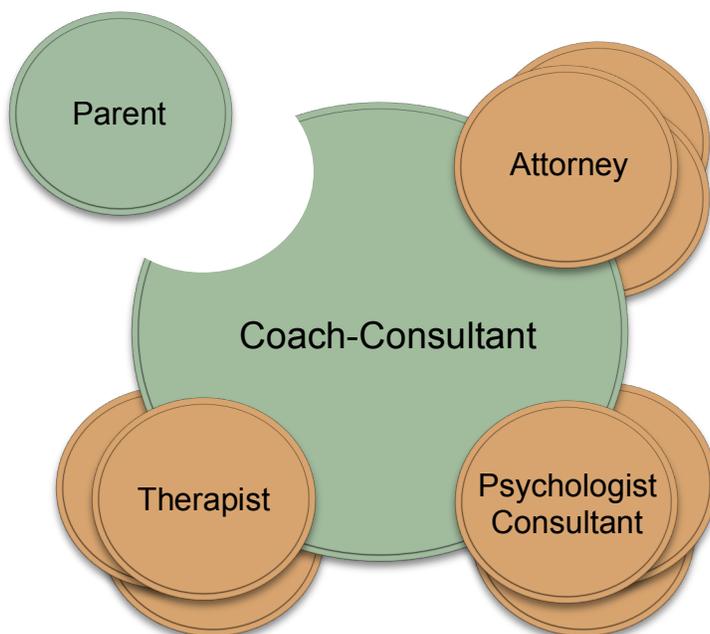


## A Treatment Team Model for Addressing Attachment-Based “Parental Alienation”

C.A. Childress, Psy.D. (2014)

### **The Treatment Team Model**

The proposed treatment team is composed of four separate but inter-related components, 1) a parenting coach-consultant who coordinates the parent’s participation in the professional team, 2) an expert family law attorney who is familiar with the attachment-based model of “parental alienation” and who takes a proactive approach to presenting and securing the child’s treatment needs, 3) a psychological consultant who can serve as an independent expert resource for the treatment team, and 4) the therapists who engage and actualize the therapeutic resolution to the child’s symptoms.



#### Coach-Consultant:

The Coach-Consultant serves as the interface with the parent and the treatment team.

The Coach-Consultant has access to a network of professional referrals available for the parent.

Each professional works independently with the parent, and can also work collaboratively with the Coach-Consultant as needed.

The Coach-Consultant works with the parent to coordinate the overall integration of the treatment team with the needs of the parent.

#### Attorney:

The Attorney is expert in an attachment-based model of “parental alienation,” its presentation in Court and the coordinated treatment needs of the family.

The Attorney takes a proactive approach to securing the family’s treatment needs. The Attorney is familiar working with the Psychological Consultants to obtain expert testimony and Treatment Needs Assessments if necessary, and with the Therapists to obtain treatment progress reports as needed. The ability of the Attorney to successfully obtain the necessary treatment depends on the strength of the mental health reports and testimony provided by the Psychological Consultant.

#### Psychological Consultant

The Psychologist Consultant can conduct independent Treatment Needs Assessments (see Appendices 2 and 3 for samples), provide expert testimony as needed regarding an

attachment-based model of “parental alienation,” and can provide independent professional review of outside mental health evaluations and treatment reports.

With appropriate training, the role of conducting targeted Treatment Needs Assessments could become a second professional role served by all child custody evaluators.

### Therapist

The Therapist provides treatment from an attachment-based model of “parental alienation” involving the resolution of induced distortions to the child’s attachment bonding motivations. The Therapist is professionally competent in attachment theory, personality disorder dynamics, and family systems theory relative to the treatment needs of the child and family.

Additional therapists within a coordinated treatment team can be engaged if needed for the child individually or for the pathogenic parent. All involved therapists are professionally competent in an attachment-based model of “parental alienation” and are comfortable coordinating their roles in professional dialogue with each other and with the Coach-Consultant and parent.

### **The Mental Health Team**

The mental health team must approach each child and family situation with a balanced and accurate assessment. It is as important to recognize when attachment-based “parental alienation” is present (i.e., a cross-generational coalition of the child with a narcissistic/(borderline) parent that is creating a cut-off in the child’s relationship with a normal-range loving and affectionate parent) as when it is not present. Not all post-divorce parent-child conflict is a reflection of a cross-generational parent-child coalition of the child with a narcissistic/(borderline) parent.

It is as important to recognize when “parental alienation” is NOT present as to recognize when it is.

**Professional Responsibility to the Child:** The mental health team has a professional responsibility to the child client to resolve the child’s symptoms and return the child to a normal-range developmental trajectory. This responsibility requires an accurate diagnosis of the source of the child’s symptoms in order to develop and implement a responsive and appropriate treatment plan. Inaccurate findings of attachment-based “parental alienation” when such a diagnosis is not warranted fail the professional responsibility to the child client. On the other hand, not identifying attachment-based “parental alienation” when it is warranted similarly fails the professional responsibility to the child client.

The professional responsibility to the child client is to determine an accurate diagnosis for the child’s symptom display.

**Professional Responsibility to the Targeted Parent:** The targeted parent wants a healthy and affectionate relationship with the child. This requires an accurate diagnosis

as to the origins of the parent-child conflict and the emotional-psychological distance in the relationship in order to develop a responsive and effective treatment plan.

If the parent-child conflict is the product of induced distortions to the child's attachment bonding motivations toward the targeted parent as a result of pathogenic parenting practices by the other, narcissistic/(borderline) parent (involving a cross-generational parent-child coalition of the child with the narcissistic/(borderline) parent against the targeted parent), then this diagnosis needs to be accurately identified in order to develop an appropriate and responsive treatment plan to restore the child's normal-range relationship with the targeted-rejected parent.

If, on the other hand, the origins of the parent-child conflict are in the problematic parenting practices of the targeted parent that are creating the emotional-psychological distance and conflict in the parent's relationship with the child, then this diagnosis needs to be accurately identified in order to develop an appropriate and responsive treatment plan to restore the child's normal-range relationship with the targeted-rejected parent.

Treating an inaccurate diagnosis will result in ineffective therapy that does not resolve the emotional-psychological distance and conflict in the parent-child relationship. The failure to restore a normal-range affectionate parent-child relationship fails the professional responsibility to the targeted parent.

The professional responsibility to the targeted parent is to determine an accurate diagnosis for the child's symptom display.

### **The Key Diagnostic Feature**

The key diagnostic feature of attachment-based "parental alienation" is a child-initiated cut-off of the child's relationship with a normal-range parent (i.e., the suppression of the child's attachment system relative to a parent). If parent-child conflict is present but there is no child-initiated cut-off of the parent-child relationship, then attachment-based "parental alienation" is not present.

A cross-generational coalition of the child with one parent against the other parent may still be a causative factor in the child's conflict with the other parent, as this family dynamic is a common causative factor in family conflicts. However, an attachment-based model involves the distorting influence of a narcissistic/(borderline) parent that is creating a child-initiated cut-off of the child's relationship with the other parent (i.e., an induced suppression of the normal-range functioning of the child's attachment system). Negative parental influence from a cross-generational parent-child coalition, while problematic, is not sufficient to warrant a diagnosis of attachment-based "parental alienation" in the absence of a child-initiated cut-off of the child's relationship with the other parent.

### **Secondary Diagnostic Features**

If a child-initiated cut-off of the child's relationship with a parent is evident in the child's symptom display, but the child does not evidence the additional characteristic

narcissistic and borderline personality symptoms (or phobic anxiety symptoms in the anxiety variant of attachment-based “parental alienation”), and instead displays situationally triggered anger with inter-episode bonding with the targeted parent, then attachment-based “parental alienation” is not present and the source of the parent-child conflict should be sought in other possibilities. The presence of five specific narcissistic/(borderline) personality disorder features in the child’s symptom display represents the “psychological fingerprints” of the parental influence on the child by a narcissistic/(borderline) parent. If these features are not present, then an attachment-based model of “parental alienation” is not present.

The additional presence in the child’s symptom display of an intransigently held fixed and false belief (i.e., a delusion) regarding the supposedly fundamental (and “abusive”) parenting of the targeted-rejected parent represents the “psychological fingerprints” of the distorted reenactment narrative of the narcissistic/(borderline) parent. The pathogenic trauma reenactment of the distorted “internal working models” of the alienating parent’s attachment system are in the pattern of 1) the abusive parent, 2) the victimized child, and 3) the protective parent, with the abusive and protective parent roles representing the splitting of the “internal working models” of the attachment bonding and avoidance motivations relative to the parental attachment figure. The presence in the child’s symptom display of a delusional belief in the supposedly “abusive” parental inadequacy of the targeted-rejected parent represents the “psychological fingerprints” of the child’s acquired/induced role in the trauma reenactment narrative of a narcissistic/(borderline) parent.<sup>1</sup>

### **Accurate and Complete Exploration of Differential Diagnoses**

The goal of mental health assessment should never be to establish the presence of attachment-based “parental alienation.” The goal should ALWAYS be the accurate diagnosis of the child’s symptom display. All possible differential diagnoses should be considered and diagnostic determinations should be based on the constellations of clinical evidence.

In some cases the diagnosis may be an attachment-based model of “parental alienation” involving the induced suppression of the normal-range functioning of the child’s attachment system as a product of distorted parenting practices from a narcissistic/(borderline) parent. In other cases the diagnosis will be that some other causative agent is responsible for the excessive parent-child conflict within the family. Mental health assessment should always be balanced and should always evaluate all possible differential diagnoses under consideration. The assessment and diagnosis should then follow the clinical evidence and be based on the emerging constellations of the clinical evidence. This approach will result in an accurate diagnosis of the child’s needs, on which effective treatment can be delivered to resolve the child’s symptoms and restore the child’s healthy emotional and psychological development.

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<sup>1</sup> Trippany, R.L., Helm, H.M. and Simpson, L. (2006). Trauma reenactment: Rethinking borderline personality disorder when diagnosing sexual abuse survivors. *Journal of Mental Health Counseling*, 28, 95-110.

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

If there is no child-initiated cut-off of the parent-child relationship, then the mental health assessment should look toward an alternative origin for the parent-child conflict besides an attachment-based model of “parental alienation.” If the child’s symptom display toward the targeted parent is absent the characteristic narcissistic and borderline personality features evidenced in an attachment based model of “parental alienation,” then the mental health assessment should look to another source for the parent-child conflict besides an attachment-based model of “parental alienation.” If the child’s symptoms are absent an intransigently held fixed and false belief system (i.e., a delusion) regarding the supposed inadequacy of the targeted-rejected parent, then alternative explanations other than an attachment-based model of “parental alienation” should be sought.

All differential diagnostic possibilities should be considered and the resulting assessment and diagnosis should be guided solely by the balanced interpretation of the clinical evidence. The goal is to successfully resolve the child’s symptoms. This requires an accurate diagnosis regarding the source of the child’s symptomatic display.

An attachment-based model of “parental alienation” is evidenced in a specific set of child symptoms,

- 1.) Attachment System: Suppression of the child’s attachment bonding motivations toward a normal-range parent as evidenced by a child-initiated cut-off in the parent-child relationship,
- 2.) Personality Disorder Features: Five specific narcissistic and borderline personality disorder symptoms in the child’s symptom display,
- 3.) Delusional Beliefs: An intransigently held, fixed and false belief (i.e., a delusion) regarding the supposed parental inadequacy of the targeted parent, which the child characterizes as being “abusive.”

Additional associated clinical signs and features are also commonly evident (Appendix 4). The presence of these associated clinical features can provide additional confirming clinical evidence for the diagnosis of attachment-based “parental alienation” when the three primary diagnostic indicators are present.

If the three characteristic diagnostic indicators for an attachment-based model of “parental alienation” are present, then the presence of these three primary diagnostic indicators in the child’s symptom display represents definitive diagnostic evidence for the presence of pathogenic parenting practices by a narcissistic/(borderline) parent as the sole causative agent for the suppression of the child’s attachment bonding motivations toward the other parent. If the three characteristic diagnostic indicators for an attachment-based model of “parental alienation” are NOT present, then some other causal factor besides an attachment-based model of “parental alienation” is responsible for the child’s symptom display.

## **Sub-Threshold Diagnostic Indicators**

If the three characteristic diagnostic indicators for an attachment-based model of “parental alienation” are present to some degree but are sub-threshold for a definitive diagnosis of attachment-based “parental alienation,” then a 6-month **Response-to-Intervention** (RTI) trial can be initiated to help clarify the diagnosis. Diagnostic clarity can also be facilitated by evaluating the additional supportive clinical evidence provided by the presence or absence of a characteristic set of theoretically predicted clinical features associated with an attachment-based model of “parental alienation” (Appendix 4).

With appropriate therapy and a cooperative targeted parent, other possible causal factors should be substantially, if not entirely, resolvable within 6 months (with the caveat that the treating therapist may request an additional 6-month extension of the RTI if warranted by treatment factors).

If a 6-month RTI trial with a cooperative targeted parent fails to resolve the child’s symptoms, and there are clear but sub-threshold clinical indicators of the three characteristic diagnostic indicators of attachment-based “parental alienation,” then a cross-generational parent-child coalition of the child with a narcissistic/(borderline) parent should be strongly considered as being responsible for the treatment failure and for the child’s continuing symptoms toward the targeted-rejected parent, and strong consideration should be given to initiating a second-phase 6-month RTI trial implementing the necessary treatment protocol for resolving an attachment-based model of “parental alienation.”

The unique developmental periods and phases of childhood are brief and exceedingly important for the future healthy maturation of the child, particularly with regard to the formation of “internal working models” within the child’s attachment system that will guide the child’s emotionally bonded relationships throughout the lifespan. Symptomatic child development, particularly involving severe distortions to the child’s attachment system functioning, should not be allowed to linger unresolved. A 6-month period of RTI for alternative possibilities, followed by a second-phase 6-month RTI trial for attachment-based “parental alienation” (i.e., a cross-generational parent-child coalition of the child with a narcissistic/(borderline) parent) if the first RTI period for alternative possibilities is unsuccessful in restoring normal-range functioning to the child’s development, represents a responsible course of treatment for sub-threshold presentations of the three characteristic diagnostic indicators of attachment-based “parental alienation” given the premier importance for the child’s healthy maturation of restoring normal-range child development as quickly as possible.

Allowing prolonged periods (over 6 months) of unsuccessful treatment with children evidencing pronounced distortions to normal-range development should be actively avoided due to the brevity of childhood developmental phases and their importance to healthy long-term maturation.

## Appendix 1: Treatment-Related Decisions

## Treatment-Related Decisions

C.A. Childress, Psy.D. (2014)

- 1.) Presence of the 3 Characteristic Diagnostic Indicators of Attachment-Based “Parental Alienation”
  - Initiate reunification therapy protocol for the treatment of attachment-based “parental alienation”
- 2.) Clear but Sub-Threshold Presence of the 3 Characteristic Diagnostic Indicators of Attachment-Based “Parental Alienation”
  - Phase 1: Initiate a 6-month RTI (Response-to-Intervention) treatment of alternative causal factors (subject to an additional 6-month extension request by the treating therapist)
  - Phase 2: If the initial 6-month RTI treatment of alternative causal explanations is unsuccessful, initiate a 6-month RTI of reunification therapy protocol for the treatment of attachment-based “parental alienation”
- 3.) The Three Characteristic Diagnostic Indicators of Attachment-Based “Parental Alienation” are Not Present
  - Initiate standard child and family therapy based on a determination of the possible causal factors for parent-child conflict

Appendix 2: Proposed Treatment Needs Assessment Report Example:  
Confirmed Attachment-Based “Parental Alienation”

## Treatment Needs Assessment Report (SAMPLE)

Date: 12/1/14

Psychologist: John Smith, Ph.D.

### Scope of Report:

A Treatment Needs Assessment was requested by the Court for the 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,

9/5/14: Clinical interview and assessment with mother

9/7/14: Clinical interview and assessment with father

9/12/14: Clinical interview and assessment with child

9/18/14: Clinical relationship assessment with mother and child

9/24/14: Clinical interview and assessment with father

10/2/14: Clinical relationship assessment with mother and child

### Results of Assessment:

Based on the clinical assessments, John displays the three symptom areas associated with an attachment-based model<sup>2</sup> of “parental alienation,” 1) 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) a set of five specific narcissistic and borderline personality disorder features in the child’s symptom display, and 3) the child evidences an intransigently held fixed and false belief (i.e., delusion) regarding the supposed inadequacy of the mother as a parent, which the child characterizes as abusive.

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 involving an induced suppression of the child’s attachment bonding motivations toward a parent (i.e., the targeted parent) as a result of distorted parenting practices of a personality disordered parent (i.e., narcissistic and borderline features, which accounts for the presence of these features in the child’s symptom display).

### Treatment Indications:

Based on this specific set of features in the child’s symptom display, treatment will require,

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<sup>2</sup> i.e., an induced distortion to the normal-range functioning of the child’s attachment bonding motivations toward a normal-range parent as a result of distorted and pathogenic parenting practices by a narcissistic/(borderline) parent involving the cross-generational coalition of the child with the narcissistic/(borderline) parent against the other parent.

## 1.) Protective Separation During the Active Phase of Treatment:

The child's protective separation from the distorting influence of the pathogenic parent (i.e., the currently allied and supposedly "favored" parent, which in this family is the father) is warranted prior to initiating family therapy designed to restore the mother-son relationship and during the active phase of treatment, in order to protect the child from becoming further triangulated into conflict by the efforts of the currently allied and supposedly "favored" parent (i.e., the father) in continuing both overt and covert support for the maintenance of the child's false beliefs and symptomatic response to the mother, even as therapy seeks to resolve the child's false beliefs and symptoms relative to his relationship with his mother.

Given the specific set of symptom features evidenced by the child, a failure to protectively separate the child from the pathogenic influence of the currently allied and supposedly "favored" parent (i.e., the father) prior to and during the child's family therapy with the mother would run the considerable risk of turning the child into a "psychological battleground" between the ongoing distorting parental influence of the currently allied and supposedly "favored" parent (i.e., the father) and the balanced and normal-range meaning constructions being provided in therapy to resolve the child's symptoms. Turning the child into a "psychological battleground" runs the risk of causing psychological harm to the child and so is not in the child's best interests.

Therefore, engaging a protective separation of the child from the pathogenic parenting practices of the currently allied and supposedly "favored" parent (i.e., the father) prior to initiating family therapy and during the active phase of therapy, would represent a professional responsibility and requirement in order to protect the child's emotional and psychological health and development during treatment.

## 2.) Child Response to a Protective Separation

The child may respond to a protective separation from the currently allied and supposedly "favored" parent (i.e., the father) with increased protest behavior and defiance, which essentially represents a tantrum reflecting the child's current over-empowered status relative to accepting authority (i.e. parental and Court authority). Responding to child tantrum behaviors with calm and steady purpose that restores the child to an appropriate social and family hierarchy will be important to supporting family therapy and resolving the child's symptoms.

Any concern regarding the child's distress at the protective separation from the currently allied and supposedly "favored" parent (i.e., the father) should recognize that the child is fully capable of ending the protective separation at any time by becoming non-symptomatic. If the child authentically wishes a termination of the protective separation, then the child simply needs to evidence normal-range affectional child behavior with the normal-range parenting practices of the mother, which are under the treatment monitoring of the family therapist.

### 3.) Ending the Protective Separation

The treating family therapist should be allowed to seek Court approval to end the child's protective separation from the pathogenic parenting practices of the currently allied and supposedly "favored" parent (i.e., the father) based on treatment gains and the recommendations of the treating family therapist. Progress reports from the treating family therapist should be provided at least every six months.

The child's protective separation from the currently allied and supposedly "favored" parent (i.e., the father) should also end upon the resolution of the child's symptomatology, and based on the recommendations of the treating family therapist. The ending of the child's protective separation should be incorporated into the ongoing family therapy to ensure a successful reintegration of family relationships. If the child's symptoms reemerge upon reintroducing the pathogenic parenting practices of the currently allied and supposedly "favored" parent (i.e., the father), then supervised visitations or another cycle of protective separation and treatment may be indicated.

Clinical Data:

<Reporting on specific clinical data obtained during family interviews>

Sincerely,

John Smith, Ph.D.  
Psychologist

Appendix 3: Proposed Treatment Needs Assessment Report Example:  
Sub-Threshold for Confirmation of Attachment-Based “Parental Alienation”  
Response to Intervention Recommendation

## Treatment Needs Assessment Report (SAMPLE)

Date: 12/5/14

Psychologist: John Smith, Ph.D.

### Scope of Report:

A Treatment Needs Assessment was requested by the Court for the 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,

9/5/14: Clinical interview and assessment with mother

9/7/14: Clinical interview and assessment with father

9/12/14: Clinical interview and assessment with child

9/18/14: Clinical relationship assessment with mother and child

9/24/14: Clinical interview and assessment with father

10/2/14: Clinical relationship assessment with mother and child

### Results of Assessment:

Based on the clinical assessments, John does not display the complete set of three symptom areas associated with an attachment-based model<sup>3</sup> of “parental alienation,” 1) 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) a set of five specific narcissistic and borderline personality disorder features in the child’s symptom display, and 3) the child evidences an intransigently held fixed and false belief (i.e., delusion) regarding the supposed inadequacy of the mother as a parent, which the child characterizes as abusive.

John’s symptom presentation does not fully evidence an intransigently held fixed and false belief in his mother’s inadequacy as a parent because the mother’s parenting practices are sufficiently problematic to warrant concerns that John’s perceptions of his mother have some component of accuracy. In addition, John expressed openness to restoring a relationship with his mother if his concerns can be adequately addressed.

However, John also evidenced a prominent suppression of normal-range attachment bonding motivations toward his mother and prominent signs of narcissistic personality disorder features in his attitude and responses to his mother, so that concerns regarding the potential pathogenic influence of the currently allied and supposedly “favored” parent (i.e., the father) continue.

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<sup>3</sup> i.e., an induced distortion to the normal-range functioning of the child’s attachment bonding motivations toward a normal-range parent as a result of distorted and pathogenic parenting practices by a narcissistic/(borderline) parent involving the cross-generational coalition of the child with the narcissistic/(borderline) parent against the other parent.

## 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 parenting practices from the father in creating and supporting the child's symptomatic relationship with his mother.

### 1.) Response to Intervention:

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

If the mother engages in normal-range and appropriate parenting in response to therapy and John's beliefs and symptoms continue despite changes in the mother's parenting practices, then this would represent strongly confirmatory 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, but that instead his symptomatic responses to his mother are being produced by distorted and pathogenic parenting practices from the currently allied and supposedly "favored" parent (i.e., the father) that are covertly or overtly supporting the child's continued symptomatic responses to his mother.

If, on the other hand, the mother is unable to sufficiently alter her problematic parenting behavior in response to therapy, then this would represent suggestive clinical evidence that the source of the mother-son conflict is authentic to their relationship dynamics, and family therapy should continue to seek resolution of the mother's problematic parenting responses.

### 2.) Compliance with Visitation and Court Orders

All Court orders, including those for visitation, should be fully complied with by all parties, including the child.

Failure by the currently allied and supposedly "favored" parent (i.e., the father) to comply with Court orders, including orders for visitation, should be viewed as non-compliance with treatment and a follow-up Treatment Needs Assessment should be engaged at the written recommendation of the treating family therapist, to determine whether a protective separation of the child from the possibly pathogenic parenting practices of the currently allied and supposedly "favored" parent (i.e., the father) may be needed for effective therapy.

Failure of the child to comply with Court orders, including orders for visitation, such as refusing visitations with the mother, should be attributed to a serious parental failure by the currently allied and supposedly "favored" parent (i.e., the father) to enact appropriate parental responsibility, and as representing the father's non-compliance with treatment by failing to enact appropriate parental responsibility as the allied and

supposedly “favored” parent. The child’s failure to comply with Court orders, including all orders for visitation, should trigger a follow-up Treatment Needs Assessment at the recommendation of the treating family therapist to determine whether a protective separation of the child from the possible pathogenic parenting practices of the currently allied and supposedly “favored” parent (i.e., the father) is needed for effective therapy.

In any follow-up Treatment Needs Assessment, consideration should tend toward the child’s treatment needs and establishing the conditions necessary for effective treatment 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 child’s effective treatment, then a change in the responsible parent providing primary care for the child may be necessary because of the demonstrated failure of the allied and supposedly “favored” parent to enact the appropriate parental authority necessary for the child’s successful treatment

Clinical Data:

<Reporting on specific clinical data obtained during family interviews>

Sincerely,

John Smith, Ph.D.  
Psychologist

Appendix 4: Diagnostic Indicators and Clinical Features of Attachment-Based  
“Parental Alienation”

# Diagnostic Indicators and Clinical Features of Attachment-Based “Parental Alienation”

C.A. Childress, Psy.D. (2014)

## The Three Primary Diagnostic Indicators

The diagnosis of pathogenic parenting by the allied and supposedly “favored” parent is made solely on the presence in the child’s symptom display of the three primary diagnostic indicators:

1. **Attachment System:** The suppression of the normal-range functioning of the child’s attachment system toward a normal-range parent,
2. **Personality Disorder Features:** The presence in the child’s symptom display of five specific narcissistic & borderline personality disorder features,
3. **Delusional Beliefs:** The presence in the child’s symptom display of intransigently held fixed and false beliefs (i.e., delusions) regarding the supposedly inadequate parenting of the targeted-rejected parent.

## Associated Clinical Signs

In addition to the primary diagnostic indicators, there are a variety of associated clinical features that are predicted a-priori by an attachment-based model of “parental alienation” to potentially be displayed by the child or from the allied and supposedly “favored” parent.

The presence of these clinical features can offer additional confirming clinical evidence for the diagnosis, or can serve as initial clinical indicators that trigger additional assessment for the presence of the three primary diagnostic indicators of pathogenic parenting associated with attachment-based “parental alienation.”

### **1. Enhancing Child Agency and Empowerment**

Statements made by the allied and supposedly “favored” parent that empower the child and place the child into a leadership position of criticizing the other parent, such as,

- “Listen to the Child”  
Quote: “I’m just listening to the child”  
Quote: “You should listen to the child”  
Quote: “We need to listen to the child”
- Advocating that the child be empowered to decide on visitation with the other parent  
Quote: “The child should decide whether or not to go on visitations with the other parent”
- Efforts by the allied and supposedly “favored” parent to have the child testify in Court

## **2. The coveted “Protective Parent” role**

Efforts by the supposedly “favored” parent to adopt and enlarge upon the coveted role as the concerned, wonderfully sensitive, wonderfully nurturing and understanding “protective parent”

- Quote: “I only want what’s best for the child”

This specific statement reflects an attempt by the allied and supposedly “favored” parent to adopt the “concerned and protective parent” role and implies that the other parent doesn’t want what’s best for the child (i.e., is selfish and self-centered for not simply accepting the child’s “justified” rejection)

## **3. Child placed in front**

The allied and supposedly “favored” parent places the child in the front, leadership position of criticizing and rejecting the other parent and the allied parent responds with supposed “helplessness” regarding the child’s attitudes and behavior toward the other parent,

- Quote: “What can I do? I can’t make the child go on visitations with the other parent – I can’t make the child get along with the other parent.”

This genre of statements is a product of the role-reversal relationship in which the child’s symptoms toward the other parent are first elicited and induced by the distorted communication and parenting practices of the narcissistic/(borderline) parent, and then are exploited by this parent to regulate this parent’s own emotional-psychological processes and to obtain power to nullify the other parent’s rights to custody and to nullify the authority and power of Court orders.

This supposedly “helpless” response of the narcissistic/(borderline) parent represents a self-serving abdication of parental responsibility and authority that provides tacit, but clearly communicated, support for the child’s rejection of the other parent.

## **4. Characteristic themes for the child-initiated rejection of the other parent**

The typical themes offered by the child (and by the alienating parent) for the child’s rejection of the other parent are,

### The Insensitive Parent

- Quote: “She always thinks of herself, she never considers what other people want.”
- Quote: “It always has to be his way. He never does what I want to do.”

### Anger Management

- Quote: “He gets angry about the littlest things. He has anger management problems.”
- Quote: “She can’t control her temper. She’s always getting angry over nothing.”

### Doesn’t Take Responsibility

- Quote: “I don’t trust my mother. She’s such a liar. She doesn’t take responsibility for anything she does wrong.”

### Vague Personhood

- Quote: “I don’t know, it’s just something about the way she says stuff... it’s so irritating... like her tone of voice or something.”
- Quote: “He just bothers me. He’ll like ask me questions and things. It’s just annoying. I just want him to leave me alone.”

### New Romantic Relationship of the Parent Neglects the Child

- Quote: “He is always spending time with his new girlfriend. He doesn’t spend enough special time with just me.”

But if a suggestion is made for the child to spend more time with the targeted-rejected parent, the child typically asserts the “non-forgivable grudge” as a means to avoid spending time with the targeted-rejected parent

### The Non-forgivable Grudge

- Quote: “I simply can’t forgive my mother for what she did in the past. I just can’t get over what happened in the past.”
- Quote: “She deserves being rejected for what she did in the past.”

The child’s attribution that the parent “deserves” to be rejected for a supposed past parental failure is characteristic of attachment-based “parental alienation.”<sup>4</sup>

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<sup>4</sup> Regarding splitting: “They tend to see reality in polarized categories of “either-or,” rather than “all,” and within a very fixed frame of reference. For example, it is not uncommon for such individuals to believe that the smallest fault makes it impossible for the person to be “good” inside... Things once defined do not change. Once a person is “flawed,” for instance, that person will remain flawed forever.” (Linehan, 1993) Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York, NY: Guilford

## 5. Absent “Ownership” of the Parent-Child Relationship

The two characteristic features of the attachment system are a possessive ownership to the relationship and a grief response when an attachment-mediated relationship is lost.

When threatened by a predator, if the child ran to any adult for protection then a non-parent might not, and likely would not, protect the child, so that genes for indiscriminant attachment bonding were removed from the gene pool – attachment motivations are very specific.

The vacancy of child “ownership” of the parent, which represents an inauthentic attachment system display, is evidenced by,

- The child referring to the biological parent by the parent’s first name rather than the ownership term “mother ”or “father” (i.e., Tom rather than “my dad”; or Sarah rather than “my mom”).
- The child applies the parental ownership label of “mother/mom” or “father/dad” to the new spouse of the supposedly “favored” narcissistic/(borderline) parent (i.e., to the step-parent).

In most typical step-families, the child refers to the step-parent by his or her first name, with the parental ownership label being reserved for the biological parent. In attachment-based “parental alienation” this sometimes is reversed, so that the new spouse of the narcissistic/(borderline) parent is given the parental label of “mom” or “dad” while the child refers to the targeted-rejected parent by the parent’s first name.

## 5. Double-binds

Attachment-based “parental alienation” is characterized by a variety of double-bind situations for the targeted-rejected parent.

### The Rejection Double-Bind

The child’s expressed rejection places the targeted parent in a double-bind:

1. If the targeted parent does not comply with the child’s expressed desire to sever their relationship, then this is used as “evidence” against the targeted-rejected parent that the rejected parent isn’t being sensitive to what the child wants. Sometimes this is offered as a reason for the child’s rejection,
  - Quote: “The reason I don’t want to see my father anymore is because he won’t let me live with my mother. If he just let me live with my mother all the time, then maybe I might want to see him.”

2. If, on the other hand, the parent complies with the child's expressed desire to sever their relationship, then the child and alienating parent use the absence of parental involvement from the targeted-rejected parent as "evidence" that this parent doesn't care about the child.
  - Quote: "The child doesn't want to be with the father because the father doesn't care about the child, he doesn't have time for the child and never wants to see the child."

### The Banishment Double-Bind

This is a variation of the Rejection Double-Bind in which the child banishes the parent from activities

- Quote: "I don't want my mom to come to my dance performance (baseball games, graduation, etc.). It just stresses me out and I can't concentrate."

The rejected parent is then placed in a double-bind:

1. Go to the event and be blamed for not being "sensitive" to what the child wants, or
2. Don't go to the event and be blamed for not caring about the child and for not being involved with the child.

### The Discipline Double-Bind

The child provokes parental discipline by being rude, defiant, or disrespectful, which places the rejected parent in a double-bind:

1. If the targeted parent responds with parental discipline to the child's provocative attitude or behavior, then the child (and alienating parent) use this parental disciplinary response as "evidence" of the overly harsh and punitive parenting practices of the targeted-rejected parent, which is then used to justify the child's rejection of the targeted parent.
2. If, on the other hand, the targeted-rejected parent ignores or accepts the child's defiance or verbal abuse, then this is offered as "evidence" that the child's problematic behavior toward this parent is the result of the poor parenting skills of this parent in responding to child misbehavior.

### The Apology/Responsibility Double-Bind

In this double-bind the child makes the accusation that the targeted-rejected parent never listens to the child's complaints and/or never apologizes for parental wrongdoing. The child then offers a distorted and inaccurate characterization of a past episode that places the parent in a double-bind:

1. If the targeted-rejected parent tries to correct the child's false and inaccurate characterization of the past event or the parent's response, then this is used as "evidence" that the parent doesn't listen to the child and doesn't apologize for past wrongdoing.
2. If, on the other hand, the parent accepts the child's distorted characterization of the event, or apologizes for his or her parental response (sometimes at the prompting of an incompetent therapist), then this parental acceptance of the false characterization gives credence to the child's false and distorted characterization of the event or parental response, which the child then uses as "evidence" to justify the child's hostility and rejection of the targeted parent ("I just can't forgive him/her for what happened in the past").

## **6. Shared Victimization**

The child's relationship with the narcissistic-borderline parent actually represents an insecure-preoccupied attachment bond in which the child seeks to maintain continual proximity to the alienating parent and is reluctant to engage in the normal-range exploratory behavior of seeking an independent relationship with the other parent. So while superficially the alienating parent appears to be the "favored" parent, the child's hyper-bonding motivation toward the alienating parent is actually a symptom of an insecure attachment bond to this parent.

The child's insecure attachment to the narcissistic-borderline alienating parent can be strengthened through the child's efforts to please the alienating parent by offering criticisms of the other parent, and by not displeasing the alienating parent by bonding with the other parent. In offering criticisms of the other parent, the child and alienating parent can form a stronger bond from their supposedly shared "victimization" at the hands of the other parent, who represents a shared enemy.<sup>5</sup>

This bond of shared victimization is sometimes expressed by the alienating parent's statement,

- Quote: "I know just how the child feels, the other parent treated me the same way during our marriage"

While superficially, this statement is offered by the alienating parent in supposed empathic understanding for the child's perception of the other parent, but it actually represents a disclosure by the personality disordered parent regarding the blurred psychological boundaries between the narcissistic-borderline parent and the child.

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<sup>5</sup> "Indeed, the sharing of hate feelings toward an object serves to cement a positive alliance." (Juni, 1995)  
Juni, S. (1995). Triangulation as splitting in the service of ambivalence. *Current Psychology: Research and Reviews*, 14, 91-111.

For the narcissistic personality, authentic empathy is impossible. Instead, the experience of empathy for the narcissistic personality is one of psychological fusion, in which the attitudes of the narcissistic personality are imposed on and adopted by the other person. In the child's relationship with the narcissistic-borderline parent, there is only one psychological structure, that of the narcissistic parent.

The statement by the narcissistic/(borderline) parent that, "I know just how the child feels" represents the psychological fusion that the narcissistic/(borderline) parent has with the child, and that the child has acquired the belief system of the narcissistic parent; i.e., that there exists a psychological fusion or enmeshment on the part of the narcissistic/(borderline) parent with the child.

## **7. Disregard of Court orders and authority**

The narcissistic personality does not recognize the construct of "authority" – only power. For the narcissistic personality, power is synonymous with authority. Court orders that are not actively supported by Court sanctions for non-compliance will simply be disregarded by the narcissistic/(borderline) parent, particularly surrounding custody and visitation.

Within the distorted processes of the narcissistic/(borderline) parent, the child's induced and elicited symptomatic rejection of the other parent is being exploited by the narcissistic/(borderline) parent to entirely nullify the parental rights of the targeted-rejected parent, as well as to completely nullify Court orders regarding joint custody and visitation. The symptom confers power. In the case of attachment-based "parental alienation," the child's induced and elicited symptomatic rejection of the other parent confers absolute power to the narcissistic/(borderline) parent to nullify Court orders and the rights of the other parent with impunity. The child refuses visitations with the other parent and the narcissistic/(borderline) parent tacitly supports the child by feigning incompetence,

- Quote: "What can I do? I can't make the child go on visitations with the other parent. What am I supposed to do, drag the child out of my car?"

Courts are typically reluctant to sanction a parent for a child's misbehavior toward the other parent, and Courts are also typically reluctant to sanction a child for not wanting to be with a parent. So the child's induced symptomatic rejection of a relationship with a normal-range parent confers absolute power to the narcissistic/(borderline) parent to nullify Court authority and Court orders, and to defy with complete impunity Court orders for joint custody and visitation.

### Child Run-Away Behavior

The defiance and disregard of legitimate authority is also sometimes evidenced in child run-away behavior from the care of the targeted-rejected parent. Often, this child-run away behavior is with the tacit or active support of the allied and supposedly "favored" parent, and may be coordinated with parental retrieval behaviors by the allied and supposedly "favored" parent.

## 8. Use of the terms “abuse” or “abusive”

Allegations of child abuse are extremely serious and should always be fully investigated.

In addition, the use of the terms “abuse” or “abusive” to describe the other parent are not normal-range terms typically used by a parent to describe the parenting practices of the child’s other parent. Instead, terms like overly strict, harsh, lax and permissive, stern, insensitive, neglectful, inappropriate, are all normal-range criticisms that are applied to the parenting practices of the other parent, and normal-range criticisms of other people are typically that they are rude, inconsiderate, annoying, insensitive, irritating, frustrating, mean, or cruel – but rarely “abusive.”

In the absence of authentic child abuse, persons who are psychologically normal-range and balanced tend to avoid the hyperbolic and extreme characterization of the parenting practices of the other parent as being “abusive.” The allegation of “child abuse” is extraordinarily serious, and has serious implications - either way - once it is made.

**Exposing Parental Attitudes:** The allegation that the parenting practices of the other parent are “abusive” of the child provides a clear and incontrovertible indicator of the psychological attitude of the accusing parent toward the other parent. There are simply no circumstances in which a parent can support the child’s relationship with the other parent who is believed to be abusing the child.

If a standard for child custody decisions is determining which parent can most effectively support the child’s relationship with the other parent, the characterization by one parent that the parenting practices of the other parent represent “abuse” entirely nullifies the accusing parent as being able to meet this standard. Following an allegation of “abusive” parenting, if authentic child abuse is not substantiated then strong consideration should be given to transferring the child’s primary custodial care to the parent who DID NOT characterize the parenting practices of the other parent as “abusive,” since this non-accusatory, non-extreme parent is best able to support the child’s ability to form a healthy relationship with BOTH parents.

In the absence of authentic child abuse, psychologically normal-range and balanced people do not characterize the parenting practices of the other parent with the extreme and hyperbolic exaggeration of child “abuse.”

However, the use of the terms “abuse” and “abusive” are common with borderline personality organization, and there are reasons for this prominent tendency of borderline personalities to use the term “abuse” when characterizing the actions of others, but that go beyond the scope of this current discussion to describe.

The use of the terms “abuse” and “abusive” should trigger BOTH a thorough investigation regarding the potential for authentic child abuse, AND a thorough psychological assessment of the parent making the allegation for the possible presence of borderline personality organization which can potentially be masked from overt display by a **narcissistic veneer** of confident self-assurance and self-assertion.

A narcissistic personality veneer can readily hide an underlying borderline personality organization,<sup>6</sup> and the serious psychopathology associated with a narcissistic/(borderline) personality organization can often be masked from overt view,

“The defensive organization of these patients [narcissists] is quite similar to that of the borderline personality organization in general... what distinguishes many of the patients with narcissistic personalities from the usual borderline patient is their relatively good social functioning, their better impulse control, and... the capacity for active consistent work in some areas which permits them partially to fulfill their ambitions of greatness and of obtaining admiration from others. Highly intelligent patients with this personality structure may appear as quite creative in their fields: narcissistic personalities can often be found as leaders in industrial organizations or academic institutions; they may also be outstanding performers in some artistic domain.” (Kernberg, 1975, p. 229)<sup>7</sup>

“While narcissism is recognized as a serious mental disorder, its manifestations may not be immediately recognized as pathological, even by persons in the helping professions, and its implications may remain unattended to... The perception is hampered by the fact that narcissistic individuals may well be intelligent, charming, and sometimes creative people who function effectively in their professional lives and in a range of social situations.” (Cohen, 1998, p. 197)<sup>8</sup>

“Narcissists can display “a deceptively warm demeanor.” (Beck, et al, 2004, p. 241)<sup>9</sup>

“When not faced with humiliating or stressful situations, CENs [i.e., narcissists] convey a calm and self-assured quality in their social behavior. Their untroubled and self-satisfied air is viewed by some as a sign of confident equanimity.” (Millon, 2011, p. 388-389)<sup>10</sup>

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<sup>6</sup> Kernberg (1975) identifies narcissistic personality processes as a variant of an underlying borderline personality organization:

“One subgroup of borderline patients, namely, the narcissistic personalities... seem to have a defensive organization similar to borderline conditions, and yet many of them function on a much better psychosocial level. (p. xiii)”

“Most of these patients [i.e., narcissistic] present an underlying borderline personality organization.” (p. 16)

“The defensive organization of these patients [narcissists] is quite similar to that of the borderline personality organization in general...” (p. 229)

Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson.

<sup>7</sup> Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson.

<sup>8</sup> Cohen, O. (1998). Parental narcissism and the disengagement of the non-custodial father after divorce. *Clinical Social Work Journal*, 26, 195-215

<sup>9</sup> Beck, A.T., Freeman, A., Davis, D.D., & Associates (2004). *Cognitive therapy of personality disorders*. (2nd edition). New York: Guilford.

<sup>10</sup> Millon, T. (2011). *Disorders of personality: introducing a DSM/ICD spectrum from normal to abnormal*. Hoboken: Wiley.

Attachment-Based “Parental Alienation”  
 Checklist of Diagnostic Indicators and Associated Clinical Features  
 C.A. Childress, Psy.D. (2014)

**Primary Diagnostic Indicators**

Present	Sub-Threshold	Absent	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. <b>Attachment system suppression:</b> A child-initiated cut-off in the parent-child relationship with a normal-range parent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. <b>Personality Disorder Features:</b> Presence in the child’s symptom display of 5 specific narcissistic and borderline personality disorder features
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. <b>Delusional Belief:</b> Presence in the child’s symptom display of an intransigently held fixed and false belief (i.e., a delusion) in the supposedly inadequate parenting of the targeted-rejected parent.

**Associated Clinical Features**

evident	not evident																						
<input type="checkbox"/>	<input type="checkbox"/>	Enhancing Child Agency and Empowerment																					
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## Associated Clinical Features

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<input type="checkbox"/>	<input type="checkbox"/>	The “Protective Parent” role sought by the supposedly “favored” parent															
<input type="checkbox"/>	<input type="checkbox"/>	Child placed in front – “favored” parent presents as helpless															
<input type="checkbox"/>	<input type="checkbox"/>	Absent “ownership” of the biological parent (or “ownership” of the step-parent)															
<input type="checkbox"/>	<input type="checkbox"/>	Shared victimization (“I know just how the child feels, the other parent did exactly the same thing with me during our marriage”)															
<input type="checkbox"/>	<input type="checkbox"/>	Parental disregard of Court orders and authority															
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