Pathogenic Parenting: Attachment-Based "Parental Alienation" (AB-PA) Treatment-Related Decision-Making

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

Clinically assess and document the parenting practices of the targeted-rejected parent using the *Parenting Practices Rating Scale* and supporting examples.

Clinically assess and document the symptom features displayed by the child using the *Diagnostic Checklist for Pathogenic Parenting*.

1.) Confirmed Presence of the 3 Diagnostic Indicators of Pathogenic Parenting:

- DSM-5 diagnosis of V995.51 Child Psychological Abuse, Confirmed.
- Initiate protective separation period:
    - A 12-week protective separation period is recommended for augmented family systems therapy that begins with a brief-intensive psycho-educational intervention supported by follow-up recovery stabilization therapy.
    - A 36-week protective separation period is recommended for standard family systems therapy focused on disordered mourning and grief resolution.
    - A variable protective separation period based on the child's behavior is recommended when a structured Strategic family systems therapy protocol is employed.
- Initiate augmented family systems therapy, standard family systems grief resolution therapy, or a structured Strategic family systems therapy protocol.
- Require collateral individual therapy for the abusive parent with the treatment goal for this parent to develop insight into the cause for the prior abusive parenting practices.
- Once the child's symptoms have been resolved and the child's recovery is stabilized, restore the child's relationship with the formerly abusive parent with sufficient safeguards to ensure that the psychological abuse of the child does not resume once the child's relationship with the formerly abusive parent is restored.

2.) Sub-Threshold Presence of the 3 Diagnostic Indicators of Pathogenic Parenting:

- Response-to-Intervention Assessment:
    - Initiate a 6-month Response-to-Intervention (RTI) trial addressing the potential problematic parenting of the targeted-rejected parent.
    - If, despite the cooperation of the targeted-rejected parent, the 6-month RTI trial addressing the potential problematic parenting of the targeted-rejected parent is unsuccessful, then initiate a 6-month RTI protocol to address the potential pathogenic parenting of the allied parent who has established a cross-generational coalition with the child against the targeted parent.

3.) The 3 Diagnostic Indicators of Pathogenic Parenting Are Not Present:

- Initiate standard child and family therapy based on a diagnostic determination of the causal factors for the parent-child conflict.

Treatment Needs Assessment Report
Example for Confirmed Diagnosis of Pathogenic Parenting

Date: <Date of Assessment>
Psychologist: <Psychologist's Name>

Scope of Report

A Treatment Needs Assessment was requested by the Court for the parent-child relationship of John Doe (DOB: 1/15/08) with his mother regarding their estranged and conflictual relationship. This Treatment Needs Assessment report is based on the following family interviews:

<date>: Clinical interview with mother
<date>: Clinical interview with father
<date>: Clinical interview with child
<date>: Clinical relationship assessment with mother and child
<date>: Clinical interview with mother
<date>: Clinical relationship assessment with mother and child
<date>: Clinical interview with father

Rating Scales Completed (attached)

Parenting Practices Rating Scale (mother)
Diagnostic Checklist for Pathogenic Parenting

Results of Assessment

Based on the clinical assessments, the child displays the three symptom indicators of pathogenic parenting associated with an attachment-based model of "parental alienation" (AB-PA; Childress, 2015):

1) Attachment System Suppression: A targeted and selective suppression of the child's attachment bonding motivations relative to his mother in the absence of sufficiently distorted parenting practices from the mother that would account for the suppression of the child's attachment system;

2) Personality Disorder Traits: A set of five specific narcissistic/borderline personality disorder features are present in the child's symptom display;

3) Encapsulated Delusional Belief System: The child evidences an intransigently held fixed and false belief that is maintained despite contrary evidence (i.e., an encapsulated delusion) regarding the child's supposed "victimization" by the normal-range parenting of the mother (i.e., an encapsulated persecutory delusion).

The presence of this specific symptom display by a child is consistent with an attachment-based framework for conceptualizing "parental alienation" processes within the family that involve an induced suppression of the child's attachment bonding motivations

toward a normal-range parent (i.e., the targeted parent) as a result of the distorted parenting practices of a personality disordered parent (i.e., narcissistic/borderline features, which accounts for the presence of these features in the child's symptom display).

The mother's parenting practices on the *Parenting Practices Rating Scale* are assessed to be broadly normal-range. The mother's parenting would be classified as Level 4, Positive Parenting; Affectionate Involvement – Structured Spectrum. The mother establishes clearly defined rules and expectations for child behavior that are well within normal-range parenting, and the mother's delivery of consequences is fair and is based on these established rules and expectations for child behavior. The mother offers parental encouragement and affection, but these offers of parental affection are typically rejected by the child. The mother's rating on the Permissive to Authoritarian Dimension would be 60, which is well within normal-range parenting. She tends toward the use of clearly established rules and appropriate parental discipline for child non-compliance. The mother's capacity for authentic empathy is normal-range. She is able to self-reflect on her actions and also de-center from her own perspective to adopt the frame of reference of other people. She is not overly self-involved nor does she project her own emotional needs into and onto the child. There are no issues of clinical concern regarding the mother's parenting.

DSM-5 Diagnosis

The combined presence in the child's symptom display of significant attachment-related developmental pathology (diagnostic indicator 1), narcissistic personality disorder pathology (diagnostic indicator 2), and delusional-psychiatric pathology (diagnostic indicator 3) represents definitive diagnostic evidence of pathogenic parenting by an allied parent with prominent narcissistic and/or borderline personality traits, since no other pathology will account for this specific symptom set other than pathogenic parenting by an allied narcissistic/borderline personality parent.

This set of severe child symptoms warrants the following DSM-5 diagnosis for the child:

309.4 Adjustment Disorder with mixed disturbance of emotions and conduct
V61.20 Parent-Child Relational Problem
V61.29 Child Affected by Parental Relationship Distress
V995.51 Child Psychological Abuse, Confirmed (pathogenic parenting)

Treatment Indications

A confirmed DSM-5 diagnosis of Child Psychological Abuse warrants the following child protection and treatment response:

1.) **Protective Separation Period:** A period of protective separation of the child from the psychologically abusive parenting practices of the allied parent is required in order to protect the child from ongoing exposure to psychologically abusive parenting practices and allow for the treatment and recovery of the child's normal-range and healthy development.

Attempting therapy without first establishing a period of protective separation from the pathogenic parenting practices of the father will continue the child's ongoing exposure to

the psychologically abusive parenting of the father that is creating significant developmental pathology, personality disorder pathology, and delusional-psychiatric pathology in the child, and will lead to the child becoming a "psychological battleground" between the treatment goals of restoring the child's healthy and normal-range development and the continuing pathogenic goals of the father to create and maintain the child's pathology.

2.) **Treatment:** Appropriate parent-child psychotherapy should be initiated to recover and heal the damaged parent-child affectional bond with the mother and resolve the impact of the prior psychological abuse inflicted on the child by the father's distorted and psychologically abusive parenting practices in order to restore the child's healthy emotional and psychological development.

3.) **Collateral Therapy:** The father should be required to obtain collateral individual therapy with the treatment goal of fostering insight into the cause of the prior abusive parenting practices.

4.) **End of Protective Separation:** The protective separation period should be ended once the child's symptoms associated with the prior psychologically abusive parenting practices of the father are successfully resolved and the child's recovery is stabilized.

5.) **Restoration of the Relationship with the Abusive Parent:** The restoration of the child's relationship with the formerly abusive parent should include sufficient safeguards to ensure that the psychological abuse of the child does not resume once contact with the father is restored. The demonstrated cooperation of the father with his individual collateral therapy and his demonstrated insight into the cause of the prior psychological abuse of the child would represent important considerations in the level of safeguards needed to ensure the child's protection.

6.) **Relapse:** If the child's symptoms reoccur once the child's contact with the father is restored, then another period of protective separation will be needed in order to again recover the child's normal-range and healthy development, and additional protective safeguards will be warranted prior to once again exposing the child to the pathogenic parenting practices of the father.

<u>Child Response to a Protective Separation</u>

The child may initially respond to a protective separation from the currently allied parent (i.e., the father) with increased protest behavior and defiance. This child response represents an emotional-behavioral tantrum reflecting the child's currently over-empowered status relative to accepting authority (i.e. both parental authority and the authority of the Court). Responding to emotional displays of child tantrum behaviors with calm and steady purpose that restores the child to an appropriate social and family hierarchy of cooperation with Court and parental authority will be important to supporting successful family therapy and the resolution of the child's symptoms.

Any concern regarding the child's expressed distress at the protective separation from the currently allied parent (i.e., the father) should recognize that the child is fully capable of

ending the protective separation period by becoming non-symptomatic. If the child wishes a termination of the protective separation period, then the child simply needs to evidence normal-range affectional child behavior in response to the normal-range parenting practices of the mother, which is under the treatment-related monitoring of the family therapist.

Ending the Protective Separation Period

The protective separation period from the pathogenic and psychologically abusive parenting practices of the allied parent should be ended upon the successful treatment and resolution of the child's symptoms and restoration of the child's healthy and normal-range development. The treating family therapist should seek Court approval to end the child's protective separation from the pathogenic parenting practices of the currently allied parent (i.e., the father) based on the treatment-related gains achieved. Progress reports to the Court from the treating family therapist should be provided at least every six months.

Sincerely,

<Psychologist name>
Psychologist, <license number>

Treatment Needs Assessment Report
Example for Sub-Threshold Symptoms for the Diagnosis of Pathogenic Parenting

Date: <Date>
Psychologist: <Psychologist's Name>

Scope of Report

A Treatment Needs Assessment was requested by the Court for the parent-child relationship of John Doe (DOB: 1/15/08) with his mother regarding their estranged and conflictual relationship. This Treatment Needs Assessment report is based on the following family interviews:

<date>: Clinical interview with mother
<date>: Clinical interview with father
<date>: Clinical interview with child
<date>: Clinical relationship assessment with mother and child
<date>: Clinical interview with mother
<date>: Clinical relationship assessment with mother and child
<date>: Clinical interview with father

Rating Scales Completed (attached)

Parenting Practices Rating Scale (mother)
Diagnostic Checklist for Pathogenic Parenting

Results of Assessment

Based on the clinical assessments, the child does not display the three symptom indicators of pathogenic parenting associated with an attachment-based model of "parental alienation" (AB-PA; Childress, 2015):

1) Attachment System Suppression: A targeted and selective suppression of the child's attachment bonding motivations relative to his mother in the absence of sufficiently distorted parenting practices from the mother that would account for the suppression of the child's attachment system;

2) Personality Disorder Traits: A set of five specific narcissistic/borderline personality disorder features present in the child's symptom display;

3) Encapsulated Delusional Belief System: The child evidences an intransigently held fixed and false belief that is maintained despite contrary evidence (i.e., an encapsulated delusion) regarding the child's supposed "victimization" by the normal-range parenting of the mother (an encapsulated persecutory delusion).

The child's symptom presentation does not fully evidence an intransigently held fixed and false belief in the child's supposed "victimization" because the mother's parenting practices are sufficiently problematic to warrant concerns that the child's perceptions of his

mother have some component of accuracy. In addition, John expressed an openness to restoring a relationship with his mother if his potentially reality-based concerns can be adequately addressed.

However, John also evidenced a prominent suppression of normal-range attachment bonding motivation toward his mother and he displayed prominent signs of narcissistic personality disorder features in his attitude and responses to his mother. The symptom features in the family also evidenced several Associated Clinical Signs (see attached *Diagnostic Checklist for Pathogenic Parenting*), so that concerns regarding the potential pathogenic influence of the currently allied and supposedly "favored" parent (i.e., the father) continue.

Mother's Parenting Practices

The mother's parenting practices are assessed to be in the Level 3 domain on the *Parenting Practices Rating Scale* (Problematic Parenting), reflecting potentially harsh discipline (Item 12) and high-anger parenting (Item 13). These parenting practices, however, may also be a product of the child's provoking these parenting responses through a high level of child non-compliance and disrespect for parental authority. A Response-to-Intervention assessment would help clarify the causal direction for the parent-child conflict.

The child is also likely impacted by chronic exposure to high levels of inter-spousal conflict involving intermittent explosive anger from one spouse directed toward the other spouse (Item 16). While this inter-spousal anger is not directed toward the child, the extent of the high inter-spousal conflict likely creates considerable stress for the child and represents a degree of parental insensitivity for the child's emotional and psychological needs by at least one, and possibly both, parents. Restricting the expression of inter-spousal anger and developing cooperative co-parenting spousal skills of respecting boundaries and for mutual displays of kindness in respectful communication would be in the emotional and psychological best interests of the child.

The mother appears to employ a more disciplinarian approach to parenting involving structured rules and consequences, and her rating on the Permissive to Authoritarian Dimension would be in the 60 to 70 range, which is in the normal-range of parenting. A reduction in parent-child conflict might be achieved by helping the mother expand her parenting options by using increased dialogue and negotiation skills that would shift her rating on the Permissive to Authoritarian Dimension into the mid-range of 45 to 55. However, it should also be noted that the mother's current parenting practices are well within the normal-range for parenting generally, and considerable latitude should be granted to parents to establish rules and values within their families that are consistent with their cultural and personal value systems.

The mother's capacity for authentic empathy with the child appears to be in the normal range. She is able to self-reflect on her own behavior and she is also able to de-center from her own perspective to view situations from alternate points of view. The mother does not appear to become overly self-involved in needing to have her perspective validated, nor does she appear to project her own needs onto the child.

There are no areas of clinical concern related to the mother's parenting.

Treatment Indications

Based on the set of symptom features in child's symptom display and the assessment of the mother's current parenting practices, a Response-to-Intervention (RTI) treatment approach is recommended for a 6-month period to further assess the role of the mother's parenting practices relative to the potential role of pathogenic parental influence from the father in creating and supporting the child's symptomatic relationship with his mother.

1.) Response to Intervention (RTI) Assessment

A 6-month period of family therapy is recommended that includes both mother-child therapy sessions to improve communication and conflict resolution skills as well as collateral sessions with the mother to expand and improve her parenting responses to John.

Authentic Parent-Child Conflict - Resolution: If the mother displays normal-range and appropriate parenting in response to treatment directives, then John's behavior toward his mother should show corresponding improvement (i.e., demonstrating that the child's behavior is under the "stimulus control" of the parent's behavior, meaning that the parent-child conflict is authentic to their relationship features). Changes to the mother's parenting practices will then lead to a resolution of the parent-child conflict.

Authentic Parent-Child Conflict – No Resolution: If the mother is unable to sufficiently alter her potentially harsh discipline and high-anger parenting behavior in response to treatment directives, then this would represent suggestive clinical evidence that the source of the mother-son conflict is potentially authentic to their relationship dynamics, and family therapy should continue to seek changes in the mother's parenting responses toward a more nurturing and affectionate parenting approach to help resolve the parent-child conflict.

Inauthentic Parent-Child Conflict: If, however, the mother displays normal-range and appropriate parenting in response to treatment directives, and John's symptoms continue despite changes in the mother's parenting practices, then this would represent confirming diagnostic evidence that John's behavior is not under the "stimulus control" of his mother's behavior and her responses to him, meaning that he is not responding to authentic difficulties in the mother-son relationship. The continuance of John's symptomatic behavior toward his mother despite changes in the mother's parenting practices would represent diagnostic evidence that John's symptomatic responses to his mother are likely being created by the pathogenic parenting practices of the father (through the formation of a cross-generational coalition of the child with his father against the mother). A Response-to-Intervention treatment plan to address the pathogenic parenting of the father in creating the child's ongoing conflict with the mother should then be developed and implemented.

2.) Compliance with Court Orders for Custody and Visitation

All parties, including the child, should comply fully with all Court orders including those for custody and visitation. Failure by the currently allied and supposedly "favored" parent (i.e., the father) to comply with Court orders for custody and visitation should be viewed as non-compliance with treatment, and a follow-up Treatment Needs Assessment should be initiated (at the written recommendation of the treating family therapist) to determine whether a

protective separation of the child from the potentially pathogenic parenting practices of the father is needed to allow for effective treatment.

Child noncompliance with Court orders for custody and visitation, such as refusing custody time-share visitations with the mother, should be ascribed as a serious failure in parenting by the currently allied and supposedly "favored" parent (i.e., the father) representing a parental failure to demonstrate appropriate parental responsibility.

- If the father is instructing the child to comply with the father's directive to cooperate with the mother's custody and visitation time and the child is refusing to comply with the father's directive, then the child is evidencing oppositional non-compliant behavior relative to the father's parental authority and the authority of the Court.

- As the allied and supposedly "favored" parent, the child's behavior is a reflection of the parenting received from the father, so that the child's oppositional non-compliance with the father's parental authority and the authority of the Court is a direct reflection on the father's parenting and his capacity for providing appropriate parental guidance to the child.

A failure to exercise effective parental responsibility and guidance by the allied and supposedly "favored" parent should be viewed as representing the father's non-compliance with the requirements of treatment by failing to exercise appropriate parental responsibility and child guidance as the "favored" and allied parent. The child's refusal to comply with Court orders, including all orders for custody and visitation, and the child's direct defiance of the father's parental authority should trigger a follow-up Treatment Needs Assessment (at the written recommendation of the treating family therapist) to determine whether a change in the responsible parent is needed to allow for effective treatment and the recovery of the child's normal-range and healthy development.

In any follow-up Treatment Needs Assessment, primary consideration should be afforded to the treatment needs of the child in establishing the treatment-related conditions necessary for effective treatment. The treatment-related needs of the child should be given precedence over parental considerations of being "favored" or "unfavored" by the child. If the allied and supposedly "favored" parent cannot establish the conditions necessary for the effective resolution of the child's symptoms, then a change in the responsible parent may be necessary due to the demonstrated parental failure of the allied and supposedly "favored" parent to enact the appropriate parental authority and guidance necessary for the child's successful treatment.

Progress reports to the Court from the treating family therapist should be provided at least every six months.

Sincerely,

<psychologist name>
Psychologist, <license number>