Ethical Issues in Coparent Counseling

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Abstract

Coparent counseling is a method of helping moderate- and high-conflict divorced or separated parents improve their shared caretaking of their children. Because it is a relatively new modality, its practitioners face ambiguity and uncertainty in their efforts to practice ethically. In the present article, information and recommendations are provided regarding confidentiality, separate meetings with parents, interactions with attorneys and the court, meetings with the children, insurance billing, competence, and informed consent.

Keywords: coparent counseling, ethics, divorce, parenting, informed consent, forensic psychology

Ethical Issues in Coparent Counseling

Coparenting is "is an enterprise undertaken by two or more adults who together take on the care and upbringing of children for whom they share responsibility" (McHale & Lindahl, 2012, p. 3). This joint enterprise does not end when parents separate or divorce. Three predominant modes of coparenting by separated or divorced parents were identified by Hetherington and Kelly (2002): "cooperative coparenting," in which parents interact relatively frequently, overtly support each other, and are flexible in making and changing arrangements; "parallel coparenting," in which parents minimize their interactions and communications (Sullivan, 2008); and "conflicted coparenting," in which even minor decisions can spark fierce conflict and major ones can lead to years of litigation. Outcomes for children are poorest in conflicted coparenting and best in cooperative and parallel coparenting (Kelly, 2007). Pruett and Donsky (2012) cite four components of a strong post-divorce coparenting relationship, "(a) acting together as the 'kids' team,' (b) sharing or dividing up direct child care, (c) managing conflict about the child, and (d) feeling supported in the process of parenting." (p. 233) These authors further comment, "Effective coparents, whether spouses or former spouses, support one another's actions and decisions, make and stick to agreements about how to raise their children, and refrain as best they can from undermining each other by deviating from these agreements unilaterally." (p. 233). These healthy coparenting relationships, whether cooperative or parallel, are characterized by a reasonable degree of trust in the other parent's good intentions for the children, respect for his or her ideas and parenting practices, and a philosophy that each parent is the authority in his or her own home.

Coparent counseling is one of several modalities that assist divorced and separated parents to develop the characteristics of these more effective coparenting relationships. Although other modalities share this goal, including mediation, particularly therapeutic

mediation, (Heitler, 1990), collaborative divorce (Nurse & Thompson, 2009), and parent coordination (Coates, Deutsch, Starnes, Sullivan, & Sydik, 2004), coparent counseling is the only modality that focuses primarily on improving parents' shared caretaking of their children. Though it is in a nascent stage, authors have begun to describe its technique and rationale.

Johnston, Roseby, and Kuehnle (2009) provide the most detailed discussion of intervention strategies, under the rubric "co-parenting counseling and parent coordination." They present a theory of parental dysfunction based on the psychoanalytic concept of splitting, an inability to bring a person's positive and negative qualities together into a cohesive whole. They go on to describe a comprehensive approach which includes detailed assessment, with interviews of the children, and intensive treatment of the family lasting six months to two years. Parents are usually asked to consent that no information from the treatment will be shared with the court and to stipulate that the clinician will not be asked to testify. The child's emotional struggles in response to the parental conflict are interpreted to the parents in a non-blaming way. The clinician then provides parents with steps they can take to ameliorate the child's plight. Successive specific issues, such as disputes over schedule changes or the child's distress at exchanges, are worked through and the parents thereby learn "principles and rules for ways that situations like this have to be handled in the future." (p. 269) There are commonly one or more crises during the therapy, to which the clinician responds from a "strongly supportive, active but confrontational stance with both parents" (p. 271).

Levite and Cohen (2012) also view high-conflict dynamics as an outgrowth of splitting and other primitive defenses (relatively crude and maladaptive methods of managing distress) discussed in psychoanalytic theory. Their approach (Cohen & Levite, 2012), which they do not describe in detail, involves a therapist working individually with each parent as part of a treatment team which includes a mediator or parenting coordinator working conjointly with the

parents. The goal of therapy is to help parents to reduce their reliance on primitive defenses and thereby function better as coparents. Like Johnston, Roseby, and Kuehnle (2009), they view intense countertransference reactions on the therapist's part as an expectable aspect of treatment and a window into the child's experience. That is, these authors believe that the therapist's emotional reactions to the couple's issues may enable him or her to understand how the child is experiencing their parent's conflicts.

Eddy's (2009) "New Ways for Families" includes components intended to improve parents' shared caretaking of their children and is therefore relevant to the present discussion. Each parent is seen individually, generally for six sessions, and taught four skills felt to be necessary for successful coparenting: Flexible Thinking, Managed Emotions, Moderate Behaviors, and Checking Yourself (i.e., reminding oneself to use the other three skills in the midst of conflict). An additional counselor sees the parents and children together. Eddy broadly agrees with the above authors regarding the origin of high conflict dynamics, though he speaks principally in terms of personality disorder rather than primitive defenses and does not draw explicitly on psychoanalytic theory. Unlike coparent counseling, New Ways for Families generally ends when a basic parenting plan has been decided on.

Directed Co-Parenting Intervention (DCI) is a method of working with parents in conflict to improve their caretaking of the children Garber (2004). It focuses on parenting practices such as establishing similar rules and expectations in the two homes and avoiding distressing interactions in front of the children during exchanges. Given that the parents are typically seen in separate sessions, DCI differs from coparenting counseling as generally defined, though many of the ethical considerations in the present paper would likely apply to DCI, particularly when parents are seen conjointly.

One definitional question is whether the goal of coparent counseling is, on the one hand, to improve the parents' relationship with each other or, on the other hand, to implement their parenting plan by adding more detailed rules and structure. Sullivan (2008) argues that it is misguided and potentially harmful to attempt to move high-conflict parents into a cooperative relationship which they are unlikely to be able to achieve. Instead, he advocates helping them to disengage from each other, in part through the use of increasingly specific rules for situations that arise. Similarly, Garber (2004) does not include improvement of the parental relationship as a goal of DCI. Cohen and Levite (2012), by contrast, advocate psychoanalytic interventions directed at improving the parents' ability to relate to each other emotionally. Counselors from these different persuasions are likely to focus on different things when assessing suitability of coparent counseling for a given set of parents and progress in coparent counseling over time. However, it is unclear at this stage to what extent this is a difference of substance as opposed to one of perspective and terminology. A counselor who thinks in terms of psychology and relationship may nevertheless, in effect, be working toward disengagement and improved adherence to agreements even while understanding this change as diminished mutual projective identification (unconsciously pressuring another person to act out aspects of oneself with which one is uncomfortable) and increased recognition of the needs of the children. By the same token, a coparent counselor or parenting coordinator helping parents disengage from each other may, in so doing, help high conflict parents to reduce mutual projective identification and improve reality testing.

We suggest that coparent counseling is not appropriate for those couples with histories of intimate partner violence (IPV), with the possible exception of circumscribed, less severe histories (Jaffe, Johnston, Crooks & Bala, 2008). When there is a history of IPV, the power

imbalance can interfere with coparent counseling, and there can be safety issues for the victim and possibly the therapist (Johnston, Roseby & Kuehnle, 2009).

Coparent counseling differs from parenting coordination as typically defined (Coates et al., 2004) in that the latter includes limited judicial authority and focuses on making ongoing parenting decisions by means of a "mediation-arbitration" approach. Sullivan (2008), however, offers a model of parenting coordination that does not focus on making such decisions but instead on helping high-conflict parents to disengage from each other. Thus, some forms of parenting coordination would fall within the definition of coparent counseling provided here. [1]

The present article addresses ethical issues across these varied approaches to coparent counseling, assuming only that one counselor will work with both parents and that he or she will have no decision-making authority. Because of its implications for a number of relevant ethical issues, the first issue discussed below is the need for the counselor to develop a reasoned stance regarding whether coparent counseling is a form of psychotherapy. Then, confidentiality and related issues such as whether the counselor will have private communication with the parents are discussed. Next, ethical aspects of the interface between the coparent counselor, attorneys, and the court are considered. Competence is an ethical issue and therefore the question of what training and experience should be obtained prior to providing coparent counseling is briefly considered. Next, the question of the counselor interviewing or evaluating the children is discussed, followed by ethical issues related to insurance billing. Informed consent is the final topic addressed because its content depends on resolution of the other topics. The present paper is limited to ethical issues; that is , we do not make recommendations on technique or take a position on the definition of coparent counseling.

Is coparent counseling a form of psychotherapy?

On the one hand, some practitioners view coparent counseling as a form of psychotherapy and the nascent literature on coparent counseling tends to characterize it as psychotherapy. On the other hand, the individual counseling component of New Ways for Families (Eddy, 2009), the coaching component of collaborative practice (Nurse & Thompson, 2009), and the approach to parenting coordination described by Sullivan (2008) have elements in common with coparent counseling yet none is defined as psychotherapy. As will become evident below, a number of ethical and possibly legal consequences flow from the decision of whether a given counselor regards coparent counseling as psychotherapy. Accordingly, considerations in making this determination are discussed in the present section.

Couple therapy is thoroughly accepted as a form of psychotherapy and it is reasonable to argue that if coparent counseling is largely based on theory and interventions used in couple therapy, then coparent counseling is appropriately considered a form of psychotherapy as well. But coparent counseling bears perhaps an equally strong resemblance to interventions that are not regarded as psychotherapy. The relationship between separated or divorced parents is often compared to a business relationship (Frieman, Garon & Mandell, 1994; Ricci, 1997). When mental health professionals (MHPs) intervene to improve the relationship between business partners or coworkers, it is viewed as coaching or organizational consulting, not psychotherapy, even if the guiding theory and the interventions are drawn from psychotherapy. An additional consideration is the similarity coparent counseling often has to mediation, which is not viewed as a form of treatment. (Even therapeutic mediation [Heitler, 1990] is typically viewed as an approach to mediation rather than as a form of psychotherapy).

For these reasons, it is not clearly the case that coparent counseling is a form of psychotherapy. Counselors should take a reasoned and consistent position on this question.

Those who use explicitly therapeutic techniques such as those developed by Johnston, Roseby, and Kuehnle (2009) are on firmer ground in viewing their coparent counseling as a form of psychotherapy, whereas those whose approach has more in common with mediation or with parenting coordination are on firmer ground not viewing coparent counseling as psychotherapy.

Confidentiality

Issues of confidentiality and disclosure are well worked out for psychotherapists. Counselors who view coparent counseling as psychotherapy need to abide by these established laws and ethical principles regarding confidentiality of psychotherapy. In brief, therapists must maintain confidentiality of psychotherapy unless a specific exception applies; assert legal privilege if disclosure is requested without an explicit release of information from the clients; and follow the stated instructions of clients when they request disclosures (Campbell, Vasquez, Behnke & Kinscherff, 2010; Knapp, Younggren, VandeCreek, Harris, & Martin, 2013). Nevertheless, the pros and cons of maintaining confidentiality in coparent counseling are worthy of discussion because counselors have some latitude regarding how they handle this. First, counselors who do not view coparent counseling as psychotherapy presumably are not constrained by psychotherapy law or by ethical standards that apply only to psychotherapy. Second, the same ambiguity might arise for counselors who do view coparent counseling as psychotherapy if this characterization were to be overruled by a court. Finally, even counselors who view coparent counseling as psychotherapy can guide clients toward or away from consenting to disclosures. These counselors may even impose requirements regarding confidentiality as a condition of providing coparent counseling.

The pragmatic reasons to ensure confidentiality in psychotherapy and mediation are to increase clients' ability to speak freely (Kelly, 2004; Miller & Thelen, 1986) and to remove incentive to say things designed to make a good impression on a judge or otherwise win

advantage in some external setting. These are presumably the reasons that some coparent counselors, such as Johnston, Roseby, and Kuehnle (2009), ask clients to agree that, unless both parents and the counselor agree, no information will ever be shared with a court. On the other hand, disclosure of information from coparent counseling serves the court's need for information to make decisions in the best interest of children and may, thereby, improve outcomes for the children. In some cases, moreover, one question before the court is whether the parents will be required to continue in coparent counseling, and courts are in a poor position to make this decision if they have no information regarding what has happened in counseling so far. Moreover, given a parenting coordinator's responsibility to integrate the work of therapists for the family (Greenberg & Sullivan, 2012), it would be ethically questionable at best for a coparent counselor to attempt to avoid information-sharing with a parenting coordinator.

To an extent, the counselor's position on the confidentiality of coparent counseling may reflect his or her view of whether coparent counseling, in general or in a particular case, is a component of a therapeutic undertaking or a legal/judicial one. If the former, then maximizing confidentiality from attorneys and the courts will likely be seen as the correct course. If coparent counseling is seen as a part of the legal process, appropriate information-sharing will make the most sense. This issue is further discussed in the section below on interaction with attorneys and the court.

Requiring clients to agree that they will not disclose information from coparent counseling without the agreement of the counselor (e.g., Johnston, Roseby & Kuehnle, 2009) is ethically and legally complex. On the one hand, such a requirement may increase the effectiveness of the counseling and even, in some instances, make the difference between success and failure. On the other hand, the overall decision of whether information is confidential is generally made by policy makers through laws on privilege and the decision about

whether to disclose information from a specific therapy is generally made by the client or clients. Therefore, a counselor who imposes confidentiality is arguably usurping the prerogatives of policy makers and clients. Regarding legal basis, psychotherapy privilege would not appear to provide a basis for this practice even when counseling is considered psychotherapy because privilege is held by the patient; contract law is more likely to be applicable as a basis for such a requirement (Donner & Alban, 2010).

Couples therapists typically require consent of both members of the couple in order to reveal any information but sometimes make exceptions to this, such as disclosing information about one member of the couple to his or her individual therapist with only that member's consent. Coparent counselors should, by the same token, have a policy in place as to whether both parents' consent will be required for disclosures or whether information about one parent may be disclosed with only that parent's consent.

Counselors should develop their stance on confidentiality after consideration of the above issues. They should also, in the words of the APA Ethics Code (American Psychological Association, 2010), recognize that "the extent and limits of confidentiality may be regulated by law" (Standard 4.01). That is, despite assertions of psychotherapy privilege or signed agreements by parents, court orders or later actions by parents might nevertheless lead to disclosures. In practice, it is likely that confidentiality is best decided case-by-case, based on the above considerations, with diminished information-sharing over time as the parents grow more able to care independently for their children, no longer relying on the court or a parenting coordinator. In any event, ethical practice for the counselor is to settle on an approach to confidentiality after consideration of the relevant issues, provide clear information about his or her approach, and respect the parents' autonomy and the role of policy makers with regard to

information-sharing while nevertheless instituting a policy on confidentiality and information-sharing that permits coparent counseling to succeed.

As likely goes without saying, counselors should disclose information only to those whose professional role requires the information and should limit disclosure to information relevant to the purpose at hand (see APA, 2010, Standard 4.04; National Association of Social Workers [NASW], 2008, Standard 1.07[c]). This principle applies whether or not coparent counseling is viewed as psychotherapy.

If the counselor sees the parents in separate sessions, the question of whether he or she will keep information revealed in these sessions private from the other parent is more a clinical question than an ethical one. If the counselor sees the children in separate sessions, the same is true regarding whether the counselor will share information from these sessions with the parents, though with the legal and ethical complications attendant on withholding children's information from their parents (Knapp et al., 2013). Though clinical considerations predominate regarding information-sharing from separate contacts, an ethical principle comes into play and contributes to the decision about whether some, all, or none of the information will remain private. When separate contacts occur, there is potential blurring as to who the counselor's client is. A separate meeting establishes a kind of relationship between the counselor and that parent or child, who may feel the counselor is on his or her "side." Thus, clarity within the counselor's own mind and in his or her communication with parents and children on this question is important (APA, 2010, Standard 10.02[a]; NASW, 2008, Standard 1.06[d]). Most coparent counselors consider the primary goal of coparent counseling to be improved caretaking of the children and this goal guides all their contacts. Parents and children meeting separately with the counselor should be helped to understand that the meeting does not carry the implication that the counselor will advocate for his or her wishes or necessarily adopt his or her perspective on the situation. It may

help in conveying this aspect of the counselor's role to state that nothing from separate meetings should be assumed to be confidential and the counselor may bring the information into conjoint meetings with the parents.

Counselors' interactions with attorneys and the court

The question of whether the counselor will interact with attorneys and the court and, if so, what the nature of the interaction will be overlaps with the issue of confidentiality but extends beyond it. First, the counselor can accept information or input without necessarily disclosing it. Second, the issue of confidentiality does not entirely determine the nature and extent of these potential interactions. Much of this will be a clinical consideration rather than an ethical one, turning on the counselor's view on how the goals of coparent counseling can most effectively be achieved and, more broadly, how the children's and parents' needs can most fully be met. The advantages of confidentiality in psychotherapy and mediation are well recognized. They include enhancing participants' ability to speak freely and reducing the element of "secondary gain," as it is called in the psychotherapy context, that is, incentives to present oneself strategically in the hope of gaining some advantage outside the therapy context. In order to obtain these advantages, the therapist generally refrains from interaction with others in the client's life (McWilliams, 2004). These considerations may lead some coparent counselors to minimize interactions with attorneys and the court. On the other hand, coparent counselors have important information for courts making decisions in the children's best interest and the counseling itself may, in some cases, be more effective if the counselor becomes, to a degree, a member of a team that includes the court, the parties' attorneys, and a parent coordinator or other professionals who may be involved (Fidnick, Koch, Greenberg, & Sullivan, 2011; Greenberg, Gould-Saltman, & Gottlieb, 2008; Lehmer, 1986).

Ethical considerations do not dictate the coparent counselor's handling of interaction with attorneys or the court. That is, it may be ethical practice to avoid such interactions or to welcome and foster them. However, the counselor should decide on his or her approach based on a thoughtful consideration of the advantages and disadvantages of different options for the parents and, more importantly, the children. Moreover, principles of informed consent and respect for the parents' self-determination (APA, 2010, Principle E, Standard 3.10; NASW, 2008, Standards 1.02, 1.03) require transparency in the handling of these interactions, if they occur. That is, counselors must inform parents as to how they will handle foreseeable situations with regard to interactions with attorneys, the court, and others. If unforeseen situations arise, counselors should confer with parents as to how they will be handled or, at minimum, inform them as to how the counselor will handle them and, if counseling is not court-ordered, give the parents the opportunity to terminate if they choose.

Ethical thinking highlights the importance of interacting or refraining from interaction with attorneys and the court on the basis of what is likely to be most helpful to the children or parents rather than what serves the counselor's interests or preferences, such as discomfort with the courts or, conversely, a desire to "network" with attorneys.

When parents are in litigation, and especially when coparent counseling has been ordered by the court, the literature on court-involved therapy should be consulted (Fidnick, Koch, Greenberg, & Sullivan, 2011; Lehmer, 1986).

Competence

Competence to provide a service is a requirement for MHPs (APA, 2010, Standard 2.01; NASW, 2008, Standard 4.01; American Association for Marriage and Family Therapy [AAMFT], 2012, Standard 3.11). Coparent counseling, as a relatively new area of practice, calls for particular reflection as to the education, knowledge, training, and experience required to

achieve competence. Suggestions are made here. One important question is whether training and experience as a couple therapist is helpful, essential, or problematic for the coparent counselor. On the one hand, the couple therapist's ability to diagnose problematic dynamics and address them with interventions can be of great value in coparent counseling. On the other hand, coparent counseling requires a paradigm shift away from the guiding framework of couple therapy. For most couple therapists, the couple relationship is, in effect, the client. That is, the goal of therapy is to improve the relationship rather than directly to improve the life satisfaction of either of the individuals in it. This corresponds to the fact that members of couples often think of their relationship as a separate entity, speaking of it as "good," "bad," "getting better," and so on. Accordingly, couple therapy typically terminates if the relationship ends. Parents in coparent counseling, by contrast, are no longer in a couple relationship. Therefore, the work in coparent counseling to improve their relationship needs to be different than work on improving the relationship between members of a couple. A couple therapist who has not undergone a corresponding paradigm shift may fall into conceptualizations or employ interventions that are at odds with the goals of coparent counseling. Thus, experience as a couple therapist is very helpful for the coparent counselor but must be accompanied by a well-developed understanding of the difference between couples and coparents.

Knowledge of the dynamics of dissolution of a couple relationship, the attendant experience of separation and loss, the impact of interpersonal violence on coparenting, and the dynamics of subsequent couple relationships and blended families is important for the coparent counselor (Coates et al., 2004; Cohen & Levite, 2012; Fieldstone & Coates, 2008; Heatherington & Kelly, 2008; Levite & Cohen, 2012; Pruett & Donsky, 2010). Equally important is an understanding of children's experience of such events and how the painful and potentially harmful aspects of their experience can be exacerbated or diminished by their parents' actions. A

solid understanding of child development is also important in order to help parents focus on the issues of current importance for their children and distinguish between age-appropriate upheavals, stress associated with restructuring the family, and psychopathology. In addition, knowledge of family law issues and processes is necessary for coparent counseling unless the counselor restricts his or her practice to the relatively small segment of this population that has not been involved with the courts [APA, 2010, Standard 2.01(f)].

Mediation training is important for those counselors who assist parents in reaching agreements to augment their parenting plan. Some counselors may routinely approach coparent counseling in this fashion (though these counselors are more likely to define the modality as parenting coordination without decision-making authority than coparent counseling) whereas other counselors may shift the focus to concrete agreements when parents prove unable to utilize a more relationally oriented approach. Because all parents in coparent counseling are likely to benefit at times from assistance in reaching and codifying concrete agreements, mediation training is likely to be helpful for all coparent counselors.

Contact with the children

Most coparent counselors have no contact with the children. If they have information about the children beyond the parents' reports, they typically receive it through the children's therapists or a previous custody evaluation. However, some counselors do involve the children to a degree in some cases. For example, Johnston, Roseby, and Kuehnle's (2009) model requires that, unless they are in psychotherapy with a therapist with whom the counselor works closely, the counselor sees the children from time to time in order in order to understand their experience of their parents' conflict and its impact on them. Thus, ethical issues related to coparent counselors' contact with the children are considered here.

The first question to consider is whether a single counselor meeting with the parents and the children constitutes taking on problematic or prohibited dual roles. It is instructive to note that in the related modality of child-inclusive mediation (McIntosh, Wells, Smyth, & Long, 2008), separate professionals take on these responsibilities. On the other hand, custody evaluators (Rohrbaugh, 2008) routinely meet separately with children and parents. So it is evident that meeting separately with children and parents does not, in itself, constitute taking on unethical dual roles. The determining factor in whether contact with children leads to dual roles is the way contacts are handled by the counselor. In order to avoid dual roles, the counselor must have an explicit formulation of how child contacts are an aspect of the coparent counseling and be sure that these contacts are handled as part of the coparent counselor role rather than drifting into interventions appropriate to child psychotherapy, for example. This requires clarity on the counselor's part about the purpose of contact with the children. Is it, for example, to evaluate and understand what they need from their parents, to learn more about the parents and their interaction with each other when the children are present, to diagnose possible psychological problems in the children, to obtain their input and "voice" in decisions their parents are making in coparent counseling sessions, and so on?

Competence to work with children requires specific knowledge, training, and experience. Before meeting with children, a coparent counselor should have training in child development, such as a graduate-level class, and consultation or training in interviewing children and adolescents.

Insurance billing

Understandably, parents often ask whether they can use their health insurance to help pay for coparent counseling. Courts, moreover, are interested in lightening the financial burden of interventions they order and thus are likely to favor steps counselors can take to make coparent

counseling available under parents' insurance. The ethical and legal requirements for the counselor, however, are significant.[2] Mental health providers often directly bill insurance companies for their services, particularly when they have a contract with the company. Alternatively, providers often prepare a bill, often called a "superbill," containing the information the client will need to seek reimbursement from the payer. Although providers in the latter situation are generally free of contractual obligations with the payer, the same ethical issues regarding accuracy and honesty apply.

Because health insurance covers treatment of recognized disorders, bills submitted to payers must indicate what treatment "procedure" was carried out and what disorder it was intended to treat. Ethical billing practice requires the practitioner to be accurate and honest regarding both procedures and diagnoses. If there is risk of miscommunication regarding the nature of a procedure, ethical practice requires the practitioner to take reasonable steps to accurately convey to the payer the nature of the service provided. Most if not all mental health insurance payers use the Diagnostic and Statistical Manual or "DSM" (American Psychiatric Association, 2013) for diagnoses and the Current Procedural Terminology or "CPT" code system (American Medical Association, 2012) for procedure names, descriptions, and numbers. Thus, the issue of ethical billing practice for coparent counseling mostly boils down to the interlocking questions of which DSM diagnoses and CPT procedures may be appropriate.

The procedures in the CPT code system that have the best chance of accurately conveying the nature of coparent counseling are likely to be "Family psychotherapy, conjoint psychotherapy with the patient present" (often used for couple therapy) and "Family psychotherapy without the patient present" (often used for collateral sessions in the psychotherapy of a child). Turning to the question of what disorder is being treated by coparent counseling, we encounter two reasons that the first of these two procedures may not be relevant

for insurance billing. The DSM-5 diagnostic possibilities for conjoint psychotherapy with the patient present are, first, a disorder in one of the parents, which is not what coparent counseling is intended to treat, or, second, "Disruption of Family by Separation or Divorce," which is not viewed as a disorder and, as such, may not lead to reimbursement. On the other hand, "Family psychotherapy without the patient present " would be appropriate if the coparent counseling is undertaken as an adjunct to treatment of one or more of the children, provided the child has been diagnosed with a psychological disorder. The diagnosis and treatment of the child would be conducted by a different therapist.

The question of whether coparent counseling is seen by the counselor as a form of psychotherapy is relevant to the ethics of insurance billing. In order for health insurance ethically to be billed, there must be treatment involved. In the case of coparent counseling, the possibilities are conjoint psychotherapy of the parents, which excludes counselors who do not view this modality as a form of treatment, or a separate psychotherapy of one or more of the children, which might justify insurance billing even when the coparent counseling is not viewed as treatment as long as it is integrated with ongoing treatment of a child.

In short, if a payer is using the DSM and CPT system, successful and ethical insurance billing for coparent counseling, whether done directly by the counselor or by providing the parents with a bill, is likely to be limited to cases in which one or more of the children is in treatment for psychological diagnoses, the counseling is oriented to a child's diagnosed difficulties, and the counseling is integrated with an ongoing child psychotherapy. If no child is in treatment, counselors who view coparent counseling as psychotherapy of the parents may ethically list the DSM-5 diagnosis of Disruption of Family by Separation or Divorce, though this diagnosis may not lead to insurance payment.

Informed consent

"Informed consent" is a decision to participate in a treatment or other activity based on adequate information provided by the professional (Campbell, et al., 2010). The information can be provided orally, in writing, or both.[3] The ethics codes of the mental health professions mandate elements in informed consent for members of each profession. For instance, the APA (2010) requires that information about psychotherapy include "the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality" (Standard 10.01) and the NASW (2008) Code of Ethics states it should include "the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent" (Standard 1.03). Beyond such mandatory elements of informed consent, the information needed varies depending on the treatment and on the concerns and questions of potential clients. Informed consent is best viewed not as a single event in which the parents are expected to understand and consider a large amount of information, nor as the pro forma signing of a form, but instead as a process, early in counseling, of conveying relevant information and helping parents to decide whether to proceed.

Aspects of coparent counseling that are likely to be relevant in obtaining informed consent include purpose and goals, procedures, fees, separate contacts with parents, cancellation policies, confidentiality and related issues, whether the counselor will have contact with attorneys, and whether he or she will have contact with the children. Each of these is discussed below. Informed consent is key to the successful provision of coparent counseling. Whether or not services are ordered by the court, it is critical that the parents and counselor have a clear understanding, preferably in writing, as services begin.

Goals

Coparent counselors typically orient their work to the needs of the children for reduced conflict and effective collaboration between their parents. By contrast, in our experience, parents often approach it, consciously or unconsciously, as a place where the other parent will be forced to behave better. Counselors should clarify their neutrality, the role, if any, of "truth-seeking" (i.e., attempting to determine which parent is more at fault for difficulties), and the priority placed on the children's well-being as compared with the parents' feelings or needs. When relevant, the informed consent process should include an explanation of the difference between parenting plan mediation (helping parents create a parenting plan and terminating when it has been agreed on) and coparent counseling. In a case in the first author's practice, for example, in their initial contacts with the counselor, parents requested coparent counseling to improve their communication and reported they had agreed on a custody schedule. However, it emerged in the initial meeting that the parenting schedule had only been agreed to for three months and one parent even disputed that agreement. The counselor explained the difference between mediation and coparent counseling and suggested that mediation would be more appropriate. (In our experience, coparent counseling is more effective once a basic parenting plan is in place.)

Procedures

The topic of coparent counseling procedures includes such general questions as: How often will meetings take place? What will happen in the meetings? Will the focus be on improving the parents' relationship or developing structured modes of interaction (e.g., email rules) to help them disengage? Will meetings have agendas and, if so, how will they be created? Will the counselor provide parents with notes from the meetings? Will the counselor review or help edit emails the parents send each other? Will the counselor meet separately with the parents or have other separate communication? The likely duration of counseling should also be

clarified. For example, in a case of the second author's, the parents arrived with a court order for "coparent counseling," which the reluctant parent interpreted as one session. Thus, it should be clarified to parents and judges that coparent counseling requires multiple sessions and often takes place over an extended period of time. In addition, the limits of the counselor's role, such as the fact that he or she cannot force compliance with agreements and does not make recommendations to the court, should be clarified with parents from the beginning, as parents may have unrealistic fantasies about the extent of the coparent counselor's power or influence.

Fees

We recommend a written fee agreement with coparent counseling clients addressing the following issues:

- Rate per session or per hour
- How fees will be apportioned between the parents or stating that the parents are responsible for determining this
- Whether the counselor's time for phone calls, emails, and other activities outside of face-to-face sessions will be billed
- How far in advance an appointment must be cancelled in order not to be billed
- If the counselor meets individually with parents, whether fees for these meetings will be apportioned in the same way as other time or paid separately by the parent with whom the counselor is meeting.

It is suggested that fee agreements be specific regarding email and other forms of electronic communication, as there is often an assumption that such time will not be billed by the therapist. For example, one parent with whom the second author worked understood that session time would be billed but sent the counselor numerous lengthy emails between sessions, assuming

that the counselor would not bill for the time spent reading them, although the fee agreement specified how email time would be reimbursed.

Confidentiality

Informed consent should cover the limits of confidentiality, including abuse reporting and protection from serious physical harm (i.e., "Tarasoff"), whether the counselor would disclose any information if only one parent gives consent, and whether the counselor will treat information from coparent counseling as falling under psychotherapy privilege. In addition, if the parents are asked to agree that no information from the counseling will ever be submitted to a court or otherwise used in adversarial legal proceedings, this must be included in informed consent. , . Defining the issue of what information will be shared and with whom in the informed consent document at the beginning of treatment can help prevent difficulties later in the process. (Lehmer, 1986).

Counselor contact with the children

This includes the question of whether the coparent counselor will interview the children, how that will be decided (e.g., by the counselor, one parent, or both parents), what the purpose would be, how frequently such meetings might take place, whether one or both parents would be present and, if not, whether information from the contacts would be shared with the parents. For example, in a case where the second author asked to meet with the children regarding a rigorous extracurricular activity schedule that seemed to reflect one parent's misreading the children's needs, that parent's attorney forbade any contact between the counselor and the children, claiming that counselor-child interviews never took place. A section in the informed consent document spelling out the purpose and anticipated extent of potential contact with the children, which parents are encouraged to review with their attorneys prior to starting counseling, may prevent such problems.

Information from separate contacts with parents

If there are to be separate contacts with the parents, informed consent should include the purpose of such contacts, whether information from them would be kept confidential from the other parent or, instead, be shared according to the counselor's best judgment as to what would be most helpful. When there is distrust between the parents or they are in litigation, a clear understanding that any individual contact with parents will be handled with complete transparency may be the wisest course of action.

Insurance billing

Because parents may assume that they will be able to use their insurance for coparent counseling, they need to know the obstacles and uncertainties discussed above and whether, in their particular situation, there is even a possibility of successfully billing insurance. For example, if none of the children is in treatment, parents should be told that the only appropriate DSM diagnosis is not considered a disorder and therefore many insurance companies will not pay for its treatment.

Conclusion

Coparent counseling is a developing modality. Many of the issues we have discussed, such as whether it is a form of psychotherapy and whether it needs to be confidential in order to be effective, have yet to be resolved. We have not taken positions on these issues in the present paper. Ethical conclusions set boundaries on what is permitted and have the potential to influence licensing boards. It is important, therefore, that they be limited to what can be clearly grounded in established ethical principles, so as to leave all appropriate latitude for clinical judgment, experience, and creativity.

The following ethical conclusions can be drawn at this time, as discussed above:

- Some view coparent counseling as a form of psychotherapy whereas others do not. Because of the different ethical and possibly legal implications of these two positions, coparent counselors need to arrive at a reasoned conclusion as to whether coparent counseling is or is not a form of psychotherapy.
- Coparent counselors need to decide whether they will attempt to keep information from the counseling confidential from the court or from the parents' attorneys, taking into account considerations on both sides of this question. Avoiding information-sharing with a parenting coordinator is unlikely to be ethical.
- Coparent counselors vary widely in whether they attempt to foster or avoid collaboration with courts and parents' attorneys. In this domain, too, counselors need to recognize competing considerations and make thoughtful decisions.
- Clear communication regarding the counselor's role, allegiance, and information-sharing is especially important when coparent counseling includes meetings with the children or individual meetings with parents.
- Competence in coparent counseling requires knowledge of relationship dissolution and loss, the impact of interpersonal violence on coparenting, the dynamics of subsequent relationships, the impact of parenting on outcomes and experience of the children, and relevant aspects of child development family law.
- Meeting with the children does not constitute an unethical dual role. However, counselors who meet with children must be competent to do so.
- Children's interests are served when financial burdens on their parents are reduced, which may be aided by the use of health insurance to help pay for coparent counseling. However, coparent counseling must be accurately represented by the counselor, even if this reduces or eliminates the possibility of insurance reimbursement.

- Informed consent for coparent counseling should include its goals, process, and cost. It should also include the counselor's practices on confidentiality, billing, individual contact with parents, cancellation, contact with attorneys, and contact with children.

Coparent counseling can provide an important service to moderate and high-conflict families of divorce. However, in our experience, these parents are often highly troubled and sometimes all too eager to embroil the counselor in their conflicts. By adhering closely to the ethical guidelines of our professional associations and by providing clear, comprehensive informed consent, we can model clear and direct communication along with appropriate problem-solving skills for these high conflict parents, which can help us become a stabilizing influence in their lives.

References

American Association for Marriage and Family Therapy. (2012). Code of ethics. Retrieved 9/16/2013, from http://www.aamft.org/imis15/Content/Legal_Ethics/Code_of_Ethics.aspx

American Medical Association. (2012). *CPT 2013 Standard Edition*. Washington, DC: American Medical Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)* (5th ed.). Arlington, VA: American Psychiatric Association.

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010)*. Retrieved 9/152013, from www.apa.org/ethics/code/index.aspx

Campbell, L., Vasquez, M., Behnke, S., & Kinscherff, R. (2010). *APA Ethics Code commentary and case illustrations*. Washington, DC, US: American Psychological Association.

Coates, C.A., Deutsch, R., Starnes, H., Sullivan, M.J., & Sydik, B. (2004). Parenting coordination for high conflict families. Family Court Review, 42(2)246-262.

Cohen, O., & Levite, Z. (2012). High-conflict divorced couples: Combining systemic and psychodynamic perspectives. *Journal of Family Therapy, 34*(4), 387-402.

Donner, M. B., & Alban, A. (2010). Protecting the therapy hour: More thoughts on stipulations and other strategies. *The California Psychologist, 43*(November/December), 25-26.

Eddy, B. (2009). *New ways for families parent workbook.* Hayward, CA: Siemens.

Fidnick, L.S., Koch, K.A., Sullivan, M., Greenberg, L.R. (2011). Guidelines for court-involved therapy. *Family Court Review,* 49(3) 557-581.

Fieldstone, L.B., & Coates, C.A. (2008). *Innovations in interventions with high conflict families.* Minneapolis, MN: AFCC.

Frieman, B.B., Garon, R., Mandell, B. (1994). Parenting seminars for divorcing parents. *Social work.* 39(5), 607-610.

Garber, B. D. (2004). Directed co-parenting intervention: Conducting child-centered interventions in parallel with highly conflicted co-parents. *Professional Psychology: Research and Practice, 35*, 55-64.

Greenberg, L. R., Gould-Saltman, D. J., & Gottlieb, M. C. (2008). Playing in their sandbox: Professional obligations of mental health professionals in custody cases. *Journal of Child Custody, 5*, 192 - 216.

Greenberg, L. R., & Sullivan, M. J. (2012). Parenting coordinator and therapist collaboration in high-conflict shared custody cases. *Journal of Child Custody, 9*, 85-107.

Heitler, S.M. (1990). *From conflict to resolution: Skills and strategies for individuals, couples, and family therapy.* NY: Norton.

Hetherington, E.M., & Kelly, J. (2002). For better or for worse: Divorce reconsidered. NY: Norton.

Jaffe, P. G., Johnston, J. R., Crooks, C. V., & Bala, N. (2008). Custody disputes involving allegations of domestic violence: Toward a differentiated approach to parenting plans. *Family Court Review, 46*, 500-522.

Johnston, J. R., Roseby, V., & Kuehnle, K. (2009). *In the name of the child: A developmental approach to understanding and helping children of conflicted and violent divorce (2nd ed.)*. New York, NY, US: Springer Publishing Co.

Kelly, J. B. (2004). Family mediation research: Is there empirical support for the field? *Conflict Resolution Quarterly, 22*, 3-34.

Kelly, J. B. (2007). Children's living arrangements following separation and divorce: Insights from empirical and clinical research. *Family Process, 46*, 35-51.

Knapp, S., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. N. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). Rockville, MD: The Trust.

Lehmer, M. (1986). Court ordered therapy: Making it work. *American Journal of Forensic Psychology*. 4(2), 16-24.

Levite, Z., & Cohen, O. (2012). The tango of loving hate: Couple dynamics in high-conflict divorce. *Clinical Social Work Journal, 40*(1), 46-55. doi: 10.1007/s10615-011-0334-5

McHale, J. P., & Lindahl, K. M. (2012). Introduction: What is coparenting? In J. P. McHale & K. M. Lindahl (Eds.), *Coparenting: A Conceptual and Clinical Examination of Family Systems* (pp. 3-12). Washington, DC: American Psychological Association.

McIntosh, J. E., Wells, Y. D., Smyth, B. M., & Long, C. M. (2008). Child-focused and child-inclusive divorce mediation: Comparative outcomes from a prospective study of postseparation adjustment. *Family Court Review, 46*(1), 105-124. doi: 10.1111/j.1744-1617.2007.00186.x

McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York, NY: Guilford Pr.

Miller, D. J., & Thelen, M. H. (1986). Knowledge and beliefs about confidentiality in psychotherapy. *Professional Psychology: Research and Practice, 17*(1), 15-19. doi: 10.1037/0735-7028.17.1.15

National Association of Social Workers. (2008). *Code of Ethics*. Retrieved from www.socialworkers.org/pubs/code.asp: 9/13/13.

Nurse, A. R., & Thompson, P. (2009). Collaborative divorce: A family-centered process. In J. H. B. M. Stanton (Ed.), *The Wiley-Blackwell handbook of family psychology* (pp. 475-486). Wiley-Blackwell: Malden, MA.

Phillips, S. C. (2010). The dilemma of diagnosis in clinical practice: Over diagnosis, under diagnosis and insurance fraud. *The California Psychologist* (Nov/Dec), 23-24.

Pruett, M. K., & Donsky, T. (2012). Coparenting after divorce: Paving pathways for parental cooperation, conflict resolution, and redefined family roles. In J. P. McHale & K. M. Lindahl (Eds.), *Coparenting: A conceptual and clinical examination of family systems* (pp. 231-250). Washington, DC: American Psychological Association.

Ricci, I. (1997). Mom's *house, Dad's house: Making two homes for your child*. New York, NY: Fireside.

Riemersma, M., & Tran, A. (2009). What is insurance fraud? Retrieved from http://www.camft.org/AM/Template.cfm?Section=Home&template=/CM/HTMLDisplay.cfm&ContentID=10560: 9/2/2013

Roberson, P.N., Nalbone, D.P., Hecker, L.H., Miller, J.A. (2010). Adult attachment styles as a predictor of coparent relationships postdivorce. *Journal of Divorce and Remarriage. 51(3),* 185-207.

Rohrbaugh, J. B. (2008). *A comprehensive guide to child custody evaluations: Mental health and legal perspectives*: New York, NY, US: Springer Science + Business Media.

Sullivan, M. J. (2008). Coparenting and the parenting coordination process. *Journal of Child Custody, 5*, 4-24.

Footnotes

[1]At present, there is no clear dividing line between coparent counseling, on the one hand, and parenting coordination without decision-making authority, on the other. Although there might be advantages to defining these two modalities in non-overlapping ways, with corresponding distinctions between the background and experience required to provide them, such a distinction is not currently in place. Accordingly, the present article does not make this distinction and therefore includes consideration of interventions that might be described as parenting coordination without decision-making authority.

[2]Legal issues are outside the scope of the present article but are important for insurance billing issues in mental health practice, including coparent counseling. See, for example, Riemersma and Tran (2009) and Phillips (2010).

[3]In addition to their value in informed consent, forms that clients sign are also used for risk management, on the principle that practitioners are unlikely to be disciplined for actions that clients previously agreed to in writing. Risk management aspects of informed consent are outside the scope of the present article, but it is likely that the informed consent process recommended here, if documented by signed forms, would be helpful in managing risk.