Family Treatment for Moderate Child Alienation

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Leonard T. Gries & James R. Gries

Child alienation is manifested by significant resistance to parental contact that is disproportional to actual past experience. Individual interviews and questionnaires with all parties and structured family interactions are needed to assess presence and severity. In cases of moderate alienation, a family treatment model featuring psychoeducation, inclusive family goal setting, progressive desensitization, exposure, and development of a new family narrative is recommended.

Jessica, a 6-year-old girl, sits clinging to her mother in your waiting room before her initial meeting with you. The family court judge ordered an evaluation and possible treatment. She reportedly refuses to see her father who has been separated from her mother for almost three years. You have previously met separately with each parent. In the interview she communicates in a succinct and direct manner, giving the impression of above average expressive vocabulary and intelligence. When asked to draw an action picture of her family, she portrays herself seated on her mother's lap, playing a video game together. She also includes her pet cat but omits her father. Without being asked, Jessica immediately exclaims, "daddy doesn't live with us … I never want to see him … he's a bad man." When asked what each parent does well, and what she likes about each parent, Jessica heaps abundant praise for her mother, but finds absolutely nothing redeeming about her father. Jessica fluently explains that "daddy did bad things to mommy and to me," reiterating her wish to have nothing to do with him. She states that her father once hit her mother, offering details that match those offered by mother. Jessica also recalls how father yelled at her and told her, "you're just like your mother." You sense a rehearsed quality to some of her comments.

Definition and Incidence of Child Alienation

The *alienated child* is defined as "one who expresses, freely and persistently, unreasonable negative feelings and beliefs (such as anger, hatred, rejection, and/or fear) toward a parent that are significantly disproportionate to the child's actual experience with that parent" (Kelly & Johnston, 2001). The child typically refuses to have any contact with the rejected parent. In contrast, an *estranged child*, who may similarly wish to avoid any contact, has good reason for taking such position, after being subjected to or exposed to a parent's abusive and/or neglectful behavior.

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Although child alienation may be regarded as uncommon in the population at large, it is relatively commonplace among cases litigated in family and matrimonial courts. The degree of distress and conflict felt by a child in a custody or divorce proceeding varies usually as a function of level of conflict and animosity between the parents. This may eventuate in some degree of estrangement or alienation that the child feels in relation to one parent.

Kelly and Johnston (2001), not surprisingly, report that children of divorce referred from family court, compared with community-based samples of separated families, have higher rates of child alienation. Comparable rates were found for both boys and girls. Incidence of alienation within family court samples of litigated cases is reported by Johnston, Lee, Walters, and Olesen (2005a) to be 20%, and by Fidler, Bala, and Saini (2013) to range between 20% and 50% among high-conflict cases. Within the approximately 25% to 30% of litigated cases in which child alienation is found, a continuum exists whereby a portion of the children manifest mild signs of alienation, another portion exhibit moderate alienation problems, and a final portion feature an extreme degree of alienation.

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Bow, Gould, and Flens (2009) reported a mean, modal, and median age of onset at 10 years among samples of child custody cases, with an incidence of 26%. Johnston, Roseby, and Kuehnle (2009) report that the most common age range found among children resisting contact is 9–15 years old. Waldron & Joanis (1996) consider the most vulnerable children to include 8-year-olds as well. With younger children, such as Jessica, the foundation for alienation may be in the formative stage, but their rejecting stance may not yet be firmly entrenched or absolute, making early intervention essential.

Diagnostic Considerations

Child alienation, also referred to as *parental alienation*, is not listed as a DSM-5 disorder. For diagnostic purposes, it may be subsumed under a combination of one or more of "Other Conditions That May Be a Focus of Clinical Attention." These include severe versions of *Parent-Child Relational Problem* V61.20 (Z62.820), *Child Affected by Parental Relationship Distress* V61.29 (Z62.898), and *Disruption of Family by Separation or Divorce* V61.03 (Z63.5).

Central to the concept of an alienated child are inaccurate beliefs that are not reflective of actual parent–child experiences. Some tell-tale signs of potential child alienation include rigid "all or none" thinking, featuring idealization of the favored parent and demonization of the rejected parent, acting aggressively or belligerently toward and exhibiting a lack of guilt regarding cruelty toward the rejected parent. The child typically manifests thoughts and feelings about the rejected parent that are in lockstep with those of the favored parent. The child may act confrontationally with the rejected parent's family members as well. With the adoption of the term *child alienation* instead of *parental alienation*, the accusatory aspect of blaming the favored parent is in many instances de-emphasized, allowing for focus on ameliorating the child–rejected parent relationship.

Johnston, Walters, and Olesen (2005b) point out that children in high-conflict families may purposefully resist contact with the rejected parent to avoid the fray. As noted by Lowenstein (1998), simple avoidance reaction may escalate to panic reaction in response to the prospect of being required to spend time with the rejected parent. Psychosomatic symptoms may then emerge, which prompt the custodial/favored parent to cancel scheduled visits. Johnston, Walters, and Olesen (2005b) also reported that severely alienated children often exhibit behaviors that are symptomatic of conduct disorder when with the rejected parent. Their expression of contempt and rage may be manifested in blatant rudeness, use of foul language, destruction of parent's property, and physically assaultive behavior.

In hybrid cases, there is some tangible basis for the child's avoidance of the rejected parent, even if the rejection is disproportionate to the level of the offenses. The rejected parent may have a history of exhibiting inept parenting practices, however well-intentioned. The use of harsh, rigid, authoritarian parenting styles can predictably support a "bad parent" image, prompting avoidance by the child (Kelly & Johnston, 2001). The rejected parent may then exacerbate the problem by critically exerting pressure on the child to interact in a positive manner. Alternatively, the rejected parent, feeling too emotionally damaged to put up with further rejection, may decide to withdraw from the battle over contact, thereby confirming to the child and the alienating parent that the rejected parent is abandoning the child. This strengthens the bad parent image that serves to justify the decision to have limited or no contact.

Darnall (1998) identifies a distinction among naïve, active, and obsessed alienators. Whereas naïve alienators "genuinely strive to develop or maintain" the relationship between child and rejected parent, their efforts are tainted by reminders to the child that the other parent is flawed. Active alienators intermittently exhibit alienating behaviors due to personal, emotional factors, and poor impulse control, while being more supportive of the rejected parent–child relationship at other times. Obsessed alienators show "persistence in wanting to destroy the rejected parent . . . they lack empathy, are unwilling to forgive, and have a strong need to be in control" (Fidler et al., 2013, page 21). Such vengeful, vindictive behavior may derive from having experienced the dissolution of the relationship with the other parent as "a deep narcissistic injury, as a complete abandonment which results in profound humiliation and rage" (Kelly & Johnston, 2001, page 256). The rage is then manifested in the repeated, angry communication of extremely negative views about the rejected parent expressed to the child.

In a retrospective study, Baker (2006) surveyed adults who were alienated as children, who recalled being exposed to relentless bad-mouthing of the rejected parent by the alienating parent and being threatened by the latter with withdrawal of love if any love was shown to the rejected parent. They recalled being made to feel guilty at such times and being pressured to express loyalty to the alienator. Approximately 50% of the subjects had alienating parents who were physically, emotionally, sexually, or verbally

abusive to them, and approximately 67% reported that parenting/contact time with the rejected parent was interfered with by the alienating parent. Twelve percent reported that the decision to proceed or not proceed with visits was left to them as children, and 20% reported that their contact with the rejected parent's extended family was disrupted.

Gordon, Stoffey, and Bottinelli (2008) report finding higher rates of psychopathology and personality disorders among alienating parents than in the general population. Specifically, they collectively evince signs of paranoia, narcissism, histories of significant family of origin dysfunction, and "unhealthy grieving of divorce" (Kopetski, 1998). A pathway to child alienation is open for those parents who learn to contain psychiatric symptoms by developing enmeshed relationships with their children. An unhealthy, symbiotic bond eventuates, featuring blurring of relationship boundaries, which is then solidified by keeping the rejected parent away (Everett, 2006). In turning the child against the rejected parent, the alienating parent facilitates and perpetuates their pathological bonding with the child. Drozd and Olesen (2010) regard this as a form of child abuse that is consistent with what is seen in Stockholm syndrome.

Assessment for Child Alienation

Most often where suspicions of child alienation exist, assessment is conducted in the context of a court-ordered forensic custody evaluation by a mental health provider with special training in such matters. The forensic evaluation report may not, however, be available to the treating clinician, necessitating preliminary assessment by the therapist to the extent that one's level of expertise permits.

Separate individual interviews should be conducted with all three parties beginning with each parent, and then the child. A joint interview and/or play session, if the child's age warrants, should subsequently be held involving the child and each of the parents separately. Psychological testing and completion of questionnaires should also be part of the assessment process. Furthermore, information supplied by collateral professionals, such as individual and family therapists who have been involved with any of the parties, as well as the child's teacher, can broaden the understanding of family dynamics. Any court documents, such as orders of protection or violations of court ordered parenting plans, are essential for providing an objective history of the case.

Clinical Interviews: Parents

A personal and family history is elicited individually from each parent. This includes questions about what went wrong in the parents' relationship with each other, and about how each perceives the other's strengths and deficits. Each parent is given the opportunity to explain and give attributions for the objectionable actions of the other. They are also asked to describe parenting practices they use with their child, and that are used by the other parent. The use of a nonstandardized questionnaire, such as the Parent Perception Inventory (Hazzard, Christensen, & Margolin, 1983) is helpful in collecting such information. Most crucial is an assessment of each parent's attitude about the importance of the child having a loving, trusting relationship with *both* parents.

The favored parent is often referred to as the "alienating parent" when there is evidence of a reliance upon the use of alienating behaviors. In some instances, alienating behavior derives from genuine attempts to be protective of the child by a parent who might be projecting their own childhood experiences of trauma (Drozd, Kuehnle, & Olesen, 2011).

Baker and Fine (2008) identify 17 alienating behaviors exhibited by active or obsessed alienators, including bad-mouthing and limiting contact with the rejected parent, referring to the rejected parent by their first name, asking the child to spy on or keep secrets from the rejected parent, and withdrawing love contingent on the child's failure to show full loyalty to the alienator. The use of alienating behaviors by the favored parent, may be identified through self-report, report by the rejected parent, and report by the child. Although it is impossible to determine the absolute veracity of what is being reported, it is helpful to look for inconsistencies between parties and within individual representations, and to look for congruity with behavioral observations during interviews as well as with the reports of professionals involved with the parties.

Most crucial is an assessment of each parent's attitude about the importance of the child having a loving, trusting relationship with *both* parents. This may be ascertained by asking for each parent's desired living arrangement and level of contact between the child and each parent, particularly the rejected parent. A telltale problematic sign is when the favored parent indicates that the level of contact, or even the absence of any contact, is a question that should be left solely in the hands of the child.

Clinical Interviews: Child

In establishing rapport with the child, it is important to explain the purpose of the interviews, emphasizing how the central objective is to help the family and others involved (e.g. court officials) develop a plan aimed at ensuring the child's well-being and happiness. A related objective is to find out how the child may have maximum access to everything each parent has to offer in the form of love, guidance, support, and protection. The child is asked about their present situation at home, and at school, including what is going well or what needs changing. The child is asked about early memories involving each parent, worst and most frightening memories, and proudest moments.

Questions are also posed about what each parent does best and what changes in each parent are desired.

In addition to content of responses, it is informative to note the child's style of responding, including degree of eye contact, presence of contradictory body language, pressured and rehearsed quality of responses, and persistent tension throughout the interview.

The alienated child often offers very negative opinions about the rejected parent even before the topic is raised by the evaluator. Conversely, there are unsolicited expressions of excessive concern about the welfare of the favored parent. It ultimately becomes apparent that the child is tasked with campaigning for an outcome that minimizes or totally excludes the rejected parent from their life. Of significance is the absence of evidence reported by the child that conclusions about the rejected parent are based on actual interactions and direct experience. Additionally, words and phrases used by the child are found to be in virtually full concordance with those used by the favored parent. Such data help the evaluator distinguish the alienated child from the estranged child.

Nonstandardized assessment tools are used in the interviews to elicit further information about the child's perception of each parent. The Rotter Incomplete Sentences Blank (Rotter, Lah, & Rafferty, 1992) is a screening instrument that helps assess overall adjustment in adolescents and adults. In an unpublished modification for younger children, referred to as the Children's Sentence Completion Test, the child is asked to complete such sentence stems as "*I sure wish my father would …*"; "*When I see mommy and daddy together, I …*" Several Child Sentence Completion Tests are reviewed in Hart, Kehle, and Davies (2019). On the Child Self-Report Questionnaire (Bricklin, 1990a), the child is asked to identify the parental resource more likely to be selected in various situations. On the "Would" Questionnaire (Bricklin, 1990b), the child is asked to predict how each parent might respond to everyday challenges.

A child assessment measure that purports to tap a child's attachment to each parent on an unconscious level is the Perceptions-of-Relationships Test (PORT), developed by Bricklin (1989). Through drawings and storytelling, the child tends to reveal their relative emotional closeness to each parent, at times revealing surprising degrees of affiliation with a rejected parent who is overtly reviled. Despite questionable validity, the PORT provides a mostly nonverbal mode of communication, which is a useful adjunct when attempting to interview highly defended children.

Conjoint Parent–Child Interview

A structured Family Interaction Interview (FII; Gries, 1996) facilitates data collection. The parent and child are asked to speak directly to each other in addressing such questions as what they appreciate most about the other, ways each would like the other to change, ways in which assistance from the other may help, and worries each may have about the other. Parent and child are given the opportunity to state their desired level of contact with the other and explain reasons they feel that way.

Much may be learned about the extent and dynamics of child alienation through observation of the child together with each parent. Behavioral observations of the child's interactions with the favored parent may provide evidence of enmeshment and boundary disturbances. Observations of interactions with the rejected parent may reveal further information about the child's reasons for avoidance, and the appropriateness of the parent's response to such rejection.

Intervention With Extreme, High-Conflict Custody Cases

Extreme, high-conflict custody cases often feature parents with psychiatric illness, severe personality disorder, and/or substance abuse disorder. A mental status examination may be necessary to determine whether family treatment is feasible, given the degree of psychopathology present. The administration of a measure such as the Minnesota Multiphasic Personality Inventory, Restructured Form (MMPI-2 RF), (Ben-Porath & Tellegen, 2008) may also be helpful in this regard.

In extreme, high-conflict cases, dueling allegations are frequently made whereby one parent alleges child abusive behavior and the other alleges child alienating behavior. The claim is made that the allegations of abuse are false and represent a mendacious attempt to alienate the child from the accused. Conversely, Fidler et al. (2013) suggest that some rejected parents who may actually have been abusive to the child make claims of parental alienation to obscure the legitimate charges made against them.

Psychiatric disorders, personality disturbances (e.g., narcissistic, emotionally immature, and antisocial tendencies), diffuse adult–child boundaries, poor parental attunement to child, and use of aggression in interpersonal functioning are likely to be more pronounced in these high-conflict cases. With such cases, the prevailing professional opinion is that "education or therapy alone, in the absence of a temporary interruption in contact with the favored parent, and possibly including change in custody, is unlikely to reverse alienation" (Fidler et al., 2013, p. 116).

Family Treatment for Moderate Child Alienation

What follows describes a treatment approach designed to address moderate levels of child alienation, with the caveat that traditional counseling and parent consultation may suffice where mild levels of alienation are present. This approach draws

from the work of Polak and Moran (2017), who use the term "Reunification Therapy" interchangeably with "Reintegration Therapy" as a treatment modality designed to ameliorate parent–child contact issues. This is consistent with Kelly and Johnston (2001), who concluded that family treatment, rather than limiting treatment to individual therapy or conjoint therapy for the child and rejected parent, should be the preferred modality in such cases.

Polak and Moran conceded that "few detailed treatment protocols or best-practice guidelines are available to inform this type of treatment" (2017, p. 71), and pointed out that competence in family therapy and cognitive behavioral therapy is required of the therapist. Other proponents of the family-based reintegration therapeutic model include Darnall (2011), DeJong and Davies (2012), Johnston (2005a), Walters and Friedlander (2010), and Gottlieb (2013). Within a family systems approach, the entire nuclear family participates in various combinations. Each family member is seen individually as well as in various combinations, including the parents together, the child with each parent, and the entire family together.

A preliminary assessment of the factors contributing to the alienation of the child, the level of alienation that exists, and the readiness of each parent to participate in family treatment is essential. If family treatment is indicated, goals of treatment, as elucidated by Johnston (2005b), may be adopted:

> protecting and removing the child from parental conflict;
>
> fostering the child's healthy relationship with both parents;
>
> restoring the parents' adequate functioning and appropriate roles;
>
> correcting the various cognitive distortions, polarization, and splitting present in parents and child;
>
> augmenting the child's coping skills and improving appropriate expressions of the child's affect;
>
> replacing inaccuracies and distortions with more realistic perceptions that reflect the child's actual experience with both parents; and
>
> improving the child's peer relationships.

The overarching objective is for the child to achieve sufficient critical thinking skills and sense of autonomy to be empowered in reaching conclusions about each parent. What follows is a description of how each of seven critical case management and clinical components may be woven into an intensive course of treatment. The components consist of:

- Maximizing structure through written contract with the parties.
- Providing psychoeducation on the adverse effects of child alienation.
- Including all family members in the goal-setting process.
- Desensitizing the anxious/fearful child to the rejected parent; developing critical thinking.
- Meeting with parents individually to address personal issues impacting response to family treatment.
- Exposing child to respectful parental interactions, following dyadic parent sessions promoting contrition, forgiveness, and commitment to cooperate in behalf of the child.
- Establishing a new family narrative through dyadic parent sessions, followed by parent–child and full family sessions.

Maximizing Structure

Maximization of structure is crucial to ensure the cooperation and genuine engagement in treatment of the parents of alienated children. Given the high rates of psychopathology and personality disorders among the favored parents of alienated children (Gordon et al., 2008), a parent may be unconsciously driven to maintain an enmeshed relationship with the child to contain their own psychiatric symptoms (Everett, 2006). Parents involved in high-conflict custody struggles are frequently defensively preoccupied with gaining control of the child and the case. We often find parents manifesting the "fight or flight" response in their pursuit of control, potentially sabotaging treatment efforts from the start. An external source of structure, such as a written contract, shifts the fight for control away from the purview of the parents, thereby short-circuiting the parties' respective fight-or-flight responses while encouraging more cooperative and goal-oriented behaviors to emerge.

Written or behavioral contracts are effective tools for promoting cooperation when addressing issues impacting children and their parents (Crane, 1995; Bowman-Perrott et al, 2014). Generally, a written contract removes ambiguity within otherwise chaotic or dysfunctional family systems by clearly defining both expectations of each party within the treatment milieu and consequences should either or both parties fail to comply. Additionally, the written contract concretizes the relationship between the parents and the therapist, enabling the therapist to monitor parents' adherence to their behavioral obligations and to serve as positive

role model for promoting positive communication and respectful interpersonal behavior. In most instances, the contract serves to elaborate and to operationalize the terms of a court order identifying the treatment provider and mandating family treatment as part of a parenting plan that addresses custody and/or visitation. In pairing the court order with the written contract, the legal exposure of the therapist to any subsequent procedural complaints from either or both litigiously prone parents is minimized.

For a written contract to be effective, both parties need to be in accord about various goals of treatment. Given the contentious nature of child alienation treatment, it is necessary to be very specific in setting goals in explicit behavioral terms and limiting the number and scope of goals at any point in time. For example, the rejected parent shall engage in parallel play/interactive drawing activity with the child for 10 minutes, without presence of favored parent; with child present, parents shall respectfully interact with each other in planning for parenting time during the upcoming holiday. The contract must also contain language explaining consequences for engaging in specified alienating behaviors, such as denigrating the other parent or interfering in the parent–child relationship of the other parent. Provisions are made for the parents to affix their signatures to the contract, thereby attesting to their understanding of their obligations in the treatment process and giving their consent for themselves and their child to enter into family treatment.

Psychoeducation

At the outset of treatment, both parents must be educated about what is at stake when a child is alienated. Likely long-term effects on the child's self-identity, social relationships, critical thinking ability, and the behavioral sequelae of deficits in these areas need to be elucidated in practical, everyday terms. It should be emphasized that the alienated child's development of self is significantly disrupted when one of the parents is regarded in toxic terms. Examples from clinical practice as well as research findings, such as those reported by Baker (2007) and Johnston and Goldman (2010), should be presented. It is essential that each parent, particularly the favored parent, comes to realize that the establishment of a psychologically healthy parent–child relationship with *both* parents is unequivocally in the child's best interests. Such realization often collides with existing beliefs about how the other parent is incapable of having healthy relationships, and how undeserving they are of having new opportunities to bond with the child.

The provision of articles or extracts from books about child alienation can supplement what is offered during sessions. Each parent is essentially being encouraged to embark on some independent research at a reasonable pace, where material may continue to be available for reference purposes after treatment is over. One such resource is a book authored by Bill Eddy, LCSW, JD, entitled "Don't Alienate the Kids! Raising Resilient Children While Avoiding High Conflict Divorce" (2010). In the introduction, Eddy defines alienation as coming from three cultures of blame: that of the family, the family court, and society. He maintains that real change occurs when the derivatives of these cultures of blame, all-or-none thinking, unmanaged emotions, and extreme behaviors are replaced by flexible thinking, managed emotions, and moderate behaviors.

Parental resistance to psychoeducation is commonplace. The parent may go through the motions of listening while maintaining a fixed perspective about what is best for the child. Psychoeducation, as the first step of the treatment process, is often initially force-fed with the backing of a strongly worded court order mentioning that questions about the custody and parenting plan may hinge upon each parent's cooperation.

Family-Based Goal Setting

The process of goal setting is an integral part of treatment. Perhaps for the first time in the history of the family, collaboration between parents and between each parent and child is being attempted. Instead of rehashing family disagreements, goal setting uses the decision of the court as a starting point and focuses on how psychoeducation can assist parents in understanding how healthy parental relationships benefit the child. This central goal is a given, and not subject to debate, hence a quantum change for the heretofore alienated child and the favored parent. It may very well be necessary to return to psychoeducation before goal setting may proceed in earnest. Goals should be tailored to where each family member is in their readiness to take the next step toward healthy family function. The general goals suggested by Johnston (2005b), alluded to previously, offer potential directions to follow, but it is the family members who should lead the way in prioritizing which area or areas are in need of immediate attention.

For example, the rejected parent may be most interested in having the favored parent abstain from making any disparaging comments about them to the child. The favored parent may be intent on receiving an acknowledgment of past wrongdoing from the rejected parent. The alienated child may simply opt for having minimal or no contact with the rejected parent. With the assistance and guidance of the therapist, a short-term objective encompassing some aspect of all three positions is identified (e.g., the favored parent agrees to limit any comments to the child about the rejected parent to statements of fact without opinion or criticism, the rejected parent identifies a past mistake that was made and expresses regret, the child is asked to select a level of contact from several choices offered).

Short-term objectives are set in clearly defined behavioral terms that may be reviewed periodically. They provide a roadmap on

the way to general goals such as improving communication, individuating child's perceptions, correcting thinking errors, developing critical thinking skills, moderating emotional and behavioral reactions to provocation, and enhancing parenting and co-parenting skills. The essential key to success involves helping family members reach their own conclusions about the importance of attaining each goal—not because it is being imposed by the therapist or the judge, but because it promises to enhance feelings of accomplishment, personal peace of mind, and adaptive function.

Desensitization to the Rejected Parent and Development of Critical Thinking

The alienated child typically presents either in a confrontational or an avoidant manner when having contact with the rejected parent. Underlying the readiness to dismiss, attack, and criticize is the child's phobic-like response—as is similarly observed in the way the favored parent regards and interacts with the rejected parent. Garber (2015) pointed out that the child is caught in a cycle, whereby avoidance of the feared parent prevents the child from having the opportunity to learn that the fear is either exaggerated or unwarranted.

Utilization of systematic desensitization is an effective means of breaking this cycle. The child is gradually exposed to the rejected parent within family and dyadic sessions, in successive steps, while ensuring that their level of anxiety is contained. Initially, exposure to written notes or cards from the rejected parent may be all the child can tolerate without having a spike in anxiety. Progressive contact may be subsequently introduced via the use of brief audiotape messages, then a brief phone conversation (where the parent speaks from an adjoining office). The use of a one-way mirror and video calls is also suggested by Weitzman (2004) and Walters and Friedlander (2010). Eventually, the child should be able to tolerate brief periods of direct, face-to-face contact with the rejected parent for progressively lengthier periods, featuring play activity and/or working together on a project of mutual interest. Ultimately, through this process of reciprocal inhibition, the child's anxiety response to the feared parent is replaced by a neutral or relaxation response when in the parent's presence.

Once the child becomes desensitized to the rejected parent, there is an opportunity to begin to re-frame the biased, erroneous beliefs that have fueled alienation. Through a CBT approach, the child is taught to look for objective evidence to support or dispute impressions they may have about the rejected parent. This paves the way for the development of critical thinking skills, which are often absent in the alienated child. The child is taught that they do not have to take sides or choose one parent over the other, and learns that two independent, loving parent–child relationships may coexist. For the child to risk taking this step toward the rejected parent, overtly expressed permission from the favored parent may be necessary.

Individual Counseling for Parents

Either or both parents may already be receiving or in need of individual counseling or therapy concurrent with family treatment. Miller (2013) emphasizes the importance of treating parents for any comorbid psychiatric conditions, which might interfere with family treatment for child alienation. After receiving appropriate consent, consultation with the parents' individual therapists is helpful in ensuring that multisource treatment efforts are synergistic.

Within the family treatment model, it is often necessary to also schedule one or more individual counseling sessions to address personal issues that are specifically relevant to the dynamics promoting alienation. For example, the favored or alienating parent may need to process their own trauma history, including past problematic relationships with family of origin members, thereby deriving insights about how past experiences are influencing current disdainful feelings about the rejected parent. The rejected parent may require individual sessions to more fully understand the dynamics of child alienation so that the profound hurt derived from rejection is not transformed into anger toward the child, or toward the favored parent, thereby exacerbating the degree of alienation. Conversely, the rejected parent may require assistance in learning how to respond assertively, yet compassionately, to the unfair treatment they are receiving.

If a parent's psychiatric illness or personality disorder prevents them from benefitting from individual counseling and psychoeducation over a period of several months or more, it may be necessary to temporarily suspend family treatment. The parent's individual therapist and/or psychiatrist would need to be apprised of this development, and to be briefed about the barriers to progress that have been observed. If the parent is not already receiving individual mental health services, then a referral should be made. The reasons for suspending family treatment would have to be explained to each family member, with the reassurance that sessions would be resumed when clinically indicated.

Exposing the Child to Respectful Parental Interactions Following Dyadic Parent Sessions

Many alienated children have little or no recollection of witnessing their parents interacting positively with each other. Some have not even had the experience of being in the same room with both parents, or even momentarily appreciating their place within their original family unit. Instead, they have observed relentless parental conflict, with one or both parents repeatedly demonizing the other. They have rarely if ever witnessed their parents interacting respectfully and sensitively with each other,

and their own behavior when with the rejected parent most often mirrors the avoidant and/or disparaging behaviors displayed by one or both parents.

Through dyadic sessions, parents are given the opportunity to gain an understanding of each other, including identification of emotional scars that have been obstacles to relationship building. This hopefully leads to expressions of contrition, acknowledgment of at least some past mistakes, and forgiveness. Additionally, as pointed out by Polak and Moran (2017), dyadic parent sessions provide a forum for developing co-parenting skills in communication, collaborative problem-solving, the sharing of responsibility for allaying child anxieties, and facilitating smooth transfers.

Subsequent full family sessions provide opportunities for the child to witness a tangible thaw in the relationship between parents, manifested by respectful interactions in place of the total rejection of the past. Family sessions are where the child receives tacit or explicit permission to embark on a new relationship with the rejected parent. This paves the way for the initiation of regular contact between the formerly rejected parent and child, although a series of therapeutic visitation-type sessions may be needed if inept parenting and a reliance on negative parenting practices by the rejected parent is evident. During the course of several full family sessions, the child witnesses how the parents now seem to be committed to work harmoniously on their behalf. Modeling of respectful, cooperative interactions between the parents introduces and strengthens pro-social behavior by the child, directed at the once fully rejected parent.

Establishing a New Family Narrative

A central goal of child alienation treatment is to create a new benign family narrative to replace a toxic narrative featuring the rigid dichotomy of demonization of one parent and idealization of the other. Rather than couch family history in malevolent terms, factually accurate accounts of the early, positive, perhaps loving initial relationship between the parents are ascertained. Both parents' desire to have a child to love and nurture is emphasized. Explanations for decisions to live separately are revised to reflect pragmatic rather than malevolent factors, which have nothing to do with the continued love that each parent feels for the child. The aim is to create a family narrative featuring normalized struggles encountered by each parent to adapt, sometimes unsuccessfully, to life's challenges—a narrative that eliminates the blame game.

The strategic use of both dyadic and full family interventions has been found to be an effective means of creating a new narrative and normalizing family relationships (Hughes, 2014; Becker-Weidman, 2012). Dyadic parent sessions are frequently used to process and resolve long-standing parental grievances and resentments between parents—in the spirit of moving forward on behalf of the child and eliminating motivation for revenge. The dyadic parent–child session is used as a means of depolarizing parent–child relationships through modeling, shaping, and rehearsal of more positive modes of communication that are devoid of any coercive or otherwise polarizing elements. Dyadic interventions help reinforce positive aspects of the parent–child relationship, while building or re-building trust that has been frequently eroded in cases involving child alienation. Family therapy is considered once basic positive elements of the parent–child relationship have been established and negative aspects of the relationship have been adequately reduced.

The scheduling of full family sessions is often indicated by a reduction in anxiety and anger states evident in dyadic sessions. Family sessions are implemented as a means of reinforcing positive communication behaviors rehearsed in prior dyadic sessions. They also provide a forum for the child to learn and accept a revised family narrative, as described by each parent in the presence of the other. Past misconceptions and long-held biases may thereby be corrected. Family sessions are especially crucial for re-empowering the rejected parent's position within the family, and creating a more holistic, egalitarian definition of family for the child. The importance of respecting each family member's relationship with all other family members, free of interference from others, is emphasized.

Summarizing the Challenge and Opportunity

Child alienation is often a by-product of high-conflict custody and divorce battles. In its many instances, it obliterates ties between the child and the rejected parent, leaving any positive or ambivalent feelings dormant. Alienation can cause a developing child to live in a state of constant anxiety, and/or anger, while devoid of critical thinking skills and an individuated sense of self. Such children are at significant risk for depression, substance abuse, interpersonal difficulties, and poor adaptive functioning.

The challenge of reversing child alienation requires the support and direct involvement of the entire family, especially the favored parent. Family treatment for moderate child alienation consists of individual, dyadic, and full family sessions within an intensive course of treatment that may require one to two years to complete. Key components of family treatment for moderate child alienation include:

- Secure court appointment to serve as therapist for mandated family treatment.

- Request assessment for child alienation, preferably by forensic evaluator, including individual and conjoint interviews of each parent and child.

- Maximize structure through written contract and consent, based on court order, and including delineation of obligations and consequences for noncompliance in behavioral terms.
- Provide psychoeducation on the adverse effects of child alienation.
- Set short- and long-term behavioral goals with full participation of all family members.
- Desensitize the anxious/fearful child to the rejected parent, facilitating the development of critical, individuated thinking.
- Address personal issues individually with each parent that are relevant to family dynamics contributing to child alienation.
- Expose child to respectful parental interactions, following dyadic parent sessions promoting contrition, forgiveness, and joint commitment to child.
- Establish a new family narrative via dyadic and full family sessions.

References available at NationalRegister.org