

Directed Co-Parenting Intervention: Conducting Child-Centered Interventions in Parallel With Highly Conflicted Co-Parents

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Children exposed to co-parents' conflict commonly experience distress and dysfunction. When various therapies and psychoeducational programs fail to adequately resolve this conflict, co-parents are left to bring their disputes into an overburdened and adversarial court system. Directed co-parenting intervention (DCI) offers a new approach to assisting conflicted caregivers to better meet their children's needs. DCI intends to (re)establish consistent, child-centered structures within and between the caregiving environments through parallel interventions in order to relieve the children's emotional burden and keep the family system out of court. DCI is most appropriate for intractably conflicted co-parents with a history of failed conjoint interventions. Counterindications for this intervention and directions for future empirical study are discussed.

When co-parents are in conflict, children are at risk for serious and lasting emotional harm (Amato, 2001; Hetherington & Stanley-Hagan, 1999; Kelly, 1998, 2000; Long, Forehand, & Brody, 1987; Pruett & Pruett, 1998). This risk is increased exponentially when children are triangulated into their parents' conflict (Amato, 2000; Amato & Fowler, 2002; Buchanan, Maccoby, & Dornbusch, 1991, 1996; Kelly & Lamb, 2000; Whiteside, 1996; Whiteside & Becker, 2000). Recognizing the impact of co-parental conflict on children mandates that child-centered mental health professionals consider the child-patient in the context of his or her family, taking care to allow that environmental factors, including co-parental conflict, can create symptoms otherwise easily mistaken for individual and/or biologically determined illnesses (Garber, 2001). For this reason, clinicians must have close at hand an arsenal of interventions intended not only to respond directly to the child's distress, but also to the presumed causes of that distress, in many instances the co-parents' conflict.

With this in mind, the clinician who accepts a child in individual psychotherapy without addressing accompanying conflicted co-parenting may not only be missing a critical opportunity to resolve those matters causing the child's distress (Bryner, 2001; Garber, 2001)¹ but also risks doing damage by implicitly confirming that the child is the problem (Roseby & Johnston, 1998). While individual (and sibling) cognitive-behavioral and supportive interventions may be useful and even necessary for the child(ren) (Garber, 1994), there are many instances in which a successful co-parenting intervention may

be at least a necessary adjunct if not a sufficient substitute in the service of the child's well-being (Bryner, 2001).

At present, conflicted co-parents who either (a) recognize the damage that they are doing to their children and therefore seek services or (b) are court mandated to seek services typically face a very limited menu of interventions. Some examples of these interventions are as follows.

1. Group divorce orientation-educational programs are available for or required of divorcing parents in many states (Geelhoed, Blaisure, & Geasler, 2001). These time-limited, generic seminars (e.g., Pedro-Carroll, Nakhnikian, & Montes, 2001) have met with mixed reviews (Doolittle & Deutsch, 1999; Johnston, 1999), and, unfortunately, they are generally unavailable to conflicted parents who never married and those who married but stay together or separate without divorce.

2. Individual psychotherapy can provide invaluable support, perspective, and catharsis to a parent engaged in intractable conflict, but it is generally not intended to help the conflicted relationship toward resolution, nor is it likely to be successful in doing so (Doolittle & Deutsch, 1999).

3. Conjoint therapies (marital therapy, couples' therapy, and postdivorce couples' therapy) are generally feelings-oriented interventions with the goal of improving the relationship, sometimes toward reunification. These affect-driven interventions can offer tremendous value to the participants and, therefore, to their children when they can be tolerated. However, highly conflicted parties are also highly defensive. For these individuals, the prospect of revealing emotions in front of an estranged co-parent can be highly threatening and therefore unacceptable (Campbell, 1993), obviating the possibility of positive change in this venue.

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¹ Bryner's (2001) literature review confirmed that "counseling children individually is considered a last resort, appropriate only when the parents cannot or will not participate" (p. 181). For want of alternatives, he added that group therapy may be the most effective intervention for children of divorce.

4. Mediation (marital, postseparation, or postdivorce and many forms of alternative dispute resolution [ADR]²), as an alternative intervention for highly conflicted co-parents, seeks to impose the (presumably) less emotional processes of compromise and negotiation for the purpose of specific dispute resolution. States vary in the use and purposes of mediation (Tondo, Coronel, & Drucker, 2001). Mediated outcomes have demonstrable long-term benefits relative to comparable court-mandated outcomes (Beck & Sales, 2000; Emery, Laumann-Billings, Waldron, Sbarra, & Dillon, 2001), although efficacy among highly conflicted co-parents is far more questionable (Doolittle & Deutsch, 1999; Ratner, 2001). Mediation, however, lacks an informed child-centered focus. It seeks to find common ground between the two disputing adults' positions, neither of which necessarily represents the child's best interests.

5. A final example involves use of a court-appointed parenting coordinator (special master, special advocate, or child access monitor; Association of Family and Conciliation Courts, 2003; Baris et al., 2000). Although titles and duties vary by state, these professionals are effectively mediator-arbiters assigned to divorcing caregivers for a time-limited period, primarily for the purposes of (a) resolving visitation-related issues, (b) establishing structures better suited to children's needs, and (c) minimizing court time. In some instances (e.g., see Ho, Monaco, & Rosen, 1999), the parenting coordinator is a state-licensed mental health professional charged with establishing visitation schedules and compliance and forestalling parental alienation, as it may impede visitation.

What Is Directed Co-Parenting Intervention?

Directed co-parenting intervention (DCI) exists as a distinct sixth option, one that is most useful when some combination of these other interventions has failed or proven necessary but not sufficient toward the goal of trying to manage the situation in the child's best interests outside of the court system. DCI is a directed, child-centered, and time-limited exercise intended to create consistent child-centered caregiving structures (boundaries, limits, and routines) within and between the child(ren)'s separate caregiving environments. DCI emphasizes each co-parent's responsibility to the child(ren), directing each caregiver, through coaching and education and with the support of collateral therapies, to implement specific, individually determined caregiving structures and practices in parallel with the other caregivers such that the child's experience of consistency across environments is maximized.

The present article defines the DCI model, emphasizing the critical value of the consistency of parenting structures across caregiving environments. Case examples are offered as illustrations of the process and its pitfalls and successes.

Goals and Philosophy

DCI works to establish child-specific, concrete parenting structures within and between a child's multiple environments, reinforcing each caregiver's responsibility for his or her respective environment and for the child's well-being in that environment while simultaneously limiting any caregiver's efforts to impose control outside of his or her environment. Consistency of caregiving structures is taken here as a secondary goal to the more desirable genuine cessation of co-parenting conflict. Because DCI

participants are typically those caregivers who have proven, time and again, to be unable to set aside their conflict and work together in their child(ren)'s best interests, establishment of consistency through a structured parallel process is accepted here as the next best thing. Indeed, it has continually been shown that increased stability, predictability, and familiarity within and between environments decrease anxiety (Fiese et al., 2002; Guidubaldi, Clem-inshaw, Perry, Natasi, & Lightel, 1986; Henry & Lovelace, 1995; Wolchik et al., 2000).

Philosophically, DCI seeks to establish clear boundaries between reconstituted family groups, diminishing the either-or competitive mentality familiar in some postseparation conflicts and the enmeshed, undifferentiated mentality familiar in others. In this regard, DCI seeks to communicate to the participant-caregivers—and, through them, to their triangulated children—that there are now two (or more) distinct families, Ahrons's (1994) "binuclear" family.

DCI is not emotion driven, expressive, or in search of insight, and in this sense it may not qualify as a form of psychotherapy. Participant-caregivers' natural and expected emotions are redirected to adjunct contemporaneous therapies, necessary practical complements to DCI and an important model of the boundary setting inherent in the process. As a directed, cognitive-behavioral intervention, however, DCI may be considered a psychotherapy on par with other cognitive-behavioral interventions (Dobson, 2002).

DCI does not seek to improve the relationship between the caregiver-participants, although the experience of improved consistency of child care and the associated reduction and even cessation of conflict do sometimes spontaneously regenerate mutual respect. Nor does DCI seek to achieve balance between disputing parties, to compromise or negotiate in the sense of the quid pro quo exchange most typical of mediation. In this regard, DCI requires that caregiver-participants endorse the facilitator's neutrality and expertise and, in so doing, allow that consistent child-centered co-parenting structures must be established in the child(ren)'s best interests.

DCI proceeds from three basic assumptions. The first of these rests in respecting each participant's capacity for caregiving, genuine love for the child(ren), and desire to meet the child(ren)'s needs. The DCI facilitator must acknowledge that, outside of the co-parental conflict, the participant-caregivers are often successful, mature, and able adults and that the co-parental conflict represents *superego lacunae*, holes in an otherwise intact intra- and interpersonal tapestry of adaptive functioning.

Second, DCI assumes that firm and consistent co-parenting structures are associated with a child's healthy and adaptive social and emotional development (Fiese et al., 2002; Olson & Haynes, 1993; Portes, Howell, Brown, & Eichenberger, 1992; Wolchik et al., 2000). When children are drawn into their parents' conflict, these structures are often and easily compromised (Pett, Lang, & Chandler, 1992). DCI posits that the failure of these structures contributes to the enormous social, emotional, developmental, and academic dysfunction commonly observed among children trian-

² Note the movement among some family law attorneys toward a process known as collaborative law or collaborative divorce (Tesler, 1999), in which conflicted parties attempt to work together to avoid the otherwise inherently adversarial nature of the legal system.

gulated into their parents' conflict (Amato, 2000; Amato & Fowler, 2002; Buchanan et al., 1991, 1996; Kelly & Lamb, 2000; Whiteside, 1996; Whiteside & Becker, 2000) and that (re)establishment of healthy and appropriate structures can contribute to a relief of this dysfunction and distress (Brody & Flor, 1997; Guidubaldi et al., 1986; Henry & Lovelace, 1995).

Caregiving structures are considered those practices that serve to psychologically and physically *contain* the child, in the form of physical and interpersonal boundaries, behavioral limits and associated consequences, and routines. For these purposes, a boundary refers to the physical structures that define space; a limit refers to behavioral expectations and the associated consequences for compliance and noncompliance, with the emphasis placed on positive consequences whenever possible; and a routine refers to predictable sequences of events across time, often illustrated in the form of "A then B then C."

Metaphorically, DCI proposes that co-parents (without regard for gender, generation, emotional relationship, or legal status) have a responsibility to cast a net within which the children are safe and secure, one that is appropriate to their individual developmental, psychological, educational, and medical needs. The purpose of DCI is to assess and repair the relative strengths and weaknesses of this net within and between caregiving environments for the purpose of identifying and repairing the holes through which the children would otherwise fall, insecure and in emotional upheaval, and the tangle in which children become so easily enmeshed. Although this work is perhaps most efficiently done cooperatively, DCI rests on the belief that similar successes can be achieved in parallel.

Third, DCI assumes that participant-caregivers are unable to resolve their conflict and that, in fact, continuing interventions aimed at mutual resolution may be aggravating the situation. Instead, DCI seeks to establish separate but complementary healthy and child-centered caregiving environments. The emphasis is on minimizing the necessary interface between the two or more caregiving environments while maximizing their similarities. This outcome is achieved by the DCI facilitator in work with the co-parents, together as possible but most often in parallel, conducting what one participant-caregiver referred to as "Kissengeresque shuttle diplomacy."

The Facilitator

The professional conducting DCI is a child-centered research-practitioner current in contemporary areas of relevant assessment, law, practice, and ethics; child and family development; and empirical research on divorce, family and child adjustment, psychopathology, domestic violence, abuse, and addictions. Relevant, too, is a working knowledge of schools and education, the court system, physical health and disability, and myriad linguistic, religious, and cultural issues that bear upon the families in question.

The DCI facilitator is experienced in working with high-conflict families. He or she is able and willing to wade into entrenched conflict in a calm, focused, and assertive manner while never succumbing to the urge to become authoritarian or condescending. The DCI facilitator is able to tolerate ambiguity while maintaining the highest standards, objectivity, and goal orientation; able to apply his or her expertise flexibly and creatively; and able to

follow up consistently and model healthy limits, boundaries, and routines to the participant-caregivers.

DCI is not about determining who is right and who is wrong, except to the extent that a given child's needs are met, and it is not about settling long-standing conflicts. Thus, the DCI therapist must be able to establish a forward-looking, constructive, and child-centered agenda despite what often and easily becomes an undertow of manipulation, anger, and shifting alliances.

The DCI therapist brings to the fore an exclusive focus on better meeting the child(ren)'s needs. This is accomplished through (a) assessment of the child(ren)'s specific social, emotional, physical, educational, and developmental strengths and weaknesses, using collateral assessments whenever possible and direct observation as necessary; (b) assessment of the resources available to the child(ren) in each caregiving environment; and (c) establishment of child-specific boundaries, limits, and routines in the two or more caregiving environments in parallel.

The Participant-Caregivers

Candidates for DCI are those caregivers who share a functional responsibility to one or more children. Candidates routinely have proven unable to co-parent in a child-centered and cooperative manner despite numerous prior interventions. As individuals, participant-caregivers are often competent and successful in their work and in their communities but are unable to apply these skills to the co-parenting relationship.

Candidates are most often referred through the court system in an effort to avoid settling child-centered matters through litigation exclusively. In the course of the development of this model, approximately 50% of referrals were received from guardians *ad litem*; 25% were referred directly from the bench, most typically in the interim between establishment of temporary and final custody orders; and the remaining 25% were received from attorneys familiar with this work, from litigants themselves, and from a local mediation service, in that order of frequency.

Participant-caregivers are not defined by their biological or legal relationship to the child(ren) or by their gender, age, or generation. Instead, an individual's day-to-day functional role in the child's life defines his or her qualifications as a participant-caregiver. Regular participation in a child's bedtime or wake-up routine, personal care, meals, or discipline may be sufficient regardless of the frequency or schedule of such involvement. This means that DCI often includes separated biological parents (regardless of legal status), their significant others, their own parents, their roommates, and, on occasion, their neighbors, their children's teachers and coaches, and their religious advisors.

In defining the co-parenting team this broadly, DCI seeks to cast the widest possible net of consistency within which a child can be held. This does not, however, mandate that all participant-caregivers are regularly invited to all meetings. Instead, subgroups are defined representing separate caregiving environments and interviewed apart, as, for example, when the biological mother and her new husband are seen in one meeting while the biological father, his girlfriend, and his mother and father are seen in a separate meeting.

The practical demands of working in parallel with the entire co-parenting system can require that DCI interviews be conducted outside of the office. Co-parents can be seen in their home.

Educators can be seen at school. This facilitates both valid assessment and practical implementation of the recommended co-parenting structures in each environment, even though it may challenge some providers' models of intervention.

DCI offers the advantage that allegations and/or findings of spousal violence need not disqualify potential participant-caregivers. Because DCI can be conducted entirely in parallel, the real or perceived threat that makes other interventions impossible can be circumvented. Given that children exposed to co-parental violence can be so significantly harmed (Jaffe & Geffner, 1998), the benefit due these children from any resulting decrease in tensions, reduction of alienation, and improvement in caregiver consistency can be rewarding and dramatic.

Although DCI can be of great value when interparental conflict is high, it offers little when one or more primary caregivers are unreliable or unsafe for reasons of florid psychosis or other debilitating psychiatric disorders, active substance abuse and related addictive disorders, and/or concerns about child abuse or neglect. These caregivers and their children's needs are best redirected to other types of intervention, most often through the legal system.

Conducting DCI

The process of DCI, from the first telephone contact through termination, is conducted in six stages. These stages are described in the sections to follow.

Stage 1: Modeling healthy boundaries, limits, and routines. The success of DCI relies on establishment of the boundaries, limits, and routines inherent in the process as much as it relies on the co-parents' implementation of child-centered boundaries, limits, and routines in their caregiving environments. In this way, DCI serves as both a directed intervention and a model to the participant-caregivers.

Although a majority of referrals are initiated by concerned third parties (e.g., guardians *ad litem*, counsel, or mediators), it is in the interest of empowering the caregivers and diminishing the common win-lose mentality of the courtroom for the facilitator to make preliminary phone contact with each caregiver him- or herself. Thus, referring third parties can be educated as to the process and its goals and practical requirements (e.g., cost and duration) but are then requested to have the caregivers reach the facilitator directly.

The initial telephone contact with each caregiver seeks, first and foremost, to establish that the facilitator is a child-centered mental health professional not allied with or against any party. Without addressing this question directly, participant-caregivers often carry unstated or unconscious alliances into the intervention that, left unaddressed, inevitably hobble the process (Campbell, 1992; Garber, 1994).

This same phone contact also serves to educate the caller regarding the process, goals, and practical requisites of DCI, emphasizing what DCI can do at least as much as what it cannot. Distinctions among DCI and psychotherapy, mediation/arbitration/ADR, and litigation commonly require explanation, with an emphasis on the fact that this process does not seek to mend the adult relationship. These terms are then clarified in detail in the form of a letter mailed (or, on occasion, transmitted via facsimile or e-mail) to each candidate caregiver detailing the terms of engagement.

Stage 2: Terms of engagement. DCI requires that each participant-caregiver receive, review, and return a signed copy of a letter documenting the terms under which DCI will be conducted. One such letter is provided in the Appendix as a sample.

This letter, while brief and informal, seeks to establish the boundaries, limits, and routines that will define the DCI process. This includes clarification of (a) the facilitator's qualifications, licenses, and certifications; (b) the facilitator's neutral position with regard to each participant and interest in serving the child-(ren)'s needs; (c) the participants' responsibilities to the process, including attending meetings, making payments, and following through with agreements; (d) the limitations of confidentiality, including the facilitator's relationship to counsel, the guardian *ad litem*, and the court, as appropriate; and (e) the conditions under which DCI can and will be terminated.

With this document in hand, candidate caregivers are encouraged to consult with others, including counsel and the facilitator, to clarify any questions or concerns in advance of the first interview. Preliminary experience with DCI suggests that two questions are most common and deserve early attention. First among these are questions of payment. Although managed health care has arguably complicated the typical mental health provider's already ambivalent position about payment and collections, the DCI model calls for complete, matter-of-fact clarity regarding these matters in advance of the first meeting. The provider who fails to plainly address which participant is responsible for how much and when will very likely find that the intervention has failed and that he or she is caught in the middle of the co-parents' poor communication and mistrust, very much like their children.

Another common question is the extent to which plans established in DCI may subsequently be binding in court. In fact, unless the facilitator has been specifically empowered by the court, outcomes may very well be subject to legal review. Above and beyond this factual answer, the question must raise discussion as to the candidate caregiver's endorsement of the DCI process and the possibility that the individual is, in fact, shopping for a venue that might validate his or her personal agenda.

The DCI facilitator must recognize that the initial telephone contact with a referring third party, subsequent phone contacts with the candidate participants, mailing out and awaiting the return of engagement letters, and fielding interim queries are usually both time consuming and unreimbursed. The nature of the process mitigates against assigning these preliminary steps to office staff, in that endorsement of the facilitator's neutrality and child-centered expertise is critical to the process. The nature of the process also mitigates against application of this model to emergency circumstances, including ego-stroking 11th-hour calls from desperate attorneys. Both the process and the caregiving goals inherent in DCI call for careful, time-intensive establishment of child-centered structures from the start to allow the greatest likelihood of later successes.

Stage 3: The initial assessment. The initial assessment involves a series of interviews intended to assess baseline structures in each caregiving environment. This is not the history and background interview process familiar to many therapists. Rather, it is similar in process and intent to the functional behavioral assessment required under the federal Individuals with Disabilities in Education Act (U.S. Department of Education, 1997) in determining a child's unique educational needs. In effect, the initial inter-

views are intended to provide the facilitator with a functional analysis of behavioral limits and consequences, boundaries, rituals, and routines and the child(ren)'s associated responses in each caregiving environment.

In practice, the initial interviews commonly require talking caregivers through the child(ren)'s typical day, highlighting common routines and points of transition (e.g., waking, bathing and toileting, meals, leaving for and returning from school, and bedtime), existing boundaries within (e.g., sleeping arrangements) and between (e.g., calls to the absent caregivers) homes, and limits (i.e., what is and is not allowed) and associated consequences (rewards and punishments) within each home. The emphasis in every instance is on identifying antecedent–behavior–consequence chains and their relative success in each home.

The entire course of the initial interviews may include two or more meetings with each caregiver or subset of caregivers, yielding a composite of the caregiving practices in each of the child(ren)'s caregiving environments. The facilitator's job in reviewing these data is to determine (a) whether such structures are child centered and appropriate to the individual child(ren)'s needs, (b) whether such structures create a desirable degree of consistency within the home, and (c) whether and how such structures are discrepant from comparable structures in the child(ren)'s other home(s).

Whenever possible, initial interviews are conducted with all co-parents present. In the relative safety and under the assertive direction provided by the facilitator, a minority of participant-caregivers can at least learn through listening to their co-parents' practices and at best use this opportunity to open a constructive and child-centered dialogue that serves the process and the children's needs thereafter. However, caregivers who are able to sit down together and engage in a facilitated exchange commonly succeed in using traditional interventions (e.g., conjoint therapies, mediation, or out-of-court settlement) and therefore never need DCI. The animosity, fear, and anger that have prevented this kind of constructive dialogue in the past will mandate separate but parallel initial caregiver interviews, either because an effort to conduct a joint co-parents' interview has failed or because the need was established from the start.

The DCI facilitator is not a referee and does not endeavor to mediate antagonistic exchanges between caregivers. Thus, the facilitator maintains the prerogative to terminate any interview whenever constructive, proactive, and child-centered movement fails. By exercising this prerogative calmly and firmly when a well-intended effort at joint exchange begins to falter, the facilitator is reinforcing the structures that define the DCI process and modeling similar structures that may be necessary in each caregiving environment.

Stage 4: Determining the child(ren)'s needs. DCI seeks not only to establish caregiving consistency within and between environments, but consistency on par with the individual child(ren)'s needs. This requires an in-depth understanding of the child(ren)'s social, emotional, medical, educational, and developmental status and operationalization of this information into caregiving practices across environments.

As one simplistic example, consider a situation involving divorced biological parents who share physical custody of their 6-year-old son. Initial interviews reveal that the mother insists on a 9 p.m. bedtime while the father allows the child to stay up until

10 p.m. While a mediated settlement might work toward establishing a 9:30 compromise bedtime in both homes, the DCI facilitator's integration of developmental expertise and information obtained from the child's pediatrician, teachers, and therapists might prompt him or her to recommend an 8 p.m. bedtime in both homes.

In some instances, determining the child(ren)'s specific needs will require direct interviews with and/or observations of the child(ren) in the office setting, classroom, and/or each of the caregiver's homes. The DCI facilitator undertakes these steps with caution, taking care that all parties are clear that this is not therapy, that this is not the beginning of an ongoing rapport, and that this does not suggest that the child is in any way at fault or the identified patient. More commonly, the DCI facilitator can avoid the potential complications and inherent expense of direct observation by relying on the records and input of collateral professionals.

Stage 5: Collateral contacts and existing assessments. Because DCI seeks to forestall litigation, participant-caregivers and children commonly have participated in multiple prior and contemporaneous assessments and therapies. Many of these resources can be incorporated into DCI to both better inform the process and minimize the time, effort, and cost imposed on the participants. In particular, it is often desirable to rely upon prior child assessments and contemporaneous child services rather than expose children who have already been triangulated into their caregivers' conflict to further intrusion.

Caregivers' mutual authorization allowing the facilitator to access a child's assessments and/or therapies can be established initially among the initial terms of engagement. Most useful to this process are those psychological, educational, developmental, medical, and related resources that identify the individual child's unique strengths and weaknesses as they might bear on determining appropriate caregiving practices.

As examples, educational records documenting that a child has a verbal–auditory processing disorder inform recommendations regarding communication within each home. Prior child therapies highlighting a child's separation issues easily inform DCI recommendations regarding transition between caregiving environments. Physician determinations about an individual child's need for more or less sleep, specific diets, and medications or medical interventions contribute to establishing appropriate, individually determined, and child-centered caregiving structures within and between homes.

By contrast, comparable professional assessments of individual caregivers and/or couples must be treated more cautiously. While assessments of individual caregivers' strengths and weaknesses can certainly bear on establishing appropriate caregiving structures in each environment, these materials can be prejudicial, at least to the extent that they were originally intended to inform contested custody matters. Particularly suspect are those materials proffered by one party about another. Because DCI assumes that individual participant-caregivers are mature and child-centered even though intractably conflicted with a co-parent, it is often sufficient to politely refuse to review such materials and rely instead on first-hand observation of the caregiver's behavior in and compliance with the DCI process.

However, a participant-caregiver's contemporaneous therapy can be an invaluable resource not in informing DCI but, rather, in

support of the caregiver's participation. These adjunct supports routinely provide participant-caregivers with the validation, perspective, and catharsis necessary to keep the DCI process child focused and proactive. Those participant-caregivers not contemporaneously engaged in their own psychotherapy are often encouraged to do so.

Stage 6: Establishing parallel and appropriate caregiving structures. The initial interview process yields a picture of the boundaries, limits, and routines in force within and between the two or more caregiving environments and the individual needs of the child(ren) residing within these structures. The course of DCI thereafter is focused on establishing consistent child-centered structures within and between environments.

The specific goals to be addressed throughout the remainder of this time-limited intervention are threefold. First priority is given to changing those caregiving structures that are ill suited to the child(ren)'s needs, most particularly any matter that the facilitator judges may compromise the child(ren)'s health or safety, whether evident in one caregiving environment or across all environments. This would include those unfortunately common inappropriate and even unsafe parenting practices that fall short of actual abuse or neglect, such as inappropriate corporal punishment and/or the use of physical restraint or excessive time-out; unnecessary and inappropriate reliance on an older sibling to care for a younger sibling, particularly when functioning as a co-parent to a single mother or father; and boundary failures around privacy, sleeping arrangements, hygiene, and personal care, particularly with teens.

Second priority is given to caregiving practices that may compromise the boundaries of the reconfigured family structure. This includes (re)establishing the boundaries and extent of each caregiver's responsibilities for the child(ren) so as to minimize the child(ren)'s experience of conflicting messages; scripting transitions between homes; establishing constructive, proactive interparental communications; and minimizing the child(ren)'s experience of being caught in the middle of co-parental conflict and of alienation.³

The third priority in establishing DCI goals involves matters of consistency between homes. Building from the premise that increased consistency between caregiving environments decreases children's anxiety, distress, and dysfunction (Brody & Flor, 1997; Guidubaldi et al., 1986; Henry & Lovelace, 1995), the DCI facilitator assists each household in shaping existing limits, boundaries, and routines toward uniformity on the basis of his or her expertise in child development and the specifics of the child(ren)'s established needs. This would typically include practices around bedtime, curfew, and wake-up; access to media, money, and valued resources; and chores, responsibilities, and privileges. Increased consistency between caregiving environments serves to decrease tension between homes and the transitional stresses migrating children otherwise face as often as one day to the next.

In working toward greater consistency, the DCI facilitator presents change in the service of the child(ren)'s needs, never in language that might describe the practices in one home as more or less favorable than the practices in the other. To take this latter approach is to participate in the implicit competition separated caregivers often experience for their children's affection and, quite possibly, in the explicit competition for custody.

Unfortunately, it is rarely the case that a point-by-point summary of caregiving recommendations is sufficient to establish

change. Instead, the facilitator's task is to use these priorities to establish an agenda and to work with the two (or more) subsets of co-parents, jointly when possible but more commonly in parallel, to implement, monitor, and modify these changes, one at a time.

For example, modifying the process of transition from one caregiver to another (a second-order priority) is a common DCI goal. Armed with the participants' respective reports about the process of transition, knowledge of the child(ren)'s needs as they might inform the transition process, and, as necessary and appropriate, direct observation or a child's first-hand report, the facilitator can proceed to script a transition routine to be practiced by all parties. As is the case with any routine, this is a sequence of words and behaviors predetermined to minimize the opportunity for conflict and maximize the child's comfort. Variables including the location and time of transition, the persons present, the child's use of transitional objects, the exchange of the child's possessions, the preceding farewell process, and the subsequent welcoming/reorienting process in the receiving home can all be manipulated to best suit the child's needs and can be modified as the process is practiced. Preliminary experience with DCI in scripting this and similar processes has shown that predetermined routines contribute to all parties' greater comfort.

As with any behavioral change, a trial and error feedback loop must be established between the facilitator and each caregiver or subset of caregivers. The DCI facilitator meets often with the participant-caregivers, usually alternating among parties, to monitor progress toward a given goal and to recommend modifications intended to improve outcomes. This requires careful record keeping and frequent communication between facilitator and co-parents, even while minimizing the need for intractably conflicted caregivers to attempt direct compromise or negotiation.

This is not to say that the facilitator serves as an intermediary between caregivers, carrying messages back and forth. Direct constructive and child-centered parent-to-parent communication must be encouraged and, indeed, may be among the first goals to be addressed. Implementation of a structured caregiver notebook, e-mail exchanges copied to the facilitator, and/or reliance on a confidential Web-based platform⁴ can lay the foundation for constructive parent-to-parent exchange, while the facilitator's role remains more similar to that of a coach working with two athletes in parallel toward the same goal, shaping each athlete's performance based on accumulated history of successes and failures to adjust the process with both. Toward these goals, participant-caregivers are encouraged to keep an objective written record of each meeting, highlighting specific plans, and to record the relevant daily events outside of meetings for subsequent discussion.

Stage 7: Terminating DCI. The course of DCI is determined in the first instance by the participants' ability to engage in a constructive, child-centered, and proactive manner. The intervention

³ It is my experience that, while the denigrating anger characteristic of co-parental alienation can seldom be diminished simply through education, establishment of child-centered caregiving structures, most particularly the boundaries between reconstituted families, is often enough to defuse all but the most malicious alienation.

⁴ The reader is directed to www.ourfamilywizard.com as one example of a confidential, Internet-based communication board that highly conflicted caregivers often find useful.

must be ended when one or more of the caregiver-participants are unable or unwilling to engage in such a manner, and they feel compelled to use this forum for little more than blaming and defensiveness, taunting, and threatening and/or they consistently fail to follow through with mutual agreements despite the facilitator's good efforts to structure and redirect. To persist under these conditions is less than constructive; it is to risk fueling the conflict by giving it an audience.

When participant-caregivers succeed in using DCI in their children's best interests, the process is subject to mutual review and renegotiation over a period determined by the facilitator. Most usually, the facilitator will recommend an epoch of between 3 and 10 meetings, intending to establish credibility through successes with a lower number of meetings early on and allowing that more difficult matters might be addressed over longer epochs later in the course of the work. At the conclusion of each epoch, progress is reviewed and the facilitator can then recommend negotiation of a subsequent sequence of meetings or termination.

A successful epoch of DCI can be as brief as three to five meetings. The process continues through negotiated epochs as long as it remains child centered and proactive and as long as specific caregiving structures remain to be addressed. DCI is not, however, a maintenance program, persisting simply for the purpose of oversight or "check-in." Once constructive, child-centered forward movement has ended, owing either to conflict or to successful implementation of consistent structures, the intervention is terminated.

When Consistency Is Inappropriate or Untenable

Despite its early clinical promise as a tool to help highly conflicted caregivers better meet their children's needs, and despite its practical and theoretical appeal, there are distinct instances in which DCI's effort to achieve greater consistency between caregiving environments is either inappropriate or impossible to achieve. Obvious instances already discussed include situations in which caregivers evidence extreme psychological dysfunction, they exhibit addictive behaviors, or they are violent, abusive, and/or neglectful.

Other, broader exceptions have emerged in clinical practice. Among these are religious and cultural differences that dictate discrepant caregiving practices. In one such instance, a father's religious beliefs and practices caused him to openly share his fears for his ex-wife's immortal soul with his children, putting them in the middle of what appeared to be a spiritually sanctioned existential alienation. In effect, the children felt compelled by their father to try to rescue their mother from certain damnation. DCI had no place in addressing either caregiver's religious beliefs. No amount of child-centered intervention could impinge upon the father's perceived religious imperative to try to save other souls or upon the mother's disbelief in the same. In this instance, litigation was necessary (although perhaps not sufficient) to grant one parent the exclusive right to determine the children's religious affiliation and to instruct the other to respect the same.

A second exception can arise around the diagnosis and treatment of a child's specific educational, developmental, physical, or psychological concern. In one instance, conflicting professional opinions left divorced parents divided over whether their son had attention deficit hyperactivity disorder and, most pointedly,

whether to medicate him. Although consistency of belief and practice remained the goal in this case, neither mediation, medical exhortation, nor DCI could influence these caregivers' diametrical opposition. This case, too, was finally settled through court assignment of exclusive medical and psychiatric care rights to one parent.

Finally, note the caregiving differences necessary and appropriate to caregivers who reside in distinctly different environments, as in the case of a city-dwelling father and rural-dwelling mother who lived several hours apart by car. While these caregivers were available and willing to work in DCI across the distance, and while adjustments of first- and second-order priority matters (safety and transition) were useful, efforts to establish consistent structures between the two homes generally made little sense even to the facilitator. Simply put, the demands of living with a large extended family on a working farm were dramatically different than the demands of living as an only child with a single working parent in an urban apartment. This intervention ended positively with the establishment of departure and reentry rituals in each home intended to minimize the child's related "culture shock."

Implications for Practitioners

To date, the menu of co-parenting interventions includes at least five approaches. This article has introduced DCI as a distinct sixth approach. DCI is a child-centered process intended to establish greater consistency of caregiving structures within and between environments even when working with intractably conflicted co-parents.

Although a variety of anecdotal reports and empirical investigations exist regarding each type of co-parenting intervention, there is as yet no report of a large-scale comparison study intended to define which individuals are most likely to benefit from a particular intervention or combination of interventions. Meta-analysis of existing data may be a place to start, but reports are likely so diverse as to severely limit the conclusions of such a study. Instead, investigators working through state judicial systems to randomly assign conflicted caregivers to each of these types of intervention, and monitoring changes in child variables (e.g., school attendance and grades, inventories of depression and anxiety, and instances of legal involvement) as a function of type of intervention, may begin to offer reliable discriminators useful in matching caregiver, dyad, and/or child variables to the most useful type of intervention.

As one such intervention, early clinical development has suggested that DCI is particularly well suited to benefiting the children of verbal and educated, child-centered and goal-directed adults who have previously proven unable to manage a more traditional and cooperative education or mediation process. DCI has succeeded with highly conflicted co-parents, either court ordered or court avoidant, without distinction for the age, gender, or number of children involved. These same preliminary impressions suggest that DCI is perhaps least appropriate and efficacious when one or more of the participant-caregivers are highly manipulative, unreliable, substance dependent, and/or abusive of the child(ren). It may also be considered inappropriate for those less severely entrenched co-parents who are able to use more cooperative and/or educational interventions to their own and their children's benefits.

Future Directions

Continuing efforts to develop DCI are focused on three areas. The first among these arises in response to the fact that children's needs change as they develop, mandating establishment of new caregiving structures within and between environments. Matters as simple as bedtime or curfew, for example, change with a child's changing needs and maturity in the usual course of development. In the absence of co-parent communication and cooperation, however, spontaneous and flexible adjustment of caregiving structures can be almost impossible. In the absence of trust, rigidity prevails. For this reason, DCI successes can seem short-lived. Present efforts are exploring whether (a) an initial DCI success can establish the precedent necessary to allow co-parents to work better together in the future; (b) an initial DCI success can set the precedent for subsequent success in more cooperative, mediated interventions; or (c) periodic DCI "booster" sessions must be made available as the child develops and as the need arises.

A second area of inquiry concerns application of the general principles inherent in the DCI safety net philosophy within school environments, and between school environments and homes, especially with special needs students. Preliminary observations of the needs of attention-disordered and autistic students suggest that improved consistency of structures within and between classes, as well as between school and home, may decrease the need for other, more intense and expensive special education interventions and for adjunct behavioral and psychological services.

Finally, perhaps of greatest interest is an effort to introduce the DCI emphasis on consistency of caregiving structures to intact high-risk families as a form of primary prevention/education. To date, small group education and co-parent training sessions focused on establishing and consistently maintaining child-centered limits, boundaries, and routines have been well received. Future plans to include a placebo control group are predicted to demonstrate the value of this model in optimizing child outcomes and quite possibly in minimizing the frequency and severity of co-parental conflict.

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Appendix

Sample Directed Co-Parenting Intervention Terms of Engagement

Dear Mr. Smith and Ms. Smith,

I am writing to follow up on our respective exchanges by phone and in order to clarify the conditions under which we might work together:

1. We have discussed beginning a directed co-parenting intervention (DCI) together. DCI is a child-centered process directed by an expert in child development and family functioning for the purposes of improving the consistency of child care practices within and between your child(ren)'s separate homes.
2. DCI should not be confused with psychotherapy, mediation, or litigation. Our work together will not be focused on you, your needs, or your postdivorce relationship with the child(ren)'s other parent(s). Our effort will be, first, to assess your child(ren)'s social and emotional strengths and weaknesses and, second, to help each of you establish caregiving conditions and practices that better serve your child(ren)'s unique needs.
3. I am a state-licensed psychologist with a special interest in responding to the needs of children and highly conflicted families. I am not an attorney, a state-certified mediator, or a guardian *ad litem*. My role in DCI will be to direct the changes within and between your homes in order to better meet your child(ren)'s needs. I can only do so to the extent that all parties acknowledge that I am entirely neutral to the adult conflict and any continuing litigation.
4. Your role is not only as the child(ren)'s parent, but as a responsible co-parent to your child(ren)'s other caregiver(s). You will be responsible to arrive for DCI meetings as scheduled, to follow through with assigned tasks or homework, to participate constructively in this process, to pay for services as described below, and to put your child(ren)'s needs first in all instances.
5. I value the participation of any adult who provides care to your child(ren) and reserve the right to invite these caregivers, regardless of age, gender, generation, and legal relationship to the child, to participate in this process.
6. Our first meeting is scheduled for _____, in my office. The purpose of this meeting is to establish specific goals which will inform the entire course of our work together.
7. Although I prefer to work with all co-parents together at once, I will schedule separate, parallel meetings whenever necessary in the interest of working more effectively toward these goals.
8. I reserve the right to discontinue any individual meeting at any time that I judge we have ceased to work together in a constructive, proactive manner. Should a meeting be prematurely concluded, the full fee will still be due.
9. I reserve the right to conclude our work together in its entirety should I judge that the participants are not complying with these terms and/or working together constructively. Should it be necessary to terminate this process prematurely, I will provide a brief written explanation to all parties documenting the reasons for termination.

(Appendix continues)

10. The cost of each hour will be ____ dollars (\$____.00), due in full at the time of service. Typically, each co-parent will be responsible for half of all costs. Please clarify any concerns about expense, payment, and/or your interest in seeking insurance reimbursement with this office well in advance of our first meeting.

11. I require a minimum of twenty-four hours' advance notice of any cancellation. If either of you have reason to cancel a planned meeting, it will become your responsibility to see that the other is properly informed and that the meeting is rescheduled.

12. Except in cases of illness or severe weather, any meeting cancelled with less than twenty-four hours' notice will incur the full fee for the assigned time. I expect that the individual who fails to arrive or who abruptly cancels a meeting is responsible for the full fee.

13. As a precondition for proceeding, I will ask that each of you sign an authorization allowing me to exchange any and all relevant information with the guardian *ad litem*.

14. Because DCI is a goal-oriented process and because the conflict that brings you to DCI is likely a very emotional matter, I will recommend that each participant simultaneously participate in individual counseling or psychotherapy. This kind of adjunct support often helps participants enter each DCI meeting in as constructive a manner as possible.

15. State and federal laws require that I alert the relevant authorities any time that I fear for any individual's health or safety.

16. The caregiving decisions that we make through DCI are not automatically sanctioned by the court. You always have the right to bring any matter discussed in the course of this intervention before the court. However, your participation in DCI represents your willingness to settle child-centered matters outside of court in your child(ren)'s best interests.

17. I resist all efforts to bring this work before the court. I find that courts too often misconstrue and antagonize what is an already dysfunctional relationship. Nonetheless, in deference to your privilege to summon me to court, please be advised that my fee for all court-related matters, including deposition, travel to and from, and appearance in court, is ____ dollars (\$____.00) per hour. Should I be called to court, I will request a retainer representing all anticipated costs in advance of my appearance.

Please take the time to review these terms with your counsel, as necessary. Please feel free to contact me with any questions. Once you understand and accept these terms, please sign and date a copy of this letter to be returned to my office at the time of our first meeting. I very much look forward to working together in your child(ren)'s best interests. I am,

Respectfully,
[Provider]

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