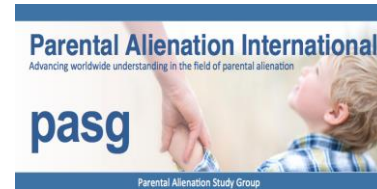


Parental Alienation International Reprint

This article first appeared as a two-part series published in the May and July 2018 issues of *Parental Alienation International*, the newsletter of the [Parental Alienation Study Group](#).



Why Do Specialists Say that Parental Alienation Is Counterintuitive?

Nine examples point to the need for significant special expertise

By Steven G. Miller, M.D., Massachusetts, USA

AMONG MENTAL HEALTH PROFESSIONALS (MHPs) who specialize in strong child alignment and related issues—including parental alienation (PA), realistic estrangement (RE), and how to distinguish between the two—it is generally understood that PA is *profoundly* counterintuitive. Unfortunately, this critical insight does not necessarily extend to MHPs who do *not* specialize in this area or, for that matter, by legal and other professionals. As I wrote more than five years ago in a clinical reference book (Miller, 2013):

[C]ases of severe alienation are likely to be highly counterintuitive. Clinicians who attempt to manage them without adequate skills are likely to find themselves presiding over a cascade of clinical and psychosocial disasters.

Since then, I have seen dozens of additional cases that fit this tragic pattern. The lack of awareness as to the counterintuitive nature of PA is a major problem that affects almost every observation, finding, conclusion, decision, and recommendation related to alienated children and their families.

Consequently, the purpose of this article is to provide a brief overview of some of the more important counterintuitive points, to provide some practical illustrations, and to alert both professionals and lay readers to some of the common pitfalls.

However, before elaborating as to what specialists mean when they say PA is counterintuitive, it may be helpful to explain what they do *not* mean. First and foremost, they are not merely warning people to “be careful.” Rather, they are trying to convey that almost everything about PA is *so* counterintuitive—*so profoundly* counterintuitive—that non-specialists will almost always make a multitude of major errors if they attempt to solve problems or make critical judgments using their usual professional intuition. The fact that they may have been “doing this for a long time” or “have seen many cases” is rarely, if ever, adequate. PA cases require *specialty-level expertise* including, for instance, a deep understanding of certain advanced clinical concepts including conditional probability, forensic causation analysis, and clinical pattern recognition at a level that is uncommon even among excellent forensic psychologists and psychiatrists who are not specialists in alienation and estrangement. Worse, clinicians who have much experience in general, but lack deep expertise with alienation in particular, tend to have great confidence in their incorrect conclusions. That should not be surprising because, in general, people who attempt to use intuition to solve counterintuitive problems tend to have great confidence in their conclusions, whether right or wrong.

I hope that the following nine examples will convince all but the most skeptical readers that to accurately identify and properly manage such cases requires substantial special expertise.

1. Alienating parents tend to present well; targeted parents tend to present poorly. As a rule, alienating parents present with the *Four C's*. They are cool, calm, charming, and convincing. That is because effective alienators tend to be master manipulators who are highly skilled at managing impressions, especially initial impressions. These traits are usually related to an underlying personality disorder, typically of the borderline, narcissistic, and/or sociopathic types.

In contrast, targeted parents tend to present with the *Four A's*. They are anxious, agitated, angry, and afraid. That is because they are trauma victims. They are attempting to manage a horrific family crisis, usually without success, often while being attacked by professionals who fail to recognize the counterintuitive issues. Indeed, non-specialists often get these cases backwards—they conclude that the alienating parent is the more competent parent. That is likely to be a catastrophic error unless a judge or other more sophisticated observer recognizes and corrects it.

2. Clinicians who do not specialize in this area often mistake pathological enmeshment for healthy bonding. In this context, pathological enmeshment is a family dynamic in which a parent essentially engulfs a child. Common in severe alienation, and often seen in moderate cases as well, this entails a pathologically dependent parent who treats the child as a “friend” or companion, rather than as a child. The enmeshed parent typically *adultifies* or *parentifies* the enmeshed child. Alternatively, the enmeshed parent may seek to keep the child dependent by *infantilizing* the child, i.e., treating the child as younger than his or her age. Either way, the enmeshed parent treats the child in a way that is not age-appropriate and that puts the parent’s need first. By definition, this involves severe boundary violations of the child by the parent to the point that the parent not only *violates* the child’s boundaries, but erases them—*obliterates* them. A form of child abuse (Hart, Brassard, Baker, & Chiel, 2018), enmeshment is very damaging to a child, and the damage is often permanent. Tragically, in cases of PA, professionals typically mistake pathological enmeshment for healthy bonding. From their perspective, the parent and the child are “close.” What they fail to appreciate is that parent and child are *too* close—*pathologically* and *dangerously* close. Worse, they often opine that the parent and child have a “healthy” relationship, and that the enmeshed parent displays great “empathy” for the child. In fact, enmeshment is anything but healthy—it is a *potentially life-threatening psychiatric emergency*. Similarly, pathological enmeshment does not indicate empathy—it represents a cascade of severe boundary violations and the extreme opposite of empathy.

3. Even in the face of abuse, children rarely reject a parent unless there is a powerful alienating influence; when they do, the behavior of estranged children is markedly different than the behavior of alienated children. It is counterinstinctual for a child to reject a parent. Since children will almost never do anything counterinstinctual unless they are induced to do so by a third party, children will rarely reject a non-abusive parent. This conclusion is supported, among other things, by a large body of evidence from the foster care literature that shows that even maltreated children develop and maintain attachment relationships with their abusive parents (Baker, Creegan, Quinones, & Rozelle, 2016). Therefore, evaluators and others need to understand that, in the absence of abuse or very significant neglect by a rejected parent, and in the presence of multiple signs of alienation in the child, most cases of severe alignment are due to alienation—not estrangement.

Moreover, in cases in which a child rejects a parent for legitimate reasons—not merely resists contact, but openly rejects the parent—the estranged children do not resemble alienated children except in very superficial ways. Furthermore, to a specialist in alienation and estrangement—that

is, a clinician who is highly skilled in distinguishing between the two—the distinction is usually obvious. By contrast, as a result of the counterintuitive nature of PA, nonspecialists will often get the situation wrong, if not backwards.

4. In cases of severe alignment, children typically align with the abusive parent, not the non-abusive one. Though some find this implausible, it is well-validated and flows logically from the previous paragraph. Since children are genetically wired to cling to their parents—even to cling to abusive parents whom they fear may leave or abandon them—if a child is strongly aligned with one parent and has rejected the other parent in the absence of abuse or severe neglect by the disfavored parent, there is a substantial probability that the favored parent is an alienating parent. Accordingly, PA should be a leading hypothesis, if not *the* leading hypothesis, in such cases.

5. Parental alienation meets standard, generally accepted criteria for child abuse; there is no controversy about that among specialists in child maltreatment. In 2018, this is settled science. Nevertheless, some professionals still claim that PA is not a form of child abuse. That claim is untenable for several reasons.

For one thing, PA meets standard definitions of psychological maltreatment as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM-5) (*American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, 2013), the American Professional Society on the Abuse of Children (APSAC) (Hart et al., 2018), and the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). For illustration, the DSM-5 definition of Child Psychological Abuse is: “Child psychological abuse is non-accidental verbal or symbolic acts by a child’s parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child.”

The APSAC and CDC definitions are substantially similar. The APSAC examples of psychological maltreatment are particularly instructive. One, listed under “EXPLOITING/CORRUPTING” [capitalization in original], is “restricting or interfering with or directly undermining the child’s important relationships (e.g., restricting a child’s communication with his/her other parent and telling the child the lack of communication is due to the other parent’s lack of love for the child). Another, listed under “TERRORIZING” [capitalization in original], is “placing the child in a loyalty conflict by making the child unnecessarily choose to have a relationship with one parent or the other.” PA clearly meets these criteria.

What’s more, it is now firmly established that, as risk factors for major physical and mental problems in adult life—including premature death—psychological and emotional abuse are at least as damaging to children as physical abuse, and even sexual abuse (Anda et al., 2006; Binggeli, Hart, & Brassard, 2001; Felitti et al., 1998; Hart et al., 2018; Nurius, Green, Logan-Greene, & Borja, 2015; Spinazzola et al., 2014; Taillieu, Brownridge, Sareen, & Afifi, 2016). Furthermore, research has shown that adverse childhood experiences (ACEs) can cause structural damage to the brain (Anda et al., 2006) and even shortening of chromosomal telomeres (Mitchell et al., 2017), thus establishing that ACEs can cause damage at cellular and molecular levels. And yet, PA cases are often managed, both in clinical practice and in court, as if PA is not really abuse, or is no big deal.

6. Since PA is a form of child abuse, the #1 priority in such cases is to protect the child from further abuse. In light of the previous section, this point should be self-evident. And yet, it is common practice for professionals to ignore or downplay the abuse issues and, instead, focus on the child’s relationship with the rejected parent. Instead of taking appropriate measures to ensure

the child's safety, they order or provide "reunification therapy." This is problematic for many reasons, including the fact that, in moderate or severe cases, traditional reunification therapy virtually *never* works, and typically makes things worse (Clawar & Rivlin, 2013; Fidler & Bala, 2010; Miller, 2013; Reay, 2015; Warshak, 2010, 2015). This crucial point is discussed in the next paragraph.

7. *Even when under court order, traditional therapies are of little, if any, benefit in regard to treating this form of child abuse.* This section heading is taken verbatim from a seminal research study. Since the title itself is instructive, I will reproduce it here: *Children Held Hostage: Identifying Brainwashed Children, Presenting a Case, and Crafting Solutions*. This summarizes a study of 1,000 cases over more than three decades, published by the American Bar Association. Chapter 1 is entitled "Brainwashing and Programming." Chapter 2 is entitled "Brainwashing techniques." Despite the authors' findings that traditional therapies were of little, if any, benefit, despite the fact that other authors have reported similar findings (for citations, see the previous paragraph), and despite the fact that Dr. Richard Warshak, a highly-regarded subspecialist, has called it a "fallacy" to believe that "severely alienated children are best treated with traditional therapy techniques while living primarily with their favored parent (Warshak, 2015)," it is common practice for courts to order such therapies and for clinicians to provide them. This is deeply troubling, to say the least.

Why do clinicians continue to provide such therapies and how do they justify such practices? In my experience, either they declare that the child is not alienated (often in the face of massive evidence to the contrary), or they claim that they are not providing "traditional therapy," but rather, "family therapy." The problem is that traditional family therapy is precisely what studies have established does not work. In fact, effective therapies are *radically* different from anything that a non-specialist is likely to provide in an office setting.

8. *Not only are traditional therapies of little, if any, benefit in regard to treating PA, but they usually make the situation worse, often catastrophically worse.* One of the oldest heuristics in medicine is *primum non nocere*—Latin for "first, to do no harm." It would be difficult to find a more common yet egregious violation of this heuristic than an order for what amounts to traditional "reunification" therapy for PA. Not only are such therapies known to be ineffective, they are known to be potentially harmful. To be sure, we do *not* have randomized, double-blind, prospective clinical trials to document this, but *do* we have copious case reports and much empirical as well as expert consensus among bona fide specialists.

What's more, one would expect this to be true on theoretical grounds. For one thing, we know that such therapies waste time that could have been used to provide effective interventions. For another thing, effective therapies employ *radically* different approaches and techniques from those of traditional therapies.

For instance, traditional therapies attempt to "validate" the child's feelings, encourage the child to express grievances, and give the child some "control" or choice while advising the rejected parent to listen, empathize, validate, and apologize (or even to "find something to apologize for"). This misguided approach runs rampant in some quarters where, referring to the parents, it is common to claim, "Both parties always participate." In effect, this further empowers the already over-empowered child, and further disempowers the already disempowered parent. This is not only likely to be *futile*, but the exact opposite of what *effective* therapies do. *Effective therapies disempower the over-empowered child and re-empower the disempowered rejected parent.* And this is only one major difference between effective and traditional therapies—there are more than

a dozen. Seen in this light, traditional therapies are *contraindicated* except, perhaps, as a brief therapeutic trial (for a few weeks, not a few months) if and only if the diagnosis is unclear.¹

9. In general, the risks of separating a severely alienated child from an alienating parent are very low, and the risks of permitting such a parent to remain in contact with such a child are very high. If one conducts a proper, evidence-based risks/benefits analysis, it should be clear that the risks of separating a child from a toxic alienating parent are minimal. Moreover, upon removal, the risks go down, not up. Nevertheless, forensic experts often make irresponsible predictions in court to the effect that protective separation of the child from the alienating parent is dangerous and would do more harm than good. Such opinions are neither scientific nor evidence-based. Warshak provides an excellent discussion of this point in the previously cited “fallacy paper.” Pointing out that it is a fallacy that “separating children from alienating parents is traumatic,” Warshak cautions, “Custody evaluators should refrain from offering opinions that reflect sensationalist predictions lacking a basis in established scientific and professional knowledge” (Warshak, 2015).

Conclusion

These nine examples of counterintuitive points barely scratch the surface. As previously noted, there are at least 20 more. Indeed, given the abysmal failure of traditional therapies – or anything remotely like them – for the treatment of PA, yet another counterintuitive point would be to understand that the vast majority of mental health professions lack the special expertise to accurately identify or properly manage parental alienation.

Since it is certainly not in a child’s best interest for major life decisions—such as those related to custody, parental access, and child protection—to be made by those who lack adequate expertise, and since PA is exceedingly counterintuitive, it is absolutely essential for those who deal with PA to have a deep understanding of the counterintuitive issues. Those who attempt to manage such cases using intuition—even professional intuition—instead of a deep knowledge of the science, are likely to make catastrophic errors. Both mental health and legal professionals need to be aware of this. ■

Steven G. Miller, M.D., who holds degrees in psychology and medicine, presently specializes in behavioral and forensic medicine in Cambridge, Massachusetts. For 30 years he was a clinical instructor in medicine at Harvard Medical School and presently does consulting work through the Massachusetts Medical Education Group, LLC. His medical interests include clinical reasoning and medical decision-making, and his professional focus includes parental alienation and other types of pathological alignment.

References

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).* (2013). Arlington, VA: American Psychiatric Association.
- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174-186.
doi:10.1007/s00406-005-0624-4

¹ Lay readers should note that the word *contraindicated* does not mean “not indicated.” It means *forbidden*. If a patient is allergic to penicillin, then penicillin is contraindicated. In the face of a penicillin allergy, it would not be proper to prescribe penicillin to see what happens.

- Baker, A. J. L., Creegan, A., Quinones, A., & Rozelle, L. (2016). Foster children's views of their birth parents: A review of the literature. *Children and Youth Services Review, 67*, 177-183. doi:<http://dx.doi.org/10.1016/j.chilyouth.2016.06.004>
- Binggeli, N. J., Hart, S. N., & Brassard, M. R. (2001). *Psychological Maltreatment of Children: The APSAC Study Guides 4*. Thousand Oaks, CA: Sage Publications.
- Clawar, S. S., & Rivlin, B. V. (2013). *Children Held Hostage: Identifying brainwashed children, presenting a case, and crafting solutions* (Second ed.). U.S.A.: American Bar Association.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marka, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.
- Fidler, B. J., & Bala, N. (2010). Children resisting postseparation contact with a parent: concepts, controversies, and conundrums. *Family Court Review, 48*(1), 10-47. doi:10.1111/j.1744-1617.2009.01287.x
- Hart, S. N., Brassard, M. R., Baker, A. J. L., & Chiel, Z. A. (2018). Psychological Maltreatment of Children *The APSAC Handbook on Child Maltreatment* (Fourth ed., pp. 145-162). California: Sage.
- Leeb, R. T., Paulozzi, L. J., Melanson, C., Simon, T. R., & Arias, I. (2008). *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements* (Version 1.0 ed.). Atlanta, Georgia: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
- Miller, S. G. (2013). Clinical Reasoning and Decision-Making in Cases of Child Alignment: Diagnostic and Therapeutic Issues. In A. J. L. Baker & S. R. Sauber (Eds.), *Working With Alienated Children and Families: A Clinical Guidebook*. New York: Routledge.
- Mitchell, C., McLanahan, S., Schnepfer, L., Garfinkel, I., Brooks-Gunn, J., & Notterman, D. (2017). Father Loss and Child Telomere Length. *Pediatrics, 140*(2). doi:DOI: 10.1542/peds.2016-3245
- Nurius, P. S., Green, S., Logan-Greene, P., & Borja, S. (2015). Life course pathways of adverse childhood experiences toward adult psychological well-being: A stress process analysis. *Child Abuse & Neglect, 45*, 143-153. doi:<http://dx.doi.org/10.1016/j.chiabu.2015.03.008>
- Reay, K. M. (2015). Family Reflections: A Promising Therapeutic Program Designed to Treat Severely Alienated Children and Their Family System. *The American Journal of Family Therapy, 1*-11. doi:10.1080/01926187.2015.1007769
- Spinazzola, J., Hodgdon, H., Liang, L., Ford, J. D., Layne, C. M., Pynoos, R., . . . Kisiel, C. (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological Trauma, 6*(S1), S18-S28. doi:<http://dx.doi.org.ezp-prod1.hul.harvard.edu/10.1037/a0037766> .
- Taillieu, T. L., Brownridge, D. A., Sareen, J., & Afifi, T. O. (2016). Childhood emotional maltreatment and mental disorders: Results from a nationally representative adult sample from the United States. *Child Abuse & Neglect, 59*, 1-12.
- Warshak, R. A. (2010). Family bridges: using insights from social science to reconnect parents and alienated children. *Family Court Review, 48*(1), 48-80. doi:10.1111/j.1744-1617.2009.01288.x
- Warshak, R. A. (2015). Ten Parental Alienation Fallacies That Compromise Decisions in Court and in Therapy. *Professional Psychology: Research and Practice*. doi:10.1037/pro0000031