

PARENTING PLANS FOR SPECIAL NEEDS CHILDREN: APPLYING A RISK-ASSESSMENT MODEL

Daniel B. Pickar and Robert L. Kaufman

Family courts are seeing an increasing number of separating or divorced families who have a special needs child. These cases present complex challenges for family law professionals charged with crafting parenting plans based on best interests standards. For many of these children, the typical developmentally based custodial arrangements may not be suitable, given the child's specific symptoms and treatment needs. We present a model for understanding how the general and specific needs of these children, as well as the demands on parents, can be assessed and understood in the context of divorce. This includes an analysis of risk and protective factors that inform timeshare and custodial recommendations and determinations. The risk assessment model is then applied to three of the most commonly occurring childhood neurodevelopmental and psychiatric disorders likely to be encountered in family court, namely, attention deficit/hyperactivity disorder, depressive disorders, and autistic spectrum disorders.

Key Points for the Family Court Community

- There has been a dramatic rise in the population of children with neurodevelopmental, psychiatric, and medical syndromes whose parents are disputing custody in the family courts.
- Family law professionals of all disciplines should develop a fundamental knowledge base about the most commonly seen special needs children in family court, such as those with neurodevelopmental conditions like autistic spectrum disorder, attention deficit/hyperactivity disorder, and severe depressive disorders (especially with teenagers), which may involve suicidal or self-harming behaviors.
- Commonly recommended parenting plans may be inappropriate for many special needs children, as some function significantly below their chronological age and pose extreme behavioral challenges.
- A systematic analysis of risk and protective factors should inform timeshare arrangements and determinations with this varied population, including the safety of the child and severity of the disorder, parental commitment and availability to pursue medical, educational, and therapeutic services, the parental attunement and insightfulness about the problem, and the differential parenting skills of each parent.

Keywords: *Attention Deficit/Hyperactivity Disorder (ADHD); Autistic Spectrum Disorders; Child Custody; Childhood Depression; Divorce and Disabled Children; Parenting Plans; and Special Needs Children.*

INTRODUCTION

The last 10 to 15 years have seen a dramatic rise in the population of children who have been diagnosed with various types of neurodevelopmental, psychiatric, and medical syndromes. The term “special needs children” is an umbrella designation that encompasses a staggering array of children who have specific learning disorders and cognitive impairment, chronic developmental disorders, physical disabilities, serious medical conditions, and severe psychiatric and behavioral disorders. Concurrent with the significant increase in children who have been diagnosed with these conditions, family courts are now seeing a rapidly expanding number of divorce and separation cases involving special needs children (Eme, 2009; Price, 2012).

Many such children require specialized parenting approaches. In these instances, ordinary parenting skills may be insufficient, as such children can place extraordinary demands upon the adults who care for them. Special needs children may also require an unusually high level of supervision and time-consuming interface with medical, educational, and mental health personnel. Sometimes marital separation or divorce may be a consequence of trying to raise these children. For example, the divorce

Correspondence: dpickar@sbcglobal.net; rk@rkaufmanphd.com

rate for parents of children with both autistic spectrum disorder and attention-deficit/hyperactivity disorder (ADHD) is significantly higher than in the general population (Hartley et al., 2010; Wymbs et al., 2008). Due to separation or divorce, there are often fewer financial resources for children. If parents disagree on treatment or educational approaches for their special needs child while married, separation, and/or divorce usually magnify these differences. Just as the tasks inherent in raising a special needs child can place undue strain on parents, separation and/or divorce in turn stresses these children, with the possibility of complicating and exacerbating the child's already problematic symptom picture.

In recent years, two prominent family law journals published special issues regarding how the best interests of special needs children are addressed in family court, highlighting concern in the family law community. The *Family Court Review* (Schepard & Johnston, 2005) dedicated a series of articles to the topic of "Special Needs Children in Family Court." Even more recently, *Family Law Quarterly* (Elrod & Spector, 2012) published a special journal issue entitled, "Symposium on Special Needs and Disability in Family Law." These journal issues emphasize the fact that family law professionals of all disciplines face complex challenges when assisting separated or divorcing families with special needs children. This is especially so when professionals advise or render decisions about effective parenting plans, as these children are at risk for very poor outcomes under circumstances that might be adequate for other higher functioning children.

Therefore, there is a more acute need for family law professionals to have some specialized knowledge and understanding of the features of many childhood disorders as well as an understanding of the particular parenting skills which might best fit the specific needs of the child. As noted by Saposnek, Perryman, Berkow, and Ellsworth (2005): "The ubiquitous presence of these children in family court cases suggests that court personnel and divorce professionals need to acquire special knowledge in order to facilitate the development of parenting plans for these high risk families" (p. 586). This sentiment was emphasized more recently by Price (2012), who stated: "In order to properly deal with the reality of today's divorce climate, all lawyers and judges handling family law cases should educate themselves on special needs and the impact they have on family law cases. Special needs children have greater needs than typical children, so they need lawyers and judges who are educated on these issues" (p. 181).

For many special needs children, commonly recommended developmentally based parenting plans may be inappropriate, as some of these children function significantly below their developmental age and pose extreme behavioral challenges. In many instances, the need for consistent routine and stability in residential placement and/or the primary need for safety and supervision may outweigh a custodial schedule that provides significant time with both parents. Crafting a parenting plan that supports the child's cognitive, social and emotional development and simultaneously provides opportunity for enhancing parent-child relationships can be a challenge. Because the moniker "special needs children" encompasses such a huge range of disorders and syndromes, no family law or even mental health professional can be an expert on every type of special needs child. It is important that family law professionals have access to information about the most commonly occurring childhood conditions and the specialized parenting challenges involved in raising such children.

The most frequently occurring childhood neurodevelopmental and psychiatric disorders likely to be encountered by the family courts are: autistic spectrum disorders, ADHD, and especially in families with teenagers, depressive disorders, which may involve suicidal or self-harming behaviors. This article will outline and discuss the symptoms and defining characteristics of these most commonly occurring conditions. Family law professionals are also likely to encounter less frequently seen types of special needs children, such as those with cerebral palsy, Downs' Syndrome, visual or hearing impairment, or high risk medical conditions. Determining living arrangements that are grounded in a child's best interests requires analysis of multiple factors. In addition to the most common statutory considerations (i.e., individual parenting skills; child-caretaker attachment relationships; parent psychological stability; which parent will best facilitate the other parent-child relationship, domestic violence), multiple health, safety, and educational issues must be weighed (Stahl, 2011). This article

will present a framework for analyzing risk and protective factors that can assist family law professionals in their efforts to identify effective parenting plans for specific types of special needs children.

RISK AND PROTECTIVE FACTORS WITH SPECIAL NEEDS CHILDREN

Like all children, those with special needs are at risk for poor outcomes when their families go through separation and/or divorce. Divorce itself is a general risk factor regarding children's adjustment and well-being, as well as a process fraught with challenges in adaptation and adjustment for all family members. Research further indicates that children who suffer from significant psychiatric and/or neurodevelopmental disorders are at risk for a host of potentially harmful short and long-term consequences. For some conditions, this even includes the risk of death. For example, higher rates of child abuse have been found in the special needs population of children with ADHD (Briscoe-Smith & Hinshaw, 2006; De Sanctis, Nomura, Newcorn, & Halperin, 2012), learning disabilities (Spencer et al., 2005), hearing impairments (Lomas & Johnson, 2012), and autism (Mandell, Walrath, Manteuffel, Sgro, & Pinto-Martin, 2005).

Children with specific learning disorders and ADHD frequently have poorer school performance and academic attainment than peers of the same age, and suffer greater social rejection. Children with ADHD are significantly more likely than others to develop conduct disorder in adolescence and antisocial personality disorder in adulthood, thereby increasing the risk for substance abuse disorders, criminal activity, and possible incarceration (Eme, 2009; Fletcher & Wolfe, 2009). Teenagers with anorexia nervosa have a 5% mortality rate. During an episode of a major depressive disorder, there is an elevated risk of suicidal or self-harm behavior, or completed suicide (American Psychiatric Association [APA], 2013). Many children with autism have difficulty establishing independence as adults and obtaining gainful employment. It is imperative that family law professionals appreciate the increased vulnerability that special needs children have to the potentially deleterious effects of divorce.

The question then arises as to how specific variables and complexities can be factored into the determination of best interests of the special needs child. Best interests statutes within each state often specify what the court must consider in determining custodial arrangements for children. State laws regarding child custody have identified additional specific factors that must be assessed to address special circumstances, like allegations of domestic violence or child relocation. For example, in most states, statutes and case law regarding domestic violence impact determinations of custody. No legislation currently exists which specifically deals with the unique custody and safety issues for divorcing families with special needs children. However, some states do have legislation addressing financial issues with special needs children in divorce (Price, 2009).

The Association of Family and Conciliation Courts (AFCC) Model Standards of Practice for Child Custody Evaluation (AFCC, 2006) specifies that child custody evaluators should have professional knowledge and training when special issues arise in child custody evaluation. For example, Standard 5.11 specifically states, "evaluators shall utilize a generally recognized and systemic approach to the assessment of such issues as domestic violence, substance abuse, child alienation, child maltreatment including child sexual abuse, relocation, and sexual orientation issues" (p. 16). Consistent with Standard 5.11 (AFCC, 2007), in cases where parenting plans and custody decisions will be made for families with special needs children, we believe that evaluators and court mediators should have specialized knowledge of the disorders and/or disabilities in question. They should also be able to apply a systematic approach to determining or opining about best interests. Unfortunately, at this juncture, such a systematic approach does not exist. There have been, however, a few attempts to explicate relevant factors the family court should consider in cases involving special needs children. For example, Saposnek et al. (2005) suggest that a case management model from the juvenile justice system (Larson & Turner, 2002), called an "individualized parenting plan (IPP)," be adapted by the family court. Another case management corollary is

children who may receive special accommodations within their schools or classrooms if they have a medical, neurodevelopmental, or psychiatric condition (which can impact learning) in accordance with federal laws protecting children with disabilities (such as section 504 of the Rehabilitation Act of 1973).

Another approach to a systematic analysis of special issues in family court has drawn on risk assessment models used in other areas of forensic psychology. In the child custody arena, there has been a well-received application of a risk assessment model in relocation cases. The model developed by Austin is grounded in multiple research studies and can guide a child custody evaluator's data analysis (Austin, 2008a; Austin, 2008b). Additionally, highly useful and empirically based risk assessment models have been developed for the child custody arena in the area of domestic violence (Austin, 2001; Jaffe, Johnston, Crooks, & Bala, 2008; Austin & Drozd, 2012).

We believe that a risk assessment can be useful for family law professionals who must weigh multiple factors in special needs cases, especially since traditional or typical developmental models may fall short of the mark. In addition to residential recommendations, family court judges need information from their mediation and mental health consultants about the types of medical, mental health and educational interventions that are most likely to produce positive benefits and reduce risk of harm for such special needs children, as parents are frequently in disagreement about such issues. Furthermore, a risk assessment shifts the focus from the possible harm caused by an individual parent to the risk of potential harm from environmental circumstances (Austin, 2008b). In general, risk factors are likely to produce more accurate predictions if they are based on scientific research rather than intuition or clinical judgment (although clinical judgment will sometimes serve an important role in custody determinations; Pickar & Kaufman, 2013).

Drozd, Olesen, and Saini (2013) note that parenting plan evaluations can be understood as risk assessments in that the evaluator weighs the relative assets and shortcomings of different plans for a particular family. These authors further point out there are no valid actuarial methods, as yet, for determining risk in child custody determinations, so they suggest using a decision tree approach, "which allows the decision maker to organize the factors and assign weights based on his or her training and experience" (p. 19). A decision tree helps evaluators consider and weigh a broad range of information and consider many possible hypotheses regarding the issues facing a given family.

A RISK ASSESSMENT MODEL FOR DEVELOPING PARENTING PLANS FOR SPECIAL NEEDS CHILDREN

We propose an application of risk assessment for use in child custody decision making with special needs children. The domains/variables are outlined in Table 1 and are drawn from several key sources in the fields of child psychiatry, pediatric medicine, and forensic mental health assessments in the field of divorce and child custody. Factors are based upon the diagnostic and treatment research literature for a range of neurodevelopmental, psychiatric, and medical disorders (APA, 2013; Christophersen & Vanscoyoc, 2013; Weisz & Kazdin, 2010). This includes symptom profiles and developmental courses of specific disorders that can eventuate in physical, social, and/or emotional compromise of the child, as well as the educational and medical risks associated with a range of childhood disorders. The domains also consider the empirically based educational, psychotherapeutic, and medical treatment interventions that can benefit children with specific disorders, as well as the risk to a special needs child if such treatment is not sought or provided. We place particular emphasis on the demands on parents to support and participate in intervention plans. The domains listed in Table 1 also integrate variables previously described in other risk assessment approaches utilized in child custody cases, such as relocation (Austin, 2008a, 2008b), domestic violence (Austin & Drozd, 2012; Jaffe et al., 2008), and a systematic analysis by using decision trees (Drozd, Olesen, & Saini, 2013). Aspects of the domains were also developed by examining the literature that has particularly focused on the topic of special needs children in divorce (Price, 2009; Jennings, 2005; Saposnek et al, 2005).

Table 1
Risk-Protection Continuum for Use with Special Needs Children

<i>Domain</i>	<i>Most likely to cause risk for harm</i>	<i>Most likely to provide protection from harm</i>
1. Safety Issues		
• Physical safety/ supervision	Lack of or inconsistent supervision	Vigilant supervision consistent with child's functional capacities
• Environmental safety	Parent has not implemented appropriate home safety modifications as needed	Parent has or is willing to implement recommended home safety modifications
2. Parenting Skills		
• Parent/child temperament match	Poor match between parent and child temperaments, which interferes with parent's ability to tolerate and manage child's behavior.	Positive match between parent and child temperaments which enables parent to tolerate and manage child behaviors.
• Structure and routine	Parent unable to implement consistent and appropriate structures and routines (i.e., meals, bedtime, hygiene, chores), and follow-thorough with in-home behavioral plan.	Parent able to implement consistent structures and routines (i.e., meals, bedtime, hygiene, chores) and follow-through with in-home behavioral plan.
• Discipline	Parent does not apply appropriate limit-setting, positive reinforcement, and consequences.	Parent applies appropriate limit-setting, positive reinforcement, and consequences.
• Time availability at home	Parent does not have adequate time to manage special needs of child at home.	Parent has time available to manage the special needs of the child at home.
• Acceptance or denial about child's condition	Parent is "in denial" about child's special needs and resists becoming educated about the child's needs.	Parent is well versed and educated regarding the child's special needs.
• Emotional attunement	Parent is not well attuned to shifts in child's moods and behavioral functioning. Parent misses or misreads cues and is unable to implement effective and timely interventions.	Parent understands and is attuned to shifts in the child's moods and behavioral functioning. Parent is able to fashion and implement effective and timely interventions.
3. Medical Needs		
• Openness to medical intervention	Parent won't consider appropriate medication for child as per recommendations of medical providers, or administer prescribed medication.	Parent is cooperative and follows-through with recommended medical interventions.
• Time availability for medical appointments	Parent is not available to take child to medical appointments and is not in contact with medical and providers.	Parent has good availability for medical appointments and prioritizes availability for child's treatment.
4. Educational Needs		
• Awareness of special educational needs	Parent is unaware of and/or uninterested in child's specific educational needs.	Parent is aware of child's educational needs and is actively involved with school and other auxiliary providers.
• Co-parenting and communication about special educational needs	Joint decision-making regarding educational needs is not possible due to divergent views or high conflict.	Parents are able to make decisions jointly and collaboratively, despite any disagreements they may have. Alternately, one parent is in charge of educational decisions.
• Takes steps to arrange for special education services	Parent has not pursued necessary educational plans for accommodations, such as IEPs or 504 plans.	Specialized educational plans, such as IEPs or 504 plans, are in place.
5. Therapeutic Services		
• Mental health therapy	Parent denies need for or refuses to pursue needed mental health services.	Parent pursues and implements appropriate mental health services.
• Occupational therapy, physical therapy, or other needed services	Parent denies need for, or refuses to pursue, needed Occupational Therapy or Physical Therapy services.	Parent pursues and implements appropriate Occupational Therapy or Physical Therapy services.
• Parent participation in services	Parent refuses to participate in parent component of therapeutic services.	Parent is available and willing to participate in parent component of therapeutic services.
6. Advocacy	Parent is passive and unable or unwilling to advocate for child.	Parent is appropriately assertive and willing to advocate for child.
7. Parenting Plan Schedule Considerations		
• Transitions between homes	Schedule with multiple transitions, especially when parents are in conflict.	Schedule that minimizes transitions and has low-key and effective transitions.
• Predictability of schedule	Schedule that has many changes week-to-week or has too much unpredictability.	Schedule that is stable, predictable, and one that the child can learn.
• Parenting plan schedule consistent with child's developmental level (not just chronological age)	Parenting plan is not consistent with child's developmental level.	Parenting plan is consistent with child's developmental level.
8. Financial Considerations	Parent is unwilling and/or unable to pay for special services. If unable, the parent is not willing to pursue alternative sources of financial support.	Parent is willing and able to pay for special services as recommended.

The domains and subvariables within each domain in Table 1 are not categorical in nature, but each risk domain exists on a continuum in which the degree of possible detriment is relative. Thus, within any domain, protective factors may be operative, which could provide a buffering or modulating effect on the potential risk. Of necessity, there will be individual differences not only between different categories of special needs children, but also within categories. For example, a child with a severe autistic spectrum disorder is more disabled than a child with a milder form of autism (previously referred to as Asperger's Disorder) and would be at higher risk for a poor outcome (McPartland, Reichow, & Volkmar, 2012). There may also be key differences in attachment relationships in the respective homes or in the availability of each parent to support necessary treatment. As is the case with all forensic evaluation models, this approach attempts to provide a systematic and predictive framework for organizing pertinent data concerning the issues that are before the court. Austin (2008a) has described that it is always helpful to the court when the evaluator conducts a psychological cost/benefit analysis associated with the decisional alternatives that are available to the court. These risk/protection domains should be examined in conjunction with other global parent variables (i.e., mental health functioning and parenting capacity), child variables (i.e., age of the child, the child's wishes, attachment issues), and co-parenting variables (i.e., level of conflict, gatekeeping) that are typically examined in a child custody evaluation, mediation recommendation, or judicial ruling.

TRANSLATING THE RISK-PROTECTION FACTORS TO PARENTING PLAN RECOMMENDATIONS

Family law professionals typically recommend or order time share plans that are in keeping with the developmental stages of the children of any given family. It is well known, for example, that younger children require frequent contact with both parents to sustain and build parent-child relationships postdivorce. School-age children, as well as preteens and adolescents, can do well with custodial schedules that allow them to settle into routines at each parent's home for longer periods of time. We have noted that there can be situations in which time-share plans based primarily on a child's developmental stage may not be optimal for a child with special needs. Because of the potentially high demands these children place on parents, as well as the heterogeneity of disorders referred to as special needs, multiple factors should be considered and weighed in determining an appropriate time share schedule. Some of these factors overlap with more typical issues considered in making such custody determinations or recommendations (such as age of the child; broad individual parenting skills; level of conflict between the parents), but others pertain specifically to the special needs of the child.

Table 2 lists these factors, which can roughly be broken down into three broad categories:

1. *Child factors*: including basic temperament; the nature and severity of the disorder; the nature and demands of the treatment plan.
2. *Parent factors*: including each parent's capacity to address the special circumstances and behaviors that arise from the child's disorder; parent availability; parent participation in the treatment plan.
3. *Parent-child factors*: including parent insightfulness and empathy for the child; the temperamental match between each parent and the child.

As with Table 1, the descriptors related to these factors should be considered on a continuum, from likely to be successful with a more typical developmentally based schedule, to those where the family law professional should give strong consideration to recommending or ordering a schedule that places a child primarily in the care of one parent. In these instances, frequent access to both parents may have to be sacrificed for the sake of safety, stability, routine and implementation of treatment and

Table 2
Factor Analysis Informs Parenting Plan Recommendations & Determinations

Factor	Traditional developmental plan may be possible	Consider alternative plan
Severity of Disorder	Mild	Severe to Moderate
Treatment Plan	Known & accepted by both parents	Unclear or in dispute
Parent Availability	Both parents available & involved	One more available & involved
Safety & Supervision	No significant issues	Significant issues present
General Parenting Skills	Both parents are sound	One stronger than the other
Special Parenting Requirements	Both parents capable	One parent more capable
Co-Parenting Relationship	Collaborative	Poor cooperation & communication
Level of Conflict	Low	Moderate to high
Quality of Parent-Child Relationship	Secure with both parents	Insecure or disorganized with one parent
Parent Insightfulness & Empathy	Both parents sound	One parent clearly stronger
Parent-Child Temperament Match	Sound and functional	Problematic match

educational plans. We have emphasized the frequent complexity of these cases. Table 2, when used in conjunction with the risk/benefit assessment, should guide the family law professional in the process of weighing data.

In the sections that follow, the risk/protection continuum model (Table 1) and the factor analysis (Table 2) will provide frameworks for examining the symptoms and defining characteristics of three of the most commonly occurring childhood neurodevelopmental and psychiatric conditions. Challenges to divorced parents in terms of raising these children, as well as the educational, psychiatric, and medical approaches that may be most helpful with these conditions will be discussed, as well as the implications for various parenting plans.

ADHD IN CHILDREN AND ADOLESCENTS

DEFINING CHARACTERISTICS AND INCIDENCE

ADHD is one of the most heavily researched psychiatric syndromes (Barkley, 2000, 2006, 2012). ADHD is also one of the most common syndromes encountered by family law professionals for a variety of reasons. While there is concern that ADHD is overdiagnosed, the fact remains that it has a high prevalence rate. Historically, it has been estimated that it occurs in 3–7% of the childhood population, with boys more likely to receive the diagnosis than girls by almost three to one. However, a recent analysis by the Centers for Disease Control (CDC) suggested that nearly one in five high-school-aged boys have been diagnosed with ADHD (CDC, 2013). For many individuals, the symptoms do not necessarily end in adolescence, as studies show that by age 25, the rate of persistence of ADHD as a syndrome is 15%, while the rate of partial persistence of impairing symptoms by this age is 65%. Thus, the overwhelming majority of these children will continue to experience challenges into adulthood, despite normative and expected brain maturation (Kessler et al., 2006).

Children with ADHD also pose challenges for parenting, especially when the disorder is moderate to severe. Because these children can be difficult to manage behaviorally and because they often suffer from co-morbid disorders, they frequently have difficulty with school performance and peer relations. It is not uncommon for divorced or separated parents to bring to the family law venue disputes regarding the best custodial plan for children with ADHD, as well as the best treatment or intervention approach. Given the fact that there is a strong heritability factor with ADHD, families in which a child suffers from this disorder frequently include a parent with similar or related symptoms (Barkley, Murphy, & Fischer, 2007).

The major characteristics of ADHD have been well studied and well defined. Children with the disorder have fundamental impairments in the ability to inhibit behavior when necessary or appropriate. They struggle to modulate impulses and have further trouble delaying gratification. These are children who are unable to stop and think before acting or speaking, often interrupting others. Their reactivity to distractions makes it difficult for them to work towards longer-term goals and rewards (Barkley, 2005).

Another hallmark of the disorder, when features of hyperactivity are present, is excessive physical movement, wherein ADHD children appear to be always on the go, restless or fidgety. A third primary feature of the disorder is difficulty staying on task, as such children struggle to apply active concentration on a consistent basis. These primary symptoms negatively impact school performance and completion of homework, leading parents and teachers to lose patience with the child with ADHD. Children with ADHD typically show signs of cognitive rigidity and poor or slow adaptability, so the contrasting pace of two households, which is so frequent in separated or divorced families, is particularly challenging for the child with ADHD (Nigg, 2006).

ADHD has specific subtypes. DSM-5 now describes a single diagnosis with four “specifiers,” a model designed to capture the heterogeneity of the disorder. They are: hyperactive-impulsive presentation, inattentive presentation, restrictive inattention presentation, and combined presentation (APA, 2013). ADHD presents in different levels of severity, which poses varied challenges not only for the child, but for those with whom he/she interacts, including parents, teachers, siblings and peers. At home, parents experience children with hyperactive ADHD as difficult to manage, hard to keep focused on homework or household chores and generally unruly and emotionally labile. They are also often rejected by peers and they suffer from not being invited to birthday parties and other group activities. Inattentive ADHD children are quite disorganized and messy, often misplacing things, but seeming indifferent to this.

A significant consideration when dealing with children with ADHD is the high incidence of coexisting psychiatric disorders. It has been estimated that up to two thirds of children with ADHD also suffer from “co-morbid” syndromes that affect their functioning at significantly higher rates than are seen in the general population (Larson, Russ, Kahn, & Halfon, 2007). These include

specific learning disabilities (46% rate in ADHD children versus 5% in others), conduct disorders (27% versus 2%), anxiety (18% versus 2%), depression (14% versus 1%), and speech and language disorders (12%; versus 3%) (Larsson et al., 2011). Apart from making the symptom picture more complex, the high occurrence of co-morbidities creates significant challenges in terms of effective treatment.

PRIMARY INTERVENTIONS FOR ADHD

Treatment and intervention strategies for ADHD have been well researched. While there is no cure for the disorder, effective treatment modalities can greatly assist to manage symptoms and produce positive results and outcomes for ADHD children (Pelham et al., 2005). A primary challenge for parents is consistently maintaining treatment strategies over time. Whether it's behavioral systems or medication, interventions must be reevaluated periodically and sometimes reformulated.

For decades, psychopharmacological treatment has been a frontline approach to treating ADHD and has been the subject of hundreds of studies. Medications have evolved over the last 20+ years, with stimulant medications generally considered to be safe and effective (Nigg, 2011). The most common medications include methylphenidate (e.g., Ritalin and Concerta), dextroamphetamine (e.g., Dexadrine), and mixed-salts amphetamines (e.g., Kerns & Prinz, 2013; Barkley, 2006). Possible side effects are well known and include reduced appetite and associated weight loss, sleep disturbance as well as elevated heart rate (Barkley & Murphy, 2006). The effectiveness of stimulant medication can be dramatic or subtle. Anecdotally, some children report they are able to sustain focus and shut out extraneous and distracting stimuli in ways they have not been able to before, while others note more modest improvement in concentration and self-regulation. The effects of the medications may be enduring over months or years, but may also diminish over time. Thus, skilled medical professionals must monitor use of stimulant medication carefully.

In terms of psychosocial interventions for children with ADHD, behavioral counseling with parents has been shown to be more effective than individual counseling with the child. Kerns and Prinz (2013) recently reviewed the extensive literature on psychosocial interventions and concluded that behavioral parent training is the most effective treatment modality. There are many programs available of varying qualities. However, they share common aims of educating parents regarding ADHD and providing parents with specific intervention strategies for coping with common behavioral demands. These programs emphasize parents adopting structured and predictable approaches with their children that not only help manage the child's challenging behavior, but also enhance the parent-child relationship. It is clear that parent participation in such programs is critical for positive outcomes, as is parental consistency and persistence.

RISK ASSESSMENT AND CHALLENGES FOR DIVORCED PARENTS

As noted, children with at least moderate ADHD can strain even fundamentally sound parent relations in intact families. The marital stress created by raising an ADHD child may increase the risk of divorce. For example, Wymbs et al. (2008) found that parents of youth diagnosed with ADHD were more likely to divorce by the time their children were 8 years of age (22.7%) than were parents of youth without ADHD (12.6%). Problems can then increase markedly with divorce, particularly when the parent relationship remains acrimonious over time (Heckel, Clarke, Barry, McDarthy, & Selikowitz, 2009). Specific issues for divorced parents occur in the following domains.

Diagnosis: Parents often view and experience their child's behavior differently, and it is not unusual for parents to disagree about whether a child even suffers from ADHD. For example, ample studies indicate that mothers and fathers rate the severity of their child's behavior differently on behavioral rating measures, with a strong positive correlation between parental stress and greater severity in rating of a child's behavior (Langberg et al., 2010; Duhig, Renk, Epstein, & Phares, 2000;

Chi & Hinshaw, 2002). Mothers typically report more problematic behavior than do fathers, which may be correlated with the amount of direct hands-on experience with the ADHD child. Divorced parents typically argue over whether a child suffers from the disorder or the steps that should be taken to clarify the diagnosis. In many divorced families, conflicting parental viewpoints are especially apparent when children do not have equal time in both households.

It is important to keep in mind that ADHD is not a static condition. Behavioral correlates frequently change over time based on maturation of the child, the extent to which children develop compensatory coping strategies, the effectiveness of medical, behavioral, and school-based interventions and parents' evolving skills. Thus, periodic reevaluation of the parenting plan may be warranted, demanding even more oversight and tracking by the parents.

Treatment planning & participation: As difficult as it can be to get divorced parents to seek appropriate assessment procedures, it can be even more challenging to get them to agree on a treatment plan. Recommended interventions will likely include parent education and implementation of behavioral plans, as well as the possible use of medication. Due to growing concerns about the overprescribing of stimulants, some parents will resist this intervention, even when it is clearly indicated. Parents often do not realize that the use of medications can be obviated or minimized only with strong parent participation and follow-through of behavioral strategies.

In family law cases, neutral professionals may be appointed by the court to resolve disputes about diagnosis and appropriate treatment options. At the extreme, one parent can be awarded sole legal decision making on medical issues. However, this does not ensure the cooperation and participation of a parent who has been reluctant to accept an accurate diagnosis and sound treatment plan.

Coordination between homes and caregivers: With a child who suffers from ADHD, more coordination and cooperation is required than is typical in divorced families. ADHD children thrive on structure, consistency and predictability in terms of behavioral expectations and consequences. This does not necessarily mean that households need to be mirror images of the other. However, parents of the ADHD child will need to target and agree upon specific desired behaviors and specific consequences that can be applied in both homes. In the absence of such agreement, a shared parenting plan may not be possible. The configuration of the homes should also be considered, as ADHD children can have difficulty adapting to environments that are too stimulating, as can sometimes occur when there are new stepchildren or siblings.

Transitions: Given the inherent difficulties with cognitive flexibility and adaptability in ADHD, these children often have trouble with shifts in environmental settings. Children with ADHD can be slower to adapt when moving from one household to another, especially when there are differences between the two environments. Thus, custodial schedules with more frequent transitions between the homes are often problematic. This is especially so with mid-week transitions, as these children need stable routines to meet the demands of school. Children with ADHD notoriously lose track of assignments, books, and other school related materials. There are also often struggles to get homework and projects done in a timely way. Absent sound communication and coordination between caregivers, ADHD children often do better with custodial schedules that minimize transitions during the school week.

Direct coordination with school: ADHD children are at risk for behavioral problems at school, scholastic underachievement, as well as a high incidence of comorbid learning disorders (Barkley, 2006). ADHD is a disorder that often meets criteria for mandated accommodations at school, either through an Individualized Educational Plan (IEP) or via section 504 of the Rehabilitation Act of 1973 ("504 Plan"). Coordination and collaboration with school personnel can include relatively lower demand responsibilities like tracking academic progress and ensuring that children follow through with assignments, to more intensive commitments like advocating for and cooperating with initial assessments and participating in periodic reviews by the school district. Parent motivation, involvement, and availability are keys to the child's success.

Heritability and Temperament Match: Family law personnel should also bear in mind that due to the strong hereditary component of ADHD, it is not unusual for at least one parent to have a similar

cognitive profile to the ADHD child, even if there has not been a formal diagnosis of that parent. While the symptom picture of adult ADHD is invariably different from its manifestation in childhood and/or adolescence, some features of the adult disorder can make effective implementation of an intervention plan challenging or problematic for the parent with adult ADHD. Needless to say, this is yet another factor to be considered in this complex nexus.

DEPRESSIVE DISORDERS IN CHILDREN AND ADOLESCENTS

DEFINING CHARACTERISTICS AND INCIDENCE

Depressive Disorders in children and teenagers include the following diagnoses: major depressive disorder, persistent depressive disorder (formerly known as dysthymia), and disruptive mood dysregulation disorder. According to the DSM-5 (2013), the common feature of all these disorders is the presence of sad, empty, or irritable moods, accompanied by bodily and cognitive changes that can significantly affect an individual's capacity to function. Children and teenagers who suffer from depression often have depressed mood and a diminished interest in activities, reduced energy for schoolwork, insomnia, fatigue, and poor concentration. Depressed teenagers in particular frequently have suicidal thinking and/or engage in self-harming behaviors that range from cutting, burning, or other forms of self-mutilation, to actual suicide attempts. Needless to say, these children or teenagers require a very high level of parental supervision.

Regarding the prevalence of depressive disorders in children and teenagers, a number of epidemiological studies have reported a rate of up to 3% in children, but a rate of 8% in 13- to 18-year-olds, making adolescence a critical time of susceptibility. For example, one in five teenagers have experienced a depressive disorder by the time they reach 18 years of age (Clarke & Debar, 2010). There is particular concern for girls, whose rates of depression are twice as high as those of boys during adolescence (Weisz & Kazdin, 2010).

Teen suicide is the third leading cause of adolescent death in our country, with the highest risk groups being gay/lesbian and African American teenagers (Berman, Jobes, & Silverman, 2006). While depressed girls attempt suicide three times more often than boys, completed suicides are four times higher in boys, due to the lethality of method (i.e., gunshot, as opposed to an overdose of pills). Nearly 20% of adolescents in middle school and high school age groups report having seriously considered attempting suicide in the past year (Berman, Jobes, & Silverman, 2006).

Nonsuicidal self-injury behavior (NSIB), a frequent behavior in suicidal teenagers, involves intentionally injuring oneself in a manner that typically results in damage to body tissue, but without any conscious suicidal intent. The enormity of this problem in today's society is evident from the fact that community studies show that approximately 12% to 14% of adolescents reported self-mutilation, and many studies suggests that the rate of self-mutilation is increasing among teenagers (Ross, Heath, & Toste, 2009; Brausch & Gutierrez, 2010).

The course of depression is highly variable, ranging from a brief depressive episode related to specific circumstances (i.e., breakup with boyfriend or girlfriend, a relocation and loss of friends, divorce), to more low-grade but ongoing despondency, now referred to as persistent depressive disorder. By definition, this is more chronic in nature. The course of depression is also related to the effectiveness of treatment interventions and the extent and effectiveness of support in the home environment(s).

PRIMARY INTERVENTIONS FOR DEPRESSIVE DISORDERS

The three most effective empirically supported psychological treatment modalities for depression in children and teenagers are: cognitive-behavioral therapy (CBT), performed both in individual and group therapy formats; interpersonal therapy for depression (IPT); Christopherson & Vanscoyoc,

2013); as well as dialectical behavior therapy (DBT; Miller, Rathus, & Linehan, 2007). CBT interventions are designed to help individuals change maladaptive thoughts, improve effective problem-solving skills, and increase participation in positive relationships and activities. In a review of psychosocial treatments for child and adolescent depression, David-Ferdon and Kaslow (2008) concluded that CBT is an efficacious intervention in most group and individual formats. Many CBT approaches are hybrid therapeutic models, which include adjunctive parent training (Stark, Streusand, Krumholz, & Patel, 2010). Parents are enlisted to help model therapeutic skills to their child, to reinforce therapeutic strategies, to employ empathic listening and conflict resolution skills, and to create a more supportive environment at home. David-Ferdon and Kaslow (2008) also concluded that interpersonal therapy (IPT) is a well-established empirically supported treatment when implemented with adolescents in an individual therapy format. IPT focuses on the current interpersonal problems of the adolescent, targeting improved communication and problem-solving skills as avenues for increasing personal effectiveness and relieving symptoms of depression.

The best empirically supported treatment intervention for adolescents who are not only depressed, but also engage in both suicidal and non-suicidal self-injurious behavior, is DBT (Miller, Rathus, & Linehan, 2007). Several studies (Fleischhaker et al., 2011; Woodberry & Popenoe, 2008; Rathus & Miller, 2002) have shown that DBT leads to improvements in multiple domains, including reducing depression, suicidality, and nonsuicidal self-injurious behavior, as well as enhancing emotion regulation. In DBT, parents and children attend weekly multifamily skills groups, which typically last 12–16 weeks, where both teenagers and parents learn skills in the areas of emotion regulation, distress tolerance, interpersonal effectiveness, mindfulness, and “walking the middle path” (Miller, Rathus, & Linehan, 2007). Parent participation is crucial in this approach, so parents can learn the DBT skills themselves to better assist their teenager in times of crisis.

Lastly, pharmacological interventions are often helpful as adjuncts to psychological and behavioral treatments, but should rarely be a stand-alone treatment. While research has clearly demonstrated that antidepressant medications, especially when combined with psychotherapy, can be very effective treatments for depressive disorders with adults, there remains controversy regarding the use of such medications with children and teenagers. Some of the newer medications, specifically the selective serotonin reuptake inhibitors (SSRIs) have mostly been shown to be safe and efficacious for the short-term treatment of severe and persistent depression in young people, although large scale research is still needed (Cheung, Emslie, & Mayes, 2005). There is also a “Black Box” warning by the Food and Drug Administration on certain SSRIs which alerts patients to possible increased risk of suicidal ideation or behavior. Again, careful monitoring of symptoms and medication effects by parents and treating professionals is necessary if SSRIs are used with children or teenagers.

RISK ASSESSMENT AND CHALLENGES FOR DIVORCED PARENTS

Divorce and Childhood Depression

While there are both temperamental and genetic factors that increase the risk of depression, adverse childhood experiences also constitute a potent risk factor for the development of depression. An adverse childhood experience would most notably include a child undergoing the disappointment, loss and stress of a divorce. However, divorce itself may not always be to blame for causing depression in children, as the cause may sometimes be the environment in the household that led to the separation or divorce (D’Onofrio et al., (2007). In some instances then, a high conflict or unhappy home environment may precipitate depression in a child or teen prior to separation, but the separation event itself and its aftermath, may also precipitate depression (Pickar, 2003). Kelly (2012) noted that separation and divorce increases the risk for psychological problems in children and teens, including depression, when compared to children in continuously married families, especially during the first 2 to 3 years after divorce. Also, children with parents in high-conflict marriages are more at risk for experiencing depressive symptoms, peer difficulties, and

poorer academic achievement, than children in low-conflict marriages. Loss of important relationships is also a major risk factor for depression. It is well documented that children view the loss of the nonresident parent after separation as the most negative aspect of a divorce. According to an important study of children from preschool to college age conducted by Braver, Ellman, and Fabricus (2003), sadness, pain, distress, depression, and longing for the father are persistent issues for children following a separation or divorce.

Parent-child attunement: Parent attunement to a teenager's mood is critical with adolescents who are prone to depression. They must also have the type of relationship with their son or daughter whereby a teenager will reveal the extent of their depression, or disclose whether they may be struggling with suicidal ideation or self-harm behaviors. Detecting depression in teenagers is especially challenging, as the overt symptom may not be depressed mood per se. Rather, depression may be expressed or masked by, a high level of irritability or increased aggression. Nonspecific physical complaints such as headaches, stomachaches, or fatigue may emerge, as well as extreme sensitivity to rejection or failure. An increase in reckless behavior or substance use/abuse might also mask underlying suicidal thoughts. For family law professionals, it is critical to determine the extent to which each parent understands the extent and complexity of the teenager's problem and is willing to actively support the youth's participation in treatment. This includes understanding that there may be symptoms, such as suicidal thoughts, that require immediate intervention, including possible hospitalization.

Teenager's safety: Mood disorders can sometimes precipitate truly dangerous behaviors, including suicidal actions or nonsuicidal self-injurious behavior. Risk is increased when teenagers abuse drugs and/or alcohol, as well as when they have access to potentially lethal means of harming themselves. This would include access to prescription and nonprescribed medications, guns, knives, or razor blades. Thus, the question becomes whether both parents can provide necessary supervision and environmental safety commensurate with actual risk. Seriously depressed or suicidal adolescents are at far more risk in the home of a parent who balks at locking up potentially dangerous items, or who fails to recognize the disinhibiting influence of alcohol and drugs.

Structure and limit setting: Depressed teens need support to maintain their regular routines and structure, and should not be allowed to use their problems as an excuse for poor school attendance, not completing homework, and not maintaining household chores and participating in family activities. Limit setting is especially important for the suicidal teenager, who may need to be carefully watched by parents and have their socialization activities restricted for a period of time to ensure both their safety and ability to manage the social world. Parent availability is a crucial concern, not only with respect to monitoring a child's mood and safety, but also regarding their ability to take the child or teen to psychotherapy or psychiatric appointments, or participate in family meetings. Consideration should be given to placing a depressed child or teen in the primary custody of the parent that is most willing to become educated about the problem, fully comprehends the risk involved, and is motivated to support and participate in treatment. Sound parent communication skills and a comfortable and comforting parent-child relationship are additional protective factors. Joint physical custody may be appropriate if both parents possess such skills, but if not, shared custody may be inappropriate. Essentially with depressed teenagers, preservation of life and participation in mental health treatment should take priority over a child-sharing plan.

Treatment support and advocacy: As with other special need disorders, there is a high demand on parents of depressed youths to support mental health interventions. This goes beyond sheer availability, as there are invariably parent and family components to treatment plans for these adolescents. Medication may also be indicated, but parents sometimes disagree with this medical intervention, especially in light of recent publicity of SSRIs possibly causing increased suicidal ideation in children and teens. If a treatment plan has been determined and one parent is unable or unwilling to support it, the parent who will cooperate with and facilitate treatment may need to have temporary sole legal custody for decision making in this domain.

Additionally, some seriously depressed children or teenagers may be unable to function in a regular school environment for a period of time. They may need to be placed on a "home and hospital"

program, whereby they complete school lessons and assignments at home, under the supervision of a teacher designated by the school. Such home-based interventions often either requires an IEP being completed by the school, or a psychiatrist's or psychologist's written diagnosis and recommendation to the school often compels the school to arrange a home and hospital program. This demands not only parent availability, but assertive advocacy. In such situations, typical joint physical custody plans for this age group (e.g., 2-2-5-5 or week on/week off) are rarely appropriate.

Parent communication and co-parenting relationship: Sound co-parenting relationships and reasonably healthy communication between parents is a general protective factor in divorce. The opposite—poor collaboration and communication—are especially salient risk factors in families with seriously depressed teens. Particularly given adolescents' normative tendency to hold private their thoughts and feelings from their parents, coupled with the fact that teenage depression is not always recognizable to adults, the stakes are high when one parents misses critical signs of danger. When one parent's resentments toward the other trump their willingness to work together, the depressed youth is extremely vulnerable. We want to emphasize however, that while it may be advisable to place a seriously depressed youth in one parent's home, there are further risks when the other parent drops out of the picture. Thus, the custodial parent should also be the parent who understands the teenager's need to keep contact with the noncustodial parent and will facilitate that contact, despite a changed timeshare schedule.

Seeking the input of teenagers is especially important in determining the best custodial arrangement for assisting the depressed child or teenager to improve his or her symptoms and reduce the possibility of suicidal or nonsuicidal self-injurious behavior.

AUTISM SPECTRUM DISORDERS

DEFINING CHARACTERISTICS AND INCIDENCE

Autism spectrum disorder (ASD) is a group of neurodevelopmental conditions whose primary features are: significant difficulties with reciprocal social interaction, deficits in verbal and nonverbal communication, and the presence of repetitive or ritualistic behaviors. The most recent version of the DSM-5; APA, 2013) has subsumed under this one nosology a cluster of related disorders previous listed individually in DSM-IV. Those conditions are: autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder, not otherwise specified. The DSM-5 revision represents a more accurate and scientifically useful way of diagnosing individuals with autism-related disorders, as the symptoms and features of autism tend to fall on a continuum, with some individuals showing mild symptoms and others having much more severe symptoms. Children with more severe forms of ASD often have accompanying intellectual and language impairment. The DSM-5 also describes three levels of severity for this condition, ranging from "requiring support" (Level 1), "requiring substantial support" (Level 2), to "requiring very substantial support" (Level 3).

In varying degrees of severity, ASD children have great difficulty with reciprocal interpersonal interactions. They also have poor nonverbal skills for social relations (i.e., not making eye contact, lacking facial expressions, not reading social cues) and may lack interest in peers. Many ASD children also evidence a restricted pattern of behavior and may also perseverate on specific areas of interest or engage in repetitive motor movements. Children with ASD frequently insist upon excessive environmental repetition and an inflexible adherence to routine. Thus, they have difficulty with transitions between settings, and they may display extreme distress at small changes in their environment.

Regarding prevalence, the number of 6- to 17-year-old children diagnosed with an ASD has been rising dramatically in the last 10 years. In 2006, The CDC found that 1 in 110 children suffered from ASD. In 2009, the rate of children diagnosed with an ASD rose to 1 in 88 (CDC, 2012). The most recent data (Blumberg et al., 2013) indicates that this trend has continued, with 1 in 50 (or 2%)

school-age children now being diagnosed with an ASD. Some of the increase may be attributable to increased awareness in the medical and educational community, as well as the general public, regarding the characteristics of autism (Blumberg et al., 2013). While the exact causes of ASD's are still unknown, the general consensus is that it is genetic in origin, although environmental factors (i.e., advanced parental age, low birth weight, fetal exposure to valproate) may influence the expression of certain genes (Levy, Mandell, & Schultz, 2009). Symptoms are typically recognized during the second year of life, but may be seen earlier than 12 months if developmental delays are severe, or noted later than 24 months if symptoms are more subtle (APA, 2013). The first symptoms of ASD frequently involve delayed language development and are often accompanied by lack of social interest or unusual social interactions.

PRIMARY INTERVENTIONS FOR AUTISM SPECTRUM DISORDERS

There are a myriad of treatment approaches for ASD and a full review of such approaches is beyond the scope of this article. Due to the severe impairments in everyday living skills found in many, if not most, ASD children, approaches to treatment are comprehensive and intensive. They also place heavy demands on parents not only to support the treatment, but to implement specific behavioral strategies. Most of the well-known therapies for ASD's use a method known as Applied Behavior Analysis (ABA), a method of teaching that uses reinforcement to motivate and shape desired behavior (Myers & Plauche-Johnson, 2007). ABA-based therapies work to reduce or eliminate problem behaviors such as self-injury or aggression while increasing the child's adaptive skills in order to maximize functional independence. Early intensive behavioral intervention (Smith, 2010), which is based on ABA, begins when children are 4 years of younger, and typically involves 20–40 hours per week of individualized ABA instruction and continues for 2 or more years. Efforts to improve treatment outcomes for ABA have led to implementing behavioral interventions directly in the child's everyday environments instead of in clinical settings. Parents and peers are involved as change agents in the natural environment. Discrete trial teaching is another widely used ABA therapy often used to teach basic skills such as paying attention, following directions, and imitating instructions, while Relationship Development Intervention is a newer treatment that focuses on activities that encourage social interaction and motivate the ASD child to become more interested in interpersonal exchanges (Rosenblatt & Carbone, 2013).

In most of the ABA models, parents are an integral part of their children's intervention teams. For the first 3–4 months of many ABA-based treatments, parents are asked to work alongside an experienced team member for 5 hours per week. Thus, parents learn to become effective therapists for their children at home. It is often crucial for parents to implement teaching procedures at home (Smith, 2010). This includes encouraging their children to use communication skills in everyday settings, incorporating self-help into children's daily routines, and arranging activities that promote further skill development, such as outings and play dates. Parents must also be strong advocates for their children by actively investigating the most appropriate school placements and regularly communicating with teachers about their child's progress. Depending upon the severity of ASD, behavioral therapy is often supplemented by pharmacological treatment, as well as speech-language therapy, occupational therapy, and in some instances, sensory integration therapy or social skills groups.

RISK ASSESSMENT AND CHALLENGES FOR DIVORCED PARENTS

Children who have ASD present major challenges for both intact and separated families. As far as family stress, Hartley et al. (2010) found that parents of children with an ASD had a higher rate of divorce than the comparison group (23.5% vs. 13.8%). Allik, Larsson, and Smedje (2006) found that mothers of ASD children had significantly poorer physical and psychological health than do mothers of age-matched peers who do not have ASD. Parents of children with ASD are also more likely to experience financial and work-related problems (Birnbaum, Lach, Saposnek, & MacCulloch, 2012).

Safety and Supervision: Regarding physical and environmental safety, an extraordinary level of supervision is required for lower-functioning ASD children and teenagers. They are especially prone to physical dangers due to excessive self-absorption such as not looking out for cars. Children with ASD can also easily become the victim of strangers. Given how serious these risks can be, family law professionals should assess which parent is most attentive to physical dangers to insure the ASD child's safety. This can include "childproofing" in unanticipated ways. Jennings (2005) noted that medical safety might also be an issue when a parent cannot recognize signs of pain or illness, especially when the ASD child is unable to report these conditions verbally. The level of needed supervision only intensifies when ASD children engage in self-destructive behavior (such as head banging) or go into extreme rages if they are frustrated. In these instances, the child may require physical restraint in addition to emotional soothing and behavioral redirection. Having a parent who can provide vigilant supervision consistent with the ASD child's functional capacities is a protective factor for ASD children.

Structure and Predictability: ASD children have an excessive need for sameness and consistency in their daily routines, and they thrive with schedules and predictability. In turn, they tend to become anxious and may have tantrums when their routine is disrupted in even small ways. It is not imperative, nor even desirable, for parents to meet the rigid standards that autistic children seem to demand. Thus, parents need a breadth of parenting skills to provide structure and consistency, but also to respond to the inevitable upsets of the ASD child. The ability to maintain a consistent structure and routine, while providing appropriate discipline, positive reinforcement, reasonable and timely consequences and firm but nonpunitive limit setting are all crucial. The parent who is "in denial" about their child's condition will have far more difficulty providing the specialized parenting needed with ASD children. As mentioned, children with a moderate to severe ASD often need 24 hour supervision, so the question frequently becomes which parent has the time availability to supervise closely and manage the child's needs, while also getting them to appointments for special therapeutic or medical services.

Medical Interventions across Homes: While pharmacological intervention is not considered a primary treatment for ASDs, recent surveys show that 45% to 50% of children and adolescents with ASDs are treated with medication to address neurobehavioral functioning and cope better with daily routines (Rosenblatt & Carbone, 2013). This is due to the fact that many ASD children have higher rates of symptoms of ADHD, depression, and anxiety than non-ASD children (Fombonne, 2003). For example, risperidone has sometimes been used effectively for the ASD child with extreme irritability or a tendency to be self-destructive during tantrums (Jesner, Aref-Adib, & Coren, 2007).

Parents frequently have strong opinions about autism, especially in terms of accuracy of diagnosis, possible causation and treatment. Especially since disagreements between parents often predate the breakup of the family, it is not unusual for one parent to take charge of services for the ASD child. This can be helpful, but often times it remains a source of tension between the parents. In these instances, it is not unusual for one parent to take a child to a physician and even implement a regime of medication without the other parent's consent or involvement. Not only might the other parent then become angry, but they might also refuse to comply with the medical regimen. This can be medically dangerous to a child, as consistent administration of medications across households is imperative. Thus, interparental conflict and a noncooperative parent are significant risk factors for the ASD child. In its extreme, the situation might have to be managed by one parent having sole legal custody over medical decisions, as well as primary or sole physical custody, with the other parent having visitation when administering medication is not necessary.

Advocacy and Availability: Most ASD children require a host of special education and therapeutic services. In divorced families, a key issue is which parent can best serve as an assertive advocate for their child by both researching and obtaining such specialized services. Furthermore, it is imperative that parents of ASD children sustain very consistent contact with teachers, counselors and treatment providers. An assertive advocate-parent is a protective factor for ASD children, while a passive parent, unwilling to put the time and effort into obtaining special services, leads to greater risks for the ASD child. In addition to needing specialized educational plans (i.e., a 504 plan or Individualized

Educational Plan), ASD children often need occupational and speech therapy. For children with moderate to severe ASD, if a form of ABA is being used, this requires a high level of parent participation and training. Thus, an important consideration for a parenting plan becomes whether only one, or both parents can be available to participate in the parent component of behavioral treatment. Also, with ASD children, there are typically a host of decisions that need to be made regarding which educational intervention to pursue and what adjunctive mental health services may benefit the child. In situations of high-conflict divorce or where parents have very limited ability to make joint decisions, it may be necessary to have one parent with the legal authority to make accurate and timely decisions. At times, there may be two reasonably effective parents who are highly invested in their child and willing to follow through with therapeutic and medical interventions, but just disagree about the type and scope of such interventions. If joint custody is maintained, the services and oversight of a Parenting Coordinator may be necessary.

Timeshare considerations: Even under the best of circumstances, when there are two capable parents with a functional co-parenting relationship and general agreement on treatment approaches, traditional joint custody timeshares may not be feasible. Because ASD children generally function at a lower developmental level than that of their chronological age, parenting plans must be recalibrated to the functional capacity of the child. Moreover, for many ASD children, the need for sameness in environment may supersede the need for sameness of routine (Jennings, 2005). Thus, even if routines in two homes are coordinated and come close to mirroring each other, the ASD child may still be stressed by merely transitioning to a different physical environment. Many ASD children or teens may desire to maintain a primary home and have few or no overnights at the other parent's home. Parenting plans must accommodate this basic need that arises out of the disorder to prevent exacerbation of symptoms. Even higher functioning ASD children find it difficult to transition between homes and require longer periods to adjust to the shift in residence.

CONCLUSION

Families with special needs children are seen with surprising frequency in family law cases, and present unique and complex issues for family law professionals. Addressing the best interests of these children is especially challenging given the heterogeneity of disorders, syndromes and conditions that fall within the umbrella term of "special needs." Traditional views of the best interests of the child often have to be recalibrated to address the specific needs of these children. At times, typical benchmarks for parenting plans based on chronological age or even developmental phase fall short of the mark. We certainly echo Saposnek et al.'s call to action, and suggested guideline to "replace 'best interests of the child' with the enhanced standard of 'best interests of the child's special needs'" (Saposnek et al., 2005, p. 579).

Specific approaches to these complex cases can enhance the likelihood that a suitable parenting plan can be identified, developed and sustained. Those approaches are summarized as follows:

1. Family law professionals of all disciplines should develop a fundamental knowledge base about the most commonly seen special needs children encountered in family court, but more importantly an in-depth knowledge of the special need(s) inherent in cases in which they are working. This article outlines three of the most common syndromes. Articles and books from respected sources, especially those based on sound research, should be consulted. When direct access to such information is not readily available, an experienced allied professional should be engaged to provide consultation. Information should be shared with all individuals involved in the case, including the parents.
2. Education should include understanding which evidence-based treatments may be necessary, as well as existing controversies about approaches to treatment. Be aware that current trends in evidence-based treatments for multiple childhood conditions include parent education and participation components.

3. Use “developmentally appropriate parenting plans” with caution as they may not be best for special needs children. In many instances, the need for stability in residential placement and consistent routine outweighs a custodial schedule that provides significant time with both parents. Be especially cautious about custodial plans that include multiple transitions, especially during times that are challenging for special needs children, such as school days.
4. Parenting plans should be informed by a comprehensive assessment of parenting skills, including knowledge of the special needs in question, acceptance of the syndrome or condition, and availability and motivation to support the treatment plan. Parent willingness and capacity to follow through on an intervention plan should be especially considered. Family law professionals should be aware of which conditions have a strong hereditary component and be alert to the possibility (but not inevitability) that a parent has similar characteristics that might impact parenting skills. This could be either an asset or a deficit.
5. In divorced families where there is a special needs child, coordination between caregivers, as well as sharing of information and establishing consistency in daily routines and structures, are especially important. For families in dispute, it may be beneficial to refer the parents to a co-parent counselor, as it is not infrequent that timely and well-informed decisions need to be made. For high conflict families with a special needs child, consider the use of a skilled parenting coordinator who can intervene decisively before conflicts grow so big that court action is required. Assignment of sole legal custody over medical and/or educational decisions to the parent who is better informed and more involved in necessary treatment protocols can be of assistance.
6. A risk assessment model can be of particular use in determining a sound course of action. Risk of poor outcomes for children is multi-determined. Some risks are inherent in the nature of the condition or syndrome (such as specific symptoms, severity, effectiveness of known treatment plans), and some are more reliant on direct parenting skills (e.g., parent’s level of education about the syndrome, ability to provide proper structure and consequences). Other risk or protective factors arise from aspects of the parent-child relationships (i.e., parent attunement and child’s willingness to follow the parent’s lead), or from the relationship between the parents (i.e., level of general conflict, ability and willingness to communicate with each other, agreement on a treatment plan).
7. Consider safety first. Some special needs children are at particular risk for self-destructive behavior or excessive risk-taking.
8. No parenting plan should be etched in stone. In cases with special needs children, custodial plans may need to be reviewed more frequently than is typical. Information from school, mental health and medical personnel may provide important feedback that must be considered to determine whether a parenting plan is effective at that point in time. Response to interventions and general maturation of the child may broaden or restrict custodial possibilities. Any proposed shift in custodial plan or timeshare should be considered with adequate information from parents and especially from neutral collateral sources, especially professionals.
9. Consider the entire family system when crafting parenting plans for special needs children. When parents remarry or have new partners, and especially when there are stepchildren and new siblings, the family system expands. Family court professionals should not make assumptions about the impact of these changes, as ultimately they can enrich a child’s life and not just complicate it. The “calculus” of parenting plans may become more complex, but professionals should consider both assets and challenges that reconfigured families bring to the special needs child.

While this article has stressed the challenges of creating parenting plans that address the best interests of the special needs child, it is important to keep in mind that these children are the focus of expanding research and there is an ever broadening knowledge base that can assist family law professionals. It’s imperative that the unique requirements of special needs children be incorporated into the family law system to ensure the best possible outcome for them.

REFERENCES

- Allik, H., Larsson, J. O., & Smedje, H. (2006). Health-related quality of life in parents of school-age children with Asperger syndrome or high-functioning autism. *Health and Quality of Life Outcomes, 4*(1), 1–8.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Association of Family and Conciliation Courts. (2006, May). *Model standards of practice for child custody evaluation*. Madison, WI: Author. Reprinted in *Family Court Review, 45*, 70–90.
- Association of Family and Conciliation Courts. (2007). Model standards of practice for child custody evaluation. *Family Court Review, 45*, 137–150.
- Austin, W. G. (2001). Partner violence and risk assessment in child custody evaluations. *Family Court Review, 39*, 483–496.
- Austin, W. G. (2008a). Relocation, research, and forensic evaluation: Part I: Effects of residential mobility on children of divorce. *Family Court Review, 46*, 137–150.
- Austin, W. G. (2008b). Relocation research and forensic evaluation: Part II: Research in support of the relocation risk assessment model. *Family Court Review, 46*, 347–365.
- Austin, W. G. & Drozd, L. M. (2012). Intimate partner violence and child custody evaluation, Part I: Theoretical framework, forensic model, and assessment issues. *Journal of Child Custody, 9*, 250–309.
- Barkley, R. A. (2000). *Taking charge of ADHD: The complete, authoritative guide for parents*. New York: Guilford.
- Barkley, R. A. (2005). *ADHD and the nature of self-control*. New York: Guilford.
- Barkley, R. A. (2006). *Attention deficit hyperactivity disorder: A clinical workbook* (3rd ed.). New York: Guilford.
- Barkley, R. A. (2012). *Executive functioning and self-regulation: Extended phenotype, synthesis, and clinical implications*. New York: Guilford.
- Barkley, R. A. & Murphy, K. R. (2006). *Attention deficit hyperactivity disorder: A clinical workbook*. New York: Guilford.
- Barkley, R. A., Murphy, K. R., & Fischer, M. (2007). *ADHD in adults: What the science says*. New York: Guilford.
- Berman, A. L., Jobs, D. A., & Silverman, M. M. (2006). *Adolescent suicide: Assessment And intervention*. Washington, DC: American Psychological Association.
- Birnbaum, R., Lach, L. M., Saposnek, D. T., & MacCulloch, R. (2012). Co-parenting children with neurodevelopmental disorders. In K. F. Kuehnle & L. M. Drozd (Eds.), *Parenting plan evaluations: Applied research for the family court*. New York: Oxford University Press.
- Blumberg, S. J., Bramlett, M. D., Kogan, M. D., Schieve, L. A., Jones, J. R., & Lu, M. C. (2013). Changes in prevalence of patient-reported autism spectrum disorder in school-age US children: 2007 to 2011–2012. *National Health Statistics Reports, 65*, 1–12.
- Brausch, A. M. & Gutierrez, P. M. (2010). Differences in non-suicidal self-injury and suicide attempts in adolescents. *Journal of Youth and Adolescence, 39*, 233–242.
- Braver, S. L., Ellman, I. M., & Fabricus, W. V. (2003). Relocation of children after divorce and children's best interests: New evidence and legal considerations. *Journal of Family Psychology, 17*, 206–291.
- Briscoe-Smith, A. & Hinshaw, S. P. (2006). Linkages between child abuse and attention-deficit/hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse and Neglect, 30*, 1239–1255.
- Christophersen, E. R. & Vanscoyoc, S. M. (2013). *Treatments that work with children: Empirically supported strategies for managing childhood problems*. Washington, DC: American Psychological Association.
- Center for Disease Control. (2012). Prevalence of autism spectrum disorders: Autism and developmental disabilities monitoring network, United States, 2008. *MMWR, 61*(3), 1–9. Retrieved from <http://www.cdc.gov/mmwr/pdf/ss/ss6103.pdf>
- Center for Disease Control. (2013). Changes in prevalence of parent-reported autistic spectrum disorder in school-aged U.S. children: 2007 to 2011–2012. *National Health Statistic Report, 65*. Retrieved from www.cdc.gov/nchs/data/nhsr/nhsr065.pdf
- Cheung, A. H., Emslie, G. J., & Mayes, T. L. (2005). Review of the efficacy and safety Of antidepressants in youth depression. *Journal of Child Psychology and Psychiatry, 46*, 735–754.
- Chi, T. & Hinshaw, S. (2002). Mother-child relationships of children with ADHD: The role of maternal depressive symptoms and depression-related distortions. *Journal of Abnormal Child Psychology, 30*, 387–400.
- Clarke, G. N. & Debar, L. L. (2010). Group cognitive-behavioral treatment for adolescent depression. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 110–125). New York: Guilford.
- David-Ferdon, C. & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychiatry, 37*, 62–104.
- De Sanctis, V., Nomura, Y., Newcorn, J. H., & Halperin, J. M. (2012). Childhood maltreatment and conduct disorder: Independent predictors of criminal outcomes in ADHD youth. *Child Abuse and Neglect, 36*, 782–789.
- D'Onofrio, B. M., Turkheimer, E., Emery, R. E., Maes, H. H., Silberg, J., & Eaves, L. J. (2007). A children of twins study of parental divorce and offspring. *Journal of Child Psychology and Psychiatry, 48*, 667–675.
- Drozd, L., Olesen, N., & Saini, M. (2013). *Parenting plan and child custody evaluations: Using decision trees to increase evaluator competence and avoid preventable errors*. Sarasota, FL: Professional Resources Press.
- Duhig, A. M., Renk, K., Epstein, M. K., & Phares, V. (2000). Interparental agreement on internalizing, externalizing and total behavior problems: A meta-analysis. *Clinical Psychology Science and Practice, 7*, 435–453.

- Elrod, L. D. & Spector, R. G. (2012). Symposium on special needs and disability in family law. *Family Law Quarterly*, 46, 177–311.
- Eme, R. (2009). Attention deficit hyperactivity disorder and the family court. *Family Court Review*, 47, 650–664.
- Fleischhaker, C., Bohme, R., Sixt, B., Bruck, C., Schneider, C., & Schulz, E. (2011). Dialectical behavioral therapy for adolescents (DBT-A): A clinical trial for patients with suicidal and self-injurious behavior and borderline symptoms with a one-year follow-up. *Child and Adolescent Psychiatry and Mental Health*, 5(3). Retrieved from <http://www.capmh.com/content/5/1/3>
- Fletcher, J. & Wolfe, B. (2009). Long-term consequences of childhood ADHD on criminal activities. *Journal of Mental Health and Public Policy Economics*, 12, 119–138.
- Fombonne, E. (2003). Epidemiological surveys of autism and other pervasive developmental disorders: An update. *Journal of Autism and Developmental Disorders*, 33, 365–382.
- Hartley, S. L., Barker, E. T., Seltzer, M. M., Floyd, F., Greenberg, J., Orsmond, G., et al. (2010). The relative risk and timing of divorce in families of children with an autistic spectrum disorder. *Journal of Family Psychology*, 24, 449–457.
- Heckel, L. D., Clarke, A. R., Barry, R. J., McDCarthy, R., & Selikowitz, M. (2009). The relationship between divorce and children with AD/HD of different subtypes and comorbidity: Results from a clinically referred sample. *Journal of Divorce & Remarriage*, 50, 427–443.
- Jaffe, P. G., Johnston, J. R., Crooks, C. V., & Bala, N. (2008). Custody disputes involving allegations of domestic violence: Towards a differentiated approach to parenting plans. *Family Court Review*, 46, 500–522.
- Jennings, S. (2005). Autism in children and parents: Unique considerations for family court professionals. *Family Court Review*, 43, 582–595.
- Jesner, O. S., Aref-Adib, M., & Coren, E. (2007). Risperidone for autism spectrum disorder. *Cochrane Database of Systemic Reviews*, 1(CD005040).
- Kelly, J. B. (2012). Risk and protective factors associated with child and adolescent adjustment following separation and divorce: Social science applications. In L. Drozd & K. Kuehne (Eds.), *Parenting plan evaluations: Applied research for the family court* (pp. 49–84). New York: Oxford University Press.
- Kerns, S. & Prinz, R. (2012). Co-parenting children with attention-deficit/hyperactivity disorder and disruptive behavior disorders. In L. Drozd & K. Kuehne (Eds.), *Parenting plan evaluations: Applied research for the family court* (pp. 330–366). New York: Oxford University Press.
- Kessler, R. C., Adler, L., Barkley, R., Biederman, J., Conners, C. K., Demler, O., et al. (2006). The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry*, 163, 716–723.
- Langberg, J. M., Epstein, J. N., Simon, J. O., Loren, R. E. A., Arnold, L. E., Hechtman, L., et al. (2010). Parent agreement on ratings of children's attention deficit/hyperactivity disorder and broadband externalizing behaviors. *Journal of Emotional and Behavioral Disorders*, 18, 41–50.
- Larson, K. A. & Turner, K. D. (2002). Best practices for serving court involved youth with learning attention and behavioral disabilities. U.S. Department of Education, Office of Special Education and Rehabilitative Services. Retrieved from cecp.air.org/juvenilejustice/docs/promising%20and%20preferred%20procedures.pdf
- Larson, K., Russ, S. A., Kahn, R. S., & Halfon, N. (2007). Patterns of comorbidity, functioning, and service use for us children with ADHD. *Pediatrics*, 127, 462–470.
- Larsson, H., Dilshad, R., Lichtenstein, P., & Barker, E. D. (2011). Developmental trajectories of DSM-IV symptoms of attention-deficit/hyperactivity disorder. Genetic effects, family risk and associated psychopathology. *Journal of Child Psychology and Psychiatry*, 52, 954–963.
- Levy, S. E., Mandell, D. S., & Schultz, R. T. (2009). Autism. *Lancet*, 374, 1627–1638.
- Lomas, G. I. & Johnson, H. A. (2012). Overlooked and unheard: Abuse of children who are deaf or hard of hearing and their experience with CPS and foster care. *The Family Journal*, 20, 376–383.
- Mandell, D. S., Walrath, C. M., Manteuffel, B., Sgro, G., & Pinto-Martin, J. A. (2005). The prevalence and correlates of abuse among children with autism served in comprehensive community-based mental health settings. *Child Abuse and Neglect*, 29, 1359–1372.
- McPartland, J. C., Reichow, B., & Volkmar, F. R. (2012). Sensitivity and specificity of proposed DSM-5 diagnostic criteria for autism spectrum disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 368–383.
- Miller, A. L., Ratus, J. H., & Linehan, M. M. (2007). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford.
- Myers, S. M. & Plauche-Johnson, C. (2007). Management of children with autism spectrum disorders. *Pediatrics*, 120, 1162–1182.
- Nigg, J. T. (2006). Attention, control, and task difficulty in ADHD (Commentary). *British Journal of Developmental Psychology*, 23, 513–516.
- Nigg, J. T. (2011). Where to with treatment for ADHD? *Current Medical Research and Opinion*. 27(Supp. 2), 1–3.
- Pelham, W. E., Burrows-MacLean, L., Gnagy, E. M., Fabiano, G. A., Coles, E. K., et al. (2005). Transdermal methylphenidate, behavioral, and combined treatment for children with ADHD. *Experimental and Clinical Psychopharmacology*, 13, 111–126.
- Pickar, D. B. (2003). Identifying children's stress-responses to divorce. *Sonoma Medicine*, 54, 15–17.

- Pickar, D. B. & Kaufman, R. L. (2013). The child custody evaluation report: Toward an integrated model of practice. *Journal of Child Custody*, 10, 17–53.
- Price, M. S. (2009). *The special needs child and divorce: A practical guide to evaluating and handling cases*. Chicago: American Bar Association.
- Price, P. (2012). Special needs and disability in custody cases: The perfect storm. *Family Law Quarterly*, 46, 177–197.
- Rathus, J. H. & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide and Life-Threatening Behavior*, 32, 146–157.
- Rosenblatt, A. I. & Carbone, P. S. (Eds.). (2013). *Autism spectrum disorders: What every parent needs to know*. Elk Grove Village, IL: American Academy of Pediatrics.
- Ross, S., Heath, N. L., & Toste, J. R. (2009). Non-suicidal self-injury and eating pathology in high school students. *American Journal of Orthopsychiatry*, 79, 83–92.
- Saposnek, D. T., Perryman, H., Berkow, J., & Ellsworth, S. (2005). Special needs children in family court cases. *Family Court Review*, 43, 566–581.
- Schepard, A. & Johnston, J. R. (2005). Special issue: Special needs children in family court cases. *Family Court Review*, 43, 541–543.
- Smith, T. (2010). Early and intensive behavioral intervention in autism. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents*. New York: Guilford.
- Spencer, N., Devereux, E., Wallace, A., Sundrum, R., Shenoy, M., Bacchus, C., et al. (2005). Disabling conditions and registration for child abuse and neglect: A population-based study. *Pediatrics*, 116, 609–613.
- Stahl, P. M. (2011). *Conducting child custody evaluations: From basics to complex issues*. Thousand Oaks, CA: Sage.
- Stark, K. D., Streusand, W., Krumholz, L. S., & Patel, P. (2010). Cognitive-behavioral therapy for depression: The ACTION treatment program for girls. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 93–109). New York: Guilford.
- Weisz, J. R. & Kazdin, A. E. (2010). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford.
- Woodberry, K. A. & Popenoe, E. J. (2008). Implementing dialectical behavior therapy with adolescents and their families in a community outpatient clinic. *Cognitive and Behavioral Practice*, 15, 277–286.
- Wymbs, B. T., Pelham, W. E., Molina, B. S., Gnagy, E. M., Wilson, T. K., & Grehouse, J. B. (2008). Rate and predictors of divorce among parents of youths with ADHD. *Journal of Consulting and Clinical Psychology*, 76, 735–744.

Daniel Pickar, Ph.D., ABPP, is a board-certified child psychologist who conducts child custody evaluations, mediation, consultation to family law attorneys, and psycho-educational evaluations of children. He previously served as chief of child and family psychiatry at Kaiser Permanente Medical Center in Santa Rosa, California for 12 years. He has published articles in the areas of child custody evaluation, mediation, and learning disabilities in children and serves on the editorial board of the Journal of Child Custody.

Robert L. Kaufman, Ph.D., ABPP, is a board-certified forensic psychologist whose practice is in Oakland and San Rafael, California. In the area of family law, he provides consultation to attorneys and conducts child custody evaluations, mediation, and co-parent counseling. His clinical practice includes psychological and neuropsychological assessment of children, adolescents, and adults. He is also a senior trial consultant with the firm of Bonora-Rountree Trial Consulting and Research in San Francisco.