At its foundational core, the family processes of attachment-based “parental alienation” represent the manifestation of a trauma reenactment narrative of a narcissistic/(borderline) parent that is embedded in the distorted “internal working models,” or “schemas,” of the narcissistic/(borderline) parent’s attachment networks.

The narcissistic/(borderline) parent is psychologically decompensating into persecutory delusional beliefs due to the activation of excessive anxiety surrounding the perceived interpersonal rejection and perceived abandonment associated with the divorce (sometimes the triggering of this perceived rejection and abandonment is delayed until the spouse remarries).

One of the foremost experts in personality disorders, Theodore Millon, describes the propensity for the narcissistic personality structure to decompensate into persecutory delusional beliefs under stress, “Under conditions of unrelieved adversity and failure, narcissists may decompensate into paranoid disorders. Owing to their excessive use of fantasy mechanisms, they 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. They tend to exhibit compensatory grandiosity and jealousy delusions in which they reconstruct reality to match the image they are unable or unwilling to give up. Delusional systems may also develop as a result of having felt betrayed and humiliated. Here we may see the rapid unfolding of persecutory delusions and an arrogant grandiosity characterized by verbal attacks and bombast.”

The reenactment of attachment trauma is also documented in the clinical treatment literature, “Reenactments of the traumatic past are common in the treatment of this population and frequently represent either explicit or coded repetitions of the unprocessed trauma in an attempt at mastery. Reenactments can be expressed psychologically, relationally, and somatically and may occur with conscious intent or with little awareness. One primary transference-countertransference dynamic involves reenactment of familiar roles of victim, perpetrator-rescuer-bystander in the therapy relationship. Therapist and client play out these roles, often in complementary fashion with one another, as they relive various aspects of the client’s early attachment relationships. (Perlman & Courtois, 2005, p. 455)

In response to the separate but interrelated psychological stresses associated with the divorce, 1) the threatened collapse of the narcissistic defenses against the experience of primal inadequacy that is triggered by the perceived interpersonal rejection inherent to the divorce (i.e., narcissistic personality processes), 2) the activation of immense anxiety from severe abandonment fears triggered by the divorce (i.e., borderline personality processes), and 3) the reactivation of attachment trauma networks when the attachment system becomes active to mediate the loss experience associated with the divorce (trauma processes), the narcissistic/(borderline) personality decompensates into persecutory delusional beliefs centering on the other parent’s “abuse” potential relative to the child.

This decompensation into persecutory delusional beliefs is centered around the pattern contained in the internal working models (schemas) of the narcissistic/(borderline) parent’s traumatized attachment networks of 1) victimized child, 2) abusive parent, 3) protective parent. The split representation for the parent role in the attachment trauma networks is the product of the “splitting” dynamic that originated in the relationship trauma involving a parent (i.e, the parent of the narcissistic/(borderline) parent as a child) who simultaneously triggers attachment bonding and avoidance motivations.

“Various studies have found that patients with BPD [borderline personality disorder] are characterized by disorganized attachment representations (Fonagy et al., 1996; Patrick et al., 1994). Such attachment representations appear to be typical for persons with unresolved childhood traumas, especially when parental figures were involved, with direct, frightening behavior by the parent. Disorganized attachment is
considered to result from an unresolvable situation for the child when “the parent is at the same time the source of fright as well as the potential haven of safety” (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999, p. 226).” (Beck et al., 2004, p. 191)

The family processes of attachment-based “parental alienation” are the product of the narcissistic/(borderline) parent creating a reenactment in the current family relationships of the narcissistic/(borderline) parent’s own attachment trauma patterns, or “schemas,” by inducing the child into adopting the “victimized child” role within the trauma reenactment narrative. The moment the child is induced into adopting the “victimized child” role, then this automatically imposes upon, and defines, the targeted parent into the role as the “abusive parent” in the trauma reenactment narrative. The definitions of these two trauma reenactment roles (which are created the moment the child adopts the “victimized child” role) then allows the narcissistic/(borderline) parent to adopt the coveted role in the trauma reenactment narrative as the wonderful and nurturing “protective parent,” in direct contrast to the role being imposed on the other parent as the all-bad “abusive parent.”

This artificially created reenactment of “various aspects” of the narcissistic/(borderline) parent’s own “early attachment relationships” (Perlman & Courtois, 2005, p. 455) represents a false drama in which the present is distorted into a re-creation of the past.

This is psychotic. The narcissistic/(borderline) parent is no longer in touch with actual reality, but is reliving and recreating early attachment relationships that do not reflect actual events in the current world.

The very term “borderline” to describe this type of personality process reflects the recognition of the psychotic core to this type of personality structure,

“The diagnosis of “borderline” was introduced in the 1930s to label patients with problems that seemed to fall somewhere in between neurosis and psychosis. (Beck et al, 2004, p. 189)

Narcissistic and borderline personality structures are simply variants of the same core 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.” (Kernberg, 1975, p. xiii)

Delusions and Psychotic Processes

Many people in the general public, and many mental health professionals, have the mistaken belief that psychotic and delusional processes will manifest as overtly “crazy” and bizarre. That’s not true.

Prior to obtaining my doctorate degree I first obtained a Master’s degree in Community/Clinical psychology and I worked for 15 years on a clinical research project at UCLA on schizophrenia. During my time with this project I was trained to clinical competence on a symptom rating scale called the Brief Psychiatric Rating Scale (BPRS) on which a variety of patient symptoms are rated, including psychotic symptoms, along a 7-point scale from mild to severe.

Psychotic symptoms can manifest along a continuum of severity, and are not always overtly bizarre. This is especially true for a diagnosis of Delusional Disorder in which the only manifestation of the psychotic process is the presence of an intransigently held, fixed and false belief that is maintained despite contrary evidence.

The diagnostic criteria for the DSM-5 diagnosis of a Delusional Disorder specifically requires that that person’s general functioning is “not markedly impaired” or “obviously odd or bizarre.”

DSM-5 Delusional Disorder

Criterion C: “Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.”

The delusional belief of the narcissistic/(borderline) parent in attachment-based “parental alienation” would be considered a nonbizarre “encapsulated” delusion.
Nonbizarre delusions express content that is within the realm of possibility, such as a fixed and false belief that the person’s spouse is having an extramarital affair. It’s possible that the person’s spouse is having an affair, extramarital affairs are not a bizarre occurrence, but it’s simply not true that the person’s spouse is having an extramarital affair. Yet no amount of contrary evidence will convince the person that his or her belief in the spouse’s infidelity is wrong. The false belief is maintained despite contrary evidence.

An encapsulated delusion is limited and contained in its scope. The jealousy delusion noted above would be an encapsulated delusion. It’s presence and impact would not generally be evident. Unless you asked the person specifically about the marital relationship you might never know of the existence of this delusional belief.

A bizarre delusion on the other hand, might be that people were inserting thoughts into the person’s mind (called “a delusion of control’). This false belief is outside the realm of plausibility. This would also not be an encapsulated delusion since it affects a broad spectrum of the person’s perceptions and functioning.

The narcissistic/(borderline) parent’s delusional belief in attachment-based “parental alienation” stems from the trauma reenactment narrative and is the false belief that the other parent represents an abusive threat to the child. It is delusional because this belief in the threat potential of the targeted parent is false and yet is maintained despite contrary evidence, it is a nonbizarre delusional belief because it is within the domain of possibility that a parent is abusive of a child, and it is an encapsulated delusion because this fixed and false belief is limited to only a narrow and contained domain of distortion, the perception of the other parent, and is not a false belief that affects a broad spectrum of the person’s perception.

At a deeper level, the delusional belief of the narcissistic/(borderline) parent in the abusive parenting threat posed to the child by the targeted parent represents a component of a trauma reenactment in which the narcissistic/(borderline) parent distorts current reality into creating and reliving a reenactment of the narcissistic/(borderline) parent’s own childhood attachment trauma patterns.

Remember what Millon said about the decompensation of the narcissistic personality under stress, “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.

The rumination and weaving of the narcissistic/(borderline) parent in which they “reconstruct reality” is guided by the attachment patterns embedded in the internal working models, or schemas, of the narcissistic/(borderline) parent’s attachment system. The distorted beliefs take on the pattern of the attachment trauma, abusive parent – victimized child – protective parent. It is the trauma reenactment narrative that is the fundamental psychotic process, of which the narcissistic/(borderline) parent’s delusional belief in the abusive threat posed by the other parent is a surface manifestation.

The psychological processes associated with attachment-based “parental alienation” represent the interwoven expression within the family relationships of 1) personality disorder processes, 2) trauma-related processes, and 3) psychotic processes (i.e., the decompensation of narcissistic/(borderline) personality structures into delusional belief systems).

The presence of a delusional belief DOES NOT mean the person will act in an overtly abnormal way, and in the case of a narcissistic/(borderline) personality the person’s nonbizarre persecutory delusional belief may go entirely unrecognized by other people, including mental health professionals, who may mistakenly accept the plausible assertions of the narcissistic/(borderline) parent as valid.

After all, the story offered by the narcissistic/(borderline) parent is not abnormal or bizarre, it’s not uncommon for a parent to be a bad parent who presents a risk of emotional abuse for a child, especially when the child is backing up this storyline, the narrative of the trauma reenactment, by adopting the role as the “victimized child.” And the narcissistic/(borderline) parent presents so well, as articulate and self-assured, and as being so protective and caring for the child’s well-being. Who suspects a delusional reenactment of childhood trauma when presented with this storyline.

A nonbizarre delusional belief is not always evident.
Professional Competence

The presence of psychotic processes is an extremely serious expression of psychopathology. That many mental health professionals are simply not recognizing and diagnosing the extreme psychopathology involved represents a highly disturbing reflection of the inadequate professional competence of these mental health professionals.

Personality disorders, the attachment system, trauma disorders, and delusional disorders are ALL established DSM constructs. There is absolutely no reason whatsoever for mental health professionals to be missing the level of severe psychopathology involved.

It doesn’t matter what their opinions are about the construct of “parental alienation,” they are required by professional practice standards to be knowledgeable about DSM disorders, particularly if they are treating that type of DSM disorder.

If a mental health professional is diagnosing and treating the family sequelae of trauma-related reenactments of a narcissistic/(borderline) parent’s psychological decompensation into delusional belief systems, in which the child is enacting the “victimized child” role within the reenactment narrative of the narcissistic/(borderline) parent’s traumatized attachment networks, then the diagnosing and treating mental health professional better know about trauma reenactments, narcissistic and borderline personality presentations and processes, and the nature of “internal working models” of the attachment system.

If a plastic surgeon decides to diagnose and treat cancer without possessing the requisite knowledge, training, and background necessary for professional competence, and the patient dies because of the lack of professional knowledge and competence of the plastic surgeon in diagnosing and treating cancer, this would likely be considered malpractice.

If a podiatrist suddenly decided to do brain surgery on a patient’s brain tumor, and the patient dies as a result of the podiatrist’s lack of professional knowledge and competence regarding brain surgery, this would likely be considered malpractice.

Why is it considered malpractice in the medical profession for a doctor to practice beyond the boundaries of his or her professional knowledge and competence but it’s not considered malpractice in mental health? Oh wait, it is considered malpractice in mental health too.


Standard 2.02 Boundaries of Competence

“Psychologists provide services, teach and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience.”

It doesn’t matter what they may think about the Gardnerian construct of “Parental Alienation Syndrome” or if they are familiar with the attachment-based model of “parental alienation” described in my writings and in my Master Lecture Series seminars. Because all of the constructs I describe in an attachment-based model of “parental alienation” are established and accepted psychological constructs within the DSM diagnostic system, AND all of the constructs have a solid and established foundation in the research base of professional psychology.

It doesn’t matter if the plastic surgeon says that he doesn’t believe in this so-called cancer disease (or never heard of cancer). If a physician is going to diagnose and treat cancer then it is incumbent upon the physician to ensure that he or she has the necessary professional knowledge and expertise to diagnose and treat cancer.

"Whoops, my mistake. Didn't know what I was doing. Sorry." is NOT an acceptable answer if the patient dies as a result of the professional's lack of appropriate knowledge and professional competence.
It doesn’t matter if the podiatrist THINKS she can do brain surgery because she went to medical school. To do brain surgery requires specialized professional knowledge and expertise. Just because a physician went to medical school does not necessarily mean the physician is competent to do brain surgery without first taking steps to acquire the specialized professional knowledge and training necessary for brain surgery.

There is nothing “NEW” regarding an attachment-based model of “parental alienation” except that these established psychological constructs are being applied to the family processes traditionally called “parental alienation.” ALL of the psychological principles and constructs discussed in an attachment-based model of “parental alienation” are firmly established and accepted psychological principles and constructs that should be part of the professional competence for ALL mental health professionals generally, and particularly for mental health professionals who are diagnosing and treating this set of psychological issues.

If you don’t know what you’re diagnosing and treating, you should probably stay away from diagnosing and treating it.

Notice that in all of my writings, I put the term "parental alienation" in quotes. That’s because the term “parental alienation” represents a popularized lay term for the psychopathology involved.

The correct clinical term is pathogenic parenting (i.e., patho= pathological; genic= genesis, creation). The term pathogenic parenting refers to the creation of psychopathology in a child through aberrant and distorted parenting practices, and the actual clinical psychopathology involved is the psychological decompensation of a narcissistic/(borderline) parent into delusional belief systems that are manifesting through a reenactment of attachment trauma patterns into current family relationships.

When I first entered private practice from my position as the Clinical Director for a children’s assessment and treatment center I knew nothing about the construct of “parental alienation.” My areas of specialty are ADHD, parent-child conflict, and marital and family therapy, and I have a secondary expertise in early childhood mental health and the neuro-development of the brain during childhood.

When I ran across my first case of “parental alienation,” however, I was able to recognize the personality disorder processes, the delusional belief systems, and the trauma reenactment. In my early writings on “parental alienation” I was discussing this clinical phenomenon as warranting the DSM-IV TR diagnosis of a Shared Psychotic Disorder and I was noting the descriptions contained within the DSM-IV TR regarding a Shared Psychotic Disorder diagnosis and the family processes traditionally described as “parental alienation.”

DSM-IV TR – Shared Psychotic Disorder:

“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).” (American Psychiatric Association, DSM-IV TR, 2000, p. 332)

“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, DSM-IV TR, 2000, p. 333)

“Aside from the delusional beliefs, behavior is usually not otherwise odd or unusual in Shared Psychotic Disorder.” (American Psychiatric Association, DSM-IV TR, 2000, p. 333)
“Without intervention, the course is usually chronic, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. With separation from the primary case, the individual’s delusional beliefs disappear, sometimes quickly and sometimes quite slowly.” (American Psychiatric Association, DSM-IV TR, 2000, p. 333)

When the diagnosis of Shared Psychotic Disorder was discontinued in the DSM-5 I wrote a paper currently up on my website in which I analyzed the clinical psychopathology of an attachment-based model for the construct of “parental alienation” relative to the newly revised DSM-5 diagnostic system, and I concluded that the clinical psychopathology represents a DSM-5 diagnosis of,

**DSM-5 Diagnosis**

309.4  Adjustment Disorder with mixed disturbance of emotions and conduct

V61.20  Parent-Child Relational Problem

V61.29  Child Affected by Parental Relationship Distress

V995.51 Child Psychological Abuse, Confirmed

Of note, is that the diagnosis of Adjustment Disorder in the DSM-5 is in the category of "Trauma- & Stressor-Related Disorders."

The clinical psychopathology involved is all comprised of standard psychological principles and constructs. It is beyond me why this pathology hasn’t been identified and resolved earlier, other than the possibility that the field was so distracted by the debate over the Gardnerian model of PAS that no one bothered to define the pathology from within standard and established psychological principles and constructs.

The pathology is there, and it is clearly evident to anyone with a knowledge of the relevant domains of pathology, and ALL mental health professionals should have at least a basic knowledge of these relevant domains (i.e., personality disorders, delusions, trauma, the attachment system) as part of their foundational understanding of the DSM diagnostic system, since all of these constructs are in the DSM diagnostic system.

I want to make sure I am entirely clear on this, **ALL** of the psychological constructs associated with an attachment-based model for the construct of “parental alienation” are established and accepted principles and constructs currently within professional psychology and the DSM diagnostic system. There is absolutely **NO REASON** why mental health professionals have not, and are not currently, making the appropriate clinical and DSM-5 diagnosis of the pathology.

- Narcissistic and borderline personality disorders are established and recognized constructs within the DSM diagnostic system.
- Delusional beliefs are established and recognized constructs within the DSM diagnostic system.
- The attachment system is a recognized construct within the DSM diagnostic system, and the attachment system has a substantial research base establishing it as a primary professional construct.
- Trauma is a recognized construct within the DSM diagnostic system, and the construct of trauma has a substantial research base establishing it as a primary professional construct, including trauma reenactment.

**Trauma Reenactment**

Regarding the reenactment of trauma, van der Kolk describes the impact of childhood exposure to “developmental trauma,”

“After a child is traumatized multiple times, the imprint of the trauma becomes lodged in many aspects of his or her makeup… Unless this tendency to repeat the trauma is recognized, the response of the environment is likely to replay the original traumatising, abusive, but familiar, relationships.” (van der Kolk 2005)
The recognition of trauma reenactment also includes the association of borderline personality symptoms to trauma reenactment processes:


As is the role of attachment trauma reenactments in the treatment of trauma-related disorders:


According to van der Kolk,

“When the trauma fails to be integrated into the totality of a person’s life experiences, the victim remains fixated on the trauma. Despite avoidance of emotional involvement, traumatic memories cannot be avoided: even when pushed out of waking consciousness, they come back in the form of reenactments, nightmares, or feelings related to the trauma… Recurrences may continue throughout life during periods of stress.” (van der Kolk, 1987, p. 5)

There is absolutely NO REASON that the pathology associated with an attachment-based model for the construct of “parental alienation” is not currently recognized and addressed within mental health OTHER than professional ignorance and incompetence.

It is NOT an issue of “parental alienation,” the pathology being expressed in the family processes involves standard, established, and accepted constructs of psychopathology.

If ANY targeted parent is in a position of educating a mental health professional regarding the nature or degree of the psychopathology involved with the construct of attachment-based “parental alienation” then this is clear evidence that a podiatrist is doing brain surgery, i.e., that the mental health professional is practicing beyond the boundaries of professional competence in likely violation of professional practice standards.

ALL diagnosing and treating mental health professionals should be sufficiently knowledgeable so that it is the mental health professional who is educating the targeted parent regarding the personality disorder dynamics, the delusional processes, the reenactment narrative structure, and the attachment system distortions involved in attachment-based “parental alienation,” NOT the other way around.

I have two invited Master Lecture Series seminars available online through California Southern University in which I discuss at a professional level the nature and severity of the pathology. Mental health professionals can watch these seminars to become educated and aware of the pathology involved.

It is NOT about “parental alienation.” All of the involved principles and constructs are established and accepted principles and constructs within the DSM diagnostic system and the established professional research base.

If you don’t know what you are diagnosing and treating, then you probably shouldn’t be diagnosing and treating it.

Podiatrists are not allowed to perform brain surgery, plastic surgeons are not allowed to treat cancer.

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References

Personality Disorder


Trauma Reenactment


Professional Standards
