COGNITIVE-BEHAVIORAL METHODS IN HIGH-CONFLICT DIVORCE: SYSTEMATIC DESENSITIZATION ADAPTED TO PARENT–CHILD REUNIFICATION INTERVENTIONS

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Children who are triangulated into their parents' conflicts can become polarized, aligning with one parent and rejecting the other. In response, courts often order families to engage mental health professionals to provide reunification interventions. This article adapts empirically established systematic desensitization and flooding procedures most commonly used to treat phobic children as possible components of a larger family systems invention designed to help the polarized child develop a healthy relationship with both parents. Strengths and weaknesses of these procedures are discussed and illustrated with case material.

Key Points for the Family Court Community:

- Family law and psychology agree that children should have the opportunity to enjoy a healthy relationship with both parents
- Adult conflict can polarize a child's relationships, including rejection of one parent
- Existing clinical and forensic "reunification" strategies often prove inadequate
- Reliable and valid cognitive behavioral methods can be adopted to facilitate this process
- A cognitive-behavioral "exposure-based" reunification protocol is discussed

Keywords: *Alienation*; *Custody Reversal*; *Desensitization*; *Enmeshment*; *Estrangement*; *Exposure*; *Flooding*; *High-Conflict Divorce*; *Parent–Child Polarization*; *Psychotherapy*; *Reconciliation*; *and Reunification*.

"The child develops an anxious and phobic-like response . . . a mutually escalating cycle of fear and anxiety develop between the child and the alienating parent; the more upset the child is, the more protective and concerned the parent is, which in turn escalates the child's reactions and so on. Learning theory demonstrates that the correction (extinction) of the avoidance is extremely difficult and requires exposure and systematic desensitization to the avoided circumstance or feared object." (B.J. Fidler, Ph.D. as quoted in W.C. v. C.E., 2010 ONSC 3575)

INTRODUCTION

The professional literature concerned with high-conflict divorce has long been consumed with defining the various dynamics that can cause a child to become triangulated into adult conflict, aligned with one parent and rejecting the other. Concerned parties representing the full spectrum of family law professions, jurisdictions, and interests have debated the definitions and relative contributions of dynamics commonly known as alienation, estrangement, and enmeshment and the confounding role of the child's experience of domestic violence (Drozd & Olesen, 2004; Meier, 2010). Many now accept that the child's polarized position within the conflicted family is most commonly the result of a hybrid constellation of these intense relationship pressures (Fidler & Bala, 2010; Friedlander & Walters, 2010; Garrity & Baris, 1994; Johnston, Roseby, & Kuehnle, 2009).

Unfortunately, the same literature has devoted far less attention to the interventions intended to repair the ruptured child–parent relationship. The little that is available suggests that the first and most desirable remedy involves a process of graduated, therapist-guided, child-centered exposure to the rejected parent, leading over time under the best of circumstances to establishment or resumption of

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routine parent–child contact (Freeman, Abel, Cowper-Smith, & Stein, 2004). When interventions of this nature prove unacceptable or ineffective, more intensive, retreat-like programs are sometimes recommended (Sullivan, Ward, & Deutsch, 2010). In the extreme, some courts have reversed custody, placing the child in the full-time (and sometimes the exclusive) care of the rejected parent (Gardner, 2001; Fidler, Bala, & Saini, 2013).

This article recognizes a distinct and valuable parallel between these court-sanctioned remedies and the cognitive behavioral therapies presently available for the treatment of childhood phobias (Meichenbaum & Turk, 1976; Stampfl, 1966; Wolpe, 1958). Similarities and differences between these otherwise disparate interventions are discussed, yielding recommendations for an empirically based, child-centered, and court-ordered cognitive behavioral reunification protocol.

ON PHOBIC AND POLARIZED CHILDREN

The phobic child lives with a persistent, intrusive, and irrational fear. By definition, the phobic individual experiences the feared object as causing disproportionate and unwarranted anxiety to the point of terror. These feelings are maintained by false or exaggerated beliefs and by avoidant behaviors that implicitly reinforce these beliefs. The phobic individual's efforts to avoid encountering and even thinking about the feared object can constrict every area of life to the point that healthy activities of daily living are neglected and previously enjoyable activities are abandoned (American Psychiatric Association, 2013). In the United States, approximately 5% of children suffer from specific phobias (Ollendick, King, & Muris, 2002). That number may be as high as 16% in 13- to 17-year-olds (American Psychological Association, 2013).

By contrast, the polarized child has been triangulated into her parents' high-conflict relationship (with or without separation or divorce) so as to become strongly allied with Parent A and resistant to or entirely rejecting of Parent B.[1] The child's polarized position may be due to exposure to Parent A's unwarranted damning words and actions concerning Parent B (alienation; Kelly & Johnston, 2001); a breakdown of healthy boundaries in the relationship with Parent A (enmeshment; Garber, 2011); and/or direct experience of Parent B's abusive, neglectful, violent, or otherwise inappropriate behavior (estrangement; Meier, 2010).

Both the phobic and the polarized child's fears are irrational and maladaptive when the feared object is known to present little or no objective threat and the child's avoidant behaviors interfere with otherwise healthy and expectable behavior and development.[2] Critical to assessing whether the polarized child's rejection of Parent B is maladaptive is assessment of that parent's parenting capacity and the child's objective risk in that parent's care. Within the limits of safety, the law presumes that children benefit from the opportunity to enjoy a healthy relationship with both parents.

COGNITIVE BEHAVIORAL THERAPY (CBT)

CBT is a form of psychotherapy focused on identifying and modifying the individual's unwanted and maladaptive thoughts and beliefs (cognitions) and behaviors in the context of a supportive professional relationship. CBT has been demonstrated to be an extremely effective treatment for children (Silverman, Pina, & Viswesvaran, 2008) and for anxiety disorders (Hans & Hiller, 2013).

Fifty years of clinical investigation and empirical research with CBT has generated a number of highly effective, time-efficient, targeted phobia treatments (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), most notably graduated exposure or desensitization and flooding. The value of these methods has been demonstrated in the treatment of phobic children as young as 4 (May, Rudy, Davis, & Matson, 2013) and continuing through adolescence (Bunnell & Beidel, 2013) and with phobias as diverse as social phobia (Shorey & Stuart, 2012), dental phobia (Gordon, Heimberg, Tellez, & Ismail, 2013), needle phobias (Wolff & Symons, 2013), and scoleciphobia, the debilitating fear of earthworms (Buchanan & Houlihan, 2008).

HOW IS A REJECTED PARENT LIKE AN EARTHWORM?

An earthworm is objectively a completely benign creature that many people happen to find disgusting. The earthworm does not have teeth or claws or venom. It cannot run or fly or swim. No one has ever been injured or killed by an earthworm. Some people are, nonetheless, so entirely terrified of the creatures that they will not leave their homes for fear of seeing one. These people are scoleciphobic.

Like the scoleciphobe, the polarized child's efforts to avoid the rejected parent can needlessly compromise quality of life and development itself. It is not uncommon to discover that a polarized child refuses to participate in previously pleasurable activities, perform in long-awaited recitals and ceremonies, and even resists going to school for fear of encountering the rejected parent. In this regard, the phobic child and the polarized child are both caught in a self-reinforcing and gradually tightening noose of anxiety and avoidance: By avoiding the feared object, they never have the opportunity to discover that their fears are exaggerated or entirely unwarranted.

Both the phobic child and the polarized child's fears are rooted in some combination of three dynamics: (1) A caregiver's direct instruction about the dangers of the feared object, (2) the child's vicarious exposure to a caregiver's fears of that object (Rachman, 1990; Broeren, Lester, Muris, & Field, 2011), and/or (3) the child's direct experience of danger from or associated with that object. The child who is told that earthworms are dangerous, who sees that her mother is terrified of earthworms, and/or who associates trauma with earthworms[3] may well become a scoleciphobe. The child who hears Parent A damn Parent B, who feels Parent A's terror in the presence of Parent B, and/or who has direct experience of Parent B's insensitive, unresponsive, or dangerous behavior is at high risk of rejecting Parent B and thereby becoming polarized within the conflicted family system.

Although only a small minority among the children of highly conflicted parents are triangulated into the adult conflict and thereby polarized, serving this small population has become an industry unto itself. In particular, questions about if and how and when to try to reunite children and their rejected parents commonly consume family courts, the attorneys who practice in them, the experts who consult to them, and the forensic psychotherapists who courageously provide court-ordered reunification services.

REAL, IMAGINED, AND IMPLANTED FEARS

The mental health professional responsible to implement a court-mandated, child-centered reunification intervention may review a sheaf of documents, interview each parent and the child, and still fail to understand why the child has allied with Parent A and rejected Parent B. In the typical case, Parent A alleges that Parent B has been abusive or neglectful, absent or inappropriate and is, therefore, deserving of the child's rejection. Parent B, of course, minimizes or denies these allegations and argues with equal conviction that Parent A has undermined the parent–child relationship (Albertson-Kelly & Burkhard, 2013; Drozd & Olesen, 2004; Meier, 2010). Both may be credible and both may be true. Police reports, child protective service investigations, psychological test reports, and various mental health professionals will all weigh in on the matter, often without consensus or conclusion. Thus, "[t]he child's vehement expressed negative emotions and rejection [of Parent B] may be as consistent with child alienation as well as a child who has been neglected and abused or exposed to domestic violence" (Sullivan, Ward, & Deutsch, 2010, p. 117).

For better or worse, the reunification therapist is seldom charged with determining the causes of the parent–child schism and may never know the truth of the matter. Instead, "this therapist aims to take a neutral and even-handed position of deliberately not taking sides" (DeJong & Davies, 2012, p. 188) so as to give the child the opportunity to enjoy a healthy relationship with both parents. This first requires that the therapist establish a trusting rapport with the child. Weitzman (2013) captures this idea concisely:

> Children who are genuinely frightened (even if the fear is a result of the concerted efforts on the part of the favored parent and not based in reality) must be amply reassured that their safety

> comes first, that they will not be forced into face-to-face meetings with the feared parent before they are ready . . .

THERAPEUTIC RAPPORT AND PARENTAL SUPPORT OF THE PROCESS

The single most effective component of any psychotherapy with any population toward any goal is the quality of the therapist's relationship with the client (Norcross, 2010). This is as true of a therapy intended to relieve a child of a debilitating phobia (Jobe, Beutler, & Green, 1975; Shipley, 1979) as it is of a therapy intended to reunify a child and a rejected parent. Thus, Freeman et al. (2004, p. 446) emphasize that "[t]hese cases are best handled by moving slowly toward the goal of building trust between the child and therapist."

Perhaps more than in any other type of child therapy, the reunification therapist's efforts to win the child's trust will depend in significant part on first winning Parent A's trust.[4] "[A]ctive support from the aligned parent is vital if contact [with Parent B] is to happen" (DeJong & Davies, 2012, p. 188).[5] Fidler emphasizes the importance of ". . . getting the favoured parent to buy into the [reunification] process."[6] In the converse, a disenfranchised, untrusting parent can undermine the child's trust in the therapist and the therapy's potential efficacy (Garber, 2004a).[7]

FLOODING AND DESENSITIZATION PROCEDURES

CBT intends to break the phobic child out of an escalating cycle of fear and avoidance through exposure to the feared object. In broad overview, exposure is provided either abruptly and completely in a method known as flooding, or gradually, over the course of carefully constructed steps paired with anxiety-reducing procedures, in a method known as systematic desensitization. It is startling to recognize how much these methods resemble the court's common remedies for the polarized child.

IMMERSION AND FLOODING AS TREATMENT OF PHOBIAS

Sometimes referred to as "implosion" (Stampfl & Levis, 1967), flooding requires that the fearful individual tolerate direct, prolonged, and/or repeated and often overwhelming exposure to the feared object (Zoellner, Abramowitz, Moore, & Slagle, 2009). The rationale is quite simple:

> The idea behind this method is that the Sympathetic Nervous System can fire for only so long, and that eventually the body has to come back to equilibrium. Flooding is often used only as a last resort because it can be upsetting and may be a risk . . .[8]

Flooding has sometimes proven quite effective (Houlihan, Schwartz, Miltenberger, & Heuton, 1994; Sreenivasan, Manocha, & Jain, 1979; Yule, Sacks, & Hersov, 1974) and has occasionally been touted as more time efficient and as yielding longer lasting benefits than other exposure techniques (Boulougouris, Marks, & Marset, 1971; cf. Moor, 1970). Nonetheless, the process poses obvious ethical and procedural challenges, not the least of which is the documented risk of causing real harm to participants. These include reports of exacerbated anxieties (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002), the development of new pathology (Hogan, 1966) including new fears, as when the procedure-induced terror is associated with other proximal stimuli, for example, the therapist or the therapy (Frankel, 1972). With these concerns in mind, it is not a surprise that many studies of "the cruelest cure" (Olatunji & Deacon, 2009) report very high subject dropout rates (Leahy, 2007).

For these and related reasons, Wiederhold (January 17, 2014, personal communication) expresses grave concerns about phobia treatment using flooding procedures, particularly with children. She cites Francis and Radka (1995) as referring to flooding interventions with phobic children as "extremely stressful." She is not alone in voicing these concerns (Deacon, 2012; Olatunji, Deacon, &

Abramowitz, 2009; Wolitzky-Taylor et al., 2012). Morganstern (1974, p. 382) summarizes concisely, stating:

> Even if implosion is effective and even if there are no detrimental outcome effects (both of which are questionable), the emotional cost to the patient during treatment is an extremely important ethical consideration . . .

CUSTODY REVERSAL AS FLOODING FOR THE POLARIZED CHILD

Flooding is to the phobic child as custody reversal is to the polarized child.

The court will sometimes order custody reversal in an effort to reunify a child with a rejected parent when the other parent has been found to have repeatedly interfered with contact. In many instances, the court will order that the child be immediately removed from the aligned parent's care and placed primarily or exclusively in the care of the rejected parent.[9]

Any clinician who has ever been present when the court has informed a child of its decision to reverse custody (or, as I was, ordered by the court to deliver this message to the child directly) understands firsthand how similar the effect is to that induced by flooding: ". . . [I]n flooding treatment the patient is instead asked to enter the worst possible phobic situation and to experience the fear at maximum intensity . . ." (Boulougouris & Marks, 1969, p. 721).

Gardner (1987, p. 226) advocated custody reversal as one means of limiting an alienating mother's impact on a polarized child:

> . . . the first step in the therapeutic process is removal of the children from the mother's home and placement in the home of the father . . . The hope here is to give the children the opportunity to reestablish their relationship with the alienated father, without significant contamination of the process by the brainwashing mother.

Unfortunately, there are no empirical studies and very few summary reports of the effects of custody reversal on children and their relationship with either parent. Fidler, Bala, and Saini (2013) summarize available reports, including impressive accounts of positive outcomes.[10] Notable among these is Gardner's (2001) report that one hundred percent of the children he studied who had been removed from the care of an alienating parent went on to repair their relationship with the rejected parent in that parent's care.

Nevertheless, most courts see custody reversal as a dangerous last resort.[11] In one notable case, an aligned mother warned the court that custody reversal would be ". . . devastating for the child as it could result in [the child's] emotional breakdown or catastrophic suicide."[12] Experts have validated these fears, testifying that custody reversal carries with it the risk that the child will run away, engage in self-destructive or suicidal behavior.[13]

Thus, the prospect of custody reversal requires that the court seek a balance of potential harm and benefit. In some instances, the decision to place a child in the care of a rejected parent is seen as worthwhile,[14,15] while in others it is not.[16] In Mercer v. Clark, for example, the court described this balancing act clearly:

> . . . if one accepts that a child becomes attached to an environment with which the child feels comfortable and happy and with a care giver who meets the needs of the child in a nurturing, caring way, then it necessarily follows that to remove the child from such a situation would be upsetting, at least initially and perhaps lastingly, for the child. Generally, the courts have taken the view that when everything is at least equal, the court will not risk a change in custody and leave the child where it is. Sometimes the evidence is so overwhelming that in spite of the current upset which may be caused, the court may conclude that it is in the long-term interests of the child to change custody.[17]

A number of prominent mental health professionals have recommended alternatives to abrupt custody reversal in the interest of easing the child's transition and optimizing the intended outcome. For

example, Meier (2010, p. 245) takes the position that ". . . forced change of custody is not [appropriate], at least not until the child's relationship with the alienated parent is sufficiently healed to make the child comfortable with such a prospect." Warshak (2010) finds that his 4-day educational camp successfully facilitates court-ordered custody reversals. Fidler and Bala (2010, p. 28) take an even more temperate position, recommending that

> [a]nother option, short of reversing custody, is for the court to order a prolonged period of residence with the rejected parent, such as during the summer or an extended vacation, coupled with counseling and *temporarily* restricted or suspended contact with the alienating parent. This arrangement, which in the long run provides less disruption and greater continuity of care, may be more appropriate than reversing custody permanently, while also affording the child and rejected parent the uninterrupted time and space needed to repair and rebuild their relationship.

GRADUATED EXPOSURE AS TREATMENT FOR THE PHOBIC CHILD AND THE POLARIZED CHILD

The generally preferred alternative to abrupt flooding procedures with children calls for a carefully structured and closely monitored process of gradual exposure to the feared object. CBT interventions with phobic individuals demonstrate conclusively that when clients are taught to monitor the degree of their subjective anxiety and to pair exposure with learned relaxation strategies, fears can be successfully overcome without concomitant risk of retraumatization. These procedures are briefly described and then generalized for application to court-ordered reunification interventions.

SYSTEMATIC DESENSITIZATION OF PHOBIAS

Systematic desensitization is empirically established as one effective means for diminishing or resolving fears and phobias (King, Muris, Ollendick, & Gullone, 2005; Paul, 1969; Wolpe, Brady, Serber, Agras, & Liberman, 1973). The process requires that the phobic client learn three distinct skills and actively practice them over the course of time:[18]

(1) Identification and expression of subjective degree of anxiety. Wolpe (1969) introduced the Subjective Units of Distress Scale (SUDS) with which a participant can learn to express felt-anxiety from 1 to 10. DeMoor (1970), popularized the method as a "Fear Thermometer." I have found that younger children can easily learn to report subjective anxiety by analogy to how full a balloon becomes as it is filled with air toward the point of popping.

(2) Prioritization of steps toward the feared object from least to most anxiety inducing. The result of this process is a hierarchy of fear. In its most elemental form, the participant is asked to deconstruct the steps toward the eventual goal of eliminating fear in the presence of the targeted object and to assign subjective anxiety ratings to each step. I have found that children understand the idea of creating a fear "deck" of 4x6-inch notecards, each describing one step in the process. The cards can be reviewed and reorganized by subjective anxiety value as the process unfolds. Children find the opportunity to rip up the card describing a successful step fun and inherently rewarding.

Graziano, Callueng, and Geffken (2010), for example, present two successful applications of CBT graduated exposure with children with a fear of vomiting. They provide the reader with a detailed analysis of one subject's self-defined steps toward overcoming this fear, working their way from "eating lot and feeling full" to "touching vomit with bare hands."

In another example, Sturges and Sturges (1998), describe the case of an 11-year-old girl whose terror of elevators significantly limited her family's activities. A stepwise hierarchy was created taking the child from looking at a tall building from the outside, entering the building and seeing the elevator, hearing the elevator "ding" upon arrival, standing in the elevator without moving, and eventually riding the elevator one floor and then many floors. Pairing these steps with reassuring self-talk and incompatible positive imagery, the child learned to use elevators normally and maintained her success at follow up.

(3) Acquisition and pairing of relaxation skills. Critical to systematic desensitization and distinguishing this method from flooding is the participant's practiced association of learned relaxation techniques and exposure so as to minimize anxiety. Wolpe (1954) described this pairing as reciprocal inhibition.

A number of therapist-instructed or self-administered relaxation methods are easily taught to children. These include guided imagery, deep muscle relaxation, (self-)hypnosis and breathing techniques (Bourne, 2005). When children can be taught these techniques together with an accompanying parent, practice outside of treatment is facilitated, the accompanying parent's endorsement of the process can be maximized, and implicit pressures in the parent–child relationship may be incidentally reduced (Glasscock & Maclean, 1990; Graziano, Callueng, & Gefken, 2010).

For example, Shaw and Thoresen (1974, p. 417) describe a systematic desensitization treatment for dentist phobia in this way:

> [T]he 12 graduated scenes were presented on audiotape after relaxation training and imagination was interrupted if any anxiety was indicated. Subjects were instructed to maintain complete relaxation at all times. If during imagination any anxiety began to arise, subjects signaled and imagination was halted immediately. After relaxation was regained, the scene was repeated as with the modeling group. When subjects could imagine a scene for 20 seconds without signaling anxiety, the next scene was presented; this process continued until all 12 scenes were imagined without anxiety.

The ease and success of systematic desensitization have popularized the methods among professionals and consumers alike (e.g., Tolin, 2012). Contemporary developments in computer technology have newly created the opportunity to add video access and virtual reality exposure to imaginal and in vivo exposure, broadening the scope of fears that can be addressed, the salience and safety of interim exposures, and the efficacy of the process (Anderson et al., 2013; Malbos, Rapee, & Kavakli, 2013; Wiederhold & Wiederhold, 2005). Controlled comparison studies find that technology-mediated and graduated virtual exposure methods can be as effective and long lasting as in vivo exposure interventions (Anderson et al., 2013; Lambrey, Jouvent, Allilaire, & Pélissolo, 2010).

SYSTEMATIC DESENSITIZATION AND THE POLARIZED CHILD

To the extent that the phobic and the polarized child are similar in that they share an irrational anxiety of a specific object, it is only logical to consider that successful interventions for one might be of value with the other. The potential application of CBT strategies with polarized children is that much more apparent in light of published references to reunification via graduated exposure in the form of ". . . de-sensitization for children whose alienation has taken on a phobic character" (DeJong & Davies, 2012, p. 194). Albertson-Kelly and Burkhard (2013) allude to assisting the rejecting child via "cognitive therapy together with relaxation techniques . . ."

Chase (1983, p. 82) must be credited as having first discussed postdivorce contact resistance in terms of phobias, albeit from a psychodynamic perspective. He referred to some children as evidencing, "visitation phobia" defined as, ". . . an irrational frightened response on the part of a child when approaching a visit with a parent." Chase goes on to recognize that

> [v]isitation phobias are treated by parent/child individual and conjoint interviews when possible. Occasionally telephone contact can be initiated with some regularity before physical contact can be approached. Visitation time, when possible, may need to be gradually increased . . . (p. 85).

PSYCHOTHERAPEUTIC INTERVENTIONS WITH POLARIZED CHILDREN

A number of comprehensive and authoritative accounts of reunification therapies have recently appeared, not coincidentally concurrent with the emergence of the alienation literature (Fidler, Bala,

& Saini, 2013; Lebow, Rekart, & Jordan, 2008; DeJong & Davies, 2012; Johnston & Goldman, 2010; Johnston, Walters, & Friedlander, 2001). For all of their differences, the consensus seems to be that the optimal intervention must be court ordered, child centered, and developmentally attuned. It must account for the strengths and weaknesses of Parent A, Parent B and the child, the family's three subsidiary dyads, the system as a whole, and the system as it functions within larger (community, legal, therapeutic) systems. In the ideal, each participant should have an individual therapist and share a common, overarching family therapy. All of these therapists must be allowed to communicate with one another so as to minimize splitting and coordinate progress while respecting each participant's (and particularly the child's) confidences so as to build trust.

Most agree that winning the aligned parent's support of the reunification process is at least valuable, if not prerequisite to success (DeJong & Davies, 2012; cf. Warshak, 2010).

What we know is that intervention must include education for all participants about relevant subjects including relationships, parenting and co-parenting strategies, emotion expression, family change, and child development (Warshak, 2010; Lebow & Gurman, 1995). At least the educational component of the process might be facilitated in a group format (Sullivan, Ward, & Deutsch, 2010; Warshak, 2010).

We know that the family therapist is responsible to design and implement an intervention intended to facilitate the child's opportunity to (re)establish a healthy relationship with each parent. More than simply repairing the child's relationship with the rejected parent, this means working to establish healthy roles and boundaries within and between each of the two parent–child dyads.

Finally, and most critically, we also know that the child's exposure to the rejected parent must be gradual and conducted in such a way so as to assure that the child feels safe. Toward this goal, Albertson-Kelly and Burkhard (2013) recommend allowing the child to observe the rejected parent via a one-way mirror. DeJong and Davies (2012) recommend allowing the child to view the rejected parent on video or in a role-play procedure from across the room. Fidler, Bala, and Saini (2013, p. 120) recommend that

> . . . individual sessions may help the child prepare for eventual sessions with a rejected parent [initially via] limited, indirect contact by way of letters or photographs and gradually include more direct contact by way of telephone or observations from behind a one-way mirror.

SYSTEMATIC DESENSITIZATION AS A COMPONENT OF REUNIFICATION INTERVENTIONS

My early efforts to think of the polarized child like the phobic child and thereby to bring CBT interventions to the process were borne of frustration and failure. Time and again, talking and insight-oriented approaches proved inappropriate with very young children and unwelcome by many others. Talking interventions furthermore seem to play into these children's most rigid defenses. This is particularly true when the child's polarized position has been at least partially scripted by the aligned parent. The polarized child may have been explicitly coached and is likely to have overheard numerous models of how to deflect and avoid, accuse and blame and otherwise sidestep healthy perspective. Thus, efforts to engage this child (with or without either parent present) in discussion about good times once shared with the rejected parent or new ways to consider past conflicts are all likely to elicit rote responses. This is not to say that these and similar methods have no value, only that they have not proven sufficient in this writer's experience.

Approaching court-ordered reunification as a mutual, parallel exercise in desensitization within the context of a larger family therapy has thus far proven far more promising. Following is a brief description of early attempts to adapt these CBT procedures to serve the needs of the polarized child and family:

(1) Recognizing and expressing anxiety by degree. Family conflict and change, litigation and court-ordered participation in a process that threatens more change, all induce powerful anxiety. Parents fear that they will not be believed and that their lies will be exposed, that the other parent has coopted the therapist, and that the child will be harmed by the process. Parent A fears that the child

will be forced into an unsafe and unwanted position while Parent B fears that the child will remain intransigent. The child, meanwhile, is worried about trusting yet another therapist or worried about being betrayed by yet another adult. The child is scared to forget Parent A's script, scared to be hurt (again) by Parent B, scared to have her own lies exposed, and terrified in equal measure that the reunification will succeed and that it will fail.

With this in mind, it is critical that each participant in this process learn how anxiety compromises thinking and mature functioning. Everyone involved must establish a common vocabulary with which anxiety can be measured and expressed. This may best be accomplished in parallel with the respective individual therapists. The details of how this is accomplished matter less than the mutuality of the process. In order to move forward, all participants must first become fluent in the language of emotion.

The question is "how much anxiety are you experiencing?" Young children may hear this best metaphorically and are aided by images in the form of questions such as "how full is the balloon?" Older children and adults may be able to use the SUDS (Wolpe, 1969) or an abstract 0–10 scale. Individual and dyadic homework (e.g., asking the child and Parent A to use this new vocabulary in mundane circumstances; asking the child to teach the scale to the school counselor to talk about an upcoming exam) all reinforce the process.

(2) Developing relaxation techniques. Using these new skills, each participant must learn and practice relaxation skills. This is, once again, best accomplished in individual therapy, taking care to coordinate the effort in parallel to include all parties. In this writer's experience, a combination of imagery and breathing techniques has proven easy to teach, easy to acquire, and has met with minimal resistance by many participants.[19]

The task is to help each participant to be able to "take a vacation" by going to a preferred safe and comfortable place in their imagination. The therapist's job is to help to elaborate the participant's chosen imagery, eliciting sight, sound, texture, smell and taste cues while simultaneously prompting attention to slowed breathing. Identifying anxiety levels at the start and conclusion of each imagery exercise ("the balloon is almost empty") provides imaginal anchor points for the anxiety scale (e.g., "At number one you're laying on that beach, listening to the waves roll in and the gulls overhead, feeling the sun bake down on your skin and the cool sand between your fingers . . .").

(3) Predesensitization. Given that the child's anxiety is fueled in part by the proximal parent's anxiety, each participant begins an imaginal desensitization process in individual therapy. Parent A's goal is to be able to talk about reunification and to accompany the child to reunification meetings with a minimum of anxiety. Parent B's goal is to be ready to sit down with the rejecting child and the reunification therapist calm and focused and not defensive. The child's goal is to anticipate separating from Parent A, joining the reunification therapist and spending time with Parent B with as little upset as possible.

In each case, imagery related to the goal state is introduced while the participant is practicing relaxation. The participant's subjective anxiety is monitored and imaginal exposure is moderated so as to assure that anxiety remains controlled. For example:

Case Illustration 1. Twelve-year-old Michael hated his father and hated the idea of seeing him. Father and son had not been in the same room together for 2 years and Michael remembered that last meeting as having been violent. Dr. Smith had done a nice job as Michael's individual therapist, aligning with him around the child's upset about the court-ordered reunification process scheduled to begin in the next month and offering to help him establish the tools he would need to deal with it.

Michael mastered the balloon analogy describing his own experience of anxiety quickly. He related the idea of the balloon being full (10) to giving a speech in his social studies class. He developed imagery associated with alternate steps down to 0 which he equated with sitting on his bed, earbuds in and iPod blasting rap music while he played his favorite video game. He understood how intentionally slowing down his breathing helped to calm his body and his emotions and reported that this technique had helped him to "level up" on the video game.

Michael was prompted to "empty the balloon" using imagery and breathing. Dr. Smith then introduced the idea that a pop-up appeared on the video screen alerting Michael that his father wanted

to talk. Michael was given control within his imagination to click on the pop-up to see his father, to Skype with his father and eventually the opportunity to click on another pop-up that would allow him to sit face-to-face with his father in a "Matrix"-like environment. Over sessions, Michael gradually agreed to take successive steps. He reported his own anxiety ("how full is the balloon?") throughout the process and was instructed to "click out" when anxiety reached 5/10. In every case, his efforts were then rewarded with return to his safe place and elaborate successes on his imagined video game. Over the course of seven 50-minute sessions, Michael was able to imagine engaging his father face-to-face while maintaining near-zero anxiety.

Michael's parents simultaneously participated in parallel exercises with their respective therapists. Michael was aware that his mother's imagined safe place was a rocking chair on the back porch of her childhood summer home and reportedly told his mother that she needed to "get her rocker" when the two argued about homework. He was unaware that his mother was learning to calm using this imagery and breathing techniques in anticipation of sending Michael back to meet with his father. Michael was similarly unaware that his father was learning to calm by controlling his breathing and imagining a quiet morning fishing alone on a favorite lake as a means of better managing the otherwise terrifying prospect of seeing his son for the first time in 2 years.

(4) Desensitization and reunification. The family therapist's first responsibility is to coordinate the individual therapists' efforts and to establish a degree of familiarity, credibility and trust with each participant. History interviews are completed with each parent and with the parents together when that is feasible. Initial meetings with the child are brief and nonintrusive and are often best facilitated with the child's trusted individual therapist present (Freeman et al., 2004).[20]

When the individual participants have established anxiety expression and relaxation skills, the family therapist begins regular meetings with the child toward the expressed goal of reunification. Building on this foundation of CBT skills, the family therapist helps the child to create a deck of 4x6-inch cards, each describing a step toward the established goal of spending time alone with the rejected parent. Every possible scenario is brainstormed and recorded on an individual card. Later, impossible and unacceptable cards are discarded. The remaining cards are each assigned anxiety values and then organized into a hierarchy from 0 to 10.

Distinct from many conventional desensitization procedures and from the individual therapist's foundational work with the child, the family therapist can integrate the child's imagery with tangible objects, computer-assisted technologies, distance contact and proximal contact. The therapist's creativity aided by the rejected parent's eager provision of requested resources and flexible availability together open the door to make each process unique.

The child is then guided through desensitization using reciprocal inhibition to manage successive steps toward a face-to-face encounter. The stimulus (imaginal, tangible, digital, or actual) is introduced, anxiety is monitored, and the child is prompted to withdraw and retreat to zero anxiety safety so as to manage upset. Each session is debriefed and successes quietly applauded so as to reward effort without inviting the child's verbal defenses. The child's individual therapist may be present and assisting with the intervention as best suits the child's needs and the unique process. The family therapist maintains open and frequent communication with the two parents and their therapists as the need arises and with the goal of helping each to manage anxiety and to better anticipate next steps.

Resistance does arise in this process as it does in any change-oriented therapy. A child may refuse to take a next step along the established hierarchy, sometimes using a report of unacceptably high levels of anxiety as an escape route. The family therapist's job in this instance is to support the child empathically, to engage the aligned parent's and the child's individual therapist's support. Care must be taken to assure that the child's resistance is not tied to concurrent events (e.g., renewed litigation) and that the aligned parent's anxiety has not similarly spiked. In some instances, resistance means that the next step in the anxiety hierarchy is too big and that interim steps will be better tolerated. Engaging the child in creating these steps can be very empowering to the child.

Case Illustration 2. Kayla had no memory of ever living with her mother and saw no reason to meet her. She insisted that her father and stepmother were all that she needed. She understood that "the

Table 1
Kayla's Hierarchy of Fears Associated with Reunification with Her Mother

	How scary?
"In my clubhouse out back with my best friend Sarah"	0
Coming here [to therapy] with dad in the room	1
Coming here [to therapy] with dad in the waiting room	2
Seeing pictures of her	3
Sending her pictures of me	3++
Making her a greeting card and sending it	4
Getting a card from her	5
Reading a letter from her in the office with dad nearby	5
Writing answers to some questions she asked in a letter	5
Hearing her voice on the answering machine	6
Opening a present from her	6
Writing her a thank you note	6
Playing an online game with her (no voice or video of players)	6
Seeing her on YouTube	7
Seeing movies of her and me playing when I was a baby	7
Making a movie to say "hi" to send to her	7
Skyping with her from the office with dad nearby	8
Skyping with her from the office without dad nearby	9
Seeing her in the office from the doorway	9
Seeing her in the office from couch	10
"Eating nuggets at McDonald's at my favorite table with her"	10 +++

judge" was making her see the woman. The idea prompted her to become tearful, regressed and withdrawn. Kayla was very proud that her hair had never been cut in all of her eight years and she used the long black sheath like a wall to hide behind when she became upset.

Dr. Jones helped Kayla to identify steps toward the goal of eating a Happy Meal with her mother at a nearby McDonald's, taking care to be as specific as possible, Dr. Jones even took Kayla to the same restaurant to enjoy the same meal and took pictures of Kayla at the table of her choice, smiling with ketchup on her face. Kayla then assigned "scared numbers" to each of the steps, using the photos to illustrate the end goal, and shuffled the deck into order from least scary to most. Kayla's hierarchy appears in Table 1.

Over the course of seventeen 50-minute interviews interspersed with continued support from her individual therapist, Kayla was able to tolerate online contact with her mother via Skype. Litigation then erupted, interfering with scheduled family therapy meetings and likely supercharging the anxiety of all involved. At last contact, Kayla and her mother remained in their respective outpatient psychotherapies. Kayla's father had interrupted or discontinued his therapy and the reunification effort remained suspended.

DISCUSSION

Family law theory and court-ordered remedies need not reinvent the wheel. Cautious and well-informed adaptation of established interventions can help to make family law process more predictable and associated outcomes more effective. More to the point, reliance on established, reliable and valid interventions can only help the court to serve the best interests of the child.

Attachment theory serves as case in point. Long the exclusive province of developmental psychology, attachment theory and established assessment methodology have recently been introduced into many custody evaluation protocols (Hynan, 2012) and are beginning to be integrated into our understanding of high conflict family dynamics (Garber, 2004b, 2012).

The present paper recommends that long-established, empirically sound and very practical CBT procedures have a place as a part of court-ordered reunification interventions. One means of adapting these procedures is discussed with an emphasis on diminishing the anxiety that tends to exacerbate the family conflict, confound the intervention and thereby needlessly complicate the child's opportunity to enjoy a healthy relationship with both parents. Early efforts to adapt systematic desensitization principles and practices to reunification have proven very useful. Further study of the costs and benefits of this approach will ultimately determine if and how this hybrid process might be useful more generally.

A PROPOSED RESEARCH DESIGN

Although research with court-involved families is necessarily complicated by unique issues of attrition, ethics, and discovery, these hurdles can be overcome. Carefully constructed research designs endorsed by a court or jurisdiction and funded so as to provide a service to those who might not otherwise be able to afford it have succeeded elsewhere (e.g., Nordal, 2010).

At issue in the present model is the efficacy of systematic desensitization as one part of an intervention intended to improve a child's relationship with a rejected parent. Among the many tenets of this proposal deserving empirical scrutiny is the significance of the cognitive behavioral method per se, as compared to interventions that include relaxation techniques independent of graduated exposure, and as compared to reunification interventions with neither. At issue is the quality of the child's relationship with both the aligned and the rejected parent at specific time intervals and as a function of numbers of hours of (facilitated) contact, where relationship quality might best be assessed using established and age appropriate attachment instruments (cf. Garber, 2009a). The present model predicts that the quality of the child's relationship with the rejected parent would be facilitated in a more time efficient (and therefore less expensive) and more lasting manner in the systematic desensitization treatment condition than in either of the other two, and more in the generic relaxation treatment condition than in the no-behavioral-treatment condition.

This methodology prompts many closely associated questions, including attention to if and how the quality of the child's relationship with the aligned parent might be incidentally affected as the child's relationship with his or her other parent is addressed. One might hypothesize that the aligned parent's relationship with the child is enmeshed (Garber, 2011) and thereby insecure, and that opening the door to a healthy relationship with the rejected parent might help the child establish a healthier bond with both.

SHOULD THE POLARIZED CHILD BE DIAGNOSED WITH A SPECIFIC PHOBIA?

Despite the explicit parallels drawn between the phobic and the polarized child and the potential value of one strategy for both children, I do not mean to imply that the two are the same. A phobia is a diagnosable condition codified in the DSM 5 (American Psychiatric Association, 2013). The polarized child may manifest any number of diagnosable conditions including phobias (Doolittle & Deutsch, 1999), but "polarized" is a description of a systemic dynamic that exists in relationships, not in the child and not as a diagnosis. Furthermore, even if a child's anxiety about a rejected parent meets the relevant criteria for Specific Phobia, evaluators are cautioned about the excess meaning of apparent mental illness in the context of high conflict custody litigation (e.g., American Psychological Association, 2013, item 10.01).

BUT THE MODEL IS IMPRACTICAL!

Coordinating a team of three or more skilled clinicians for the purpose of helping a child work toward healthy relationships with each of two highly conflicted, litigious parents is challenging at best, and very expensive. Many recommend that the complexity of the problem calls for a team intervention

(Lebow, Rekart, & Jordan, 2008). But why couldn't a single mental health professional serve in all of the roles relevant to implementation of this model?

The professional who provides systemic intervention unassisted risks working in dual and conflicting roles, breaching confidences and compromising rapports on all sides. The polarized child's vulnerability to see the world in a black-white, with-me-or-against-me manner (Johnston, Walters, & Friedlander, 2001) amplifies these risks a hundredfold. Nevertheless, a skilled professional who defines roles and boundaries with exquisite clarity from the start and who establishes a "multipartial" alliance (Lebow, Rekart, & Jordan, 2008) may be able to manage the process adequately, with a single remaining concern: This work can be excruciating. The professional who functions alone does so without the invaluable benefit of colleagues' experience, support and perspective (Blow & Daniel, 2002; Garber, 2009b).

IS THE ALIGNED PARENT'S SUPPORT NECESSARY?

The literature generally agrees that a child will most easily be reunified with a rejected parent with the child's aligned parent's active support (cf. Warshak, 2010). Requiring the aligned parent's support must be understood as somewhat circular reasoning, however, in that if Parent A supported the child's relationship with Parent B in the first place, the problem might never have arisen.

As an empirical matter, this question cannot yet be answered. Certainly the CBT literature concerned with systematic desensitization for children with phobias proceeds without first assuring all caregivers' active supports. The analogy fails, of course, to the extent that the child has been implicitly forced to choose sides in the parents' battles.

Anecdotally, it is this writer's experience that as long as the child continues contact with the aligned parent, that parent's support and involvement in the reunification process is absolutely essential. As long as the child and aligned parent remain in contact, the aligned parent's nonverbal cues (if not explicit threats, bribes and promises) will set the stage for the child's approach to the process. When Parent A feels engaged and valued and has begun to trust the therapists involved, the child is likely to feel the same. Conversely, when Parent A feels ignored and railroaded into a process that is seen as destructive, the child's anxiety will be piqued and the process becomes far more difficult.

It is perhaps at this point that residential interventions with both parents (Sullivan, Ward, & Deutsch, 2010) or solely for the child and rejected parent (Warshak, 2010) and flooding in the form of custody reversal have a place. Reunification in the face of an aligned parent's (emotional, if not physical) resistance is a Sisyphean task. The hope and expectation that the rejected-cum-residential parent will thereafter facilitate the child's opportunity to enjoy a positive relationship with both parents is yet to be reliably demonstrated.

NOTES

1. Garber (2012) introduced generic reference to each of two parents as A and B so as to minimize the suggestion of gender specificity. This convention is used throughout this paper.

2. Among the diagnostic criteria for Specific Phobia, DSM 5 (American Psychiatric Association, 2013, p. 197) requires that, "[t]he fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context."

3. If the idea of discovering an earthworm in your breakfast cereal causes you to shiver or gasp in disgust, the point is made.

4. This is likely most true when the child is enmeshed with Parent A.

5. By contrast, Warshak (2010, p. 57) explains that in his psycho-educational and explicitly nontherapeutic program, "we do not find that a successful reunification is dependent on the favored parent's support of the process. Naturally, this parent's positive involvement helps reduce the child's inner turmoil and facilitates the child's healthy relationship with both parents. But, it is not essential to the repair of the damaged child–parent relationship."

6. Fidler as quoted in W.C. v. C.E., 2010 ONSC 3575.

7. "If excluded from the intervention plan, an aligned parent can become more powerful and polarized, the family pathology can become more entrenched, and therapy can become stalemated" (Johnston, Walters, & Friedlander, 2001, p. 317).

8. To illustrate, consider Hogan's (1966, p. 26) description of imaginal flooding: "A person afraid of a snake would be requested to view himself picking up and handling a snake. Attempts would be made to have him become aware of his reactions to the animal. He would be instructed to feel how slimy the snake was. Next, he would be asked to experience the snake crawling over his body and biting and ripping his flesh. Scenes of snakes crushing or swallowing him, or perhaps his falling into a pit of snakes would be appropriate implosions."

9. For example: "This order is to take effect immediately and the children are to be transferred to the father following the conclusion of this proceeding. In the event that the children are not currently at the court house, it is ordered that X.F.F. and S.R.F. are to be taken into the care and control of their father at any place where they may be situated. This transfer of the children into the care and control of Mr. A.F. shall occur without any interference or disruption by the respondent or the respondent's immediate family or any other person; and any assistance, if need be, shall be provided by the local police department . . ." (A.F. v. D.G.1., 2012 ONSC 764 at 243).

10. It is not clear, however, what the criteria of success are in a custody reversal matter. As Johnston and Goldman (2010, p. 112) highlight, "[c]hildren may resume contact with a parent but their negative attitude towards and beliefs about that parent may not shift, their behavior toward that parent might remain unpleasant or avoidant, and the truce between parent and child can be short lived."

11. "Across the country, the great weight of authority holds that conduct by one parent that tends to alienate the child's affections from the other is so inimical to the child's welfare as to be grounds for a denial of custody to, or a change of custody from, the parent guilty of such conduct." Renaud v. Renaud (97–366); 168 Vt. 306; 721 A.2d 463 Accessed January 19, 2014, at http://libraries.vermont.gov/sites/libraries/files/supct/168/97-366op.txt.

12. W.C. v. C.E., 2010 ONSC 3575 at 106.

13. W.C. v. C.E., 2010 ONSC 3575.

14. "There is no doubt that the boys will experience some immediate trauma and grief. However, I am satisfied that this will be a temporary condition" (J.W. v. D.W., 2005 NSSF 2).

15. Grigsby v. Grigsby, (07.07.2010) FLA. 2D09-5255, Accessed January 19, 2014, at http://www.2dca.org/opinions/Opinion_Pages/Opinion_Page_2010/July/July%2007,%202010/2D09-5255.pdf.

16. ". . . [T]he short and long term risks [of custody reversal] are simply too great to give serious consideration to this option.." (W.C. v. C.E., 2010 ONSC 3575).

17. Mercer v. Clark (1989) 90 N.S.R. (2d) at p. 4, Daley J.F.C.

18. "In systematic desensitization, the exposure is preplanned in graduated steps. In general, this procedure involves teaching the patient to relax and then having him imagine or actually encounter increasingly disturbing situations. The patient usually does not move on to a more disturbing item until he can remain deeply relaxed with a less disturbing one . . . If a patient is afraid of heights, for example, the therapist works together with the patient to develop a list of increasingly fearful situations. For example, the patient might say he is very afraid of looking out from the top of the Empire State Building, but hardly afraid at all of climbing a small ladder. He then is trained to relax, and the therapist asks him to imagine each of the series of situations, starting with the one he is least afraid of, the one arousing little or no tension or fear. Over a series of therapy sessions, the patient is then exposed systematically to the whole list of fearful situations and, at the end of treatment, is able to maintain his relaxed state even while imagining scenes that were initially extremely fearful. Patients are usually encouraged to try out their newly learned ability to relax in the face of the formerly fearful situation outside of the therapy setting. Generalization of the effects of systematic desensitization from the treatment setting to real life is typically found, especially when the patient has done the "homework" of gradually facing what used to be fearful." (Stolz, Wienckowsky, & Brown, 1975, p. 1033).

19. Readers are alerted to the phenomenon known as relaxation-induced anxiety (Schwartz & Schwartz, 1995), the panic that many abuse survivors experience as they consciously let their guard down. While this problem has not yet arisen in this writer's experience with reunification interventions, the concordance of abuse history and high conflict divorce suggests that it will.

20. "The child's therapist is always present at the first and any other face-to-face meetings [with the absent parent] early in the process" (Freeman et al., 2004, p. 453).

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