

An Attachment-Based Model for the Pathology of "Parental Alienation" is Not a New Form of Pathology

C.A. Childress, Psy.D. (2016)

The pathology typically called "parental alienation" in the popular culture is **NOT** some "new form" of pathology. It is all standard and established stuff.

Rejection of a parent is an **attachment-related pathology**.

The attachment system is the brain system that manages all aspects of love and bonding throughout the lifespan, including grief and loss. Within attachment theory (Bowlby, 1969, 1973, 1980), this family attachment-related pathology would be considered a form of "pathological mourning" surrounding the divorce.

"The deactivation of attachment behavior is a key feature of certain common variants of pathological mourning." (Bowlby, 1980, p. 70)

The pathology is fundamentally the inability of the family (of the narcissistic/(borderline) parent within the family) to process the **grief and loss** surrounding the divorce. Instead, the narcissistic/(borderline) personality transforms the sadness and grief into **anger and resentment**, loaded with revengeful wishes:

"They [narcissists] are especially deficient in genuine feelings of sadness and mournful longing; their incapacity for experiencing depressive reactions is a basic feature of their personalities. When abandoned or disappointed by other people they may show what on the surface looks like depression, but which on further examination emerges as anger and resentment, loaded with revengeful wishes, rather than real sadness for the loss of a person whom they appreciated." (Kernberg, 1975, p. 229)

The characterological inability of the narcissistic/(borderline) personality to process sadness and grief creates the "pathological mourning" and "deactivation of attachment behavior" in the family - in the child - through the child's *cross-generational coalition* with this parent.

Cross-Generational Coalition: "The people responding to each other in the triangle are not peers, but one of them is of a different generation from the other two... In the process of their interaction together, **the person of one generation forms a coalition with the person of the other generation against his peer**. By 'coalition' is meant a process of joint action which is *against* the third person... The coalition between the two persons is denied. That is, there is certain behavior which indicates a coalition which, when it is queried, will be denied as a coalition... In essence, the perverse triangle is one in which the separation of generations is breached in a covert way. When this occurs as a repetitive pattern, the system will be pathological." (Haley, 1977, p. 37; emphasis added)

This is not some "new form" of pathology. We already know exactly what it is. It's just that many, most, almost all, current mental health professionals are simply incompetent. They are **misdiagnosing** the pathology.

(Gardnerian PAS experts... are you correctly diagnosing the pathology?)

The personality pathology of the allied parent is the product of childhood attachment trauma (a disorganized attachment) that coalesced in late adolescence and early adulthood into their narcissistic and borderline personality traits.

"Disturbances of personality, which include a bias to respond to loss with disordered mourning, are seen as the outcome of one or more deviations in development that can originate or grow worse during any of the years of infancy, childhood and adolescence." (Bowlby, 1980, p. 217)

The rejection and abandonment by the attachment figure of the spouse surrounding the divorce reactivates the "**internal working models**" (the **schemas**) of the childhood attachment trauma for the narcissistic/(borderline) personality parent.

Internal Working Models

"No variables, it is held, have more far-reaching effects on personality development than have a child's experiences within his family: for, starting during the first months of his relations with his mother figure, and extending through the years of childhood and adolescence in his relations with both parents, he builds up **working models** of how attachment figures are likely to behave towards him in any of a variety of situations; and on those models are based all his expectations, and therefore all his plans for the rest of his life." (Bowlby, 1980, p. 369; emphasis added).

"Every situation we meet within life is construed in terms of the **representational models** we have of the world about us and of ourselves. Information reaching our sense organs is selected and **interpreted in terms of those models**, its significance for us and for those we care for is evaluated in terms of them, and plans of action conceived and executed with those models in mind." (Bowlby, 1980, p. 229; emphasis added)

Schemas

"How a situation is evaluated depends in part, at least, on the relevant underlying beliefs. These beliefs are embedded in more or less stable structures, labeled "schemas," that select and synthesize incoming data." (Beck, et al., 2004, p. 17)

"The content of the schemas may deal with personal relationships, such as attitudes toward the self or others, or impersonal categories... When schemas are latent, they are not participating in information processing; when activated they channel

cognitive processing from the earliest to the final stages... When hypervalent, these idiosyncratic schemas displace and probably inhibit other schemas that may be more adaptive or more appropriate for a given situation. They consequently introduce a systematic bias into information processing." (Beck, et al., 2004, p. 27)

"In personality disorders, the schemas are part of normal, everyday processing of information." (Beck, et al., 2004, p. 27)

"Arntz (1994) hypothesized that childhood traumas underlie the formation of core schemas, which in their turn, lead to the development of BPD [borderline personality disorder]." (Beck, et al., 2004, p 192)

"BPD patients process information through a specific set of three core beliefs or schemas of themselves and others, i.e., 'I am powerless and vulnerable', 'I am inherently unacceptable', and 'Others are dangerous and malevolent'. Needing support in a dangerous world but not trusting others brings BPD patients into a state of hypervigilance. Schema-specific information is highly prioritized or difficult to inhibit in this state, resulting in biases in early information processing phases." (Sieswerda, Arntz, Mertens, & Vertommen, 2006, p. 1011)

"Patients with BPD were characterized by higher self-reports of beliefs, emotions, and behaviors related to the four pathogenic BPD modes (detached **protector**, abandoned/**abused child**, angry child, and **punitive parent** mode)." (Beck, et al., 2004, p 192)

The "internal working models" for the childhood attachment trauma of the narcissistic/(borderline) parent are in the pattern, "**abusive parent**"/"**victimized child**"/"**protective parent**"

"Young elaborated on an idea, in the 1980s introduced by Aaron Beck in clinical workshops, that some pathological states of patients with BPD are a sort of regression into intense emotional states experienced as a child. Young conceptualized such states as schema modes... Young hypothesized that four schema modes are central to BPD: the abandoned child mode (the present author suggests to label it the **abused and abandoned child**); the angry/impulsive child mode; the **punitive parent** mode, and the **detached protector** mode." (Beck, et al., 2004, p. 199)

"One primary transference-countertransference dynamic involves reenactment of familiar roles of **victim-perpetrator-rescuer**-bystander in the therapy relationship. Therapist and client play out these roles, often in complementary fashion with one another, as they relive various aspects of the client's early attachment relationships." (Pearlman & Courtois, 2005, p. 455)

These patterns of "internal working models" become overlaid onto the current family members. The current child is assigned the role as the supposedly "**victimized child**," the

targeted parent is assigned the trauma reenactment role as the "abusive parent," and the allied narcissistic/(borderline) parent adopts and conspicuously displays to others the coveted role as the all-wonderful "protective parent."

The "bystander role" is assigned to the various mental health professionals, attorneys, parenting coordinators, judges, and school personnel whose role becomes to validate and legitimize the false trauma reenactment narrative created by the narcissistic/(borderline) parent.

The trauma-roles (the "internal working models" of attachment trauma) are all in place to reenact the childhood trauma of the narcissistic/(borderline) parent into the current family relationships. All that's required to initiate the trauma reenactment narrative is to convince the child through manipulative communication techniques to adopt the role of "victimized child" relative to the parenting practices of the targeted parent.

This is important to understand... the rejection of the targeted parent is **not** created by the allied parent "bad-mouthing" and saying negative things about the other parent. The child's rejection of the targeted parent is created by convincing the child through manipulative techniques of subtle psychological influence and control to accept the role as the "victimized child." The allied narcissistic/(borderline) parent gets the child to believe that the child is being victimized by the supposedly inadequate, insensitive, and "abusive" parenting practices of the other parent.

This is accomplished by first **eliciting from the child** a complaint about the other parent through motivated and subtly directive questioning by the narcissistic/(borderline) parent. Once the child offers a criticism, no matter how small, the narcissistic/(borderline) parent then responds with distorted and exaggerated displays of concern regarding the supposedly inadequate and insensitive parenting practices of the other parent, thereby distorting the normal-range parenting practices of the targeted parent into supposed evidence of "abusive" parental inadequacy - "Oh you poor thing. I can't believe the other parent treats you so horribly." The key is to convince the child that the child is a "victim" of the other parent's inadequate and insensitive parenting.

To all external appearances, however, the allied narcissistic/(borderline) parent is not "badmouthing" the other parent; it's the child who is criticizing the other parent. The allied narcissistic/(borderline) parent presents as simply being a nurturing and protective parent (or so it appears) - "I'm just listening to the child." Manipulative, manipulative, manipulative. The narcissistic/(borderline) parent is first **eliciting a criticism from the child** through motivated and directive questioning, and then is hiding their manipulation behind this elicited criticism - "I'm just listening to the child. It's not me, it's the child who is saying these bad things about the other parent. I'm just listening to the child."

The moment the child surrenders to the manipulation of the narcissistic/(borderline) parent and adopts the (false) "victimized child" role relative to the other parent, this immediately imposes the "abusive parent" role in the trauma reenactment narrative onto the targeted parent, irrespective of the targeted parent's actual parenting behavior, and the

child's presentation as the "victimized child" allows the narcissistic/(borderline) parent to adopt and conspicuously display to the "bystanders" the coveted role as the all-wonderful "protective parent."

But none of this created storyline is true. It is all a kabuki theater display of a false drama created in the childhood trauma of the narcissistic/(borderline) parent, embedded in the internal working models - the schemas - of this parent's attachment networks. It is a reenactment of childhood attachment trauma into the current family relationships.

Trauma Reenactment

"**Reenactments of the traumatic past** are common in the treatment of this population and frequently represent either explicit or coded repetitions of the unprocessed trauma in an attempt at mastery. Reenactments can be expressed psychologically, relationally, and somatically and may occur with conscious intent or with little awareness." (Pearlman & Courtois, 2005, p. 455; emphasis added)

"Freud suggests that overwhelming experience is taken up into what passes as normal ego and as permanent trends within it' and, in this manner, **passes trauma from one generation to the next**. In this way, trauma expresses itself as time standing still... Traumatic guilt --- for a time buried except through the character formation of one generation after the next --- finds expression in an **unconscious reenactment of the past in the present**." (Prager, 2003, p. 176; emphasis added)

"Victims of past trauma may respond to contemporary events as though the trauma has returned and re-experience the hyperarousal that accompanied the initial trauma." (Trippany, Helm, & Simpson, 2006, p. 100)

"When the trauma fails to be integrated into the totality of a person's life experiences, the victim remains fixated on the trauma. Despite avoidance of emotional involvement, traumatic memories cannot be avoided: even when pushed out of waking consciousness, they come back in the form of **reenactments**, nightmares, or feelings related to the trauma... Recurrences may continue throughout life **during periods of stress**." (van der Kolk, 1987, p. 5; emphasis added)

None of this trauma reenactment narrative is true. The child is **not** a victim. The targeted parent is **not** abusive. And the narcissistic/(borderline) parent is **not** a protective parent. None of it is true.

It is a fixed and false belief that is maintained despite contrary evidence. It is a **delusion**. An encapsulated delusion. An encapsulated persecutory delusion.

Encapsulated Delusion: "A delusion that usually relates to one specific topic or belief but does not pervade a person's life or level of functioning."
(www.medilexicon.com)

Persecutory Delusion: "Delusions that the person (or someone to whom the person is close) is being malevolently treated in some way" (American Psychiatric Association; DSM-IV TR)

It is an encapsulated persecutory delusion. This is called diagnosis. This is not a theory. The application of standard and established psychological constructs and principles - and, by the way, these are all scientifically validated and fully peer reviewed psychological constructs and principles - to a set of symptoms is called diagnosis. Diagnosis.

This is not Dr. Childress saying this stuff, it's some of the most respected figures in the field of professional psychology: Aaron Beck, John Bowlby, Otto Kernberg, Bessel van der Kolk, the American Psychiatric Association, and in a moment one of the top experts in personality disorder pathology, Theodore Millon. This is all standard and fully established stuff.

This pathology represents an encapsulated persecutory delusion of a narcissistic/(borderline) parent that is being transferred to the child through the distorted parenting practices of the narcissistic/(borderline parent):

ICD-10 Diagnostic System of the World Health Organization. Diagnostic Description of a Shared Psychotic Disorder Diagnosis (F24): "A condition in which closely related persons, usually in the same family, share the same delusions. A disorder in which a delusion develops in an individual in the context of close relationship with another person who already has that established delusion."

This pathology is a delusional disorder - a shared delusional disorder. It is a psychotic disorder created by the psychological collapse of a narcissistic/(borderline) personality surrounding the divorce.

From Theodore Millon:

"Under conditions of unrelieved adversity and failure, narcissists may decompensate into **paranoid** disorders. Owing to their excessive use of fantasy mechanisms, they are disposed to misinterpret events and to construct **delusional** beliefs. Unwilling to accept constraints on their independence and unable to accept the viewpoints of others, narcissists may isolate themselves from the corrective effects of shared thinking. Alone, they may ruminate and weave their beliefs into a network of fanciful and totally invalid suspicions. Among narcissists, **delusions** often take form after a serious challenge or setback has upset their image of superiority and omnipotence. They tend to exhibit compensatory grandiosity and jealousy **delusions** in which they reconstruct reality to match the image they are unable or unwilling to give up. **Delusional** systems may also develop as a result of having felt betrayed and humiliated. Here we may see the rapid unfolding of **persecutory delusions** and an arrogant grandiosity characterized by verbal attacks and bombast." (Millon, 2011, pp. 407-408; emphasis added).

This is NOT some "new form" of pathology. We absolutely understand exactly what it is.

From the American Psychiatric Association; DSM-IV TR Shared Delusional Disorder:

"The essential features of Shared Psychotic Disorder (Folie a Deux) is a delusion that develops in an individual who is involved in a close relationship with another person (sometimes termed the "inducer" or "the primary case") who already has a Psychotic Disorder with prominent delusions (Criteria A)." (American Psychiatric Association, 2000, p. 332)

"Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person. Individuals who come to share delusional beliefs are **often related by blood** or marriage and have lived together for a long time, sometimes in relative isolation. If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear. Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, **especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs.**" (American Psychiatric Association, 2000,p. 333; emphasis added)

"especially in **family situations** in which the **parent is the primary case** and the **children**, sometimes to varying degrees, **adopt the parent's delusional beliefs.**"

This is NOT some "new form" of pathology. We absolutely 100% understand what this pathology is. It's simply that some - many - most - nearly all - mental health professionals are **misdiagnosing** the pathology because of their profound professional **ignorance** and **incompetence**.

A psychotic disorder is sitting right in front of them in their offices, right there, in the chair right across from them, and they are entirely missing the diagnosis of a **psychotic disorder** sitting right in front of them. Incompetence, incompetence, incompetence. Profound professional incompetence. A **psychotic** disorder. Inexcusable.

This is NOT some "new form of pathology." We absolutely know what it is. It's just that profound professional incompetence is entirely missing the diagnosis of a psychotic pathology that is sitting right in front of them.

The pathology commonly referred to as "parental alienation" in the common culture represents an **encapsulated persecutory delusion** of a narcissistic/(borderline) parent that is being transferred to the child by the manipulative psychological influence and distorted **pathogenic parenting** practices of the allied narcissistic/(borderline) parent in a **cross-generational coalition** with the child.

The pathology commonly referred to as "parental alienation" in the common culture represents the trans-generational transmission of attachment trauma from the childhood of the allied narcissistic/(borderline) parent to the current family relationships (through the creation of a **false trauma reenactment narrative**), mediated by the **personality disorder pathology** of the narcissistic/(borderline) parent which is itself a product of this parent's childhood attachment trauma.

It is an attachment-related pathology. It is a trauma-related pathology. It is a delusional-psychotic pathology.

The complexity of this attachment-related, trauma-related, and personality disorder pathology warrants the designation of children and families evidencing this form of pathology as a "**special population**" requiring specialized professional knowledge and expertise to competently assess, diagnose and treat.

Failure to possess the necessary professional competence in attachment-related pathology, trauma-related pathology, and personality disorder pathology required to properly assess, accurately diagnose, and effectively treat this form of attachment-related, trauma-related, and personality disorder pathology would very likely represent practice beyond the boundaries of professional competence in violation of Standard 2.01a of the APA ethics code.

Failure to properly assess for this form of attachment-related pathology, trauma-related pathology, and personality disorder pathology would likely represent a violation of Standard 9.01a of the APA ethics code which requires that "Psychologists base the opinions contained in their... **diagnostic** or evaluative statements, including **forensic testimony**, on information and techniques sufficient to substantiate their findings." If the psychologist has **not even assessed** for the attachment trauma pathology of a shared encapsulated delusion (the false trauma reenactment narrative), then the diagnostic statements (or forensic testimony) of the psychologist cannot possibly be based on "information and techniques sufficient to substantiate their findings."

Diagnostic Checklist for Pathogenic Parenting:

<http://www.drcachildress.org/asp/admin/getFile.asp?RID=108&TID=6&FN=pdf>

Pathogenic parenting that is creating significant developmental pathology in the child (diagnostic indicator 1), personality disorder pathology in the child (diagnostic indicator 2), and delusional-psychiatric pathology in the child (diagnostic indicator 3) in order to meet the emotional and psychological needs of the parent represents a **DSM-5** diagnosis of **V995.51 Child Psychological Abuse, Confirmed**.

Pathogenic parenting is not a child custody issue; it is a **child protection** issue.

Because of their profound professional incompetence, many, far too many, mental health professionals are colluding with the psychological abuse of children.

Holding Mental Health Accountable

Targeted parents must begin holding ALL mental health professionals accountable to standards of professional competence (Standards 9.01a and 2.01a of the APA ethics code). Mental health professionals are NOT ALLOWED to be incompetent. It's not me saying this, it's the American Psychological Association saying it. Mental health professionals are not allowed to be incompetent.

All actively incompetent mental health professionals must be made to understand that they will - with 100% certainty - face a licensing board complaint for their professional incompetence when they fail to properly assess and accurately diagnose this form of attachment-related, trauma-related, and personality disorder pathology.

I don't care what the licensing board chooses to do. If they choose to collude with the psychological abuse of children by allowing professional incompetence, there is nothing we can do about that. But we need to make it clear to every single mental health professional that they are playing Russian roulette with their license.

"Did the licensing board do anything this time? No? Lucky you. How about this time, did the licensing board do anything this time? No? Lucky you. How about this time, did the licensing board do anything this time?..."

We need to make all actively incompetent mental health professionals play Russian roulette with their professional career. There may not be a bullet in the chamber this time, but what about the next board complaint, and the next one, and the next one...

We will not abandon the children to professional incompetence. We will fight. We will fight with Standards 2.01a requiring professional competence, and we will fight with Standard 9.01a requiring appropriate assessment. These are the professional practice Standards of the American Psychological Association. These Standards belong to you. They are to protect you. Use them.

Eventually, the licensing boards will begin to grow weary of colluding with professional incompetence, eventually the licensing boards will grow uncomfortable allowing the psychological abuse of children.

We will not abandon your children.

We will not stop and we will not relent until we have achieved **professional competence** in the professional assessment and diagnosis of this attachment-related, trauma-related, and personality disorder pathology.

This is not a "new form" of pathology. We know exactly what it is. We just need an accurate diagnosis.

Pathogenic parenting that is creating significant developmental pathology in the child (diagnostic indicator 1), personality disorder pathology in the child (diagnostic indicator 2), and delusional-psychiatric pathology in the child (diagnostic indicator 3) in order to meet the emotional and psychological needs of the parent represents a **DSM-5** diagnosis of **V995.51 Child Psychological Abuse, Confirmed**.

This is not a child custody issue; it is a **child protection** issue.

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