

Family-Based Therapy for Parent–Child Reunification

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Children in highly conflicted, divorced families can become triangulated and polarized in their relationships with their parents. In time, this can lead to a child refusing to have a relationship with a parent, refusing for example, to see or talk to him or her. This access refusal can sometimes become extended, lasting months to years. When this occurs, the courts may request professional involvement to help facilitate parent–child reunification. This article outlines a family-based treatment model for parent–child reunification cases. This family-based treatment incorporates treatment goals for each family member and each family member is asked to be a part of the solution in resolving the family's problems. I provide a case illustration as well as helpful tips for treating these families. © 2016 Wiley Periodicals, Inc. *J. Clin. Psychol.*: In Session 72:498–512, 2016.

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A definition of a *perfect storm* is a catastrophic event that occurs when an unusual combination of circumstances comes together and results in an enormous calamity.

A child whose parents are divorced refuses to see or talk to one of his parents. In fact, not only does the child refuse to have a relationship with one of his parents, he also blatantly rejects that parent. Accusations may abound. Allegations of abuse, neglect, and more may be levied. The child may have been physically aggressive with the parent, disrespectful, and openly vocal to everyone about his hatred and rejection of that parent. Years may go by without access or contact with this parent. This rejected parent (RP)—and everyone and everything connected to this parent—is outwardly disdained and avoided. In a high-conflict divorce, this is the “perfect storm.”

Children of divorce may “reject” a parent and limit access to a parent for a variety of reasons (Friedlander & Walters, 2010). When children are younger, they may resist seeing a parent because they feel anxious when they are separated from a primary parent. Adolescents may reject a parent and resist access because they are tired of going back and forth between two homes. They want one home base and the RP is not accepting of this developmental shift in preference. Other children may reject a parent because they may be dissimilar in personality, temperament, and/or interests. Alternatively, a child may pick one parent because of that parent's characteristics (e.g., that parent is more permissive or the child believes that parent needs to be taken care of). Perhaps the child has never felt close to this parent because of a previous limited or infrequent parenting access schedule. Still other children may hunker down in one home as a way to avoid conflict between parents. By choosing one side, the child may believe that perhaps a war can be avoided.

The above-mentioned explanations reflect a wide variety of reasons that a child may resist a relationship with one parent. Adding in parent factors and behaviors further complicates the situation. At the most extreme, a parent may intentionally set out to sabotage the relationship of the child with the other parent. A parent may also unintentionally and naively harm a relationship between a child and parent because he or she is unaware of how to fully support a child's relationship with the other parent. Anxious parents may be excessively worried when

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their child is apart from them and may unintentionally foster a child's anxiety (Kelly & Johnston, 2001).

Parents may also act in a way that fractures the parent–child bond, such as being insensitive and less empathic than is needed in a highly conflicted family. They may be more authoritarian in their parenting approach, leading the child to have an adverse emotional experience when they are together. A parent may be critical and demeaning toward the other parent, leading the child to defend the other parent.

These are the perfect storm cases. Contributing factors may be found at every level of the family. These factors interact with each other so seamlessly, perpetually feeding into a dysfunctional cycle that appears almost impossible to break. These families demonstrate such significant pathology that they overwhelm the courts, the professionals, and even outsiders who may just peripherally be involved with the family.

This article will primarily focus on these highly complex, very difficult polarized cases. Some label these cases as “parental alienation.” This term, however, refers only to one of the many reasons for the estrangement. For the purposes of this article, no labels will be provided so that the focus can remain on the treatment and how to help all families experiencing these types of parent–child access and relationship difficulties. This article will concentrate on how to repair these families and how to help a child reunify with a parent. Excluded from this discussion are families with documented abuse, violence, or safety risks that warrant a cessation of parent–child contact.

A Confluence of Factors

High-conflict family system. In a divorced family, children must learn to move back and forth between residences, adapting to each parent, household, and extended family system. They experience feelings of loss and anxiety as they move from one parent to another. In high-conflict divorced families, children must also learn to navigate across a minefield. They may even be asked to become soldiers in their parents' ongoing, unending war. This request may be direct or subtle. This type of high-conflict family context is one of the factors necessary for creating this perfect storm.

Aligned parent's lack of support for reunification. The aligned parent (AP) is the parent with whom the child is closely connected. The AP often is quite resistant to any type of reunification and treatment and does not want to be a part of the therapeutic process because he or she believes that the rejected parent (RP) is to blame for any access refusal by the child. Aligned parents may present with traits resembling a clinical or personality disorder, replete with their own family history of relationship ruptures. Abuse and/or neglect may also be a part of their history. The AP may be an anxious, overprotective parent or a parent with very high standards and expectations. There is no typical AP. However, one characteristic that is universal when this factor is present is a lack of genuine support for the child's relationship with the other parent. For example, the AP may profess to support the child's relationship with the other parent and the reunification process. But when it comes to scheduling, therapeutic reunification sessions will be placed last on the list of priorities in the child's schedule. The AP may explain that everyone needs to focus on the child and the child's needs, thus presenting as quite child centered. However, in effect, the AP's child-centered focus and presentation are justification for the lack of true support and priority in fixing the parent–child relationship and access issues. The AP's lack of support for the other parent is another necessary factor in creating this perfect storm.

The RP's mistakes are magnified. RPs usually are desperate for access to their child and eager for the therapy to begin and progress. They feel victimized, often by the AP and sometimes by the courts and various professionals. They also may feel victimized by their children. The RP may have a mixed presentation, including but not limited to being angry, downtrodden, depressed, and scared. Similar to the AP, there is no one typical presentation of the RP. However, when it comes to the RP, there is some mistake or misstep that can be found

in the history, which may have occurred within the parent–child relationship, the coparenting relationship, or in the court process. This is another element within this perfect storm. It is impossible not to make a mistake or misstep even in the best of family circumstances. However, in these families, there is an overfocus on the RP's mistakes and missteps. This will need to be addressed within the therapeutic process.

The child's vulnerabilities. The children are the final members of the primary family system. They are of course the most vulnerable victims. These children have lived under tremendous pressure and conflict. By the time these children enter into a reunification process, they can present as hardened, insensitive, angry, afraid, paranoid, and sometimes even outwardly callous and cruel. These children may present as though they are quite mature, aged well beyond their developmental years. Not surprisingly, these children have had to deal with very adult issues and have been the recipients of vast amounts of adult information. Despite the outward appearance of maturity, these children often present as quite emotionally and cognitively immature. In essence, it is pseudomaturity. They can be very black and white in their thinking, inflexible, perfectionistic, and easily influenced. They often present with reduced levels of empathy for the RP and demonstrate reduced levels of problem solving. They also can present as quite anxious and avoidant. These child characteristics or behaviors are critical elements of this perfect storm.

Extended family involvement. The extended family of the AP and RP can also be quite integral to the family dynamics. There may be a stepparent, grandparents, aunts and uncles, and other family members who perpetuate the perfect storm. Because the nuclear family system is so polarized, it is not surprising that extended family members may become polarized as well. Sometimes these extended family members actively polarize and alienate others. Other times, these family members may directly reinforce the polarization and conflict by actively supporting one of the parents and/or the children. At still other times, extended family members may support the polarization and conflict by just their silence and inaction.

Blame and redirection. When trying to treat a family that is struggling in this domain, blame is abundant. This is not surprising given that these families enter an adversarial court system in which finding someone guilty and to blame is an inherent part of that system. Thus, some court-involved families may fall deeply into this vortex. In families that are struggling with high polarization and parent–child access difficulties, the RP is typically blamed for the current problems. The RP, on the other hand, often will blame the AP. Blame (rather than trying to understand what is occurring in the dynamic of the family) is a fundamental facet of these families. These family's identities will wrap around a “who is to blame” principle, with everyone in the family desperate to defend themselves from any allegations.

When it comes to the treatment of these families, blame not only is unhelpful in ameliorating these issues but also can be deeply detrimental. The treatment must focus on helping each member of the family understand that he or she must be a part of the solution to the family's problems. Each must actively commit to doing something differently to help the family move forward. By the time the family enters therapy, the continued focus on cause and blame can be likened to misdirection in a magic trick. Look *there* and not *here*. When these moments of cause and blame occur within the treatment, the clinician should steadfastly look *here* and not *there* instead.

Structure of the Treatment

In probably no other treatment modality is the structure of the treatment more important than in treating parent–child reunification cases. A lack of appropriate structure, clarity, and definition at the outset of the treatment can later undermine the progress of the therapy. Furthermore, in more extreme cases, a nexus between the court and the treatment is critical to success.

There is a growing consensus that the most effective treatment modality for parental alienation or parent–child access cases is family therapy. Family therapy promotes the idea that all members should be a part of the therapeutic process. Every member of the family is considered to be a

part of the solution to any ongoing family difficulties. Previously, “reunification treatment” was recommended for parent–child access and alienation cases. However, this treatment permits only two members of the family system to participate and be a part of the solution (e.g., the child and RP). Often, the AP’s “buy in” is one of the major components in creating change in any type of access rejection or refusal. Siblings may also be contributing to parent–child relationship difficulties, especially ones who may also be alienated or estranged from the RP. Therefore, family therapy is the optimal treatment modality.

Court support and monitoring is another critical component in remedying these issues (Fidler & Bala, 2010). A strong court presence is a key variable in determining whether the reunification will be a success. This can be achieved through strong, detailed court orders, regular court monitoring, and even accountability and sanctions for noncompliance. Ideally, there should be a parenting plan already defined and in place before the start of therapy. This is important so the family therapist is solely treating the family system and moving the pacing along toward the designated parenting time goal. The family therapist *should not* be a decision maker regarding any major decisions pertaining to the family. This helps to protect the family therapist’s alliance with each member of the family. However, the therapist should be able to decide on smaller issues such as pacing, context of visits, and the timing of overnights if the parents are not able to agree on these decisions.

Time is an enemy in these cases. Typically, months to years have already been lost in the parent–child relationship before the family even enters the therapist’s office. Each transitional step is difficult for the children, so extending the time can heighten their anxiety and make the situation feel even worse for them. Within 90 days, one typically should see progress in the reunification and family system. If that is not happening, additional court support and monitoring or additional treatment parameters may be necessary.

Cognitive-behavioral therapeutic techniques are very helpful within this treatment (Garber, 2015). This type of therapy has a strong educational component because it teaches clients to identify how thinking patterns affect behaviors and helps them to exercise greater flexibility in their thinking and beliefs. Coaching and modeling are other important components of the treatment.

Similar to other treatments, there is alternating progress and regression. Often it will feel like one step forward, two steps back. This is expected and normative but nonetheless quite difficult. An example of this alternating progress and regression can be seen when the child and RP have a “breakthrough.” The child may have had a positive shared experience with the RP and is able to acknowledge such at the time. However, when the child returns to the next session, he or she may have returned to the original script, again expressing anger and upset at the RP and adamantly denying the occurrence of a positive shared experience with the RP.

Treatment Goals

When conducting any type of family-based treatment, treatment goals are set for not only the family system but also individual family members. In reunification cases, it is important to identify these individual and family goals so that they can guide the treatment forward. In addition, developing an action plan around achieving these goals can help promote change. Table 1 presents typical treatment goals in these cases as well as some examples of recommended actions to help achieve these goals.

Course of Treatment

Some reunification cases need to move swiftly, while others can move at a slower pace. Sometimes the court may prescribe a specific timeline. If the court has not set forth any such expectations, a decision regarding the pacing of therapy can be made using the severity of the parent–child access issue as a guide. For example, if the issues are falling on the mild end of the spectrum, moving slowly may be acceptable. However, if the issues are more extreme, moving swiftly may better serve the family, in particular the children. Over time, the spacing of sessions generally increases as the family begins to stabilize.

Table 1
Treatment Goals & Action Plan

Family member	Treatment goals	Action
Aligned parent	Increase support for the child's relationship with the other parent.	AP will not call or text the child during RP's parenting time.
	Increase understanding that the child should not make important adult-type decisions.	AP will identify what are appropriate child decisions and what are adult decisions.
	Increase sharing of information about the child with the RP.	AP will share information about the child's current status with RP to help facilitate the reunification.
Rejected parent	Remedy any vulnerable areas in the rejected parent's parenting.	RP will learn about some of the child's interests and be able to communicate meaningfully with the child about these interests.
	Respond sensitively to the child's upset and allegations.	RP will practice responding to the complaints of the child in advance of the reunification sessions.
	Learn about the child's interests, activities, and current status to ease the reconnection.	RP will learn about the child's interests, activities, and current status and research any relevant information to help ease communication.
The child	Increase the child's understanding of the anxiety cycle.	Child will discuss with the therapist anxious thoughts and feelings about the RP and identify helpful thoughts and behaviors.
	Decrease the child's black and white thinking.	Child will identify black and white thoughts and will replace them with more nuanced, flexible thoughts.
	Balance the child's thinking and memories about each of the parents.	Recall positive memories about the RP and recall negative memories about the AP.
The family	Improve communication and coparenting between the parents.	AP and RP will send regular messages to each other about the child.
	Establish appropriate roles and boundaries within the family.	AP and RP will identify a coparenting process to discuss decisions that need to be made about the child. They agree to not discuss this with the child until the decision has been made.
	Disrupt patterns of triangulation.	AP will redirect the child back to the RP if the child expresses any complaints about the RP.

Often the build up to the first session is the worst part of the process for all members of the family. However, this is particularly true for the children who present in considerable distress. Typically, their anxiety, fears, and concerns far exceed the reality of that first session. The AP is similarly distraught, so even as the children are struggling to manage their emotions and behaviors, they may not be able to access their parent for additional support. In these cases, it may be beneficial to move the therapy into a more intensive format. Essentially, a certain number of therapeutic hours are spent, but they may be shifted to occur in bulk over a shorter period of time (e.g., a half day over a weekend).

Treating these families can be difficult, exhausting, and, at times, overwhelming. Therapists inherently want to "do good." They want to help. They want their patients to have a positive relationship with them. But in treating a family struggling with reunification, at least half of the family system doesn't want to be in treatment and they may not like the therapist (at least not at the outset, and through the entire treatment). The therapist will have to work with patients who are being forced to be in their office. Many of these patients do not want help and have not asked for it.

For a therapist working with this type of family, balance and neutrality are critical. The therapist needs to forge a working therapeutic relationship with each member of the family. The therapist will need to shift to whom they provide support and at what times, being careful that support is offered in a way that ideally appears balanced and unbiased. At the beginning, the therapist will need to help the RP to reenter into the family system. By providing this support, the others in the family often will perceive the therapist to be aligned with the RP. This is understandable, especially when the goal of treatment is to reunify the RP with the children. In essence, the goal of the treatment highlights this inherent alignment. However, the therapist needs to work toward aligning with and supporting all family members. It is important to explain to family members what to expect. This can help them to understand that some of their thoughts, feelings, and experiences are normative and predictable. For example, the therapist can speak with the children about the first reunification session, noting that children often are afraid to see the parent and most children feel this way. The therapist can share with the child how other children have felt after the first session, for example, that many children acknowledge it wasn't as bad as they expected it to be.

A cycle of anxiety, fear, and avoidance is a core dynamic in the child's relationship with the RP. The child avoids the RP just as a child afraid of the water avoids the pool. Every family member needs to learn about the anxiety cycle and how avoidance is the behavioral reaction to anxiety. Just as a child who is school phobic should not be reinforced to avoid school, a child who is avoidant of a parent should not be reinforced to avoid that parent. If the child continues to avoid the RP, then they will have even more difficulty resolving any issues and moving forward. Thoughts, feelings, and behaviors are inextricably linked. A change in any part of this linkage will lead to change in the other links. Cognitive-behavioral strategies can be useful in addressing this behavioral dynamic.

Case Illustration

Client Description and Presenting Problem

Amanda (age 37) and Patrick (age 38) Jameson separated 10 years ago. They had one child, Catherine (age 12). Catherine has no memories of her parents' marriage. Amanda remarried shortly after the divorce. Jake, Catherine's stepfather, was in many ways Catherine's primary father figure. However, Amanda's second marriage ended approximately 3 years ago. Patrick has been in a long-term relationship with a woman, Jennifer (age 40). They moved in together about a year ago.

Amanda and Patrick had a very high-conflict divorce and the high conflict has continued throughout the years. In fact, over the last 8 years, over 200 motions have been filed in family court. Catherine began to resist seeing her father when she was about 8 to 9 years old. She completely stopped seeing her father about 18 months ago and during that time has not spoken to or corresponded with him. Patrick tried to see his daughter throughout this period but visitation was not enforced. If Patrick tried to see Catherine at school or at an activity, she would break down, cry, and then leave the activity. Catherine's previous therapist recommended that Patrick temporarily stop trying to see her since it was too upsetting to her. He continued to call and text her cell every day. However, she did not respond. Catherine asserted that her father had an anger issue, yelled a lot, and scared her. She did not want to have any contact with him ever again. The court recommended reunification therapy and ordered that all family members participate. A status conference to check in on progress was scheduled to occur every 30 days.

Case Formulation

The case formulation was derived through individual interview sessions with Amanda, Patrick, and Catherine. Additional information was secured from records reviewed by this therapist and phone calls with various professionals who had been involved with the family.

Many professionals had worked with this family over the years. Individual therapists had previously been involved with each family member. Reunification therapy with Patrick and Catherine had previously been attempted, but Catherine refused to see her father.

Supervised contact had also been ordered. However, again, Catherine refused to see her father. The lawyers involved with the matter were concerned that if the reunification did not occur, then the court might order a temporary or physical change in custody. This was the last attempt that would be tried before a custody trial.

Amanda's family background was remarkable in this case and appeared to have a strong bearing on this current family system. Amanda did not have a close relationship with her own biological father. Her parents divorced when she was very young. She was told that her father had mental health issues. Amanda's stepfather raised her. However, that marriage eventually ended as well and disrupted her attachment with her stepfather. Nonetheless, Amanda formed strong relationships with each of her mother's partners and used each of these partners as a father figure.

Amanda was clear that she did not believe that Catherine needed to have her biological father in her life. She noted that anyone could be a father: "Biology doesn't mean anything." She also had many romantic relationships and exposed Catherine to these relationships quickly. Amanda struggled as a single mother when she had no partner in the home. Amanda's therapeutic history revealed a history of sporadic depression. When these depressive periods arose, Catherine often had to do considerable housework and take on a great deal of responsibility.

It was also noted that Amanda and Patrick became pregnant with Catherine after only a few months of dating. Patrick came from a devout Catholic family. He married Amanda after news of the pregnancy. He wanted to ensure that Catherine would be born into a marriage. However, Patrick felt deceived from the outset. He explained that Amanda reported she had been on birth control and so he was surprised by the pregnancy. Nonetheless, he wanted the child and was excited to become a father. The relationship was tumultuous from the start, with Amanda regularly threatening to get an abortion when she was upset with Patrick. Patrick described feeling like he was walking on eggshells all of the time.

After Catherine was born, Amanda immediately began to try to keep Patrick away from his daughter. Amanda slept with Catherine every night and refused to allow Patrick in the bedroom. Amanda would not leave Patrick alone with Catherine, explaining that he did not know how to care for a baby. Patrick felt like Amanda did not consider him to be an equal parent to her. The growing rift eventually led to a tumultuous separation. Police often were called to the residence and Patrick was arrested one time.

From the time of divorce onward, Patrick reported that he had to fight for every minute of time with his daughter. Amanda allegedly always tried to interfere with his contact, using any excuse to cancel visitation. He also felt that Amanda tried to present her ex-husband, Jake, as a father to Catherine, thereby minimizing Patrick's role and influence in Catherine's life. Patrick was a passive man by nature and he tried to avoid conflict with Amanda as much as he could. However, she was regularly critical and accusatory throughout the years. Therefore, he typically surrendered when these times became too tumultuous. Patrick denied that he was an angry man. He reported that Amanda was the angry one who always yelled. At times, Patrick did raise his voice to Catherine, but this was reportedly infrequent. Typically, these instances occurred when Catherine would be outwardly disrespectful and combative toward Patrick.

Catherine was a straight-A student in middle school. She was involved in a variety of sports and an avid piano player. Her schedule was quite intense. Catherine was perfectionistic. She was quite hard on herself when she didn't perform perfectly. She frequently resorted to intellectualization in her discourse. She presented as cold and unempathic at the start of treatment. Her thinking was quite black and white when it came to relationships. She tried to present herself as mature, but her immaturity came through. She was protective of her mother, refusing to talk about her or her residence. She was overly aligned with her mother and quite dependent on her. Even at the age of 12, her mother sat with her and did her homework with her, watched over her piano playing, and went to all of her sports practices. Catherine sounded a lot like Amanda. Their perceptions were "shared" in that they saw their family situation identically and generally had very similar views on life. Catherine was quite adultified.

Catherine felt that her life was fine without her father. According to her, he brought no real value to her life. She described a distant, sporadic relationship with him. She always felt closer to her mother. Catherine thought that her father should have apologized to her for his mistreatment

of her and her mother. Catherine heard from her mother about some of the accusatory statements that were written in the court filings. She described her mother as being a perfect, ideal mother and described her father as someone who was angry, frightening, and incompetent. Catherine also contended that her father's girlfriend and her father's extended family were "losers" and so she shouldn't have to spend her time with them.

Course of Treatment

For each of the different phases of treatment discussed below there will be a brief discussion of what happened clinically and then a short commentary on each major component of that phase.

Initiation of Treatment

Patrick immediately entered treatment and wanted to see Catherine as soon as possible. He was frustrated he wouldn't be able to see her within a few days. He referenced the court order, which dictated there must be access. He adamantly denied the allegations levied against him. He believed that Amanda had "put ideas into Catherine's head" and "brainwashed" her.

It is difficult for RPs to be patient with the process. They want the process to move quickly. They may also ask the therapist to come out strongly against the AP, as a way to punish the AP for what he or she has done. The therapist needs to help the RP to be patient with the process so the best therapeutic outcomes can be attained.

When Amanda entered treatment, she explained she was being forced to participate and was not interested in supporting the reunification. She believed Catherine was old enough to make a decision as to whether she should have a relationship with her father. She supported Catherine's wishes. She explained that a lot of Catherine's complaints about Patrick reminded her of her marriage to Patrick, so she knew Catherine was telling the truth. She believed Catherine's emotional and physical safety were at risk. She felt Catherine was doing well in all spheres of her life and did not need her father to ruin things for her. She was concerned that therapy would cut into Catherine's full life and busy schedule.

The AP often is resistant to the treatment and reunification and will present as "child centered," manifest as supporting the child's wishes without question, and will generally want treatment to progress slowly. The therapy and reunification will be presented as a bottom of the list priority. The therapist will need to remind the AP that therapy is a high priority right now and the court is asking for regular feedback. The therapist will try to work within the child's schedule as much as possible, but the therapy must temporarily be given high priority.

Catherine entered treatment and easily shared her thoughts and feelings with me. She discussed how her father was a "sociopath" and had an "anger issue." As noted earlier, she claimed he yelled all the time and scared her. He also treated her like a "slave." She felt like Cinderella in his home. She stated she never had a good relationship or a positive experience with him. She did not want to see him again. She was only here because she was being forced to. She insisted nothing would change how she feels about her father and he will never change. She refused to see him because she was afraid he would get angry and hurt her.

The child typically enters treatment resistant to the therapeutic process and the reunification. Significant alliance building must occur so that the child will trust the therapist. The therapist will need to assure the child that he or she will be emotionally and physically safe during the therapeutic sessions. In addition, the therapist will need to use cognitive-behavioral therapeutic methods to begin to correct dysfunctional thinking patterns and to widen the child's belief system. Hyperbolic statements will also need to be addressed.

The Initial Reunification Sessions

In preparation for this meeting, I had coached Patrick how to most effectively initiate the interaction. He was informed he should thank his daughter for coming. I furthered explained the need for him to be understanding of and sensitive to her discomfort and distress. Working with Catherine, I had encouraged her to use me for assistance and support if she felt overwhelmed

in any way. I reassured her that she would be safe in the session. This was an opportunity for her to voice her concerns.

Catherine came into the initial reunification session with significant resistance and anger. She did not want to see her father. She again explained she was being forced to do this and that her mother was being forced as well. She was upset that her father was putting her in this position and explained this was another example of how her father did not love her. I spent time helping to calm her. We discussed again how she might use this session as an opportunity to share her thoughts and feelings with him.

When Patrick entered the session, Catherine did not make eye contact with him. Patrick opened up the conversation by saying hello and thanking Catherine for coming. He empathized with her discomfort and noted how difficult it must be to come and meet with him. He explained that he wanted to hear from her and hoped that she would be willing to share her concerns with him.

Catherine quickly began to raise all of her complaints about her father. After presenting her complaints, she expressed frustration that he never took her concerns seriously and always accused her of being “brainwashed” by her mother. She asserted that this insulted her because she has her own strong, independent mind. She also explained she has never loved him and considers her stepfather her “real” father. She wanted him, her biological father, to leave her alone.

The apology. A phenomenon that is almost universally present in these cases is the request for the apology. The AP and the child often will request that the RP apologize for indiscretions. This can be a particularly difficult hurdle to overcome because the RP will profess he or she is not guilty of these charges. How do you apologize for something that you didn’t do? A helpful suggestion is for the RP to apologize for hurting the child in any way. A blanket apology, which covers all past hurts and harms, is usually a successful approach to take with a child who is demanding an apology. For example, “I am so sorry that I have hurt you. I love you and never wanted to cause you harm. I hope that we can move past this.”

Catherine and Patrick discussed some of their previous experiences together. Not surprisingly, they had different recollections about some of the negative past instances. Catherine became upset and insisted Patrick was lying and that her version was the “truth.”

I then began working with Catherine about black and white thinking, encouraging her to be accepting of the fact that she and her father may not see things and remember situations exactly the same way. I explained this often happens in relationships and does not have to automatically imply truth versus lie. I pointed out that this was another example of black and white thinking and asked her to think of other hypotheses that might be contributing to the current impasse between them. She was able to identify other possible causes of their differing perceptions. For example, she entertained the possibility that maybe her father wanted her to relax because he knew how hard working and determined she was and not because he didn’t love her.

I asked Catherine how she felt now that she could entertain a different thought, to which Catherine explained that she felt less angry. Patrick explained to her that although they may not remember these past experiences identically, he fully acknowledged that she felt hurt on these occasions, and he was sorry about that. He reiterated that he wanted their relationship to be better than it was so that those negative incidents, which had come to define their relationship, could be minimized. He asked her to have hope that things could get better if they all worked on it together.

Different perceptions. Another common obstacle that arises during the reunification process is the differing perceptions of key events. The child will report his or her perception or version of an incident involving the RP; the RP will report his or her perception or version of the same incident. Not surprisingly, these versions do not always match. Again, it is typical for the child to return to black and white thinking and accuse the RP of being a liar, etc. Unfortunately, it is difficult to sort out the reality of the past. When this moment occurs, it is helpful for the clinician to educate both family members that it is common to have different perceptions, especially when there is an emotionally charged event. In the future, any difficult events that

arise can be dealt with in the therapeutic venue in a timely fashion. This will be the opportunity to discuss any difficult events that may arise. Unfortunately, sometimes the best that can be done is for the family members to acknowledge that someone was upset or hurt and apologize for that.

Treatment Goals

Examples of treatment goals with each family member are described below. These treatment goals were identified at the beginning of treatment and were targeted throughout the therapy.

Treatment goal for RP: Increase Patrick’s sensitivity toward Catherine. After hearing from Catherine about her concerns, I shared some of these concerns with Patrick so he could better understand them. He continued to deny that her concerns were valid, blaming Amanda’s brainwashing instead. I worked with Patrick to understand that it was important for him not to be dismissive about Catherine’s statements. Even if he disagreed with her “reality,” he still had to acknowledge her emotional experience. Patrick had gotten into a pattern whereby he blamed Catherine just as much as he blamed Amanda. He was able to understand this was not helpful to his relationship with his daughter. She was just a child and in an incredibly difficult situation. Patrick and I role-played various scenarios that typically arise in the initial parent–child reunification sessions. I provided feedback to Patrick when needed.

The RP needs to understand how to respond sensitively and empathically toward the child. Actual practice through role-play is usually needed. By the time the RP enters into treatment, he or she often knows in advance what the child’s complaints are, by either having heard them directly from the child or having read them in court filings. Therefore, it is important that the RP practices how to respond to the child’s concerns in session so he or she does not inappropriately confront or invalidate the child’s experience.

Treatment goal for AP: Increase Amanda’s support of Patrick in Catherine’s life. Amanda was quite dismissive of Patrick’s role in Catherine’s life. She saw him as unimportant. Catherine had men in her life who could serve in this father figure role. I worked with Amanda to understand the importance of having a biological father in Catherine’s life. Catherine was provided with reading material about the importance of fathers. She was also provided with material to understand her critical role in facilitating a relationship between a father and daughter. We discussed strategies that she could use between sessions to help reinforce this principle. For example, Amanda was instructed to talk with Catherine at least once during the week about how her father could potentially help her with something (e.g., homework, needing a ride).

Sometimes the lack of support from the AP is direct and verbal; other times it can be indirect and nonverbal. As an example, a child may leave a reunification session and show the AP a picture drawn in session. The AP does not remark, places the picture down, frowns, and does not respond to the child. And the child is then ushered out of the office. Although this parent never directly made a negative statement to the child, his or her nonverbal presentation and silence have been just as damaging. The child learned not to share positive emotion with this parent regarding the reunification sessions. It is important for APs to understand the ways they can undermine a parent–child relationship as well as the strategies they can use to bolster a parent–child relationship.

Treatment goal for the child: Increase Catherine’s problem-solving capacities. Catherine’s black and white thinking made it difficult for her to problem solve emotionally charged situations. She raised examples of problems that she had in her father’s household. We used these moments to discuss these situations, post hoc. For example, she voiced how her father wanted her to put away her laundry and would not let her get her homework done when she needed to. This led to a huge fight with both of them screaming at each other. Eventually, Catherine threw the basket of laundry across the room. Patrick responded by yelling at her. We discussed different actions that Catherine could have taken in that moment. Catherine was able to acknowledge that she could have asked her father if she could put away the laundry after her homework was done. The goal was to help Catherine understand that she can control only her

own behaviors and her and her father's actions are linked. By changing her responses, she has a better opportunity to change his responses.

Treatment goal for the family: Disrupt triangulation. I worked with Catherine and Amanda to help them understand that when they have a concern about someone, the best person to discuss this with is the person with whom they have that concern. When Catherine turns to Amanda to vent about her father, Amanda cannot truly help Catherine rectify the situation. The only thing she can do is emotionally support her, which can lead to further alignment of mother and daughter against father. Therefore, I worked with Amanda to redirect Catherine back to the source when she had complaints about her father or me. Both Amanda and Catherine agreed to follow this protocol.

One of the treatment goals is to disrupt the triangulated family system. This can be accomplished by informing each family member to directly communicate with the family member with whom they are upset. The therapist's task is to help the AP understand how he or she is participating in a triangulation and why this is unhealthy for the child. The AP would then be instructed to redirect the child back to the RP or the therapist. Most of the time specific instructions are needed. For example, if the child shares with the AP details of an upsetting experience during the visit, then the AP should respond: "I am sorry to hear that. Have you told RP yet? You should let RP know. He isn't able to make it better if he doesn't know what upset you." In addition, the AP can be instructed to share this information with the RP as a coparenting communication.

One Step Forward, Two Steps Back

As the treatment proceeds forward, it is common for the therapist and family to experience alternating progress and regression. After a successful transition point, it is normative for a family member to act in a way that will likely undo the progress and return the family to its previous mode of functioning. It is important for the therapist to remain steadfast during these times.

Although progress and regression is typical in any therapeutic process, it is even more extreme in the reunification process. The therapist will observe the tremendous progress in session, only to have the child return in an even more polarized state than when he or she began the family treatment. This can be quite discouraging to the therapist as well as the RP. However, as noted above, this is an expected and normative part of the process. Children and family members alike will fear the unknown and will not naturally trust in the progress. This resistance will need to be worked through with the therapist. It's important that the therapist work with both the AP and the child around the regression to get back on path. Again, the refocus should be on their anxiety and understanding that this is an attempt to recalibrate the family. The therapist's role is to attempt to stall further regression and encourage and support the family's efforts to move to a new, different way of functioning as a family.

The Crisis

After multiple sessions with Catherine and Patrick, they were ready to transition to community-based interactions. The idea was that they needed to begin rebuilding positive interactions and memories together. I informed Amanda of this transition and she was adamant this was not in Catherine's best interests. To her, it was okay for Catherine to see her father in a therapist's office but that was the extent of it. Amanda began to accuse me of being on Patrick's side and fulfilling Patrick's agenda. She believed that I was not listening to Catherine's concerns, including her daughter's fear of her father's anger when they were alone together.

Amanda came into my office and proceeded to yell at me and make accusations. Catherine was in the waiting room and overheard much of what Amanda said. When Catherine came into session, her head was down and she initially refused to talk. She felt that she had tried to be cooperative with what was being asked of her, but she was not okay with seeing her father outside of the therapy.

I asked Catherine what she was most afraid of regarding this next step. Catherine reiterated her original list of complaints against her father. I asked again what she was most afraid of. Catherine had no response, but she began to cry. I asked her if she overheard the last interaction between her mother and I, and she said she had and agreed with her mother. I told her that I was sorry that she overheard that and I suspected that she regularly overheard conflicts in her life, although most were likely between her mother and father. Catherine cried and explained that her parents were always fighting. She didn't want to see her father because at least then she had some peace and quiet in her life. I reminded Catherine that the goal of the treatment was for her to have peace and quiet and still have both of her parents in her life.

Children are so dependent on the adults in their life. To experience conflict, especially severe conflict between the adults on whom who they most depend, is overwhelming and unbearable to them. Children cannot cope with this level of stress and will make a Solomon-like decision if this will provide them respite.

I then had to “repair” with Amanda. I spoke with Amanda and similarly asked her what she was most afraid of if the visits were out in the community. I assured her that I would accompany Catherine and Patrick and further assured her that Catherine would be safe and comfortable. I also pointed that her accusations about me were not accurate—I was quite committed to trying to help their family move forward. I further explained that her daughter was not appropriately sheltered from her (Amanda's) own upset behavior toward me and it had a negative effect upon my therapeutic relationship with Catherine. I pointed out that these types of actions likely negatively affected Catherine's relationship with her father. I suggested that a change in this behavior should be a goal for her and encouraged her to work with her own individual therapist on this particular goal.

Just as any good movie has a climax and any good song has a crescendo, reunification therapy typically will have at least one crisis or climax within the treatment. At some point during the treatment, the therapist will typically become the rejected, hated object. At this point, distortions and misperceptions may begin to be reported by the child and/or AP. However, instead of this involving the RP, it will involve the therapist. Allegations may be levied against the therapist. At the less extreme level, the therapist may be accused of being imbalanced and partial toward the RP. At more extreme levels, the therapist may be accused of having an improper relationship with the RP or even being “paid off” by the RP. The therapist may even be accused of lying, child abuse, and more. The goal is to alienate the therapist from the family system. Rejection and dismissal of the therapist is the objective, which will then interrupt the movement toward parent and child reunification.

If the family can work through this crisis with the therapist, then healing and repair can begin within the family system. When this crisis occurs, it is important that the therapist address the clients' thoughts and feelings directly. For example, the therapist may point out to the child that he or she has misperceived or misreported on a situation. The therapist may discuss his or her own perception and recall. By verbalizing what is going on in the room, the therapist can assist the child in understanding the interpersonal dynamics that are present. Thereafter, by being able to repair and move forward with the therapist, the child can use this experience as a way to do this successfully with the RP. This may also occur with the AP. For example, the AP may turn to other professionals, complaining about the family therapist and trying to gather support from others. The therapist can then point out to the AP that he or she is engaging in triangulating behaviors and try to redirect the AP to address concerns with the therapist. Again, this can assist the AP to learn these skills and understand how these behaviors are not helpful within the family system as well.

Outcome and Prognosis

Ultimately, Catherine was able to successfully reunify with her father. The first couple of weeks were spent in my office and then we moved out to community-based visits. Initially, I accompanied Catherine and her father on these visits, which then transitioned to my presence only at the start and the end of the visit. This allowed an opportunity for any therapeutic work to be conducted contemporaneously with parent–child time. Catherine then agreed that she was ready

to go back to her father's home, but that she wanted to go for daytime visits only. Therefore, I again accompanied her on this transition to help the family with this next transition.

The transition to overnight contact was the most difficult step for Catherine, above and beyond the first visit. I worked with Catherine to identify what her fears were and to problem solve these concerns. For example, Catherine was worried that she would miss her mother. Therefore, a plan was set in place in which Catherine's first overnight visit with her father ended the following morning so that she could reconnect with her mother. Within 3 months, she was having overnight visits and full weekends with her father. They successfully returned to the original parenting plan, as the court had initially requested.

Catherine was able to express openly in my office that the time with her father was going well. She was also enjoying having another female in the home with her father. She enjoyed the "girl time" with her father's girlfriend. Catherine improved in asserting boundaries with her mother, particularly regarding her relationship with her father. However, she still found herself not openly sharing with her mother those positive experiences that occurred during her father's parenting time. In fact, later in the treatment, Catherine explained that she was starting to wonder if her mother wanted her to hate her father. This insight arose toward the end of our therapeutic work together. Catherine began to have a flood of memories around statements that had been made by her mother. She also was feeling much angrier toward her mother in general. I helped her to process through these memories and her feelings of anger and upset. However, I also worked with her to not further split and triangulate her family. Even though she was angry with her mother, it was still okay to love her and have a relationship with her. I wanted to ensure that Catherine did not shift her alignment toward her father in an unhealthy manner, further perpetuating the original family dynamic.

Family therapy terminated after approximately 6 months, although during the last couple of months the sessions were more widely spaced. Amanda and Patrick were referred to coparenting counseling so that they would have continued support in their coparenting relationship (for a description of coparenting, see "A Model for Developing a Coparenting Relationship After Protracted Litigation: The Case of Antonia, a 14-Year-Old Caught in the Crossfire," by A. Rotter, in this issue). Catherine was referred for individual therapy so that she could continue to receive therapeutic support as a child in a high-conflict family system. Unfortunately, Amanda refused to engage in further individual therapy and the court did not order her to be in treatment. Patrick did reengage in individual therapy.

Clinical Issues and Summary

Treatment of high-conflict divorced families can be quite complex, replete with both therapeutic and pragmatic obstacles. When reunification therapy is prescribed for a family, the family has in essence reached their "bottom," even though they may not recognize it. Often, this therapy may be the final attempt in a long sequence of attempts to remedy the family pathology. If the therapy does not resolve the access issues, then the court may become involved and may order a temporary or permanent change in custody. Understanding how to treat these multifaceted families is integral to therapeutic success and the successful resolution of the family's legal matters.

Some helpful tips in treating these families are as follows:

- Work with each family member to understand the difference between a decision that a child can make and a decision that an adult should make. The child should be allowed to have a voice and to have choices. However, larger decisions such as choosing to have or not have contact with a parent are not developmentally appropriate. This principle will need to be reviewed regularly throughout the treatment.
- Provide feedback to the AP after each reunification session. Children can misreport after sessions, possibly because of high emotions in the session or pressure they may feel from the parent. Therefore, one way to work with this issue is to share details of the reunification session with the AP. Ideally, the child will share this information in the presence of the therapist. If this doesn't happen, then the therapist can share this information with the AP in the presence

of the child. It is important that the child confirm whether it was an accurate representation to avoid any potential distortions later.

- Children who reject a parent can present their concerns with strong, extreme language and labels. It is important that the therapist query the children for details and examples. By doing so, the child will see that the data they used to formulate their conclusions are scant or open to multiple meanings. This type of exercise teaches children the importance of avoiding hyperbolic language and statements and using actual details to present their concerns instead.
- If possible, the therapist should accompany the child on “firsts” because any change in the access quantity or quality may prompt a regression. For example, the clinician may need to be present the first time the child reenters the home of the RP or when the child and the RP spend some time together in the community. The therapist’s presence provides support to the child and the RP and helps to reduce the possibility of distortions and misperceptions.
- For any sessions that involve the child (individual or RP and child), the therapist should plan to meet with all family members, even if briefly. For example, after an individual session with the child, the therapist may meet with the AP briefly to discuss general themes of that session and/or goals for the week (e.g., child will respond to RP by text at least once daily).
- The child’s fear about seeing the RP is generally much greater than the fear experienced in the actual meeting. Typically, after the child sees the RP, he or she quickly sees that what was imagined was much worse than what actually occurred. It is important to educate the child about this common experience (i.e., how other children have responded) so that he or she has examples in advance of the session. After the session, the child’s success at getting through the first session and overcoming fear can be used as an example for other transition points in the therapy (e.g., going out together in the community).
- Shift family members’ focus to the present and future. Although reviewing past incidents is important, it is a he said/she said scenario. The parents will try to place the therapist into the role of a judge. However, the therapist ultimately will not know the truth and should not become a surrogate judge or assessor of “the truth.” Therefore, after processing relevant past instances, it is important to conduct therapeutic work in the present.
- Allow the child to provide feedback on the sessions as well as to the therapist per se. After each session, it is important that the therapist gathers feedback from the child. This demonstrates that the therapist cares about the child and respects the child’s thoughts and feelings and further models a reciprocal adult–child relationship that is not based on dependency, fear, or imbalance. The relationship is one that is based on concern and respect. The goal is for this type of modeling to transfer to the child’s relationship with both parents.
- In reunification cases, often it is impossible to resolve all treatment goals and issues. The family has a limited amount of time, energy, and resources available by the time they start treatment. Therefore, these treatments are usually short term and focused on the specific goal of the family returning to a parenting access schedule that allows the child to have a relationship with both parents.

Ethical Issues

Court-involved therapies bring forth a higher level of risk than typical clinical therapies. In fact, some organizations have detailed guidelines regarding court-involved therapy (AFCC, 2010). As noted previously, for reunification therapy, there is generally at least one family member (and sometimes several) who does not want to be involved in the treatment. This brings forth a complicated context in which to conduct the therapy. For example, the consent to be in treatment may be marginal at best if the family’s attendance is court ordered. In addition, the litigation and adversarial context brings forth additional risk. Through years of high conflict and/or litigation, these families are primed to externalize blame.

The therapist is an easy target. Below are some common ethical and risk management strategies family therapists should be aware of:

- Misperceptions and distortions can be relatively common. Documentation becomes even more critical because of this. Contemporaneous notes are very helpful. If this is not feasible, then note taking should occur right after the session.

- Similar to other types of exposure-based therapies, this type of reunification process can result in short term distress. Anxiety, fear, sadness, anger, and guilt are just some of the emotions that may be experienced within this therapeutic process. Some short-term distress is expected and normative. Change is being asked for, and emotional distress often accompanies change. Participants should understand that this may occur as a part of the process.
- Reunification therapy does not resemble typical therapy. For example, the therapeutic process in reunification therapy moves quicker, with more frequent and/or longer sessions. In addition, the therapist is more directive in this treatment modality. There is also a significant amount of coordination with other professionals. These typical differences should be explained to participants so that they are aware of what to expect. This is particularly true for individuals who have already been in a supportive-based therapy. This type of treatment can look and feel notably different than a supportive-based therapy.
- There often is a lack of confidentiality in the treatment process. In a reunification case, the family therapist may be asked to testify, and progress reports and updates may be issued. Participants should understand this lack of confidentiality. Any resistance and/or concerns will need to be worked through with family members.

Conclusion

Separation and divorce are two of the most traumatic processes that a family can go through. When the divorced family unit becomes highly conflicted, all members of the family suffer. However, this is particularly true for the children who must rely on their parents for support. Children of divorce are at a higher risk for parental estrangement and alienation. Previously, courts and clinicians struggled to address these parent–child relationships and access issues. Fortunately, there is now a much deeper knowledge and understanding about what these families need regarding legal and therapeutic interventions. This article is presented as another potential resource to consider when working with these families.

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