(A Therapeutic Vacation)

Reunification Therapy for Severe Parental Alienation[1] or for the Disruption of a Parent-Child Relationship

A short-term, effective treatment program to restore a healthy relationship between parent and child *and* to promote a civil and respectful co-parenting relationship

Treatment by Linda J. Gottlieb, LMFT, LCSW-R

Program Philosophy

This program is based upon the principles of structural family therapy as founded by my mentor, child psychiatrist, Salvador Minuchin. Its philosophical underpinnings are effective and logical: people are most likely to change for those whom they love and for those who love them. Based on that axiom, my program elevates the rejected parent into the position of the healer of the child. To quote from my book:

> No quantity or quality of words between the child and the therapist—who is nonetheless a stranger—can possibly have as powerful and as meaningful an impact as when the therapist provides, instead, an environment in which emotions and experiences are released among family members. No therapist, however competent and well intentioned, can possibly recreate a

[1] By definition, the term *parental alienation* describes a family dynamic in which a child deprecates and rejects a parent (known as the alienated parent) *in the absence* of a reasonable or valid reason, such as child abuse/maltreatment, and justifies the rejection for weak, trivial, frivolous or absurd reasons. The rejection by the child is orchestrated by the other parent/parental figure (known as the alienating parent/figure) and is achieved through a brainwashing process of the child by the alienating parent/parental figure, whose goal—at least in severe cases—is to sever the relationship between the alienated parent and their child. The child and alienating parent/parental figure form a coalition against the alienated parent. This dysfunctional cross-generational coalition is typified as "pathological enmeshment."

> relationship with the child that rivals intimate family relationships—particularly the meaningful parent/child relationship.
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> It seems so evident, then, that the crucial player to assume the deprogramming role for the child is the "formerly" loved and loving rejected parent. Indeed, I assert that the deprogrammer who has the greatest potential for success is the rejected parent—who is not only the holder of the family truths—but who has had the loving relationship with the child. The role then for the therapist is to serve as a catalyst, who encourages and guides the creation of healthy, corrective transactions between the rejected parent and child as well as among all the family members. (P. 143)

Using various mementos of the family history—such as photographs, video recordings, cards, letters, drawings, etc.—I will assist the rejected parent and child to travel down memory lane together so as to help them emotionally reconnect with one another as their memories come alive by reviewing such mementos and reliving the experiences in which the mementos had been created. As a result of corrective experiences with the rejected parent, the child will lift the repression of her/his genuine loving feelings and need for the rejected parent. Through this process, the child's instinctual, although repressed, positive emotions for the rejected parent emerge. These experiences have a powerful impact upon all involved. This approach—as with all schools of family systems therapy—appreciates the compelling effect of experience over words to produce change.

To accomplish this, the rejected parent must bring to the therapy mementos of their family life and relationship with the child. There is the unfortunate reality that, in many of these cases, such mementos have been denied to the rejected parent—who, in some cases, has been excluded from the child's life for several years. The favored parent must therefore lend/provide to the rejected parent any and all meaningful material about the child's life—and, in particular, the child's life with the rejected parent.

I will also support the rejected parent to correct the child's revisionist history about her/him and about the family events—but without pathologizing or criticizing the source of the misinformation. I will assist the rejected parent to sensitively correct the child's distorted, and perhaps delusional thinking about her/him and about the family history. The rejected parent will be inspired to remind the child of their prior positive and meaningful relationship as memories come to life through the reminiscing. Positive new experiences will be created to replace unhealthy, inaccurate ones. The healing process is a give and take in which the child will be supported in expressing her/his feelings and beliefs—but always in a respectful and civil manner. Inaccurate perceptions and beliefs will be corrected. Accurate perceptions will be validated and worked through. In recognition that no parent is perfect, I will help the child and rejected parent resolve any *legitimate* issues that the child may have with the rejected parent. Respect for the child's chronological age and developmental stage will be considered—after all, due to the rupture of

some of these relationships that span several years, the child may require very different responses from the rejected parent, who no longer knows whom she/he is and has become. Special attention will be provided to help the child deal with guilt from having maltreated and rejected a parent.

The treatment approach not only involves the events occurring in the therapy office but also through the daily activities in which the child and parent engage in together as they go through the day to day activities outside of the therapy office. Again complying with the philosophical underpinnings of family systems therapy, change occurs—not as a result of talking about new experiences—but *actually creating experiences.* I will actively participate in accomplishing these activities outside of my office.

Extended family of the alienated parent are urged to participate in the therapy and are usually very helpful to achieving the reunification and proving beneficial to the child. Who such members are will be nominated by the alienated parent.

Why reunification is essential to the child's healthy behavioral, cognitive, and emotional development

1. Emotional cutoffs are never an appropriate remedy for interpersonal conflicts—especially with respect to the vital parent/child relationship. Remaining with hatred and anger is not healthy under any circumstances, especially when directed at a parent.

2. How a child relates to and resolves conflicts with each parent is the single, most significant factor that will determine how the child interacts with peer and other authority relationships.

3. A child cannot develop healthy self-esteem if she/he perceives a parent to be evil, abusive, unloving, worthless, etc. Expert consensus recognizes that children think very concretely—I am half my mother and half my father. The qualities the child attributes to parents are therefore introjected by the child and experienced as characterlogical to her/him.

4. If a child feels unloved *by a parent*, then the child cannot help but feel unlovable *in general* and will pursue the perilous goal of seeking love in all the wrong places.

5. Misperceptions and misconceptions about the rejected parent and about the family history are often so extreme that they represent a break with reality. Cognitive stability is therefore put at risk if not corrected for the child.

6. It is anti-instinctual to hate and reject a parent. The child must therefore create an elaborate delusional system to justify the rejection.

7. The child is existing under a cloud of anxiety due to the fear that of a slip of the tongue or a slip of behavior will reveal the child's true loving feelings and need for the rejected parent. This situationally caused anxiety is frequently mistaken for a chemical imbalance—and the child consequently receives inappropriate treatment.

8. The rejection of a parent is essentially a loss—and one of the deepest of all. Generally the rejection extends to the rejected parent's family of origin so that loving grandparents, aunts, uncles, and cousins are likewise rejected. Losses of this magnitude often lead to depressive symptoms. These symptoms are, again, often assumed to be the result of a bio-chemical imbalance rather than being situationally caused. As a result, the child is often needlessly treated with powerful, psychotropic medications.

9. The rejecting child is subject to suffering from guilt because, at some point, the child accepts that she/he has maltreated a parent. And if that parent is no longer available for an apology should the child become free to provide it, the guilt will last a lifetime.

10. The emotional hole left in the child from the loss of a parent is frequently filled with a great deal of negativity including, but not limited to: eating disorders, suicidal symptoms, self-cutting, criminal activities, oppositional and other antisocial behaviors, defiance, disrespect for other authority figures, cognitive distortion, depression, anxiety, panic attacks, other forms of emotional dysregulation, unhealthy peer relationships, underperformance in school, drug abuse, and a general malaise about one's life.

Standard clinical practice for severe cases of parental rejection

By overwhelming consensus among specialists in cases of severe parental rejection, my treatment protocol is standard clinical practice given the grave circumstance of the severing of a meaningful relationship between a child and a parent.

The treatment protocol requires a 90-day sequestration period in which there can be no contact in any form between the alienating/favored parent and child, this is to include all forms of electronic communication. This requirement has scientific support for its necessity as well as support from evidence-based practice from hundreds of successful treatments in my practice as well as in the practices of my colleagues who provide this very specialized treatment. Just briefly, the necessity derives from our experience that the rejecting child will readily invest in the rejected parent absent any influence on the child from the favored parent. The favored parent must temporarily be relieved of exercising power and control over the child—that is, the child must be psychologically free from the conflict of feeling disloyal to the favored parent because of acceptance of the rejected parent. The

sequestration period is a necessity beyond the 4-day intensive treatment phase in order to prevent the child's *regression and relapse*—which I have witnessed occurring in a mere one-hour phone conversation between the child and the favored or alienating parent.

I recognize that there are some situations in which the favored or alienating parent either fails to recognize or denies any role in influencing the child to reject the other parent. Indeed, I have heard some professionals offer the argument that the influencing parent should be held blameless—with the implication for not being responsible—should her/his behaviors be the result of operations occurring on an unconscious level. To the contrary, this situation might actually be more detrimental to the child and more insidious—one cannot correct what one does not recognize to be a problem. The alienating parent's denial must therefore be lifted as the preliminary step to remedying the alienating behaviors.

The Rejecting or Alienated Child

It is one of many counterintuitive issues in the situation of parental alienation to assume that the rejected parent must have done something to warrant the child's rejection. To the contrary, when one considers how very rare it is for a child to reject a parent—even an abusive parent—another explanation must be pursued. I discovered just how rare this is in my professional work with 3000 foster children, who had been removed from their homes due to adjudicated abuse and/or neglect. This population rarely rejected a parent and craved to be reunited with their parents. Furthermore, they were quite protective of their abusive parents—often denying or minimizing the abuse.

Why is it that abused and/or neglected children do not reject their parents? Firstly, the instinct to have and need a parent is so powerful that it is surpassed only by the instinct for survival and the instinct to protect one's young. Indeed, because our dependency period is so long, we *need* our parents intensely. *The need for a parent is therefore in the genes*. Were it not, the human species would have likely become extinct in the first generation! Secondly, we believe that, if our own parents maltreated us, we must be bad; and this self-perception is intolerable to live with. So we crave connection even to the abusive parent (the *perceived* abusive parent, in cases of alienation) in order to undo the self-perception of being bad, defective, unworthy of love, etc. (Please refer to articles on this website and those on my sister website: www.endparentalalienation.com)

It is only the intense brainwashing by the other parent that has the power to overcome the child's powerful, self-protective, and survival instinct to have and need a parent. (Please refer to articles on the suggestibility of children cited on both of my websites.)

So *particularly* in cases when abuse and/or neglect have not occurred or when the rejected parent has not created a situation that resulted in traumatizing the child, an

alternate hypothesis for the rejection must be explored. This alternate hypothesis is that the child had been unduly influenced by the other parent or a parental figure to engage in the rejection. That being the case, we must recognize that the child's rejection is *not genuine*. The child is *not* opposed to restoring the relationship with the rejected parent. To the contrary, the child secretly relishes the reconnection, but—because of loyalty to the influencing parent—the child cannot initiate contact and must actively oppose it. But when the contact is imposed by outside forces, the child experiences an albatross being lifted from around her/his neck. When professionals release the child from the untenable position of being like the rope in a tug of war between her/his parents, it is exactly what the child needs and desires. *Children really do not want to chose!*

In other words, when the child expresses rejection and hatred for, and fear of the rejected parent, the sentiments are not genuine to the child. The child is merely going along to get along and is doing the bidding of the favored/alienating parent. This being the case, the child will *flip like a light switch* should the favored/alienating parent grant the child permission to welcome the rejected parent back in her/his life. But such reversal of behavior on the part of severe alienating parents rarely occurs spontaneously. It generally occurs only in the face of legal consequences.

Do not be fooled by threats of self-harm and running away. I have not experienced a child who acted on such threats in this situation. Certainly acquiescing to a child's threats would only serve to further empower the child—who is already overly-empowered in cases of parental separation in general and very specifically in cases for which this therapy is being suggested. Appropriate measures, instead, must be employed to handle a child's threats and demands—just as we would do should the child engage in threats to manipulate the adults to acquiesce to any other demand. And anyone who has been a parent knows exactly how manipulative a child can be should the child come to believe she/he can get away with it.

★ My program does not have an age requirement for the rejecting/alienated child. I have treated children as young as 12 months for refusal to be cuddled by a loving parent at the instigation of the other parent. At the other end of the spectrum, I do not have an upper age limit. It a parent-child relationship needs healing, go for it no matter the age of the adult child!

The Favored or Alienating Parent

It is necessary that the favored or alienating parent provide a letter to the child stating genuine support for the restoration of the child's relationship with the rejected parent. It is also necessary to include a statement as to why the child needs the rejected parent meaningfully in her or his life—that is, to state clearly and explicitly what the rejected parent has to offer their child.

I am committed to facilitating a meaningful and respectful co-parenting relationship between both parents and developing a resolution to the family dysfunction that will assure that both parents are meaningfully involved with their child. But it must be acknowledged that the favored parent plays a significant role in the success of the reunification therapy. When the favored parent is *genuinely* supportive of the reunification, the child knows and *experiences* it and acts accordingly—just like the child cooperates with any *genuine* parental expectation. Specialists on the family—nay, even a prudent parent's perception—recognize that parental competency involves the capacity to get the child to do *what the parent really wants the child to do.*

Because I recognize that the severing of the parent/child relationship is so inimical to the child's best interests, I will engage the favored/alienating parent to address the barriers to lifting the sequester period *in the least amount of time*. I will be encouraging daily contact with me to provide the parent with updates on her/his child's progress in the therapy and education services via phone or in person in my office—should the parent chose to come in person, although separately from the child. It is important that the favored/alienating begin treatment with a local therapist to address any behaviors that had been employed—either consciously or unconsciously—to unduly influence the child against the rejected parent and/or to have failed to employ proactive behaviors to *require* the child to have a relationship with the rejected parent—*just as a competent parent would require the child attend school and keep medical appointments*. I will work collaboratively with the parent's local therapist so that insight and behavioral change are facilitated as quickly as possible. It will be a collaborative effort with the local therapist to make any necessary/required recommendations to the court for relevant family developments.

But we further must acknowledge that severe alienation cases are complex clinical situations requiring other factors to become the focus of clinical attention: *normal* parents *do not* perpetrate alienation on their children; *normal* parents will not selfishly keep the child for themselves, drive a fit parent from their child's life; and represent themselves as the only biological parent the child needs for optimal development. We have peer-reviewed research which confirms that severe alienators suffer from at least one but as many as four personality disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a personality disorder as follows:

> "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture." The pattern is "inflexible and pervasive across a broad range of personal and social situations." The pattern is manifested in the areas of cognition, affectivity, interpersonal functioning, and impulse control." DSM 5, P. 646.

Furthermore, it should be noted that the most common and most prevalent personality disorder characteristic of a severe alienator is "borderline personality

disorder" (BPD.) One diagnostic criterion for BPD is "recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviors." (P. 663.)[2] Because of the pathological enmeshment[3] between the child and severe alienator, the alienated child is at risk for suicide should the pathological enmeshment not be terminated. This is one of many reasons why I have written that parental alienation is a form of psychological maltreatment of a child.[4]

The Rejected Parent

Not infrequently the mental health clinician/forensic evaluator who is not a specialist in alienation misdiagnoses the rejected parent with a characterlogical/dispositional disorder or with a psychological problem. What occurs in this situation is that the professional has failed to assess whether the symptom/symptomatic behavior is situationally caused—because of the trauma from the alienation/rejection—as opposed to being a characteristic internal to the rejected parent. When attributing the problems to the latter, absent an assessment to rule out for the situation, this error is known as the "fundamental attribution error." It is a very common cognitive and clinical error in these cases. Before arriving at the finding that the problematic behaviors are characterlogical, one must establish that the behaviors were casually connected to the rejection—that is, temporally connected or *preceding* the rejection. If the problematical behaviors were a *response* to the rejection, then the cause is situational. Rejected/alienated parents are trauma victims; they are *reacting* to the rejection, humiliation, and maltreatment by their beloved children. Surely, it is an example blaming the victim when professionals then criticize and pathologize the rejected parent for having a normal human reaction of anger, fear, anxiety, and any other symptom associated with trauma.

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[2] There are 9 diagnostic criteria for BPD, 5 of 9 being needed to make the diagnosis. This means that the obsession with suicide and/or self-harm may not be present for the diagnosis to be made.

[3] Enmeshment is a term coined by child psychiatrist Salvador Minuchin. Dr. Minuchin did not precede the term with "pathological" because he deemed *all* enmeshment to be a dysfunctional family interactional pattern. As defined by Dr. Minuchin, enmeshment is a severe boundary violation of a dependent child by an adult in a parental role so that the parental figure imposes her/his feelings and beliefs on the child to the point that the child must repress her/his own feelings and beliefs. Boundary violation in cases of severe alienation involves behaviors by the alienating parent such that the parent "hijacks" the child's mind, body, and soul. The violation occurs across all spectrums—psychological, cognitive, and behavioral. The child loses her/his critical reasoning skills and connections to her/his own feelings and does the bidding of the alienating parent. The child becomes an extension of the parent to do that parent's bidding to deprecate and reject the other parent and often maltreat the parent.

[4] For an detailed discussion of how alienation is a form of psychological child abuse, please refer to my Amicus Brief on the subject, listed on this website and on my other website, www.endparentalalienation.com

Should the rejected parent evidence symptoms of a trauma victim, therapy is recommended. But it must be emphasized that the rejected parent *not* be deemed to be the problem *nor* assessed as having contributed equally to the family dysfunction. Indeed, when a proper clinical assessment is considered for *severity*, the rejected parent's possible contribution is generally miniscule.

Family Healing

No family is perfect. This therapy will therefore support the expression of needed apologies by all members for any individual behaviors that *may* have contributed to the family dysfunction and breakdown. Apologies may take written as well as verbal form and could involve an appropriate behavioral gesture—given that actions speak louder than words. In addition to the goal of reunification between the child and rejected parent, I have the goal of promoting healthy family functioning and providing tools to the family that will enable them to solve future problems without professional intervention.

Timely Transition to the care of the Alienated Parent

Given the research we have about the psychological instability of the typical severe alienator—and especially if the favored/alienating parent has had a history of suicidal ideation, attempts, and/or threats or if there are other significant red flags for instability—a careful evaluation must be made to determine if the child will be safe remaining in the alienating/favored parent's care upon issuance of the Court ruling for the therapy but before the therapy can be initiated. In such cases involving psychological instability on the part of the favored/alienating parent, I would have concerns should the child not be transitioned out of that parent's care immediately upon the issuance of the order for the reunification therapy. Therapy should ideally begin immediately upon issuing of the court order. Should this not be possible, an interim placement for the child should be planned until the therapy is initiated. The alienated parent's relatives are a good option. But again, this should be effectuated after a risk assessment for the child is undertaken.

Location:

The family will need to travel to New York near my office and secure housing at a local hotel or make arrangements to stay with family or friends.

Requirements:

There must be a court order to include the following stipulations: 1) for the child to accompany the rejected parent to my office for 4 days; 2) a temporary or permanent order for the transfer of physical and legal custody to the alienated parent; 3) a 90 day no-contact period between the child and the favored/alienating parent; this

must include telephone and electronic communications as well as physical contact; this is a necessary protective provision to prevent the child's relapse and regression; 4) a requirement for the favored/alienating parent to accept parent education services with me—either in person or on the telephone; 5) The favored/alienating parent is to provide the child with a letter stating the importance of having the rejected parent in the child's life and in what specific ways and that, further, she/he supports the reunification; 5) the favored/alienating parent is to provide the alienated parent with any mementos, resources, and materials of the family history and of the alienated parent's interactions with their child; 6) a provision for an indefinite extension of the no-contact period should the favored/alienating parent fail to support the rejected parent's relationship with their child (ren.) It is at my discretion as to the determination of the alienating parent's cooperation and support. This provision is based upon my professional opinion that the rejection would end as quickly as flipping a light switch should the favored/alienating parent *genuinely* support the reunification; 7) the favored/alienating parent is to engage with a local therapist to address any behaviors that had been unsupportive of the relationship between the other parent and their child (ren;) that the favored/alienating parent must acknowledge that alienation is a form of psychological child abuse and to recognize that it is in the child's best interests for the other parent to be in the child's life. The local therapist must have provided documentation that the favored/alienating parent is ready, willing, and able to support the relationship between the other parent and their child and will abstain from any alienating behaviors; 8) an adjourned court date or a process by which the court can be notified about the relevant family developments.

Travel to my Program

There can be two options for travel to my program. But the preferable option is for the child (ren) to travel with the rejected/alienated parent to my office.

Given my extensive experience assessing and/or treating cases in which alienation has occurred—involving direct work with more than 550 alienated children and another 250 whom I assessed from the clinical/legal files, I can state with a high degree of clinical certainty that the alienated child secretly craves the reunification—even if the desire has been severely repressed. When this secret craving of the child for the alienated parent is combined with *a genuine* expression by the alienating parent in support of the reunification, I have not had difficulty with this transportation option. The alienated parent can utilize the assistance of any family and friends with whom the child has had a prior positive relationship. Alienated children will genuinely not resist this travel option nor the treatment once they understand that 1) the professionals have made the decision for the therapy; 2) the treatment goal is for them to have a healthy relationship with both parents; 3) the swift resolution to this family crisis and the reinstatement of a relationship with

both parents is contingent upon the child's cooperation; 4) the favored/alienating parent has conveyed to the child *genuine* support for the reunification process.[5]

The assistance of any and all relatives or significant friends of the alienated parent who had had a previously positive relationship with the child is welcomed and appreciated. They should accompany the child and alienated parent on the travel and will further be meaningfully incorporated into the reunification therapy.

As an alternative option, the favored/alienating parent can escort the child (ren) to my office and transition the child (ren) to the care of the rejected/alienated parent in my presence. It is helpful to the child (ren) and further indicative of the favored/alienating parent's *genuine* support for the reunification if the letter that was previously written about the importance of the alienated parent to the child can be read aloud in the presence of all parties. Upon the transition, the favored/alienating parent will promptly depart Ms. Gottlieb's office and will not remain within 60 miles of her office.

In response to the comments that I have heard from a small number of professionals as well as from some mental health professionals—generally those who have not had extensive experience with treating alienation—I hope that I can impart research-validated information that resolves the concern that this treatment—including the travel to my program—is traumatic for the child. My response follows:

> None of the evidenced based practices or the research undertaken on Family Bridges and on Family Reflections—the treatment upon which *Turning Points 4 Families* is modeled—support this concern. Quite the opposite, the children love the activity portions of *Turning Points 4 Families*, and the therapeutic sessions are *no more* traumatic than what is the norm for other models of therapy.[6] I would ask any therapist who has this concern to

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[5] I have not experienced resistance on the part of the child to accompanying the rejected parent to my office when the favored/alienating parent has conveyed to the child *genuine* support for the reunification. As previously stated, when a child has rejected a fit parent, it can be only at the behest of an alienating influence. That is why the alienating/favored parent must play an important role in the reunification. If, however, the alienating/favored parent fails to convey to the child *genuine* support for the reunification, then the situation is that of child abuse. I stated in my Amicus Brief on the subject as to why the alienation-aware professional community has adopted the position that alienation is child abuse. We must therefore treat the case of alienation as we do any other case of child abuse. Alienation cases are *not* an ordinary custody case in which a determination must be made as to who is the better parent between two fit parents. To the contrary, in alienation, the alienating parent is *not* a fit a parent.

[6] The reader who is a therapist recognizes that any therapeutic model—*if it is to be effective in moving the client/patient to a higher level of functioning and to reduce psychic pain*—initially causes some degree of discomfort. Any discomfort in TP4F commonly does not last long *nor* exceed the degree of discomfort that typically occurs in other therapeutic models.

contemplate a response to a request for therapeutic services for the rejection of a parent in an *intact* family—that is, a family in which both parents are living together with the child. Certainly, no therapist who treats families would reject such a request on the basis of a speculation—and this concern is no more than speculation. Speculation is the only basis for this concern: *there is nothing in the peer-reviewed clinical literature that maintains that such programs are traumatic to the child!* In fact, the clinical literature supports just the opposite: *that the repairing of the parent-child relationship is in the child's best interests.*[7]

If one thinks logically and scientifically, it is quite understandable why the child offers resistance—if at all—only at the inception of reunification programs. As I previously stated, these children secretly crave a relationship with the rejected parent. But, out of loyalty to the favored/alienating parent, the child cannot reveal the craving. As professionals, we must relieve the child from making such a choice. Doing so is in their best interests. We must be courageous, consider severity, undertake a risk-benefits analysis of the options—doing nothing is doing something—and be prepared to act immediately after weighing the options. We must recognize that there are serious detrimental consequences to the child of not intervening in the alienating environment—specifically such consequences that result from the loss of a relationship with a fit parent.

Payment of Fees:

Fees will be provided upon written request and are considered to be reasonable for this type of treatment. For the most effective and swift results, the favored/alienating parent should be primarily responsible for the treatment services--should the alienating have this means. Therapy is *significantly swifter and progress maintained if the favored/alienating parent incurs a financial investment the therapeutic process*—this is simply human nature. Dependent upon verified financial status, at least some financial investment by the favored/alienating parent is highly recommended.

A therapy session will be provided daily on each of the 4 days. A daily session will last for a minimum of 3 hours or as much as 7—depending upon how events develop. The balance of the day is also therapeutic—perhaps even more so; this is because the rejected parent and child will be engaging in continual new corrective *experiences* with each other**.** They can enjoy each other by exploring the local attractions and experiencing mutually satisfying activities. They can visit the local library where the rejected parent can provide tutorial services where needed. We

[7] TP4F is based upon the premise that the rejected/alienated parent is fit; that is, at the minimum, the parent exceeds the standard of "minimal degree of care." And in fact, the clinical literature supports the finding that the rejected/alienated parent is typically a *high functioning* parent who exceeds the parental functioning of the favored/alienating parent.

have museums, amusement parks, gardens, swimming, boating, hiking, rock climbing, trampoline activities, and of course, toy and electronic stores. The rejected parent's authority with the child will be re-established as a result of the supervision, nurturing, and support being provided by her/him throughout the four days. I will accompany them on these activities, coaching and intervening when necessary and monitoring the developments.

I will be on call 24/7 should my services be needed in an emergency—which has never happened, by the way!

Follow-up services:

Follow-up treatment with a local, experienced therapist assures the maintenance of the reunification as well as facilitating the development of a civil and respectful co-parenting relationship. I will be available to provide collaboration services to the therapist(s.)

Statistical Outcomes

Turning Points for Families has proven to be a highly successful reunification program. We have maintained statistics for several factors regarding the program's short-term outcomes; the psychological, cognitive, and behavioral improvements of the child; and the long-term outcomes for the child's relationships with both parents. Please email our office to arrange for a consultation regarding our definition of "successful" and of other terms and for information regarding our statistics.

ALL SESSIONS ARE VIDEO RECORDED AND ARE SUBJECT TO HIPAA PROTECTION

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