

Pathogenic Parenting and the Attachment System: Question and Answer Format

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What is the Attachment System?

The attachment system is a neuro-biologically embedded motivational system that strongly promotes parent-child emotional and psychological bonding.

What is the origin of the Attachment System?

The attachment system developed over millions of years of evolution involving the selective predation of children. Children are prey animals. Predators are selectively targeting the old, the weak, and the young. Children who formed close attachment bonds to their parents would receive parental protection from predators. These children would survive and their genes for strong attachment bonding would be increased in the collective gene pool. Children who did not form close attachment bonds to their parents would be eaten by predators, so that the genes for weak attachment bonding would be selectively eliminated from the gene pool.

So does a strong and healthy Attachment System confer survival advantage to children?

Yes.

In the context of the development of the Attachment System, what would happen if children rejected their parents?

Children who rejected their parents would become vulnerable to predators, and genes that supported children rejecting their parents would be selectively eliminated from the gene pool.

So would a child's rejection of a relationship with a parent represent normal or abnormal functioning of the child's Attachment System?

A child's rejection of a parent would represent extremely abnormal functioning of the child's attachment system.

And is the Attachment System a primary motivational system?

Yes.

Is the Attachment System embedded in the neurological structure of the brain?

Yes

With regard to brain development, what does the term "experience-expectant" mean?

The developing brain expects and is prepared to receive certain experiences, such as language. The brain expects language and so already has networks dedicated to receiving the experience of language acquisition.

Is the Attachment System an experience-expectant motivational system within the brain?

Yes

With regard to brain development, what does the term “experience-dependent” mean?

In addition to expecting certain experiences, the development of specific neural pathways also depends on the specific features of these experiences. Again, for example, with language, the brain expects language and so has brain networks already established to receive language, but the specific language learned, whether it's Chinese, or Russian, or English, is experience-dependent.

So is the development of the specifics of the Attachment System also experience-dependent?

Yes

What are some other brain-based motivational systems?

Hunger. Thirst. Sex.

So in term of the neuro-biological foundations of the Attachment System, is the Attachment System akin to these other motivational drive systems in being a primary motivational system in humans that is inherently embedded in our brain networks?

Yes.

Why is this?

Because it confers survival advantage, the attachment system has therefore been subjected to millions of years of selective evolutionary pressure. Children with weak or no attachment bonding were selectively eliminated from the gene pool. Children with strong attachment bonding received greater parental protection so that genes for strong attachment bonding were selected for by the survival advantage these genes conferred.

What is the DSM?

DSM stands for Diagnostic and Statistical Manual. It is the diagnostic system of the American Psychiatric Association.

Does the DSM recognize the Attachment System among its categories of disorders?

Yes. There is one diagnosis in the DSM related to a dysfunction in the child's attachment system.

What is that diagnosis?

A Reactive Attachment Disorder.

Is it easy to produce a disorder to the Attachment System?

No

Why is that?

Because the attachment system confers significant survival advantage to children, the evolutionary pressures of selective predation of children have resulted in an extremely resilient system promoting parent-child bonding. Children are strongly motivated to bond to parents, even bad parents, since even bad parents are better than the predator.

According to the DSM, what factors are necessary to produce a disorder in the Attachment System?

The DSM requires the presence of pathogenic parenting.

What is pathogenic parenting?

It is parenting that is so aberrant and deviant that it results in creating a pathology in the child. Patho – pathology; genic – genesis, creation. Pathogenic parenting is parenting that creates a psychopathology in the child.

What would be some examples of pathogenic parenting?

A chronically alcoholic parent who is prone to fits of excessive rage and physical abuse of the child; or a parent addicted to methamphetamine who spends days high on drugs, neglecting the child's basic needs, and then days crashing from the high, again neglecting the child's basic needs; or a parent who was chronically and persistently excessively hostile-abusive to the child over a very extended period.

What about a parent who frequently punished the child by taking away toys or games, would that be sufficient to represent pathogenic parenting that produces an attachment disorder?

No.

What about a parent who becomes angry at a child for not doing homework, or for having a messy room, and yells at the child, would that be sufficient to represent pathogenic parenting?

No.

Why not?

Because those parental behaviors are broadly normal-range parenting practices involving standard discipline approaches. While there might be concern regarding the emergence of emotional or behavioral problems with the child if parental discipline were to become too excessive or extreme, such parenting would typically not result in a disorder to the basic motivational drive system of attachment bonding, since the attachment system allows for broad parameters regarding normal-range parental discipline.

The DSM diagnosis of a Reactive Attachment Disorder, at what age does that disorder typically develop?

Typically below the age of 5.

So if a child did not have a Reactive Attachment Disorder by the age of 5, would you expect to see the child develop that disorder later, say at the age of 8 or 10.

No.

Why is that?

The basic relationship patterns for the attachment system are established in early childhood. These patterns then serve as the foundation for the attachment system's later functioning in older childhood and adulthood. Whatever attachment patterns are established during early childhood endure through later childhood and adulthood. It's similar to the development of the language system. While we learn a specific language, in early childhood, such as English, Chinese, or Russian, once this specific language is learned it is used throughout the remainder of our lifetimes. And once language is learned we don't suddenly forget it at age 8 or 10. Similarly, once the basic patterns of the attachment system are established, these tend to remain fairly stable over later childhood and adulthood.

If the relationship patterns of the attachment system are formed in early childhood, does the attachment system continue to function in later childhood, or is it only relevant to early childhood?

The attachment system continues to mediate close emotionally bonded relationships throughout the lifetime, similar to how we use the language we learned in early childhood throughout our lifetimes. John Bowlby, who first described the attachment system, discussed how the relationship patterns formed during early childhood create "internal working models" guiding the development of future close bonded relationships.

Are there features of relationships in later childhood, adolescence, and adulthood that are indicative of the operation of the attachment system regarding these relationships?

Yes. The presence of the attachment system in mediating relationships in older childhood, adolescence, and adulthood is evident in two characteristics of these relationships. First, the attachment system motivates a possessiveness to the relationship. There is an ownership quality regarding the other person. That's MY mother, that's MY father – MY child – MY husband, MY wife. This ownership quality can almost reach a level of property ownership of the other person. That person BELONGS to me. The second characteristic is a grief response at the loss of the attachment mediated relationship. When a parent dies, we experience a grief response. When a child or spouse dies, we experience a grief response. However, when a parent of a friend or acquaintance dies, we may feel a sense of shared sadness and sympathy for the other person, but we don't experience a grief response commensurate with what we would feel when our own parent, or our own child dies.

So if a 12 year-old child were to lose a parent, the normal-range functioning of the child's attachment system would provoke a grief response?

Yes.

What about if a 16 year-old lost a parent?

The loss of a parent, at any age, will prompt a grief response from the normal-range functioning of the attachment system. Even a 20, 30, or 40 year-old adult-child who loses a parent will experience a natural grief response at the death of a parent. When we lose a parent, the normal-range functioning of the attachment system will provoke a grief response whether we're 8 years old, 15, or 30.

So, hypothetically, if you were to see in your practice a child who did not evidence the possessive ownership of a parent, and who overtly rejected a relationship with that parent, and who did not display a grief response relative to the loss of a relationship with this parent, what would you conclude about the child's attachment system functioning?

That the normal-range functioning of the child's attachment system is extremely disrupted, and that the child is displaying highly abnormal and aberrant behavior relative to the normal-range functioning of the attachment system.

And is the attachment system a fundamental drive state embedded in the structure of the brain?

Yes.

Similar to the drive systems for hunger and thirst?

Yes.

So the child who did not evidence a sense of possessive ownership of a parent, who rejected a parent, and who did not display a grief response relative to the loss of the relationship with that parent would be evidencing a large-scale disruption to a fundamental motivational drive system that is embedded in the neurological structures of the brain?

Yes

What would be the consequences for the child from such a large-scale disruption to the child's attachment system?

I would be concerned about the functioning of the child's attachment system relative to other relationships that are also mediated by the functioning of the attachment system, such as the potential negative impact on the child's future spousal relationship and on the child's future parent-child relationships with his or her own children.

Why is this?

Because the patterns of relationship laid down within the attachment system form an "internal working model" for future relationships. If the functioning of this "internal working model" becomes severely disrupted, then the relationships mediated by the attachment system functioning are also likely to be severely disrupted.

On a scale of 1-10, with 10 being a high degree of concern, how concerned would you be as a clinical psychologist about such a large-scale disruption to the child's attachment system?

Depending on the severity of the symptoms, probably between 7-10, with 10 representing a very high degree of concern.

Why such a high degree of clinical concern?

Because the attachment system is a fundamental motivational system embedded in the brain networks of the child. A disruption to a primary motivational system is of much greater concern than the more commonly occurring symptoms of excessive emotional outbursts by the child or parent-child communication or relationship conflicts. The attachment system is a primary motivational drive system similar to the hunger system. So, by analogy, a disruption to the attachment system would be similar to a disruption to the primary motivational system of the hunger drive, which would be akin to a diagnosis of anorexia, where the basic hunger system itself is extremely disrupted. By analogy, normal-range parent-child conflict, and by normal range I mean clinically normal-range, what I would typically see in my clinical practice, angry-hostile parent-child relationships, frequent child defiance, frequent angry outbursts by the child, excessive child anxiety or depression, loss of school motivation, etc., those symptoms would represent problems in the expression of the attachment system similar to problems in the expression of the hunger drive, such as obesity or very poor eating habits leading to nutritional deficits. However, a significant disruption to the attachment system itself would represent a fundamental disruption to the basic

operation of the drive-state itself, similar to anorexia relative to the hunger system, where the motivational drive state itself is malfunctioning.

And so it is this disruption to the underlying drive state of attachment bonding that causes you such a high degree of concern?

Yes

Is it possible to differentiate the child's behaviors associated with what you refer to as clinically "normal-range" parent-child conflict from the parent-child conflict associated with a disrupted attachment system?

Yes.

How could you differentiate between the two?

John Bowlby, who first described the attachment system, identified a set of child behaviors he termed "attachment behaviors" since these behaviors serve to promote parent-child attachment bonding. Attachment behaviors include behaviors such as cooing, smiling, following, eye-gaze, and protest behavior. Protest behavior, what we would typically call problem behavior, such as anger outbursts, defiance, excessive displays of anxiety, etc., child protest behavior represents an attachment behavior in that it is designed to elicit GREATER parental involvement, and there are neuro-biological reasons for this.

What are those reasons?

Brain systems develop based on the principle of "we build what we use." When we use a brain cell or brain system, structural and chemical changes take place that make the used brain system stronger, more sensitive, and more efficient. The neuroscientist, Donald Hebb referred to this use-dependent development as "neurons that fire together - wire together."

Behavior and emotional displays are simply external manifestations, external expressions, of the integrated or non-integrated functioning or dysfunctioning of the underlying brain systems. When the child's brain systems for emotional or behavioral organization and regulation become disorganized or dysregulated, then the child will emit disorganized and dysregulated emotional displays and behavior. These displays of emotional and behavioral dysregulation are what we would call "protest behavior," or "problem behavior," and these displays of protest behavior serve to elicit the involvement of the parent.

The parent then becomes involved with the child who is emitting the protest behavior and helps the child return to a regulated-organized brain state through a series of communication, discipline, or guidance-based approaches to responding to the child's protest behavior. In helping the child transition from a disorganized-dysregulated brain state to an organized-regulated brain state, all of the brain systems used in this

transition become stronger, more sensitive, and more efficient. We build what we use. And in this way the parent helps to build the child's capacity to transition from disorganized-dysregulated brain states, which is being expressed as disorganized-dysregulated behavior, to more regulated, organized and socially integrated brain states, expressed as calm, cooperative, and socially integrated behavior. We typically refer to this parent-supported developmental process as the child's development of improved frustration tolerance, or the development of increased self-control, or the development of emotional regulation.

So is parent-child conflict a natural process designed to elicit greater parental involvement in order to help the child develop greater frustration tolerance, increased self-control, and improved emotional regulation?

Yes.

And is normal-range parent child conflict consistent with the normal and healthy functioning of the attachment system?

Yes.

Even if the parent-child conflict includes displays of anger and defiance, would such conflict still be consistent with the normal and healthy functioning of the attachment system?

Yes. Protest behavior is an attachment behavior.

What about parent-child conflict that emerges from a disrupted attachment system, how is that different?

In that case, the child's protest behavior is not an attachment behavior designed to elicit greater parental involvement. Instead, the child's protest behavior represents a DETACHMENT behavior designed to sever the parent-child relationship. The child's behavior that is emerging from a disrupted attachment system is rejecting a relationship with the parent, and seeks to terminate the relationship with the parent. Protest behavior that is designed to sever the parent-child relationship is inconsistent with the normal and healthy functioning of the attachment system, whereas normal-range, typical, protest behavior is designed to elicit greater parental involvement consistent with the healthy neuro-biological development of brain systems for frustration tolerance, emotional and behavioral self-control, and emotional self-regulation.

So if normal-range parent-child conflict remains consistent with the normal and healthy expression of the attachment system, would you also expect to continue to see the two primary characteristics of the attachment system, possessive ownership and a grief response?

Yes. Even in high parent-child conflict situations, the child still recognizes the parent as "my mom" or "my dad," and the child still recognizes himself or herself as "belonging" to

the parent. And a loss of the parent-child relationship, such as through the death of the parent, would still provoke a grief response in the child.

What about in parent-child conflict associated with a disrupted attachment system, would you also expect to continue to see the two primary characteristics of the attachment system, possessive ownership and a grief response?

No. The DETACHMENT behavior of a child expressing a disrupted attachment system will not display the possessive belonging to the parent. The child completely rejects the targeted parent and seeks to eliminate that parent from the child's life. And the child will not evidence any grief response over the loss, and indeed is actually seeking such a loss of relationship. So the parent-child conflict prompted by a disrupted attachment system lacks the key characteristics of a normal and functional attachment system.

If the relationship patterns of the attachment system form during early childhood, what could cause such a large-scale disruption to the attachment system in an older child or adolescent?

A large-scale disruption to the attachment system requires pathogenic parenting; parenting behavior that is so excessively aberrant and deviant as to induce a significant psychopathology in the child, which in this case is the severe disruption to the attachment system.

So how would you evaluate for the presence of this pathogenic parenting?

I would first look to the parenting behavior of the rejected parent, since the child's rejection of this parent would seem to suggest that this parent's behavior is responsible for the loss of normal-range functioning to the attachment system.

What factors would you look for in the parenting behavior of the rejected parent?

Since the attachment system is a deeply ingrained neuro-biological relationship system, it requires a great deal of stress to induce a significant disruption to such a fundamental drive system. I would look for things like an alcoholic or drug-abusing parent who was frequently in a substance induced state with the child, or who was frequently and excessively angry, hostile, and verbally or physically abusive to the child.

What about a parent who disciplines the child by taking away toys, or who yells at the child for misbehavior, could that account for such a large-scale disruption to the attachment system?

No

Why not?

Because those parental behaviors are broadly normal-range parental discipline activities. The attachment system evolved across millions of years of selective

predation of children because it confers significant survival advantage. Children who rejected parents became prey. Genes for weak, or even moderate, attachment bonding were selectively eliminated from the gene pool. Children who formed strong attachment bonding survived and genes for strong attachment bonding increased in the gene pool. The attachment system motivates children to form very strong emotional and psychological bonds with parents that are highly resistant to disruption.

So when you assess the parenting of the rejected parent, what if you find roughly normal-range parenting for the rejected parent, what else could account for a disrupted attachment system under these circumstances?

A significant disruption to the attachment system requires the presence of pathogenic parenting. If the rejected parent has broadly normal-range parenting, then I would next look to the parenting behavior of the other parent, the idealized parent. But in this case I'd be looking for a different kind of pathogenic parenting.

Different in what way?

If the idealized parent is the source of the pathogenic parenting, then this pathogenic parenting from the idealized parent is inducing the APPEARANCE of a disrupted attachment system with the child, when the child's attachment system is actually normal-range. Since the child is rejecting a parent whose parenting behavior is normal range, then the child's attachment system is actually not disrupted, because the rejected parent's parenting behavior cannot account for the child's symptom display. Because the parenting behavior of the rejected parent cannot account for the child's symptom display, the child has a normal range attachment system with regard to the rejected parent, but the child's normal range attachment bonding is instead being artificially suppressed relative to the rejected parent by the pathogenic parenting of the idealized parent.

How is this suppression of the child's attachment bonding to the rejected parent accomplished?

One of the primary methods of suppression of a normal attachment bonding to one parent occurs when the other parent strongly signals to the child that the targeted parent represents a threat to the child. When one parent signals to the child that the other parent represents a threat, this shifts the meaning of the targeted parent for the child's attachment system from one where the targeted parent is a protector-parent of the child to one where the targeted parent represents the predator, or threat, to the child. By defining the other parent as a threat to the child, the idealized parent defines the targeted parent as the predator, thereby disrupting the expression of the child's natural attachment bonding to the targeted parent.

Are you familiar with a 1989 study by Michael Cook and Susan Mineka in the Journal of Abnormal Psychology regarding the observational development of fear in primates?

Yes.

Can you describe this study?

The researchers wanted to discover how baby monkeys developed their fear of snakes, since it obviously wasn't through direct experience of being bitten by snakes, since this would result in dead monkeys not fearful monkeys. So they first placed a baby monkey in a cage with a snake, and the baby monkey showed absolutely no fear of the snake. They next placed the baby monkey and the mother monkey in the cage with the snake. The mother monkey showed an intense fear of the snake, climbing the side of the cage and making distress calls. From that moment on, the baby monkey showed an intense fear of the snake. The baby monkey had acquired a fear of snakes by socially referencing the meaning construction of the mother monkey regarding the snake.

How do you understand the findings of this study relative to child development?

Because children's brain development is in an immature state throughout childhood, there is a strong evolutionary pressure for children to socially reference the meaning construction of parents, particularly regarding potential danger or threat. When a parent signals that something is a threat or danger, the child nervous system is designed to also adopt this parental construction of meaning.

So is this how the idealized parent suppresses the natural, normal-range functioning of the child's attachment bonding to the targeted parent, by signaling to the child that the targeted parent is a danger or threat to the child?

Yes.

Does the idealized parent need to tell the child in language that the other parent is dangerous and represents a threat?

No. The communication will primarily occur through the emotional tone of the idealized parent and through a set of communication signals called "relational moves." The monkeys in the study didn't have language. The communication is through emotional tone and behavioral signals.

What are "relational moves?"

Relational moves are a series of parent-child interactions where the parent and child each respond in a back-and-forth fashion to the behaviors and actions of the other.

Can you give an example of a set of relational moves that could communicate to the child that the other parent represented a threat?

For example, if the child returns from a visitation with the targeted parent and the idealized parent asks with a tone of heightened concern about the visitation, so that the expression of parental concern signals an emotional tone of anxiety that conveys a communication signal regarding possible danger or threat. In response, the child

reports on a negative parent-child interaction with the targeted parent. The idealized parent then elevates the expression of parental concern, signaling disapproval for the parenting activity of the targeted parent and that the parenting of the targeted parent is harmful for the child. For example, this might occur in the following set of relational moves, the child returns from visitation with the father, who represents the targeted parent, and the idealized parent, the mother, asks with a tone of elevated concern "How did things go at your father's house?" The child responds, "Dad and I had an argument and he took away my computer game." The mother, then escalates her emotional tone and responds, "I can't believe your father! Why does he always do that. You're a good boy, why does he always have to start these fights with you just so he can punish you. All he has to do is talk with you. That's what I do, I just talk with you and explain the reason, and you cooperate just fine. Your dad just likes to punish you." It is through the communication of increased concern and anxiety about the parenting behavior of the other parent, followed by the escalation of expressed concern and condemnation for the parenting of the other parent in response to the child's report, that the idealized parent communicates that the other parent, and the parenting behavior of the other parent, represents a threat or danger to the child's well-being.

So in communicating that the other parent is a threat, does this suppress the child's expression of attachment bonding to the other parent because the other parent now represents a predator, a threat, relative to the child's attachment system functioning?

Yes.

Once this communication pattern of relational moves is established between the child and the idealized parent does it continue?

Typically, yes.

Why?

Because the child recognizes the idealized parent's joyfulness in expressing dissatisfaction with the parenting of the other parent. Conversely, if the child returns from a visitation with the other parent and reports to the idealized parent that things went well with the other parent, the idealized parent will signal disappointment, a drop in emotional tone from anxious concern to slight sadness and dejection. And the idealized parent may walk away, breaking the joint relationship field otherwise being shared with the child. And this will all signal to the child the parent's dissatisfaction with the child's report of positive parent-child interactions with the other parent. On the other hand, if the child reports on negative parent-child interactions with the other parent, the idealized parent becomes animated and activates into an almost joyful-animated exhortation of the other parent and the parenting behavior of the other parent. In this criticism of the other parent, the idealized parent may praise the child for being a wonderful and well-behaved child with the idealized parent and therefore not deserving of the bad parenting of the other parent, and the idealized parent will continue to socially engage with the child across multiple interaction sequences, thereby supporting the continuation of the parent-child relationship, as opposed to the

parent disengaging from the child if the child reports on positive interactions with the other parent.

So does the idealized parent need to speak negatively about the other parent?

No, not necessarily. It is the child who is reporting on the negative interactions with the other parent, it is the child who is criticizing the other parent. This allows the idealized parent to simply react to the child's report. So the criticism of the other parent by the idealized parent is framed as simply supporting the child's negative criticism of the other parent. It is the child who is initiating the expression of unhappiness, it is the child who is critical of the other parent. The idealized parent can simply support the child, thereby avoiding the perception by others that it is the idealized parent who is provoking the rift between the child and the other parent, while also allowing the idealized parent to adopt the stance of the concerned, involved, and protective parent.

In your diagnostic interviews with the idealized parent, are there ways to identify this process of allowing the child to express the negative criticism regarding the other parent so that the idealized parent can adopt the stance as a supportive and protective parent?

Frequently this process is expressed by the idealized parent as a statement of wanting people to "simply listen to the child." When this phrase occurs in the clinical interview, that we should simply "listen to the child," this phrase suggests a potential for an underlying set of relational move communications in which the child is being induced to carry the burden of criticizing the other parent so that the idealized parent can follow the child's initial criticism by then simply adopting the stance of the concerned, supportive, and protective parent.

Does the idealized parent's communication to the child that the other parent represents a threat or danger influence the child's relationship with the idealized parent?

Yes.

In what way?

By framing the other parent as a threat, as the predator relative to the attachment system, the idealized parent de-activates the normal motivational drive of the attachment system for bonding with the now dangerous parent, who has become the predator instead. In addition, by identifying a threat, a danger, a predator, the idealized parent has also activated the child's attachment drive for seeking parental protection, in this case seeking the protection of the idealized parent since the other parent has been nullified as a source of protection and instead has been identified as the source of threat. So the child's activated motivation for protective attachment bonding will be directed toward the idealized parent, so we will see a hyper-bonding of the child to the idealized parent, evidenced in the child's idealization of this protective parent. One parent becomes the source of threat, thereby nullifying the child's attachment bonding to this parent, while the other parent becomes the source of protection, thereby motivating the child to hyper-bonding to this protective parent.

Once this suppression of the expression of the child's attachment system has been initiated, does it automatically continue?

No, not necessarily. If the disruption to the child's attachment system occurred through authentic pathogenic parenting originating from the rejected parent, this would fundamentally damage the relationship patterns of the attachment system. However, in the case where the expression of the child's attachment system is simply being suppressed and has not been fundamentally damaged by authentic pathogenic parenting from the rejected parent, the underlying relationship patterns of the child's attachment system remain relatively intact, although they are being distorted by the continual effects of the suppression and may eventually become highly aberrant unless the distortions resulting from the ongoing suppression of the attachment system are relieved.

Because the underlying networks of the attachment system remain relatively normal-range but simply suppressed, the normal functioning of the attachment system will continually try to motivate the child toward an attachment bond to the now rejected parent, particularly if the rejected parent makes positive overtures to the child encouraging affectionate attachment bonding. So in order to maintain the suppression of the attachment system in the presence of the rejected parent, the child needs to maintain a continual suppressive effort.

How does the child maintain this continual suppression of the attachment system's natural motivation to establish an attachment bond to the rejected parent?

A continual suppression of attachment bonding while in the presence of the rejected parent can be maintained in one of two ways, either through maintaining a chronic state of anger or through maintaining a heightened and over-exaggerated state of anxiety relative to the rejected parent.

How does a state of chronic anger sustain the suppression of the child's attachment system?

The emotion of anger inhibits the activation of the two relationship systems of the brain, the attachment system for emotional bonding, and a second relationship system called "intersubjectivity" that involves forming a psychological connection with the other person whereby we feel what the other person feels as if we were having the experience ourselves. The emotion of anger inhibits the activation of both relationship systems; I no longer care about you (the attachment system), and I no longer feel what you feel (the intersubjective system). Anger's inhibition of the relationship systems is what allows us to say and do hurtful things to other people when we're angry, that we may later regret when we calm down and exit the angry state.

How does a heightened and over-exaggerated state of anxiety sustain the suppression of the child's attachment system?

Anxiety signals threat. So the presence of anxiety defines the rejected parent as a threat. By continually defining the rejected parent as a threat, the child continues to actively nullify the expression of the attachment system relative to the source of threat. The communication of anxiety also serves as a social stimulus to the idealized parent that justifies a protective response from the idealized parent toward the child, and this protective response from the idealized parents acts to confirm the child's meaning construction of the rejected parent as a threat.

When a child engages heightened anxiety to maintain the suppression of the attachment system, is the child's anxiety authentic?

No. It is being induced through interpersonal communication processes contained in a set of relational moves.

Are there characteristic features of the child's anxiety presentation that indicate it is inauthentic?

Yes

What are those features of the child's anxiety symptoms that indicate it is not an authentic display of anxiety?

If we examine the child's anxiety symptoms relative to the rejected parent, we will find that the child's symptoms will meet the DSM diagnostic criteria for a specific phobia. But the idea that a child can develop a specific phobia relative to a parent is not plausible. The attachment system would over-ride any capacity for a child to develop a specific phobia relative to a parent. The attachment system promotes parent-child bonding and would be completely antithetical to the development of a phobic response to a parent.

What are the DSM criteria for a specific phobia?

First, a marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation, in this case the rejected parent.

Second, that the exposure to the phobic stimulus provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

Third, that the person recognizes that the fear is excessive or unreasonable, however the DSM also specifically indicates that in children, this feature may be absent.

Fourth, that the phobic situation is avoided or else is endured with intense anxiety or distress.

Does the DSM specify types of phobias?

Yes

What are the types of phobias specified by the DSM?

Animal type, natural environment type, such as an excessive fear of heights, or storms, or water, phobias regarding blood, injections, or injury, situational phobias which includes things like an excessive fear of flying, elevators, enclosed places, things like that, and then an other type that includes things like an excessive fear of choking, vomiting or contracting an illness, or in children an avoidance of loud sounds or costumed characters.

Where would a phobic response to a mother or father fall in the specific types of phobia?

It wouldn't. There is no credible diagnosis of a mother phobia or father phobia, primarily because it would be fundamentally prevented by the attachment system. If anything, it might be considered a variant of an animal type, but even there a phobia regarding snakes or dogs involve all animals of the particular category, not a specific animal in the category while other animals of the same category are tolerated without fear. So there simply isn't a credible type of category for capturing a display of a mother phobia or father phobia.

So because a specific phobia is not a reasonably credible diagnosis for the child's anxiety, does this mean a specific phobia is not an accurate diagnosis of the child's symptoms?

No, the diagnosis is accurate according to the child's symptoms. The child's symptoms meet the criteria for a specific phobia, therefore it is an accurate diagnosis. What it means is that the child's symptoms are not authentic. What it means is that the child's symptoms are not emerging from the authentic functioning of the child's nervous system, but are instead being induced, which would be consistent with their induction as part of an interpersonal process targeting the suppression of the child's attachment system.

So the fact that the anxiety symptoms meet criteria for a specific phobia, which simply isn't credible, means that the symptoms are inauthentic?

Yes.

But what if the child or idealized parent maintain that the child's anxiety symptoms are the result of some trauma the child experienced with the rejected parent, would this change the DSM diagnosis of the anxiety symptoms?

Possibly, although if the symptoms nevertheless meet the criteria for a Specific Phobia, this diagnostic possibility, and the implications of this diagnostic possibility, remain current.

What would the DSM diagnosis be if the child's anxiety symptoms are related to a prior trauma experience with the rejected parent?

If anxiety symptoms are the result of a trauma experience, then the diagnosis is a Post-Traumatic Stress Disorder, or PTSD. The issue with this diagnosis involves the specification of the trauma event.

How is the specification of the trauma important?

The DSM requires that the trauma involve witnessing or experiencing an event that involved actual or threatened death or serious injury, or the threat to the physical integrity of self or others. The issue is that the diagnostic term “trauma” has a specific meaning relative to a PTSD diagnosis as opposed to how the word is typically used in the day-to-day conversation of lay persons.

What is this difference in the meaning of the term “trauma” between its diagnostic use and use in the general population?

With regard to a PTSD diagnosis, the term trauma refers to an extreme neurological over-activation, commensurate with the experience of threatened death or serious injury, whereas in day-to-day usage the term “trauma” is often used to describe an emotional response of great sadness. So for example, a wife finding out about a marital affair of her husband’s might be described as traumatic in the day-to-day usage of the term, but would be far from the DSM requirement of an excessive neurological over-activation associated with the DSM usage of the construct of trauma.

So what would this mean relative to the explanation of the child’s anxiety symptoms as being the result of a traumatic experience with the rejected parent?

If the child’s current anxiety symptoms are the result of a traumatic experience with the rejected parent, then this event would need to be an experience in which there was a threat to the child’s life or of serious bodily injury to the child.

Would a parent yelling at a child or being insensitive to the child’s needs meet this criteria?

No.

So if there was no neurologically traumatic experience as defined by the DSM, yet the child displayed continuing anxiety toward the rejected parent, what would you conclude about the diagnosis of the child’s anxiety?

That it is likely to be an inauthentic display of anxiety, and that the likely source might be socially induced rather than an authentic display of the child’s neurological functioning.

But what about a parent who is excessively hostile with the child, if a child is anxious about being with that parent would you typically see the child reject a relationship with that parent?

No.

Why not?

Hostility of an adult toward a child will typically induce submissive behavior from the child. The child's anxiety relative to a hostile parent would be displayed as increased submissiveness. A child who rejected a parent, however, would be showing assertion in the face of the hostility of the parent. The display of assertion as reflected in the child rejecting the parent would be inconsistent with the normal response of increased submissiveness as a result of the anxiety produced by a hostile parent. Typically, when a child is in relationship with an excessively hostile parent, we would see a withdrawn, non-assertive child and we would infer the child's anxiety from the child's hyper-compliance and hyper-submissiveness, which would then alert us to look more closely at the parenting behavior. A child who is in relationship with an excessively hostile parent and who asserts a rejection of the hostile parent runs the considerable risk of being even more victimized by the hostility of the parent. Children do not typically assert into a hostile parent, instead their anxiety typically prompts a submissive stance. Anxiety resulting from parental hostility tends to produce increased submissive behavior in children, not assertive-rejection of the parent

Regarding the current case, have you interviewed the participants in the current case regarding the potential presence of these types of attachment issues?

No

So you are unaware of whether these issues apply to the current case?

Correct.

If you were to apply this information about the functioning of the attachment system to a particular case, what factors would you assess for?

I would first identify that the child displayed a symptom pattern in which the child rejected a relationship with one parent while simultaneously hyper-bonding to the other parent.

Once this symptom constellation was identified, I would assess the child's attachment system functioning regarding the presence or absence of normal range possessive ownership of the parent that would be expected by the normal functioning of the child's attachment system, and if the child was rejecting of the parent, I would assess for a normal-range grief response at the loss of an attached relationship.

If the child did not display normal-range possessive ownership of a parent, as evidenced by the child's rejection of a relationship with that parent, i.e., that the parent no longer belonged to the child and the child no longer belonged to that parent, then this would be indicative of a highly disrupted attachment system and I would begin further assessment regarding the cause of the attachment system disruption.

If the child rejected a parent then I would expect a grief response from the child based on the normal-range functioning of the attachment system relative to the loss of a parent. If the child did not display a normal-range grief response, then this would also be indicative of a highly disrupted attachment system, and I would begin further assessment regarding the cause of such a disruption.

I would direct this initial assessment toward the quality of parenting evidenced by the rejected parent, since this is the directed target of the child's overt rejection, in order to identify if the parenting behavior of the rejected parent was sufficiently pathogenic that it could reasonably account for the child's symptom display of a disrupted attachment system. If the parenting behavior of the rejected parent was so aberrant and outside of normal-range parenting as to account for the child's rejection of this parent, then this would account for the child's symptom display of a disrupted attachment system.

If, however, the parenting behavior of the rejected parent was broadly normal-range, then the parenting behavior of the rejected parent could not reasonably account for the child's symptom presentation of a severely disrupted attachment system, so I would then begin an assessment of the parenting behavior of the idealized parent to examine the degree to which it could be pathogenic in inducing the suppression of the child's normal attachment bonding to the other parent.

In this regard I would look for the following features, the child and idealized parent both characterize the other parent, or the parenting behavior of the other parent, as somehow dangerous or as representing a threat to the child, and that this characterization is not reasonably supported by the proffered evidence and is not consistent with the independent clinical assessment of the other parents' parenting behavior, which is determined by the prior clinical assessment to be broadly normal-range. I would also be alert to the child appearing very comfortable in offering criticisms of the parenting behavior of the rejected parent and appearing to anticipate a supportive response from the adult recipient of this report, which would be consistent with the pattern of relational moves engaged in with the idealized parent in which it is the child who offers the criticism of the rejected parent, and the idealized parent responds with supportive, accepting, and protective communications. I would also assess for evidence of a hyper-activation of the child's attachment system bonding relative to the idealized parent. If these factors are present, this would suggest the potential for an induced suppression of the child's normal attachment system functioning, so I would then engage in a second tier of symptom assessment relative to this initial presentation.

What would this second tier of assessment entail?

I would begin to assess for the presence of specific personality disorder traits in the symptom display of the child, particularly centering on borderline traits and narcissistic traits.

Is this because you suspect the child has a personality disorder?

No.

Then why would you assess for personality disorder traits?

This level of assessment is to evaluate whether possible borderline and narcissistic personality disorder traits of the idealized parent are being transmitted to the child, who is displaying these traits in the symptom constellation. The personality traits belong to the idealized parent, and the pathogenic parenting that is resulting in the suppression of the child's attachment system functioning is originating in these personality disorder features, particularly borderline and narcissistic processes. In adopting the meaning constructions of the idealized parent, the child would also be adopting the aberrant meaning constructions arising from the idealized parent's prominent borderline and narcissistic personality disorder features, and so these personality disorder features of the idealized parent would be present in the induced symptom display of the child, a symptom pattern that is being induced by the personality disordered psychopathology of the idealized parent.

Why would you suspect that the idealized parent had personality disorder traits?

Because pathogenic parenting that disrupts a child's attachment system represents severely disordered parenting. If the pathogenic parenting is coming from the rejected parent, the type of severely disordered parenting would be things like chronic drug or alcohol abuse, extremely excessive anger and abuse, or serious parental psychopathology such as an untreated Bipolar Disorder or Borderline Personality Disorder. Similarly, if the source of the pathogenic parenting is the idealized parent, then this would similarly represent serious psychopathology in the idealized parent, typically associated with narcissistic and borderline personality disorder processes.

Why would narcissistic personality disorder processes be involved?

The central feature of a narcissistic personality process is a tremendous feeling of core-self inadequacy. The rejection inherent to the divorce process can trigger this deep sense of inadequacy in the narcissist resulting in what's called a "narcissistic injury."

Why would you be assessing for narcissistic features?

Because a highly narcissistic personality disorganizes under the stress of rejection in characteristic ways, leading to the development of paranoid and persecutory beliefs. These paranoid and persecutory beliefs of the decompensating narcissistic personality can serve as the core of the belief that the other parent represents a threat or danger to the child, which is then communicated to the child through relational moves, thereby de-activating the child's natural attachment bonding to the targeted parent while also hyper-activating the child's attachment motivation toward the protective parent, who becomes the idealized parent.

What does the term "decompensating" mean?"

That the personality organization of the person is deteriorating into more primitive processes.

So under stress, a narcissistic personality can decompensate into paranoid and persecutory processes?

Yes.

What are the narcissistic symptoms you would assess for?

A sense of entitlement, a loss of empathy, exploitation, a grandiose self-inflation.

How would these narcissistic features of the idealized parent show up in the child's symptoms.

Since the child is adopting the pathogenic meaning construction of the idealized parent, the child would also evidence the narcissistic features of the idealized parent within the child's symptom display. The child would evidence a sense of entitlement relative to the rejected parent in which the child expresses an expectation of special treatment and retaliates toward the rejected parent for failure to meet the child's standard for special treatment. The child would evidence a lack of empathy for the rejected parent as evidenced by the child's saying very mean and hurtful things to the rejected parent without any apparent concern or empathy for the parent's feelings; the child essentially treats the rejected parent like an object rather than a person. The child would evidence grandiosity through an attitude of elevated superiority relative to the rejected parent, in which the child feels entitled to sit in judgment of the rejected parent, both as a parent and also as a person.

What about the narcissist symptom of exploitation?

Typically this symptom feature is displayed more directly by the idealized parent who exploits the child's expressed animosity toward the other parent, or sometimes the child's expressed hyper-anxiety relative to the other parent, and the idealized parent exploits these child symptoms to disrupt and undermine the child's visitations with the other parent; sometimes by impeding the transfer of the child to the other parent or by frequent intrusive phone calls, texts, or emails to the child while in the care of the other parent, under the excuse of supporting or protecting the child.

At other times this exploitation symptom can be expressed by the idealized parent as selective parental incompetence relative to the child's symptoms. The idealized parent will often use the phrase "I can't make the child go on visitations" as a way of exploiting the child's symptom display to undermine visitations with the other parent. It is a selective parental incompetence in that in other areas of functioning the child is highly obedient with the idealized parent. It is only in relation to visitation transfers that the idealized parent displays this level of parental incompetence.

The idealized parent will also evidence an exploitative use of Court orders when those orders are in favor of the idealized parent, and a corresponding grandiose disregard for Court orders that are in opposition to what the idealized parent wants.

Why would the disregard of Court orders be a symptom of narcissistic grandiosity?

The grandiose sense of entitlement inherent to the narcissistic personality does not recognize constraints upon his or her desires. The narcissistic personality also lacks empathy for others, meaning that the narcissist cannot recognize the rights and feelings of others. Because of the entitled grandiosity and lack of empathy, the narcissistic personality does not perceptually register the construct of “authority.” The construct of “authority” is simply not recognized, not registered, by a narcissistic personality. What the narcissist recognizes is the construct of power; the power to compel, and the narcissist equates these two constructs as equivalent. Authority represents the power to compel. A Court order, by itself, does not have the power of authority for the narcissist, so unless it is accompanied by sanctions or the threat of sanctions, then the narcissist does not perceptually register the inherent authority of the Court order, and therefore the narcissist simply disregards the Court order as inconvenient until such time as the Court order is attached to some aspect of Court power.

So if your assessment found a disrupted attachment system with the child, normal range parenting by the rejected parent, attributions by the child and idealized parent of threat to the child from the parenting of the other parent, and personality disorder traits in the symptom presentation of the child, what would you conclude from such clinical evidence?

That the disruption to the child’s attachment system is the likely result of external suppression of its normal functioning relative to the rejected parent, caused by the pathogenic parenting of the idealized parent.

Is there other symptom evidence that would confirm this clinical diagnosis?

Yes.

What would that evidence be?

It has to do with the locus of stimulus control governing the child’s rejecting behavior.

What is the meaning of the term “stimulus control?”

It is an operant conditioning term for the control of behavior expression through the presentation of a stimulus that elicits a behavior. The easiest way to explain the term “stimulus control” is through its meaning in the laboratory setting. The procedures of operant conditioning, what would be called “behavior modification,” were studied extensively in the 1940s and 50s using laboratory rats, primarily by the investigator B.F. Skinner using an apparatus that took his name and is called a “Skinner box.” The Skinner Box is a small box containing a lever, a food dish, a food dispenser, and typically a signal light above the lever. When we begin to train a rat’s behavior in the Skinner

Box, the first thing we do is to achieve stimulus control over the rat's behavior. Whenever the rat nears the food dish, we deliver a pellet of food while the food dispensing mechanism makes a clicking sound. Gradually, by pairing the delivery of food with the sound of the click the rat comes to associate the delivery of food with the sound, through a process called "Classical Conditioning."

Once the rat associates the food with the clicking sound we are said to have "stimulus control" over the rat's behavior, because we can now begin to shape whatever desired behavior of the rat we seek, for example standing on hind legs. Once we have stimulus control of the rat's behavior, every time the rat begins to rise on its hind legs, we deliver a food pellet, and the mechanism makes a clicking sound that signals to the rat that it just received a food pellet, thereby reinforcing the preceding behavior of the rat. Gradually, in this way, we can shape the rat's behavior into anything we seek.

If we want to confirm that the rat's behavior is under our stimulus control, all we need to do is change what behavior receives the reinforcement of the food pellet and we will witness a corresponding change in the rat's behavior. For example, let's say we had previously reinforced the rat for standing on hind legs and then, once we had achieved this behavior in the rat we then shifted to reinforcing the rat for running in circles. If the rat's behavior is under our "stimulus control" we will then see the rat stop standing on hind legs and begin running in circles because the rat's behavior is under our stimulus control.

So how can you use the concept of stimulus control to confirm that the child's attachment system is being externally suppressed by the pathogenic parenting of the idealized parent?

If the child's behavior is an authentic response to the parenting behavior of the rejected parent, then the child's behavior is under the stimulus control of the parenting behavior of the rejected parent. So if we change the parenting behavior of the rejected parent we should see a corresponding change in the child's behavior. If, however, when we change the parenting behavior of the rejected parent we do not produce a corresponding change in the child's behavior, then this is indicative that the child's behavior is not under the stimulus control of the parenting behavior of the rejected parent. So if the child's behavior is not under the stimulus control of the parenting behavior of the targeted-rejected parent, then the question emerges as to what is the source, or locus, of stimulus control for the child's rejecting behavior toward the targeted parent. In the case of an externally induced suppression of the child's natural attachment bonding to the targeted parent, the locus of stimulus control is the pathogenic parenting of the idealized parent.

Does identifying the locus of stimulus control of the child's rejecting behavior toward the targeted parent have treatment implications?

Yes, most definitely.

What are those treatment implications?

If the child's behavior is not under the stimulus control of the targeted-rejected parent, then it is pointless to try to change the child's behavior by changing the parenting behavior of the targeted-rejected parent. The two, the child's rejection and the parenting of the rejected parent, are not associated with each other. In order to change the child's behavior we will need to target our interventions on the correct locus of stimulus control for these child behavior. If the child's attachment bonding to one parent is being artificially suppressed by the pathogenic parenting of the other, idealized, parent, then the locus of stimulus control for the child's rejecting behavior toward the target parent is the pathogenic parenting of the idealized parent. So in order to obtain a change in the child's behavior, we must target the correct locus of stimulus control for the child's rejecting behavior; the pathogenic parenting of the idealized parent.

If this is the case, that the child's rejection of one parent is under the stimulus control of the other parent's pathogenic parenting, would you anticipate therapy targeting changes in the rejecting parent's behavior to be effective in reducing the child's rejection of that parent?

No.

What would need to happen to achieve effective therapy?

We would need to decouple the child's behavior from the stimulus control of the pathogenic parenting of the idealized parent, either at the child end by altering the child's construction of meaning regarding the threat posed by the targeted parent, or at the pathogenic parenting end by altering the pathogenic parenting behavior of the idealized parent.

How would you go about altering the child's construction of meaning regarding the threat posed by the targeted-rejected parent?

This is very difficult as long as the child is receiving communications from the pathogenic parenting of the idealized parent that communicate that the other parent, the rejected parent, does indeed represent a threat to the child. If we simply try to alter the child's meaning constructions we will merely be making the child a psychological battleground for competing meaning constructions between the unbalanced and aberrant meaning constructions being provided through the pathogenic parenting of the idealized parent, and our efforts in therapy to provide a more balanced and normal-range meaning construction regarding the targeted parent. If we try to alter the child's meaning construction then we will likely be seen as simply being allied with the rejected parent, so that our alternate perspectives will be discounted by the child, and the child is likely to simply entrench more firmly into the alliance with the idealized parent.

In addition, the idealized parent believes that the parenting behavior of the other parent actually represents a psychological or emotional threat to the child, and the idealized parent has a self-perception of simply responding to the child's expressed dissatisfaction with the other parent and of protecting the child from the inadequate

and potentially abusive parenting of the other parent. So if we try to encourage a more normal-range construction of meaning regarding the targeted-rejected parent, it is likely that the allied-idealized parent will see us as placing the child at increased risk of emotional or psychological abuse from the other, rejected parent, and so the idealized parent will likely fight our treatment efforts with great vigor.

How will the idealized parent fight treatment efforts at altering the child's rejection of the targeted parent?

Likely through the same means that the pathogenic parenting achieves the rejection of the targeted parent, through the child's display of symptoms. The child will be induced-encouraged to express a great dislike of therapy and may begin to express excessive anxiety about attending therapy, or non-cooperation with going to therapy, i.e., a rejection of therapy in the same way the child rejects the targeted parent. The idealized parent will then use the child's expressions of distress regarding therapy to seek Court orders terminating therapy in order to protect the child from the "abusive" therapy that is not sufficiently understanding and accepting of the child's point of view. Or the idealized parent may undermine therapy by not bringing the child to appointments, perhaps using the same selective parenting incompetence evidenced in visitation exchanges, only this time expressed as not being able to make the child attend therapy, which reflects the identical process as "I can't make the child go on visitations with the other parent."

Would you anticipate that the idealized parent would seek to undermine therapy in other ways?

Yes. One of the primary ways will be to seek ineffective therapy that extends the process without achieving any productive changes. The idealized parent will seek therapy that "listens to the child" since the child is the carrier of the criticisms of the rejected parent. However, if we simply "listen to the child" then the therapy will simply support the child's false construction of meaning regarding the other parent representing a realistic threat, and we will simply be replicating the same relational move sequences that established the dynamic in the first place, of the child carrying the criticism while the other person, either the idealized parent or in this case the therapist, adopts the stance of the supportive other relative to the child's aberrant and distorted constructions of meaning. If the therapist accepts the child's symptoms as authentic, when they are actually inauthentic, then this response from the therapist will simply reinforce the false meaning construction of the rejected parent as a threat. This would actually be counter-therapeutic and would only further entrench the pathology within the family system. By seeking therapy that "listens to the child" the idealized parent seeks to nullify therapy's effectiveness in creating change and re-establishing a positive parent-child attachment bond with the rejected parent.

What about intervening on the correct locus of stimulus control at the other end of the relationship, by altering the pathogenic parenting of the idealized parent?

The difficulty here is that the idealized parent often has entrenched narcissistic and borderline personality disorder features that are highly resistant to change. In addition, the idealized parent has no motivation for change. Their pathological lack of empathy prevents them from understanding the benefits to the child from a positive and affectionate relationship with the other parent, and the child's rejection of the other parent actually serves the emotional-psychological needs of the idealized parent by punishing the rejected parent for the narcissistic injury inflicted by the divorce. By divorcing the narcissistic parent, the targeted parent rejected the narcissistic parent and inflicted a narcissistic injury. The child's subsequent rejection of the targeted parent serves as retribution and retaliation for the narcissistic injury. So the narcissistic, idealized parent is simply not motivated to change, and in fact supports the child's continued rejection of the targeted parent.

Under these circumstances, what would be the goals of the idealized parent in inducing the suppression of the child's attachment bonding to the other parent?

The primary goal is to retaliate toward the other parent for inflicting the narcissistic injury of divorcing-rejecting the idealized parent. This retaliation is achieved by inducing the disruption to the child's attachment bonding to the other parent, thereby causing great emotional suffering to the other parent from the loss of the attached relationship with the child. A characteristic feature of the attachment system's functioning is that it creates a grief response at the loss of the attached relationship.

The longer the idealized parent extends the child's rejection of the other parent, the more suffering is induced in the other parent, and the greater the satisfaction is achieved for the idealized parent relative to their narcissistic injury and desire for retaliation. So one of the goals of the idealized parent becomes to extend the rejection process for as long as possible, preferably indefinitely. This means that the idealized parent is not motivated to end the rejection, and is instead highly motivated to do everything possible to extend the rejection process.

So is there no solution?

The solution is to target the locus of pathogenic parenting, the idealized parent, so as to discontinue the active suppression of the child's attachment system functioning, which will then allow appropriate therapy to restore the child's normal range attachment system functioning. Once the active suppression of the child's attachment system through the pathogenic parenting of the idealized parent has been interrupted, then the child's attachment system can be targeted for restoration without making the child any more of a battlefield than is absolutely necessary to altering the child's already established aberrant and unbalanced meaning constructions that have been induced by the pathogenic parent.

From a treatment perspective, how would you recommend interrupting the ongoing influence of the pathogenic parenting during the restoration of the child's normal-range attachment bonding?

I would recommend ending all contact of the child with the idealized parent during the active phase of the child's treatment. As long as the child's attachment system shows highly aberrant functioning, then the ongoing pathogenic influence of the idealized parent in suppressing the normal-range functioning of the child's attachment system will be counter-therapeutic, will effectively undermine treatment, and will simply cause the focus of treatment to shift to the child's end of the dysfunction, thereby making the child a psychological battlefield.

As a clinical psychologist, I would be strongly adverse to making the child any more of a battlefield than is absolutely necessary for the restoration of the child's normal-range functioning of the child's attachment system. However, I would be equally adverse to allowing the child's severely disordered attachment system to remain untreated. From a clinical psychotherapy perspective, the best option is to separate the child from the source of the pathogenic influence during the active phase of treatment, and then to reunify the child with the psychopathology of the pathogenic parent once the child's attachment system functioning has returned to balanced and normal-range functioning.

What if the idealized parent objects to the interruption of his or her contact with the child?

I would fully anticipate that the idealized parent would object. The motivational goal of the idealized parent is to extend the suffering of the other parent for as long as possible, preferably indefinitely. However, if the idealized and pathogenic parent truly wanted to maintain contact with the child, all that is required is an end to the pathogenic parenting as evidenced in a return of the child's normal-range attachment bonding to the currently rejected parent.

The pathogenic parent may assert that he or she has no control over the child, but such an assertion would not be consistent with the clinical determination based on the child's symptoms. Furthermore, the pathogenic parent may assert that his or her parenting behavior is normal-range as evidenced by the child's report regarding the quality of the parent-child bond with the pathogenic parent. But the child's report is simply a feature of the activation of the protection-seeking response of the child's attachment system as the result of the pathogenic parent's communication to the child of threat from the other parent. The child is symptomatically hyper-bonding with the idealized parent for protection from threat.

The fundamental, and sole issue is the child's symptoms. When the child's symptoms of severely disturbed functioning to the child's attachment system resolve, then contact with the psychopathology of the pathogenic parenting can be restored, with ongoing and active therapeutic monitoring to ensure that the pathogenic parent does not re-introduce suppressive effects on the child's attachment system.

It should be the severity of the child's symptoms that guide treatment decisions, and the symptoms of induced suppression of the child's attachment system will require separation from the source of the pathogenic parenting during the active phase of the child's treatment and recovery. Once normal-range functioning of the child's attachment system has been restored, then the relationship contact with the pathogenic

parent can also be restored under therapeutic monitoring to ensure that the treatment gains with the child are maintained when the pathogenic parenting is re-introduced.

As a clinical psychologist, would you anticipate that the child's severely disrupted attachment system expression can be effectively treated without separation from the pathogenic parenting of the idealized parent?

No. As long as the child's attachment system is being actively suppressed by the pathogenic parenting of the idealized parent, then treatment efforts will be unsuccessful.

Why will treatment without separation be unsuccessful?

For two primary reasons. First, the pathogenic parent is motivated to maintain the child's dysfunctional attachment system and so will actively undermine efforts at treatment and recovery. Second, the therapy efforts will be obstructed by the continued active suppression of the child's attachment system functioning as a result of the ongoing pathogenic parenting.

How would you anticipate the pathogenic parent would undermine therapy?

The pathogenic parent will seek to undermine therapy in several ways, by seeking to delay therapy indefinitely through legal delays and possible accusations of abuse toward the rejected parent that require extensive investigation, by seeking ineffective forms of therapy that are focused on "listening to the child," and by objecting to effective therapy by inducing anxious or angry symptoms in the child toward the effective form of therapy and then using these induced child symptoms to seek termination of that therapy.

How will delay serve to undermine therapy?

Brain networks are built on the principle of "we build what we use" – "neurons that fire together, wire together." The longer the suppression of the child's attachment system goes on, the more entrenched become the aberrant and unbalanced relationship patterns. During periods of delay in obtaining effective treatment, the pathogenic parent can continue the active suppression of the attachment system, which will serve to entrench these relationship patterns into the child's neural networks.

The ongoing suppression of the child's attachment system can occur through covert communications of aberrant and unbalanced meaning constructions that are made through relational move patterns of encouraging the child to make the initial criticism of the rejected parent, which allows the pathogenic parent to then simply adopt a stance of supporting and protecting the child, or sometimes the pathogenic parent will engage in a more active effort to suppress the child's attachment bonding with the rejected parent by disrupting visitation transfers and actively defying Court orders, and by overtly acting to undermine the capacity of the rejected parent to restore healthy and normal-range attachment bonds with the child. Delays allow these relationship

patterns to become more firmly entrenched within the brain's neurological networks, and therefore increasingly difficult to treat and resolve.

Furthermore, once an extended period of time has passed, the Court may become increasingly reluctant to enforce the separation from the pathogenic parenting which is a necessary requirement for effective therapy and the recovery of normal-range attachment system functioning. The Court may become increasingly reluctant to disrupt the child's lifestyle that has been established with the idealized parent and Court may become increasingly reluctant to enforce a treatment necessary separation from the idealized parent in the face of the child's expressed hyper-bonding to the idealized parent, a symptomatic hyper-bonding that is produced through the pathogenic parenting of the idealized parent. Without treatment however, the severely distorted attachment system of the child will remain, with potentially serious negative consequences for the child's healthy development.

What are other ways that the pathogenic parent can undermine effective treatment?

The pathogenic parent may also seek to undermine effective therapy by objecting to therapists who begin to produce change. In order to challenge effective therapy, the pathogenic parent will employ the same basic approach that was used in undermining the child's relationship with the other parent, by inducing/encouraging the child's expression of symptoms, either angry or anxious, toward the effective therapy that allows the pathogenic parent to then adopt the stance of being supportive and protective of the child in demanding an end to the what might potentially be effective therapy. The child will make the initial complaint against the therapy, similar to how the child is induced/encouraged to make the initial complaint against the rejected parent. The pathogenic parent will then rise up, ostensibly in support of the child, and demand that we "listen to the child" and terminate therapy, or at least therapy with this particular therapist. The idealized parent will typically frame this potentially effective therapy as harmful to the child, making therapy a threat similar to how the idealized parent frames the other parent as a threat, which thereby justifies a seemingly protective response from the idealized parent. In making this demand, the pathogenic parent will seek alternative ineffective forms of therapy that "listen to the child" but which assume that the child's symptoms are an authentic expression of the child's authentic nervous system functioning.

How can this potential undermining of effective therapy be averted?

By allowing the rejected parent sole authority to select the treatment provider, since it is the attachment bond between the child and the currently rejected parent that is disrupted.

If we allow the rejected parent sole authority for selecting the treatment provider, how should the idealized parent's concerns regarding the child's expression of anger or anxiety related to therapy be addressed?

In two ways. First, with the assumption of professional activity by the licensed mental health professional, so that the assertion of harm to the child is not credible since harming a patient is antithetical to professional practice. Second, with the assumption that the rejected parent also has the child's best interests at heart and would not allow the child to be harmed by therapy. If it is accepted that the therapy selected by the rejected parent might be harmful to the child, then this supports the false meaning construction that the rejected parent is dangerous to the child, since it is being asserted that the rejected parent would select therapy that would harm the child. In the context of the prior clinical assessment, this represents the foundational false belief that is serving to continually suppress the activation of the child's healthy and normal-range attachment system. The rejected parent is not a danger to the child and will not place the child at risk.

Together, the assumptions in the professional practice of a licensed mental health therapist and the positive concern and care of the rejected parent for the well-being of the child, and within the context of the family dynamic in which child symptoms are induced by the pathogenic parenting of the idealized parent, these factors should serve to allay concerns about the child actually being harmed by therapy.

Addendum 1: Types of Child Therapy

What are the types of child therapy available?

There are primarily four schools of child therapy, expressive Play Therapy and talk therapies that are based in either a psychoanalytic or humanistic-existential theory base, Behavior Therapy, which is based in the principles of Operant and Classical Conditioning studied in the 1940s and 50s with lab animals, Family Systems models, of which the two primary forms are Structural Family Systems and Strategic Family Systems therapy, and neuro-biological relationship-based treatments that are emerging from the field of early childhood brain research and research in child development.

You said the idealized parent will seek ineffective forms of therapy in order to undermine the recovery of the child's authentic attachment system functioning. What would be the ineffective forms of child therapy that would be sought by the pathogenic parent?

Child therapy assumes an authentic nervous system. However, when the child's neuro-biologically embedded attachment system is being actively suppressed by the pathogenic parenting of the idealized parent, the child's normal nervous system functioning is being actively disrupted, so that therapies that assume an authentic nervous system expression will be ineffective. For example, expressive play therapy or talk therapy designed to validate the child's feelings assume an authentic nervous system with the child. Play therapy or supportive talk-therapy from either the psychoanalytic or particularly the humanistic-existential framework will be counter-therapeutic in that they will simply offer social support and credence to the child's aberrant and unbalanced constructions of meaning that are being induced by the pathogenic parenting of the idealized parent.

Similarly, behavioral or communication-based interventions that target the parenting behavior of the rejected parent assume that the child's behavior is authentic, and so is under the stimulus control of the rejected parent's behavior. However, when the child's natural and normal-range attachment system functioning is being suppressed by the pathogenic parenting of the idealized parent, the child's rejecting behavior is not authentic, so it is not under the stimulus control of the rejected parent. Instead, the locus of stimulus control for the child's behavior is the pathogenic parenting of the idealized parent. Behavioral and communication-based therapies might be effective if they target the correct locus of stimulus control for the child's behavior, the pathogenic parenting of the idealized parent, but this is typically a difficult, if not impossible, treatment effort, since the pathogenic parent is highly committed to maintaining the suppression of the child's attachment system and the pathogenic parent typically lacks insight and empathy.

What would be an effective treatment?

Effective therapy must begin with separating the child from the ongoing influence of the pathogenic parenting during the course of active treatment and recovery of the child's normal-range attachment system functioning, otherwise we engage a significant risk of simply making the child a psychological battlefield between the pathogenic meaning constructions of the idealized parent and the more balanced and normal-range meaning constructions provided by therapy. Once separation from the ongoing influence of the pathogenic parenting is achieved, family systems therapy, either Structural or Strategic family systems therapy, would be effective since these models approach the child's functioning within the relationship context of normalizing family relationship patterns. A neuro-developmentally based therapy focused on restoring the attachment system would also be effective, since the focus of this type of therapy would be on restoring the authentic nervous system functioning of the child relative to relationships, with a particular understanding for and focus on the attachment system.

In general, effective therapy would need to actively challenge the false, aberrant, and unbalanced meaning constructions of the child that sustain the suppression of the attachment system, while simultaneously offering a more balanced and normal-range construction of meaning regarding both parents and the divorce process. In treating attachment system disruptions it will be important for any treating therapist to have an understanding for the attachment system, how it functions and dysfunctions, in order to be able to effectively restore normal range attachment system functioning.

Addendum 2: "Reunification Therapy" with the Rejected Parent

What would you expect to happen if reunification therapy between the child and the rejected parent is ordered by the Court but without separation from the influence of the pathogenic parent?

As long as the child remains under the influence of the pathogenic parent's suppression of the child's natural attachment system bonding with the other parent, the child's functioning will be neuro-biologically inauthentic. Since the child's neuro-biological

functioning is inauthentic, the child's rejecting behavior is not authentically under the stimulus control of the rejected parent, so changes in the behavior of the rejected parent will have no influence on the child's symptoms. Therefore, reunification therapy with the rejected parent will be unsuccessful because it is targeting the wrong locus of stimulus control for the child's relationship behavior with the rejected behavior. The correct locus of stimulus control for the child's rejection of the targeted parent is the pathogenic parenting of the idealized parent.

Can problems emerge if reunification therapy is attempted without separating the child from the pathogenic parenting?

Yes. If therapy is attempted without separating the child from the ongoing pathogenic parenting of the idealized parent then the child becomes a psychological battlefield for conflicting constructions of meaning. If the child is not separated from the pathogenic parenting, and is continually subjected to the ongoing suppressive effects on the attachment system of the pathogenic parenting, then therapy targeting the child's expression of symptoms will be obstructed by the countervailing influence of the pathogenic parenting, and so will be ineffective.

Without separation from the pathogenic parenting, therapy will need to overcome the obstacle of the ongoing suppression of the child's attachment system by making the child a battleground for conflicting constructions of meaning between the pathogenic parent's aberrant and unbalanced constructions of meaning and therapy's more balanced and healthy constructions of meaning.

As a clinical psychologist, I would be highly concerned about making the child a psychological battlefield of conflicting meaning constructions. Without separation from the ongoing pathogenic parenting during the active phase of treatment, ethical concerns would emerge with simply trying to treat the child's symptoms. So, without separating the child from the ongoing pathogenic parenting and its continual suppression on the normal-range functioning of the child's attachment system, either therapy will be ineffective or ethically problematic.

Yet, the alternative to making the child the psychological battlefield for conflicting constructions of meaning would be to simply abdicate the effort to restore normal-range functioning to the child's attachment system. This would mean accepting the child's distorted attachment system functioning, which would be of great clinical concern regarding the healthy developmental functioning of the child, both currently and in the future. That's why separation of the child from the ongoing suppressive efforts becomes such an important part of the treatment. Separation from the pathogenic parenting that is actively suppressing the child's healthy and normal-range attachment system functioning for the period of active treatment and recovery of normal-range functioning is essential to effective resolution of the induced disruption to child's healthy attachment system functioning.