

**SPECIAL CONSIDERATIONS IN CHILD CUSTODY EVALUATIONS
FOR CHILDREN WITH HIGH-FUNCTIONING AUTISM
SPECTRUM DISORDER**

with Foreword by Sol R. Rappaport, Cecily Kanter, and Kara Anast

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Asperger's Disorder, which now is subsumed under Autism Spectrum Disorder (ASD) in the *DSM-5*, is increasingly being identified in children and adolescents. As a result, professionals in family law courts will have more exposure to children with ASD. However, there are limited guidelines and few published studies directing how family court professionals should take into account the unique needs of these families. This article will provide the reader with an understanding of high-functioning ASD, the impact it has on the family, and comorbid issues. This article provides specific suggestions for how evaluators should assess families when a child has ASD and will provide guidance for attorneys and judges.

Keypoints for the Family Court Community:

- The rate of autism has increased in recent decades leading to more children with autism being involved with family court professionals.
- Attorneys, judges, and mental health professionals working in family court need to understand high-functioning autism and its impact on children, parents, and their families.
- Families with children with high-functioning autism require custom-made parenting plans that address the unique needs of the child.
- In developing parenting plans, family court professionals need to consider comorbid disorders when dealing with children and adolescents with autism.
- Family court professionals should have additional training and expertise when working with families where a child has high-functioning autism.
- When families of children with autism are involved in family court, they present a broad range of unique factors which impact educational issues, parenting plans, decision making, treatment, and the entire family system.

Keywords: *Asperger's Disorder; Assessment; Autism Spectrum Disorder; Child Custody Evaluation; Children of Divorce; Divorce; and Family Court.*

INTRODUCTION

Professionals involved in the legal system are increasingly coming into contact with families where a child has an autism spectrum disorder (ASD). With the increase in incidence of autism, (Centers for Disease Control and Prevention [CDC], 2015, August; Fombonne, 2003) lawyers, judges, and mental health professionals involved in the legal system should have a good understanding of this disorder and its impact on families. Children with ASD who are high functioning (previously diagnosed as Asperger's disorder [AD]) present unique challenges for those in family court (Birnbaum, Lach, Saposnek, & MacCulloch, 2012; Jennings, 2005). The level of functioning and needs of children with ASD who do not have intellectual or language impairments are significantly different from those on the lower end of the spectrum, or what historically has been referred to as autism. Their needs are also different from neurotypical children. This knowledge can directly impact recommendations and decisions made about families where a child/adolescent has high-functioning ASD. Without this knowledge, evaluators may misinterpret a child's or parent's behavior leading to

Correspondence: srappaport@counselingconnections.net

untrustworthy conclusions and recommendations. Attorneys may not have the knowledge and data to guide their clients toward an appropriate settlement or conduct a proper direct or cross-examination, and judges may make decisions that may not be in the best interests of the children without a greater understanding of this disorder and its impact on families.

The purpose of this article is fivefold. The first goal is to describe children and adolescents with high-functioning ASD and discuss the impact of AD's recent removal from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*; American Psychiatric Association [APA], 2013). The second goal is to discuss the impact of a child having high-functioning ASD on the family and its functioning. Third, we address issues of comorbidity and the importance of understanding that many children with ASD also have other psychological/psychiatric issues. Fourth, we describe the manner in which parents of children/adolescents with high-functioning ASD may appear different than other parents in the divorce process. Finally, we address unique factors that evaluators, attorneys, and judges should consider as a part of the child custody evaluation process and parenting plan recommendations specific to families where a child has high-functioning ASD.¹

AD, ASD, AND HIGH-FUNCTIONING AUTISM. WHAT ARE THE DIFFERENCES?

Until 2013, AD fell under the category of pervasive developmental disorders in the *DSM-IV-TR* (APA, 2000). Pervasive developmental disorders are described as pervasive and severe impairment in several areas, including "reciprocal social interaction skills, communication skills, or stereotyped behaviors, activities, and interests" (APA, 2000, p. 69). Now the *DSM-5* (APA, 2013) directs that "individuals with well-established *DSM-IV* diagnosis of autism disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder" (p. 51). However, people who were not previously diagnosed as having AD may not meet the new criteria.

The *DSM-5* criteria are more stringent than the *DSM-IV-TR* criteria, which explains why some children will not be able to obtain a diagnosis of ASD even though they would have met the criteria for AD in the *DSM-IV-TR*. This had led some to believe that many people on the high end of the spectrum will not be diagnosed with autism under the *DSM-5* even though they meet the criteria using the *DSM-IV-TR* (Maenner et al., 2014). Maenner et al. (2014) found that approximately 80% of children who meet the criteria for an ASD under *DSM-IV-TR* also meet the criteria for the *DSM-5*. Obviously, approximately 20% do not. Jabr (2012) reports that several recent studies suggest that it will be more difficult for undiagnosed people with high-functioning autism to obtain a diagnosis of ASD due to the stringent requirements in the *DSM-5*. For example, he cites the work of Mattila (2011, cited in Jabr, 2012) who found that of 26 eight-year-olds with an IQ of 50 or higher who met criteria for ASD in *DSM-IV* only 12 qualified under *DSM-5*. However, if the threshold for ASD was lowered to require only two instead of three symptoms in the social interaction and communication group, 25 of the 26 qualified. Frazier et al. (2012) and Mandy, Charman, and Skuse (2012) also found the *DSM-5* to be more restrictive than *DSM-IV-TR*. As a result, disputes may arise in family court between parents and professionals about whether a child has ASD.

According to *DSM-5*, ASD is characterized by "persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communication behaviors, and skills in developing, maintaining and understanding relationships" (APA, 2013, p. 31). Additionally, to fit the diagnosis the person should manifest restricted and repetitive patterns of activities, behaviors, and interests (APA, 2013). AD, or high-functioning autism, now encapsulated by the diagnosis of ASD, can be distinguished from traditional views of autism by addressing language issues. The language delay found in autism is not found in high-functioning ASD, as children with high-functioning ASD reach their language development in a timely manner (Baron-Cohen & Hammer, 1997). In AD, the impairment in communication may include a delay in or complete lack of spoken language (APA, 2000). In ASD there were often associated cognitive impairments but in AD (high-functioning ASD) there are not significant delays in the acquisition of language and cognitive abilities typically fall into the normal range (APA, 2000). Because social,

communication, and repetitive difficulties are found in both disorders, they are commonly referred to as being a part of a spectrum or continuum, with AD/high-functioning ASD on the end closer to normal functioning (Baron-Cohen & Hammer, 1997). Children with high-functioning ASD and classic autism tend to have communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building friendships appropriate to their age (CDC, 2015, February). In addition, children with each of these disorders may be overly dependent on routines, highly sensitive to changes in their environment, and/or intensely focused on inappropriate items (CDC, 2015, February). The symptoms of people with ASD will fall on a continuum, with some individuals showing mild symptoms and others having much more severe symptoms.

RATES OF ASD AND DIVORCE

ASDs are on the rise (CDC, 2015, August; Fombonne, 2003). The CDC (2015, August) first reported in 2007 that about 1 in 150 children had ASD (based on 2002 data from 14 communities). In 2009, it was reported that 1 in 110 children had ASD (based on 2006 data from 11 communities). In 2012, the CDC (2015, August) reported that 1 in 88 children had ASD (based on 2008 data from 14 communities). The estimated prevalence of ASD has increased roughly 29% since 2008, 64% since 2006, and 123% since 2002. As a result, it will likely become more prevalent in family court cases than in the past.

Currently, the CDC (2015) estimates that 14.7 per 1,000 children age 8 have been identified with ASD. This equates to 1 in 68 children (CDC, 2015). There are significant gender differences in the rate of ASD and high-functioning ASD, with the latter being a subset of people with ASD. Estimates are that there is a 4:1 or 5:1 male:female sex ratio in classic autism (Rutter, 1978, cited in Baron-Cohen & Hammer, 1997). In high-functioning autism the sex ratio is even higher, favoring males (Baron-Cohen & Hammer, 1997). The rate may be as high as 9:1 (Barlow & Wolf, cited in Wing, 1981) but a recent study by the CDC found it to be approximately 5:1 (CDC, 2015).

There is an ongoing debate over the divorce rate among parents of children with a disability. Weiner (as cited in Sobsey, 2004) stated that the divorce rate for families with a disabled child is 70%. However, other research does not support this statistic. Seltzer, Greenberg, Floyd, Pettee, and Hong (2001) followed 7,000 Wisconsin high school graduates over time and found no difference in divorce rates for parents of children with disabilities than from all other parents. Only a few studies have assessed the divorce rate of parents with a child with autism. Hartley et al. (2010), using a sample size of 391 parents of children with ASD and a matched representative sample of parents of children without disabilities, found that parents of children with ASD had a higher rate of divorce. Parents of a child with ASD divorced at a rate of 23.5% versus 13.8% for the comparison group. The rate of divorce for parents of a child with ASD remains high throughout childhood and into early adulthood, while the rate of divorce for parents with children without ASD decreased after around age 8. Hartley et al. (2010) also found that younger mothers who had a child with ASD and had other children born before their child with ASD were predictive of divorce. According to Hartley, parents appear to be at greatest risk of divorce during the first 8 years of their child's life if they have a child with ASD. Other differences, such as younger maternal age when the child was born and having the child born later in the birth order were also predictive of divorce. Freedman, Kald, Zablotzky, and Stuart (2011), using data from the 2007 National Survey of Children's Health, found that there were no significant differences in the rate of divorce of parents of children with diagnosis of ASD. Thus, there are conflicting data as to whether there is a higher divorce rate among parents whose child or children have autism. Regardless, with the increasing rate of ASD in American society, there will inevitably be an increase in family law cases in which a child has ASD.

ASD AND COMORBIDITY

Children with ASD may have other psychiatric difficulties as well (Kuusikko-Gauffin et al, 2008; Mazzone, Ruta, & Reale, 2012). Ghaziuddin, Weidmer-Mikhail, and Ghaziuddin (1998) found that

65% of their subjects with autism also had a history of psychiatric illness at the time of the study and 2 years later. Mazzone et al. (2012) summarized a variety of studies and suggested that the rate of mental disorders among people with ASD is over 70%. The *DSM-5* states that “about 70% of individuals with autism spectrum disorder may have one comorbid mental disorder, and 40% may have two or more comorbid mental disorders” (APA, 2013, p. 58). Those involved in the family court system should understand comorbidity in order to properly develop parenting plans for families. Evaluators, attorneys, and judges need to be able to differentiate which problematic behaviors are a function of high-functioning autism versus a comorbid diagnosis. This analysis is critical to developing a parenting plan that meets the needs of the child at issue. Professionals in family court may need to weigh whether to focus more on features of autism or comorbid issues when developing parenting plans and be able to articulate the reasons for their decision.

It is not easy to detect and recognize another psychiatric comorbidity as a result of it being masked by the autistic symptoms (Mazzone et al., 2012). Many children with high-functioning ASD may have other psychiatric difficulties that are often attributed to the ASD rather than recognizing it is a separate disorder, such as obsessive-compulsive disorder (OCD). This makes it difficult to make a decision about the appropriate diagnosis and treatment strategies (Mazzone et al., 2012). Individuals with high-functioning ASD can display difficulties in processing and explaining their feelings and emotions. As a result, the information obtained to diagnose these individuals is often provided by family members and other professionals working with the individuals (Mazzone et al., 2012). Mazzone et al. (2012) states,

In the clinical practice, various psychometric instruments, such as clinical interviews, self-report questionnaires and checklists, are widely used to assist in the diagnosis and they constitute a valuable support for clinicians. However, these diagnostic tools have been designed and standardized to spot different clusters of psychopathological symptoms referring to the general population and they may not be appropriate to ASD.

Psychiatric disorders associated with ASD can be broken up into three groups: internalizing disorders (depression, OCD, and anxiety), externalizing disorders (attention deficit/hyperactivity disorder [ADHD], disruptive behavior, and conduct disorder), and tic disorders and other disorders such as Tourette’s syndrome and schizophrenia (Mazzone et al., 2012). Depression is frequently seen in people with high-functioning ASD and this may be the result of difficulties coping and the social stigma associated with autism (Ghaziuddin et al., 1998; Mattila et al., 2010; Mazzone et al., 2012). Mazzone et al. (2012) found that estimates of depression range from 17% to as high as 70%. People with high-functioning ASD often have more difficulties with social anxiety when compared to healthy control individuals (Kuusikko-Gauffin et al., 2008). Kuusikko-Gauffin et al. (2008) found this to be true even in the situation in which the symptoms of the social anxiety were clinically intersecting with the social problems characteristic of a typical person with high-functioning ASD. Kuusikko-Gauffin et al. (2008) reported that 57.1% of adolescents with high-functioning ASD exceeded the cutoff on a self-report measure regarding anxiety. Lugnegård, Hallerback, and Gillberg (2011) found that comorbid anxiety disorders were found in 56% of people with high-functioning ASD. Matilla et al. (2010) found that 56% of children and adolescents in their study also had an anxiety disorder.

OCD is a particularly difficult disorder to discriminate as a result of many symptoms overlapping with the high-functioning ASD symptoms. Ruta, Mugno, D’Arrigo, Vitiello, and Mazzone (2010) found that children with high-functioning ASD showed higher regularities of compulsive hoarding, repeating, and ordering when compared to the typically developing children and children with OCD. The children with OCD showed significantly higher frequencies of contamination and aggressive obsessions and checking compulsions when compared to the typical children and children with ASD (Ruta et al., 2010). Mazzone et al. (2012) found that people with high-functioning ASD are likely to have similar frequencies of obsessive compulsive symptoms as people with OCD but that children with high-functioning ASD report more compulsions and obsessions than typical children.

There are also higher rates of externalizing problems among children with high-functioning ASD (Mazzone et al., 2012). According to *DSM-IV-TR* criteria, a child who is diagnosed with AD cannot

also be diagnosed as having ADHD (APA, 2000). However, *DSM-5* considers ADHD as one of the possible comorbid disorders under the criteria for ASD. The *DSM-5* (APA, 2013) states:

Individuals with ADHD and those with autism spectrum disorder exhibit inattention, social dysfunction, and difficult-to-manage behavior. The social dysfunction and peer rejection seen in individuals with ADHD must be distinguished from the social disengagement, isolation, and indifference to facial and tonal communication cues seen in individuals with autism spectrum disorder. Children with autism spectrum disorder may dysregulate, or exhibit what some people refer to as tantrums, due to an inability to tolerate a change from their expected course of events. In contrast, children with ADHD may misbehave or have a tantrum during a major transition because of impulsivity or poor self-control (p. 64).

Some studies estimate that approximately 28% of children with ASD also have ADHD while others suggest that rates may be much higher (Mazzone et al., 2012). Matilla et al. (2010) found that 50% of children and adolescents with high-functioning ASD also had a comorbid behavior disorder. Thus, when working with families in which a child has ASD, it is important to recognize that conduct problems may be a separate issue from the ASD.

Tourette's syndrome is also commonly found in school-aged children with high-functioning ASD. Studies suggest that 20% of children with high-functioning ASD also have Tourette's syndrome (Ehlers & Gillberg, 1993). Mattila et al. (2010) found that 14% of children with high-functioning ASD also had Tourette's syndrome and that there was an overall rate of tic disorders (which includes Tourette's) of 38%. For many years, autism had been considered an early diagnosis for psychosis (Mazzone et al., 2012). There are not many studies completed exploring the connection between autism and psychosis (Mazzone et al., 2012). Systematic studies of schizophrenia in children have found high rates of childhood-onset schizophrenia being preceded by or comorbid with ASD (Dvir & Frazier, 2011).

Comorbid disorders are not the exception with high-functioning ASD but rather a common feature. There may also be multiple comorbid psychiatric disorders, thus making assessment and treatment more difficult for a child with ASD. This may lead to complications for assessments in family court settings as well. These children often need a variety of support services and assessments, which at times may need to occur while conflict is heightened during litigation. Parents as well as professionals need to understand that some difficulties experienced by children and adolescents with ASD are not solely a function of ASD, but may be a function of another disorder.

Family court professionals need to be able to develop/recommend a parenting plan that takes into account a child's difficulties related to autism, as well as challenges associated with a comorbid diagnosis. Professionals should never paint by the numbers (Gould & Stahl, 2001) yet many times there are consistent responses to common problems. For example, many children with high-functioning ASD struggle with transitions. Children and adolescents with ASD often need more preparation for transitions, and transitions are often more difficult for them. Family court professionals need to assess and consider this issue in determining parenting plans. Furthermore, those with a comorbid diagnosis may have even more difficulties adjusting to and understanding changes and transitions than those without a comorbid diagnosis. Given the long-standing problems associated with autism, professionals need to consider problems associated with autism as the foundation for developing parenting plans, and then, in addition, take into consideration those needs or issues that are a function of a comorbid diagnosis.

THE IMPACT ON PARENTS AND THE PARENTAL INFLUENCE ON CHILDREN

Due to the severe and pervasive nature of ASD, the level of stress involved in raising children with ASD is high (Baron-Cohen & Hammer, 1997; Hughes, Plumet, & Leboyer, 1999; Montes & Halterman, 2007). Parents of children with ASD have reported higher levels of stress than parents of children without disabilities and parents of children with other developmental disabilities, including but not limited to Down's syndrome, cystic fibrosis, and fragile X syndrome (Bishop, Richler, Cain, & Lord, 2007; Donovan, 1988; Rao & Beidel, 2009; Weiss, 2002).

Parental stress has been extensively studied with respect to social support (Bromley, Hare, Davison, & Emerson, 2004; Hassal, Rose, & McDonald, 2005). Lower levels of social support have been found to be consistently associated with higher levels of stress in parents of children with ASD and other disabilities (Bromley et al., 2004; Hassal et al., 2005). Low levels of social support are a common predictor of anxiety and depression in mothers of children with ASD (Boyd, 2002; Wannamaker & Glenwick, 1998). Parents of children with ASD may also experience increased stress due to their child's atypical behavior. Angold et al. (1998) looked at parents' perception of burden and found that parents of children with externalizing behaviors reported more burden than did parents of children with other types of problems. Furthermore, the greater the level of a child's impairment, the higher the burden experienced by parents. These studies tend to suggest that difficult or unusual behavior may be what leads parents of children with ASD to experience higher levels of perceived negative outcomes. These parents need more social support than many others, which needs to be considered as parenting time determinations and other recommendations are made. Parents may need time away from their children to access their social support networks and may benefit from involvement in support groups for families with children with special needs. In divorce proceedings, these parents may rely more on their attorneys for support than other parents, which can be emotionally draining for attorneys.

Parents of children with disabilities are more likely to experience anxiety, depression, distress, somatic complaints, and other difficulties as well (Gray, 2002; Weiss, 2002). When mothers and fathers experience the same family stress or conflicts, the way they interpret the stress is much different, with mothers experiencing it as more detrimental than fathers (Gray, 2003). Mothers of children with disabilities report that the major impact their child's disability has on their life is with respect to their careers; as the majority of mothers studied were only employed outside of the home part time (Gray, 2003). They also reported grief and ambivalence about the amount of time they have to commit to their disabled child (DeMyer, 1979). Mothers of disabled children report that they are the primary caretaker and primary person to take their children to doctor visits, an often difficult experience (Gray, 2003). Mothers with children with high-functioning ASD report that doctor visits caused them the most anxiety and stress because their child's disability is not well understood (Gray, 2003). Mothers are also often charged with presenting their families to the outside world and this presentation is presumed to be a direct reflection of their parenting abilities (Gray, 2003). Mothers may experience more stress due to the social pressure that often accompanies the expectation that mothers are often more responsible for the care of their children than fathers. Therefore, mothers reported a significant impact on their stress and anxiety as it relates to their child's behaviors. If their child's behaviors were poor in public, mothers assumed that others would look negatively on their abilities without taking into account their child's disability (Gray, 2003). Mothers have also been found to have a much higher rate of social anxiety than fathers of children with high-functioning ASD but with both having more social anxiety than parents whose children do not have ASD (Kuusikko-Gaufflin et al., 2013). The social anxiety the parents experience is likely a fear of humiliation and/or embarrassment in social situations, often leading to avoidance of and distress in social situations. It is critical for evaluators, attorneys, and judges to understand that, even though fathers may not experience the same level of stress as mothers in regard to their child's difficulties, this does not inherently mean mothers cannot handle the children well.

Custody evaluators need to understand that there are gender differences in how parents of children with ASD cope with stress and to not overpathologize coping strategies. Gray (2003) noted that men and women use coping strategies and resources differently. There is a distinction between problem-focused and emotion-focused coping strategies. Problem-focused coping strategies focus on attempts to cope with the situation by changing the nature of the problem. Emotion-focused coping strategies focus on activities that distract the attention of the person affected by the stressful situation. Such activities include expressing feelings and withdrawal (Gray, 2003). Men are more likely to use the problem-focused coping strategies and women emotion-focused coping strategies (Gray, 2003). Mothers are also more likely to express or vent their feelings and frustrations than fathers (Gray, 2003). There are ways to help reduce the amount of stress parents experience. The support from a

spouse can have a great impact on buffering the stress of raising a child with ASD (Weiss, 2002). In family litigation this support is typically not available.

CONSIDERATIONS IN FAMILY COURT

It is important to have an understanding of ASD, and particularly high-functioning ASD, when working with families during litigation. Some issues to be considered include the financial burden of raising a child with ASD. It is estimated that it costs over \$17,000 more per year to raise a child with ASD compared to a child without ASD (Lavelle et al., 2014). Child support should be set in accordance with the actual costs involved in raising a child with ASD. Custody evaluators, attorneys, and judges should understand the impact having a child with high-functioning ASD has on the family system and most importantly understand how parenting plans may need to be different than with neurotypical children. Custody evaluators need to understand the unique educational needs of these children as well as how to assess for it. Attorneys and judges need this same information so that they can better assess whether or not a custody evaluator's report and recommendations are trustworthy. The following are specific recommendations that court advisors, whether it be a custody evaluator or a guardian ad litem, need to consider and assess when a child in a family has high-functioning ASD.

EDUCATIONAL ISSUES

1. Advisors to the courts such as guardians ad litem and child custody evaluators should gain a thorough understanding of the school systems in the areas where they conduct evaluations. During the evaluation, the evaluator should investigate where each of the parents will reside and compare the services available in each district. Furthermore, the evaluator should assess whether the parents have spoken to the directors of special education in those districts and the level of each parent's involvement in the educational process. Evaluators should contact the special education directors to inquire about what services can be provided, how they are provided, and where they are provided. For example, some districts may be able to meet a child's needs within the public school setting, while other districts may not have the resources and may send a student to a program at another school within the district, to a school outside of the district, or to a private therapeutic day school. Evaluators should become familiar with the special education services that can be provided for children with ASD. To further investigate issues, evaluators should talk to the student's teachers, review Individual Education Plans (IEPs) and speak to other people who have been involved in the development of the IEP to obtain a thorough understanding of the child's needs as well as what specific therapeutic services can be provided. Evaluators and attorneys for children who are making recommendations about children's needs should also be familiar with common treatment modalities that schools may employ including applied behavioral analysis, social stories, social skills training, cognitive behavioral therapy, and occupational therapy. By having an understanding of these types of services, attorneys and evaluators will be in a better position to assess which school best fits the needs of the student with high-functioning ASD.
2. Related to the above, evaluators should address whether the child needs after-school care and what each potential district can provide. Some schools will provide what is referred to as "extended day" for children who need additional help/services. Also, some districts can provide year-round schooling for children with special needs. If an evaluator/attorney does not know about this, s/he may not know to ask. Special education directors in potential districts can provide information on the availability of additional programs where the child may reside.
3. Evaluators and attorneys should ascertain each parent's involvement with the school in a more in-depth manner than is typically done in custody evaluations. Specifically, evaluators

should assess each parent's involvement in attending parent-teacher conferences, back-to-school nights, and other school events. Evaluators need to know each parent's involvement in the development and implementation of the IEP. It is important to assess which parent has been more supportive of the child receiving services and with which parent the school prefers to work. This can help lead to developing a parenting plan that is more likely to ensure that a child's needs continue to be met.

4. Evaluators need to understand the distinction between a *DSM-5* diagnosis of ASD and how federal law defines autism in relation to special education services. The individual with Disabilities Education Act has a more broad definition than *DSM-5*. Yet, it states that a student is not eligible for services as a student with autism if the child's educational performance is primarily adversely affected due to a comorbid emotional disturbance. If a student has a diagnosis of ASD, and the multidisciplinary team at the school concludes that the child's educational functioning is primarily adversely affected by emotional problems, then the student would not be eligible for special education services under the eligibility of autism. Becoming familiar with both section 504 of the Rehabilitation Act of 1974 and the IDEA is helpful so that evaluators understand the rights of the students and families they are serving. Assessing the parents' knowledge of their rights is also important to determine the ability of each parent to effectively advocate for their child. Evaluators also need to be familiar with Response to Intervention and how this may relate to students with high-functioning ASD. A custody evaluator needs a thorough working knowledge of educational law and parental rights.

ASSESSMENT OF ASPERGER'S DISORDER/HIGH FUNCTIONING ASD

5. Evaluators, attorneys, and judges should familiarize themselves with tests/assessment tools designed for this population. Although custody evaluators will be unlikely to conduct diagnostic evaluations as a part of the child custody evaluation, they should be reading reports from evaluations that have been conducted. Understanding the tests/assessment measures used can help an evaluator decipher whether or not they agree with the assessment and can help them understand a child's needs. This includes having a working knowledge of the Autism Diagnostic Observation Schedule-2nd ed., Autism Diagnostic Interview-Revised, Gilliam Asperger's Disorder Scale, Asperger Syndrome Diagnostic Scale, Autism Spectrum Rating Scale, Gilliam Autism Rating Scale-3, and others. Evaluators should understand the level of functioning of children with high-functioning ASD in part by reviewing this data.
6. It is our belief that evaluators cannot obtain a thorough understanding of high-functioning ASD by merely attending seminars and reading research/books. Rather, they need experience in working with this population. We believe that only then can an evaluator fully understand some of the unique intricacies of this population of children and adolescents. Furthermore, without this experience an evaluator runs the risk of misinterpreting a child's behavior. For example, if a child does not interact much with a parent, make eye contact, or have a strong desire to be near the parent, it may be symptomatic of the child's condition, rather than a problem in the parent-child bond. The Association of Family and Conciliation Courts (AFCC) Model Standards for Child Custody Evaluation (2006) 5.11 states that "when evaluators lack specialized training in particular areas of concern for the evaluation, they shall either decline the appointment for the evaluation or seek professional consultation. . ." (p. 16). Evaluators who have limited experience with this population would be wise to obtain consultation.
7. Not all problematic or atypical behavior in a child with ASD is inherently a function of this diagnosis. Child custody evaluators should be able to assess for other problems/disorders as well. Sometimes a behavioral problem is not a function of any diagnosis, but rather just a problematic behavior that can occur in any child. Having an understanding of the interplay

between high-functioning ASD, other mental health problems, and ordinary behavior is vital when developing age- and developmentally appropriate parenting plans.

PARENT ISSUES

8. Evaluators need to understand that parents of children with high-functioning ASD can come across as obsessive and vigilant (Woodgate, Ateah, & Secco, 2008). For many of these parents, it is not that they were always this way, but that they have developed this coping strategy in response to working with support systems, such as schools, and other professionals who did not understand their children and did not meet their children's needs (Griffith, Totsika, Nash, Jones, & Hastings, 2012). These parents often have had to fight for their children to a greater degree than parents of children with other disabilities; parents must often be vigilant in their advocacy for their children (Saposnek, Perryman, Berkow, & Ellsworth, 2005). While pushy parents may not always be likable, these parents are often the ones who fight for their children and make sure their children get their needs met. This knowledge can assist evaluators and attorneys in understanding that parents of children with high-functioning ASD may act in a way that to some may appear unusual but in fact is understandable and helpful given the situation. This knowledge can help family court professionals be less likely to attribute a parent's behavior to a mental health issue when it is a functioning behavior in the situation.
9. Parents of children with high-functioning ASD may appear depressed, and anxious and experience burnout (Weiss, 2002) and a greater level of stress than parents of children without a child with disabilities (Epstein, Saltzman-Benaiah, O'Hare, Goll, & Tuck, 2008). They may feel stigmatized (Gray, 2002); have decreased parenting efficacy, and have more mental and physical health problems as compared to parents with neurotypical children (Karst & Vaughan Van Hecke, 2012). These difficulties may be in part a function of the strain of parenting a child with ASD without adequate support (both emotional and financial), as well as guilt and self-blame. This may especially be true for the main caregivers. Boyd (2002), in a review of the research, found that low levels of social support were the most common predictor of depression and anxiety in mothers of children with ASD. As a result, evaluators and attorneys should be mindful of the research when considering the mental health of the parties. A parent's personal difficulties may not be a function of significant mental health problems, but may be an ordinary and understandable reaction to the stress of being the main caregiver of a child with special needs. This knowledge can help lead to the development of parenting plans that take into account the current circumstances and needs of the family members.
10. Raising a child with high-functioning ASD is stressful and challenging. As a result, make sure to thoroughly assess for each parent's ability to manage his/her stress. Do they have friends/relatives as a support system? At times, parents may need a break, and when developing parenting plans evaluators need to not only consider the child's need for structure, routine, and stability, but also balance this with the parent's need for a break. Knowing the involvement of friends of the parents, stepparents, grandparents, and other extended family members is an important area to assess. The evaluator should assess how they support the parent, and if they are significantly involved, assess whether they understand the child's needs and the need for the child to obtain services. The AFCC Model Standards of Practice for Child Custody Evaluations states "evaluators shall assess each parent and any other adults who are currently living in a residence with the children and performing a caretaking role" (AFCC, 2007, p. 80). We believe that this standard should be extended to caretakers and proposed caretakers who are not living in the home but will have significant involvement with the children such as grandparents and day care providers. Each parent may have a different set of relatives or caregivers, and it is important to assess their knowledge of

high-functioning ASD and how to care for a child with special needs when developing parenting plans.

11. Evaluators should ask how parents have informed themselves about ASD. Have the parents attended seminars on ASD? Have either or both joined support groups?
12. Evaluators should pay close attention to which parent first noticed the child having difficulties and which parent was more involved in making sure the difficulties were addressed and obtain a thorough history of every professional with whom the child has been involved, how the professional was chosen, who went to appointments, and who followed through with recommendations. Assess each parent's beliefs regarding the use of medication and what has been prescribed, why it has been prescribed, and whether the parents have been supportive of it, and if not, the reasons for this. Our experience has been that in many families one parent is much more aware of their child's difficulties, more accepting of them, and more willing to make sure their child gets the necessary services. This needs to be given considerable weight when determining what is in the child's best interests. While often evaluators pay close attention to which parent has been more involved and which parent the child is closer to, it is in the best interests of the child to get the services s/he needs and the parent who is more willing to do this needs to be given considerable weight in the determination.
13. Evaluators should assess the parent's understanding of the unique needs of their child. For example, some children will have a hard time getting used to two different buses for school while others do not. If a particular child struggles with transitions and change, it may be important for the child to only take one bus to school. Evaluators need to determine the parents' understanding of this and assess for how this can be accomplished. Evaluators should obtain a clear understanding of where each parent plans on residing following the divorce, the reasons for it, and its impact on the child's daily life. We worked with one family where the nonresidential parent had midweek overnights, but in the morning drove the child to the regular bus stop so that his routine could remain the same. This worked well for the child, but may not work well in all families, depending on their level of conflict and ability to cooperate. This needs to be taken into account when developing parenting plans.
14. Children with high-functioning ASD can dysregulate and have what many think of as meltdowns. Evaluators should assess which parent is best able to handle these meltdowns and also which parent is better at reducing dysregulating behavior by identifying when a child is becoming upset/agitated; implementing sensory strategies, such as the use of soothing techniques; and can implement other strategies to prevent further dysregulation. It is also important to assess each parent's willingness to work with the other in being consistent with their use of sensory strategies. This can impact whether the child can handle a more shared parenting schedule or if one parent needs to be the main caregiver the majority of the time.
15. Assessing the level of cooperation between the parents related to the child's services is vital. While assessing parental cooperation is an expected part of any evaluation, it takes on additional meaning for families where a child has ASD. For example, are both parents willing to live near each other so that in-home services can be done at both homes. If services cannot be done at both homes, are the parents supportive of bringing the child over to the other parent's home where services can be obtained? Can the parents allow the child(ren) to take objects back and forth between homes, especially if it provides comfort for them? This again can impact the type of parenting plan that family court professionals recommend.
16. Assessing the degree of flexibility between parents is an important component of a child custody evaluation for any family, but especially where a child has ASD. When a child emotionally dysregulates when it is time to go to the other parent's home, is the other

- parent understanding of the fact that the child may be late or will the parent assume/believe the other parent is trying to dominate their time.
17. Because of the research supporting a possible genetic inheritance of autism (CDC, 2015, February), evaluators should make sure to assess for the possibility that either parent may be on the spectrum, or possibly have features of ASD. Evaluators need to have an understanding of the features of high-functioning ASD in children and adults (Birnbaum et al., 2012; Jennings, 2005). Understanding these features will assist evaluators in developing appropriate parenting plans by taking into account the unique needs of these children and parents (Birnbaum et al., 2012). For example, if a parent also has features of ASD, it may be difficult for them to follow a flexible parenting schedule. S/he may also come across as more rigid in an evaluation. Evaluators need to understand and take into account that a parent with features of ASD may not be attempting to be resistant to being flexible, but rather does not have the capacity to be as flexible as other parents.
 18. Although not typically under the purview of a custody evaluator, guardians ad litem, attorneys, and judges must consider the additional costs of raising a child with ASD. It has been estimated to cost more than \$17,000 per year to raise a child with ASD as compared to a child without a disability (Lavelle et al., 2014). Medical expenditures for children and adolescents with ASD were between four and six times greater than for children without ASD (Shimabukuro, Grosse, & Rice, 2008). Thus, deviations from standard child support guidelines may need to be considered.

PARENTING PLANS

19. Children with high-functioning ASD are more likely than other children to have difficulty with change and transitions (Jennings, 2005). Professionals involved in family court need to assess children's ability to handle transitions. Professionals should try to minimize the number of transitions and make sure transitions occur as a regular part of the child's routine. The transitions should be conducted as similarly as possible in order to provide consistency for the child. Furthermore, parents need to be educated that if their child has difficulty with transitions, it may not be a function of the other parent doing something wrong or on purpose. Furthermore, professionals and parents need to understand that while some children over time adjust to the changes and the transitions, children with ASD may take longer to make this adjustment or may continually struggle with some of the transitions and changes.
20. When there is high conflict between parents, evaluators at times recommend that transitions occur in public places. However, for a child with high-functioning ASD, a location that is loud and busy may create sensory overload for the child. While the assessment of a child's ability to manage transitions should be a part of every evaluation, evaluators also should assess what type of environment allows for the best transition so as to decrease the possibility of difficult transitions. If transitions cannot occur at the parents' homes, it may be better to consider pickups and dropoffs from school or at a mutually agreed-upon friend's home or other location where it may be quieter with fewer people present.
21. When considering various parenting plans, consider the child's psychological/developmental level of functioning, rather than their age (Jennings, 2005). A 14-year-old with high-functioning ASD, while having an average or above average IQ, may emotionally function like a much younger child. Assessing emotional maturity is an important factor in the development of appropriate parenting plans.
22. If the child custody evaluation includes adolescent children, evaluators need to inquire about the parents' plans for guardianship when the child turns 18. Evaluators may want to write the court to ascertain whether they should make a recommendation as to guardianship upon the child attaining the age of 18 or if joint conservatorship is appropriate. The

assessment process alone will provide the evaluator with information as to whether the parents have even thought about this issue and which parent, or both, have considered long-term planning. Also, by addressing this during the divorce process it may decrease conflict (Jennings, 2005) and the likelihood of returning to court.

23. At times evaluators are asked to make interim recommendations. Evaluators should assess a child's ability to move between two homes or whether on a temporary basis nesting (where the child stays in the home and the parents rotate coming in and out) is a better option. However, caution is noted as the AFCC Model Standards of Practice for Child Custody Evaluation standard 4.5 states "Evaluators shall refrain from offering interim recommendations or treatment interventions pertaining to custodial placement, access, or related issues" (p. 13). In a situation where there is an urgency to provide assistance on an interim basis due to high levels of conflict between the parents, the evaluator may wish to have the court order the evaluator to provide the pros and cons of nesting versus having the child temporarily go between two homes without making a recommendation of which should occur. This can be done either as general pros and cons for children and adolescents with ASD or it can be specific to the child(ren) in question. While we strongly recommend that evaluators follow the AFCC standards, we understand that there are some unique circumstances that arise where immediate input may be needed to protect the child(ren).
24. When developing parenting plans, siblings of children with high-functioning ASD need time with each parent away from the child with special needs (Jennings, 2005). Having this one-on-one time can be vital to these siblings and fun for the parents. A parenting plan scheduled with separate time for each child with each parent should be considered as a more significant issue than is typically the case. In some cases, the best interests of the children may be served by separating the siblings, but still making sure they spend some time together. This may allow each parent to be more effective in their parenting because they may only have to assist one child (or possibly more, but not all at the same time). If children are separated, the report needs to address the reasons as outlined in the section 5.8(b) of the AFCC Model Standards of Practice for Child Custody Evaluation.
25. If relocation is an issue, there must be a thorough investigation of the educational/therapeutic services that can be provided by the new school district and other services available in the area must be assessed. This must be weighed against both the services provided if the relocation is not granted and the ability of the child to adjust not only to a move and seeing one parent possibly much less frequently, but to a schedule that in some ways may be more consistent and in other manners be more disruptive. The schedule may be more consistent because if a child relocates and does not see the other parent much, the primary caregiver can have the child in a set routine that may be beneficial for the child. However, if the child is going to return to the other parent's home, it may be more disruptive for the child because the child may not be comfortable there and may not know the routine as well. Furthermore, it may be difficult for services to be provided in both locations. If both parents are knowledgeable about their child's needs and will work diligently to help their child and if the child can manage spending long periods away from each parent (e.g., the school year primarily in one home and the summer in the other), then relocation may work. On the other hand, if the parent who is not moving has significant difficulty accepting or acknowledging the child's difficulties, the child may not receive services during the summer when the child is with him/her. A parenting plan needs to be developed that allows the child to still receive the special services that are needed. If relocation is granted in this situation, it may be better for the child not to spend most of the summer with the other parent.

Children with high-functioning ASD present unique challenges for mental health professionals, attorneys, and judges involved in family court. Having a greater knowledge and understanding of the unique needs of families where a child has ASD will assist family court professionals in guiding these families during the divorce and postdecree process. It will allow judges to make more informed

decisions, attorneys to better represent their clients, and mental health professionals to better advise the court. Ultimately, it will help ensure that these children and families are better understood by those involved in the family court system that can lead to better outcomes for families.

NOTES

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1. For the purposes of this article, Asperger's Disorder and high functioning Autism may be used interchangeably. I have kept the original phrase Asperger's Disorder when referencing previous literature that addressed Asperger's Disorder but have used high functioning Autism Spectrum Disorder whenever I am not referencing specific citations.

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Sol R. Rappaport, Ph.D., ABPP, is board certified in clinical child and adolescent psychology. His major area of focus is forensic psychology. He has been appointed in over 700 custody evaluations. He also provides consultation services to attorneys regarding custody evaluations including assisting attorneys with trial preparation. He presents nationally to various organizations on custody-related issues, including psychological testing in custody evaluations, Autism Spectrum Disorders (ASD) in custody evaluations, and the cross-examination of custody evaluators. He is a partner in Counseling Connections, a multidisciplinary practice in northern Illinois. He is also a founder of New Connections Academy, a therapeutic day school for children with high-functioning autism/Asperger's disorder. He has published articles in peer-reviewed journals and has authored the book Child Sexual Abuse Curriculum for the Developmentally Disabled.

Cecily Kanter, Psy.D., is a licensed clinical psychologist. She is a graduate of the Illinois School of Professional Psychology, Chicago, with a doctoral degree in clinical psychology. She is in private practice in Palatine, Illinois, and specializes in the assessment and treatment of ASD.

Kara Anast, Psy.D., graduated from the Illinois School of Professional Psychology with a doctoral degree in clinical psychology in September 2012. The majority of her career has focused on working with individuals with ASD, including in-home applied behavior analysis. She completed her postdoctoral fellowship at New Connections Academy, a therapeutic day school for children with high-functioning autism. She is in private practice with Counseling Connections and consults with New Connections Academy, a therapeutic day school for children with high-functioning ASD.

BEST INTERESTS OF THE SPECIAL NEEDS CHILD: MANDATING CONSIDERATION OF THE CHILD'S MENTAL HEALTH

Hindi Mermelstein, Jamie A. Rosen, and Carolyn Reinach Wolf

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There has been a considerable increase in the number of separation and divorce cases in family court involving special needs children. However, most states do not consider the mental and physical health needs of the child in determining what is in the best interests of the child. The special needs of the child due to a mental illness or behavioral disorder must be a statutorily required factor when a court makes a custody decision and/or designs a parenting plan under the "best interests of the child" standard.

Practitioner's Key Points:

- The existence of a mental illness or behavioral disorder in a child presents unique challenges to the family court in determining custody and designing a parenting plan.
- Commonly recommended parenting plans may not be appropriate for a special needs child, especially when that child will require parental involvement beyond age eighteen.
- The special needs of the child due to a mental illness or behavioral disorder must be a statutorily required factor when a court makes a custody decision and/or designs a parenting plan under the "best interests of the child" standard.
- Family court judges can consult with clinical experts to adequately understand the child's needs and address them in the custody decision and parenting plan.

Keywords: *Behavioral Disorder; Best Interests; Custody; Divorce; Mental Health; Mental Illness; and Special Needs.*

I. INTRODUCTION

In adjudicating child custody or designing a parenting plan, the court is required to weigh multiple factors to determine what is in the best interests of the child.¹ In most states there is no prescribed formula, only a list of factors that the court should consider, including the parenting skills of each parent, the physical and mental health of the parents, domestic violence, existing custody agreements, and finances of the parents, among others.² This list of factors to consider in determining the best interests of the child, while not exhaustive, is heavily focused on the parents. Absent from this list, and from the list of factors that most family courts in the United States consider in making a custody determination, is the psychological well-being and mental health of the child.³ When a child suffers from any type of mental health, psychiatric, or behavioral disorder, the family will likely face a variety of challenges that must be addressed throughout the process of a custody dispute.⁴

Custody decisions and parenting plans⁵ for typical children do not contemplate many of the unique decisions that must be made for those with special needs. Commonly recommended parenting plans may not be appropriate for a special needs child, especially when that child will require parental involvement beyond age eighteen. First, children with special needs are more likely to thrive in a structured environment, requiring "consistent and predictable routines" and "advanced preparation for changes."⁶ Second, parenting plans must contemplate the child's increased need for supervision and/or professional intervention in order to ensure that the child has the necessary psychiatric, behavioral, and medical support s/he needs. Lastly, an appropriate parenting plan for a special needs child should provide flexibility, allowing the parents to plan ahead and hopefully avoid court intervention to modify any agreements.

Correspondence: drhmermelstein@optimum.net; jrosen@abramslaw.com; cwolf@abramslaw.com

The special needs of the child due to a mental illness or behavioral disorder must be a statutorily required factor when a court makes a custody decision and/or designs a parenting plan under the best interests of the child standard. This article will examine the specific challenges facing a family court judge when determining custody and designing a parenting plan for a special needs child, specifically a child that suffers from a mental illness or behavioral disorder. Part II presents an overview of a “best interests of the special needs child” analysis, including the unique needs of a special needs child, parenting capacity to attend to those unique needs, and consideration of other family members, particularly siblings, if any. Part III discusses the issues of a typical parenting plan and how parenting plans must be catered to the child’s specific mental health needs. Part IV explores a proposal for statutory change, requiring that the mental health needs of the child be considered in a best interests analysis. Part V addresses how judges can consult with clinical experts in order to adequately understand the child’s needs and address them in the custody decision and parenting plan. Finally, Part VI concludes by reinforcing that when evaluating what is in the best interests of the child, we must focus on the child’s specific needs.

II. UNDERSTANDING THE SPECIAL NEEDS CHILD AND THE FAMILY DYNAMIC

Determining parenting plans and living arrangements that are grounded in a child’s best interests requires an individual analysis of each family member. All states have statutes requiring that the court consider the child’s best interests when decisions are made “regarding a child’s custody, placement, or other critical life issues.”⁷ However, there is no standardized list of factors, and few states have mandatory factors that the court must consider in its best interests analysis. In New York, for example, the court must base its custody determination on the totality of the circumstances.⁸ Courts view each of the factors independently and no one factor is determinative.⁹ In the case of a custody dispute over a special needs child, the court must be required to examine the child’s specific psychological or mental health needs; the parents’ ability to understand, support, and pay for those needs; and the needs of any siblings.¹⁰

A. THE SPECIAL NEEDS CHILD

The safety and well-being of the child is the family court’s primary concern in making a custody decision. That being said, it should follow that the court must evaluate the particular needs of the individual child in order to ensure that s/he is safe and well cared for. For the special needs child, the safety risks and the need for care is often elevated. A custody decision and parenting plan should, in part, be based on the nature and severity of the illness; the necessary medical or mental health and behavioral treatment; and the child’s emotional, social, educational, and financial needs.¹¹

The treatment regiment of a special needs child typically occupies part of the child’s daily routine. The child may require ongoing medical or mental health care, medication, and/or appointments with professionals in the medical and mental health fields.¹² Because the individual in question is a minor, all of this care and treatment requires constantly evolving decision making and consent of the child’s parents. The court, in determining custody and designing a parenting plan, must delineate who will be responsible for making these critical decisions, who will monitor the process, and how information will be shared.

A special needs child often requires increased emotional or social support and encouragement. Special needs children frequently have worse school performance, face many societal issues, and in turn may experience elevated risks of self-harming behavior.¹³ The special needs child may qualify for special education and/or require an Individualized Education Program. All of these needs incur costs and may require financial support throughout the child’s life, extending well beyond the age of eighteen. When it comes to planning for the special needs child’s future, the parenting plan should consider options for postsecondary education, employment, and independent living.¹⁴ In fact, many

psychiatric disorders are often exacerbated with age or may lead to dual diagnoses with a substance or alcohol abuse problem.¹⁵ Additional expenses include, but are not limited to, private education or tutoring, medical care and therapy, mental health treatment and medication, and residential living or supervised living arrangements.¹⁶ Parents may need to plan in advance how they will support the adult special needs child who is incapable of supporting him/herself.¹⁷

B. THE PARENTS

A special needs child demands a higher level of supervision and care. As a result, a special needs child requires “extraordinary parenting.”¹⁸ The court must consider the parents’ insight and understanding of the child’s special needs and the parents’ respective commitment and availability to pursue medical, educational, therapeutic, and financial assistance for the child.¹⁹ In a perfect world, both parents would acknowledge and understand their child’s mental illness or behavioral disorder, inquire about the child’s unique needs, find appropriate clinical professionals to provide the necessary evaluation and treatment, and work together to support and advocate for that child in an ongoing way.²⁰ Unfortunately, this ideal is not a reality especially if the couple is involved in a custody dispute before a family court judge.

The court must evaluate each parent’s awareness and acceptance of the child’s special needs, history of involvement with treatment, and willingness to provide the multifaceted supports required. An obvious issue occurs when a parent denies a psychological or mental health issue exists, refuses to cooperate with treatment, and impedes or actively intervenes to prevent treatment. On the other hand, a parent might be extremely devoted to the child and his/her needs, advocating zealously for that child to succeed, making and attending doctor appointments, researching therapies or advancements in psychology or psychiatry, handling insurance issues, and appropriately administering medication. Somewhere in the middle might be a parent who acknowledges a mental health issue exists, but is careless or even irresponsible when it comes to attending doctor appointments or administering medication, or a parent who does not have the energy, emotional stamina, time, or money to properly tend to the child’s needs.

The parents’ availability and financial resources are two very important factors to consider when determining which parent should have physical custody of the child.²¹ Often the parent with the most time and means will be the best option for primary caretaker.²² The court must review records of all the current and potential future costs of the child’s care and treatment including therapy, counseling, doctor visits, medications, possible hospitalization costs, hiring of case managers or other clinical professionals, nonparental caregiver costs, transportation, and any other costs.²³ With the extreme cost of a contested divorce proceeding in addition to the high costs of care required for the child, one or both parents may not be available as a full-time caregiver. There is frequently a need for employment outside of the home, which further limits the availability of even the primary parent.²⁴ Unfortunately the costs do not end when the child turns eighteen. It is important for the court to understand, in detail, how the child’s potential inability or decreased ability to earn a living will impact the finances of each of the parents, taking into consideration the child’s job potential, future income, need for comprehensive health insurance, and eligibility for public benefits, among others.²⁵

C. THE WELL CHILD OR TYPICAL SIBLING

If there are other children within the family unit, the court’s determination of what is in the best interests of the children must also adequately consider the other siblings who may be well or who may themselves have special needs. The court must weigh the benefits and risks of splitting up siblings versus keeping them together. For example, if the children are close, they should remain with each other as much as possible. If one sibling has parenting time with the noncustodial parent, the special needs child should also be permitted the same parenting time, if possible. If the children are separated or not permitted the same visitation, the child with special needs may feel different or not

good enough.²⁶ However, the court's determination must adequately address the needs of all of the children, both healthy and disabled, and assess each child's needs individually.²⁷ The parenting plan should specifically include the typical children.

III. DEVELOPING A PARENTING PLAN FOR A SPECIAL NEEDS CHILD

Childhood is a time of physical, cognitive, psychological, and social growth. The successful negotiation of the stages of maturation allows entry into adulthood with relational and emotional health, having completed a series of developmental milestones. Unfortunately, some children are beset by significant problems in bio-psycho-social arenas with resultant emotional, behavioral, cognitive, and even physical difficulties.

All development is the product of the interaction of interrelated biological and psychosocial influences. Divorce, which disrupts the family structure, the primary environment, and social context for children, has now become a normative event affecting a large number of marriages in the United States. Though each child will react to the trauma of divorce in his/her or own unique way, overall, children of divorce are affected by the experience both immediately and in the long term. A series of studies has reported that children of divorce are more likely to suffer from lower self-esteem, increased depression, lower academic achievement, poor social competence, and acting-out behaviors during childhood and adolescence and may have increased risk for problems with intimacy and adult relationships.²⁸ Postdivorce childcare, custody, and living arrangements are ideally based on the best interests of the child. However, the problematic elements considered may be limited in scope, tend to lack fluidity and flexibility, and lack adequate attention to future needs. The explosive growth in the number of children affected by divorce has led to increased attention to this topic in general, but the special needs of the mentally ill or behaviorally disordered child remains an active area of concern.

A. NEED FOR CONSISTENCY, STABILITY, AND STRUCTURE

A healthy psychological outcome is most likely when children are raised in a milieu that is psychologically and physically safe while providing a consistent, supportive, and nurturing environment. By tending to basic needs, primary caretakers, most often parents, create the setting in which children can develop into their optimal selves. Divorce, which disrupts the protective nest, is most often experienced by children as sudden and traumatic, even in families marked by high conflict. It is the stable attachment and consistency of primary caregivers that enable children to internalize the concept that others are trustworthy, to develop a positive sense of self, and to have confidence in their ability to effectively respond to the world around them.²⁹ In the immediate postdivorce period children yearn for and fantasize about reunification and may suffer from the grief at the threat of loss, real or perceived, of the primary parent.³⁰

Furthermore, for the noncustodial parent there is a loss of time spent with children as well as a decrease in the level of closeness. Divorce can lead to a change in the financial status of the parents, particularly when the custodial parent is the mother. There is frequently a need for employment outside of the home, which further limits the availability of even the primary parent. Additionally there is a high incidence of postdivorce depression among the adults, which adds to the emotional withdrawal felt by the children with an exaggerated effect for preschoolers.³¹

Jeopardizing the constancy and integrity of the parent-child relationship is psychologically traumatic. It is the second most significant contributor to the negative impact of divorce on children, second only to high levels of conflict.³² For the child who already suffers from anxiety and depression, psychotic thinking, or severe attention deficit disorder, this breach of security and threatened destabilization of the usual psychological support system puts the child at a greater risk for increased symptoms (both emotional and behavioral), declining function, and decompensation. Children who are

psychiatrically ill are fragile and have a limited ability to cope with change in the best of times, let alone during the tumult of a divorce. This is exacerbated by the loss of the stable family unit, particularly the mother–child relationship, which provides consistency, support, and modeling.³³ Young children’s tendency to engage in imaginary thinking is fraught with risk for psychiatrically unstable children. Such children have an increased predilection to assume responsibility for the conflict and therefore the divorce causes them to suffer from feelings of guilt, failure, exacerbated depression, and poor self-efficacy and esteem.³⁴

When the structure of the household is ruptured, as in divorce, there is a resultant loss of the ability to provide the necessary stable platform. Children who are psychiatrically ill often struggle in school, irrespective of intellect level, due to a variety of factors including disorganized thinking, decreased concentration, mood symptoms, sleep disturbance, amotivation, psychotic ideation, or hallucinations. Learned adaptive behaviors can moderate the impact of divorce, but children whose cognitive ability is affected lose important skills for handling trauma.³⁵ Parents play a pivotal role in the development and application of educational-treatment plans.³⁶ They provide the platform on which children can learn behavioral regulation and learning habits.³⁷ A number of studies have shown that divorced custodial parents invest less time, have fewer rules, and less supervision than married couples, but at the same time are harsher with discipline and have more parent–child conflict.³⁸ As with the psychological stressors, the education-related impediments experienced by both the custodial and noncustodial parent exacerbate an already problematic situation and lessen the potential for stabilization and adaptation for the child that requires structure, patience, tolerance, behavioral practicing, time, and consistency.

Mentally ill and behaviorally disordered children require an increased degree of constancy because they have a reduced ability to cope with change. Though alienation of the noncustodial parent can occur in any population, the high level of anxiety, difficulty adjusting, acting-out behaviors, and regressed relationships frequently present during divorce add to the risk.³⁹ In this population there may be a benefit to sole physical custody where the child remains physically with the primary parent. This may limit the disruption divorce causes for the child and decrease his/her terror of abandonment and anxiety about an unpredictable future. Particularly in the immediate postdivorce period, there is likely to be a temporary worsening of the symptoms, increased levels of stress, and intensification of acting-out behaviors. Maintaining normal routines that are stable, predictable, and consistent can help reassure the child and create a dependable base on which adaptation to the new normal can begin to occur. Custody decisions and parenting plans for this population should underscore these serious concerns. When assessing the best interests of the child, all the components (psychological, psychiatric, educational, social, medical, legal, and financial) should be acknowledged and carefully assessed from a risk–benefit perspective for this very vulnerable population.⁴⁰

B. NEED FOR SUPERVISION AND INTERFACE WITH MENTAL HEALTH PROFESSIONALS

Special needs children already suffer from many of the problems that normally occur in the predivorce period, which amplifies their distress and dysfunction and reduces their adaptive ability. At this time when their needs are most heightened, the very person(s) they rely on for guidance, support, coping skills, and care may not be psychologically or physically available to them. Adverse events, such as divorce, amplify the risk for decompensation with a resultant increase in psychiatric morbidity and even death. A study of adolescents admitted to psychiatric units found a disproportionate percentage were children of divorce.⁴¹ Depression involves an inherent risk of suicide or parasuicidal behavior, as do psychotic disorders, particularly in the early stages. Substance abuse, school problems, poor socialization skills, and high levels of psychological distress plague these children and are all exacerbated by the crisis of divorce. Parenting plans should attend to the need for supervision both for safety and to ensure that the parent(s) are themselves able to function and to provide the necessary emotional, cognitive, and behavioral support that the children require.

Families undergoing divorce find themselves caught in a judicial system that may be alien to them. There are often multiple people involved in a variety of capacities. However, for the special needs child there must be an active interface with mental health professionals to assess, recommend, consult, and treat the child and the family system. Psychiatric symptoms can be ameliorated, quality of life can be improved, and distress can be diminished with the possibility for an improved prognosis over time. Mental health professionals should ideally have familiarity with forensics as well as child and family issues. The children's need for bio-psycho-social care is ongoing and the parenting plan should include a component mandating this care and monitoring the delivery of care.

C. NEED FOR FLEXIBILITY AND PLANNING AHEAD

Parenting plans are typically predicated on the current needs and the relatively predictable future development of the child. The level of functioning of the special needs child has wide variability depending on the nature of the illness, the child's clinical state, and the level of symptom control. Psychiatric illness is dynamic; the child's clinical status and hence his/her care needs continually change. It is nearly impossible to accurately predict or even approximate what will be required in the future.⁴²

That being said, it is difficult to reopen a custody case or modify a parenting plan without encouraging litigation.⁴³ Most parenting plans agreed upon by both parents "will govern the daily rhythm and schedule of children without change until they turn [eighteen]."⁴⁴ All parenting plans must provide for a method of making modifications, as well as a schedule of periodic review of the plan. This type of provision is absolutely essential to ensure the needs of the child are adequately met as that child ages or as the child's mental illness progresses. For example, children with mood disorders can function far below their developmental level while depressed, but function at grade level between episodes.⁴⁵ Children with prodromal psychosis are at risk for worsening social and academic outcomes, which presages the illness. However, the first break of schizophrenia most commonly occurs in late adolescence or even young adulthood and will likely require special care for life.⁴⁶ Older children with attention deficit disorder may appear childlike or age appropriate depending on the setting and circumstances.⁴⁷ Clear drafting of a parenting plan will help parents overcome disagreements and make decisions in their child's best interests without delaying needed treatment or returning to court.

The parenting plan for a special needs child must contemplate that child's future beyond age eighteen, including an evaluation of several legal and financial issues. For example, who will care for the child once s/he reaches the age of majority? It may be wise for parents to discuss guardianship or conservatorship in anticipation of the fact that the special needs child will require care and treatment as an adult. There are also several long-term financial obligations to consider such as housing arrangements, medical and mental health treatment, medications and medical equipment, education, and potential unemployment throughout the child's future adult life.⁴⁸ It is important for parenting plans to anticipate these uncertainties and provide avenues for modification as the child ages to avoid continuous litigation.

Parenting plans for the psychiatrically ill, special needs child are best designed with inherent flexibility. The assignment of a professional to oversee the child's progress should also be charged with modifying the treatment and parenting plan as clinical situations and needs change. Particularly in this population, it is critical to not only think about the state of the child at present, but also contemplate the fluctuating impact of the condition over time.

D. CONCLUSION

Children function best when they are attended to and cared for in a stable, consistent, and loving way. Children with mental illness or behavioral disorders struggle with the added burden of illness that can affect their ability to think clearly, behave rationally, and even experience life at its fullest. Disruption of the family unit affects everyone it touches. Most individuals recover and may even develop

hardiness, a resiliency that will serve them well in the future. The special needs child is at greater risk for adverse reactions to, and outcomes of, the traumatic event both immediately, at the time of divorce, and in the long term. Parenting plans for this pediatric subgroup needs to address the multidimensional clinical situation, attend to the need for stability and consistency, and provide the supervision and risk assessment required, all while maintaining a flexible, optimistic, and future-oriented approach.

IV. PROPOSAL FOR STATUTORY CHANGE: MANDATORY CONSIDERATION OF THE CHILD'S MENTAL ILLNESS OR BEHAVIORAL DISORDER

The special needs of a child due to mental illness or behavioral disorder must be a mandatory factor to consider in making a custody decision and designing a parenting plan under the best interests of the child standard. While the presence of domestic violence in the home, for example, is a mandatory factor that New York courts must consider when determining the best interests of the child, the special needs of a child is only a possible factor the court *may* consider. No legislation currently exists that specifically mandates courts to consider the custody and safety issues for divorcing families with special needs children.⁴⁹

Almost every state and the District of Columbia list in their statutes specific factors for courts to consider in making determinations regarding the best interests of the child. While the factors vary considerably from state to state, some factors considered include parenting capacity, the child's wishes, age of the child, parents' respective willingness to support the child's relationship with the other parent, and physical and mental health of the parents, among others. In determining what is in the best interests of the child it only makes sense that the court should be required to evaluate the mental and physical health of all individuals involved, especially the children, and specifically the child's mental illness or behavioral disorder, if any.

A. DOMESTIC VIOLENCE IS A MANDATORY FACTOR IN ALMOST EVERY STATE'S BEST INTERESTS OF THE CHILD STANDARD

As of 2008, the presence of domestic violence in the home was listed as a specific factor to be considered in the best interests of the child statute of forty-three states.⁵⁰ In addition, nineteen state statutes provide extra weight for domestic violence as a factor when considering custody determinations.⁵¹ In New York, domestic violence is a mandatory factor to be taken into consideration when making a custody or child support decision based on the best interests of the child standard.⁵² The statute provides that "the court must consider the effect of such domestic violence upon the best interests of the child, together with such other factors and circumstances as the court deems relevant."⁵³

It is time for New York and the remaining states to implement the "mental and physical health needs of the child" or some other variation, as a mandatory factor to be evaluated in a best interests of the child analysis. This will allow courts to make better determinations when dealing with a family separation where a child has special needs, but more importantly it will benefit the special needs child who has more critical and distinct needs than the typical child.

B. REQUIRING CONSIDERATION OF THE SPECIAL NEEDS OF THE CHILD IN A BEST INTERESTS ANALYSIS

Family court judges are more frequently facing separating or divorcing families who have a special needs child.⁵⁴ There have been considerable increases in the number of young children diagnosed with special needs, including but not limited to acute, life-threatening medical conditions; chronic developmental disorders; and psychiatric illness and behavior syndromes.⁵⁵ Added to the explosive growth in the number of children diagnosed with autism, attention deficit disorder, and other neuropsychological problems, there is hardly a day that a family law judge across the country is not faced with a special needs child.⁵⁶ However, as of 2012, only eight states and the District of

Columbia specifically consider the mental and physical health needs of the child.⁵⁷ For example, Virginia courts determining the best interests of the child consider the “physical and mental condition of the child, giving due consideration to the child’s changing developmental needs”.⁵⁸ Maryland case law provides the court with a list of factors that the court *may* take into consideration in determining the best interests of a child, including the “stability and mental health of each child.”⁵⁹ In addition, there are often guiding principles for the court when making best interests determinations, but only nineteen states provide a specific principle in regards to the “health, safety, and/or protection of the child.”⁶⁰

The number of court decisions in which the judge had to consider the special needs of a child in the best interests standard has been increasing. For example, in *Walter v. Walter*, the Supreme Court of Wyoming found that shared custody arrangements were not appropriate for the special needs children.⁶¹ Moreover, visitation schedules were changed on appeal due to the children having difficulty with transitions between the households.⁶² In *Maillet v. Maillet*, the Superior Court of Connecticut determined that the mother was best able to manage the unique needs of her three special needs children and should therefore be the primary custodial parent.⁶³

In recent years, New York cases have specifically mentioned and factored in the special needs of a child. In *Mark RR. v. Billie RR.*, the court determined it was in the special needs children’s best interests to award sole legal and primary physical custody to the father.⁶⁴ The court found that the mother’s inability to understand or cope with the children’s special needs contrasted with the father’s maintenance of a stable home environment as well as his involvement in ensuring that the children’s medical, emotional, and educational needs were satisfied.⁶⁵ In *Goldsmith v. Goldsmith*, the court awarded sole custody of the child to the father because the mother refused to cooperate with school officials in addressing the child’s special educational needs and had consistently made unilateral decisions affecting the child’s care and development.⁶⁶ In *Ganzenmuller v. Rivera*, the Supreme Court, Appellate Division, held that the father was better equipped to provide a stable home environment and to provide for the child’s special needs.⁶⁷

Failing to incorporate the special needs of a child due to mental illness, behavioral disorders, and other disabilities as a mandatory factor for courts to consider in a best interests of the child analysis will lead to a slippery slope of future risks to the special needs child. Courts must “keep everyone’s focus on the duty to protect the weakest, most vulnerable actor in the separation or divorce process.”⁶⁸ To achieve this goal, state standards regarding the best interests of the child must mandate the mental health of the child, as they have already done with domestic violence. Changes need to be made as the number of families appearing in court with a special needs child continues to increase.

V. CONSULTING EXPERTS TO PROVIDE A CLINICAL REVIEW OF THE CHILD’S SPECIAL NEEDS

The family court system must navigate the unique needs of the special needs child in resolving a custody dispute.⁶⁹ Judges are not mental health professionals, nor do they usually have the essential behavioral and social science or medical training needed to evaluate the pertinent clinical information and understand how it impacts a child’s life and the ability to parent. Therefore, it is highly recommended that family court judges use a variety of experts available to them such as custody evaluators and/or co-parenting counselors. The court may also wish to review information from the child’s teachers, therapists, or other clinical professionals currently treating the child, including school and medical records.⁷⁰ These individuals can provide the clinical analysis needed to appropriately evaluate all of the information relevant to a final custody determination and parenting plan.

A. CUSTODY EVALUATORS IN CHILD CUSTODY PROCEEDINGS

One of the family court’s greatest obstacles in a child custody proceeding is the lack of adequate and credible information regarding the child’s special needs and the parents’ respective abilities to

provide for those needs.⁷¹ The parties almost invariably disagree on the severity of the disability and/or the child's abilities. Through the appointment of an expert, in the form of a custody evaluator or forensic evaluator, the court can obtain the necessary information about the child's condition, treatment, and prognosis as well as the parents' skills and deficits.⁷² Such evaluation may be requested by the parents or attorneys or ordered by the court.⁷³ The expert is usually a licensed mental health professional, such as a psychologist, psychiatrist, or clinical social worker.

The purpose of a child custody evaluation is to assist the judge in determining the best interests of the child. This requires an objective assessment of the needs of the child, the parents' respective ability to meet those needs, and the overall family dynamic. The evaluation should encompass a review of medical and mental health records, interviews and psychological testing of both parents and the children, home visits with each parent, and collateral contacts such as friends or other family members. The Association of Family and Conciliation Courts Model Standards of Practice for Child Custody Evaluation specifies that child custody evaluators should have professional knowledge and training when special issues arise in child custody evaluations.⁷⁴ Consistent with such standard, where parenting plans and custody decisions will be made for families with special needs children, evaluators should have specialized knowledge of child mental illness or behavioral disorders and/or any disabilities in question.⁷⁵ In general, child custody evaluators must demonstrate a certain level of expertise requiring constant training and education about psychiatric illness, child and family development, and the impact of divorce on children, among others.⁷⁶

In New York, the Mental Health Professionals Panel was established by the Appellate Division, First and Second Judicial Departments, to ensure that courts and parties have "access to qualified mental health professionals" that are available to evaluate the parties and to assist courts in reaching appropriate decisions as to custody and visitation.⁷⁷ This panel is responsible for recommending eligible professionals and recommending removal of those that are not fit. While courts cannot delegate to a mental health professional its authority to determine issues involving the best interests of the child,⁷⁸ the court has the ability to read the reports, and make decisions incorporating the unbiased determinations of such a professional.

A court-appointed forensic evaluation is a well-established part of custody litigation, intended to provide the court with an unbiased professional opinion.⁷⁹ The result of the evaluation is a written report with recommendations such as parenting time, medical or mental health care, and education. This report may encourage parents to reach an agreed-upon parenting plan or, if not, can assist the judge in making a final determination of custody by providing a credible clinical review of the child's needs.⁸⁰

B. CO-PARENTING COUNSELOR FOR ONE OR BOTH PARENTS

Raising a special needs child after divorce requires a high degree of collaboration between the parents. Even without this dynamic, parents will often use a child as a pawn to get back at their ex-spouse. A parent may reject a choice of school or camp simply because the other parent supports it. In extreme cases, a parent in denial of the child's needs may not take the child to appointments or administer medication. Putting a special needs child in the middle of this kind of tug-of-war and manipulation can have only harmful consequences, both to the parents and, more importantly, to the child.⁸¹ The court must evaluate each parent's ability to accurately assess and meet the emotional, intellectual, and physical needs of the child.⁸² In contentious cases like this, the court may require a co-parenting counselor for one or both parents. These counselors, who can be psychologists, psychiatrists, social workers or marriage and family counselors, will help parents forge a working relationship that puts their child's interests first.⁸³

In New York, a court may appoint a parent coordinator to resolve issues of visitation between the parents and the child. Where the record shows a need for therapeutic intervention to end destructive behavior toward each other and themselves, a co-parenting counselor or parenting coordinator is encouraged.⁸⁴ Co-parenting is an arrangement where both parents share responsibility for raising

their child or children in a spirit that promotes cooperation, healing, and growth. This counselor allows parents the opportunity to discuss the best interests of their children in a neutral environment and get input and advice from a professional who is experienced in working with children and families of divorce.⁸⁵ Parents of a special needs child may need clinical or family counseling to discuss the unique therapy, medical, and educational needs of the child, as well as discuss that child's future beyond age eighteen.

VI. CONCLUSION

Divorce is a distressing, painful, and disruptive process for all involved. The impact on both adults and children is often significant in the short term and may persist over time. For many children, divorce is a major life event and can have negative emotional, behavioral, social, and academic consequences. For special needs children, particularly those who struggle with mental illness and behavioral disorders, this trauma exacerbates their everyday symptoms, adding to the already present risk for poor psychological, social, and academic outcomes. The universal need of children for consistency, stability, and structure is even more critical in this pediatric group.

Custody arrangements are designed with the safety and well-being of the children in mind and are predicated on the best interest of the child. However, what factors must be considered in these decisions vary and hereto most courts have not recognized the specific, critical issues that exist when dealing with children with special needs due to mental illness and behavioral disorders. Similarly, common parenting plans may not sufficiently take into account the challenges that occur in this population. As outlined above, there are factors that should be mandatory considerations when these cases are adjudicated. In addition, judges should consult with professionals who can best evaluate the multifaceted elements for both the children and the parents, and whose involvement may be required over time, perhaps even for a child's lifetime. Though the pain of divorce is unavoidable, perhaps in this way the cost to the children need not be further amplified.

NOTES

1. Andrew Schepard, *Best Interests of the Child*, available at <https://www.childcustodyproject.org/essays/best-interests-of-the-child/> (last visited June 30, 2015). See, e.g., N.Y. DOM. REL. LAW § 240 (2014).

2. Susan L. Pollet, *Impact of Separation or Divorce on Special Needs children*, 244 N.Y.L.J. (2010), available at <https://www.nycourts.gov/ip/parent-ed/pdf/specialneedsarticle.pdf>.

3. There are several types of special needs children that appear in family court matters. For the purposes of this article we use the term "special needs" to focus specifically on children suffering from a mental illness, psychological dysfunction, or behavioral disorder, including anxiety, mood, and psychotic disorders; problems with adjustment and temperament; and conduct disorders, among others. While some of the concepts in this article may apply to children suffering from a medical condition, physical disability, developmental disorder, or autism spectrum disorder, this article does not specifically address those syndromes. See Donald T. Saposnek et al., *Special Needs Children in Family Court Cases*, 43 FAM. CT. REV. 566, 567 (2005).

4. Renée A. Rubino, *Marital Settlement Agreements: The Key to Life After Divorce*, 279 N.J. LAW. MAG. 46, 48 (Dec. 2012).

5. A parenting plan is a document created to govern the relationship between the parents relating to how decisions about the child will be made, how information will be shared between the parents, and often a time-sharing schedule for the parents and child. Jacqueline W. Silbermann, *Child Custody in Contested Matrimonials*, 80 N.Y.S.B.J. 16 (Jan. 2008).

6. Saposnek, *supra* note 3, at 572.

7. Child Welfare Information Gateway, *Determining the Best Interests of the Child* (2012), available at https://www.childwelfare.gov/pubpdfs/best_interest.pdf.

8. *Eschbach v. Eschbach*, 56 N.Y.2d 167, 171, 451 N.Y.S.2d 658, 436 N.E.2d 1260 (1982); *Friederwitzer v. Friederwitzer*, 55 N.Y.2d 89, 432 N.E.2d 765 (1982).

9. Joel R. Brandes, *Judging the "Best Interests of the Child"*, N.Y.L.J., Feb. 23, 1999.

10. Ingrid B. Keller, *Raising Children on the Spectrum in Florida: Navigating the Road Less Travelled*, 83 FLA. B.J. 35, 36 (Jan. 2009).

11. *The Child's Best Interests in Custody Arrangements*, available at <http://family-law.lawyers.com/child-custody/the-childs-best-interests-in-custody-arrangements.html> (last visited June 30, 2015).

12. Barbara Epperson, *When Parents of Children with Disabilities Divorce*, 25.3 GPSOLO (April/May 2008), available at https://www.americanbar.org/newsletter/publications/gp_solo_magazine_home/gp_solo_magazine_index/parentsdivorce.html.
13. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013).
14. Epperson, *supra* note 12.
15. See *Mental Illness Exact Heavy Toll, Beginning in Youth*, Press Release, NAT'L INST. OF MENTAL HEALTH (June 6, 2005), available at <http://www.nimh.nih.gov/news/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>.
16. Sherri Donovan, *Listen to Our Children in Need: Special Needs Children and Divorce*, HUFFINGTON POST, May 4, 2012, available at https://www.huffingtonpost.com/sherri-donovan-esq/special-needs-children-and-divorce_b_1446587.html.
17. If unable to obtain employment, the adult child might be eligible for public benefits such as Supplemental Security Income and Medicaid. The parents may also choose to set up a Special Needs Trust to protect access to those government benefits. See Carolyn Wolf & Ellyn Kravitz, *Who Will Stand in My Shoes?*, 83.6 N.Y.S.B.A. J. (July/Aug. 2011).
18. Saposnek, *supra* note 3, at 566.
19. See Daniel B. Pickar & Robert L. Kaufman, *Parenting Plans for Special Needs Children: Applying A Risk-Assessment Model*, 53 FAM. CT. REV. 113, 125 (2015).
20. Heidi P. Perryman, *Parental Reaction to the Disabled Child: Implications for Family Courts*, 43 FAM. CT. REV. 596, 596 (2005).
21. While this article does briefly address the financial implications of having a special needs child, this article does not discuss child support and/or maintenance, which may be affected by the increased cost of the child's care.
22. Sunni Ball, *Children with Special Needs in Divorce*, at 3 (Dec. 2002), available at <http://www.familymattersassociates.ca/images/SPECIALNEEDSCHILDRENINDIVORCE2.pdf>.
23. Margaret P. Price, *Special Needs and Disability in Custody Cases: The Perfect Storm*, 46 FAM. L.Q. 177, 184 (2012).
24. Keller, *supra* note 10, at 36.
25. Price, *supra* note 23, at 184.
26. Ball, *supra* note 22, at 7.
27. Perryman, *supra* note 20, at 597.
28. Paul R. Amato & Bruce Keith, *Parental Divorce and the Well-Being of Children: A Meta-Analysis*, 53 J. MARRIAGE AND FAM. 43, 46 (1991); Jennifer E. Lansford, *Parental Divorce and Children's Adjustment*, 4 PERSP. ON PSYCHOL. SCI. 140 (2009); Judith S. Wallerstein, *The Long-Term Effects of Divorce on Children: A Review*, 30(3) J. AM. ACAD. CHILD ADOLESC. PSYCH. 349 (1991); Nicholas Zill et al., *Long-Term Effect of Parental Divorce on Parent-Child Relationships, Adjustment and Achievement in Young Adulthood*, 7 J. FAM. PSYCHOL. 91 (1993); Ingunn Storksen et al., *Adolescents with a Childhood Experience of Parental Divorce: A Longitudinal Study of Mental Health and Adjustment*, 28 J. ADOLESC. 725 (2005).
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30. John Bowlby, *Symposium on the Contribution of Current Theories to the Understanding of Child Development*, 30(4) BRITISH J. OF MED. PSYCHOL. 230 (1957).
31. Marsha Kline Pruett et al., *Family and Legal Indicators of Child Adjustment to Divorce Among Families with Young Children*, 17 J. FAM. PSYCHOL. 169, 170 (2003).
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61. *Walter v. Walter*, 346 P.3d 961 (Wyo. 2015). The wife was the primary caregiver, but the court’s decision to award custody to the father was based on the mother’s history of mental instability, lack of credibility, inability to communicate with the father, refusal to foster a positive relationship between the father and the children, and inability to respect the father’s rights and responsibilities. *Id.* All of these factors relate directly to the special needs of the three children. *Id.*
62. *Id.*
63. *Maillet v. Maillet*, 2012 WL 6582561 at 3 (Conn. Super. Ct. 2012). The court found that the husband’s philosophy of parenting the three special needs children would have an extreme emotional cost to the children given their specific needs and it would not lend itself to be a productive, long-term parenting technique for the children. *Id.* See also CONN. GEN. STAT. ANN. § 46(b)–56(c) (2014) (listing factors to consider when determining the best interests of the child).
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66. *Goldsmith v. Goldsmith*, 50 A.D.3d 1190, 1192 (2008). See also *Adriano D. v. Yolanda A.*, 94 A.D.3d 448, 448 (2012) (the court held the best interests of the child were served by awarding custody to the father because he was “able to provide for the child financially and emotionally and demonstrated that he has been actively involved in the child’s education and special needs”).
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Hindi Mermelstein has been a board-certified general psychiatrist in New York for over twenty-five years with added board-certified expertise in psychosomatic and geriatrics, treating the spectrum of individuals and families suffering from complicated medical and psychiatric conditions using a variety of modalities including telemedicine. Additionally, her work as an educator, researcher, and administrator informs her clinical work and academic interests.

Jamie A. Rosen is an associate attorney at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, & Wolf, LLP, located in Lake Success, New York. Her practice is primarily focused on mental health, health care, and elder law. As part of the firm's Mental Health Law practice, she represents major hospital systems, individuals, and families. This includes mental hygiene law matters such as Kendra's Law applications (Assisted Outpatient Treatment), involuntary psychiatric treatment and retention, and adult guardianship proceedings, among others. She received her J.D. from the Maurice A. Deane School of Law at Hofstra University in 2013 where she was an associate editor of the Hofstra Law Review.

Carolyn Reinach Wolf is an executive partner in the law firm of Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP and director of the firm's Mental Health Law practice. Her practice concentrates in the areas of mental health and health care law, representing mental health and health care professionals, major hospital systems and community hospitals, institutional and community outpatient programs, skilled nursing facilities, higher education institutions, individuals, and families. In addition, she often serves as co-counsel in matrimonial matters involving mental health law issues. She is a frequently invited speaker and consultant to health care institutions and institutions of higher education, specifically university counseling centers and administrators, throughout the country regarding risk management and mental health law issues. The New York Times Sunday Edition (February 8, 2013) ran a front-page story entitled “A Guide in the Darkness” in the Metro section on her and her unique mental health law practice as it impacts the lives of people with serious mental health issues and their families.