

Therapist Alienation: Foreseeing and Forestalling Third-Party Dynamics Undermining Psychotherapy With Children of Conflicted Caregivers

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The phenomena of impasse and rupture in the psychotherapy relationship have been discussed mostly in terms of the dynamics of the therapist–patient dyad. *Therapist alienation* identifies the disruptive impact of third-party contamination of the patient’s therapeutic alliance with the therapist. Therapist alienation and its intrafamilial cousin, parental alienation, are examined here from an attachment perspective, emphasizing the role of the cognitive schemas underlying each relationship. Case examples are drawn from the author’s experience conducting psychotherapy with children of highly conflicted caregivers. Specific recommendations are offered to minimize the likelihood of therapeutic rupture due to therapist alienation. How to respond when and if therapist alienation is suspected and future directions for clinical work, empirical research, and legal process are discussed.

The children of highly conflicted caregivers are at once among those most in need of psychotherapeutic support and those most difficult to maintain in the psychotherapeutic process. The difficulty, of course, is not necessarily in engaging the child–patient him- or herself. The difficulty lies instead in working to extricate the child from destructive triangulation¹ without allowing the therapy itself to become drawn into the family conflict.

The extant clinical literature offers many and varied accounts of why psychotherapies sometimes fail (e.g., Ahn & Wampold, 2001; Maltzman, 2001). Time and again, this literature emphasizes a single conclusion: The quality of the therapist–patient alliance is consistently associated with the quality of outcomes across modalities of treatment, patient demographics, and treatment goals (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Blatt & Behrends, 1987; Horvarth & Symonds, 1991; Krupnick et al., 1996; Martin, Garske, & Davis, 2000; Ruae, Goldfried, & Barkham, 1997; but see Maltzman, 2001).

Therapeutic alliance has been defined and operationalized in many ways across these studies, generally with the intent of measuring “the collaborative and affective bond between therapist and patient” (Martin et al., 2000, p. 449). As one example, the California Psychotherapy Alliance Scales (Gaston, 1991) operationalize alliance as a function of four factors: (a) patient capacity to work purposefully in psychotherapy, (b) the therapist’s empathic understanding and involvement, (c) therapist–patient concordance regarding goals of psychotherapy, and (d) the patient’s affective bond with the therapist.

Given the consistent association between patient–therapist alliance and the quality of treatment outcomes, researchers and clinicians alike have increasingly focused on those processes that disrupt therapeutic alliance and are therefore likely to interfere with therapeutic success. To date, however, the study of such therapeutic ruptures has focused primarily on forces that arise from *within* the therapy dyad (e.g., Safran, Crocker, McMains, & Murray, 1990; Safran & Muran, 1994, 1996; Safran, Muran, & Samstag, 1994).

In fact, forces exerted by family members *outside* of the therapeutic dyad can and often do rupture the patient–therapist bond. In particular, a patient’s intimate others, fearing exposure, jealous or resentful of the patient’s new relationship, misinformed or otherwise biased, can effectively undermine the therapeutic alliance (Kerr & Bowen, 1988). This is perhaps nowhere more common than when highly conflicted coparents enroll their child in psychotherapy.

The present article identifies and discusses *therapist alienation*, that dynamic in force when third parties, particularly a patient’s intimate others, effectively undermine the patient–therapist alliance from outside of the therapeutic dyad. Therapist alienation is conceptualized here as first cousin of the intrafamilial dynamic known as parental alienation (e.g., Gardner, 1987, 1992a, 1992b, 1998, 2002a; Kelly & Johnston, 2001) and as operationalized by Garber (2004) within contemporary attachment theory.

Contemporary Attachment Theory

Bowlby’s (1969, 1973, 1988) presentation of attachment theory as operationalized by Ainsworth and Wittig (1969) has provided a robust framework within which to understand the quality and vicissitudes of intimate dyadic relationships from infancy onward. Whereas research once suggested that the quality of early child-

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¹ Although this presentation focuses largely on dyadic relationships, the triangulation inherent in these dynamics as captured in family systems theory (e.g., M. Kerr, personal communication, October 2003; Kerr & Bowen, 1988) must be acknowledged.

hood attachment was strongly associated with the quality of later cognitive, emotional, and interpersonal functioning (e.g., Connell, 1976; Erikson, Sroufe, & Egeland, 1985; Main & Weston, 1981; Rutter, 1995; Waters, 1978), contemporary analyses confirm that attachment security is, in fact, adaptive, dynamic, and responsive to the caregiving environment (Broberg, 2000; Thompson, 2000).

Thompson (2000) described the quality of the child's relationship with a specific caregiver as discontinuous over time, "when intervening changes occur in the quality of parental care. A secure attachment does not predict more positive psychosocial functioning when, for example, the mothers of initially secure infants are later observed to behave intrusively and insensitively" (p. 146). Borrowing from the therapeutic alliance literature, any such change might be referred to as a *rupture* of the previously secure attachment relationship.²

Functionally, the adaptive nature of the attachment relationship is built on the individual's internal working model (IWM; Bowlby, 1969), a cognitive structure that "provide[s] the individual a set of rules for the direction of affect, thinking and behavior in social interactions with attachment figures" (Creasy, 2002, p. 365). The IWM digests and distills the individual's experience and knowledge of the attachment figure, integrating an ever-expanding range and variety of information as sensory, motor, and cognitive skills develop. With the growth of verbal comprehension, in particular, the IWM can begin to incorporate "secondary representations of [the caregiver] . . . mediated through parental discourse" (Thompson, 2000, p. 150).

Alienation, Attachment, and the Therapeutic Alliance

As language skills develop, cognitive structures become capable of incorporating not only direct experience but verbally mediated information as well. This allows, for example, accommodation of the IWM of an attachment figure to both direct experience with that figure and to a third party's report about that targeted figure (Thompson, 2000).

Parental alienation describes one instance of this dynamic, the harm done to the child's security with one caregiver as a result of exposure to another caregiver's denigrating actions toward or damning words about that targeted figure. This can result in otherwise inexplicable avoidance of, resistance to, or fear of the targeted attachment figure (e.g., Johnston, 1993; Johnston, Walters, & Friedlander, 2001; Ward & Harvey, 1993).

The concept of alienation within the family (as in *alienation of affections*) originates in the U.S. common law tradition of chattel, that is, the proposition that the wife and children are the legal property of the husband/father (Wood, 1994). Richard Gardner subsequently co-opted this term in describing *parental alienation syndrome* (PAS; e.g., Gardner, 1987, 1992a, 1992b, 1998, 2002), which he defined as "a disorder of children, arising almost exclusively in child-custody disputes, in which one parent (usually the mother) programs the child to hate the other parent (usually the father)" (Gardner, 1992a, p. 59).

Unfortunately, the many well-reasoned and robust critiques of Gardner's PAS (e.g., Dallam, 1998a, 1998b, 1999, 2000; Poliacoff & Greene, 1999; Rybicki, 2001; Wood, 1994; but see Warshak, 2001b) have left the scientific and legal communities wary of any use of the term *alienation* when, in fact, the problem lies not in the concept but in its specific application. This means that although the

notion of people as chattel has been soundly rejected and although PAS is largely recognized as biased, nonscientific, and inflammatory, the concept of alienation may yet have valid meaning.

In fact, Kelly and Johnston (2001) have offered a reformulation of parental alienation, emphasizing that the impact of a caregiver's denigration of another on the child is mediated by the child's developmental status and the quality of the preexisting relationships among all parties. Garber (2004a) casts this dynamic on the stage of attachment theory, positing that the alienating caregiver's words and actions cause the child to accommodate his or her IWM of the targeted caregiver such that the quality of the attachment relationship is ruptured. The resulting insecurity can be manifested as avoidance, resistance, or refusal of contact with the targeted caregiver.

Therapist Alienation

In the present frame, the patient-therapist alliance is construed as an attachment relationship (e.g., Blatt & Behrends, 1987; Legiero & Gelso, 2002; Mallinckrodt, 1991; Mallinckrodt, Coble, & Gantt, 1995; Mallinckrodt, Gantt, & Coble, 1995; Satterfield & Lyddon, 1995). Therapeutic progress is built upon the patient's security in this alliance, in which security itself is mediated by the patient's evolving IWM of the therapist-as-caregiver. That resistance arises within this relationship, sometimes rupturing the alliance, is well known (e.g., Safran et al., 1990, 1994; Safran & Muran, 1994, 1996). That resistance and rupture can result from the words and actions of persons outside of the therapy can now be examined in a larger theoretical context.

Therapist alienation is defined here as one variant of the alienation dynamic as viewed within attachment theory. Therapist alienation occurs when a party outside of the therapeutic alliance, particularly a significant other, exposes the patient to negatives about the therapy or the therapist. The result is contamination of the patient's IWM of the therapist, causing the patient to feel less secure in the therapeutic relationship, impeding therapeutic progress and presumably decreasing the therapist's threat to the family's existing dynamic balance. Therapist alienation is manifest as otherwise inexplicable resistance, impasse, or, in the extreme, rupture of the therapeutic alliance. As such, therapist alienation must be carefully distinguished from the other causes of these same outcomes, namely, resistance as generated from within the therapy.

Therapist alienation can interfere with any psychotherapy with any population of any age or gender, regardless of therapeutic setting, modality, or goal. It is evidence of the family system's defenses at work to maintain the system's stability, no matter how dysfunctional. Therapists who work with individual adult patients, for example, are commonly faced with resistance spawned by the denigrating words or actions of a patient's absent partners, parents, children, or colleagues. Couples, family, and child therapists have all seen patient resistance flare and therapies end prematurely without apparent explanation, only later to learn that some absent significant other had disparaged the therapy or the therapist such that the participants no longer felt secure in the process.

² Broberg (2000) illustrated the flip-side of the same coin, demonstrating that psychotherapy with formerly intrusive, inappropriate caregivers can result in a shift toward greater attachment security.

Therapist Alienation and Therapy With Children of Conflicted Caregivers

Children caught in the midst of their caregivers' conflict present a special case for consideration. These children are at very high risk for serious social and emotional harm (Amato, 2000; Amato & Fowler, 2002; Buchanan, Maccoby, & Dornbusch, 1991; Kelly & Lamb, 2000; Whiteside, 1996; Whiteside & Becker, 2000) and are therefore very much in need of psychotherapeutic support. Ironically, the very intrafamilial dynamics that create the child's intense need for therapy can work to undermine that therapy through the process of therapist alienation.

Conducting psychotherapy with the children of highly conflicted caregivers (regardless of custody, visitation, cohabitation, or marital status) poses unique and specific practical challenges (Garber, 1994, 2004b). Just as the adult conflict can lead the child to feel pulled toward each caregiver and away from the other, his or her trust in and cooperation with the therapist can come to be experienced as an act of loyalty to one caregiver or betrayal of another.

The noncustodial father, for example, neglected by an eager or overworked therapist, unavailable by virtue of distance or schedule, uninvited by an angry or abused or antagonistic custodial mother, easily feels threatened by his daughter's therapy. His disparaging remarks about the therapy or the therapist to or around the child contaminate the child's evolving IWM of the therapist, potentially undermining the therapeutic alliance and sabotaging the therapy's potential for success. This little girl may feel that trusting the therapist, talking to the therapist, or even traveling to a therapy appointment will fuel her parents' continuing conflict at least and cost her her father's love at worst.

Divorcing parents, as a second example, still living in the same home but court ordered to enroll their son in therapy, may each be eager advocates of the process until one begins to feel that the therapist is more sympathetic with the other. That caregiver, feeling estranged from the son's therapy, threatened by changes in the relationships within the home or otherwise anxious, may then work to demean the therapy or the therapist in a self-serving and misinformed effort to regain a level playing field. The child, thus triangulated, loses the comfort and security that the therapy might have represented and comes to experience the process as yet another battlefield.

Foreseeing and Forestalling Therapist Alienation

The present model provides a framework within which to conceptualize therapeutic impasse and rupture due to third parties in general, and it highlights this dynamic as it is played out in the course of conducting psychotherapy with children of conflicted caregivers, in particular. Aware of these potentials, clinicians can take a number of steps to prevent and, as necessary, to respond to suspected therapist alienation most appropriately.

Intrafamilial Systems

The therapist must recognize and respond to the child-patient as part of a delicate balance of intrafamilial relationships. To offer therapy to a child without a thorough understanding of and respect for the family systems in which he or she participates is to

minimize the potential value of that therapy. The process of extricating a child from a destructive family system may require intervention with the whole system.

The Patient and Intimate Others

Intimate others who feel informed, valued, and validated are less likely to alienate. This premise at once dictates the means of minimizing the likelihood of therapist alienation and raises a number of dilemmas the therapist must be prepared to address. In short, it highlights the fine line the therapist must walk between validating the patient's intimate others on the one hand and respecting the patient's confidences on the other.

Within the limits of safety, the adult patient can dictate how this balance is struck, allowing or forbidding the therapist to exchange information with third parties as he or she sees fit. The therapist's responsibility here is more than upholding legal and ethical conventions concerning confidentiality. It is to consider and, as appropriate, bring the clinical implications of these decisions into the therapy.

The adult patient, for example, who refuses to inform her husband about the course of therapy, who refuses to invite him to attend therapy with her on occasion, and who refuses to allow the therapist to return the husband's phone calls and letters, needs to talk through these decisions very carefully. In some instances, these limits can be healthy and appropriate to the patient's needs. In other instances, however, the same limits can set the stage for the patient to feel torn between her partner and her therapist, fertile ground for therapist alienation.

These same questions become that much more difficult when the patient is a child. In these instances, the therapist walks a fine line between the child-patient's needs on the one hand and the caregivers' ethical and legal rights on the other. Add conflict and triangulation among caregivers and the therapist easily finds him- or herself balancing high up on a trapeze without a net. When associated legal conflicts bring court rulings, attorneys, and child advocates (e.g., guardians *ad litem*) into play, even the most well-balanced professional can plummet into therapist alienation and a failed psychotherapy.

For exactly these reasons, the clinician can minimize the likelihood of therapist alienation by fully assessing the patient's emotional support network, acknowledging each of these parties' unique roles and concerns, educating patients and their intimate others regarding therapy and alienation, defining the therapist's own role and boundaries clearly, and establishing appropriate means of communication throughout the intervention.

Role of Significant Others

Any initial psychosocial evaluation must identify not only a prospective patient's social supports but also each of these party's positions regarding the proposed psychotherapy. This process can be relatively straightforward with most adult patients and can open the door for education about therapist alienation.

Child therapists can minimize the risk of subsequent alienation and maximize the likelihood of a successful intervention by inviting all of the child's caregivers to contribute from the start. Not only does this offer the advantage of multiple perspectives on the

child's functioning, but it minimizes the likelihood that one or another caregiver will feel threatened by the process.

However, it is usually the case that the need to acknowledge and include all of a child's caregivers from the start of psychotherapy increases just as the ease of arranging their participation decreases. Caregivers who are highly conflicted, who communicate poorly, who are territorial, who are openly hostile, or who are participating in a legal system that breeds adversity present the highest risk of therapist alienation. The therapist must therefore work from the first phone contact forward to win all caregivers' mutual support (Garber, 2004b); that is, to effectively establish him- or herself as neutral to the adult conflict and the therapy as a safe haven for the child outside of his or her otherwise polarized and conflicted world.

Education About Alienation

Educating patients early in the process of psychotherapy about the value of extratherapeutic support can be sufficient to invite subsequent discussion of therapist alienation, at the least, and to defuse the destructive dynamic should it arise, at the most. Indeed, when the torn loyalties inherent in budding therapist alienation can become an explicit part of an ongoing therapy, the door is open to the patient to learn to cope better with other similar conflicts elsewhere in his or her world. This is perhaps nowhere more relevant than when conducting therapy with the children of conflicted caregivers as these child-patients are often enrolled in therapy explicitly because of their experience of divided loyalties. In this context, labeling the child's reluctance to trust the therapist for fear of betraying other alliances can set the stage for exploration of the child's torn alliances between caregivers.

Explicit Clarification of Roles and Alliances

The opportunity for therapist alienation is diminished when the therapist is clear and consistent in establishing the nature and limits of his or her role not only with the patient but vis-à-vis the patient's significant others as well. In some instances, explanation about the limitations of confidentiality and dual roles (e.g., American Psychological Association, 2002, Standards 8.04 and 10.02, respectively) is sufficient. In others, the interplay of roles becomes so complex that further definition is warranted.

The clinician working with children, for example, is routinely obliged to clarify his or her role and alliances in a variety of circumstances. These include identification of the child, not the referring caregiver(s), as the patient, clarification of how the child's privacy will be balanced against the custodial caregiver's legal right to the child's records, whether and how information will be shared with caregivers, and whether and under what circumstances information gleaned from one caregiver might be shared with another. When litigation is involved, further questions of role and alliance must be proactively addressed, including the therapist's responsibility to the court and whether and under what circumstances the therapist will be willing to address legal questions such as custody and visitation.

Without these clear definitions, ambiguities can arise that quickly triangulate the therapist or the therapy. It is not unusual, for example, for a separated mother who enrolls her son in psychotherapy to assume that the therapist is thus her ally in custody

litigation planned or pending. The mother proceeds to include the therapist's name on a witness list submitted to the court even without the therapist's knowledge, a list that is received by the father's attorney and communicated to the father who immediately feels betrayed by the therapist's supposed alliance with his estranged wife. Because the father's attorney advises that withdrawing the child from therapy would look bad before the court, the father proceeds to communicate to the child that the therapist is not to be trusted. The boy is torn. His previously secure relationship with the therapist is undermined. The therapy has been compromised. The therapist recognizes an impasse in the boy's new resistance but cannot identify its source. Without explicit clarification of roles and alliances, the therapy is at risk for failure.

Establishing the Extent and Means of Ongoing Communication

When communications between a therapist and a patient's intimate others are necessary and appropriate, defining the timing, medium, and limits of such communications in advance can forestall many instances of potential therapist alienation. Child therapists are perhaps most likely to need to maintain communication with the child-patient's significant others, most usually the child's parents. When coparents communicate with one another constructively, it may be adequate for the clinician to speak with one or the other parent as events arise. When coparent communication breaks down, as when caregiver conflict escalates, the clinician who communicates primarily with one caregiver risks marginalizing the other, contributing to an unhealthy equilibrium within the family structure and setting the stage for potential therapist alienation.

Divorcing parents and their allies, for example, commonly seek frequent contact with their child's therapist, particularly in matters that might bear on concurrent litigation. A father calls with the expressed intent of keeping the therapist up to date about the child when he is, in fact, trying to win an ally in his campaign against the mother. A mother intercepts the clinician after each session, expressing concern for the child's progress even while she seeks evidence to support her motions to the court. Each of these exchanges risks triangulating the therapist into the caregiver conflict and thereby opens the door to alienation.

With these very common dynamics in mind, it is often best to defer all but the most emergent issues to regularly scheduled joint caregiver meetings. By speaking with the caregivers together in the same room, the likelihood of miscommunication and associated triangulation is diminished. Written and electronic communications with copies to all parties may serve the same purpose. In every instance, concerns about the security of the communication and the child-patient's confidentiality must be considered first and foremost.

Indicators of Therapist Alienation

Because impasses in psychotherapy can arise for any number of reasons (e.g., Safran et al., 1990, 1994; Safran & Muran, 1994, 1996), distinguishing genuine therapist alienation from the other causes of resistance that more commonly erupt from within the psychotherapy dyad can be very difficult. By analogy, Garber (1996) described how a child's apparent aversion to contact with

one caregiver can be as easily due to a dislike for that caregiver's pets as actual coparental alienation.

However difficult, first determining that a therapeutic impasse is not the result of a dynamic generated within the dyad is critically important. At the least, a clinician's invalid allegation that a caregiver is alienating a child-patient can become a self-fulfilling prophecy. At the worst, allegations that a caregiver is impeding a court-mandated therapy can be grounds for contempt, possibly resulting in punitive actions and even imprisonment.

Certainly the clearest clues to actual therapist alienation are defined by observation or report of unambiguous acts. The 8-year-old child-patient who confesses, "Mommy told me not to talk to you"; the belligerent father who separates from his son in the therapist's waiting room with a hug and the words, "Be careful what you say!"; and the teen, arms crossed, eyes downcast, who announces to the therapist, "Dad told me that you won't let me visit him!" may each have been alienated from the therapeutic alliance by a caregiver's specific words.

As the ambiguity of the evidence grows, so too do the difficulties the therapist is likely to face in determining the cause of a therapeutic impasse or rupture. The child who refuses to talk in therapy, for example, has scores of possible reasons to resist therapy (e.g., the appointment precluded a fun activity), only one of which might include caregiver alienation of the therapist or the therapy. The accompanying parent who separates from his son with a hug and the words, "Remember what I told you," is as likely looking forward to stopping for ice cream after the meeting as prompting the child's resistance.

As in the case of coparental alienation, one important clue lies in the apparent concordance between the child's words or actions and evident affect. The patient who declares her mistrust or hatred of the therapist even while she engages that same therapist with evident pleasure may be echoing someone else's words. The child who refuses to speak in therapy but is so pressured that any artifice (e.g., writing notes rather than talking to the therapist) is sufficient for the words to come pouring out may feel bound by a caregiver's externally imposed directives or fear the repercussions of betraying such directives.

The difficulties inherent in distinguishing therapist alienation from other causes of therapeutic rupture are compounded by the clinician's own investment in the matter. Working with the children of highly conflicted caregivers, for example, is an emotionally evocative process. When such a therapy breaks down, the clinician may have a self-serving investment in blaming the impasse on the interference of a third party. For this reason, suspicions of therapist alienation in all but the most explicit instances call for peer consultation before any further step is taken.

As a clinical matter, peer consultation may offer the clinician the perspective to consider processes internal to the dyad and how the dyad fits into the larger family system, sometimes overcoming an impasse otherwise too quickly credited to a meddling third party. As a risk management matter, peer consultation can validate allegations of therapist alienation and offer support that may be invaluable should the matter come before a court.

Responding to Therapist Alienation

What is most clear is what is least appropriate: The therapist who responds to suspicions of therapist alienation by denouncing

the child-patient's loved one as wrong may be harming the patient no less than has the alienator him- or herself. To respond to the boy who confesses, "My daddy told me not to talk to you," with anything suggesting that the father is wrong may well be alienating the child from his parent, committing an instance of parental (as opposed to coparental; Garber, 2004a) alienation. The clinician who suspects that an impasse in a therapy may be due to a third party's alienation, who has reviewed the matter carefully in peer consultation, who has sought to understand the impact of the child's therapy on the larger family system, and who has side-stepped the opportunity to further triangulate the patient must carefully decide how to proceed.

When the patient is an adult, the therapist is free to respond to the perceived resistance like any other, keeping in mind and probing as appropriate for the possibility that an absent third party has contaminated the relationship. When the patient is a child, it may yet be appropriate to explore the resistance, taking care not to put the child in the position to feel the need to choose between caregivers. Seeing the child in each of his or her separate family groups³ can simultaneously become part of an assessment of the dynamics within each and can serve to defuse whatever anxiety might motivate alienation of the therapist.

In the extreme, an emergency coparent meeting may be necessary for the purpose of addressing the suspicions or evidence of therapist alienation, taking care to proceed within the limits of privacy established with the child-patient and the expectations about mutual communications established with the coparents. In the best of circumstances, misunderstandings can be corrected and a caregiver's nascent mistrust, feelings of estrangement, or anger toward the therapist can be vented appropriately. On occasion, continuing education about alienation and its impact is sufficient to defuse a budding problem.

When these steps are not sufficient, when there is reason to believe that therapist alienation persists undeterred (or even exacerbated) by education and direct discussion, when the alienation is so complete and the child's mistrust and animosity toward the therapist so pervasive that even attending therapy meetings represents a painful betrayal, when the prospect for reestablishing a positive rapport seems so unlikely and the possibility of a successful intervention so remote, then two options must be considered.

The first option applies when caregivers are involved in the court system, as, for example, when a guardian *ad litem* is active. In this circumstance, the therapist might seek relief from the courts in the form of an order or injunction against the alienating caregiver.

If court intervention fails to end the alienation and resolve the therapeutic impasse, or in those instances in which court intervention is not available, therapeutic termination must be considered (see American Psychological Association, 2002, Standard 10.10 regarding termination). Therapeutic termination means ending a therapeutic process in a patient's best interests, in this case because

³ I recognize that some family therapists might recommend working with the child and the conflicted caregivers together. It is the present position that, to the extent that the coparents intend to remain apart (regardless of legal status), reuniting the original family for purposes of therapy too often provides the child-patient with the secondary gain of superficial reunification, however brief.

the therapist has become intractably triangulated into a destructive family dynamic and associated in the child-patient's eyes with betrayal of a loved one. The course of termination in this situation likely requires the following: (a) a coparent meeting intended for the purpose of clarifying the status of the treatment, identifying the intractable bind in which the child has been placed as a result of the therapist alienation and the therapist's decision to withdraw; (b) a termination meeting with the child, recognizing that the therapist may genuinely be a valued attachment figure despite the impasse caused by forces external to the relationship; and (c) delivery of a written termination summary to each of the caregivers intended to forestall a repetition of the alienation should the child be enrolled in a future therapy and to inform the court, as appropriate.

Future Directions

Formally acknowledging the familiar experience of therapist alienation and its roots in family dynamics adds another voice to the continuing dialogue intent on discovering the means to best meet the needs of our children. This recognition offers family law professionals the tools with which to foresee and forestall much potential interference in court-ordered mental health services for children just as it offers mental health professionals both the conceptual and practical tools with which to work to avoid and, as necessary, respond to destructive triangulation of the child's psychotherapy.

For child-centered mental health professionals in both venues, many questions remain concerning the phenomenon of therapist alienation specifically and the alienation dynamic more generally. Among these considerations must be greater understanding of the intrapsychic and interpersonal dynamics that predispose some individuals to alienate a child from a valued caregiver (e.g., Siegel & Langford, 1998), what other domains of child life (e.g., student-teacher relationships, peer relationships) might be subject to the effect of a caregiver's alienating words or actions, what combination of education, active involvement, prohibition, and threat of sanction is most effective in preventing these acts, and the long-term sequelae of therapist alienation on the child's ability and willingness to benefit from future psychotherapies.

Garber (2004a) reviewed data that begin to address the closely related question of the combination of factors within the child, the alienator, and the object of the alienation and in the quality of the relationships among the three that might facilitate or inhibit the impact of any such alienation. Specifically, preliminary data suggest that the quality of the child's attachment to the alienator may be one factor that mediates the impact of the alienator's message.

Finally, and perhaps of greatest practical value, is the question of how to correct or remediate the impact of a caregiver's campaign of alienation (e.g., Gardner, 1992a, 1992b, 2001; Johnston & Roseby, 1997; Johnston et al., 2001; Kelly & Johnston, 2001; Ward & Harvey, 1993; Warshak, 2001b), particularly to the extent that such remedies may work to preserve otherwise child-centered therapies. Can an alienating caregiver's subsequent endorsement ("alignment"; see Garber, 2004a; Warshak, 2001a) diminish or even undo the destructive impact of a prior alienating message? Can other caregivers' endorsements counterbalance the alienator's message? Or do these mixed messages from one or from several caregivers only confuse a child, trigger additional anxiety and

distress, and, paradoxically, possibly compromise the quality of the child's relationship with the alienator him- or herself?

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