

DSM-5 Diagnosis of “Parental Alienation” Processes

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The family processes traditionally referred to as “parental alienation” represent the trans-generational transmission of attachment trauma from the childhood of the alienating parent to the current family relationships. This process is mediated by narcissistic and borderline personality disorder processes of the alienating parent that center on themes of primal self-inadequacy and an intense fear of abandonment, that represent the coalesced product of insecure anxious-disorganized/anxious-preoccupied attachment networks from the childhood of the alienating parent.

The divorce and dissolution of the family activates the traumatized attachment networks and personality disorder processes of the alienating parent in order to mediate the relationship loss experience associated with the divorce and family’s dissolution (Bowlby, 1973, 1979, 1980). The activation of the alienating parent’s insecure anxious-disorganized/anxious-preoccupied attachment networks, and of the narcissistic and borderline personality disorder processes that represent the coalesced product of these distorted attachment patterns, result in the distorted communication and parenting practices of the alienating parent that ultimately create the characteristic symptom display of the child, involving the induced suppression of the normal-range functioning of the child’s attachment bonding motivations toward one parent, the targeted-rejected parent, and a hyper-bonding motivation expressed toward the other parent, the favored and allied alienating parent (figure 1).

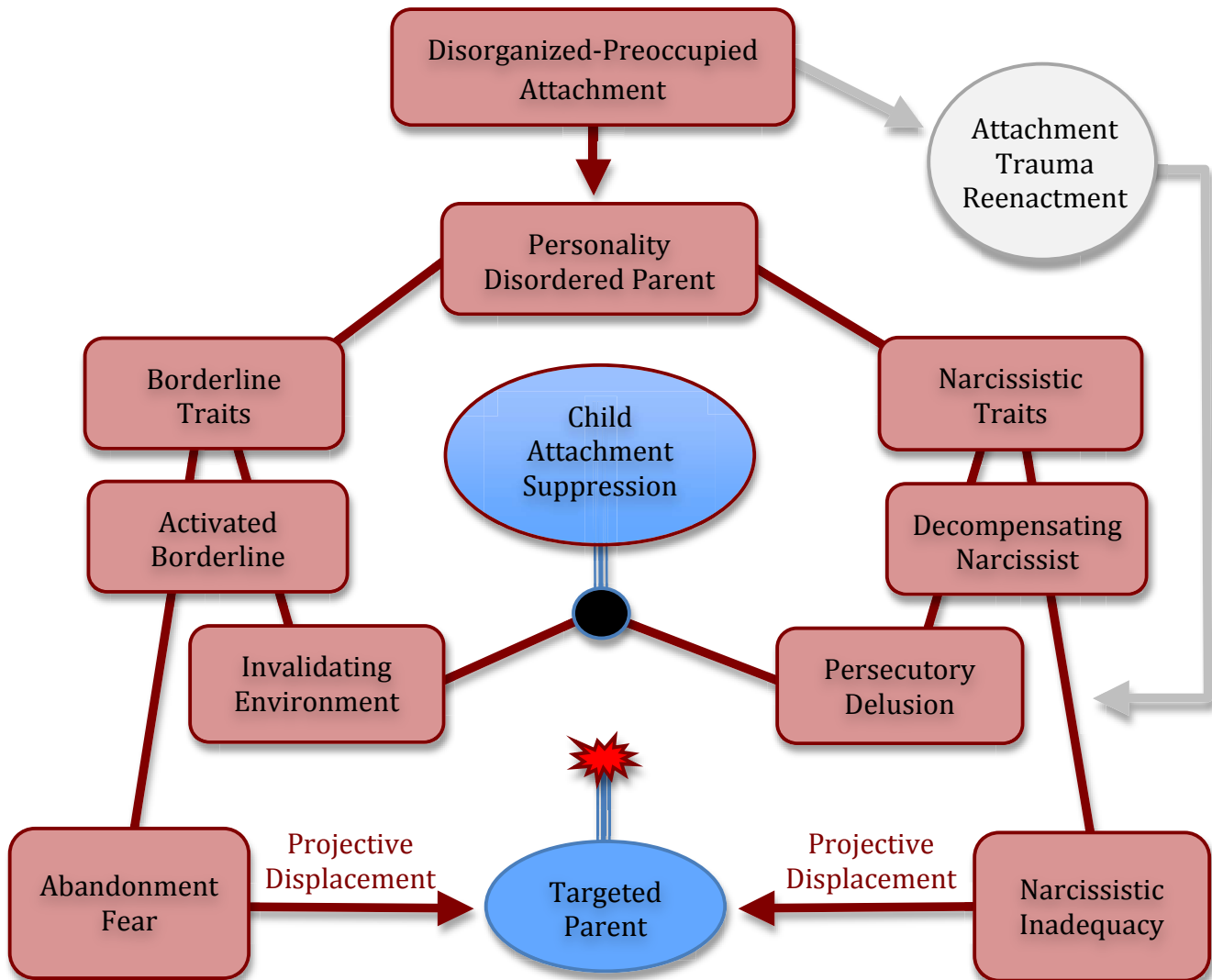
The diagnostic categories of the DSM-5 (American Psychiatric Association, 2013) tend to reflect an individualistic orientation to characterizing psychiatric disorders that requires careful diagnostic consideration when applied to induced child symptomatology that is the product of distorted parenting practices involving the trans-generational transmission of relationship trauma. This article will examine the appropriate DSM-5 diagnosis for an induced suppression to the normal-range functioning of the child’s attachment bonding motivations toward a normal-range parent that is the product of aberrant and distorted parenting practices of a personality disordered parent (narcissistic and borderline traits) who is engaging the child in a role-reversal parent-child relationship to regulate the personality disordered parent’s own psychopathology; a process classically referred to as “parental alienation.”

The Attachment System

The central child symptom associated with what has traditionally been referred to as “parental alienation” involves a prominent disruption to the child’s attachment system, in which the child entirely rejects a relationship with one parent, the targeted-rejected parent, and shows a corresponding hyper-bonding motivation toward the allied and favored alienating parent. Understanding both the functioning and the characteristic dysfunctioning of the attachment system is therefore required to appropriately diagnose the child’s symptom display.

Parental Alienation Schematic

The alienating parent's disorganized-preoccupied attachment coalesced during childhood into narcissistic and borderline personality disorder traits that were reactivated during the divorce. The alienating parent's activated personality disorder dynamics then enacted distorted relationship and communication processes with the child that induced the suppression of the child's attachment bonding motivations toward the targeted parent.



The child's symptomatic rejection-abandonment of the targeted parent serves to projectively displace the alienating parent's own fears of inadequacy and abandonment onto the targeted parent ("You're the inadequate and abandoned parent (person); not me").

The child's symptomatic rejection-abandonment of the targeted parent acts to define the targeted parent as the fundamentally inadequate and entirely abandoned parent, as opposed to the definition of the alienating personality disordered parent created by the child's symptomatic expressions of hyper-bonding as representing the ideal, perfect, and never-to-be-abandoned parent.

Figure 1. Parental Alienation Schematic

The attachment system is a neuro-biologically embedded primary motivational system that developed through the selective predation of children. Children who formed strongly attached relationships with their parents were more likely to receive parental protection from predators, so that genes motivating children to form strongly attached relationships with parents increased in the collective gene pool. Conversely, children who formed weak, or even moderate attachment relationships with parents were at greater risk from predation, so that genes that allowed for weak or moderate attachment bonding to parents were systematically eliminated from the collective gene pool. As a result of the evolutionary pressures from the selective targeting of children by predators, a very strong and resilient, neuro-biologically embedded primary motivational system developed that strongly promotes children's attachment bonding to parents (Ainsworth, 1989; Bowlby, 1969).

The attachment system develops patterns, or "internal working models," during childhood regarding relationship expectations for close intimate relationships, and these internal working models of attachment expectations continue to mediate closely bonded attachment relationships throughout the lifespan (Ainsworth, 1989; Bartholomew & Horowitz, 1991; Bowlby, 1969; Hesse, 1999; Sable, 2008; Sroufe, 2005), including the marital relationship (Feeney & Noller, 1990; Hazan, & Shaver, 1987; Simpson, 1990) and a person's relationship with his or her own children (Ainsworth, 1989; Benoit & Parker, 1994; Bretherton, 1990; Fonagy, Steele, & Steele, 1991). According to Bowlby (1969), "Confidence in the accessibility and responsiveness of attachment figures, or lack of it, is built up slowly during all the years of immaturity and that, once developed, expectations tend to persist relatively unchanged throughout the rest of life" (p. 359). The internal working models of the attachment system mediate both the formation of close psychological and emotional relationships throughout the lifespan, as well as the loss of these relationships (Bowlby, 1969; 1973; 1979; 1980).

Since the attachment system confers significant survival advantage to children, it is highly resistant to spontaneous dysfunction. Children who evidenced a spontaneous disruption to their attachment bonding motivations toward their parents were more likely to fall prey to selective predation, so that genes allowing the spontaneous dysfunction of attachment bonding motivations were selectively removed from the collective gene pool. Instead, disruptions to the functioning of the attachment system reflect goal-corrected responses to distorted parenting practices, in which the maximum degree of parent-child bonding is maintained within the context of the distorted parenting practices (Ainsworth, 1979; Bowlby, 1969). In response to inadequate or abusive parenting practices, children develop an insecure attachment bond that motivates increased goal-corrected efforts from the child to establish an attached bond with this parent, resulting in characteristic patterns of dysfunctional child bonding to parents in response to the characteristic features of the distorted parenting practices to which the child is exposed (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Hesse, 1990)

In response to inconsistent parental availability, children develop an insecure anxious-ambivalent attachment pattern (also referred to as an anxious-preoccupied attachment pattern when displayed by adults) marked by increased child protest behaviors and increased signals for attachment bonding that elicit greater parental involvement

(Ainsworth, 1979; Cassidy, & Berlin, 1994). Children's response to parents who are psychologically overwhelmed and who withdraw further from child demands for involvement is to develop an insecure anxious-avoidant attachment pattern of being low-demand and overly compliant, thereby maximizing the parental involvement that is available by not over-taxing the overwhelmed parent (Ainsworth, 1979; Finnegan, Hodges, & Perry, 1996). In response to incoherent, disorienting, or frightened-and-frightening parenting, children are unable to develop any coherent strategy for establishing and maintaining an attachment bond with the parent and will therefore display a disorganized array of attachment approach and avoidance behaviors referred to as an insecure anxious-disorganized attachment (Lyons-Ruth, Bronfman, & Parsons, 1999; Main & Hesse, 1990; van IJzendoorn, Schuengel, Bakermans-Kranenburg, 1999).

Children's response to available and nurturing parents, on the other hand, is to develop a secure attachment to the parent that is characterized by the child's greater comfort with separations from the parent, greater independent exploratory behavior away from the "secure base" of the parent, and fewer overt displays of attachment seeking behaviors (Ainsworth, 1979; Bowlby, 1969; 1979; 1988). Conversely, children who evidence a hyper-bonding motivation to remain in continual proximity with the parent, who are reluctant to engage in normal-range exploratory activity away from the parent, and who emit a high frequency of bonding signals to the parent, such as overly frequent displays of affection toward the parent or of frequently seeking affectionate displays from the parent, are insecurely attached with this parent (Ainsworth, 1979; Bowlby, 1969; 1973; 1980).

Induced Suppression of the Attachment System

Since the attachment system is a predator-driven motivational system, it is highly responsive to parental signals of threat or danger. Within the family communications traditionally described as "parental alienation," the personality disordered alienating parent provides the child with communicative signals indicating that the alienating parent perceives the child's independent relationship with the other parent as representing a threat to the child. These parental signals of threat are conveyed to the child through the alienating parent's emotional signals of over-anxious concern regarding the child's separations from the personality disordered alienating parent, especially the child's visitations with the other parent, and from the over-anxious parental concern and dismay displayed by the alienating parent at the supposedly inadequate parental care the child is receiving from the other parent, typically framed as the other parent being insufficiently responsive to the child's emotional and psychological needs.

Parental signals of threat are also communicated to the child through the high frequency of parental retrieval behaviors (Bowlby, 1969) displayed by the narcissistic/borderline parent, such as frequent text messages, emails, and phone calls made to the child while the child is on visitation with the other parent, and by emotionally supportive responses offered to the child by the personality disordered alienating parent whenever the child expresses reluctance to go on visitations with the other parent. Parental retrieval behaviors seek to actively limit the child's separation from the parent and represent a parental response to perceived threat, such as the presence of a predator

(Bowlby, 1969). By signaling a parental perception of threat, parental retrieval behaviors trigger the child's own attachment motivations to maintain proximity with the "protective parent" and to actively avoid and flee from the parentally identified source of threat.

In communicating to the child that the parent-child relationship and parenting practices of the other parent represent a threat to the child, the personality disordered alienating parent essentially defines the other parent as being "the predator" relative to the functioning of the child's attachment system motivations. The attachment system does not motivate children to bond with the predator, so that the imposed definition of the other parent as supposedly representing a threat to the child, which is provided to the child by the distorted communications and parenting practices of the alienating parent, effectively turn off the child's attachment motivations toward the other parent. Instead, the attachment system motivates children to flee from the parentally identified threat (i.e., from "the predator") and to seek and maintain protective proximity with the protective parent, which in the case of "parental alienation" family processes is the self-ascribed and self-adopted role of the personality disordered alienating parent.

This distorted construction of the family role relationships created by the personality disordered alienating parent creates the foundation for the child's symptom display. In response to parental communications of threat, the child's activated attachment system motivates the child to withdraw from normal-range exploratory behavior of forming an independent relationship with the other parent, who is identified by the alienating parent as being a source of the threat to the child, so that the child begins rejecting visitations with the other parent. Instead, the child is motivated to seek the continual protective proximity of the alienating parent who is presenting to the child as being the protective-nurturing parent, directly contrasting with the presented definition of the other parent as being a threat or danger to the child.

Inducing Child Rejection of the Other Parent

The personality disordered alienating parent induces the child's symptomatic rejection of the other parent by first eliciting through over-anxious and subtly directive questioning by the alienating parent a child criticism of the other parent or a description of an minor incident of parent-child conflict with the other parent. The alienating parent responds to these elicited child criticisms of the other parent with exaggerated parental responses of outrage and concern, thereby distorting and inflaming the child's elicited criticism of the other parent into supposed "evidence" of the "abusive" parental inadequacy of the other parent. The alienating parent's distorted and exaggerated response to the elicited criticism of the other parent defines for the child the meaning of the child's interactions with the other parent, and the child then accepts this distorted meaning through processes of social referencing (Asch, 1952; Hornik, Risenhoover, & Gunnar, 1987; Mineka, Davidson, Cook, & Keir, 1984; Schachter & Singer, 1962; Sherif, 1958; Sorce, Emde, Campos, & Klinnert, 1985; Walden, & Ogan, 1985).

This distorted communication process reflects the influence of an "invalidating environment" associated with borderline personality processes (Linehan, 1993), in which

the authentic experience of the child is nullified and replaced with the parentally desired meaning. According to Fruzzetti, Shenk, and Hoffman (2005),

In extremely invalidating environments, parents or caregivers do not teach children to discriminate effectively between what they feel and what the caregivers feel, what the child wants and what the caregiver wants (or wants the child to want), what the child thinks and what the caregiver thinks. (p. 1021)

Within this process, the alienating parent never offers the initial criticism of the other parent, but instead elicits this criticism from the child through over-anxious, over-concerned, and subtly directive parental questioning, leading the child to falsely believe that the child is independently offering the criticism of the other parent and that the alienating parent is only responding with “supportive understanding” for the child’s expressed grievances. This distorted communication dynamic of anxious over-concerned parental questioning by the alienating parent also serves to define the personality disordered alienating parent as the concerned, “nurturing-protective” parent, in direct contrast with the imposed definition of the other parent as the insensitive and “abusive” parent. Court orders and therapist directives to the parents not to speak negatively about the other parent are thereby rendered functionally irrelevant since the initial criticism is being elicited from the child, allowing the personality disordered alienating parent to adopt the role of a “nurturing and caring” parent who is simply “listening to the child.”

This relationship process is indicative of a role-reversal relationship (Bacciagaluppi, 1985; Bowlby, 1980; Kerig, 2005) in which the alienating parent first induces the child’s symptoms and then exploits these induced child symptoms. The alienating parent hides his or her own motivational agenda behind the child, who is placed in the lead of having to initiate the rejection of the other parent, so that the personality disordered alienating parent can present as the nurturing-protective parent who is simply “listening to the child.” The personality disordered alienating parent then presents this coveted role as the “nurturing-protective parent” to others throughout subsequent enactments of the alienation drama, receiving social validation for the alienating parent’s narcissistic inflation as the all-wonderful, perfectly nurturing and caring parent. This dynamic has Munchausen Syndrome by Proxy overtones (Rand, 1997), in which child symptomatology is induced for the secondary gain provided to the parent, although in “parental alienation” the induction of child symptomatology is a non-conscious product of the alienating parent’s inherent psychopathology. The clearly inappropriate placement of the child into the lead position of criticizing and rejecting the other parent, a role position that is then exploited by the alienating parent, is directly indicative of a role-reversal relationship process (Kerig, 2005) in which the child is being exploited by the narcissistic/borderline parent to regulate the parent’s own emotional and psychological functioning.

Personality Disorder Symptom Expression

In acquiring the distorted meaning constructions of the personality disordered alienating parent the child also acquires the personality disordered attitudes of the narcissistic/borderline parent toward the other parent, so that the child’s symptom display toward the targeted-rejected parent also evidences a characteristic set of narcissistic and

borderline personality disorder features. These narcissistic and borderline features that are evidenced in the child's symptom display are not endogenous to the functioning of the child's own psychological processes, but instead represent the acquired product of the child's psychologically enmeshed relationship with a narcissistic/borderline parent, who represents the actual originating source for the personality disordered processes.

The child's personality disorder symptoms therefore act as a lens into the personality disorder traits of the alienating parent, and may include additional personality disorder features, such as paranoid, antisocial, histrionic, and obsessive-compulsive personality disorder symptoms. These personality disorder processes of the alienating parent, expressed in the child's symptoms, represent the coalesced product of disordered attachment networks of the alienating parent, so that individual variations in the displayed personality disorder features merely reflect the individuality of the alienating parent's childhood attachment experiences. However, narcissistic and borderline personality disorder features will always be present, reflecting the central organizing structure of the alienating parent's attachment networks involving a fundamental self-experience of primal inadequacy (i.e., narcissistic personality processes) and an intense fear of abandonment (i.e., borderline personality processes), that then subsequently drive the alienation processes within the family.

The child's symptom display evidences a specific set of narcissistic and borderline features that includes,

- 1) **Grandiosity:** an inappropriately elevated sense of grandiosity in which the child perceives himself or herself to be of an elevated status in the family hierarchy above that of the targeted parent that allows the child to feel entitled to sit in judgment of the targeted parent's adequacy, both as a parent and as a person (DSM-5 Narcissistic Personality Disorder criterion 1; American Psychiatric Association, 2013),
- 2) **Entitlement:** a prominent sense of child entitlement in which the child feels justified in expecting that every child desire be met by the targeted parent to the child's satisfaction, and if these entitled expectations are not met to the child's satisfaction then the child feels justified in exacting a retaliatory revenge against the targeted parent, punishing the parent for the alleged failures as a parent, (DSM-5 Narcissistic Personality Disorder criterion 5; American Psychiatric Association, 2013),
- 3) **Absence of Empathy:** a complete absence of normal-range empathy for the suffering inflicted by the child on the targeted-rejected parent (DSM-5 Narcissistic Personality Disorder criterion 7; American Psychiatric Association, 2013),
- 4) **Haughty-Arrogant Attitude:** a haughty and arrogant attitude of contemptuous disdain for the targeted-rejected parent (DSM-5 Narcissistic Personality Disorder criterion 9; American Psychiatric Association, 2013),
- 5) **Splitting:** a splitting dynamic of polarized relationships in which the alienating parent is perceived by the child as being the ideal and perfect parent, while the

targeted-rejected parent is entirely devalued and demonized as being a fundamentally inadequate, and therefore “abusive,” parent (DSM-5 Borderline Personality Disorder criterion 2; American Psychiatric Association, 2013).

As a symptom characteristic, splitting has been associated with both narcissistic and borderline personality disorder traits (Kernberg, 1975; Watson & Biderman, 1993). This splitting process relative to borderline personality disorder dynamics is described by Linehan (1993),

“They tend to see reality in polarized categories of “either-or,” rather than “all,” and within a very fixed frame of reference. For example, it is not uncommon for such individuals to believe that the smallest fault makes it impossible for the person to be “good” inside... Things once defined do not change. Once a person is “flawed,” for instance, that person will remain flawed forever.” (p. 35)

Misattribution of Causality

The narcissistic and borderline personality disorder traits of the alienating parent represent the coalesced product of insecure anxious-disorganized/anxious-preoccupied attachment networks (Agrawal, Gunderson, Holmes, & Lyons-Ruth, K. 2004; Beck, Freeman, & Associates, 2004; Brennan & Shaver, 1998; Fonagy, Luyten, & Strathearn, 2011; Fonagy, Target, Gergely, Allen, & Bateman, 2003; Holmes, 2004; Jellema, 2000; Levy, 2005; Lyddon & Sherry 2001; Pistole, 1995; Smolewska & Dion, 2005). The attachment system mediates both the formation of bonded relationships as well as the loss of these attached relationships (Bowlby, 1969; 1973; 1980). The divorce and family’s dissolution activates the alienating parent’s attachment networks in response to the loss of the attachment-mediated spousal relationship and the dissolution of the family. The activation of the alienating parent’s attachment networks correspondingly activate the narcissistic and borderline personality disorder processes of the alienating parent that represent the constellated product of the insecure anxious-disorganized/anxious-preoccupied attachment networks.

The organizing core of the alienating parent’s narcissistic personality disorder processes involve an intense self-experience of primal inadequacy (Beck, Freeman, & Associates, 2004),¹ which produces a compensatory narcissistic over-inflation of self as a defense against the experience of fundamental self-inadequacy. The central organizing theme of the alienating parent’s borderline personality processes involve an intense fear of abandonment that results in “frantic efforts to avoid real or imagined abandonment” (Borderline Personality Disorder Criterion 1; American Psychiatric Association, 2013; p. 663). The divorce and family’s dissolution threatens to collapse the alienating parent’s narcissistic defense against the experience of primal self-inadequacy and also activates the

¹ “The core belief of narcissistic personality disorder is one of inferiority or unimportance. This belief is only activated under certain circumstances and thus may be observed mainly in response to conditions of self-esteem threat. Otherwise, the manifest belief is a compensatory attitude of superiority.” (Beck, Freeman, & Associates, 2004, p. 249)

alienating parent's intense fear of abandonment, creating for the personality disordered alienating parent an overwhelming experience of intense anxiety, the source of which is poorly comprehended by the personality disordered alienating parent so that the causal origin of the alienating parent's intense anxiety becomes prone to misinterpretation and misattribution by the alienating parent. This potential for the misattribution of meaning regarding an experience emanating from the internal working models of the attachment system is described by Bowlby (1980).

One or a set of responses the person is making may be disconnected cognitively from the interpersonal situation that is eliciting it, leaving him unaware of why he is responding as he is. He may mistakenly identify some other person (or situation) as the one who (which) is eliciting his responses. (p. 65)

Fear represents an emotional signal of threat or danger. The personality disordered alienating parent lacks sufficient insight and self-reflective capacity to accurately attribute the experience of intense anxiety to activated internal working models of attachment trauma, and instead misinterprets the experience of intense anxiety associated with the divorce and family's dissolution as representing an emotional signal of an actual threat posed by the other parent, who, as the abandoning/rejecting attachment figure, is the triggering cue for activating the alienating parent's attachment networks and anxieties. However, the grandiose self-inflation of the alienating parent's narcissistic personality processes reject that the other parent represents a direct threat to the alienating parent, so instead the attribution of causality for the intense experience of anxiety is shifted into the patterns of the internal working models of the attachment system as "abusive parent/victimized child."

The internal working models of the attachment system represent cognitive-emotional schemas (Platt, Tyson, & Mason, 2002) that guide the person's understanding and interpretation of interpersonal experiences. Collins (1996) describes the influence that internal working models of attachment have on interpreting attachment-related events,

Working models of attachment are highly accessible cognitive constructs that will be automatically activated in memory in response to attachment-relevant events. Once activated, they are predicted to have a direct impact on social information processing (including attention, memory, and inference) and on emotional response patterns... The impact of working models on behavior in any given situation will be largely mediated by the subjective interpretation of the situation along with one's emotional response. (p. 812)

For the personality disordered parent, the cognitive-emotional schemas that comprise the internal working models of the attachment system are unable to flexibly accommodate to the challenging information associated with the interpersonal rejection of the divorce, so that the internal working models of the alienating parent's attachment networks instead distort the interpretation of information to match, and become aligned with, the pre-existing structures of the attachment-related schemas. For the personality disordered alienating parent, the misinterpretation of an authentically experienced but

uncomprehended anxiety as representing an authentic emotional cue that the other parent represents a threat becomes the perceptual-experiential core around which a primary cognitive distortion develops, in which the alienating parent perceptually registers the other parent as being an actual “abusive” threat to the child as a result of cognitive distortions imposed on the assimilation of information by the alienating parent’s pre-existing cognitive schemas that cannot be altered to accommodate information that is discrepant to these schemas (i.e., internal working models). Instead, the alienating parent’s cognitive models impose their “reality” onto the assimilation of information, distorting the interpretation of information to match the pre-existing cognitive beliefs.

The alienating parent’s misinterpretation and misattribution of causality for an authentic but uncomprehended experience of intense anxiety leads to the formation of an intransigently held, fixed and false belief system regarding the “abusive” threat posed to the child by the supposedly inadequate parenting practices of the other parent, which then supposedly requires a “protective” parental response from the alienating parent. This false belief system of the alienating parent regarding the supposedly “abusive” parenting of the other parent is not amenable to change by contrary and disconfirming evidence because it is being fixed into place by the alienating parent’s misattribution of causality for an authentically experienced, but misattributed, intense anxiety, that then distorts the assimilation of information into matching the pre-existing false belief system. If conflicting and contrary information is presented to the alienating parent, it is simply cognitively disregarded (a cognitive process akin to denial).

The misattribution of meaning regarding an authentic but uncomprehended emotional-perceptual experience reflects the developmental sequelae of the “invalidating environment” associated with borderline personality disorder processes (Linehan, 1993), in which distorted and invalidating parental communications interfere with the development of accurate attributions regarding self-experience. Kernberg (1975) describes this association of narcissistic and borderline personality processes, “one subgroup of borderline patients, namely, the narcissistic personalities... seem to have a defensive organization similar to borderline conditions, and yet many of them function on a much better psychosocial level” (p. xiii).²

Both borderline and narcissistic processes are vulnerable to disorganization into psychotic cognitive processes. Beck et al. (2004) note that “the diagnosis of “borderline” was introduced in the 1930s to label patients with problems that seemed to fall somewhere

² “The defensive organization of these patients [narcissists] is quite similar to that of the borderline personality organization in general... what distinguishes many of the patients with narcissistic personalities from the usual borderline patient is their relative good social functioning, their better impulse control, and... the capacity for active consistent work in some areas which permits them partially to fulfill their ambitions of greatness and of obtaining admiration from others. Highly intelligent patients with this personality structure may appear as quite creative in their fields: narcissistic personalities can often be found as leaders in industrial organizations or academic institutions; they may also be outstanding performers in some artistic domain.” (Kernberg, 1975, p. 229)

in between neurosis and psychosis” (p. 189), and Millon (2011) describes the formation of delusional beliefs in the psychological decompensation of narcissistic personality processes under stress,

Owing to their excessive use of fantasy mechanisms, they [narcissists] are disposed to misinterpret events and to construct delusional beliefs. Unwilling to accept constraints on their independence and unable to accept the viewpoints of others, narcissists may isolate themselves from the corrective effects of shared thinking. Alone, they may ruminate and weave their beliefs into a network of fanciful and totally invalid suspicions. Among narcissists, delusions often take form after a serious challenge or setback has upset their image of superiority and omnipotence... Delusional systems may also develop as a result of having felt betrayed and humiliated. Here we may see the rapid unfolding of persecutory delusions... (p. 407-408)

The DSM-5 (American Psychiatric Association, 2013) defines delusions as “fixed beliefs that are not amenable to change in light of conflicting evidence” (p. 87). Garety & Freeman (1999) note that some forms of delusional beliefs can develop from causal misinterpretations of authentically experienced but uncomprehended perceptual experiences. The formation of the delusional beliefs of the alienating parent as a consequence of authentically experienced but uncomprehended, and so misinterpreted, trauma-related and personality disorder anxieties would be consistent with this type of delusion formation process. The narcissistic and borderline processes of the personality disordered alienating parent are particularly vulnerable to creating this type of false and distorted causal attributions regarding interpersonal relationships because of the formative impact of the invalidating environment in the development of these disordered personality structures, and the underlying vulnerabilities of the personality structure of the narcissistic/borderline parent.

The intransigently held, fixed and false beliefs of the alienating parent regarding the supposedly “abusive” threat posed to the child by the parenting practices of the other parent would meet the DSM-5 diagnostic definition for a delusional belief. The child’s acquisition of this intransigently held, fixed and false belief as an induced product of the distorted communication and parenting practices of the personality disordered parent (representing a trans-generational transmission of the “invalidating environment” associated with the formation of borderline personality disorder processes), would therefore represent a shared delusional process (Ellis, 2000).

The formative seed for the child’s own causal misattribution of self-experience is also similarly based in a misinterpretation of an authentically experienced, but uncomprehended, emotional experience, under the distorting influence of the invalidating environment created by the personality disordered parent. While the alienating parent’s misattribution of causality concerns an authentic, but uncomprehended, experience of excessive anxiety, for the child this causal misattribution of meaning is for an authentic but uncomprehended experience of grief and mourning, arising from the uncompleted attachment bonding motivations the child has for the targeted-rejected parent. Ainsworth (1989) describes the emotional responses produced by the attachment system,

I define an “affectional bond” as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional bond, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief. (p. 711)

The relationship definition imposed on the targeted parent as representing an “abusive” threat to the child acts to artificially suppress the behavioral expression of the child’s attachment bonding motivations toward the targeted parent. However, the attachment system nevertheless remains a primary motivational system embedded in the neurological networks of the child’s brain systems, and so continues to function normally beneath the induced suppression of its behavioral expression. So that the authentic functioning of the child’s underlying attachment system continues to motivate the child toward attachment bonding with the targeted parent even as the child behaviorally rejects a relationship with this parent as a consequence of the distorted parental influence of the personality disordered alienating parent.

As described by Ainsworth (1989), “in attachments, as in other affectional bonds, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss” (p. 711). The failure of the child’s attachment system to achieve completion of its motivational press for “affectional” bonding with the targeted parent will produce a grief and mourning response in the child as a consequence of the disrupted attached bond with the targeted parent (Ainsworth, 1989; Bowlby, 1969; 1973; 1979; 1980). According to Bowlby (1980),

A feature of the attachment behavior of the greatest importance clinically, and present irrespective of the age of the individual concerned, is the intensity of the emotion that accompanies it, the kind of emotion aroused depending on how the relationship between the individual attached and the attachment figure is fairing. If it goes well, there is joy and a sense of security. If it is threatened, there is jealousy, anxiety, and anger. If broken there is grief and depression. (p. 4)

The narcissistic personality structure of the alienating parent, however, lacks the empathic capacity to comprehend the child’s experience of grief and mourning at the loss of the child’s “affectional” attachment with the targeted-rejected parent, so that the narcissistic/borderline alienating parent is characterologically unable to help the child comprehend an authentic experience of grief and mourning at the loss of an affectional attachment bond with the targeted parent. According to Kernberg (1975),

They [narcissists] are especially deficient in genuine feelings of sadness and mournful longing; their incapacity for experiencing depressive reactions is a basic feature of their personalities. When abandoned or disappointed by other people they may show what on the surface looks like depression, but which on further

examination emerges as anger and resentment, loaded with revengeful wishes, rather than real sadness for the loss of a person whom they appreciated. (p. 229)

Under the distorting and invalidating influence of the personality disordered alienating parent, the child is led into a misinterpretation of an authentic experience of sadness (i.e., the grief response at the loss of an affectional relationship with the targeted parent) as falsely representing emotional “evidence” for the supposedly “abusive” parenting practices of the other parent (i.e., the alienating parent’s interpretation as “anger and resentment, loaded with revengeful wishes”). This induced misinterpretation of an authentic emotional experience of grief and mourning is further supported by the child’s own experience of differential rises and falls in sadness that are triggered by the presence or absence of the targeted parent.

When the child is with the targeted parent, the increased availability of the beloved-but-rejected targeted parent increases the child’s affectional attachment motivations for bonding, thereby also increasing the child’s corresponding grief response at the failure of the child’s attachment motivation to achieve completion. Alternatively, when the child is away from the targeted parent and is in the care of the alienating parent, the child’s attachment motivation for affectional bonding with the targeted parent is less since the targeted parent is not available and so is not triggering the child’s attachment motivations for bonding, so that the child experiences a decrease in sadness (i.e., the grief response) when the child is with the alienating parent.

Under the distorting influence of the personality disordered parent’s invalidating parenting practices and communications, the child is led into misinterpreting an authentic experience of sadness at the loss of a bonded relationship with the other parent as instead being the product of supposedly “abusive” parenting practices by the other parent. Furthermore, the differential rise and fall in an authentic experience of sadness creates an avoidance response in the child, in which the child seeks to avoid the increased experience of sadness (i.e., the grief response that is being misattributed to “abusive” parenting) associated with being in the presence of the targeted parent, so that a conditioned avoidance response further contributes the child’s expressed desire to terminate contact with the targeted-rejected parent.

Paradoxical Relationship Display

The child’s misattribution of causality for an authentically experienced but uncomprehended grief response produces a distinctive paradoxical feature of the child’s relationship with the targeted-rejected parent; that the kinder and more affectionate the targeted-rejected becomes with the child, the more hostile and rejecting the child becomes. When the targeted-rejected parent becomes kinder and more affectionate with the child the child’s motivations for affectional attachment bonding with the targeted parent also become stronger, which then produces a stronger and more intense grief response at the loss of an affectionally bonded relationship with the targeted parent. However, the child misinterprets this increase in authentically experienced emotional pain as being the product of “abusive” parenting from the targeted parent (who represents the triggering cue for the child’s increased emotional pain) leading the child to lash out at the targeted-

rejected parent in angry retaliation (i.e., the acquired alienating parent's attribution of "anger and resentment, loaded with vengeful wishes"), so that symptomatically the child becomes openly demeaning of the targeted parent's expressions of love and loss, since these expressions increase the child's attachment motivations and so increase the child's pain, which the child then interprets as the product of "abusive" parenting.

Therapy that targets eliciting greater displays of kindness and understanding from the targeted-rejected parent toward the child, without also targeting the child's misattribution of meaning regarding an authentically experienced but misattributed grief response, will therefore be singularly ineffective in restoring the parent-child relationship. When the targeted-rejected parent expresses greater kindness and affection for the child, the child will simply dismiss and demean these expressions of love and affection by the parent as being "fake," and will instead switch the justification for the continued rejection of the targeted parent to the child's lack of trust for the parent, sometimes framing this as the targeted-rejected parent "fooling" other people into thinking that he or she is a kind and loving parent (i.e., "You don't know what she's really like. She acts different when she's around other people. She's so fake."), so that the child's behavior is no longer under the stimulus control of the parent's behavior and parental responses to the child, and the actual interactions that occur with the targeted-rejected parent will simply be distorted by the child's pre-existing, intransigently held, fixed and false beliefs into matching these pre-existing beliefs.

The child's failure to respond appropriately to parental displays of kindness and affection represents the inability of the child's (induced) delusional belief system to accommodate to contrary information. Since a central feature of the alienation process is the formation of a shared delusional belief system regarding the "abusive" parenting of the targeted-rejected parent, the contrary evidence provided by displays of parental kindness and affection from the targeted parent will be unable alter the child's fixed delusional belief that is being maintained by the child's misinterpretation of real sadness emanating from an authentic but uncomprehended grief response. Instead, the cognitive inflexibility of the delusional belief system will simply distort the child's perception and interpretation of the targeted parent's behavior into an interpretation consistent with the pre-existing false belief.

In order for treatment to be effective, it must recognize the central role of the shared delusional process in creating an irreconcilable parent-child conflict that is the product of authentically experienced but uncomprehended experiences for both the alienating parent and the child; anxiety for the parent, grief and mourning for the child. The resolution the parent-child conflict requires that the child's delusional misattribution of meaning must also be resolved. However, resolving the child's false belief system and misattribution of meaning will be difficult as long as the child's false attribution of meaning, representing a shared delusional process, is receiving continual support and validation from the distorted communication and parenting practices of the primary case; the alienating parent.

Parental Anxiety Regulation

The alienating parent must regulate three interrelated sources of intense anxiety,

1) **Narcissistic Personality Anxiety:** involving the threatened collapse of narcissistic defenses against primal self-inadequacy in response to the inherent interpersonal rejection associated with the divorce experience,

2) **Borderline Personality Abandonment Fears:** involving the experience of an intense fear of abandonment triggered by the loss of the spousal attachment figure and the family's dissolution,

3) **Attachment-Trauma Anxiety:** an intense anxiety emanating from reactivated trauma anxiety networks from the childhood of the alienating parent, contained within the internal working models of the alienating parent's attachment networks. This trauma-related anxiety reflects the relationship pattern of "abusive parent/victimized child." The alienating parent's traumatized attachment networks represent the original dysfunctional relationship source for the formation of the anxious-disorganized/anxious-preoccupied attachment networks, that subsequently coalesced during the childhood and adolescence of the alienating parent into narcissistic and borderline personality disorder processes involving themes of primal self-inadequacy and an intense fear of abandonment.

The narcissistic/borderline alienating parent regulates the twin personality disorder anxieties of self-inadequacy and an intense fear of abandonment by psychologically expelling these fears through projective displacement onto the other parent, by means of a role-reversal exploitation of the child's induced symptomatology in which the child's induced rejection of the other parent automatically creates the definition of the targeted parent as being the fundamentally inadequate parent (and person) who is being rejected (abandoned) by the child because of this fundamental parental, and personal, inadequacy. The alienating parent uses (exploits) the child's induced symptomatic rejection of the other parent to create a definition of the other parent in which the alienating parent's own narcissistic and borderline personality disordered fears can be projectively displaced onto the other parent, who becomes, through the child's induced symptoms, the fundamentally inadequate and entirely abandoned parent and person (i.e., "I'm not the inadequate person; you are. I'm not the abandoned person; you are. And you're being abandoned because of your fundamental inadequacy as both a parent and as a person.").

The use of projection as a psychological defense is associated with both narcissistic and borderline personality processes (Kernberg, 1975; Beck, Freeman, Davis, & Associates, 2004). According to Beck et al. (2004), "a borderline organization is described as an immature personality, characterized by identity diffusion and the use of primitive defenses such as splitting and projective identification" (p. 189). Cohen (1998) also describes the narcissist's use of projection as a primary psychological defense against experiences of self-inadequacy,

The propensity to blame is an outstanding feature... of narcissistic behavior in general. It is a way for the narcissist to see himself in a good light and a manifestation of the splitting off of the negative aspects of the self and projecting

them onto others that is a major narcissistic defense. (p. 206)

The child's induced symptoms of rejecting the targeted parent define the targeted parent as inadequate and rejected/abandoned, which can then be exploited by the alienating parent in a role-reversal parent-child relationship (Kerig, 2005) to regulate the emotional state of the narcissistic/borderline parent by projectively displacing the alienating parent's own inadequacy and abandonment fears onto the other parent.

In an interrelated knot of psychological processes, the child's induced symptoms also act to support the alienating parent's narcissistic defense against the experience of primal self-inadequacy that is activated by the divorce, by defining the alienating narcissistic/borderline parent as the ideal and "all-wonderful" parent in direct contrast to the devalued targeted parent, thereby supporting the alienating parent's own narcissistic defense of self-inflated grandiosity that is being threatened by the interpersonal rejection inherent to the divorce. In addition, the child's induced symptomatic rejection of the targeted parent and hyper-bonding expressions toward the alienating parent also act to allay the alienating parent's borderline personality abandonment fears by defining the idealized alienating parent as the "never-to-be-abandoned" parent, again in direct contrast to the targeted parent as the "entirely abandoned" parent. So that the child's induced rejection of the other parent acts to projectively displace the alienating parent's inadequacy and abandonment fears onto the other parent, while simultaneously supporting the alienating parent's own narcissistic defenses that were challenged by the divorce, and also serving to resolve the abandonment fears of the personality disordered alienating parent by defining this parent as the "never-to-be-abandoned parent" (person).

Trauma Reenactment

The relationship trauma that created the alienating parent's insecure anxious-disorganized/anxious-preoccupied attachment subsequently coalesced during the childhood and adolescence of the alienating parent into narcissistic and borderline personality disorder processes involving the themes of primal self-inadequacy and abandonment fears (Agrawal, Gunderson, Holmes, & Lyons-Ruth, K. 2004; Brennan & Shaver, 1998; Fonagy, Target, Gergely, Allen, & Bateman, 2003; Fonagy, Luyten, & Strathearn, 2011; Holmes, 2004; Jellema, 2000; Levy, 2005; Lyddon & Sherry 2001; Pistole, 1995; Smolewska & Dion, 2005). The formation of an anxious-disorganized attachment is associated with parenting practices that simultaneously activate incompatible child attachment motivations for both bonding and avoidance, in which the parent simultaneously represents both a nurturing and a threatening attachment figure that prevents the child from forming a coherent attachment strategy, resulting in the development of an insecure anxious-disorganized attachment (Main & Hesse, 1990; Lyons-Ruth, Bronfman, & Parsons, 1999; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). The psychological tension created by the continual simultaneous activation of the child's incompatible motivations for attachment bonding and avoidance, caused by parenting that is simultaneously both a source of nurturance and of threat, can result in the fragmentation, or splitting, of the child's incompatible attachment motivations for bonding and avoidance into separate and functionally isolated networks in order to regulate the

child's intense ambivalence, since "splitting avoids the juxtaposition of two opposing affects so that tempering of respective feelings is not necessary" (Juni, 1995, p. 96).

Through the splitting process, the attachment motivations for bonding achieve psychological coherence by being organized around the separate, and functionally isolated, representations of the nurturing and protective parent, while the incompatible attachment motivations for avoidance achieve a separate coherence by being split off into a functionally separate network organized around representations for the frightening and threatening parental attachment figure. This fragmenting of the attachment motivations for bonding and avoidance into functionally separate and isolated networks results in the "splitting" dynamic evidenced with both narcissistic (Kernberg, 1975; Watson & Biderman, 1993) and borderline (Kernberg, 1975; Linehan, 1993) personality disorder processes, since the personality disorder features represent the coalesced product of the child's insecure anxious-disorganized/anxious-preoccupied attachment.

Within the "parental alienation" process, this splitting dynamic contained within the internal working models of the alienating parent's attachment networks is manifesting trans-generationally through the child's symptomatic splitting of attachment motivations toward the respective parents into separate and isolated motivations for bonding and avoidance relative to each parent, with the child entirely rejecting a relationship with the supposedly "abusive" and inadequate targeted parent, while simultaneously seeking an entirely bonded relationship with the supposedly nurturing and protective personality disordered parent. The child's splitting of attachment motivations into isolated and functionally separate motivations for bonding and avoidance relative to each parent represents the symptomatic product of the trans-generational transmission of attachment trauma from the childhood of the alienating parent to the current family relationships (Benoit & Parker, 1994; Fonagy & Target, 2005; Jacobvitz, Morgan, Kretchmar, & Morgan, 1991; Prager, 2003; van Ijzendoorn, 1992).

The internal working models of the alienating parent's attachment system are organized around three primary relationship roles,

- 1) **The Victimized Child:** This representational network contains the alienating parent's self-representations as a child in relationship with a hostile and threatening attachment figure.
- 2) **The Abusive Parent:** This representational network is comprised of the child's split off and functionally separate internal working models for the hostile-threatening parental attachment figure who triggered the child's intense anxiety and avoidance motivations.
- 3) **The Nurturing-Protective Parent:** This representational network contains the child's split off and functionally separate representations for the nurturing parental attachment figure, who triggered the child's attachment bonding motivations. During the childhood of the alienating parent, the psychological presence of the split off representational network for the nurturing attachment figure served to

psychologically protect the child from the “arrival” of the separate, hostile and threatening attachment figure.

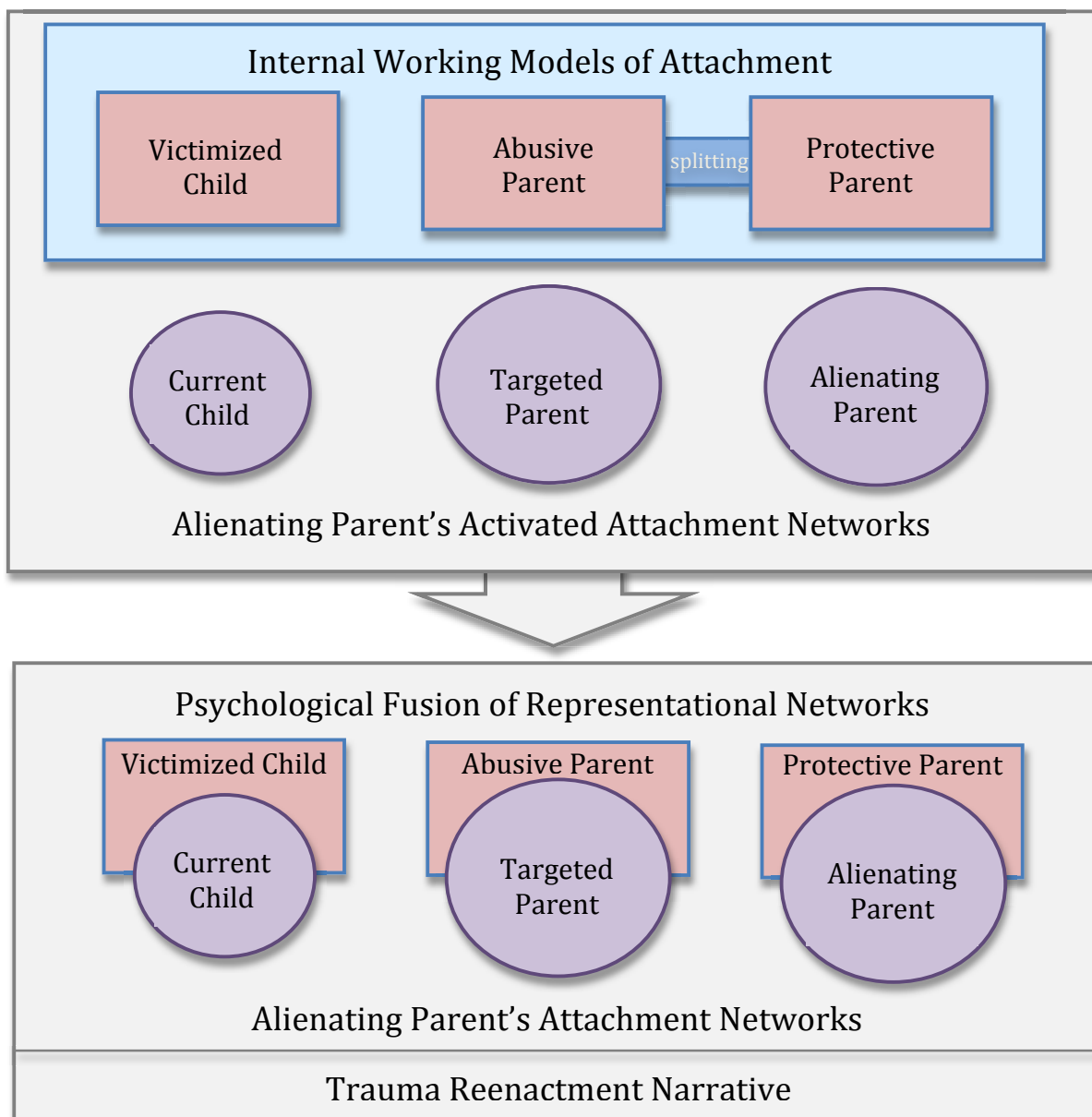
The divorce and family’s dissolution activates the internal working models of the alienating parent’s attachment networks to mediate the interpersonal loss experience, so that two sets of representational networks for attachment figures become concurrently activated, one from the past as embedded in the internal working models of the alienating parent’s attachment networks, and one representing the current attachment figures represented by the current spouse and child. Within the personality disordered attachment system of the alienating parent, the concurrent activation of two sets of attachment figure representational networks creates an overlay of attachment figure representations in which the representational networks contained within the internal working models of past relationships become psychologically equivalent to, and fused with, the representational networks for the current attachment figures (figure 2).

Within the personality disordered processes of the alienating parent, the representational network for the current child becomes equivalent to the “victimized child” representational network of the internal working models of the alienating parent’s attachment system; the representational network for the other parent becomes psychologically equivalent to the split-off representational network for the “abusive parent” originating within the internal working models of the alienating parent’s attachment networks; and the self-representational network for the alienating parent becomes psychologically equivalent to the split-off representational network for the “nurturing-protective” parent within the internal working models of the alienating parent’s attachment system. This psychological fusion of representational networks for past and current attachment figures results in the reenactment in current relationships of the alienating parent’s childhood relationship trauma (van der Kolk, 1989), through which the alienating parent is able to both regulate the reactivated trauma anxiety associated with the “abusive parent/victimized child” experience of childhood that is being re-experienced because of the current activation of the alienating parent’s traumatized attachment networks, as well as to psychologically reprocess and work through the childhood trauma experience. According to Prager (2003),

Trauma, as a wound that never heals, succeeds in transforming the subsequent world into its own image, secure in its capacity to re-create the experience for time immemorial. It succeeds in passing the experience from one generation to the next. The present is lived as if it were the past. (p. 176)

Within the current family relationships, the alienating parent initiates the trauma reenactment by first eliciting criticisms of the other parent from the child, that are then exaggerated and inflamed by the alienating parent through distorted parental responses of excessive concern and dismay into the necessary “evidence” of the child’s alleged “victimization” from the supposedly “abusive” parenting of the other parent, which then requires a “nurturing-protective” parental response from the alienating parent, thereby reenacting all three roles from the internal working models of the alienating parent’s attachment system in the current family relationship drama.

Formation of Trauma Reenactment Narrative



The divorce and family's dissolution activates the alienating parent's attachment system to mediate the loss experience. Within the alienating parent's attachment system, two sets of representational networks become concurrently activated, the internal working models of attachment from childhood trauma and representational networks for the current family members of the other parent/spouse and child.

The concurrent activation of two sets of representational networks leads to their psychological fusion in the mind of the personality disordered alienating parent, resulting in the reenactment of the past childhood attachment trauma in current relationships.

Figure 2: Formation of the Trauma Reenactment Narrative

The reenactment narrative, however, contains two important variations from the original childhood trauma experience of the alienating parent that allow the alienating parent to regulate the reactivated trauma anxiety and reprocess the trauma experience,

- 1) **Active Child Agency:** In the original childhood trauma experience, the alienating-parent-as-a-child was a helpless victim of abusive parenting practices that created the insecure anxious-disorganized/anxious-preoccupied attachment that subsequently coalesced into the narcissistic and borderline personality disorder processes that are organized around themes of fundamental self-inadequacy and an intense fear of abandonment. The reactivation of these attachment trauma networks triggers an intense anxiety for the alienating parent associated with feelings of helplessness. The alienating parent regulates this trauma anxiety in the reenactment by empowering the active agency of the current “victimized child” (who represents the fused psychological equivalency of the current child with the alienating parent as the “victimized child” contained within the internal working models of the alienating parent’s attachment networks) in rejecting the current representation for the “abusive parent” (i.e., a role ascribed to the current targeted-rejected parent). The empowerment and active agency of the “victimized child” thereby becomes a central organizing theme of the reenactment narrative in regulating the alienating parent’s own trauma anxiety, resulting in a nearly obsessional fixation for the alienating parent in empowering the child’s active agency in rejecting the other parent (e.g., “we should listen to the child,” “the child should decide whether or not to go on visitations with the other parent,” “what can I do, if the child doesn’t want to go on visitations with the other parent I can’t make the child go.”).
- 2) **Real-World Protector:** In the original childhood trauma experience, the child (i.e., the alienating-parent-as-a-child) could only achieve a limited psychological protection from the hostile and threatening parenting practices of the abusive parent by psychologically splitting off the representations for the abusive and threatening experiences into an experientially separate and functionally isolated network from the representational networks for the nurturing parent. The experiential presence of the separate and functionally isolated representational network for the nurturing parent acted to psychologically protect the child from the “arrival” of the separate representational network for the hostile-abusive parent. In the trauma reenactment narrative, however, the current representation for the “victimized child” (i.e., the equivalency of the current child with the alienating parent as a “victimized child”) has an actual real-world protecting parental figure in the role and person of the alienating parent, who “protects the child” from the supposedly dangerous and abusive parenting practices of the other parent, i.e., the “abusive parent.” The importance of this alteration in the reenactment narrative from the original trauma experience in regulating the alienating parent’s reactivated trauma anxiety is evidenced in the obsessive focus of the alienating parent on “protecting the child.” The alienating parent will call, text message, and email the child frequently when the child is with the other parent, and will generally disrupt the ability of the other parent to form an independent relationship with the child, all ostensibly to “protect the child” from the supposedly “abusive” parenting practices of

the other parent. The alienating parent may even try to enlist the aid of others, such as therapists, the Court, and child protective services in this obsessive need to “protect the child.”

The alienating parent’s focus on “protecting the child” from the supposedly “abusive” parenting practices of the other parent are a manifestation of the splitting processes of the personality disordered parent. According to Kernberg (1975),

Patients with borderline personality organization tend to present very strong projective trends, but it is not only the quantitative predominance of projection but also the qualitative aspect of it which is characteristic. The main purpose of the projection here is to externalize the all-bad, aggressive self and object images, and the main consequence of this need is the development of dangerous, retaliatory objects against which the patient has to defend himself.” (p. 30)

The alienating parent’s projection of his or her own internal representations for the “abusive parent” (i.e., the “all-bad, aggressive self and object images”) onto the other parent creates in the mind of the alienating parent the perception of a “dangerous” threat posed to the child by the other parent that then, according to the alienating parent, requires a “protective” response from the “nurturing/protective” alienating parent.

Clinical Diagnostic Indicators

The psychological and family relationship processes traditionally referred to as “parental alienation” represent a characteristic set of signs and symptoms associated with the trans-generational transmission of attachment trauma from the childhood of the alienating parent to the current family relationships, mediated by narcissistic and borderline personality disorder processes of the alienating parent that represent the coalesced product of insecure anxious-disorganized/anxious-preoccupied attachment networks involving themes of fundamental self-inadequacy and an intense fear of abandonment. From a clinical diagnostic framework, the processes associated with what has traditionally been referred to as “parental alienation” can be recognized by a characteristic set of three child symptom features,

1. **Attachment System Suppression:** The child’s symptom display evidences a selective and targeted suppression of the normal-range functioning of the child’s attachment bonding motivations toward one parent, in which the child entirely rejects a relationship with this parent. A clinical assessment of the parenting behavior of the rejected parent provides no evidence for severely dysfunctional parenting (such as chronic alcoholism or drug abuse, or the physical or sexual abuse of the child) that would account for the child’s complete rejection of the parent, so that the parenting of the targeted-rejected parent is assessed to be broadly normal-range, with due consideration for the range of parenting practices typically displayed in normal families and with appropriate regard for the normal-range exercise of parental authority and discipline.

2. **Personality Disorder Symptoms:** The child's symptoms evidence a specific set of narcissistic and borderline personality disorder symptoms comprised of,

Grandiosity: the child's grandiose self-perception of having an elevated status in the family hierarchy above that of the rejected parent that allows the child to feel entitled to sit in judgment of the rejected parent, as both a parent and as a person,

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

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

Haughty and Arrogant Attitude: a haughty and arrogant child attitude of contemptuous disdain for the rejected parent,

Splitting: the splitting dynamic expressed in the child's differential relationship with his or her parents, in which the favored parent is idealized as the all-good and nurturing parent while the rejected parent is devalued as the all-bad and entirely inadequate parent.

Anxiety Variant: Younger children may not yet display these personality disorder symptoms but may instead evidence an excessive anxiety regarding the rejected parent. This symptom of excessive anxiety is the product of the child's acquisition of the alienating parent's perception of the other parent as representing a threat to the child. The younger child may not yet possess sufficient cognitive sophistication to be able to acquire the alienating parent's personality disorder distortions, but the child nevertheless acquires the alienating parent's emotional anxiety related to the perception of threat regarding the other parent, so that the younger child more directly expresses these acquired anxiety distortions. In the anxiety variant of "parental alienation," the child's anxiety symptoms will meet diagnostic criteria for a Specific Phobia (as an induced product of the alienating parent's communicated perceptions of threat), but the type of phobia will be a bizarre and unrealistic "father type" or "mother type." The attachment system would prevent children from developing an authentic phobic response to a parent since a "mother phobia" or "father phobia" would differentially expose children to increased survival risk, thereby systematically removing their genes from the collective gene pool. A child's symptom display of a "mother type" or "father type" of Specific Phobia represents an inauthentic child symptom presentation reflecting the induced product of the distorted parenting practices of the alienating parent.

3. **Delusional Belief System:** The child's symptoms display an intransigently held, fixed and false belief regarding the fundamental parental inadequacy of the targeted-rejected

parent that characterizes the targeted-rejected parent as being emotionally or psychologically “abusive” of the child (i.e., that the child is in need of “protection”).

DSM-5 Diagnosis

While the child’s symptoms are the induced product of parental psychopathology, a formal diagnosis of parental psychopathology is not required for making an appropriate diagnosis based on the child’s symptomatology. The family processes associated with “parental alienation” can be reliably identified entirely through the child’s symptom display, which evidence the three characteristic diagnostic indicators, 1) a selective and targeted suppression to the normal-range functioning of the child’s attachment system relative to one parent, 2) the presence in the child’s symptom display of a characteristic set of narcissistic and borderline personality disorder symptoms (or unrealistic phobic anxiety), and 3) the presence in the child’s symptom display of an intransigently held, fixed and false belief regarding the fundamental inadequacy of the rejected parent which is characterized by the child as being psychologically or emotionally abusive.

The combined presence in the child’s symptom display of this specific set of disparate types of symptoms can only be accounted for by the trans-generational transmission of attachment trauma from the childhood of the alienating parent to the current family relationships, mediated by narcissistic and borderline personality disorder traits of the alienating parent which represent the coalesced product of insecure anxious-disorganized/anxious preoccupied attachment networks involving a parental self-experience of fundamental inadequacy and intense abandonment fears, that are being projectively displaced onto the other parent through a role-reversal relationship with the child in which the child’s elicited and induced rejection of the other parent serves to regulate the personality disordered parent’s own emotional processes by reenacting within the current family relationships, with select modifications, the attachment trauma dynamics of the personality disordered parent; which, in total, represents a family relationship process classically referred to as “parental alienation.”

According to the Merriam-Webster Dictionary, the definition of the term “syndrome” is,

1: a group of signs and symptoms that occur together and characterize a particular abnormality or condition. 2: a set of concurrent things (as emotions or actions) that usually form an identifiable pattern (syndrome. Merriam-Webster Online, 2013)

The trans-generational transmission of attachment trauma associated with “parental alienation” family processes, as described in this paper, reflects a coherent set of identifiable “signs and symptoms that occur together and characterize a particular abnormality and condition,” and these indicators form an “identifiable pattern” of emotions and actions which would seemingly qualify these processes for designation as a syndrome under both definitional criteria.

Induced Attachment System Suppression

The DSM-5 describes two disorders of attachment, a Reactive Attachment Disorder in which the child fails to form appropriate attachment bonds to caregivers, and a

Disinhibited Social Engagement Disorder, in which the child forms indiscriminant attachment bonds with unfamiliar adults. Both of these attachment disorders reflect fundamental disruptions to the underlying functioning of the child's attachment system as the result of severely neglectful parenting.

Within "parental alienation" processes, on the other hand, the fundamental functioning of the child's attachment system remains intact, but its selective expression toward a single individual, the targeted-rejected parent, is artificially suppressed by the distorted communication and parenting practices of a personality disordered parent by co-creating with the child a false definition of the targeted parent as representing a threat to the child, thereby selectively suppressing the child's affectional bonding motivations toward the targeted parent and instead activating the child's attachment motivations to flee from the parentally identified threat and seek continual protective proximity with the protective parent. Neither DSM-5 attachment disorder captures this process of selectively induced suppression of the child's attachment motivations.

Within the DSM-5 diagnostic system, the induced selective suppression of the expression of the child's attachment system is best captured by two secondary DSM-5 diagnoses, V61.20 Parent-Child Relational Problem and V61.29 Child Affected by Parental Relationship Distress. The DSM-5 diagnostic criteria for a Parent-Child Relational Problem includes "unwarranted feelings of estrangement" (American Psychiatric Association, 2013, p. 715) between the parent and child, suggesting that this diagnosis is directed toward the child's relationship with the targeted-rejected parent rather than toward the aberrant and distorted parenting practices of a personality disordered, favored and allied parent that are inducing significant developmental, emotional, and psychiatric symptoms in the child.

While the child's symptomatic relationship with the targeted-rejected parent is a focus of clinical attention, a more central clinical concern is the pathogenic parenting practices of the personality disordered parent that are inducing the child's symptomatic state. By analogy, if an infection (i.e., a pathogenic cause) is producing a fever (i.e., the symptomatic result), then some degree of clinical focus on resolving the fever would be warranted, yet the primary focus of clinical attention would be on resolving the pathogenic origins of the symptomatology that lay in the infectious disorder. Clinical attention focused solely on resolving the symptom while not also addressing the underlying pathogenic cause of the symptom will fail to effectively resolve the symptom and will simply result in continual efforts directed toward symptom control rather than symptom resolution.

So while one focus of clinical attention is certainly on resolving the child's symptomatic expression of a troubled relationship with the targeted-rejected parent, as captured by the diagnosis of a Parent-Child Relational Problem, a more central clinical focus is on resolving the pathogenic source of the child's symptomatology, i.e., the distorted and aberrant parenting practices of the personality disordered parent, even though the child's relationship with this favored and allied parent is not overtly expressing pathological symptoms that would independently call for clinical attention to this relationship.

The DSM-5 diagnosis of a Child Affected by Parental Relationship Distress is also warranted by the child's symptom presentation. The DSM-5 indicates that,

This category should be used when the focus of clinical attention is the negative effects of parental relationship discord (e.g., high levels of conflict distress or disparagement) on a child in the family. (American Psychiatric Association, 2013, p. 716)

This diagnosis would capture the distorting influence on the child's developmental, emotional, and psychological functioning caused by the pathogenic parenting practices of the personality disordered alienating parent who is responding to attachment related trauma as a consequence of the divorce and family's dissolution. However, of clinical note regarding this diagnosis is that the aberrant and distorted parenting practice of the personality disordered parent may not be expressed as overt conflict with the other parent, but may instead involve indirect approaches to initiating conflict with the other parent of using the child as a triangulated proxy expression for the inter-parental/"spousal" conflict. This proxy use of the child to express inter-parental/"spousal" conflict can involve supporting the child's induced symptomatology of rejecting the other parent under the guise of "listening to the child" and being "unable to force the child to go on visitations with the other parent" despite Court orders for such visitation, and by interfering with the other parent's ability to form an independent relationship with the child.

The distorted parenting practices of the personality disordered parent also may not involve directly disparaging the other parent, but will instead manifest through eliciting the initial criticism of the other parent from the child through over-anxious, over-concerned, and subtly directive parental questioning, and then supporting and inflaming this elicited child criticism by responding with exaggerated parental displays of outrage and concern at what are essentially normal-range parenting practices of the other parent. So that the superficial appearance presented to the child (and others) is that the alienating parent is simply "listening to the child," and is merely offering "support" and "understanding" for the child's expressed (i.e., elicited and induced) dissatisfaction with the other parent. However, a modicum of clinical acumen and professional competence in the domains of attachment theory (Bowlby, 1969; 1973; 1979, 1980; Lyons-Ruth, Bronfman, & Parsons, 1999; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999), personality disorder dynamics (Beck, Freeman, Davis, & Associates, 2004; Millon, 2011), and delusional processes (American Psychiatric Association, 2013; Garety & Freeman, 1999) should be able to identify the inappropriate parent-child coalition and role-reversal relationship (Haley, 1977; Minuchin; 1974; Shaffer & Sroufe, 2005) in which the child's symptomatic rejection of the targeted parent is first induced and then exploited by the personality disordered (narcissistic with borderline features) alienating parent.

Personality Disorder Processes

While the child's symptoms display a characteristic set of narcissistic and borderline personality disorder features, these symptoms are not endogenous to the child's own authentic personality structure, but instead represent the acquired product of the child's enmeshed psychological relationship with a personality disordered parent. As the child

acquires the distorted belief systems of the enmeshed personality disordered parent, the child also acquires the personality disorder features of the narcissistic/borderline parent's orientation toward the other parent, that are then expressed in the child's selective display of narcissistic and borderline personality disorder features directed only toward the targeted-rejected parent. The child's relationships with others, such as teachers and therapists will typically not display these narcissistic and borderline personality disorder traits, and may actually evidence "co-narcissistic" personality indicators (Rappoport, 2005) of over-compliance and over-sensitivity to social cues, acquired through the child's relationship with a narcissistic parent.

The narcissistic/borderline parent may not overtly evidence severe psychopathology, and may present as a confident, self-assured, "ideal" parent who is merely trying to "protect the child" from the "abusive" parenting practices of the other, inadequate, parent. Kernberg (1975) describes the outward presentation of the narcissistic personality,

The defensive organization of these patients [narcissists] is quite similar to that of the borderline personality organization in general... what distinguishes many of the patients with narcissistic personalities from the usual borderline patient is their relative good social functioning, their better impulse control, and... the capacity for active consistent work in some areas which permits them partially to fulfill their ambitions of greatness and of obtaining admiration from others. Highly intelligent patients with this personality structure may appear as quite creative in their fields: narcissistic personalities can often be found as leaders in industrial organizations or academic institutions; they may also be outstanding performers in some artistic domain. (p. 229)

Cohen (1998) notes the difficulty in identifying narcissistic personalities in clinical practice,

The perception [of narcissism in a patient] is hampered by the fact that narcissistic individuals may well be intelligent, charming, and sometimes creative people who function effectively in their professional lives and in a range of social situations (Akhtar, 1992; Hendlar, 1975)... While narcissism is recognized as a serious mental disorder, its manifestations may not be immediately recognized as pathological, even by persons in the helping professions, and its implications may remain unattended to. (p. 197)

One of the clearest clinical indicators of parental narcissistic pathology may be the absence of empathy for the experience of the targeted parent, and for the child in having to reject a parent. The absence of empathic resonance will be evident in the assertion by the alienating parent that the targeted parent "deserves" the child's rejection because of that parent's fundamental inadequacy as a parent (and person). Beck et al., (2004) describe this quality of a narcissistic personality,

If others fail to satisfy the narcissist's "needs," including the need to look good, or be free from inconvenience, then others "deserve to be punished" ... Even when punishing others out of intolerance or entitlement, the narcissist sees this as "a lesson they need, for their own good" (p. 252).

The narcissistic personality will also fail to empathically comprehend the child's psychological conflict and sadness at having to reject a parent and the loss of an affectional bond with the targeted-rejected parent, possibly because the narcissistic vacancy of an authentic grief response (Kernberg, 1975).³ Instead, the narcissistic parent will seemingly nonchalantly support the child's rejection of the other parent as justified, without apparent comprehension of the difficult psychological experience for a child who is rejecting a parent.

Another indicator of a parental narcissistic personality processes may be that parent's seeming disregard for authority and the rights of the targeted parent, perhaps evidenced as repeated disregard of Court orders for visitation. According to Beck et al. (2004),

Narcissistic individuals also use power and entitlement as evidence of superiority... As a means of demonstrating their power, narcissists may alter boundaries, make unilateral decisions, control others, and determine exceptions to rules that apply to other, ordinary people. (251)

Millon (2011) echoes this description of the narcissistic personality,

There is also a tendency for them [narcissists] to flout conventional rules of shared social living. Viewing reciprocal social responsibilities as being inapplicable to themselves, they show and act in a manner that indicates a disregard for matters of personal integrity, and an indifference to the rights of others. (p. 389)

The presence in the child's symptom display of narcissistic features and splitting should, however, clearly alert the clinician as to the potential presence of narcissistic and borderline personality disorder processes in a parent, which the child is acquiring through the child's relationship with this personality disordered parent.

Since the child's symptomatic display of a specific set of narcissistic and borderline personality disorder features is not the product of actual personality disorder processes with the child, but instead represent the acquired product of a relationship with a personality disordered parent who is the actual source for the narcissistic and borderline features displayed by the child, an independent child diagnosis of personality disorder features is not warranted relative to the family relationship dynamics involved. However, a child's chronic exposure to the severely aberrant and distorted parenting practices of a narcissistic and borderline parent may ultimately create personality disturbances for the

³ "They [narcissists] are especially deficient in genuine feelings of sadness and mournful longing; their incapacity for experiencing depressive reactions is a basic feature of their personalities. When abandoned or disappointed by other people then may show what on the surface looks like depression, but which on further examination emerges as anger and resentment, loaded with revengeful wishes, rather than real sadness for the loss of a person whom they appreciated." (Kernberg, 1975, p. 229)

child (Dutton, Denny-Keys, & Sells, 2011; Shaw, 2010; Stepp, Whalen, Pilkonis, Hipwell, & Levine., 2011), so that if an adolescent presents a more general social display of personality disorder features then an additional assessment of a possibly endogenous personality disturbance for the adolescent may be warranted.

Delusional Disorder

The trans-generational transmission of the personality disordered parent's attachment trauma to current family relationships, including the reenactment of the attachment trauma patterns, involves the formation of a parental delusional belief system as a consequent product of a misattribution of meaning regarding an authentic, but uncomprehended, experience (Garety & Freeman, 1999) of intense anxiety. The formation of the delusional belief system regarding the abusive parenting of the other parent is consistent with Millon's (2011) description of delusion formation processes associated with the psychological decompensation of a narcissistic personality under stress.

The child's acquisition of this parental delusional belief regarding the "abusive inadequacy of the targeted parent is also associated with a misattribution of meaning (i.e., of the child's authentic but uncomprehended grief response as a result of the loss of an affectional attachment bond with the targeted-rejected parent), which is acquired under the distorting influence of the "invalidating environment" (Linehan, 1993) associated with the alienating parent's borderline personality processes. For the child, the induced acquisition of an intransigently held, fixed and false belief system (i.e., a delusion) regarding the fundamental inadequacy and abusiveness of the parenting practices of the targeted-rejected parent represents a shared delusional process, in which the personality disordered parent is the primary case, and the child is the secondary case who is acquiring the parental delusional belief through the aberrant and distorted communication and parenting practices of a personality disordered parent that are distorting the child's interpretation of an authentic, but uncomprehended grief response.

Within the prior framework of the DSM-IV TR diagnostic system, this shared delusional process would warrant a diagnosis of a Shared Psychotic Disorder (Ellis, 2000). The DSM-IV TR (American Psychiatric Association, 2000) diagnostic criterion for a Shared Psychotic Disorder indicates that,

The essential features of Shared Psychotic Disorder (Folie a Deux) is a delusion that develops in an individual who is involved in a close relationship with another person (sometimes termed the "inducer" or "the primary case") who already has a Psychotic Disorder with prominent delusions (Criteria A).

The DSM-IV TR also notes that,

Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person. Individuals who come to share delusional beliefs are often related by blood or marriage and have lived together for a long time, sometimes in relative isolation. If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear. Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can

occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs. (American Psychiatric Association, 2000, p. 333)

Furthermore, while the manifest delusional content in "parental alienation" centers on the false belief in the abusive parental inadequacy of the other parent, the more primary psychotic process involves the personality disordered parent's reenactment of past relationship trauma in current relationships, in which past and current representational networks for attachment figures become psychologically fused and equivalent for the personality disordered parent, so that current relationships are distorted into replicating past trauma patterns contained within the internal working models of the personality disordered parent's attachment system. The key to initiating this trauma reenactment is inducing the child into accepting the "victimization" role relative to the other parent, which then automatically defines the other parent into the "abusive parent" role, which then allows the personality disordered parent to adopt the "nurturing-protective" parent role of the trauma reenactment narrative. The severely distorted underlying perceptions of the personality disordered parent that are creating the reenactment of childhood attachment trauma in the current family relationships essentially represent a psychotic distortion to the alienating parent's perceptions of the current relationships as a product of trauma-related and personality disordered psychological processes.

However, while a diagnosis of a shared delusional process would be directly applicable for the "parental alienation" processes involving the trans-generational transmission of attachment trauma, the diagnosis for a shared delusional process is no longer available within the DSM-5 diagnostic system. Within the DSM-5 diagnostic framework, the diagnosis of delusional processes appears to be directed at capturing the type of psychotic processes associated with schizophrenia-like psychotic disorders, rather than a more expanded diagnostic framework that would include delusions that form from a misattribution of meaning regarding an authentic but uncomprehended perceptual or emotional experience (Garety & Freeman, 1999), or from the psychological decompensation of personality disorder dynamics under stress (Millon, 2011). In order for the child to receive a DSM-5 diagnosis relative to the delusional belief system acquired through the distorted parenting practices of the personality disordered parent, who is the primary source for the delusional belief system, the child would need to receive an independent diagnosis of a Delusional Disorder, since a more accurate diagnosis reflecting a shared delusional process is not available within the DSM-5 diagnostic system.

Diagnosing the child with an independent Delusional Disorder would misrepresent that the child is the primary case and that the child has an independent psychotic process, which is not diagnostically accurate. In addition, DSM-5 Criterion E for a Delusional Disorder requires that the condition "is not better explained by another mental disorder" (American Psychiatric Association, 2013, p. 90). While the child displays an acquired delusional belief system, the child's acquisition of this delusional belief would likely be better captured within the DSM-5 diagnostic system (as opposed to the DSM-IV TR or ICD 10 diagnostic systems) by a diagnostic focus on the trans-generational transmission of attachment trauma mediated by the distorted parenting practices of a personality disordered parent, rather than ascribing an independent psychotic process to the child.

Therefore, despite the prominent display in the child's symptomatology of an intransigently held, fixed and false belief system that meets DSM-5 definitional criteria for a delusional belief, the DSM-5 diagnostic system, unlike the DSM-IV TR and the ICD 10 diagnostic systems, does not allow for a diagnostic identification of this important feature of the child's symptom presentation.

Trauma Related Diagnoses

The interpersonal family processes classically described as "parental alienation" represent the trans-generational transmission of attachment trauma from the childhood of the alienating parent to the current family relationships, in which the attachment trauma contained within the internal working models of the alienating parent's attachment system is reenacted in current relationships by means of a role-reversal relationship that induces the child into enacting a "victimized child" role that automatically defines the other parent into the "abusive parent" role, which allows the alienating parent to self-adopt the "nurturing-protective" role of the trauma reenactment narrative. This distorted interpersonal process is driven by the psychological decompensation of a narcissistically organized parent with borderline personality features as a consequence of the interpersonal stresses created by the divorce and family's dissolution, which threaten to collapse the parent's narcissistic defenses against a primal experience of fundamental core-self inadequacy and that activate intense abandonment fears associated with borderline personality processes. In addition, the two attachment related disorders of the DSM-5, a Reactive Attachment Disorder and a Disinhibited Social Engagement Disorder, are categorized as Trauma- and Stressor-Related Disorders in the DSM-5. Therefore, a DSM-5 diagnosis within the Trauma- and Stressor-Related Disorders category would be indicated to capture the trauma-related processes associated with an induced suppression of the child's attachment system, classically referred to as "parental alienation."

Among the Trauma- and Stress-Related Disorders available from the DSM-5, the most appropriate child diagnosis would be 309.4 Adjustment Disorder with mixed disturbance of emotions and conduct. Within this diagnostic assignment, the child is experiencing excessive difficulty in adequately adjusting to the divorce and family's dissolution that would allow the child to maintain positive and healthy relationships with both parents, as a consequent product of the distorted communication and parenting practices of a narcissistic/borderline parent who is engaging the child in a role-reversal relationship involving induced child symptomatology in order to regulate the personality disordered parent's own emotional and psychological functioning.

The disturbance to the child's emotions involve an unprocessed grief response that the child is misinterpreting under the influence of the personality disordered parent's psychopathology, leading the child to misattribute an authentic grief response at the loss of a bonded relationship with the targeted-rejected parent to supposedly "abusive" parenting practices allegedly committed by the targeted-rejected parent. The child's misunderstood and misinterpreted grief response is being inflamed by the distorted communication and parenting practices of the personality disordered parent into the child's angry and hostile rejection of the targeted parent, so that the child's anger toward the targeted-rejected parent also represents a disturbance to the child's emotional functioning associated with

the Adjustment Disorder. In young children who evidence the anxiety variant of the alienation process, the disturbance to the child's emotional functioning is the child's symptomatic phobic display in response to the targeted parent.

The disturbance to the child's conduct is the suppressed functioning of the child's attachment system relative to normal-range parent-child affectional bonding that is evidenced in the child's rejection of a relationship with the targeted parent. In addition, the child's rejection of the targeted parent may be accompanied by a child attitude of argumentative disrespect for the targeted-rejected parent that creates excessive parent-child conflict.

Relative to the stressors associated with a diagnosis of an Adjustment Disorder, the DSM-5 describes the range of potential Adjustment Disorder stressors,

"The stressor may be a single event (e.g., a termination of a romantic relationship), or there may be multiple stressors (e.g., marked business difficulties and marital problems). Stressors may be recurrent (e.g., associated with seasonal business crises, unfulfilling sexual relationships) or continuous (e.g., persistent painful illness with increasing disability, living in a crime-ridden neighborhood). Stressors may affect a single individual, an entire family, or a larger group or community (e.g., a natural disaster). Some stressors may accompany specific developmental events (e.g., going to school, leaving a parental home, reentering a parental home, getting married, becoming a parent, failing to attain occupational goals, retirement)" (American Psychiatric Association, 2013, p. 267).

With regard to the child's induced symptomatic rejection of a relationship with a parent (the targeted-rejected parent), the stressor (Criterion A) is the continuous exposure of the child to the distorted communications and parenting practices of a personality disordered parent that is producing chronic "spousal" and family conflict subsequent to the divorce and family's dissolution, and into which the child is being triangulated (Haley, 1977; Mann, Borduin, Henegeler, & Blaske, 1990; Minuchin, 1974). The functional impairment caused by the child's symptoms (Criterion B) is that the child's responses to the divorce are disproportionate to what would be considered normal-range post-divorce parent-child conflict and to the assessed normal-range parenting practices of the targeted-rejected parent, so that the child's exposure to the continuous stressor of the distorted communications and parenting practices of the personality disordered parent is creating a significant impairment to the child's capacity for normal-range family functioning.

Additional Diagnostic Consideration

An additional DSM-5 diagnostic consideration would be V995.51 Child Psychological Abuse, Suspected/Confirmed. The DSM-5 diagnostic criteria describe Child Psychological Abuse as the " non-accidental verbal or symbolic acts by a child's parent or caregiver that result, or have a reasonable potential to result, in significant psychological harm to the child" (p. 719). The research regarding the psychologically damaging effects on children of narcissistic and borderline parenting (cf., Stepp et al., 2011) and the developmental trauma resulting from the profound failure of parental empathy associated with narcissistic

parenting and role-reversal relationships (cf., Kerig, 2005; Moor & Silvern, 2006), would suggest that the highly distorted parenting practices of a narcissistic/borderline parent that result in a symptomatic suppression to the child's normal-range attachment bonding to the other parent as a product of the reenactment of the parent's own childhood trauma; the child's acquisition and symptomatic display of specific narcissistic and borderline personality disorder traits; and an induced delusional belief system evidenced by the child that significantly distorts the child's cognitive-emotional perceptions of, and affectional bonding with, the other parent, would have a reasonable potential of resulting in "psychological harm to the child," thereby meeting the criteria for the DSM-5 diagnosis of Child Psychological Abuse.

The distorted parenting practices emanating from the role-reversal relationship associated with borderline personality disorder processes can have a seriously deleterious impact on healthy child development. Millon (2011), for example, discusses Masterson's view of the damaging effects of borderline personality parenting on the child's development, which may itself lead to the development of borderline personality traits in the child,

The ideas proposed by J. Masterson (1972, 1976) draw heavily on the developmental theses of Bowlby and of Mahler. Stressing the belief that the mother may have been borderline herself, Masterson sees the child as being encouraged to continue symbiotic clinging, while the mother threatens to withdraw love should the child persist in striving for autonomy. Relating to mothers who are intensely conflicted about their child's growing independence, these youngsters are faced with a dilemma: Becoming autonomous will mean a loss of maternal love. This ambivalence creates an intrapsychic schism; any form of assertiveness threatens abandonment. This deep template within the future borderline's psyche sets the groundwork for unstable relationships, repeated intrapsychic ruptures, fruitless searches for idealized unions, and periodic states of emptiness and depression. (p. 901)

Linehan and Koerner (1993) identify the damaging effects resulting from the "invalidating environment" associated with borderline personality processes on the child's ability to develop adequate self-regulation and authentic self-experience,

Invalidating environments contribute to emotional dysregulation by: (1) failing to teach the child to label and modulate arousal, (2) failing to teach the child to tolerate stress, (3) failing to teach the child to trust his or her own emotional responses as valid interpretations of events, and (4) actively teaching the child to invalidate his or her own experiences by making it necessary for the child to scan the environment for cues about how to act and feel. (p. 111-112)

Fruzetti, Shenk, and Hoffman, (2005) elaborate on the negating effects of the "invalidating environment" created by the personality disordered parent on the child's capacity for authentic self-experience,

In extremely invalidating environments, parents or caregivers do not teach children to discriminate effectively between what they feel and what the caregivers feel, what the child wants and what the caregiver wants (or wants the child to want), what the child thinks and what the caregiver thinks. (p. 1021)

The child's incorporation into the trauma reenactment narrative of the personality disordered parent robs the child of an authentic childhood, replacing it with an imposed role in a false drama, in which the child's relationship with an available, affectionate, and loving parent is denied to the child by the distorted and unhealthy role-reversal parenting practices of a narcissistic and borderline parent. The damage to the child of being incorporated into a reenactment of parental trauma is described by Prager (2003), "what is lost, in a word, is an identity that demarcates the children's experience from their parents: what is produced, in the same instance, is lost childhoods and lost generations." (p. 174)

The failure of parental empathy associated with narcissistic parenting practices represents an additional source of damage to children's healthy emotional and psychological development. In their research on child abuse, Moor and Silvern (2006) found that the long-term negative impact of child abuse is mediated by the failure of parental empathy associated with narcissistic parenting, which allows for the creation of the role-reversal relationship in which the child is used (exploited) by the narcissistic parent to regulate the parent's own emotional and psychological functioning. Moor and Silvern (2006) describe the narcissistic origins of the role-reversal relationship that creates the context for child abuse,

Only insofar as parents fail in their capacity for empathic attunement and responsiveness can they objectify their children, consider them narcissistic extensions of themselves, and abuse them. It is the parents' view of their children as vehicles for satisfaction of their own needs, accompanied by the simultaneous disregard for those of the child, that make the victimization possible." (p. 104)

They further identify the central role in child abuse of the empathic failure associated with narcissistic parenting,

The act of child abuse by parents is viewed in itself as an outgrowth of parental failure of empathy and a narcissistic stance towards one's own children. Deficiency of empathic responsiveness prevents such self-centered parents from comprehending the impact of their acts, and in combination with their fragility and need for self-stabilization, predisposes them to exploit children in this way. (Moor and Silvern, 2006, p. 94-95)

Their research also supports the theoretical work of Kohut (1977) and Winnicott (1988) that views the chronic failure of parental empathy associated with narcissistic parenting practices as representing a cumulative traumatic experience for the child, consistent with van der Kolk's (2005) conceptualization of developmental trauma,

The indication that posttraumatic symptoms were no longer associated with child abuse, across all categories, after statistically controlling for the effect of perceived parental empathy might appear surprising at first, as trauma symptoms are

commonly conceived of as connected to specifically terrorizing aspects of maltreatment (e.g., Wind & Silvern, 1994). However, this finding is, in fact, entirely consistent with both Kohut's (1977) and Winnicott's (1988) conception of the traumatic nature of parental empathic failure. In this view, parental failure of empathy is predicted to amount to a traumatic experience in itself over time, and subsequently to result in trauma-related stress. Interestingly, even though this theoretical conceptualization of trauma differs in substantial ways from the modern use of the term, it was still nonetheless captured by the present measures." (Moor & Silvern, 2006; p. 107)

Shaw (2010) also notes the traumatic impact for the child of narcissistic parenting, and the potential for this "relational trauma" to be transmitted to later generations,

Exposure to parental narcissistic pathology constitutes cumulative relational trauma, which subverts the development of intersubjective relating capacities in the developing child. This trauma is inherited and bequeathed intergenerationally." (p. 46)

The research evidence regarding the severe psychological and developmental harm inflicted on children from narcissistic and borderline parenting practices (Dutton, Denny-Keys, & Sells, 2011; Fruzzetti, Shenk, & Hoffman, 2005; Millon, 2011; Moor & Silvern, 2006; Shaw, 2010; Stepp, et al., 2011) would merit both child protection concerns and a diagnostic identification of the distorted parenting practices associated with narcissistic and borderline personality disordered parenting as representing a form of psychological child abuse.

The reenactment of the personality disordered parent's own attachment trauma in the current family relationships involving the child (Trippany, Helm, & Simpson, 2006; van der Kolk, 1989) would represent a "symbolic" act in which the child becomes incorporated into a false drama originating from the traumatized internal working models of the personality disordered parent's disordered attachment system. The resulting aberrant and distorted parenting practices of the narcissistic/borderline parent then create significant developmental, psychiatric, and interpersonal symptoms in the child so that the personality disordered alienating parent can exploit these symptoms in a role-reversal relationship to meet the emotional and psychological needs of the alienating parent. As a result, the child's loses a relationship with a normal-range and nurturing parent (i.e., the targeted/rejected parent) as a direct consequent product of the narcissistic/borderline parent's psychopathology and distorted parenting practices.

While the delusional beliefs of the alienating parent and the profound failure of parental empathy associated with the narcissistic personality disorder processes restrict this parent's ability to recognize the nature and extent of his or her psychopathology, the nature of the role-reversal relationship in which this parent is engaging the child, and the significant degree of psychological child abuse involved, the psychological abuse inflicted on the child is nevertheless present, including a significant and foreseeable risk to the child's healthy development, which would warrant a DSM-5 diagnosis of Child Psychological Abuse and a child protection response.

DSM-5 Diagnosis

Based on the foregoing diagnostic considerations, an appropriate DSM-5 diagnosis for the child's symptom presentation representing the trans-generational transmission of attachment trauma, as classically identified by the term "parental alienation" would be,

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

Mandatory Reporting of Child Abuse

Although the DSM-5 diagnoses of Suspected and Confirmed Child Psychological Abuse are identified by the same diagnostic number, V995.51, they are presented as separate diagnostic headings in the text of the DSM-5, suggesting that the clinician is to diagnostically differentiate between these alternative diagnostic options, Suspected or Confirmed, when assigning the diagnostic number. However, the DSM-5 does not specify criteria by which the presence of psychological child abuse can be confirmed relative to diagnostically sub-threshold parenting practices, or in differentiating a suspicion from confirmation of psychological child abuse. The diagnostic threshold for a clinical suspicion of child psychological abuse is also undefined, although it would seemingly represent a lower clinical threshold than for a confirmed diagnosis. However, the professional assignment of either DSM-5 variant of the diagnosis, Suspected or Confirmed, would seemingly trigger professional responsibilities for the mandated reporting of child abuse, since mandated reporting laws engage professional responsibilities at the lower threshold of suspected child abuse.

Although the DSM-5 does not specify the criteria by which psychological child abuse can be confirmed, it would seem that the combined presence in the child's symptom display of specific and diagnostically identifiable developmental and psychiatric symptoms, involving 1) a targeted and selective suppression of the child's attachment motivations toward one parent, 2) a specific set of narcissistic and borderline personality disorder features in the child's symptom display, and 3) a delusional child belief in the inadequacy of the targeted parent which the child characterizes as being emotionally or psychologically abusive, which in total represent a child symptom set that can only be the product of a role-reversal relationship in which the child is being induced by a narcissistic/borderline parent into enacting a distorted role within the trans-generational reenactment of the parent's own attachment-related trauma, would seemingly represent sufficient diagnostic indicators in the child's symptom display for confirming psychological abuse of the child as a consequent product of a role-reversal relationship enacted by a personality disordered parent, and should easily trigger the lower threshold for a suspicion of possible psychological child abuse.

If a mental health professional assigns either a Suspected or Confirmed DSM-5 diagnosis of Child Psychological Abuse and does not make a report of suspected child abuse to an appropriate child protective services agency, then it would seemingly be incumbent upon the mental health professional to document in the clinical record the reasons why a

child protection response is not warranted under the circumstances, given the nature of the professional diagnosis. On the other hand, if the child's symptoms display a characteristic set of diagnostic indicators of a role-reversal relationship with a narcissistic/borderline parent, yet the minimum DSM-5 diagnosis of Child Psychological Abuse, Suspected is not assigned, then it would seemingly be incumbent upon the mental health professional to document in the clinical record why a suspicion of potential child psychological abuse involving the role-reversal induction and exploitation of child symptomatology by a personality disordered parent is not warranted given the child's diagnostic indicators.

Furthermore, if a report of suspected child abuse is made based on a DSM-5 diagnosis of V995.51 Child Psychological Abuse, Suspected, this report would then require that investigating child protective services agencies determine whether psychological child abuse is confirmed and whether a child protection response is warranted. The responsibility and diagnostic challenges for confirming a DSM-5 diagnosis of Child Psychological Abuse involving the role-reversal parental exploitation of induced developmental and psychiatric child symptoms would then be transferred from the mental health professional to the child protective services agency. The potential for inadequate diagnostic training within child protective service agencies regarding the diagnostic criteria for confirming psychological child abuse involving a parental role-reversal induction and exploitation of child psychiatric symptomatology may result in the continuing exposure of children to the psychological child abuse associated with the distorted parenting practices of a narcissistic and borderline personality disordered parent, who is inducing and then exploiting child symptomatology through a role-reversal relationship in order to regulate the parent's own personality disordered emotional and psychological processes.

The professional issues surrounding the DSM-5 diagnosis of Child Psychological Abuse when applied to a role-reversal relationship involving a narcissistic/borderline parent who is inducing and then exploiting significant developmental disturbances (i.e., the targeted and selective suppression of the child's attachment system) and psychiatric symptoms (i.e., personality disorder and delusional symptomatology) as an exploitative means to regulate the personality disordered parent's own emotional and psychological processes, seemingly merits additional professional dialogue and clarification, since a professional failure to engage a child protection response may represent an abandonment of the child to the trans-generational transmission of parental psychopathology.

Boundaries of Professional Competence

To the extent that the family relationship processes associated with what has classically been referred to as "parental alienation" reflect the trans-generational transmission of disordered attachment networks from the childhood of a personality disordered parent to the current child and broader family relationship dynamics, in which the current child's attachment motivations are being artificially suppressed and distorted, and that includes the prominent interpersonal involvement of both personality disorder and delusional processes, it would seem reasonable to require that diagnosing and treating mental health professionals who are involved with this type family process possess the

requisite professional knowledge, training, and expertise in attachment theory (Ainsworth, 1989; Bowlby, 1969; 1973; 1979; 1980; Bretherton, 1992; Hesse, 1999; Lyons-Ruth, Bronfman, & Parsons, 1999; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999), personality disorder processes, particularly the formation and expression of narcissistic and borderline personality disorder processes (Beck, Freeman, Davis, & Associates, 2004; Kernberg, 1975; Linehan, 2003; Millon, 2011), and delusional processes (Garety & Freeman, 1999), particularly as related to personality disorder dynamics (Kernberg, 1975; Millon, 2011) and trauma reenactment (Krugman, 1987; McLean & Gallop, 2003; Prager, 2003; Trippany, Helm, & Simpson, 2006; van der Kolk, 1989). A professional failure to possess the requisite professional knowledge of attachment theory, personality disorder processes, and delusion formation (particularly related to personality disorder dynamics) may result in harm to the client child and targeted parent through professional errors in diagnosis and treatment relative to this specific type of family relationship process.

Consideration should therefore be given as to whether children and families who are evidencing this type of trans-generational transmission of disordered attachment dynamics, mediated through parental attachment networks reflecting narcissistic and borderline personality disorder processes, warrant a professional designation as a “special population” requiring specialized professional knowledge, training, and expertise to responsibly diagnose and treat, and as to whether professional diagnosis and treatment of this special population of children and families without the requisite professional knowledge of attachment theory and the impact of personality disorder processes on family relationship interactions, would represent professional practice beyond the boundaries of professional competence in violation of professional practice standards (Standard 2.01; American Psychological Association, 2002).

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