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Highlights…

How to make divorce family-friendly — or at least much less traumatic, especially to children, is the topic of our first lead article in this issue.

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Editor's Commentary

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Free Parent Handout…

Bullying, in Teen Sports and Elsewhere, Requires Parent Intervention

Monthly reports on the problems of children and adolescents growing up

Family Matters

Collaborative divorce: An oxymoron?

By Marina Tolou-Shams, Ph.D.

In 1989, an attorney from Minnesota named Stu Webb became highly disenchanted with his divorce litigation practice and the damaging effects he perceived it having on his clients and himself as their attorney. He decided that he either needed to leave his divorce law practice or consider an alternative approach to handling divorce cases (i.e., one that would not involve years of distressing court hearings). In 1990, Webb came up with the idea of couples retaining attorneys as "settlement-only" specialists, who work with the divorcing couple outside of the court system and hand the case over to trial lawyers only if the settlement process fails. Webb named his approach to divorce settlement "collaborative law," a practice for resolving divorce that is currently available to couples in most, if not all, states.

By 1994, collaborative law was being practiced widely in Northern California as attorneys eagerly adopted Webb's alternative dispute resolution model. At the same time (and completely separate of the collaborative law movement), two psychologists (Peggy Thompson and Rodney Nurse) who worked with divorcing couples were meeting with divorce attorneys and financial professionals in the San Francisco Bay Area to come up with an interdisciplinary approach to resolving divorce cases and associated issues (e.g., parenting plans, custody issues). These psychologists eventually collaborated with a licensed social

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Neonates

CDC, conflicting with standard of care, proscribes opioids for pregnant women

The federal Centers for Disease Control and Prevention (CDC) advised pregnant women across America that if they take prescription opioids, their babies might have birth defects. The message, issued in a January 22 press release to accompany a study of opioid analgesia prescribing in that week's *Morbidity and Mortality Weekly Report* (*MMWR*), also advises that women of reproductive age should not take prescription opioids because they might get pregnant and subject the child to birth defects.

The message completely contradicts the advice of the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society for Addiction Medicine (ASAM), the American Congress of Obstetricians and Gynecologists (ACOG), and multiple studies in the literature showing that pregnant women not only can safely take methadone or buprenorphine, both opioids, but that if they are addicted to heroin, they should take these medications.

Sources told *CABL* that the CDC report could be used in malpractice suits, child custody cases, and in addition could sow confusion among women in treatment with methadone or buprenorphine, setting back recent advances in treatment

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to 3.8%) or drugs (11.4% compared to 6.9%).

Adolescents with a history of mental illness, or with a history of suicidality, with or without a history of mental illness, were just as likely to report access to a gun in the home as those without such histories.

Of the study sample, 51% met criteria for at least one lifetime mental health disorder, and 28.9% for at least two. Compared to adolescents without gun access, slightly more had a history of a mental health disorder (53.6% compared to 49.2%). A greater proportion of adolescents with substance abuse had access to guns compared to adolescents without access to guns: for recent alcohol abuse, 8.2% had access compared to 2.9% without access, and 10.1% of adolescents with a lifetime history of alcohol abuse had access to guns compared to 3.8% without access; 11.4% of adolescents with access to guns had a lifetime history of drug abuse compared to 6.9% of adolescents without access. These numbers are troubling due to the link between intoxication and impulsive behavior.

Thirteen percent of the sample reported a lifetime history of suicidal ideation, and 4.1% had attempted suicide; in 5.8% of the sample, suicidal ideation was recent, and in 1.8% attempts were recent. There were no differences found in suicidal ideation, planning, or attempts between adolescents with and without access to guns.

This cross-sectional analysis found that of the one-third of study participants with a gun in the house, 40% had the ability to access and shoot it, and that these adolescents also had a significant rate of mental illness. Also, those at increased risk for suicide were just as likely to have gun access as those without risk factors.

Implications

"To our knowledge, this is the first study to comprehensively describe the burden of mental illness among adolescents with firearm access," the researchers conclude. They noted that previous studies have found that parents with their own problems of substance use were less likely to store a gun safely than those without such problems. "Given that alcohol- and drug-related disorders cluster within families, these findings may help explain the increased firearm access among adolescents with substance abuse histories," the researchers said.

The researchers had hypothesized that with health care professionals encouraging limiting access to guns in houses with adolescents with risk factors, this access would be less. However, it wasn't; even subgroups with a recent suicide attempt had access that was comparable to those with no risk factors. "This suggests that many parents or guardians of adolescents with suicide risk factors and a firearm in the home may not be aware or convinced that (1) their child has access to the firearm, (2) firearm access is a risk to their child, or (3) limiting firearm access may mitigate the risk of having a firearm in the home," the researchers said.

The researchers pointed out that the NCS-A prevalence of disorders aren't formal clinical diagnoses, and therefore may "represent unrecognized mental health risk factors among US adolescents."

"These findings present an area for intervention by policy makers, health care systems, health care professionals, and parents," the researchers wrote. However, they note that the limited literature already shows that "most parents are unlikely to comply with health care professionals' recommendations to remove firearms from their home." Nevertheless, they said that parents do accept safe-storage recommendations. "Given the significant morbidity and mortality associated with firearm injuries among this population, particularly by self-directed violence, further attention to developing and implementing evidence-based strategies to decrease firearm access among adolescents is warranted," they said.

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The authors reported no conflicts of interest.

Simonetti JA, Mackelprang JL, Rowhani-Rahbar A, et al. Psychiatric comorbidity, suicidality, and in-home firearm access among a nationally representative sample of adolescents. *JAMA Psychiatry* 2015 Feb; 72(2):152–159. doi: 10.1001/jamapsychiatry.2014.1760. E-mail: simonja@uw.edu.

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worker (Nancy Ross) and several attorneys (including Pauline Tesler) practicing collaborative law to meet regularly to discuss cases; they referred to their work as "collaborative practice." This working group then led to the establishment of the American Institute of Collaborative Professionals (in 1999), which then became the International Academy of Collaborative Professionals (IACP) in 2001 (www.collaborativepractice.com). The IACP has at least 4,000 members (i.e., attorneys, mental health professionals, financial planners officially trained in the collaborative practice model) all over the world; collaborative practice is starting to become an option for divorcing couples in Rhode Island, particularly through trained legal professionals practicing collaborative law. An increase in trained mental health professionals providing collaborative practice services may be seen in the coming years.

What is collaborative divorce?

Collaborative divorce is an alternative dispute resolution model, a way to achieve resolution between parties outside of the courtroom. The model requires that both spouses and both attorneys agree to civilly dissolve the marriage and divide assets with no intention of ever going to court. Attorneys and clients work toward negotiated settlement as the sole purpose of retention, and collaborative attorneys act solely as settlement attorneys. Clients sign a "participant agreement" that outlines the collaborative law process to resolve differences, including different rules for disclosure of information (than occurs in the litigation process), expectations regarding communication, goals around participation with integrity, and the role of experts (e.g., mental health professionals) in the collaborative process. In collaborative divorce, each attorney must sign papers disqualifying

themselves from ever appearing in court on behalf of either of the clients against the other. If litigation is needed, due to the collaborative divorce model not achieving settlement, new attorneys must be retained. Collaborative professionals feel that the clear expectation of potential transfer to new attorneys if the case is unresolved through collaborative practice has the inherent effect of creating incentive to work on resolution through collaborative practice for all parties and professionals involved.

What is the role of the mental health professional?

Collaborative divorce relies on a team of professionals to collaboratively work on the clients' presenting concerns and disputes. At minimum, "four-way" meetings are a central tenet of the collaborative model. These meetings include attendance from both clients and their respective, collaborative attorneys. Other professionals, such as psychologists, licensed clinical social workers, and/or financial planners, may attend these meetings depending on the presenting issues. Mental health professionals are typically retained as either a "divorce coach" or a "child specialist," which are independent roles. Typically, each partner has their own divorce coach, but in some cases (and some states, depending on the model they have instituted), there may be one divorce coach for all parties. The role of the divorce coach may include teaching: effective problem-solving communication between partners (e.g., to help each side listen and understand what the other is saying to them), ways to reduce conflict, emotion regulation strategies, and short- and long-term goal setting. In some cases, the parties may choose to meet with a "divorce coach" even prior to retaining a collaborative attorney, but it is more typical for parties to retain a collaborative attorney and then hire coaches, as needed, to assist in the process of achieving settlement.

When children are involved and there are concerns related to parenting plans, visitation, and/or custody arrangement, a child mental health professional trained in collaborative practice may also be retained by the parties to have individual meetings with parents and children, attend collaborative "five-way" meetings (two clients, two attorneys, and one child specialist), consultation through meetings, conference calls, and email communication with the divorce coaches about child- and parent-related issues, and provide intervention to resolve child-related disputes as they may arise over the course of the collaborative divorce process. This "child specialist" is the child's own representative in the collaborative divorce process and is not acting as a psychotherapist to either the child or parents. The child specialist starts by meeting with both parents and then the children to hear their perspective and concerns, which allows the children to meet with a neutral, objective trained professional to allow them to safely share their concerns, fears, and emotions (Tesler & Thompson, 2006). The "five-way" meeting is designed for the child specialist to describe his/her observations, to hear perspectives on what is and is not working with parenting, to identify strengths and weaknesses in parenting and eventually leads to a platform to, with the assistance of both the child specialist and divorce coach(es), create a parenting plan (for visitation schedule, parenting goals, etc.), which the collaborative lawyers then review and discuss with their clients separately and sometimes at a "four-way" meeting. Different from traditional litigation practice, the goal of the lawyers is not to argue for the "best plan" for their client but rather to ensure that each parent fully understands the plan and that it addresses the parents' concerns as well as to make sure it addresses all points that require resolution (Tesler & Thompson, 2006). Thus, collaborative divorce child specialists and divorce coaches work closely with the collaborative attorneys and clients to address a myriad of emotional, behavioral, and interpersonal issues that are inherent in the difficult, tumultuous process of divorce. They act as "coaches" only and must refer to other outside mental health providers if psychotherapy or more intensive psychological intervention is warranted for either client or their child(ren).

The child specialist has a unique and powerful role in working closely with the parents at the initial stages of the divorce to assist them in gaining specific parenting skills and managing their own emotions and parent-child communication styles to buffer against such negative outcomes for their children.

The collaborative divorce process can, in particular, have profound positive effects for the children involved; conflict is reduced early on, and parents are proactively learning co-parenting skills and ways to reduce conflict when/if it eventually arises and are also receiving psychoeducation about the potential negative effects of divorce on children's outcomes. The most salient predictor of worst emotional and behavioral outcomes for children of divorce is parental conflict (Zill, Morrison, & Coiro, 1993; Zimiles & Lee, 1991). Thus, the child specialist has a unique and powerful role in working closely with the parents at the initial stages of the divorce to assist them in gaining specific parenting skills and managing their own emotions and parent-child communication styles to buffer against such negative outcomes for their children. From a child mental health prevention perspective, using trained child professionals to intervene with divorcing families who are seeking to achieve dispute resolution outside of the courtroom appears ideal.

Who is collaborative divorce for?

Certain client qualities may make collaborative divorce a more effective

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approach to dispute resolution for some versus others. Collaborative practice is not likely appropriate for those clients in which active domestic violence is of concern (and professionals should always determine if there are active restraining orders open). However, there have been successfully resolved collaborative divorce cases in which a previously existing restraining order was lifted and all parties were able to sit in a "four-way" meeting to resolve disputes. In addition, clients with serious psychiatric disorders who are unresponsive to medication or psychotherapeutic intervention are not as likely to achieve success with the collaborative model.

Clients are also concerned about the cost of collaborative divorce in that there are many professionals "at the table," and costs to retain so many individuals can quickly add up. While this is a valid concern, parties often don't realize the costs associated with lengthy litigation battles in the court that can take years upon years and large attorney's fees to resolve. Thus, while the collaborative divorce model may require more up-front money, there are data to suggest that it is a cost-effective practice in the long run (Lande, 2011). In addition, when parties go through the litigation process (and may spend a lot of money throughout the process), they do not typically walk away with decreased stress and a sense of satisfaction as parties involved in collaborative divorce do.

Trained collaborative professionals often state that even when their clients' outcomes are not exactly as they wanted, they walk away from the resolved process feeling empowered and satisfied because they were a part of the process and the outcomes versus feeling disempowered by the court and the adversarial process dictating all outcomes, particularly those that involve their children.

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and further deepening the stigma of medication-assisted treatment rather than lifting it.

The *MMWR* report found that more than a third of women ages 15 to 44 in Medicaid, and more than a quarter of those with private insurance, filled a prescription for an opioid pain medication between 2008 and 2012. "Taking opioid medications early in pregnancy can cause birth defects and serious problems for the infant and the mother," said CDC Director Tom Frieden, M.D., in the press release. "Many women of reproductive age are taking these medicines and may not know they are pregnant and therefore may be unknowingly exposing their unborn child. That's why it's critical for health care professionals to take a thorough health assessment before prescribing these medicines to women of reproductive age."

The press release said opioid use in pregnancy could increase the risk of defects of the baby's brain and spine, heart, and abdominal wall. It also mentioned the risk of neonatal abstinence syndrome (NAS). "Women, who are pregnant, or planning to become pregnant, should discuss with their health care professional the risks and benefits for any medication they are taking or considering." said Coleen Boyle, Ph.D., director of the CDC's National Center on Birth Defects and Developmental Disabilities, in the press release. "This new information underscores the importance of responsible prescribing, especially of opioids, for women of child bearing age."

ACOG: Opioids are 'standard of care'

The physicians who treat pregnant women, obstetricians, say that while heroin use during pregnancy is associated with adverse outcomes, treatment with methadone and buprenorphine for heroin addiction is the "standard of care." From an ACOG Committee opinion: "Opioid use in pregnancy is not uncommon, and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes. The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, but emerging evidence suggests that buprenorphine also should be considered. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Patient stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists."

Also from ACOG: "During pregnancy, chronic untreated heroin use is associ-