

Recommended Treatment-Related Assessment Protocol for Parent-Child Attachment Pathology Surrounding Divorce

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The Attachment System

A child's rejection of a normal-range and affectionally available parent surrounding divorce has received the name of "parental alienation" in the general culture. However, the construct of "parental alienation" is not a defined construct in clinical psychology.

In clinical psychology, a child's rejection of a parent represents an **attachment-related pathology**. The attachment system is the brain system responsible for governing all aspects of love and bonding throughout the lifespan, including grief and loss. One of the preeminent researchers of the attachment system, Mary Ainsworth, offers the following description:

"I define an 'affectional bond' as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional bond, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief.

"An 'attachment' is an affectional bond, and hence an attachment figure is never wholly interchangeable with or replaceable by another, even though there may be others to whom one is also attached. In attachments, as in other affectional bonds, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss." (Ainsworth, 1989, p. 711)¹

The attachment system is a neurologically based primary motivational system that evolved in response to the selective predation of children. Children who formed strong attachment bonds to parents received parental protection from predators (and other environmental dangers) and their genes for forming strong attachment bonds increased in the collective gene pool. On the other hand, children who formed weaker attachment bonds to parents were more fully exposed to predation and other environmental dangers, and their genes for forming weaker attachment bonds were selectively removed from the collective gene pool. Over millions of years of evolution, a very strong and resilient *primary motivational system* developed that strongly motivates children to form affectional attachment bonds to parents.

"The biological function of this behavior [attachment] is postulated to be protection, especially protection from predators." (Bowlby, 1980, p. 3)²

¹ Ainsworth, M.D.S. (1989). Attachments beyond infancy. *American Psychologist*, 44, 709-716.

² Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. NY: Basic.

Child Rejection of a Parent

The attachment system is referred to as a “goal-corrected” primary motivational system because of the critical survival advantage it provides to children. The attachment bonding motivations of children always seek the **goal** of forming an attachment bond to the parent. In response to problematic parenting, the attachment behaviors of the child become distorted in characteristic ways (called “insecure attachments”), but the motivational goal of the child’s attachment system is always to form an affectionally attached bond to the parent. All children love their parents, and all children want the love of their parents in return.

The attachment system never spontaneously dysfunctions. Forming an attachment bond to parents is too critical to the child’s survival. The attachment system only becomes distorted in response to **pathogenic parenting** (patho=pathology; genic=creation). Pathogenic parenting is the creation of significant pathology in the child through aberrant and distorted parenting practices. The attachment-related pathology of a child rejecting a parent is caused by pathogenic parenting, either emanating from the rejected parent (such as occurs with incest and in cases of chronic parental violence), or from the other parent, the allied and supposedly “favored” parent who has manipulated the child into forming a **cross-generational coalition** with the allied parent against the targeted-rejected parent. The preeminent family systems therapist, Jay Haley, defines the construct of the cross-generational coalition:

“The people responding to each other in the triangle are not peers, but one of them is of a different generation from the other two... In the process of their interaction together, the person of one generation forms a coalition with the person of the other generation against his peer. By ‘coalition’ is meant a process of joint action which is *against* the third person... The coalition between the two persons is denied. That is, there is certain behavior which indicates a coalition which, when it is queried, will be denied as a coalition... In essence, the perverse triangle is one in which the separation of generations is breached in a covert way. When this occurs as a repetitive pattern, the system will be pathological. (Haley, 1977, p. 37)³

The attachment-related pathology of a child rejecting a parent (i.e., the suppression of the normal-range functioning of the child’s attachment bonding motivations toward a parent) must either be the result of severely **pathogenic parenting** by the targeted-rejected parent (such as the sexual abuse or chronic physical abuse of the child) or by the distorted parenting practices of the allied and supposedly “favored” parent who has formed a **cross-generational coalition** with the child against the other parent. The goal of a treatment-related assessment is therefore to identify the source of the pathogenic parenting; either from the targeted-rejected parent (through incest or chronic parental violence), or from the allied and supposedly “favored” parent (through the formation of a cross-generational coalition with the child against the other parent).

³ Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. Weakland (Eds.), *The interactional view* (pp. 31-48). New York: Norton.

Disordered Mourning

The family pathology traditionally called “parental alienation” in the general culture, in which the child’s normal-range attachment bonding motivations toward a normal-range and affectionally available parent are artificially suppressed as a result of a **cross-generational coalition** of the child with the allied and supposedly “favored” parent against the targeted parent, represents a form of attachment-related pathology called “pathological mourning” (Bowlby, 1980).

“The **deactivation of attachment behavior** is a key feature of certain common variants of *pathological mourning*” (Bowlby, 1980, p. 70; emphasis added)

The reason for the disordered mourning within the family centers around the narcissistic/(borderline) personality pathology of the allied parent who has formed a cross-generational coalition with the child against the other parent (Haley; Minuchin⁴). The personality pathology of the allied parent is characterologically incapable of processing sadness, grief, and loss, and instead turns sadness and mourning into “anger and resentment, loaded with revengeful wishes” (Kernberg, 1975):

“They [the narcissistic/borderline personality] are especially deficient in genuine feelings of sadness and mournful longing; their incapacity for experiencing depressive reactions is a basic feature of their personalities. When abandoned or disappointed by other people they may show what on the surface looks like depression, but which on further examination emerges as **anger and resentment, loaded with revengeful wishes**, rather than real sadness for the loss of a person whom they appreciated.” (Kernberg, 1975, p. 229; emphasis added)⁵

The preminent attachment theorist, John Bowlby, also links personality disorder pathology to “disordered mourning”:

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

The pathology traditionally called “parental alienation” in the popular culture, in which a child rejects a normal-range and affectionally available parent, is actually a form of attachment-related pathology called “**pathological mourning**” in which the allied parent in a cross-generational coalition with the child against the other parent has narcissistic and/or borderline personality traits that interfere with this parent’s ability to adequately process the sadness, grief, and loss surrounding the divorce. The allied narcissistic/borderline personality parent is then transferring this parent’s own disordered mourning to the child through manipulative and distorted parenting practices (pathogenic parenting) of psychological control and influence that create a “**cross-generational coalition**” with the child against the other parent (Minuchin; Haley).

⁴ Minuchin, S. (1974). Families and family therapy. Harvard University Press.

⁵ Kernberg, O.F. (1975). Borderline conditions and pathological narcissism.. New York: Aronson.

Psychological Control of the Child

The manipulative influence of the allied parent who has formed a cross-generational coalition with the child against the other parent is created through a process of “psychological control.” In his book, *Intrusive Parenting: How Psychological Control Affects Children and Adolescents*,⁶ published by the American Psychological Association, Brian Barber and his colleague, Elizabeth Harmon, define the psychological control of children by a parent:

“Psychological control refers to parental behaviors that are intrusive and manipulative of children’s thoughts, feelings, and attachment to parents.” (Barber & Harmon, 2002, p. 15).⁷

Parental psychological control of the child represents a fundamental violation of the psychological integrity of the child.

“The essential impact of psychological control of the child is to violate the self-system of the child.” (Barber & Harmon, 2002, p. 24).

In the *Journal of Emotional Abuse*, Kerig (2005)⁸ describes the child’s surrender to the psychological control of the manipulative parent:

“Rather than telling the child directly what to do or think, as does the behaviorally controlling parent, the psychologically controlling parent uses indirect hints and responds with guilt induction or withdrawal of love if the child refuses to comply. In short, an intrusive parent strives to manipulate the child’s thoughts and feelings in such a way that the child’s psyche will conform to the parent’s wishes.” (p. 12)

“In order to carve out an island of safety and responsivity in an unpredictable, harsh, and depriving parent-child relationship, children of highly maladaptive parents may become precocious caretakers who are adept at reading the cues and meeting the needs of those around them. The ensuing preoccupied attachment with the parent interferes with the child’s development of important ego functions, such as self organization, affect regulation, and emotional object constancy.” (p. 14)

The psychological control of the child has been found to be associated with high levels of inter-parental conflict. In Chapter 3 of *Intrusive Parenting: How Psychological Control Affects Children and Adolescents*, Stone, Buehler, and Barber (2002)⁹ describe their

⁶ Barber, B. K. (Ed.) (2002). *Intrusive parenting: How psychological control affects children and adolescents*. Washington, DC: American Psychological Association.

⁷ Barber, B. K., & Harmon, E. L. (2002). Violating the self: Parenting psychological control of children and adolescents. In B. K. Barber (Ed.), *Intrusive parenting* (pp. 15-52). Washington, DC: American Psychological Association.

⁸ Kerig, P.K. (2005). Revisiting the construct of boundary dissolution: A multidimensional perspective. *Journal of Emotional Abuse*, 5, 5-42.

⁹ Stone, G., Buehler, C., & Barber, B. K.. (2002) Interparental conflict, parental psychological control, and youth problem behaviors. In B. K. Barber (Ed.), *Intrusive parenting: How psychological control affects children and adolescents*. Washington, DC.: American Psychological Association.

research on the association of parental psychological control of children and inter-parental conflict:

“Parental psychological control is defined as verbal and nonverbal behaviors that intrude on youth's emotional and psychological autonomy.” (p. 57)

“The central elements of psychological control are intrusion into the child's psychological world and self-definition and parental attempts to manipulate the child's thoughts and feelings through invoking guilt, shame, and anxiety. Psychological control is distinguished from behavioral control in that the parent attempts to control, through the use of criticism, dominance, and anxiety or guilt induction, the youth's thoughts and feelings rather than the youth's behavior.” (p. 57)

“One important aspect of covert interparental conflict is triangulating children (Minuchin, 1974). This involves active recruitment (even though this activity might be fairly subtle) or implicit approval of child-initiated involvement in the parents' disputes.” (p. 56)

In their empirical research on parental psychological control of children, Stone, Buehler, and Barber (2002) found that increased psychological control of children was associated with high inter-parental conflict, and they offer an explanation for this finding.

“The analyses reveal that variability in psychological control used by parents is not random but it is **linked to interparental conflict**, particularly covert conflict. Higher levels of covert conflict in the marital relationship heighten the likelihood that parents would use psychological control with their children.” (Stone, Buehler, and Barber, p. 86; emphasis added)

“The concept of triangles “describes the way any three people related to each other and involve others in emotional issues between them” (Bowen, 1989, p. 306). In the anxiety-filled environment of conflict, a third person is triangulated, either temporarily or permanently, to ease the anxious feelings of the conflicting partners. By default, that third person is exposed to an anxiety-provoking and disturbing atmosphere. For example, a child might become the scapegoat or focus of attention, thereby transferring the tension from the marital dyad to the parent-child dyad. Unresolved tension in the marital relationship might spill over to the parent-child relationship through parents' use of psychological control as a way of securing and maintaining a **strong emotional alliance** and level of support from the child. As a consequence, the triangulated youth might feel pressured or obliged to listen to or agree with one parents' complaints against the other. The resulting enmeshment and **cross-generational coalition** would exemplify parents' use of psychological control to coerce and maintain a parent-youth emotional alliance against the other parent (Haley, 1976; Minuchin, 1974).” (Stone, Buehler, and Barber, 2002, p. 86-87; emphasis added)

Treatment-Focused Assessment Protocol: Diagnostic Indicators

Every form of child pathology will evidence a specific and distinctive pattern of symptoms. The trans-generational transmission of *pathological mourning* (Bowlby) from the allied narcissistic (or borderline) personality parent (Beck, Kernberg, Millon)¹⁰ in a cross-generational coalition with the child against the other parent (Haley; Minuchin) is no exception.

The pathogenic parenting of an allied parent that creates the child's rejection of a normal-range and affectionally available parent following divorce will be reflected in a set of three definitive diagnostic indicators in the child's symptom display:

1.) Attachment System Suppression. The child will evidence a suppression of normal-range attachment bonding motivations toward a normal-range and affectionally available parent. This child symptom identifies the family pathology as an attachment-related form of pathology.

2.) Personality Disorder Symptoms: The child's symptom display will evidence a set of five a-priori predicted narcissistic personality traits directed toward the targeted parent. These narcissistic personality features in the child's symptom display represent the "psychological fingerprint" evidence of the psychological control of the child by a narcissistic/(borderline) parent. The *primary case* for these narcissistic personality traits is the allied parent who is transferring these deviant attitudes and beliefs to the child through this parent's psychological influence and psychological control of the child.

3.) Encapsulated Persecutory Delusion. The child symptoms will evidence a fixed-and-false belief that is maintained despite contrary evidence (i.e., a delusion) regarding the child's supposed "victimization" by the normal-range parenting of the targeted parent. This symptom evidenced by the child represents an encapsulated persecutory delusion. Again, the *primary case* for this encapsulated persecutory delusion is the allied narcissistic/(borderline) personality parent, and the origins of this fixed and false belief is in the "internal working models" (schemas) of this parent's childhood attachment trauma (Childress, 2015).¹¹

A treatment-focused clinical assessment of the pathogenic parenting associated with the trans-generational transmission of disordered mourning should assess for and document the presence or absence of these three diagnostic features in the child's symptom display. The **Diagnostic Checklist for Pathogenic Parenting** (Appendix 1) represents a structured method for documenting the presence or absence of these three diagnostic symptom indicators in the child's symptom display.

¹⁰ 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.

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

¹¹ Childress, C.A. (2015). *An attachment-based model of parental alienation: Foundations*. Claremont, CA. Oaksong Press.

Treatment-Focused Assessment Protocol: Parenting Practices Assessment

In addition to documenting the child's symptom features, the normal-range or problematic parenting of the targeted-rejected parent should also be assessed and documented. The **Parenting Practices Rating Scale** (Appendix 2) is designed to document the results of the clinical assessment regarding the parenting practices of the targeted-rejected parent. Normal-range parenting on the Parenting Practices Rating Scale would be parenting at Levels 3 and 4 along with a rating on the *Permissive to Authoritarian Dimension* within the range from 25 to 75. These ratings of parenting practices are based on the clinical judgement of the assessing mental health professional and are a means to document this professional clinical judgement.

Treatment-Focused Assessment Protocol: Session Structure

The clinical assessment process is conducted across a set of six to eight targeted clinical assessment sessions.

- **Initial Sessions:** The initial two treatment-focused clinical assessment sessions are to collect history and symptom information from each parent individually.
- **Direct Assessment:** The middle two sessions are a direct assessment of the child's symptoms, either in individual clinical interviews with the child or in parent-child dyadic sessions with the child and targeted parent (at least one dyadic session should be conducted). Clinical probes of the child's symptom features during these sessions can help illuminate the child's symptom display.
- **Parent Response:** The final two sessions are feedback sessions provided to each of the parents to assess the "schemas" of each parent in response to the clinical findings from the prior sessions.

Additional sessions can be added if needed, but typically six to eight sessions should be sufficient to document the presence or absence of the diagnostic indicators of pathogenic parenting associated with the attachment-related pathology of disordered mourning.

Treatment-Focused Assessment Protocol: Recommended Report Format

Treatment-focused assessments can produce a targeted report for the Court regarding the treatment requirements needed to resolve the family pathology. Two examples of the type of report available from a treatment-focused assessment protocol, one for a confirmed diagnosis of pathogenic parenting and one for a sub-threshold display of child symptoms, are contained in Appendix 3.

In reports to the Court, it is recommended that the Diagnostic Checklist for Pathogenic Parenting and the Parenting Practices Rating Scale be included with the report for review by the court in its decision making function.

Treatment-Focused Assessment Protocol: Summary Structure Format

The recommended treatment-focused clinical assessment entails the following protocol:

- 1.) **Focus of Assessment:** To assess for the attachment-related pathology of disordered mourning (Bowlby) involving an allied narcissistic/(borderline) parent (Beck; Kernberg; Millon) who is in a cross-generational coalition with the child against the other parent (Minuchin; Haley).
- 2.) **Diagnostic Checklist for Pathogenic Parenting:** To document the child's symptom features of clinical concern relative to the potential of pathogenic parenting.
- 3.) **Parenting Practices Rating Scale:** To document the normal-range parenting of the targeted parent or document areas of problematic parenting concern to be addressed in the treatment plan.
- 4.) **Assessment Session Structure:** A set of six to eight clinical assessment sessions are recommended to document the presence or absence of the diagnostic indicators of pathogenic parenting by an allied narcissistic/(borderline) parent.

Appendix 1: Diagnostic Checklist for Pathogenic Parenting

Diagnostic Checklist for Pathogenic Parenting: Extended Version

C.A. Childress, Psy.D. (2015)

All three of the diagnostic indicators must be present (either 2a OR 2b) for a clinical diagnosis of attachment-based “parental alienation.” Sub-threshold clinical presentations can be further evaluated using a “Response to Intervention” trial.

1. Attachment System Suppression

Present	Sub-Threshold	Absent	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The child’s symptoms evidence a selective and targeted suppression of the normal-range functioning of the child’s attachment bonding motivations toward one parent, the targeted-rejected parent, in which the child seeks to entirely terminate a relationship with this parent (i.e., a child-initiated cutoff in the child’s relationship with a normal-range and affectionally available parent).

Secondary Criterion: **Normal-Range Parenting:**

yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	The parenting practices of the targeted-rejected parent are assessed to be broadly normal-range, with due consideration given to the wide spectrum of acceptable parenting that is typically displayed in normal-range families.

Normal-range parenting includes the legitimate exercise of parental prerogatives in establishing desired family values through parental expectations for desired child behavior and normal-range discipline practices.

2(a). Personality Disorder Traits

Present	Sub-Threshold	Absent	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The child’s symptoms evidence all five of the following narcissistic/(borderline) personality disorder features displayed toward the targeted-rejected parent.

Sub-Criterion Met

yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	Grandiosity: The child displays a grandiose perception of occupying an inappropriately elevated status in the family hierarchy that is above the targeted-rejected parent from which the child feels empowered to sit in judgment of the targeted-rejected parent as both a parent and as a person.
<input type="checkbox"/>	<input type="checkbox"/>	Absence of Empathy: The child displays a complete absence of empathy for the emotional pain being inflicted on the targeted-rejected parent by the child’s hostility and rejection of this parent.
<input type="checkbox"/>	<input type="checkbox"/>	Entitlement: The child displays an over-empowered sense of 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 then the child feels entitled to enact a retaliatory punishment on the rejected parent for the child’s judgment of parental failures
<input type="checkbox"/>	<input type="checkbox"/>	Haughty and Arrogant Attitude: The child displays an attitude of haughty arrogance and contemptuous disdain for the targeted-rejected parent.
<input type="checkbox"/>	<input type="checkbox"/>	Splitting: The child evidences polarized extremes of attitude toward the parents, in which the supposedly “favored” parent is idealized as the all-good and nurturing parent while the rejected parent is entirely devalued as the all-bad and entirely inadequate parent.

2(b). Phobic Anxiety Toward a Parent

Present Sub-Threshold Absent

The child's symptoms evidence an extreme and excessive anxiety toward the targeted-rejected parent that meets the following DSM-5 diagnostic criteria for a specific phobia:

Criterion Met
yes no

Persistent Unwarranted Fear: The child displays a persistent and unwarranted fear of the targeted-rejected parent that is cued either by the presence of the targeted parent or in anticipation of being in the presence of the targeted parent

Severe Anxiety Response: The presence of the targeted-rejected parent almost invariably provokes an anxiety response which can reach the levels of a situationally provoked panic attack.

Avoidance of Parent: The child seeks to avoid exposure to the targeted parent due to the situationally provoked anxiety or else endures the presence of the targeted parent with great distress.

3. Fixed False Belief

Present Sub-Threshold Absent

The child's symptoms display an intransigently held, fixed and false belief regarding the fundamental parental inadequacy of the targeted-rejected parent in which the child characterizes a relationship with the targeted-rejected parent as being somehow emotionally or psychologically "abusive" of the child. While the child may not explicitly use the term "abusive," the implication of emotional or psychological abuse is contained within the child's belief system and is not warranted based on the assessed parenting practices of the targeted-rejected parent (which are assessed to be broadly normal-range).

DSM-5 Diagnosis

If the three diagnostic indicators of attachment-based "parental alienation" are present in the child's symptom display (either 2a or 2b), the appropriate DSM-5 diagnosis is:

DSM-5 Diagnosis

309.4 Adjustment Disorder with mixed disturbance of emotions and conduct

V61.20 Parent-Child Relational Problem

V61.29 Child Affected by Parental Relationship Distress

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

Checklist of Associated Clinical Signs (ACS)

evident	not evident	
<input type="checkbox"/>	<input type="checkbox"/>	ACS 1: Use of the Word "Forced"
<input type="checkbox"/>	<input type="checkbox"/>	ACS 2: Enhancing Child Empowerment to Reject the Other Parent
		evident
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		not evident
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ACS 3: The Exclusion Demand
<input type="checkbox"/>	<input type="checkbox"/>	ACS 4: Parental Replacement
<input type="checkbox"/>	<input type="checkbox"/>	ACS 5: The Unforgivable Event
<input type="checkbox"/>	<input type="checkbox"/>	ACS 6: Liar - Fake
<input type="checkbox"/>	<input type="checkbox"/>	ACS 7: Themes for Rejection
		evident
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		not evident
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ACS 8: Unwarranted Use of the Word "Abuse"
<input type="checkbox"/>	<input type="checkbox"/>	ACS 9: Excessive Texting, Phone Calls, and Emails
<input type="checkbox"/>	<input type="checkbox"/>	ACS 10: Role-Reversal Use of the Child ("It's not me, it's the child who...")
<input type="checkbox"/>	<input type="checkbox"/>	ACS 11: Targeted Parent "Deserves to be Rejected"
<input type="checkbox"/>	<input type="checkbox"/>	ACS 12: Allied Parent Disregards Court Orders and Court Authority
		evident
		<input type="checkbox"/>
		<input type="checkbox"/>
		not evident
		<input type="checkbox"/>
		<input type="checkbox"/>

Appendix 2: Parenting Practices Rating Scale

Parenting Practices Rating Scale

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

Name of Parent: _____ Date: _____

Name of Rater: _____

Indicate all that apply.

Child Abuse Ratings: Do not indicate child abuse is present unless allegations have been confirmed. In cases of abuse allegations that have neither been confirmed nor disconfirmed, or that are unfounded, use Allegation subheading rating not Category rating.

Level 1: Child Abuse

- 1. Sexual Abuse
As defined by legal statute.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 2. Physical Abuse
Hitting the child with a closed fist; striking the child with an open hand or a closed fist around the head or shoulders; striking the child with sufficient force to leave bruises; striking the child with any instrument (weapon) such as kitchen utensils, paddles, straps, belts, or cords.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 3. Emotional Abuse
Frequent verbal degradation of the child as a person in a hostile and demeaning tone; frequent humiliation of the child.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 4. Psychological Abuse
Pathogenic parenting that creates significant psychological or developmental pathology in the child in order to meet the emotional and psychological needs of the parent, including a role-reversal use of the child as a regulatory object for the parent's emotional and psychological needs.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 5. Neglect
Failure to provide for the child's basic needs for food, shelter, safety, and general care.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 6. Domestic Violence Exposure
Repeated traumatic exposure of the child to one parent's violent physical assaults toward the other parent or to the repeated emotional degradation (emotional abuse) of the other parent.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

Level 2: Severely Problematic Parenting

- 7. **Overly Strict Discipline**
Parental discipline practices that are excessively harsh and over-controlling, such as inflicting severe physical discomfort on the child through the use of stress postures, using shaming techniques, or confining the child in an enclosed area for excessively long periods (room time-outs are not overly strict discipline).
- 8. **Overly Hostile Parenting**
Frequent displays (more days than not) of excessive parental anger (a 6 or above on a 10-point subjective scale).
- 9. **Overly Disengaged Parenting**
Repeated failure to provide parental supervision and/or age-appropriate limits on the child's behavior and activities; parental major depression or substance abuse problems.
- 10. **Overly Involved-Intrusive Parenting**
Enmeshed, over-intrusive, and/or over-anxious parenting that violates the psychological self-integrity of the child; role-reversal use of the child as a regulatory object for the parent's anxiety or narcissistic needs.
- 11. **Family Context of High Inter-Spousal Conflict**
Repeated exposure of the child to high inter-spousal conflict that includes excessive displays of inter-spousal anger.

Level 3: Problematic Parenting

- 12. **Harsh Discipline**
Excessive use of strict discipline practices in the context of limited displays of parental affection; limited use of parental praise, encouragement, and expressions of appreciation.
- 13. **High-Anger Parenting**
Chronic parental irritability and anger and minimal expressions of parental affection.
- 14. **Uninvolved Parenting**
Disinterested lack of involvement with the child; emotionally disengaged parenting; parental depression.
- 15. **Anxious or Over-Involved Parenting**
Intrusive parenting that does not respect interpersonal boundaries.
- 16. **Family Context of Elevated Inter-Spousal Conflict**
Chronic child exposure to moderate-level inter-spousal conflict and anger or intermittent explosive episodes of highly angry inter-spousal conflict (intermittent spousal conflicts involving moderate anger that are successfully resolved are normal-range and are not elevated inter-spousal conflict).

Level 4: Positive Parenting

- 17. **Affectionate Involvement – Structured Spectrum**
Parenting includes frequent displays of parental affection and *clearly structured* rules and expectations for the child's behavior. Appropriate discipline (loss of privileges or desired objects, or appropriate use of time-out) follows from clearly defined and appropriate rules.
- 18. **Affectionate Involvement – Dialogue Spectrum**
Parenting includes frequent displays of parental affection and *flexibly negotiated* rules and expectations for the child's behavior. Parenting emphasizes dialogue, negotiation, and flexibility.
- 19. **Affectionate Involvement – Balanced**
Parenting includes frequent displays of parental affection and parenting blends clearly defined and structured rules with flexible negotiation at times. Parenting effectively balances structured discipline with flexible parent-child dialogue.

Appendix 3: Examples of Potential Treatment-Focused Assessment Reports Available from
a Treatment-Focused Clinical Assessment

A Treatment-Focused Assessment Report Example for a Confirmed Diagnosis of Pathogenic Parenting

Date: <Date of Assessment>

Psychologist: <Psychologist's Name>

Scope of Report

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

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

Rating Scales Completed (attached)

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

Results of Assessment

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

- 1) **Attachment System Suppression:** A targeted and selective suppression of the child's attachment bonding motivations relative to his mother in the absence of sufficiently distorted parenting practices from the mother that would account for the suppression of the child's attachment system;
- 2) **Personality Disorder Traits:** A set of five specific narcissistic/borderline personality disorder features are present in the child's symptom display;
- 3) **Encapsulated Delusional Belief System:** The child evidences an intransigently held fixed and false belief that is maintained despite contrary evidence (i.e., an encapsulated delusion) regarding the child's supposed "victimization" by the normal-range parenting of the mother (i.e., an encapsulated persecutory delusion).

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

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

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

DSM-5 Diagnosis

The combined presence in the child's symptom display of significant attachment-related developmental pathology (diagnostic indicator 1), narcissistic personality disorder pathology (diagnostic indicator 2), and delusional-psychiatric pathology (diagnostic indicator 3) represents definitive diagnostic evidence of pathogenic parenting by an allied parent with prominent narcissistic and/or borderline personality traits, since no other pathology will account for this specific symptom pattern other than pathogenic parenting by an allied narcissistic/borderline personality parent. This set of severe child symptoms warrants the following DSM-5 diagnosis for the child:

309.4 Adjustment Disorder with mixed disturbance of emotions and conduct

V61.20 Parent-Child Relational Problem

V61.29 Child Affected by Parental Relationship Distress

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

Treatment Indications

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

- 1.) Protective Separation Period: A period of protective separation of the child from the psychologically abusive parenting practices of the allied parent is required in order to protect the child from ongoing exposure to psychologically abusive

- parenting practices and allow for the treatment and recovery of the child's normal-range and healthy development. Attempting therapy without first establishing a period of protective separation from the pathogenic parenting practices of the father will continue the child's ongoing exposure to the psychologically abusive parenting of the father that is creating significant developmental pathology, personality disorder pathology, and delusional-psychiatric pathology in the child, and will lead to the child becoming a "psychological battleground" between the treatment goals of restoring the child's healthy and normal-range development and the continuing pathogenic goals of the father to create and maintain the child's pathology.
- 2.) Treatment: Appropriate parent-child psychotherapy should be initiated to recover and heal the damaged parent-child affectional bond with the mother and resolve the impact of the prior psychological abuse inflicted on the child by the father's distorted and psychologically abusive parenting practices in order to restore the child's healthy emotional and psychological development.
 - 3.) Collateral Therapy: The father should be required to obtain collateral individual therapy with the treatment goal of fostering insight into the cause of the prior abusive parenting practices.
 - 4.) End of Protective Separation: The protective separation period should be ended once the child's symptoms associated with the prior psychologically abusive parenting practices of the father are successfully resolved and the child's recovery is stabilized.
 - 5.) Restoration of the Relationship with the Abusive Parent: The restoration of the child's relationship with the formerly abusive parent should include sufficient safeguards to ensure that the psychological abuse of the child does not resume once contact with the father is restored. The demonstrated cooperation of the father with his individual collateral therapy and his demonstrated insight into the cause of the prior psychological abuse of the child would represent important considerations in the level of safeguards needed to ensure the child's protection.
 - 6.) Relapse: If the child's symptoms reoccur once the child's contact with the father is restored, then another period of protective separation will be needed in order to again recover the child's normal-range and healthy development, and additional protective safeguards will be warranted prior to once again exposing the child to the pathogenic parenting practices of the father.

Child Response to a Protective Separation

The child may initially respond to a protective separation from the currently allied parent (i.e., the father) with increased protest behavior and defiance. This child response represents an emotional-behavioral tantrum reflecting the child's currently over-empowered status relative to accepting authority (i.e. both parental authority and the authority of the Court). Responding to emotional displays of child tantrum behaviors with

calm and steady purpose that restores the child to an appropriate social and family hierarchy of cooperation with Court and parental authority will be important to supporting successful family therapy and the resolution of the child's symptoms. Any concern regarding the child's expressed distress at the protective separation from the currently allied parent (i.e., the father) should recognize that the child is fully capable of ending the protective separation period by becoming non-symptomatic. If the child wishes a termination of the protective separation period, then the child simply needs to evidence normal-range affectional child behavior in response to the normal-range parenting practices of the mother, which is under the treatment-related monitoring of the family therapist.

Ending the Protective Separation Period

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

Sincerely,

<psychologist name>

Psychologist, <license number>

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

Date: <Date>

Psychologist: <Psychologist's Name>

Scope of Report

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

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

Rating Scales Completed (attached)

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

Results of Assessment

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

- 1) **Attachment System Suppression:** A targeted and selective suppression of the child's attachment bonding motivations relative to his mother in the absence of sufficiently distorted parenting practices from the mother that would account for the suppression of the child's attachment system;
- 2) **Personality Disorder Traits:** A set of five specific narcissistic/borderline personality disorder features are present in the child's symptom display;
- 3) **Encapsulated Delusional Belief System:** The child evidences an intransigently held fixed and false belief that is maintained despite contrary evidence (i.e., an encapsulated delusion) regarding the child's supposed "victimization" by the normal-range parenting of the mother (i.e., an encapsulated persecutory delusion).

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

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

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

Mother’s Parenting Practices

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

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

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

The mother’s capacity for authentic empathy with the child appears to be in the normal range. She is able to self-reflect on her own behavior and she is also able to de-center from her own perspective to view situations from alternate points of view. The

mother does not appear to become overly self-involved in needing to have her perspective validated, nor does she appear to project her own needs onto the child.

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

Treatment Indications

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

1.) Response to Intervention (RTI) Assessment

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

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

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

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

Intervention treatment plan to address the pathogenic parenting of the father in creating the child's ongoing conflict with the mother should then be developed and implemented.

2.) Compliance with Court Orders for Custody and Visitation

All parties, including the child, should comply fully with all Court orders including those for custody and visitation. Failure by the currently allied and supposedly "favored" parent (i.e., the father) to comply with Court orders for custody and visitation should be viewed as non-compliance with treatment, and a follow-up treatment-focused assessment should be initiated (at the written recommendation of the treating family therapist) to determine whether a protective separation of the child from the potentially pathogenic parenting practices of the father is needed to allow for effective treatment.

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

- If the father is instructing the child to comply with the father's directive to cooperate with the mother's custody and visitation time and the child is refusing to comply with the father's directive, then the child is evidencing oppositional non-compliant behavior relative to the father's parental authority and the authority of the Court.
- As the allied and supposedly "favored" parent, the child's behavior is a reflection of the parenting received from the father, so that the child's oppositional non-compliance with the father's parental authority and the authority of the Court is a direct reflection on the father's parenting and his capacity for providing appropriate parental guidance to the child.

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

In any follow-up treatment-focused assessment, primary consideration should be afforded to the treatment needs of the child in establishing the treatment-related conditions necessary for effective treatment. The treatment-related needs of the child should be given precedence over parental considerations of being "favored" or "unfavored" by the child. If the allied and supposedly "favored" parent cannot establish the conditions necessary for the effective resolution of the child's symptoms, then a change in the

responsible parent may be necessary due to the then demonstrated parental failure of the allied and supposedly “favored” parent to enact the appropriate parental authority and guidance necessary for the child’s successful treatment.

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

Sincerely,

<psychologist name>
Psychologist, <license number>