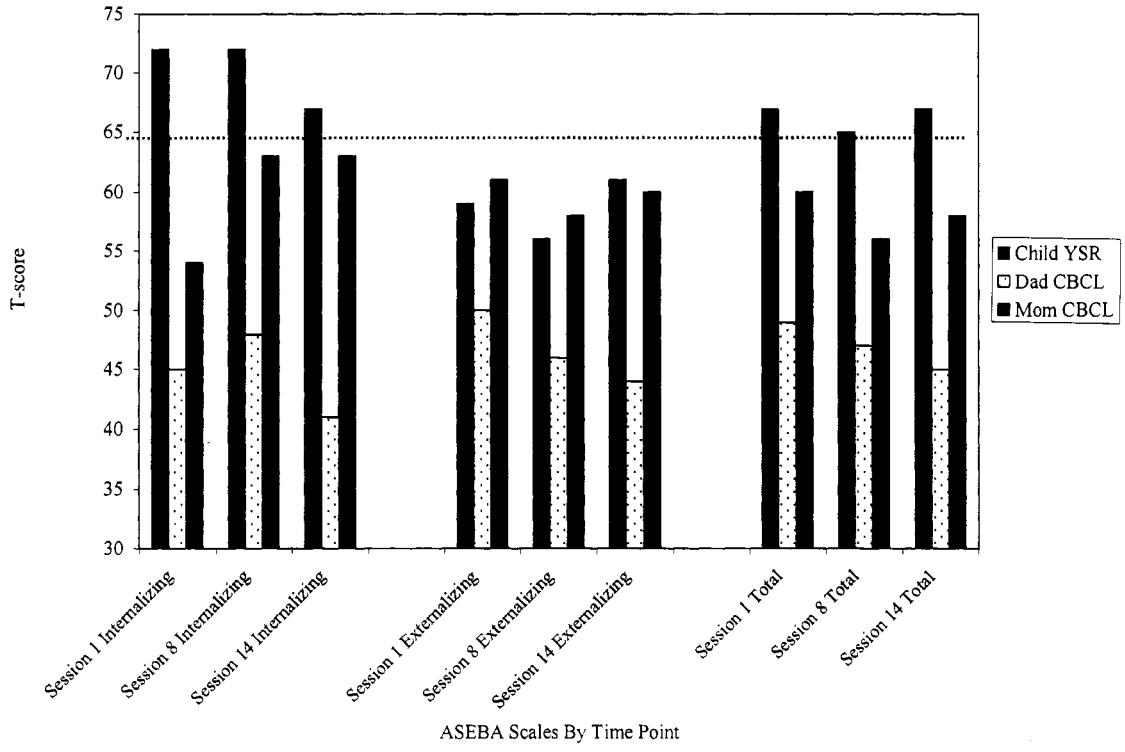

Figure 33. Family 4 Child Adjustment.

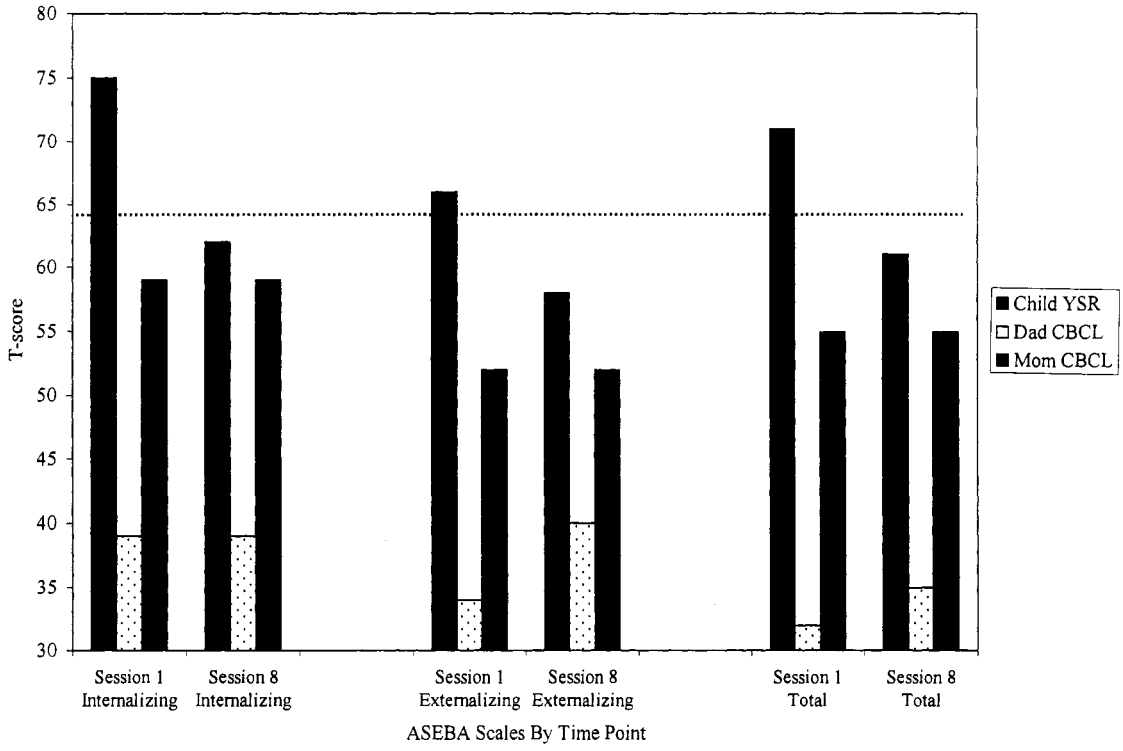

Figure 34. Family 5 Child Adjustment.

According to parent report, the child in Family 5 did not experience clinical levels of Internalizing, Externalizing, or Total Problems across time points (see Figure 34). The child's self-report did indicate clinical levels of problems across all domains assessed at Session 1. At Session 8, significant changes were noted across YSR scales as Internalizing, Externalizing, and Total Problems were perceived to be in the normal range.

Overall, the children enrolled in this study tended to demonstrate normal levels of child adjustment. Across all reporters, both children in Family 1 and the child in Family 3 were in the normal range in terms of child adjustment across all time points. ICT did not have an impact on the child in Family 4 who reported significant internalizing and total problems across all time points. One child in Family 2 and the child in Family 5 reportedly experienced clinical levels of adjustment problems at baseline, and were in the non-clinical range at termination. The other child in Family 2 indicated clinical levels of internalizing and total problems across all time points. Likely due to the study therapist's alerting the parents to this child's at-risk status, both parents reported a greater number of internalizing and total problem behaviors in this child as treatment progressed.

Discussion

Overall, Intensive Co-parenting Therapy (ICT) looks to be a very promising treatment for families of separation and divorce. ICT significantly impacted all outcome variables measured, although the clinical significance of that impact varied greatly across domains. ICT had the greatest impact on legal and communication outcome variables. Interestingly, these domains were measured in a very objective and events-based manner. Results in the domains of co-parenting and parenting behaviors, family functioning, and child adjustment, while noteworthy and reflective of positive outcomes, were more varied. They were also measured in a way that reflected more subjective appraisals.

Legal Outcomes

ICT had the strongest impact on the various legal outcomes measured throughout treatment. Most notably, 100% of families in the study resolved at least some portion of their custody and/or visitation disputes. Thus, the intervention appears to have posed some relief to the court system. Remarkably, 40% of families dropped their legal dispute entirely. These families cited an improved co-parenting relationship as well as removing a frustration with a cumbersome and expensive legal process as their reasons for settling their disputes. Both families selected a shared custody arrangement upon termination. The remaining 60% of families were able to determine holiday, summer, and/or visitation schedules based on the needs of their families rather than leaving those details for a judge to determine.

Throughout treatment, no emergency court hearings were called and no complaints were filed with Child Protective Services. While most families did not have problems paying child support or following their court orders, the two families that did have problems in these areas had perfect child support and court order compliance by termination. 80% of families did not have other legal problems that were unrelated to custody and visitation. ICT had no impact on the ability of the one family that did have significant legal problems to resolve their additional dispute.

All families experienced some change in custody status. All families shared joint legal custody by termination, although four had entered treatment with this arrangement. 80% of families increased the visitation time allotted for the noncustodial parent between baseline and termination; these families shared joint physical custody at termination. On average, noncustodial parents had 4.25 additional overnights at termination as compared to baseline. Two families also granted additional after school time to the noncustodial parent. The one family that actually decreased the visitation of the noncustodial parent returned their custody to the arrangement that existed prior to their legal dispute. As the goal for this family was to return the children to their mother's primary care, the final custody determination for this case was considered a treatment success. In terms of legal outcomes, ICT had the strongest impact on Family 4. This family entered treatment with the father having primary legal and physical custody and were able to instate a 50/50 arrangement by termination, completely resolving their dispute.

Communication

All families set a goal to communicate at least two times per week. Four of the five families met this goal and three exceeded the goal. Throughout treatment, Family 2 continued to have some weeks without communication. On weeks when they did communicate, they generally met the goal of two contacts per week. It is important to note that this family did improve over time from their pre-treatment rate of communication which was estimated to be seven contacts per year. All families increased communication throughout treatment as compared to their pre-treatment baseline. Telephone was the most common mode of communication, accounting for 76% of all contacts.

In addition to increased frequency of communication, families appeared to increase their ability to keep their communication child-focused. Across families from session 5 through termination, 80% of contacts were reported to be 100% child focused. ICT also had a strong impact on the success of communication, suggesting that not only the quantity but the quality of co-parenting communication improved over time. All families showed an upward trend in communication success ratings as treatment progressed. Across families, success ratings showed a minimum of a 2.5 point gain between Session 2 and termination. Family 4 showed the greatest improvement, beginning treatment with a 2/10 success rating and ending with a 10/10 rating. Family 5 did not show changes over time, as they rated the success of their communication to be excellent throughout treatment.

Co-Parenting and Parenting

Overall, most co-parenting and parenting scales on the CBQ were rated within the normal range across all time points. These data are surprising since the hostility of the co-parenting relationship and the inability of the co-parents to communicate or cooperate tended to be the reasons for their referral to treatment. Additionally, the study therapist considered four out of the five families to be experiencing clinically significant co-parenting difficulty at baseline.

CBQ outcome data were relatively inconclusive. Children in two of the families noted significant improvements in parental respect/cooperation. Additionally, two families indicated a significant decrease in triangulation (putting the children in the middle). Only one family endorsed a clinically significant improvement in interparental communication. Finally, the children in two families noted a decrease in interparental conflict over the course of treatment. All findings were in the expected direction.

Maternal parenting behaviors in particular, showed some significant changes as measured by the CBQ parenting scales as treatment progressed. This is likely due to the fact that children in the study more often had conflict with their mothers than their fathers at baseline. In general, father's parenting behaviors were perceived as more competent at baseline. In Family 1, where one child had a significant conflict with the mother, that child noted that the mother's parenting behaviors significantly increased throughout treatment. Ironically, the other child in this family indicated that the mother's parenting behaviors significantly decreased over time. That same child indicated that the father's

discipline and monitoring decreased over time, although both domains were still rated within the normal range. Over the course of treatment, two additional families indicated that maternal warmth significantly increased throughout treatment. One family also found that maternal monitoring and mother-child communication increased over time.

While it is often argued that child report is the most accurate perception of parenting and co-parenting behaviors (Ferrante, 2005; Macie & Stolberg, 2003; Mullett & Stolberg, 1999), study results may contradict this view. For example, only one family made clinically significant improvements in interparental communication according to child report (CBQ). According to parent records of all interparental communication, all five families increased both the quantity and the quality of their interparental communication. In this case, parent records are certainly a more objective measure of this outcome. The large discrepancy between child and parent report suggests that there may be similar discrepancies across other scales. If parents are co-parenting well and communicating out of earshot of the children, it is unlikely that children will be able to report accurately the quantity or quality of this communication. Further, it is important to note that the CBQ has never been used before as a treatment outcome measure. Perhaps, the test-retest reliability of the CBQ should be assessed to determine whether repeat administrations are recommended. The CBQ may be more of a "trait" than a "state" measure of family processes.

Family Functioning

As measured by both the FES and FPSC, Intensive Co-parenting Therapy had little impact on family functioning. Across all five families, no changes were found in FES scores. FPSC results were slightly more promising. In three of the families, one respondent did indicate significant improvements in family functioning. Specifically, the fathers in Families 4 and 5 indicated improved family functioning on the FPSC. One of the children in Family 2 also noted improvements in family functioning. Again, results should be interpreted with caution as the families in the study found the items on both the FES and FPSC confusing and expressed significant difficulty in answering the questions.

Child Adjustment

Overall, the children enrolled in this study tended to demonstrate normal levels of child adjustment across all time points; child adjustment was measured in terms of internalizing and externalizing behavior problems on the ASEBA. Because level of child adjustment was not the referral source for families, children varied greatly in terms of their adjustment. Across all reporters (parents, child, and teacher), both children in Family 1 and the child in Family 3 were in the normal range in terms of child adjustment across all time points. ICT did not have an impact on the child in Family 4 who reported significant internalizing and total problems across all time points. This child's adjustment was rated by both parents to be in the normal range across time points.

One child in Family 2 and the child in Family 5 reportedly experienced clinical levels of adjustment problems at baseline. Both of these children were in the non-clinical

range at termination. It is believed that their parents' improved co-parenting relationships had a positive impact on child adjustment in these cases.

In general, children who were experiencing clinical levels of internalizing and/or externalizing behavior problems were referred for individual treatment. In one case (Family 2), a child indicated clinical levels of internalizing and total problems across all time points. Because this child endorsed both suicidal ideation and parasuicidal behaviors, the study therapist informed the parents and referred the child for individual treatment. This referral appears to have increased the parents' recognition of the child's distress. Therefore, both parents reported a greater number of internalizing and total problem behaviors in this child as treatment progressed. While at first glance this child appears to have worsened in symptoms over time, it seems more likely that the child's symptoms were unchanged by ICT and the parents' perceptions were heightened.

The true impact of ICT on child adjustment is likely a variable that requires long-term measurement. Certainly, ICT is meant to improve child adjustment in the short-term in families for which conflicted co-parenting has negatively impacted a child's functioning. In most cases, though, ICT is used as a preventative intervention to decrease the negative impact of divorce and interparental conflict on child adjustment over time. Thus, long-term follow up is needed to measure child adjustment at least one year after co-parenting therapy termination.

Strengths and Implications

This study's most significant contribution to the field is the establishment of Intensive Co-parenting Therapy (ICT) as a *possibly efficacious* intervention. According to Chambless and Hollon (1998), a treatment is classified as *possibly efficacious* when a series of at least three single-case experiments support the efficacy of that treatment. Using a reliable 14-session treatment manual with a defined population of litigating co-parents, this study utilized a rigorous multiple baseline, multiple informant approach to monitor treatment progress. Results verified the feasibility of child-focused ICT as a useful approach in working with families of divorce and separation. Additionally, the manualized nature of the treatment will allow the study to be replicated on a larger scale.

This is the first study to subject a manualized co-parenting therapy program to methodologically rigorous examination toward the establishment of an evidence-based treatment. Further, it is the first intervention aimed at parents of older children (11-18 years old); the only other program to be systematically evaluated targeted families with children under the age of 6 (Pruett, et al., 2005). This Stage I study (Rounsaville & Carroll, 2001) has laid the groundwork for much future research.

Because interventions that promote child adjustment and alleviate litigation costs are in such high demand (Pedro-Carroll, et al., 2005), the exceptional ability of ICT to impact legal variables (i.e., dispute resolution, child support payments, etc.) is particularly relevant for the juvenile and family court system. The ability of ICT to increase the visitation of noncustodial parents and the rate of joint custody for study

participants also has positive implications. Because of their ability to facilitate ongoing positive involvement with both parents, joint custody arrangements appear to be the most advantageous for children of divorce (Bauserman, 2002).

Compared to the various co-parenting interventions available, ICT results most closely mirror the success of mediation services. Typically, between 60 and 80 percent of couples reach agreement via mediation services (Ooms, 2001). Given that all of the families in the current study failed previous attempts at formal mediation, the fact that, by termination, 40% dropped their legal dispute entirely and 100% were able to resolve some portion of their dispute is particularly powerful. It is also important to remember that the goal of mediation is to negotiate a divorce settlement, not to improve family relationships (Emery, et al., 1999). ICT's ability to significantly improve both the quantity and quality of interparental communication, as well as its positive impacts on interparental respect and cooperation and child adjustment, confirm that ICT directly improves family relationships in addition to legal variables. Stylistically, ICT is also less intrusive than Parent Coordination (Bailey, 2005) where the parent coordinator has the ability to write court orders. The role of the ICT therapist creates less of a power dynamic between the clients and the therapist and empowers the co-parents to apply the communication and problem-solving skills they have learned in therapy to their co-parenting conflicts. This empowering strategy may have longer-term benefits for families of divorce.

Finally, the inclusion of both Caucasian and African-American families is a strength of the current study. While the single-case design of the study did not allow for comparisons of treatment success across racial groups, study results appeared to be strong for both Caucasian and African-American families. In contract, the Collaborative Divorce Project (Pruett, et al., 2005) found that their intervention was less helpful for minorities than for Caucasians.

Limitations and Directions for Future Research

Certainly, the most obvious limitation of this study is the small sample size. While this sample was insufficient to make comparisons across families, the single case design employed made it possible to rigorously measure changes within families. Still, the study design prevented all comparisons across demographic characteristics (i.e., race, age, length of time since divorce, etc.). Since ICT has shown promise in this Stage I study, future studies should employ Stage II research methodologies (Rounsaville & Carroll, 2001). A larger scale randomized clinical trial is needed to replicate the findings of the current study with a larger sample that allows for between-subject comparisons.

Much like the Collaborative Divorce Project (Pruett, et al., 2005), the only other co-parenting therapy program that has been systematically evaluated in the literature, this study is limited by the inclusion of a largely middle-class sample. This may be a product of the county from which families were recruited. Further, families of lower socioeconomic status may be less likely to be chronic litigators due to the enormous

expense of frequent litigation. Future studies should seek to recruit families from a wider range of urban, rural, and suburban areas.

Study findings are further limited by the low response rate of teachers involved in the study. In some cases, teacher report was not available due to summer vacation. Still, most teachers opted not to participate during the school year. Teachers are a valuable resource in acquiring accurate reports of child adjustment. Due to their extensive knowledge of normative child behavior, they are most prepared to compare a child's behavior to the relevant peer group. Methods to increase teacher research engagement should be identified.

Furthermore, the limited 11-18 age range for children involved in the study eliminated families with younger children. Younger children were excluded from the present study due to their inability to complete most self-report questionnaires. Future studies should aim to test ICT in families with younger children. Finally, it was not possible to examine retention within the current study design. Because all families were court-ordered to participate in the fourteen-week program, it is unclear whether self-referred families would be willing to commit to fourteen sessions.

Lessons Learned

The following are the anecdotal observations of the study therapist. To protect participant confidentiality, references will not be made to specific families. Global themes will be identified.

One significant obstacle in co-parenting therapy is the existence of an Axis II Disorder in one or both of the participating parents. For this reason, parents who presented with Axis II traits at baseline were excluded from the protocol. It is believed that parents with Axis II symptomatology are capable of becoming cooperative co-parents; however, it appears that they require additional intervention. A manualized intervention may not be appropriate for this population. Often, it is helpful for these parents to be involved in concurrent individual psychotherapy whereby the individual therapist and the co-parenting therapist are permitted to consult on the case. Additionally, they appear to benefit from the high structure and authority of the court system. Given the additional confidentiality protection granted to research participants and the exceptional and unusual protection of confidentiality guaranteed by Virginia State law and by case law, the study therapist was not permitted to converse with the court or attorneys with much frequency. This posed a particular disadvantage in cases where parental Axis II traits were evident. Specifically, it prevented the study therapist from aligning with the other professionals involved in the case to truly determine the best interests of the child. This communication between the study therapist, *guardian ad litem*, and attorneys is vital to prevent the parent with the Axis II disorder from splitting, or labeling the professionals involved as either "good" or "bad".

Another obstacle in co-parenting therapy appears to be limitations in the intellectual capacity of the parents involved in treatment. Parents with low intellectual functioning, poor insight, or those who have experienced brain injuries may have

difficulty grasping the concepts of co-parenting. These parents may have increased difficulty modulating their emotions during co-parenting conflict, preventing them from appropriately applying communication and problem-solving skills out of session. In these cases, the study therapist found it helpful to be more directive in sessions. Rather than quickly progressing from modeling to applying problem-solving skills, it may be more useful for the therapist to outline acceptable solutions to co-parenting conflicts. A detailed co-parenting agreement with rules for communication and problem-solving may provide a more useful and concrete understanding of co-parenting concepts.

While the treatment manual for ICT provides reliable and replicable structure for the intervention, the flexibility written into the design is vital for co-parenting therapy. While there are many common problems for divorced parents, the co-parenting therapist must have the flexibility to apply universal communication and problem-solving skills to the particular problems of the family. The hierarchy created in Session 3 was noted by families to be a particularly useful tool for gauging treatment goals.

Two issues not specifically addressed in ICT were repeatedly identified as treatment obstacles. First, lack of trust between co-parents was frequently cited as an impediment to cooperative co-parenting. This mistrust, rooted in past relationship and co-parenting failure, proved difficult to overcome despite the success of families. While parents were able to appreciate the success they had during treatment, many continued to report an automatic assumption that their co-parent was not trustworthy. The study therapist reassured families that increased trust would come with time and success. For

long-term durability of treatment results, co-parents need to learn to trust each other and agree to continue to monitor their own co-parenting behavior. The Co-parenting Commitment Contract that was signed in Session 9 (see Appendix F) attempts to address this underlying issue.

Second, the intense focus on the present was reportedly difficult for families. While it was repeatedly suggested by the study therapist that focusing on the past was unhelpful, some co-parents wished to rehash past conflicts. Co-parenting must be based on the assumption that the past is unchangeable; ICT is about moving beyond the failures of the past to cooperate for the benefit of the children. It can be useful to address issues of the recent past, not for the purpose of resolving past conflicts, but toward identifying more positive solutions to future problems that may be similar in scope. Deeper exploration of intense anger and/or grief resulting from divorce would be more appropriately addressed in individual psychotherapy.

Finally, community support for the ICT program was extraordinary. Local judges, attorneys, and *guardians ad litem* were extremely receptive to the notion of co-parenting therapy. In fact, despite being informed that this study was a pilot study for ICT, their passion for the program preceded the existence of empirical support. As previously noted in the literature review, this tendency for legal professionals to endorse psychological interventions without empirical support can be problematic. Nonetheless, interdisciplinary partnerships between legal and mental health professionals appear to be the most promising avenue for addressing the needs of divorced and separated families.

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Appendix A

Outline of Psychoeducation Workshop Content

SESSION 1: INTRODUCTION TO CO-PARENTING

A: Introduction of speaker – experience with working with children/ families/ divorce/ co-parenting

B: Definition of expectations:

1. Attend all four session – rule about substitutions
2. Be on time
3. This is education not therapy

C: What is co-parenting and why is it important?

Co-parenting is working with your ex-spouse for the best interests of the children. It is sacrifice. It will often not feel "fair". It is taking the high road on conflicts and letting go of whatever choices your ex-spouse makes. It is the most difficult accomplishment you may ever work towards.

1. Statistics on divorce and second marriage divorce
2. Parenting is about sacrifice

D. Have them make a list of things the kids want from their parents during a divorce.

Hand out the list generated and discuss any differences. What do they notice is the repeating theme in the list? Have them look at Be happy yourself. This one is a unique one on the list. Can they say why a child might have this on the list? Introduce the idea that it is important for kids to be kids and adults to be adults. In divorce, children often become 'parentified' (i.e., they take care of the other parent emotionally, physically)

Two primary factors, which determine adjustment of the kids to divorce

1. Degree of hostility between the parents both during the divorce and afterwards (remember this is not just directly expressed hostility)
2. Loss of either parent through either physical or emotional distance

This is why we co-parent – to minimize the damage from the divorce which is an adult decision. Kids want their parents together. Co-parenting is about sacrifice. It will rarely feel equal.

E. What are the qualities of a good parent?

Generate their ideas and place on board in two columns representing opposite qualities where they list the opposite. Then have the group list the positive opposite of each quality that is listed on the board. For example: The opposite of structure/discipline might be spontaneous. Surprisingly, there is a positive opposite to each one. This develops the idea that parenting is on a continuum of strengths and weakness. Talk about that you cannot be good at both ends of the spectrum. For example, the highly structured individual is usually less skilled at being spontaneous.

Then introduce the concept that kids need both sides to the continuum because in life they will be exposed to all kinds of people. In general, we marry our opposite. Therefore, the child, even in a two-parent home learns to live with differences and gains from this exposure. Parenting is about choices and strengths and weaknesses. The weaknesses of one parent could be strength in the other and visa versa.

F. What to tell the kids about divorce?

Emphasize that they may have already told the kids something and if they have, there may need to be some repair work done.

Have the group generate a list of reasons that people give to the kids about divorce. Write on the board. At the end, talk about what each reason teaches the child about relationships etc.

The children do not need a specific reason for the divorce, especially one that sends blame to one particular parent. The divorce occurred for adult reasons stated in a way that takes into consideration the age of the child is really all they need to hear.

Parents divorce each other, not the children. The other spouse did not leave the children, only the spouse.

G. Children need to be children and adults need to be adults.

Don't:

Have the children carry messages between the parents (tell your mom... tell your dad..)

Tell your children to keep a secret about what goes on at your house.

Ask them questions about what goes on at the other house.

Kids need to know when visitation is going to occur and they need to know that they can participate in their activities at either parent's house. If the parents were still together, the kids would be at all of the basketball practices etc. Be on time for all visits, call if you are not going to be there and explain to the child why and take them to all of their activities the majority of the time.

SESSION 2: CO-PARENTING COMMUNICATION

IMPORTANT THINGS YOU TOOK AWAY FROM LAST SESSION

Generate list

My emphasis: Both parents are important

Try to reduce hostility

Let kids be kids

COMMUNICATION IS A SKILL

It can be learned.

It is not easy.

It is critical to co-parenting.

WHAT TYPE OF RELATIONSHIP DO YOU HAVE?

- ✓ Perfect Pals
- ✓ Cooperative Colleagues
- ✓ Angry Associates
- ✓ Fiery Foes

Show Video. The relationship changes with the topic discussed. Take a moment and write down for your use only, the topics that you successfully discuss either as perfect pals or cooperative colleagues. Then write down the topics that result in anger and conflict.

GUIDELINES FOR COMMUNICATION

Have the group generate the rules/things to keep in mind for positive communication. Hand out the Rules for Fair Fighting and compare list. Have them add anything they generated that is not on this handout.

Of course there are rules that are unique to co-parenting. First, it may take longer than ½ hour to come back and talk about the issue. In fact, it may take 24 hours to calm down and think about another perspective for the argument.

1. Remember this is anew relationship with your ex-spouse where the focus is on what is best for the child. Marriage has ended but you will be connected for the rest of your lives. Anger, etc is a bitter pill that stays with you forever. If you are having trouble letting go of your anger and/or hurt, consider going into individual therapy.
2. Think about where to discuss the problem. Schedule a time to talk about the issue that is not in front of the children. Tell your ex-spouse that this may be a difficult conversation but you want it to remain positive. Try sending an e-mail, which sets out the discussion. Have a friend who will give you honest feedback look at the e-mail before you send it.

3. C. Change your expectations. The things that your spouse did for years are likely not going to change. Accept these differences and pick the battles that are truly significant. Is what you are going to discuss critical to your child or to you. .
4. Remember to be supportive of the role and contribution of the other parent in your child's life. Children should not have to choose between parents. They love you both.
5. Compromise, compromise, compromise. It is not about winning. It is about doing what is best for the children. Will the fight over this cause more damage than it is worth? Remember that the two greatest causes of pain for the children are hostility and/or loss of a parent. How important is this conflict?

MAJOR BLOCKS TO POSITIVE COMMUNICATION

1. Assumptions: Assumptions are things in our head that we believe are right but often aren't. Listen to this scenario. A son, age 8 comes back from visit with his dad very quiet. He answers mom's questions with it was ok. What did you do? Oh you know, the usual. No big deal. He seems sad and goes into his room and plays quietly with his Lego's. What do you think are the reasons for this quiet behavior?

   Generate a list in response to this question.

   Have the group look at this list and talk about the assumptions behind the reasons. Focus on finding positive or neutral understanding of the behavior.

   Another example: Your 13 year old daughter comes back from mom's house saying she screamed at me and wouldn't let me wear that shirt you bought me. She never lets me wear anything you buy.
   Generate a list of assumptions a parent might make. In truth (in this slightly altered scenario) the mother had screamed and refused to let the girl wear the shirt but only because it was inappropriate for Church and she had been telling her that for the past 30 minutes and now they were late for Church. How can this couple avoid the possible problems that this conflict can create between the parents in the future?

   Now have the group write a list of their own assumptions about their ex-spouse, not to be shared with the group. Now look at this list. Is there a way to re-think the assumptions? For example, what are the positive sides to this aspect of your ex-spouse? Think back to the first session and what we learned about positive sides to what may seem to be negative and the importance of celebrating differences.

Negative assumption: He doesn't spend time with the kids. I always hear them complain about the visits. Other possible explanations: The kids feel they need to only tell you the negative about the visits; They may have unrealistic expectations of time with dad; May be if he was told they wanted more time, he would freely give it… he is visiting which shows a wish to have a relationship It would be easier to just send a check and have no other contact if he didn't care about them.

2. Emotions run high: It is very hard to think clearly when we are upset, angry or worried. Our brain releases chemicals that impair our judgment. We begin to act more like the monkeys and make poor decisions. Therefore, it is very important to calm these chemicals down before trying to continue the discussion. Picture your brain as much like a river… when it becomes turbulent, the higher functioning abilities can drown in the emotions created. So, use your raft.
   Have the group generate a list of ways to take care of themselves and calm down during the time-out period.

   Share this list and have them add to it anything they generated that is not present on this list.
   a. Deep breathing… calm breathing directly soothes these feelings and helps us all to make better decisions. Take a moment and breathe deeply. Practice exhaling slowly and count as you exhale. Getting to around 15 is a sign that you are still calm.
   b. Change your thinking. Look at what is perpetuating this hostility. Try to see the views of your ex-spouse. They must have a reason. See if you can understand why they are making these choices from the belief system that they love the kids too and want what is best for them.
   c. Find ways to pamper yourself. Get together with friends, exercise, and take a long bath. Go back to doing the things that bring you peace.
   d. Find a friend you can just vent to and do so. Make sure the children cannot hear this conversation… this includes the children of your friend.
   e. Avoid negative solutions like drinking, overeating and/or isolation.

WAYS TO COMMUNICATE WITH THE CHLDREN

1. Remember that their feelings, experiences are different from yours. The ex-spouse divorced you not the children.
2. Give your children your full attention when they talk to you. These talks may occur at the most surprising moments. Stop and listen to them. The opportunity can often not be repeated.
3. Try to find ways to talk about positive things about their mom or dad. The things they do that remind you of them (stay positive). Make sure that the kids know it is ok for them to talk about the other parent etc in front of you.

Have pictures of the other parent with the child in the child's room – again to communicate that you believe both parents are important to him/her.

4. If you hear something upsetting from your child – stay calm. Don't assume that what you are hearing is accurate. Children feel an intense need to be loyal to the parent in front of them for developmental reasons. Even without you encouraging this thinking, they tend to push for choosing sides. "If you're friends with Suzy then you can't be friends with me…" kind of thinking.

SESSION 3: COMMON CONFLICTS FOR PARENTS WHO ARE DIVORCED

First, Go over what they learned from last week. Some points to emphasize are: What are the roadblocks to effective communication?

1. Assumptions
2. Emotions running too high

Here are three things to remember when thinking about how to begin a potentially difficult topic with your ex-spouse:

1. Is this worth it? What impact will it have on the children?
2. How can I approach this problem most effectively?
3. How do I keep the kids out of the potential conflict?

Now for tonight's discussion.

1. Normalize the degree of conflict experienced:

These are things that many divorced couples get into conflicts about. These areas may not be a problem now but they may become problematic later. Having the disagreement is not the problem. Its how you handle the conflict that can become damaging to the children.

2. Review the Bill of Rights pages

These are the guidelines to use in working through the vignettes. Remember that co-parenting is ultimately not about being fair, being recognized for doing the right thing… it is a self-less act in which the needs of the children outweigh you own need to be right, to win and/or to be recognized for being a good parent

3. Vignettes:

Before giving them vignettes, write on the Board the list of the things that cause the most conflict for divorced couples. These are: Holidays/schedules, money, activities, routines, expectations/rules, school and relationship with stepparents.

Break them up into small groups or have each person take a vignette and address with possible solutions. Remind them to have the solutions as specific as possible. What should this couple actually do to resolve the problem? Each vignette would

have a mom perspective and a dad perspective. It is important to remember that there are specific answers in co-parenting… and that we must be fairly direct in providing these answers

As they give their answers, have them sit with their group as it encourages more participation and have each group designate a speaker before they begin to work. Keep the group discussion focused in the beginning and then let it expand out to broader examples of the same issue. For example on the step-parenting vignette, answer that specific question before digressing to talking about step-parenting in general.

Assumptions answers: Steer the discussion to looking at the negative assumptions and positive assumptions that could be made.

Solution answers: As they present the solutions, steer the discussions to have the group look at the following for each one:

1. What will each solution require from the parents:
    A. Emotionally
    B. Physically
    C. Financially

For example, on the holiday vignette, a solution might be for the child to go with the dad. However, the emotional cost to the mom is missing the holiday, feeling like she is "losing", letting go of control; the physical cost might be the transportation issues, her own need to perhaps travel now so she doesn't spend it alone; the financial cost might be loss of time with the kids which might impact support issue (highly unlikely but still). The point of going over the costs is to get them to realize that solutions require sacrifice on everyone's part and to be sensitive to the other perspectives and costs.

Other things to consider are: What are the underlying beliefs in each parent's view of the problem? What are alternative, creative solutions?

Holidays: a vignette involving conflict about whose turn is it? Dad had the Thanksgiving Holiday last year. He readily acknowledges it is mom's turn. However, his dad (kid's grandfather) is turning 100 and the family is celebrating it over the holiday…. The kids want to go and see cousins etc that they haven't seen in awhile. Mom has no family celebrations planned. However, she does not want the dad to take her time with the kids. After all, this is her holiday. What should both parents consider? What are some possible solutions to the conflict?

Homework: A vignette involving conflict about who takes school more seriously: Mom believes that dad does not take Timmy's schoolwork seriously. Dad has Timmy for two overnights per week. Timmy may have ADD. Dad disagrees and thinks that mom has convinced the school of that diagnosis partly in an effort to win custody. He does not believe that there is a problem. "She babies him too much. I'm trying to teach him to be more independent. If he doesn't get the work done, it's his responsibility." Mom feels that dad doesn't take the time that Timmy needs to get the work done. She feels he doesn't understand the help he needs. On her nights, she sits down with him and helps with the homework. Sometimes she may rewrite some of his stories because he is just too tired to finish. On many of dad's nights, the homework is not completed and it affects his grades. What is the ultimate goal for school? What is the overriding area of disagreement? What would you suggest they do for Timmy?

Relationship with step-mom: A vignette involving the forming of new family relationships. Dad remarried about 2 years after the divorce to a woman who had no children. She was often the first home with the kids and so took on the role of homework etc until dad got home at 6:00. The kids complained to mom that she yelled all the time, didn't seem to want them around and that they didn't like her. Dad reports to mom in an angry tone that it is none of her business, that the kids really like the step-mom and to give her a chance. There have been some angry exchanges between the two women at the soccer games. Are kid's descriptions always accurate? What role should a stepparent play in the discipline? How can the other parent help or hurt this beginning relationship?

Activities after school: Whose job is it to decide what activity a child can participate in? Mom is primary custodian for the children. Dad sees them every other weekend and one night per week. Both kids participate in girl scouts and soccer. The games and activities often fall on dad's weekend. He resents driving the kids to various activities and not getting time, just he and the girls. "She shouldn't plan things on my time." Often, if it is a Girl Scout activity, he doesn't want to go because he doesn't know the other families and there are hardly any dads that go. He gets really angry when there are multiple activities on his weekend. Besides, the girls often tell him that they don't want to go anyway. How do couples decide how many and what kinds of activities the children can participate in? Who pays for these activities? What about the time issue?

Money: How do the parents share the expenses when the kids stay with each of them half of the time? The parents have a 50/50 shared custody arrangement on a week on/week off schedule. As a result, there is a very minimal child support payment that goes to the mom and there is no spousal support. Dad makes about 80% more a year than mom does. Neither is remarried although mom is dating a guy very seriously and may remarry soon. They have agreed to buy clothes for each house on their own but conflict still occurs around things like winter coats, soccer shoes and dresses for prom etc. – what you might call the big clothing expenses that are special and usually one-time events. In

addition, while they discuss the activities, neither can agree who should pay for soccer, school supplies and fees, camps and big school trips like the trip last year to New York that the chorus made. What are some fair financial options for sharing expenses or should they even be shared?

Routines: a vignette involving conflict about which rules should be the same at both houses. How much difference is ok? Dad tends to let the kids go to bed whenever. On school nights, things are a little different but still they go to bed 10 or later. The kids are 10 and 11 years old. He doesn't like to cook so often the kids fix whatever they want and watch TV while they eat. Mom ahs a lot more rules. She has a bedtime of no later than 9:00 and they tend to eat dinner together around a table. Dad does not check their homework while mom goes through the backpack every night and checks to see if the homework is correct. They sometimes re-write it if it is messy. How much routine is too much or not enough? What should both parents consider? When does the routine need to be the same at both houses?

Each vignette sheet has the following questions at the bottom: Try to find multiple solutions to the problem. Think about what each solution will require of each parent financially, emotionally and physically. Think about the underlying assumptions of each parent.
At the end, direct their attention to the sheet, which includes the rules for seeking a solution in any conflict:

1. When it gets heated, walk away and give yourself time to calm down. While calming down, try to honestly see the other parent's perspective. Sometimes it helps to actually write down what their argument is… why it is valid from their perspective etc.
2. Have at least one person in your life that will tell you when you are out of line in an argument. There are always people who will support your side of an argument, even when you are wrong. In these high conflict situations, find someone who will be honest with you and point out the ways in which you are being stubborn etc.
3. Try talking about the conflict via e-mail and limiting the e-mail to the conflict itself. Do not make references to past events – only the current conflict.
4. Avoid using words like you always, you never. Start each sentence with I feel or I think and watch your tone. Is it accusatory? Are you open to being wrong?
5. If you are unable to resolve an issue, seek out a therapist who specializes in co-parenting and have them help you both work through the problem.
6. DO NOT under any circumstances involve the children in the disagreement either directly by saying things like, Your dad won't… Your mom said… or indirectly by implying something negative about the other parent.

SESSION 4 OUTLINE: DATING

Review from previous week.

Emphasize:

There is often a diversity of solutions. Even if there is only one solution, it is important to respect and talk about the emotional, physical and financial costs to each parent with any solution.

Often, a person gets stuck when they can't see beyond their own assumptions about why the other parent is doing what they are doing ie. She's just trying to get back at me. It is hard to compromise and work together on solutions when negative assumptions are in charge.

Walk away when emotions are running too high and try to work on the solutions another time when you are calmer.

DATING:

Talk about the self-confidence and anxiety around dating. When is it ok to date? When do you let the children meet the significant other? How do these individuals meet the children?

1. In general, dating where the kids are involved should only occur when the relationship is serious and there is some expectation that it may be permanent.
2. Dating just for fun can occur early on after separation but BEWARE the tendency to become serious early. Divorce leaves one feeling vulnerable and emotionally upset. It is easy to give into depending on someone else to help fix these feelings and to rush therefore into a serious relationship. Give yourself lots to time before you settle down.
3. Remember the kids are going to be as much as 2 -3 years behind you in grieving the divorce. Therefore, they are likely not going to be ready to see you date long before you may be ready. Keep them out of the relationships for as long as possible.
4. Remember that they are not ready to allow the new person to take a significant role in discipline. 2-3 years involvement with kids before the other person takes on a significant discipline role is a good rule of thumb.

Divide the group into women and men. Give them each the biographies and have each group generate a list of the issues each person will face regarding dating. Then have each group report back and share their ideas. Look for differences along gender lines.

Then give them a brief scenario of each child biography. Have them again break into groups and look at how each age might react differently to dating by their parent. Have each group look at the sex of the parent in relation to the child and what impact this might have.

The ages of the children are 4, 10, 13 and 17. This allows them to look at general developmental changes at ages where there are significant differences.

Briefly review all four weeks.

Week 1: Two major causes of problems with divorce – hostility and/or loss of parent
Parenting can be very different and still be good enough.
Children need both of their parents

Week 2: Communication is a skill we can learn.
There are two major roadblocks: making negative assumptions and trying to communicate when the emotions are too high
Always ask yourself: Is this worth the conflict that might occur? If it is, how can I approach it in the best way that keeps the kids out of it and keeps us talking?

Week 3: There are areas that all parents struggle with when co-parenting. This is normal.
Try to look at conflicts as having more than one solution. Look at what each solution cost the parents emotionally, physically and financially. Appreciate the costs to your co-parent when they compromise with you. Appreciate the degree of difficulty of the request you are making.
Week 4: Dating is very difficult for everyone. Make sure you are not rushing into a relationship. Respect that the grief process for the children is slower. Do not rush into exposing them to your dating and especially make sure the relationship has some possibility of permanency before introducing them to the kids. Take your time.

Hand out the evaluations and the certificates.

Appendix B

Outline of Co-parenting Therapy Manual

I. Phase I: Specific Parenting Problem and Skill Deficiency Identification

A. Session 1: Intake

1. Will meet with each parent separately to understand their perspectives on the divorce.

2. Review divorce-related information from screening.

B. Session 2: Joint Intake

1. Meet with co-parents together and engage them in an exercise intended to observe attitudinal/affective impediments and communication patterns (i.e., ask each parent to describe their perspective on a common co-parenting conflict).

2. For homework, therapist will develop hierarchy of co-parenting treatment goals related to attitudes, behavioral/skill deficiencies, and behaviorally specific co-parenting problems.

C. Session 3: Hierarchy of Distress of Solvability

1. Together with clients, rank order items on hierarchy in terms of severity and disruptiveness the problems (in the child and between the parents).

2. Identify the problem that is most amenable to change and most central to the parents.

3. For homework, ask the parents to bring in a picture of their child(ren) to next session.

D. Session 4: Enhancing Motivation

1. Ask the parents to discuss their child(ren). Specifically, they should tell the other parents their likes, dislikes, worries, fears, etc.

2. Remind client that their child is the target beneficiary of the intervention.

3. Have parents identify what they do that may hurt their child (i.e., take responsibility for their contribution to the problem).

4. Take a co-parenting problem from worksheet and have parents identify what they do to contribute to this problem and what they might do to improve the problem.

Comment: Throughout first four sessions, incorporate review of concepts from Wert psychoeducation program. In addition to weekly monitoring of communication and other relevant co-parenting behaviors, homework assignments may be specific to psychoeducation.

II. Phase II: Communication Skills Training

A. Session 5: Reflective Listening

1. Teach and rehearse reflective listening using example from hierarchy.

2. Practice as time allows.

3. For homework, assign Derailments Questionnaire.

B. Session 6: Identifying Derailments

1. Review derailments to communication identified by co-parents.

2. Discuss derailments from each parent's perspective, practicing reflective listening skills.

C. Session 7: Rules for Communication

1. With co-parents, develop reasonable rules for co-parenting communication.

2. Rules should keep with expectation that co-parents should communicate at least two times per week.

D. Session 8: Nonverbal Communication and Conveying Respect

1. Brief psychoeducation on nonverbal communication and its impact on conflict (i.e., what you are saying "between the lines").

2. Using a problem from the hierarchy, have co-parents discuss problem using reflective listening skills.

3. Obtain parent and therapist ratings of nonverbal communication during exercise.

4. For homework, ask parents to write a set of 5-year letters to themselves and linked to important developmental events (i.e., child's graduation)

E. Session 9: Developing and maintaining co-parenting/family commitments

1. Have co-parents discuss experience of writing letter to themselves.

2. Have co-parents explain to one another what co-parenting means.

3. Ask parents to make a long-term commitment to co-parenting (a 30-year process) by signing co-parenting commitment contract.

III. Phase III: Problem Solving Training

A. Session 10: Pitfalls and Triggers

1. Present co-parents with list of common co-parenting pitfalls and triggers.

2. Review co-parenting problems from family's hierarchy and compare to common pitfalls and triggers to identify problems with identified solutions.

3. Discuss applicability of defined solutions to this family's conflicts using reflective listening and relevant psychological literature as support.

B. Session 11: Problem-solving

1. Have clients problem-solve a co-parenting problem from their hierarchy that is not a commonly identified conflict (therapist will facilitate problem-solving). They may identify one or two "easy" problems from their hierarchy.

2. Have parents attempt to resolve this issue using communication skills and their understanding of the divorce literature as support for their resolution.

3. For homework, ask parents to select an issue from their hierarchy to problem-solve over the week.

C. Session 12: Decision-making

1. Repeat procedures of previous session but therapist will take a less active role leading problem-solving in this session.

2. Have parents come up with their individual solutions to the identified problem that reflects the best interest of the child.

3. Have parents present their solutions to the other parent using communication skills.

D. Session 13: Primary Decision Influencers (PDIs)

1. Review literature on the potentially negative impact of PDIs.

2. Have co-parents identify helpful and non-helpful PDIs in their lives.

E. Session 14: Wrap Up/Termination

1. Review initial treatment goals and relevant progress.

2. Review take-home messages of intervention.

Appendix C

Informational Questionnaire

Please provide the following information about yourself. Your answers will assist your therapist in understanding your background, your divorce, and the arrangements you and your former spouse have made regarding your children.

1. Age: _____

2. Gender: MALE FEMALE

3. Race: _____

4. Occupation: _____

5. What is the highest level of education you have obtained?
   a. Did not complete high school
   b. High school or GED
   c. Some college
   d. College
   e. Graduate/Professional Degree

6. Please estimate your annual household income: _____

7. Please record the following information about your child(ren):

Name	**Age**	**Gender**	**Race**	**Grade in School**	**Is this child your biological child?**

8. Are any of your children receiving any special services at school (for example, services for a learning disorder, a behavior disorder, mental retardation, remedial classes, advanced/honors/gifted classes, etc.)? YES NO
If yes, please describe these services: _____

_____

_____

9. Are any of your children currently receiving any psychological services or counseling? YES NO
If yes, please describe: _____

_____

10. When did you first separate from your co-parent (please give the year if possible)?

_____

11. When were you divorced from your co-parent (please give the year if possible)?

_____

12. How old were your child(ren) when you separated? _____

_____

13. How long were you married to your co-parent?_____

14. Do your child(ren) live in your house at least half of the time? YES NO

15. Please tell us about your child custody arrangements:

    a. Who has legal custody? MOTHER FATHER JOINT

    b. Who has physical custody? MOTHER FATHER JOINT

    c. Which parent do your child(ren) spend the most time with?

        MOTHER FATHER ABOUT EQUAL

    d. How is your children's time split between mother and father? (For example,

the children might live primarily with the mother, and see the father on weekends; the children might live with the father and rarely see the mother; the children might alternate living with the mother one week and the father the next week). Please be specific in how often the child sees the non-custodial parent if there is one. _____

_____

_____

_____

16. In a one-month period, how many nights do the child(ren) sleep at the mother's house? _____

At the father's house? _____

17. Have you remarried since the divorce? _____

Has your ex-spouse remarried? _____

18. Was your divorce from your co-parent your first divorce? _____

How many times have you been divorced?

19. In the past year, have you and your ex-spouse been involved in any legal proceedings related to custody, visitation, or child support issues? YES NO

If yes, did you go to court over this matter? YES NO

If yes, how many times have you been to court due to custody, visitation, or child support issues? _____

Appendix D

Co-Parenting Behavior Questionnaire

ID#_____

Date_____

Please give the following information about yourself.

---

1. AGE: _____

2. Are you a boy____ or a girl ____? (check one)

3. GRADE: _____

4. Rate your parents' divorce:

1	2	3	4	5
hard for you				easy for you

5. Have you ever talked to a school counselor or psychologist about problems you have had at home, at school, with friends, etc.? Yes No

Thank you for answering these questions. On the following pages, you will see sentences that have to do with you and your parents.

Following each statement, there is a scale from 1 to 5 (1 = almost never, 3=sometimes, and 5= almost always).

Circle the number that tells HOW OFTEN this statement happens. Think about how things have been in the **past 2 months**, or the last school grading period.

1. My parents complain about each other.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

2. My dad tells me bad things about my mom.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

3. My parents argue about money in front of me.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

4. When my parents argue, I feel forced to choose sides.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

5. When my parents talk to each other, they accuse each other of bad things.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

6. My parents talk nicely to each other.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

7. My mom asks me questions about my dad that I wish she would not ask.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

8. I feel caught between my parents.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

9. My dad asks me to carry messages to my mom.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

10. My parents fight about where I should live.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

11. My dad asks me questions about my mom that I wish he would not ask.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

12. My mom wants me to be close to my dad.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

13. When my mom needs to make a change in my schedule, my dad helps.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

14. My parents argue in front of me.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

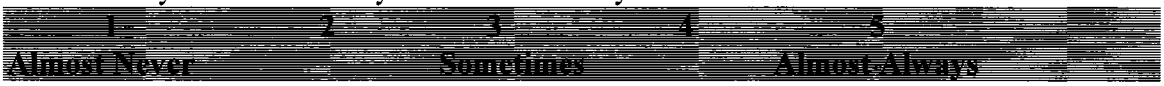
15. My mom tells me to ask my dad about child support.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

16. It is okay to talk about my mom in front of my dad.

17. My parents talk to each other about my problems.

18. It is okay to talk about my dad in front of my mom.



19. My parents talk to each other about how I feel about the divorce.

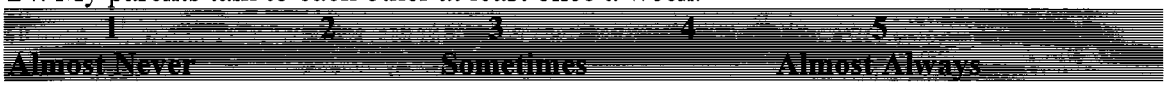
20. My parents talk to each other about my school and my health.

21. My dad gets angry at my mom.

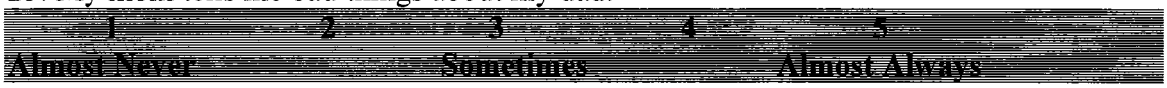
22. When my parents talk to each other, they get angry.

23. My parents talk to each other about big choices in my life.

24. My parents talk to each other at least once a week.



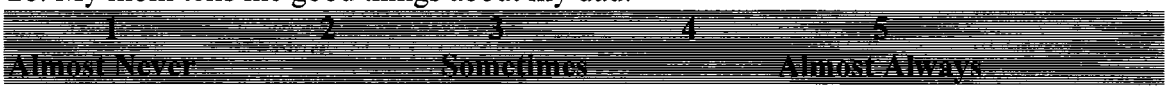
25. My mom tells me bad things about my dad.



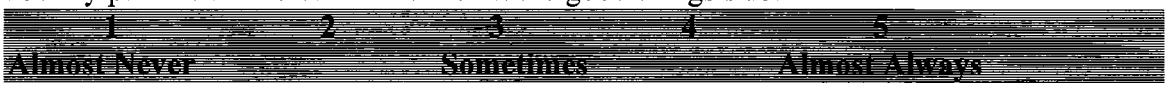
26. When my mom needs help with me, she asks my dad.

27. My mom asks me to carry messages to my dad.

28. My mom tells me good things about my dad.



29. My parents talk to each other about the good things I do.



30. When my dad needs help with me, he asks my mom.

31. My mom gets angry at my dad.

32. My dad tells me good things about my mom.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

33. My dad wants me to be close to my mom.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

34. My parents get along well.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

35. My parents yell at each other.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

36. When my dad needs to make a change in my schedule, my mom helps.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

CBQ - PART B

37. My dad likes being with me.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

38. My mom and I have friendly talks.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

39. My mom asks me about my day in school.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

40. When I do something wrong, my mom talks to me about it.

41. I feel that my mom cares about me.

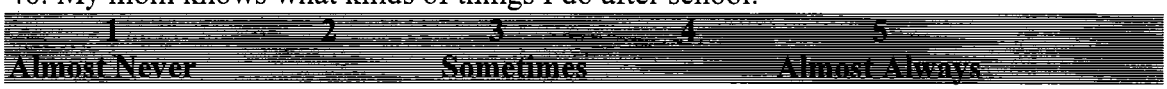
42. My dad talks to me about big choices in my life.

43. I feel that my dad cares about me.

44. I spend time doing fun things with my mom.

45. My mom knows who my friends are and what they are like.

46. My mom knows what kinds of things I do after school.



47. My mom likes being with me.

48. I talk to my mom.

49. I have chores to do at my dad's house.

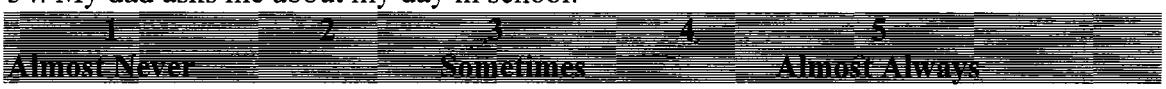
50. My dad says he loves me and gives me hugs.

51. When I leave the house, my dad knows where I am and who I am with.

52. If I have problems in school, my dad knows about it.

53. When I break one of my mom's rules, she punishes me.

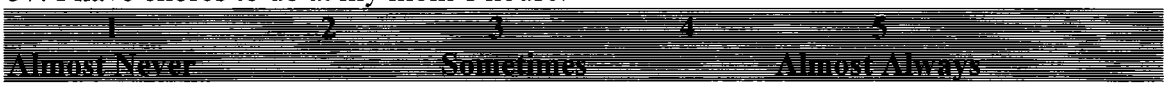
54. My dad asks me about my day in school.



55. My dad knows who my friends are and what they are like.

56. My dad knows what kinds of things I do after school.

57. I have chores to do at my mom's house.

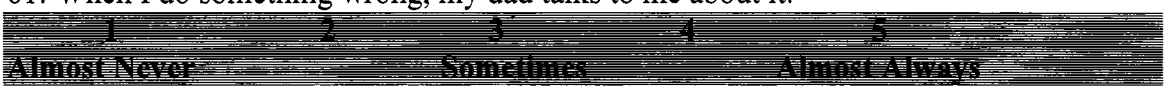


58. When I leave the house, my mom knows where I am and who I am with.

59. My mom talks to me about big choices in my life.

60. If I have problems in school, my mom knows about it.

61. When I do something wrong, my dad talks to me about it.



62. My dad praises me when I do something good at home or at school.

63. I talk to my mom about my problems.

64. If I get in trouble at school, my mom punishes me.

65. My mom says nice things about me.

66. I spend time doing fun things with my dad.

67. My dad knows who my teachers are and how well I am doing in school.

68. I have rules to follow at my dad's house.

69. I talk to my dad.

70. I talk to my dad about my problems.

71. My dad says nice things about me.

72. I have rules to follow at my mom's house.

73. My dad and I have friendly talks.

74. When my dad says he is going to punish me, he does it.

75. My mom knows who my teachers are and how well I am doing in school.

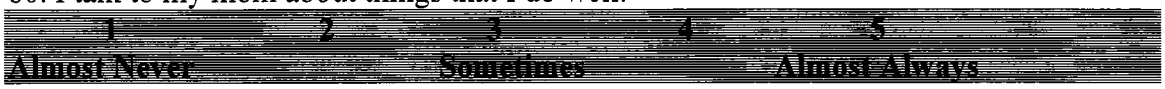
76. When I break one of my dad's rules, he punishes me.

77. My dad talks to me about my friends.

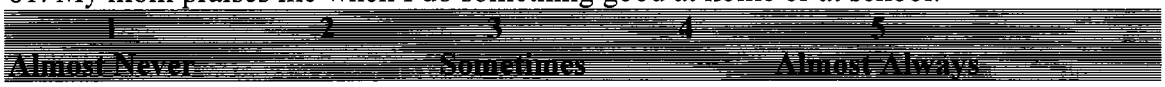
78. My mom talks to me about my friends.

79. My dad is patient with me.

80. I talk to my mom about things that I do well.



81. My mom praises me when I do something good at home or at school.



82. My mom says she loves me and gives me hugs.

83. If I get in trouble at school, my father punishes me.

84. My mom is patient with me.

85. I talk to my dad about things I do well.

86. When my mom says she is going to punish me, she does it.

Appendix E

Sample Idiographic Measure

Co-parenting Communication Log

Date: _____
Time: _____
How did we communicate: ☐ In person ☐ Phone ☐ Voicemail ☐ Email ☐ Letter
Topic discussed: _____
Was this conversation child-focused?: ☐ Yes ☐ No ☐ Somewhat
Length of communication (time): _____
How successful was this communication (Circle a number below)?

0------1------2------3------4------5------6------7------8------9------10
Not at all Moderately Extremely

Date: _____
Time: _____
How did we communicate: ☐ In person ☐ Phone ☐ Voicemail ☐ Email ☐ Letter
Topic discussed: _____
Was this conversation child-focused?: ☐ Yes ☐ No ☐ Somewhat
Length of communication (time): _____
How successful was this communication (Circle a number below)?

0------1------2------3------4------5------6------7------8------9------10
Not at all Moderately Extremely

Date: _____
Time: _____
How did we communicate: ☐ In person ☐ Phone ☐ Voicemail ☐ Email ☐ Letter
Topic discussed: _____
Was this conversation child-focused?: ☐ Yes ☐ No ☐ Somewhat
Length of communication (time): _____
How successful was this communication (Circle a number below)?

0------1------2------3------4------5------6------7------8------9------10
Not at all Moderately Extremely

Appendix F

Co-parenting Commitment Contract

We, _____ and _____, AGREE, as part of our commitment to ourselves and our children's well-being to the following:

- I state that my goal is to promote my children's healthy adjustment to my divorce. I will achieve this goal by putting my children's needs before my own.

  _____ (Mother initial) _____ (Father initial)

- I declare that my goal is to cooperate with my co-parent on all matters regarding our children.

  _____ (Mother initial) _____ (Father initial)

- I understand that my marital history with my co-parent prevents me from achieving this goal, while focusing on the present will help me to achieve my goal. I therefore promise myself to work on learning to put aside my feelings about my co-parent and work together to create a healthy co-parenting relationship.

  _____ (Mother initial) _____ (Father initial)

- I understand that when my co-parent and I had children together we became connected for the rest of their lives.

  _____ (Mother initial) _____ (Father initial)

- I believe that my children have the right to see their parents cooperate.

  _____ (Mother initial) _____ (Father initial)

- Finally, I promise myself to abide by the terms of this contract and agree that I will not break the contract.

_____ _____
Mother's Signature Date

_____ _____
Father's Signature Date

Vita

Jill Allison Ferrante Gasper was born on November 1, 1979, in Malden, Massachusetts, and is an American citizen. She graduated as valedictorian from Georgetown High School in Georgetown, Massachusetts, in 1997. In 2001, she earned a Bachelor of Arts in Psychology with a concentration in personality and social psychology from Cornell University in Ithaca, NY. At Cornell, she also held academic concentrations in English and Women's Studies. In August 2005, she earned a Master of Science in Clinical Child Psychology from Virginia Commonwealth University, Richmond, VA. Her research interests relate to co-parenting interventions for intact and divorced families as well as child custody evaluations. Ms. Gasper will earn a Doctor of Philosophy in Clinical Child Psychology from Virginia Commonwealth University in August 2008. She is currently completing her predoctoral internship at Virginia Treatment Center for Children in Richmond, VA.