
INFANT MENTAL HEALTH, CHILD MALTREATMENT, AND THE LAW: A JURISPRUDENT THERAPY ANALYSIS

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ABSTRACT: Scholarly and clinical discussions of the legal issues facing infant mental health professionals typically focus on the seemingly intractable differences in philosophies, goals, and approaches inherent in the law and the mental health professions. We argue that forensically informed approaches to practice with very young children can potentially enhance many mental health and child welfare outcomes. This article describes the relatively new conceptual frameworks known as “therapeutic jurisprudence” and “jurisprudent therapy.” Using these conceptual frameworks, we analyze representative problems that are typical in infant mental health practice with maltreated children through case examples drawn from their evaluations of children and families in the child protection and legal systems. Demonstrations of how such dilemmas can be approached with enhanced analytic decision-making and practice approaches are presented. We argue that applying such jurisprudent therapy approaches opens up fresh perspectives for evidence-based practices that facilitate creative, rigorous, and intellectually stimulating clinical work.

RESUMEN: Las discusiones investigativas y clínicas acerca de los asuntos legales que enfrentan los profesionales de la salud mental infantil se enfocan por lo general en las aparentemente intratables diferencias en principios, metas y acercamientos inherentes en la ley y las profesiones de la salud mental. Los autores de este ensayo sostienen que los acercamientos para la práctica con niños muy pequeños, que estén basados en la ciencia forense, pueden potencialmente mejorar muchos resultados en cuanto a la salud mental y el bienestar del niño. Este artículo describe los relativamente nuevos marcos conceptuales conocidos como “jurisprudencia terapéutica” y “terapia de jurisprudencia.” Usando estos marcos conceptuales, los autores analizan problemas representativos que son típicos en la práctica de la salud mental infantil con niños maltratados. Esto se hace por medio de casos que sirven de ejemplo y que fueron sacados de sus evaluaciones de niños y familias en los sistemas legales y de protección a la niñez. Se presentan demostraciones de cómo puede el investigador manejar tales dilemas con mejores acercamientos analíticos de toma de decisiones y de práctica. Se sostiene que al aplicar tales acercamientos de terapia de jurisprudencia se abre la puerta a nuevas perspectivas para las prácticas basadas en la evidencia, las cuales facilitan el trabajo clínico creativo, riguroso e intelectualmente estimulante.

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RÉSUMÉ: Les discussions de recherches et les discussions cliniques des problèmes légaux auxquels les professionnels de la santé mentale du nourrisson doivent faire face mettent en général l'accent sur les différences apparemment inflexibles entre les philosophies, les buts, et les approches inhérents au droit et aux professions de santé mentale. Les auteurs de cet article soutiennent que les approches jurisprudentielles avec de très jeunes enfants peuvent potentiellement améliorer bien des résultats de bien être et de santé mentale de l'enfant. Cet article décrit une structure conceptuelle relativement nouvelle, connue en tant que "jurisprudence thérapeutique" et "thérapie par le droit." En utilisant ces structures conceptuelles, les auteurs analysent des problèmes représentatifs qui sont typiques de professionnels de la santé mentale du nourrisson avec des enfants maltraités à travers des exemples de cas pris de leurs évaluations des enfants et de ces familles de ces systèmes de protection de l'enfant et de ces systèmes légaux. Des démonstrations de la manière dont ces dilemmes peuvent être abordés avec des prises de décision analytiques améliorées et des approches pratiques sont présentées. Nous soutenons que le fait d'appliquer de telles approches de jurisprudence thérapeutique ouvre de nouvelles perspectives pour des pratiques objectives qui facilitent un travail clinique créateur, rigoureux et intellectuellement stimulant.

ZUSAMMENFASSUNG: Die wissenschaftlichen und klinischen Diskussionen der rechtlichen Aspekte der Arbeit der Fachleute im Gebiet der seelischen Gesundheit des Kleinkinds beziehen sich typischerweise auf anscheinend unlösbare Differenzen der Philosophien, Ziele und Zugänge, die den rechtlichen und den psychiatrischen Berufen innewohnen. Die Autoren behaupten, dass der forensisch informierte Zugang zur Praxis mit sehr jungen Kindern möglicherweise viele Ergebnisse in der psychiatrischen und der Jugendwohlfahrtsarbeit verbessern könnte. Dieser Artikel beschreibt diese relativ neuen Konzepte als „therapeutische Jurisprudenz“ und „jurisprudente Therapie“. Bei Anwendung dieser Konzepte analysiert der Autor repräsentative Probleme, die in der psychiatrischen Arbeit mit misshandelten Kindern typisch sind, indem er Fallbeispiele aus der Beurteilung von Kindern und Familien im Kinderschutz- und rechtlichen System verwendet. Es werden Dilemmata aufgezeigt, die besser mittels speziellen analytischen Entscheidungsmethoden und besonderen praktischen Zugängen bearbeitet werden können. Es wird behauptet, dass - indem man jurisprudente Therapie anwendet - sich neue Perspektiven eröffnen, die helfen können evidenzbasierte Praxis zu gestalten und dadurch kreative, genauere und intellektuell stimulierende klinische Arbeit ermöglichen.

抄録： 乳幼児精神保健の専門家が直面する法律問題の学問的、臨床的議論は、典型的には法律と精神保健の専門性に付き物の、哲学、目標、そしてアプローチ法についての、一見解決できない差異に焦点づけている。著者は、非常に幼い子どもの臨床に対する法廷での知識に通じたアプローチは、多くの精神保健と児童福祉の結果を増強する潜在能力があることを論じる。この論文では、「治療的法学 therapeutic jurisprudence」と「法学的治療 jurisprudent therapy」として知られる、比較的新しい概念的枠組みを記述する。これらの概念的枠組みを用いて、子どもの保護と法律システムのなかで評価した子どもと家族から引用した臨床例を通して、虐待された子どもの乳幼児精神保健の臨床に特有の典型的な問題を、著者は分析する。増強された分析的意志決定および臨床アプローチを用いて、どのようにこのよ

うなジレンマにアプローチすることができるかが、提示される。このような法学的治療アプローチを適用することによって、創造的で厳密で知的な刺激となる臨床の仕事を促進するような、根拠に基づく実践のための新鮮な視点が開かれることが、議論される。

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Scholarly and clinical discussions of forensic mental health typically focus on the seemingly intractable differences in philosophies, goals, and approaches inherent in the law and the mental health professions. Stone (1984), an early commentator, described the worlds of medicine and law as profoundly divergent, with dangerous moral consequences ensuing when mental health professionals participated in forensic work.

Others have argued that fundamental, cognitive biases and moral prejudices demonstrated by most mental health professionals in the clinic pose significant obstacles to just outcomes in the courtroom (Perlin, 1994). More recently, Clark (1998) argued that forensic work often thrusts the mental health professional into courtroom battles regarding human nature, the exercise of free will, and the centrality of reason.

Despite these theoretical and practical problems, the work of criminal and civil courts proceeds, and mental health professionals are extensively involved and even embedded as participants in these systems. Infant mental health professionals working with children who have been victims of maltreatment, embroiled in custody disputes, or committed to state custody as foster children will find themselves involved in criminal and civil proceedings because of their unique professional roles in the lives of those children (Galatzer-Levy & Kraus, 1999). It appears essential that all parties involved should have conceptual and procedural frameworks that enhance their work together rather than relying on those emphasizing the “warfare” metaphors and approaches that have traditionally animated relationships among lawyers, judges, and experts working through the adversarial processes that American law traditionally considers essential to the discovery of truth and the administration of justice (Clark, 1999; Sales & Shuman, 1996; Wexler, 1996a). Fortunately, over the past 15 years, more promising approaches for analyzing and addressing such challenges have emerged. The first, *therapeutic jurisprudence*, was defined by Wexler (1996b) as

[T]he study of the law as a therapeutic agent—is a truly interdisciplinary enterprise designed to bring mental health insights into the development of the law. The therapeutic jurisprudence perspective suggests that the law itself can be seen to function as a kind of therapist or therapeutic agent. Legal rules, legal procedures, and the roles of legal actors (such as lawyers, judges, and often therapists) constitute social forces that, like it or not, often produce therapeutic or antitherapeutic consequences. Therapeutic jurisprudence proposes that we be sensitive to those consequences, rather than ignore them, and that we ask whether the law’s antitherapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and justice values. (p. 453)

Therapeutic jurisprudence has proven a robust intellectual framework for international, interdisciplinary, and multisystemic approaches to the study of mental health law (Wexler, 1992). It has proven an important application of social science in law (Wexler, 1993) and has influenced the development of problem-solving courts such as family courts, mental health courts, and

drug courts. In these settings, professionals collaborate to protect the legal rights of offenders and victims while exercising an ethic of care which provides specific assessment and treatment interventions to enhance the health and mental health of all parties (Rottman & Casey, 1999).

One outcome of applying therapeutic jurisprudence has been for prosecutors and defense attorneys to structure pleas and sentencing agreements that move defendants into treatment, and to publicly emphasize that victims are not responsible for being victimized. For example, instead of accepting plea bargains that do not require a defendant's admission of guilt, a judge might approve plea bargains only for those child sexual abuse defendants who openly state in detail the specific crimes committed against the child, including their intentionality. Such courtroom allocutions, possibly observed by the child victim, family members, and the community, could assist the traumatized child and family in developing a therapeutic narrative of their experiences and also serve as the first step for the offender in correcting the cognitive distortions inherent in predatory thought processes (Rottman & Casey, 1999). In such cases, the rules of justice would be met through legal procedures that are potentially therapeutic.

The second approach, jurisprudent therapy, can be considered an extension of therapeutic jurisprudence and concerns whether "... psychological theories, their clinical and policy-making applications, and the people who develop and provide them [are] making a fair, just, and legally supportable contribution to the lives of the people they are intended to serve . . ." (Drogin, 2000a, p. 492). This approach recommends that mental health professionals evaluate their diagnostic and treatment theories as well as clinical procedures and techniques, especially when these impact patients who are involved in the legal system. This perspective examines whether mental health paradigms, strategies, and activities produce jurisprudent, neutral, or antijurisprudent effects on people, systems, and policies. For example, Drogin (2000b, 2000c) used this approach to evaluate the validity and credibility problems related to the psychological evaluation and testing of sexual offenders, as well as the problems associated with the expert psychological and psychiatric testimony in civil and criminal trials.

Importantly, therapeutic jurisprudence scholars have correctly anticipated that such approaches raise important legal, ethical, political, and scientific problems that should elicit thoughtful public debate and generate diverse, empirical investigation (Gould & Perlin, 2000; Madden & Wayne, 2003; Wexler & Winick, 1996). Infant mental health's involvement with complex legal processes provides fertile ground for applying and testing these frameworks. Zeanah, Larrieu, and Zeanah (2000) argued that "... each of the many disciplines involved in and with infant mental health has different roles, and, therefore, concerns; yet each shares a stake in the body of knowledge comprising this field" (p. 552). To effectively assess and treat infants and children involved in the justice system, it is critical that the many intersections among the legal and mental health professions should be considered as part of this multidisciplinary matrix.

In this article, the authors will apply the jurisprudent therapy approach to infant and child mental health problems that face professionals in contemporary practice. We will first describe the University of Kentucky Comprehensive Assessment and Training Services (UK CATS) Project—a program that utilizes jurisprudent therapy approaches. We then describe a representative case involving two children who have been removed from their parent by the child protection system (CPS). We describe the case facts and the actions taken by mental health professionals, and then analyze the effects of those approaches using jurisprudent therapy principles. We conclude with a discussion of the strengths and limitations of therapeutic jurisprudence and jurisprudent therapy for infant mental health, and offer recommendations for its applications for clinical practice in infant mental health.

THE UK CATS PROJECT

The UK CATS Project was developed to provide assessment and treatment for infants and children involved in the state CPS (Sprang, Clark, Kaak, & Brenzel, 2004). The College of Social Work and the College of Medicine (psychiatry) were approached by officials in the Kentucky Cabinet for Families and Children in 1999 to develop a state-of-the-art assessment protocol to expedite permanence and protection decisions in accordance with American Safe Families Act requirements. The principal investigators designing the program were trained in clinical social work, psychiatry, and pediatrics, and drew on their clinical and research backgrounds in the areas of child trauma, parent–child psychotherapy, child psychopathology and health, and forensic mental health. The CATS Project was designed as a major university–governmental partnership that acknowledged from the beginning that it would actively collaborate with the systems of care serving maltreated children and their families, including the court system.

Importantly, the CATS Project also committed itself to using assessment and intervention approaches that were evidence-based. Drawing upon attachment theory (Zeanah & Larrieu, 1998), trauma theory (McFarlane & van der Kolk, 1996), and developmental psychopathology approaches to child maltreatment (Sameroff & Chandler, 1975) as well as the scientific investigations associated with these research domains, the CATS Project developed a multidimensional assessment protocol that grounded its assessment and reporting procedures in scientific and evidence-based approaches. Additionally, the CATS Project embraced the commitment to employ individual, group, and organizational approaches to identify and reduce sources of error and bias endemic to assessment processes, especially those that require decision making and judgment under conditions of uncertainty (Berlin & Marsh, 1993; Sprang et al., 2004).

Children (most often living in foster care or relative placements) and their caregivers are referred to CATS by the Kentucky Cabinet for Health and Family Services for mental health evaluation. The goals of the subsequently generated assessment reports are to analyze data gathered through clinical interventions, structured clinical observations, psychometric screens, home and school observations and health, mental health, social service, and criminal justice record reviews. The final report explicitly presents inferences drawn from the data and provides the reader with specific conclusions based on the empirical evidence described in the report. Recommendations for placement, case planning, and specific treatments are made, with the hope that implementation of these will assist in enhancing the child's permanency and safety.

CASE DESCRIPTION AND ANALYSIS

The following is drawn from a case recently seen at the CATS Project. While the account disguises identifying information to ensure anonymity, the facts and clinical activities reflect the type of work routinely done at the clinic. This scenario begins as a young mother is referred to the CATS Clinic by CPS. The CATS intake procedure is a crucial part of the assessment protocol. It posits three goals: (a) eliciting informed consent to participate in the assessment protocol, (b) engaging the participant to enhance cooperation, and (c) the development of a valid database, especially the components that rely on the participant's activities in the clinic (e.g., structured interviews, structured observations, psychometric screening, and formal psychological testing).

Case Description: Part 1

Sue is a 25-year-old, White female who presented at the CATS Clinic for evaluation. Sue's children, Ronnie (24 months old) and Cindy (4 months old), had been removed 2 months ago

and placed in foster care because they were found alone in her apartment by the landlord. CPS had referred Sue to understand how to develop a case plan that would assist reunification, if that goal was indeed viable. Sue had four previous complaints filed with CPS, and two of these had been substantiated as “neglect.” CPS also had communicated to CATS that Sue had “graduated” from the foster care system herself, and suffered from posttraumatic symptoms, which had culminated in two suicide attempts when she was a teen. Sue currently struggles with alcohol and benzodiazepine abuse, although recent urine screens have been negative. She is living alone after the father of her children was convicted and incarcerated for domestic violence and attempted murder.

When Sue presented for the intake interview, she was noticeably anxious and guarded. “I don’t see why I have to do this to get my babies back,” she angrily told the clinician. The clinician empathized with Sue’s anxiety and confusion about the required assessment and stated her intention not to continue with the evaluation process until it had been thoroughly explained and that Sue understood her rights and all potential implications of the evaluation. The CATS Project was described as a university-based, neutral, third party, separate from public child welfare, with the responsibility and interest in presenting a well-balanced, fair accounting of her family’s strengths and weaknesses. During this early engagement process, Sue was empowered to ask questions about the clinic and the procedures, and encouraged to express concerns.

This process of engagement was lengthy as Sue was suspicious and mistrustful of the process. Her clinician continued this early rapport-building phase for an extended amount of time without pressure to complete the procedure within a specified time frame. This rapport-building process was designed to help the clinician build a solid relationship with Sue, which became the basis for subsequent, successful motivational interviewing. Next, the clinician discussed the informed consent procedure, the use of the data to be gathered about Sue and her children, and the risks and benefits of participating. Sue appeared surprised that she was being given this kind of information. She asked questions about the effects of participating on her and the children. She asked suspiciously, “Are you telling me that whatever I say here will not stay private, and that my caseworker and even the judge might see it?” When the clinician replied in the affirmative, Sue said, “That’s the first time anyone like you has ever told me the truth.” The clinician repeated that Sue would be taking a risk if she agreed to proceed and talk honestly about her life and her problems. She also suggested that Sue would have the opportunity to “tell her side of the story,” and that her perspectives would be included in the report.

While still ambivalent about moving ahead, Sue agreed to participate. Acknowledging Sue’s ambivalence, the clinician handed Sue the informed consent forms. By this point, the clinician had determined that Sue was an alert and intelligent young woman, and her review of the consent forms was congruent with this impression; she posed reasonable questions that emerged from reading the documents. She signed the forms, again verbally indicated her consent to proceed, looked at the clinician with a mixture of respect, suspicion, and nascent hopefulness, and said, “Well, if you want to know my story, I’m ready to tell it.”

Jurisprudent Therapy Analysis. Shea (1998), building on the work of Harry Stack Sullivan (1970), emphasized the importance of recognizing interviewee anxiety as the most typical impediment to collecting valid data during the first interview. Decreasing anxiety must be a priority for the interviewer to encourage interviewee cooperation, honesty, and motivation to fully participate. Miller and Rollnick (2002) argued that the initial interview should explicitly focus on motivating interviewees toward preparation to cooperate with assessment and treatment. All of

these researchers insisted that confrontation and coercion increase anxiety and decrease motivation. Interviewing techniques that create a safe place (Schafer, 1983) are therapeutic because they suggest to most interviewees that they can gradually lower their defenses and work collaboratively with the clinician. This approach is absolutely essential for effective work with victims of traumatic violence (Briere, 2004). Importantly, informing the interviewee about the assessment procedure, including the risks and benefits of participation, suggests that the clinician is willing to acknowledge the power structure of the clinical encounter. Along with such information, the clinician also is communicating that the interviewee has a real choice to participate or refuse participation, which suggests that while there might be coercive elements in the referral process, there is a way to “exit” if the assessment process becomes unsafe or too painful.

Sue was surprised by the explicit discussion of risks and benefits of the assessment because previous child welfare and mental health professionals always seemed to have forced her to cooperate or assumed that she would do so without ever asking her opinion. Sue also had found herself unable or not permitted to talk about her side of the story, especially in official case-planning sessions and certainly never in court. She liked the clinician’s matter-of-fact-but-interested approach; it was neither intrusive nor distant. Sue decided that she would cooperate and see what happened. In doing so, she found herself telling parts of her story—especially her own experiences as a maltreated girl—that she had not disclosed previously. This apparently manipulative and cynical woman impressed the clinician as also having been a courageous and traumatized child who had learned to survive by fleeing abusive caregivers by connecting with abusive paramours and by self-medicating her pain. The clinician no longer saw Sue’s self-destructive approach to life as a “black box” but as a series of efforts to become independent, happy, and loved. Unfortunately, these efforts had led to very poor outcomes for her children and herself.

Implementing an effective procedure for participant informed consent is a legal duty and ethical obligation required of every mental health professional (Koocher & Keith-Spiegel, 1998; Reisner, Slobogin, & Rai, 1999). Society has sanctioned the intrusive and extraordinary activities of professionals because they serve the public good. In agreeing to practice as a licensed professional, the professional acknowledges this fiduciary duty (Koehn, 1994). These ethical foundations animate practice approaches which emphasize the freedom and dignity of persons with whom the professional works; paternalism and undue control of others is to be avoided. Beneficence and well-meaning motivations do not trump the rights of persons to decide whether they will permit a clinician to initiate assessment and treatment procedures (Faden, Beauchamp, & King, 1986).

Another reason for the duty to provide informed consent is that members of the public can make knowledgeable and reasonable decisions about their participation. Persons who enter assessment procedures through an informed consent process have a better chance to understand the risks and benefits they might experience. This right to refuse or consent to assessment is an integral part of the due process ideal of the judicial system. It should help create a fair and explicit process of developing clinical data that ultimately are admitted as evidence in subsequent court hearings.

Child welfare procedures sometimes culminate in a Termination of Parental Rights (TPR) hearing. The severing of parental rights is among the most extreme judicial decisions, so the clinical procedures informing such a decision should optimally produce valid and clear data leading to coherent conclusions and recommendations. Such valid and meaningful clinical information is possible when the those evaluated are honest, cooperative, and motivated to assist

in the assessment process, thereby creating jurisprudential effects. Engaging clients through the use of informed consent and motivational interviewing approaches enhances the subjective, first-person validity of data collected from those interviewees, even while it does not guarantee “objective” validity. In other words, it seems clear that a TPR decision that flows from evidence based on invalid clinical data, derived from a flawed clinical protocol, conducted by coercive staff, and experienced by ill-informed, manipulated interviewees increases the likelihood of poor judicial decisions and other antijurisprudential effects.

Reviewing Sue’s case, it might be argued that while CPS “coerced” her to begin a CATS assessment, the CATS informed consent procedure provided a safety mechanism that informed her of the probable risks and benefits of participation. These included the possible outcome that information she disclosed or allowed to be disclosed (e.g., mental health records) might lead to judicial findings unfavorable to her personal goal of reunification with her two children. Sue had the choice to continue and to assume these risks and benefits or to exit the assessment process before it formally commenced. In this case, Sue’s decision to participate led to authorities gaining a more realistic and balanced understanding of her. It also allowed the court to direct CPS to provide necessary and evidence-based treatment for Sue in a manner that the judge would be able to subsequently evaluate her motivation and potential for developing the capacity to safely parent her children. No matter the ultimate findings and remedies, such a process would be fair to the adult and enhance the exercise of a jurisprudential, effective discharge of the state’s *parens patriae* role in the lives of Sue’s children Ronnie and Cindy.

Case Description: Part 2

Sue’s case presented some interesting challenges for the CATS evaluators. As a foster child, Sue received treatment services from many providers in her community over the years, and her family of origin had a long history of involvement with social services. This provided a wealth of longitudinal data to evaluators, yet threatened to confound objective analysis of the data. It was difficult to locate providers who did not have strong opinions about Sue as a parent, regardless of whether they had firsthand information about her relationship with her children or her style of parenting. In fact, there was considerable disagreement among providers about her functioning as a parent and her prognosis for change.

The children’s pediatrician (who also had been Sue’s pediatrician), diagnosed Ronnie with bipolar disorder, claiming that Sue’s inability to manage him was in part due to his illness and subsequent out-of-control behavior. The pediatrician’s recommendations placed responsibility for family functioning on Ronnie and his service providers. From this perspective, Sue’s capacity to parent and her relationship with Ronnie were secondary to his mental health issues, and medication management was identified as the primary intervention of choice. However, the child psychologist treating Ronnie disagreed with that diagnosis, claiming Ronnie’s behaviors were developmentally appropriate and most likely the result of inadequate supervision, exposure to parental domestic violence and substance misuse, and iatrogenic medication effects. Under this scenario, Sue’s mental health and interpersonal functioning became the targets of intervention. Due to conflicting expert opinions, and the confused responses to these by the child welfare system, the CPS case plan appeared incoherent to the family court judge, and there were subsequent delays in the implementation of all interventions.

The judge, growing increasingly frustrated with the conflicting testimony and lack of progress, agreed to a defense motion for a Daubert hearing. As a result of the cross-examination

in this proceeding, the experts' reports were disallowed because neither professional could articulate the scientific basis for their diagnostic procedures in this case; the same fate awaited the CPS caseworker's testimony. On the other hand, a CATS clinician (representing the team) testified about the scientific and clinical best practices used to develop the CATS protocol. The judge admitted the CATS report into evidence and court-ordered a new case plan that included the recommended health, mental health, and psychosocial interventions.

Jurisprudent Therapy Analysis. The CATS method of protocol development and execution is the hallmark characteristic of the evaluation process and has important forensic implications. At CATS, clinical protocols are guided by methodological principles that are scientifically based and designed to enhance the validity of assessment findings. Protocols are designed (a) to determine the degree of convergence (or divergence) between multiple measures of the same trait, (b) to reduce the risk of systematic distortion or bias that is inherent in the use of only one method, and (c) as a means of producing a more complete picture of the investigated phenomenon. Since the variations of qualitative and quantitative methodologies used in the project are developed naturally using different theoretical and epistemological assumptions, combining the methods increases the scope and breadth of the evaluation.

There are a number of interesting scientific problems that impact the quality of assessment and treatment with young children and, consequently, the utility of data presented to the court as expert testimony or clinical recommendations. Clinical methods that are developed and implemented in the absence of bias reduction techniques lead to misdiagnosis, inadequate treatment planning, poor outcomes, and ambiguous legal remedies. In Sue's case, the data used by these service providers were likely confounded by reliance on self-report, unidimensional assessment methods, personal bias, lack of knowledge, and competing roles (e.g., between advocates, treatment providers, investigators, and evaluators). All of these factors may compromise the professional's capacity to provide objective, valid data to the courts, potentially creating antijurisprudent effects.

Social science clearly identifies methods for controlling error and identifying confidence levels. A peer-review process ensures that studies published in top journals have met scientific standards in the ways research has been conducted and presented. The CATS Project utilizes this literature to guide protocol development and implementation. The empirical literature provides useful information about multimodal, multidimensional, and multidisciplinary approaches to data collection that "triangulate" data, thereby controlling for error introduced by a singular focus or discipline-specific predispositions. The result is enhanced accuracy and effectiveness in the assessment and intervention process. Professionals who rely on practice wisdom or clinical intuition alone are probably less able to identify or manage their assessment biases and potentially contribute to the development of poor treatment plans, poor prognostic forecasting, and inadequate treatment outcomes.

At the CATS Project, this scientist-practitioner model also guides personnel selection and the methods used to evaluate and synthesize data. In other words, CATS clinicians are recruited and hired because they possess certain habits of the mind, including the ability to tolerate ambiguity, to critically examine their own biases, and to consider multiple perspectives. CATS professionals are challenged to bridge the gap between science and practice in the way they execute their duties.

During a CATS evaluation of Sue and her family, the historical information provided by community providers was supplemented by observations, psychometric testing, and interviews

as well as a careful analysis of the existing record. The validity of each report was challenged and weighted accordingly. All data were considered in the context of the empirical literature, paying careful attention to differential diagnoses and the temporal sequencing of events. This process allowed the CATS team to make some startling discoveries. As an asthmatic, Ronnie had been prescribed an Albuterol inhaler by a local health department physician. His manifestation of hypomanic-like symptoms could be traced to the time he began using this inhaler. Sue had not mentioned the new prescription to her pediatrician. Because the majority of the children's health care had been provided by the local emergency department, the pediatrician did not possess or review these records as part of his evaluation. Cessation of this medication coincided with symptom reduction.

Additionally, interviews with the children revealed that Ronnie and Cindy were often left unattended at home or in a neighbor's care. A criminal-background check revealed that the neighbor was a paroled, registered sex offender conditionally released with the mandate to have no contact with children. CPS and the courts had no knowledge of his contact with the children. Any scientifically based assessment of Ronnie would naturally involve an exploration of all caregivers and a full medical history. Failure to conduct or request such an investigation by the treating providers was not consistent with empirically based standards of care and, as such, could not withstand the scrutiny of judicial examination. The delay generated by the judge's well-placed skepticism created a therapeutic effect, which allowed for discovery of this data and provided a new context for understanding Ronnie and his behavior.

The utility of existing models of child psychopathology poses another scientific dilemma. Objective standards of psychiatric morbidity are sorely lacking in the area of early childhood mental health. According to the National Institute of Mental Health (2000), bipolar disorder is difficult to recognize and diagnose in young children because it does not precisely fit the symptom criteria established for adults. Its symptoms can occur comorbidly with those of other common childhood-onset mental disorders such as attention deficit hyperactivity disorder, specific language disorders, or child sexual abuse (Geller & Luby, 1997). In addition, symptoms of bipolar disorder may be confused with developmentally appropriate emotions and behaviors. The fact that diagnostic criteria based on adult and adolescent samples often fail to capture the experiences of young children is compounded by the problem that evidence-based practices and psychopharmacological interventions are often developed with the same types of clinical samples (Schneider, Atkinson, & El-Mallakh, 1996).

Furthermore, data-collection efforts are hampered when clinicians solely rely on parents' accounts that often under- or overreport symptoms. In Sue's case, one expert cited Sue's collateral report of Ronnie's symptoms and a positive family history of bipolar disorder as the sole basis for his diagnosis. Equating evaluation with diagnosis can lead to clinical error and preclude valid conclusions about the child and family. At CATS, the ultimate goal of this type of evaluation was not the formal diagnosis but rather a phenomenological description of each individual's mental health status, along with empirically based treatment recommendations.

Public child welfare caseworkers are called upon often to interpret mental health data from practitioners and create case plans that include therapeutic requirements, even though these workers usually have limited relevant health or mental health credentials. These individuals are often mislabeled as "social workers" even though they have no formal educational training in social work, mental health, or child development. In such cases, they are asked to practice outside their capacity on a daily basis. This problem extends into the courtroom when they are asked to testify to the validity of the data that guided case-plan development and their subsequent

decisions about risk. Utility of the testimony is questionable because a CPS worker's ability to apply scientific standards to decision making may be questionable (i.e., lack of knowledge of the literature, base rates, prediction issues, etc.).

To prevent "junk science" from being presented in the courtroom, judges have called upon recent U.S. Supreme Court decisions such as *Daubert* and *Kumho* to weigh the admissibility of evidence in court (Krafka, Dunn, Johnson, Cecil, & Miletich, 2002; McCann, Shindler, & Hammond, 2003). These decisions provide guidance to federal and state judges regarding how to determine what types of theories and data experts are allowable. Child mental health practitioners who cannot successfully defend their practices in court according to scientific or "best-practice" standards sometimes disqualify their data and opinions. In such cases, information important for considering the child's best interests may be excluded from the judicial decision-making process, creating profound antijurisprudent effects.

Furthermore, if infant mental health professionals understand that the ultimate mental health outcomes for children may rest on the courts' child-placement decisions, they will be even more attentive to the defensibility of their clinical decisions. This can contribute to an organizational climate for careful focus on decision-making and judgment processes as cases are being assessed, inferences are drawn, and conclusions and recommendations are rendered (Clark & Sprang, 2004). Clinicians from such organizations can more confidently testify that the evidence they are presenting meets scientific and best-practice standards, and will assist the court with identifying the precise needs of the children involved.

Clinicians serve the moral ideal of "health," and prioritize the promotion of the child's mental health. While such a bias is helpful in the clinic, child mental health professionals often do not consider how this impacts matters of justice. When parents' rights significantly conflict with the child's best interests (according to a mental health perspective), the court must address the conflict between salient interpretations of the law and the clinical opinions presented. Conversely, the inherent bias in the judicial process is to use a doctrinal analysis to uphold the law and promote justice. In this narrow analysis, child well-being variables are potentially given less weight or even excluded from the judging process. This is of particular concern when "voiceless" young children are involved. The challenge facing systems of care is to find ways to be therapeutic and just in child welfare cases, recognizing that clinical activities will not benefit children if they create antijurisprudent therapy effects such as inadmissibility rulings by the court.

DISCUSSION AND CONCLUSIONS

The purpose of this article was to demonstrate the utility of applying the jurisprudent therapy approach for mental health work with infants and children. The case vignettes and analyses were drawn from the work of the CATS Program, a mental health assessment program that has evaluated about 1,000 maltreated children. CATS professionals work closely with CPS and the courts to assist in the development of viable case plans and legal decisions that can enhance well-being outcomes such as child safety, timely and permanent placement with adequate caregivers, and effective involvement in health, mental health, educational, and other types of programming (Sprang et al., 2004).

Slobogin (1996) and Petrila (1996) argued that the school of therapeutic jurisprudence faces important limitations that should attenuate its enthusiastic reception, including the dangers of paternalism, vagueness in the definition of "therapeutic," and empirical indeterminism. Similarly, note that our discussion of jurisprudent therapy presents some important issues.

First, just as it is difficult for lawyers and judges to determine which decisions might lead to therapeutic outcomes, mental health professionals are often unsure as to what outcomes might be truly “just” in complex child placement and treatment situations. Young children’s “best interests” often are extraordinarily difficult to determine, even in principle (Kopelman, 1997; Schuerman, 1997). While it is sometimes easier to ignore the conflicting interests of parents, foster parents, relatives, and even among particular children in sibling groups, child mental health professionals risk abrogating their ethical responsibilities if they do not take these into account (Goldstein, 1999). Unfortunately, it is usually difficult to sort, weigh, and judge the conflicting issues—justice is, indeed, often elusive.

Second, when professionals do pay attention to jurisprudential therapy problems, this creates the risk that they will shape or distort their clinical judgments to “ensure” some desired outcome believed to be jurisprudential in nature. This loss of role integrity can paradoxically create greater antijurisprudential therapy effects because the clinicians have abandoned the scientific and best practices standards that should guide their conclusions and recommendations to the court. It can be difficult to open the issue of ultimate legal outcomes in the clinic, even when doing so is necessary, because of such risks of practicing beyond their domains of clinical expertise.

Third, even if professionals were able to confidently identify jurisprudential outcomes and to properly restrict their deliberations to their areas of professional expertise, the problem of “predicting” how their procedures and decisions will actually affect the legal process still remains. Because there are so many unpredictable and intervening events as well as multiple professionals of differing and firm opinions involved in such cases, clinicians will always operate under high levels of uncertainty that their approaches will actually result in just and therapeutic decisions for children.

Fourth, despite the fact that judges desire rigorous child and parenting assessments (Waller & Daniel, 2004), there are significant disagreements within the mental health professions about what constitutes valid and therapeutic approaches to evaluating parents and children (Ackerman, 2001; Azar, Lauretti, & Loding, 1998; Galatzer-Levy & Kraus, 1999; Hovarth, Logan, & Walker, 2002; Nicholson & Norwood, 2000). In other words, there is no “gold standard” acceptable to all concerned. In the current environment of limited clinical resources dedicated to infant mental health, even if such a standard existed, the likelihood that it could be feasibly and reliably applied in all cases across all jurisdictions—or even in the majority of these—is highly doubtful. Additionally, the use of socioculturally “sensitive” assessment protocols is both difficult and infrequent in current practice (Azar & Cote, 2002; Tseng, Matthews, & Elwyn, 2004).

Finally, only a limited number of approaches to child assessment and treatment have been rigorously evaluated or empirically tested, and even those that have been shown to be promising have been poorly disseminated to the wider mental health community (Cohen et al., 1998; Lambert, Bergin, & Garfield, 2004; President’s New Freedom Commission, 2003; U.S. Public Health Service, 2000). Indeed, the use of such limited outcome research in the area of child protection interventions have led legal analysts such as Shuman (1996) and Levine (1996) to argue that it is difficult to conclude that CPS activities are helping to “rescue” children from dangerous homes, or that mandating therapists to report child abuse creates therapeutic or jurisprudential effects.

This task environment makes it extremely challenging for infant mental health professionals to exercise their duties in therapeutic and jurisprudential ways—but not impossible. Despite the problems described earlier, we have found that careful and ongoing consideration of the jurisprudential and antijurisprudential effects of their assessment protocols, assessment reports, and

interactions with CPS and court systems to be intellectually and ethically stimulating. The CATS professionals work to maintain professional role integrity through the use of multidisciplinary teams, explicit decision processes, and ongoing dialogues with CPS officials, lawyers, and judges. Importantly, by engaging in systematic observation and scientific investigation of our own activities, we have found that the jurisprudent therapy approach enhances clinical creativity, encourages scientific rigor, and generates the ongoing, humbling realization that clinical work with children is complex and often unpredictable. Such work demands the development of fresh approaches to grapple with the tension between providing therapeutic services for children while respecting the requirements of justice.

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