Family Separation Clinic

Policy Briefing

Relational trauma in children of divorce and separation

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Family Separation Clinic

The Family Separation Clinic is a specialist, London-based private partnership delivering therapeutic services to families around the world. We specialise in cases of childhood relational trauma and the emotional harm of children in the context of divorce or family separation, which often come to light through, and are typically connected with, a child rejecting a relationship with one of their parents. The Clinic has significant experience of working within the Family Courts of England and Wales, including the High Court, and has also worked in the Courts of Ireland, Hong Kong and Sweden.

The Clinic's lead therapist, Karen Woodall, was recently commended by Mr Justice Keehan, sitting in the High Court,* 'for her professionalism and dedication in her work,' noting that, in 'Ms Woodall's role as an expert witness where she has been instructed in cases before me and, most especially, in this case, I have always found Ms Woodall to be a very experienced, independent, dedicated and effective expert witness.'

The Clinic has delivered training to professionals working with children's post-divorce alignment and rejection behaviours, including psychologists, psychotherapists, social workers, judges, lawyers and domestic violence agencies, across Europe, the United States and elsewhere in the world.

The Clinic roots all of its work with children and families in standard psychodynamic, psychotherapeutic, structural and child development theory and practice. We do not accept theoretical constructs such as *Parental Alienation*.

* Case No: ZC18P01363. Re A and B (Children: 'Parental Alienation') (No. 5)]

Attachment is a universal behaviour that compels children to maintain close physical and psychological proximity to their primary care-givers. It can, therefore, be assumed that any behaviours in a child that run counter to this fundamental survival strategy are an indication that the child is at risk. The task for the courts and for any professional working with such dynamics is to understand the aetiology of the child's maladaptive behaviours and work to restore the child to healthy psychological functioning.

As mental health practitioners and psychotherapists, we recognise the hyper-alignment of a child to one parent, leading to the subsequent rejection of or resistance to the other, as a relational problem in which a child unconsciously utilises the maladaptive, primitive defence of ego splitting in response to a relational landscape that has become frightening and overwhelming. As such, each case must be recognised as having its own unique and specific dynamics, and each treatment route must respond to the individual needs of the child and the wider family.

The majority of cases where a child has become hyper-aligned to one parent, leading to a rejection of the other, come to light in private, child arrangements (s.8. CA1989) proceedings under which the Court's primary focus is likely to be 'with whom a child is to live, spend time or otherwise have contact, and when a child is to live, spend time or otherwise have contact with any person' (s.8.1. CA1989). In determining any question with respect to the upbringing of a child or the administration of a child's property or the application of any income arising from it, 'the child's welfare shall be the court's paramount consideration' (s.1.1. CA1989).

It is our concern that, because such cases are typically heard under s.8, the focus on the child's living arrangements in the context of adversarial litigation (not least in the minds of the litigants), can distract attention from the child's more fundamental welfare best interests.

The Family Separation Clinic takes the view that such cases, where determined, should be treated, first-and-foremost, as chid protection cases and that consideration of whom the child should live with and who they should spend time or otherwise have contact with should be ancillary to the child's physical, emotional and psychological well being. The determination of such cases therefore requires the greatest attention to the underlying dynamics that are causing the child to become, or be at risk of becoming, hyper-aligned to one of their parents and, in the process, being induced into rejecting the other.

Fundamentally, it requires an understanding of the maladaptive behaviours that children in such situations are liable to display and Court processes that focus on the short, medium and long-term harm that children displaying such maladaptive behaviours are susceptible to.

Whilst the issue of the child's place of residence will, undoubtedly, form part of an assessment of the child's welfare best interests, the greatest risk to the child's medium to long-term emotional and psychological well being is not whether a child is spending time with a parent - as this is simply a symptom of the child's underlying difficulties - but the psychological maladaptations that are induced in the child that causes them to act counter to the evolutionary imperative to remain in close physical and psychological proximity to a primary attachment figure (see, for example, Fairbairn, 1943; Ainsworth, 1969; Bowlby, 1988; Benoit, 2004; Nolte, Guiney, Fonagy, Mayes & Luyten, 2011; Fisher, 2017).

Whilst we do not accept the proposition that, what has become known as, *parental alienation* is a diagnosable mental health condition, our understanding of the dynamic does draw upon the psychoanalytic formulation and clinical descriptions of the term alienation, meaning, 'the state of being, or the process of becoming, estranged from either oneself or parts of oneself' (Rycroft, 1995, p. 6). The psychoanalyst, Pearl King (2005, p. 177) highlights the work of noted psychiatrists Donald Woods Winnicott and R. D. Laing, who conceived of alienation:

> *in terms of a split in the self, so that the individual has, as it were, two selves – that is, a "true self" which he identifies with and a "false self" which he operates from and which may be variously described as a compliant or placating self, care-taking self, an unembodied self, or a false-self system.*

Winnicott, himself (1959-64, p.133), noted that, 'the false self is built up on the basis of compliance' and has a 'defensive function, which is the protection of the true self,' and Fisher (2017, p. 5) notes that:

> *Childhood abuse necessitates self-alienation: we must disown that humiliating "bad child" and work harder to be the "good child" acceptable to our attachment figures. In the end, we survive trauma at the cost of disowning and dissociating from our most wounded selves.*

Fisher (2017, p.66) notes that, 'alienation from the self is often necessary (...) to maintain some semblance of attachment to grossly neglectful and abusive caretakers.' Fromm (1963, p. 120) refers to the individual being 'estranged from' themselves, and Horney (1992, p. 111) notes that it is not possible to 'suppress or eliminate essential parts of ourselves without becoming estranged from ourselves.' Benjamin (2018, p. 9) reports that:

> *The alienation of self from its own needs through splitting and dissociation follows upon the denial of recognition; these alienating forms aim to get around the withholding of needed caregiver attention, that which alone stabilizes the psyche.*

We, therefore, recognise alienation in the child as the emergence of a dominant false self state, which is precipitated by pronounced defensive splitting, in which the child's normal attachment relationships become temporarily or permanently incapable of being activated consistently. Consequently, we, conceptualise alienation in children, first and foremost, as an alienation from the self.

This understanding of alienation (as opposed to the child's alienation from a parent which may, perhaps, be regarded as a variation of the common law tort alienation of affections), recognises the child as a subject of their own lived experience rather than an object of a parental dispute. From this perspective, the focus of resolution becomes, not a settlement of the parental dispute but, the wider and deeper welfare best interests of the child; specifically, its psychological and emotional health and well being.

A child's hyper-attachment to one parent and concomitant rejection of the other must, first and foremost, be recognised as an attachment disruption and a relational trauma. Attachment theory, 'emphasizes (...) the primary status and biological function of intimate emotional bonds between individuals, the making and maintaining of which are postulated to be controlled by a cybernetic system situated within the central nervous system, utilizing working models of self and attachment figure in relationship with each other' (Bowlby, 1988, p. 135).

Whilst attachment is the psycho-biological connection that develops between infants and their primary caregivers, it also provides the relational template for the child as it grows and reaches adulthood (Bowlby, 1988). Initially, the attachment bond

provides the infant with a safe haven in which it can rely on his or her primary caregivers for comfort at times whenever she or he feels threatened. It also provides the child with a secure base that creates a foundation from which she or he can develop their own coping skills. In the early part of their lives, infants will maintain physical proximity to their attachment figures.

In time, however, the child will begin to explore the world around them but return to proximity with an attachment figure if they feel insecure or threatened. Typically, children will become unhappy and sorrowful when they are separated from a caregiver. In response to the attentiveness and quality of the care that parents provide, each child develops a somewhat different attachment style (Howe, 2011).

Attachment is an instinctive behaviour and a basic adaptation for survival in infancy (Ainsworth, 1989; NICE, 2015). The evolutionary imperative for attachment to caregivers is not contingent upon the quality of the care provided by the attachment figure. As Benoit (2004, p. 543) notes:

> *[A] normally developing child will develop an attachment relationship with any caregiver who provides regular physical and/ or emotional care, regardless of the quality of that care. In fact, children develop attachment relationships even with the most neglectful and abusive caregiver,*

and, because attachment behaviour is instinctive, children are also compelled to find a way to adapt to the abusive, neglectful, or otherwise difficult behaviours in their parents (Fonagy, Gergely, Jurist & Target, 2004; Salberg, 2015).

As a consequence, any breach in an attachment relationship or cessation of the attachment confirming behaviours in the child must be regarded as being maladaptive and, therefore, harmful for the child. It is these circumstances that the Court is charged with identifying in order to restore the child's healthy attachment responses and prevent developmental harm.

Although children will, typically, develop separate and unique attachment bonds to each of their parents, in the intact family the child will have what may be described as a unified attachment experience where shifts in the child's attachment focus are fluid and do not stimulate psychological stress. However, in the post separation family, the child must find ways to maintain their attachment bonds in a fractured, rather than unified, relational world.

When the post separation dynamics within the family do not present significant obstacles, the child will normally be able to shift its attachment focus with only minimal impairment. However, when dynamics in the post separation landscape put pressure on the child's attachment system, transition may become difficult and, in some circumstances, impossible for the child to achieve. It is in these circumstances that the child may develop the defence of ego splitting. It is the splitting defence that poses the greatest threat to the child's wellbeing and development over the medium to long-term.

Splitting refers to the unconscious failure to integrate aspects of self or others into a unified whole. It is a schizoid, primitive or 'infantile', defence mechanism. Rycroft (1995, p. 173) summarises splitting as a:

> *[p]rocess by which a mental structure loses its integrity and becomes replaced by two or more part-structures (...) After splitting of the ego, typically only one resulting part- ego is experienced as "self", the other constituting a (usually)unconscious "split-off part of the ego"*

The term splitting is often colloquially used, in this field, as a description of the child's responses to its parents; it is said that the child splits its parents. However, clinically, the term refers to the unconscious process in the child's ego functioning. As Klien (1946, p. 101) makes clear, 'the ego is incapable of splitting the object – internal and external – without correspondingly a splitting within the ego taking place.'

Overwhelmed by the fear of abandonment, and the consequent threat to attachment security, the child's unconscious impulses are directed at retaining ego stability. Faced with the overwhelmingly contradictory and unmanageable pressure of retaining one primary attachment figure at the expense of the other, the child splits off the powerless and vulnerable aspect of the self as a separate object representation (Klein, 1946; Winnicott, 1986; Fisher, 2017; Hinshelwood, 2018; Vliegen, Tang, Midgley, Lutyens, & Fonagy, 2023). The inability to hold an integrated sense of self is then projected outwardly, whereby, one parent becomes the embodiment of every this that is good and the other parent the embodiment of everything that is bad.

Fisher (2001, p. 2) suggests that splitting 'allows for the separate but simultaneous awarenesses that what is happening is wrong, while keeping intact their idealization of and loyalty to the adults who mistreat them,' and is the key unconscious defence mechanism induced in children faced with the irreconcilable task of feeling they must reject one parent in order to retain the other. She adds that:

> *Childhood abuse necessitates self-alienation: we must disown that humiliating "bad child" and work harder to be the "good child" acceptable to our attachment figures. In the end, we survive trauma at the cost of disowning and dissociating from our most wounded selves (2017, p. 66).*

The work of Professor Peter Fonagy, Chief Executive of the Anna Freud National Centre for Children and Families, and colleagues (Vliegen, Tang, Midgley, Lutyens, & Fonagy, 2023, p.72) highlights the ways in which splitting, as an intrapsychic primary defence (something that happens in the mind of the child), can become projected into the external relational world. They note that:

> *in a desperate attempt to manage anxieties, [children who have experienced complex trauma] often resort to primary defence mechanisms in which they attempt to keep good and bad experiences and representations split off from each other by projecting these on to different people. In this way, traumatised children are often - although unintentionally or at least unconsciously - at the source of tense relationships among the people responsible for their care who have been designated "good" and "bad" carers.*

Whilst splitting serves a developmental function, as the newborn infant's first attempt to create psychological order from sensational chaos (Klien, 1946; Dean, 2004), Ruppert (2011) notes that although pathological splitting '*may bring temporary relief for the child, it carries the potential for serious and lasting psychological harm,*' including alternating between hyper-alignment and sudden and absolute rejection in relationships, self-loathing, anxiety, depression, and low self-esteem, and at risk of diagnoses of bipolar and borderline personality disorder (Fisher, 2017).

It is reported that adults with BPD are more likely to report childhood emotional abuse and neglect or impaired parental care, suggesting that '*traumatic victimization and compromised primary caregiving relationship are aetiological contributors to BPD*' (Van Dijke, Hopman, & Ford, 2018, p. 3), and West (2018, p.27) notes that a parent's consistent or unpredictable psychological unavailability, emotional bullying or neglect '*will lead to substantial relational trauma*' in the child.

Closely associated with pathological splitting is the primitive defence of projective identification which is often present in children who have become hyper-alignment to one parent, leading to the subsequent rejection of or resistance to the other. Projective identification may be seen as '*an unconscious phantasy in which aspects of the self or an internal object are split off and attributed to an external object*' ((Bott Spillius et al, 2011, p. 126), and Kernberg (1989), summaries projective identification as a defence that has the primary purpose of expelling intolerable anxieties from the self and projecting them into another, with the unconscious aim of inducing in the object what is projected in the actual interaction with the object. Through the defence of projective identification, intolerable aspects of the self - feelings and experiences that cannot be accepted as belonging to the self - are projected into an external object and then re-introjected as though they belonged to the target of the projection (Klein, 1946; Segal, 1973, Ogden, 1982; Cashdan, 1988). Critically, Klein (1946, p. 103) notes that, '*the violent splitting of the self and excessive projection have the effect that the person towards whom this process is directed is felt as a persecutor*.'

Through the unconscious processes of splitting and projective identification, the child disowns the feelings of overwhelming anxiety and powerlessness and, importantly, is able to ascribe their own feelings of anger and fear onto the parent that they must reject. Indeed, because projective identification specifically (though unconsciously) involves '*the behavioural and emotional manipulation of others*' (Cashden, 1988, p. 56), the child may induce negative responses such as emotional dysregulation in the parent they feel they must reject, thereby disowning the guilt response that would otherwise regulate their behaviour towards that parent.

Whilst a child's hyper-alignment to one parent and subsequent rejection of or resistance to the other can sometimes be precipitated by overt parental behaviours, such as inducing a child believe they have been abused, making the child fell they are unsafe in the other parent's care, involving the child in a hostile narrative, or encouraging the child to make false or fabricated allegations, the child's behaviour is very often driven by parental behaviours that are woven into the parent-child relationship and are, therefore, much less easy to detect.

These behaviours may include emotional shunning and covert abandonment threat, emotional dysregulation or psychological decompensation, anger or emotional terrorisation of the child, or creating anxiety in a child through displays of anxiety or withdrawal when the child attempts to relate to the other parent. These behaviours may, in some cases, be regarded as conscious 'strategies' but in may cases are simply the result of 'leakage' from the parent. However, irrespective of the cause, the harm to the child is the same.

We consider that this problem does not emerge 'out of the ether' but is woven into the very fabric of the family system and parent-child sub-system, and that it is in the disruption to that system that is created by the family breakdown that these pathological inter-psychic dynamics are brought to the service.

Role corruption is a common feature of the relationships between parents in the aligned position and children who are rejecting or resisting a relationship with their other parent. These may include enmeshed parent-child relationships including parentification (Boszormenyi-Nagy & Spark, 1973) where the child serves as a caregiver to parent, and spousification (Minuchin, 1974) in which the child serves as a primary source of intimacy for parent.

Kerig (2005) notes that parentification is rooted in the child's insecure attachment responses to the parent in which the child takes on the responsibility for regulating the

parent's psychological stability, thereby placing developmentally inappropriate responsibilities on the child. She notes that '*although the parent may be ostensibly protective and solicitous, parentification has negative implications for child development in that the parents*' emotional needs are being met at the expense of the child's' (ibid, p.13) and concludes that '*when parent-child boundaries are violated, the implications for developmental psychopathology are significant. Poor boundaries interfere with the child's capacity to progress through development which (...) is the defining feature of childhood psychopathology*.'

A longitudinal study of parental abuse of infants and small children (Steel, 1970) observed that '*the abuser's attitude toward infants is the conviction, largely unconscious, that children exist in order to satisfy parental needs*' (p. 450), and Morris & Gould (1963, p. 46) note that '*role reversal is a constant social factor that identifies the presence of the neglected/battered-child syndrome, as well as it predicts its continuance and recurrence*.'

Psychiatric and psychological assessments of parents to whom children have become hyper-aligned often highlight the presence of complex personality profiles and personality disorders including Narcissistic Personality Disorder, Borderline (Emotionally Unstable) Personality Disorder, Histrionic Personality Disorder, Paranoid Personality Disorder, and Sociopathic Personality Disorder.

Children growing up in the care of parents with complex personality profiles and personality disorders face a range of developmental challenges. For example. children who grow up with a borderline parent '*are often not allowed to express their needs, their feelings, or their passions in life without being punished or shamed*' (Tanasugarn, 2022). Borderline parents also have '*severe abandonment issues in their own lives which they typically pass down to their children(...) as dependency*' (ibid). This can make it very difficult for children to make psychological transitions and will feel compelled to soothe the parents' anxieties by not leaving them.

Intuitively, we might expect a child to reject a parent whose behaviours are harmful to them. A child's hyper-alignment to a threatening, frightening, or psychologically overwhelming parent is, therefore, counterintuitive. Linehan & Koerner (1993, p. 112) note that:

> *invalidating environments contribute to emotional dysregulation by (...) actively teaching the child to invalidate his or her own experiences by making it necessary for the child to scan the environment for cues about how to act and feel.*

When fear and anxiety forms the backdrop to the parent-child relationship, the child must find ways to adapt their behaviours in order to accommodate the parent's unpredictable or abusive behaviours (Haliburn & Mears, 2012).

Of children in the care of abusive parents, Ferenczi (1933, p. 228) suggests, '*one would expect the first impulse to be that of rejection, hatred, disgust and energetic refusal*,' but concludes:

> *These children feel physically and morally helpless, their personalities are not sufficiently consolidated in order to be able to protest, even if only in thought, for the overpowering force and authority of the adult makes them dumb and can rob them of their senses. The same anxiety, however, if it reaches a certain maximum, compels them to subordinate themselves like automata to the will of the aggressor, to divine each one of his desires and to gratify these; completely oblivious of themselves they identify themselves with the aggressor.*

In the care of a threatening or out of control parent, as in all experiences of trauma, the child's attachment system is hyper-activated; the child accepts the abuse because

they are unable to survive without the parent and are compelled by the attachment process to retain physical and emotional proximity. Having been '*traumatically overwhelmed, the child becomes hypnotically transfixed by the aggressor's wishes and behavior*' (Howell, 2014, p. 48). Howell (*ibid*, p. 52) goes on:

> *the child's sense of agency, identity, and integrity of self are diminished in the process of identification with the aggressor. The child, experiencing her—or himself as an object of use for the caretaker, rather than as a person of intrinsic value, becomes highly alert to the caretaker's needs and responses, focusing intently on the abuser's postures, motions, facial expressions, words, and feelings*

and notes that, '*as a dissociative defense, it has two enacted relational parts, the part of the victim and the part of the aggressor'* (ibid, p. 48); something that can very often be witnessed in the child's violent and persecutory behaviours towards a parent they are rejecting.

Although the defence of identification with the aggressor serves a vital immediate survival function, longer-term impacts may include development a *'dissociative dominant/submissive personality organization that especially characterizes Dissociative Identity Disorder' and 'alternating shifts of self-state organization that characterize borderline personality organization, of which Borderline Personality Disorder (BPD) is a prime example*' (Howell, 2014, p. 49).

Ferenczi (1933) adds that, as well as:

> *passionate love and passionate punishment there is a third method of helplessly binding a child to an adult. This is the terrorism of suffering. Children have a compulsion to put to rights all disorder in the family, to burden, so to speak, their own tender shoulders with the load of all the others; of course this is not only out of pure altruism, but is in order to be able to enjoy again the lost rest and the care and attention accompanying it.*

Sometimes, the defence of identification with the aggressor is induced in children through the behaviours of an overtly violent or threatening parent. This can often be a post-separation continuation of domestic violence and abuse, including patterns of coercive control. In other situations, the child is responding to less overt behaviours such as the threat of abandonment. This often forms part of an unhealthy attachment relationship that dominates and overpowers the child's identity.

It has been proposed that certain types of what might be called 'bad parenting' will cause a child to reject a parent. In Parental Alienation Theory, this is referred to as 'estrangement' or 'justified rejection' and is considered to be a '*rejection of a parent for a good reason*' (see, for example, Bernet, Wamboldt, & Narrow, 2016). We consider this to be highly problematic as it is not rooted in an assessment of the child's underlying psychological well being or the potential for the rejecting behaviours to be driven by maladaptive defences.

It is our position that whilst '*attachment behavior may be heightened or dampened by situational factors,*' because '*attachments themselves are durable, even under the impact of adverse conditions*' and because children have a neuro-physiological compulsion to direct attachment behaviors toward specific objects of attachment (Ainsworth, 1969, p. 971), any breach of normal functioning attachment seeking behaviour must be regarded as a signal that the child may be experiencing harm or abuse, and be at risk of medium to long-term psychological harm. In these cases, the focus of the Court must be the child's capacity to retain ambivalence (being the opposite of splitting) together with the degree to which the child may need protection from particular behaviours.

It follows, therefore, that the focus of any investigation must extend not only to the parent's observable behaviours but, crucially, to the child's health and well being. The Court must, first and foremost determine whether the child is being, or at risk of being, harmed, and then determine the cause of the harm.

Whilst a full and thorough investigation of all the circumstances is always required in determining the best interests of the child, the presence of harm can initially be indicated through an understanding of whether the child retains the capacity for ambivalence (the capacity to see both good and bad in the parent they are rejecting) or whether the child is displaying primary defences such as splitting, projection, and projective identification, which are the clinical markers of maladaptive responses and an indication of psychological harm.

Bowlby (1988, p. 37) identifies that:

> *a system controlling such crucial behaviour as attachment can in certain circumstances be rendered either temporarily or permanently incapable of being activated, and with it the whole range of feeling and desire that normally accompanies it is rendered incapable of being aroused.*

Whist Fonagy (2004, p.198) notes:

> *The alien self is present in all of us, because transient neglect is part of ordinary caregiving; it is pernicious when later experiences of trauma in the family or the peer group force the child to dissociate from pain by using the alien self to identify with the aggressor. Hence, the vacuous self comes to be colonized by the image of the aggressor, and the child comes to experience himself as evil and monstrous.*

The long-lasting and transgenerational consequences of children's defensive maladaptations in psychologically harmful environments is well documents. For example, van der Kolk (1989, p. 399) writes that disruption of the attachment bond:

> *causes longlasting psychobiological changes that not only reduce the capacity to cope with subsequent social disruption but also disturb parenting processes and create similar vulnerability into the next generation.*

A child's hyper-attachment to one parent and concomitant rejection of the other must, first and foremost, be regarded as a child protection issue rather than a 'care and contact' issue and all assessments and interventions must be implemented within a child protection framework.

We consider that the Court's paramount duty to determine the best welfare interests of that child, enshrined in s.1 of the Children Act 1989, places a responsibility for all those working will children in such circumstances to look beyond questions of 'care and contact' and ensure that, at the heart of all decision making is the child's immediate protection from harm, including all forms of physical or mental violence, injury, abuse, or maltreatment, including sexual abuse, while in the care of parents.

We consider that any cases in which parents, deliberately or unconsciously, cause psychological and emotional harm by: interfering with the child's attachment bonds; causing fear; inducing maladaptive psychological defences; threatening or enacting violence; parentifying, spousifying or otherwise causing role corruption; and any behaviours that draw children into a parent's intra or inter-personal conflicts at the expense of their own physical, psychological and emotional wellbeing fall within these parameters, and it is the responsibility of the Courts, child protection services and others to protect children from such harm.

Case law in England and Wales [(Re A and B (Children: 'Parental Alienation') (No. 5) Case No: ZC18P01363] establishes that, in cases of this nature, the actions of a parent can cause serious harm, even when the actions of a parent are not readily visible to others and when a parent refuses to acknowledge their role, or is able to recognise their role in causing that harm. A failure to protect the child in such circumstances, by not recognising established facts in case law, will inevitably lead to heightened risk of harm to children in both private and public law proceedings.

The principle purpose of any treatment intervention must primarily be the healing of the splitting defence in the child. Treatment can only be carried out in conditions where the court takes responsibility for management of the dynamics around the child and ensures constraint of, or protection from, the aligned parent's problematic behaviours. In this regard, the judge acts as a 'super parent' who establishes a functioning family hierarchy through its powers to compel.

Where progress towards restoration of the child's natural relationship with a rejected parent becomes stalled, the court may wish to consider whether removal from the parent found to be harming the child may be required in order for the child's maladaptive defences to drop. In such cases, the court may wish to consider whether the child's other parent is able to provide good enough care or whether temporary or permanent removal into non-kinship care may be required. Removal of a child from harm and placing them with a safe and good enough kinship care offers the child relief from psychological distress in the short term and provides protection from longer term harm. Alongside such structural changes, treatment must also include therapeutic aftercare in order to support the child and wider family back to psychological health.

References:

Ainsworth, M. D. S. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. Child Development, 40, 969-1025.

Ainsworth, M. D. S. (1989). Attachments beyond infancy. American Psychologist, 44, (4), 709-716.

Benjamin, J. (2018). Beyond doer and done to: Recognition theory, intersubjectivity and the third. Abingdon: Routledge.

Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. Paediatrics & child health, 9(8), 541–545.

Bernet, W. (2020). The five-factor model for the diagnosis of parental alienation. Feedback: Journal of the Family Therapy Association of Ireland, 6: 3-15.

Bernet, W., & Baker, A. J. (2013). Parental alienation, DSM-5, and ICD-11: response to critics. The journal of the American Academy of Psychiatry and the Law, 41(1), 98–104.

Bernet, W., Wamboldt, M. Z. & Narrow, W. E. (2016). Child affected by parental relationship distress. Journal of the American Academy of Child & Adolescent Psychiatry, 55(7):571–579.

Bott Spillius, E., Milton, J., Garvey, P., Couve, C. & Steiner, D. (2011). The new dictionary of Kleinian thought. Routledge.

Boszormenyi-Nagy, I., & Spark, G. (1973). Invisible loyalties: Reciprocity in intergenerational family therapy. Harper & Row.

Bowlby, J. (1988). A secure base: Clinical applications of attachment theory. Brunner-Routledge.

Cashdan, S. (1988). Object relations therapy:Using the relationship. W. W. Norton & Company.

Dean, A. C. (2004). Splitting in normal and pathological populations from the perspective of predictive control theory: A reconceptualization. Theory & Psychology, 14(1): 29–55.

Fairbairn, W. R. D. (1943). The repression and the return of bad objects (with special reference to the 'war neuroses'). In Psychoanalytic studies of the personality, pp. 59-81. Routledge.

Ferenczi, S. (1933). Confusion of tongues between adults and the child. In M. Balint (Ed.) Final contributions to the problems and methods of psych-analysis, Mosbacher, E. and others (trans.). Hogarth; Institute of Psycho-Analysis, 1955, pp. 156-167.

Fisher, J. (2001, May). Dissociative phenomena in the everyday lives of trauma survivors. Paper presented at the Boston University Medical School Psychological Trauma Conference, Boston, MA.

Fisher, J. (2017). Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation. Routledge.

Fonagy, P. (2004). Affect regulation, mentalization and the development of the Self. Karnac.

Fonagy, P., Gergely, G., Jurist, E. l. & Target, M. (2004), Affect regulation, mentalization, and the development of the self. Karnac.

Fromm, E. (1963). The sane society. Routledge & Kegan Paul.

Gardner, R. A. (1985). Recent trends in divorce and custody litigation. Academy Forum, 29(2), 3–7.

Haliburn, J., & Mears, D. (2012). The story of a therapeutic relationship. In R. Meares (Ed.), Borderline personality disorder and the conversational model (pp. 45-109). W. W. Norton.

Hinshelwood, R. D. (2018). Glossary. In J. Abram & R. D. Hinshelwood (Eds.). The clinical paradigms of Melanie Klein and Donald Winnicott (pp. 182-205). Routledge.

Horney, K. (U.d. 1988). The neurotic personality of our time. W. W. Norton.

Horney, K. (1992). Our inner conflicts: A constructive theory of neurosis. W. W. Norton.

Howe, D. (2011). Attachment across the lifecourse: A brief introduction. Palgrave.

Howell, E. F. (2014). Ferenczi's concept of identification with the aggressor: Understanding dissociative structure with interacting victim and abuser self-states. The American Journal of Psychoanalysis, 74, (48–59).

Kerig, P. K. (2005). Implications of parent-child boundary dissolution for developmental psychopathology: Who is the parent and who is the child? New York: Haworth Press.

Kernberg, O. F. (1989). Projection and projective identification: Developmental and clinical aspects. In J. Sandler (Ed.), Projection, identification, projective identification (pp. 93-115). Karnac Books.

King, P. (2005). Alienation and the individual. In B. Kahr and K. Robinson (Eds.), Time Past and Time Present: Selected Papers of Pearl King. Karnac, pp. 169-184.

Klein, M. (1946). Notes on some schizoid positions. The International Journal of Psych-Analysis, 27: 99-110.

Linehan, M. M., & Koerner, K. (1993). Behavioral theory of borderline personality disorder. In J. Paris (Ed.), Borderline personality disorder: Etiology and treatment (pp. 103-121). American Psychiatric Press.

Liotti, G. (2011). Attachment disorganization and the controlling strategies: An illustration of the contributions of attachment theory to developmental psychopathology and to psychotherapy integration. Journal of Psychotherapy Integration, 21(3), 232–252.

Lorandos, D. Bernet, W & Sauber, S. R. (2013). Parental Alienation: The handbook for mental health and legal professionals. Charles C. Thomas.

Minuchin, S. (1974). Families and family therapy. Harvard University Press.

Morris, M. G. & Gould, R. W. (1963). Role reversal: A concept in dealing with the neglected/battered-child syndrome. In, The neglected battered child syndrome: Role reversal in parents (pp. 26-46). Child Welfare League of America.

National Collaborating Centre for Mental Health (UK). Children's Attachment: Attachment in Children and Young People Who Are Adopted from Care, in Care or at High Risk of Going into Care. London: National Institute for Health and Care Excellence (NICE); 2015 Nov. (NICE Guideline, No. 26.) 2, Introduction to children's attachment.

Nolte, T,. Guiney, J., Fonagy, P., Mayes, L. C. & Luyten, P. (2011). Interpersonal stress regulation and the development of anxiety disorders: An attachment-based developmental framework. Frontiers in Behavioural Neuroscience, 5: 55.

Ogden, T. (1982). Projective identification and psychotherapeutic technique. Jason Aronson.

Ruppert, F. (2011). Splits in the soul: Integrating traumatic experiences. Steyning: Green Balloon Publishing.

Rycroft, C. (1995). Critical dictionary of psychoanalysis (second edition). Penguin Books.

Salberg, J, (2015). The texture of traumatic attachment: Presence and ghostly absence in transgenerational transmission. The Psychoanalytic Quarterly. 84(1), 21-46.

Segal, H. (1973). Introduction to the work of Melanie Klein. London: Hogarth.

Steel, B. F. (1970). Parental abuse of infants and small children. In E. J. Anthony & T. Benedek (Eds.), Parenthood: Its psychology and psychopathology (pp. 449-478). Little, Brown.

Tanasugarn, A. (2022). The long-term effect of being raised by a borderline parent. Retrieved from https://www.psychologytoday.com/gb/blog/understanding-ptsd/202212/the-legacy-of-being-raised-by-a-borderline-parent

van der Kolk, B. A. (1989). The compulsion to repeat the trauma re-enactment, revictimization, and masochism. Psychiatric Clinics of North America, 12(2), 389-411.

Van Dijke, A., Hopman, J. A. B, & Ford, J. D. (2018). Affect dysregulation, psychoform dissociation, and adult relational fears mediate the relationship between childhood trauma and complex posttraumatic stress disorder independent of the symptoms of borderline personality disorder, European Journal of Psychotraumatology, 9:1.

Vliegen, N., Tang, E., Midgley, N., Lutyens, P., & Fonagy, P. (2023). Therapeutic work for children with complex trauma: A three-track psychodynamic approach. Routledge.

Winnicott, D. W. (1959). Classification: Is there a psycho-analytic contribution to psychiatric classification. In: The Maturational Processes and the Facilitating Environment (pp. 124-139). Hogarth Press.

Winnicott, D. W. (1967). Mirror-role of mother and family in child development. In P. Lomas (Ed.), The predicament of the family: A psycho-analytical symposium (pp. 26–33). Hogarth Press.

Winnicott, D. W. (1986). The concept of the false self. In C. Winnicott, R. Shepherd & M. Davis (Eds.), Home is where we start from: Essays by a psychoanalyst (pp. 65-70). Penguin.

The Family Separation Clinic's work with children and families is guided by the following principles:

Conceptualisation of the problem:

We conceptualise the problem for children, first and foremost, as a relational trauma and an alienation from the self as a consequence of defensive splitting.

Primacy of the child:

Whilst we seek to re-establish the psychological health of the whole family, the primary focus of all clinical work is the psychological health of the child; we never regard the child as an object of a parental dispute but always as a subject of their own lived experience and it is the child's lived experience that is the focus of all clinicalwork; the primary aim of all clinical work is the resolution of the splitting defence in the child.

Children's hyper-alignment and rejection is a relational problem:

We do not regard alienation to be a problem in the child but recognise it as an induced splitting defence in response to the inter and intra-psychological pressures experienced by the child in its attempt to maintain attachment unity after family separation.

Aetiological uniqueness:

Whilst acknowledging the common clinical markers of alienation in children, we do not utilise or support quasi-diagnostic approaches such as 'eight signs' and 'the five factor model'.

Restoration of integration:

Any intervention that restores the child's relationship with the previously rejected parent but does not honour and attend to the child's attachment relationship to the previously favoured parent may be considered to be a failed intervention; whilst a child may need to be protected from the harmful behaviours of a parent, a successful intervention allows and supports a child to retain a positive relationship with their internalised object relationship to that parent.

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