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Consultation Report: <name>

Date: 4/9/19

Psychologist: Craig Childress, Psy.D.

File Reviewed: <family name>

Father <name>; Mother <name>; <child name> (DOB); <child name> (DOB)

### **Scope of Report:**

Dr. Childress was provided with a compiled data profile from <source>, summarized in a *Diagnostic Checklist for Pathogenic Parenting* (Childress, 2015). Dr. Childress was asked to provide his opinion on the data set submitted to him as summarized in the *Diagnostic Checklist for Pathogenic Parenting*.

The opinion contained in this report is based on the accuracy of the compiled data profile provided to Dr. Childress as summarized in the *Diagnostic Checklist for Pathogenic Parenting*. If substantial alterations to the data profile provided for opinion occur, then the opinions of this report would change.

### **Diagnostic Checklist for Pathogenic Parenting:**

The *Diagnostic Checklist for Pathogenic Parenting* documents child and family symptoms associated with a specific form of complex family conflict involving one parent creating severe pathology in the child in order to use the child as a spousal weapon of revenge and retaliation against the other parent. Creating pathology in a child through distorted parenting is called “pathogenic parenting” (patho=pathology; genic=genesis, creation). Pathogenic parenting is the creation of significant psychopathology in the child through aberrant and distorted parenting practices.

The *Diagnostic Checklist for Pathogenic Parenting* does not make a diagnosis, it documents the symptoms associated with a specific type of trauma pathology in a family which is being expressed in the complex family conflict surrounding divorce. Childhood trauma in one (or both) parent(s) is being brought into current family relationships surrounding a divorce, and the allied parent is using the child(ren) as a weapon of revenge and retaliation against the other spouse (and parent) for perceived inadequacies of the marriage and for the divorce.

### **Intimate Partner Violence**

In many cases, this type of family pathology represents a form of Intimate Partner Violence by proxy (IPV; domestic violence), in which one spouse is inflicting inter-spousal emotional abuse on the ex-spouse in revenge and retaliation for the divorce, using the children as weapons. The core issues in IPV are *power*, *control*, and *domination*. When these themes are present in family relationships, the possible IPV issues warrant assessment. The IPV themes of *power*, *control*, and *domination*, potentially using the

children as the weapon and vehicle for this, should receive proper attention in any assessment of complex family conflict surrounding divorce.

### **The Pathology:**

In using the children as weapons of spousal revenge and retaliation, the allied parent creates significant pathology in the children across three sets of symptoms, 1) **attachment bonding** symptoms, involving a severe breach in the children's bonding to the targeted parent (targeted for emotional abuse; IPV), 2) **personality development**, in which the child is acquiring the personality disorder symptoms and attitudes of the allied parent (pathological narcissism; grandiosity, absence of empathy, entitlement, haughty and arrogant attitude, and splitting), and 3) **delusional-psychiatric pathology** in which the child has a fixed and false believe in their supposed "victimization" by the targeted parent (a belief created in the child by the pathogenic parenting of the allied parent).

The *Diagnostic Checklist for Pathogenic Parenting* is not an assessment instrument per se, it a symptom checklist instrument on which these three specific areas of child pathology, that are indicative of the child's weaponization by one parent into the spousal conflict surrounding divorce, can be documented to aid in diagnosis and decision-making regarding treatment. For formal diagnosis, the documentation of these symptoms would have to be made by a mental health professional. The three symptom areas (attachment, personality pathology, and persecutory delusions) are all mental health pathologies that would require professional assessment. If these symptoms are confirmed by a professional mental health assessment, the DSM-5 diagnosis for the child would be:

Child:

309.4 Adjustment Disorder

V61.20 Parent-Child Relational Problem

V61.29 Child Affected by Parental Relationship Distress

V995.51 Child Psychological Abuse, Confirmed (pathogenic parenting)

Allied Parent:

Rule-Out: 300.19 Factitious Disorder Imposed on Another

Targeted Parent:

Rule-Out: 309.81 Post-Traumatic Stress Disorder (complex trauma; traumatic grief)

In many cases, however, a formal DSM-5 diagnosis is not required for decision-making surrounding treatment, and the symptom information organized by the *Diagnostic Checklist for Pathogenic Parenting* may be useful for informal decision-making surrounding treatment needs for the family (e.g., a trauma-informed assessment, or a trauma-informed and solution-focused treatment approach). The information organized by the *Diagnostic Checklist for Pathogenic Parenting* may help identify areas of concern that would then lead to additional focused assessment by a mental health professional to confirm or disconfirm

these concerns. Additionally, many decisions involving families do not require confirmation of a formal diagnosis, and organizing the information surrounding complex family conflict using the symptom categories of the *Diagnostic Checklist for Pathogenic Parenting* may be helpful in general decision-making and guidance on potential treatment approaches, without the need for a formal diagnosis of pathology.

Ultimately, the goal of clinical psychology is the resolution of family conflict needed to allow the child to have a normal-range and healthy childhood, which includes affectionate attachment bonds to both mother and father. In healthy parent-child relationships, the most important factor is the directional flow of love, we always want the child to be receiving abundant love from mother, and abundant love from father. Children thrive when they receive parental love, and they are damaged when the flow of parental love is interrupted.

The goal of clinical psychology is always focused toward treatment and solutions that ensure that the child has a healthy, safe, and normal-range childhood of love and affection. By identifying a specific form of complex family pathology surrounding divorce (i.e., the use of the child as weapon of spousal revenge and retaliation in the spousal conflict surrounding divorce; pathogenic parenting), the *Diagnostic Checklist for Pathogenic Parenting* can help guide treatment-related decision-making for the child and family.

### **Complex Family Conflict**

The attachment trauma pathology in the family identified by the *Diagnostic Checklist for Pathogenic Parenting* can be described professionally in various ways, depending on which information sets from professional psychology are applied to the family symptoms (family systems therapy, attachment, personality disorders, complex trauma). In general-culture terms, the pathology is the child's weaponization into the spousal conflict by one spouse-and-parent (the allied parent) who is using the child as a weapon of spousal revenge and retaliation against the other spouse, and parent (the targeted parent). Oftentimes, this becomes a family environment of IPV (Intimate Partner Violence by proxy), in which the one spouse is emotionally abusing the other spouse for the divorce, using the children as the weapon.

When the constructs of family systems therapy are applied to this form of complex trauma family pathology, the description of the family pathology becomes:

**Family Systems Pathology Description:** The child is being *triangulated*<sup>1</sup> into the spousal conflict through the formation of a *cross-generational coalition*<sup>2</sup> with the allied parent against the other parent (the targeted parent), resulting in an *emotional cutoff*<sup>3</sup> in the child's relationship with the targeted parent (an "emotional

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<sup>1</sup> **Triangulation** refers to the child being "put in the middle" of the spousal conflict, turning the two-person (spouse-spouse) marital conflict into a three-person (parent-child-parent) conflict; the triangle

<sup>2</sup> **Cross-generational coalition** refers to an alliance between a parent and child against the other parent (called a "perverse triangle"; Haley).

<sup>3</sup> **Emotional cutoff** is the family systems construct for a child rejecting a parent (family member rejecting a family member). It is a family pathology of boundary violations and multi-generational trauma (Bowen).

cutoff" is the professional term in family systems therapy for the child rejecting a parent).

Minuchin; Haley; Bowen; Madanes; Family Systems Therapy (Appendix 1)

When the constructs of attachment trauma and personality pathology are applied, the description of the pathology becomes:

**Attachment Trauma Pathology Description:** The child's rejection of a parent following divorce is the product of the *trans-generational transmission* of the parent's own childhood *attachment trauma* to the current family relationships, mediated by the *personality disorder pathology* of the parent that is itself a product of this parent's childhood attachment trauma.

The presence in the child's symptoms of the three Diagnostic Indicators of pathogenic parenting documented on the *Diagnostic Checklist for Pathogenic Parenting* identifies this specific form of family **attachment trauma** pathology from a parent that is being transferred into current family relationships. The data compilation methods of <source> produced a rating for the *Diagnostic Checklist for Pathogenic Parenting* based on criteria used by <<source>> to identify the possible presence or absence of symptoms. Since the symptoms are mental health symptoms, if a confirmation of these symptom identifications is needed, then a professional trauma-informed clinical psychology assessment of the family pathology would be needed.

**The Diagnostic Checklist - <name>:**

The <source> symptom identification for pathogenic parenting by an allied parent in a cross-generational with the child against the targeted parent are:

Diagnostic Indicator 1: Attachment Suppression	<b>Likely Present</b>
Diagnostic Indicator 2: Personality Disorder Traits (in the child)	not determined
Diagnostic Indicator 2b: Phobic Anxiety (toward a parent)	<b>Likely Present</b>
Diagnostic Indicator 3: Persecutory Delusion (in a child toward a parent)	<b>Likely Present</b>

If confirmed by a mental health assessment, this pattern of child symptoms would diagnostically confirm pathogenic parenting by the allied parent (creating significant psychopathology in the child through aberrant and distorted parenting practices). If this data is accurate, then the allied parent (the mother in the <name> family) is using the child as a weapon of revenge in the spousal conflict surrounding the divorce.

In addition, there are Associated Clinical Signs listed on the *Diagnostic Checklist for Pathogenic Parenting*. These are not "diagnostic" features of the multi-generational attachment trauma pathology, but they are often co-occurring features, and there are reasons in the psychology of the pathology for expecting the presence of these associated clinical indicators. The presence of Associated Clinical Signs can be used as additional

confirmation of the diagnosis based on the three Diagnostic Indicators (a preponderance of clinical psychology evidence beyond a reasonable doubt for diagnosis of the pathology).

The data profile for the Associated Clinical Signs in the <name> family are:

<b>Associated Clinical Signs</b>	
<source> Determination: <b>Substantial Support</b>	
ACS-1:	<b>Present</b>
ACS-2:	<b>Present</b>
*ACS-3:	<b>Present</b>
*ACS-4:	not identified in the data
ACS-5:	<b>Present</b>
ACS-6:	not identified in the data
ACS-7:	<b>Present</b>
ACS-8:	<b>Present</b>
ACS-9:	<b>Present</b>
ACS-10:	not identified in the data
ACS-11:	<b>Present</b>
ACS-12:	<b>Present</b>

The number of Associated Clinical Signs reported in the data for the family would provide **substantial support** to the clinical diagnosis of *pathogenic parenting* made by the diagnostic checklist if this data had been collected and confirmed by a mental health professional. Of particular note is the reported presence of ACS-3, the Exclusion Demand feature, in the data set. This ACS symptom is almost 100% diagnostic of pathogenic parenting by an allied parent (using the child as a weapon in the spousal conflict) since it never occurs in normal child development, and never occurs in any other form of pathology. The reported presence of ACS-3 provides additional, **highly substantial support** to the identification of pathogenic parenting made by the 3 Diagnostic Indicators of the checklist.

### **Parenting Practices Rating Scale**

The *Parenting Practice Rating Scale* is a data documentation instrument designed to capture the clinical determination of the parenting practices for the targeted-rejected parent. The concern that is meant to be addressed by this scale is any problematic

parenting practices by the targeted-rejected parent that could account for the child's symptom presentation.

Two *Parenting Practices Rating Scales* were provided by <source>, one for the mother and one for the father. In this family, the concern is that the mother is the allied parent with the children and the father is the targeted parent, so it would be the father's parenting practices that would be of concern relative to diagnosis of pathology. Is the father's parenting so deviant from normal-range that would be considered abusive of the child, or is it normal-range?

### Father's Parenting

The *Parenting Practices Rating Scale* is designed to assign parenting practices into two broad categories, abusive (Levels 1 and 2) or normal-range (Levels 3 and 4). If the parenting practices of the targeted-rejected parent (the father in the <name> family) are deemed to be broadly normal-range (Level 3 or 4 parenting), then the normal-range parenting of the targeted parent cannot account for the child symptoms as documented on the *Diagnostic Checklist for Pathogenic Parenting*.

Dr. Childress has no information regarding the parenting practices of the father besides the ratings made on the *Parenting Practices Rating Scale* provided by <credible source>, and professional opinions regarding the data will rely entirely on the accuracy of the data. Typically, parenting practices are assessed by clinical interview with the involved family members.

Assuming the accuracy of the *Parenting Practices Rating Scale* provided for the father, the father's parenting is normal-range and healthy. His type of parenting would be considered **Level 4: Positive and Healthy** parenting, and the ratings reflect a blend of parenting strategies from affectionate structure and affectionate support and guidance strategies. This is the type of parenting we strive to achieve with parents. If this data is accurate regarding the father's parenting practices, then the father's parenting practices could not have produced the child symptoms reported on the *Diagnostic Checklist for Pathogenic Parenting*.

### Mother's Parenting

<source> provided a *Parenting Practices Rating Scale* for the mother. Typically this data is not used in clinical analysis for several reasons, primarily because the pathology presents with a highly "favorable" presentation for the allied parent that is not accurate to the subtle signs of significant pathology. The coordinated use of the *Parenting Practices Rating Scale* with the *Diagnostic Checklist for Pathogenic Parenting* is simply to identify areas of concern with the targeted-rejected parent. However a positive presentation bias was distinctly not evident in the *Parenting Practices Rating Scale* for the mother provided by <source>.

Based on the *Parenting Practices Rating Scale* for the mother provided by <source>, there would be prominent child protection concerns if this data is accurate. Sufficient professional concerns exist regarding child protection and professional obligations for a duty to protect, that Dr. Childress notified the <source> (Appendix 2) of these concerns to

discharge his professional obligations. Dr. Childress has not interviewed the family members and cannot confirm or disconfirm the accuracy of the rating he received. Dr. Childress reviewed elements of the raw data that confirmed professional concerns.

According to the *Parenting Practices Rating Scale* for the mother, there are allegations neither confirmed nor disconfirmed of **Level 1 Abusive** parenting; Sexual Abuse (Category 1), Physical Abuse (Category 2), Emotional Abuse (Category 3), Psychological Abuse (Category 4), Neglect (Category 5), Domestic Violence Exposure (Category 6). These allegations are neither confirmed nor disconfirmed. A profile like this could reasonable represent the profile of a parent in the attachment trauma pathology captured in the three diagnostic indicators of the *Diagnostic Checklist for Pathogenic Parenting*.

That there are so many child abuse allegations across the entire spectrum suggests either parenting of deep professional concern, or unfounded allegations from a highly over-anxious reporting source (possibly the father). The father's parenting as Level 4 healthy and positive parenting would not be consistent with the high-anxious reporting of false abuse allegations. If the father is the reporting source for these concern, then the potential for child abuse should be immediately assessed surrounding the mother's parenting, and the allegations should be confirmed or disconfirmed by assessment. Leaving child abuse allegations in an indeterminate state should be avoided if at all possible.

The *Parenting Practices Rating Scale* for the mother also indicates multiple **Level 2: Severely Problematic Parenting** categories of concern. These parenting practices would be considered to be in the abusive-range, but just sub-threshold to the level of severity for Level: 1 Child Abuse. The mother's parenting is reported to display; Overly Strict Discipline (Category 7), Overly Hostile Discipline (Category 8), Overly Disengaged Parenting (Category 9), Overly Involved and Intrusive Parenting (Category 10), and Family Conflict of High-Interspousal Conflict (Category 11). This would be a consistent profile (although extreme) for the pathology captured by the symptoms of the *Diagnostic Checklist for Pathogenic Parenting*.

The mother is also reported to be highly disengaged and neglectful in her general approach to parenting, into the neglectfully abusive range (a rating of 10 on a 1-100 scale). Her capacity for empathy is rated as 1 on a seven-point scale, which is in the rigidly self-absorbed and narcissistic spectrum of parenting. Narcissistic parenting is associated with child abuse potential. Issues of potential clinical concern identified on the *Parenting Practices Rating Scale* for the mother include a reported history of prior substance abuse (not in current treatment or recovery), a reported history of narcissistic or borderline personality traits (not in current treatment), and a parental history of trauma (not in current treatment). This report of surrounding characteristics would be consistent with the meaning of the symptoms captured by the *Diagnostic Checklist for Pathogenic Parenting*.

This report for the mother's parenting has not been confirmed or disconfirmed by Dr. Childress. If accurate, this profile describing the mother's parenting would be both consistent and extreme with the information from the *Diagnostic Checklist for Pathogenic Parenting* reported for the child's symptoms. This severely problematic parenting, with disordered empathy and trauma history (narcissistic and borderline personality pathology

are trauma-born pathology) is exactly the pathology that creates the three diagnostic indicators captured by the *Diagnostic Checklist for Pathogenic Parenting*.

Dr. Childress has not confirmed the parenting practices for the mother reported in the <source> data. Any confirmation or disconfirmation of the mother's parenting would need to be through clinical interviews with the involved family members. The data provided to Dr. Childress for an opinion is of extremely high clinical concern.

### **Conclusions from Review**

The data supplied by <source> for the *Diagnostic Checklist for Pathogenic Parenting* and the *Parenting Practices Rating Scale* is fully consistent with unresolved parental trauma in the allied parent (in the <name> family, the mother) that is creating significant psychopathology in the child surrounding the child's attachment bond to the other parent. In typical conversation this would be described as the mother using the child as a weapon of retaliation and revenge in the spousal conflict surrounding divorce. Considerations of IPV factors of whether the mother is using the child as an instrument of *spousal* emotional abuse directed toward the father are warranted and should be assessed.

If the information submitted for review is confirmed by clinical interview with the involved family members, the DSM-5 diagnosis for this form of attachment-trauma pathology in the family would include a diagnosis of V995.51 Child Psychological Abuse for the child. A confirmed DSM-5 diagnosis of Psychological Child Abuse would activate immediate child protection concerns surrounding the parenting practices of the mother. It is of important note, that the data on which this statement of possible diagnosis relies is neither confirmed nor disconfirmed for accuracy when applied to a specific family. If however, the pattern of data presented for review is accurate, then prominent child protection concerns exist.

### **Treatment Considerations**

With the pathology identified by the *Diagnostic Checklist for Pathogenic Parenting*, the DSM-5 diagnosis would include V995.51 Child Psychological Abuse. In all cases of child abuse, physical child abuse, sexual child abuse, emotional and psychological child abuse, the standard of professional practice and the duty to protect require the child's protective separation from the abusive parent.

The damage caused by the child's prior exposure to the abusive parenting practices is treated, and the child's normal and healthy development is recovered and restored. Once the child's healthy development has been recovered and stabilized, the child's contact with the formerly abusive parent is reestablished with sufficient safeguards in to ensure that the child abuse does not resume once contact with the formerly abusive parent is restored. This is the standard of practice in all forms of child abuse.

Typically, the abusive parent is required to enter collateral treatment during the protective separation period to develop insight into their abusive parenting. With this type of complex trauma pathology as reported for the <name> family, collateral therapy should be trauma-informed and should focus on treating and resolving the formerly "allied" parent's currently unresolved childhood attachment trauma. The pathology of concern in

the <name> family (based on the reviewed information), and the origins of this specific pathology, is in unresolved attachment trauma in the allied parent (the mother in the <name> family), which is affecting and distorting current parent-child relationships between the children and the other, healthier, and normal-range parent. If the data provided by <source> is accurate and confirmed, then this unresolved trauma pathology in the family should be referred for therapy as a necessary condition for family recovery.

The recommended treatment for complex family conflict with the reported symptoms being discussed would adopt a family systems approach (Minchin, Bowen, Haley, Madanes). The integration of a solution-focused therapy approach (Berg) with the family systems therapy is also recommended to address the trauma factors in the family. The focus of family systems therapy is that divorce ends the marriage, not the family. The family is merely transitioning from its prior intact family structure that was united by the marriage to a new separated family structure that is now united by the children, through their shared bonds of affection with each parent.

The pathological processing of sadness, grief, and loss by one spouse (and parent) surrounding the divorce creates the severe disruption to the family's transition to a healthy separated family structure, evidenced in the symptoms of the complex family conflict surrounding the children's attachment bond to a parent that follows the divorce. Assisting the more vulnerable parent (the allied parent in the pathology) to more effectively process their sadness and loss surrounding the divorce (processing deficits created by their unresolved childhood trauma) will assist the family in making a healthy transition into its new post-divorce separated family structure.

However, with this type of family trauma pathology in a parent, the allied parent is frequently reluctant to join and cooperate with family therapy that has as its goal the restoration of the child's relationship with the other parent. The allied parent will typically seek to disrupt, undermine, and prevent the child's bonding to the targeted parent at all costs, despite treatment directives. Greater external control of the pathogenic parent's ability to disrupt family therapy that's designed to restore bonds of love and affection with the targeted parent (targeted for emotional abuse; IPV) may be needed until the child's recovery is stabilized, relative to the ongoing exposure to pathogenic parenting from one parent.

The goal of more restrictive monitoring of parenting is not to limit parent access or involvement, the goal is ensure that the child has a healthy flow of love from both parents, mother and father. The directional flow of love that is of clinical treatment concern is from the parent to the child.

On a scale of 1-100, we always want 100 mom-love and 100 dad-love reaching the child. This is irrespective of time or access. Every time the child is with that parent, mother or father, we want 100 mom-love and 100-dad love reaching and being received by the child. If the amount is less (an 80 dad-love or 60 mom-love), then we will always have a treatment bullet point to increase the mom-love or dad-love reaching and being received by the child until it is 100. That is the treatment goal for healthy child development.

With this type of complex trauma pathology, the unresolved attachment trauma in the allied parent disrupts - and entirely severs - the child's bond with the other parent

(zero mom-love or zero dad-love reaching the child). This is an extremely unhealthy situation for the child, for the child to be entirely deprived of access to the love of mother or father.

There are four primary parent-child relationships, mother-son, father-son, mother-daughter, father-daughter. Each of these primary relationship types is unique in its value to the child, they are each equivalent in their value, and each is essential to the healthy emotional and psychological development of the child. The child's healthy development should never be deprived of the love from mother or the love from father, these affectional bonds are critical to healthy child development.

When the parenting practices of one parent surrounding divorce severely interferes with a child's healthy emotional and psychological development (pathogenic parenting), then restrictions on parental access may be needed until the child is sufficiently stable in self-organization to more fully cope with the pathogenic parenting they are exposed to from one, more vulnerable parent. Trauma-informed collateral family therapy for the formerly allied parent can be helpful in limiting the need for restrictions, and in lifting any restrictions that may be needed to protect the child's relationships with each and both parents.

It is always best for families struggling with conflict to shift focus from legal to treatment solutions. A typical treatment plan in clinical psychology is for a 3- to 6-month resolution of the prominent pathology. That would be in the recommended range for the initial treatment for the pathology identified by the *Diagnostic Checklist for Pathogenic Parenting*.



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## Appendix 1: Family Systems Therapy Constructs

## **Family Systems Therapy**

Family systems therapy is one of the four primary schools of psychotherapy:

**Psychoanalytic Psychotherapy:** Emerged from the work of Sigmund Freud developing insight into deep unconscious motivations. Individual focus to therapy.

**Cognitive-Behavioral Therapy:** Emerged from laboratory experiments with animals on the Learning Theory and behavior change principles of reward and punishment. Individual focus to therapy.

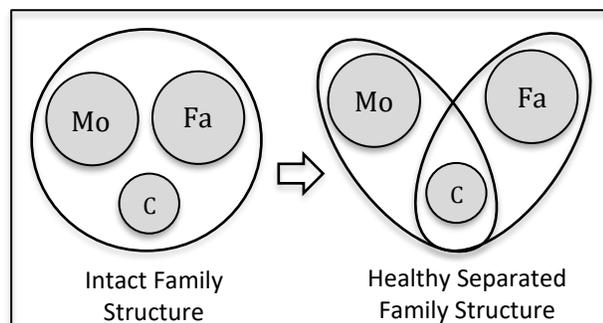
**Humanistic-Existential Therapy:** Emerged from philosophical roots of existentialism, personal growth, and self-actualization. Individual focus to therapy.

**Family Systems Therapy:** Describes the interpersonal processes of both healthy and pathological family relationships. Interpersonal focus.

Of the four primary schools of psychotherapy, only family systems therapy deals with resolving the current interpersonal relationships within families. All of the other models of psychotherapy are individually focused forms of therapy. Family systems therapy is therefore the appropriate conceptual framework for understanding and resolving family conflict and family pathology.

Divorce ends the marriage, but not the family. With divorce, the family structure shifts from an *intact family structure* that was previously united by the marriage, to a new *separated family structure* that is now united by the children, through the continuing co-parenting responsibilities and by the continuing bonds of shared affection between the children and both parents.

Families must adapt to various transitions over the developmental course of the family. A central tenet of family systems therapy is that when a family is unable to successfully adapt to a transition (such as a divorce and the transition to a new separated family structure), symptoms emerge within the family (often with the children) to stabilize the family's maladaptive functioning.

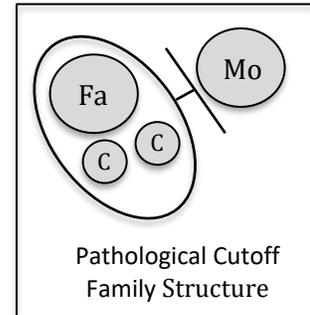


Divorce represents one of the most impactful transitions that any family must navigate; the transition from an intact family structure united by the marriage to a separated family structure united by the children. One of the principle founders of family systems therapy, Murray Bowen, refers to the symptom of one family member rejecting another family member as an “emotional cutoff.” (Bowen, 1978; Titelman, 2003).<sup>4</sup>

<sup>4</sup> Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Titelman, P. (2003). *Emotional cutoff: Bowen family systems theory perspectives*. New York: The Hawthorn Press, Inc.

Within the principles of family systems therapy, a child's rejection of a parent following divorce represents the symptom of an "*emotional cutoff*" that is the product of the family's unsuccessful transition from its prior intact family structure united by the marriage to the new separated family structure following divorce, a separated family structure that is now united by the child's shared bonds of affection with both parents.



Within the standard and established principles of family systems therapy, the child's rejection of a normal-range parent surrounding divorce represents the child's "triangulation" into the spousal conflict through the formation of a "cross-generational coalition" of the child with the allied parent, that results in an "emotional cutoff" in the child's relationship with the targeted-rejected parent.

### Cross-Generational Coalition

A cross-generational coalition is when an emotionally fragile parent creates an alliance with the child against the other spouse (and parent). This coalition between the parent and child provides additional power to the allied parent in the spousal relationship (two against one). However, a cross-generational coalition is also very damaging to the child, who is being used by one parent as a weapon against the other parent in the spousal conflict. In mild cases, the arguing and conflict between the child and targeted parent is high, but they maintain their relationship. In severe cases, the allied parent requires the child to terminate (cutoff) the child's relationship with the other parent out of "loyalty" to the allied parent in their coalition. When this occurs, the emotional and psychological damage to the child is severe.

Children are not weapons, and children should never be used as weapons by one parent against the other parent in their marital-spousal disputes.

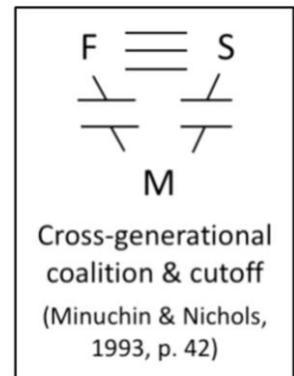
The renowned family systems therapy (co-founder of the *Strategic* school of family systems therapy), Jay Haley, provides the professional definition of a cross-generational coalition:

**From Haley:** "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)<sup>5</sup>

<sup>5</sup> Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. Weakland (Eds.), *The interactional view* (pp. 31-48). New York: Norton.

Most mental health professionals consider Salvador Minuchin or Murray Bowen to be the preeminent family systems therapists. Salvador Minuchin (the founder of *Structural* family systems therapy) provides a *structural* family diagram for the pathology of concern, in his book with Michael Nichols, *Family Healing*.<sup>6</sup> In this diagram, the triangular pattern to the family relationships is evident, with the child “*triangulated*” into the spousal conflict.

Also evident is a symptom feature called the “inverted hierarchy” in which the child becomes empowered by the coalition with the allied parent into an elevated position in the family hierarchy, from which the child is empowered to judge the parent (as if the parent were the child). In the diagram by Minuchin, this symptom feature of the *inverted heirarchy* is reflected in the child’s elevated position above the hierarchy line with the father, above the mother who is being “judged” by the child.



The *emotional cutoff* caused by the *cross-generation coalition* is reflected in the broken lines from the child to the mother, and from the father to the mother; but that spousal break is divorce. The break in the spousal line reflects the divorce, the break in the mother-son line represents the influence on the child by the allied parent; the cross-generational coalition.

The three lines between the father and son represent the violation of the child’s self-autonomy and psychological integrity (psychological boundary violations; called “enmeshment”). This is a very destructive psychological relationship for a child to have with a parent. It’s why Haley calls it the “perverse triangle.” Psychological boundaries and self-autonomy in a child should always be respected by the parent. Many times, the parent experienced this type of “boundary violation” in their own childhood relationships, and the current psychological violation of the child’s autonomy and psychological integrity represents the “trans-generational transmission” of the parent’s attachment trauma.

In her 2018 book, *Changing Relationships: Strategies for Therapists and Coaches*, the famed family therapist Cloe Manades provides a description of the cross-generational coalition at the start of Chapter 3 on Hierarchies.

From: Madanes, C. (2018). *Changing relationships: Strategies for therapists and coaches*. Phoenix, AZ: Zeig, Tucker, & Theisen, Inc.

### Cross-Generational Coalition

In most organizations, families, and relationships, there is hierarchy: one person has more power and responsibility than another. Whenever there is hierarchy, there is the possibility of cross-generational coalitions. The husband and wife may argue over how the wife spends money. At a certain point, the wife might enlist the older son into a coalition against the husband. Mother and son may talk disparagingly about the father and to the father, and secretly plot

<sup>6</sup> Minuchin, S. & Nichols, M.P. (1993). *Family healing: Strategies for hope and understanding*. New York: Touchstone.

about how to influence or deceive him. The wife's coalition with the son gives her power in relation to the husband and limits the husband's power over how she spends money. The wife now has an ally in her battle with her husband, and the husband now runs the risk of alienating his son. Such a cross-generational coalition can stabilize a marriage, but it creates a triangle that weakens the position of both husband and wife. Now the son has the <source> of power over both of them.

Cross-generational coalitions take different forms in different families (Madanes, 2009). The grandparent may side with the grandchild against a parent. An aunt might side with the niece against her mother. A husband might join his mother against the wife. These alliances are most often covert and are rarely expressed verbally. They involve painful conflicts that can continue for years

Sometimes cross-generational coalitions are overt. A wife might confide her marital problems to her child and in this way antagonize the child against the father. Parents may criticize a grandparent and create a conflict in the child who loves both the grandparent and the parents. This child may feel conflicted as a result, suffering because his or her loyalties are divided.

## Appendix 2: Discharge of Duty to Protect

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LICENSED CLINICAL PSYCHOLOGIST, PSY 18857

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4/8/19

To:

Re: Duty to Protect

Hello

I am reviewing the information surrounding the family that you requested an opinion on. I have reached a point in my professional review that has triggered my duty to protect obligations as a psychologist. The information under review raises professional concerns regarding the parenting of the mother because of the ratings from the *Diagnostic Checklist for Pathogenic Parenting* and the ratings provided from the *Parenting Practice Rating Scale*.

If this data is accurate and current, then child protection considerations may be warranted and should be reviewed. Since I have had no contact with the family, I consider this letter to you as having discharged my duty to protect based on the information I have available to me. I will continue my review of the family information and will provide a report on my opinions as requested.



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