2025 Harold R. Kemp Annual Family Law Symposium
October 13, 2025
Columbus, Ohio

Put Me in Coach: Benefits and Limitations of Parenting Coaches in Family Law Cases

Panel: **Jamie C. Niesen, MA, LPCC-S**
Niesen Resolution Services, Worthington, Ohio

Jennifer R. Szeghi, MA
Successful Parenting, LLC, Cincinnati, Ohio

Elizabeth M. Bach-Van Valkenburg, MSSA, LISW-S, CNM
Clinical and Coaching Services, Solon, Ohio

Moderator: **Zachary D. Smith, Esq.**
Zachary D. Smith, LLC, Cincinnati, Ohio

Materials Table of Contents

Jamie C. Niesen, MA, LPCC-S
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EDUCATION

January 2016- December 2017	**Capella University, Columbus, OH** Master of Science in Clinical Counseling
September 2007 – May 2009	**University of Denver, Denver, CO** Master of Arts in Forensic Psychology
August 2003 – May 2006	**University of Denver, Denver, CO** Bachelor of Arts in Clinical Psychology Bachelor of Arts in Criminology

PROFESSIONAL EXPERIENCE

Owner and Director for Niesen Resolution Services, LLC
February 2020- Current
Clinical Forensic Evaluator, Mediator, Parent Coordinator, and Therapist

- Conduct child custody evaluations, parental capacity, and psychological assessment.
- Research and advise best practices for parental assessment and programing in Neutral Evaluations.
- Conduct trainings regarding best practices for family intervention for court involved families.
- Provide weekly therapy to individuals, parents, and families in the context of domestic court.

Private Practice with Dr. David Tennenbaum
May 2016- February 2020
Clinical Forensic Evaluator and Therapist

- Conduct child custody evaluations, parental capacity, and psychological assessment.
- Research and advise best practices for parental assessment and programing in Early Neutral Evaluations.
- Conduct trainings regarding trauma and the impact on delinquency and mental health in juveniles to local court administration (i.e., Guardian ad Litem subcommittee)

- Provide weekly therapy (trauma, adjustment, family) to juveniles involved in the domestic and juvenile courts.

Marion County Family/Domestic Court
May 2016- June 2016
Clinical Administrator of Family Court

- Conducted child custody evaluations, parental capacity, and psychological assessment.
- Planned, organized, and coordinated activities and services of juvenile court.
- Conducted trainings regarding trauma, drug use and mental health and the impact on recidivism rates.
- Provided weekly consultation with team members in order to provide efficient mental health services to juveniles involved in the family court system.

Child Custody Analytics
December 2015- May 2016
Contracting Child Custody and Parenting Expert

- Conducted research regarding best practices for parents within custody evaluations.
- Researched and created/advised parental guidelines regarding practices within custody evaluations and parenting agreements.
- Conducted trainings with law practices to educate regarding mental health evaluations within divorce and child custody cases.
- Wrote on-line articles and blogs regarding parenting guidelines, mental health, and the impact of trauma on developmental milestones for references for law practices, parents, and professions in Family law.
- Provided weekly consultation with team members in order to provide efficient trainings for law practices and mental health professionals.

Pathways Psychology Services, Winfield, IL
April 2013 –July 2013, July 2014- December 2015
Clinician and Court advisor

- Conducted custody evaluation on behalf of Department of Child and Family services.
- Conducted Parent-Child Interaction Therapy, individual therapy, and family therapy
- Participated as a Specialty Court: Adult Mental Health administrator for parenting involved in DCFS case.
- Provided therapeutic services to Juvenile Mental Health Court and advised on specific probationary requirements to adhere to mental health court enrollment.
- Developed treatment plans for each client including requirements that adhere to mental health court standards.
- Provided testimony, court reports, updates, and recommendations to the Domestic and Juvenile court.

Department of Child and Family Services: Our Children's Homestead, Naperville, IL

May 2012 – July 2013, July 2014-April, 2016
Individual Therapist, Program Development Supervisor

- Conducted ongoing therapy with children and adolescents to address mental health, probationary goals.
- Coordinated with community leaders, district attorney, and law enforcement to determine need for new programs to support rehabilitation over recidivism.
- Conducted interviews, assessment, and transitional training for residential applicants and potential foster care providers.
- Provided case review to determine eligibility for program applicants while assuring program standards were consistently met and supported.

Department of Child and Family Services: Our Children's Homestead, Naperville, IL
October 2015-December 2015
Program Director and Grant Writer for Project REACH

- Sought grant opportunity and applied for funding for Specialty programing.
- Responsible for grant reimbursements, documentation, data collection, performance measurements, and evaluation.
- Directed, planned, and administrated eligibility requirements, standards of practice, and measures of evaluation in program development for juveniles.
- Provided direction, supervision, and administration of Project REACH, a new initiative to address Foster Care reform and specialty mental health court standards in the State of Illinois.
- Educated Clinical team on research and evidence-based practice models for identifying indicators of need for juvenile accountability, and success.
- Received State approval and full grant support to initiate Project REACH in Summer of 2016.

Harris County Juvenile Probation Department
Girls Court Administrator
August 2013-July 2014

- Provided administration, direction, and counsel for a Specialty Girl's Court.
- Responsible for overseeing girls court resources and budget, grant writing, and maintain files for participating.
- Responsible for compiling statistical data, guiding program evaluation, contract management, and management of court documents.
- Solicited community support, interacted with government officials to develop community partnership and support to assist in fundraising and increasing awareness.
- Responsible for instituting a culturally competent program that addresses goal-oriented incentives and sanctions, family engagement (if possible) and educational linkages.
- Provided weekly supervision, evaluation, and professional guidance to practicum students.

- Conducted Determination of Mental Retardation, Certification, Competency, Legal Responsibility, and Fitness to Proceed evaluations. Coordinated treatment with and supervised a multi-disciplinary treatment team by synthesizing relevant information and offering clinical insight.
- Employed crisis intervention while working with a diverse, incarcerated population of youth (ages 10-17).
- Provided family and individual therapy focusing on mindfulness-based practices, Acceptance and Commitment Therapy, and Dialectical Behavior Therapy.
- Led individual and family engagement groups through Love and Limits curriculum.
- Provided behavioral consultation and trainings to juvenile justice staff in order to increase continuity of treatment.
- Provided weekly supervision, evaluation, and professional guidance to doctoral practicum students.

Lone Star Community College, CyFair Campus, Houston, TX
August 2013 –January 2014
Adjunct Faculty

- Instructed four classes including Human Development, Introduction to Psychology, Abnormal Psychology, and Criminology.
- Developed and utilized a course syllabus for each course while following institutional guidelines.
- Advised students in academic affairs.
- Provided access to students through electronic communication and archives.
- Planned, developed, and utilized a variety of teaching methods and materials to assist students in meeting learning objectives.

Dr. Alan Jaffe and Associates, Chicago, IL
August 2011 – February 2013
Child Custody and Psychological Evaluator

- Completed full psychological test batteries e.g., WAIS, MPI-II, PAI, Sentence Completion, Rorschach, ASPECT(12) on child and involved legal parties.
- Created reports for court testimony assessing the Illinois State Standard for Best Interest of the Child (750 ILCS 5/602).
- Conducted child evaluation including observations, clinical interviews, and psychological testing (Conners', Rorschach, WISC).
- Collected collateral data from court documents, medical records, and school records and interfaced with legal personal.
- Assessed for neglect and abuse and provided reports reflecting parental fitness and ability.
- Provided expert testimony on child welfare, and parental responsibility statutes in Illinois
- Maintained professional contact with Lawyers, GALS, caseworkers, Department of Child Protection and Social Services, and other professional resources.

The Forensic Center, Chicago, IL
January 2011– June 2012

Treatment Provider for Juvenile Specialty Court

- Conducted mental health evaluations with juveniles with substance abuse concerns referred from Specialty Mental Health Court and Juvenile Drug Courts
- Provided collaborative planning and treatment intervention to diverse juveniles using a guided self-change evidence-based practice.
- Assisted clients by coordinating care and connecting individuals with community resources.
- Created goals and indicators of success including behavioral observation tracking, skill monitoring, and use of discipline scales with underserved families.
- Assisted in education programming to address case load factors within Juvenile Specialty courts.

Boulder County Jail, Boulder, CO
January 2010 – August 2010
Mental Health Evaluator and Clinician for Specialty Adult Mental Health Court

- Provided comprehensive treatment planning to participants of Mental Health Court.
- Introduced "Life Skills" training component to incarcerated members attempting to enter MH court to enhance rehabilitation efforts.
- Served as crisis evaluator for inmates expressing psychological concern or suicidal or homicidal ideations.
- Evaluated level of care and management procedure for inmates and correctional officers.
- Created behavioral plans and effectively implemented case management for inmates approaching probation.
- Presented court reports in adjudication hearings in regards to mental health involvement with inmates.
- Presented trainings and seminars on topics including cultural sensitivity and symptom management to correctional officers and intake team to further promote mental health awareness within the correctional system.

Boulder Mental Health Residential Services, Boulder, CO
April 2009 – August 2010
Program Supervisor and Clinician

- Primary therapist and coordinator for a residential treatment center for mentally ill young adults with co-occurring substance abuse or law involvement.
- Administered intelligence, personality, and risk assessments such as the WAIS, WISC, MMPI-2, MCMI III, MAYSI, and Beck Depression Inventory
- Conducted individual and group therapy, which focused on mental health management, substance abuse, and life skills.
- Created program curriculum based off of a Psychosocial Rehabilitation and provided evidence-based and psychosocial rehabilitation-based services to dual diagnosis consumers.
- Hired, trained, and evaluated a team of staff members including case managers, therapists, and administrative assistants.

- Managed compliance with HUD, HIPPA, Department of Health, and SSI and SSDI program requirements.
- Connected consumers to community resources such as DSS, LEAP, SSI, SSDI, Food Stamps, and other relevant agencies.
- Created and managed concise written documentation regarding intake, treatment notes, and discharge planning as well as performed crisis intervention and de-escalation tactics with clients.
- As a QMAP administrator, dispensed medications and acted as a consultant to clients.

Arapahoe Sheriff's Office, Corner's Officer, Denver, CO
January 2009 –May 2011
Therapy Psychological Extern: Family and Crisis Intervention

Completed two rotations for psychological and medical assistance. First rotation included crisis intervention and family grief counseling.

- Provided Crisis intervention with next of kin.
- Provided assistance at death scenes, (i.e., documentation, pictures of the scene condition)
- Determined identification of the deceased, contacted the next of kin, and determined cause and manner of death.
- Administered victim's assistance and crisis intervention to those at the scene.
- Formulated a death scene report, collaborated with law officials regarding foul play deaths.
- Assisted in fingerprinting, toxicology, and autopsy.

(Earlier work experience available upon request)

PUBLICATIONS

Niesen, J., Reed, L., & Todd, L. (2012, March). Coercion, Types, Techniques, and Justification. *Forensic Student Newsletter*, 7 (2) 5-7.

Niesen, J. (2014). *Personal Resiliency as a Buffer Against the Adoption of Moral Disengagement in Youth Exposed to Community Violence.*

Niesen, J. et al. (2024, November 12). How Divorced Parents Can Help Their Teens Make Healthy Relationship Choices. Our Family Wizard, Blog, https://www.ourfamilywizard.com/blog/how-divorced-parents-can-help-their-teens-make-healthy-relationship-choices

PRESENTATIONS

Niesen, J, (2024, October). *Conquering Conflict: The Power of Semantics,* Ohio Supreme Court, Webinar (PC training)

Niesen, J, (2024, June). *Conquering Conflict: The Power of Semantics*, AFCC National Conference, Boston, MA.

Niesen, J, (2024, April). *Reunification in the Trenches,* AFCC Ohio Conference, Columbus, OH

Niesen, J, (2024, February). *Attachment and parenting foundations,* Ohio Bar Association.

Niesen, J, (2023, October). *Reunification from a family systems perspective*, Ohio Bar Association.

Niesen, J. (2023, June). *Foundations of Reunification,* Ohio Judges Convention, Domestic Relations Division, Salt Fork, OH.

Niesen, J (2023, June). *Neurodivergence and Reunification,* AFCC National Conference, Los Angeles, CA.

Niesen, J (2022, September). *Solutions for PCCP within reach,* AFCC and Judges conference, Delaware County, OH.

Niesen, J (2022, June). *Reunification from a family systems perspective,* AFCC National Conference, Las Vegas, NV.

Niesen, J, (2022, February). *Reunification from a family systems perspective*, Ohio Bar Association.

Niesen, J (2021, September). *Pathology and influence within refuse and resist dynamics,* AFCC, Cincinnati OH.

Niesen, J (2020, September). *Reunification within the domestic courts*, Ohio Counselors Association Conference.

Niesen, J (2020, January). *Children caught in loyalty conflicts*. Presented for GAL Quarterly Meeting.

Earlier presentations available upon request

PROFESSIONAL AFFILIATIONS

April 2023-Present	**Ohio State Board for AFCC**
April 2022-Present	**Ohio Counselor and social worker board**
January 2016-Present	**Ohio Psychological Association Member**
January 2016-Present	**Ohio Bar Association: Associate Member**
January 2016-Present	**Association of Family and Conciliation Courts: National**
January 2016-Present	**Association of Family and Conciliation Courts: Columbus**
April 2015-Present	**International Association of Trauma Professionals**
July 2013–July 2014	**Houston Psychological Association**
August 2010 – Present	**Illinois Psychological Association**

REFERENCES

References available upon request

SUCCESSFUL PARENTING, LLC
4357 Ferguson Rd. Suite #190 45245 Phone (513) 518-8657
• E-mail jennifer.szeghi@successfulparentingllc.com

JENNIFER R. SZEGHI, MA

EDUCATION

May 2010- Aug. 2010 **Chicago School of Professional Psychology** Chicago, IL *Post-Graduate Certificate in Child & Adolescent Psychology*

Sept. 2003-May 2005 **Chicago School of Professional Psychology** Chicago, IL
Master of Arts in Forensic Psychology.

June 2001 – Dec. 2002 **University of Cincinnati** Cincinnati, Ohio
Bachelor of Arts in Psychology, with an emphasis in Criminal Justice.

Aug. 1999 - May 2001 **Cincinnati Bible College** Cincinnati, Ohio
Majored in Elementary Education.

PROFESSIONAL EXPERIENCE

May 2008- Present **Successful Parenting, LLC** Cincinnati, Ohio
Parent-Child Coach, Co-parent Coach, Reunification Specialist, & Parenting Coordinator

- Founder of business focusing on teaching parents stress management techniques, healthy parenting styles, the developmental needs of their children and how the parent can meet the cognitive, emotional, physical, and social needs of the child. Educating the child to enhance coping skills and emotional regulation skills. Addressing parent-child conflicts while helping them implement communication skills, conflict resolution skills, coping skills, assertive skills, ultimately enhancing the relationship between the parent and the child while increasing the child's resiliency.
- Educate high conflict co-parents on self-awareness, emotional regulation, communication skills, conflict resolution skills, and the developmental needs of their children. Helping parents implement these skills while resolving parenting disputes in order to make a decision in the best interest of the child. In parent coordination cases, provide arbitration services by gathering facts and information about the issue, in the occurrence parents cannot come to a conclusion on their own, in order to make a parenting decision that is in the best interest of the child.
- Reunifying parents & children in cases of parent-child contact problems by identifying the barriers in the parent-child relationship and helping the family develop the skills needed to reunite and strengthen the relationship between the parent and the child.

September 2005-May 2020 **Cincinnati State Technical & Community College** Cincinnati, Ohio
Adjunct Instructor

- Creating an exciting and motivating learning environment for college students by teaching the concepts of the course and applying them to real life examples. Courses taught include: Abnormal Psychology, Adolescent Development, Child Development, Introduction to Psychology I & II, & Lifespan Development.

April 2009- Dec 2011 **Dr. Brinn & Associates** Cincinnati, Ohio
Psychology Assistant/ Outpatient Therapist

- Providing individual and family therapy for children, adolescents, and adults; with a variety of mental health disorders. Other duties included: participating in IEP meetings and testifying in court.

June 2005- April 2009 **Child Focus, Inc.** Cincinnati, Ohio
Outpatient Therapist

- Providing individual, family, and group therapy, as well as crisis interventions to children and adolescents with a variety of mental health disorders in traditional and home-based settings. Other duties included: attending IEP and cluster meetings for clients, correspondence with CPS and probation, and testifying in court.

July 2004-May 2005 **Metropolitan Family Services** Skokie, Illinois *Youth Outreach Coordinator*

- Responsible for the *Just for Kids Court Program.* Completed court intakes for juvenile offenders, provided psychological assessments, wrote recommendations to the court for the juveniles, administered individual and family therapy, taught anger management education groups, and oversaw interns who accepted cases from this program.

April 2003-Aug. 2003 **Hamilton County Juvenile Court** Cincinnati, Ohio
Residential Treatment Counselor

- Assisting male juvenile offenders with following treatment plans, behavior modification, improving social skills, anger management, identifying suicidal or AWOL behavior, and conducting groups.

Jan. 2003 –Aug. 2003 **Mercy Mt. Airy Hospital** Cincinnati, Ohio

Mental Health Specialist

- Assisting the patients in the child/adolescent psychiatry unit with behavior modification, symptom monitoring, redirecting patients experiencing psychosis, conducting groups, and providing support for the patients.

June 2001– April 2003 **Cincinnati Restoration Inc.** Cincinnati, Ohio
Residential Manager and Community Service Provider

- Assisting the mentally ill with maintaining daily living skills, medication monitoring, symptom management, crisis management, following terms of probation, obtaining & maintaining housing, identifying community resources, maintaining medical & psychiatric appointments, obtaining benefits, and developing individual service plans.

- Received the *Department Employee of the Year Award for 2002.*

SPEAKING ENGAGEMENTS

May 2025 **AFCC 62nd Annual Conference** New Orleans, LA
Words to Conquer Conflict

April 2025 **Children for Tomorrow** Houston, Texas
10 Commandments for Rejected Parents

February 2025 **Ohio Supreme Court- Judicial College** Columbus, Ohio
Words to Conquer Conflict

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
Lessons From the Trenches of Reunification

Oct. 2024 **Ohio Supreme Court- Judicial College** Columbus, Ohio
Words to Conquer Conflict

June 2024 **AFCC 61st Annual Conference** Boston, MA
Words to Conquer Conflict

April 2024 **AFCC Ohio Annual Conference** Westerville, Ohio
Lessons from the Trenches of Reunification

May 2023 **Court of Domestic Relations Hamilton County** Cincinnati, Ohio
Parental Reunification in Resist & Refuse Dynamics

November 2022 **Cincinnati Bar Association** Cincinnati, Ohio
High Conflict in Family Court

October 2022 **Northern Kentucky Bar Association** Covington, KY
Parental Reunification in Resist & Refuse Dynamics

February 2022 **Court of Domestic Relations Hamilton County** Cincinnati, Ohio
The Profiles of Parental Alienation

May 2021 **Court of Domestic Relations Hamilton County** Cincinnati, Ohio
Parent Alienation: From Semantics to Saving Our Children

July 2019 **Upward Bound Youth Leadership Conference** Cincinnati, Ohio
You vs. the Test: Strategies to Conquer Test Anxiety

April 2019 **Cincinnati State Psychology Club** Cincinnati, Ohio
The Stress Less Button

CERTIFICATIONS & TRAININGS

May 2025 **AFCC 62nd Annual Conference** New Orleans, LA
Missing Pieces: Different Angles & Approaches to Reunifcation Cases

May 2025 **AFCC 62nd Annual Conference** New Orleans, LA
Applying Family Systems to Conflicted Families

May 2025 **AFCC 62nd Annual Conference** New Orleans, LA
Draining the Swamp—Preventing and Responding to "Stuck" Child Custody Cases

May 2025 **AFCC 62nd Annual Conference** New Orleans, LA
Speech is Free, But Words Have a Cost: Communicating in Family Conflicts

May 2025 **AFCC 62nd Annual Conference** New Orleans, LA
Applying Family Systems to Conflicted Families

April 2025 **Ohio AFCC Innovations Conference** Westerville, Ohio
Responsible Use for AI in Dispute Resolutions

April 2025 **Ohio AFCC Innovations Conference** Westerville, Ohio
Creative Parenting Plans Supporting Attachment & Safety for Parents with Substance Misuse.

April 2025 **Ohio AFCC Innovations Conference** Westerville, Ohio
Best Practices for Substance Use Assessments

April 2025 **Ohio AFCC Innovations Conference** Westerville, Ohio
Considerations for Mental Health Professionals and Attorneys when Superintendence, Local Rules, and Court orders Conflict.

March 2025 **International Maxwell Conference** Orlando, Florida
Certified Life Coach & Speaker

December 2024 **Ohio Judicial College** Columbus, Ohio
Advanced Domestic Abuse Issues for Parenting coordinators and Mediators

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
Unintended Consequences of Coercive Control Legislation

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
Including Children's Voices in Family Law Proceedings: Risks and Unintended Consequences

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
A View from the Trenches: Practical Strategies for IPV and PCCP

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
Allegations of Child Sexual Abuse in the Context of Child Custody Evaluations (Judicial Track)

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
Conducting Risk Assessments in the Context of Domestic Violence

November 2024 **AFCC 16th Symposium on Child Custody** Columbus, Ohio
Scars of a High-Conflict Divorce

September 2024 **Hamilton Co. Dispute Resolutions/Dr. Saini** Cincinnati, Ohio
Mastering Disclosure Meetings in Parenting Plan Evaluations: Enhancing Transparency with Verbal Recommendations

June 2024 **AFCC 61st Annual Conference** Boston, MA
Should children participate in Family Law Process? Consider the Brain

June 2024 **AFCC 61st Annual Conference** Boston, MA
The Use and Misuse of an Apology in the Search for Family Forgiveness

June 2024 **AFCC 61st Annual Conference** Boston, MA
Herding Cats: Setting Goals in Resist/Refuse Cases

June 2024 **AFCC 61st Annual Conference** Boston, MA
Gaining Control Amidst Intimate Partner Violence, High-Conflict Couples, and Addiction

June 2024 **AFCC 61st Annual Conference** Boston, MA
Lausanne Trialogue Play in Child-Parent Rejection: The Italian Systemic Approach

June 2024 **AFCC 61st Annual Conference** Boston, MA
Depolarizing by Example: AFCC Peace Talks on Parent-Child Contact Problems

June 2024 **AFCC 61st Annual Conference** Boston, MA

June 2024 **AFCC 61st Annual Conference** Boston, MA
Moving Towards Consensus on Parent-Child Contact Problems

June 2024 **AFCC 61st Annual Conference** Boston, MA
Parenting Coordination: Timing of Meetings and Managing Conflict Using Neuroscience

April 2024 **Ohio Judicial College** Columbus, Ohio
Disruptions of Attachment: Implications for Parenting Coordination

April 2024 **Ohio Judicial College** Columbus, Ohio
Untangling the Trauma from the Drama

December 2023 **Ohio Judicial College** Columbus, Ohio
Advanced Parenting Coordinator Training: Parent-Child Contact Problems Current and Historical Concepts, Definitions, & Controversies

November 2023 **Ohio Judicial College** Columbus, Ohio
Danger's No Stranger: Dealing with Parental Pathology in Parenting Coordination

March 2023 **AFCC Ohio Chapter Conference** Westerville, Ohio
Expanding the Toolbox to Manage Children's Resistance & Refusal

March 2023 **Touching Trees- Jenni McBride-McNamara** Eagan, MN
Certification in Co-parenting Coaching

December 2022 **William James College** Boston, MA
Overcoming Parent-Child Contact Problems

November 2022 **AFCC 15th Symposium on Child Custody** Las Vegas, NV
What to do When Your Child Does Not Want to go to Their Other Parent's Home

November 2022 **AFCC 15th Symposium on Child Custody** Las Vegas, NV
My Child Hates Me: Research Recommendations on Parent-Child Estrangement

November 2022 **AFCC 15th Symposium on Child Custody** Las Vegas, NV
Unsticking the Stuck Client: A Process for Going From Resistance to Resilience

November 2022 **AFCC 15th Symposium on Child Custody** Las Vegas, NV
The Impact of Adverse Childhood Experiences on Court-Involved Children

November 2022 **AFCC 15th Symposium on Child Custody** Las Vegas, NV
Factitious Disorder, Imposed by Another: What Research Shows

November 2022 **AFCC 15th Symposium on Child Custody** Las Vegas, NV
Co-parent Coaching

September 2022 **AFCC Webinar** Cincinnati, Ohio
The Power of Values in Family Law Disputes

April 2022 **AFCC Ohio Chapter Conference** Columbus, Ohio
Breaking Through Conflict: Maximizing Results for Families & Professionals

September 2021 **Breakthrough Parenting, INC** Fresno, CA

Certified Breakthrough Parenting Trainer

April 2021 **National Association for Parent Alienation Specialists** Clearwater, FL
Effective Litigation of Family Law Cases in Parent Alienation

April 2021 **Association of Families & Conciliation Courts** Columbus, Oh
Moving Beyond Intractable: Working Successfully with Entrenched Litigants

February 2021 **High Conflict Institute** San Diego, CA
Licensed Provider in New Ways for Families

October 2020 **Ohio Judicial College** Columbus, OH
GAL: Advanced Topics in Divorce 2020

July 2020 **National Board of Forensic Evaluators** Ormond Beach, FL
Parent Alienation Syndrome- How to Assess the Brainwashed Child

December 2019 **Ohio Judicial College** Columbus, OH
Child-Centered Decision Making for Best Interests of the Child

October 2018 **Ohio Judicial College** Cincinnati, OH
Guardian Ad Litem Training

October 2017 **Ohio Supreme Court** Columbus, OH
Advanced Family Mediation Training

May 2016- November. 2016 **Community Mediation Services of Central Ohio/ Ohio Supreme Court** Columbus, OH
Mediation Training: Basic Mediation, Specialized Family/Divorce Mediation, Domestic Abuse Issues in Mediation, Parent Coordination, & Advanced Parent Coordination.

March 2009 **Child Focus, INC** Cincinnati, Ohio
Certification in The Incredible Years.

May 2006 **Cincinnati Children's Hospital & Medical Center** Cincinnati, Ohio
Certification in Trauma Focused Cognitive Behavioral Therapy

BOARD MEMBER/MEMBERSHIPS

April 2025- Present **Ohio AFCC Board Member**

June 2023- Present **Parental Alienation Consortium Committee**

April 2021- Present **Association of Family & Conciliation of Courts**
Ohio Chapter

INTERNSHIPS & VOLUTEER EXPERIENCE

May 2001–Jan 2003 **Old St. Mary's Pregnancy Crisis Center**
Cincinnati, Ohio

Dec. 2001- Feb.2002 **Cincinnati Prosecuting Attorneys' Office**
Cincinnati, Ohio

Sept. 2001- Nov 2001 **The Talbert House– Men's Extended Treatment**
Cincinnati, Ohio

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malory214@yahoo.com

EDUCATION

Case Western Reserve University, Cleveland Ohio; Master Degree of Applied Social Science Administration-concentration in adult mental health, May 1995
Case Western Reserve University: Mandel Center for Non-Profit Management, Cleveland; Ohio, MNO Certificate, January 2008
Virginia M Satir Center, Chapel Hill, North Carolina; Legacy Program, July 2024-Current
Milwaukee Mediation Center, Milwaukee Wisconsin; Domestic Relations Mediation Training, April 2022
Mediation Training and Consulting Institute, Ann Arbor Michigan Cornerstones of Mediation and Domestic Relations Training, June 2018
Gestalt Institute of Cleveland, Cleveland Ohio; Group Track Training, May 2003
Gestalt Institute of Cleveland, Cleveland Ohio; Couples and Family Training Program, March 2002
Gestalt Institute of Cleveland, Cleveland Ohio; Individual Counseling Training Program, March 2000
Gestalt Institute of Cleveland, Cleveland Ohio; Post Graduate Training Program, March 1999
Stephens College, Columbia Missouri; BA of Philosophy/Religion and Women's Studies, May 1990

TEACHING EXPERINCE

Case Western Reserve University
Jack, Joseph, and Morton Mandel School of Applied Social Science
January 2020-Current Full Time Lecture Faculty
Responsibilities include:

- Academic advising for students in the on-line program
- Course development, design, and editing
- Supporting and training adjunct professors
- Informal mentoring and support of students in three educational formats
- Course management as the lead instructor for SASS 441,517, and SASS 554
- Teaching assigned courses in three program formats; virtual format intensive weekend format, and traditional 14-week format
- Courses taught:
    - SASS 517 Family Systems Interventions (I contributed content to this course re-development)
    - SASS 582 Social Work in Child Abuse and Family Violence (I edited this course for on-ground weekly and intensive weekend)
    - SASS 441 Adult Development (I designed this course for the On-line Program)
    - SASS 509 Group Theory and Practice
    - SASS 508 Individual and Family Theory and Practice
    - SASS 504 Theories in Human Diversity and Human Development (I co-designed this course)
    - SASS 549 Theory and Practice Approaches in Direct Practice Social Work

- SASS 550 Trauma Informed Social Work Practice with Children
- SASS 554 Trauma Informed Social Work Practice with Adults (I re-designed this course for all three formats)
- SASS 519 Family Theory and Practice
- SASS 477 Direct Practice Generalist Methods
- SASS 598 Independent Study and Reading

Winner of the John A. Yankey Out Standing Teacher Award (full time) 2024

Case Western Reserve University
Jack, Joseph, and Morton Mandel School of Applied Social Science
August 2007 to January 2020- Adjunct Instructor
Responsibilities include:

- Teaching assigned courses in three program formats; virtual format intensive weekend format, and traditional 14-week format
- Courses taught:
  - SASS 441 Adult Development (Virtual Format, IW, Traditional 14 Week Format)
  - SASS 477 Social Work Methods (Virtual Format and Traditional 14 Week Format)
  - SASS 550 Trauma Informed Care with Children and Teens (Virtual Format)
  - SASS 554 Trauma Informed Care with Adults (IW and Traditional 14 Week Format)
- Served as the lead instructor for SASS 441 Adult Development-virtual format beginning 2015-current.
- Served as the course developer for SASS 441 Adult Development-virtual format beginning 2016-current
- Provided continuing education programs on a variety of topics

Gestalt Institute of Cleveland
April 2001 to 2007
Responsibilities include:

- Providing group psychotherapy, screening for group fit, and administrative responsibilities as assigned by the Institute.
- Providing continuing education programs on a variety of topics
- Providing teaching support to the educational tracks in the clinical programs

Professional Training Provided
These are trainings that I have authored, co-authored, and presented throughout the United States. They are approved by the State of Ohio Social Work Board for continuing education.

- Ethical Considerations When Working with Survivors of Trauma (3 ceu's)
- Ethical Issues in Everyday Practice (3 ceu's)
- Ethical Issues: When the right thing does not feel right (3 ceu's)
- Basic Collaborative Divorce Training (12 ceu's)
- Supervising Those Who Work with Survivors of Trauma (3 ceu's)
- When Helping Hurts: Understanding Vicarious Trauma (3 Ceu's)
- Crisis Intervention in Clinical Care (2 Ceu's)
- Working with High Conflict Couples (3 Ceu's)
- Family Systems 101 (3 ceu's)
- Working with Traumatized family Systems (3 ceu's)
- Transference and Counter Transference in Supervision (3 ceu's)
- Process Oriented Group Work (16 ceu's)

- Collaborative Divorce 101 for Therapists (3 ceu's)

WORK HISTORY

Private Psychotherapy and Divorce Mediation Practice
September 2000 to present
Responsibilities include:

- Providing psychotherapy to individuals, couples, and groups
- Maintaining clinical records and submitting billing
- Administrative tasks related to ruining a private practice
- Professional education and consulting services to other organizations
- Collaborative Divorce practice
- Providing mediation services to divorcing families

Cleveland Rape Crisis Center
April 2004 to December 31, 2008 - Associate Director and Director of Client and Clinical Services
Responsibilities include:

- Clinical oversight of the Therapeutic Services Team, Education and Volunteer Services Team
- Overseeing programmatic and administrative functions for the agency
- Performing administrative tasks of the executive director in her absence.
- Hiring, training, and disciplining staff
- Writing and teaching curriculum developed while working at the Cleveland Rape Crisis Center
- Creating and maintaining collaborative relationships with other community agencies, funders and the media

Cleveland Rape Crisis Center
July 2001to April 2004-Director of Clinical Services
Responsibilities include:

- Administrative oversight of the Therapeutic Services program
- Maintaining a caseload of 20 individual clients
- Providing supervision to staff and interns
- Providing group psychotherapy
- Providing three professional trainings per year
- Building and supporting relationships within the community

Mental Health Services Inc.
July 2000 to August 2001 - Clinical Supervisor of the Children Who Witness Violence Program
Responsibilities include:

- Providing clinical supervision for a staff of 10 clinicians
- Managing day to day program operations
- Supervising interns
- Quality assurance
- Training other professionals on topics related to children and trauma

Saint Vincent Charity Hospital
November 2002 to November 2004- Psychiatric Social Worker
Responsibilities include:

- Performing psychosocial assessments on the in-patient psychiatry unit
- Assisting In the maintaining of the therapeutic milieu of the unit

- Assisting patients in preparing for discharge

Cleveland Rape Crisis Center
August 1999 to July 2000: Adult Counselor
Responsibilities included:

- Providing individual and group psychotherapy to survivors or sexual assault and their families
- Training volunteers
- Working on the 24 hour sexual assault crisis hotline
- Creating a series of topical psycho-educational workshops for survivors of sexual assault
- Collaborating with other agencies that provide services to victims of violence.

Mental Health Services Inc.
December 1997 to July 1999: Program Manager of the Child Mobile Crisis Team
Responsibilities included:

- providing individual supervision 10 clinicians whom provided emergency psychiatric services for children in Cuyahoga County
- Work with other community providers to coordinate on-going treatment plans for clients once the crisis was managed
- Train other professionals on suicide prevention
- Work with schools throughout the county on their suicide prevention plans as well as providing in-services for students and faculty

Mental Health Services Inc.
June 1996 to December 1997: Crisis Intervention Specialist for the Adult Mobile Crisis Team
Responsibilities included:

- Providing crisis intervention services and diagnostic assessment to adults in psychiatric crisis
- Answering calls on the suicide prevention line
- Screening people for admission to the State Psychiatric Hospital
- Working with other community mental health centers to ensure that clients are linked for on-going services

Professional Organizations

- Satir Global Network
- Virginia M. Satir Center
- Cleveland Academy of Collaborative Professionals
- National Association of Social Workers
- International Academy of Collaborative Professionals
- Trauma and Addictions Collaborative of Cuyahoga County
- SA-OHIO (Sexual Assault Ohio List Serve)
- Gestalt Institute of Cleveland
- Co-Founder of Three Circles, llc
- Continuing Education provider for the State of Ohio Counselor Social Work and Marriage and Family Therapist Board
- Brene Brown “Daring Greatly” professional training group

Volunteer and Community Service

- Founder and Manager of the Orange Community Farmers and Artisan Market, Orange Ohio
- Planned Parenthood, Lansing Michigan and Cleveland Ohio
- Cleveland Rape Crisis Center, Cleveland Ohio

- Stagecrafters Community Production, Pepper Pike Ohio
- Rescue Village, Novelty, Ohio

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ARTICLE

The Efficacy of Parent Management Training With or Without Involving the Child in the Treatment Among Children with Clinical Levels of Disruptive Behavior: A Meta-analysis

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Abstract

A systematic review and meta-analysis was conducted where we evaluated the effects of Parent Management Training (PMT), Parent–Child Interaction Therapy (PCIT) and PMT combined with child cognitive behavioral therapy (CBT) using data from 25 RCTs on children with clinical levels of disruptive behavior (age range 2–13 years). Results showed that PMT ($g = 0.64$ [95% CI 0.42, 0.86]) and PCIT ($g = 1.22$ [95% CI 0.75, 1.69]) were more effective than waiting-list (WL) in reducing parent-rated disruptive behavior, and PMT also in improving parental skills ($g = 0.83$ [95% CI 0.67, 0.98]) and child social skills ($g = 0.49$ [95% CI 0.30, 0.68]). PCIT versus WL had larger effects in reducing disruptive behavior than PMT versus WL. In the few studies found, the addition of child CBT to PMT did not yield larger effects than PMT or WL. These results support offering PMT to children with clinical levels of disruptive behavior and highlight the additional benefits of PCIT for younger ages.

Keywords Meta-analysis · Parent Management Training (PMT) · Disruptive behavior disorder · Randomized controlled trials · Parent–Child Interaction Therapy (PCIT) · Cognitive behavioral therapy (CBT)

Disruptive behavior disorders (DBD), such as oppositional defiant disorder (ODD) [1] and conduct disorder (CD) [1] are strenuous conditions for children and families, associated with a higher risk for antisocial development [2] and internalizing disorders [3]. Disruptive behavior disorders are also associated with a substantial burden and high costs for society [4–7]. Here, we investigate the effectiveness of three therapy programs in the treatment of disruptive behavior disorders and compare their relative effectiveness.

Previous research has shown that Parent Management Training (PMT) is an effective treatment for disruptive behavior during childhood. In PMT, parents are taught strategies for handling behavior problems and improving the quality of the parent–child relationship. PMT programs embrace positive parental involvement with the child, increased parental attention on adaptive behaviors, and enhanced parent–child communication. PMT also includes teaching parents to prepare instructions for the child ahead of time, to use clear instructions, to respond with positive attention and warmth especially when the child shows desirable behavior, and to reduce the risk of reinforcing negative behavior by not focusing on minor disruptive behavior and work with non-punitive consequences [8].

The effects of PMT compared to waiting-list (WL) or treatment as usual (TAU) have been examined in an extensive number of clinical trials and in several meta-analyses and reviews [e.g., 9–18], showing moderate between-group effect sizes in reduced ODD- and CD-symptoms, or disruptive behavior in general. However, when examining the effects of PMT in randomized controlled trials, few meta-analyses focus solely on the effects of PMT for children with disruptive behavior within a clinical range (i.e., children with disruptive behavior diagnosis or disruptive behavior

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problems above a clinical cut-off). The effects of PMT on children with large problems have been captured in two earlier meta-analyses by Leijten and colleagues by including studies conducted in treatment settings [17, 19]. However, an inspection of the studies included in these meta-analyses, indicates that although they are conducted within treatment settings, a proportion of these include children with subclinical levels of disruptive behaviors, or focus on attention deficit/hyperactivity disorder (ADHD). Another example of a meta-analysis with studies on children with ADHD alongside studies on children with disruptive behavior disorders is Battagliese et al. [14].

We have only found three meta-analyses that exclusively included randomized controlled trials (RCT) in children and adolescents with clinical levels of disruptive behaviors. In 2005, Bradley and Mandell conducted a meta-analysis on studies of school-aged children, with five studies on children with ODD and two studies on aggressive behavior [15]. In that meta-analysis, PMT was evaluated alongside child directed treatment and school-based treatment, compared to any control, demonstrating reduced disruptive behavior of PMT (standardized mean difference [*SMD*] = 1.06, 95% CI 0.70 to 1.41) as well as of child directed treatments (*SMD* = 0.93, 95% CI 0.52 to 1.34) on disruptive behavior outcomes. Only seven studies were included in this meta-analysis, conducted several years ago, and the studies on aggressive behavior were not above a clinical cut-off. Furlong and colleagues [13] included studies of PMT for families with children in the clinical range. The mean effect size reported was 0.53 (95% CI 0.34 to 0.72). This meta-analysis included studies up until 2010. A third meta-analysis based on RCTs [20], included 17 studies of children and adolescents 2–18 years of age with an ODD- or CD diagnosis or clinical levels of conduct disorder symptoms. This meta-analysis included PMT and other psychosocial treatments for ODD and CD, such as school-based treatments and multisystemic treatments for youth, thereby complicating the possibility to draw conclusions regarding PMT effectiveness specifically.

To summarize, previous PMT meta-analyses that include RCTs and have samples with clinical levels of disruptive behavior in children are few and have either not focused solely on PMT efficacy [20], were performed over a decade ago [13, 15], have included studies on children with ADHD only among the children with disruptive behavior disorders [14] or, in addition to studies with clinical samples also included studies on children whose disruptive behavior problems were not above a clinical cut-off, even though referred to a treatment setting [17, 19]. Although earlier meta-analyses have contributed with important information regarding mixed samples and it can be assumed that PMT has a similar effect on children with clinical levels of disruptive behavior, it has not been investigated in a separate meta-analysis on PMT.

The possible long-term effects of PMT on child disruptive behavior have been evaluated in a meta-analysis by Van Aar et al. [12]. The authors included children with clinical as well as non-clinical disruptive behaviors and identified a sustained effect of parenting interventions, regardless of the initial levels of child disruptive behavior problems, age, gender or ethnicity. Long-term effects on clinical levels of disruptive behavior have also been examined in a meta-analysis, where PMT and other types of treatment modalities (such as child CBT alone, PMT combined with child-directed CBT, and multidimensional treatments such as Multisystemic treatment) were evaluated with no comparison or compared to WL [10]. Long-term within-group effects were examined from post-treatment to follow-up, showing sustained treatment effects on conduct problem outcomes. A limitation with the meta-analysis by Fossum et al. [10], was the inclusion of non-RCTs and the inclusion of different treatment modalities alongside PMT in the analysis, making the specific long-term effects of PMT hard to distinguish.

PMT delivered to parents individually or in groups is often the recommended treatment of choice in clinical guidelines [e.g., 21]. Another path to decreased disruptive behavior is to include or address the child in the treatment. In the NICE guidelines, two treatment approaches where the child is involved are described: (1) individual parent and child training programs, where the parent uses principles learned in treatment with the child, and receives guidance and feedback from the therapist (e.g., as in Parent–Child Interaction Therapy [PCIT]) [22], and (2) child focused social- and cognitive problem-solving and social skills training programs where the child takes part in the treatment by itself (e.g., Cognitive Behavioral Therapy [child CBT]). PCIT [22] is an individual parent and child training program (ages 2–7 years) where the therapist guides the parent via a bug-in-the-ear device with the child present in the treatment room in order to coach the parent to enhance the parent–child relationship, improve parenting skills, and to reduce the child's externalizing behavior problems. PCIT has shown reduced behavior problems in meta-analyses on clinical and subclinical levels of disruptive behavior and non-RCTs [23–25], but no meta-analysis evaluating the effects of PCIT with both RCTs and clinical levels of disruptive behavior as inclusion criteria has yet been conducted. Child CBT involves social and cognitive problem-solving training for children 9–14 years of age [21]. In child CBT, children with disruptive behavior are taught strategies to handle aggression, regulate emotions, use problem-solving techniques, and practice perspective-taking. A recent meta-analysis examined the effects of child social skills training on aggression, delinquency, and violence in either universal, selective, or indicated prevention studies, showing a medium effect size

post-treatment for indicated samples in moderator analyses ($d = 0.49$, 95% CI 0.36–0.62) [26]. Other studies have evaluated child CBT in combination with PMT and reported an increased effect size compared to when only PMT is delivered [27] or compared to a control group at 1-year follow-up [28], although not all studies have reported such effects [29]. PMT with child CBT is often studied with an addition of kindergarten- or school-based treatment, where teachers are involved in the treatment [30, 31]. In previous meta-analyses, the addition of school-based treatment has sometimes been incorporated in the calculation of effect sizes [20, 32]. Thus, for clinicians and policymakers, it would be important to synthesize the potential additive effect of child inclusion in or alongside the PMT treatment at clinical levels of disruptive behavior as well as without a school-based treatment component, as school-based treatment may be out of reach in psychiatric settings.

The present meta-analysis aims to fill the described knowledge gaps. We aimed to evaluate the treatment effects of PMT compared to waiting list (WL) or TAU for children with a mean age of 3 to 17 years, with clinical levels of disruptive behaviors in studies with a randomized controlled design. We evaluated differences in treatment effectiveness between PMT and PCIT, and between PMT and PMT with child CBT. Outcome measures examined were parent-, teacher- and clinician-rated disruptive behavior, social skills, parenting skills, parental sense of competence, and parental stress. Treatment time, treatment sessions, gender, age, and study quality as moderators of treatment effects were also examined. The following research questions were formulated:

(1) How effective is standard PMT and PMT with the child involved in the treatment (i.e., PCIT, PMT with child CBT) in treating children with clinical levels of disruptive behavior at post-treatment and follow-up?
(2) Is there a difference in effectiveness between standard PMT and PMT with the child involved in the treatment (i.e., PCIT, PMT with child CBT)?

Methods

Eligibility Criteria (PICOS)

Participants

Inclusion criteria were studies with children with a mean age between 3 and 17 years. The children had to have disruptive behavior problems at a clinical level, either defined as fulfilling criteria for a diagnosis of ODD or CD, or disruptive behavior problems over clinical cut-off on a well-known and established teacher or parent rating scale of disruptive behavior. Two studies were included where 1.5 SD below the mean was well above the clinical cut-off [33, 34]. Preventive studies targeting universal or selective populations with non-clinical, subclinical, or borderline behavioral problems were excluded. Studies including comorbid diagnoses such as ADHD were accepted as long as the children also had ODD, CD, or behavior problems at a clinical level, as defined above. Studies in which the participating children were developmentally or cognitively delayed, or suffered from disorders other than ODD or CD, were excluded. Studies where children were referred for maltreatment or were living with foster parents were excluded.

Interventions

The interventions evaluated were: (1) Standard PMT (in this meta-analysis defined as PMT directed towards parents and including core PMT treatment components [8]; (2) Parent–Child Interaction Therapy (PCIT; full model or abbreviated); (3) PMT combined with child CBT (PMT with child CBT). Treatments had to consist of at least 3 h of therapist-client contact. Studies evaluating the effects of medication were excluded.

Comparisons

PMT, PCIT, and PMT with child CBT were individually compared to WL. PMT was also compared directly within the same study to PMT with child CBT. In addition, the effects of PMT versus WL, PCIT versus WL, and PMT with child CBT versus WL were compared in moderator analyses.

Outcome Measures

Primary outcomes were measures of behavioral problems rated by parents, teachers, children, and clinicians post-treatment and at follow-up 6 or more months post-treatment. We included instruments with adequate psychometric properties measuring disruptive behavior problems. The following measures of disruptive behavior were included in the dataset: Child Behavior Checklist and Teacher Rating Form (CBCL; Externalizing, Aggression and Delinquent subscales) [35]; Eyberg Child Behavior Inventory (Intensity scale) [36]; Parent Daily Report (PDR) [37]; Strengths and Difficulties Questionnaire (SDQ CD scale) [38]; Disruptive Behavior Rating Scale (DBD; ODD subscale) [39]; Behavior Assessment System for Children 2 (BASC-2) [40]; Preschool and kindergarten behavior scales (Externalizing scale) [41]; Behar Preschool Behavior Questionnaire (PBQ) [42]. Measures of behavior problems in combination with other conditions, such as ADHD or anxiety, were not included.

Secondary outcomes were measures of social skills. The following measures were included: The Social Competence

Scale (PCOMP) [43]; Social Skills Rating Scale (SSRS) [44]; Strengths and Difficulties Questionnaire (SDQ Prosocial subscale) [38]; Child Behavior Checklist and Teacher Rating Form (CBCL Social competence subscale, Teacher Rating Form Prosocial) [35]; Social Competence and Behavior Evaluation (SCBE) [45]; Parent Daily Report (Prosocial scale) [37].

We also included measures of parental strategies: the Parenting Practices Interview (PPI) [46], the Alabama Parenting Questionnaire [47], and the Arnold Parenting Scale [48]. Furthermore, we included measures of parental stress, the Parenting Stress Index [49], and a measure of the parent's sense of competence, the Parents Sense of Competence scale (PSOC) [50].

Apart from rating scales, we also included three measures of clinician-rated observation of parent–child interaction: Revised Family Observation Schedule (FOS-RIII) [51]; Gardner's Procedure for Home Observation [52]; Dyadic Parent–Child Interaction Coding System (DPICS) [53].

Study Design

Randomized controlled trials with randomization at the individual or site level were included. Studies had to be published in English-language peer-reviewed journals.

Literature Search

Database searches were conducted on four occasions: December 2014, April 2016, October 2017, and April 2019, and aimed to include all published studies. The databases used were Medline (Ovid), Psychinfo (Ovid), ERIC/ProQuest (Ovid), Cochrane (Wiley), PubMed (Complementary search), Web of Science (Thomson Reuters), Scopus (Elsevier), Cinahl (Ebsco), SweMedcombined, and Embase (Embase). Search strategies for the different databases are presented in Supplementary file 1. We also hand-searched papers that were referred to in other papers or cited in earlier meta-analyses.

Study Selection

In total, 5106 articles were identified. A total of 4491 articles were excluded at the abstract level and 578 after full-text reading, which left 37 eligible articles. Nine of these articles, involving comparisons with TAU, were subsequently excluded since too few RCTs per comparison were identified. Ultimately, 25 RCTs were included [27–29, 31, 33, 34, 54–73], with two of them [28, 71] having complementary outcome data in three additional articles [74–76], bringing the total number of articles to 28.

All titles and abstracts were screened by the first and last author (MH and PE). Studies were selected for reading in full-text if the inclusion criteria were fulfilled: age over 3 (mean) and below 18 years, PMT, RCT, clinical level of disruptive behavior. Studies selected at this phase were first reviewed in a full-text format by the first author (MH) to confirm that the inclusion criteria were fulfilled. All included studies were subsequently controlled by the authors, PE, DW, LGÖ, and by two research assistants. All articles that were excluded during the full-text reading stage were discussed by the first and last author. Causes for exclusion were documented for each study. An overview of the inclusion process and reasons for exclusion can be seen in the flow chart, Fig. 1.

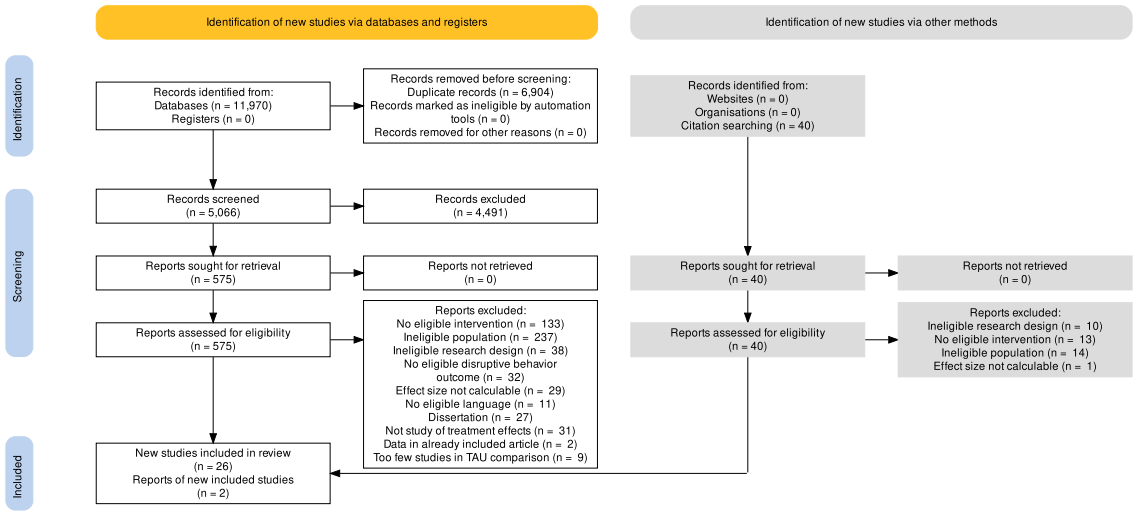

Fig. 1 Flowchart of study selection. In the end, 28 articles were included, in total describing data from 25 different RCTs. The flowchart was created using an online tool for generating PRISMA flowcharts [77].

Data Extraction

Effect data (i.e., information about means, standard deviations, and numbers of treated individuals) were extracted by the first author and research assistants and subsequently reviewed by DW and PE. In two cases where articles did not provide data that could be extracted and the article was less than 11 years old, authors were contacted and asked to share information about means, standard deviations, and numbers treated. The contacted authors shared their data [28, 58]. In some studies, follow-up results and different outcomes for a study were published separately. When relevant, these results were extracted and added to the original study.

Data Items

For the primary analyses, the following information was extracted from each included study: intervention type, comparison, measurement name, type of informant (parent, teacher, child, or clinician), and effect data. In order to evaluate effects of child and study characteristics, we extracted characteristics of the participants (mean age in years; % boys), intervention characteristics (treatment format; number of sessions; total treatment time, i.e., total number of treatment hours; treatment duration in weeks), and study origin.

Summary Measures

Summary measures at post- and follow-up were between-group effect sizes between conditions in the same studies. Hedges' *g* was calculated using the R package compute.es (version 0.2.4) [78] taking the mean difference between the treatments, dividing it by the pooled standard deviation, and multiplying the result with a correction factor designed to counteract upward bias in small samples. In the case multiple measures and time points were reported in the study, all data were classified into the outcome categories of interest, generating multiple effect sizes per study.

Synthesis of Results

The majority of studies in the present meta-analysis included multiple measures, and in some cases also multiple treatment arms. The within-study correlation was handled using robust variance estimation (RVE) [79], which is considered standard best practice for meta-analyses [80]. This technique can handle dependent data and, thus, permits us to include multiple effect sizes and multiple comparisons from the same study sample without breaking any assumptions of the model. In analyses employing RVE, multiple effect sizes are reweighted using an approximate variance–covariance matrix, resulting in valid point estimates and significance tests even when the variance–covariance matrix of effect sizes within studies remains unknown. All analyses were estimated assuming an inter-correlation within studies of $q = 0.8$ and a random-effects model was used. Analysis was made in RStudio using the package robumeta with small sample adjustment (version 2.0) [81]. According to Tipton [82], the RVE estimators perform best when the Satterthwaite degrees of freedom are greater than 4. When the degrees of freedom were below 4 (in figures marked with [a]), a value of $p < 0.01$ was used instead of $p < 0.05$ to avoid type I error, as suggested in Tanner-Smith et al. [83]. We chose to present the results when at least three studies were included in an analysis.

We conducted separate meta-analyses for the different types of outcomes judged to represent different underlying constructs: disruptive behavior, social skills, parenting skills, parental sense of competence (data found only in the standard PMT versus WL comparison), and parental stress. Parenting skills were divided into positive parenting skills (use of positive skills such as praise and rewards), and negative parenting skills (use of negative strategies such as harsh, overreactive, or submissive parenting) in order to detect differences in treatment effect between these two constructs. Furthermore, the effects of PMT versus WL, PCIT versus WL, and PMT with child CBT versus WL were compared in moderator analyses, also using robust variance estimation. For these moderator analyses, an alternative method is network meta-analysis in which effect sizes from all arms of a study can be incorporated rather than just from a single comparison. This would be relevant for the two studies [28, 29] in our dataset that used three-arm designs. We replicated our moderator analyses using this method with one outcome measure for each study, finding a similar pattern of results (contact authors for further details).

Moderator analyses, determining potential effects of child and study characteristics, were conducted by means of a meta-regression, but only for the standard PMT versus WL comparison at post-treatment on the disruptive behavior outcome, as the heterogeneity was judged large enough with an I^2 between 50 and 70% [84]. All moderators (i.e., mean age in years, % boys, total treatment time in hours, study quality) were analyzed in the same model following current best practice [80]. In a subsequent analysis, total treatment time in hours was substituted with the number of treatment sessions.

Assessment of Study Quality and Risk of Bias

The psychotherapy outcome study methodology rating scale [85] and the Cochrane risk-of-bias tool [86] were used for assessment of methodological study quality.

The psychotherapy outcome study methodology rating scale consists of 22 items: (1) Clarity of sample description, (2) Severity/chronicity of the disorder, (3)

Representativeness of the sample, (4) Reliability of the diagnosis in question, (5) Specificity of outcome measures, (6) Reliability and validity of outcome measures, (7) Use of blind evaluators, (8) Assessor training, (9) Assignment to treatment, (10) Design, (11) Power analysis, (12) Assessment points, (13) Manualized, replicable, specific treatment programs, (14) Number of therapists, (15) Therapist training/experience, (16) Checks for treatment adherence, (17) Checks for therapist competence, (18) Control of concomitant treatments, (19) Handling of attrition, (20) Statistical analyses and presentation of results, (21) Clinical significance, (22) Equality of therapy hours (for non-WL designs only). The scale generates a summary score per study. Each item is rated as 0 (poor), 1 (fair), or 2 (good), allowing for a range of 0–44 points. In the present meta-analysis mean study quality score was 21.6 (SD 4.75) with an overall range of 13–33. Scores for each study can be seen in Table 1. The ratings of study quality were made by trained research assistants with no connection to the evaluated studies. The interrater reliability, based on 20% randomly selected studies, was ICC = 0.88 for the total score, indicating good interrater reliability. Differences between raters were discussed in order to reach agreement.

In line with the Cochrane risk of bias tool (RoB) [86], the studies were coded "low", "some", and "high" risk in respective domains, and a summary risk of bias was estimated. In total, 6 studies were coded as having high, 19 some, and zero had low risk. For the domain randomization process, all studies were randomized controlled studies but did not report how allocation sequence was generated or whether allocation was concealed (13 studies were coded as low risk, 10 some risk, and 2 high risk). For the domain Deviation from intended intervention, most of the studies reported no deviation (17 low, 5 some, and 3 high risk). As for the domain missing outcome data, bias was detected in half of the studies (12 low, 9 some, and 4 high risk). Regarding the domain Measurement of the outcome, as in many studies on the effects of PMT, the parents were aware of the treatment they received and were the main informants of program effects (25 some risk). For the domain Bias in selection of the reported results, the majority of studies were conducted before registration of study protocol became mandatory (5 low and 20 some risk). Interrater reliability was assessed in four out of the 25 articles. The total proportion of agreement was 0.85, with 17 out of 20 items agreed upon. Individual variables had the following proportions of agreement: Randomization = 1, Deviation from intended treatment = 0.75, Missing outcome data = 0.75, Blinding outcome measurement = 1, Selection of reported results = 0.75.

Publication bias, the tendency to report and publish only large and significant effects constitutes a risk to external validity in a meta-analysis. Common methods used to analyze possible publication bias are funnel plots and Egger's test of funnel plot symmetry. However, as these methods have been shown to perform less well in meta-analysis with multiple and dependent effect sizes [80, 87] they were not performed.

Sample Characteristics

A total of 2023 individuals participated in the included studies. The mean age was 5.5 years and the age range was 2–13 years (no studies with children above 13 years of age were found). Sixty-nine percent were boys (see Table 1). In seven out of 25 studies, the proportion of children with comorbid ADHD was presented ranging from 3 to 82% (mean 55%). The 25 studies found were published between 1983 and 2018 and were conducted in 12 countries, representing four continents. In 16 studies, standard PMT was compared to WL. Six studies compared PCIT to WL. In three studies, PMT with child CBT was compared to WL. Four studies compared PMT to PMT with child CBT. A few studies included multiple comparison groups (see Table 1). Additional information on baseline levels of disruptive behavior, separately for PMT, PCIT, and PMT with child CBT can be found in Supplementary file 2, Table S1.

Unfortunately, only two studies were found with follow-up assessments in the PMT versus WL comparison [61, 88]. The only comparison condition where three or more studies included follow-up assessments was the PMT versus PMT with child CBT comparison ($n = 3$).

Parent-rated outcomes were found in all studies. In one comparison, PMT with child CBT versus WL, we were able to analyze teacher-rated outcomes. Child-rated outcomes were too few to analyze. Clinician-rated outcomes were found in the standard PMT versus WL, PCIT versus WL, and PMT with child CBT versus WL comparisons, but not in the PMT versus PMT with child CBT comparison.

Results

How Effective is Standard PMT and PMT with the Child Involved in the Treatment?

As can be seen in Fig. 2, standard PMT was significantly more effective than WL, with medium effect sizes on parent-rated measures of child disruptive behavior (k = 16) and social skills (k = 5), and a large effect size on negative parenting skills (k = 9). For positive parenting skills (k = 3), parental stress (k = 5), and parental sense of competence (k = 4), standard PMT was not significantly more effective than WL, although the effect sizes were in the expected direction. Forest plots can be found in Figs. S1-S10 Supplementary file 2.

Table 1 Descriptives of the studies and treatment conditions included in the meta-analysis

Author	Country	Treatment	Comparison	Assessment	Rater	Treatment time PMT	Quality score	N	% Boys	Age range	Mean age	Therapy format	PMT method	PMT manual
Axberg, 2012	Sweden	PMT	WL	Post	P, T	24	25	62	84	4–8	6.0	G	IY	Webster-Stratton, 2001
Barkley, 2000	USA	PMT	WL	Post	P	30	19	81	64	4–6	4.8	G	Barkley	Barkley, 1997
Braet, 2009	Belgium	PMT	WL	Post	P, T	22	13	64	64	4–8	5.6	G	PMT	-
Brestan, 1997	USA	PMT	WL	Post	P	-	16	30	83	3–6	4.5	I	PCIT	Eyberg & Boggs, 1989
Carvalho Homem, 2015	Portugal	PMT	WL	Post	P, Clin	28	23	83	73	3–6	4.5	G	IY	Webster-Stratton, 2001
David, 2014	Romania	PMT	WL	Post	P, T	15	24	85	48	4–12	6.0	G	PMT	Clark, 1996
Enebrink, 2012	Sweden	PMT	WL	Post	P	11	23	104	58	3–12	6.8	Int	KOMET	Kling, 2006
Eyberg, 1995	USA	PMT	WL	Post	P, Clin	13	17	22	80	3–6	4.5	I	PCIT	Eyberg & Durning, 1994
Frank, 2015	New Zealand	PMT	WL	Post, 6 mon	P	11.5	18	42	69	3–8	5.6	G	Triple P	Sanders, 2012
Gardner, 2006	UK	PMT	WL	Post	P, Clin	28	20	76	74	2–9	5.9	G	IY	Webster-Stratton, 2001
Helander, 2018	Sweden	PMT	PMT + child-CBT	Post	P	28	27	120	73	8–12	9.3	G	KOMET	Kling, 2006
Hutchings, 2007	UK	PMT	WL	Post	P, Clin	30	15	153	60	3–5	3.8	G	IY	Webster-Stratton, 2001
Kazdin, 1992	USA	PMT	PMT + child-CBT	Post, 12 mon	P, Child	28	25	68	78	7–13	10.3	I	PMT	Kazdin, 1987
Larsson, 2009[1]	Norway	PMT, PMT + child-CBT	WL, PMT + child-CBT	Post, 12 mon	P, T, Child	24	30	127	80	4–8	6.6	G	IY	Webster-Stratton, 2001
Leung, 2015	Hong Kong	PMT	WL	Post	P, Clin	-	24	111	74	2–7	4.5	I	PCIT	Eyberg & Funderburk, 2010

Table 1 (continued)

Author	Country	Treatment	Comparison	Assessment	Rater	Treatment time PMT	Quality score	N	% Boys	Age range	Mean age	Therapy format	PMT method	PMT manual
Markie-Dadds, 2006	Australia	PMT	WL	Post	P	3	23	26	76	2–6	3.9	I	Triple P	Sanders, 1999
McGilloway, 2012	Ireland	PMT	WL	Post	P, Clin	28	21	149	62	2–7	4.8	G	IY	Webster-Stratton, 2001
Nixon, 2003	Australia	PMT	WL	Post	P, Clin	22	22	54	70	3–6	3.9	I	PCIT	Hembree-Kigin & McNeil, 1995
Pepler, 2010	Canada	PMT + child-CBT	WL	Post	P, T	18	20	87	0	5–11	8.6	G	SNAP	Augimeri, 2007
Sanders, 2000	Australia	PMT	WL	Post	P, Clin	10	24	136	68	3–4	3.4	G	Triple P	Sanders, 1999
Schuhman,1998	USA	PMT	WL	Post	P, Clin	13	17	64	81	3–6	4.9	I	PCIT	Eyberg & Durning, 1994
Scott, 2001[1]	UK	PMT	WL	Post, 48 mon	P	30	19	141	74	3–8	5.7	G	IY	Webster-Stratton, 2001
Webster-Stratton, 2004	USA	PMT	WL	Post	P	42	33	57	90	4–8	5.9	G	IY	Webster-Stratton, 2001
Webster-Stratton, 1997	USA	PMT, PMT + child-CBT	WL, PMT + child-CBT	Post, 12 mon	P, T, Child Clin	36	25	70	74	4–7	5.7	G	IY	Webster-Stratton, 2001
Zangwill, 1983	USA	PMT	WL	Post	P, Clin	14	16	11	-	2–8	3.0[2]	I	PCIT	Hanf & Kling, 1974

Treatment = The active treatment; Comparison = The condition that the active treatment is compared against; PMT = Parent Management Training; PMT + child-CBT = PMT with child CBT; WL = Waiting list; Assessment = Time point of between group effect size difference at post assessment and number of months post treatment assessment; Rater: P = Parent T = Teacher, Child = Child, Clin. = Clinician rated outcomes/observations; Treatment time PMT = Approximate number of hours with treatment; Quality score = Rating of quality according to the psychotherapy outcome study methodology rating scale (Öst 2008); N = Number of children participating in the relevant conditions in each study; Therapy format: G = group, I = Individually, Int. = Internet with therapist contact at least 3 h; PMT Method: IY = Incredible Years, PCIT = Parent Child Interaction Therapy, SNAP = Stop Now And Plan. [1]For two of the studies [28, 71], complimentary data was found [74–76], not presented in this table. [2] Median age

Comparison	Rater	Measure	*k(n)*	*p*	*tau²*	*I²* (%)
Standard PMT vs. WL	Parent	Disruptive behavior	16(31)	<.001***	0.12	66.2
Standard PMT vs. WL	Parent	Social skills	5(6)	<.01**[a]	0.00	0.00
Standard PMT vs. WL	Parent	Parenting skills, positive	3(5)	.14[a]	0.35	83.1
Standard PMT vs. WL	Parent	Parenting skills, negative	9(17)	<.001***	0.01	14.0
Standard PMT vs. WL	Parent	Parental stress	5(7)	.01[a]	0.03	29.1
Standard PMT vs. WL	Parent	Parental sense of competence	4(7)	.13[a]	0.20	76.8
Standard PMT vs. WL	Clinician	Disruptive behavior	4(5)	<.01**[a]	0.00	0.00
Standard PMT vs. WL	Clinician	Social skills	1(2)	-	-	-
Standard PMT vs. WL	Clinician	Parenting skills, positive	5(6)	.03[a]	0.13	71.7
Standard PMT vs. WL	Clinician	Parenting skills, negative	5(6)	.17[a]	0.11	72.8
Standard PMT vs. WL	Teacher	Disruptive behavior	7(8)	0.85	0.01	6.6

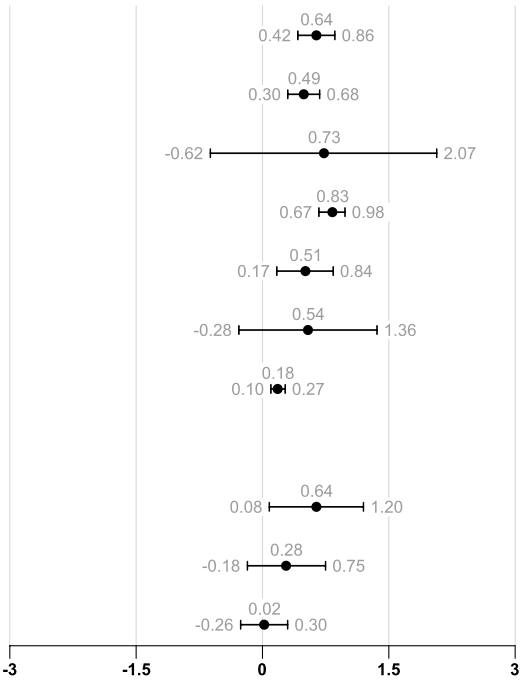

Fig. 2 Robust variance estimations of between group effect sizes (Hedges' g) of standard PMT compared to WL at post-treatment assessment for different raters and measures. Only results from analyses comprising more than two studies are shown. Error bars denote the 95% confidence intervals. Comparison = The comparison that is being investigated; Rater = The type of rater that has contributed with the dependent measure; Measure = The dependent measure that is being investigated; *k(n)* = Number of studies/number of effect sizes; *p* = The *p*-value. *p*-values marked with "a" means that they are unstable due to degrees of freedom being below 4. In these cases, only *p*-values below .01 are regarded as significant. **p* <.05, ***p* <.01, ****p* <.001; tau^2 = Between study variance; I^2 (%) = Percentage of variation across studies that is due to heterogeneity rather than to chance.

In teacher-rated disruptive behavior outcomes, examined in seven studies, no significant effect was found regarding disruptive behavior. We found a significant effect size for clinician-rated disruptive behavior, favoring PMT when compared to WL (evaluated in four studies). For clinician-rated parenting skills, no significant differences were found in this small sample.

Too few studies were found to analyze follow-ups of six months or longer. In standard PMT compared to WL, only two studies included follow-up data. Therefore no analysis was conducted of longer-term effects.

When examining parent-rated effectiveness of PCIT (six studies), PCIT was significantly more effective compared to WL with large effect sizes for reduced disruptive behavior and parental stress (see Fig. 3; forest plots can be found in Figs. S11-S16 Supplementary file 2). Regarding clinician-rated parent–child interactions, examined in five studies, the effect size of positive and negative parental strategies were large and significant for PCIT compared to WL. We also examined three studies where PMT combined with child CBT was compared to WL. No significant effects were found in parent- or teacher-rated outcomes. Too few studies were found to analyze follow-ups of six months or longer in PCIT or PMT with child CBT versus WL.

Is There a Difference in Effectiveness Between Standard PMT and PMT with the Child Involved in the Treatment?

We were also interested in examining if there was increased effectiveness of PMT when the child was included in the treatment, as in PCIT and PMT with child CBT. The results are presented in Figs. 4 and 5. First, we ran a moderator analysis with the type of PMT as a moderator (standard PMT, PCIT, and PMT with child CBT) and analyzed treatment effects of the three versions of PMT compared to WL (see Fig. 4). Results showed that the effect of PCIT versus WL was significantly larger compared to standard PMT versus WL in reducing disruptive behavior, while the effect of PMT with child CBT versus WL did not differ significantly from the effect of

Comparison	Rater	Measure	*k(n)*	*p*	*tau²*	*I²* (%)
PCIT vs. WL	Parent	Disruptive behavior	6(13)	.<01**[a]	0.00	0.96
PCIT vs. WL	Parent	Social skills	0(0)	-	-	-
PCIT vs. WL	Parent	Parental strategies, positive	0(0)	-	-	-
PCIT vs. WL	Parent	Parental strategies, negative	1(2)	-	-	-
PCIT vs. WL	Parent	Parental stress	4(7)	.02[a]	0.00	0.00
PCIT vs. WL	Clinician	Disruptive behavior	2(3)	-	-	-
PCIT vs. WL	Clinician	Parental strategies, positive	5(8)	<.01[a]	1.64	87.8
PCIT vs. WL	Clinician	Parental strategies, negative	5(8)	<.01[a]	0.25	61.2
PMT with child CBT vs. WL	Parent	Disruptive behavior	3(9)	.20[a]	0.15	65.2
PMT with child CBT vs. WL	Parent	Social skills	1(2)	-	-	-
PMT with child CBT vs. WL	Parent	Parental strategies, positive	1(2)	-	-	-
PMT with child CBT vs. WL	Parent	Parental strategies, negative	1(4)			
PMT with child CBT vs. WL	Parent	Parental stress	2(4)	-	-	-
PMT with child CBT vs. WL	Teacher	Disruptive behavior	3(3)	.59[a]	0.26	79.5

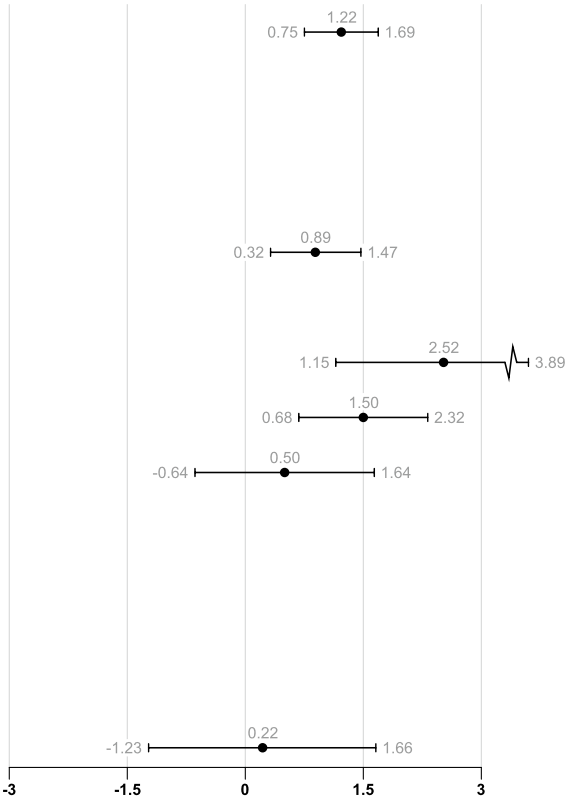

Fig. 3 Robust variance estimations of between group effect sizes (Hedges' g) of PMT with the child included in the treatment (PCIT or PMT with child CBT) compared to WL at post-treatment assessment for different raters and measures. Only results from analyses comprising more than two studies are shown. Error bars denote the 95% confidence intervals. Comparison = The comparison that is being investigated; Rater = The type of rater that has contributed with the dependent measure; Measure = The dependent measure that is being investigated; *k(n)* = Number of studies/number of effect sizes; *p* = The *p*-value. *p*-values marked with "a" means that they are unstable due to degrees of freedom being below 4. In these cases, only *p*-values below .01 are regarded as significant. **p* <.05, ***p* <.01, ****p* <.001; tau^2 = Between study variance; I^2 (%) = Percentage of variation across studies that is due to heterogeneity rather than to chance.

standard PMT versus WL. In parental stress outcomes, PCIT versus WL showed a non-significant larger effect compared to standard PMT versus WL. One possible explanation of the differences between PCIT and standard PMT could be related to the age of the children. In our analysis, the mean age in the PCIT studies (4.22, SD 0.68) and the standard PMT studies (5.30, SD 1.00) were significantly different. Another difference between PCIT and standard PMT is that the treatment time may differ. However, there was no significant difference in the number of treatment sessions between PCIT (M = 13.25, SD = 1.57) and PMT (M = 12.75, SD = 4.06).

We were also able to examine the effects of standard PMT compared directly to PMT with child CBT at post-measurement within four studies (see Fig. 5; forest plots can be found in Figs. S17-S22 Supplementary file 2). No significant differences in effect sizes were discovered in disruptive behavior outcomes and there were large variations in effect sizes among the studies in all outcomes.

In the comparison between standard PMT versus PMT with child CBT, three studies had a follow-up assessment. At one-year follow-up effect sizes were small and non-significant, with large variation among studies.

Moderator Analyses

In order to determine whether child characteristics, treatment characteristics, or study quality moderated treatment results, a meta-regression analysis of the effect size for standard PMT compared to WL was used (see Table 2). No significant effects were found for the variables age, sex, and treatment time in hours, indicating that these factors did not moderate treatment effectiveness. Since group- and individual treatment may differ in the amount of time that is directed to a specific family, we also analyzed whether the number of treatment sessions (instead of treatment time in hours) moderated the effect, which was not the case (not reported). Study quality, determined by the psychotherapy outcome study methodology rating scale [85] was found to moderate treatment effect significantly, with higher study quality being associated with a larger effect size.

Comparison	Rater	Measure	*k(n)*	*p*	*tau²*	*I²* (%)
			23(53)		0.10	59.4
Standard PMT vs. WL	Parent	Disruptive behavior	16(31)	<.001***		
PCIT vs. WL	Parent	Disruptive behavior	6(13)	.01*		
PMT with child CBT vs. WL	Parent	Disruptive behavior	3(9)	0.49[a]		
			5(8)		0.00	0.00
Standard PMT vs. WL	Parent	Social skills	5(6)	<.01[a]		
PCIT vs. WL	Parent	Social skills	0(0)	-		
PMT with child CBT vs. WL	Parent	Social skills	1(2)	-		
			3(7)		0.10	62.9
Standard PMT vs. WL	Parent	Parental skills, positive	3(5)	0.12		
PCIT vs. WL	Parent	Parental skills, positive	0(0)	-		
PMT with child CBT vs. WL	Parent	Parental skills, positive	1(2)	-		
			10(23)		0.02	24.1
Standard PMT vs. WL	Parent	Parental skills, negative	9(17)	<.001***		
PCIT vs. WL	Parent	Parental skills, negative	1(2)	-		
PMT with child CBT vs. WL	Parent	Parental skills, negative	1(4)	-		
			9(18)		0.01	15.0
Standard PMT vs. WL	Parent	Parental stress	5(7)	.02[a]		
PCIT vs. WL	Parent	Parental stress	4(7)	0.06		
PMT with child CBT vs. WL	Parent	Parental stress	2(4)	-		

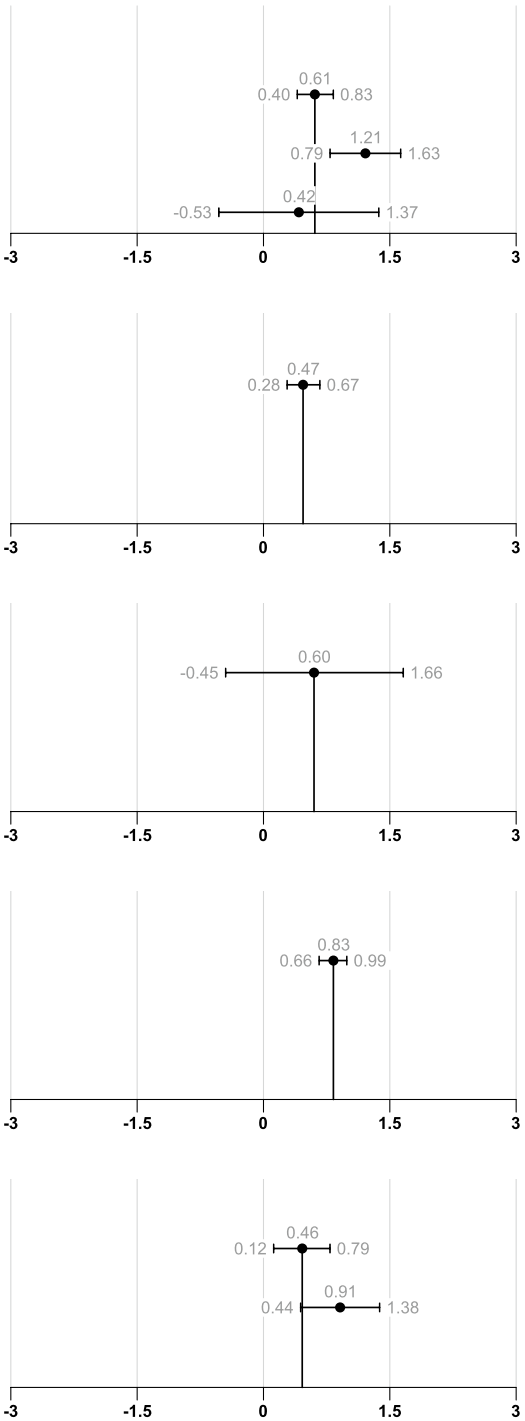

Fig. 4 Robust variance estimation moderator analyses of type of comparison for between group effect sizes (Hedges' g) at post-treatment parent assessment for different measures. In total, five different analyses are presented. The first row of each analysis gives information about overall *k*, *n*, τ^2, and I^2, whereas the second row is the intercept and the subsequent rows denote and test for the difference from that intercept. In the presentation of these analyses, the intercept effect sizes have been added to the subsequent effect sizes and confidence intervals in order to simplify the interpretation. Only comparisons that include more than two studies are shown. Error bars denote the 95% confidence intervals. Comparison = The comparison that is being investigated; Rater = The type of rater that has contributed with the dependent measure; Measure = The dependent measure that is being investigated; *k(n)* = Number of studies/number of effect sizes; *p* = The *p*-value. *p*-values marked with "a" means that they are unstable due to degrees of freedom being below 4. In these cases, only *p*-values below .01 are regarded as significant. **p* <.05, ***p* <.01, ****p* <.001; *tau*^{2} = Between study variance; I^2 (%) = Percentage of variation across studies that is due to heterogeneity rather than to chance.

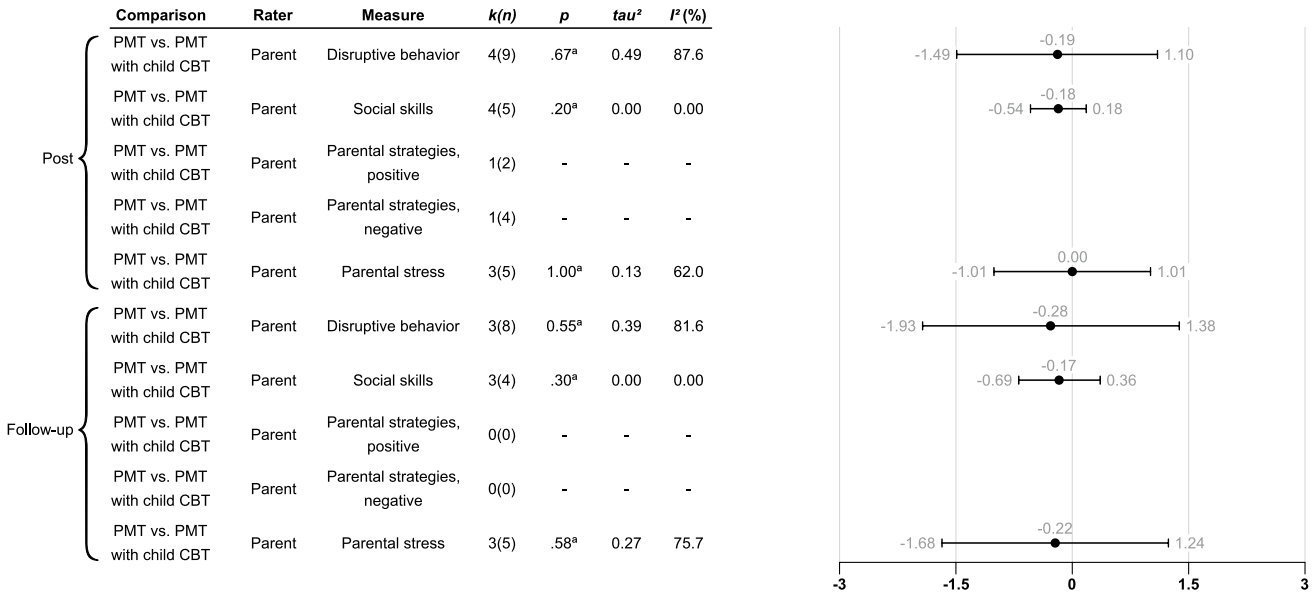

Fig. 5 Robust variance estimations of between group effect sizes (Hedges' g) of parent rated standard PMT compared to PMT with child CBT for different measures at different timepoints. Only results from analyses comprising more than two studies are shown. The first five rows denote post-treatment scores while the last five rows denote follow-up scores (12 months after treatment completion). Error bars denote the 95% confidence intervals. Comparison = The comparison that is being investigated; Rater = The type of rater that has contributed with the dependent measure; Measure = The dependent measure that is being investigated; *k(n)* = Number of studies/number of effect sizes; *p* = The *p*-value. *p*-values marked with "a" means that they are unstable due to degrees of freedom being below 4. In these cases, only *p*-values below .01 are regarded as significant. **p* <.05, ***p* <.01, ****p* <.001; tau^2 = Between study variance; I^2 (%) = Percentage of variation across studies that is due to heterogeneity rather than to chance.

Table 2 Moderator analysis of age, gender, treatment time, and study quality on parent's ratings of disruptive behavior for PMT vs. WL

Measure		*k(n)*	Beta	95% CI	*p*	tau^2	*I* (%)
		16(31)				0.08	55.6
Disruptive behaviour	Intercept		0.74	0.51, 0.98	< .001***		
	Mean age		− 0.06	− 0.33, 0.21	.56		
	Proportion boys		0.06	− 0.19, 0.30	.54[a]		
	Treatment time		− 0.20	− 0.55, 0.15	.20		
	Study quality		0.27	0.08, 0.46	.01*		

k(n) = Number of studies/number of effect sizes; Beta = indicates the value of the slope for each continuous variable; [a] = *p*-value is unstable due to degrees of freedom below 4, therefore, a *p*-value at .01 is regarded as non-significant whereas a *p*-value below .01 is regarded as significant; **p* < .05, ***p* < .01, ****p* < .001; tau^2 = between study variance; I^2 (%) = percentage of variation across studies that is due to heterogeneity rather than to chance

Discussion

This meta-analysis exclusively investigated the effectiveness of PMT on clinical levels of disruptive behavior without inclusion of other treatments, synthesizing findings from 25 RCTs. Our first research question focused on the effectiveness of standard PMT. We can conclude that standard PMT targeting children with clinical levels of disruptive behavior was significantly more effective at post-treatment with a medium effect size compared to WL. The effect size found in this study of standard PMT compared to WL was somewhat larger compared to meta-analyses that also included subclinical levels of disruptive behavior [11, 12, but see also 9]. Our effect size was closer to the ones obtained by Furlong et al. [13] and Fossum et al. [89] showing medium effect sizes on clinical levels of disruptive behavior for PMT compared to WL. This may suggest a larger effect of standard PMT when treating clinical levels of disruptive behavior as compared to non-clinical levels of disruptive behavior.

Only a few standard PMT studies included follow-up data in both treatment and comparison conditions, prohibiting comprehensive analyses. Although a previous meta-analysis using within-group effects has shown sustained effects of PMT over time [12], it is clear that more RCTs on PMT effectiveness on clinical levels of disruptive behavior with follow-up data in both comparisons are needed before firm conclusions can be drawn.

This meta-analysis initially had the ambition to also investigate PMT versus TAU. Surprisingly, only two RCTs were found per comparison (standard PMT versus TAU, PCIT versus TAU, and PMT with child CBT versus TAU), highlighting an important knowledge gap in the literature and stressing that more studies are called for. A low number of relevant studies was also evident when attempting to analyze PMT with child CBT compared to WL, resulting in unreliable effects, thereby prohibiting conclusions to be drawn.

We were interested in evaluating the effects of PMT when the child was involved in treatment. We found a large and significant post-treatment effect size for disruptive behavior for PCIT compared to WL. These results are in line with a previous meta-analysis on PCIT [23]. The present meta-analysis contributes by extending the results to clinical levels of disruptive behavior. In contrast, PMT combined with child CBT was not significantly more effective than WL. The lack of reliable effect, albeit a medium effect size in the expected direction, may be related to that the number of studies were few.

Our findings on disruptive behavior confirm the results of previous studies investigating the effect of PMT versus WL. Moreover, we found a reliable effect on social skills for PMT. This is notable as it shows that parents perceive their child's social ability to have improved following treatment, in spite of the child not being active in the treatment or social skills being specifically targeted. Similar findings have been reported by Battagliese and colleagues [14]. More expected and also found in previous meta-analyses [13, 15] were that negative parenting skills (PMT) and parental stress (PCIT) improved.

Our second research question examined if there was a difference between standard PMT and PMT with the child involved in the treatment. Our results showed significantly larger effect sizes for PCIT versus WL compared to PMT versus WL, suggesting that PCIT could be more effective than standard PMT in the treatment of clinical levels of disruptive behavior. PCIT is generally used in the treatment of younger children, 2–7 years old, while standard PMT is designed for children between 3 and 12 years old. In accordance with this, our analysis showed that the mean age of children in PCIT studies was lower than the mean age in PMT studies. Thus, it cannot be ruled out that the difference in treatment effects is related to the age difference. Although the treatment time may differ between PCIT and standard PMT, this was not the case here, suggesting that the number of treatment sessions does not explain the larger effect for PCIT. The larger treatment effect might also be explained by the individual delivery format in PCIT, which enables individual tailoring to the family. In a previous meta-analysis, individually delivered PMT has been found to be superior to group-delivered PMT [90]. In the present meta-analysis, the individually delivered PMTs were to a large extent PCIT studies, which prohibited us from systematically investigating the importance of an individual format among standard PMT. Our results are supported by a meta-analysis [91], showing that PCIT tended to have larger effect sizes on parent-rated disruptive behavior compared to one of the standard PMT programs (Triple-P) on clinical and subclinical child disruptive behavior. Nonetheless, more studies with direct comparisons of PMT and PCIT are needed before firm conclusions on the effectiveness of PCIT compared to PMT can be drawn.

Contrary to our expectations, PMT with child CBT compared to WL did not significantly differ from standard PMT compared to WL at post-treatment. Furthermore, when PMT was compared directly to PMT with child CBT, no significant effects were found at post-treatment or one-year follow-up on parent-rated outcomes. There was large variability in effect sizes and few studies comparing PMT with child CBT to standard PMT, suggesting that more studies are needed in order to bring clarity to the potential additive, or lack of additive, effects of child CBT to PMT.

Teacher ratings of disruptive behavior were provided in a limited number of studies, showing no significant effects in any comparison. The variability among studies was large and *p*-values were unstable. Previous studies indicate that there is typically low correspondence between teacher- and parental ratings of disruptive behavior [92], one potential reason being that disruptive behavior can be more prominent at home compared to school. Symptoms can be present in only one setting and still constitute major distress with such a low level of functioning that the disruptive behavior is considered to be at a clinical level. In the RCTs included in this meta-analysis, teachers were not involved in the treatments. Our results suggest that the effect does not automatically generalize to the school when the school is not involved in the treatment.

In a total of eleven studies (six PMT and five PCIT), clinicians had observed parent–child interactions. The results in the clinician-rated outcomes were largely in concordance with parent-rated measures on child behavior, which supports the validity of the parent-rated outcomes for this outcome. For PMT, parent- and clinician-rated positive and negative parenting skills were in the same direction, although not always with significant effects. The association

between parent-reported and observed parenting behavior has recently been examined in a multilevel meta-analysis indicating a weak but significant overall correlation [93]. When it comes to the association between parent- and observer ratings on child disruptive behavior, a study showed high discrepancy between parent-rated and clinician-rated disruptive child behavior with parents scoring higher levels of disruptive behavior than observers [94]. In this study children with sub-clinical levels of disruptive behavior were included, which could, hypothetically, help explain the discrepancy with our results.

Previous meta-analyses on the efficacy of PMT that included non-clinical levels of disruptive behavior and/or various forms of treatment designs did not find a moderator effect of age [20, 95] or gender [20, 89] on PMT effectiveness. Our study confirms these findings in clinical samples. Treatment time in hours has not been explored specifically in earlier meta-analyses, however, analyses of number of treatment sessions have indicated no moderating effect [20, 90], which corresponds well to our finding that neither treatment times in hours nor number of sessions moderated standard PMT treatment effectiveness.

We found that higher study quality was associated with a higher effect size on standard PMT compared to WL. In contrast, a meta-analysis by McCart [18] including non-randomized studies and mostly clinical levels of disruptive behavior, found that improved study quality, as measured by a quality rating scale by Durlak et al. [96], was associated with lower effectiveness. When comparing our meta-analysis with the McCart meta-analysis [18], only seven studies (23%) of the McCart studies were included in our study, which indicates that conclusions are based on different bodies of studies, which might explain the difference in results. Furthermore, the scale used in McCart, developed by Durlak et al. [96], is not equivalent to the one we used [85]. High study quality has previously been found to be a positive moderator of CBT treatment effects in a meta-analysis on OCD treatment for children [97]. Tentatively, high-quality trials have more homogenous, representative, and well-diagnosed (e.g., structured interviews) samples, reliable and valid instruments, higher-powered studies, and specific treatment programs run by well-trained and competent therapists. It is possible that high quality on these factors may lead to less noise in the data and, therefore, to larger effects.

Risk of bias was assessed as low in approximately half of the studies concerning randomization, deviation from treatment, and missing outcome, according to the RoB tool [86], whereas the majority of studies had some risk of bias in the remaining two domains: blinding of assessors and selective reporting of data. Although all studies were randomized controlled studies, older studies did not report how allocation sequence was generated and, as always, the parents were aware of the treatment they received and were the main informants of program effects. In addition, the majority of studies were conducted before registration of study protocol became mandatory. Seeing the small number of studies with high risk, in spite of older studies being included in the meta-analysis, the results of the meta-analysis can be assumed to be valid.

Strengths and Limitations

A major strength of this meta-analysis was the selection of RCTs that include clinical levels of disruptive behavior only, combined with a selection of studies on PMT without interference of other treatment types. Another strength of this meta-analysis is that we were able to compare standard PMT with two other versions of PMT in which the child is involved in the treatment, identifying treatment gains of bringing the child into the treatment setting. We were also able to broaden the assessment by evaluating not only disruptive behavior, but also child social skills, parental strategies, parental sense of competence, and parental stress. Finally, our results were analyzed using robust variance estimation enabling us to handle within-study and informant dependencies, thereby enhancing power and producing reliable estimations.

A limitation of the meta-analysis is that some of the planned comparisons were not possible to undertake due to the limited number of studies conducted. Even though the number of RCTs at clinical levels of disruptive behavior has increased largely, the number of studies with a TAU comparison and studies with follow-up assessments including a WL were too few to enable conclusions to be drawn. The lack of RCTs at clinical levels of disruptive behavior with a TAU comparison and with continued follow-up assessment highlights the imminent need for further studies. In addition, studies investigating the efficacy of PMT with child CBT were few, thereby limiting the conclusions that could be drawn. Furthermore, we included studies on children with disruptive behavior above a clinical cut-off based on rating scales or with a disruptive behavior disorder diagnosis, but it would have been preferable to only include studies on children with a clinician-rated diagnosis. Only seven of the 25 studies included children with a disruptive behavior disorder diagnosis, reflecting the immaturity of the field, and illustrating the need for more high-quality studies. Finally, it is possible that different baseline levels might contribute to the relative effectiveness of PCIT over PMT. We therefore compared the baseline values of the ten PMT and six PCIT studies that included Eyberg Child Behavior Inventory (ECBI) [36] measurements (i.e., six studies were not included in these analyses since they did not use the ECBI), finding no difference in baseline difficulties in behavior problems (see Table S1 Supplementary file 2 for further information).

Conclusions

In the treatment of children with clinical levels of disruptive behavior, standard PMT is more effective than WL in reducing disruptive behavior and enhancing functional parental strategies. These findings support current treatment recommendations to offer PMT to parents of children with clinical levels of disruptive behavior. We can also conclude that PCIT, the PMT approach where the parent receives guidance and feedback from the therapist through a bug in the ear while interacting with the child, shows large effects, which should have implications for future treatment recommendations. Nonetheless, further studies comparing PCIT directly to PMT are needed.

Summary

PMT is the recommended treatment for disruptive behavior disorder in school-aged children. Updated meta-analyses investigating the effects of PMT at clinical levels of disruptive behavior in RCTs are lacking, as are evaluations of the possible additional effects of PMT treatment with child involvement. In this meta-analysis, 25 studies and 2023 individuals were included. We synthesized RCTs of PMT compared to WL at clinical levels of disruptive behavior in children (age range 2 to 13). We also synthesized RCTs of PMT with the child involved in the treatment (i.e., PCIT and PMT combined with child CBT) compared to WL. In addition, we compared the effects of PMT combined with child CBT with PMT alone. We used random-effects meta-regression models with robust variance estimates to summarize overall effects and explore potential moderator effects. Results showed that PMT ($g = 0.64$ [95% CI 0.42, 0.86]) and PCIT ($g = 1.22$ [95% CI 0.75, 1.69]) were more effective than waiting-list (WL) in reducing parent-rated disruptive behavior, and PMT also in improving parental skills ($g = 0.83$ [95% CI 0.67, 0.98]) and child social skills ($g = 0.49$ [95% CI 0.30, 0.68]). PCIT versus WL ($g = 1.21$ [95% CI 0.79, 1.63]) had larger effects in reducing disruptive behavior than PMT versus WL ($g = 0.61$ [95% CI 0.40, 0.83]). In the few studies found, the addition of child CBT to PMT did not yield larger effects than PMT ($g = 0.19$ [95% CI − 1.10, 1.49]) or WL ($g = 0.50$ [95% CI − 0.64, 1.64]). To conclude, the present meta-analysis gives support to treatment recommendations to offer PMT to children with clinical levels of disruptive behavior and highlights the additional benefits of PCIT for younger ages.

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Taking Stock of Parent Education in the Family Courts: Envisioning a Public Health Model

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Abstract

The paper reviewed the development and current status of the parent education movement in the Family Courts. Parent education programs are now being implemented in courts throughout the United States and have a high level of public acceptance; however, a stronger research methodology to evaluate the effects and continued work to align the goals with the content and teaching strategies of these programs are needed. A new conceptual framework is proposed for parent education, which views divorce as a public health problem for children as well as a legal issue. The three-level framework uses concepts from public health to align the goals, content and format of parent education programs and to enable rigorous evaluations of the outcomes achieved by these programs.

Introduction

Parent education programs emerged in the 1980s and 1990s as a part of what Singer (2009) has labeled the "velvet revolution" in which the law-oriented, judge-focused adversary model in family law was replaced with more collaborative, interdisciplinary and future-focused dispute resolution processes. The last three decades have seen a widespread and sustained proliferation of a diverse set of parent education programs that possess a range of goals, teaching strategies, institutional affiliations and authority. Parent education, in particular, represents a departure from previous family court practice because many courts, through mandatory attendance policies, engage most separated and divorcing parents[1] in services designed to prevent or mitigate divorce-related risk (Schepard, 2004). This approach mirrors a public health model and contrasts with the traditional family court practice of referring to services (e.g., mediation, child custody evaluation, parenting coordination) only in response to a legal conflict that may require adjudication, rather than to prevent future family conflicts or to promote children's adjustment.

Parent education programs are widespread and popular (Pollet & Lombreglia, 2008; Thoennes & Pearson, 1999) with many programs delivering important information to separated and divorcing parents. This is a promising beginning, however the field as a whole continues to lack a cohesive approach to service delivery, a uniform set of priorities, an agreed-upon set of practice guidelines and sufficient rigorous program evaluation necessary

The order of authorship is alphabetical and does not reflect the equal contributions of the authors.

[1]In this article we use the term "separated and divorcing parents" to refer to both parents who were married and those who were never married and may never have lived together.

to claim that parent education programs have a positive effect on those who participate or their children (Blaisure & Geasler, 2000; Kierstead, 2011, Sigal, Sandler, Wolchik, & Braver, 2011).

We believe that if parent education programs are to thrive in the future they must continue to work toward a better understanding of what is effective and toward widespread implementation of effective programs. Better understanding of what is effective can then lead to the development of evidence-based priorities and practice guidelines for parent education programs. Considering increasingly limited resources along with critiques of parent education programs stating (we believe erroneously) that they do not meet their stated goals (Schaefer, 2010), a lack of progress and failure to produce solid evidence of effectiveness may leave parent education programs vulnerable to the continuous stream of court budget cuts.

Our call for evidence-based parent education programs in the courts parallels a broader movement toward implementation of evidence-based practice across medical services (e.g., Affordable Care Act), mental health and substance abuse treatment and prevention services (National Registry of Effective Programs, SAMHSA), education (What Works Clearinghouse, National Institute of Education) and social policies (Center for Evidence Based Policy). The movement for evidence-based programs and practices is based on the recognition that while many social programs are very effective (NRC/IOM, 2009), many practices and policies implemented by well-meaning professionals do not work, or even have unintended negative effects. In order to maintain the public's trust and the taxpayers' support, social institutions must evaluate the effectiveness of the programs they deliver. Although there are many challenges to developing evidence-based services, particularly in family courts that are already under-resourced, services that are demonstrated to reduce family risk for the problems that often follow divorce and separation (e.g., mental health and substance abuse problems of children) should be able to compete successfully for federal, state and local funding designated to prevent such problems.

The purpose of this paper is to take stock of the history, current status and potential future directions for parent education programs in the family court. Part I examines the growth and development of parent education programs. Part II integrates concepts from public health with those from the legal system into a broad framework for future development of parent education in the family court. We believe this framework has the potential to enable family courts to evaluate the kinds of parent education programs they wish to adopt and to evaluate the success of those programs to accomplish their intended goals.

I. History of Parent Education in the Courts

The first documented parent education programs were based in neighboring counties in Kansas and evolved from divorce adjustment programs for parents that began in the late 1970s and early 1980s. Wyandotte County's "Sensible Approach to Divorce" (SAD) and Johnson County's "General Responsibilities as Separating Parents" (GRASP) were mandated in 1986 but began several years earlier as voluntary programs. They are believed to have been the first court-mandated parent education programs in the United States (James & Roeder-Esser, 1994). During the late 1980s, the number of educational programs increased, spurred in part by pre-mediation orientation sessions that were developed as part of a growing number of court-connected mediation programs (Lehner, 1994; Salem, 1995). In the late 1980s and early 1990s, private providers began to market packaged programs that included a curriculum, workbooks and videos[2] resulting in implementation of similar program content and materials in multiple jurisdictions (Geasler & Blaisure, 1998).

Parent education programs proliferated rapidly in the 1990s, with the number of programs tripling between 1994 and 1998 (Geasler & Blaisure, 1999), accompanied by multiple efforts to develop legislation that supported court affiliated programs (see, e.g., Lee, 1997). A 1998 national survey found that 44 states had state or local laws authorizing courts to require attendance at a program – 25 by state statute and 19 through local court or administrative rules – quadrupling the number of states that statutorily authorized or mandated attendance at such programs over a four-year period (Clement, 1999). This growth paralleled a significant increase in the number of unrepresented litigants in family courts during the 1990s (Schepard, 2004). Thus, parent education programs, especially those providing information about the court system and legal process, had important potential to provide information to those without legal representation to which they might not otherwise have access.

Program growth was buoyed by a range of related activities. In 1994, nearly 400 participants attended the First Congress on Parent Education Programs, sponsored by the Association of Family and Conciliation Courts (AFCC). Subsequent AFCC conferences and programs helped establish networks for program providers, administrators and researchers that offered support for developing legislative initiatives and program guidelines and helped develop a competitive market for program dissemination and training. These activities were accompanied by national media coverage that led to increased public awareness of parent education programs for divorcing families (Salem, Schepard & Schlissel, 1996). Program growth was also promoted by the U.S. Federal Office of Child Support Enforcement, which provided modest financial support for parent education programs through its Access/ Visitation Grant Program, a program designed to support services that facilitate noncustodial parents' access to their children (U.S. Dept. of Health and Human Services http://www.acf.hhs.gov/programs/cse/access_visitation/). The growth of these programs was accompanied by modifications of program design in response to concerns raised by various stakeholders. For example, concerns about programs' focus on co-parenting were expressed by advocates for battered women, leading many program developers to revise their curriculum to address this concern (see, e.g., Frazee, 2005; Fuhrmann, McGill & O'Connell, 1999; Lutz & Grady, 2004).

By the turn of the century programs were widely disseminated and firmly established. However, although no national surveys that systematically examined the number of programs and their characteristics have been published since those conducted by Geasler and Blaisure (1996; 1999), there are indications that the surge of enthusiasm, innovation and activity of the parent education movement have diminished over the past decade. For example, there was a steady decline of attendance at AFCC's Congress on Parent Education Programs (AFCC, 2007), and these Congresses were subsequently cancelled. Also, the pace of evaluation of parent education programs has slowed, with more than 70% of studies reviewed in two recent reviews (Fackrall, Hawkins, & Kay, 2011; Sigal et al. 2011) published prior to 2003.

This is not to say that activity related to parent education programs has come to a standstill. Programs are operating in 46 states, they continue to be popular with the courts and users (Pollet & Lombreglia, 2008) and providers are developing and evaluating online and web-based programs (Bowers, Mitchell, Hardesty & Hughes, 2011). However, the rapid growth and enthusiasm of what Schepard (1994) referred to as a "grass roots parent education movement" has clearly subsided.

[2]Examples include Michigan's SMILE (Start Making it Livable for Everyone) Program, Families First's Transparenting Program and in the Center for Divorce Education's Children in the Middle Program.

This loss of momentum is not surprising. When an innovation, such as a court-affiliated parent education program, is in the process of development and initial implementation, as was the case during the 1990s, it commands time, energy and resources from judges, administrators and providers, to make certain that it is functioning well and that stakeholders' needs are adequately addressed. But these innovations are typically one small piece of a larger agenda of the court or agency; therefore, once a program is established, it is natural for the additional attention and resources to be redirected toward other court or agency needs.

It is also not surprising that there has been a loss of momentum in the evaluation of parent education programs. Although evaluations of parent education programs, which typically use satisfaction surveys, have been overwhelmingly positive (see, e.g., Thoennes & Pearson, 1999) once a program is well established and popular with stakeholders, providers and administrators may not wish to rock the boat by calling attention to the program by requesting funds for conducting additional research on its effects. Once positive evaluations are in hand, the wise course of action may be to continue to operate the program quietly and under the radar rather than bringing attention to a program that may represent a potential budget savings to a court administrator or elected official. However, we believe it is healthy for organizations to periodically take stock of their practices, even ones as well accepted as parent education. Taking stock provides an opportunity to assess what is actually being done in the program and whether the program goals are being accomplished and to identify ways to improve the service.

Variation in Parent Education Programs

The parent education programs that emerged over the last quarter-century vary on nearly every dimension including their goals, length, content, instructional staff, institutional base, court affiliation, statutory authority, attendance policies, funding sources and the existence of an evaluation component (and its methodological rigor). Surveys of parent education programs conducted by Blaisure and Geasler (1996), Geasler and Blaisure (1998, 1999) and Braver, Salem, Pearson and DeLuse (1996) chronicle the variability in program characteristics. Programs range from single session court-connected mediation orientation programs (typically evaluated, if at all, with client exit surveys) (Lehner, 1994; Salem, 1995), to the New Beginnings Program at the Arizona State University Prevention Research Center, a ten-session program that has been subjected to rigorous (and costly) scientific evaluation with funding from the National Institute of Mental Health and National Institute of Drug Abuse (Wolchik, Sandler, Weiss, & Winslow, 2007). Program length ranges from one to 36 hours (Geasler and Blaisure, 1999). The number of participants ranges from fewer than ten (Wolchik et al., 1993; 2000) to more than 150 (Petersen & Steinman, 1994). Providers include staff in family court service offices; public, private and non-profit mental health agencies; universities and extension programs; and independent, solo practitioners. Although most programs are designed for parents, some target both children and parents or include separate but coordinated components for parents and children (Salem, 1995). In this paper, we adopt a broad conceptualization of parent education to include the full a range of educational programs.

In the 1990s, there were efforts to conceptualize parent education programs as a distinct field of practice (Salem et al., 1996) to help develop greater coherence across programs. For example, Salem et al. (1996) recommended the development of national program guidelines. Also, Geasler and Blaisure (1998) called for a clearer articulation of programs' conceptual foundations to ensure continuity between theory and practice and to better assist potential users determine whether a program would be a good fit for their setting. Through a series of conferences, committees and publications, AFCC attempted to develop an organizational home to enable the professional community to share information and research concerning

parent education programs to facilitate a more consistent approach to developing and implementing programs. Despite these efforts, today there is no uniform set of priorities on which parent education programs are based (Kierstead, 2011) and there is little evidence, anecdotal or otherwise, to suggest that the field is any more cohesive than it was in its early stages of development.

The lack of coherence in the goals, priorities, practices and evaluation of parent education programs is consistent with the experiences of other family court-related practices, such as mediation and collaborative law (see, e.g., Folberg, Milne & Salem, 2004; Webb & Ousky, 2011). It can be argued that diversity is desirable because it helps to create an innovative, creative and energetic professional community, raises the level of professional discourse, and offers multiple choices for courts and other agencies interested in implementing programs that meet the specific needs of their community. However, program diversity also creates challenges in understanding what reasonable goals for these programs are, and identifying the approaches that are effective in achieving these goals. These, too, are important considerations if individual programs and the field are to progress.

Goals of Parent Education Programs Vary

Program goals can be viewed as the lynchpin for parent education programs for several reasons. The goals articulated for a program send an important message to judges, legislators, administrators, providers and users about a program's priorities and about what outcomes the sponsoring court or agency hopes to achieve by implementing the programs. A clear articulation of program goals also makes it possible to align program content and teaching strategies with the intended outcomes. Further, program goals provide a basis on which to evaluate whether the program is successful in achieving its intended outcomes.

We define goals as the intended outcomes of a parent's participation in a particular parent education program. Goals can range from learning specific information (e.g., the impact of parental conflict on children's adjustment) to the development of skills (e.g., conflict resolution or parenting). In some instances, program goals go beyond changing immediate (or proximal) outcomes, such as change in parents' knowledge about the effects of parental conflict on children's adjustment, to accomplishing more distal objectives, such as improving children's post-separation or divorce adjustment or reducing relitigation.

Not surprisingly, research shows that program goals vary widely. In separate reviews, Sigal, Sandler, Wolchik and Braver (2011) and Geasler and Blaisure (1995) identified more than thirty distinct goals and noted that many programs reported having multiple and overlapping goals. Geasler and Blaisure (1995) categorized program goals as child-, parent- and court-focused and found that programs placed most emphasis on child-related information and least on issues related to the courts and legal processes. Lehner (1994) found that many California programs focused on how educational programs impacted the mediation process with an overarching goal to "…make the [mediation] process more effective for clients and to provide some "normalizing" data on how divorce affects parents and children" (Lehner, 1994, p.51). The focus on mediation in these programs is not unexpected given that (1) California is historically regarded as first and foremost in court-connected family mediation; and (2) Lehner surveyed court-connected agencies that also provide mandatory mediation services. These data on programs in California demonstrate how program goals are influenced by community and stakeholder priorities and highlight the challenges of establishing consistency across jurisdictions.

Some program goals focus on imparting information, such as educating parents about the impact of divorce on children's adjustment (Pedro-Carroll, Nakhnikian & Montes, 2001) or informing parents about more positive ways to interact with ex-spouses (Shifflett &

Cummings, 1999). Other programs seek to impact participants' feelings or skills, such as facilitating a parent's adjustment to custody and visitation arrangements (McKenry, Clark & Stone, 1999), reducing children's exposure to inter-parental conflict (Arbuthnot, Kramer & Gordon, 1997) and increasing inter-parental communication, co-parenting and conflict resolution (Homrich, Glover & White, 2004). Goals in some programs are longer-term in nature, such as improving children's post-divorce adjustment (Wolchik et al., 2002). Also, some program goals extend beyond changes in interactions in the family to include interactions with the legal system, such as reducing relitigation (Kramer & Kowal, 1998). Although all of these goals fall under the parent education umbrella, it is clear that different content, teaching strategies and resources, including program length, are necessary to achieve them.

The wide variation in program goals may be a natural byproduct of the roots from which parent education programs have grown. Parent education programs have been developed by a variety of institutions and disciplines and have been rapidly disseminated throughout family courts. Professionals from multiple disciplines, including lawyers, judges, social workers, counselors, psychologists, mediators, and social science researchers, have all been involved in program development. These professionals come from very different cultures and function in different organizational contexts with different stakeholders, rewards systems, areas of expertise and priorities, and different capacities and support for program evaluation. It is therefore not surprising that such a range of program goals have emerged. Although this is understandable, the wide range of goals can create confusion and may lead to a misalignment between the intended outcomes of the programs and their content, strategies and the resources that are given to them.

Aligning Goals, Content, Teaching Strategies and Resources

Aligning content, teaching strategies and resources with program goals is critical to achieving desired outcomes. Concerns over the potential misalignment between program goals and the content and format of parent education programs have been articulated since the early stages of the parent education movement. Geasler and Blaisure wrote: "Whereas initial stages of program development require establishment of concise, measurable goals, attainable in a given time frame, expecting behavioral changes in parents and a major impact on the workload of court systems as a result of a 2-hour program may be unreasonable" (1995, p. 489). Salem et al. (1996) agreed: "Challenging goals are laudable, but overpromising places in jeopardy the long-term credibility and viability of the field… It is inadvisable to suggest that parent education will create long-term behavior change, heal the emotional scars of divorce, clear crowded dockets or settle custody disputes without solid empirical evidence to support these claims" (1996, p. 14). The concern about overpromising is highlighted when a composite description of a hypothetical typical program is juxtaposed with an ambitious goal. The "typical" parent education program has been described by some as a two to four hour program with a goal or focus on improving the well-being of children (see, e.g., Pollet & Lombreglia, 2008; Schaefer 2010). We believe that it is highly unlikely that such short programs can accomplish the challenging goal of improving children's adjustment and that creating such expectations is problematic.

Surveys conducted in the 1990s found a pattern among parent education programs that was consistent with Geasler and Blaisure's (1995) child-, parent- and court- focused framework with the greatest emphasis on information about the impact of separation and divorce on children, followed by information tailored to parents, then court, legal and dispute resolution processes. Braver et al,'s (1996) survey of program representatives at AFCC's First Congress on Parent Education Programs found most intensive coverage dedicated to the benefits of parental cooperation vs. conflict, typical post-divorce reactions of children, impact of "badmouthing" or "brainwashing" children, and different reactions and needs of

children at different ages. Adult reactions to divorce, conflict management skills, additional divorce-related resources and parenting plans received moderate coverage. Content areas receiving the least intensive coverage were legal and financial issues and the "nuts and bolts" of how to navigate the court system. Geasler and Blaisure's (1998) review of program materials and national survey of programs (Geasler & Blaisure, 1999) found almost identical patterns. These studies were also consistent in their findings related to teaching strategies. All reported greater use of strategies such as lecture, videos, discussion and handouts and less frequent use of self-assessment tools, role plays and skill practice (Braver et al, 1996; Geasler & Blaisure, 1998). These surveys however, did not systematically assess whether the content and strategies used in individual programs were aligned with their described goals.

Blaisure's and Geasler's Divorce Education Intervention Model (2000) provides a conceptual framework of three levels of programs that appropriately align their goals, content, teaching strategies and resources, and cite examples of programs at each level. This model is an important attempt to systematically describe how different goals require different content, teaching strategies and resources. A Level 1 program (what we have referred to as a "typical" program) has the goal of providing information and perhaps motivating parents to seek additional resources. These programs usually involve a large number of parents, are brief and largely didactic, with limited parental involvement. A Level 1 program might be a single session, two-hour program combining video, lecture and handouts which focus on providing information on children's divorce adjustment, co-parenting and court processes. A Level 2 program aims to develop or enhance skills such as co-parental communication and conflict resolution. These programs include multiple sessions and experiential learning activities. Given the experiential nature of these programs, they often serve fewer parents than Level 1 programs. Whereas Level 2 programs are targeted to most separated and divorcing parents, Level 3 programs are designed for subgroups, such as high-conflict parents, and might aim to reduce interparental conflict. Level 3 programs are primarily experiential and multiple sessions in length.

Evaluations of the Effects of Parent Education

As noted above, in the absence of a coherent framework for describing the goals, content and strategies used in parent education it is difficult to evaluate the effectiveness of these programs. It should be noted that there is broad evidence across evaluations that there is a high level of parent satisfaction with parent educations programs (Sigal et al., 2011). The information they provide is seen as very helpful both by parents who voluntarily attend and those who are mandated to attend (Kierstadt, 2011). This outcome is important in that it likely increases their respect for the legal system; however, it is also important to learn whether these programs are achieving their broader goals. As noted below, methodological weaknesses in the studies used to evaluate these programs limits our ability to have confidence that they are accomplishing their intended goals. We believe the logical next step is more methodologically rigorous and systematic evaluation to identify whether participants are learning the information that is presented, whether they are putting the information to use and whether it is impacting their own or their children's behavior in a meaningful way. Such evaluations should enable more widespread implementation of programs that are effective, promote continuous improvement in those programs and solidify court and public support for parent education programs in the court system.

There have been several qualitative reviews that address the question of whether parent education works (Cookston, Braver, Sandler, & Genalo, 2002; Goodman, Bonds, Sandler, & Braver, 2004; Sigal et al. 2011). Based on their critical evaluations of the research methodology in most studies, these reviews have concluded that there is *not yet* convincing evidence that parent education programs reduce inter-parental conflict, enhance parent-child

relationships or improve children's post-divorce adjustment. Some view such conclusions as evidence that parent education does not work and that it should be drastically curtailed (e.g., Schaefer, 2010). However this is an erroneous interpretation of these reviews. It is more appropriate to conclude that "It is too soon to draw clear conclusions concerning the efficacy of such programs" (Cookston et al, 2002, p. 190). Indeed, there is some reason to be optimistic that continued development of parent education programs will yield programs with benefits that are clearly demonstrated in rigorous evaluations.

Recently, Fackrell, Hawkins and Kay (2011) conducted a meta-analysis of 19 studies that evaluated parent education programs. A meta-analysis provides a statistical summary of program effects across studies rather than relying on the judgments of the reviewers. This meta-analysis showed that those who participated in a parent education program were significantly better off than those who did not on several outcomes including co-parenting conflict, parent-child relationships, child well-being and parent well-being. Similar to the qualitative reviews described above (e.g., Sigal et al., 2011), these authors note that many of the studies in this analysis have serious methodological weaknesses. Thus, although the findings from the meta-analysis are encouraging, the consensus across the qualitative and meta-analytic reviews is that there is a need for rigorous evaluation to more definitively assess the effects of parent education.

This conclusion about the current state of evidence points to several important directions for the development of the field. First, given that there is limited research in this area, additional evaluations are needed. Second, given that there are methodological weaknesses in most of the existing studies, future evaluations should use rigorous methodology, including the use of randomized experimental designs. Third, achieving goals such as reducing inter-parental conflict, enhancing parent-child relationships or improving child post-divorce adjustment may require more extensive programs in terms of content, teaching strategies and length than those in Level 1 programs.

For future research to contribute to the development of more effective parent education programs, we believe there is a need for a coherent conceptual framework that describes the multiple goals of these programs and aligns these goals with the content of the programs, strategies used to teach this content and resources necessary to accomplish the goals. Part II of this paper proposes such a framework.

II. A comprehensive framework for parent education: Integrating a public health model within the family court system

We propose that integrating a public health model into the family court system can provide a comprehensive conceptual framework for the delivery of parent education programs in the courts and for the evaluation of their effects. From a public health perspective, the goals of parent education programs can be viewed as promoting processes that reduce the risk of negative outcomes for children and their parents following separation or divorce. We believe that the goals of promoting children's and parents' adjustment are complementary to outcomes that are highly valued by the court, such as reducing inter-parental conflict, promoting positive co-parenting following the divorce and parents agreeing on parenting plans that are in the best interest of the child (Edwards, 2007). These public health goals are very similar to those that have been identified in nationwide surveys of court parent education programs (e.g., Braver et al., 1996; Geasler & Blaisure, 1999). Legal scholars (e.g., Schepard, 1998; 2004) as well as social science researchers (e.g. Braver, Hipke, Ellman, & Sandler, 2004; Pedro-Carroll, 2005) have argued that a public health role is built into the very nature of the work of the family court. Legal issues that are generally resolved with family court practitioners such as legal custody, parenting time and relocation are

greatly influenced by psychological issues and their resolution may have significant effects on children's health and well-being (Bauserman, 2002; Fabricius, Diaz & Braver, 2012). Indeed, a critical criterion used in court decisions concerning issues such as parenting time and custody is their impact on children's well-being, (i.e., the best interests of the child, a term included in every state's statutory scheme) (Salem & Dunford-Jackson, 2008).

Below, we describe four key elements of a public health model of divorce, including a multi-level conceptual model of parent education in which different levels of intervention are delivered to families with different levels of need.

Divorce as a public health issue

The four key components of conceptualizing divorce as a public health issue include: (1) Divorce is viewed as a risk factor for negative outcomes of children; (2) Children's post-divorce adjustment problems are associated with protective factors and risk factors that are potentially malleable by interventions; (3) There is solid empirical evidence of the effectiveness of programs for divorced families; and (4) Different levels of parent education are appropriate for families with different levels of need.

1. Divorce as a risk factor for children—Divorce is a highly prevalent risk factor in most industrialized nations, and particularly in the United States. Although the rate of divorce has stabilized or decreased somewhat since the 1970s (Bramlett & Mosher, 2002; U.S. Census Bureau, 2005), it is estimated that 30 to 50% of youth in the United States will experience divorce in childhood or adolescence (Kennedy & Bumpass, 2008; National Center for Health Statistics, 2008). The public health concept of risk refers to a factor that is associated with a higher likelihood of a negative outcome. Compelling evidence demonstrates that divorce confers increased risk for multiple problems in childhood and adolescence, including substance use and abuse and cigarette smoking (e.g., Barrett & Turner, 2006), mental health problems and increased use of mental health services (e.g., Amato, 2001; Amato & Keith, 1991), high risk sexual behavior (Hetherington, 1999; McLanahan, 1999) and physical health problems (Troxel & Matthews, 2004). Further, the negative impact of divorce can continue into adulthood. Increased levels of substance abuse and mental disorder (Kessler, Davis, & Kendle, 1997); poorer educational, occupational and marital adjustment (e.g., Biblarz & Gottainer, 2000); and increased health problems (Sachs-Ericsson, Blazer, Plant, & Arnow, 2005) occur more often for those from divorced families versus those who grew up in non-divorced families. Illustratively, McLanahan's (1999) analysis of ten national probability samples showed school dropout rates of 31% and teen birth rates of 33% for adolescents in divorced families vs. 13% and 11%, respectively, for adolescents in non-divorced families.

The high prevalence of divorce and its effects on multiple problem outcomes means that reducing the risk associated with divorce can have a substantial impact to improve the public health. The concept of population attributable risk (PAR), which is often used in public health research, can be applied to illustrate the potential effects of reducing problem outcomes for children from divorced families. PAR refers to the proportion of a problem in the overall population that could be prevented by removing a risk factor *or its consequences*. Using estimates of risk derived from studies with nationally representative samples (i.e., Furstenberg & Teitler, 1994; Kessler et al., 1997; Zill, Morrison, & Coiro, 1993) it is estimated that 20% of substance abuse problems, 30% of mental health problems and 23% of school dropouts could be prevented by reducing the risks associated with divorce.

The increased "risk" associated with divorce does *not* mean that all children from divorced families will experience problem outcomes. To the contrary, most children adjust well following divorce. Kelly (2012) estimates that approximately 25% of children whose parents

divorce experience adjustment problems, which is about twice the rate for youth whose parents do not divorce. Amato (2010) points out that the doubling of risk experienced by children from divorced families is comparable to the increased risk of having a heart attack that is conferred by elevated cholesterol (i.e., 7% of those with high cholesterol will experience a heart attack as compared to 4% of those who do not have high cholesterol). Most of the individuals in both of these "at-risk" groups (i.e., children who experience parental divorce and individuals with high cholesterol) will *not* experience serious problems, but the rate of serious problems is about twice as great in the group that has the risk factor than in the group without it.

2. Factors associated with child problems following divorce—The keys to developing effective interventions for divorcing families are (1) identifying factors that contribute to elevations in risk for negative outcomes and protective factors that reduce risk; and (2) developing strategies for changing the risk and protective factors in a positive direction. The factors that are most consistently associated with the elevation in risks conferred by parental divorce are now well-established. In a comprehensive review of the literature, Kelly (2012) identified the following factors as having the greatest impact: (1) high levels of conflict between the parents, (2) domestic violence, (3) poor quality of parenting provided by the mother and father, (4) a poor co-parenting relationship, (5) low economic resources, and (6) loss of a relationship with one of the parents. Research indicates that it is the relative presence of these factors rather than the divorce per se that leads children to either experience problems or to adapt well following divorce of their parents (e.g. Kelly, 2012; Kelly & Emery, 2003; Sandler, Wolchik, MacKinnon, Ayers, & Roosa., 1997; Wolchik, Sandler, Braver, & Fogas, 1986). From a public health perspective, the question is this: Are there interventions that have been shown to affect these factors and that can be delivered within the court system?

3. Parent-focused programs to reduce risk—A recent report of the National Research Council and Institute of Medicine (NRC/IOM, 2009) presents impressive evidence of the effectiveness of many parent- focused preventive interventions that might be adapted for parent education to improve outcomes for separated and divorcing families. For example Sandler, Schoenfelder, Wolchik & MacKinnon (2011) reviewed 47 randomized experimental trials of parenting-focused interventions that have demonstrated that teaching effective parenting skills led to reductions in a wide range of child problems including substance use, mental health problems and juvenile arrests and to improvements in educational outcomes several years following program delivery. Further, research with both divorced and non-divorced families demonstrates that children benefit when either the father or the mothers participate in parenting skills training programs (Sandler et al., 2011). Some of the strongest evidence of the effectiveness of parenting interventions has been found for separated and divorced families (Wolchik et al., 2002; Forgatch, Patterson, Degarmo, & Beldavs, 2009). For example, the New Beginnings Program has been demonstrated to improve parental warmth and effective discipline and that these changes in parenting led to reductions in rates of children's mental health and substance use disorders, frequency of substance use and abuse, and high risk sexual behavior; and to improvements in grades and self-esteem six (Wolchik et al., 2002) and fifteen years (Wolchik et al., 2011) following program participation. There is also evidence that parenting programs can decrease interparental conflict following divorce (Fackrell, et al., 2011). For example, a randomized experimental trial of Dads for Life, an eight-session program for non-custodial divorced fathers, reduced interparental conflict as well as child behavior problems one year following the program (Braver, Griffin & Cookston, 2005; Cookston, Braver, Griffin, De Luse, & Miles, 2007). Although these effective programs are significantly longer than a brief two to four hour parent education program and thus could not be delivered to all divorcing families,

they demonstrate a significant principle – some of the most important risk and protective factors for children from divorced families can be changed by parent education programs.

4. Levels of parent education—A public health model includes multiple levels of interventions, which are differentiated by whether the program is provided to the entire population or a segment of the population that differ in terms of their level of need for services. Need for services can be defined in terms of the likelihood of parental behaviors leading to harm to the children‘s adjustment problems. Similar concepts for differentiated levels of parent education services have been developed in the family courts and in the field of public health. As noted above, Blaisure and Geasler's (2000) Divorce Education Intervention Model (2000) conceptualized three levels of service that vary by the level of presenter, nature of parent involvement, resources required and goals of the programs. Notably, this model aligns the goals, personnel and resources within each level of parent education.

Kierstadt (2011) argues that it is justifiable for courts and legislatures to mandate universal attendance to what Blaisure and Geasler (2000) refer to as Level 1 programs that are *informational* in nature and promote better parental decision making regarding legal and dispute resolution processes that may impact children's well-being. We agree but would extend the scope of these programs to include information about risk and protective factors that influence children's post-divorce adjustment and discussion of actions parents may take to make the transition easier for their children, including *voluntarily* using more intensive programs that have been shown to improve children's post-divorce adjustment. Providing such information enables parents to be informed consumers of court services as well as other services offered to separating and divorcing parents. However, Kierstead suggests, the court is only justified in *requiring* participation in programs that focus on changing parents' behaviors in cases where these behaviors put the child at risk of harm. We believe that beyond an informational program to enable *voluntary* decisions about use of more intensive services, there should be judicial findings of fact based on legal standards and that due process considerations must be addressed before *mandating* participation in these programs. We would add that those programs be evaluated to ensure that they are accomplishing their intended outcomes.

The field of public health uses the concepts of universal, selective and indicated to describe differentiated levels of prevention services as a function of the potential benefit and the level of intrusiveness or burden placed on the public (Mrazek & Haggerty, 1994; NRC/IOM, 2009). Universal programs and policies are those with demonstrated benefit that place no or minimal burden on the individual. Flouridation of the water is an example of a universal public health intervention. Providing information on the risks of using some products (e.g., cigarettes) and the benefits of other products (e.g., nutrition labels on packaged food or calories listed on restaurant menus) is another example of a universal public health approach to provide information for the public to make decisions concerning engaging in behaviors that impacts their health. Selective interventions place somewhat greater burden on individuals and although they may be recommended, should only be offered on a voluntarily basis. Individuals who decide to participate have decided that the benefits offset the burden of participation. For example, the decision to voluntarily undergo an intrusive screening (e.g., colonoscopy) is based on the participant's decision, with the advice of a trusted medical professional and informed by research, that their elevated risk (e.g. due to age or family risk factors) justifies the discomfort of the procedure. Indicated interventions place an even greater burden on the individual and are more intrusive and are only justified when the individual is at even greater risk, such as showing early signs of a developing problem. For example, statin medications are used to lower elevated cholesterol, although they require periodic blood tests to monitor for possible iatrogenic side effects. In public health, the

decision to use indicated interventions is voluntary, although in cases where there is demonstrated danger to another, such as child maltreatment, the state actively intervenes.

One important distinction between the public health model and current use of parent education in the court is that there is a greater reliance on scientific evidence in making decisions in the public health approach. For example, in the public health model, a critical question to ask in considering a particular program is whether there are data demonstrating positive effects. Acquiring the evidentiary base for making such decisions has not been as high a priority in the family court. Below, we describe a three-level model of parent education in the courts that integrates the concepts of risk and protective factors and evidence-based decision making from the field of public health with the distinction between voluntary and mandated participation that can help define boundaries for the authority of the courts to mandate programs and to promote parents' ability to make informed decisions about the services they wish to voluntarily use. The model is visually presented in Figure 1. Throughout, we emphasize the importance of methodologically strong evaluations to build the evidence base to evaluate whether parent education programs are achieving their goals.

Universal parent education programs to support parents as informed consumers of services: A universal program could be designed that treats parents as informed consumers encountering a stressful legal and personal situation that affects their own and their children's well-being. This program would provide information to help parents make knowledgeable decisions about how to address the personal and legal issues facing their families. Because the burden of participating in a brief program is minimal compared to the potential benefit, it would be required of all separated and divorcing parents. To promote informed decision making about children's post-divorce adjustment, this program would provide scientifically accurate and up-to-date information about factors that affect post-divorce adjustment. Information would be based on methodologically rigorous research that has identified the major risk and protective factors that are associated with children's adjustment following divorce (Kelly, 2012). This program could also include tools for parents to assess their family's needs for additional services. For example, parents could be provided with a tool that assesses how their family is doing on factors that are known to predict problem outcomes for children, such as the child's current problem behaviors, conflict between the parents, and quality of the parent-child relationships (Dawson-McClure, Sandler, Wolchik, & Millsap, 2004). Similar tools are commonly used in physical health settings (e.g., assessing risk factors for cardiovascular disease) to help people make decisions about their health behavior (e.g., increase exercise, lose weight). Parents could use such a self-assessment to make voluntary decisions about whether or not to participate in programs for parents that have been demonstrated to be effective in helping families through this time of change or child coping enhancement programs that have been demonstrated to be effective (e.g., Boring, 2012).

Universal programs would also include a component on legal process and court services including information about the role of legal representation, parenting plan and dispute resolution options, child support guidelines and services for self-represented litigants. These programs could also include a self-assessment of the parents' needs for legal assistance. Information could be provided both in group sessions and through other modalities, including court websites and self-help centers and answer lines.

The universal program proposed here is not necessarily new or a dramatic change from existing programs. Indeed, a number of court-affiliated parent education programs have curricula and services that include many, if not most of the components noted above (Geasler & Blaisure, 1998). However, the proposed universal program differs from many that are currently provided in two ways. First, it proposes that universal programs focus on

providing information on risk and protective factors that are consistently supported by research. Second, the goal articulated by the proposed programs, to provide parents with information that is helpful for making well-informed decisions about the personal and legal issues they are facing, is much more focused than that of many existing universal mandated programs. Research is needed to evaluate whether universal parent education programs such as described above will increase parents' awareness of the risk and protective factors affecting children's post-divorce adjustment and help parents assess whether they need additional services to deal with psychological or legal concerns.

Selective voluntary parent education programs to promote the well-being of children: Selective programs would be available to those parents who voluntarily elect to participate in programs that focus on skills for enhancing their children's post-divorce adjustment. Examples would be skill-building programs that teach effective discipline, effective co-parenting, methods for reducing inter-parental conflict and ways to handle common concerns such as communication around school or health-related issues. There is increasing evidence that short (i.e., single-session) programs or web-based programs can be effective in teaching parents skills to handle specific problems (Lim, Stormshak & Dishion, 2005; Sanders, Markie-Dadds, & Turner, 2003). In this model, participation in selective programs is intended to be voluntary; however it would not be a surprise if some judicial officers "strongly encouraged" participation of some parties. Although this is perhaps not an ideal referral process from a due process perspective, it is a reality of the court system and may nonetheless benefit these families.

For selective programs, the court could serve as a conduit rather than a direct program provider, endorsing those that are evidence-based and that align with the needs identified by the families. Alternatively, to enhance access, courts may elect to provide some programs that they deem particularly useful for the families they serve. The list of selective programs would likely change over time as new needs are identified and new services are demonstrated to be effective. An array of such services might be offered depending on the specific needs most often identified by parents in a community and on the availability of programs that have been shown to be effective to meet these needs. Illustratively, the Summit Project of the Arizona Association of Family and Conciliation Courts (2011) has developed a parent communication resource for professionals involved with high conflict divorces that provides guidance on how to handle specific situations that often lead to conflict. Similar material might be developed to guide parents in how to reduce conflict in these situations. These resources would need to be carefully evaluated to establish that they are accomplishing their intended goals.

To create greater awareness about the availability of voluntary selective services, parents could be informed about them during the mandatory universal component. For example, in a recent study, parents in a mandated universal parent education program were shown a brief DVD that invited them to voluntarily attend an evidence-based ten-session program that focused on enhancing parenting skills. Over 50% of parents expressed an interest in attending the longer program and 10% of parents in the universal program who were eligible attended the ten-session program (Betkowski et al., 2012). It is noteworthy that attendance at the ten-session parenting program was higher (approximately 20% of eligible) for parents who rated their families as experiencing more problems following the divorce than for those who reported fewer problems. There currently are several longer skill building parent education programs that have been shown through randomized experimental trials to reduce inter-parental conflict (Cookston et al., 2007), strengthen parenting (Wolchik et al., 2002) and improve outcomes for children many years later (Forgatch, Patterson, & DeGarmo, 2005; Wolchik et al., 2002), indicating that linking parents to such programs can have a significant public health benefit.

Indicated mandated parent education programs to protect the well-being of children: Indicated services are appropriate for parents who are behaving in a way that the court deems to be harmful to their children's well-being. Such behaviors might include intimate partner violence or chronic high levels of inter-parental conflict, particularly conflict that puts the children in the middle or that involves repeated re-litigation over issues of parenting time, which leads to a lack of family stability. Indicated services are analogous to what Blaisure and Geasler (2000) describe as a Level 3 program. We agree with Blaisure's and Geasler's (2000) comment that programs designed to change behaviors, such as reducing inter-parental conflict, are more likely to be more intensive and require more resources than universal or selective programs. However, it is important to note that simply having a longer and more intense program does not necessarily equate to one that is effective. Relatively short but intense programs can be effective. For example, a short mandated program for high conflict parents has demonstrated encouraging results to reduce interparental conflict and improve children's adjustment in a randomized experimental trial (e.g., Sandler, Braver & Hita, 2012). The critical dimension that leads to efficacy of conflict reduction programs may not simply be the length and intensity of the program, but may involve other factors such as the degree to which they teach the parents new conflict reduction skills, provide parents with an opportunity to practice those skills and motivate parents to change. The only way to have confidence that a program is effective is to conduct a methodologically strong evaluation of the program, and to monitor quality of delivery of the program over time. These programs might be mandated by the court based on legal standards and judicial findings of parental behaviors that are potentially harmful to the child's well-being. Importantly, mandating intensive and potentially costly and burdensome services should not be taken lightly. As noted above, there are important due process considerations that are beyond the scope of this paper. Mandated indicated programs would need to be very goal specific, for example, to teach parents skills to reduce behaviors that are known to be damaging to their children such as exposing them to chronic inter-parental conflict, and should be differentiated from therapies to change mental health problems more generally.

Integrating universal, selective and indicated parent education programs with other court services: In considering the adoption of a public health model for parent education programs, courts should consider how parent education might relate to other services provided by the court. For example, a mandatory universal program that provides information on risk and protective factors might be complimented by an overview of the legal system, a self-help center, online information or a case manager or referral system to help inform the parent about the available services and identify the most appropriate dispute resolution process for a given family. A voluntary selective program that enhances skills to promote child well-being could be complimented by mediation, collaborative law or cooperative law.[3] An indicated program, such as an intensive program for high conflict parents, might be mandated while a child custody evaluation or parenting coordination is being conducted. Optimally, the different levels of parent education and legal services would be coordinated so that the diverse needs of different parents are met by a court system that processes cases efficiently and in a timely manner. The Collaborative Law Project (Kline-Pruett, Insabella, & Gustafson, 2005) provides one example of a coordinated effort. An evaluation of the Collaborative Law Project that used a randomized experimental trial showed that it reduced factors that increase the risk of children's adjustment problems (e.g., interparental conflict) and had positive effects on the use of court services (e.g., increased use of less expensive services and decreased use of more expensive services). Hopefully, with increased use of rigorous evaluations to identify effective parent education programs at

[3]Although mediation is mandated in many jurisdictions, like selective services, it is traditionally considered a voluntary process.

universal, selective and indicated levels of service the courts will have a broader array of effective services that they can adopt to meet the needs of the families they are serving.

Conclusion: Parent education has great potential to improve outcomes for children and families seen in family courts

This paper reviewed the history and current status of parent education programs in the United States. It also proposed a public health model for conceptualizing parent education programs in the court. We believe that a public health model is appropriate because children in separated or divorced families are at increased risk for multiple problem outcomes that have individual and societal costs (e.g., substance abuse and mental health problems). Further, support for the utility of a public health model is provided by research that has identified the risk and protective factors for children's post-divorce problem outcomes as well as demonstrated the efficacy of interventions to reduce these problem outcomes. A three-level model of parent education programs was proposed to meet the wide range of needs of divorcing families while respecting the limits on the court's power to constrain parental autonomy. This model can be useful for courts considering how to systematically integrate parent education into the full array of services provided by the court. Because the goals, content and format of the parent education programs are aligned within each of the levels, the model should be amenable to rigorous evaluations to assess the degree to which the programs are accomplishing their goals. Parent education programs have enormous potential to improve outcomes for children and families. Courts that provide a well-integrated set of evidence-based parent education services can make a significant contribution to reducing the problems experienced by children following divorce.

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Key Points for the Family Court Community

- Educational programs for separated and divorcing parents are widely disseminated, popular and diverse in their structure, goals and teaching strategies.
- To enhance the value of parent education programs a more cohesive approach to program development and rigorous evaluation is needed to work toward dissemination of evidence-based programs.
- A model is proposed to integrate concepts from public health into court-affiliated parent education programs.

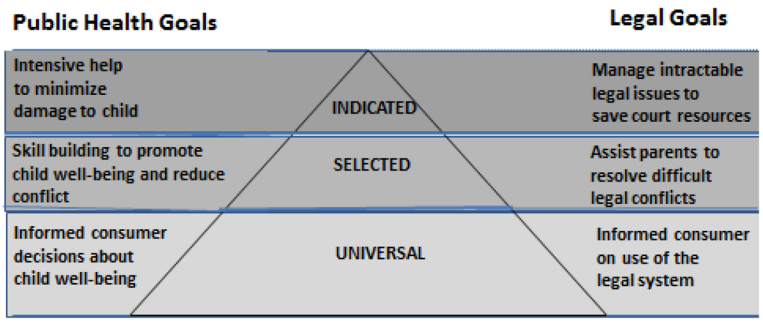

Figure 1.
Levels of Parent Education: Public Health and Legal Goals

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SPECIAL FEATURE

Delaware County, Ohio, domestic relations court programs designed to reduce family conflict and reach agreements

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Abstract

Families experiencing separation and divorce often find it difficult to provide emotional stability for children as the parents struggle with financial, parenting, and relationship decisions. The effect on children can be especially precarious. Adverse childhood experiences, or ACEs, are risk factors that potentially affect children for the rest of their lives. Parental separation and divorce are identified as adverse childhood experiences and the experiences of stress and loss, reduced parental effectiveness, and exposure to parental conflict, among other stressors, may explain some of the negative outcomes often observed in children following divorce. It is essential that public institutions, including courts, are informed about the risks and protective factors associated with ACEs and resolve to mitigate the effects for children and families whom they serve. Domestic Relations Courts are uniquely equipped to address the effects that parental separation and divorce have on children, given the courts' authority to govern the legal divorce and custody process. The Domestic Relations Court in Delaware, Ohio, is committed to assisting families navigate separation and divorce in a way that is in the best interests of all, especially the children. The Court has created four specific programs to help litigants navigate their emotions, create new narratives, and explore solutions to conflict outside of trial. These

innovative programs go beyond traditional court practices to treat the spouses and parents as unique individuals, giving them ample opportunities to address traumatic events and be validated for their lived experience. The suite of services includes Settlement Weeks, Neutral Evaluation, Co-parent Coaching, and Brief Family Assessments. In the subsequent sections, we will delve into each program, exploring their promise for improving outcomes for the public, the litigants, and the court as a whole.

KEYWORDS
assessments, co-parent coaching, court programs, decision-making, Delaware County domestic relations court, dispute resolution, emotions, high-conflict, listening, multiple perspectives, neutral evaluation, Ohio, parents, settlement week, teamwork, validation

Key points for the family court community

- The Delaware County Domestic Relations Court has implemented four specific programs: Settlement Weeks, Neutral Evaluation, Co-Parent Coaching, and Brief Family Assessments. These programs aim to assist families in navigating separation and divorce with reduced stress compared to traditional litigation alone.
- Successful programs prioritize promoting self-regulation and well-being among individuals involved in separation and divorce proceedings.
- Structured processes that validate emotions and highlight choices empower individuals to navigate their emotions and make informed decisions during legal proceedings.
- Through inclusive development processes and continuous improvement efforts, the Delaware County Domestic Relations Court has led a paradigm shift in the domestic relations community.

Productive resolution of conflict meets significant individual, family, and community needs.[1] When encountered in a structured and supportive manner, engaging in conflict allows people to discuss important issues; welcome new and creative ideas; release emotional tension; and provide a forum whereby people reevaluate and clarify goals and

[1]Pedro-Carroll, J. L. (2010). *Putting children first: Proven parenting strategies for helping children thrive through divorce.* New York, N.Y.: Penguin Group.

needs.[2] In so doing, they can resolve situations in their own lives that have a ripple effect into the community and beyond.[3]

These advantages suggest that conflict is normal and healthy, and they underscore the importance of understanding and handling conflict in a way that leads to healthy change. But perhaps more familiar is the negative side of conflict; heated exchanges spiraling out of control, resulting in frustration, tension, stress, hard feelings, and, ultimately, more conflict. Separating and divorcing parents often perceive significant threats and may be consumed by worry of diminishing resources.[4] Children, especially, do not fare well in high-conflict and it can have long-term consequences, including the deterioration of a relationship with a parent, and even issues with safety.[5]

The court system provides a structured process for people to obtain resolutions for their disputes. In some family law cases, a significant disparity seems to exist between the information the parents present to the court as compared to their real-life experiences. In other words, what a parent includes in their court pleadings may be characteristically very different than the information revealed in personalized, one-on-one settings with a trusted professional. In the book chapter, "Attribution in the Context of Conflict and Separation in Close Relationships," Harvey et al. (2018), describe emergent work on people's attributions and perceptions of conflict and separation.[6] Their basic assumption is that people have an urge to try to explain why problems plague the relationship or why the relationships have ended.[7] This attempt to explain the situation gets more pronounced after separation. Harvey and his co-authors say, "Whether this striving for understanding is based on a need for future control, simple curiosity, or some other mechanism, causal attribution in this context often manifests itself in elaborate, interpretive rationales filled with such feelings as anger, hate, despair, failure, and self-deprecation."[8] While on the outside it may appear to be a lack of emotion that drives the analysis, in reality, it is often heavy emotions motivating the need to answer, "Why?"

Authors and trauma-informed professionals Rebecca Bailey, Deborah Dana, Elizabeth Bailey, and Frank Davis, in their application of poly-vagal theory to family law cases, help us understand the threat response exhibited in high-conflict cases.[9] They state, "By understanding these behaviors as adaptive survival responses and exploring the factors triggering the sense of a lack of safety, clinicians and professionals can move away from assigning motivation and moral meaning towards in favor of increased awareness, understanding, and a greater capacity to intervene effectively."[10]

Professionals outside the realm of family law also have valuable insights into the role of emotion in conflict. According to Donna Hicks, Ph.D., an international conflict resolution specialist, in her book, *Dignity: Its essential role in resolving conflict* (2011), "Our self-protective instincts are so ready to respond in threatening situations that we feel as though they take us over. Emotional hijacking happens to us all. How many times have we told ourselves that we will not let someone rile us and then, in spite of our best intentions, entered into a heated argument?"[11]

Conflict hinges on the belief that a situation diminishes or threatens to diminish one's power or status, or results in unavoidable negative emotions.[12] The word that best encapsulates the need for power, control, and worth, is "dignity."[13] Hicks writes, "As a psychologist, I always gravitate toward the unspoken conversations that perhaps were

[2]Brahm, E. (2004). Benefits of intractable conflict. *Beyond Intractability*. Retrieved from https://www.beyondintractability.org/essay/benefits.
[3]PON Staff. (2023). To achieve a win situation, first negotiate with yourself. *PON - Program on Negotiation at Harvard Law School*. Retrieved from https://www.pon.harvard.edu/daily/negotiation-skills-daily/to-get-to-yes-with-others-first-negotiate-with-yourself-nb/.
[4]Bailey, R., Dana, D., Bailey, E., & Davis, F. (2020). The application of the polyvagal theory to high conflict co-parenting cases. *Family Court Review*, *58*(2), 525–543. https://doi.org/10.1111/fcre.12485.
[5]Pedro-Carroll, *supra* note 1, at 170–172.
[6]Harvey, J. H., Ickes, W. J., & Kidd, R. F. (2018). *New directions in attribution research*. New York, N.Y.: Psychology Press.
[7]*Id.*
[8]*Id.*
[9]Bailey et al., *supra* note 4, at 525–543.
[10]Bailey et al., *supra* note 4, at 525–543.
[11]Hicks, D. (2011). *Dignity: Its essential role in resolving conflict*. New York, N.Y.:Yale University Press.
[12]*Id.*
[13]*Id.*

taking place at the negotiation table (or under the table). Emotional riptides wreaked havoc on the people and the dialogue process. I eventually concluded that the force behind their reactions was the result of primal insults to dignity."[14] Hicks goes on to say, "Treating others with dignity, then, becomes the baseline for our interactions. We must treat others as though they matter, as though they are worthy of care and attention."[15] This statement has an opposite, says Hicks, "Treating others as instruments to further one's own goals and interests."[16] With dignity intact, events or situations are impervious to conflict; individuals can refrain from personalizing them, thus maintaining emotional independence even in the turmoil of threats of loss of power, status, and positive emotion.[17]

With all the complex and often threatening decisions facing parents during court involvement, professionals can be more effective when they understand the nature of reactivity that is normal under stress.[18] According to Bailey et al. (2020), in their article, "The application of the poly-vagal theory to high conflict co-parenting cases," family members "can be more effective in problem-solving when they are able to reliably recognize and then subsequently regulate their internal states."[19] They go on to say, "Self-(emotion) regulation can promote better communication, clearer thinking, and improved problem-solving abilities."[20] Thus, self-regulation is key for reducing conflict and restoring optimal thinking and parental abilities.

Innovative court programs at the Delaware County Domestic Relations Court serve as a means to address conflict in a more efficient, as well as compassionate way, enabling people to preserve their well-being instead of experiencing cognitive and emotional turmoil in court. These programs are built on three core concepts: validation, choices, and a structured process for navigating thoughts and emotions. These principles empower individuals to safeguard their well-being during legal proceedings by addressing the unique needs and lived experience of each person.

Validation in this context does not simply mean affirming the facts presented by each party; it is more about believing the real-life experiences they share in their relationship narratives and operating from their present vantage points. This validation forms the compassionate core of co-regulation, a crucial component of self-regulation of emotions.

Choices play a significant role in empowering individuals. Even seemingly small, personal choices provide people with agency over their lives and help them recognize that they have control not only over their reactions, but also over their future beliefs. When a litigant declares, "I have no choice," we recognize their limited self-identity. Our hope is that with significant support, people experiencing intense relationship dysfunction can see themselves making choices to create a brighter future. In her book chapter, "From Victim to Survivor to Overcomer," Ben-David (2020), informs readers that a "key realization of this (thriving) stage is that an individual has gotten through the trauma intact, or mostly intact. This understanding allows the person to begin integrating the trauma into his or her life story, to take control of life, and to recognize the potential for change and growth. In addition, the individual is less pessimistic, and begins to recognize and embrace new possibilities."[21]

Structured processes for listening to and working with a litigant's actual lived experiences enable litigants to not only acknowledge the reality of their situation, but to feel psychologically safe in doing so. One of many trauma-informed court practices is to be predictable and reliable as professionals – declaring what we are going to do and following through reliably.[22] Our structured court dispute resolution processes include opportunities for litigants to

[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] Bailey, Dana, Bailey, & Davis, *supra* note 4, at 525–543.
[19] *Id.*
[20] *Id.*
[21] Ben-David, S. (2020). From victim to survivor to overcomer. In J. Joseph & S. Jergenson (Eds.), *An international perspective on contemporary developments in victimology* (pp. 21–30). Springer, Cham. https://doi.org/10.1007/978-3-030-41622-5_2.
[22] Meyer, B. (2022). *Beyond trauma-informed: Becoming a trauma competent court* [PowerPoint slides]. Supreme Court of Ohio, Judicial College. Retrieved From: https://www.supremecourt.ohio.gov/docs/JCS/specDockets/EducationSeries/2022/December/121522.pdf.

voice input on legitimate choices, such as needs for breaks or to ask questions, thus respectfully giving them a sense of some control.[23]

SETTLEMENT WEEK

The first court program we implemented to reduce conflict and stress for families going through our court was Settlement Week. Our Settlement Week Program started in 2018 and prioritized dispute resolution as a way to resolve family disputes. This court program sent a clear message to the domestic relations community by highlighting the benefit of dispute resolution to reduce conflict and stress for families involved in the court system. It represented a paradigm shift away from a litigation model to a dispute resolution model. While courts do a good job of resolving family law cases and making decisions when families cannot agree, there is often a better, less adversarial way to resolve family law cases.

Creating a Settlement Week Program has little to no cost for the court. Our program utilizes private mediators to help families resolve their disputes. The mediators accept a reduced fee to be part of the program. The families directly pay the mediator's fee. If the family is indigent, the court can pay the mediator out of special project funds or the court can require mediators to accept some pro bono cases to be part of the program.

The court does not hold hearings or trials during Settlement Week so that all court personnel can be on hand to answer questions and support the settlement process. The judge and magistrates are available to place agreements on the record and finalize plans for the resolution of the cases. It also has the extra benefit of creating additional writing time for judges and magistrates.

Our first Settlement Week was conducted in November 2018. After observing the successful resolution of family disputes, we decided to devote court resources to provide two Settlement Weeks per year. As of this writing, the Delaware County, Ohio, Domestic Relations Court has offered 11 Settlement Weeks over five years.

In our program, mediators agree to mediate cases assigned to Settlement Week on the days they are available. We utilize some of the most highly trained mediators in central Ohio. It has been our experience that mediators are excited to be part of Settlement Week and several have called requesting to mediate cases in our court program. Mediators benefit from participating in our program as they can showcase their mediation skills to the attorneys involved in the case and the court.

Attorneys may request to have their cases in Settlement Week, or the judge or magistrates may select a case for Settlement Week. After being screened, cases are selected to participate in the program. Attorneys attend the mediation session with their clients.

Mediation sessions are scheduled for three hours, and additional sessions are scheduled as needed. Settlement Week has a reputation of not only helping cases settle but prioritizing settlement and using court resources to demonstrate that settlement is possible, and the court will make every effort to assist. Mediation validates the litigants, gives choices, and provides a structured process whereby the litigants have support in a helpful format to reduce conflict.

Settlement Week was created to meet the needs of Delaware County, Ohio. Other courts may tailor a Settlement Week Program differently to best meet their needs. For example, courts with a smaller caseload may not need a full week dedicated to the program. Also, courts with larger caseloads may not be able to clear the court's docket during Settlement Week.

We conducted our latest Settlement Week in November 2023. Seventeen cases participated in our program. Of the 17 cases, 13 cases (76.47%) reached full settlement, 3 cases (17.65%) reached partial settlements, and only 1 case (5.88%) had no settlement.

[23] *Id.*

Settlement Week can be conducted successfully virtually. During the pandemic, we conducted three Settlement Weeks virtually. Mediation sessions were conducted via Zoom. If an agreement was reached, the attorneys drafted the documents, and the court circulated the agreement to be signed electronically. The judge or magistrate took the acknowledgment under oath, on the record, via Zoom. Then, the court e-filed the documents and served the attorneys via email.

Our Settlement Week program was recently praised by Ohio Chief Justice Sharon Kennedy in her 2023 State of the Judiciary Address.[24] The Chief Justice encouraged other Ohio judges to consider implementing a Settlement Week Program in their courts.[25] Several Ohio courts have expressed interest in creating a Settlement Week Program and we have worked with another Ohio court to create their Settlement Week Program. Additionally, we have participated in roundtable discussions to educate and assist other courts regarding Settlement Week.[26]

NEUTRAL EVALUATION

Our second court program, which began in 2020, is Neutral Evaluation. Many times, people involved in a court case do not have a clear understanding of likely outcomes in court. The Neutral Evaluation Program, formerly called Early Neutral Evaluation, is used at any point during the case when the parties need direction from an experienced panel of professionals to learn the strengths and weaknesses of their case and the likely outcomes if their case proceeds to trial.

Distribution of assets and debts, valuation of businesses, spousal support, child support, designation of school placement, and allocation of parental rights and responsibilities, are typical issues brought to Neutral Evaluations. In the Delaware County, Ohio, program, the Neutral Evaluation process involves a panel of neutral professionals that includes a magistrate, who is not the magistrate assigned to the case, and another neutral professional. In cases with financial issues, the neutral professional is a forensic accountant. In cases involving issues of custody or companionship time, a licensed mental health professional is used as the other neutral professional on the panel.

In our program, each party is given 15 minutes to present their side of the case; the attorney (if they have one) is given five minutes each; and if a guardian ad litem is involved in the case, they can present for up to 20 min. The Neutral Evaluation proceeding is not recorded. The presentations give each person a chance to be heard, before a magistrate and another neutral professional, about the most important aspects of their case, without the restrictive application of the Rules of Evidence. Then, the magistrate and neutral professional ask questions to elicit more information as needed.

The entire Neutral Evaluation process is confidential and privileged, meaning, the discussion cannot be shared with others and no one from the panel can be called to testify in court. There are a few exceptions to this rule, such as someone threatening or abusing another person or disclosing information regarding the commission or planning of a felony.

Once everyone has had their chance to speak and the panel members ask questions, the panel members caucus and discuss the merits of each issue. Sometimes the panel will caucus with each side to verify their understanding of positions, information, and issues. When one or both sides have experts, the panel reviews the expert reports first and then will caucus with the experts to ask questions and gain understanding. Then, the panel reviews, with the family and other professionals, the strengths and weaknesses of the case and indicates how the court might rule on matters. The parties and counsel are given the opportunity to meet without the panel to discuss the feedback. Next, the parties may choose to mediate the issues in the case with the assistance of the neutral panel members. Almost

[24]Kennedy, S. (2023, September 14). *SotJ settlement week clip* [Video]. The Ohio Channel/Ideastream. https://www.ohiochannel.org/video/sotj-settlement-week-clip.
[25]*Id.*
[26]Sukosd, C. (2023, September 1). *Settlement week offers faster and less costly resolution to cases*. Court News Ohio. Retrieved From: https://courtnewsohio.gov/happening/2023/SettlementWeek_090123.asp.

always, the participants choose to attempt mediation, and the matter proceeds. However, should one or both sides choose not to mediate, then the Neutral Evaluation process ends.

In Neutral Evaluations, each case is taken very seriously and the part of the case which is in dispute is examined with great care. During the Neutral Evaluation process, the parties can feel validated in a structured process and make choices about how they want to proceed given direction from the panel.

Our Neutral Evaluation program has had great success resolving disputes with families. To date, we have conducted 29 Neutral Evaluations. Of the 29 Neutral Evaluations, 24 (82.76%) have reached full settlement on the issues presented, 3 (10.34%) have reached partial agreement, and 2 (6.90%) have not reached an agreement.

One of the most important benefits of the Neutral Evaluation process is that it allows each person to feel heard. Each person talks directly to the neutral panel in a court-like setting. After being heard by the panel, they hear the panel discuss their concerns. This process of being heard in a court-like setting is empowering and validating for the family members involved in the conflict.

The Neutral Evaluation Program gives litigants the two most important deliverables desired: one, the opportunity to tell their story in their own words; and two, the timely resolution of their case. The litigants and taxpayers also save thousands of dollars avoiding trials, objections to decisions, and appeals to decisions. The court gains valuable time in its docket, through this judicial economy, to focus on the cases and issues that must be tried.

CO-PARENT COACHING

Co-parent Coaching is our third court program that gives parents an extended opportunity to process their real-time experience, whether or not they are working toward settlement of their case. Beginning in 2020, Co-parent Coaching began as a pilot program and has since become a sought-after service for settlement-minded attorneys and their clients. Co-parent Coaching carries with it the assumption that even well-meaning and high-functioning co-parents can struggle with co-parenting. Differences in communication preferences, parenting styles, and the high-stakes and emotional nature of parenting all contribute to the potential conflicts arising from separating children into two homes. Co-parent Coaching creates a forum for parents to develop their goals for co-parenting and potential options for structuring their communications and decision-making processes to meet their goals.

Coaching is big business in the larger context outside of the field of family law. According to the International Coaching Federation (ICF), which claims to uphold the "gold-standard" for coaches, coaching is currently a multi-billion-dollar industry.[27] Coaching in domestic relations courts, however, is in its infancy. The Co-parent Coaching Program in Delaware County has its roots in the ICF competencies. At the time of this writing all coaches in the program are accredited or on the path to accreditation through an ICF-authorized training program.

According to Harvard Business Review, the hallmark feature of coaching is the nature of the coach-coachee relationship, which is oriented toward supporting, rather than directing, change. The coach is trained to expertly ask questions that tap into the coachee's readiness to change.[28] Robert Quinn, in his classic book, *Change the World* (2000), states that, "the least effective way for people to change is to tell them to change."[29] Coaching, on the other hand, inspires change through inquiry, feedback, and a deep listening presence.[30]

Timothy Clark, author of *The Four Stages of Psychological Safety* (2020), opines that "change happens when people feel psychologically safe to do so."[31] A big part of a coach's job is to help people experiment with new

[27]International Coaching Federation. (2023). Global coaching study 2023 executive summary. Retrieved From: https://coachingfederation.org/app/uploads/2023/04/2023ICFGlobalCoachingStudy_ExecutiveSummary.pdf

[28]Boyatzis, R. E., Smith, M., & Van Oosten, E. (2019). Coaching for change. *Harvard Business Review*. Retrieved From: https://hbr.org/2019/09/coaching-for-change.

[29]Quinn, R. E. (2000). *Change the world: How ordinary people can accomplish extraordinary results* (1st ed.). Jossey-Bass.

[30]Ordońez, J. (2023, July 13). The art of listening in coaching. *International Coaching Federation*. https://coachingfederation.org/blog/the-art-of-listening-in-coaching.

[31]Clark, T. R. (2020). *The 4 stages of psychological safety: Defining the path to inclusion and innovation*. Berrett-Koehler Publishers.

behaviors.[32] The Co-parent Coaching process at the Delaware County Domestic Relations Court allows parents to discuss goals and interests without legally binding agreements to try new behaviors and ideas for co-parenting.

One of the issues addressed in Co-Parent Coaching is emotion regulation, which has its roots in attachment theory. Trusted professionals can serve as a proxy attachment figure, to provide psychological safety similar to the feelings of safety and security from secure interpersonal and familial relationships.[33] When a professional serves as a reliable source of protection and support, they can become an attachment figure to another adult.[34]

The security experienced with the attachment figure leads to curiosity to explore options, willingness to ask for help, and lower stress reactivity.[35] Additionally, the protection offered by the trusted professional invites return to full cognitive functioning after stressful interactions, re-calibrating thinking and feeling states, and returning the brain to a state of optimal reasoning.[36] In summary, it is co-regulation with the professional serving as an attachment figure that makes an enormous difference in helping litigants safeguard their well-being during their court-involvement.

In the Co-parent Coaching Program, individual sessions with each parent give the coach an opportunity to build rapport with each parent and get to know their individual concerns and stressors. While coaching sessions are specifically designed to avoid advice on the "right way" to co-parent, the coach is uniquely qualified to expose potential risks for the child in the middle of adult conflicts, or possible blind spots affecting each parent as they undertake parenting without the contributions, or buffer of the other parent in the same home.

The Delaware County, Ohio, Co-parent Coaching Program involves three phases. First is the introductory phase of individual sessions. Typically, one to two 30-45-minute sessions are adequate for the litigant to sense the coach's commitment to safeguard their well-being and provide guardrails for joint sessions. Second, up to six sessions in-person or over the Zoom platform with both parents present allows parents to explore options and determine what needs to be articulated in order to have closure on their past dynamic. Third, up to two Co-parent Coaching sessions allow the coach and parents to firm up any agreements that will be passed on to a guardian ad litem or attorneys, or to close the loop on referrals to outside counseling or other supportive services that will uphold a new family dynamic on-going.

The coach helps the parents see their options to communicate more, less, or simply differently. Parents have the opportunity to imagine new ways of getting along and jointly supporting their child's needs, even if they choose a parallel or otherwise hands-off approach to co-parenting. It is clear in the Co-parent Coaching Program that there is no "one-size-fits-all" approach to parenting, let alone co-parenting. We emphasize that stress is real, but not an excuse to give up. We teach parents to look closely into the real-time experiences and needs of each family member, rather than in preconceived ideas of how parenting "should" be. No matter your circumstances, the "right" answers to parenting questions are those which are your own.

Some parents prefer to meet in shuttle-style sessions, and some prefer to meet in person, often having conversations for the first time in years. It is common in Co-parent Coaching sessions for parents to surprise one another with expressions of support or intentions contrary to what has been filed in court proceedings. With the help of the Co-parent Coach, parents can identify the areas best served by their attorneys in settlement conferences, informal negotiations or trial, and which issues they prefer to address in the informal Co-parent Coaching conversations.

The Co-parent Coaching Program is unique in that it allows the parents to talk about the real, underlying issues, not just the legal issues as they might in mediation. By addressing the underlying emotional issues with a skilled facilitator in structured sessions, the parents become better equipped to reach agreements and co-parent their children.

[32]Boyatzis, Smith, & Van Oosten, *supra* note 28.

[33]Taylor, P. J., Rietzschel, J., Danquah, A., & Berry, K. (2015). The role of attachment style, attachment to therapist, and working alliance in response to psychological therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(3), 240–253. https://doi.org/10.1111/papt.12045.

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[36]Jung, N., Wranke, C., Hamburger, K., & Knauff, M. (2014). How emotions affect logical reasoning: evidence from experiments with mood-manipulated participants, spider phobics, and people with exam anxiety. *Frontiers in Psychology*, *5*, 570. https://doi.org/10.3389/fpsyg.2014.00570.

The Delaware County Domestic Relations Court uses efficient data analysis to guide the implementation of its Co-parent Coaching Program. Applying this research approach, participants took confidential online surveys regarding their perceptions of co-parenting before and after receiving coaching services. The amount of time between pre-surveys and post-surveys tended to be three months, meaning that average differences in responses likely reflect changed perceptions. However, without treatment and control groups, differences between pre- and post-surveys could also be attributed to the passage of time and/or functioning of other family court processes, such as legal negotiations and litigation. These survey responses were then analyzed with a statistical process called an ordinal logistic regression, which estimates the likelihood of a change in ordered categories ("High," "Somewhat High," "Moderate," "Somewhat Low," and "Low") associated with each variable. Control variables included gender, whether the co-parents were previously married, the presence of a guardian ad litem in the case, and whether each respondent was represented by an attorney, among others.

The first phase of this research measured pre- versus post-survey differences and found statistically significant improvements in three of four main indicators (less conflict, more mutual understanding, and greater confidence in the ability to resolve future disputes). Following this success, the second phase added treatment and control groups and found that mutual understanding post- versus pre-survey improved by a statistically significant margin in the treatment versus control group. However, adding a control group also meant that magistrates referred more cases to potential coaching, including cases where litigants were not identified as being particularly motivated to improve their co-parenting skills under the guidance of a coach. The data analysis efforts therefore abandoned the control group for 2023, and the third phase of the analysis is currently underway at the time of this writing.

BRIEF FAMILY ASSESSMENTS

Our fourth, and newest program, is Brief Family Assessments. This program was initiated as a pilot program and is in the early stages of development. Not to be confused with brief focused evaluations, an AFCC-supported intervention, the Brief Family Assessment Program is not a comprehensive view of any one issue facing conflicted court-involved families. On the contrary, this program is designed to be a birds-eye snapshot of the family without detailed evidence that could complicate early litigation. Rather, the program serves the purpose of raising awareness of early signs of needs which, if addressed promptly, could prevent further entrenchment of family dysfunction.

The Brief Family Assessment process was born out of a commitment to address family needs as appropriately as possible, which often includes early intervention. When conflicted parents file motions and affidavits for temporary orders, they often present a confusing or complex narrative which does not lend itself to obvious next steps for court intervention. A "red flag" could go up for the judge or magistrate when the parents demonstrate significant dysfunction, especially those putting the child or children at risk for harm. For example, if the parents' narratives of what has happened resulting in separation or the end of the marriage are incongruent, it may be difficult for the court to identify the best next steps to help the family sort through the many decisions that lie ahead of them.

We have observed that incongruent narratives between the parents are especially pronounced in cases involving parent–child contact problems. The court recognizes parent–child contact problems as a serious situation, which is best addressed promptly and thoroughly. A Brief Family Assessment can help determine the most likely hypotheses regarding the reasons the child resists contact. Common questions running through the assessor's thinking include, "Is this a situation where there is justified resistance due to parental neglect or abuse?" or, "Is the child a victim of alienating behaviors of the preferred parent?" or, "Is the child experiencing developmentally appropriate alliance with one parent with whom the child has similar interests?"

The parents are responsible for scheduling in-person or zoom appointments with the Brief Family Assessor. The Assessor will devote 10 hours or less to interview relevant persons, and possibly meet with the parents together to observe their dynamic. Following the interviews, the family assessor drafts a brief report, one to two pages, and files the report in the family case file within a short period of time. The recommendations in the report are considered for prompt court action, such as making temporary orders or ordering resources for the family that could include co-parent

coaching, appointing a guardian ad litem, therapy for individuals or for the family, or additional assessments such as a psychological or custody evaluation, domestic violence assessment, or substance abuse evaluation. With prompt, meaningful information for temporary orders, we find that the family progresses through the system in a way that supports and improves the well-being of each family member, each parent–child relationship and the co-parenting relationship.

It can be said that Brief Family Assessments are triage on steroids. While the Assessor cannot gain a thorough understanding of the family history, dynamic and needs in 10 hours, they can provide the court better and more meaningful information than when the court could only rely on a review of conflicting affidavits. Additionally, the Brief Family Assessment may result in recommendations for prompt improvements in how the parents are communicating and meeting the needs of the children including safety, educational, medical, social, and other developmental needs.

CONCLUSION

When developing each court program, we focused on including domestic relations professionals in the process. We started each court program in a pilot phase. While a program is in the pilot phase, we work with attorneys and other domestic relations professionals involved in the cases selected for the pilot program, to ensure their understanding, comfort, and buy-in to our court program. Once our pilot program is completed and we are ready to launch it as a stand-alone court program, we offer attorneys a free lunch and learn education via zoom. We offer attorneys free continuing legal education credits to learn, ask questions and understand our program. We also consult with mental health professionals to learn their perspective and gain their buy-in to the program.

By including multidiscipline domestic relation professionals, we have developed goodwill in the domestic relations community. This approach increases the likelihood of success for our court programs.

Delaware County Domestic Relations Court is continuously improving court processes to support not only the legal needs of petitioners and litigants, but to understand and support the well-being of the whole person. The Settlement Week Program gives focused attention of court resources to effectively and efficiently resolve family disputes. Neutral Evaluation answers key questions that can help litigants get unstuck and reach resolution. Co-parent Coaching allows new insight and behaviors to drive a new dynamic and paradigm for parenting and co-parenting, some of which generate legal agreements. Brief Family Assessments are a work-in-progress as the court identifies new ways to provide early intervention to prevent intractability and exacerbation of family problems.

Our approach to developing new, innovative programs to reduce family conflict and stress and to resolve family disputes, has created a paradigm shift in the domestic relations community. When we first offered alternatives to an adversarial approach to resolving family disputes, we experienced some resistance from the domestic relations community. As we continued including and working with many multidisciplinary domestic relations professionals, we have developed buy-in to a new, less adversarial, approach to resolve family conflict. This results in a validating and empowering approach to resolve family disputes with less family conflict. Ultimately, this approach benefits the families, especially the children, involved in the court process.

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Hon. Randall D. Fuller, was elected in 2016 to be the first judge of the unified Common Pleas Court of Delaware County, Ohio, Domestic Relations Division. Judge Fuller currently serves as President of the Ohio Association of Domestic Relations Judges. He was appointed to the Board of Trustees for the Ohio Supreme Court Judicial College and serves on the Executive Committee for the Ohio Judicial Conference. He also serves on several Ohio Judicial Conference committees including Domestic Relations Law and Procedure, Court Technology, Legislative and the Judicial Advisory Group. Judge Fuller is on the Board of Directors for the Association of Family and Conciliation Courts (AFCC). He is also a Board Member and Immediate Past President of the Ohio Chapter of the Association of Family and Conciliation Courts. Judge Fuller is a frequent presenter for the Ohio Judicial College to Domestic Relations Judges and Magistrates. He also presents for the Ohio Judicial College for New Judge Orientation and is a mentor to a new Ohio judge. He has testified several times before the Ohio House of Representatives, Civil Justice Committee and Criminal Justice Committee, and the Ohio Senate, Judiciary Committee, on behalf of the Ohio Judicial Conference and the Ohio Association of Domestic Relations Judges. He received his undergraduate degree from The Ohio State University and his Juris Doctor from the University of Toledo, College of Law.

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Use of solution-focused and family narrative approaches in working with high conflict families: Strategies and techniques that can be utilized in parenting coordination and co-parenting coaching

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Use of solution-focused and family narrative approaches in working with high conflict families: Strategies and techniques that can be utilized in parenting coordination and co-parenting coaching

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ABSTRACT

This article will outline the basic tenets and potential practical application of both a solution-focused and a family narrative approach in providing alternative and helpful techniques that can be utilized by parenting coordinators and co-parenting coaches working with high conflict families transitioning to a post separation or divorce state. It is suggested that children and parents adapt better to their new family circumstances when they are empowered to find their own solutions to the challenges they face and are given the opportunity to create, for themselves, a positive and desirable family story.

KEYWORDS

Co-parenting coaching; family narrative; high conflict; parenting coordination; solution-focused

In both the United States and Canada, the rate of separation and divorce among married couples with children is estimated to be over 40% with an even higher rate attributed to subsequent marriages (Ambert, 2009; Kennedy & Ruggles, 2014). In addition, these figures are further inflated by a growing number of couples living in common law relationships whose rate of separation is even higher. Over the years, numerous authors (Kelly, 2000; Lamb, Sternberg, & Thompson, 1997; Wallerstein, 1991) have written regarding the impact this had on family life and, more importantly, the potential deleterious consequences on the well-being of children. It should be noted, however, that although the majority of parents and children are able to eventually adapt and normalize their life situations with minimal assistance, a growing percentage become entangled in chronic conflict and are constantly in disagreement over the care and support of their children. Intervening with these parents is a daunting task and a challenge for most professionals who often lack the necessary understanding and training as to how to proceed and, consequently, end up becoming part of the problem and entangled in the very conflicts they have hoped to de-escalate. According to Kelly (2002), services should be available that can offer feuding parents with viable means of resolving their disputes and sensitizing them to the needs of their

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children. Interventions might include, divorce education programs, custody evaluations, and mediation and when a more directive input is required, co-parenting coaching and parenting coordination, usually mandated by the court. Do these alternative interventions have 'something constructive to offer' (Kelly, 2003) and in what ways can they help keep chronic litigants out of court? The following article will discuss how co-parents caught in high conflict separation and divorce can benefit from these aforementioned services using a unique combination of a solution-focused and narrative approach.

High conflict families

The process of separation and divorce generates, in most situations, a certain degree of conflict related to the multitude of stressful events and complex issues that confront most couples before, during, and following the decision to end a marriage or relationship (Garrity & Baris, 1994; McIntosh, 2003). According to many experts, parental conflict can be best understood when considered on a continuum that includes low, medium, and high levels.[1] While estimates vary (between 5 and 15%) as to the number of families that we can label as being high conflict in their post separation and divorce relations (Kelly, 2003), they present, irrespective of their low numbers, an enormous challenge to the court system and professionals working in the legal and mental health field. Not only do they use up an inordinate amount of court time and free legal services, but they also consume the lion's share of available and scarce psycho-social services (Baris et al., 2000; Saini & Birnbaum, 2007).

What distinguishes high conflict patterns of interaction from those that are considered either low or medium in intensity is the fact that these parents are constantly angry, distrustful, and unable to appropriately communicate their feelings and needs (Coates et al., 2004; Kelly, 2003). Furthermore, they become entrenched in never ending litigation and court battles that promote an escalation of conflict while contributing to an inability to move beyond the hostility, recrimination, and bitter feelings toward the other parent that tend to spiral out of control (Kelly, 2000).

High conflict divorce, especially involving custody disputes, can be characterized by intractable and protracted legal disputes, never ending conflict over parental rights and parenting practices, chronic hostile interactions, false allegations of physical and sexual abuse and emotional, physical and psychological abusive actions (Jaffe, Johnston, Crooks, & Bala, 2008). These conflicts are most often fueled by pre-separation, separation, and post separation/divorce factors operating at the individual, interactional, and external level (Johnston, 1994; Eddy, 2005). Furthermore, research indicates that a high level of conflict between parents (verbal and physical disputes, persistent

litigation, mistrust and hostile behavior, parental alienation) place children at risk and destroy the benefits that more positive parental relations can provide (Baris et al., 2000). In the most difficult cases, judges often order or recommend that parents use mediation services, psychosocial evaluation, or consultation, but these resources are ineffective with many couples who are caught in chronic conflict. As well, parents who are separated/divorced and experiencing high conflict tend to over use available services (child protective services expertise, mediation) and tend to engage in numerous legal proceedings at a very high cost to society and the family. In these circumstances judges have increasingly turned to parenting coordinators as well as co-parenting coaches to provide these parents with much needed guidance, education, and the problem solving skills required in assuming their parental responsibilities.

Parenting coordination

Parenting coordination (PC) is a relatively new approach in working with families experiencing high conflict and is defined by the Association of Family & Conciliation Courts (AFCC) (2006) as:

> a child-focused alternative dispute resolution process in which a mental health or legal professional with mediation training and experience assists high conflict parents to implement their parenting plan by facilitating the resolution of their disputes in a timely manner, educating parents about children's needs, and with prior approval of the parties and/or the court, making decisions within the scope of the court order or appointment contract. (p. 2 of guidelines)

From a historical perspective, PC emerged in the 1990s in response to an ever growing need of the family court system to make more effective use of mental health professionals and experts in helping high conflict couples going through the process of a difficult separation or divorce. Garrity and Baris (1994), in their seminal book entitled, Caught in the Middle: Protecting Children of High Conflict Divorce, identified parenting coordination as an important service that could greatly assist parents to find solutions in very stressful situations in which children become the unwitting victims of their parents' on-going disputes.

In the past 20 years, PC practice has burgeoned throughout the United States, Canada, and Europe and has become, according to Sullivan (2013), the most intensive intervention that professionals have at their disposal in dealing with highly conflicted and maladaptive parents caught in vicious cycles of mutual recrimination, chronic litigation before the courts, and over use of limited existing resources. As a process, every effort is made to help parents resolve their disputes in a timely manner with the aim of keeping them out of the court system. The parenting coordinator who is a highly trained professional in child development, family dynamics and crisis management strives, while acting in a multidimensional role, to create boundaries

and disengagement while re-structuring family ties and bonds in a manner that facilitates more constructive and positive relations and interaction. Focusing on solutions and helping parents and children construct a positive and meaningful family story can become added tools in the PCs arsenal.

PC practice can vary depending on the orientation and limitations created by local legislative laws and the professionals providing the service (Kirkland & Sullivan, 2008; Boyan & Termini, 2005). The model of service that lends itself best to the use of a solution-focused and a family narrative approach is one where the PC does not have any decision making power that is attributed by the court. For obvious reasons, this model allows the coordinator/coach to be less imposing of his expert knowledge and better able to "join" with either parent in offering his knowledge, guidance, and experience to them.

Co-parenting coaching

Co-parenting coaching (CPC) is also a relatively new but widely used approach in working with families experiencing medium to high conflict and can be a useful intervention in those instances when a less coercive and legally binding intervention is required or possible (Bonnel, 2015). Coaching, in its broadest meaning, can be defined as a process involving training and development in which an "expert" provides guidance and support to a 'learner' in an effort to reach specific goals and acquiring new skills and techniques on a personal or professional level. Historically, the practice of coaching goes back centuries, but has come into prominence in the 80's and 90's as it began to borrow heavily from the fields of human development, education, psychology, neuroscience, and social organization (Davison & Gasiorowski, 2006). In the mental health field, coaching has steadily gained popularity in the last few years as witnessed in its far reaching involvement with individuals suffering from personality disorders (Kets de Vries, 2014), ADHD (Hamilton, 2011), and those experiencing a difficult separation or divorce (Keenan, 2015). The difference between coaching and therapy, fundamentally, has to do less with outcome than approach to intervention. Coaching focuses on the future rather than the past and focuses primarily on helping individuals find solutions to their problems rather than a "cure" in the medical sense of the term. On the other hand, coaching and 'therapeutic intervention' both tackle difficult issues and, often, debilitating conditions and place great importance on behavioral change at the personal, family, and organizational level (Brennan & Gortz, 2008; Caspi, 2005; Grant, 2006; Hart, Blattner, & Leipsic, 2001).

In CPC, the coach works with both parents (usually in joint sessions unless otherwise indicated) with the aim of helping them find new skills and behaviors and develop a more functional collaborative parenting style that will bring new insights with regards to how they can exercise their parental

responsibilities in the best interest of their children. There is a strong reliance on dialogue with the parents and having the latter, as much as possible, come up with answers for themselves. At the same time, coaching does include an element of psycho-education and counseling in particular with regards to effective communication, children's needs, family re-organization, and joint decision-making on issues involving the children.

Solution-focused and family narrative approaches

It is not uncommon for professionals workings with high conflict families to take a more past-oriented and problem solving approach that tend to facilitate the re-surfacing of destructive past events and actions. This process all too easily results in parents renewing old bitter feuds and rancorous interactions forcing them in an endless spiral of blame and recrimination. Given the high complexity of most conflicts that have evolved over time and involve many problematic elements that are intricately inter-wound, traditional attempts at 'single problem' definition and simple explanations based on past events are usually ineffective in both understanding and finding solutions to current conflictual situations. Furthermore, recurring problems and their escalation is often indicative of the fact that "first order attempts at change" are ineffective and that something different needs to be tried (Swenson & Anstett, 2009; Watzlawick, Weakland, & Fish, 1974). Using a solution-focused and family narrative approach, the parenting coordinator or co-parenting coach is in a better position to avoid stalemates and becoming caught in vicious circles that invariably prevent co-parents from moving forward and successfully creating for themselves "a future with a difference" (Banning, 2007).

Solution-focused orientation

A solution-focused orientation in working with high conflict families places a great deal of importance on re-directing the attention that parents put on the problems they face to finding more viable solutions that are beneficial to all concerned. In the process, these parents are encouraged to focus on what impacts them most in the here and now (the present) and what effects any of their actions will have in the future. Past events and actions that have had a significant effect on their couple and family relations are acknowledged but left behind in favor of identifying and creating more constructive and beneficial behaviors. To be sure, this approach is greatly inspired by the theoretical constructs and practical applications found in the Solution Focused Brief Therapy model developed, in the 1980s, by De Shazer (1985) and Berg (2005) and the ADR model of Solution Focused Conflict Management (Banning, 2010) that followed several decades later. Both models of intervention ultimately consider the client to have the ability of defining what

future path and goals to take and the means needed to get there. Clients are encouraged to do more of what has worked for them and to try something different when what is tried does not produce the desired results. Several therapeutic techniques are utilized, notably the miracle question, looking for exemptions and scaling. The miracle questions asks clients to imagine what would change or improve if their problematic situation miraculously improved (e.g., co-parents able to work together with minimal escalation of conflict) while exploring exemptions clients are asked to consider when the conflict was less serious and they were better able to attain their desired goals. It is very useful in situations when clients become stuck in past experiences and are unable to envision a better future. Scaling (from 1 being negative to 10 being positive) is a means to measure improvement and the incremental changes that are needed in order to move forward.

Recent applications of a solution-focused approach in family mediation have advanced the use of "solution-focused conversations" that lead clients to reflect on what they hope for in the future, those actions that already work and should be continued, and what other steps will help to realize desired change (Banning, 2007). These future oriented conversations are not dissimilar to the use of therapeutic questions to explore a person's personal life story and the need to create an alternative and more desirable personal and family narrative.

Family narrative perspective

Recounting one's family story and history has been a common practice since the dawn of human existence and the ability of man to record and verbally exchange information. Human beings are, generally speaking, interpretive in their need to make sense of their experience of the world around them, and their life stories that are constructed with others in their social and cultural environment become an essential and indispensable frame of reference. Individuals live, primarily, in families and the latter necessarily become the main conduit through which their members derive meaning and connectedness. Children, in particular, tend to respond well and benefit significantly in terms of developing a strong sense of self when they are exposed and are able to integrate a strong family narrative (Bohanek et al., 2006; Feiler, 2013). In studies conducted by Duke, Lazarus, and Fivush (2008) on the impact of shared family stories on children and adolescent well-being, found that the latter develop a stronger sense of identity, connectedness, and resilience to adversity when they are able to share family stories with other members of their extended families. Children tend to benefit and learn from the accounts of how family members dealt with negative events and adversity as well as from those that are more positive and uplifting. Consequently, it is the manner in which parents discuss past family events, as well as the content of the

accounts, that can profoundly influence how children view themselves and behave.

The family narrative perspective in working with high conflict families also derives a great deal of its clinical usefulness from the emergent use of family narratives as a therapeutic tool in working with problems presented by children and parents. White and Epston (1990) presented a therapeutic model in which it was posited that an individual's identity is embedded in a personal narrative that is often created and perpetuated at a societal level and by ideas held by "significant others." The therapist, essentially, attempts to change problematic internalizations by helping the individual to deconstruct negative stories and to see them from different and healthier perspectives. By externalizing the problem (White & Epston, 1990), the parents are separated from the problem that is then identified as the focus of intervention.

In terms of intervention, the use of a family narrative approach can prove to be a powerful tool and its impact on co-parents and children caught in high conflict cannot be underestimated. Through conversation and therapeutic questioning, parents and children are helped to acknowledge the destructive and toxic family narratives in which they are enveloped and are encouraged to create more viable and functional ones based on positive values and actions that will shape future family relations (Cobb, 1994).

Interventions strategies using a solution-focused and family narrative orientation

PC and CPC share common goals with regards to assisting parents caught in intractable conflict.[2] These parents ultimately value family life and desire, for the most part, less problematic family relations and a family story that is more positive and one in which their children can invest and take pride as they grow up. When co-parents are referred, it is usually because they are caught in a spiral of conflict and have lost their bearing as to how to attain a much more desirable level of functioning in the present and future. Simply put, our aim as coordinators/coaches is to utilize certain intervention strategies and techniques that will help parents and their children find more constructive ways of relating to each other and, in the process, re-fashion their family story or narrative so that it will better correspond to a more "desirable future."

While there are certain differences that set these two approaches apart, there are, at the same time, far more similarities that permit the parenting coordinator and co-parenting coach to apply some of their complimentary core concepts and strategies concomitantly and with a high degree of effectiveness (Chang & Nylund, 2013; Chang & Phillips, 1993; Freedman & Combs, 1996; Payne, 2006). Both the solution-focused and family narrative

approaches are considered to share a post-modern, client-focused and nonpathological perspective. Through the use of similar techniques such as the miracle question and variation thereof, the use of exceptions/unique outcomes, scaling, externalization of the problem, and strategically crafted written and verbal feedback, the client is encouraged to create a new and more desirable outcome. In recent practices there has been an increasing tendency to combine the two approaches under a "larger umbrella" (Chang & Nylund, 2013), one that might more effectively correspond to the needs and circumstances presented by high conflict parents.

It should be stressed that although the strategies that follow borrow heavily from both the solution-focused and family narrative approaches to therapy, there is no attempt to replicate faithfully the theoretical constructs that characterize and define their clinical application. As the services provided by a coordinator/coach are not therapy per se, the process itself and the interventions made might not exactly resemble what a solution-focused or narrative therapist might do. Necessarily, the coordinator/coach must choose his tools and conduct his work strategically within boundaries and limits already set by the socio-legal context in which the parents find themselves and by the nature of the referral itself. This is particularly evident in PC where the goal of the intervention provided is as much set by the parents themselves as it is already prescribed by a specific judicial mandate or court order (Kirkland & Sullivan, 2008). Keeping these limitations and contextual realities in mind, the professionals involved need to be judicious in how they can use the tools available to them in a manner that best meets the real needs of the parents and their children while making every effort to give adequate space to the clients themselves in determining what is best for their family. The process becomes one whereby they extend and make available their expertise rather than impose it on the parents. As such, interventions tend to be less 'top-down' or hierarchical and more lateral in that change and a more desirable future are collaboratively constructed (De Shazer, 1988). PCs, in particular, need to be vigilant in not succumbing to the power of their court mandated role and always ensuring that their primary goal is to help parents ultimately settle their own disputes (Kelly, 2008) and create a more favorable family story for themselves and their children. This process can be less problematic and greatly facilitated when the PC does not have the power to make decision arbitrarily and must, therefore, rely more on a client focused intervention that aims to help parents create a new reality for themselves (Freedman & Combs, 1996). In those instances where that power is extended to the PC, it is imperative that it be used sparingly and as a last-ditch effort to avoid impasse and re-litigation (Coates, Deutsch, Starnes, Sullivan, & Sydlik, 2003). Such a problem does not confront a co-parenting coach, as a decision-making role is rarely included in a service mandate.

Interview protocol

The actual use of a solution-focused/family narrative approach in working with high conflict parents can best be demonstrated when interviewing both the parents and their children in the course of service delivery. In both the PC and CPC models of intervention, the parents are, generally, seen individually, at the onset, to help forge a working alliance and 'bonding' that can make it easier to establish goals, tasks, and contractual obligations (Gelso & Hayes, 1998; Kelly, 2008). At the same time, the professional is able to obtain more pertinent information about family functioning that might influence future interventions focused on helping these parents and their children to find solutions and create a more desirable and enduring family story. As both PC and CPC are, essentially, focused on the well-being of the children involved, the latter are also interviewed by the parenting coordinator or co-parenting coach early on in the process (Kelly, 2008). Irrespective of the service being provided (PC or CPC), a similar interview protocol can be utilized in which questions are posed using a solution-focused and family narrative approach (see Appendix A).

1. The first contact with the parents and their respective lawyers is normally made on the telephone after receiving a mandate (usually court ordered) to provide PC or CPC services. The lawyers in question are contacted to obtain more detailed information about the problem their respective clients are experiencing and, equally important, to obtain as much information as is possible regarding how they perceive the situation and what they see as possible solutions or a better outcome for the future. Posing the miracle question to them in terms of what they envision as changing or being different can usually provide important feedback to the professional with regards to their expectations and legal positions. Taking into account what the lawyers (and other professionals) are thinking and what they see as possible solutions is an invaluable road map that can be used for setting intervention strategies throughout the process.

   The coordinator/coach will then initiate an initial telephone contact with each parent to introduce himself/herself stating the reason for the call and to set up an appointment at the earliest possible time. The call should be short and to the point explaining to the parent that he/she will have ample opportunity to present their story and obtain more information about the nature of the service and the process.
2. The initial individual interview with each parent is of critical importance as it is during this meeting that an alliance is created (Hilsenroth & Cromer, 2007) and a number of techniques using a solution-focused and narrative approach are utilized in order to set the stage for future interventions. This may be labeled as the deconstruction phase whereby information pertaining to the parents' perceptions, beliefs, and family story are discovered

and analyzed through the use of "pre-emptive techniques" (Saposnek, 1998) and specifically crafted questions that elicit 'a free narrative response' (Powell, Fisher, & Wright, 2005). According to De Shazer (1994), the first interview is "text focused," that is, whatever information is collected comes out of what the parents recount about their predicament and life stories.[3] Usually these stories are laden with conflict and discord and the parents need to be prompted with open-ended questions to remain on track. Once the parents recount what has brought them to their present predicament, they are encouraged to talk about how the problem is being experienced by other members of the family (in particular, their children and co-parent) as well as other involved professionals (judges, lawyers, therapists, experts).

Each parent is then requested to think of those times when the situation was not problematic and their family narrative was much more positive. These exceptions or unique outcomes to the problem that are recovered from an otherwise bleak account of their family story provide not only new insights of what went unnoticed, but inject some hope in the possibility that things could be better. This information is utilized in subsequent sessions to remind parents that they have the ability to bring about change and "re-author" their family story, one in which co-parenting relations are more satisfying and functional. By the use of the scaling question, the coordinator/coach is able to create a baseline with regards to establishing how well the parents are presently able to deal with the problems identified. Incremental changes needed in attaining a more desirable outcome can be instituted and monitored more realistically throughout the process.

In what may be termed as the "reconstruction" phase, the "miracle question"[4] or variations of it can be a powerful tool in helping high conflict parents to envision what would be different or change in a future time with regards to their co-parenting relations and other situations that they have identified as problematic. The coordinator/coach might make reference to specific goals that have been already established (particularly important in parenting coordination) or to particular problematic situations involving co-parenting practices. This exercise is undertaken with each parent, their respective lawyers, and the children with the aim of highlighting, in subsequent sessions and written reports, those visions for change that are shared and that are expected to contribute to a more desirable future and family narrative.

3. The children are usually seen at the beginning of the process and normally after the initial interviews with the parents unless otherwise indicated. While some professionals choose to have minimal contact with the children involved, the prevalent practice is that PC (as well as CPC) is a child focused service and, as such, it is important for the coordinator/coach to meet with the children and obtain firsthand knowledge as to their needs

and wishes (Kelly, 2014; Carter, 2010). The scheduling of interviews can consist of an initial interview with the children alone and/or with their parents unless there is indication that such a joint interview would not be in their best interest.

Subsequent meetings can be scheduled at the coordinator/coach's discretion to gather more information or in response to a particular situation. Interviews should be held in a comfortable environment with toys, drawing material and a chart on which the children can draw. One parent can be asked to bring the children and the other parent can pick them up at the end of the meeting. This arrangement reinforces the fact that the parents are collaborating and will also allow the coordinator/coach to use the experience to highlight how they continue to be available for their children. In the interview, children are made to feel comfortable and told that what they say will not be disclosed to their parents unless they allow disclosure or that they are considered to be at risk by what is revealed. Children tend to be eager to talk and only need a little prodding:

- Children[5] are asked to relate 'their family story' (family narrative) and what brought them to the present situation.
- Questions should be simple, open and posed from the general to the specific.
- Children are encouraged to provide their own ideas as to what needs to happen in order for their situation to improve. A variation of the miracle question is used so that it can be easily understood and answered (see Appendix A).
- Following the individual interviews, parents are usually seen together at the office with or without the presence of the children and at predetermined intervals.

4. In parenting coordination as well as in co-parenting coaching, it is desirable, when possible, to conduct, at some determined point in the future, one or more family meetings that include the parents with their children and, when possible, with other significant family members. These family encounters provide a good occasion for the coordinator/coach to discuss with everyone present the progress being made with regards to the goals (or more accurately, the solutions) that were identified at the onset of the service and re-visit their family story whose script has been evolving and changing, hopefully for the better.

Prior to each session, the parents are asked about "pre-session changes" (Beyebach, Rodriguez, Palenzuela, & Rodriguez-Arias, 1996) that have occurred since the last time they were seen. It is surprising how parents can often become engaged in between-session activities that can bring about real change (De Shazer, 1985). The emphasis here is on having them relate what has changed (spontaneously or by design) that is considered positive

and "going in the right direction." These events are inscribed in the session summary that is subsequently sent to both parents as part of the written feedback (see Appendix B) that figures so prominently in both a solution-focused and narrative approach.

Session summaries

Providing written feedback to clients whether in the form of letters, synopsis, or summaries of sessions is frequently utilized by therapist with the aim of clarifying, motivating and reinforcing the work done in session. In family narrative and solution-focused therapy, this technique is often used to help externalize the problem and re-author the clients' experience leading to more desirable change (Berg, 2005; De Shazer, 1985; White & Epston, 1990).

In working with high conflict families, the coordinator/coach can make use of carefully worded summaries of conjoint meetings between the parents to highlight the progress being made as well as maintain a focus on the identified solutions and desired outcomes of the work being undertaken. These summaries can also provide an excellent way of ensuring continuity with regards to the content and process from session to session over a lengthy period of time. As demonstrated in Appendix B, the manner in which it is structured is consonant with a solution oriented and future directed approach that reinforces progress toward a more desirable outcome. Of equal importance is the fact that it highlights collaboration and mutual decision-making as opposed to the problems and disagreements that have given rise to previous high conflict behavior. In a very concrete way, these summaries contribute to the coordinator/coach's goal of helping parents focus on solutions and envision and create a more positive script for themselves and their children.

Conclusion

Working with high conflict families in a post separation and divorce situation poses certain challenges to professionals that do not necessarily present themselves when conflict is low or negligible between parents (Coates et al., 2003; Garrity & Baris, 1994) and when proceedings before the courts are not hotly contested. In most instances, these parents are not customers or even visitors in solution focus terms (De Shazer, 1985), but reluctant participants who are generally not eager or willing to engage in resolving their fight. For many, it is a process that is imposed on them either by a judge who has reached his/her wits end or as a last alternative to continued litigation exacting an unbearable financial and emotional cost. As well, issues related to mental health and psychological functioning and well-being can compound the difficulties and present further challenges to the coordinator/coach. At the same time, these parents, generally, are looking for a better way of doing things and a better

future for themselves and their children. While they often have not adequately taken stock of how their actions have impacted their family story, it is rare for any of these parents caught in high conflict to not envision a more positive script and outcome or be indifferent to the family legacy that they will leave to their children. It is generally assumed that most would not relish the thought that their progeny might feel shame or resentment in what they did or did not do in their parenting roles. Helping co-parents find more constructive and viable ways of relating to each other, of searching for solutions and a better way of doing things, of creating a family legacy that they and their children can be proud of are, after all, primary goals of parenting coordination and co-parenting coaching.

The use of techniques inspired from interventions predicated on finding solutions or creating a more positive family narrative seem, therefore, a good fit in any effort to help high conflict parents improve relations between themselves and with their children and embark on a more positive post separation and divorce path. To be sure, many who practice solution-focused or family narrative therapy will tend to see our efforts as perhaps 'cherry picking' those techniques that are most useful and that we can integrate in our model of practice. As Chang and Nyland (2013) have argued, however, most practitioners tend to broaden their theoretical influences and incorporate ideas from many sources that are outside of their field of expertise. Theoretical purity is often eschewed in favor of innovation and a desire to use those techniques that can best respond to the needs of the clients being served. Furthermore, it should be stressed that interventions made in PC and CPC are technically not considered to be therapy but rather, as we have previously mentioned, consist more of a multi-modal approach that can make use of a therapeutic approach as well as many other modalities of practice (Hayes, Grady, & Brantley, 2012).

As we have attempted to demonstrate, the use of solution-focused and family narrative approaches can be effective interventions that can complement many other techniques used in working with high conflict families. Furthermore, it should be emphasized that while both solution-focused and narrative family therapy are widely accepted and validated therapeutic approaches in working with individuals and families, the same cannot be said with regards to using these same techniques in high conflict post separation situations. As such, further research needs to be undertaken that will not only fine tune the techniques utilized, but also provide more practice based evidence that using such an orientation will greatly enhance our work in helping parents and children transition to more normal and less conflicted family relations. Refining those techniques that the coordinator/coach can effectively use to empower high conflict parents to find their own solutions and re-author their own family narrative while respecting a court mandate that might require a PC to be more directive and even assume the role of an arbitrator continues to be a challenge to practitioners and a focus for further research.

Notes

1. Baris et al. (2000) created five levels of conflict from minimal to severe.
2. Although there are some fundamental differences between PC and CPC with regard to the mandate and length of service, contractual obligations and issues related to confidentiality and disclosure, they, nevertheless share many common goals and modalities of intervention as well as circumstances leading to the referral for service as previously outlined.
3. Other information is also obtained by consulting the legal file or reports submitted.
4. The miracle question can be posed differently especially when there might be objections to its formulations based on religious convictions or when it is too confusing (e.g., with young children).
5. All children 14 years or older must give their consent before they are seen. Very young children are not interviewed but seen in a family context with their siblings and parents.

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Appendix A. PC/CPC process and interview strategies that focus on a solution and family narrative approach.

PC/CPC phases	Goals and strategies	Process	Interventions with parents, children and other professionals involved
Referral process and data collection	• A file is opened and an initial screening of the referral is made. • Become familiar with family composition and dynamics in preparation for initial contact with clients. • Establish link with the lawyers involved and obtain their input as to what needs to happen (optional for CPC). • Make initial telephone contact with each parent to set a first appointment.	• Clients are usually referred by a presiding judge or they can be referred by lawyers. Parents can also request PC or CPC services themselves. • Gather information from court files, client assessments, reports and administered parent questionnaires (if any). • Interview legal representatives and solicit their input as to what has and is creating difficulties for the family and what they consider needs to change. Questions are solution focused and are aimed to elicit their perceptions of the family story. • An initial assessment is made with regards to family dynamics and interaction as well as the level and nature of the conflict from documents received and discussion with attorneys. • Lawyers should be contacted (optional for CPC) prior to the first meeting with parents. In exceptional situations, they may also be invited to accompany their clients. • The PC/CPC will set the first appointment with each parent individually.	• Interviews with lawyers representing the parents and children: It is important to establish a good working relationship with these legal representatives and to have a good sense of how they view the problem and, more importantly, what they consider to be possible solutions, knowing their clients best. • Legal representations are asked to give their opinion: 1. "Tell me, from your perspective, what has happened for your client to require (or judge to have mandated) our services?" 2. "If our PC/CPC services were to be successful in helping your client cope more effectively with his/her situation, what changes would you consider important to the present situation?" 3. "Knowing your client what are his best chances of moving forward and what would we need to take into consideration?" • Call and set the time and agenda for the first individual face-to-face interview with each parent.
Initial contact and interview with each parent	• Establish rapport with parents as well as goals to be attained. • Identify the parenting plan or judgement that is to be applied.	• Parents are seen individually. • PC/CPC clarifies ground rules, complaint and termination procedures as well as decision making process.	• Introduction: The PC establishes rapport with the parents and makes them feel at ease and welcomed. He asks about their life situation and shares information about himself and the service.

(*Continued*)

Appendix A. Continued.

PC/CPC phases	Goals and strategies	Process	Interventions with parents, children and other professionals involved
	• Obtain consent from parents and have them sign the PC/CPC contract and other appropriate forms. • PC/CPC attempts to get a better understanding of the family history and family dynamics (relations between the parents and those involving the parent and their children), level of conflict, and the needs and goals of each member of the family. • Determine the modality of interventions, scheduling and frequency of appointments. For CP services, long term intervention is suggested (typically 1 1/2 years) taking into account the court mandate, challenges and needs presented. • Conduct a domestic violence screening with each parent to determine if special measures are needed to ensure safety and to comply with any restraining order issued by the court.	• Parents sign the PC/CPC contract and any necessary authorizations so that the PC/CPC has access to any relevant documents (e.g., psychological reports, psychosocial evaluation, restraining orders, etc.) • The parents are asked to talk about their family history by posing specific questions that will help to highlight their perceptions and understanding of what has and is happening in their family. • PC/CPC asks the parent specific questions that focus on what changes are needed to attain the desired goals and improve family functioning (e.g., miracle question, searching for exceptions, and scaling). • Conduct domestic violence screening using appropriate tools designed for that purpose. • The PC schedules future meetings with both parents as well as with their children.	• Situate the parent's circumstances and concerns: Allow each parent to briefly relate their story and perception of the problem as well as the needs of their children. Look for exceptions to the problems presented and help them re-focus on when things were better, even if slightly. *"I'm curious to know what are the circumstances that brought you here? Was there a time when things were better between you?"* • Focus on future course of action and possible solutions: PC/CPC encourages parents to project how their situation as co-parents can be better. List these items highlighting those that they hold in common. *"If our work together were to be successful, what would change or be different with regard to your relations with your co-parent and children? What would the parenting plan look like? How would you be making decisions about your children?"* • Establish a starting point to bring about these changes: Quite often these parents are used to being in a conflict mode and are skeptical or mistrustful of any proposed change. It is important to start small and at the speed that they are willing and able to move forward. *"What would indicate to you that we are making progress? What small step do you think is possible to take that would push us toward a more hopeful future?"* • They are also asked to measure on a scale of one to ten (ten being the highest) the extent to which they are able to function as co-parents (collaboration, implementing parenting plan and ability to make decisions together). *"On a scale from one to ten (ten being the highest) where would you place the effectiveness of your co-parenting relationship with regards to collaborating together; making joint decisions about your children; able to implement your parenting plan."*

(*Continued*)

Appendix A. Continued.

PC/CPC phases	Goals and strategies	Process	Interventions with parents, children and other professionals involved
Interview with the children	• Give children an opportunity to voice their views about the family transition and offer their own solutions to make things better. • Have children recount their family story.	• The children are seen after obtaining consent from both parents. • Utilize open questions and the "free-narrative" recounting of their family story by using: (a) simple language, (b) absence of specific details or coercive techniques, (c) flexibility on the part of the interviewee to choose what details will be reported, and (d) encouragement of an elaborate response (Powell & Snow, 2007). • Pose the miracle question and have them note on a poster board what they feel would be different.	• Engage the children in a conversation about their experience: "Tell me how you have experienced family life since your parents separated?" "Were things different or better before that?" • The children are then asked to consider re-scripting their family story. "How would things be like if the relationship between your parents improved?" *"What would be different?" What would change?" "How will you know that a change has taken place?"*
Joint interview with parents	• The parents are seen together usually after they are seen individually. It can also be decided that they are initially seen together, in which case the individual interview protocol is used. • The aim is to connect with both parents to make them feel comfortable and secure. • The parents sign the PC/CPC contract and all necessary consent forms such that the coordinator/coach has access to relevant documents (e.g., psychological reports, psychosocial assessments, restraining orders, etc.). • Focus attention on the family story the parents presented.	• The coordinator/coach acknowledges how difficult it is to meet together and thanks parents for coming. • The responses to the miracle question that were submitted by both parents are presented to them for discussion. This exercise is important because it will combine all of the changes that the co-parents feel need to be made. The new list becomes a plan for change.	• Pre-emptive statements are meant to engage the parents in a difficult process: "*I appreciate the fact that both of you are together here in my office; I guess this must be stressful for you as the last time you met was probably at court."* • Parameters are also set for the work ahead: *The last time we met individually, we discussed coordination parenting (or coaching) service that I can provide as coordinator." Go over basic rules and sign the contract.* • Explore their willingness to look at possible solutions – *"I am very happy that you have both agreed to work together to find solutions to problems that have persisted for a long time in your co-parenting relationship. In our last individual meetings, I asked you to envision a future where your co-parenting relationship would be better and more functional: Here is a list of what you mentioned could be different or change:…."* • The parents are asked if there have been any changes since the last individual meetings; if any, they are recorded. • Scaling exercise is repeated and compared to previous answers. Discussion on what needs to be done for them to attain the next step. • The family story is re-visited and possible new and more positive scripts discussed.

Appendix B

Session summary in parenting coordination and co-parenting coaching Practice

Summary of Parent Coordination/Co-Parenting Coaching Session

Held on _____

Between _____

In a meeting held with _____, parenting coordinator/co-parenting coach, they have discussed the following issues and concerns and have tentatively agreed on several points which they will make every effort to implement in the best interest of the minor children:

Progress and change taking place in their children's best interest since the last meeting:

Issues and concerns discussed:

Both parents expressed agreement on the following points:

Items left for future discussion:

Changes identified by both parents to help normalize family relations:

When both parents were asked, in previous meetings, what would change or be different if their co-parenting relationship would normalize and would better respond to their children's needs, Father and, Mother stated that:

Next meeting will take place on _____

Submitted by _____

Date _____

N.B.

Appendix B is not intended as a verbatim account of the meeting held between the two parents, but rather it is a summary made by the PC of proceedings and decisions taken by the parents in the best interest of their minor child and to be of use by the co-parents and the PCCPC. It is agreed by both parties that this document while it may be shared with their respective lawyers, is not to be used in any future court proceeding or litigation.