

The Failure of Gardner's Model of "Parental Alienation"

Craig Childress, Psy. D. (2013)

The Gardner model of "parental alienation" is a failed paradigm. Gardner was correct in identifying a clinical phenomena in which a child is induced by one parent to reject a relationship with the other parent, and his model for describing "parental alienation" succeeded in directing professional and legal attention to the issue. However, his forays into the veracity of sexual abuse allegations were problematic, and his troubling personal views distracted from a more central focus on the clinically relevant issue of induced child rejection of a parent. In addition, his initial gender focus on alienating mothers distracted from a more balanced perspective of recognizing the clinical phenomena of induced child rejection of a parent as equally prevalent across both genders of parents. The model initially proposed by Gardner created an unfortunate schism within professional psychology.

In the decades since its introduction into professional dialogue, Gardner's (1987) model of "parental alienation" has been rejected as a legitimate psychological construct. The most recent rejection of Gardner's model of "parental alienation" is evidenced by its failure to be included, even by mention, in the DSM-5 (American Psychiatric Association, 2013) despite concerted efforts by the supporters of the construct who actively lobbied for its inclusion in the DSM-5.

Gardner's model of "parental alienation" represents a failed paradigm in four major domains; legal, theoretical, diagnostic, and treatment.

The Legal Domain:

Gardner's model for describing "parental alienation" has achieved some success in the legal arena, due in large measure to the laudable efforts of researchers such as Amy Baker (Baker, 2006; Baker & Darnall, 2007), and it has been admitted into legal evidence in some cases. However, while the legal system may be well suited to structure schedules for child custody visitations, the legal arena is an ill-suited venue for resolving interpersonal family conflicts. The process of proving "parental alienation" in Court is typically long, arduous, and extremely expensive for targeted parents, often placing this avenue for resolution of "parental alienation" beyond the financial scope of many targeted parents. Furthermore, proving "parental alienation" in Court requires experienced legal representation. For many targeted-rejected parents the financial expense of continual legal battle becomes too great, so they must turn to self-representation. Yet without the benefit of expert legal counsel the practicality of proving "parental alienation" in the legal arena can prove extremely difficult, if not impossible.

In addition, even if "parental alienation" is eventually proven in Court, the years of protracted legal battles that have been necessary to prove "parental alienation" in any particular case may only have allowed the alienation to become so firmly entrenched by the passage of time and the continuing negative influence of the alienating parent that it has essentially become treatment resistant. With "parental alienation," time and delay are

on the side of the alienator. The longer that effective intervention can be delayed, the more intractable to treatment the alienation becomes.

Furthermore, even if parental alienation is proven in Court, the failure of Gardner's model of "parental alienation" to effectively identify a professionally accepted treatment framework undermines the potential responsiveness of the Court to the proven alienation. Oftentimes, the Court will be reluctant to remove custody from the "favored" parent out of concern for the potentially "traumatic" impact of such a decision on the child, an (erroneous) opinion that will be voiced by some mental health professionals in support of the child's continued custody with the alienating parent. Reluctant to remove custody from the "favored parent," Court orders will often split custody between the parents and require something called "reunification therapy" for the child and targeted-rejected parent, which far too often proves to be entirely ineffectual because the therapy lacks a coherent model for understanding the nature of "parental alienation" that would allow for a coherent treatment framework.

So while some gains have been made in the legal arena regarding Gardner's model of "parental alienation," these gains have been wholly inadequate to resolving the issue for the vast majority of targeted-rejected parents. The process of proving Gardner's model of "parental alienation" in Court remains prohibitively expensive, inexact, excessively long, and of uncertain ultimate outcome, even if "parental alienation" is proven.

Theoretical Domain:

Gardner was correct in identifying a set of interrelated clinical phenomena reflected in a child's induced rejection of a relationship with a parent. However, he too quickly abandoned the structure of traditional psychology in proposing a new "syndrome" characterized by a set of disparate symptom indicators that held no association to any established psychological or psychiatric process or diagnosis, and his problematic foray into the veracity of sexual abuse allegations was conceptually flawed and generated excessive controversy. In abandoning the structure of established psychological constructs, Gardner abandoned the necessary professional rigor that would allow for a more complete understanding for the clinical phenomena he observed. Yet it must also be kept in mind that Gardner was one of the first theorists in this clinical domain of investigation, and some leeway in judging from hindsight an investigator's initial exploratory models should be allowed to the initial investigators of any clinical phenomena. At the same time, the more conservative elements of professional psychology were correct, and remain correct, in rejecting his initial conceptualizations as scientifically inadequate.

Gardner's model of "parental alienation" lacks sufficient conceptual rigor. He too quickly moved outside of established and accepted psychological constructs, and he failed to adequately respond to criticisms regarding the absence of conceptual rigor. Rather than offering increasingly elaborated frameworks for "parental alienation" using established psychological principles and constructs, Gardner and his supporters steadfastly pressed for the accuracy of his initial conceptualizations and diagnostic

indicators. This led to controversy and the splitting of the professional community into supporters and detractors of the construct of “parental alienation.”

This splitting¹ of the professional community has been extremely unfortunate, as it distracts from a professionally unified effort to develop an accurate model of the clinical phenomena first noted by Gardner, that employs established psychological constructs which can illuminate the exact nature and features of the clinical phenomena of “parental alienation,” and which would allow, in turn, for the development of reliable diagnostic indicators and effective treatment frameworks. Once a theoretical model for “parental alienation” is established within standard and professionally accepted psychological and psychiatric constructs, then professional standards of practice can be established to guide both the diagnosis and treatment of “parental alienation,” and to which mental health professionals can be held accountable.

A unifying theoretical framework allows for the return of the family conflict associated with “parental alienation” to the proper venue of mental health instead of the ill-suited domain of the legal system. Once mental health speaks with a single voice, the legal system can act with the decisiveness and clarity necessary to resolve the psychological issues associated with what has traditionally been referred to as “parental alienation.” Targeted and rejected parents are not concerned about professional squabbles within mental health; they just want their relationship with their child restored. Targeted-rejected parents are fully aware that “parental alienation,” in whatever form mental health professionals may wish to describe it, exists and is an all too real and tragic nightmare. They simply want it identified, treated, and resolved.

For the benefit of our clients, the children and targeted-rejected parents who are so tragically hurt by this clinical phenomenon, it is time to resolve the split within mental health and work together in developing a more complete and accurate description for the

¹ I would wonder whether the “split” within mental health regarding “parental alienation” represents a parallel process to the splitting dynamic emanating from the narcissistic/borderline personality processes associated with “parental alienation” (for a discussion of the personality disorder dynamics, see Childress, 2013a; Childress, 2013b). Professional clinical psychology should be sufficiently sensitive to the potential of parallel processes when treating borderline personality disorder dynamics (such as splitting) so as to be able to recognize its occurrence and prevent its infection of professional practice. Linehan (1993) describes the propensity for the splitting of professionals in the treatment of borderline personality processes,

“Staff splitting,” as mentioned earlier, is a much-discussed phenomenon in which professionals treating borderline patients begin arguing and fighting about a patient, the treatment plan, or the behavior of the other professionals with the patient... arguments among staff members and differences in points of view, traditionally associated with staff splitting, are seen as failures in synthesis and interpersonal process among the staff rather than as a patient’s problem... Therapist disagreements over a patient are treated as potentially equally valid poles of a dialectic. Thus, the starting point for dialogue is the recognition that a polarity has arisen, together with an implicit (if not explicit) assumption that resolution will require working toward synthesis.” (p. 432)

Unfortunately, I am not sure that this professional recognition of parallel process has been forthcoming with regard to “parental alienation,” despite the apparent presence of the splitting symptom in the child’s symptom display. If the current controversy regarding “parental alienation” represents a manifestation of parallel process splitting, then a concerted professional response toward synthesis of the polarities appears warranted for the benefit of our professional response to the client issues.

construct of “parental alienation” that employs established and professionally accepted constructs that can be used to guide diagnosis and treatment, and that can establish a professionally accepted standard of practice. To the extent that Gardner’s model continues the professional rift, even after decades of professional discourse, and continues to divide and distract from professional efforts to resolve the clinical phenomena of “parental alienation,” Gardner’s model represents a failed paradigm, and an alternative paradigm is called for that can bring mental health together in a common effort.

Diagnostic Domain:

Gardner’s model of parental alienation also fails diagnostically. While commendable efforts have been engaged to support the diagnostic criteria identified by Gardner, none of Gardner’s diagnostic criteria are associated with any established psychological or psychiatric disorder or process. The vague and imprecise specification of the psychological processes by which “parental alienation” occurs has undermined professional confidence in the both the construct and the symptom identifiers proposed by Gardner. A more coherent explanation of the underlying dynamics of “parental alienation” that employs established psychological constructs would be able to more adequately support the conceptual reasoning for identifying a specific set of symptom indicators.

In the absence of an underlying conceptual framework that relies on established and accepted psychological constructs, the diagnostic indicators identified by Gardner represent an incoherent array of disparate qualities and features, some of which may be present, some of which may be absent, and many of which may overlap with non-alienation parent-child conflict, so that the differential diagnosis of “parental alienation” from non-alienation parent-child conflict becomes inexact. Furthermore, since the diagnostic indicators of Gardner are outside of established psychological constructs, they cannot provide an accepted standard of practice to which mental health professionals can be held accountable. Gardner’s model also fails to provide clinically definitive criteria for determining the presence or absence of proposed symptom identifiers, or established guidelines for the required number of symptoms necessary to assign a diagnosis of “parental alienation.” This leaves much of the diagnosis of “parental alienation” to the discretionary judgment of the diagnostician, which undermines diagnostic reliability.

Gardner’s diagnostic indicators do not provide sufficiently clear and professionally accepted standards of practice to which mental health professionals can be held accountable. In order to provide appropriate clinical utility, the diagnostic indicators of “parental alienation” must reliably identify every case of “parental alienation” and they must reliably differentiate every case of non-alienation parent-child conflict. Gardner’s model of “parental alienation” cannot accomplish this goal, and so represents a failed diagnostic paradigm.

Treatment Domain:

Even if a custody evaluator or therapist identifies “alienation” as a factor in the child’s rejection of visitations with a parent, there exists no standard of practice for

resolving the problem since Gardner's model is outside of accepted and established psychological constructs. What is the treatment for "parental alienation"? While Gardner offers his opinions, these opinions are countered by alternative opinions from other mental health professionals. Gardner, for example, recommends separating the child from the alienating parent whereas other mental health professionals respond that abruptly separating the child from the "favored" parent would be too "traumatic" for the child. How is this disagreement to be resolved? We are potentially looking at another 20 years of treatment research, even if and once Gardner's model of "parental alienation" is accepted as a legitimate construct, in order to identify what the treatment response should be.

So even though a custody report may identify "parental alienation," the proposed recommendations of the evaluation may nevertheless be inadequate to resolve the child's rejection of a parent. Often, the recommendation of the custody evaluation is for joint custody and "reunification therapy," yet there is no clear model within professional psychology for what "reunification therapy" entails. Within professional psychology, there are models for family therapy (Haley & Hoffman, 1967; Minuchin, 1974), cognitive behavioral therapy (Beck, 1976; Beck, Freeman, Davis, & Associates, 2004; Ellis, 1962), psychodynamic therapy (Kohut, 1984; Stolorow, Brandchaft, & Atwood, 1987), and humanistic-existential therapy (Frankl, 1997; Rogers, 1961, Yalom, 1980), but there exists no proposed and accepted model within professional psychology for what constitutes "reunification therapy." The construct of "reunification therapy" is a myth. There is no such thing.

Mental health therapists who supposedly engage in this mythical "reunification therapy" are therefore free to engage in any form of dialogue, discussion, or approach in their "therapy" without reference to any established model. In some cases, this reunification therapy is simply listening to the child's litany of complaints against the targeted parent, having the targeted parent apologize to the child for supposed parental failures (often exaggerated, distorted, or even fabricated by the child), and encouraging the further disempowerment of the targeted parent who must seek to appease the child, continually, and without success in altering the child's rejection.

In other cases where the "reunification therapy" employs approaches that may be effective, tactics of the alienating parent and child, who postpone, reschedule, and fail to attend appointments, will delay the "reunification therapy". The targeted parent must then return to Court to seek legal enforcement of Court orders for "reunification therapy," thereby incurring additional delays in acquiring the necessary therapy across months, and sometimes even years, as legal schedules respond to the petitions of the targeted parent and legal maneuverings of the alienating parent. In other cases, the child and alienating parent engage in tactics to remove therapists who challenge the child to behave more appropriately, in favor of therapists who enable the child's over-empowerment and collude with the family psychopathology that is manifesting in the child's rejection of the targeted parent. A common tactic to remove non-desired therapists is for the child to become "symptomatic" (typically "anxiety" and "stress") related to the therapy, which the alienating parent then exploits to obtain a change in therapists so as avoid "stressing" the child by therapy. The exploitation of the child's (elicited) symptomatology by the narcissistic/borderline parent is the established pattern for control.

In order for the construct of “parental alienation” to be useful, it must be defined sufficiently within established mental health constructs so that it provides a clear treatment framework for its resolution, and which can define clear standards of practice regarding the nature of “reunification therapy” to which mental health professionals can be held accountable. Gardner’s model does not provide sufficient professional acceptance of the underlying theoretical constructs, which lay outside of existing and professionally accepted psychological frameworks, so as to provide accepted treatment standards. Gardner’s model of “parental alienation” therefore represents a failed treatment paradigm.

Conclusion:

Gardner was the first pioneer in a new domain. Consideration should be given to both his clinical acumen and his professional courage. His pioneering efforts drew professional and legal attention to an important clinical phenomenon, and have served as comfort to many targeted-rejected parents that the upside-down world they were experiencing was the product of the other parent’s psychopathology. But after 30 years of professional review, Gardner’s model of “parental alienation” has failed to provide the vast majority of targeted-rejected parents with actualized solutions, and it has not provided a standard of practice to guide diagnosis and treatment, and to which mental health professionals can be held accountable.

The division within mental health regarding the construct of “parental alienation” only harms the client. In line with Linehan’s (1993) observation on the splitting of mental health professionals as the consequence of working with borderline personality processes,

Therapist disagreements over a patient are treated as potentially equally valid poles of a dialectic. Thus, the starting point for dialogue is the recognition that a polarity has arisen, together with an implicit (if not explicit) assumption that resolution will require working toward synthesis. (p. 432)

It is time to resolve the split within mental health regarding the construct of “parental alienation” so that we can work toward a synthesis within professional psychology that recognizes the “equally valid poles” of the dialectic. The advocates for the construct of “parental alienation” are correct; there exists a valid clinical phenomenon that they identify. In addition, the opponents of the construct of “parental alienation” are correct, Gardner’s model lacks sufficient scientific foundation and conceptual rigor. A polarity arose with two “equally valid poles.” The synthesis requires a reconceptualization of “parental alienation” from within established psychological principles and constructs that offers theoretical coherence, explanatory power, testable hypotheses, diagnostic reliability, and clarity regarding the necessary treatment framework.

In my view, an attachment-based reconceptualization of the construct of “parental alienation” offers this synthesis.

- The central symptom of “parental alienation” is the child’s rejection of a parent. This central symptom represents a massive distortion to the normal-range

functioning of the child's attachment bonding motivations toward a parent that requires clinical explanation.

- The child's symptom display also evidences narcissistic (grandiosity, entitlement, lack of empathy, haughty/arrogant attitude) and borderline (splitting) personality disorder features that strongly suggest potential narcissistic and borderline personality disorder dynamics within the family.
- Narcissistic and borderline personality disorder processes are increasingly being linked to insecure disorganized and anxious-preoccupied attachment (i.e., internal working models of attachment related to themes of personal inadequacy that coalesce into narcissistic defenses, and internal working models of attachment involving an intense fear of abandonment that coalesce into borderline personality disorder traits), suggesting that an attachment-based exploration of personality disorder processes within the family would be productive.
- Research has indicated that attachment patterns are transmitted across generations. An insecure anxious-disorganized attachment is associated with role-reversal parent-child relationships, and "parental alienation" represents a role-reversal parent-child relationship in which the child's induced symptoms are being used (exploited) by the alienating parent.
- The term "borderline" personality was initially given to this type of personality structure because this type of personality was thought to reside on the "borderline" between neurotic and psychotic processes. Kernberg (1975) conceptualized narcissistic personality structure as a type of borderline personality organization. Millon (2011) describes the ready decompensation of narcissistic personality processes into persecutory delusions under stress. The inherent interpersonal rejection (abandonment) of divorce and the family's dissolution would represent just the sort of "narcissistic insult" (Beck, Freeman, & Associates, 2004) that could create a decompensation into persecutory delusional beliefs (Millon, 2011). The formation of a shared delusional belief regarding the supposedly "abusive" parental inadequacy of the targeted-rejected parent is reasonable within the context of the potential reenactment of attachment-related trauma and the decompensation of a narcissistic/borderline parent into persecutory delusional beliefs in response to the narcissistic injury and perceived abandonment associated with the divorce.
- Within an attachment-based framework, the disordered internal working models of a parent's traumatized attachment networks (that resulted in the formation of prominent narcissistic and borderline personality disorder traits) would be activated by the rejection (abandonment) and narcissistic insult associated with divorce, potentially resulting in the reenactment and trans-generational transmission of the attachment trauma patterns, that are imbedded in the internal working models of the alienating parent's attachment networks, from the childhood of the alienating parent to the current family relationships, mediated by the narcissistic and borderline personality disorder traits of the alienating parent

(that, in themselves, represent the coalesced product of the alienating parent's disordered attachment system).

In my professional view, there are sufficient clinical indicators to suggest that an attachment-based reconceptualization of the construct of "parental alienation" can afford a synthesis of the "equally valid poles" of the dialectic, which can repair the split in professional psychology to the benefit of the clients we serve. In my work (Childress, 2013a; Childress, 2013b), I have proposed an attachment-based model to describe the clinical features of "parental alienation" from entirely within established psychological constructs. My hope is that this initial model, subject to revision and elaboration, can formulate professional dialogue that leads to a broader synthesis that brings mental health together into a single voice to address the needs of our clients.

References

- Baker, A.J.L. (2006). Patterns of parental alienation: A qualitative research study. *American Journal of Family Therapy*, 34, 63-78.
- Baker, A.J.L. & Darnall, D. (2007). A construct study of the eight symptoms of severe parental alienation syndrome: A survey of parental experiences. *Journal of Divorce and Remarriage*, 47, 55-75.
- Beck A.T. (1976) *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.
- Beck, A.T., Freeman, A., Davis, D.D., & Associates (2004). *Cognitive therapy of personality disorders*. (2nd edition). New York: Guilford.
- Childress, C.A. (2013). *Reconceptualizing Parental Alienation: Parental Personality Disorder and the Trans-generational Transmission of Attachment Trauma*. Retrieved 11/18/13 from <http://www.drcachildress.org/asp/Site/ParentalAlienation/index.asp>
- Childress, C.A. (2013). *DSM-5 Diagnosis of "Parental Alienation" Processes*. Retrieved 11/18/13 from <http://www.drcachildress.org/asp/Site/ParentalAlienation/index.asp>
- Ellis A. (1962). *Reason and emotion in psychotherapy*. New York: Stuart.
- Frankl, Viktor (1997). *Man's Search for Meaning*. Pocket.
- Gardner, R.A. (1987). *The Parental Alienation Syndrome and the differentiation between fabricated and genuine child sex abuse*. Cresskill, NJ: Creative Therapeutics.
- Haley, J., & Hoffman, L. (1967). *Techniques of family therapy*. New York: Basic Books.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford
- Millon. T. (2011). *Disorders of personality: introducing a DSM/ICD spectrum from normal to abnormal*. Hoboken: Wiley.
- Minuchin, S. (1974). *Families and Family Therapy*. Harvard University Press.

Rogers, Carl. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.

Stolorow, R., Brandchaft, B. & Atwood, G. (1987), *Psychoanalytic treatment: An intersubjective approach*;

Kohut, H. (1984) *How does analysis cure* Chicago: Univ. Chicago Press.

Yalom, I. (1980). *Existential Psychotherapy*. Basic Books.