

Clinical Perspectives

When Caregivers Disagree: Clinical Decision Making in High-Conflict Custody Arrangements

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High-conflict custody arrangements introduce additional complexity into child psychiatric care, particularly in the domains of consent, communication, and continuity of treatment. In these settings, clinical decision-making must extend beyond diagnosis and pharmacological management to account for legal custody structures and divergent caregiver perspectives. This article presents 3 clinical vignettes illustrating common challenges: 1) inconsistent treatment implementation across households; 2) perceived physician alignment during treatment disagreements; and 3) breakdowns in communication following unilateral clinical decisions. Across cases, tensions arise between evidence-based care, caregiver preferences, and the realities of shared custody. These scenarios highlight the need for structured communication strategies, explicit alignment with custody-based consent, and anticipatory planning to maintain safety and continuity of care. Clinical neutrality is reframed as an active process requiring transparency, consistency, and deliberate engagement with both caregivers. Practical approaches are discussed to support shared decision-making and reduce conflict in complex family systems.

When caregivers are involved in high-conflict custody arrangements and disagree about a child's psychiatric care, clinical decision-making becomes considerably more complex. Although separation and divorce may formally end a parental relationship, interparental conflict often persists through poor communication, mistrust, limited cooperation, and disagreement about a child's needs. In these circumstances, treatment planning, consent, and implementation of clinical recommendations may be complicated by competing caregiver perspectives and conflicting accounts of the child's symptoms and functioning.

Children in high-conflict custody situations may be drawn into ongoing parental discord. This can manifest as triangulation, in which the child becomes entangled in interparental conflict and competing caregiver narratives.¹ During clinical encounters, triangulation may be observed as shifts in the child's self-report depending on which caregiver is present or manifest as guarded disclosure when discussing the nonpresent caregiver. Such patterns may reflect the child's efforts to manage perceived parental tension or navigate loyalty pressures, rather than representing their true experience of symptoms.² These dynamics often complicate psychiatric assessment and underscore the ways in which persistent parental conflict following separation is

associated with adverse effects on child adjustment and emotional functioning.³

The following scenarios illustrate how these dynamics may present in clinical practice. They have been composed for educational purposes only and do not represent actual patient cases.

CASE SCENARIO #1

Catherine, an 8-year-old girl with attention-deficit/hyperactivity disorder, combined presentation, lives primarily with her mother following her parents' divorce. She has been treated with methylphenidate for 6 months, with improvement in attention and classroom performance. At a follow-up visit, her mother reports that afternoon symptoms, including impulsivity, restlessness, and difficulty completing homework, continue to impair functioning. The psychiatrist recommends an additional short-acting afternoon dose of methylphenidate to address residual symptoms. The mother agrees with the recommendation but expresses reluctance to inform the father, as she anticipates he will become upset about the additional dosage.

This case presents the psychiatrist with an ethical dilemma between respecting the wishes of the present caregiver and ensuring transparent, coordinated care across



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households. Here, a caregiver's intent to withhold changes in medication from the other parent should alert clinicians to the risk of fragmented care across households. When caregivers share medical decision-making authority, undisclosed medication changes may result in conflicting treatment plans, inconsistent administration, and difficulties monitoring treatment response and adverse effects. In such situations, psychiatrists should clarify decision-making authority, establish expectations regarding communication, and ensure that treatment plans are implemented in a manner that promotes the child's safety and best interests.^{4,5}

CASE SCENARIO #2

Jane, a 13-year-old eighth grader, recently joined her school volleyball team and initially enjoyed the experience. Over the course of the season, she develops increasing anxiety related to academic demands and athletic performance. She reports difficulty sleeping, with persistent rumination about mistakes during games and worries about upcoming performance. During the day, she experiences impaired concentration in class, escalating difficulty completing schoolwork, and declining grades. Given the severity of symptoms and functional impairment, pharmacological treatment with fluoxetine is recommended in addition to psychotherapy. The mother supports initiation of medication, citing worsening academic performance and functional decline. The father disagrees and prefers psychotherapy alone, stating that he does not observe significant anxiety symptoms or school impairment when Jane is in his care.

While the recommendation to start an antidepressant is consistent with evidence-based guidelines and aligns with one caregiver's preferred approach, this alignment can be perceived as an alliance between the psychiatrist and one caregiver over another, complicating the shared decision-making process. In such situations, the challenge lies in translating evidence-based recommendations into care within a framework of competing caregiver perspectives and determining the best interest of the child.⁵

CASE SCENARIO #3

Ethan, a 10-year-old boy with autism spectrum disorder and catatonia, is hospitalized for close monitoring. On the third evening, nurses find him standing motionless at his bedside, not blinking and unable to follow commands. The on-call psychiatrist reviews the medical record and speaks with Ethan's father, who is present at the bedside, and decides to rapidly increase the lorazepam dose to prevent further deterioration. The change is documented in the medical record. The following afternoon, Ethan's mother, who lives separately, reviews the documentation in the electronic medical record through the patient portal and arrives at the unit upset, questioning why she was not contacted regarding the child's medical condition and a significant medication change.

This scenario illustrates how even clinically necessary inpatient treatment changes may be perceived as exclusionary in high-conflict custody arrangements when communication is not timely between caregivers. In the setting of worsening catatonia, an urgent treatment decision

needed to occur with the available caregiver. Although the psychiatrist acted appropriately and documented the medication adjustment in the medical record, this alone does not substitute for timely communication with caregivers in high-conflict custody arrangements.

In such situations, the ethical challenge lies less in the decision to treat and more in ensuring timely and structured communication with all legally involved caregivers when feasible. While real-time inclusion may not always be possible in acute care settings, proactive follow-up can help reduce perceptions of exclusion and support continuity of care and shared understanding of treatment decisions.^{4,5}

These cases highlight how child psychiatric care is shaped not only by diagnostic and treatment decisions, but also by family dynamics and custody arrangements in which care is delivered. Maintaining an alliance with both parents or caregivers does occur automatically but needs to be achieved through an active process, requiring deliberate and consistent communication among caregivers as well as paying attention to the medical decision-making framework within the custody arrangements. These processes are consistent with shared decision-making in pediatrics, which emphasizes structured communication, consistent caregiver engagement, and alignment of treatment goals to improve adherence and outcomes.⁶ In high-conflict custody settings, the psychiatrist must function not only as a clinician, but also as a coordinator of care across medical, legal, and family systems, ensuring that treatment remains centered on the child, while minimizing the impact of caregiver discord.

During initial evaluation, careful history-taking should extend beyond symptom assessment to include clarification of custody arrangements, medical decision-making authority, and caregiver expectations regarding communication and involvement in care. Establishing these parameters at the outset can help mitigate future misunderstandings and reduce conflict around treatment decisions. Adjustments include allocating extended appointment times, scheduling longer initial evaluations to allow for more comprehensive discussion, including both caregivers when possible, and clearer alignment of treatment goals. While such adjustments may be difficult to implement within the constraints of routine clinical practice, they can ultimately improve efficiency and reduce conflict downstream as well as promote continuity of care.

PLAIN LANGUAGE SUMMARY

High-conflict custody arrangements can fragment child psychiatric care by creating inconsistent treatment decisions across households as illustrated in Case 1. Maintaining an alliance with both parents is an active process that hinges upon transparency, consistency, and shared decision-making to maintain continuity and safety as illustrated in Case 2. Effective care requires structured, proactive communication with caregivers and clear alignment with custody-based consent frameworks as illustrated in Case 3.

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