

Possible Causes of Action Available from an Attachment-Based Model of “Parental Alienation”

1) Boundaries of Professional Competence

The construct traditionally referred to as “parental alienation” represents:

- A. An induced distortion to the normal-range functioning of the child’s attachment system;
- B. The distortion to the child’s attachment system is created and mediated by narcissistic and borderline personality disorder processes of the pathogenic parent;
- C. The narcissistic and borderline personality traits of the pathogenic parent are creating/inducing a shared delusional belief system with the child regarding the supposedly “abusive” parenting of the other parent (the targeted-rejected parent) as a component of a trauma reenactment narrative emerging from the “internal working models” (i.e., the core relationship schemas) of the narcissistic/borderline parent’s attachment system.
- D. The induced distortion to the normal-range functioning of the child’s attachment system is the product of a cross-generational coalition of the child with a narcissistic/borderline parent against the other parent in which the addition of parental personality pathology (particularly the splitting dynamic) transforms the cross-generational coalition into a particularly malignant and virulent form that seeks to entirely terminate the other parent’s relationship with the child.

A full description of the psychopathology of attachment-based “parental alienation” is contained in *An Attachment-Based Model of Parental Alienation: Foundations*, by C.A. Childress, Psy.D.

As a result of the complex and interwoven pathology of attachment-based “parental alienation,” the professional assessment, diagnosis, and treatment of the pathology associated with an attachment-based model of “parental alienation” requires specialized professional knowledge, training, and expertise in the following domains of professional practice:

- **Attachment Theory:** Since the fundamental pathology involves a distortion to the child’s attachment bonding motivations, a professional expertise is required regarding the attachment system, including the functioning and characteristic patterns of dysfunctioning displayed by the attachment system, the parent-child co-regulation of emotional and psychological states, and the psychological and interpersonal processes involved in the trans-generational transmission of attachment trauma. This domain of professional competence corresponds to the pathology of 1A listed above.

- **Personality Disorder Dynamics:** Since the distortion to the child’s attachment system is the product of parental narcissistic and borderline personality traits, a professional expertise is required regarding narcissistic and borderline personality dynamics, including the clinical identification of narcissistic and borderline personality processes and a professional understanding for the impact of parental narcissistic and borderline personality disorder processes on family functioning, particularly with regard to the psychological decompensation of narcissistic and borderline personality processes into persecutory delusional beliefs and the impact of a role-reversal relationship and the “invalidating environment” on parent-child relationships. This domain of professional competence corresponds to pathology 1B listed above.
- **Delusional Processes:** Since the narcissistic and borderline personality processes of the pathogenic parent are decompensating into encapsulated persecutory delusional beliefs regarding distortions to the perceived threat potential posed by the parenting practices of the other parent (which are then being transferred to the child’s belief systems and are then distorting the child’s attachment bonding motivations toward the other parent, who is a normal-range and affectionally available parent), professional expertise is required regarding the formation of delusional belief systems, including the formation of persecutory delusional belief systems associated with the psychological decompensation of narcissistic and borderline personality disorder dynamics, and the interpersonal processes by which these fixed and 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).

To the extent that the formation of these delusional beliefs represent the reactivation and reenactment of childhood attachment trauma patterns embedded in the “internal working models” (or “schemas”) of the pathogenic parent’s attachment networks (that subsequently produced the narcissistic and borderline personality traits of the pathogenic parent), professional expertise in childhood developmental trauma and trauma reenactment is also required. These domains of professional competence correspond to pathology 1C listed above.

- **Family Systems Therapy:** Since the pathology of the child’s induced suppression of attachment bonding motivations toward a normal-range and affectionally available parent represents the child’s “triangulation” into the spousal conflict through the formation of a cross-generational parent-child coalition of the child with a narcissistic/borderline parent in which the addition of parental personality pathology (i.e., the splitting dynamic) to the cross-generational coalition is transforming the pathology of the parent-child coalition into a particularly malignant and virulent form that seeks to entirely terminate the child’s relationship with the other parent (i.e., with the targeted-rejected parent), a professional level of expertise

is required in family systems theory in which the child's symptomatic expressions are recognized as embedded in a larger context of family relationship and communication patterns, with a minimum level of professional competence in Structural family systems theory (i.e., Minuchin) expected, and more advanced competence in Strategic family systems theory (e.g., Haley, Madanes) and the primary family systems theorists (e.g., Bowen, Satir, Böszörményi-Nagy) being strongly recommended. This domain of professional competence corresponds to pathology 1D above.

Failure to possess the requisite professional knowledge and experience needed to competently assess, diagnose, and treat this special population of children and families would likely represent practice beyond the boundaries of professional competence in violation of Standard 2.01 of the Ethics Code of the American Psychological Association,¹

“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” (Standard 2.01; APA Ethical Principles of Psychologists and Code of Conduct).

Practice beyond the boundaries of professional competence may also represent a possible violation of explicit state laws governing the practice of professional psychology.²

2) Harm to the Client

Treatment of an attachment-based model of “parental alienation” without first acquiring the child's protective separation from the ongoing *pathogenic influence* of the allied narcissistic/borderline parent would result in the child's increased **triangulation** into the inter-spousal/inter-parental conflict as therapy tries to restore the balanced and healthy psychological functioning of the child while the allied pathogenic parent is simultaneously seeking to induce and maintain the child's psychopathology. This would effectively turn the child into a “psychological battleground” between the balanced and normal-range meaning constructions being provided through therapy and the continuing aberrant and distorted meaning constructions being provided by the allied pathogenic parent.

¹ American Psychological Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.

² California Business and Professions Code § 2960. “The board may refuse to issue any registration or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee if the applicant, registrant, or licensee has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to... (p) Functioning outside of his or her particular field or fields of competence as established by his or her education, training, and experience.”

California Business and Professions Code § 2936. “The board shall establish as its standards of ethical conduct relating to the practice of psychology, the “Ethical Principles and Code of Conduct” published by the American Psychological Association (APA). Those standards shall be applied by the board as the accepted standard of care in all licensing examination development and in all board enforcement policies and disciplinary case evaluations.”

Turning the child into a “psychological battleground” as a consequence of the psychological pressure placed on the child by the pathogenic parent for the child to remain symptomatic while therapy is simultaneously trying to return the child to normal-range functioning would be psychologically harmful to the child.

In order to protect the child’s emotional and psychological development during therapy, professionally responsible treatment requires that the child first be protectively separated from the ongoing *pathogenic parental influence* of the allied narcissistic/borderline parent during the active phase of the child’s treatment and recovery stabilization, in which the child’s authentic and normal-range functioning is being recovered and restored. Initiating therapy for the pathology associated with an attachment-based model of “parental alienation” without first acquiring a **protective separation** of the child from the *pathogenic parenting* of the allied personality disordered parent will place the child at an unacceptable risk of psychological harm.

Standard 3.04 of the APA Ethics Code on Avoiding Harm states that,

“Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients and others with whom they work, and to minimize harm where it is foreseeable and unavoidable” (Standard 3.04; APA Ethical Principles of Psychologists and Code of Conduct).

In addition, unless a protective separation of the child is engaged, the only way to provide therapy that does not **further triangulate** the child into the inter-spousal conflict and place the child at psychological risk as a result of the continuing *pathogenic parental influence* of the narcissistic/borderline parent is to provide “therapy” that does not place pressure on the child to become non-symptomatic, i.e., “therapy” that sustains the child’s symptomatic state in accordance with the desires of the allied narcissistic-borderline parent. Providing ineffective therapy, however, is in violation of Standard 10.10 of the Ethics Code of the American Psychological Association. According to Standard 10.10 of the Ethics Code of the American Psychological Association, therapists are required to terminate therapy if the therapy is likely to harm the client or be ineffective;

“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” (Standard 10.10; APA Ethical Principles of Psychologists and Code of Conduct).

Treating a child for attachment-based “parental alienation” without first acquiring the child’s protective separation from the *pathogenic parenting* practices of the allied narcissistic-borderline alienating parent would likely represent a breach of professional standards of practice, either by irresponsibly exposing the child to psychological harm (in violation of Standard 3.04) or through providing therapy that will be ineffective and from which the child is “unlikely to benefit,” (in violation of Standard 10.10).

3) Duty to Protect

Mental health professionals have a “duty to protect” clients from harm. Mental health professionals are also responsible for all diagnoses within the DSM diagnostic system as a standard of professional competence. Among the diagnoses in the DSM-5 is the diagnosis of V995.51 Child Psychological Abuse, either Suspected or Confirmed.

A role-reversal relationship elicited by a narcissistic/borderline parent with the child that is inducing prominent developmental,³ psychological,⁴ and psychiatric⁵ symptoms in the child that then directly leads to the child’s loss of an affectionately attached relationship with a normal-range and affectionally available parent would reasonably represent Child Psychological Abuse as defined within the DSM-5, either at the lower standard of “Suspected” or reasonably at the higher standard of “Confirmed” based on the child’s symptom display. Standards of professional practice would require that mental health professionals diagnose V995.51 Child Psychological Abuse, either “Suspected” or “Confirmed,” when that diagnosis is warranted by the child’s symptoms.

Furthermore, the duty to protect would require an appropriate protective response from the mental health professional to a diagnosis of Child Psychological Abuse, either Suspected or Confirmed, and documentation of this child protection response by the mental health professional in the client’s treatment record. One possible protective response to suspected or confirmed child abuse would be to file a formal Suspected Child Abuse report with the appropriate child protective service agency in accordance with the intent of mandated child abuse reporting laws. If a mandated child abuse report is not made in response to a professional diagnosis of V995.51 Child Psychological Abuse, Suspected or Confirmed, then the mental health professional incurs a responsibility based on the *duty to protect* to take an alternative appropriate action and document this protective action in the client’s treatment record.

³ The artificially induced suppression of the normal-range attachment bonding motivations of the child toward a parent.

⁴ The prominent display in the child’s symptom presentation of narcissistic and borderline personality disorder traits created by pathogenic parenting practices.

⁵ The child’s symptom display of an intransigently held fixed and false belief (i.e., delusion) regarding the supposedly “abusive” parenting of the targeted parent, which represents the induced product of a shared delusional process with the narcissistic-borderline alienating parent.