Mental health professionals’ practice of reintegration therapy for parent-child contact disputes post-separation: A phenomenological study

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Factor-Inwentash Faculty of Social Work
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Abstract

Over the last decade, family courts have seen an increase in the number of parent-child contact problems and allegations of alienation. Children resisting or refusing contact with a parent post-separation pose considerable challenges to the mental health professionals tasked to work with them.

Reintegration therapy (RT) has recently evolved to help ameliorate parent-child contact issues and alienation. However, little is known about what consensus exists on RT, or how it is defined and delivered by mental health practitioners. Limited evidence exists on treatment models, or evaluations of RT, and no standards or practice guidelines are available for the treatment of parent-child contact issues.

The purpose of this study was to: 1) Explore how RT is defined and practiced among experienced mental health professionals in Canada and the United States; 2) identify underlying theory informing practitioners’ understanding of the issues and on clinical practice in RT; and 3) use findings for practice recommendations to advance knowledge for clinical practice with this population. To this end a hermeneutic, phenomenological design was chosen to elicit thick descriptions for a phenomenological analysis and theme development. A purposive sample of fourteen (14) practitioners was obtained. Initial analysis revealed substantial variance among practitioners’ training, underlying theoretical frameworks, clinical approaches and service
delivery models utilized.

Three distinct themes/subthemes emerged from in-depth analyses representing a measure of consensus among respondents. First, RT is generally viewed as a therapeutic process to help improve family relationships as a whole. Second, participants identified frequently used assessment criteria necessary for determining suitability for RT. Finally, agreement on overall treatment goals for families participating in RT was identified. These study findings illustrate the need for more and better-developed training in RT, integrated theory development, and the creation of best practice guidelines based on scientific and rigorous evaluation preferably using a longitudinal approach.
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Chapter 1
Introduction and Research Focus

Introduction

The process of separation and divorce\(^1\) often involves significant changes in family relationships and dynamics. Upon separation, pre-existing adult relationship patterns come to an end, assets are divided, and the former couple and children that were once a nuclear family living together in one home will transition to a bi-nuclear family living in two homes. In the vast majority of cases, children will travel between homes and spend time in both parent’s care (Cancian, Meyer, Brown & Cook, 2014).

The physical and emotional changes in the family require parents to restructure their individual parenting roles and responsibilities. To ensure active parental participation and continuity of care for the children involved, parents must develop a new co-parenting relationship that includes frequent communication, cooperation and collaboration to maintain similar expectations and parenting practices. Needless to say, the entire family may experience a myriad of emotions associated with the physical, emotional, and psychological tasks of renegotiating family relationships (Emery, 2012).

Studies show that at 40% of parents are moderately or extremely angry during the initial separation period and engage in intense conflict as they adjust to the breakdown of the relationship (Kelly, 2004; Johnston, Roseby & Kuehnle, 2009). The normative course for 75-80% of separating couples is a reduction in anger, hostility and conflict over a period of two to

\(^{1}\) While the terms separation and divorce have different legal definitions and implications, these terms are used interchangeably, hereinafter, unless stated otherwise.
three years as the couple begins to emotionally disengage from each other, accept their new social reality, and move forward with their separate lives (Hetherington & Kelly, 2002; King & Heard, 1999). These bi-nuclear families stabilize and are able to maintain healthy inter-parental co-parenting encompassing effective communication patterns, clear boundaries, and healthy parent-child relationships. They will co-parent their children in a synchronized fashion and generally experience low conflict in the ensuing years (Hetherington, 1999; Johnston et al., 2009; Kelly, 2012; Maccoby & Mnookin, 1992).

Longitudinal data report that approximately 20% of parental relationships remain conflictual six years post separation (Hetherington & Kelly, 2002). Estimates based on litigation rates suggest that approximately 10% of parents will remain stuck in “high conflict” (Johnston et al., 2009; Maccoby & Mnookin, 1992). At the moment, no formal definition of “high conflict” separation/divorce exists with much ambiguity in its use.

High conflict families have been characterized by high levels of anger, hostility and distrust, aggression, protracted litigation, discordant co-parenting, involvement of multiple professionals (e.g. police, child welfare agencies, assessors, guardian ad litem/children’s lawyers, therapists etc.) and strained parent-child relationships which continues two to three years post separation (Birnbaum & Bala, 2010; Fidler, Bala & Hurwitz, 2014; Johnston & Roseby, 1997; Johnston et al., 2009; Maccoby & Mnookin, 1992). According to Birnbaum and Bala (2010), there has been a noticeable increase in the use of the term “high conflict” among Canadian judicial decisions over the last decade. The ambiguity in the definition of “high conflict” has allowed for other descriptive terms such as “acrimonious”, “toxic” or “warfare” to be used interchangeably and indiscriminately within the family law arena. In Canada, courts will often refer to a family as being “high conflict” when deciding whether or not it is appropriate for joint
custody due to the presumption against joint custody in cases of “high conflict (Birnbaum &
Bala, 2010). Researchers report that families characterized by “high conflict” take up an
inordinate amount of the court and professionals’ time (Neff & Cooper, 2004; Johnston et al.,
2009). Overall, there is recognition that families characterized by high conflict pose significant
challenges. It is unclear and there are limited empirical studies or assessment tools available to
help differentiate between what is considered “normal conflict” to that which is “high conflict”
post-separation (Birnbaum & Bala, 2010).

Impact of High Conflict

Extensive divorce research has revealed that it is the high inter-parental conflict, as
opposed to the act of separation itself that is the most significant predictor in children’s
maladjustment and overall functioning (Amato, 2001; Amato, 2010; Booth & Amato, 2001;
Kelly, 2000; Kelly & Emery, 2003; Kelly & Lamb, 2000). This is empirically supported with
multiple studies demonstrating that children from low conflict divorced homes show better
functioning and overall well-being than children from intact families fraught with high conflict
(Amato & Keith, 1991; Amato, 2001; Buehler et al., 1997; Coleman & Glen, 2010; Cummings,
George, McCoy & Davies, 2012; Emery, 1982; Hetherington & Kelly, 2002; Johnston, Gonzalez
& Campbell, 1987; Johnston & Roseby, 1997; Johnston et al., 2009; Kelly, 2000; Sandler, Mills,
Cookston & Braver, 2008). Studies show mixed results on whether pre-divorce conflict or post-
divorce conflict is a more potent predictor of children’s maladjustment. For instance, Buehlar
and colleagues (1997) and King and Heard (1999) found that marital conflict was a more potent
predictor of children’s maladjustment, whereas Hetherington (1999) reported post-divorce
conflict had more adverse effects than marital conflict. In contrast, Booth and Amato (2001)
found no relationship. Nevertheless, it is agreed that high conflict is contraindicated and contributes to children’s psychological and social adjustment problems in both situations.

Researchers report that the type of conflict most consistently associated with negative outcomes for children, in both intact and separated families, is conflict where children become involved in the parental dispute (Fosco & Grych, 2010; Kelly, 2012, Kelly, 2000), conflict that results in children feeling distress or impacting their emotional security after witnessing or becoming involved (Cummings & Davies, 2011; Cummings & Miller-Graff, 2015), and conflict resulting from child-related disagreements (Grych, 2005).

Children exposed to high levels of inter-parental conflict are at increased risk for emotional and behavioural problems including: depression (Amato & Keith, 2001; Buchanan, Maccoby & Dornbusch, 1996), anxiety (Amato & Keith, 2001; Buchanan, Maccoby & Dornbusch, 1996), anger and aggression (Amato & Affifi, 2006; Amato & Keith, 2001; Hetherington, 1999), low self-esteem (Hetherington, 1999), delinquency (Amato & Keith, 2001; Kelly, 2000; Kelly & Emery, 2003; Hetherington, 1999) academic decline (Amato & Keith, 2001; Hetherington, 1999; Kelly, 2000) and deterioration in the parent-child relationships (Amato & Keith, 2001; Amato & Affifi, 2006; Fosco & Grych, 2010).

**Strained Parent-Child Relationships Post Separation: A Social Issue**

Extensive national and international studies have revealed that children of divorce generally show better outcomes on measures of emotional, behavioural, psychological, physical and academic well-being when they maintain close emotional bonds, frequent contact and quality relationships with both parents (Amato & Gilbreth, 1999; Amato & Sobolewski, 2001; Booth, Scott & King, 2010; Fabricius & Luecken, 2007; Fabricius, Braver, Diaz & Velez, 2010, 2012; Kaspi et al., 2009; Kelly, 2000; King & Sobolewski, 2006, Lamb, 2002, 2012; Melli &
Brown, 2008; Pruett, McIntosh & Kelly, 2014). Fabricius and Leucken’s (2007) study of 1,154 college students found that the more time a child spent with a supportive father (non-custodial parent) the better their relationship was with that parent independent of the amount of conflict between the parents. Having a warm and close relationship with both parents was associated with better psychological, social and academic outcomes (Amato & Gilbreth, 1999; Booth et al., 2010; King & Sobelowski, 2006). This research finding has contributed to greater awareness among policy and decision makers and custody law reforms that support and encourage healthy parent-child involvement and relationships post-separation (Kaspiew et al., 2009; Kelly, 2012; Lamb, 2012; Nielsen, 2013a, 2013b; 2014; Warshak, 2014).

While most children will continue to want contact and have a relationship with both parents post-separation (Cashmore & Parkinson, 2008; Cashmore, Parkinson & Taylor, 2008; Cashmore & Parkinson, 2009; Johnston, 2005; Parkinson, Cashmore & Single, 2005), a subgroup of children will resist or refuse having contact with a parent post-separation while remaining aligned with the other parent (Fidler & Bala, 2010; Saini, Johnston, Fidler & Bala, 2016). The term strained parent-child relationship has been used as an umbrella term to describe various types of compromised parent-child relationships.

A child may resist or refuse a parent for developmental reasons such as: age, gender, specific interests, or personality traits; feelings of anger, hurt or guilt resulting from the separation; ongoing and chronic high parental conflict; having experienced or witnessed abuse, neglect or poor parenting; or the presence of alienation (Fidler & Bala, 2010). Parental alienation is a generic term that has been widely used to describe a child who has been influenced to reject one parent. In extreme cases, the term is used to describe a child who has been ‘brainwashed’ or ‘indoctrinated’ by a malicious parent to reject the other (Saini et al., 2016). An alienated child
will persistently resist and/or refuse contact with a parent post-separation and holds negative feelings and beliefs that are disproportionate to the actual experiences they shared with that parent prior to the separation (Gardner, 2001; Kelly & Johnston, 2001; Fidler, Bala & Saini, 2013).

The frequency of reported strained parent-child relationships and allegations of alienation following separation has increased in family courts (Bala, 2012). In response to this increase, a number of therapeutic programs have evolved in an attempt to help improve these relationships. Reintegration therapy (RT) is a recently developed therapeutic approach intended to improve strained parent-child relationships, parent-child contact issues and alienation (Baker & Sauber, 2013; Fidler et al., 2013; Judge & Deutsch, 2016). However, there is a lack of consensus on how reintegration therapy is defined and delivered by mental health practitioners and a lack of evidence on the effectiveness and efficacy of these interventions. Using an interpretive phenomenological research design, this study explores how reintegration therapy is defined and practiced among mental health professionals. The rationale behind this study and specific guiding research questions will be discussed in greater detail later in this chapter.

Prevalence Rates

Prevalence rates of children that resist and/or refuse contact remain unclear and vary depending on the operational definition and the sampling strategy used. For instance, Johnston’s studies (1993, 2003) revealed that 15% of children from community samples and 21% to 27% of court-involved custody-disputing families were rejecting of one parent while remaining aligned with the other. In contrast, Lampel’s (1996) study of custody litigating parents and their children examined children’s alignment towards one parent. To test for alignment, the Family Relation Test was used (FRT, Bene & Anthony, 1985). The FRT provides a child, ages four through
fourteen years, with mild and strong positive and mild and strong negative statement written on small cards that a test administer reads to the child. The child then assigns the cards to boxes that represent family members that include, but are not limited to parents, siblings, stepparents and grandparents. The affect associated with each person is assessed based on the number of positive and negative cards placed in each box. Positive messages were given a positive weight, and negative messages were given a negative weight. The relationship with the parent was labeled “aligned” if the sum was above zero for one parent (the preferred parent) and at or below zero for the other parent (the nonpreferred parent). Results revealed that of the 24 children, 11 (45.8%) were nonaligned, with positive scores for both parents. Three children had scores of zero for both parents but positive scores for other family members, typically grandparents. However, 10 (41.7%) of the 24 children had positive scores for one parent and negative scores for the other parent and considered ‘aligned’. When using this much broader definition of alignment, findings significantly increased to 40%.

Research findings reveal that a number of children resist and refuse parental contact in intact, separated, divorced and litigating families but are reported in greater frequency among separated and custody litigating families (Hands & Warshak, 2011; Johnston, 2003; Moné & Biringen, 2006). Research also reveals that children will resist and reject both mothers and fathers equally with the non-custodial parent more often being the rejected parent. Among the litigating sample in research and case law, fathers are more likely to be the non-custodial rejected parent (Bala, Hunt & McCarney, 2010; Lavadera, Ferracuti & Togliatti, 2012; Lopez, Iglesia & Garcia, 2014). Within the research literature, in cases where children resist or refuse parental contact, the custodial parent is also referred to as the “favoured”, “preferred”, “aligned”, or
“alienating” parent whereby these terms are used interchangeably. The non-custodial parent is referred to as the “targeted”, “rejected”, “non-preferred,” or “alienated” parent.

**Underlying Legislation**

When parents separate, and seek a legal determination of the custody of their children, courts in most jurisdictions use a “best interests” approach for allocating physical and legal custody. Ontario courts follow the Best Interests of the Child principle pursuant to s. 24(2) of the *Children’s Law Reform Act* and the Maximum Contact Principle pursuant to s. 16(10) of the *Divorce Act*. The best interest statute provides a list of eight factors judges take into consideration in making decisions and Orders during custody and access disputes. Factors include: the child’s emotional welfare; the love, affection and emotional ties between the child and each parent, the wishes of the child if they can be reasonably ascertained; and the willingness of each parent to facilitate, support and encourage the other parent’s access to the child, also known as the “friendly parent principle” (Divorce Act, 1985).

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2 s. 24(2) – The court shall consider all the child’s needs and circumstances, including,
   (a) the love, affection and emotional ties between the child and
      a. each person entitled to or claiming custody of or access to the child,
      b. other members of the child’s family who reside with the child, and
      c. persons involved in the child’s care and upbringing;
   (b) the child’s views and preferences, if they can reasonably be ascertained;
   (c) the length of time the child has lived in a stable home environment;
   (d) the ability and willingness of each person applying for custody of the child to provide the child with guidance and education, the necessities of life and any special needs of the child;
   (e) any plans proposed for the child’s care and upbringing;
   (f) the permanence and stability of the family unit with which it is proposed that the child will live;
   (g) the ability of each person applying for custody of or access to the child to act as a parent; and
   (h) the relationship by blood or through an adoption order between the child and each person who is party to the application.  2006, c.1, s. 3(1)


3 s. 16(10) – In making an order under this section, the court shall give effect to the principle that a child of the marriage should have as much contact with each spouse as is consistent with the best interests of the child and, for that purpose, shall take into consideration the willingness of the person for whom custody is sought to facilitate such contact.

The maximum contact principle ensures parents are facilitating contact and the child has as much contact with each parent as is consistent with their best interests. Of note, the term maximum contact does not imply or mean equal contact between the parents.

In the United States, S. 402 [Best Interest of Child] of the *Uniform Marriage and Divorce Act*[^4] (uMDA) is the legal test used by judges when making Orders for child custody and access disputes post-separation. The uMDA is the foundation for individual state laws and the factors identified and described are similar to those outlined in Ontario.

These legal standards are consistent and take into account recent empirical social science research which maintains children generally have better psychological and emotional outcomes when they maintain close relationships with both parents post-separation (Adamson & Johnson, 2013; Bala et al., 2010; Fabricius & Leucken, 2007; Fehlberg, Smyth, Maclean & Roberts, 2011).

Further, almost all countries around the world, except for the United States, have ratified the *United Nations Convention on the Rights of the Child*[^5], giving children the right to participate

[^4]: § 402. [Best Interest of Child], *Uniform Marriage and Divorce Act* [1974]

The court shall determine custody in accordance with the best interest of the child. The court shall consider all relevant factors including:

1. the wishes of the child's parent or parents as to his custody;
2. the wishes of the child as to his custodian;
3. the interaction and interrelationship of the child with his parent or parents, his siblings, and any other person who may significantly affect the child's best interest;
4. the child's adjustment to his home, school, and community; and
5. the mental and physical health of all individuals involved.

[^5]: *Convention on the Rights of the Child*

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49

*Article 12*

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

in the family justice system and legal disputes involving their care (Cashmore & Parkinson, 2009). This allows courts to factor in the children’s views and preferences when making decisions involving their custody and access time with each of their parents.

In the context of custody disputes, legal and mental health professionals are challenged when children resist contact or indicate it is their wish and personal right to reject contact with a parent post-separation. This is especially problematic when in tandem, the rejected parent alleges the child has been alienated, unduly influenced and/or that the child’s decision is unjustified and not in their best interests (Bala, 2012).

Family courts have seen a significant increase in the number of parent-child contact problems and allegations of alienation and unjustified rejection of a parent in the last decade (Bala, Hunt, & McCarney, 2010). While the reason for the significant increase in contact problems are unknown, one can speculate it may be due to growing public and professional awareness on this issue and the rampant use of the term parental alienation (Bala et al., 2010). It may also be due to recent court reforms that promote joint custody arrangements combined with the shifts among families over the years. At the moment, there are more women in the workforce and greater levels of paternal involvement than ever before (Pruett, 2015, 2016; Spinks, 2013). The current social climate values dual parental involvement with a strong ideological commitment to co-parenting post-separation. These factors, in conjunction with the high divorce rate, may leave many parents vigilant and hypersensitive to contact issues.

**Legal and Therapeutic Approaches to Parent-Child Contact Problems**

There are several possible dispositions if a court determines that a child’s resistance or rejection of a parent is unwarranted, unjustified and not in the child’s best interests.
In the least intrusive case, judges will educate the parents that stand before them on the importance of children having a relationship with both parents. Judges can refer parents to general psycho-educational programs that are exclusive to separated families with the hopes that it will help improve their co-parental relationship. There has been a proliferation of psycho-educational programs designed for parents post-separation over the last decade in North America (Salem, Sandler & Wolchik, 2013; Sigal, Sandler, Wolchik & Braver, 2011). These programs are specifically tailored to help improve the co-parent relationship, but are not specifically designed to deal with parent-child contact disputes.

In the most intrusive and severe cases, judges will order the placement of the child in the custody of the rejected parent (often the non-custodial parent), or a neutral space (e.g. foster home) and may suspend or require supervised contact to the former custodial parent (Fidler et al., 2013; Warshak, 2010). This measure has been referred to as a “parentectomy” within the research literature. It typically occurs after multiple failed attempts to remedy the contact problem and when the court has found there to be alienation and determined that parent-child contact is in the child’s best interests (Bala & Herbert, 2017). In Bala, Hunt and McCarney’s study (2010) they found the court made a determination of alienation in 16 of 51 (31%) cases where alienation was alleged. Of the 16 cases, 12 (75%) resulted in an order for a reversal of custody to the rejected parent.

In other cases, the court may decide that there is no resolution possible without fear of doing greater damage. In these cases, the court may determine it is beyond the scope of its authority or power to force a child of a certain age to undergo treatment or have contact with a parent (Warshak, 2010). This typically occurs in cases where children are older or in cases where
there is fear the child may put their own life at risk. In this case, the status quo is maintained and the parent-child relationship is potentially lost.

Another approach being utilized in attempt to help remedy parent-child contact issues and improve the parent-child relationship is therapy. This therapy has been referred to as “reintegration therapy” or “reunification therapy” interchangeably within the research. Other terms that have been used include “reconciliation” or “family focused” therapy for parent-child contact problems. Recently, Walters and Friedlander (2016) used a behavioural description calling it therapy for the intractable resist/refuse dynamic. At the moment, there is no consensus on what term one should use to label this therapeutic intervention. For consistency, the term reintegration therapy (RT) will be used throughout.

A review of Canadian case law from 1989-2008 revealed judges ordered reintegration therapy as a potential remedy in 27% of cases where it was alleged that children were unjustifiably resisting or rejecting parental contact (Bala et al., 2010).

This researcher suspects this number has since increased as more parent-child contact issues are being brought forth along with greater general awareness and sensitivity to this hot topic.

**Research Focus: The Problem**

Over the last ten years, there has been a significant increase in the number of innovative outpatient and intensive/residential programs that have been developed for children who resist or refuse parental contact (Polak & Moran, 2016). Interventions vary from whole family approaches to parent-child interventions in both outpatient and multi-day intensive (i.e. residential) formats. Despite the increase in the number of court orders that mandate this therapeutic approach, along with the mental health professionals that carry out these
interventions, there is a lacuna in the research literature on evidence based assessment criteria to differentiate the types of parent-child contact problems, evidence based treatment models and evaluations of these approaches. A large gap exists between research and clinical practice where it is uncertain which families, what circumstances, and what reintegration treatment approach is most likely to help ameliorate the strained parent-child relationship and contact problem.

Currently, no guidelines or standards of practice exist for the treatment of parent-child contact issues. This results in multiple clinical opinions and multiple approaches being used to address this complex and controversial issue among practicing mental health practitioners.

There is a lack of consensus and questions around: (1) what is considered to be reintegration therapy; (2) under what circumstances is reintegration therapy practiced; (3) how is reintegration therapy practiced; (4) what underlying theory informs professionals’ clinical practices; and (5) what are the goals of this therapy.

The lack of knowledge and understanding in this area leaves many mental health professionals with little direction on how to navigate and clinically engage with families who present with parent-child contact issues. This results in the possibility where depending on a mental health professional’s awareness, understanding, training, and personal bias around this issue, different therapeutic approaches may be offered to the same family. Within practice, it is not uncommon to encounter contrasting opinions for the same family depending on how the mental health professionals’ understanding of this issue informed their assessment and subsequent therapeutic practice.

To further compound this issue, these families are also frequently involved in litigation. This leaves many mental health professionals who enter this work with good intentions vulnerable to the unfamiliar legal landmines that often accompany these complex and
contentious cases. For instance, lawyers may call the therapist as a witness or place the therapist in the erroneous position of providing parent-child access recommendations, based on therapeutic progress. The complexity and controversy of these cases combined with the involvement of the legal system leave many mental health professionals unwilling to enter this terrain.

**Study Objective**

Given the wide array of reintegration therapeutic practice approaches available, along with minimal research evidence to guide mental health professionals, using an interpretive phenomenological approach, the purpose of this dissertation is to address this gap, generate knowledge, and develop a greater understanding on how reintegration therapy is understood and practiced among experienced mental health professionals in the field. A further goal of this research is to identify theoretical constructs underlying this therapeutic intervention. Experienced mental health professionals are able to provide rich, descriptive accounts of their experiences in providing this therapy, and the underlying theoretical framework(s) that inform their practice.

Generating this knowledge can help advance the field of social work by creating a common understanding of what constitutes reintegration therapy and its practice. It can inform practice through the development of a knowledge base for providing competent and effective practice when working with this difficult and vulnerable population. As well, it can help develop some level of standardization to this new and underdeveloped area of practice.

**Guiding Research Questions**

The primary research questions guiding this dissertation include:

1. What is the experience of mental health professionals practicing reintegration therapy?
a. In what ways are they informed in the practice of reintegration therapy?

b. How is reintegration therapy typically provided? (E.g. assessment criteria, clinical modalities used, service delivery models, etc.)

2. What theoretical framework(s) guide mental health professionals’ practice of reintegration therapy?
   a. What theoretical constructs can be identified in the practice of reintegration therapy?

3. From the mental health professional’s perspective, what are the short and long term goals of reintegration therapy?

Chapter Summary

This chapter provided information on the impact of high conflict separation and divorce in children and families. Focus was given to the increase in strained parent-child relationships and contact problems that develop in high conflict separated families. The term alienation was described and legislative information on children’s custody and access arrangements post-separation was provided. Attention was given to the different judicial and therapeutic approaches currently used to manage parent-child contact problems and alienation. Reintegration therapy was presented as a recently developed clinical approach used to improve strained parent-child relationships, parent-child contact problems and alienation.

While the courts are frequently ordering reintegration therapy, no guidelines or standards of practice exist for this therapy. There is a lack of consensus and questions around: (1) what is considered to be reintegration therapy; (2) under what circumstances is reintegration therapy practiced; (3) how is reintegration therapy practiced; (4) what underlying theory informs professionals’ clinical practices; and (5) what are the goals of this therapy.
Using an interpretive phenomenological research design, the current study will explore how reintegration therapy is understood and practiced among experienced mental health professionals in the field. Arriving at some consensus on reintegration therapy is desperately needed given the disparity currently noted among practicing professionals.

Chapter two of this study provides information on how strained parent-child relationships is conceptualized. This chapter provides the reader with the terminology currently used within research and practice. The historical development of how strained parent-child relationships and, in particular, alienation was considered in the field and the associated debates and controversy is presented.

Chapter three of this study highlights relevant psychological theories that have been used to help understand strained parent-child relationships and alienation. In particular, feminist theory, attachment theory, cognitive theory, family systems theory and ecological systems theory are applied to help explain and/or understand the development of strained parent-child relationships and alienation. A review of the available empirical evidence on alienation is provided.

Chapter four of this study presents the theory and empirical evidence available on reintegration therapy. The different models of reintegration therapy and their underlying theoretical frameworks are provided.

Chapter five of this study focuses on the design and methodology used for this study. Interpretive phenomenology using McCracken’s (1988) Long Interview model is described in detail as the research design used for this study.

Chapter six presents the findings from this study. A thick description of the training, theory, clinical techniques and service delivery models used by the study’s respondents is
provided. In addition, common themes that surfaced from the in-depth analysis of the data are presented.

Lastly, chapter seven offers a discussion of the study’s results. Implications of this study’s results for mental health practitioners currently practicing reintegration therapy are offered along with future research recommendations.
Chapter 2

Conceptualizing Parent-Child Contact Problems and Historical Development

Parental alienation has all the features that make a great story: a heartbroken parent, an evil ex, and a victimized child. If real life were like Hollywood, the story would eventually end with the evil ex being punished (or seeing the light and repenting) and the formerly heartbroken parent re-united with their now loving and devoted child. Unfortunately, real life is not Hollywood, and such picture-perfect endings rarely occur. In this case it is the mother who is the Director and the key person to determine if there will be a happy ending, or if this saga will continue for years to come to the detriment of the children. While both parties, their families, and their friends have each played a role in this ongoing battle… J. Ingram [Ciarlariello v. Ciarlariello, 2014 ONSC 5097]

This chapter beings by providing the reader with information on how strained parent-child relationships and contact problems are currently conceptualized within the research literature and presents the terminology used to describe the different types of parent-child relationships. Following, historical information on how strained parent-child relationships and contact problems have developed over the years is presented. Various conceptualizations have been described, each with different terminology, theory of etiology, perpetuating factors, and treatment approaches. Understanding the historical development is critical as it can provide context to the underlying theories that have been used to help explain this phenomenon. Attention is also given to the controversy and debates that have accompanied this issue over the years.
Conceptualizing Strained Parent-Child Relationships on a Continuum

Parent-child relationships have been depicted as falling on a continuum, from positive and healthy to negative and pathological (Kelly & Johnston, 2001). This continuum provides front line mental health professionals and researchers with a differential approach to understanding parent-child contact problems among separated and divorced families. At the healthiest end of the continuum, and in the majority of cases post-separation, children want to spend a significant amount or equal amounts of time with both parents and have positive relationships with both parents (Cashmore & Parkinson, 2009; Johnston et al., 2009).

Affinity

Further along the continuum, also at the healthy end, a child will continue to want contact with both parents, but displays an affinity or preference towards one parent. Children who show an affinity feel closer to one parent over the other, and may occasionally express an overt preference for a parent, but still want substantial contact and love from both parents. An affinity may occur for a variety of developmentally appropriate reasons such as: age, gender, specific interests, or preference of parenting practices and can shift over time with changing developmental needs and situations (Fidler et al., 2013; Johnston et al., 2009; Kelly & Johnston, 2001).

Alignment

Moving further along the continuum, but also at the healthy range are children that have an alignment with one parent. Aligned children do not completely reject or terminate contact with the non-preferred parent. Rather, these children report wishing to have limited contact with the non-preferred parent after separation (Johnston et al., 2009; Kelly & Johnston, 2001). These children are characterized by their ambivalence towards the non-preferred parent and may
express realistic feelings of sadness, anger, hurt, love and resistance to contact as a result of the separation itself (Fidler et al., 2013; Friedlander & Walters, 2010; Kelly & Johnston, 2001; Johnston et al., 2009).

**Justified Rejection**

Children that resist or refuse contact with a parent as a result of having experienced and/or witnessed abuse, neglect, family violence, or extreme parenting deficiencies fall under a separate category. Research refers to this subset of children as exhibiting a “realistic estrangement” or a “justified rejection” with these words often used interchangeably (Drozd & Olesen, 2004, 2011; Fidler & Bala, 2010; Fidler et al., 2013; Friedlander & Walters, 2010; Kelly & Johnston, 2001). Despite these children resisting or refusing contact, they are viewed and treated differently by mental health professionals and judges. Rather, these responses are considered to be justified, adaptive, healthy and protective (Baker & Darnall, 2007; Drozd & Olesen, 2004, 2010, 2011; Fidler & Bala, 2010; Gardner, 1985, 1992, 2001; Kelly & Johnston, 2001).

**Alienated Children**

Alienated children are at the most negative and pathological end of the continuum. This subgroup of children is characterized by a complete refusal to have contact with the rejected parent; vicious vilification and campaign of denigration towards the rejected parent; outward rejection and defiance towards the rejected parent and his/her extended family; polarized opinion of each parent, and lack of guilt or ambivalence regarding unkind behaviour towards the rejected parent. It is combined with overt and/or covert parental alienating behaviours that are either intentional or unintentional by the favoured parent (Fidler et al., 2013; Gardner, 1985, 1999; 2001; Johnston & Kelly, 2004).
Parental Alienating Behaviours (PAB’s) have been defined as explicit negative communication and behaviours perpetrated by one parent, which evokes disturbance and has the potential to distance, damage, or destroy a child’s relationship with the other parent (Baker & Darnall, 2007; Darnall, 1998). Baker and Darnall (2006) found over 1300 behaviours that could be considered PAB’s and categorized them into eight groups: (1) badmouthing (e.g. belittling/denigrating the other parent portraying parent as mean or dangerous); (2) limiting or interfering with actual contact (e.g. arranging fun activities while child is scheduled to be with other parent, early pick-ups/late drop-off’s.); (3) limiting or interfering with phone/mail contact (e.g. blocking or monitoring calls/mail); (4) limiting or interfering with symbolic contact (e.g. limiting mention of the other parent; no photographs of the other parent); (5) interfering with information (not providing other parent information, using child as a messenger); (6) using emotional manipulation (e.g. withdrawing love if child expresses positivity about the other parent, rewarding for rejection); (7) fostering an unhealthy alliance (e.g. asking the child to spy or keep secrets); and, (8) miscellaneous (badmouthing to teachers, doctors etc.).

The distinguishing feature of the subgroup of alienated children is that the reactions exhibited by the child are unjustified and disproportionate to the rejected parent’s behaviours. In contrast to children who justifiably reject a parent, these rejected parents are considered “good enough”, and sometimes exemplary, with no verified or substantiated history of physical, sexual or emotional abuse towards the child (Johnston & Kelly, 2004). Prior to the separation, alienated children may have had an excellent, good, or good enough relationship with the rejected parent (Fidler & Bala, 2010; Friedlander & Walters, 2010; Kelly & Johnston, 2001).

Figure one below provides an illustrated figure of Kelly and Johnston’s (2001) original continuum of parent-child relationships after separation and divorce.
Hybrid Cases

In 2010, researchers Friedlander and Walters coined the term “hybrid case”. Friedlander and Walters reported that based on anecdotal clinical based research, the majority of cases brought forth before the courts are mixed cases. Mixed cases involve a combination of parental alienating behaviours, enmeshment between the favoured parent and the child, along with some level of compromised parenting by the rejected parent that lends itself to some proportional resistance by the child (Friedlander & Walters, 2010). These cases have been labeled and referred to as “hybrid” cases since both parents in some way contribute to the child’s rejection. The hybrid classification used to describe cases of children resisting or rejecting parental contact has received some criticism for being too simplistic in nature, demoting allegations of abuse and safety concerns in favour of alienation concerns, and unintentionally, but inevitably, marginalizing credible abuse and risk to children (Meier, 2010).
High Conflict

Not included in Kelly and Johnston’s (2001) original continuum, but often cited as a cause in a child resistance/rejection of a parent is the presence of high conflict. Meta-analytic research reveals that children caught in high inter-parental conflict situations have poorer quality relationships with both parents. These children are frequently placed “in the middle” of parental disputes and may feel pressure to pick a side (Buchanan et al., 1991; Buchanan & Heiges, 2001; Emery, 2012; Grych, 2005). A child may pick a side based on his/her interpretation of which parent is “right”, which parent was hurt the most or is most vulnerable. One hypothesis is that children in high conflict situations align with one parent and resist the other as a way of stepping out of the parental war zone (Buchanan et al., 1991; Emery, 2012). The child’s resistance or rejection to parental contact is used as a coping mechanism to remove themselves from the contentious high conflict (Buchanan et al., 1991; Grych, 2005; Johnston & Roseby, 1997; Johnston et al., 2009). Another hypothesis is that children in high conflict situations split their parental relationships where each relationship is kept separate and private from the other parent (Polak & Saini, 2015). In these cases, the child provides no insight about their relationship status with either parent and may present as guarded where each parent assumes they are aligned with the other. Researchers Birnbaum and Bala (2010) report that while not all high conflict cases involve alienation, all alienation cases are characterized by high conflict. At the moment, the pathway in which high conflict can develop into parent-child contact problems or alienation remains poorly understood with difficulty in distinguishing which cases children resist/refuse contact as a result of high conflict.
Gatekeeping

The term ‘gatekeeping’ has also recently started making its appearance in the literature. Initially the term gatekeeping was used in the psychology research literature to examine the inhibitory process of a mother’s influence over the father-child relationship (Ganong, Coleman, & McCaulley, 2012). Pruett and colleagues (2003) broadened the definition of gatekeeping to “facilitative and inhibitory functions exercised by one or both parents that determine who will have access to their children, and the nature of that access” (p.171). The term provides a description of parental attitudes, behaviours and actions that have the potential to positively or negatively impact the quality of the other parent’s relationship and involvement with the child (Austin et al., 2013a; 2013b).

On its own, gatekeeping is a non-directional concept; gate opening refers to attitudes and behaviours that facilitate and encourage co-parents involvement. For instance, this includes speaking positively to the child about the other parent or actively encouraging the child’s relationship with the other. Gate closing refer to actions that inhibit involvement. Examples of gate closing behaviours include asking the child to keep secrets from the other parent or withholding information about a child’s activities/needs from the other parent (Ganong et al., 2012; Trinder, 2008).

Adaptive gatekeeping behaviours serve the purpose of doing what is in the child’s best interests. That is, it promotes the parent-child relationship so long as it is safe, and protects the child if he/she is in need of protection from the other parent. Maladaptive gatekeeping behaviours, on the other hand, do not consider the child’s best interest but is based on the parent’s own needs and can be used as a form of revenge against the other parent (Drozd, Olesen & Saini, 2014). Protective gatekeeping, refers to a situation in which a parent uses gate closing
or inhibitory behaviours in an attempt to protect the child from risk of “harm, emotional distress, behavioural problems, adjustment difficulties, or negative developmental impact” from spending time with the parent (Drozd et al., 2011, 2014). This may be justified such as in cases where there is reasonable cause to fear or hold negative beliefs about a parent (e.g. incidents of abuse/neglect); it may also be unjustified such as in cases where concerns remain unsubstantiated even after repeated investigations (Drozd et al., 2011).

Lastly, restrictive gatekeeping refers to attitudes and behaviours that inhibit and interfere with the other parent’s involvement and are unsupportive of the parent-child relationship (Drozd, Kuehnle, & Olesen, 2011; Ganong et al., 2012; Pruett et al., 2016). An unjustified restrictive gatekeeper can be seen as parallel to a parent that actively engages in alienating behaviours that undermine the parent-child relationship.

With a view to include the most recent terms introduced over the years and further assist in distinguishing and differentiating strained parent relationships, Polak and Saini (2015) adapted Kelly and Johnston’s (2001) continuum of parent-child relationships to incorporate high conflict and hybrid cases while simultaneously including the newer gatekeeping terminology. On one side of the arrow, this figure uses the diagnostic terminology of ‘affinity’, ‘alignment’, ‘splitting’ ‘hybrid’ and ‘alienation’. The figure depicts that as the level of conflict increases a more negative and pathological parent-child relationship develops. On the other side of the arrow, gatekeeping terminology that most closely reflects the diagnostic terminology of the parent-child relationship is provided. This diagram is a helpful tool to visually illustrate the differentiation of parent-child relationships.
Figure 2: Strained Parent-Child Relationships on a Continuum

Historical Development of Parent-Child Contact Problems

Parental Alienation Syndrome

The phenomenon of a child who resists and/or refuses contact with a parent post-separation has been reported in divorce literature dating back to 1980 (Wallerstein & Kelly, 1980). In 1985, late American psychiatrist Richard Gardner introduced the controversial term Parental Alienation Syndrome (PAS). Gardner defined it as:

Parental Alienation Syndrome (PAS) is a disorder that arises primarily in the context of child custody disputes. Its primary manifestation is the child’s campaign of denigration...
against a parent, a campaign that has no justification. It results from the combination of a programming (brainwashing) parent’s indoctrination and a child’s own contribution to the vilification of the target parent. When true parental abuse and/or neglect are present, the child’s animosity may be justified, and so the parental alienation syndrome explanation for the child’s hostility is not applicable (p. 4).

Gardner described a child’s resistance/rejection of a parent as a disorder or pathological alignment between the child and favoured parent most frequently encountered among contested child custody cases (Gardner, 1985). Gardner’s definition involves the intentional denigration of the bond between a child and one parent seen almost exclusively in child custody disputes and typically perpetrated by the custodial parent (usually the mother) in an attempt to attack and harm the non-custodial parent (Gardner, 2003). Using Gardner’s (1985) definition of PAS, the major contributing factor leading to a child’s rejection of the other parent is the conduct and pernicious influence of the favoured parent, who intentionally and systematically influences the child. Without the influence of the alienating parent’s behaviour, a child’s rejection of a parent would not otherwise occur.

According to Gardner (1985, 1992) a diagnosis of PAS is dependent on eight behavioural factors identified in the child that include:

1) a campaign of denigration against the rejected parent;

2) weak, frivolous, or absurd rationalizations for the deprecation;

3) lack of ambivalence by the child toward the rejected parent;

4) the “independent thinker” phenomenon (child claims beliefs are his/her own, not the alienating parent’s beliefs);

5) reflexive support of the alienating parent;

6) absence of guilt over cruelty to and/or exploitation of the rejected parent;
7) presence of borrowed scenarios from the favoured parent; and,

8) spread of rejection to friends and/or extended family of the alienated parent.

Based on the above criteria, Gardner proposed a framework to differentiate the severity of the alienation (i.e. mild, moderate or severe) and suggested treatment options (Gardner, 1999).

Gardner proposed that children in the mild category exhibit relatively superficial manifestations of the eight symptoms. This type of alienation is weak and children often cooperate during visitations, but are intermittently critical and disgruntled (Gardner, 1998). He suggested treatment may consist of a therapist for the child and the contact issue usually alleviates itself (Gardner, 1998).

In the moderate type, the alienation is more formidable; children are more disruptive and disrespectful, and the campaign of denigration may be almost continual. In these cases, all eight primary manifestations are likely to be present and more advanced than in the mild cases. Gardner proposes treatment by a court appointed therapist and legal action such as sanctions (e.g. withholding financial support, house arrest, incarceration). In some moderate circumstances, Gardner proposes a custody reversal to the alienated parent (Gardner, 1998).

In cases where children present with severe alienation, all eight manifestations are likely to be present to a significant degree. Children may have temper tantrums or display phobic reactions to the rejected parent. Visitations may become impossible or, if the child attends the rejected parent’s home, he/she is hostile enough to become destructive and physically violent towards the rejected parent. Gardner (1998) indicates that in many of the severe cases, the children’s hostility may have reached paranoid levels where delusions of persecution and/or fears that they will be murdered by the rejected parent may be present. In these cases, a reversal in custody to the alienated parent is proposed, or transfers of care to a transitional site, such as a
boarding school or inpatient treatment facility where contact between the child and favoured parent is suspended for a period of time.

While Gardner was the pioneer for labeling the issue of children who resist and/or reject parental contact post-separation, identified behavioural symptomology in children that exhibit contact issues, categorized symptomology as mild, moderate and severe and provided differential treatment options for parent-child contact problems, his views are widely criticized and considered highly controversial.

Gardner’s view that a malicious favoured parent is the culprit and single etiological agent contributing to the parent-child contact problem has been eschewed upon. Researchers attest this belief is simplistic, reductionist and fails to consider or assess for other contributing factors that may be equally important, such as inept or severely compromised parenting (Drozd & Olesen, 2004; Johnston & Kelly, 2004; Kelly & Johnston, 2001; Fidler & Bala, 2010). This is also not supported by clinical research that indicate many high conflict separated parents engage in alienating behaviours and does not result in a child resisting or refusing contact (Birnbaum & Bala, 2010; Johnston, 1993, 2005; Johnston, Walters & Olesen, 2005a). The draconian measures Gardner recommends as treatment options have been viewed negatively with the potential of causing further damage including death (Kelly & Johnston, 2004; Meier, 2009).

Malicious Mother Syndrome

Turkat (1999) proposed a more extreme form of parental alienation syndrome, which he called the “Malicious Mother Syndrome”. According to Turkat (1995), the definition encompasses four major criteria:

1. A mother who unjustifiably punishes her divorcing or divorced husband by:

   • Attempting to alienate the child(ren) from the father
• Involving others in malicious actions against the father

• Engaging in excessive litigation

2. The mother specifically attempts to deny her child(ren):

• Regular uninterrupted visitation with the father

• Uninhibited telephone access to the father

• Paternal participation in the child(ren)'s school life and extra-curricular activities

3. Pervasive pattern that includes malicious acts towards the husband including:

• Lying to the children

• Lying to others (e.g. alleging ex-husband sexually abused the children)

• Violations of law

4. The disorder is not specifically due to another mental disorder although a separate mental disorder may co-exist.

Of grave concern is that this mother-blaming syndrome has been published in academic journals based on the author’s personal clinical experience. No empirical evidence exists to support this conceptualization.

**Parental Alienation**

Darnall (1998, 2011) coined the term *Parental Alienation* (PA) to describe the same phenomenon. Darnall stated PA and PAS differ in three respects: first, PAS focuses on the child’s behaviour whereas PA does not focus on the child’s behaviour, but instead, focuses on the parent’s behaviour. Second, in PAS Gardner emphasizes that the child is required to be an active participant with the alienating parent in degrading the targeted parent. In contrast, PA focuses more on the alienating parent’s behaviour than on the child’s role in degrading the
victimized parent. Lastly, Darnall hypothesized there were three main kinds of alienators, and provided criteria on how to recognize and differentiate the three types of alienators.

Despite using distinctive terminology, both Gardner and Darnall share the view that a major contributing factor leading to a child’s unjustified rejection of the other parent is the conduct, malicious influence and behaviours of the favoured parent, typically the mother.

The Alienated Child

Based on the lack of empirical support for PAS as a diagnostic syndrome, Kelly and Johnston (2001) noted a critical need to reformulate a more useful conceptualization of parent-child contact problems. Kelly and Johnston (2001) proposed a systems-based, multifactor model to help explain why some children will resist and/or reject contact with one parent while becoming aligned with the other parent. The term *Alienated Child* was coined, placing the focus on behaviours manifested by the child, rather than the favoured parent. Using this label, the parent-child contact problem begins with a primary focus on the child, the child’s observable behaviours, and the parent-child relationship.

The authors redefined *child alienation* as “a child who expresses, freely and persistently, unreasonable negative feelings and beliefs (such as anger, hatred, rejection and/or fear) towards a parent that are significantly disproportionate to the child’s actual experience with that parent” (Kelly & Johnston, 2001, p.251).

Kelly and Johnston’s (2001) model acknowledges multiple contributing factors and the need to differentiate a child who resists or rejects contact in consequence to a favoured parent’s malicious influence and behaviours, from one who resists or refuses contact for other reasons. The factors proposed include:
1) the aligned parent’s behaviours and negative beliefs, or PAB’s;

2) the rejected parent’s counterproductive negative, angry or punitive reactions to the child’s rejection (referred to as “counter-rejection” in the research literature);

3) compromised parenting, domestic violence, and child abuse/neglect;

4) the child triangulated in intense marital conflict prior to separation;

5) high conflict and chronic litigation post-separation resulting in the involvement and contribution of new partners, extended kin and professionals in the dispute (referred to as “tribal warfare” in the literature);

6) child developmental factors (e.g. age appropriate separation anxiety and cognitive capacity of dealing with conflict); and

7) a child’s temperament and personality vulnerabilities (e.g. anxious, fearful, dependent, psychologically troubled, poor coping skills).

Further, these authors conceptualized children’s relationships to each parent post-separation along a continuum of positive to negative, with the most negative being alienation. The authors first coined the terms “allied children”, “aligned children” and “estranged children”. This model differentiates parent-child relationships and provides more utility for both legal and mental health practitioners working with these families. However, there is still no guidance to understand what is meant by a ‘disproportionate’ reaction or provide ways to assess whether or not the child’s reaction is in fact disproportionate.

**Resist Refuse Dynamic (RRD)**

Most recently, Walters and Friedlander (2016) removed all labels and reference to the term alienation. The authors coined the term Resist/Refuse Dynamic (RRD) to refer to children who refuse contact with a parent as a result of “complex interacting factors, family dynamics,
personality characteristics and vulnerabilities, conscious and unconscious motivations, and other idiosyncratic factors that combine to contribute to the unjustified rejection of a parent” (Walters & Friedlander, 2016, p. 424). This may be helpful since the term alienation has stirred up controversy over the years and despite attempts to focus on the child, the term is incendiary that brings attention and blame towards the favoured parent. Removing all labels may help guide clinicians to focus solely on behaviours manifested by all individual family members.

**Debates and Controversy**

**Lack of Consensus on Terminology**

While there have been significant developments in research on this topic, there is no formal consensus on the term used to describe the parent-child contact refusal dynamic with no consensus on the operational definition of alienation (Saini et al., 2016). As well, despite having different meanings, the research literature use the terms resist and refuse interchangeably. This author suggests behavioural, emotional and cognitive differences exist among children that resist contact versus those that refuse contact. Children that resist contact are generally still more agreeable and able to have some form of contact compared to those that completely reject. A table outlining differences between children that resist and refuse contact has been developed and is depicted below (Table 1). Acknowledging Drozd and Walters (2016) progress for resolving resist refuse dynamics checklist and Gardner’s (1998) differentiation of mild, moderate and severe alienation, this table offers clinical indicators one may potentially use when assessing a child presenting with resist/refuse dynamics. This area requires further research and development to help differentiate between these two terms given their treatment implications.
Table 1: Clinical Differentiation between Resist and Refuse

(Acknowledgments: Gardner, 1998; Drozd & Walters, 2016)

<table>
<thead>
<tr>
<th>Behavioural Indicators</th>
<th>Child Resisting Contact</th>
<th>Child Refusing Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child has difficulty transitioning at the time of visitation</td>
<td>1. Child completely refuses to attend visits</td>
<td>1. Child displays negative beliefs, and perception about rejected parent but holds rigid thinking patterns.</td>
</tr>
<tr>
<td>2. Child often wishes to skip visits, leave visits early or has infrequent visits.</td>
<td>2. No contact or very infrequent contact</td>
<td>2. Child presents with cognitive distortions and shows no awareness into the distorted thought.</td>
</tr>
<tr>
<td>3. Child may present with discomfort during visit.</td>
<td>3. Child displays extreme discomfort around rejected parent and may run away to avoid contact.</td>
<td></td>
</tr>
<tr>
<td>5. Limited conversation in between visits (e.g. infrequent text messages)</td>
<td>5. Does not respond to text messages and may block or delete rejected parent from contacts</td>
<td></td>
</tr>
<tr>
<td>6. Mild to moderate denigration of the rejected parent</td>
<td>6. Moderate to extreme denigration of the rejected parent</td>
<td></td>
</tr>
<tr>
<td>7. Displays ambivalence with respect to wanting a relationship with parent and may extend to extended family members.</td>
<td>7. Displays no ambivalence. Child clearly expresses desire for not having a relationship with parent and extended family members.</td>
<td></td>
</tr>
</tbody>
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<thead>
<tr>
<th>Emotional Indicators</th>
<th>Child Resisting Contact</th>
<th>Child Refusing Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Displays difficulty engaging emotionally and shares limited to no personal information with rejected parent</td>
<td>1. Child does not engage emotionally with parent and does not share personal information with rejected parent</td>
<td></td>
</tr>
<tr>
<td>2. Difficulty in allowing the rejected parent to ‘get close’ emotionally (e.g. share feelings, thoughts etc.)</td>
<td>2. Child does not allow rejected parent to ‘get close’ emotionally and does not share feelings, thoughts etc.</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Cognitive Indicators</th>
<th>Child Resisting Contact</th>
<th>Child Refusing Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child displays negative beliefs, and perception about rejected parent but has the ability to shift thinking patterns with support (e.g. therapeutic, neutral third party, etc.)</td>
<td>1. Child displays negative beliefs, and perception about rejected parent holds rigid thinking patterns.</td>
<td></td>
</tr>
<tr>
<td>2. Child presents with cognitive distortions but can at times show awareness into distorted thought.</td>
<td>2. Child presents with cognitive distortions and shows no awareness into the distorted thought.</td>
<td></td>
</tr>
</tbody>
</table>
Emotional and Psychological Consequences of Alienation

In a recent review of empirical studies on alienation, Saini and colleagues (2016) report that although a range of profoundly negative long-term consequences of parental alienation has been asserted, empirical findings have been mixed and unreliable.

A number of retrospective studies have found negative consequences for children exposed to PAB’s and those that resisted parental contact. For example, Baker (2005) conducted a qualitative retrospective study of 38 adults who self-identified as having experienced parental alienation as children. Findings from this study revealed that the adults who self-identified as being alienated as children were more likely to suffer from low self-esteem, depression, drug/alcohol abuse, lack of trust, alienation from own children, future divorce and other negative psychological outcomes (e.g. self-blame, guilt). These results are similar to results from Reay (2007) and Carey’s (2003) dissertations where adults who self-identified as being alienated as children perceived experiencing greater levels of psychological distress and difficulty developing romantic relationships. Similarly, in Godbout and Parent’s (2012) qualitative study of six adults who self-reported as being alienated from a parent indicated they experienced difficulties at school, internal and external behaviour problems, and a search for their identity after reaching adulthood. While findings of these retrospective studies all appear to highlight negative long-term consequences of alienated children, the limitations of these studies include the non-random, self-selected and small samples used, its retrospective research design and lack of comparison group.

More recently, larger studies using undergraduate students have been conducted showing a relationship between self-reports of exposure to parental alienation as a child and poorer psychological functioning as an adult. Baker and Verrocchio’s (2013) study of 257
undergraduate students found that children who reported being exposed to parental alienation had higher rates of parental psychological maltreatment, and poorer functioning with respect to self esteem, depression, adult attachment styles, alcohol abuse, self direction and cooperation. The use of standardized tools to measure depression and self-esteem, the robust sample size and the use of a compare group are strengths of this study. However, the retrospective nature of the study, the fact the information came from the undergraduate student only and the vagueness in how alienation was actually assessed or defined are limitations.

Lastly, Rowen and Emery (2014) conducted a study of 648 undergraduate students and found that children who described higher levels of parental denigration reported feeling less close to both parents. Reports of denigration were correlated with reports of feeling less mutual trust, poorer communication quality, and increased feelings of isolation from both parents. Although denigrating behaviours distance children from both parents, children felt especially distanced from the denigrator parent. It is important to highlight that this study looked at denigrating behaviours, which is not the same as alienation, and did not rule out any other factors that could have accounted for the behaviours (e.g. mental health).

Among studies that did not use a retrospective design, Johnston and colleagues (2005b) conducted an empirical study of the psychological functioning of 74 alienated children (ages 5-12) among custody disputing families. The authors found that alienated children exhibited more behavioural problems of clinically serious proportions when compared to children who maintained relationships with both parents. According to personality assessments using the Rorschach inkblot test, alienated children displayed poor reality testing, illogical cognitive operations, simplistic and rigid information processing, inaccurate or distorted interpersonal perceptions, disturbed and compromised interpersonal functioning, and coping deficits. While
this study used standardized measures, triangulated data, made intragroup comparisons between alienated and non-alienated children, and had a more robust sample size, it is problematic because of the lack of assessment tools available to assess for alienation to make intragroup comparisons.

More recently, Lavadera and her colleagues (2012) conducted a qualitative analysis of 96 psychological reports produced by 12 different experts appointed by the Rome Law Courts. The researchers selected all of the families where severe PAS was diagnosed and compared it to those in which PAS was not diagnosed. Results showed that children in the PAS group more frequently displayed manipulative behaviour, tended to distort family reality, and showed less respect for parental authority than children in the control group. Children in the PAS group were reported to have more identity problems and experienced greater difficulty in relationships than children in the control group. It is unclear what criteria the court experts used to diagnose PAS. As well, it is unclear why Gardner’s PAS diagnosis was considered since alienation has been widely discounted as a syndrome.

In sum, while there appears to be some support that child alienation is associated with negative long-term emotional and psychological consequences in children, these results should be taken with caution due to methodological limitations.

**Gender-Based Debates**

The concept of alienation has sparked significant controversy and strong polarized gendered polemics. There is a strong presence of Father’s Rights groups claiming courts are biased in dealing with child custody matters and responding to alienation (Bala, 2012; Fathers for Justice, 2016; Fidler & Bala, 2010). These groups raise concerns related to the lack of father involvement in our society and fuel the perception of bias against fathers by publicly stating
contact should be enforceable in the same manner that child support or spousal support is enforced (Bala, 2012).

The most controversial claims brought by this group rise from Gardner’s initial development of PAS theory and Turkat’s (1999) Malicious Mother Syndrome. Based on Gardner’s own case experiences, he held that parental alienation was a disorder of children arising almost exclusively in child custody disputes, whereby the custodial parent, usually the mother, programs the child to hate the non-custodial parent, usually the father (Gardner, 1985). Gardner claimed that child sexual abuse allegations were rampant in these cases and claims brought up in the context of custody litigation were often false and should be treated as suspect (Gardner, 1991). Similarly, Turkat described Malicious Mother Syndrome, which portrays mothers breaking the law and intentionally lying (e.g. telling child that the father is not their biological father), in an attempt to punish their divorcing husbands.

This has led Father’s Rights groups to claim that only mothers foster parental alienation and fabricate false abuse allegations against fathers (Meier, 2009; Bala, 1999). These groups maintain that mothers frequently make false allegations of spousal or child abuse to gain a tactical legal advantage in custody/access proceedings or to seek revenge (Bala, 1999; Johnston et al., 2005a).

There is limited empirical evidence available to support this view. Rather, Gardner’s work has been criticized for being self published, lacking scientific rigor, credibility, reliability, and failing to provide empirically verified pathogenesis to consider it a diagnostic syndrome as per the American Psychiatric Association (American Psychiatric Association, 2000; Bruch, 2001; Drozd & Olesen, 2004, 2010; Faller, 1998; Kelly & Johnston, 2001; Meier, 2009).
Gardner’s claims of false abuse allegations have been extensively contradicted by empirical research that reports the contrary. Results from the Canadian Incidence Study of Reported Child Abuse and Neglect (OIS-13) found that only 4% of all maltreatment investigations are considered intentionally fabricated. From the subsample of parties that are in a custody/access dispute, the rate of false allegations increases significantly to 14%. Irrespective of whether or not allegations were verified, 34% of investigations involving a child custody/access dispute involved allegations of exposure to inter-parental violence and 23% involved allegations of neglect (Deljavan, Black, Saini & Fallon, 2015; Houston & Bala, 2016).

Of these, neglect is the most common form of intentionally fabricated maltreatment with anonymous reporters and non-custodial parents (usually fathers) most frequently making the false reports. According to the CIS-98, custodial parents (usually mothers) and children were the least likely to fabricate reports of abuse or neglect (Trocme & Bala, 2005).

Feminist scholars and advocates consider claims of alienation as fabricated allegations by male perpetrators of intimate partner violence, who were likely also abusive fathers (Meier, 2009, 2010; Walker, Brantley & Rigsbee, 2004). These allegations are made in an attempt to maintain power and control over the victimized mother and have contact with children who are justifiably resisting and rejecting contact (Meier, 2009, 2010). Abusive ex-spouses are seen as making exaggerated claims about their good relationship with their children and use litigation as a new forum to continue their power and coercive control over their former partners (Drozd & Olesen, 2004; Jaffe, Lemon & Poisson, 2003; Johnston, Walters & Olesen, 2005a).

The denial of the existence of alienation can also do a disservice to mothers who are alienated from their children by abusive men. This is seen in cases where children avoid contact with their mother in order to please an intimidating, abusive father or to avoid his anger and
subsequent emotional repercussions. Drozd and Olesen (2004) identified cases where abusive parents (often fathers) engage in behaviours to sabotage the child’s relationship with the victim parent. The aggressor takes advantage of the victim parent’s vulnerabilities and engages in sabotaging alienating behaviours that result in the child rejecting contact. Johnston, Walters and Olesen’s (2005a) study of 125 children from custody disputing families revealed that domestic violence was the most frequent allegation reported. Regression analysis in this study revealed that it is a father’s domestic violence (not the mothers’) that predicted parental alienating behaviour. That is, a father’s alienation of their children from their mother post-separation is predicted by his own abusive behaviour during the course of their relationship. The authors posited that this type of psychological control and manipulation of their children could be viewed as an extension of their physically abusive and controlling behaviour.

Unfortunately, these dichotomous perspectives mirror the thinking observed by families and professionals in the field. However, it is not an either/or proposition. There are children who resist or reject a parent as a result of abuse or domestic violence, children who resist or reject a parent unjustifiably, and times where children resist or reject a parent due to both factors occurring simultaneously (Drozd & Olesen, 2010). At the moment, the field remains in its infancy. Mental health professionals are challenged with articulating criteria that identifying these cases, and moreover, are challenged in how to respond to them.

**Alienation as a Diagnostic Syndrome**

Another controversial issue discussed in the research literature was with respect to a recently failed effort to include alienation as a diagnostic syndrome in the DSM-V. Proponents for including the term alienation in the DSM-V acknowledged that the term had been identified as a valid concept and could be the result of developmental factors (e.g. a disorder of
attachment). Further, proponents reported that the inclusion of the term could promote more systematic research, help clinicians work more effectively with divorced families, and reduce opportunities for abusive parents and unethical attorneys to misuse the concept in child custody disputes (Bernet et al., 2010).

In contrast, critics of calling alienation a syndrome, maintain that it is not a clinically valid diagnosis and evidence of such a diagnosis should not be admissible in court (Bruch, 2001; Drozd & Olesen, 2004; Faller, 1998; Johnston & Kelly, 2004). Critics argue it should not be included in the DSM due to the lack of scientific and empirical evidence of data supporting the construct (Walker & Shapiro, 2010). The existing evidence is mostly anecdotal using circular logic that affirm arguments (Peptin et al., 2012) with insufficient criteria to meet the requirements of a psychiatric syndrome as per the American Psychiatric Association (Johnston & Kelly, 2004). There is a concern that it will result in more blame, polarization and misuse amidst an existent adversarial system (Johnston, 2010) and fear that PAS will be used to refute claims of realistic child abuse and domestic violence (Jaffe, Lemon, & Poisson, 2003; Meier, 2009). Instead, using a syndrome as a label oversimplifies these cases, rather than addressing the complexity of the family situation (Johnston et al., 2009; Neilson, 2010 as cited in Fidler et al., 2013).

Parental Alienation Syndrome was not included in the latest revised version of DSM. Instead, “unwarranted feelings of estrangement” is listed as an example of a Parent-Child Relational Problem (American Psychiatric Association, 2013, p.715).

**Profound Negative Impact of Custody Reversals on Children**

In severe cases of unjustified rejection and alienation, judges have at times ordered children to be placed in the physical custody of the rejected parent or in a neutral setting apart
from both parents and extended kin (e.g. foster care). Anecdotal clinical opinions have warned that removing children from the favoured parent’s home can be psychologically and emotionally damaging to children and may lead to devastating consequences including lethality.

Experts predict dire consequences to children, trauma, and long-term psychological damage if the court separates a child from the favoured parent and places him/her with the rejected parent (Jaffe, Ashbourne & Mamo, 2010). Jaffe and his colleagues (2010) state that the trauma associated with removal from a favoured parent’s home may precipitate out-of-control behaviour or suicide attempts. Changes in custody may disrupt children’s social and school relationships that are important sources of stability and conflict-free zones for them. Further, teenagers can become angry, cynical and lose respect for a court that, from their perspective, purposely contradicts their voice and appears to have a sole focus on parental rights. As such, many professionals believe that disrupting the emotional bond between a favoured parent and a child through a change of custody can be more damaging to the child than severing ties with a less close rejected parent.

In contrast, Warshak (2015) states such predictions of dire consequences are based on a flawed interpretation of attachment theory and anecdotal accounts not grounded in valid research. He reports no peer-reviewed study has documented harm to severely alienated children from the reversal of custody. Rather, he purports that experts draw this conclusion from children who were placed in prolonged institutional care as a result of being orphaned, or separated from their families, for other traumatic reasons. Warshak further claims attachment theory and research do not support generalizing the negative outcomes of traumatized children who lose both parents, to situations where children leave one parent to spend time with the other parent (Warshak, 2014; 2015). Warshak reports this lack of empirical support contrasts the benefits of
removing a child from the care of a disturbed pathological parent, and placed with a parent whom the court considers to be better able to meet the child’s needs. In these cases, proponents for a change of custody believe the favoured parent’s behaviours are psychologically and emotionally abusive where the child is at risk of emotional harm and long-term negative consequences. These consequences outweigh any potential distress that may be experienced upon the initial change of physical custody to the healthier, rejected parent.

To date, this topic continues to be a difficult and controversial one amongst mental health professionals and the courts. Anecdotally, it appears that courts and mental health professionals are cautious when ordering or recommending drastic physical custodial changes for fear that dire circumstances may result. The question of whether or not, and under what circumstances, custody reversals should be recommended or court ordered remains a stark dilemma, hotly debated within the field.

**Chapter Summary**

This chapter provided a more nuanced understanding of strained parent-child relationships where children resist and/or refuse parental contact. At the moment, there is no single definition for children who resist or refuse parental contact or parental alienation (Bow, Gould & Flens, 2009; Fidler et al., 2013). There continues to be ongoing debate and formulations about its existence, etiology, perpetuation of the problem and the treatment approaches to best remedy the problem (Saini et al., 2016). As well, it remains a challenge to fully comprehend the complex and interconnecting factors that result in children resisting or refusing parental contact.

Since this study focuses on alienation as it relates to reintegration therapy, the next chapter provides a literature review on the theory and research on alienation and parent-child contact problems. Following that, a literature review and critical analysis on the theory and
research available on reintegration therapy is provided which segues to the research questions guiding this study.
Chapter 3

Insights of Theory and Empirical Research on Alienation

Psychological Theories to Explain Parent-Child Contact Problems

Several theories have been proposed to help shed light on factors that may contribute to parent-child contact problems. The following chapter is divided into two sections. The first section reviews how strained parent-child relationships and subsequent parent-child contact problems and alienation are viewed using several theoretical lenses including: feminist theory, attachment theory, cognitive theory, family systems theory, and transactional ecological theory. These theories have been used to help explain the development and underlying etiology for parent-child contact problems and alienation.

The second section of this chapter provides a succinct review of the empirical evidence available on the etiology of parent-child contact problems and alienation. Despite considerable research and several schools of thought with respect to its etiology, the theory underlying the development of contact problems appears to be still evolving.

Feminist Theory

Over the last few years, there has been much debate about whether or not domestic violence and alienation can co-occur with no clear consensus on this issue. Feminist proponents assert that alienation and domestic violence are dichotomous in nature, and cannot occur simultaneously. In contrast, other researchers argue that parent-child contact problems are not resolved using an either/or dichotomous perspective, but elements of alienation and domestic violence could be comorbid (Drozd & Olesen, 2004; Drozd, 2016). The research literature has revealed evidence of cases where strained parent-child relationships and contact issues are a
result of alienation or domestic violence. However, the research is less clear on how to
differentiate cases when elements of both domestic violence and alienation overlap. This is an
area that is still under developed and not clear. As such, this chapter presents the various ways in
which contact problems and alienation are viewed.

**Applying Feminist Theory to Explain Alienation**

Feminist scholars argue that the alienation claim is used as a means of denying abuse and
shifting attention away from dangerous or lethal behaviours of an abusive parent who is seeking
custody or access (Meier, 2010). For instance, Meier (2010) reports that abusive ex-partners will
often make allegations of alienation in cases where children are realistically resisting or refusing
contact. Meier (2010) asserts that in family court, alienation has been widely used to falsely deny
abuse and is selectively invoked against mothers. Mothers are blamed for attempting to protect
the child where the abusive ex-partner presumes the parent is lying and poisoning the child’s
mind (Bruch, 2001; Meier, 2009; 2010). Feminist advocates contend that the alienation label
serves to blame and pathologize mothers portraying them as “vengeful” towards their ex-
husbands in their attempts to gain custody (Bruch, 2001; Faller, 1998; Meier, 2009, 2010). Jaffe,
Crooks and Bala (2009) report that abusers will most often claim alienation to refute claims of
abuse. This has unfortunately led to the removal of children from victimized mothers and placed
in the custody of manipulative and violent fathers (Meier, 2009; Olesen & Drozd, 2004). A
further complicating feature, is that providing the abusive parent with greater access may in fact
further re-traumatize women by forcing them to work with their abuser for the sake of the
children (Bowen, 2008).

Further, it has been reported that children can also become alienated from their mothers as
a result of being intimidated by abusive fathers, wanting to please their fathers and/or wishing to
avoid their wrath and/or emotional and financial repercussions for having a relationship with their mother (Johnston et al. 2005a). As highlighted previously, Johnston et al. (2005a) found that fathers who engaged in alienating behaviours were more likely to have perpetrated domestic violence against their spouses. This behaviour was seen as an extension of their physically abusive and controlling behaviour post-separation.

Lastly, feminists contend that the legal system can become a further tool used by the abuser in maintaining power and control, and continued emotional and financial abuse of women. This occurs through chronic litigation where denigrating, humiliating, accusatory and/or false allegations are filed in affidavits and subsequently become public record. Due to the nature of the legal system that requires evidence to support one’s claims, it becomes the women’s burden to gather evidence to repudiate alleged claims made against her. Not only can this be psychologically and emotionally taxing, but given the high costs often involved when in the legal arena, it can quickly become financially onerous. Intentionally engaging in chronic litigation can be used as an abusive tactic to ensure women become financially depleted, in debt, and emotionally depleted.

It is also important to note that a child’s access with a parent is inextricably linked to monthly child support payments in Ontario legislation\(^6\) and most jurisdictions. It is not uncommon to see the underlying motivation behind wishing to increase access time with a child

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\(^6\) O. Regulation 391/97: Child Support Guidelines under *Family Law Act, R.S.O. 1990, C.F.3*

Where a parent or spouse exercises a right of access to, or has physical custody of, a child for not less than 40 per cent of the time over the course of a year, the amount of the order for the support of a child must be determined by taking into account,

(a) the amounts set out in the applicable tables for each of the parents or spouses;
(b) the increased costs of shared custody arrangements; and
(c) the condition, means, needs and other circumstances of each parent or spouse and of any child for whom support is sought. O. Reg. 391/97, s. 9.

[https://www.ontario.ca/laws/regulation/970391](https://www.ontario.ca/laws/regulation/970391)
for financial benefits rather than a pre-existing close parent-child relationship. Again, this financial gain to an abusive ex-partner is a financial loss to the women who may depend on the income.

From a feminist perspective, women are often at an economically disadvantaged position within society. Often, the legal battle required to reduce one’s parenting time to less than the 40% threshold (in Ontario) may be too daunting and/or financially prohibitive. The fact that the legislation is such where parenting time is associated with child support guidelines highlights the structural issues that can become contributory agents to ongoing oppression women face.

**Attachment Theory**

The basic tenet of attachment theory is that a child’s healthy socio-emotional development is dependent on an ongoing, warm and intimate relationship with a responsive primary caregiver (Sroufe, 2000). The caregiver-child attachment is seen as an evolutionary based behavioural system that functions to ensure an infant’s survival by promoting proximity to their caregiver in times of stress (Bowlby, 1969, 1982).

Attachment is the ability of a primary caregiver to be psycho-biologically attuned to an infant and child’s shifting states of arousal and to regulate these different emotional states (Sroufe, 2000). Bowlby maintained that infants are biologically driven and genetically “hard-wired” to form attachments that are necessary for their survival (Bowlby, 1969). These relationships will influence a child’s future interactions with others (Bowlby, 1969; Barron, 2000; Bretherton, 1992). This attachment relationship shapes the ability for an infant to communicate and relate to the primary caregiver and eventually other human beings (Schore & McIntosh, 2012; Schore, 2012).
Based on repeated patterns of interaction, all infants form a preferential relationship with one or a small number of caregivers by 10-12 months of age (Sroufe, 2000). Upon feeling distress, an infant/child will require contact with the caregiver who offers comfort, protection and helps them self-regulate. An infant/child will also feel more comfortable in novel situations and will demonstrate more exploratory behaviours (e.g. playing more freely) when they perceive the caregiver is present and responsive (Sroufe, 2000). The quality of a child’s attachment to a particular caregiver refers to the child’s willingness and ability to use the caregiver as a “secure base” from which they draw emotional comfort (Garber, 2004; Faber & Wittenborn, 2010).

Repeated interactions with primary caregivers are internalized as internal working models (IWM) of one’s self and the world. IWM are organized memories of past experiences, attachment needs, and an expectation about the responsiveness of the attachment figures’ ability to meet individual needs (Barron, 2000; Bowlby, 1988; Bretherton, 1992; Faber & Wittenborn, 2010). A child’s IWM of their parent is integral to the quality of the parent-child relationship and future relationships.

Ainsworth and Bell (1970) were the first to empirically study Bowlby’s attachment theory through the development of the “Strange Situation” to differentiate between attachment styles in the infant-caregiver relationship. Her laboratory work standardized a paradigm for assessing infant-mother attachment resulting in a classification system describing attachment relationships (Ainsworth, Blehar, Walters & Wall, 1978). Based on the balance of exploration, attachment seeking behaviours, and responses to reunions and separations, infants are classified into one of four categories: secure, insecure-resistant, insecure-avoidant and disorganized (Barron, 2000; Faber & Wittenborn, 2010; Smith, Coffino, Van Horn & Lieberman, 2012). A secure attachment is associated with a parent’s level of sensitivity and attunement to the needs of the child, levels of
Some debate exists regarding the relative stability of attachment patterns over time. Various researchers have found consistency between infant and adult attachment classifications (Waters, Treboux, Crowell, Merrick & Albersheim, 2000), while others have found little stability and believe attachment classification can change over time. These attachment patterns are vulnerable to difficult and chaotic life experiences (e.g. parental divorce, parental substance use, life threatening illness of parent or child, death of a parent, physical/sexual abuse by a family member etc.) (Waters et al., 2000; Weinfield, Sroufe & Egeland, 2000). While working models remain relatively stable throughout one’s lifespan, they can be altered by subsequent life experiences and environmental factors (Sroufe, 2000). Because attachment is a reflection of interactive experiences between a child, and their caregiver and IWM’s, it is expected to change as caregiving changes. For instance, sudden loss of a parent, a traumatic experience, domestic violence, the potential trauma of a highly conflictive parental separation or negative chronic post-separation dynamics can impact a parent’s ability to be responsive to their children. This in turn may affect a child’s working models and quality of the parent-child attachment relationship (Lieberman, 2004).

**Applying Attachment Theory to Help Explain Alienation**

Garber (2004) used an attachment-based lens to help explain child alienation. Garber (2004) proposed that alienation could result from a child developing a distorted IWM of the rejected parent. This distortion is formed when a child modifies their IWM to reflect the favoured parent’s subjective experiences and overt and/or covert influences. Garber (2004) hypothesizes “in the extreme, one caregiver’s denigrating and inaccurate messages can prompt a
child to accommodate her IWM of another caregiver such that her subjective experience of security with that caregiver has little or no relationship to his or her actual sensitivity and responsiveness” (p. 61). The corrupted or distorted IWM includes inaccurate beliefs not reflective of the historical parent–child experiences. Rather, the distortions reflect the favoured parent’s subjective experiences and overt or covert influences.

Since there are no specific measures to test IWMs and this construct is typically inferred based on behaviour, it cannot be corroborated by empirical research (Polak & Moran, 2016). Clinical observations have supported this hypothesis where literature indicates alienated children exhibit inaccurate or distorted interpersonal perceptions (Johnston & Roseby, 1997; Johnston et al., 2005; Lampel, 1996; Warshak, 2010). One empirical study (Johnston et al., 2005b) revealed that alienated children in custody disputing families are more likely to have difficulty processing information and present distorted perceptions of their interpersonal relationships. However, more empirical research examining the link between attachment patterns and IWM among children displaying contact issues is needed to further support an attachment-based theory.

**Adult Attachment Styles and Strained Parent-Child Relationships**

Theorists have postulated that adult romantic relationships develop and are maintained through many of the same principles encountered in the parent-child attachment relationship (Hazan & Shaver, 1987). Adult romantic relationships are influenced by early attachment experiences and the IWM of both partners. The dissolution of an intimate relationship can evoke profound feelings of distress at the loss of a significant attachment figure (Saini, 2012). For some parents, separation can result in feelings of sadness, hurt, shame, humiliation and fear of abandonment. In some cases, this vulnerability is the result of previous traumatic losses (Johnston et al., 2009). These strong emotions can trigger parental attachment needs, for which
they may turn to their children to fill. Researchers in the separation and divorce field have opined that parents may attempt to undo the loss of the marriage by becoming dependent on the child and developing enmeshed and/or blurred boundaries between the parent and child (Kelly & Johnston, 2001; Johnston et al., 2009; Johnston et al., 2005).

Attachment research has shown that infants and children are attuned to their caregiver’s feelings and intentions (Schore, 2012). Since the child may believe their parent’s wellbeing depends on them and their presence, they may begin to show ambivalence and resistance when separating from that parent to visit with the other parent (Johnston et al., 2009). If the child picks up negative feelings against the rejected parent, the child may accommodate to the parent’s needs in order to maintain the emotional ties that he/she may not otherwise receive (Jurkovic, 1998). This insecure style of attachment can maintain or reinforce a child’s alignment or alienation. However, no direct empirical research has been conducted that establishes a pathway or relationship between adult insecure attachment patterns and parent-child contact problems post-separation.

**Cognitive Theory**

Cognitive theory is proposed since researchers and clinicians posit a child’s cognitive development may put them at risk for choosing one side over the other when conflicting opinions emerge (Grych, 2005; Johnston et al., 2009). Findings from psychological evidence reveal alienated children show distorted interpersonal perceptions and illogical cognitive operations (Johnston et al., 2005b). Further, as previously outlined, one of the intended objectives of reintegration therapy is to improve critical thinking and help remedy distortions in perception and thoughts (Friedlander & Walters, 2010; Walters & Friedlander, 2010). Given these findings,
cognitive theory is explored to help understand its potential contribution to the development of these dynamics.

Cognition is the process of organizing and making meaning of experiences (Newman & Newman, 2003). Jean Piaget is the most widely known and influential cognitive theorist (Slee & Shute, 2003). Piaget postulated that every organism strives to achieve equilibrium; once equilibrium is achieved, one can effectively interact with the environment. According to Piaget, equilibrium is achieved through the formation of schemes and operations, which form systematic ways of understanding and analyzing one’s experiences (Newman & Newman, 2003). Equilibrium is further achieved through “adaptation”. Adaptation is the process of modifying existing schemes to account for discrepancies between what is known from what is actually experienced. The process occurs via “assimilation” or “accommodation” (Block, 1982). Assimilation is the tendency to interpret new experiences in terms of an existing operating scheme. When assimilating a new experience, a pre-existing schema integrates it, explains it and incorporates it into a system of established associations (Block, 1982). In contrast, accommodation is the tendency to modify existing schemas to account for new dimensions brought forth by an event or experience. Accommodation requires changes to the schema to incorporate the new experience (Stiles et al., 1990). According to Piaget, cognitive development occurs in four stages characterized by a unique capacity to organize and interpret information. The stages are: sensori-motor period (0-2 years), pre-operational period (3-7 years), concrete operations period (7-11 years) and formal operation period (11+) (Slee & Shute, 2003).

**Applying Cognitive Theory to Help Explain Strained Parent Child Relationships**

Schemas can be used as one lens to help explain a child’s rejection of a parent in both justified and unjustified cases. In cases where a rejected parent exhibits a harsh or authoritarian
parenting style, a child’s mental representation or pre-existing cognitive schema is one where he/she cannot trust or rely on that parent. The script developed has become a pattern organizing the child’s unconscious rules for predicting, interpreting, controlling and responding to their experience with that parent. Scripts that are derived from emotionally charged scenes can be conflated in memory and psychologically magnified (Johnston et al., 2009). As such, the resistance or rejection of a parent may be an adaptive response to control and respond to the pre-existing script.

Research on children’s adjustment to interparental conflict also reveals that when children are exposed to conflict, conflict schemas become activated eliciting emotions, expectations, and appraisals associated with prior experiences (Grych & Cardoza-Fernandes, 2001). A child’s appraisal of events is associated to their developmental stage. A child’s appraisal of conflict, their coping efforts and emotions are influenced by their beliefs about the causes of the interparental conflict. Cognitive appraisals affect children’s feelings and behaviour towards each parent (Grych & Cardoza-Fernandes, 2001). In this case, a child who appraises a situation and attributes fault to one parent, also reinforced by previous experiences, may cope by resisting or rejecting contact with the parent they believe is at fault.

Unjustified rejection of a parent may be the result of cognitive/developmental processes. Memories of experiences are believed to be reconstructive, where autobiographical recall is filtered through beliefs, knowledge, expectations and motivations (Kuehnle, Ludolph & Brubacher, 2016). Memories can be distorted by beliefs and expectations, and affected by confusion among related experiences. Memory can also be reshaped by information acquired after the fact, with the mind vulnerable to filling in the blanks when parts of a memory are not recalled or understood (Kuehnle, Ludolph & Brubacher, 2016). Recent cognitive research has
shown that children’s memory errors may be influenced by their increased knowledge of the world and their acquiescence to authority (Klemfuss & Ceci, 2012).

Using a cognitive lens to understand unjustified rejection, a child may resist or reject a parent based on inaccurate, fragmented scripts or memories influenced by beliefs, knowledge, and perceived expectations. A child who has been exposed to significant conflict may wish to maintain a simplified script of their parents or impressions. In these cases, a child may incorporate unrelated scenes, inaccurate or fragmented recollections as a method of maintaining the negative script and simplifying their perceptions of the world (Johnston et al., 2009). A child may also acquiesce to the subtle or blatant alienating behaviours and expectations exhibited by the favoured parent.

Another hypothesis suggested is the idea that the cognitive process of assimilation and accommodation may be taking place as a result of PAB’s (Garber, 2004). Assimilation and accommodation refers to the process that ensures new information and experiences specific to a caregiving figure is consistent with the previous internal working model held of that attachment figure. That is, if a child’s perception of new information is perceived as consistent with the existing IWM of that caregiver, it presumably reinforces the child’s experience of relative security in that relationship. If the information is perceived as being inconsistent, it will either be assimilated into the existing IWM (ignored) or the child may be prompted to accommodate their IWM to more accurately reflect the new information (Block 1982). Assimilation is the tendency to interpret new experiences in terms of an existing operating scheme. When assimilating a new experience, a pre-existing schema integrates it, explains it and incorporates it into a system of established associations (Block, 1982) In contrast, accommodation is the tendency to modify existing schemas to account for new dimensions brought forth by an event or experience.
Accommodation requires changes to the schema to incorporate the new experience (Elliott et al., 1990). Whether a child assimilates or accommodates information is determined by systemic factors including the child’s cognitive, social, and emotional maturity, the quality of their relationship with the caregiver, the context in which the message occurs, and the perceived content and emotional valence of the new information (Garber, 2004). Garber (2004) posits that in the extreme cases of alienation, a favoured parent’s denigrating and inaccurate messages of the other parent can prompt a child to accommodate their IWM such that their subjective experience of security with that parent has little or no relationship to their actual level of sensitivity and responsiveness. In effect, the child’s security with that caregiver has been corrupted or distorted. Garber (2004) notes that these cases are the ones where the child speaks of each parent in polarized, inflexible terms of good versus evil. The child will be overly-involved with the favoured ‘good’ parent and will resist or refuse contact with the other parent.

Lastly, cognitive research suggests that a certain level of cognitive sophistication and maturity is needed to understand multiple, differing, and simultaneous perspectives (Polak & Saini, 2015). Cognitive maturity allows the child to hold more than one idea in mind at the same time. Before that, the child displays shifting allegiances between parents or to see younger children tending to “forget” their scripts or their anger (Garber, 2014; Johnston & Roseby, 1997). Once a child can hold contradictory ideas at the same time, the child may choose to align with one parent to cope and avoid having to reconcile the two disparate perspectives (Johnston & Roseby, 1997). The literature has found that it is unusual to see children whose alienation from a parent is consolidated prior to age seven or eight, with younger children tending to forget their scripts or anger. The most common age range found among children resisting contact is from nine to fifteen years of age, once sufficient cognitive maturity has been reached (Johnston et al.,
Cognitive Distortions

Cognitions are influenced by how information is processed and attribution of feelings (Robin & Foster, 1989). The relationship between thoughts, feelings and behaviour is paramount wherein positive cognitions elicit positive affect while negative cognitions elicit negative affect. Over time, multiple negative interactions in a relationship result in negative cognitions, which lead to perceiving the relationships in negative terms (Robin & Foster, 1989, 2002).

Information may be processed accurately or inaccurately depending on the individual, affective states, and a host of other variables (Robin & Foster, 1989). Beck and his colleagues (1967) identified common distortions in information processing including all-or-nothing thinking, overgeneralization, and magnification or minimizing among others. The extent to which information is distorted during interactions influences behaviour (Robin & Foster, 2002). Cognitive distortions influence parent-child conflict wherein faulty belief systems translate into rigid positions. Inflexible stances rapidly polarize the family during problem solving and hinder conflict resolution. Robin and Foster (2002) theorize that the more rigid and distorted cognitive processes are, the greater the degree of expected conflict. While there is limited research on cognitive distortions and parent-child conflict, studies have found that distorted beliefs are negatively related to individuals’ experiences of satisfaction in romantic relationships (Addis & Bernard, 2002). Hamazi (2007) investigated the association among dysfunctional relationship beliefs, adolescents’ perception of relationship with parents and their conflict resolution behaviour. From this study, results revealed an expected negative relationship between dysfunctional relationship beliefs and conflict resolution behaviour; in contrast to Robin and
Foster (2002), dysfunctional relationship beliefs were not correlated to the perceived parent-adolescent relationship. More research is needed to conclusively determine the correlation between cognitive distortions and one’s perception of their relationship.

**Applying Cognitive Distortions to Explain Strained Parent-Child Relationships**

Based on the behaviours manifested, the cognitive distortions typically found among children resisting and rejecting contact include: all-or nothing thinking (a child see’s one parent as all-good and the other as all-bad), selective abstraction (a child focuses on one detail of the rejected parent and ignores other salient features), overgeneralization (the child draws a conclusion on the basis of one or more isolated incidents), magnification (a child exhibits gross errors in evaluating events) and absolute dichotomous thinking (child polarizes all experiences in extremely negative or positive categories) (Polak & Saini, 2015; Polak & Moran, 2016). These distortions influence a child’s behaviour, which may lead to parental contact issues. The only empirical research that supports this assertion is Johnston et al (2005b) study of the psychological functioning of alienated children. The study found that children showed impaired information processing when using the Rorschach inkblot test. No other empirical research directly examined the relationship between cognitive processing or the presence of cognitive distortions and parent-child contact issues.

**Learning Theories**

Learning theorists can argue that resisting or rejecting parental contact is a learned response. Learning theorists propose mechanisms that account for behavioural changes, which occur as a result of experience. The two learning theories that can best be applied to help understand strained parent-child relationships are operant conditioning and social learning theory.
Operant Conditioning

Operant conditioning emphasizes the role of repetition and consequences of behaviour when learning (Skinner, 1984). Reinforcement is a consequence that increases the probability of a behaviour to occur. It is defined as a stimulus that makes repetition of a behaviour more likely to occur. On the other hand, punishment is a consequence that decreases or weakens the probability of a behaviour to occur; the stimulus used makes repetition of a behaviour less likely to occur. There are two forms of reinforcement and punishment: positive and negative. When something is added or presented as a means of increasing the likelihood of behaviour, it is referred to as positive reinforcement. Examples of positive reinforcement include: verbal praise, reward, etc. Examples of positive punishment include: yelling or nagging (an added stimulus) to decrease likelihood of a behaviour being repeated. In contrast, when something is removed or taken away in order to increase the likelihood of desired behaviour, it is referred to as negative reinforcement (Ashford, Lecroy & Lortie, 2001; Newman & Newman, 2003). An example of negative reinforcement is a baby’s cry. A caregiver will increase the likelihood of repeating a behaviour if that behaviour leads to ending the baby’s crying. An example of negative punishment is taking away a child’s favourite (removal of a stimulus) toy for breaking the house rules. In this case, a stimulus is being removed (the child’s toy) to decrease the likelihood of a behaviour re-occurring.

Applying Operant Conditioning to Help Explain Strained PC Relationships

A favoured parent’s attitudes, implicit, explicit and/or maladaptive restrictive gatekeeping behaviours can serve as reinforcement and punishment to change behaviours and interaction patterns. As an example, a favoured parent that withdraws love from the child every time the child states he/she had a good time with the other parent is using negative punishment.
The parent is removing something pleasant (physical display of love/affection) from the child thereby decreasing the likelihood of the child repeating the preceding behaviour. Another example could include a child getting rewarded (positive reinforcement) for stating they do not want to spend time with the rejected parent. The reward serves to increase the likelihood of repeating the behaviour (refusing contact with the parent). Both these behaviours are emotionally manipulative, parental alienating behaviours, that over time can lead to behavioural changes and/or a fixed response. There is a vast amount of literature on the use of positive and negative reinforcement/punishment to support changes in children’s behaviours (Kazdin, 1997; Webster-Stratton & Reid, 2010). No specific empirical research literature exists that examines the association between parental attitudes, implicit, explicit and/or maladaptive restrictive gatekeeping behaviours directly with a child’s learning or learned responses.

**Social Learning Theory**

Social learning theory posits that learning takes place as a result of observing and imitating other people’s behaviour (Bandura, 1971). Research has shown that children have been found to imitate aggressive, altruistic, and helping models and models that hold resources or are rewarded (Bandura, Ross & Ross, 1963). Models may be parents, siblings, peers, teacher, etc. Bandura and Walters (1963) suggested that children observe behaviours carried out and its consequences. When the model’s behaviour is rewarded, the behaviour is more likely to be imitated through a process called vicarious reinforcement (Bandura, 1977). Vicarious reinforcement has been extensively supported among the empirical evidence (Bandura, Ross & Ross, 1963; Kazdin, 1973). Social cognition is a process through which a child becomes acquainted with general concepts of a situation and specific behaviours through observation. Over time, a symbolic representation of a situation, along with the required behaviours and
expected outcomes are formed. Rules for behaviour are abstracted from what has been observed in watching others, historical experiences, and what one understands about the situation (Newman & Newman, 2003).

**Applying Social Learning Theory to Explain Strained PC Relationships**

One way to apply social learning theory to the salient issue is via children modeling behaviours they have observed. A child who has witnessed interparental hostility, aggressive behaviour and poor conflict resolution has learned to deal with their own problems in a similar manner and lacks adaptive coping mechanisms for dealing with interpersonal conflict (Grych & Fincham, 1990; Zimet & Jacob, 2002). For instance, a child may imitate abusive, passive aggressive or criticizing/disparaging behaviours towards the rejected parent after seeing this behaviour displayed by the favoured parent or their siblings.

Unfortunately, there are no empirical studies that support this explanation within the divorce literature. Clinical observations have revealed that younger siblings who have older siblings that resist or reject parental contact will at some point imitate and follow the same behaviour (Johnston & Roseby, 1997; Johnston et al., 2009). However, no research about what leads to this pathway has been reported.

**Family Systems Theory**

A system is defined as a set of inter-related units comprised of individual constituents that is different from the sum of its parts (Broderick, 1993). Likewise, a family is seen as a system that is more than the sum of its individual members. The family is a self-regulating, open system, constantly sending and receiving input from other members and the environment while adapting to the demands it faces (Broderick, 1993; Minuchin, 1974).

*Family Structure*
The family operates and maintains itself through transactional patterns. Transactional patterns regulate family members’ behaviour and establish how members relate to one another (Minuchin, 1974). This is maintained by implicit rules and expectations negotiated among family members and structure. Families are structured in a hierarchical manner marked by differences in power. For instance, parents have a different level of authority and power than their children thereby occupying a different hierarchical status (Minuchin, 1974). The family system further differentiates itself and functions through subsystems, formed by generation, sex, interest, or function (Minuchin, 1974). The subsystems identified in the family include the spouse subsystem, the parental subsystem, the sibling subsystem, and each parent-child subsystem (Minuchin, 1974).

The family, its subsystems and its individual members are guided by a set of rules referred to as boundaries. Boundaries range along a continuum with the two extremes of boundary functioning being disengaged (rigid) and enmeshed (diffuse).

Overly tight family bonds and boundaries characterize enmeshment where the differentiation of the family system is diffuse (Broderick, 1993; Minuchin, 1974). At this end of the continuum, the behaviour of one member immediately affects others, and stress in an individual member easily transfers across boundaries into other subsystems. The enmeshed family responds to any variation from the accustomed transactional pattern with speed and intensity (Minuchin, 1974). In contrast, disengaged families exhibit extremely rigid boundaries. The disengaged family tends not to respond when a response is necessary (Minuchin, 1974). Most families are believed to lie somewhere in the middle along the continuum; operating at the extreme ends of the continuum is indicatory of possible pathology (Minuchin, 1974).
A family must accommodate and respond to demands that emerge from developmental changes, stressors in individual members and/or subsystems, or changes occurring from environmental factors (Minuchin, 1974). To adapt to the stress or pressure, family members may change how they typically relate to each other to maintain continuity. The accommodation can be contained within the subsystem or permeate to the whole family system resulting in dysfunctional patterns of interaction and structural changes in the family (Minuchin, 1974).

One dysfunctional pattern of interaction that may arise during times of stress, contributing to strained parent-child relationships, is via triangulation. Triangulation is the dysfunctional utilization of the child during interparental conflict. Three structural configurations of triangulation have received significant attention: the child as a scapegoat, the child as mediator, and cross-generational coalitions (Broderick, 1993; Minuchin, 1974). The child as mediator and cross-generational coalitions are most applicable to strained parent-child relationships and contact issues post-separation.

**Child as Mediator/Parental Child**

Family therapists refer to the concept of “Child as Mediator” or “Parental Child” in situations where the child involves him/herself in parental disputes in an attempt to resolve the conflict. It is also used to describe situations where the allocation of parental power is given to the child. In these cases, an inverted parent-child relationship exists, where the child takes responsibility for guiding the parents and monitoring parental behaviour (Minuchin, 1974; Broderick, 1993). Based on the continuum and differentiation of strained parent-child relationships, this is most descriptive of enmeshment and blurred parent-child boundaries.

**Cross-Generational Coalition**
Family therapists use the term cross-generational coalition when one parent joins the child in a rigidly bounded coalition against the other parent (Broderick, 1993; Minuchin 1974). According to family systems theory, this typically occurs when chronic interparental discord leads to children being drawn into the parental conflict in order to resolve it or diffuse the resulting tension (Minuchin, 1974; Fosco & Grych, 2010). Minuchin explains this dynamic as a child having undifferentiated/enmeshed boundaries with one parent while being disengaged from the other.

Fosco and Grych’s (2010) longitudinal study examined the relations between triangulation, appraisal of conflict and parent-child relations in a sample of 171 adolescents. The adolescents completed standardized measures at two points in time (T1 and T2- 6 months later). Standardized measures were used to assess interparental conflict, triangulation, and appraisal of interparental conflict and parent-adolescent conflict. Results revealed that interparental conflict was related to higher levels of adolescents’ triangulation, feelings of threat, blame, and lower levels of coping efficacy. Adolescents reported the highest levels of triangulation in families with intense, frequent and poorly resoled interparental conflict (Fosco & Grych, 2010). Further, adolescents who reported feeling triangulated into parental conflict at T1, felt less close to both mothers and fathers at T1 and T2. A link was found between triangulation and deterioration in the parent-adolescent relationship. It is posited that triangulation contradicts adolescent’s positive view of their parent as dependable sources of support and may lead them to withdraw from their relationships (Buchanan & Waizenhofer, 2001; Grych & Fosco, 2010).

**Applying Family Systems Theory to Explain Strained PC Relationships**

Several concepts from family systems theory can be applied to understand the dynamics of strained parent-child relationships and children resisting or rejecting contact. Particularly,
triangulation, enmeshed boundaries, parentification and the theory that pressure from one sub-system can impact other sub-systems explains dynamics found among this population.

Consistent with past research on triangulation, a child is more likely to become triangulated when intense, frequent and poorly resolved interparental conflict is present (Grych, Raynor, & Fosco, 2004; Minuchin 1974). One of the mechanisms in which interparental conflict, both pre and post-separation, is a risk factor to the development of strained parent-child relationships occurs vis a vis the triangulation of the child into the parental conflict (Amato & Affifi, 2006; Buehler & Welsh, 2009). According to family system’s theorists, a child’s triangulation in parental conflict is related to internalizing adjustment problems (Buehler & Welsh, 2009). Existing evidence supports this hypothesis. Buehler and Welsh (2009) conducted a longitudinal, multi-method study of adolescents and their parents. Findings from this study replicate findings by others of the link between triangulation and adolescent internalizing symptoms (Amato & Affifi, 2006; Buehler & Welsh, 2009). Children have been reported to be most at risk when parents use the children to express their anger and disputes. These parent behaviours include: asking children to carry hostile messages to the other parent, asking the child intrusive questions about the other parent, creating a need in the child to hide information or conceal their feelings about the other parent, and denigrating or demeaning the other parent. This kind of behaviour increases the risk of depression and anxiety in children, greater levels of anger, stress and deteriorated parent-child relationships (Amato & Affifi, 2006; Kelly, 2012). More recently, Fosco and Grych (2010) assessed the outcomes of adolescents’ triangulation (n=171, ages 14-19) into parental conflict. Findings revealed that adolescents who triangulated themselves into the parental conflict showed higher levels of self-blame and poorer parent-adolescent relationships for both boys and girls and in both intact and separated families.
A child’s triangulation may result in the formation of cross-generational coalitions. In severe cases, a child may resist, reject or become punitive towards the other parent (Kelly & Johnston, 2001). Cases of children resisting or rejecting contact can be viewed as an extreme form of a cross-generational coalition.

An enmeshed or excessively close parent-child relationship is a distinguishing trait in cross-generational coalitions between the favoured parent and the child (Margolin, Oliver & Medina, 2001). A favoured parent may show neediness and dependency on the child, or use the child as a confidante, thereby diffusing psychological boundaries. Clinically based practice research reports that this subgroup of children is typically aware of details of the interparental conflict, legal dispute and contents of the court documents (Johnston et al., 2009). This illustrates a clear boundary violation where a child is provided with a level of knowledge and power beyond their developmental capacity. As a result of the enmeshed boundaries and knowledge, the child may become parentified and console the parent they feel is correct or needs sympathy, which is beyond their developmental capacity.

In Johnston et al (2005a) empirical study 125 custody-disputing families, the authors found that parents who were alienating had poor boundaries and engaged in role reversal with their children. Using a regression model, engaging in role reversal was one of six predictors of the development of parent-child contact problems and accounted for 49% of the variance. These findings support a multi-factor explanation of parent-child contact problems, but reveal that poor boundaries are a potent predictor.

Family systems theory is based on the idea that dysfunction in one sub-system can affect another part of the system (Minuchin, 1974). The literature refers to this as the “spillover hypothesis”. It implies that affect experienced and expressed in one relationship system is
transferred or spilled over to other relationship systems (Erel & Burman, 1995; Cox, Paley & Harter, 2001). In applying the spillover hypothesis to this situation, the negative affect that arises from the interparental conflict and disputes “contaminates and disrupts” the parent-child interactions (Cox et al., 2001 p. 250).

**Ecological Systems Theory**

Since several different theories can be drawn upon to better understand the etiology behind parent-child contact problems, this researcher used Bronfenbrenner’s transactional ecological systems theory (1977) as the underlying conceptual framework to understand the multiple factors implicated in strained parent-child relationships. Ecological systems theory is seen as a form of systems theory, with these terms often used interchangeably (Germain, 1973). The theory’s primary assumption is the person and their environments are inseparable and must be considered jointly (Bronfenbrenner, 1979). Bronfenbrenner (1979) conceptualized the idea of an ecological environment as “a set of nested structures, each inside the next, like a set of Russian dolls” (p. 22).

The individual’s environment is described as a hierarchy of systems of four levels that surround the individual moving from the most proximal to the most distal (Bronfenbrenner, 1979). The four levels include: 1) *microsystem*, defined as the developing person’s interpersonal face-to-face relations in their immediate setting (e.g. family); 2) *mesosystem*, defined as the interrelations between two or more settings containing the developing person (e.g. school and family); 3) *exosystem*, defined as the linkages between two or more settings one of which does not contain the developing person but may impact the developing person (e.g. parent’s workplace and school); and, 4) *macrosystem*, defined as the overarching patterns of a given culture or the broader social context (e.g. political systems, law) (Bergen, 2008; Greene, 2008).
Drawing on Bronfenbrenner’s ecological theory, Belsky (1980) argued that a person’s ontogenic development is important to consider upon examination of the multiple systems at play.

Ontogenic development refers to an individual’s personal history, personal development (social, emotional, cognitive), genetic predispositions and vulnerabilities.

Ecological systems theory is well suited to the study of the family. Individuals are seen as having distinct characteristics, predispositions and vulnerabilities while embedded within their families, families embedded within neighbourhoods, neighbourhoods embedded within communities and communities embedded within a geo-political macrospace (Bronfenbrenner, 1979; Loukas et al., 1998). Bronfenbrenner’s conceptual model highlights the impact of these nested environments and their reciprocal influences jointly in shaping a child’s development (Cicchetti & Toth, 1997).

Empirical support exists for multi-level risk factors that can potentially contribute to the development of strained parent-child relationships and contact problems. Using Bronfenbrenner as the underlying framework, Polak and Saini (2015) provided a comprehensive review and developed a model (See Figure 3) of ontogenic, microsystem, mesosystem, and macrosystem risk factors that can potentially contribute to parent-child contact problems.

**Ontogenic Risk Factors**

The following ontogenic risk factors have been identified in the empirical literature for having the potential to contribute to the development of strained parent-child relationships: compromised/inept parenting (Buchanan et al., 1991; Davies & Cummings, 1994; Erel & Burman, 1995; Johnston, 2005), parent psychopathology (Berg-Nielsen et al., 2002; Loukas et al., 1998; Pruett, William, Insabella & Little, 2003; Zahn-Waxler et al., 2002), personality disorders (Berg-Nielsen et al., 2002; Johnston et al., 2005), substance use (Kuperman et al.,
Findings from empirical research reveal that the presence of compromised parenting (e.g. authoritarian parenting style, lack of warmth or empathy, uninvolved parenting, poor child attunement) psychopathology, frank personality disorders, and substance abuse is associated with poor parent-child relationships vis a vis compromised parenting. The key diagnostic feature is compromised parenting since psychopathology, personality disorders and/or substance abuse have been shown to be correlated with diminished parenting capabilities, which in turn is associated with poorer child outcomes and poorer parent-child relationships (Berg-Nielsen et al., 2002; Pett, Wampold, Turner & Vaughan-Cole; 1999; Tschann, Johnston, Kline & Wallerstein, 1990; Westbrook & Harden, 2010; Whiteside & Becker, 2000).

Polak and Saini (2015) drew from cognitive theory and included the child’s cognitive capacity based on empirical and anecdotal findings (Garber 2014; Johnston & Roseby, 1997; Johnston et al., 2009) that the most common age range found among children resisting contact is from 9 to 15. Drawing on attachment theory, the authors included the historical parent-child relationship preseparation as an ontogenic risk factor that may contribute to contact problems.

**Microsystem Risk Factors**

With respect to microsystem factors, the authors included alienating and counter-rejecting behaviours, enmeshed boundaries, domestic violence, high interparental conflict, and impact of stepfamily and siblings in the microsystem category.

Empirical and clinical support reveals that a parent’s engagement in alienating behaviours is a common risk factor and contributory element to parent-child contact problems (Baker, 2008; Drozd & Olesen, 2004; Johnston, 2005; Fidler & Bala, 2010). At times, the level
of rejection faced by rejected parents is so great, and they are so hurt by the child’s behaviours and rejection that they react negatively towards the child as a response to how they are being treated. This has been referred to as counter-rejecting behaviour (Baker & Andre, 2008; Fidler & Bala, 2010; Warshak, 2010). Counter-rejecting behaviour consists of a parent vacillating between passivity and confrontational behaviour or aggression including punitive reactions as a response to how they are being treated (Baker & Darnall, 2006; Kelly & Johnston, 2001; Warshak, 2010). The key diagnostic criterion, compromised parenting, is again displayed. This form of compromised parenting perpetuates existing dynamics and has the potential to affirm distorted beliefs held by the child.

Empirical and clinical support also exist on the presence of enmeshed boundaries between the favoured parent and child(ren). Johnston et al.’s (2005b) regression analysis established that alienating parents had “poor boundaries, engaged in role reversal with their children and had difficulty distinguishing their own feelings from those of their child” (p. 207). As noted earlier, practitioners report that favoured parents will often share information that is inappropriate for a child’s ages and stages of development (e.g. affidavits, court orders) and receive emotional support from the child (Garber, 2011; Johnston et al., 2005; Ellis & Boyan, 2010).

As noted in the Family Systems section above, empirical support exists for the presence of high interparental conflict (both pre and postseparation) and compromised parenting behaviours (Amato & Booth, 1996; Cox et al., 2001; Davies & Cummings, 1994; Grych & Fincham, 1990). Compromised parenting appears to be the main pathway in which conflict translates into poor parent-child relationships. Two meta-analytic reviews (Erel & Burman, 1995; Krishnakumar and Buehler, 2000) supported the notion that marital conflict was associated
with poor parenting. Parents that were engaged in high conflict relationships were found to be more irritable, use harsher discipline, were emotionally drained and provided less attentive and sensitive caregiving (Erel & Burman, 1995; Krishnakumar and Buehler, 2000).

There is ample evidence in the research literature on the detrimental impact of domestic violence on children’s cognitive, emotional and behavioural development (Evans, Davies & DiLillo, 2008; Graham-Berman, Howell, Miller, Kwek & Lily, 2010; Holden, 1998; Holt, Buckley & Whelan, 2008; Kitzmann, Gaylord, Hold & Kenny, 2003). The research has also focused on how parenting may be impacted in the context of domestic violence. For instance, a mother’s parenting capacity, quality of the parent-child attachment and overall parent-child relationship can be compromised if she is living in an abusive context (Holt et al., 2008; Levendosky et al., 2003). Further, a mother’s overall psychological functioning can become impaired consequently impacting the parent-child relationship via parenting style.

Less is known about an abuser’s parenting style and the parent-child relationship between a child and an abusive parent. The research does point out that children exposed to domestic violence are fifteen times more likely to experience physical abuse and neglect directed towards them (Osofsky, 1999). Studies have also pointed to an association between perpetration of violence and negative parenting behaviours including lack of warmth and rejection of children (Stover, Easton & McMahon, 2013). This was also seen in Fox and Benson’s (2004) study, which revealed vast differences in parenting styles between non-violent and maritally violent fathers. In this study, violent fathers showed harsher parenting styles. Peled’s (1998) qualitative study showed that children felt torn between their love of their fathers and wanting to spend time with them while being cognizant of the condemnation of their behaviours. Carter and Forssell’s (2014) qualitative study of maltreated children’s perceptions of their abusive fathers revealed
that children perceived their father as a disengaged care provider. Children’s descriptions of a mere absence of violence by their father were judged as “good enough” fathering. However, little empirical evidence has been gathered on the parent-child relationship post parental separation when an abusive parent is involved. For instance, how often and/or in what circumstance do children sever ties with an abusive parent? What personal characteristics are attributed to this subgroup of children and their family?

The separation/divorce research revealed that 27% of children that resisted or rejected parental contact experienced substantiated abuse (neglect, physical or sexual) with domestic violence encountered in 44% of families (Johnston et al., 2005a). Regression analysis also revealed that a father’s alienation of the children against their mother was predicted by his own abusive behaviour as a spouse.

Drawing on family systems theory, Polak and Saini (2015) also considered the impact of stepfamily and siblings as potential contributing factors to parent-child contact problems. There is some evidence in the literature that alludes to the impact of siblings on a parent-child relationship. Warshak (2010) writes that while younger siblings of older children who reject a parent might initially have a good relationship with both parents, as time passes, younger siblings tend to follow older siblings’ patterns and begin showing rejecting behaviours.
Exosystem Factors

Using Bronfenbrenner’s transactional ecological approach as the underlying theoretical framework, structural and physical changes associated with separation and divorce were also considered. For example, it is recognized that separation and divorce is typically associated with negative financial implications. That is, the same income that once supported one home now needs to support two homes. The research indicates that children living with mothers are more likely to have fewer economic resources than those living with fathers (Kelly, 2012). In addition, a positive correlation was detected between parents that consistently pay child support and more frequent parent-child contact and better overall child adjustment (Amato & Gilbreth, 1999; Hetherington, 1997). Given these results, it is hypothesized that children are attuned to the financial disparities between parents, which can potentially contribute to the development of alignments and subsequent contact problems.

As well, being cognizant of actual changes in the amount of time children spend with each parent as per the established parenting plan and potential environmental changes (e.g., changes in jurisdiction, school, neighbourhood) may contribute to children resisting and refusing contact. In cases where a parent moves to a different neighbourhood or community, children may wish to stay with the parent that lives in the neighbourhood most familiar to them and where the majority of their friends reside (Polak & Saini, 2015).

Macrosystem

There has been some focus in the literature about the contribution of the larger judicial system to on-going conflict and litigation over child custody and access by divorced parents (Johnston & Campbell, 1988; Deutsch, 2008; Blank & Ney, 2006). The judicial system in North America is inherently adversarial in nature with a “win”/”lose” approach (Emery, 2012; Johnston
et al., 2009). The legal system requires parties to file documents that support their legal positions. Documents are often slandering, and can fuel and intensify anger, conflict, and hostility.

High conflict cases are characterized by “tribal warfare” or the involvement of third party professionals and extended family. These third parties form alliances and inadvertently confirm negative, polarized or distorted thoughts further entrenching the fight (Johnston et al., 2009). There are no direct empirical research studies that link the parent-child relationship with a parent’s involvement in a litigious adversarial system (Polak & Saini, 2015). Johnston (2003) used multivariate data analysis and path models to best identify the predictors of alienation. Results revealed that chronic custody litigation in family court was one of four predictors found in families where a child is alienated from a parent. In addition, Bing, Nelson and Wesolowski (2009) found that children showed poorer levels of adjustment (e.g. aggression, academic problems) when parents were litigating issues of custody/access and property. Based on the notion that the quality of parent-child relationships are most often impacted by compromised parenting, one can extrapolate that the stress of being involved in an adversarial system can potentially impact parenting capacity and the parent-child relationship (Polak & Saini, 2015).
Figure 3: Risk Factors Associated with the Development of Strained Parent-Child Relationships and Contact Problems

(Polak & Saini, 2015).
Empirical Research

Based on the comprehensive theoretical review, it is evident that several theories can be used to help understand the development of parent-child contact problems. In an effort to explain the etiology behind parent-child contact problems empirically, eight empirical studies (Darnall & Steinberg, 1998; Johnston, 1993, 2003; Johnston et al., 2005a; Mone, 2008; Racusin, Copans & Mills, 1994; Sarrazin, 2009; Stoner-Moskowitz, 1998) have been published that attempt to understand the development of parental alienation by exploring child and family dynamics. These studies tested causal models, or used multivariate analysis, to determine predictive and moderating factors believed to produce a child’s alienation to a parent. Results from these studies support the notion that multiple factors are associated with parent-child contact problems.

Looking at the most recent evidence available, Sarrazin (2009) and Mone’s (2007) dissertations both attempted to understand the etiology and development of parent-child contact problems and alienation. Sarrazin (2009) sought to empirically identify the characteristics of children caught in an alienating dynamic. Using archival case analysis, Sarrazin (2009) analyzed 36 files that had been identified by a court expert as involving a child with a high likelihood of being in a PA dynamic. Experts in charge of these cases considered that the children in question were at high risk to be living a PA dynamic in the present moment or in the near future. Results revealed that a child who shows signs of lack of communication with people around him/her, and does not display any negative externalized behaviour, has the highest risk of alienation. That is, children who are caught up in parental conflict around custody issues, and do not tend to communicate with people around themselves, while at the same time showing no signs of externalized disorders, are significantly at risk for being victims of PA from one of their parents.

Mone (2007) examined the dynamics and family relationships when interparental conflict
and parental alienation are present. A qualitative analysis of three families identified three meta-themes. The first meta-theme was dichotomy: parents exhibited dichotomous views by describing each other in primarily negative ways. Children maintained dichotomies in their thinking and meaning construction. The theme of dichotomy reflected how children viewed their parents and their involvement in the parental conflict. The second meta-theme was control. The need for control seemed to be the underlying motivation for family members’ response to conflict and alienation. Parents acted in ways to control their situation by limiting communication or physical presence with their former spouse. Some parents used legal means to control encounters and children’s access with the other parent. The third meta-theme identified was the involvement of multiple family members in the parental alienation dynamic. This meta-theme supports the suggestion that parental alienation is a family systems issue whereby many family members contribute to the perpetuation of the problem.

The most recent empirical article published in a scholarly journal is that of Johnston, Friedlander & Walters (2005). Johnston and her colleagues (2005) tested four hypotheses to attempt to explain why children reject a parent. Authors analyzed records that described parent-child relationships in separated and divorced custody-litigating families. The sample consisted of 125 children from custody-litigating families that were referred to family counseling or custody evaluation by the courts. Using multivariate analysis, children’s rejection of fathers was predicted by: a child’s age, a mother’s alienating behaviours, separation anxiety with the mother, a mother’s warm and involved parenting, lack of a father’s warm and involved parenting, and father’s abuse of the child. The rejection of a mother was predicted by a father’s alienating behaviours, separation anxiety with the father, and child abuse by the mother. Role reversal and alienating behaviours by both parents were highly correlated with child alienation. In cases of
domestic violence, perpetrators attempted to alienate their child from the victim parent. These results support a multi-factor explanation of children's rejection of a parent with both the aligned and rejected parents contributing to the problem, together with role reversal. Results from these studies support the understanding that no one specific factor is solely responsible for alienation and or the development of parent-child contact problems.

**Chapter Summary**

This chapter provided a critical review of the psychological theories and how they have been used in the research literature to help understand the etiology of parent-child contact problems and alienation. Feminist, attachment, cognitive, and family systems theories were explored with greater attention given to Bronfenbrenner’s transactional ecological systems theory for understanding the dynamics associated with the development of alienation. A visual ecological systems model of multi-level risk factors associated with the development of strained parent-child relationships and contact problems was provided. A review of the empirical evidence provided support for a multifactor model being the best predictor of the development of child alienation.

It is imperative to recognize that multiple theories have been used to help understand the development of alienation. This understanding lays the foundation to the multiple treatment approaches used to help treat this problem. The next chapter provides an in-depth review of the theoretical and empirical research literature on reintegration therapy.
Chapter 4

Insights of Theory and Empirical Research on Reintegration Therapy

This case sadly raises again the difficult issue of how to deal with a situation in which a child has been deliberately alienated from a parent. Here, the father, SGB, severely undermined and destroyed his sons' relationship with their mother, SJL. The arbitrator for the parties concluded this is a case of irrational alienation from a parent. The judge who heard the appeal from the arbitration agreed. The fact of irrational alienation is not in dispute. While the problem is obvious, the potential solution is not. J. Mesbur [S.G.B. v. S.J.L., 2010 ONSC 3717ON].

Chapter Overview

This chapter offers an in-depth review of the theoretical and empirical research literature currently available on outpatient and intensive models of therapeutic interventions specifically designed for parent-child contact problems post-separation. Having a comprehensive understanding of the existing research literature on this topic highlights the deficits and limitations in this area of practice segueing into this study’s research questions and design.

Reintegration Therapy

As noted in chapter one of this study, parents or courts will often use therapeutic interventions offered by mental health professionals to directly respond to contact issues with the expectation that it will help resolve the emotional issues undermining the exercise of access.

In Bala et al. (2010) study of all reported Canadian cases between 1989 and 2008 that dealt with claims of “alienation” authors found that court ordered therapy occurred in 47/175 (27%) cases. These orders occurred in cases where alienation was found by the court and in cases where the court rejected the claim of alienation. This suggests that reintegration therapy is
not only used for alienation, but also generally used in cases of strained parent-child relationships and subsequent contact problems post-separation.

There have been a number of terms used interchangeably both within the research and the field to refer to this therapy. These include terms such as: “reunification therapy”, “reintegration therapy”, “reconciliation therapy” and “family focused” therapy”.

Historically, the term “reunification therapy” was used within the child welfare context when efforts were made to reunify biological parent(s) with his or her child(ren) by child welfare workers. These parents often exhibited child abuse, neglect or suffered from severe addiction problems and the child(ren) were placed in protective custody or foster care (Greif, 2009; Sauber, 2013). The term has also been used to refer to efforts made by mental health professionals tasked with reunifying recovered abducted children with their family or custodial parent (US Department of Justice [DOJ], 1992). Given the historical use of the term ‘reunification therapy’, anecdotally, the term is discouraged among practitioners working with high conflict separated/divorced families experiencing parent-child contact problems.

Reintegration therapy is a recently coined term that refers to the therapeutic modality specifically designed to help address parent–child contact issues in high-conflict, litigious families (Polak & Moran, 2016). However, some argue that this term should also be avoided and instead be replaced with therapeutic interventions for families that manifest a resist refuse dynamic (Walters & Friedlander, 2016).

At the moment, there is no consensus in the literature or in clinical practice on what term should be used to label this therapeutic intervention for parent-child contact problems.

According to researchers and clinical practitioners who conduct this therapeutic intervention, the intended objective of the therapy is not only to reunify or reconnect the child
with the rejected parent, but also improved individual functioning for all family members, the co-
parent relationship and the family as a whole. Based on a review of the literature (Baker &
Sauber, 2013; Darnall, 2011; DeJong & Davies, 2012; Johnston, 2005; Johnston, Walters &
Friedlander, 2001; Fidler et al., 2013; Friedlander & Walters, 2010; Sullivan et al., 2010;
Warshak, 2010) Polak & Moran (2016) summarized the general goals of reintegration therapy
for both the child and the parents and is depicted in table two below.

Table 2: General Goals of Family Reunification Interventions

(Polak & Moran, 2016)

<table>
<thead>
<tr>
<th>Goals for the child</th>
<th>Goals for the Parents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase contact with the rejected parent</td>
<td>• Eliminate alienating and counter-rejecting behaviours</td>
</tr>
</tbody>
</table>
| • Improve child’s relationship with rejected parent                                | • Shift from conflicted to parallel or cooperative co-
| • Develop a healthy relationship with both parents                                 |   parenting                                                |
| • Minimize involvement in co-parenting conflict                                    | • Restore the rejected parent’s parental roles              |
| • Reduce the child’s cognitive distortions, polarized and negative stereotypic thinking and attitudes about the rejected parent | • Negotiate mutually supported parenting practices related to family reunification |
| • Improve the child’s coping and critical thinking skills                          | • Reduce reliance on behavioural health and legal professionals for decision-making about the family |

Despite courts mandating reintegration therapy with greater frequency than ever before,
few detailed treatment protocols or best-practice guidelines are available to inform this type of
treatment. Some agreement exists that the reintegration therapist should have specialized knowledge in high-conflict separated families, domestic violence, parent-child contact refusal dynamics and competence in family therapy and cognitive–behavioural therapy (Polak & Moran, 2016). The therapist should not be placed in a dual role and should not be expected to make any form of recommendations around custody or access. It is believed that if the reintegration therapist were placed in a position to make custody/access recommendations, it would distract the therapist and the family from focusing and engaging in the necessary clinical work (Darnall, 2011; Fidler & Bala, 2010).

A review of the literature found various outpatient and intensive/residential models used for providing reintegration therapy. Outpatient models refer to the traditional forms of therapy where family members see the therapist on a weekly or bi-weekly basis in an office setting. Intensive models are residential-like interventions that require a family or specific members of a family to reside in a facility for a number of days for treatment to occur. The theoretical models clinicians report to draw on for the practice of reintegration therapy includes: family-system based models, attachment based models, cognitive science, cognitive behavioural-based models and animal assisted/equine based models. It is posited that practice models used are dependent on a clinician’s training, assessment, and underlying theoretical understanding of the etiology of parent-child contact problems.

**Family Based Approaches**

A number of researchers and clinicians support using a family based approach when working with families where children resist or reject parental contact (Darnall, 2011; DeJong & Davies, 2012; Fidler & Bala, 2010; Friedlander & Walters, 2010, 2014; 2016; Gottlieb, 2013; Johnston et al., 2001; Judge & Deutsch, 2016; Smith, 2016; Sullivan et al., 2010). The
underlying assumption in family based approaches is that all members of the family should be a part of the therapeutic process and are considered part of the solution to the ongoing family dynamics (Johnston, Friedlander & Walters, 2001; Friedlander & Walters, 2010, 2014; Judge & Deutsch, 2016).

The approach involves the participation of the entire family in various combinations (i.e., individual sessions, co-parent sessions, parent–child sessions, and entire family sessions) along with the inclusion of significant others or important family members when necessary (Fidler et al., 2013; Friedlander & Walters, 2010; 2016; Gottlieb, 2012, 2013; Johnston et al., 2001; Smith, 2016; Sullivan et al., 2010). Given the complex dynamics often present, frequently more than one clinician will work with the family at one time. For instance, one clinician may focus on the co-parenting issues while another clinician may focus on the parent-child issues. Collaboration and open communication between the two (or more) therapists is required and considered an integral component of therapy. These family focused interventions require the use of a directive approach by a collaborative team of mental health professionals.

For those who subscribe to a family based treatment model, goals are set to all individual members of the family and the entire family system as a whole. Friedlander and Walters’ (2016) model also suggest the inclusion of the judicial or quasi-judicial system, by incorporating frequent communication between the family therapist, the parent coordinator and/or overseeing judge/arbitrator as part of the therapeutic structure. The authors’ report that involving the judicial system assists in the shared understanding that both the parents and children are court ordered to engage and participate in therapy and may be helpful in overcoming the initial resistance of the favoured parent and child. As well, the inclusion of the judicial or quasi-judicial system (e.g.
Parent Coordinator) provides the accountability component that the therapy is progressing as is intended (Friedlander & Walters, 2016). Clinical interventions vary but include:

- Cognitive restructuring or reframing and other cognitive–behavioural techniques to address cognitive distortions and encourage multiple perspectives and critical thinking;
- Desensitization to relieve anxiety associated with having contact with the rejected parent;
- Parent coaching to help parents understand, recognize, and acknowledge how his or her behaviours have contributed to the situation and set appropriate limits and boundaries;
- Psycho-education to help parents understand:
  - The importance of children having relationships with both parents after separation;
  - The negative outcomes associated with chronic conflict, parentified children and severed relationships; and
- Conflict resolution skills which includes improved:
  - communication skills;
  - coping skills;
  - problem solving skills and;
  - acknowledging responsibility for behaviours including historical incidents that may have occurred.

Currently, no outcome research is available on the use of outpatient reintegration therapy using a family based model.

**Attachment Based Model**

Dr. Craig Childress developed an attachment-based model of reunification therapy for the treatment of parental alienation. Childress (2014) states that the primary treatment foci for
reunification therapy are the child’s symptoms, which are considered manifestations of pathogenic parenting practices by a parent with borderline and narcissistic personality features who engages in parental alienating behaviours.

The essence of attachment-based reunification therapy is to help the child understand, process, and resolve the normal experience of grief and loss resulting from the family’s dissolution. The therapist helps the child find his or her own authentic experiences, in contrast to those projected onto the child by the alienating parent. This process aims to help foster the child’s capacity to recognize and differentiate his or her own experiences, including thoughts, feelings, and perceptions.

In stark contrast to the family based model, Childress argues that it is necessary for the child to be separated from the alienating parent’s pathogenic parenting practices during the active phase of treatment (Childress 2015). The favoured parent, as well as extended family and friends of the favoured parent are prohibited from personal, phone, email, Internet, or text communication with the child during the entire initial intervention period, which typically lasts for six weeks (Childress, 2015). Once the child demonstrates a period of “appropriate” behaviour towards the rejected, but normal-range and affectionally available parent, then the period of protective separation ends and the child’s contact with the formerly allied pathogenic parent is restored (Childress, 2015). Childress further states that the child’s relationship with the rejected parent should be monitored upon reintroduction to the alienating parent to ensure that treatment gains are maintained and consolidated.

Childress’ model suggests the therapists’ responsibilities include monitoring the child’s progress towards completing the requirements for ending the protective separation period, monitoring family relationships, monitoring the accuracy and integrity of the child’s behaviours
and monitoring the integrity of the protective separation. Childress reports that if violations of
the court-ordered protective separation occur, the monitoring therapist is empowered to add
sanctions commensurate with the violation. Sanctions can include added days (e.g. three days
added to the requirement for completion of the protective separation for each day that contact
between the child and favoured parent was made) or a “full protective separation” which imposes
a court ordered 9-month period of complete protective separation of the child from the
pathogenic negative parental influence of the favoured parent.
According to Childress (2014; 2015) treatment “success” for the child is defined by changes in:

1) Attitude: From hostile to affectionate

2) Cooperation: From directly defiant to highly cooperative

3) Sociability: From sullen and withdrawn to sociable and engaged.

Completion of the initial intervention period ends when the child achieves six successful weeks
of positive behaviour, the last four of which are consecutive. A successful day is defined as a
rating of four or higher on all three-child behaviour scales listed above. A successful week is
defined as six successful days in a 7-day period (Childress, 2015). Unlike the family systems
models, limited information is provided on the clinical interventions and skills that are used to
achieve the desired goals and specifically how this therapeutic practice draws on attachment
theory. As well, there is no research available on outcomes when using this attachment-based
model.

Cognitive–Behavioural Models

Recent approaches also include cognitive-behavioural models to address parent-child
contact problems (Baker & Andre, 2013; Garber, 2015; Weitzman, 2013; Walters and
Friedlander, 2010). In a recent article, Garber (2015) states that a child who resists parental
contact and holds extreme polarized beliefs presents in a phobic-like manner. Garber (2015) and Deutsch (2014) hypothesize that the child is caught in a cycle where she or he avoids the feared object (i.e., the rejected parent), and the avoidance prevents the child from having the opportunity to learn that the fear is either exaggerated or unwarranted. Given the success of cognitive–behavioural therapy (CBT) for the treatment of phobic children, Garber suggests breaking the phobia gradually by systematically exposing the child to the rejected parent. He proposes a model where individual members of the family engage with an individual therapist in a process of systematic desensitization using imaginal desensitization paired with relaxation techniques. The goal is to decrease subjective feelings of anxiety, to promote mastery and develop confidence in having contact with the rejected parent. Once these goals are established, the family reintegration therapist can begin regular meetings with the child toward the expressed goal of reunification.

Consistent with CBT principles of systematic desensitization, the reintegration therapist holds meetings in successive steps, starting with the least anxiety-provoking situation on a child’s fear hierarchy, with the ultimate goal of a face-to-face encounter with the rejected parent. Early in the process, imaginal or visual exposure (e.g. using photographs of the rejected parent and child) may be used. Weitzman (2013) and Walters and Friedlander (2010) also suggested the use of imaginal and visual desensitization methods such as the use of a one-way mirror, speakerphone, Skype/Facetime as a means to slowly introduce a rejected parent and child.

Also informed by CBT, Baker developed the psycho-educational “I Don’t Want to Choose” program to address children’s loyalty conflicts (Baker & Andre, 2013). The goal of this program is to teach children alternative ways of coping with conflict, develop problem-solving skills, develop critical thinking skills, identify alienating behaviours, identify their feelings and
differentiate their emotions from those of others, and find healthy coping strategies to disengage from the conflict. The program uses CBT principles such as cognitive restructuring and Socratic questioning.

The questions authors and psychologists Baker and Andre (2013) employ with children to accomplish these goals are: “Why do I believe what I believe?” “Is there evidence to support my belief?” “What are my choices?” “What am I being pressured to do?” “What am I feeling?” and “What do I know to be true about each of my parents?” At the present time, there appears to be no research available on outcomes when using this cognitive-behavioural approach on an outpatient basis.

**Intensive Reintegration Models**

Cases considered ‘moderate to severe’ are believed to require a more intensive approach to reintegration therapy. Over the last few years, a growing number of intensive programs have been developed for the treatment of parent-child contact problems and alienation. Intensives range from therapeutic interventions conducted in a resort for a rejected parent and child only, entire family therapeutic interventions run at a family camp with multiple families at a time, intensives with a whole family conducted in a hotel room, and intensives using equine assisted approached conducted in a farm setting for an individual family or in parent-child dyads. These intensives are often court ordered (Bala & Hebert, 2017) and appear to be premised on different theoretical underpinnings.

**Family Bridges: A Workshop for Troubled and Alienated Parent-Child Relationships (FB)**

Psychologists Randy Rand, Deidre Rand, and Richard Warshak developed Family Bridges (Warkshak, 2010). This program is an innovative, four consecutive day educational and
experiential residential program offered only to the rejected parent and the child. After the four-day program, the parent-child dyad is encouraged to vacation together for a few days prior to returning home.

The parent–child dyad participates in the intervention after a court has made an interim or permanent award of custody to the rejected parent. A pre-requisite of this program is a 90-day period of suspended access between the favoured parent and child. Thus, families are typically referred to Family Bridges via court order (Warshak, 2010). The favoured parent can voluntarily participate in a modified version of the workshop separate from the rejected parent and child.

Warshak (2010) stipulates eight program goals and ten basic principles that guide the structure. The stipulated program goals include:

- facilitate, repair, and strengthen children’s ability to maintain healthy relationships with both parents;
- help children do what they can to avoid being in the middle of their parents’ conflicts;
- strengthen children’s critical-thinking skills;
- protect children from unreasonably rejecting a parent in the future;
- help children maintain balanced views and a more realistic perspective on each parent as well as themselves;
- help family members develop compassionate rather than excessively harsh or critical views of one another’s actions;
- strengthen family members’ ability to communicate effectively with one another and to manage conflicts in a productive manner; and
- strengthen parents’ skills in nurturing their children by setting and enforcing appropriate limits and avoiding psychologically intrusive interactions.
This program emphasizes learning and education through the use of engaging video materials as opposed to therapy. Warshak (2010) reports the program is based on social psychological principles (e.g., common errors in perception, suggestibility, response to authority, negative stereotype formation) and teaches critical thinking, communication, problem-solving, and parenting skills. Warshak (2010) does not make specific references to theoretical models that inform the practice. Based on the program's description, however, Family Bridges appears to draw on cognitive science and cognitive-behavioural theory.

Warshak (2010) conducted an evaluation of “Family Bridges: A Workshop for Troubled and Alienated Parent-Child Relationships” (FB). The study provided a description of the program, inclusion criteria, intake procedures, and goals of the program. The author used a post-test design study where evaluation took place immediately following the intervention and two-to-four years post-treatment. The evaluation consisted of 12 families with 23 children. Findings reveal that at the conclusion of the intervention, 22/23 children (96%) restored a positive relationship with the rejected parent as per the child’s own statements, the therapist’s observations, and reports from the after care specialist. Among the 22 children that ended on a positive note, four children (18%) regressed after renewed contact with the favored parent (Warshak, 2010).

Some limitations of this evaluation are noted. As with most research in this area, this study used a small non-random sample limiting the generalizability of findings. Aside from the fact that the families who participated in the program were court mandated, little is known about the dynamics and characteristics of the families that participated in the intervention.

The author does not describe the therapeutic modalities used, the desired outcome measures, and/or how they were assessed. Finally, the rejected parent and the therapist, who is
also the author of the study, assessed the outcome of the intervention limiting the internal validity of the study due to potential experimenter bias and social desirability effects. It is unclear why the child was not included for outcome evaluation since a child’s perception of the parent-child relationship may be different to what is reported by the rejected parent.

**Overcoming Barriers Approach**

Overcoming Barriers Family Camp (OBFC) is a 5-day, 4-overnight family camp program designed to deliver intensive treatment to high-conflict families where a child is resisting parental contact. The program allows for 5-7 families to participate in the intervention at any given time with a court order. The program is a combination of psycho-education, clinical intervention, and milieu therapy and recreation (Sullivan, Ward & Deutsch, 2010; Ward, Deutsch & Sullivan, 2016). The program uses a family based approach requiring the participation of all family members including new marital or live-in partners. The goals of OBFC are to provide intensive psycho-education to all members of the family, including co-parenting work (meeting multiple times with the parent dyads) and creating safe connections between the rejected parent and the child in a carefully constructed camp milieu (Ward et al., 2016; Sullivan et al., 2010). Aftercare recommendations are provided based upon agreements between co-parents and children that are made at the camp and include referrals for continued monitoring and/or therapy. This program explicitly states that it uses a family systems model and cognitive-behavioural theory to inform its practice (Ward et al., 2016).

Sullivan et al (2010) conducted an evaluation of the Overcoming Barriers Family Camp (OBFC). The study provides a description of the camp settings, intake procedure, overall purpose of the program and the multiple therapeutic modalities utilized. The research design used was a post-test evaluation occurring immediately following completion of the program and six months
after participation for families that attended in 2008 and a 1-month follow-up for participants that attended in 2009. Five families attended the camp each year resulting in a total of 10 families that formed the evaluation.

Evaluation of this program consisted of satisfaction rating exit interviews along with a six-month follow-up to determine the gains made post camp. In 2008, parents overall rated the program positively, with scores of 4 or 5 on a 5-point scale. At the 6-month follow-up, findings revealed that 2 out of 5 (40%) families had improved where children were having regular contact with the rejected parent. Another 2 out 5 (40%) families showed “mixed outcomes” and in 1 family, the rejected parent was not having any contact and gave up pursuit.

While the authors provided some guidelines of the selection criteria and their intake procedure, it remains unclear how families were actually selected to participate in the program and how they controlled for extraneous variables potentially contributing to the contact problem. As well, the study did not include the collection of data from children. Adding children’s reports could have provided insight into the components of the program.

Saini and Deutsch (2016) conducted an updated evaluation of the Overcoming Barriers Family Camp. Authors developed a logic model to systematically document success and advanced the field by using common definitions about process and outcome variables. The evaluation was conducted in 2013 and 2014 in Vermont, USA, which consisted of a repeated measures (pre-post) mixed methods within-group design.

In total, 20 parents and 24 children participated in the evaluation. In the 2013 evaluation, 9 of the 10 parents participated in the pre and post surveys (five mothers and four fathers) and all children (n=11) agreed to be interviewed by a member of the third party research team on the last day of the camp. In the 2014 evaluation, 11 of the 14 parents participated in the evaluation (four
mothers and seven fathers) and all children (n=13) agreed to complete a post only online survey on IPads on the last day of the camp. Results were based on key outcomes being measured as per the logic model. Overall, results revealed most parents and children expressed positive experiences from camp attendance. Results also showed non-significant positive change on all outcomes. Parents appeared to benefit from the therapeutic encounters while children developed group cohesion and received peer support.

This evaluation showed improvement from the previous evaluation given the use of a mixed methods repeated measures design, use of a neutral third party to evaluate the program and use of a logic model that captured data on various intervention components to better evaluate and understand short, intermediate and long term outcomes (Saini & Deutsch, 2016). The limitations of this evaluation include lack of information of the selected sample, small sample size and lack of standardized measures used.

**Family Reflections Reunification Program (FRRP)**

FRRP is residential program developed in 2013 by family therapist and custody evaluator, Kathleen Reay, in British Columbia, Canada (Reay, 2015). The program consists of a four-day retreat intended for the rejected parent and child only. Acceptance into the program is contingent on a court order with suspension of direct and indirect contact between the alienating parent and the child “for a period of time until the child’s resilience to any negative messaging or to an enmeshed relationship can be rebuilt and the child’s attachment to the rejected parent rebuilt” (Reay, 2015, p. 7). Acceptance generally requires a court order for a reversal of custody in favour of the rejected parent that may or may not be permanent, the duration of which can be determined “by the alienator’s response to counselling, including the parent’s insight, judgment,
conduct, behaviour and parenting skills” (Reay, 2015, p.7/8). The suspension or custody reversal provides the child with time to rebuild the attachment to the rejected parent.

The intervention takes place in Okanagan Valley, British Columbia. The facility functions as a year-round retreat for reunifying children with their rejected parents.

According to Reay (2015), the program goals include

- promote healthy child adjustment;
- improve the child’s critical-thinking skills;
- help the child understand how and why the alienation occurred;
- help the favoured parent understand how and why the alienation occurred;
- work with each family member to create more appropriate parent–parent and parent–child roles, responsibilities, and boundaries;
- strengthen each parent’s ability to communicate with the other parent and resolve relevant parent–parent and parent–child conflicts;
- maintain the reunification process; and
- promote relationships between the child and both parents unless specific circumstances preclude such a relationship.

There is virtually no information on the clinical modalities Reay and her team use to help address the severe parent-child contact problems. Reay (2015) does not reference any specific theory FRRP draws on for reintegration therapy.

Reay (2015) evaluated the Family Reflection Reunification Program using a post-test design. Twelve families were followed at 3-month, 6-month, 9-month and 12-months post intervention. The sample of rejected parents was comprised of six mothers and six fathers and twenty-two children (14 boys and 8 girls). Reay (2015) reports that in each case, there had been
at least one previous failed attempt at counselling. The pilot revealed a 95% success rate (21 of the 22 children) in re-establishing a relationship between the child and their once rejected parent between the second and third day of the program based on children’s statements, parents’ statements and observations of the multi-disciplinary team at the retreat. Reay reported that one child was prematurely released and could not complete the program. She reports that all 21 children who completed the program maintained positive, healthy, loving attachments with their once rejected parent.

In this study, several methodological limitations are noted. For instance, information is lacking such as intake process, a description of the clinical sample that attended the program (i.e. children/parent ages), whether or not this sample was homogenous (i.e. nature of the parent-child contact problem and its intensity) and the actual clinical interventions utilized for the family. As well, it is unclear what observations and statements were made to aftercare specialists, to determine a successful or positive outcome.

**Transitioning Families Therapeutic Reunification Model (TFTRM)**

The Transitioning Families Therapeutic Reunification Model (TFTRM) runs in Sonoma County, California under the leadership of psychologist Rebecca Bailey. This program is based on the intervention guidelines for responding to child abduction developed by the Department of Justice (Behrman-Lippert & Hatcher, 2000; 1992) and a range of theoretical influences such as family systems therapy (Minuchin & Fishman, 1981), attachment theory (Ainsworth & Bowlby, 1954; Bowlby, 1980), trauma theory (Bloom, 1999; Bloom & Farragher, 2011), solution-focused family therapy (Lebow, 2014).

The goal of the TFTRM is to assist families in transitioning from crisis, challenge, or
conflict to connection and growth. These goals are achieved by integrating solution-focused family therapy within an experiential framework that includes equine and other animal-assisted therapies, cooking, and recreational activities (Judge, Bailey, Behrman-Lippert, Bailey, Psalia & Dickel, 2016). The program is implemented with one family at a time for 3 to 6 days depending on individual case dynamics. This model emphasizes a case specific approach and family member’s participation is dependent upon clinician’s individual assessment. This program explicitly reports the multiple theories it draws on for the intervention and highlights the fact that the interventions are not “cookie cutter” or “one size fits all”. Rather, family member participation and activities are customized to the individual family. No evaluation of this program has yet been conducted.

**High Road to Family Reunification Protocol**

The High Road to Family Reunification protocol is an intensive 4-day psychoeducational intervention developed by Dorcy Pruter and is part of Dr. Childress’ model. It involves a series of sequential steps that systematically restores the child’s normal range and healthy functioning. It is appropriate in cases where children resist contact with a parent post-separation, in recovered child abduction cases, and or run away cases where the court has determined placement of the children. The High Road protocol is not psychotherapy, but a systematic step-wise approach to restoring the child’s healthy family relationships (Childress, 2015). The four phases to the workshop include:

- **Family Stabilization:** A 4-5 day coaching and educational workshop that involves the children and the rejected parent’s participation, followed by a fun vacation of 3-7 days.
- **Family Maintenance:** The rejected parent and child work with a local therapist who is trained in the High Road Maintenance Care Protocol to solidify the skills learned in the
workshop. This phase is where the favoured parent is also taught the skills needed to reintegrate with the child(ren). There is a protective separation between the child and favoured parent of a minimum of 90 days.

- **Family Reintegration:** A High Road professional will reintroduce the favoured parent in a supervised capacity in order to protect the child. The favoured parent is reintroduced when the child and favoured parent have demonstrated the ability to master and apply concrete tasks from the Family Maintenance phase.

- **The New Family Paradigm:** This phase happens when the maintenance care professional for the children has observed the child’s ability to successfully integrate into both homes without the re-manifestation of the child's symptoms.

While Childress (2015) indicates using an attachment based model, aside from placing the child in the care and custody of the rejected parent, it is unclear why it is considered attachment based and what attachment based clinical skills are utilized. At the moment, there appears to be no research literature available that provides information on the types families that attend this workshop, or outcomes when using this approach.

**Other Intensive Models**

Single whole family intensives are also conducted at hotels/resorts within Ontario, Canada and the United States (Families Moving Forward, 2016; Forging Families’ Futures Program, 2016). These programs are two to three days in duration and require the participation of the entire family in different combinations throughout the day. The intensive is conducted in a large two to three bedroom hotel suite. The child(ren) sleep in one of the bedrooms of the suite while the therapists or recreation therapist sleep in the other. Parents are required to each sleep in their own room within the hotel (Families Moving Forward, 2016).
The goals of the program include helping the child and family address unresolved feelings about the separation, promote healthier individual and family functioning, correct cognitive distortions, and teach skills to improve critical thinking, effective parenting, co-parenting, family communication and problem solving (Families Moving Forward, 2016). The program reports using an underlying family systems model and uses a combination of psychotherapy, psycho-education, multi-media, and recreation to achieve program goals. Post-intervention monitoring, also referred to as aftercare, is recommended for the family by either the Families Moving Forward clinicians or local therapists (Families Moving Forward, 2016). No evaluation of this program has yet been executed.

Other Evaluations

There have been other evaluations conducted to date. For instance, Gardner (2001) conducted a case analysis of his own clinical cases (99 PAS children from 52 families) to evaluate the outcomes of custody reversal in cases he determined were severe cases of alienation. In all cases, Gardner himself had conducted a custody/access evaluation and recommended a custodial transfer because of the tenacity of alienating behaviours or the severity of PAS. The court followed his recommendation in 22 cases by ordering a change in custody and reduced access to the favoured parent. The author reported that in all 22 cases (100%), the PAS symptoms were completely reduced and/or eliminated. Among the 77 cases where the court chose not to transfer custody or reduce access, Gardner reports an increase in PAS symptomatology in 70 cases (90.9%) and spontaneous improvement in the other 7 cases (9.1%).

Limitations of this study include the lack of standardized tools used to assess the severity of PAS that would warrant a recommendation of a reversal in custody. The author solely diagnosed PAS based on his practice experience and assessment of the family. In addition, the
evaluation relied only on information obtained from the rejected parent and failed to incorporate the child or favoured parent. This limitation fails to consider other potentially valid and realistic reasons for the child’s rejection or refusal such as bona fide abuse. The author further fails to provide information on how PAS symptomatology was measured in order to state that it increased in 70 of the 77 cases.

Kumar’s (2003) dissertation evaluated a therapeutic supervised visitation program for children to examine the factors that interfere with the resolution of visitation refusal. The sample included 105 families who had attended the Smart Parenting Office and the reason for attendance was due to a child’s refusal to have contact with a parent. All family members completed questionnaires and consented to a passive-observational design. In this sample, mothers were the custodial parent in 77% and fathers were the custodial parent in 23%. Results revealed that 60% of children reconciled with their parents after using the Smart Parenting program. Children aged 13 and over, were less likely to reconcile than younger children. Findings also revealed that length of time since visits and the level of parental conflict had little impact on reconciliation. Interestingly, Kumar found that children were more likely to reconcile with rejected parents if the co-parents had an amicable relationship (parents willing to communicate).

Rand, Rand & Kopetski (2005) conducted an evaluation of structural and therapeutic interventions for “interrupting parental alienation syndrome toward the severe end of the spectrum” (p. 15). From the author’s own practice, Kopetski obtained longitudinal follow-up information from 45 PAS children (25 families) whom she evaluated over a period of 20 years commencing in 1976. Of the sample, mothers were considered the alienating parent in 18 cases and fathers were considered the alienating parent in 7 cases. Results revealed that 20 children from 12 families had the PAS process “interrupted”, 11 children from 5 families showed
“mixed” outcomes, and 14 children from 8 families had alienation “completed”. The authors concluded that the court’s ruling on custody and access was essential for interrupting or preventing alienation. They further concluded that therapy as the primary intervention was ineffective for interrupting alienation and at times worsened the situation.

Limitations of this study include the lack of standardized tools used to differentiate between moderate and severe alienation and failing to operationalize the terms “interrupted” and “mixed” outcomes and how it was assessed. It is also unclear what type of therapeutic treatment was provided, who provided the treatment, who participated in the treatment, what clinical modalities were used in the treatment and on what evidence the authors state that therapy alone worsened the situation.

Lastly, Toren et al., (2013) study reports the findings of a 16-session therapeutic program for alienated children and their parents. Authors compared 22 children and 38 parents to a group enrolled in a standard community treatment. Children in the treatment group were considered alienated if they had refused to visit the alienated parent for a minimum of 4 months. Interventions in the treatment group included cognitive behavioural modules and the implementation of interpersonal skills and coping techniques. Results revealed that children’s level of anxiety and depression decreased significantly following the therapeutic intervention. Results also revealed statistically significant improved cooperation between parents enrolled in the treatment group when compared to those in the standard community treatment.

Similar to the other studies, limitations of this study include lack of standardized measures to assess for alienation, lack of control for alternative explanatory factors that would provide insight about the child’s contact refusal, and a non-random and small sample size that limits generalizability.
Conclusions

It is evident from this review that there are multiple treatment approaches being utilized in different settings and each with a different underlying theoretical premise. It is difficult to compare studies given the various clinical and legal approaches used from custody reversals, to group programs, to entire family system intensive therapeutic approaches among others. Evaluations conducted to date each use different research designs and methods, and consider different outcome variables of success ranging from a “repaired” parent-child relationship (Gardner, 2001; Kopetski et al., 2001; Reay 2015; Warshak, 2010), a reduction in alienating behaviours (Gardner, 2001), parent satisfaction (Saini & Deutsch, 2016; Sullivan et al., 2010), child satisfaction of intervention (Saini & Deutsch, 2016), improved co-parent communication and cooperation (Toren et al., 2013) and children’s overall levels of anxiety and depression levels (Toren et al., 2013). The lack of consistency on the operational definitions used for alienation, sample composition, clinical modalities used, underlying theoretical models, or measures of success make it difficult to formulate any conclusions or draw generalizations.

Most, if not all of the studies are fraught with limitations including weak research designs using posttest-only treatment evaluations of interventions designed by the researchers themselves (Reay, 2015; Sullivan et al., 2010; Warhsak, 2010), small sample sizes (Reay, 2015; Saini & Deutsch, 2016; Sullivan et al., 2010; Warhsak, 2010), unclear inclusion criteria to differentiate type of strained parent–child relationship (Reay, 2015; Saini & Deutsch, 2016; Sullivan et al., 2010; Warhsak, 2010), lack of a control group (Reay, 2015; Saini & Deutsch, 2016; Sullivan et al., 2010; Warhsak, 2010) among others.
Chapter Summary

This chapter highlighted the several therapeutic approaches currently being used to help ameliorate parent-child contact problems post separation. The research literature identified several theory based clinical approaches that can be utilized with families. While some of the intensive models explicitly state the underlying theory the intervention drew on, others appeared atheoretical. It was also evident that while some models claimed to draw on a theory (e.g. Childress’ Model), more information was needed on the clinical modalities used during the intervention where such a claim could be made possible.

Gold standard clinical research is not only costly, but also difficult to conduct in these settings. This is apparent given the few empirical studies available on reintegration therapy. Clinicians cannot draw hard conclusions from the empirical studies available due to the variation in treatment approaches used, multiple outcomes being assessed, multiple definitions of success, weak research designs (i.e. post-test designs) and methodological limitations. Nonetheless, it presents an opportunity for further dialogue and continued evaluation development. While waiting for more quality empirical research, interventions are guided by many factors, including clinical experience.

Given the wide disparity in treatment approaches available, along with the limited accompanying evidence, the next chapter segues into the research questions, research design and methodology used to undertake this study. Some consensus is essential among mental health practitioners on how reintegration therapy is defined and practiced to help further this important field.
Chapter 5
Research Design and Methodology

Chapter Overview

Based on the review of the theory and literature, it is evident that research in the area of reintegration therapy is still in its infancy. Various therapeutic approaches are being used in the practice of reintegration therapy, which may depend on the practitioner’s clinical training or understanding of the etiology of parent-child contact problems post-separation. Aside from formal theories, the wisdom and knowledge of experienced practitioners engaged in front-line practice provides a rich source for professional knowledge building (Schon, 1983). These arguments provided the rationale to adopt an interpretive phenomenological qualitative research design. Grounded theory assumes there is a “social, psychological or social structural process occurring in the situation that accounts for all data” (Crooks, 2001, p.11) and emphasizes theory development that is grounded in data from the field. The end result in grounded theory is to generate a theory illustrated in a figure. In contrast, phenomenology attempts to analyze and examine a phenomenon by describing the common characteristics of participants’ lived experiences (Creswell, 2007). The focus of phenomenology is to understand the essence of an experience and is best suited to answer questions that require a description of the essence of a lived phenomenon or a shared experience (Creswell, 2013). The end result of this type of inquiry is a description of the “essence” of the experience (Creswell, 2013, p.105).

Since the primary aim of this dissertation was to gain a better understanding of how reintegration therapy is experienced and practiced among mental health professionals, along with understanding the underlying theoretical constructs that inform this therapy, the use of
interpretive phenomenology was selected using *The Long Interview Method* (McCracken, 1988) research method to answer this question.

This methodology was the best approach for this study as it enabled this researcher to probe implicit theories and tacit knowledge of experienced mental health professionals practicing reintegration therapy and generate thick descriptions of that knowledge. The current chapter begins with a description of phenomenology and describes the research process utilized in the current study.

**Phenomenology**

Phenomenology is an inductive qualitative research tradition rooted in the philosophical traditions of Edmund Husserl and Martin Heidegger. It was developed as an alternative to the empirically based positivist paradigm (McConnell-Henry, Chapman & Francis, 2009). The objective for phenomenological researchers is to return to embodied, experiential meanings and obtain complex and rich descriptions of a phenomenon or human experience as it is experienced (Dowling, 2007; Finlay, 2009). Husserl is considered the founder of phenomenology as a philosophy and the descriptive approach to inquiry (LeVassuer, 2003). Descriptive phenomenology is concerned with describing, highlighting core concepts, and generalizing specific life events or experiences (Lopez & Willis, 2004). It aims to discover universal aspects of a phenomenon that have never been or have been incompletely conceptualized in prior research (Wojnar & Swanson, 2007). Researchers using a descriptive phenomenological approach attempt to understand and describe a phenomenon as free and unprejudiced as possible through the use of “bracketing” (Dowling, 2007; Racher & Robinson, 2003; Wertz, 2005; Wojnar & Swanson, 2007). Bracketing involves the researcher setting aside preconceived biases, knowledge, presuppositions, and judgments in order to obtain the authenticity of the participants’
experience (Giorgi, 1997; Hamill & Sinclair, 2010; Lopez & Willis, 2004; Wertz, 2005).

Heidegger, one of Husserl’s students and developer of interpretive phenomenology, agreed with Husserl’s main objective of understanding the essence of a phenomenon, but disagreed with his view on the importance of description rather than understanding (Racher & Robinson, 2003). Heidegger advocated for the use of hermeneutics as a research method (Dowling, 2007). Hermeneutics moves beyond description, or core concepts of the experience, but seeks meanings that are embedded in the occurrences, which can be uncovered (Reiners, 2012). Heidegger also rejected the idea of bracketing. He argued that fully comprehending a lived experience is, in essence, an interpretative process and bracketing is not warranted because hermeneutics presumes prior understanding (Heidegger, 1962; LeVasseur, 2003; McConnell-Henry, Chapman & Francis, 2009; Tufford & Newman, 2010). He believed that people are, by nature, interpretive beings, and that any attempt to bracket oneself from a phenomenon will fail because it is intrinsically impossible to suspend all judgments and prior knowledge (McConnell-Henry, Chapman & Francis, 2009). That is, all individuals come to a situation with some form of practical familiarity from their own world and sociocultural background, which makes interpretation possible (Wojnar & Swanson, 2007). Heidegger stated “understanding is never without presuppositions. We do not, and cannot, understand anything from a purely objective position. We always understand from within the context of our disposition and involvement in the world” (Johnson, 2000, p.23). This philosophical approach is well suited and compatible to the social work notion of ‘person-in-environment’, the belief that a person is considered inseparable from their environment. As such, social location, culture/religion, social and political contexts are considered prior to interpretation and analysis.
In relation to this study, interpretive phenomenology was necessary given this researcher’s deep interest in this topic, specialized knowledge and professional clinical experience with this population over the last eight years.

This researcher has been employed in public agencies and private settings as a custody evaluator, mediator, parent coordinator, and therapist for high conflict separated families involved in the court system. Further, this researcher has had professional experience working clinically with families where parent-child contact problems present themselves as a consultant, custody evaluator, and reintegration therapist. Due to the challenging nature of clinical work with these families, this researcher has attended numerous conferences and trainings over the years that focus on working with these family dynamics. As a result of this researcher’s professional training and personal experience in working with this population over the last number of years, it would be difficult, if not impossible, to fully bracket or suspend judgment, and previous knowledge. This would have been a critical component when interviewing participants and ensuring authenticity of the data when using a descriptive phenomenological approach.

According to researchers subscribing to an interpretive qualitative methodology, being cognizant of assumptions, knowledge and biases can assist in the development of pertinent research questions, determining the sample, the development of questions and follow-up questions for a qualitative interview and the analysis/interpretation of subsequent data (Finlay, 2009; Lopez & Willis, 2004; McCracken, 1988; McConnell-Henry, Chapman & Francis, 2009). This researcher used previous experience and knowledge as an advantage as it aided in the development of the interview guide, knowing when to ask for clarification and/or elaboration throughout the interview process and during the process of data analysis.
The Long Interview Method

This study utilized *The Long Interview* (McCracken, 1988) as the model for data collection and analysis. This method served as a powerful method for eliciting rich information by collecting detailed narratives that allowed for in-depth analysis of participant experiences. *The Long Interview* method uses a semi-structured interview process with questions and accompanying probes, while remaining sufficiently open-ended. This method was well suited to capturing participant’s implicit knowledge, beliefs and assumptions (McCracken, 1988). All of the respondent interviews lasted approximately 60-90 minutes. As presented by McCracken (1988), the *Long Interview* method involves four structured steps including:

1. Review of Analytic Categories (Literature Review)
2. Review of Cultural Categories (Researcher’s Self Examination)
3. Discovery of Cultural Categories (Data Collection)
   a. Sampling
   b. Construction of interview guide
   c. Interview Process
   d. Interview Transcription
4. Discovery of Analytic Categories (Data Analysis)
   a. Identifying utterances and making observations (coding)
   b. Expanding observations or creating meaning units
   c. Comparison of observations
   d. Theme development
   e. Bringing themes together to a conclusion
The following sections of this chapter provide a detailed description of the methodology followed and implemented in this study to gain insight into clinician’s experienced knowledge.

**Review of Analytic Categories (Literature Review)**

The *Long Interview* begins with an exhaustive review of the theoretical and empirical literature aimed at achieving the following objectives: establishing familiarity with the topic; “deconstructing” the literature by analyzing assumptions and identifying limitations of scholarly work; generating hypothesis; and aiding in the development of the interview guide by identifying categories and relationships that merit investigation (McCracken, 1988).

In keeping with this methodology, the current study began with a critical review of the theoretical and empirical literature as presented in the preceding chapters providing a picture of what is known and still undetermined in the field. Research limitations were identified as well as current gaps in the empirical knowledge base pointing to the need for discovery oriented qualitative research.

The literature review laid the foundation of formal knowledge used to highlight recurrent themes and concepts and incorporated in the construction of the interview guide and subsequent analysis. The interview guide (Appendix C) was designed to be sufficiently open-ended to allow for unanticipated data, yet structured in a way as to elicit narratives from practitioners. The interviews were conducted in a conversational-like style in order to provide comfort (Flood, 2010) to the mental health professionals in sharing their experiences and concrete descriptions of conducting reintegration therapy. As well, the formal knowledge was used in a comparative analysis with mental health professionals’ experienced knowledge. Proficiency with the literature enabled this researcher to be attentive to ways in which practitioners’ ideas confirmed, contradicted, or highlighted concepts identified in the literature. Counterexpectational data is
considered provocative data, signalling the existence of unfulfilled theoretical assumptions, which are the origins of intellectual innovation (Kuhn, 1962).

**Review of Cultural Categories (Self Examination)**

The second step of McCracken’s (1988) model includes what is referred to as a cultural review requiring the researcher to use the self as an instrument of inquiry and undergo an introspective examination of personal experiences, associations, expectations and assumptions surrounding the phenomenon under study. In interpretive research, the researcher is considered a part of the interpretation process and not kept separate from it; a researcher’s personal experience with the topic is not considered a source of bias, but rather “represents vitally important intellectual capital without which analysis is the poorer” (McCracken, 1988, p.34). The objective of this step was to give this researcher a systematic appreciation of personal experience with the topic of interest and to establish “distance” with the data by being able to identify and ground familiar expectations and establish distance from deeply embedded assumptions. This is essential for the process of data collection and analysis. In keeping with McCracken’s (1988) guidelines for a cultural review, this researcher recalled and reflected on personal and professional experiences, assumptions and values. What follows is a brief first-person introduction to the researcher and some assumptions that surfaced.

**Self Reflection**

My interest in this topic stemmed from my own lived experience of encountering children that resist and reject parental contact post-separation within a professional context. I as the researcher am also a social worker with experience working as a reintegration therapist. I find these cases complex, challenging, frustrating, and heartbreaking. In my own experience, despite significant legal and therapeutic efforts, parents often remain in conflict and parent-child contact
issues typically persist despite intervention.

My desire to learn more about this issue led me to attend specialized training in this area of practice. From my training and personal experience, I came to view the notion of parent-child contact issues as a systemic family issue rather than an isolated parent-child issue. I believe that in the majority of cases, children should have some form of relationship with their parents post-separation. My training and beliefs has shaped and biased my own practice to where I use a family systems model and require the entire family’s participation. I view reintegration therapy as needing to be tailored specifically to the family and their specific needs. Further, in my experience, families who participate in reintegration therapy are typically mandated to do so. As such, unless both parents and the child(ren) have a vested interest in meaningfully participating, outcomes are typically unsuccessful in the short term. This experience has led to my profound interest in understanding other mental health professionals’ experiences and thoughts about working with these challenging families.

Being cognizant of my own biases prior to undertaking this study allowed me to be sensitive and keep an open mind to possibilities for different outcomes and approaches professionals may use with these families. Given the stable rate of separation/divorce in our society, and the increase in the number of alleged parent-child contact problems encountered in family courts, it is clear this a realistic issue facing affecting many different stakeholders. Along with my deep curiosity and interest in this topic, it is my goal to help improve the practice of RT.

**Discovery of Cultural Categories (Data Collection)**

**Sample**

Consistent with interpretive inquiry designs and *The Long Interview* method, purposive, non-probability sampling was utilized. Purposive sampling was used on the basis of the
researcher’s knowledge of the population and the nature of the research questions (Rubin & Babbie, 2008; Singleton & Straits, 2010). Selected participants were able to provide in-depth knowledge of this phenomenon in line with McCracken’s (1988) words “qualitative research does not survey the terrain, it mines it” (p.17). McCracken (1988) considers eight participants to be sufficient for saturation in most studies. Saturation is reached when new participants reveal no new findings, when information coming forward becomes repetitive (Crist & Tanner, 2003) and when continuous themes are identified. To be thorough, the current study selected a purposive sample of 14 participants.

Since the research literature identified a shortage of experienced mental health professionals that practice reintegration therapy (Fidler & Bala, 2010), the sampling frame was open to mental health professionals practicing in Canada and the United States in an attempt to maximize results and for transferability of findings.

For the inclusion criteria, mental health professionals self selected themselves as providing reintegration therapy. The definition of reintegration therapy was a therapeutic treatment intended to ameliorate parent-child contact problems that can occur post-separation and divorce. These families are often high conflict families and involved in the court system (e.g. custody/access disputes) as a result of a child that resists and/or refuses parental contact.

**Inclusion Criteria**

Inclusion criteria for participation in this study included:

1. Participants that identified themselves as experienced mental health professionals (e.g. social worker, psychologist, psychiatrist, mediator, custody evaluator) in either Canada or the United States currently practicing reintegration therapy;
2. Participants had at least three years of practicing reintegration therapy experience for the purpose of ameliorating parent-child contact problems that occur post-separation/divorce;

3. Participants reported having extensive knowledge of high conflict post-separation/divorce dynamics;

4. Participants had provided reintegration therapy for at least one family over the last 12 months; and

5. Participants had a working knowledge in the English language.

Exclusion criteria for the study were mental health professionals who provided reintegration therapeutic services following a child’s return to their family of origin as a result of a child protection proceeding (e.g. apprehension and placement in foster care due to child welfare concerns).

**Recruitment**

Mental health professionals affiliated with the Office of the Children’s Lawyer (OCL) Ministry of the Attorney General in Ontario, Canada; Canadian Association of Social Workers, and ‘Best Interests’ listserv (US and Canada) received an invitation to participate in an in-depth qualitative interview, over the phone, or in person at the Factor-Inwentash Faculty of Social Work, University of Toronto (Appendix A). The email included information about the study, participant inclusion/exclusion criteria and an informed consent (Appendix B). Since the practice of reintegration therapy is relatively new, snowball recruitment strategies were also employed. Snowball sampling is used in research studies when members of a population are difficult to locate (Visser, Krosnick & Lavrakas, 2000). This type of sampling was implemented by collecting data on the few members of the target population and asking those members to
distribute this researcher’s contact information and advertisement to other eligible mental health professionals who may wish to participate in the study (Singleton & Straits, 2010). The advertisement also asked professionals to forward this researcher’s contact information to other eligible mental health professionals. Upon contact with the researcher, verification of the inclusion criteria was sought.

**Interview Guide**

The focus of the interview guide was to elicit narratives about practitioner’s experienced knowledge on the practice of reintegration therapy, the theoretical beliefs underpinning parent-child contact problems, which subsequently can inform and translate into practice approaches used with families. Questions and accompanying probes were designed to incorporate themes emerging from the analytical and cultural reviews.

The interview guide (See Appendix C) consisted of seventeen, open-ended questions with planned prompts to use when needed. The interview guide remained open-ended to allow for new and/or unanticipated findings. The interview guide reflected a breakdown of the major research questions as well as constructs from the literature. The interview guide was circulated to committee members to vet for its cohesiveness and completeness prior to its use.

As per McCracken’s (1988) suggestions, the questionnaire began with a set of biographical questions followed by a series of question areas. *Grand tour* questions with *floating prompts* were readily used. Additionally, the interview guide consisted of planned prompts in the form of *special incident* questions. Grand tour questions are designed to encourage respondents to tell rich, descriptive, detailed stories of their practice experience in their own words. Floating prompts are the exploitation of features in everyday speech used to sustain a conversation such as the raising of one’s eyebrows or repeating last remark with an interrogative tone. Planned
prompts are used to give the respondents an opportunity to consider and discuss phenomena that do not readily come to mind or speech. These questions provided the opportunity for respondents to analyze and make meaning of their practice. Lastly, exceptional incident questions are questions that ask the respondent to recall exceptional incidents where the research topic was implicated.

**Trustworthiness**

In order to ensure trustworthiness of the data and subsequent analyses, multiple methods were used to enhance the rigor of the qualitative data (Tufford & Newman, 2010). Four main ways were used to ensure trustworthiness: credibility, dependability, confirmability and transferability (Drisko, 1997).

Credibility, which refers to a researcher’s confidence about the accurateness of the study’s findings and interpretations (Shenton, 2004), was achieved through persistent observation, triangulation, and peer debriefing. Persistent observation was sought through the use of the in-depth interview intended to elicit narratives and pursue meaning. Triangulation of findings was achieved by comparing and contrasting respondents experienced knowledge with that of the formal knowledge of the profession, found in the literature. Credibility was also enhanced through the use of peer debriefing. This researcher engaged in periodic discussions and reflections with the thesis supervisor and members of the doctoral committee. These discussions provided a “sounding board” (Shenton, 2004) for the testing of developing ideas and interpretations and helped this researcher recognize any biases or preferences (Padgett, 1998; Shenton, 2004). It was further peer-reviewed by the three doctoral committee members. The fresh perspective brought forth by the committee members helped challenge assumptions made by this researcher, whose closeness to the project may have inhibited the ability to view data
with detachment (Shenton, 2004). Lastly, this researcher ‘member checked’ with respondents during the interview itself by asking them to clarify or elaborate on ideas in order to minimize misunderstandings and misinterpretations.

To ensure dependability, step-by-step instructions of the methodological process utilized to implement the research study were provided (Kvale, 1996). This researcher followed McCracken’s *Long Interview* method for data collection and analysis. The process within the study was reported in detail to ensure study replication. Dependability of the data was achieved through recordings of the interviews and verbatim transcription of the interviews to ensure that the words of the participants were not inadvertently altered or changed in any way.

Confirmability was established through the use of direct quotes to support findings, the use of an audit trail and by explicitly disclosing personal biases that may have shaped this analysis (Drisko, 1997; Lincoln & Guba, 1985). First and most importantly, this researcher provided detailed quotations of the participants to support findings and interpretations, which serves to also ensure confirmability. By providing direct quotations, readers are able to judge for themselves whether or not the quotes represent the themes as identified by this researcher (Drisko, 1997). Second, an audit trail was kept which provides a detailed account of how results were derived. Minutes of every meeting with the doctoral committee team were also kept as part of the audit trail and reviewed during the analytical stages.

Lastly, because this researcher is also the research instrument in qualitative research, engaging in self-reflection and being explicit about past experiences, biases and orientations that have likely shaped the interpretation of this study were provided (Creswell, 2013; Drisko, 1997). This researcher engaged in self-reflexivity through journaling following participant interviews and peer debriefing with professionals engaged in this line of work and research. These critical
reflections and provoking thoughts were reviewed during the analytical stages of this process.

Finally, the transferability of the findings was achieved by providing sufficient contextual information to enable readers to make transferability inferences to similar or like populations. Rich, thick descriptions allowed readers to make decisions regarding transferability because the researcher described in detail the context, participants and setting under study. Due to the detailed descriptions, the researcher enables readers to transfer information to other settings and to determine whether the findings can be transferred “because of shared experiences” (Creswell, 2013; Erlandson et al., 1993, p. 32; Lincoln & Guba, 1985). This is distinguished from generalizability, typically used in quantitative research, which refers to the researcher’s ability to generalize results from the sample to the population it was drawn from as a whole (Devers, 1999). Transferability does not involve broad claims, but rather invites readers of the research to make connections between the study and their own experience.

**Ethical Considerations**

Prior to recruitment, approval for this study was sought through the University of Toronto Research Ethics Board (REB) (Appendix D). All participants were provided with an informed consent that outlined the purpose for the study and highlighted participant rights and responsibilities (Appendix B). The informed consent included information about the purpose of the study, the risks and benefits, confidentiality, dissemination practices and contact information. Participants had the option to print and keep the consent form for their records. Before initiating in an interview, this researcher obtained a signed copy of the informed consent and reviewed the form with them.

Participants were advised that this was a voluntary process and were free to withdraw from the study at any time or choose not to answer questions if uncomfortable. Participants were
advised that if they chose to withdraw, all their information would be destroyed and their narratives would not be used in analysis. Further, participants were advised that no identifiable information was required from them and all transcriptions would be redacted with no identifying data on any of the material.

There was no group or individual-level vulnerability related to the research that needed to be mitigated. Personal questions were not asked of the professionals. All questions focused on professionals’ experience related to parent-child contact problems post separation and clinical interventions used for the practice of reintegration therapy. No questions about specific cases were asked.

Procedures for maintaining confidentiality and privacy were followed including the secure storage of all records in locked cabinets and digital information stored on a secure password-protected and encrypted computer.

The Interview

Participants selected for inclusion were contacted via email. Participants provided this researcher with a time and date they were available for the interview. Participants had the option to participate in the interview over the phone and if feasible, in person at the Factor-Inwentash Faculty of Social Work, University of Toronto, Canada.

This researcher portrayed herself as a neutral, accepting and curious individual eager to listen to respondents’ experiences with interest. In order to facilitate an open and friendly inquiry process, this researcher introduced herself as a fellow practitioner who was currently engaged in doctoral studies and interested in this complex area of practice.

This researcher stayed close to the interview guide, listened with great care, and probed for elaboration and/or clarification to avoid contributing personal thoughts, beliefs or
impressions about participant experiences.

Many participants thanked this researcher for engaging in this area of research. Participants remarked that they consider this area of practice to be very complex where more research is desperately needed. Participants welcomed the opportunity to reflect on their practice and appeared to appreciate putting their practice, intuitive understandings and implicit theories that guide their work into words.

Transcription

All interviews were audiotaped. Verbatim transcriptions were made of each interview. Long pauses, laughter, and gestures that indicate one is in deep (hmmm….let’s see) thought were noted. Participant anonymity was protected by numerically identifying all interviews (e.g. participant #1, participant #2 etc.). Transcripts were exported into NVivo (11.1) for data analysis.

Discovery of Analytic Categories (Data Analysis)

McCracken’s (1988) method of data analysis was utilized to redact emergent themes found among the sample of participants. McCracken (1988) provides a five-step procedure for data analysis. In practice, McCracken notes the stages are fluid. The five steps include:

1. Identifying utterances and making observations (coding)
2. Expanding observations or creating meaning units (through evidence in the transcript)
3. Comparison of observations while looking for themes, patterns or interconnections
4. Development of patterns and themes
5. Bringing themes together into a conclusion

Coding

This researcher began by first reading the interview transcripts in their entirety to gain an overall sense of the data prior to importing the transcripts into NVivo. This is in line with
Cresswell’s (1998) suggestion to begin data analysis by reading transcripts in its entirety before engaging in line-by-line coding. This ensured the researcher understood the participant’s context. This researcher imported the transcripts into Nvivo and engaged in open coding by marking phrases (i.e. utterances) used by the respondent that stood out as significant. Utterances and accompanying coded observations were treated independently of each other ignoring its relationship to other aspects of the text. This researcher attempted to keep participants’ voice in the text by using their own words as coded observations.

**Meaning Units**

The researcher then identified the utterances and coded observations and attempted to establish meaning based on what the participant was saying as evidenced in the transcript. At this stage of the data analysis, the researcher begins to ask the interpretive question “What is going on here?” or “What is this participant saying?” Attention shifted from line-by-line analysis to larger segments composed of sentences and paragraphs. Labels were created for these meanings based on this researcher’s knowledge of the literature review, own cultural review and evidence found in the transcript.

**Comparison of Observations**

In this stage of the data analysis, meaning units were examined in relation to each other to look for interconnections patterns or themes. Similarly, identified observations were grouped into categories and subcategories. In this part of the analysis, the focus shifted away from the transcript and toward the observation itself and its associated text, which linked them to each other and the literature.
**Theme Development**

Through an iterative process of examining and re-examining categories and subcategories, themes and subthemes were identified. Grouping the categories and subcategories into manageable themes, lent itself for greater ease in analyzing inter-theme consistency and contradictions between participants. This required the examination of the relationship of the themes to each other, comparing/contrasting them, and determining how themes may be developed into a broader conceptual framework of meaning emerging from the analysis. Evidence (i.e. associated quotations) confirmed or refuted the connections between themes. The last stage involved movement from the particular to the general (McCracken, 1988). It involved weaving individual narratives into a broader conceptual framework of meaning.

**Chapter Summary**

This chapter began by reviewing the research questions that provided the rationale to utilize an interpretive phenomenological qualitative research design using the *Long Interview* method for data collection and analysis. The chapter continued by providing information on phenomenology as a research method and a step-by-step description of the data collection and data analysis process. The following chapter presents the study findings and analysis.
Chapter 6
Study Findings

Chapter Overview

This chapter is broken down into two sections. The first section describes the sample of participants and offers a thick description of practitioners’ narratives to the primary research questions. The second section of this chapter presents the overarching themes and subthemes that emerged from the interview data during the analysis. These overarching themes and subthemes allow one to draw some consensus among practitioners in their understanding and clinical practice of reintegration therapy.

Description of Sample

The sample consisted of a total of 14 participants (eight females and six males) from both Canada and the United States. Given how specialized this area of practice is, in order to protect the confidentiality of respondents, a detailed chart linking respondents to demographic information will not be presented. Instead, a descriptive overview is offered in its place.

Of the 14 participants, eight participants (four females and four males) were from different parts of the United States and six participants (four females and two males) were from different part of Canada (i.e. Ontario, Alberta and British Columbia). Participants held doctoral level psychology degrees (n=9, PhD); master of social work degrees (MSW, n=3) and master level counselling psychology degrees (MA, n=2).

All participants reported significant levels of professional practice experience. The vast majority (n= 10) reported over twenty years of clinical and forensic practice experience. The average years of clinical experience of this study’s sample was 24.2 years. All respondents were
actively practicing licensed mental health practitioners in their respective jurisdiction. Of the 14 participants, 13 held a private practice dedicated to separated/divorced families involved in the court system. One participant was employed as a mental health professional in the public sector on a full time basis but had established a private practice specializing in high conflict separated and divorced families for over 10 years. Of the 14 participants, three reported specializing in reintegration therapy.

Variation was seen in the number of years practitioners reported practicing RT. The number of years ranged from 3-5 years (n=5), 6-10 years (n=1), 11-15 years (n=2), and 16-20 years (n=6). Variation was also seen in the number of RT cases practitioners had conducted in the past twelve months ranging from 1-5 cases (n=6), 6-10 cases (n=3), 11-15 cases (n=2) and over 15 cases (n=3). Overall, the sample is comprised of experienced, well-educated practitioners whose knowledge is derived and developed from their involvement in direct frontline practice.

**Thick Description of Training in Reintegration Therapy**

**RT Training**

Eleven of the fourteen participants reported receiving some level of formal training to learn how to work with these complex families. Formal training was obtained by attending workshops and conferences (n=9) in the subject area. In addition to the workshops and conferences five of the eleven participants received more intensive training by leading experts in the field.

Intensive training consisted of attending either a two-day educational workshop that provided education and techniques for working with these families, an in-vivo multiday
immersion experience with families in a residential setting (e.g. camp, farm, resort etc.) or the opportunity to assist/intern on an individual case with a leading expert in the field.

Participants’ reported workshops and conferences were predominantly held through the Association of Family and Conciliation Courts (AFCC). This organization describes itself as an interdisciplinary international organization of professionals dedicated to improving the lives of children and families through the resolution of family conflict. Seven of the eleven participants reported receiving training by attending a 90-minute AFCC workshop.

Of the 11 participants that received formal training, six identified feeling that formal training provided them with a greater understanding of the complexities of these families and insight into how to clinically work with them. This was illustrated with comments such as:

It [training] has changed my understanding of the context of the interventions and helped me appreciate how important it is to have the proper legal set up to the intervention and to clarify to the parents the limitations of the intervention.

Another participant reported:

I think it [training] has been pretty essential. All of my training…has been incredibly important and then all of my training and experience in the court system, which these cases are embedded in and therefore impacted by, has been really important.

In contrast, two participants that attended workshops reported feeling ill equipped to clinically work with these cases. These respondents reported they believed training and education is still lacking. This is illustrated by the following comment:

I don’t think it [training] has prepared me, no. I think we know a whole lot more about what is wrong with these families than how to fix them...But, with that said, I don’t think that we really know a whole lot about this or really how to do this work well. I think we still really struggle with these cases…. We don’t really know what we’re doing. We just do the best that we can and we hope that it works…we’re just kind of groping in the dark.

Similarly, another participant reported:
This is a developing skill set, or expertise area for me. I treat any case like a lab, like you know: What is going on here? And, how can I learn and reflect on it?

Five of the eleven participants reported training with leading experts in the field either by taking an intensive two day workshop (n=3) or participating in a multiday in-vivo immersion training where they could observe the intensive treatment models in action (n=2). Of the two respondents that participated in the immersion experience, one respondent also reported having conducted an internship with an expert in the field. In contrast to the immersion, the internship allowed the respondent to assist the principal clinician and the ability interact directly throughout treatment of a family.

The respondents who participated in the immersion training appeared to have benefitted from the in vivo experience and reported that not only did it help shape their understanding of this complex issue, but they also reported being able to transfer new clinical knowledge and skills when working with their own clients.

My internship was incredibly useful in running the ins and outs and any sort of pitfalls to working with these families… I worked with a family camp one year and so that training, actually doing it, I think is the most useful because you can watch the team around you and how it works and get real life interaction with these families. So that was incredibly helpful.

The second respondent indicated

It wasn’t until 2013 that I went to the family camp that I felt I received any training that provided me with effective skills on how to do the interventions…. My focus changed significantly at that point and hasn’t changed back since then. So I would say that since the camp, my practice has been very different following those principles.

It appears that having the direct experience of observing families and clinical work in action provides clinicians with a richer understanding of the complex dynamics, has shaped their practice, and based on their feedback, helps respondents feel more confident in its practice.
Related to the idea that direct experience provides a more profound level of understanding and training, the vast majority of participants (n=11) felt that their individual clinical experience with high conflict families prepared them to provide reintegration therapy. As one participant stated:

It has been my clinical experience that has been the best teacher of all and my clients through the years have offered me opportunities to learn new things.

Other participants who expressed similar views reported:

I feel like the most important part of my training has been my real-life experience with it.

Well, I would certainly say my own experience, you know 24 years of conducting custody/access assessments and really 24 years of private practice have been the biggest learning tool.

Based on these statements, it is evident that respondents perceive direct practice being most helpful in understanding the nuances of high conflict families.

Of interest, four participants reported participating in training that was indirectly related to this area of practice. These participants reported being able to transfer skills and knowledge to the population of children resisting parental contact. Participants reported finding training in mediation, custody/access assessments, domestic violence, trauma, recreation and experiential therapy helpful when working with these families. One participant stated:

Getting training in recreation and experiential therapy is really, really important umm which I have done because these families often times resist traditional talk therapy.

While this finding could be used to help advance the current available training models, respondents were unable to articulate what specific features of the related trainings they found helpful and how they were able to utilize and transfer that knowledge in their practice of reintegration therapy.
Thick Description of Underlying Theory

Underlying Theoretical Understanding of Reintegration Therapy

Based on the discrepancy in the theory based service models found in the research literature, participants were asked to share what theories they draw on to understand parent-child contact problems and link how their theoretical understanding has directly informed their clinical practice.

Participants appeared to struggle when answering these questions, especially when answering how theory has informed their practice. Respondents took long pauses, sighed or asked the researcher if it was possible to list multiple-choice options or provide examples to help solicit responses. Based on the verbal and non-verbal responses, these questions appeared to elicit thought and provide an opportunity for respondents to reflect on their own practice. This was apparent by gestures or comments such as “hmmm”, “let’s see”, “oh gosh, theory?” “wow, I’ve never thought of that before”, and “these are good questions to ask ...I don’t think about these things”. Based on these responses, it was apparent that practitioners’ experienced knowledge had not been fully formed and articulated.

Three participants were unable to identify theories and instead, provided examples to describe what they look for or encounter when dealing with contact disputes. For example, one respondent shared the following:

I have done some training in attachment, uh so I do… rely on that background in terms of evaluating attachment between parents pre and post conflict…So attachment, you know the family systems umm … oh gosh, I don’t know.

In this excerpt, the respondent struggled in identifying the theory used and admitted not knowing what theory is used to understand parent-child contact problems post-separation.

Another participant stated:
Well I mean umm it’s probably broken into like 3 main issues. One is that the parent did do something that umm you know hurt the child, put the child at risk…and that parent needs to you know take responsibility for that and look at what changes need to happen as far as their behaviour…so you know there is, that is one sort of theory or issue. The next one is the mistrust between, the animosity between the parents, leads to the parent believing that the child is at risk at the other parents umm household and so the caregiving parent creates a divide and you know influences the child into believing that they are at risk …

In the response above, the participant was unable to deduce a specific theory, but instead used concepts likely gathered from the literature and/or practical work experience that provided the respondent with thoughts, beliefs and working hypothesis on reasons that resist refuse dynamics develop. It is posited that these working hypothesis shape respondents’ assessment and practice with families.

The other eleven respondents reported drawing on several theories that help explain parent-child contact problems post-separation. The theories reported included: ecological systems theory/family systems theory wherein participants used these terms interchangeably (n=10), cognitive/cognitive behavioural theory (n=6), attachment theory (n=8) and child developmental theory (n=5). One participant reported that the field and the underlying theory of understanding this dynamic is still developing and did not offer any one specific theory.

**Does Theory Inform Practice?**

Using the coding and matrix coding query feature in Nvivo, few participants showed congruency in their stated theoretical understanding of contact disputes and using the same theoretical understanding and principles to inform their practice via the structure of therapy, clinical techniques used and/or identified outcome goals (See Table 3). Stated differently, few participants were able to provide examples of how their theoretical understanding of the problem was in some way used to inform the treatment they provided to their clients.
Ecological Systems Theory

While the majority of respondents indicated drawing on ecological systems/family systems to help them understand contact disputes, only five participants showed congruency in its direct application to therapeutic practice. Those that showed congruency were required to view the contact problem as an overarching systems problem with their service model reflecting this paradigm. For the purpose of this study, this researcher determined congruency was based on: 1) respondent’s inclusion of all family members in different combinations, as directed by the clinician; 2) the inclusion of extended family members or significant others, 3) The ability to receive information from other professionals that were involved with the family and 4) the inclusion of the larger macro legal system from the outset upon receiving the referral. This could include requiring a court order or on consent agreement for therapy or having contact with legal counsel to inform them about the objectives of therapy and review the service agreement.

Results revealed that five of the ten participants who reported using ecological systems/family systems theory incorporated the entire system as depicted above. Those that did report including all systems, including the legal system, reported that doing so ensures everyone is on the “same page” from the outset and is working in synchrony with the therapist. This is eloquently stated in the following response:

I think first of all having a systemic perspective really guides my work because I try very hard to pull all the players in right from the beginning. As I said already, that could even include the court in some instances, but legal counsel, of course the parents and the children, any other professional that have been or are involved. Because I just believe that we all have to be on the same page right from the beginning, and we have to have a similar view, a similar goal and a similar model that we are all working from.

Similarly, these respondents reported at times when dealing with complex cases, a team approach is used. The team approach requires the inclusion of all family members, extended family and court order or on consent agreement. In a team model, the clinicians each work with
different parts of the family system (e.g. co-parent system, parent-child system etc.) In these cases, the ecological systems model is maintained by ensuring frequent communication and information exchange between the therapists, synchronized goals and coordinated service. As is stated:

Looking at family as a system and trying to figure out how to intervene at a systems level. So I might have one person working with a child and rejected parent, somebody else working with the parent, somebody else is working with the child on their own outside of the process to help them sort things out…

The remaining five respondents who indicated drawing on family systems/ecological systems theory used contradictory methods in actual practice and failed to include all family members in treatment. Instead a variety of approaches were offered including working therapeutically with the rejected parent and child only, working with the co-parents only and only minimally including the child, or working individually with the child and each parent in dyad sessions, but never the co-parents together and never holding a whole family therapeutic session. Several reasons were provided to rationalize their approach, which appeared to vary based on the specific family dynamics encountered. Reasons provided included: too much animosity between the parents, co-parents refusing to attend meetings together previously in other capacities, restraining orders in effect, court orders that specify the family members that should participate in therapy or viewing the issue as primarily a co-parenting issue that should be handled between the co-parents only. One of the respondents reported:

The cases I have been involved with there is very little trust, or there is a restraining order or there is just been too much water under the bridge because of allegations. I could not possibly have both parents in the same room.
As such, while the majority of practitioners reported subscribing to using a family systems approach, this was not supported in 50% of respondents' actual practice methods. These results are summarized and presented visually in Table three below.

**Table 3: Congruency between purported theory and practice: Family Systems/Ecological Systems Theory**

<table>
<thead>
<tr>
<th>Ecological Systems Theory</th>
<th>Drawing on Ecological/Systems theory in practice</th>
<th>Requiring participation of all family members</th>
<th>Congruency between Purported Theory and Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents reported:</td>
<td>10</td>
<td>5</td>
<td>5/10</td>
</tr>
</tbody>
</table>

**Attachment Theory**

Eight participants reported attachment theory as an essential theory to help understand parent-child contact disputes and inform their practice. It is unclear how respondents conceptualized the idea of attachment and its direct relation and importance to contact disputes. For instance, it was unclear if respondents were using attachment theory with respect to understanding the relationship between the rejected parent and child, the relationship between the favoured parent and child, or if they were referring to the attachments patterns of the family as a whole or each party’s individual attachment style developed through family of origin experiences. Respondents used different key words such as ‘feeling safe,’ ‘safety in relationships,’ ‘attachment issue’, ‘enmeshment’ ‘extreme loss’ and ‘secure attachment’ when making reference to attachment theory and its direct link to practice.

Findings revealed that respondents pull on different aspects of attachment theory when tailoring their intervention via therapeutic structure, clinical techniques or outcome goals. For example, some clinicians viewed contact problems as an attachment disruption between the rejected parent and child in which psycho-education and experiential activities were used as
clinical techniques to attempt to repair the attachment. Other clinicians drew on attachment theory to explain the enmeshed relationship often encountered between the child and the favoured parent. In this case, the goal was to assist in helping an enmeshed parent separate their needs from that of their children. The use of psychotherapy was promoted where the therapist was able to provide the support they needed to help differentiate needs. For instance, in the following excerpt the respondent reported viewing the parent-child contact problem as an attachment disruption between the rejected parent and the child. This respondent identified working primarily with the rejected parent and teaching that parent skills to be able to repair the attachment relationship.

I’m really looking at it as an attachment disruption as opposed to, I don’t see this is just a program for alienation. It is all attachment stuff, and where we pull on the same information in the sense of training the parent, we have a process we put them through which is basically attachment boot camp where we are going to train you on attachment because you have to become a master of attachment when you are trying to re-attach with your child.

In contrast, other respondents viewed the contact problem stemming from the favoured parent’s enmeshment with the child. In this case, the clinician’s focus was on the favoured parent’s ability to develop healthier attachment patterns. As stated in the following excerpt:

Attachment theory has been extremely informative around doing this work. I think the understanding of family dynamics particularly in regard to enmeshment that can occur in families and how that can be understood and worked with. What do enmeshed parents need in order to be able to let a child separate?

In contrast another participant used attachment theory to understand each parent’s individual attachment style based on family of origin experiences. This participant assessed individual attachment style as it relates to each parent’s ability to deal with the emotions associated with the physical separation and its impact on one’s parenting. This participant
reported using elements of psychodynamics as clinical techniques in attempt to repair the family relationships. This is illustrated in the following excerpt:

I look to attachment theory and so what kind of connection and attachment style the parent has, and what their connection with their family of origin’s attachment style is and in the connection with the kid or kids… I try to come to a formulation of what is the critical dynamic going on here, and what kind of transactions can I invent, create or promote in the office, or outside the office to engage the parties to create a new experience.

Based on the several different responses, it is evident that clinicians conceptualize and utilize aspects of attachment theory differently impacting the clinical work selected with the families and the outcomes they wish to achieve. Table four below illustrates the distinct ways in which attachment theory was applied in respondents understanding of parent-child contact problems.

**Table 4: Application of Attachment Theory to Understand Parent-Child Contact Problems**

<table>
<thead>
<tr>
<th>Contact Problem Viewed As:</th>
<th># of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment disruption between the rejected parent and child</td>
<td>2/8</td>
</tr>
<tr>
<td>Enmeshed relationship between favoured parent and child</td>
<td>1/8</td>
</tr>
<tr>
<td>Each parent’s individual negative attachment patterns and its contribution to contact problem</td>
<td>1/8</td>
</tr>
<tr>
<td>Not described</td>
<td>4/8</td>
</tr>
</tbody>
</table>

**Congruency**

To assess congruency between theory and practice, this researcher analyzed different clinical techniques one could use to target attachment. In particular, this researcher assessed whether respondents used 1) experiential techniques as a way to facilitate improved relationships
in real time, 2) psycho-education with emphasis on teaching parents how to be emotionally attuned and responsive to the child’s needs, and 3) psychotherapy to provide emotional support, develop a therapeutic alliance, and provide the family or parent-child dyad with a supportive holding environment. Lastly, this researcher also analyzed whether respondents identified improved attachment patterns as an outcome goal of RT.

Of the eight respondents that purported subscribing to attachment theory, six participants identified using experiential techniques to achieve this goal, six reported actively using psycho-education, and four reported using psychotherapy. In addition, six of the eight participants that purported subscribing to attachment theory identified improved attachment as an actual outcome goal of RT. Table five below visually summarizes this information.

**Table 5: Congruency between purported theory and practice: Attachment Theory**

<table>
<thead>
<tr>
<th>Attachment Theory</th>
<th>Attachment Theory as overarching theory</th>
<th>Use of Experiential Clinical Techniques</th>
<th>Use of Psycho-Education</th>
<th>Use of Psychotherapy</th>
<th>Improved Attachment Patterns as Outcome goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># of respondents reported:</td>
<td>8</td>
<td>8</td>
<td>13</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Congruency between reported theory and practice</td>
<td>5/8</td>
<td>6/8</td>
<td>4/8</td>
<td>6/8</td>
<td></td>
</tr>
</tbody>
</table>
Cognitive and Cognitive-Behavioural Theory

A total of six participants acknowledged using cognitive and cognitive behavioural theory to inform their understanding of contact refusal dynamics and their practice. Four of these six respondents showed a direct link of theory to practice by identifying using cognitive therapy, behaviour therapy and cognitive behavioural techniques as a specific therapeutic technique with clients.

Discrepancy was noted whereby eight respondents reported using cognitive behaviour therapeutic techniques when working clinically with these families, but did not consider cognitive theory as a theoretical framework that informs their practice. Similarly, eight respondents reported addressing cognitive distortions was a goal for reintegration therapy but only one of these eight respondents showed congruency by also identifying cognitive theory as a theory that informed their practice and addressing distortions as a key goal of reintegration therapy.

Table six below provides a visual illustration of results that depict the congruency between respondents’ who considered cognitive theory and cognitive behavioural theory as an overarching theoretical framework and the direct link to practice via the use of CT/CBT clinical techniques and/or identifying addressing cognitive distortions as an outcome goal.
Table 6: Congruency between purported theory and practice: CT and CBT

<table>
<thead>
<tr>
<th>Cognitive Theory (CT) and Cognitive-Behavioural Theory (CBT)</th>
<th>CT or CBT considered overarching theory</th>
<th>Active use of CBT clinical techniques</th>
<th>Addressing cognitive distortions identified as an outcome goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># of respondents reported:</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Congruency between reported theory and practice</td>
<td>4/6</td>
<td>1/6</td>
<td></td>
</tr>
</tbody>
</table>

**Child Developmental Theory**

Lastly, five respondents reported drawing on child developmental theory to help inform their understanding of parent-child contact problems. Several conceptualizations and definitions of how they understood this theory in relation to the contact problem were offered. For instance, one participant reported that a child’s age and stage of development was important to take into consideration for understanding a developmentally appropriate affinity between a parent and child. This participant stated:

The developmental issue of the age of child, stage of child and where they are you know. That there is understanding that children at a certain age are more vulnerable to certain things and have connections with one parent perhaps in a way that’s more developmentally appropriate because of shared interest or they’re of the same gender and so on…

Another participant looked at child development to determine whether the child’s reaction to the conflict was a developmentally appropriate reaction. In particular, the respondent identified with the notion of a child picking a side as a protective defense in coping with the parental conflict. This was illustrated with the comment:
The idea that the child is being caught in the middle and having to themselves take a position to protect themselves from the conflict between the parents.

In another instance, the participant reported that a child’s ability to reason and think critically, which improves as one matures, is a key factor to consider. This was illustrated by the comment:

It was basically early developmental theory because the child had not reached the age where they could reason, and therefore was persuaded by who gives the most and who can promise the most.

In contrast, another participant reported using child developmental theory more broadly to help them understand where each family member is at from a developmental perspective. This participant reported:

I also think that a developmental approach is critical. Both in terms of understanding each individual child and their developmental trajectory but also understanding the development of each of their parents and how that may foreshadow the kind of problems that the family system is now facing.

Table seven below visually captures the way in which child developmental theory was applied and/or conceptualized to understand parent-child contact problems.
Table 7: Application of Child Developmental Theory to understand Parent-Child Contact Problems

<table>
<thead>
<tr>
<th>Conceptualization of Child Developmental Theory in Relation to Contact Problem:</th>
<th># of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s age and stage of development taken into consideration</td>
<td>1/5</td>
</tr>
<tr>
<td>Child’s reaction to conflict in relation to developmental stage of development</td>
<td>1/5</td>
</tr>
<tr>
<td>Child’s maturity and ability to reason</td>
<td>1/5</td>
</tr>
<tr>
<td>General consideration of family development</td>
<td>1/5</td>
</tr>
<tr>
<td>Not Described</td>
<td>1/5</td>
</tr>
</tbody>
</table>

Based on the various responses and conceptualizations offered of child developmental theory, this researcher accepted psychotherapy and the use of psycho-education with a focus on developing better conflict resolution skills and improved critical thinking skills as applicable and potential clinical techniques that could be used by respondents that reported being informed by child developmental theory.

All five respondents reported using psycho-education and psychotherapy. However, respondents did not indicate whether the focus of these sessions was to improve critical thinking skills, which also overlaps with cognitive/cognitive behavioural therapy and theory. Three of the five respondents reported focusing on conflict management and conflict resolution skills to help the child navigate their way out of being in the middle.

With respect to key outcome goals, only two of the five respondents indicated that improved critical thinking for the child was a key goal. One of the five respondents identified improved coping mechanisms and none of the five respondents that identified drawing on child developmental theory indicated improved conflict resolution skills. Table eight below illustrates the congruency between theory and practice from the sample of respondents.
Table 8: Congruency between purported theory and practice: Child Developmental Theory

<table>
<thead>
<tr>
<th>Child Developmental Theory</th>
<th>Child developmental theory considered overarching theory</th>
<th>Use of psychotherapy to improve critical thinking</th>
<th>Use of psycho-education improve conflict resolution</th>
<th>Identified improved coping mechanisms and improved critical thinking as RT outcome goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># of respondents reported:</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

In sum, it appears that clinicians report a number of theories they draw on, but only a select few were able to directly link theory to actual practice by way of the delivery of therapy, clinical techniques used and reported key outcome goals.

**Thick Description of Screening Methods**

**Screening Methods/Assessment Tools**

Much disparity was seen in respondents’ screening methods prior to accepting to clinically work with a family in reintegration therapy. Generally, respondents made the decision to proceed with providing clinical service based on receiving a court order, clinical interviews, information received from collateral reports and their professional judgment.

Thirteen of the fourteen participants reported conducting clinical interviews with the parents (often referred to as an ‘intake’ interview), in which background information and context are gathered. However, the questions and information sought by clinician’s during the intake
interview differ. There appears to be no standardized questionnaire or specific screening
questions routinely asked by all respondents during the intake interview.

There is widespread recognition within the field that reintegration therapy is not suitable
for families where there has been serious domestic violence or abuse. However, there is limited
guidance available on what would constitute serious versus less serious domestic violence.

All 14 respondents reported that they would not provide services in cases where there
was ‘severe’ domestic violence. While this was conveyed, only six of the 14 respondents
reported screening for domestic violence. Of the six respondents, only one respondent reported
using a formal screening tool for domestic violence, but was unable to recall the name of the
screening tool used. The other five respondents reported they asked questions during their intake
interview that serve to detect power imbalances and domestic violence. One of the six
participants reported screening for domestic violence by confronting both the alleged victim and
perpetrator about claims and allegations that were disclosed. This is in contrast to some domestic
violence screening training that advises against confronting a supposed perpetrator about an
alleged incident (Linton, 2014).

Ten of the fourteen participants reported reviewing relevant collateral reports by tertiary
professional providers. This included reviewing child custody evaluations, child protection
records, police records, reports from other therapists and relevant court documents.
Professionals reported receiving context from these sources and referring to these sources to
ascertain the veracity of statements and allegations. For instance, respondents reported that if
there were allegations of child abuse in the past, they would look at child welfare reports or court
documents to see if the concern was “verified” or “substantiated”. Respondents appeared to rely
on the findings of the tertiary providers to inform their decision.
This finding may have severe implications since it is widely known that domestic violence is often underreported where police reports and/or other authorities may fail to capture the dynamics (Ellsberg, Jansen, Heise, Watts & Garcia-Moreno, 2008). Similarly, abuse may not be ‘verified’ per se as a result of a child providing inconsistent statements that would meet the threshold to verify the abuse, but does not preclude the fact that some type of parent-child altercation occurred. Further, researchers have criticized custody evaluators for lack of training and knowledge in the area of domestic violence and evaluators’ underuse of specialized instruments for assessing domestic violence (Bow & Boxer, 2003; Haselschwerdt, Hardesty & Hans, 2010; Horvath, Logan & Walker, 2002).

None of the participants identified using specific behavioural indices or assessment tools to assist them in determining whether or not to accept a case based on the type and intensity of the presented strained parent-child relationship. One participant reported using a brief mental health test to determine a client’s level of functioning and willingness to participate in therapy. However, this respondent acknowledged that is not an assessment tool to help determine the type of contact problem.

Eight respondents identified that in conjunction to clinical interviews and collateral information, they use their own clinical judgment and reserve the right to accept or refuse a case based on whether they believed the case was suitable for reintegration therapy.

It is evident that significant disparity exists among respondents on what information is gathered and how the information is used to consider suitability in reintegration therapy. Currently, there are no formal assessment tools available to help mental health professionals differentiate the type of strained relationship or its intensity. Unlike the ability to accurately diagnose medical conditions and its related clinical stage (e.g. Stage I, II, III, etc.) based on a
multitude of tests and images, there is no clear way for a mental health professional to definitively know whether a case is an ‘alienation’ case, ‘hybrid’ case, ‘justified rejection’ case or its intensity (i.e. mild, moderate, severe). The implications of the absence of an assessment tool, failure for many to actively screen for domestic violence, and substantial weight placed on tertiary reports, risks placing children and families in unsuitable treatment.

While there is significant disparity in screening methods used for engaging in reintegration therapy, and concerns that arise from this, some consensus on selected criteria to determine suitability for participation in reintegration therapy emerged among respondents. This will be described in detail later in the chapter.

Thick Description of Clinical Techniques

Clinical Techniques Utilized

Consistent with the several theories used to guide/inform respondent’s practice, numerous clinical techniques were reportedly used among respondents. The analysis of the data revealed no connections between respondents’ educational background and years of experience with the clinical techniques used. Clinical skills identified by respondents appear to be eclectic and based on respondent’s personal preference, previous training and/or level of comfort with a technique and specifically targeted to the presenting family. Respondents identified five main clinical skills used: psycho-education and psychotherapy where parent coaching, skill building, and conflict management are heavily emphasized, an experiential therapeutic approach; cognitive and behavioural therapeutic techniques, and the use of authority.

I. Psycho-education

Psycho-education was a clinical approach used by all fourteen respondents. Several topics that respondents discussed with family members fall under the larger category of psycho-
education. For instance, respondents shared they provide information to parents and children about behaviours that promote the development of contact refusal dynamics, research findings about the negative long-term consequences of poor parent-child relationships, information about the law, parent-child access arrangements and the importance of children not being placed in a position to choose whether they will follow the court order, skills to engage in healthy communication patterns, information about attachment and security among others.

Heavy emphasis was placed on the ability for families (i.e. parent-child dyads and co-parents) to learn the necessary skills to manage and resolve conflict successfully with one another. This finding is made based on information shared by nine respondents who noted focusing in this area with the families and evidenced in the following statement:

I spend a fair amount of time in sort of psycho-educational orientation mode, orienting them to different you know, different components of the intervention and my role as conversational manager. What I mean by that is that I tell the parents that like a referee in a football game, I am in charge of making sure that things are moving in a productive way.

Respondents emphasized providing parent coaching and skill building as essential components of both psycho-education and psychotherapy. Respondents qualified parent coaching as teaching parents’ skills on how to react and respond to concerns present in the family dynamics or specifically brought up by the children. This included helping the rejected parent respond to a child’s concerns in a suitable manner and taking accountability for realistic behaviours that may have upset the child. For instance, one respondent reported:

Another thing that I do, that is really critical, is meet with each child separately and get an understanding of what their concern might be with the rejected parent and coaching the rejected parent in a separate session to umm be aware of what these concerns are and to be able to listen and be calm and be patient and be understanding

In line with this idea, another respondent reported:
Preparing the parent to take ownership and responsibility and acknowledging and apologize.

Respondents’ noted that often in these cases children present with challenging oppositional behaviours during access visits. As such, they report coaching the rejected parent in responding to difficult problem behaviours that may present themselves. For instance, this is depicted in the following excerpt:

Coaching them prior to the visit. Like if it is a rejected parent let’s say for example, coaching them about how to deal with behaviour if it presents itself during the visits. So how to react and how not to react.

This researcher posits this is an active way for clinician’s to teach the rejected parent practical parenting strategies to ensure that parent does not engage in counter-rejecting behaviours.

Respondent’s also reported using coaching with the favoured parent specifically with respect to helping them learn how to better support the child’s contact with the rejected parent. Respondents indicated they would coach the favoured parent by assisting them in finding different language to use with the child(ren) about contact with the rejected parent and different behaviours that had not been used before. For example, the following excerpt illustrates a respondent coaching the favoured parent in shifting language and behavioural patterns.

Yesterday I had a case and you know we came up with the language on what to say to the child that the parent is comfortable, and supportive, and encouraging and you are going to be okay. You know you are going to have visits with your mother and you are going to be okay and I have no concerns…You are going to be okay!

Lastly, respondents also reported working with the child to help acknowledge and communicate difficult thoughts or feelings with both their parents. This was highlighted by the response, “helping the child assert their feelings with both the rejected parent and the favoured parent”.
II. Psychotherapy

There was significant overlap between psycho-education and psychotherapy since both parent coaching and skill building elements could be conducted within individual therapeutic sessions. Respondents reported that an element of focus in psychotherapy was building a therapeutic alliance and trust with the clients (n=5), exploring individual thoughts and feelings (n=3) and providing emotional support (n=1).

Statements supporting this include:

Beyond that I try and provide a lot of support. Try and help the parents clarify their own feelings about things, help them to understand, observe themselves and you know regulate their own conscious or unconscious processes and how it results in communication and things like that.

I generally just try to build a therapeutic alliance with them so that they will trust me, because these kids usually hate anything to do with the court, attorneys or anybody else who is court ordered.

Developing a trusting therapeutic relationship appeared to be essential for developing insight into the individual family members’ way of understanding and relating to each other. This enables a therapist to develop more awareness into their behavioural patterns and assist in supporting the parents and the child.

III. Experiential Therapeutic Elements

An experiential component was identified as an essential element when working with these families. Respondents who identified using this approach reported one of the key elements for improving relationships is to help family members develop new experiences and provide a safe space for connections and reparative experiences to occur. Experiential elements varied in forms and respondents included examples of playing games (e.g., board games, card games), cooking together, bringing olfactory memories to the forefront, eating together, playing sports
(e.g. volleyball, basketball), watching movies, engaging in recreational activities, and using animals. For instance, two respondents reported:

I use a lot of play. Get out for a ball, give them a positive experience and then maybe have an opportunity to talk.

The ability to parallel play while talking again helps children and parents connect. Even when they don’t, maybe they’re not connecting in a cognitive intellectual way, but behaviourally they are connecting by doing an activity with the team and the parent involved. Umm we might do cooking, ummm, which again is a way of building a sort of connection and can bring an olfactory memory of meals they used to share together. It can actually create new memories of meals they plan to share together umm and again sort of an experiential way of interacting behaviourally.

Respondents who reported using an experiential approach indicated the experiential component was essential in bringing about a different level of connection and bonding experience. Respondents who frequently utilized experiential approaches for reconnection, reported difficulty in recreating this type of connecting experience in an office setting. This is illustrated by the following comment:

You need to have the combination of supported reconnection experiences, which are just normal positive connections like going to the park, like going shopping, like watching a movie, and then you pair that with therapeutic sessions where you both prepare for those and you also debrief those…You cannot fully reconnect in an office setting.

IV. Cognitive and Cognitive Behavioural Therapy Techniques

Ten respondents shared using cognitive and cognitive behavioural techniques to help family members minimize anxiety. Respondents reported all members of the family might be exhibiting anxiety for different reasons. For instance, the child may be exhibiting anxiety about having contact with a parent, where in some cases, contact has not occurred for several months or even years. The favoured parent may be showing signs of anxiety about the child spending time or having contact with the rejected parent; the rejected parent may exhibit anxiety about
spending time with a child who has been resisting/refusing contact or whom they have not seen for a prolonged period of time.

Two of the ten respondents reported using gradual exposure/systematic desensitization, a type of behavioural therapy, to help minimize anxiety related to re-establishing contact. This would occur by starting the reconnection process using indirect contact (e.g. letters) and gradually increasing the level of contact where direct contact is the end result. One example of such a method is provided in the following narrative:

Gradually expose the rejected parent and the details will depend on the circumstances, the child’s age, the degree of resistance, but will often include things like: photographs of past times together. I’ll have the rejected parent write a letter, make a call, send videos, make an audio recording, and gradually monitoring the child’s anxiety and resistance as he or she is exposed to that rejected parent.

Nine respondents described using cognitive therapy to assist parents and children address cognitive distortions, to help family members learn to view situations from multiple perspectives and develop more realistic and balanced thoughts. While nine respondents stated the use of cognitive therapy, only five respondents used examples of how it is used in practice. For instance, one respondent candidly reported:

If there is a sexual abuse allegation that has been disproved over and over again and the preferred parent is still seeing the resisted parent as a sexual predator who was sexually abusive I would call that one straight on and say that “how is it that despite all these disconfirmations… you have this continued perception of your ex spouse”?

The use of careful monitoring was reported to be an essential component for being able to capture distortions and behaviours that are incongruent to what is occurring in the therapeutic milieu. Four of the nine respondents reported that immediately following a therapeutic session or a community visit, the rejected parent and child return to the office and the visit is debriefed, individually with the child and jointly with the parent-child dyad prior to meeting with the
favoured parent. Once the preferred parent arrives to the office, the visit is again debriefed with the child, the favoured parent and therapist. The therapist is able to catch when distortions are being made and assess the favoured parent’s reaction as encouraging, discouraging, or accepting as it evolves.

V. Use of Authority

Three respondents shared using their authority or threat of a potential custody reversal as a technique that could promote change in the dysfunctional family dynamic. These respondents reported being aware of the level of power they had and the expectation to report to those who are in a position to adjudicate. For instance, this is captured in the following narratives:

I mean the court has usually given me pretty broad authority and, if I may say, some power. I do think there are ways in which we can use our influence or our power, or the perceptions of our power to get people motivated to do things they might not otherwise do.

I tell the parent you are going to listen to the child and….you are going to thank the child for being brave for telling them…and the parent is told very clearly if you start arguing, if you start saying no that never happened, if you blame the other parent for it... I will throw you out faster than you can blame me and I will refuse to work with you and I will send a report to the court that this happened.

Aside from providing psycho-education and psychotherapy, there appears to be considerable inconsistencies amongst the clinical skills and techniques used by respondents with families. Generally, respondents appeared to struggle articulating what clinical tools they use with these families. The struggle may have been either because skills vary depending on the family’s presenting problems or due to the multiple clinical skills needed when working with these complex and contentious cases.
The diagram below illustrates the five large categories of clinical skills described by respondents as being primarily used for the practice of reintegration therapy. Under each, a list of the specific elements respondents emphasize from the category is provided.

**Figure 4: Clinical Skills Used in Reintegration Therapy for Parent-Child Contact Disputes**
Thick Description of Service Delivery Models

Outpatient Treatment

In line with the several different responses provided with respect to training and theoretical frameworks, a wide range of service delivery models for treatment was also noted. Respondents were asked to provide detailed accounts of their service delivery model when conducting outpatient treatment. Questions on the family members involved in reintegration therapy, structure of sessions (i.e. individual, dyadic, family sessions, other approaches), length, frequency, setting where sessions are held and typical length of treatment were asked.

Respondents had different viewpoints on which family members were expected to participate in reintegration therapy. Findings revealed respondents believed participant involvement should include the co-parents only (n=2), the entire family system (n=8), both parents and the child separately while excluding the co-parents together (n=2), and the rejected parent and child only (n=3). Discrepancy was also reported in the structure of the delivery itself; respondents identified holding individual, dyadic and family sessions (n=8) individual and dyadic sessions only (n=4), and utilizing a team approach (n=6) where different therapists work with different family members, collaborate together, and conduct clinical sessions together with the family members. Two of the six respondents that indicated using a team approach reported needing to use this method especially in severe or entrenched cases. However, the way in which severity of parent-child contact problem was measured or assessed was not identified.

The following excerpt illustrates this idea of utilizing a team approach:

There are two different ways we do it. It depends on the severity. If we’ve got something that is just really extreme, we may have a therapist for the child and a therapist for each parent... When we have the initial parent-child sessions, we’re going to have 2 therapists involved. We’re going to have the parent’s therapist there as coach, security guard, whatever you want to call it and we’re going to have the child’s therapist there trying to facilitate the reunification.
There was no consistency around the length, frequency, setting of sessions or length of involvement. Respondents identified length of sessions were typically one hour (n=3), one and a half hours to two hours (n=5), two and a half hours to three hours (n=3) or varied (n=3). Frequency of sessions were typically held once a week (n=8), twice a week (n=1), once every two weeks (n=2), and once a month (n=3). Almost all respondents identified that a families’ financial resources and geographical distance were determining factors for the frequency in which sessions were held. Finally, there was significant discrepancy with the setting in which therapy took place and a therapist’s length of involvement. Settings where sessions take place ranged and included: the respondent’s office, in the client’s home, in the therapist’s home, on a large farm, within the community, among others. As well, respondent’s length of involvement with a family ranged anywhere from one month to three years. Two respondents indicated that if a family has not made progress within three to six months, there is little hope that the family situation will improve.

Table nine below summarizes this information and illustrates the variations in service delivery provided.
Table 9: Outpatient Service Models Available

<table>
<thead>
<tr>
<th>Family Members Involved in Treatment</th>
<th>Structure of Sessions</th>
<th>Length of Sessions</th>
<th>Frequency of Sessions</th>
<th>Setting</th>
<th>Length of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire family system in different combinations including individual, parent-child, co-parent and family sessions (n=8)</td>
<td>Individual, Dyadic and Family sessions (n=8)</td>
<td>One hour (3)</td>
<td>One time per week (n=8)</td>
<td>Office only (n=3)</td>
<td>3-4 sessions or one month (n=1)</td>
</tr>
<tr>
<td>Entire family involved with the exception of clinician holding joint co-parent and/or entire family sessions (n=2)</td>
<td>Individual and Dyad only (n=4)</td>
<td>One and a half hours to two hours (n=5)</td>
<td>Two times per week (n=1)</td>
<td>Office and client home (n=2)</td>
<td>4-10 sessions or 3 months (n=2)</td>
</tr>
<tr>
<td>Co-Parents only (n=2) [minimal child involvement]</td>
<td>Team Approach (n=6)</td>
<td>Two and half to three hours (n=3)</td>
<td>Bi-weekly (n=2)</td>
<td>Office and Therapists home (n=1)</td>
<td>Six months (n=3)</td>
</tr>
<tr>
<td>RP and Child only (n=3)</td>
<td>Varies (n=3)</td>
<td>One time per month (n=3)</td>
<td>One time per month (n=3)</td>
<td>Office and community (n=7)</td>
<td>One year (n=2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Farm/Cottage (n=2)</td>
<td>Two Years (n=2)</td>
</tr>
</tbody>
</table>

Intensive Treatment Models

Four of the fourteen respondents interviewed identified providing intensive interventions to treat parent-child contact problems. Intensive interventions differ from outpatient treatment in that it requires the participation of select family members for several hours a day, several
consecutive days in a row. The intensive models typically occur in a different city or jurisdiction and sleeping arrangements are taken into consideration. A detailed account of respondents’ service delivery model for intensive interventions was provided. This included: information about which family members are involved and participate in the therapy, how sessions are structured (i.e. individual sessions, dyadic sessions, family sessions, or other approaches), length, setting, and sleeping arrangements.

Two of the four respondents who identified providing the intensive treatment model indicated doing so using an entire family systems approach. This includes participation of the child(ren), rejected parent, favoured parent, and any other significant member of the family (e.g. new partners etc.). Two models for providing this whole family intensive intervention were described. The first model was a multi-family model with several families participating in the intervention at once. Respondents reported having multiple families at once creates a unique experience for families as it provides the opportunity for individual members to identify with other families and individual family members that are experiencing similar dynamics. The second model identified was an intensive intervention held for one individual family at a time.

The other two respondents reported deciding which family members participate in the intervention based on the respondent’s assessment of the level of conflict, receiving specific facts about a case or based on a pre-existing court order. These respondents indicated that depending on the nature of the case, they would conduct the intervention with the child and rejected parent only, or as an entire family system. Intensives are conducted with one family at a time and are customized to that particular family.

The following excerpt illustrates this point.

Well umm after an assessment that’s when we decide who is typically involved umm ideally it involves both parents and the children, sometimes it’s just one parent depending
on the level of conflict. Also depending on the dynamics of the family system, the grandparents might be involved… so definitely extended family can be involved as long as it is clinically appropriate and supportive.

All four respondents who provide intensive treatment models indicated using a team approach where co-therapists are involved. Two of the participants reported having one therapist work with the rejected parent, another therapist work with the favoured parent, one therapist for the child(ren), and an administrative person who is ensuring that everything is functioning as needed while the intervention is occurring. The other two respondents indicated that there are at least two therapists involved during the intensive and they work collaboratively with each other and the family during the course of the intervention. All four respondents indicated that family members participate in several different combinations including individual sessions, dyadic sessions and entire family sessions (if the entire family is involved) during the course of the intensives.

The length of the intensive programs varied. Respondents reported the length of the multi-family intensive is four to five days. For family intensives with one individual family, two of the respondents reported the length of the program is two to three days, and the other two respondents reported the program varies from three to five days and can go longer than five days for severe cases. Respondents were unable to provide specific factors, assessment criteria or measurement tools used to label a family as severe or determine the number of days the family required in treatment. Length of service may also depend on a family’s available financial resources. Respondents who indicated five or more days indicated this typically occurs in cases involving familial abduction. This is described in the following excerpts:

The cookie cutter intensive is about three and a half days. And in the last couple of years they have begun to sort of grow in the sense of it might be anywhere between, in less severe cases three days to three and half to five days. And then as I said in a very rare
circumstance, it would be an extended stay. That is usually severe enough that it’s either a familial abduction scenario where the alienation was so severe the parent abducted the child and now has been returned by law or other extremes.

The setting was an important component of the intensive intervention and sleeping arrangements were dependent on the setting. Two respondents reported that the multi-family intensive model takes place at a quiet, remote camp location. In this setting, each member of the family sleeps in a different cabin (e.g. mothers in one cabin; fathers in another cabin) with the children sleeping separated from the parents. If there is more than one child, siblings are often separated into different cabins. This sleeping arrangement is a prerequisite of the program.

It’s a prerequisite [for children to sleep separate from parents]. If they’re too young to separate then they can’t come

Respondents did not provide an explanation for the reason why family members are separated to sleep. This researcher believes the sleeping arrangement attempts to ensure each family member remains open to the information being presented and the clinical work taking place.

One respondent reported that in the two-day individual family intensive intervention, due to financial constraints, the intervention took place from 8:30am until 5:30/6 pm in the clinician’s office during the weekend. In this arrangement, the children slept as per the usual parenting plan.

The other two respondents reported that the intervention takes place on a 1.25-acre farm. The grounds themselves are equipped with a multitude of recreational activities and a variety of animals that are an essential part of the therapeutic treatment.

These respondents reported their model allows for the participation of the rejected parent and child(ren) only, or the entire family system. Respondents reported that there is a house on premise, which families have the option of renting. In cases where the rejected parent and child
attend the program, this house is where the rejected parent and child sleep. A staff member may sleep in one of the rooms of the house as well. In cases where both parents participate, the favoured parent will stay in a hotel located nearby and the child(ren) stay with the rejected parent in the house on premise.

Table ten below summarizes this information and illustrates the differences in intensive service delivery provided. Information on which family members participate, length of program, setting and sleeping arrangements is provided.
<table>
<thead>
<tr>
<th>Participant Involvement</th>
<th>Structure of Sessions</th>
<th>Length of Program</th>
<th>Setting</th>
<th>Sleeping Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire Family System (n=4)</td>
<td>Team Approach (n=4)</td>
<td>4-5 days in multi-family camp intervention (n=2)</td>
<td>Held at a camp Held in farm/cottage Held in office</td>
<td>Each member of the family sleeps in a different location. Children sleep in a cabin separated from parents. Each parent in own cabin (n=1). Children sleep as per the parenting schedule (n=1). Child sleeps in a rental house with rejected parent and oftentimes (but not always) a staff member. Favoured parent sleeps in a nearby hotel (n=2)</td>
</tr>
<tr>
<td></td>
<td>Individual, Dyadic and Family (n=4)</td>
<td>Range between 2-5 days for individual families (n=2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejected parent and Child only (n=2)</td>
<td>Individual and Dyad (n=2)</td>
<td>Range between 2-5 days for individual families (n=2)</td>
<td>Held in farm/cottage</td>
<td>Child sleeps in a rental house with RP and oftentimes (but not always) a staff member</td>
</tr>
</tbody>
</table>
Thematic Analysis of the Data

Emerging Themes from Data Analysis

While significant discrepancies were noted in respondent’s use of theory, clinical skills and service delivery models, some commonalities surfaced. Three major themes and related subthemes emerged from the data illustrating patterns in the practice of reintegration therapy among respondents. These themes can be used to develop a collective understanding of reintegration therapeutic practice and can potentially assist in the formation of more formal practice guidelines. The three themes that appeared in the data include:

1. Reintegration therapy is viewed as a therapeutic process to improve family relationships;
2. Assessment criteria essential for accepting/refusing cases for RT; and
3. Overall treatment goals of reintegration therapy.

The following illustration (See figure 5) features the emerging themes and related subthemes found in this study in its entirety. A comprehensive review of each theme and subtheme follows.
Figure 5: Emerging Themes and Subthemes

**Themes**

**Theme One**
- Therapeutic process to improve family relationships

**Theme Two**
- Assessment Criteria

**Theme Three**
- Treatment Goals

**Subthemes**
- Healing Experience
- Mechanism for Reconnection
- Fostering Healthy Child Adjustment
- Determined to be in the child’s best interest’s
- Do No Harm
- Parents demonstrate reflective capacity for change
- Parents demonstrate willingness and commitment to therapy
- Re-establish Contact and Improved Parent-Child Relationship
- Functional Parenting
- Healthy Family Functioning
- Address Cognitive Distortions
Theme One: Therapeutic process to improve family relationships

The first theme and related subthemes that emerged from the data analysis was the way in which reintegration therapy was defined. Reintegration therapy appeared to demand more than a physical space to reconnect a resistant or reluctant child with a rejected parent. Rather, the main theme captured by respondents’ narratives was that reintegration therapy was a process intended to improve the family’s relationships. Three subthemes were derived from the main theme, which appeared to be essential components to the therapeutic process of improving family relationships. Figure six below provides a visual illustration of the overarching theme where reintegration therapy is viewed as a process of improving family relationships and its related subthemes that demonstrate how this is achieved. The bi-directional arrows between the subthemes depict the notion that these aspects occur concurrently rather than sequentially during the reintegration process.

Figure 6: RT viewed as a process to improve family relationships
I. Healing Experience

The first subtheme identified was that the process of reintegration therapy facilitated a healing experience to occur. Depending on the service delivery model used, the healing experience could be between the rejected parent and child, between the co-parents or the entire family as a whole. Healing occurs by exploring thoughts and feelings, providing an opportunity to address painful or historical incidents that may not have been resolved and addressing valid and realistic concerns.

This was captured in the following narrative:

Where the child is resisting contact, or rejecting contact with a parent then we facilitate the opportunities to heal those relationships and work on those relationships and reintegrating the parent and child back into a relationship whether it is from alienation or estrangement circumstances

This narrative depicts the use of reintegration therapy both for alienation cases and cases where realistic issues could have attributed to the contact problem. The ability to discuss any concerns in a therapeutic environment can facilitate the healing process.

By providing a positive experience to the parent-child dyad and co-parents within a clinical setting and/or the use of experiential techniques facilitates healing, a reparative experience and allows members to experience new and more positive experiences. As captured by the excerpt:

If I just have the rejected parent and the child of course that would be a reparative experience focus between those two….. Get out, yeah, get out for a ball, give them a positive experience and then maybe have an opportunity to talk.

II. Mechanism for Reconnection

The second subtheme was related to the idea of reconnection. It is not uncommon in cases where families seek or require reintegration therapy for there to have been a considerable
amount of time where meaningful parent-child contact has occurred. There may have been a complete rupture with no parent-child contact for a length of time (e.g. several months to years of no contact) or resistance to contact where the rejected parent and child cannot establish a meaningful connection. Similarly, there may have been a lack of meaningful contact between the co-parents. Respondents considered reintegration therapy as providing the child(ren), and co-parents (for respondents who used a family system approach), with the physical space and emotional security to reconnect with the rejected parent. The physical space and emotional safety is achieved via the clinical setting and clinical work conducted in preparation for the connection. One respondent reported:

[Reintegration therapy] is to re-establish that relationship, so that the child or children can again trust or have a decent relationship with the parent from who they have either been alienated or estranged. It is a process of reintegrating children with the parents whom they have rejected for reasons that don’t really add up.

Using different methods, respondents illustrate the notion of using reintegration therapy to positively reconnect the parent-child dyad, and co-parents, in any manner (e.g. letters, telephone, face-to-face) and re-establish a positive and more meaningful relationship.

III. Fostering Healthy Family Adjustment

The third subtheme that characterized the process of reintegration therapy is to aid in fostering overall healthier family adjustment. Multiple factors are believed to be operating within the family system that give rise to the development of strained relationships and dysfunctional dynamics. Factors may include one’s individual functioning, impaired communication and conflict resolution skills, and a poor co-parental relationship. Respondents emphasized that reintegration therapy involves addressing the multiple factors in an attempt to change the overall dynamics within the family system.
I think the adjustment and functioning is really the core. I think that is sort of the umbrella and falling underneath that of course is restoring and facilitating the contact. But, I think, umm, the I will say the macro is umm the overall adjustment on, for all parties, parents and children.

This excerpt stressed the idea of improving the adjustment and functioning of all family members as a core component. Reintegration therapy involves more than reconnecting the parent and child, but the development of a more functional system as a whole.

In sum, the experiences of the practitioners in this study lend support to the idea that reintegration therapy is a therapeutic process intended to improve family relationships as a whole.
**Theme two: Assessment Criteria**

Consensus was found among respondents in the assessment criteria used to consider a family’s suitability in reintegration therapy with provisions typically used to determine whether or not to engage in clinical service. Analysis of the data revealed four subthemes respondents considered as necessary criteria to determine suitability and provide service. The subthemes uncovered were: 1) Reintegration therapy is believed to be in the child’s best interests; 2) Respondents were following the principle of Do No Harm; 3) Parents demonstrate reflective capacity for change; and 4) Parents demonstrate willingness and commitment to therapy. Figure 7 below provides an illustration of the theme and its subthemes. Following, additional detail is provided of each subtheme.

**Figure 7: Assessment criteria for suitability in RT**

- **Do No Harm**
- **Determined to be in best interests of the child**
- **Parents demonstrate willingness and commitment to therapy**
- **Parents demonstrate reflective capacity for change**
- **Clinical Interviews**
- **Clinical Judgment**
- **Tertiary Reports**
- **Clinical Observations**

Assessed using:

Assessment Criteria
I. Child’s Best Interests

Thirteen of the fourteen respondents reported that they would only engage in providing therapy if it has already been determined by a court, an auxiliary process such as a child custody evaluation, or an on consent legal agreement that the family’s engagement in reintegration therapy is believed to be in the child’s best interests.

In many of these cases, allegations of domestic violence or abuse are encountered. In these circumstances, respondents indicated that they view their role of reintegration therapist as a therapeutic role and do not consider themselves to be in position of needing to assess the veracity of allegations. Instead, respondents clarified that they work under the assumption that the court or child custody evaluator has already taken into consideration the allegations brought forth and reintegration therapy has been determined to be in the child’s best interests. Respondents reported relying on reports completed by other professionals including: child protection workers, child custody evaluators, police reports, and court documents.

This is explained in the following narratives:

Remember, these are court ordered cases. I am not assessing whether the children should be with the rejected parent. I am helping the parent comply with the court’s order that the children should be with the rejected parent. I’m not the one advising the courts where the kids should be. I’m trying to help them work towards an outcome that better suits the children's needs, or better said, an outcome that the court has already chosen.

For me, the critical thing in terms of me taking something on, or else it’s absolutely a no go, is it has to be made very clear to the family before anything happens that it has already been determined that this is in the children’s best interest. I mean if there is issues of you know, if a parent that has been abusive and so on, again…has it been determined even though that is the case, that this is in fact in the children’s best interest?

Respondents also reported that if new allegations are brought forth which have not been formally assessed, the case is not accepted until a determination has been made. Respondent’s excerpts
depict the condition that suitability for participation in reintegration therapy is based on the finding that RT is in the child’s best interests. There was consensus that if allegations were made, these allegations would have been previously identified and investigated where the final outcome was that parent-child contact was still in the child’s best interests.

II. Do No Harm

Twelve of the fourteen respondents reported following a Do No Harm principle. Respondent’s indicated that if they determined a child’s participation in reintegration therapy would in some way cause harm, they would refuse to accept the case or discontinue treatment. Respondents provided three classifications where harm could potentially occur and would warrant the refusal or termination of treatment. The categories included:

- Active concerns over the child’s physical safety;
- Risk of the child being re-traumatized and;
- Concerns over the child’s emotional wellbeing because of their participation in therapy.

In the case of active physical safety concerns, respondents identified this occurs in cases where a child is at risk of experiencing violence or compromised safety due to active substance use, severe and/or untreated mental health issue or history of ‘severe’ domestic violence. For instance, responses included:

Well safety. First and foremost, really is there an issue here of safety? And how can that be mitigated, or even should it be mitigated?...But safety is always really paramount.

Based on the information I gather there and from collateral data, I would make a determination whether or not it seems as though the case, the history of domestic violence is significant such that moving forward with reunification efforts seems counter indicated.
As well, respondents appeared to be aware and mindful of the potential risk of a child being re-traumatized in cases where there was a severe history of abuse. As one respondent reported:

I fully believe that after speaking with her and gathering history, the contact with mom, even the thought of mom, especially mom, re-traumatizes this child. With what she says she witnessed, or maybe I should say, what she alleges is that mom has been physically and sexually abusive both to herself and to her older sister...

Lastly, respondents reported considering the emotional well being of the child before commencing therapy or proceeding with therapy. It was unclear how emotional wellbeing was defined or assessed since many children who attend reintegration therapy do so unwillingly and often present with significant levels of distress. For instance, one respondent reported:

I think that there are those cases where there is more likely going to be hardship or damage to the children by going through the reconciliation process then there is by having reconciliation accomplished… The best interest of the child for me always means what is going to optimize the child’s health, growth, and development… I’m not a big fan of trying to force the hand of a 14, 15, 16 year old who is otherwise doing well in their life. The older the child, and the more they are functioning well in their life outside of the strict issue of the custody dispute, the more likely I am to say lets leave it alone, we want this child to do well.

While respondents were able to identify categories where there is risk of harm occurring, no respondent provided specific ways this was assessed. Respondents are clear that they will do no harm, but there is no clear understanding on how this would be assessed. This is especially the case since different assessment and screening criteria are used. In these cases will a family’s destiny depend on how a mental health practitioner operationalizes the term ‘severe’ domestic violence or their threshold of ‘acceptable’ vs. ‘not acceptable’ domestic violence and subjective beliefs on whether trauma can occur?
III. Parents Demonstrate Reflective Capacity to Change

Eleven of the fourteen respondents reported they would be unable to work with a family and would cease services if a parent did not have adequate insight and reflective capacity to realize how their behaviours have contributed to the contact problem and unwilling to make behavioural changes. Respondents described encountering this difficulty with parents in their inability to take responsibility or accountability for their behaviour. Respondents reported this could be due to a character disorder or untreated mental health issues. This is typically assessed during the course of treatment by the reintegration therapist.

Six of the respondents articulated actively looking for this during the intake process through tertiary reports, clinical interviews and observed behaviours during the intake process.

For instance, one respondent shared:

I think a good and sophisticated clinical assessment involving taking history and understanding many of the things that a custody evaluator would be asking. Marital history, parenting capacities, trying in the beginning doing an observation of both parents with the child and it may take a while

Others reported the need to terminate therapy once it had already commenced where these behaviours were observed. For example, one respondent shared:

she like just totally denied you know anything but she also continued to blame the father for everything and she took no responsibility…And it was really the probation officer that provided the most insight and said you know, this woman is you know basically a big fat liar … just hostile and blaming of the father and just taking no responsibilty at all. So I recommended, I would not put the kids at risk by trying to, you know, ummm promote reintegration…She had no insight into how to deal with you know the future .

The examples above illustrate respondents’ point where it is necessary that parents show adequate insight into their behaviour and show commitment and willingness to change their behaviours. This is carried out by doing the necessary clinical work in therapy with the child
and/or co-parent and following through with clinical recommendations, taking ownership and accountability for past mistakes, and refraining from engaging in the same behaviours. This appears to be evaluated by the respondent’s clinical judgment during the therapeutic process.

IV. **Parents Demonstrate Willingness and Commitment to Therapy**

Nine of the fourteen respondents reported an integral assessment criterion they consider in their decision to provide service or cease therapy is both parents’ willingness and commitment to the therapeutic process. Respondents reported that for the favoured parent, it is critical they support and “buy into” the process and what the process entails. This includes the favoured parent’s commitment to bringing the child to appointments, actively and genuinely participating in sessions when necessary, and changes in attitude and behaviour to improve the family dynamics and being supportive of improving the parent-child relationship. Respondents reported that without having the support and commitment from the favoured parent, it is difficult to try and forge a relationship between the other parent and the child. Similar to former subthemes, respondents indicated that they assess parents’ support and commitment using clinical judgement based on the observed behaviours and attitudes displayed during clinical interviews. The following samples illustrate this subtheme.

So, what I want to ascertain is that the preferred parent will have at least a minimal level of support for the process because if they’re not going to, it’s not going to work very well. Because we’re then putting this kid in a pressure cooker where I’m trying to establish a relationship and the preferred parent is getting mad at them because they’re trying to go forward with this. So, if there is those kind of issues then it’s going to stop right there…

often times [favoured] parents are, I don’t want to use the word coerced, but they feel like they have to proceed with this process because it’s been court ordered but they don’t really believe that this is the right thing for the children, and umm, so as I go through the steps of the process I start to see whether they are actually able to demonstrate this whether it’s by their words in our session or whether it’s by their deeds with their
children. And at some point, the critical part is of course how they receive the meeting between their child and the rejected parent.

These excerpts illustrate the criteria that respondents consider a favoured parent’s support and commitment to therapy essential and will discontinue therapy in cases where a favoured parent is observed to be sabotaging the treatment.
Theme Three: Overall Treatment Goals

There was significant disparity discovered among respondents in identifying and differentiating between key goals, short term and long-term goals. Based on the substantial overlap in responses provided by the participants, it was not possible to categorize and differentiate key goals, short-term or long-term goals or whether they occur sequentially or concurrently. Perhaps with further development and research in the field, differentiation of short and long-term outcomes will be attainable. In this study, four subthemes related to the overall treatment goals of a family’s participation in reintegration therapy surfaced. Figure 8 captures the treatment goal theme and its four related subthemes. An individual description of each subtheme follows.

Figure 8: Overall treatment goals identified for RT
I. Re-establish Contact and Improved Parent-Child Relationship

The first subtheme related to overall treatment goals that surfaced was the expectation that reintegration therapy would assist in re-establishing contact and an improved parent-child relationship. There appeared to be no consensus among respondents in whether this was a key goal, short or long-term goal, but all respondents reported this as a goal for families participating in reintegration therapy.

In cases where an extended period of time had lapsed with no contact between the parent and child(ren), participation in the therapeutic process was intended to provide a safe physical space for the child and parent to reconnect. In these cases, the therapeutic milieu facilitated some type of connection to occur. The connection could occur either in a direct (i.e. face-to-face) or indirect manner (i.e. letters, telephone). Nevertheless, the setting itself was expected to provide the physical space for that initial connection to occur.

Several responses were provided offering insights into how parent-child contact should continue at the conclusion of treatment. For instance, some respondents believed parent-child contact should return to the previously court ordered parenting schedule. Other responses respondents provided was the requirement that contact be unsupervised or for contact to occur at least a few hours a week. In contrast, two respondents did not provide a specific amount of time they believed was necessary. Instead, these respondents believed the goal was achieved if the child had contact that was not previously present. Ultimately, the treatment goal identified and agreed upon by all respondents is the need to re-establish a connection with the rejected parent and an improved parent-child relationship. Consensus is needed in understanding what is meant by ‘connection’, what it looks like and how it is measured.
II. Developing Functional Parenting

The second subtheme that emerged is categorized as developing functional parenting. Functional parenting consists of parents’ ability to take responsibility and accountability in their behaviours and the improvement of one’s parenting skills.

Respondents reported that often times both the rejected parent and favoured parent engage in behaviours that inherently perpetuate the dynamic. For instance, the rejected parent may have engaged in behaviours that are upsetting or hurtful towards the child or was perceived this way by the child. Acknowledging the child’s feelings and perceptions and taking responsibility for inappropriate behaviours are essential during the course of the treatment.

Equally, respondents shared the favoured parent may engage in subtle/or blatant alienating behaviours that do not support the parent-child relationship, but rather perpetuates the contact issue. Assisting the parent in developing awareness and acknowledging their contribution to the dynamic was viewed as an essential treatment goal.

The following narrative capture the thought of the rejected parent’s need to acknowledge and take accountability for behaviours that were experienced as painful for the child. The second narrative captures the idea of helping the favoured parent become aware of implicit messages that condone the child’s contact refusal.

The goal for these parents, particularly for the rejected parent, is to hear the child's anger, sadness, grief, guilt whatever it is without defending yourself and explaining that it wasn’t my fault, it was the other parents fault and here’s why. And instead offering sensitive responses and support to the child.

The position that I often hear is the parents saying, “well it’s up to the kids. If they don’t want to go they don’t have to go. You know, I can’t make them go, they don’t want to.” But there is messaging in there you know that we as parents that have made a decision that we support the other parents is not taking place.
Functional parenting was also related to the act of improving one’s individual parenting skills. Respondents reported that both parents often require coaching and education to help develop and improve parenting skills. In the case of the rejected parent, respondents provided a range of examples that illustrate the idea of that parent developing concrete parenting skills. Responses ranged from giving the parent tools for knowing how to parent teenagers, how to set appropriate limits, and be more empathic, sensitive, emotionally responsive and attuned to the needs of child.

For example, this was captured in the following narratives:

I think that they key goal for the resisted parent is the development of hands on parenting skills…they are faced with parenting challenges that are exceptional and it seems to me that almost with every instance that they are not equipped to respond skilfully to the various interactional challenges they encounter and so they have to usually develop a lot more sensitivity to the emotional component of their communications and be emotional responsive to the kids.

So some of the parents who come here haven’t been with their kid since they were 8 and they don’t understand why the kid comes to their house wants to go in their room and close their door. And so reality basing with them, but wait you have a 15 year old ... So helping them have a really realistic appraisal of the individual child in front of them.

With respect to the favoured parent, respondents indicated that a change in attitude and behaviour is essential and part of being a more functional parent as a whole. In particular, participants reported that attitudes and behaviours need to be consistent with the objective of wanting the rejected parent to be involved and a part of the child’s life. This was captured in the following narrative:

I think it is attitudes and behaviour certainly… I mean they can say ‘ya go see your mom’ but then say terrible things about mom at other times. So it, you know their attitude and behaviour has to be congruent with that goal and umm I think ultimately the goal is really umm having them learn to be more functional as a parent and you know within that is their ability to express very clearly in their behaviour, in their words, in their attitudes that umm its okay for their child to have another parent in their life.
III. Developing Healthy Family Functioning

The third subtheme revealed from the data is largely categorized as developing healthy family functioning. This consists of re-establishing healthy boundaries, improving the family’s conflict resolution and communication skills, and managing emotions, with particular emphasis given to feelings of anxiety and loss.

Participants shared the need to re-establish healthier boundaries between all members of the family. This includes de-triangulating the child from the conflict and ensuring the child remains in the child subsystem and its related power within the hierarchy of the family system. Respondents described diffuse parent-child boundaries often identifying the favoured parent-child relationship as enmeshed. Hence, during the course of treatment, parents are often tasked during individual therapeutic sessions to separate their needs and interests from that of their children and allow the child to feel safe in having a relationship with both their parents.

Respondents further reported that children in these families have often been given an excessive level of power to make decisions not suitable for children. Consequently, in a parallel fashion, significant improvements and improvement within the co-parent relationship and co-parent subsystem is essential to shift dysfunctional family patterns.

The following excerpts capture the idea of improving the boundaries within the family:

The key goal is really to have a healthy relationship with both parents and to not feel caught in the middle and for the parents to take on the parenting role and take it away from the child. For the parents to be empowered rather then child. For the child to be a child and, not umm, feel they have to make the decisions or control the matter.

You know with a child, one is empowering the child to you know think the child can sort of decide what she wants or he wants or I look at the parents behaviour and what the messaging their giving the child about the relationship with the other parent. So I work with the parents around that and then I try to empower the parents to make a plan and to take some action and decide what needs to happen to improve, you know their communication, the issues around the child, you know that kind of stuff…
These narratives portray the notion of re-establishing more appropriate, healthy and functional boundaries between the members of the family and the subsystems. Specific attention is drawn to de-triangulating the child and improving the to co-parent subsystem. In essence, healthy parent-child relationships and boundaries along with a healthy and functional co-parent relationship can prevent the formation of loyalty binds and allow the child to feel safe in having a relationship with both parents.

The second concept that encompassed the healthy family functioning subtheme was the need to improve the family’s conflict resolution and communication skills. Respondents expressed that when faced with conflict, parents and child(ren) in these families struggle with voicing concerns or managing disputes in a functional manner. Both the child(ren) and favoured parent will typically use avoidance as a conflict resolution strategy. The use of avoidance in these cases is an unhealthy coping mechanism and maladaptive conflict resolution strategy. As well, communication between the co-parents is often non-existent or limited to communication through legal counsel and court documents. As such, assisting both parents and the child(ren) in the development of healthy communication patterns and conflict resolution were seen as critical elements necessary to restoring healthy family functioning. The following narratives reveal this knowledge.

Co-parents need to develop the ability to sustain cooperative communication and negotiate solutions that doesn’t require the presence of a professionally trained third party. The overall goal for the co-parents both individually and collectively is to both contain conflict on the one hand, and on the other hand, to develop, to increase their capacity for cooperative co-parenting…...they probably both need to learn conversational management skills because every time, in every family that I deal with…the conversation quickly escalates into more heated exchange, into disorganized agendas, into unskilful verbalization …so they need to learn how to regulate their participation in the conversation that keeps it orderly and cooperative.
Avoidance is a huge driver to the kids’ stance in these cases and avoidance tends not to be a very healthy coping mechanism, particularly when they’re avoiding something that has value added to them… We push kids to not just avoid.

These narratives recognize that an important aspect of developing healthier family functioning is by assisting families to develop more functional conflict resolution skills and improve communication patterns.

Respondents remarked on helping family members manage emotions, which constitutes as part of the overall functioning of the family. Respondents gave particular emphasis to helping family members manage feelings of anxiety and loss. Underlying anxiety appeared to be a significant factor perpetuating the ongoing resist/refuse dynamics. Respondents looked at the need for the child, favoured parent and rejected parent to learn more functional ways of managing their anxiety. For instance, when working with the child, respondents reported using systematic desensitization or working at the child’s pace to help decrease and mitigate anxiety associated with having contact with a parent.

Respondents described increased levels of anxiety in the favoured parent when openly discussing or working towards the idea of the child having safe contact with the rejected parent. Respondents also commented on their need to clinically work with the rejected parent’s increased levels of anxiety when first meeting with a child, where contact was ruptured, in fear that they will say or do the wrong thing. Lastly, one respondent mentioned the underlying anxiety of both parents especially when they are together, which is revealed by their body language, behaviours and the emotional energy subsequently picked up by the child. The following excerpts depict the idea of needing to manage anxiety as a significant factor necessary for the development of healthier family functioning.
Monitoring the child’s anxiety, and the child’s reaction, keeping in touch with the aligned parent after and between meetings to the point where perhaps we'll have a phone call with the rejected parent, or Skype with the rejected parent.

I love the words the expressed intentions. They [child(ren)] need to really feel that when mom and dad are in the same room together their heartbeats are similar, their palms are not sweaty, they’re able to look into each other’s eyes and be polite and respectful. There are non-verbal cues that carry so much weight. You can teach parents to say the right things but you can’t change the physiology that kids read the adults…more powerfully than any words

Make them [favoured parent] feel reassured that the access between the child and the rejected parent is safe and will be, you know, be safe moving forward regardless how, what it looks like.

Lastly, the notion of loss and effectively managing feelings of loss was shared as an essential attribute that constituted healthy family functioning. Respondents shared the idea that the parents and/or the child may be struggling to accept their perceived loss. This may include the loss of the nuclear family unit, loss of a romantic partner, or loss of the dream of what the relationship was “supposed to be”. In this case, part of the treatment goal to improve the overall family functioning is to help the individual manage the loss. This was captured in the following responses:

Long term? To accept what the dream of this marriage was supposed to be, to come to terms with the loss a bit and to move on to the rest of life and relationships.

How have each of the parents and kids dealt with loss, and how have the kids been prepared to deal with loss or helped with the transition from let’s say an intact family to a whatever separated mess they are in.

**IV. Addressing Distortions**

The last subtheme of the overarching treatment goal theme was the need to address and challenge distortions among all family members. More than half of the respondents reported children and favoured parents present with rigid and distorted thinking patterns. These thought
patterns may not be based in reality, but instead are comprised of reconstructed or distorted memories or perceptions. For instance, a favoured parent may perceive the rejected parent as being dangerous or inept despite information that indicates otherwise. This perception is then shared with the child directly or indirectly. Similarly, respondents reported rejected parents may have a distorted perception that the child is resisting contact as a result of the favoured parents influence rather than a realistic appraisal of their child based on their own interaction processes. Respondents reported helping both the child and parents develop critical thinking skills by using evidence-based data, the use of self-examination and by helping them learn to reality test their perceptions. The following excerpts depict the notion of addressing cognitive distortions with all family members as necessary outcome goals.

Distortions all around are key goals. …. The preferred parent, to the extent that there are distortions vis a vis their child and vis a vis their co-parent, you want to intervene to have that be more realistic...to the extent that its negative, which it always is, and distorted, that’s a problem.

To help them [child] reality test the degree to which their perceptions of the parent are not in congruence with the available data of what that parent is actually like

In more intractable cases there is an encapsulated delusion that the parent has about the danger the rejected parent to the child, the long term goal for the preferred parent would be to help that parent to be able to reassure the child that the resisted parent is not dangerous or unsafe and be able to explain why they originally felt that way but have changed their mind.

In sum, challenging cognitive distortions among all members of the family and the development of critical thinking skills were seen as essential to the overall treatment goals of reintegration therapy.

Chapter Summary

This chapter presented the results of this study by providing thick descriptions of practitioners’ narratives on how they have been trained to provide reintegration therapy, the
underlying theory used to help inform treatment, the screening/assessment methods utilized and details around clinical techniques and service delivery models used for reintegration therapy. The thick descriptions revealed significant discrepancy and inconsistency among respondents and their respective elements.

Next, the chapter presented three overarching themes that materialized from the data revealing some consensus among respondents. Firstly, reintegration therapy appears to be defined as a therapeutic process intended to improve family relationships. The core elements that make-up this therapeutic process is to offer a mechanism for parent-child reconnection to occur, provide opportunities for healing and reparative experiences to occur, and to foster overall healthier family adjustment.

Secondly, despite the discrepancy noted in respondents’ screening/assessment methods, agreement was observed in four specific assessment criteria necessary to provide clinical service. In particular, respondents shared the requirement that reconnection has been determined to be in the child’s best interests by an auxiliary process. Since the process is viewed as being therapeutic in nature, respondents reported ensuring they follow the mandate of Do No Harm. Lastly, respondents reported requiring parents to demonstrate both insight and reflective capacity for change to occur along with willingness and commitment to the therapeutic process. Respondents reported these last two requirements are necessary factors to ensure suitability in therapy. In cases where a family member’s behaviours indicate otherwise, respondents indicated terminating treatment.

Lastly, it was not possible to distinguish between key, short-term or long-term treatment goals or whether these goals occur sequentially or concurrently. However, consensus around treatment goals of reintegration therapy was found. All respondents agreed the goal of
reintegration therapy was to re-establish contact and improve the parent-child relationship, develop more functional parenting, develop overall healthier family functioning and address cognitive distortions. The general implications of these findings and the results of this study are discussed in next and final chapter.
Chapter 7
Discussion and Implications for Practice

Parent-child contact problems in families involved in the family justice system post-separation pose significant challenges to mental health professionals, lawyers, judges, and of course, the families impacted. Mental health professionals are increasingly being asked to become involved and to assist in ameliorating or repairing parent-child contact issues. Mental health practitioners have a critical role in assessing and responding to these challenging and complex cases. Currently, no treatment protocols or best practice guidelines have been established to help inform mental health professionals on how to practice this type of therapy. There are a limited number of research studies available that evaluate the efficacy of this treatment or its practice. Reintegration therapy is not yet an evidenced based practice; nevertheless, courts are mandating families to seek this treatment by mental health professionals.

To fill this gap between research and practice, using an interpretive phenomenological research design, this study sought to generate knowledge and develop a greater understanding on how reintegration therapy is understood and practiced among experienced mental health professionals in the field. The primary research questions that guided this study were:

1. What is the experience of mental health professionals practicing reintegration therapy?
   a. In what ways are they informed in the practice of reintegration therapy?
   b. How is reintegration therapy typically provided? (E.g. intake assessment criteria, clinical modalities used, service delivery models, etc.)

2. What theoretical framework(s) guide mental health professionals’ practice of reintegration therapy?
3. From the mental health professional’s perspective, what are the short and long term goals of reintegration therapy?

To date, this is the first study that explores mental health professionals understanding and practice of reintegration therapy in an attempt to help contribute to this developing area of practice.

**Results and Social Work Practice Implications**

Results from this study revealed that those who conduct reintegration therapy are highly educated and highly skilled mental health professionals holding doctoral and master level psychology and social work degrees. Thirteen of the fourteen respondents were solely in private practice specializing in the area of separation and divorce. All fourteen respondents had received training in working clinically within the forensic arena and had a working knowledge of the legal system. Given its forensic nature, level of complexity and amount of clinical work often involved, this is a costly therapy to deliver. As such, it is not surprising that it is mostly private practitioners who offer this service.

In this study, psychologists were frequently the mental health professionals providing this service. This may be due to the fact that social workers in Canada are typically employed in public agencies (e.g. child welfare, family service, mental health, hospitals, etc.) that do not specialize in this type of forensic service. In fact, many public agencies in Ontario will refuse to provide services for families that are also involved in the court system (Bala, Polak, Jones & Zisman, 2017). This inherently leaves private practitioners that have knowledge in this area tasked with delivering this service for families.

Given the increase in reported parent-child contact problems, and the high costs typically associated with this therapy, it is essential that more social workers and public social work
agencies become familiar and comfortable providing this service. Similar to the notion of domestic violence teams often encountered in public agencies, the development of “high conflict families” team should be considered. Extensive and specialized training would need to be offered to the workers to include topics and information on family law, high conflict separated/divorced families, domestic violence, alienation and child custody evaluations in addition to specialized clinical training (e.g. CBT). This expansion could provide families that are unable to afford private therapeutic services the opportunity to salvage or improve the parent-child relationship. More public and affordable services would help reduce the number of families in court and assist the courts in the case management of these families.

**Training**

All of the respondents from this study’s sample belonged to the Association of Family and Conciliation Courts (AFCC) organization. The AFCC organization is an international organization comprised of researchers, academicians, legal and mental health professionals, dedicated to the resolution of family law disputes. Of the respondents who indicated having received specific training in reintegration therapy, conferences and workshops were all hosted by the AFCC organization. Those that reported receiving training by the leading experts in the field also reported these experts had presented at AFCC conferences or were believed to be AFCC members.

It is uncertain what criteria qualifies a practitioner as an ‘expert’ in the area of reintegration therapy since no guidelines for this therapeutic practice have yet been established. It is posited that leading experts are those who have published on reintegration therapy in academic journals, developed reintegration therapeutic programs and have provided this service for many years. While it appears to be an area of practice that is developing attention within the
research literature, an interesting finding was that six participants reported they believed they had been practicing reintegration therapy for 16-20 years. These results suggest that respondents felt they have been carrying out this therapeutic practice long before the concept of reintegration therapy was even formalized.

Based on results from this study, it appears that formal training for reintegration therapy by way of workshops and conferences is slowly beginning to develop. Considering that this study’s participants were all members of the AFCC organization and attended trainings hosted by AFCC, it is unknown how reintegration therapy is practiced among mental health professionals who are not AFCC members and do not have specialized training and knowledge in working with separated/divorced families. Namely, what differences, if any, may exist in the practice of reintegration therapy among practitioners not affiliated with AFCC? Could these differences suggest yet another model of practice not covered in this study and, if so, what potential implications can result from these unexplored models? Can these unexplored models potentially worsen the parent-child contact problem or in the worst-case scenario, cause harm?

Not surprisingly, some respondents also indicated providing reintegration therapy without receiving any type of formal training. A noteworthy finding was that only six of the eleven respondents that received formal training reported they believed the training was helpful for their practice. Respondents that participated in either the intensive workshops and/or immersion training found this approach to be more helpful and applicable to their direct application in clinical practice when compared to shorter conferences/workshops. These results offer implications for changes in the way in which training sessions should be offered to ensure professionals feel more competent, guided and confident that their work is likely to be helpful or applicable when they encounter these cases in practice.
Drawing from the results of this study, it is recommended that training involve a practical component in addition to an educational/theoretical component. The practical component could include observing or interning with a leading practitioner in the field. An alternative option could be the use of simulations during training to illustrate the clinical skills and the complexity involved when working with these families. This practical component is suggested due to the tremendous value the immersion experience appeared to provide experienced respondents of this study. Those that engaged in a practical component of training reported the training influenced their way of thinking about these cases from a theoretical standpoint and subsequent clinical practice with these families. Further, those providing training in reintegration therapy should ensure they articulate the direct link between underlying theory and practice. Linking underlying theory to practice models provides a systematic and conscious approach to clinical work and clarifies roles and expectations for both the social worker and the family.

It is presumed that changes in training to include these components will help professionals develop the necessary skills to feel more confident in this area of practice. As this is a burgeoning field of practice, it is hypothesized that training will inevitably improve with further developments in research and continued clinical experience.

**Lack of Operational Definition**

There is no consensus on the terminology used to refer to the subgroup of children demonstrating parent-child contact issues. That is, some researchers refer to this dynamic as alienation, others refer to this as resist refuse dynamics and others refer to this more broadly as a parent-child contact problem. As well, no agreement exists within the research literature on the operational definition of alienation (Saini et al., 2016). This impacts practice since various terms, despite having potentially different understandings, are used interchangeably. This poses serious
concerns due to the level of controversy and attention the concept of alienation invokes along with its incendiary and polarizing effect within the legal realm.

There is no consensus on the terminology that should be used to refer to this therapeutic practice. To date, different terms are being used for both research and practice interchangeably further insinuating how nascent this field of practice is within the research literature. Further development in research is needed to come up with consensus and an operational definition for what constitutes alienation versus other types of parent-child contact problems and the name of the therapy used for its treatment.

**Assessment/Screening Protocols**

Findings from this study reveal significant inconsistency in the screening methods and information relied upon to determine whether or not to accept a family into reintegration therapy. Respondents described reviewing collateral reports by tertiary professional providers including child custody evaluations, child protection records, police records, reports from other therapists and other relevant court documents in conjunction to clinical interviews and their own clinical judgment to determine whether they believed the case was suitable for reintegration therapy. Less than half of the respondents conducted their own screening for domestic violence. Respondents of this study reported they do not investigate the veracity of allegations made. Rather, respondents generally work under the premise that allegations of abuse and/or domestic violence had already been investigated and/or found by a court. This creates the risk that a referred family may not be appropriate for reintegration therapy based on a flawed assessment of the impact of domestic violence on the family or lack of tertiary reports that support this finding. This is of significant concern seeing as the research evidence confirms that most cases of domestic violence go unreported and are significantly underreported (Alaggia, Regehr & Jenney,
Studies have criticized custody evaluators’ lack of knowledge and nuanced understanding of domestic violence and failure to use standardized screening tools to assess domestic violence.

As well, the lack of standardized assessment criteria used leaves room in the way in which domestic violence is interpreted. This was seen among participant responses where most participants reported reintegration therapy is contraindicated in cases where there had been a history of ‘severe’ domestic violence. In these cases, it is unclear how ‘severe’ domestic violence is defined or assessed. Due to the disparity among respondents’ screening approaches and assessment criteria, what one practitioner may consider ‘severe’ domestic violence, another practitioner may consider as ‘moderate’ and acceptable for therapy. Having some criteria outlined can help practitioners use a more systematic approach for deciding whether to provide service or cease therapy in an undeveloped area of practice.

The implication of these results suggests the need and ethical responsibility for social workers and psychologists providing reintegration therapy to conduct their own screening for domestic violence at all times rather than only relying on tertiary reports. Some clear criteria need to be established to inform practitioners on when to accept cases for reintegration therapy. As well, guidelines should be developed on how to proceed and what modifications may be required in cases where domestic violence was encountered, but reintegration therapy is still determined to be in the child’s best interests.

**Differentiation of Strained Parent-Child Relationships**

The biggest challenge that remains in the field is the absence of reliable measures to assess and differentiate the several types of strained parent-child relationships. Currently, there is no assessment tool available to help distinguish whether a child is alienated, whether a child is
justifiably rejecting a parent, whether it is a combination of both alienation and justified rejection or whether it is a reaction to the chronic conflict. Given the variation in screening/assessment methodology used, it is unknown whether the appropriate population is in fact being included in treatment interventions. Most recently, Bernet (2016) proposed using a simple psychological questionnaire, the *Parental Acceptance-Rejection Questionnaire* (PARQ) he believes distinguishes between children who resist contact as a result of alienation versus those that justifiably reject contact. Unfortunately, no evaluations have been conducted to determine the construct validity and/or reliability of this measure.

As well, the research literature does not differentiate between a child that is resisting contact from a child that is rejecting contact. These terms appear to be used synonymously despite distinct behavioural, emotional and cognitive differences between these groups of children. This is a critical issue when considering treatment options for children and families as it has been established among research and case law, that treatment recommendations should vary based on the severity of the contact issue (Bala, Hunt & McCarney, 2010; Fidler et al., 2013). This area requires significant attention and development within research and field of practice.

**Theory Development**

Competent social work practice mandates that social workers act from an informed and research-based knowledge base. Theory provides social workers with the tools to offer individuals and families effective clinical services. Practitioners interviewed for this study had difficulty articulating a unified theoretical framework underlying their practice. Respondents who were able to articulate theory reported drawing on a number of different theories in an eclectic, but not integrative, manner.

The most commonly reported theories used were family systems/ecological (used
interchangeably), attachment, cognitive/cognitive behavioural and child developmental theories.

The fact that family systems/ecological systems were used interchangeably despite its theoretical differences and the different conceptualizations of attachment and child developmental theory that were used reveals a lack of systematic application to theory. This has a direct impact and influence over the practice of reintegration therapy vis a vis the clinical focus, clinical techniques used and overall treatment goals. It was unsettling that few professionals were able to directly link theory to their actual practice. For instance, this was seen with respondents who indicated drawing on family systems/ecological systems theory but failed to include all family members in treatment. Similarly, other respondents reported drawing on cognitive theory but did not consider challenging cognitive distortions as a clinical technique to use with the family or an overall treatment goal.

The value of theory application in the practice of reintegration therapy provides practitioners with a way to help explain family situations, assists practitioners in having an organized approach to their work, and reduces the potential for deviating that can easily occur in practice. The use of theory provides accountability and gives social workers a perspective to conceptualize, screen and identify relevant information and address clients’ problems with appropriate interventions (Payne, 2014).

Results from this study led this researcher to believe that further theory development is needed for this population. At the moment, family systems and cognitive behavioural framework appear to provide some guidance to the practice of reintegration therapy. Not included in the literature review of this study but based on the high conflict nature of the parent-child contact problems, frequent allegations of abuse and high levels of distress commonly associated, the inclusion of trauma theory and evidence-based trauma informed approaches (such as TF-CBT)
might also serve as beneficial to the practice of reintegration therapy. This is suggested as both the child and favoured parent appear to be using the flight response and flee from the conflict by resisting or refusing contact. More research and development on this theory and its potential application to reintegration therapeutic practice is needed.

**Service Delivery Models**

In light of the discrepancy reported among respondents in the underlying theory informing parent-child contact disputes post-separation, it is not surprising to see multiple service models being used to deliver reintegration therapy. A significant finding from this study, consistent with the current state of the evidence, is that there appears to be no ‘standard’ way or best practice for conducting reintegration therapy.

Professionals described models that require the participation of all family members in different combinations, all family members as well as significant partners or extended family, all family members with the exception of joint co-parent sessions or whole family sessions, the participation of rejected parent and child only, or alternatively, the participation of the co-parents only with limited child involvement. Some professionals use a multi-faceted approach by providing individual, dyadic and whole family sessions, whereas others only provide individual and dyadic sessions. Frequency of sessions varied from one to two times a week to once a month. Frequency of sessions appeared to be related to a family’s financial resources and geographical distance to the mental health professional rather than specific clinical indicators or measures of success. The setting in which therapy was conducted also differed with professionals choosing to practice from their office to professionals providing service in the client’s home and/or in community settings.

Similarly, discrepancy was noted in the intensive treatment models. Some professionals
required the participation of all family members while others required the rejected parent and child only. Depending on who was present, professionals provided individual, dyadic and whole family sessions. The length of the program varied from two days to five (or more) days. The intensive treatment models take place at a family camp, in a large farm/cottage and in an office setting where sleeping arrangement differed depending on treatment setting.

Different outcome measures or measures of success were also reported among respondents. For instance, some respondents reported a complete reconnection with the rejected parent with frequent parent-child contact was the measure of success, whereas others reported an ‘improved’ parent child relationship. Other measures of success included developing healthy attachment patterns, improved communication, improved problem-solving skills among others. Further, due to the level of overlap, it was not possible to differentiate between key, short and long-term outcomes.

**Evidence Informed Research**

The state of the evidence evaluating reintegration therapeutic programs is extremely limited and fraught with methodological limitations making it difficult to draw conclusions. The majority of studies use small samples; provide limited information about the characteristics that made-up the sample; use different treatment approaches with differences in therapeutic structure, dosage, theoretical frameworks and clinical interventions. Further, the evaluation studies use different measures of success to assess treatment outcomes. This is an area that requires significant attention and research. Further evaluations in this area would facilitate the development of fidelity checklists to ensure therapy is being conducted the way it is intended, and outcomes are clearly articulated, resulting in further differentiation of components of the treatment that achieve success for various populations. Results from evaluations can provide
suggestions on modifications that may be required to better meet families’ needs.

**Direct Contribution to the Field of Social Work**

This study directly contributes to social workers and mental health practitioners who provide reintegration therapeutic services. First, this researcher provided suggestions on behavioural, emotional and cognitive indicators to differentiate between children that resist contact versus those that refuse contact. These indicators could be used as a systematic way to assess a case and inform subsequent treatment recommendations. For instance, experiential clinical approaches may be more appropriate and useful for accelerating the process of reconnection in cases where the child has completely rejected contact and/or there has been a lengthy interruption in contact compared to cases where a child has contact but displays resistance (e.g. difficulty at transitions, skips visits, leaves early).

Second, this is the first study that directly explored respondents’ underlying theoretical understanding of parent-child contact issues and its direct link to practice. Results from this study revealed that clinicians articulated drawing on family systems/ ecological systems theory, attachment theory, cognitive and cognitive behavioural theory and child developmental theory in an eclectic manner but were not necessarily able to integrate principal tenets of these theories into their practice. Further theory development is needed in this area. As well, by exploring clinical practice, this study identified the multiple clinical skills reportedly being used among respondents in the practice of reintegration therapy.

Third, this study discovered consensus among mental professionals in their understanding and practice of reintegration therapy and presented three overarching themes and related subthemes. Reintegration therapy is generally viewed as a therapeutic process to help improve family relationships as a whole. The therapeutic environment provides the physical space for
reconnection to occur between the rejected parent and child, facilitates healing and reparative experiences to occur among family members, and can assist the family in changing pre-existing interactional patterns to more functional ones. There was no consensus among the sample on what is implied by the term reconnection, or how it is embodied. In essence, confusion lies on what is meant by the term reconnection in relation to the strained parent-child relationship.

Regardless, this conceptualization is different to the pre-existing literature that focused on reconnection between the child and rejected parent. Re-conceptualizing reintegration therapy in this manner provides multiple points of entry for intervention for the social worker. Further, this conceptualization helps delineate more specific goals for the family. It provides families requiring this service with a more realistic understanding of the expectations and process of reintegration therapy. Greenberg, Fick and Doi’s (2016) latest article held a similar view with their model revealing multiple points of entry for intervention. The authors’ report their model promotes children’s development of effective coping abilities, and focuses on establishing healthy, pro-social behaviour in the child, as well as protection and support for the child’s emotional independence.

The second theme found in this study that directly contributes to the field was consensus in factors to consider when assessing suitability for participation in reintegration therapy. All participants reported reviewing relevant documentation, conducting clinical interviews, and using their professional judgment to ensure four essential criteria were met. These criteria included: reintegration has been determined to be in the child’s best interests; practitioners follow the ethical principle of Do No Harm; parents demonstrate willingness and commitment to the therapeutic process; and parents demonstrate insight/reflective capacity into their behaviours necessary for change.
There was no consensus for differentiating clear distinctions between key, short and long-term goals; rather, substantial crossover was noted. The substantial crossover between short-term, long-term and key goals implies that there is some agreement on overall treatment goals when families participate in reintegration therapy. Treatment goals not only include re-establishing parent-child contact or reconnection, but also, were more holistic encompassing changes among all family members. This finding underscores the importance of including all family members, in some capacity, when practicing reintegration therapy. That is, emphasis should not only be placed on the rejected parent-child dyad, but on the entire family’s overall interactional patterns. Implications from the results of the treatment goal theme and related subthemes led this researcher to believe that social workers providing reintegration therapy should also be assisting the family to:

- Develop more functional parenting skills that directly impact the parent-child relationship;
- Ensure parents take responsibility and accountability for their behaviours;
- Develop healthier family boundaries by de-triangulating the child from the conflict and improving the co-parent relationship;
- Improve communication skills among the several subsystems in the family;
- Improve conflict resolution skills among all family members;
- Manage emotions with attention paid to feelings of anxiety and loss among family members; and
- Address rigid and distorted thinking patterns in all family members.

It is unclear what the short and long terms goals are to assist social workers in tailoring the interventions accordingly. Again, perhaps with further development in the field, more
differentiated treatment goals could be established to advance this practice.

**Limitations**

All research studies have limitations with this study bearing no exception. The most notable limitation to this study was the selected sample. Despite efforts to attract mental health professionals from diverse locations and agencies, including public mental health agencies, no participants identified working in a public mental health agency or children’s mental health agency. Rather, all of the participants identified being members of AFCC, an organization specialized to professionals involved in the family law realm. Thirteen of the fourteen participants held a private practice where most, if not all, of their work was dedicated to helping separated/divorced families who were in some way involved with the courts. Having such a specialized sample can potentially obscure other treatment models that are being used to treat this population. Different results could be encountered among mental health professionals that work in public agencies that likely do not have the specialized knowledge required for working with high conflict separated/divorced families. Implications of these potential differences would require consideration.

The literature also describes intensive models that take place with individual families for several days at a time in hotels (Families Moving Forward, 2016; Forging Families’ Future, 2016) and intensive models where a pre-requisite for participation in the program is a custody reversal to the care of the rejected parent along with a 90-day no contact order between the child and favoured parent (Warshak, 2010; Childress, 2015). None of the participants described engaging in these types of intensive models. As such, it was not possible to capture all of the approaches being used where other implications for practice may have been considered.
As well, given that participants were from different provinces in Canada and different States within the US, the majority of interviews were conducted over the telephone. A limitation of conducting interviews over the telephone is potentially missed or undetected facial cues or body language. McCracken (1988) provides a structured interview procedure wherein the interviewer is required to pay close attention to participant cues as this may elicit further elaboration in their response. Having the opportunity of seeing facial cues or body language may have elicited richer responses among participants.

Lastly, one key difference between qualitative and quantitative research is limits of generalizability to a wider population (Shenton, 2004). Since the purpose of the qualitative design was to explore the unique experiences of selected professionals and to gain a rich description of RT, it is impossible to demonstrate whether the findings and conclusions could be applicable to other situations and populations. Participants self-selected themselves for the study based on whether they viewed themselves as offering RT. There may be others in the field that offer support for strained parent-child relationships, but without classifying their support as RT. Participants also consisted primarily of private practice practitioners, typically serving clients with the financial resources available to afford these type of RT services. This thesis is the first known study to explore the various dynamics of RT. Although the findings provide some useful insights into the field, further research will need to be conducted before a broader picture of the various models and practices of RT begin to emerge.

**Practice Recommendations**

Based on this study’s findings, it is suggested that practitioners providing reintegration therapy have specialized knowledge in the area of high conflict separated/divorced families, abuse/domestic violence, the research literature on resist/refuse dynamics and comfort working
Mental health professionals appear to desire more training in the area of reintegration therapy for parent child contact problems. While there has been an increase in training opportunities over the number of years, professionals reported finding the training itself insufficient to being able to practice reintegration therapy competently. The only exceptions were the members who participated in intensive workshops or immersion training opportunities. Future training models should consider replicating the in-vivo experience to mental health practitioners via the use of simulation with case examples showing the direct link between theory and practice. The training models should also include information on the current state of the research evidence linking the research and theory to service delivery models. This may reduce some of the confusion that currently exists among practitioners in the field. It is recommended that any professional wishing to enter this area of practice receive relevant training and in-vivo clinical experience through immersion, observation or internship experience.

In addition, the field can benefit from the development of best practice guidelines that take into account results gathered from this study. Best practice guidelines can provide a roadmap for professionals to systematically assess suitability in family’s participation as well as a more standardized model for the practice of this therapy. Suggestions for guidelines include:

1. The need to individually screen for domestic violence to determine suitability and tailor interventions accordingly;
2. Consensus and training on the screening that should be used to assess domestic violence and trauma;
3. The inclusion of all family members in the process of reintegration therapy;
4. The inclusion of multiple treatment goals involving the entire family as well as the
parent-child dyad;

5. Awareness of the complexity of these cases that potentially require a team approach to tackle the several clinical components;

6. The use of experiential approaches to facilitate the connection experience;

7. The need for parents to demonstrate reflective capacity for change and willingness and commitment to therapy as necessary assessment criteria;

8. The development of treatment goals based on behavioural, emotional and cognitive indicators to measure changes in the parent-child relationship;

Future Research Recommendations

There is limited evidence based research available on the practice of reintegration therapy. Much of this field remains unknown or inconclusive at this time. The biggest area of concern is the absence of assessment tools available in the field to ensure practitioners are in fact working with the intended population. Future research should consider working on the development of an assessment tool to assist in accurately assessing the type and severity of parent-child contact problem present. While some attempts have been made to provide behavioural descriptions of mild, moderate and severe contact problems (Fidler, Bala, Birnbaum & Kavassalis, 2008; Fidler et al., 2013; Gardner 2001) its use along with the recommended therapeutic modality has not been empirically tested with families. Being able to use an assessment tool that systematically differentiates between mild, moderate and severe parent child contact problems can ensure that families are expeditiously referred to and receive the most appropriate treatment service.

Further, there is no consensus on the terminology one should use to refer to these dynamics or its treatment. It is imperative that while assessment tools are being developed
consistency and consensus on the terminology be established.

Lastly, more and better-developed evaluations that look at reintegration therapeutic programs longitudinally should be conducted. These evaluations can assist in determining the types of families that are more likely to benefit from the program. It can provide social workers and other mental health practitioners offering this therapy information on what aspects may require modification to better meet families’ needs.

In light of AFCC’s mission and value statements, the composition of the organization from a professional standpoint and that the current trainings that have been hosted by this organization, results would suggest the development of a research task force or think tank to focus on the development of this area of practice.

**Conclusions**

In conclusion, the narratives of mental health professionals in the present study help inform the clinical work in the area of parent-child contact issues by providing some level of consensus on the understanding and practice of reintegration therapy. The themes discovered help generate a better understanding to this complex area of practice. This is an important area of practice that impacts researchers, judges, lawyers, mental health professionals, parents and children. It is hoped that this study is the first of many attempts to explore this area of practice in order to help advance this important field. All things considered, results from this study can provide some direction and consistency for social workers handling these complex cases.
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Appendix A: Letter of invitation to participate in the study

Invitation to Participate

Are you a mental health professional that practices Reintegration Therapy? If so, this study may be for YOU!

“Mental Health Professionals’ Experienced Knowledge of Reintegration Therapy in Cases of Children Resisting Parental Contact Postseparation: A Phenomenological Study”.

**Description:**

Family courts have seen an increase in the number of parent-child contact problems over the last decade. However, given the lack of guidelines or standards in place for the treatment of parent-child contact issues various clinical opinions and service models are being used to address this issue.

The purpose of this research is to generate knowledge, and develop a greater understanding on how reintegration therapy is understood and practiced among experienced mental health professionals. It is hoped that this study can help advance the field by creating a common understanding, which ultimately informs practice.

**What I am asking you to do:**

If you are:

- A practicing mental health professional (e.g. psychologist, social worker, psychiatrist, psychotherapist, mediator, custody evaluator) in Canada or the United States;
➢ Have at least three years of experience practicing reintegration therapy for the purpose of ameliorating parent-child contact problems that occur postseparation/divorce;

➢ Have provided reintegration therapy to at least one family over the last 12 months;

➢ Have extensive knowledge of high conflict post-separation/divorce dynamics and;

➢ Have a working knowledge in the English language

You are invited to take part in a 60-90 minute interview to share your experiences on your practice of reintegration therapy

Your participation is purely voluntary and all interviews will be anonymous.

If you are interested in participating, or if you have any questions about the study, please contact Shely Polak at Shely.Polak@mail.utoronto.ca to coordinate a date and time at your convenience.

Please feel free to forward my contact information or a copy of this advertisement to other mental health professionals you be believe may be eligible to participate in this study.

I thank you in advance for your time and consideration.

Sincerely,

Shely Polak, MSW, RSW, Acc.FM
Doctoral Candidate
Factor-Inwentash Faculty of Social Work
University of Toronto
246 Bloor Street West
Toronto, ON M5S 1V4
Email: Shely.Polak@mail.utoronto.ca
Appendix B: Interview Informed Consent Form

Interview Consent Form:

Dear potential participant,

My name is Shely Polak and I am a doctoral candidate at the Factor-Inwentash Faculty of Social Work, University of Toronto working under the supervision of Professor Ramona Alaggia. I would like to invite you to take part in a research study entitled “Mental Health Professionals’ Experienced Knowledge of Reintegration Therapy in Cases of Children Resisting Parental Contact Postseparation: A Phenomenological Study”.

Purpose of Study
The purpose of this research is to generate knowledge, and develop a greater understanding on how reintegration therapy is understood and practiced among experienced mental health professionals in the field. In particular, I am interested in exploring the different service models available and the underlying theory that informs the practice of reintegration therapy.

Requirements
Participation in this study is completely voluntary. If you agree to participate, you will be asked to partake in a 60-90 minute interview at the Factor-Inwentash Faculty of Social Work, University of Toronto. Alternatively, if you reside outside the Greater Toronto Area, a telephone interview will replace the face-to-face interview at a time that is convenient for you. If a telephone interview is preferred, to ensure privacy, this researcher will speak to you confidentially from her private professional office. With your consent, the interview will be audio-recorded and later transcribed.

Eligibility Requirements
You are eligible to participate if you: 1) identify as a practicing mental health professional (e.g. psychologist, social worker, psychiatrist, psychotherapist, mediator, custody evaluator) in Canada or the United States; 2) have at least three years of experience practicing reintegration therapy for the purpose of ameliorating parent-child contact problems that occur postseparation/divorce; 3) identify as having extensive knowledge of high conflict post-separation/divorce dynamics; 4) have provided reintegration therapy to at least one family over the last 12 months; 5) have a working knowledge in the English language.

Risks and Benefits
By participating in this study, you are entitled to know of any risks and benefits that may impact your involvement in this study. There are no immediate benefits to you for participating in this study. Your participation will have a long-term benefit of providing a better understanding of how reintegration therapy is understood and practiced among accomplished practicing mental health professionals. This may advance the field by creating a common understanding, which ultimately informs professional practice.

There is potential for social and psychological risk. Given the ambiguity and contradictory opinions about the practice of reintegration therapy, participants may feel hesitancy or
embarrassment about their practice of reintegration therapy. To minimize this risk, no personal questions will be asked. All questions will focus on participants’ knowledge and experience on clinical interventions used in the practice of reintegration therapy for parent-child contact problems post separation. No questions about specific cases will be asked.

**Compensation**
There will be no monetary compensation for participating in the study.

**Confidentiality**
All interviews will be audiotaped and transcribed verbatim and stored on an encrypted password-protected server. All names mentioned in the interviews will be omitted in the transcription. After transcription, all audio recordings of the interviews will be permanently deleted. All hard copy data will be stored in a locked cabinet in my private professional office and only accessible by the research team. All data analysis will be conducted on an encrypted password-protected computer at the Faculty of Social Work. Hard copy data will be kept for 7 years upon completion of this research project. After this time, all information will be destroyed in accordance with the guidelines of the Faculty of Social Work.

**Withdrawal and Dissemination:**
Your participation in this study is completely voluntary and your decision to participate or not will be kept completely confidential. During the course of the interview, you may choose to not answer a question, skip a question, pause the interview, or stop the interview and reschedule. You are free to withdraw from the study at any time without explanation and with no consequence. If you choose to withdraw from the study, the data gathered up to that time will be retained. Results may be disseminated in presentations or publications. However, no identifying data will be presented in any reports.

You will have the opportunity to receive an aggregated report of the research findings. No personal identifiable information will be in this report.

Please feel free to contact me by email at Shely.Polak@mail.utoronto.ca if you have any questions or concerns about the study. You can also call directly at 647.883.2415 during normal business hours.

You can contact the University of Toronto’s Research Ethics Manager, Daniel Gyewu, at 416-946-5606 or ethics.review@utoronto.ca

Thank you for your time and interest.

**Summary:**
My signature below indicates that I have reviewed the Interview Consent Form.

I have read and understand all the information that was provided within this document. I have been offered the opportunity to ask any questions regarding the study and have been provided with the additional information I wished to receive. Any questions I have asked about the study have been answered to my satisfaction.
I am giving my consent to participate in this study and I understand all the potential risks and benefits involved. I understand that my participation is purely voluntary and that I may withdraw at any time, without consequence. If I choose to withdraw from the study, the data gathered up to that time will be retained.

I understand that all my information will be kept confidential in locked cabinets at the researcher’s private professional office or on an encrypted and password-protected computer.

If requested, I will be given a copy of the final report.

Would you like a copy of the final research report? YES □ NO □

I hereby consent to participate in this study.

<table>
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<th>Signature of Participant</th>
<th>Name of Participant (printed)</th>
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This form can be sent to the Attn: Shely Polak via fax @ 289.304.0886 or scanned and emailed to Shely.Polak@mail.utoronto.ca
Appendix C: Interview Guide

Filled out by researcher:

Today’s Date: 
Place: 
Time: 
Participant Number:

Preliminary Biographical Questions:

Gender: 
Education (highest degree held): 
Professional Discipline: 
Where do you practice? 
City: 
Province/State: 
Country: 
What is your practice focus/specialization? (E.g. forensic, general therapy, family therapy, etc.) 
How long have you been in practice in family law related matters? 
How long have you been providing reintegration therapy? 
How many reintegration cases would you say you have provided within the last year? 
How many reintegration cases would you say you have provided in total?
Interview Guide

4. In your experience, how are families typically referred to you for reintegration services?

Planned Prompts:
   a) Court ordered or on agreement?

5. Can you describe what you consider to be reintegration therapy or the core components of reintegration therapy?

Planned Prompts:
   a) Perhaps think of a specific case: Can you explain the specific steps taken and the outcome?

6. Which families are ideal or more likely to do well in reintegration therapy?

7. Can you describe how you assess whether a case is appropriate for reintegration therapy?

Planned Prompts:
   a. Describe the assessment protocols or screening tools you use?
   b. What factors do you consider when assessing suitability?
   c. How do you assess level of risk?
   d. Describe which collateral sources inform your initial assessment for suitability?

8. In your experience, what do you do when a party alleges a history of domestic violence or intimate partner violence?

Planned Prompts:
   a. Are these assessed on a case-by-case basis?
   b. What factors do you consider to screen them in or out?
9. Similarly, what do you do when a party alleges alcohol or substance abuse?

Planned Prompts:

a. Are these assessed on a case-by-case basis?

b. What factors do you consider to screen them in or out?

10. Which cases are inappropriate for reintegration therapy?

Planned Prompts:

a. Can you describe a time you accepted a case, which in hindsight was an inappropriate candidate.

11. In what ways have you been trained to provide reintegration therapy?

Planned Prompts:

a) Specialized workshops, please specify.

b) Conferences? please specify.

c) Books? please specify.

d) Clinical Experience? please specify.

12. How has your training prepared you for this type of work?

13. What are the key theoretical constructs that underlie the development of this complex dynamic?

14. In what ways has your theoretical understanding of the issue of children resisting parental contact informed your clinical practice of reintegration therapy?
Planned Prompts:

a. What theoretical constructs can be identified in your practice of reintegration therapy?

15. In your experience, what would you say the key goal in reintegration therapy is for:
   
a. The preferred/favored parent?
   
b. The resisted/rejected parent?
   
c. The child.

16. What would you consider to be the short and long term outcomes of reintegration therapy for:
   
a. The preferred/favored parent?
   
b. The resisted/rejected parent?
   
c. The child.

17. What type of service model do you offer? (I.e. outpatient/intensive models)

18. Please describe the service delivery model you use in the your practice of reintegration therapy?

**Planned prompts for outpatient model:**

a. Who is typically involved in the therapy? How is this determined?

b. Do you hold individual sessions? Joint sessions? Family sessions?

c. How frequent are the sessions?

d. What is length of time of each session?

e. How much time is devoted to individual, joint, and family sessions?
f. In what setting do you hold your sessions? (E.g. office/community)

g. What clinical techniques are typically used with the: child? preferred parent? rejected parent? For joint and family sessions?

h. What kind of materials do you use?

Planned prompts for intensive/residential model:

a. Who is typically involved in the therapy? How is this determined?

b. What is the duration of the program/intervention?

c. Do you offer individual, joint, family sessions as part of the intervention?

d. How much time is devoted to individual, joint, and family interventions?

e. Do children sleep in locations separated from the parents?

f. What clinical techniques are typically used with the: child? preferred parent? rejected parent? For joint and family sessions?

g. What kind of materials do you use?

h. What is typically suggested post intervention?

19. Overall, what do you think is necessary to achieve success?

a. Are court orders necessary?

b. Is a parenting plan that stipulates time with both parents necessary?

c. Is a non-confidential process necessary?

20. Do you have anything else to add or any concluding thoughts?
Appendix D: Research Ethics Board Approval

PROTOCOL REFERENCE # 32170

October 29, 2015

Dr. Ramona Alaggia Ms. Shely Polak
FACULTY OF SOCIAL WORK FACULTY OF SOCIAL WORK

Dear Dr. Alaggia and Ms. Shely Polak,

Re: Your research protocol entitled, "Mental health professionals' experienced knowledge of reintegration therapy in cases of children resisting parental contact postseparation: A phenomenological study"

ETHICS APPROVAL
Original Approval Date: October 29, 2015
Expiry Date: October 28, 2016
Continuing Review Level: 1

We are writing to advise you that the Health Sciences Research Ethics Board (REB) has granted approval to the above-named research protocol under the REB's delegated review process. Your protocol has been approved for a period of one year and ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Elizabeth Peter, Ph.D. Daniel Gyewu
REB Chair REB Manager

<Ethics Approval Letter - Protocol ID 32170.PDF>