

Documenting Attachment-Based “Parental Alienation” in a Legal Context
C.A. Childress, Psy.D. (2014)

Caveat: Dr. Childress is not an attorney. This article does not represent legal advice. For legal advice, consult an attorney and follow the recommendations of the attorney. This article discusses potential approaches to documenting psychological constructs with sufficient clarity to possibly meet the standards of proof required by a legal context.

Proving the psychological constructs associated with Gardner’s model of Parental Alienation Syndrome (PAS) in a legal setting can be highly challenging. From a clinical psychology perspective, the anecdotal clinical indicators identified by Gardner for the construct of PAS are not associated with any established psychological principles or constructs and lack sufficient diagnostic clarity to allow for the consistent identification of “parental alienation” with the necessary degree of certainty. This absence of diagnostic certainty can lead to disputes among mental health diagnosticians and therapists regarding the interpretation of the clinical data, so that the Court is left with ambiguous guidance from mental health expertise in evaluating the emotional, psychological, and development needs of the child relative to the family conflict and the matters before the Court.

Clarity in diagnosis requires the reliable determination of a diagnostic construct’s presence or absence. The anecdotal clinical indicators described by Gardner for the construct of PAS, however, are vague descriptive constructs with no linking association to any established psychological theory or mental health diagnoses. The absence of diagnostic clarity can lead to professional disagreement regarding whether PAS is a valid psychological construct and, if it is a valid construct, whether the diagnostic criteria are present in any specific case. In addition, Gardner’s diagnostic criteria for the construct of PAS result in a dimensional rather than categorical diagnosis, meaning that applying Gardner’s PAS diagnostic criteria results in professional interpretations regarding degrees of “parental alienation,” ranging from mild to severe, rather than a clear and definitive determination of whether pathogenic parenting by one parent, the alienating parent, represents the directly responsible causative agent for the cut-off in the child’s relationship with the other parent.

Decisions made within a legal context involving the mental health needs of children who are exposed to “parental alienation” processes benefit from a dichotomous (yes-no) mental health diagnosis regarding whether the pathogenic parenting of one parent represents the causative agent in creating the cut-off of the child’s relationship with the other parent. In the absence of clear diagnostic criteria for making this determination, many mental health professions feel more comfortable blending causality by offering the opinion that both parents are partially responsible for the cut-off in the child’s relationship with the rejected parent. However, when the family contains a narcissistic/(borderline) personality disordered parent, the attribution of blended causality is not true. The severely distorting psychopathology of a narcissistic/(borderline) parent can easily produce, on its own, the severely distorted family relationship processes evidenced by a cut-off of the child’s relationship with the other, normal-range and affectionate parent.

When the primary child symptom is a desire to terminate a parent-child relationship following a divorce, the potential presence in the family of a narcissistic/(borderline) parent should be one of the primary causative factors evaluated in a mental health assessment. It is extraordinarily difficult, and relatively rare, to produce a cut-off in the parent-child relationship based solely on the problematic parenting practices of the rejected parent without the additional supportive influence provided by a narcissistic/(borderline) parent who adopts the appearance as the “favored” nurturing-protective parent within the family. On their own, problematic parenting practices by a parent almost never produce a suppression of the child’s attachment system necessary for a cut-off of the child’s relationship with the problematic parent. Instead, problematic parenting practices that exist on their own will produce an insecure attachment bond of the child to that parent, which then motivates the child toward increased attachment bonding with the problematic parent. Problematic parenting practices by themselves typically produce a stronger motivation in the child to establish a parent-child bond.

Many times the increased child motivation for attachment bonding that results from problematic parenting practices manifests as child “protest behavior,” such as increased child defiance, argumentativeness, school failure, or excessive emotionality, that acts to generate greater parental involvement with the child as a product of the increased child protest behavior and the ensuing parent-child conflict. Predators will not target children who are being attended to by the parent, even if that attention is in the form of parent-child conflict. In response to problematic parenting practices, the increase in child protest behavior represents an “attachment behavior” that is designed to generate greater parental involvement in response to the insecure parent-child attachment bond created by the problematic parenting practices.

However, the cut-off of the child’s attachment bonding motivation toward a parent evidenced in “parental alienation” instead represents a “detachment behavior” designed to terminate the parent-child relationship. This is an exceedingly rare symptom display by a child and is diagnostically characteristic of the presence of narcissistic parenting practices (Table 1). The narcissistic parenting creating the detachment behavior of the child may be emanating either from the parent who is being rejected by the child, in which case the cut-off of the child’s attachment bonding motivations toward the parent represents an authentic child response to the narcissistic parenting practices of the rejected parent, or the source of the narcissistic parenting may be the apparently “favored” parent, in which case the cut-off represents a cross-generational coalition (i.e., a “perverse triangle”; Haley, 1977)¹ of the

¹ “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.” (p. 37)

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

Family Constellation 1: Narcissistic “Favored” Parent - Normal-Range Targeted Parent		
	Par 1: Narcissistic “Favored” Parent	Cut-off in relationship with Parent 2 through the distorted parenting practices of narcissistic Parent 1
	Par 2: Normal-Range Targeted Parent	
Family Constellation 2: Narcissistic “Favored” Parent – Problematic Targeted Parent		
	Par 1: Narcissistic “Favored” Parent	Cut-off in relationship with Parent 2 through the distorted parenting practices of narcissistic Parent 1
	Par 2: Problematic Targeted Parent	
Family Constellation 3: Normal-Range Parent - Problematic Parent		
	Par 1: Normal-Range Parent	NO cut-off in relationship with either parent – increased parent-child conflict may be evident with one or both parents
	Par 2: Problematic Parent	
Family Constellation 4: Normal-Range Parent – Normal-Range Parent		
	Par 1: Normal-Range Parent	NO cut-off in relationship with either parent – low-level parent- child conflict may be evident with one or both parents
	Par 2: Normal-Range Parent	
Family Constellation 5: Normal-Range Parent – Narcissistic Targeted Parent		
	Par 1: Normal-Range Parent	Cut-off in relationship with Parent 2 is possible as a product of severe parental violence by Parent 2, i.e., physical child abuse, domestic violence, or sexual/psychological violence (incest)
	Par 2: Narcissistic Targeted Parent	
<p>Analysis:</p> <p>A cut-off of the parent-child relationship is ONLY evidenced in the presence of narcissistic parenting practices by one or the other parent.</p> <p>In family constellations 1 and 2, the pathogenic parenting practices of the supposedly “favored” parent (Parent 1) produce a cut-off in the child’s relationship with other parent, Parent 2. These family constellations are traditionally described as “parental alienation.” In family constellation 5, the narcissistic parenting practices of Parent 2 are manifested through parental violence, such as physical child abuse, severe domestic violence, or the sexual/psychological violence inherent to sexual abuse/incest with the child, which creates a cut-off (i.e., suppression of the child’s attachment system) in the child’s relationship with the narcissistic parent who is perpetrating the violence.</p> <p>In the absence of narcissistic parenting (family constellations 3 and 4), however, no cut-off in either parent-child relationship occurs. Problematic parenting practices by one parent DO NOT produce a cut-off in the parent-child relationship in the absence of narcissistic parenting practices, either by the cut-off parent (family constellation 5) or by the supposedly “favored” parent (family constellations 1 and 2).</p>		

Table 1: Family constellations involving a cut-off of a parent-child relationship.

child with a narcissistic parent that is targeting the other parent for the child's hostility and rejection.

Gardner's model of PAS relies on anecdotal clinical indicators rather than established psychological constructs to describe the underlying dynamics of the child's cut-off in a relationship with a parent, which severely limits the clinical utility of the PAS model. A reconceptualization of the family processes that are traditionally described as "parental alienation" from entirely within standard and established psychological principles and constructs is needed in order to generate clear diagnostic criteria that can reliably establish the clinical diagnosis, so that reliable professional guidance can be provided to the Court regarding the child's emotional, psychological, and developmental needs.

The cut-off in a child's relationship with a parent represents a severe distortion to the normal-range functioning of the child's attachment system that requires the presence of pathogenic parenting from a narcissistic parent, either from the supposedly "favored" and allied parent, in which case it represents the traditional construct of "parental alienation," or from the parent who is being rejected by the child, in which case the cut-off in the parent-child relationship represents the product of child abuse. The attachment system is a very strong and exceedingly resilient motivational system, so that the degree of child abuse required to create a cut-off of a parent-child relationship needs to be fairly severe. The child abuse necessary to terminate the parent-child relationship can occur directly through the physical or sexual abuse of the child by the narcissistic parent, or indirectly through the child's prolonged exposure to the emotional and psychological abuse associated with domestic violence.

The pathogenic influence of a narcissistic parent can create a termination of the child's relationship with the other parent through the formation of a cross-generational coalition with the child that targets the other parent for the child's hostility and rejection (family constellations 1 and 2 in Table 1). This dynamic may represent a variant of emotional and psychological domestic violence in which the child becomes an instrument used by a narcissistic parent to inflict emotional and psychological violence against the other parent, so that families with a history of emotional and psychological domestic violence may be particularly susceptible to the pathogenic parenting of the narcissistic parent that will create a cut-off of the child's relationship with the targeted parent following the divorce.

Diagnostic Criteria for "Parental Alienation"

In order for mental health to provide clear and definitive guidance to the Court, there must be clear and unequivocal diagnostic criteria that allows for a dichotomous identification of all cases of the pathogenic parenting associated with "parental alienation." When mental health is able to speak with a single voice, the Court will be able to rely on the findings of mental health for resolving the family dynamics associated with "parental alienation." But for mental health to speak with a single voice requires clearly articulated diagnostic criteria that rely on established psychological principles and constructs.

Since a cut-off in a parent-child relationship represents a severe distortion to the normal-range functioning of the child's attachment system relative to a parent, an attachment-based framework for understanding the family processes of "parental alienation" can provide the theoretical substrate necessary for identifying the key diagnostic features of the induced suppression of the child's attachment bonding motivations toward a parent (i.e., a cut-off in the parent-child relationship) that is the product of the pathogenic parenting practices of the allied and supposedly "favored" parent.

In addition, the psychological control of a child by a narcissistic/(borderline) parent will leave clinical indicators in the psychological symptoms of the child. These child symptom indicators represent "psychological fingerprints" of the influence by a narcissistic parent on the child's relationship with the other parent, and can serve as additional diagnostic indicators of the pathogenic influence of the allied and "favored" parent on creating the child's motivation to terminate the relationship with the other parent.

Finally, if the cut-off in the child's relationship with a parent is the authentic product of the narcissistic and pathogenic parenting of the parent who is being rejected by the child, then these narcissistic parenting practices should be clearly evidenced in the clinical data. There should be a clearly evident history of physical child abuse, incest, or domestic violence that can reasonably account for the cut-off of the child's attachment bonding motivations toward the rejected parent. However, absent such substantiated evidence of physical child abuse, incest, or the prolonged exposure of the child to domestic violence, then alleged problematic parenting practices will not, of themselves, produce a cut-off in the child's attachment bonding motivations toward a parent. Problematic parenting produces an insecure attachment bond that generates increased child protest behavior designed to elicit increased parental involvement. Problematic parenting does not produce child detachment behavior associated with a cut-off in the parent-child relationship.

Prolonged frustration of the child's attachment bonding motivation, that initially produced an increase in child protest behavior, may eventually produce discouragement at the inability to form an affectional attachment bond with the parent, so that the child may begin to withdraw emotionally and psychologically from the relationship. If, however, affectional bonding with the problematic parent becomes available, then the child's dormant attachment bonding motivations will reactivate in an effort to restore an affectional attachment bond. Emotional and psychological withdrawal from the parent-child relationship as the product of the child's discouragement about obtaining an affectional attachment bond with a parent is different in both its origin and its symptomatic features from a cut-off in the child's attachment bonding motivation toward a parent who is available.

Caution should also be exercised in determining what constitutes problematic parenting practices. Normal-range parenting practices span an exceedingly large range, from flexible and permissive parenting to more structured and authoritarian parenting. While normal-range parenting at the extremes of this spectrum may produce child behavior problems (i.e., increased child "protest behavior"), problematic parenting within the normal-range NEVER produces a cut-off in the parent-child relationship in the absence of

narcissistic parental influence from the other, allied and “favored” parent. Considerable latitude should be given to parental rights and parental prerogatives in establishing family values and the exercise of parenting choices. In general, children should adjust to the values displayed in the parenting practices of their parents rather than supporting the child’s ability to terminate a relationship with a parent due to the child’s dissatisfaction with the parenting practices of this parent.

The presence of parental narcissistic and borderline personality disorder dynamics, however, can readily lead to the cut-off of the child’s relationship with a parent, and under conditions of adversity such as encountered with divorce, these parental narcissistic and borderline personality disorder traits can decompensate into persecutory delusional beliefs. One of the leading experts in personality disorder dynamics, Theodore Millon, describes this inherent vulnerability of the narcissistic personality,

Under conditions of unrelieved adversity and failure, narcissists may decompensate into **paranoid disorders**. Owing to their excessive use of fantasy mechanisms, they are disposed to misinterpret events and to construct **delusional beliefs**. Unwilling to accept constraints on their independence and unable to accept the viewpoints of others, narcissists may isolate themselves from the corrective effects of shared thinking. Alone, they may ruminate and weave their beliefs into a network of fanciful and **totally invalid suspicions**. Among narcissists, **delusions often take form after a serious challenge or setback has upset their image of superiority and omnipotence**. They tend to exhibit compensatory grandiosity and jealousy delusions in which they reconstruct reality to match the image they are unable or unwilling to give up. **Delusional systems may also develop as a result of having felt betrayed and humiliated**. Here **we may see the rapid unfolding of persecutory delusions** and an arrogant grandiosity characterized by verbal attacks and bombast. Rarely physically abusive, anger among narcissists usually takes the form of oral vituperation and argumentativeness. This may be seen in a flow of irrational and caustic comments in which others are upbraided and denounced as stupid and beneath contempt. These onslaughts usually have little objective justification, are **often colored by delusions**, and may be directed in a wild, hit-or-miss fashion in which the narcissist lashes out at those who have failed to acknowledge the exalted status in which he or she demands to be seen.” (Millon, 2011, pp. 407-408; emphasis added)²

Another form of “psychological fingerprint” in the child’s symptom display that is evidence of the pathogenic influence applied to the child by a narcissistic/(borderline) parent in creating the cut-off of the child’s motivation for attachment bonding with the other parent is the presence of persecutory delusions³ in the child’s symptom display toward the cut-off parent.

² Millon, T. (2011). *Disorders of personality: introducing a DSM/ICD spectrum from normal to abnormal*. Hoboken: Wiley.

³ A delusion is defined as an intransigently held fixed and false belief that is non-responsive to change from contrary evidence.

When all three symptom indicators are present, 1) the selective suppression of the normal-range functioning of the child's attachment system in the absence of sufficiently pathogenic parenting by the rejected parent to account for the cut-off in the child's attachment bonding motivations toward this parent, 2) the presence in the child's symptom display of narcissistic and borderline personality disorder traits, and 3) the presence in the child's symptom display of persecutory delusional beliefs directed toward the targeted-rejected parent, then this would represent exceedingly strong clinical evidence for the presence of pathogenic parental influence by the allied and "favored" narcissistic/(borderline) parent as being the causative agent responsible for the cut-off in the child's motivations for normal-range attachment bonding with the other parent. No other psychological or interpersonal process other than the pathogenic parenting by a narcissistic/(borderline) parent could account for this specific symptom display by the child. The presence of these three disparate diagnostic features in the child's symptom display represents a definitive diagnosis for the origin of the child's cut-off of a relationship with the targeted-rejected parent as being produced by the pathogenic parenting practices of a narcissistic/(borderline) personality disordered allied and "favored" parent.

While some problematic parenting practices of the targeted-rejected parent may possibly be present (i.e., family constellation 2 in Table 1), considerable caution should be exercised in judging the parenting practices of the targeted-rejected parent as being contributing factors to the termination of the child's attachment bonding motivations toward this parent. Problematic parenting practices in the absence of narcissistic parenting (i.e., family constellation 3 in Table 1) do not produce a cut-off in the child's attachment bonding motivations toward a parent. Furthermore, societal values regarding what constitutes normal-range parenting allows for a broad array of parenting practices that may possibly be considered problematic from one perspective or another. Broad latitude is therefore typically granted to parental prerogatives in establishing family values and in parenting choices.

Any potential problematic parenting of the cut-off targeted-rejected parent can usually be resolved within 6-12 months of appropriate parent-child therapy. Even parent-child conflict caused by severely problematic parenting can usually be resolved within 18 months of appropriate therapy with a cooperative parent. The legal system should be reluctant to micro-analyze the judgment of parenting practices. Responding to problematic parenting is better handled by psychotherapy than through the legal system. Professional mental health expertise can help guide the Court in the likely causative factors for the child's symptomatic cut-off in a relationship with a parent and in what treatment considerations are needed to restore the normal-range functioning of the child's attachment bonding motivations that are being distorted by pathogenic parenting practices, including the resolution of any problematic parenting possibly being displayed by the targeted parent.

An attachment-based model for the cut-off in a parent-child relationship (traditionally referred to as "parental alienation") establishes a set of three clearly defined diagnostic criteria using standard and established psychological principles and constructs that can reliably determine in every case the presence of pathogenic parental influence emanating from the allied and supposedly "favored" parent as being the causative agent

responsible for the cut-off of the child's attachment bonding motivations toward the other parent,

1. **Attachment System Suppression:** The child's symptom display evidences a selective and targeted suppression of the normal-range functioning of the child's attachment bonding motivations toward one parent, in which the child seeks to entirely cut-off a relationship with this parent. A clinical assessment of the parenting behavior of the rejected parent provides no evidence for severely dysfunctional parenting (such as chronic parental substance abuse, parental violence, or parental sexual abuse of the child) that would account for the child's complete rejection of the parent, so that the parenting of the targeted-rejected parent is assessed to be broadly normal-range, with due consideration given to the broad range of acceptable parenting practices typically displayed in normal-range families, and to the legitimate exercise of parental prerogatives in establishing family values, including parental prerogatives in the exercise of normal-range parental authority, leadership, and discipline within the parent-child relationship.
2. **Personality Disorder Symptoms:** The child's symptom display toward the targeted-rejected parent evidences a specific set of five narcissistic and borderline personality disorder symptoms that are diagnostically indicative of parental influence on the child by a narcissistic/(borderline) personality parent. The specific set of narcissistic and borderline personality disorder symptoms displayed by the child toward the targeted-rejected parent are,

Grandiosity: the child displays a grandiose self-perception of having an elevated status in the family hierarchy above that of the targeted-rejected parent, whereby the child feels entitled to sit in judgment of the targeted-rejected parent as both a parent and as a person,

Entitlement: an over-empowered sense of child entitlement in which the child expects that his or her desires will be met by the targeted-rejected parent to the child's satisfaction, and if the rejected parent fails to meet the child's entitled expectations to the child's satisfaction, the child feels entitled to enact a retaliatory punishment and retribution on the rejected parent for the judged parental failure,

Absence of Empathy: a complete absence of empathy for the emotional pain of the targeted-rejected parent that is being caused by the child's hostility and rejection of this parent,

Haughty and Arrogant Attitude: the child displays an attitude of haughty arrogance and contemptuous disdain for the targeted-rejected parent,

Splitting: the child evidences the psychological process of splitting involving polarized extremes of attitude, expressed in the child's symptoms as the differential attitudes the child holds toward his or her parents, in which the "favored" parent is idealized as the all-good and nurturing parent while the

rejected parent is completely devalued as the all-bad and entirely inadequate parent.

Parental influence of the child is evidenced in both the presence of personality disorder symptoms in the child's symptom display and through the selective display of these personality disorder symptoms toward one targeted person, the rejected parent, indicating that these personality disorder symptoms are not endogenous to the child and instead have an interpersonally induced origin. The child will typically not display these narcissistic and borderline personality disorder traits with persons other than the targeted-rejected parent, such as with therapists or teachers, and may instead display a overly mature presentation of pleasant cooperation and well-developed social maturity that is characteristic of co-narcissistic behavior (Rappoport, 2005).⁴ If the child displays narcissistic or borderline traits across a range of situations and persons, then consideration of a personality disorder diagnosis for the child may be warranted.

Anxiety Variant:

Some children may display extreme and excessive anxiety symptoms toward the targeted-rejected parent rather than narcissistic and borderline personality disorder traits. Extreme and excessive anxiety in response to the targeted parent is often the symptom pattern displayed by younger children (e.g., ages 4 to 9 years old). Sometimes older children will report symptoms of excessive anxiety related to being in the presence of the targeted-rejected parent, although for older children these anxiety symptoms usually occur in conjunction with additional narcissistic and borderline personality disorder symptoms as well, so that the older child (e.g., ages 10 to 18) more rarely presents solely with anxiety related symptoms.

In the anxiety variant of attachment-based "parental alienation" the child's anxiety symptoms will meet the following DSM-5 diagnostic criteria for a Specific Phobia:

- A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving and injection, seeing blood).

[Note: the feared object in attachment-based "parental alienation" is a specific parent]

- B. The phobic object or situation almost always provokes immediate fear or anxiety.
- C. The phobic object or situation is actively avoided or endured with intense fear or anxiety
- D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context

⁴ Rappoport, A. (2005). Co-narcissism: How we accommodate to narcissistic parents. *The Therapist*.

- E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- F. The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013)⁵

However, in attachment-based “parental alienation” the type of phobia displayed by the child will be a bizarre and unrealistic “father type” or “mother type.” The bizarre and unrealistic type of phobia displayed by the child is a direct reflection of the inauthenticity of these anxiety symptoms. The child’s supposed phobic anxiety directed toward the targeted parent is the product of the distorted and pathogenic parenting practices of the allied and “favored” parent.

Phobic anxiety symptoms occur across a category of experience, such as a fear of heights or a fear of being in enclosed spaces. Phobic symptoms do not develop relative to a single specific object within the category, such as the fear of heights in a specific building but not in any other building or circumstance, or phobic fear of flying in one specific airplane but not of any other airplane or circumstance. Furthermore, the overwhelming bonding motivations of the attachment system would prevent children from developing an authentic phobic response to a parent, since a “mother phobia” or “father phobia” would differentially expose these children to greater survival risks from predation and environmental dangers, thereby systematically removing genes that allowed for the development of a “mother phobia” or “father phobia” from the collective gene pool. The symptom display by a child of a “mother phobia” or “father phobia” is non-realistic and inauthentic.

The child, and sometimes the allied and “favored” parent, may offer that the child’s phobic response to the targeted-rejected parent represents a realistic and/or understandable response to an authentic risk posed to the child by the parent. If the clinical evaluation of the parenting practices of the targeted-rejected parent do not support this assertion, then this justification of the child’s anxiety as a realistic response to the danger posed by the targeted-rejected parent represents a manifestation of the persecutory delusional belief shared jointly by the allied parent and child.

In other cases, the allied parent and child may propose that the child’s phobic response toward the targeted parent is the product of supposedly “traumatic” experiences the child has had with the targeted-rejected parent in the past. This essentially represents a definition the child’s severe anxiety symptoms as representing a form of post-traumatic stress disorder (PTSD). However, diagnostically authentic PTSD does not present as a specific phobia. Furthermore, the DSM-5 diagnostic criteria for a traumatic experience capable of producing PTSD symptoms is that “the person was exposed to: death, threatened death, actual or

⁵ American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

threatened serious injury, or actual or threatened sexual violence.” In order to account for the development of a phobic child response toward a specific parent, the child’s prior traumatic experience with this parent would need to reach this level of severity.

- 3. Delusional Belief System:** The child’s symptoms display an intransigently held, fixed and false belief (i.e., a delusion) regarding the fundamental parental inadequacy of the targeted-rejected parent in which the child characterizes a relationship with the targeted-rejected parent as being emotionally or psychologically “abusive” of the child. The child may use this fixed and false belief regarding the supposedly “abusive” inadequacy of the targeted parent to justify the child’s rejection the targeted parent (i.e., that the targeted parent “deserves” to be rejected because of the supposedly “abusive” parenting practices of this parent).

The clinical diagnosis of attachment-based “parental alienation” requires the complete presence of all three diagnostic indicators. If the complete set of all three diagnostic indicators is not present, or if one or more of the diagnostic indicators are sub-threshold, such as only three of the personality disorder symptoms are present, or the child’s beliefs about the inadequacy of the parenting practices of the targeted-rejected parent are not false or are maintained with some degree of doubt, then the clinical diagnosis of attachment-based “parental alienation” is not warranted. In cases of sub-threshold symptom displays by the child, a 6-12 month Response-to-Intervention (RTI) trial of parent-child therapy, with the possible separate collateral participation of the allied and “favored” parent, may be considered in order to clarify diagnostic considerations.

Analysis of Clinical Data

An attachment-based model of parental alienation, and the diagnostic criteria that it provides, establishes a theoretical framework within established psychological constructs for interpreting clinical data. Instead of trying to establish the presence of vague clinical descriptors from the PAS model, such as “borrowed scenarios” or an “independent thinker phenomenon,” an attachment-based model provides clear criteria for the professional collection and interpretation of clinical data, 1) the display of the child’s attachment system functioning, 2) the presence of narcissistic and borderline personality disorder traits in the child’s symptom display, and 3) the presence of a fixed and false belief in the fundamental inadequacy of the targeted-rejected parent.

If the child’s symptom display evidences the diagnostic criteria for an attachment-based model of “parental alienation,” then the cut-off in the child’s relationship with the targeted-rejected parent is the product of pathogenic parenting practices of the allied and supposedly “favored” parent, and any potential problematic parenting by the targeted-rejected parent is not responsible for the cut-off in the child’s relationship. Normal-range parenting practices span a broad range of parental responses, from flexible and permissive parenting to structured and authoritarian parenting, so that a broad latitude should be granted to normal-range parental prerogatives in establishing family values and parenting approach. Litigating the parenting practices of the targeted-rejected parent should be

avoided, and any possible problematic parenting of the cut-off parent can be addressed through therapy.

The presence in the child's symptom display of all three diagnostic indicators of attachment-based "parental alienation" represent definitive clinical evidence that the cut-off in the parent-child relationship is the direct product of the distorted and pathogenic parenting practices of the allied and supposedly "favored" parent that are inducing severe emotional, psychological, and developmental psychopathology in the child. The presence of pathogenic parenting seemingly shifts both the mental health and legal consideration from one of custody and visitation to one of child protection. Based on a clinical analysis of the psychological processes associated with attachment-based "parental alienation" (Childress, 2013),⁶ the appropriate DSM-5 diagnosis for a child who evidences the three diagnostic indicators of attachment based "parental alienation" would be,

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

An induced cut-off of a child's relationship with a parent involves an extremely serious distortion to the child's attachment system, which is a neuro-biologically based primary motivational system responsible for regulating close emotional bonding across the lifespan. This is an extremely serious clinical symptom. That this cut-off is induced by the distorted and pathogenic parenting practices of a narcissistic/(borderline) parent, resulting in the loss for the child of an affectionally bonded relationship with a normal-range, loving, and supportive parent, raises prominent child protection concerns. In the professional opinion of Dr. Childress, the presence in the child's symptom display of the three definitive diagnostic indicators of an attachment-based model for "parental alienation" (i.e., narcissistic pathogenic parenting that produces a cut-off in the child's relationship bonding motivations toward the other parent) represents the higher standard of Child Psychological Abuse, Confirmed which would require a child protection response from both mental health services and the Court.

Professional Standards of Practice.

The child and family processes associated with attachment-based "parental alienation" (i.e., the induced suppression of the normal-range functioning of the child's attachment system as a product of severely distorted and pathogenic parenting practice of a narcissistic/(borderline) parent) represent a "special population" of children and families that requires specialized professional knowledge, training, and expertise to appropriately diagnose and treat. Failure to possess this specialized professional knowledge may

⁶ Childress, C.A. (2013). DSM-5 Diagnosis of "Parental Alienation" Processes. Retrieved 11/18/13 from <http://www.drcachildress.org/asp/Site/ParentalAlienation/index.asp>

represent practice beyond the boundaries of professional competence in violation of professional practice standards.⁷

An attachment-based model of “parental alienation”⁸ requires the following specialized domains of professional expertise regarding the assessment (e.g., child custody evaluations) and treatment (i.e., reunification therapy; Childress, 2014)⁹ of attachment-based “parental alienation” processes within the family:

- **Attachment Theory:** The professionally competent assessment and treatment of a serious distortion to the child’s attachment system requires a professional level of competence related to the developmental origins of the attachment system, the interpersonal and psychological functions served by the attachment system across the lifespan, the features of the attachment system, characteristic patterns of dysfunctioning, and the attachment system’s expression in parent-child relationships, particularly with regard to the role of child “protest behavior” in eliciting increased parental involvement (Appendix 1 contains a list of recommended readings regarding the attachment system that would be relevant to establishing professional competence for the diagnosis and treatment of attachment-based “parental alienation”).
- **Personality Disorder Dynamics:** The interpersonal family processes associated with attachment-based “parental alienation” are driven by the narcissistic and borderline personality disorder dynamics¹⁰ of the alienating parent. A professional level of

⁷ Standard 2.02 of the ethics code of the American Psychological Association states, “Psychologists provide services, teach and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience.”

⁸ i.e., the induced suppression of the normal range functioning of the child’s attachment system as manifested in a cut-off of the child’s attachment bonding motivations toward a parent as an induced product of the severely pathogenic parenting practices by a narcissistic/(borderline) parent that represents the reenactment in current family relationships of prior childhood relationship trauma contained within the “internal working models” of the narcissistic/(borderline) parent’s attachment networks; reflecting, in its entirety, the trans-generational transmission of attachment trauma from the childhood relationships of the narcissistic/(borderline) parent (that are responsible for the development of the narcissistic and borderline personality processes) to current family relationships that are essentially normal-range.

⁹ Childress, C.A. (2014). Reunification Therapy: Treating “Parental Alienation” Retrieved 5/1/14 from <http://www.drcachildress.org/asp/Site/ParentalAlienation/index.asp>

¹⁰ 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.

competence is therefore required in the following areas of personality disorder processes:

- 1) Professional familiarity with the clinical display of narcissistic and borderline personality dynamics (Beck, et al., 2004; Kernberg, 1975; Linehan, 1993; Millon, 2011),¹¹ including the expression of these personality dynamics in family relationships and the features of co-narcissistic behavioral displays in children (e.g., Rappoport, 2005)¹²
 - 2) The characteristic features of narcissistic and borderline personality decompensation into persecutory delusional beliefs under stress, (Millon, 2011)
 - 3) The nature of the “invalidating environment” associated with borderline personality disorder processes and its impact on the parent-child relationships (Linehan, 1993)
- **Delusional Processes:** The child’s symptoms display an intransigently held, fixed and false belief (i.e., a delusion) regarding the alleged parental inadequacy of the targeted-rejected parent. This delusional belief is being acquired from a similar belief system in the allied and “favored” narcissistic/(borderline) parent. Delusional beliefs and shared delusional beliefs are an unusual child symptom in general clinical practice, but it is a defining feature of the “special population” of children and families evidencing attachment-based “parental alienation.” Competent professional practice with this special population of children and families requires a professional understanding for the formation of persecutory delusional belief systems, particularly those associated with the psychological decompensation of narcissistic and borderline personality organization, as well as professional familiarity with the interpersonal relationship and communication processes by which these false beliefs can be transferred to a child within a parent-child relationship (e.g., parent-child enmeshment, parental emotional signaling, selective and differential parental attunement and misattunement to child communications and self-experience, and children’s inherent predisposition to socially reference parents for meaning, particularly in ambiguous situations and situations in which the parent is communicating the presence of a threat or danger).
 - **Family Systems Therapy:** In attachment-based “parental alienation,” the child’s symptomatic expressions are embedded in the larger context of family relationship and

¹¹ Beck, A.T., Freeman, A., Davis, D.D., & Associates (2004). *Cognitive therapy of personality disorders*. (2nd edition). New York: Guilford.

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

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford

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

¹² Rappoport, A. (2005). Co-narcissism: How we accommodate to narcissistic parents. *The Therapist*

communication patterns. The personality disorder dynamics of the narcissistic/(borderline) parent are preventing the family's successful transition from an intact family structure that was unified by the marriage, to a separated family structure that is unified by the children and by the continuing parental roles both parents have with the children.

The core issue in this failed transition is the inability of the narcissistic/(borderline) parent to accurately comprehend and metabolize the sadness and grief surrounding the marital dissolution and the loss of the intact family structure. The narcissistic personality interprets sadness "as anger and resentment, loaded with revengeful wishes, rather than real sadness for the loss of a person whom they appreciated." (Kernberg, 1975, p. 229).¹³ The narcissistic/(borderline) parent then leads the child into a similar interpretation of the child's own sadness and grief at the loss of the intact family structure, so that the child also comes to a similarly distorted interpretation of the child's own sadness at the loss as instead representing "anger and resentment, loaded with revengeful wishes" directed toward the targeted-rejected parent.

The primary embedding of the child's symptoms in broader family relationship processes requires that diagnosing and treating mental health professionals possess a professional level of understanding for family systems theory that includes, at a minimum, a professional level understanding for Structural family systems theory (Minuchin), with an additional professional level of knowledge for the other primary family systems theorists (e.g., Haley, Madones, Bowen, Satir, Böszörményi-Nagy) being strongly recommended.

In a legal context, an attachment-based model of "parental alienation" allows for the examination of mental health professionals regarding professional competence in these required domains of professional knowledge that are directly relevant to the professional assessment and treatment of distortions to the functioning of the child's attachment system as a consequence of pathogenic parenting by a narcissistic/(borderline) parent. A professional failure to possess the requisite professional knowledge, training, and expertise to appropriately diagnose and treat the unique psychological and interpersonal dynamics associated with this "special population" of children and families may represent practice beyond the boundaries of professional competence in violation of professional practice standards.

Treatment Implications

Gardner's model of PAS is outside the boundaries of established psychological principles and constructs, so that its diagnosis does not directly link to any prescribed treatment approach. An attachment-based model of "parental alienation," on the other hand, is entirely based within standard and established psychological principles and constructs, so that the presence of these established psychological factors can be

¹³ Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson.

extrapolated into an appropriate model for the treatment and resolution of the induced cut-off in the child's relationship with a parent (see for example, Childress, 2014).¹⁴

Because Gardner's model of PAS is outside of standard and established psychological constructs, it does not provide guidance to therapists or to the Court regarding the treatment needs of children who evidence PAS. Even if the construct of PAS is determined to be the cause of the cut-off in the child's relationship with the targeted-rejected parent, there can remain disagreement among mental health professionals regarding the treatment approach. For example, some mental health professionals may be reluctant to separate the child from the seemingly bonded relationship the child has with the allied and apparently "favored" parent, so that they may advocate for continued primary child placement with the alienating parent while a recommendation is made that the child and targeted parent engage in "reunification therapy."

An attachment-based model of "parental alienation," however, recognizes that leaving the child with a narcissistic/(borderline parent) whose distorted parenting practices rise to the level of a DSM-5 diagnosis of Psychological Child Abuse, Confirmed, would be exactly the wrong treatment approach. Once attachment-based "parental alienation" is identified through the presence of the three specific diagnostic indicators, then the issue switches from child custody to child protection considerations.

Since an attachment-based framework for understanding the dynamics of "parental alienation" is based entirely within standard and established psychological principles and constructs, it allows for treatment interventions to be identified based on these existing psychological principles and constructs. Not only does an attachment-based reconceptualization of "parental alienation" provide more definitive diagnostic criteria for determining the presence of pathogenic parenting by the allied and seemingly "favored" parent that is responsible for producing the cut-off in the child's attachment motivations toward the other parent, an attachment-based model of "parental alienation" also allows for a clearly delineated treatment framework to be articulated regarding the treatment conditions necessary for resolving the cut-off in the parent-child relationship that is being induced by the pathogenic parenting of the narcissistic/(borderline) parent.

1) Protective Separation

The treatment framework necessary for the resolution of attachment-based "parental alienation" requires an initial period of protective separation of the child from the ongoing pathogenic influence of the narcissistic/(borderline) parent during the active phase of the child's treatment and recovery in order to protect the child from becoming a psychological battleground between the normal-range and balanced meaning constructions being provided in therapy and the aberrant and distorted meaning constructions being continually provided by the narcissistic/(borderline) parent who seeks to maintain the child's symptomatic state relative to the other parent. Initiating treatment while the child

¹⁴ Childress, C.A. (2014). Reunification Therapy: Treating "Parental Alienation" Retrieved 5/1/14 from <http://www.drcachildress.org/asp/Site/ParentalAlienation/index.asp>

remains under the continuing pathogenic influence of the narcissistic/(borderline) parent risks harming the child's emotional and psychological development as a direct consequence of the active resistance to treatment by the narcissistic/(borderline) parent while therapy is seeking change in the child's symptomatic state.

The child's symptomatic rejection of the targeted parent is being used (exploited) by the narcissistic/(borderline) parent to regulate this parent's own emotional and psychological state surrounding the narcissistic injury of the divorce and the abandonment fears associated with this parent's borderline personality organization. For the narcissistic/(borderline) parent, the child represents a narcissistic object whose possession serves as a narcissistic symbol of superiority over the other parent. According to Kernberg (1975),¹⁵

The need to *control* the idealized objects, to use them in attempts to manipulate and exploit the environment and to "destroy potential enemies," is linked with inordinate pride in the "possession" of these perfect objects totally dedicated to the patient. (p. 33)

It is therefore a driving imperative to the emotional and psychological functioning of the narcissistic/(borderline) parent that the child maintains the symptomatic rejection of the other parent. Treatment efforts designed to restore the child's relationship with the targeted-rejected parent will be met with increased pressures on the child from the narcissistic/(borderline) parent to maintain the child's rejection of the other parent. This will essentially turn the child into a psychological battleground between the goals of treatment to resolve the child's symptoms and restore a healthy parent-child relationship with the cut-off parent, and the goals of the narcissistic/(borderline) parent for the child to remain symptomatic and to continue to reject a relationship with the other parent.

Turning the child into a psychological battleground will impose significant psychological stresses on the child and entails a significant risk of harming the child's emotional and psychological development. The alternative treatment option, however, is to discontinue therapy so as avoid harming the child, thereby surrendering the child to the pathogenic parenting of the narcissistic/(borderline) parent that is producing significant developmental psychopathology in the child and that will ultimately result in a complete cut-off of the child's healthy relationship with the other parent, who represents a normal-range and affectionate parent who can serve an important developmental role for the child as a protective counter-balancing influence to the distorted parenting practices of the narcissistic/(borderline) parent. This represents an unresolvable dilemma imposed on the therapy by the distorted pathogenic parenting of the narcissistic/(borderline) parent; initiate therapy and turn the child into a psychological battleground to the detriment of the child's emotional and psychological development, or relinquish the treatment goal of restoring the child's healthy relationship with the other parent and in doing so surrender the child to pathological development imposed by the pathogenic parenting of the narcissistic/(borderline) parent.

¹⁵ Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson

Guidance in addressing this treatment dilemma is found in Standard 3.04 of the “Ethical Principles of Psychologists and Code of Conduct”¹⁶ of the American Psychological Association (2002), which requires that “psychologists take reasonable steps to avoid harming their clients/patients... and to minimize harm where it is foreseeable and unavoidable.” In order to minimize the foreseeable harm to the child of initiating therapy while the child remains under the ongoing pathogenic parental influence of the narcissistic/(borderline) parent requires the child’s protective separation from the pathogenic parental influence of the narcissistic/(borderline) parent during the active phase of the child’s treatment and recovery because of the associated risk of harm to the child of turning the child into a psychological battleground as a direct consequence of the continuing pathogenic influence of the narcissistic/(borderline) parent. Requiring that the Court first establish the treatment conditions necessary to adequately protect the child during the active phase of the child’s treatment and recovery meets the professional obligations of Standard 3.04 to “minimize harm where is foreseeable and unavoidable.”

Therapy provided to this special population of children and families without first acquiring the child’s protective separation during the active phase of the child’s treatment may represent a violation of Standard 3.04 of the ethics code of the American Psychological Association, and so may expose the treating clinician to administrative or legal action. On the other hand, ineffective therapy that does not risk turning the child into a psychological battleground becomes complicit in the pathological goal of the narcissistic/(borderline) parent to maintain the child’s symptomatic cut-off of a relationship with the other parent. Standard 10.10a¹⁷ of the ethics code of the American Psychological Association requires that psychologists terminate therapy if therapy is likely to harm the client or be ineffective. In either case, effective therapy that harms the child by making the child a psychological battleground due to the response of the pathogenic parent, or ineffective therapy that is complicit with the pathogenic parenting of the narcissistic/(borderline) parent to maintain the child’s pathology, is likely to violate professional practice standards. Responsible professional therapy for attachment-based “parental alienation” requires that the child first be protectively separated from the ongoing pathogenic influence of the narcissistic/(borderline) parent during the active phase of the child’s treatment and recovery.

The responsible exercise of professional obligations to protect the emotional and psychological well being of the child during treatment places the following decision before the Court,

1. To initiate a short-term, treatment-guided protective separation of the child from the pathogenic parenting practices of the narcissistic/(borderline) parent during the

¹⁶ American Psychological Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.

¹⁷ Standard 10.10a: “psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, **is not likely to benefit, or is being harmed** by continued service” (emphasis added)

active phase of the child's treatment and recovery in order to allow therapy to restore the child's relationship with both parents and return the child to a normal-range emotional and psychological developmental trajectory, or

2. To allow the child to remain under the influence of the pathogenic parenting practices of the narcissistic/(borderline) personality disordered parent who is inducing significant developmental psychopathology in the child that will result in the complete-cut off of the child's relationship with the other parent as a direct consequence of the pathogenic parenting practices of the narcissistic/(borderline) parent.

That the pathogenic parenting of the allied and supposedly "favored" parent represents the causative agent in creating the cut-off of the child's relationship with the other parent is established by the presence in the child's symptom display of the three characteristic and defining diagnostic indicators of attachment-based "parental alienation." There is no other possible causative agent for the presence of this specific set of diagnostic features in the child's symptom display other than the pathogenic influence of an allied and seemingly "favored" narcissistic/(borderline) parent whose pathogenic influence is creating the cut-off in the child's attachment bonding motivations toward the other parent.

From a psychological perspective, a cut-off in a parent-child relationship is of such extraordinary clinical concern for both the short-term and long-term emotional and psychological development of the child that a temporary protective separation of the child from the pathogenic influence of one parent in order to restore the normal-range development of the child relative to both parents represents the responsible treatment choice. Once the child's symptoms have been resolved through therapy and the normal developmental trajectory of the child has been restored, then the pathogenic parenting of the narcissistic/(borderline) parent can be reintroduced in order to allow the child to have normal-range relationships with both parents.

An objection to the short-term protective separation of the child from the pathogenic parenting practices of the narcissistic/(borderline) parent during the active phase of the child's treatment and recovery as representing an emotional hardship on the child because of the child's separation from the seemingly "favored" parent is insubstantial. First, the "favored" status of the narcissistic/(borderline) parent originates in the pathogenic parenting practices of this parent involving a role-reversal relationship in which the child becomes a narcissistic object for the parent. The child's role in the symbiotic relationship with the narcissistic/(borderline) parent is to reflect this parent's narcissistic self-perception as the ideal "all-wonderful" parent, which then contrasts to the child's definition of the other parent as the "all-bad" and fundamentally inadequate parent. The supposedly "favored" status of narcissistic/(borderline) parent is not a product of a healthy parent-child relationship as it may superficially appear, but instead represents a symptom manifestation of the role-reversal relationship the narcissistic/(borderline) parent has created with the child in which the child is used to feed the emotional and psychological needs of a narcissistic/(borderline) parent. From a psychological perspective, the "favored"

parental status of the narcissistic/(borderline) parent is a symptom of the psychopathology, not evidence of a healthy or desirable parent-child relationship.

Second, the protective separation is under the full control of the child to resolve. The goal of therapy is to restore a balanced and normal-range relationship between the child and the currently cut-off parent. Once the child ceases to evidence symptomatic psychopathology and displays normal-range child behavior toward the targeted parent, the treatment goals have been achieved and the child's relationship with the narcissistic/(borderline) parent can be reestablished under the treatment-related monitoring of the therapist in order to ensure that the child's symptoms do not reemerge once the pathogenic parenting of the narcissistic/(borderline) parent is reintroduced. If the child objects to the protective separation necessary for responsible therapy and wishes to restore the relationship with the narcissistic/(borderline) parent, then the child simply needs to evidence normal-range behavior toward the other parent.

Requiring that a child display normal-range behavior toward a parent is a reasonable expectation. An assertion that a child's pathological behavior in response to broadly normal-range parenting practices represents a reasonable response to the parenting practices of the targeted parent is not valid. As noted earlier, normal-range parenting spans a large spectrum of parenting behavior from flexible-permissive parenting to structured and authoritarian parenting. As long as the parenting practices are under the therapeutic monitoring of a capable and competent therapist, any effort to justify the child's pathological cut-off of a relationship with a parent ostensibly because of the child's judgments regarding the adequacy of the parent's parenting practices is not warranted. Significant latitude is given to parental rights and parental prerogatives in determining family values and parenting approach. Within this context, children must adjust to the parenting practices of their parents, and therapy can help resolve any parent-child conflicts that emerge. An expectation that the child display normal-range behavior toward a parent is reasonable.

As an example, a child may favor a lax and permissive parenting style of one parent over the more firm and disciplinarian style of the other parent. However, this does not necessarily equate to better parenting by the lax and permissive parent. The firm and disciplinarian style parenting behavior may result in better child grades and greater self-responsibility that will lead to improved success in life. The firmer and more disciplinarian parent may also provide more appropriate parental supervision that prevents the child from engaging in misbehavior. On the other hand, the lax and permissive parent whose style the child favors may not provide adequate parental supervision, so that the child is inappropriately exposed to violent or sexualized video game or movie content and may become more likely to engage in drug and alcohol experimentation and precocious sexual behavior as a consequence of lax parental involvement and supervision. Child preferences regarding parental behavior are not necessarily the best guide in determining the best interests of the child, and the legal system should be reluctant to micro-evaluate parenting practices.

Broad discretionary latitude should generally be provided to parental rights and parental prerogatives, and if concerns exist then these issues can be addressed through therapeutic oversight of the parent-child relationship. An expectation of normal-range child behavior toward a parent is not unreasonable. If the child wishes to end the period of protective separation then this is entirely within the child's control by simply displaying normal-range behavior toward the parent as assessed by the treating therapist. Once the child's symptoms resolve then the treatment goals have been achieved and the need for the protective separation ends.

Finally, a protective separation of the child represents a valuable treatment intervention in its own right. The child who is caught in a family evidencing attachment-based "parental alienation" is being placed into the "spousal" conflict by the pathogenic parenting practices of the alienating parent who is creating a polarized family situation of loyalty conflicts. A characteristic feature of narcissistic and borderline personalities is a prominent tendency toward black-and-white polarized thinking, called "splitting." The American Psychiatric Association defines splitting as,

The individual deals with emotional conflict or internal or external stressors by compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of self or others into cohesive images. Because ambivalent affects cannot be experienced simultaneously, more balanced views and expectations of self or others are excluded from emotional awareness. Self and object images tend to alternate between polar opposites; exclusively loving, powerful, worthy, nurturant, and kind – or exclusively bad, hateful, angry, destructive, rejecting, or worthless. (American Psychiatric Association, 2000, p. 813)¹⁸

Consistent with the splitting dynamic associated with narcissistic and borderline personality dynamics, in attachment-based "parental alienation" the personality disordered narcissistic/(borderline) parent requires and creates a child's expressed perception of the narcissistic/(borderline) parent as the exclusively all-good, all-nurturing wonderful parent, and to simultaneously respond to the other parent as representing the exclusively bad, hateful, and worthless parent.

The splitting dynamic and pathogenic influence of the narcissistic/(borderline) parent places the child into a loyalty conflict relative to the child's authentic affectional bonding motivations toward the other parent by forcing the child into extreme perceptions of each parent. If the child demonstrates affectional bonding toward the targeted-rejected parent that suggests that this parent is not the entirely devalued-rejected parent required by the splitting dynamic of the narcissistic/(borderline) parent, then the child betrays the relationship with the narcissistic/(borderline) parent and violates the emotional and psychological needs the child serves for this parent. A child's demonstration of disloyalty to the narcissistic/(borderline) parent and the violation of the role-reversal emotional and psychological function served by the child for this pathological parent exposes the child to

¹⁸ American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (Revised 4th ed.). Washington, DC: Author.

retaliatory rejection and hostility from the narcissistic/(borderline) parent. The requirement imposed on the child by the narcissistic/(borderline) parent is that the child must remain dependent on the narcissistic/(borderline) parent and reject a relationship with the other parent in order to maintain the child's loyalty to the alliance with the narcissistic/(borderline) parent and in which the child meets the pathological emotional and psychological needs of the parent.¹⁹

The child's rejection of the other parent is then exploited by the narcissistic/(borderline) parent to effectively nullify both the parental rights of the other parent and Court orders for custody and visitation. The Court is typically reluctant to impose sanctions on the seemingly "favored" parent for the child's behavior toward the other parent in the absence of clear evidence that the child's rejection of the other parent is being caused by the parenting practices of the "favored" parent, and Courts are also typically reluctant to impose sanctions on a child for conflicts with a parent that may represent legitimate child reactions to the current or prior problematic parenting of this parent. So the exploitation of the child's induced symptomatic rejection of the other parent effectively confers absolute power to the narcissistic/(borderline) parent to nullify with complete impunity the parental rights of the other parent and Court orders for visitation and custody, so that the narcissistic/(borderline) parent achieves full possession of the narcissistic object represented by the child irrespective of Court orders for joint custody of the child. Through the narcissistic exploitation of the child's induced and elicited symptomatology toward the other parent, Court orders are made irrelevant.

This exploitation of the child's induced rejection of the other parent to entirely nullify the parental rights of the other parent and completely negate Court orders for joint custody represents a clear reflection of the narcissistic process described earlier by Kernberg (1975),²⁰

"The need to *control* the idealized objects, to use them in attempts to manipulate and exploit the environment and to "destroy potential enemies," is linked with inordinate pride in the "possession" of these perfect objects totally dedicated to the patient. (p. 33)

¹⁹ According to Cassidy and Berlin, "It seems likely that the child himself would feel most comfortable when the parent is most comfortable... Children are skillful in recognizing what leads to parental comfort and then attempt to cooperate with their parents in maintaining the desired state. In the case of insecure/ambivalent children, the child recognizes at some level that the parent desires a relationship in which attachment is emphasized. The child may realize that this pattern of preoccupation with the parent, heightened dependency, and reduced exploration are at some level reassuring to the parent: his immaturity reassures the parent that she will be needed; his dependency reassures the parent that the child will remain close, that is, 'reassures the parent that he will not become an adult and leave' (Bacciagaluppi, 1985, p. 371)." (Cassidy & Berlin, 1994, p. 985)

Cassidy, J., & Berlin, L. J. (1994). The insecure/ambivalent pattern of attachment: Theory and research. *Child Development*, 65, 971–991.

²⁰ Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson

The protective separation of the child from the pathogenic parenting practices of the narcissistic/(borderline) parent during the active phase of the child's treatment and recovery serves to therapeutically reverse these destructive dynamics. The protective separation of the child from the pathogenic parenting and exploitation by the narcissistic/(borderline) parent frees the child from the loyalty conflict imposed by the narcissistic/(borderline) parent by redefining the meaning of the child's affectionate bonding with the beloved targeted parent. Instead of the child's rejection of the targeted parent acting as an indicator of the child's loyalty to the narcissistic/(borderline) parent, the protective separation of the child allows the child to act in an affectionately bonded way with the targeted parent in order to show loyalty to the narcissistic/(borderline) parent, since such a return to normal-range affectional bonding with the targeted parent will terminate the child's protective separation from the narcissistic/(borderline) parent. The protective separation of the child reverses the loyalty meaning of the child's rejection behaviors and affectional displays toward the targeted parent, thereby freeing the child from the loyalty conflict imposed on the child by the psychopathology of the narcissistic/(borderline) parent.

Furthermore, the protective separation of the child from the pathogenic parenting practices of the narcissistic/(borderline) parent during the active phase of the child's treatment and recovery nullifies the power conferred to the narcissistic/(borderline) parent by the child's induced cut-off of a relationship with the other parent. Whereas prior to the child's protective separation the child's symptomatic rejection of the targeted parent confers absolute power to the narcissistic/(borderline) parent to nullify the parental rights of the other parent and Court orders for visitation and custody, so that the narcissistic/(borderline) parent achieves full "possession" of the narcissistic object represented by the child, following the protective separation of the child from the narcissistic/(borderline) parent the child's symptomatic rejection of the targeted parent confers no power to the narcissistic/(borderline) parent, and instead results in the transfer of the coveted "narcissistic object" (i.e., the child) to the targeted parent. The nullification of the power conferred to the narcissistic/(borderline) parent by the child's symptomatic rejection of the other parent will effectively remove, and indeed reverse, the motive force for the narcissistic/(borderline) parent's continuing pathogenic influence of the child.

When the narcissistic game is no longer producing the desired results, and is instead producing non-desired results of rewarding the other parent with "possession" of the coveted narcissistic object represented by the child, then the narcissistic parent will discontinue this very destructive and malevolent narcissistic game. It is no longer serving its exploitative function for the narcissistic/(borderline) parent.

Therefore, the protective separation of the child from the pathogenic parenting practices of the narcissistic/(borderline) parent during the active phase of the child's treatment and recovery provides three important functions,

1. To protect the child from being turned into a psychological battleground by the ongoing pathogenic influence of the narcissistic/(borderline) parent that requires

the child to remain symptomatic even as therapy strives to eliminate the child's symptoms,

2. The protective separation of the child also serves a powerful treatment function that removes the child from the loyalty conflict imposed by the pathogenic parenting of the narcissistic/(borderline) parent,
3. The child's protective separation from the narcissistic/(borderline) parent reverses the power dynamic associated with the child's symptoms, thereby eliminating the central incentive for the narcissistic/(borderline) parent to maintain the child's symptomatic rejection of the other parent.

Conclusion

An attachment-based model of "parental alienation" offers three significant advantages over a Gardnerian model of PAS relative to the legal context.

1. **Clearly Delineated Diagnostic Criteria:** An attachment-based model of "parental alienation" provides clear diagnostic criteria from within established psychological principles and constructs that provide an unambiguous determination that the cut-off in the child's behavior toward one parent is the direct result of pathogenic parenting practices by the other parent. Mental health can then provide clear and unambiguous guidance to the Court regarding the family processes and treatment needs of the child.
2. **Established Standards of Professional Practice:** An attachment-based model of "parental alienation" provides articulated domains for establishing professional competence in the diagnosis and treatment of this special population of children and families that can be used in the examination of professional witnesses.
3. **Direct Treatment Implications:** Since an attachment-based model of "parental alienation" is grounded in established psychological principles and constructs, it can provide direct guidance to the Court regarding the treatment needs of the child and the therapy necessary to resolve the psychopathology evident in the family and the child's symptoms.

In situations where the Court may seek preliminary guidance from mental health regarding whether a protective separation of the child is indicated, the Court can request that a treatment needs assessment be conducted by a mental health professional competent in the relevant domains of professional practice in order to determine whether the child's symptoms display the characteristic three diagnostic indicators of attachment-based "parental alienation." A treatment needs assessment can likely be conducted in far less time and at far less expense than a more extensive child custody evaluation, since the focus of the treatment needs assessment is more limited in scope and goal and is targeted solely on identifying the diagnostic features present in the child's symptom display.

When the child's symptoms are sub-threshold for a definitive diagnosis of attachment-based "parental alienation," then a 6-12 month Response-to-Intervention (RTI) trial can be initiated with a competent mental health therapist to add greater diagnostic clarity to the child and family dynamics. If the parent-child conflict is the authentic product of problematic parenting practices with this parent, then 6-12 months of appropriate therapy with a cooperative parent should resolve the issues. If an RTI trial of 6-12 months of appropriate therapy with a cooperative parent has not resolved the cut-off in the child's relationship with a parent, then the sub-threshold symptoms initially displayed by the child more likely represent a variant of attachment-based "parental alienation" requiring the child's protective separation from the pathogenic parenting of the allied and seemingly "favored" parent during the active phase of the child's treatment and recovery. However, this determination can be more fully established by the treating psychotherapist following a 6-12 month period of unsuccessful therapy.

Appendix 1

Recommended Reading for Professional Competence in Attachment Theory Relative to the Diagnosis and Treatment of Attachment-Based “Parental Alienation

Recommended Reading for Professional Competence in Attachment Theory Relative to the
Diagnosis and Treatment of Attachment-Based “Parental Alienation

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

Core Reading

- Bowlby, J. (1969). *Attachment and loss. Volume 1 Attachment*. NY: Basic Books.
- Bowlby, J. (1973). *Attachment and loss: Volume 2. Separation: Anxiety and anger*. NY: Basic Books.
- Bowlby, J. (1980). *Attachment and loss: Volume 3. Loss: Sadness and depression*. NY: Basic Books.
- Bowlby, J. (1988). *A secure base: clinical implications of attachment theory*. London: Routledge.
- Ainsworth, M.D.S. (1989). Attachments beyond infancy. *American Psychologist*, 44, 709-716.
- Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 1992, 28, 759-775.

Recommended Reading

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum.
- Lyons-Ruth, K., Bronfman, E. & Parsons, E. (1999). Maternal frightened, frightening, or atypical behavior and disorganized infant attachment patterns. In J. Vondra & D. Barnett (Eds.) *Atypical patterns of infant attachment: Theory, research, and current directions*. *Monographs of the Society for Research in Child Development*, 64, (3, Serial No. 258).
- Fonagy P. & Target M. (2005). Bridging the transmission gap: An end to an important mystery in attachment research? *Attachment and Human Development*, 7, 333-343.
- Fonagy, P., Target, M., Gergely, G., Allen, J.G., and Bateman, A. W. (2003). The developmental roots of Borderline Personality Disorder in early attachment relationships: A theory and some evidence. *Psychoanalytic Inquiry*, 23, 412-459.
- Cassidy, J., & Berlin, L. J. (1994). The insecure/ambivalent pattern of attachment: Theory and research. *Child Development*, 65, 971–991.
- Bretherton, I., & Munholland, K. (2008). Internal working models in attachment relationships: Elaborating a central construct in attachment theory. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment* (pp. 102-130). New York: Guilford Press.
- Bretherton, I. (1990). Communication patterns, internal working models, and the intergenerational transmission of attachment relationships. *Infant Mental Health Journal*, 11, 237-252.

- Brennan, K.A. and Shaver, P.R. (1998). Attachment Styles and Personality Disorders: Their Connections to Each Other and to Parental Divorce, Parental Death, and Perceptions of Parental Caregiving. *Journal of Personality* 66, 835-878.
- Benoit, D. and Parker, K.C.H. (1994). Stability and transmission of attachment across three generations. *Child Development*, 65, 1444-1456
- Jacobvitz, D.B., Morgan, E., Kretchmar, M.D., and Morgan, Y. (1991). The transmission of mother-child boundary disturbances across three generations. *Development and Psychopathology*, 3, 513-527.
- Macfie, J. Fitzpatrick, K.L., Rivas, E.M. & Cox, M.J. (2008). Independent influences upon mother toddler role reversal: Infant-mother attachment disorganization and role reversal in mother's childhood. *Attachment and Human Development*, 10, 29-39
- Lyddon, W.J. and Sherry, A. (2001). Developmental personality styles: An attachment theory conceptualization of personality disorders. *Journal of Counseling and Development*, 79, 405-417
- 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.
- Agrawal, H.R., Gunderson, J., Holmes, B.M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review. *Harvard Review of Psychiatry*, 12, 94-104.