**Traditional Counseling/Family Therapy Fails Severely Alienated Children**[1]

By Robert A. Evans, Ph.D.

It is a myth that severely alienated children are best treated with traditional therapy techniques while living primarily with their favored parent. Unfortunately, professionals in both the legal and mental health fields continue to refer severely alienated children and rejected parents to these therapeutic approaches only to discover months later that not only has the situation not been resolved but has actually gotten worse. And regardless of these results, Courts will frequently order another round of same or similar treatment while the children remain living with the favored parent, the one alleged to be the alienating parent.

Research and clinical experience indicate that therapeutic treatment of children who remain under the care of their favored parent is unlikely to repair a rejected parent and alienated child's relationship; in fact, has frequently made the situation worse (Dunne & Hedrick, 1994; Fidler & Bala, 2010; Garber, 2015; Lampel, 1986; Lowenstein, 2006; Rand & Rand, 2006; Rand et al., 2005; Warshak, 2003a; Weir & Sturge, 2006). Furthermore, there are no studies that have demonstrated effectiveness of any form of psychotherapy in resolving severe alienation in children who have no regular contact with the rejected parent.

Some therapists treat alienated children's problems as a child's phobia to the rejected parent (Garber, 2015; Lampel, 1986). Having this perspective, they use cognitive–behavioral therapy methods, particularly systematic desensitization in which gradual exposure to the feared parent is paired with relaxation training (Garber, 2015). Garber gave two case illustrations using these methods. After 17 sessions interspersed with the therapist's ongoing support, an 8-year-old girl was able to tolerate only online contact with her alienated mother before litigation erupted and reunification efforts were suspended. The second case illustration reported that after seven sessions a 12-year-old boy was able to be nearly free of anxiety while *imagining* contact with his alienated father, yet the case report notably included no information about the child's actual reconciliation with his father.

Lampel (1986) reported on six cases using phobia reduction techniques; none resolved the child's alienation. One reason why phobia reduction techniques fail to overcome children's refusal to spend time with a parent is that most of these children, except preschoolers, do not really fear their rejected parent. If they act frightened of the parent, often this is a ruse to avoid contact. The lack of genuine fear is evident in the children's uninhibited denigration, expressions of hatred, and disrespect toward the rejected parent, as opposed to the obsequious or withdrawn behavior typical of children's interactions with a feared adult. Even with children who have learned to fear a parent, systematic desensitization may miss the mark for another reason. This treatment method helps children gradually overcome irrational anxieties toward places and objects (Wolpe, Brady, Serber, Agras, & Liberman, 1973). But an alienated child's aversion to one parent is not solely internally generated. Phobic

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[1] Adapted from *Ten Parental Alienation Fallacies That Compromise Decisions in Court and in Therapy,* by Richard A. Warshak, published in the Professional Psychology: Research and Practice, 2015, Vol. 46, 235-249

children are surrounded by adults who encourage them to overcome their fears and who emphasize the benefits of doing so. By contrast, alienated children who live in the home in which their problem arose are around a parent, and perhaps siblings or other relatives, who at the very least provide no effective encouragement to overcome their aversion, and in most cases actively contribute to its perpetuation.

As opposed to the poor response of alienation to traditional therapy techniques, marked reduction of alienation has been reported for children who were placed for an extended period of time with their rejected parent (Clawar & Rivlin, 2013; DeJong & Davies, 2012; Dunne & Hedrick, 1994; Gardner, 2001; Lampel, 1986; Rand et al., 2005; Warshak, 2010b, in press). Despite limitations such as small sample sizes and lack of random assignment to treatment conditions, the collective weight of the literature suggests that contact with the rejected parent is essential to healing a damaged parent– child relationship.

No evidence supports the efficacy of treating severely alienated children while they remain primarily in the custody of their favored, alleged alienating parent and out of touch with their rejected parent. Not only is such treatment unlikely to succeed, it postpones getting children the relief they need. When an evaluation finds that a child is severely and irrationally alienated from a parent, and that it is in the child's best interests to repair the damaged relationship, the evaluator should exercise caution about recommending a course of traditional psychotherapy while the child remains apart from the rejected parent.

Recommendations for therapy in such circumstances should include advice to the court about imposing (a) a time frame after which the impact of treatment will be assessed, (b) explicit criteria for evaluating progress and success of treatment, and (c) contingency plans in the event that the treatment is ineffective. For instance, if the judge informs the parties that a failed course of therapy may result in an increase in the child's time with the rejected parent or in a reversal of custody, this may help increase the child's motivation to participate meaningfully in treatment and the favored parent's support for treatment gains.

A therapist's facilitation of a child's complaints about a parent and rehashing conflicting accounts of the parent's past behavior may be counterproductive and prevent the parent and child from having experiences that move the relationship in a positive direction. Instead interventions can teach children and parents about (a) the nature of negative stereotypes, (b) the hazards of selective attention, (c) the ubiquity of perceptual and memory distortions, (d) the importance of recognizing multiple perspectives, (e) critical thinking skills, (f) effective communication and conflict management skills, and (g) the value of maintaining positive and compassionate relationships with both parents (Warshak, 2010b).

The court should be informed that psychotherapy is most likely to be effective if (a) there have been no prior failed attempts, (b) the parent with whom the child is aligned (i.e., the favored/alienating parent) is likely to cooperate and support the child's treatment and progress, and (c) the child has ample time to experience care and nurturing from the rejected parent. On the other hand, if one of more attempts

with psychotherapy have already failed to remedy the problem, if the aligned/alienating parent is likely to sabotage treatment, and if the child is empowered to avoid contact with the rejected parent, the court should understand that ordering another round of psychotherapy without changing the amount of contact the child has with each parent is unlikely to remedy the problem and may postpone or even prevent effective intervention until it is too late. In circumstances where treatment failure is highly likely and may aggravate problems, court-appointed therapists should not unnecessarily prolong treatment. Early in the treatment the therapist may feel ethically bound to inform the court that treatment should be discontinued.

Given the state of the art as described above, the question remains why do legal and mental health practitioners, in this area continue to refer alienated children and their rejected parent to non-specialized therapists?

The answer may lie in the fact that these cases are profoundly *counterintuitive*. As such, therapists who attempt to treat these cases without adequate skills are likely to find themselves presiding over a cascade of clinical and psychosocial disasters (Miller, 2013). The lack of awareness of the counterintuitive nature of parental alienation is a major problem that affects observations, findings, conclusions, decisions, and recommendations related to these cases. Exacerbating this situation are clinicians who have much experience in general, but lack deep expertise with alienation, tend to have great confidence in their incorrect conclusions. Not surprisingly people who attempt to use intuition to solve counterintuitive problems tend to have great confidence in their conclusions, whether right or wrong.

Accurately identification and proper management of alienation cases requires special expertise. The following is an attempt to illuminate why this is so[2].

1. *Alienating parents tend to present well; targeted parents tend to present poorly.* Dr. Miller (2018) describes alienating parents as presenting with the *Four C's.* the care "cool, calm, charming, and convincing". Effective alienating parents tend to be very good at manipulation and can manage impressions, including lasting initial impressions. Frequently this characteristic commonly emanates from a borderline, narcissistic personality disorder, and sociopathic types.

   Rejected parents, however, according to Dr. Miller (2018), tend to present with the *Four A's.* That is, "anxiety, agitation, anger and afraid". Targeted/rejected parents are victims of trauma, actually so are the alienated children, and they are trying cope with a horrific family crisis. Frequently they are attacked by professionals who fail to recognize the situation as counterintuitive (i.e., things are not what they appear to be). Alienating parents are frequently seen as more competent resulting a catastrophe for the family, especially the child.

[2] Adapted from *Why Do Specialists Say That Parental Alienation is Counterintuitive?* By Steven G. Miller, 2018, Parental Alienation International, newsletter of the Parental Alienation Study Group.

2. *Clinicians who do not specialize in this area often mistake pathological enmeshment for healthy bonding.* Pathological enmeshment is where a parent engulfs a child creating an unhealthy dependent relationship between them and the child. Children can be adultified or parentified where they are treated as a friend or a companion not as a dependent. The opposite is also frequently observed where the child is infantilized or treated as a younger child, i.e., as a baby, rather than their current chronological age. Either way, enmeshed children are treated in ways that are not age appropriate and puts the parent's needs before those of the children. Enmeshment involves serious boundary violations of the child and obliterates an boundary between parent and child. According to Hart, Brassard, Baker, and Chiel (2018), enmeshment is child abuse and can result in permanent damage to the child. Far too frequently mental health and legal professionals mistake pathological enmeshment for healthy bonding. What these professionals claim is that the child is simply very close to their parent. What is overlooked is that "very close" is too close, pathologically, and dangerously close. Included among the mistakes many make is their testimony that the alienating parent and alienated child have a healthy relationship and the favored parent show great empathy for the child. Pathological enmeshment does not indicate empathy, is anything but healthy and is comprised of severe boundary violations that are potentially life-threatening psychiatric emergencies.

3. *Even in the face of abuse, children rarely reject a parent unless there is a powerful alienating influence; when they do, the behavior of estranged children is markedly different than the behavior of alienated children.* Dr. Miller (2018) tells us: "It is counter instinctual for a child to reject a parent". Children do not behave in a counter instinctual manner unless they are manipulated by a third party. Also, children will rarely reject an abusive parent. This conclusion is supported by a large body of evidence that shows even maltreated children develop and maintain attachment relationships with their abusive parents (Baker, Creegan, Quinones, & Rozelle, 2016). Therefore, mental health and legal professionals need to understand that, in the absence of genuine abuse or even very significant neglect by a parent that in most cases of severe alignment are due to alienation—not estrangement. This becomes especially evident in the presence of multiple indications of alienating strategies and symptoms of alienation in the child.

Moreover, in cases in which a child vigorously rejects a parent, not merely resists contact, but openly and angerly rejects the parent, the estranged child does not resemble alienated children except in very superficial ways.

4. *In cases of severe alignment, children typically align with the abusive parent, not the non-abusive one.* Most mental health professionals agree with this although to some it sounds implausible, however, it is well-validated. Children are innately attached to their parents, even to abusive ones whom they fear may leave or abandon them. If a child is strongly aligned with one parent and has rejected the other parent in the absence of abuse or severe neglect by the rejected parent, there is a substantial probability that the

favored parent is an alienating parent. Accordingly, parental alienation should be a leading hypothesis, if not *the* leading hypothesis, in such cases.

5. *Parental alienation meets standard, generally accepted criteria for child abuse; there is no controversy about that among specialists in child maltreatment*. Some professionals still claim that parental alienation is not a form of child abuse. Here's why that position is untenable. First, parental alienation meets standard definitions of psychological maltreatment as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM-5) (*American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, 2013), the American Professional Society on the Abuse of Children (APSAC) (Hart et al., 2018), and the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). For example, the DSM-5's definition of Child Psychological Abuse is: "Child psychological abuse is non-accidental verbal or symbolic acts by a child's parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child." The APSAC and CDC definitions are substantially similar. The APSAC examples of psychological maltreatment are particularly instructive. One, listed under "EXPLOITING/CORRUPTING" [capitalization in original], is "restricting or interfering with or directly undermining the child's important relationships (e.g., restricting a child's communication with his/her other parent and telling the child the lack of communication is due to the other parent's lack of love for the child). Another, listed under "TERRORIZING" [capitalization in original], is "placing the child in a loyalty conflict by making the child unnecessarily choose to have a relationship with one parent or the other." Parental alienation clearly meets these criteria. In addition, it is firmly established that, as risk factors for major physical and mental problems in adult life—including premature death—psychological and emotional abuse are at least as damaging to children as physical abuse, and even sexual abuse (Anda et al., 2006; Binggeli, Hart, & Brassard, 2001; Felitti et al., 1998; Hart et al., 2018; Nurius, Green, Logan-Greene, & Borja, 2015; Spinazzola et al., 2014; Taillieu, Brownridge, Sareen, & Afifi, 2016). Furthermore, research has shown that adverse childhood experiences (ACEs) can cause structural damage to the brain (Anda et al., 2006) and even shortening of chromosomal telomeres (Mitchell et al., 2017), thus establishing that ACEs can cause damage at cellular and molecular levels. And yet, parental alienation cases are often managed, both in clinical practice and in court, as if parental alienation is not really abuse, or is of no major consequence. Astonishingly, one can actually hear an expert witness state that we don't really know if parental alienation is harmful. big deal.

6. *Since Parental Alienation is a form of child abuse, the #1 priority in such cases is to protect the child from further abuse*. This point should be self-evident. And yet, it is common for professionals to ignore or downplay the abuse issues and, instead, focus on the child's relationship with the rejected parent. Instead of taking appropriate measures to ensure the child's safety, they order or provide "reunification therapy." This is problematic for many

reasons, including the fact that, in moderate or severe cases, traditional reunification therapy virtually *never* works, and typically makes things worse (Clawar & Rivlin, 2013; Fidler & Bala, 2010; Miller, 2013; Reay, 2015; Warshak, 2010, 2015).

7. *Even when under court order, traditional therapies are of little, if any, benefit in regard to treating this form of child abuse* (Clawar and Rivlin, 2013). Clawar and Rivlin (2013) wrote *Children Held Hostage:Identifying Brainwashed Children, Presenting a Case, and Crafting Solutions*. The authors studied 1,000 cases and had their findings published by the American Bar Association. Chapter 1 is entitled "Brainwashing and Programming." Chapter 2 is entitled "Brainwashing techniques." Despite the authors' findings that traditional therapies were of little, if any, benefit, despite the fact that this has been well documented earlier, it is common practice for courts to order such therapies and for clinicians to provide them.

Why do clinicians continue to provide such therapies and how do they justify such practices? They either they declare that the child is not alienated (often in the face of massive evidence to the contrary), or they claim that they are not providing "traditional therapy," but rather, "family therapy." The problem is that traditional family therapy is precisely what studies have established does not work. In fact, effective therapies are *radically* different from anything that a non-specialist is likely to provide in an office setting.

8. *Not only are traditional therapies of little, if any, benefit in regard to treating parental alienation, but they usually make the situation worse, often catastrophically worse.* One of the oldest heuristics in medicine is "first, to do no harm." It would be difficult to find a more common yet egregious violation of this heuristic than an order for what amounts to traditional "reunification" therapy for parental alienation. Not only are such therapies known to be ineffective, but they are also known to be potentially harmful. To be sure, we do *not* have randomized, double-blind clinical trials to document this, but *do* we have copious case reports and much empirical as well as expert consensus among bona fide specialists. What's more, one would expect this to be true on theoretical grounds. For one thing, we know that such therapies waste time that could have been used to provide effective interventions. For another thing, effective therapies employ *radically* different approaches and techniques from those of traditional therapies. For instance, traditional therapies attempt to "validate" the child's feelings, encourage the child to express grievances, and give the child some "control" or choice while advising the rejected parent to listen, empathize, validate, and apologize (or even to "find something to apologize for"). This misguided approach runs rampant in some quarters where, referring to the parents, it is common to claim, "Both parties always participate." In effect, this further empowers the already over empowered child, and further disempowers the already disempowered parent. This is not only likely to be *futile*, but the exact opposite of what *effective* therapies do. *Effective therapies disempower the over-empowered child and re-empower the*

*disempowered rejected parent*. And this is only one major difference between effective and traditional therapies—there are more than a dozen. Seen in this light, traditional therapies are *contraindicated* except, perhaps, as a brief therapeutic trial (for a few weeks, not a few months) if and only if the diagnosis is unclear.

9. *In general, the risks of separating a severely alienated child from an alienating parent are very low, and the risks of permitting such a parent to remain in contact with such a child are very high*. If one conducts a proper, evidence-based risks/benefits analysis, it should be clear that the risks of separating a child from a toxic alienating parent are minimal. Moreover, upon removal, the risks go down, not up. Nevertheless, forensic experts often make irresponsible predictions in court to the effect that protective separation of the child from the alienating parent is dangerous and would do more harm than good. Such opinions are neither scientific nor evidence based. Warshak provides an excellent discussion of this point presented above. In addition Warshak cautions, "Custody evaluators should refrain from offering opinions that reflect sensationalist predictions lacking a basis in established scientific and professional knowledge" (Warshak, 2015).

**Conclusion**

These are but some examples of counterintuitive points barely scratch the surface. It is absolutely essential for those who deal with parental alienation to have a deep understanding of the issues presented herein. Those who attempt to manage such cases using intuition—even professional intuition—instead of a deep knowledge of the science, are likely to make catastrophic errors. Both mental health and legal professionals need to be aware of this.

This paper challenges one of many common assumptions that detract from the quality of timesharing and custody recommendations, treatment, and courts' decisions. Accumulation and awareness of the evidence exposing these false beliefs, and an open mind to future discoveries, should guide decision makers and those who assist them to avoid biases that result in poor outcomes for alienated children. The result will be a better understanding of the needs of alienated children and decisions that are more likely to get needed relief to families who experience this problem.

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