Child Affected by Parental Relationship Distress

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Objective: A new condition, "child affected by parental relationship distress" (CAPRD), was introduced in the *DSM-5*. A relational problem, CAPRD is defined in the chapter of the *DSM-5* under "Other Conditions That May Be a Focus of Clinical Attention." The purpose of this article is to explain the usefulness of this new terminology.

Method: A brief review of the literature establishing that children are affected by parental relationship distress is presented. To elaborate on the clinical presentations of CAPRD, four common scenarios are described in more detail: children may react to parental intimate partner distress; to parental intimate partner violence; to acrimonious divorce; and to unfair disparagement of one parent by another. Reactions of the child may include the onset or exacerbation of psychological symptoms, somatic complaints, an internal loyalty conflict, and, in the extreme, parental alienation, leading to loss of a parent–child relationship.

Results: Since the definition of CAPRD in the *DSM-5* consists of only one sentence, the authors propose an expanded explanation, clarifying that children may develop behavioral, cognitive, affective, and physical symptoms when they experience varying degrees of parental relationship distress, that is, intimate partner distress and intimate partner violence, which are defined with more specificity and reliability in the *DSM-5*.

Conclusion: CAPRD, like other relational problems, provides a way to define key relationship patterns that appear to lead to or exacerbate adverse mental health outcomes. It deserves the attention of clinicians who work with youth, as well as researchers assessing environmental inputs to common mental health problems.

Key words: child affected by parental relationship distress, intimate partner distress, intimate partner violence, loyalty conflict, parental alienation

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When the *DSM-IV-TR* transitioned to the *DSM-5*, there were many important changes in the text, such as the removal of 54 diagnoses and the addition of 39 new diagnoses. One of the new terms introduced in the *DSM-5* was "child affected by parental relationship distress" (CAPRD). There is little elaboration of the meaning of CAPRD in the *DSM-5*, with the brief explanatory text simply saying: "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, including effects on the child's mental or other medical disorders."[1(p716)] The codes for CAPRD are V61.29 (as in the *International Classification of Diseases, 9th Revision* [*ICD-9-CM*]) and Z62.898 (as in *ICD-10-CM*).

CAPRD is in the chapter of the *DSM-5* "Other Conditions That May Be a Focus of Clinical Attention." It is in the first section of that chapter, which is headed "Relational Problems." The introductory material notes that parent–child relationships can be "protective, neutral, or detrimental to health outcomes."[1(p715)] Also, "a relational problem may come to clinical attention either as the reason that the individual seeks health care or as a problem that affects the course, prognosis, or treatment of the individual's mental or other medical disorder."[1(p715)] The other relational problems presented in the chapter, "Other Conditions That May Be a Focus of Clinical Attention," are parent–child relational problem; sibling relational problem; upbringing away from parents; relationship distress with spouse or intimate partner; disruption of family by separation or divorce; high expressed emotional level within family; and uncomplicated bereavement. Also included in the chapter "Other Conditions That May Be a Focus of Clinical Attention" are defined terms for both child maltreatment and adult maltreatment.

CAPRD captures the interplay among environmental stressors, genetic vulnerabilities, children who are more susceptible to psychopathology, and those who are resilient. This review explains how children who are exposed to parental relationship distress (e.g., domestic violence) may develop a variety of mental disorders, ranging from an adjustment disorder to major depressive disorder. When children have a mental disorder, adding the diagnosis of CAPRD or other relational problem, as appropriate, may help to differentiate treatment outcomes. On the other hand, children who are unusually resilient—because of innate hardiness, support from extended family, community resources, or other situational factors—may experience parental relationship distress and manifest no psychological symptoms at all.

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There are no doubt many genetic factors, most of them unknown as yet, that contribute to a child's inherent biological strengths and weaknesses.[2] A good example is having the long allele of the serotonin transporter gene, which appears to protect children from mental conditions who are facing severe psychosocial stressors.[3,4] As elegantly argued by Teicher and Samson, exposure to child maltreatment is a risk factor for the development of numerous mental disorders in childhood as well as adulthood.[5] In their article, they summarize studies that show differential brain changes, pathophysiology, and treatment outcomes for patients with similar diagnoses, for example, major depression, with or without a history of childhood maltreatment. Furthermore, they propose using the term "ecophenotype" to delineate these psychiatric conditions, as well as to add the specifiers "with maltreatment history" or "with early life stress" to the disorders that have differential trajectories dependent on early life stressors, so that those populations can be studied separately or stratified within samples. CAPRD is one of the early life stressors that should be cited.

The purpose of this article is to explain how clinicians and researchers can use the new terminology of CAPRD. Since two of the authors of this article (M.Z.W. and W.E.N.) developed the chapter on "Other Conditions," our comments here are consistent with the structure, content, and intentions of the *DSM-5*. Parallel to the development of the *DSM-5*, a group of family researchers was organized to collect the scientific evidence and to create the conceptual frameworks necessary to bring greater attention to interpersonal relationships in clinical practice. That team of research personnel, the Relational Processes Working Group, advised both the *DSM-5* Task Force and the Topic Advisory Group for Mental Health, the component of the World Health Organization that has been revising the *International Classification of Diseases,* regarding the presentation of relational problems in their respective nosological systems.[6] The Relational Processes Working Group has produced several publications including two books, *Relational Processes and* DSM-V: *Neuroscience, Assessment, Prevention, and Intervention*[7] *and Family Problems and Family Violence: Reliable Assessment and the* ICD-11.[8]

Members of the Relational Processes Working Group summarized the effects of parental relationship distress in this way: "Relationship distress influences both parental adjustment and parenting behavior toward children.… Whereas healthy families, or families characterized by low levels of stress and conflict, have been linked to resilience and mental health and adjustment in both children and adults; unhealthy families, or families characterized by high levels of stress and conflict, have been linked to a wide range of parenting problems, such as poor discipline, increased negativity, and decreased warmth, as well as adjustment difficulties in children, including mental illness" (citations omitted).[9(p95)]

PROPOSED DEFINITION FOR CAPRD

When clinicians are initially exposed to the terminology of CAPRD, it may seem like a fuzzy concept. As the one-sentence definition in the *DSM-5* is not detailed enough to clarify the concept, we propose the following expanded definition for CAPRD: This category should be used when the focus of clinical attention is the negative effects of parental relationship distress on a child in the family, including effects on the child's mental or medical disorders. For this category, "parental relationship distress" refers to: persistent disparagement of one or both parents by the other parent; high levels of conflict; intimate partner distress (dissatisfaction with the relationship as well as difficulty resolving conflicts, lack of positive exchanges, coercive exchanges, or persistently perceiving negative intentions in the partner); and intimate partner violence (physical force such as hitting, slapping, and biting; extreme psychological manipulation; and/or coercive sexual acts). Typically, a child affected by parental relationship distress displays impaired functioning in behavioral, cognitive, affective, and/or physical domains. Examples of behavioral problems include oppositionality and the child's reluctance or refusal to have a relationship with a parent without a good reason (parental alienation). Cognitive problems may include cognitive dissonance (discomfort due to conflicting beliefs), attempting to maintain affection for both parents simultaneously (loyalty conflict), and/or adopting the false belief that the rejected parent is evil or dangerous (parental alienation). Affective problems may include anger, anxiety, depressed mood, and posttraumatic symptoms. Physical symptoms may include stomachaches, headaches, and exacerbation of general medical conditions.

MEASURING PARENTAL RELATIONSHIP DISTRESS

Family researchers have successfully operationalized the assessment of marital or intimate partner relational problems (for example, with the Marital Satisfaction Inventory–Revised [MSI-R]).[10] There is a short form of the MSI-R that can be used as a screening tool, which consists of only 10 questions.[11] The interviewer asks questions such as: "Does your partner often fail to understand your point of view on things?" "Do minor disagreements with your partner often end up in big arguments?" "Is your sexual relationship entirely satisfactory?" If 4 or more of the 10 questions are answered in a manner consistent with a distressed relationship, the couple is "probably in need of further assessment and possible intervention."[8(p103)] Of course, a more complete assessment of intimate partner relationship distress would involve clinical interviews and multidimensional self-report measures differentiating among sources of relationship distress.[12]

The MSI-R pertains to couples or parents who are living together. When parents split up, a substantial degree of parental relationship distress is usually referred to as a high-conflict separation or divorce. The behavioral or external markers of high-conflict separation or divorce include: ongoing animosity between the parties and inability to agree on parenting schedules and other parenting decisions; verbal acts, such as abusive language, threatening violence; physical acts, endangering each other; actual or alleged domestic

violence; actual or alleged child sexual abuse; involvement of child welfare agencies in the dispute; the unusual number of times the case goes to court; and the length of time it takes for the case to be settled.[13-15]

SCOPE OF CAPRD

Children, of course, are influenced for better or worse by events that occur in their family, which include the opinions, moods, and actions of the parents and also the interactions between the parents and among all of the family members. Depending on the circumstances of his or her family, a child may be adversely affected to a significant degree when there is persistent or substantial conflict between the parents. Several large studies of psychosocial risk factors for the development of mental health problems in children document that dysfunctional parental relationships lead to increased problems in children. For example, the Adverse Childhood Experiences (ACE) study of more than 18,000 insured adults found that 12.5% of participants reported exposure to interparental violence, and 23.3% dealt with parental divorce.[16] These were two of eight stressors noted to lead to impaired health in adulthood. Several studies from the Duke Developmental Epidemiology Program showed that interparental problems alone were associated with increased risks (odds ratio [OR] = 3.1) for disruptive behavior disorders in children compared to children with no risks, and contributed to both internalizing and externalizing problems in children when other risks were also present.[17] The Duke studies reported on more early childhood stressors than the ACE study, and were able to separate "interparental problems" from divorce, exposure to interparental violence, or childhood maltreatment (all of which were also tabulated). These studies also showed that increased numbers of childhood stressors led to increased likelihood of development of a number of internalizing and externalizing disorders in children. Children may be affected by a number of parental relationship problems, including intimate partner distress, intimate partner violence, parental triangulation of the child resulting in loyalty conflicts within the child, and a combination of dynamics known in the forensic literature as "parental alienation." These four scenarios are described below.

Intimate Partner Distress

Intimate partner distress (IPD) may have negative effects on the emotional and physical wellbeing of both partners of the relationship, as well as their children. Relationship distress is associated with impaired functioning in the following: behavioral domains, for example, conflict resolution difficulty, withdrawal, and overinvolvement; cognitive domains, for example, chronic negative attributions of the other's intentions or dismissal of the partner's positive behaviors; and/or affective domains, for example, chronic sadness, apathy, and/or anger about the other partner.[18] IPD is the most common cause of acute emotional distress in treatment-seeking samples.[19] Researchers have used taxometric methods to assess the prevalence of intimate partner distress,[20,21] and found it to be 0.20 for newlyweds and 0.32 across all couples. There is a sizeable literature linking IPD to a broad range of psychiatric problems.[22] Cummings and Davies have written, "Effects of marital conflict on child development are well documented. Many of the associations, for example in predicting children's internalizing and externalizing disorders, have been demonstrated repeatedly" (citations omitted).[23(p31)]

When children have been adversely affected by IPD between their parents, CAPRD would be an appropriate diagnosis. The following vignette illustrates how an adolescent may develop psychological symptoms after exposure to continuing intimate partner conflicts of this kind:

> **Case 1.** Nicole was the daughter of parents who engaged in frequent displays of interparental hostility and conflict. By adolescence, Nicole had developed significant problems with anxiety and depression. Numerous family circumstances complicated both Nicole's and her parents' problems. Nicole's mother and father both evidenced depressive symptoms. In addition, Nicole's father attempted to self-medicate his symptoms with alcohol, and had thus developed a drinking problem. Moreover, it appeared that in response to these conflicts, the father's alcohol abuse, and other family stressors, the mother developed major depression. Nicole became highly emotionally distressed when her parents fought–evidencing sensitivity and reactivity to her parents' conflicts, even when they were relatively mild. She felt compelled to mediate the parents' disputes and to try to alleviate her parents' distress and sadness. Over time, these many family problems took a heavy toll on Nicole's well-being.[24(p6)] Cummings EM, Davies PT. Marital Conflict and Children: An Emotional Security Perspective. New York: Guilford Press; 2010. Reprinted with permission of Guilford Press.

Intimate Partner Violence

Domestic violence (DV) refers broadly to physical, sexual, or psychological abuse of one family member by another, so it includes both intimate partner violence (IPV) (e.g., violence between the parents) and physical, sexual, or psychological maltreatment of a child. IPV is a pattern of behavior in which one intimate partner uses physical violence, coercion, threats, intimidation, isolation, or emotional, sexual, or economic abuse to control the other partner in the relationship. Of course, violence between partners can be perpetrated by one partner or by both partners. The *DSM-5* definition of IPV was written to be inclusive of partners of any sexual orientation and marital status.

There has been considerable research regarding the effects on children of exposure to IPV.[25,26] Crooks *et al.* wrote, "The existing studies show that as a group, children who have been raised in families where there has been violence between the adult intimate partners fare worse than their peers across a range of social, behavioral, and learning outcomes," and furthermore, "Research indicates that

children exposed to DV are more likely than other children to be aggressive and have behavioral problems, have different physiological presentations, [and] exhibit higher rates of posttraumatic stress disorder symptomatology" (citations omitted).[27(p22-24)]

When IPV has occurred in a family, it is likely that the children in the family experience CAPRD. It is psychologically traumatic for a child to witness persistent or substantial conflict between parents. When high levels of violence occur, the child may develop posttraumatic stress disorder.[28] When relatively low levels of violence occur chronically, the child may develop anxiety (such as separation anxiety disorder or generalized anxiety disorder) or depression. In order for clinicians to clearly describe and communicate the child's condition, it is possible to use these conditions together. For example, a child who has seen her father repeatedly berate and occasionally slap her mother may have nightmares related to the father's behavior and refuse to go to school because of fear of losing her mother. The clinician may use both separation anxiety disorder and CAPRD to describe the child's condition.

Sadly, there are many vignettes of children exposed to IPV. The following vignette, taken from the author's (M.Z.W.) clinical practice, illustrates how exposure to IPV can modify a child's physical and mental health, both directly as well as through changes in parenting practices.

> **Case 2.** Gregory was an 8-year-old boy with chronic, poorly controlled asthma, brought to a tertiary care center by his mother. During his mother's pregnancy with Gregory, she was hit and pushed by Gregory's father several times. The father's behavior improved temporarily when Gregory was born, but worsened again when Gregory developed asthma at age 2 years. When Gregory was a toddler, his mother was holding him during a mild asthma attack and his father became so enraged that he choked her. (The evaluator did not have contact with the father and was not able to determine precisely why he behaved in that manner.) Gregory was released from his mother's arms only when she slumped to the floor unconscious. Following that episode, the parents divorced, and Gregory did not see his father again. Gregory's asthma became very difficult to control, necessitating numerous steroid bursts as well as several hospitalizations. During work at the asthma specialty hospital, it became apparent that when Gregory developed a slight wheeze or mild cough, his mother would become quite anxious and over-vigilant, likely linked to her posttraumatic stress symptoms from the choking episode, which in turn led Gregory to develop secondary panic anxiety when he had mild asthma symptoms. This anxiety was difficult for the family and primary care physicians to distinguish from asthma, so his symptoms were often over-treated with steroids. While Gregory denied having any overt memories of the IPV, he would often try to avoid inhalers or nebulizers, perhaps an avoidance of a trigger of his posttraumatic anxiety. Thus, he was frequently nonadherent to daily steroid inhalers, and only utilized his epinephrine inhalers when desperate. Once the exposure to IPV and secondary anxiety symptoms in both mother and child were understood and treated, Gregory's asthma was able to be well controlled. (Adapted from Wamboldt, Weintraub, Krafchick, Berce, and Wamboldt, pp. 142-144)[29]

Loyalty Conflict

A loyalty conflict occurs in a child when she tries to maintain affection and good feelings toward each of her parents (or other caregivers), even though they are angry and hostile toward each other. Having a low level of divided loyalty for a short duration is usually not problematic for the child. The child realizes that her parents sometimes argue, but usually they are able to work out their disagreements.

However, a child may experience a high degree of divided loyalty if parental conflicts are obvious and persistent. Also, a more serious loyalty conflict may develop if one or both parents pressure the child to support that parent's side in the daily or weekly disagreements that occur between them:

> If Mom expects the child to agree with her, the child feels guilty at not siding with Dad; if Dad pressures the child to be on his side, the child feels distressed in rejecting Mom. … It is extremely uncomfortable to be caught in an unending battle that features external conflict (between the two parents) and internal conflict (the child's affection for Mom versus her affection for Dad).[30(p52)]

In family systems theory, this pattern may be described as triangulation, a concept that explains the origin and maintenance of some dysfunctional family relationships. A common form of triangulation is cross-generational coalition, which family therapists have linked to maladjustment of the involved children.[31,32]

Children frequently develop physical and psychological symptoms when they experience high levels of loyalty conflict stress, as illustrated in the following case vignette:

> **Case 3.** The most common psychosomatic symptoms that occur in children are headaches and stomachaches, and Stephanie, age 11, had both. Stephanie had a good relationship with both of her parents prior to their divorce. After the divorce, she lived most of the time with Mom, but had considerable parenting time with Dad. The parents divided their responsibilities. With regard to homework, Mom focused on arithmetic and science, while Dad helped Stephanie with spelling tests and geography. The problem was that the parents endlessly bickered with each other and frequently argued when Stephanie transitioned from one household to the other. Stephanie dreaded the "switching hours" and developed anticipatory physical symptoms including abdominal pain and vomiting. The headaches and stomachaches vanished when the parents firmly resolved to stop disagreeing in front of Stephanie.[30(p53)] Adapted from Bernet W, Freeman B. The psychosocial assessment of contact refusal. In:

Lorandos D, Bernet W, Sauber SR, eds. Parental Alienation: The Handbook for Mental Health and Legal Professionals. Springfield, IL: Charles C Thomas; 2013:47-73. Reprinted with permission of Charles C Thomas.

It is noteworthy that loyalty conflicts frequently occur in the context of IPD and IPV, the two scenarios previously described in this article. If the focus of attention is on the child, CAPRD is the appropriate term to use; if the adult partners are in treatment, the appropriate term to use would be either IPD and/or IPV, depending on which criteria were met. Children with loyalty conflicts experience a specific mental state (attempting to maintain good feelings toward 2 individuals who are in conflict with each other) that should be identified by evaluators and therapists. Triangulation and loyalty conflicts may occur in intact families as well as divorced families; likewise, CAPRD may occur in intact families as well as divorced families. In this type of case, CAPRD is an appropriate designation because the relational problem involves the father, the mother, and the child. The child is symptomatic due to feeling caught in the middle. In the case of Stephanie, the parent–child relational problem diagnosis would not be used because the child did get along individually with each parent.

Parental Alienation

Parental alienation refers to a child's reluctance or refusal to have a relationship with a parent without a good reason. Typically, the child has a false belief that the rejected parent has been abusive or neglectful. Children with false beliefs about events that never actually occurred may develop false memories, that is, memories of non-events.[33] In cases of parental alienation, the false beliefs or false memories drive strongly expressed contact refusal and hostility. In most cases, parental alienation is created in the context of a high-conflict separation or divorce by one parent's indoctrinating the child to unjustifiably dislike or fear the other parent. The former is referred to as the preferred or alienating parent; the latter as the rejected or target parent. In terms of severity, parental alienation may be mild, moderate, or severe.[15] Mild parental alienation means that the child resists contact with the target parent but enjoys the relationship with that parent once parenting time is underway. Moderate parental alienation means that the child strongly resists contact and is persistently oppositional during parenting time with the target parent. In cases of severe parental alienation, the child persistently and adamantly refuses contact and may hide or run away to avoid being with the target parent.

In some cases of parental alienation, the alienating parent induces the child to say, believe, and falsely remember that he or she was sexually abused by the target parent. In the following vignette, the child was induced by her mother and by psychotherapists to have a severe degree of parental alienation, including false allegations of sexual abuse.

Case 4. When Tom and Mary divorced, Mary received primary custody of their 3-year-old daughter. After 3 uneventful post-divorce years of normal visitation and friendly relations, Mary initiated legal proceedings to deny Tom normal visitation and voiced suspicions that "something" had happened to their child. A court-appointed psychologist found no evidence of any abuse by Tom, and described a strong father–daughter relationship. Unhappy with the opinion of the court-appointed psychologist, Mary spent over $25,000 on two therapists, whose progress notes indicated that their sessions focused on trying to get the child to accuse her father of abusing her. The child repeatedly refused to accuse her father of anything worse than making her eat vegetables. She repeatedly told the therapists that she loved her father. After 60 therapy sessions, the child finally began to make bizarre accusations of sadistic sexual abuse against her father, her father's friends, and other adults. The sexual abuse accusations led to the complete rupture of the father–daughter relationship and two serious criminal indictments against the father, which were ultimately dropped by the district attorney. Nine years later, at age 16, the daughter said she never wanted to see her father again.[34(p126)] Adapted from Bernet W, ed. Parental Alienation, DSM-5, and ICD-11. Springfield, IL: Charles C Thomas; 2010. Reprinted with permission of Charles C Thomas.

Children who experience parental alienation almost always fulfill the definition for CAPRD; that is, the child is affected by conflict between the parents, with the result of forming an enmeshed relationship with one parent and rejecting a relationship with the other parent. Depending on the focus of clinical attention, other *DSM-5* conditions may be assigned in cases of parental alienation. If the focus of clinical attention is on the impaired relationship between the child and the target parent, the term "parent–child relational problem" may be used. If the focus of clinical attention is on the parent who caused the child's parental alienation through manipulation and indoctrination, the term "child psychological abuse" may be used.

When the *DSM-5* was in development, there was a proposal to include parental alienation disorder as a new diagnosis.[34] In response, members of the *DSM-5* Task Force never said that they doubted the reality or the importance of parental alienation. However, they concluded that parental alienation did not meet the standard definition of a mental disorder, that is, "the requirement that a disorder exists as an internal condition residing within an individual" (Letter from D.A. Regier, January 24, 2012). Task Force members said that parental alienation should be considered an example of a relational problem because it involves a disturbance in the child's relationship with one or both parents.

Parental alienation is a term more frequently used in forensic settings, where the psychiatrist or psychologist is asked to determine a more objective "truth" than what practicing clinicians are asked to assess. Practicing clinicians deal with the beliefs of the child and know that there may be distortions in those beliefs, but seldom are allowed the intense evaluation of forensic mental health experts.

However, it is important for both clinicians and forensic practitioners to distinguish parental alienation (rejection of a parent without a good reason) from realistic parental estrangement (rejection of a parent for a good reason, such as a history of abuse or neglect by that parent). There have been concerns reported in the literature that acceptance of the "parental alienation" construct may lead some clinicians to discount a child's true fears of a parent who has maltreated him or her.[35,36] For this reason, the Relational Processes Work Group recommended that it would be better not to include parental alienation as a specific relational problem but instead to use the appropriate broader category, that is, CAPRD, parent–child relational problem (PCRP), and/or child psychological abuse.

DIFFERENTIATING MALADAPTIVE FAMILY PATTERNS

Although the 4 maladaptive patterns of family interaction that illustrate the CAPRD diagnosis may overlap in features and may co-occur in some families, it is important to understand how they differ from each other.

Intimate Partner Distress Versus Intimate Partner Violence

Although both IPD and IPV are commonly seen in clinical samples, they may or may not be on a continuum. Having verbal conflict with an adult partner or persistently avoiding the partner is a very different matter from escalating to violence. In addition, intermittent brief episodes of violence in the context of arguments are a different "type" of IPV than chronic, calculated, and pervasive control of the partner through violence. The first is more amenable to treatment, and the second is more likely to be associated with antisocial personality disorder and to be refractory to treatment.[37] Obviously, IPV involves a more serious level of dysfunction. IPD usually refers to difficulty resolving conflicts, withdrawal of affection for the other person, or being emotionally overinvolved with each other. IPD is thought to range from 31% to 40% of the population in the United States, depending on the method whereby it is assessed.[38] IPV has several subtypes, which may or may not occur together: intimate partner physical abuse, intimate partner psychological abuse, intimate partner sexual abuse, and intimate partner neglect. Thus, IPV can involve physical force such as hitting, slapping, and biting; extreme psychological manipulation such as threats to harm a loved person or pet; or coercive sexual acts. Assessing rates of IPV in the population is complicated by variability in methodology, design, and definitions. The World Health Organization collated studies from more than 50 countries and found lifetime prevalence rates varying from 13% to 34%.[37] Both IPD and IPV are risk factors for maladjustment in the couple's children; both IPD and IPV may cause CAPRD.

Loyalty Conflict Versus Parental Alienation

The difference between loyalty conflict and parental alienation is qualitative, that is, different methods of coping with parental conflict. A child with a loyalty conflict puts mental and emotional energy into maintaining a good relationship with both parents. The child is not pretending but actually feels an attachment to both parents, who are intensely fighting with each other: when he is with his father, he loves his father but misses his mother; when he is with his mother, he loves his mother but misses his father. The child is tasked with loving two people who do not love each other. That scenario evokes cognitive dissonance, which causes discomfort and anxiety.[39] The child may resolve the anxiety by aligning with one parent against the other, especially if one parent is able to successfully manipulate the child into believing that the other parent was abusive or neglectful. Although that is not an adaptive or healthy solution in the long term, adopting a pattern of parental alienation does solve the child's immediate problem of being caught between warring parents. We describe the difference between these two conditions as "qualitative" because there is a clear difference between the two mental processes: maintaining two conflicting thoughts simultaneously (a loyalty conflict) as opposed to strongly endorsing affection for one parent and strongly denying affection for the other parent (parental alienation).

Both loyalty conflicts and parental alienation may be designated as CAPRD when they become a focus of clinical attention. However, it is critical to assess whether there is IPV and/or child maltreatment involved before designating a child as having parental alienation. A child may quite rationally decide not to have a relationship with a parent who perpetrates violence (either to the child or other family members), and this should not be designated as parental alienation. If there is no occurrence of IPV or child maltreatment, the primary distinction between a loyalty conflict and parental alienation is in the mental state of the child, that is, trying to maintain affection for both parents versus enmeshing with one parent and totally rejecting the other parent. There may also be a difference in the cause of those two conditions, in that the external stressor prompting parental alienation (active indoctrination of one parent against the other) is usually more intense than the cause of a loyalty conflict (e.g., both parents vying for the child's affection).[40] If one parent does actively disparage the other to the child, and if the disparagement is distorted in magnitude or content, this may be designated as psychological abuse toward the child.

The idea that unusually intense loyalty conflicts may evolve to parental alienation was explained more than 20 years ago by a German child and adolescent psychiatrist. Klosinski wrote,

> A child can figuratively become paralyzed when caught in a conflict of loyalties toward his or her parents and can no longer bear the ambivalence of power and helplessness and the accompanying feelings of guilt….[A] frequently observed defensive reaction of the child is a sudden and exaggerated taking of sides with one parent and a turning against the other: resorting to unrealistic black and white, good and bad dichotomous thinking.[41(p561)]

Although Klosinski described the phenomenon of parental alienation, he did not use that term, which had been introduced several years previously by Gardner.[42]

Parental Alienation Versus Parental Estrangement

The primary symptom in both parental alienation and parental estrangement is the child's refusal to have a relationship with one of his parents, sometimes called contact refusal or visitation refusal. In parental estrangement, there is a good reason for the contact refusal, such as a history of abuse or neglect by the rejected parent. In parental alienation, on the other hand, the child's contact refusal lacks legitimate or rational justification, but instead is driven by the false belief that the rejected parent is evil, dangerous, or not worthy of his time and affection. Estrangement is considered a rational response to an unhealthy situation (avoiding a relationship with an abusive parent), whereas alienation is usually a maladaptive mental condition (extremely oppositional behavior due to a false belief). However, depending on the family circumstances, both parental estrangement and parental alienation may occur in the context of CAPRD.

In a clinical or forensic evaluation, it may be difficult to distinguish alienation from estrangement. Determining when a child's negative feelings about one parent are rational or irrational is more often than not quite challenging. In some respects, the process is similar to differentiating a non-bizarre delusion from a persistent, justified worry. Proposed methods for distinguishing alienation from estrangement (beyond the scope of this article) have been described by several authors.[30,43,44]

It is remarkable that abused children frequently remain attached to their abusive parents, whom they might perceive as charming and charismatic. Through various mental processes, maltreated children persist in fearing, loving, hating, being dependent on, and longing for the love and acceptance of their abusive and neglectful mothers and fathers.[45,46] As a result, a maltreated child may have ambivalent feelings toward the abusive parent; however, the alienated child almost always has highly negative attitudes toward a nonabusive parent. It is counterintuitive that an alienated, nonabused child may be more negative toward the rejected parent than a child who was actually abused.

Child Affected by Parental Relationship Distress Versus Parent–Child Relational Problem

Both CAPRD and PCRP are relational problems in the *DSM-5*. These relational problems may or may not occur together. The criteria for a PCRP are more fleshed out in the *DSM-5*, and indeed there has been a field trial of those criteria yielding good interrater reliability.[47] It is methodologically easier to establish criteria for a dyadic relationship, for example, a parent and child, than a triadic relationship, such as CAPRD. It is possible that a child may only have a difficult relationship with one parent and relate well to the other parent. It is also possible that the child may have a good relationship with each parent but still react to the conflict between them (e.g., in the scenario for a loyalty conflict). Thus, the clinician should choose either or both of those terms that help to identify risk factors for the child's symptoms when formulating a case. When billing, the clinician should choose the relational problem that they are focusing on in treatment with the child.

DISCUSSION

CAPRD is a concept that clinicians and research personnel will find useful once they become familiar with its meaning, scope, and implications. For research in this area to proceed, use of the more stringent definitions for intimate partner maltreatment and intimate partner relationship distress, found in the *DSM-5*, may be helpful in ascertaining whether either of those problems are occurring in the parents of children presenting with health complaints. The World Health Organization is currently testing these definitions in a large, multinational field study to assess cultural relevance in low-, middle-, and high-income countries, as well as whether these definitions add additional clinical utility.[48] Clinical treatment studies for children with specific disorders, for example, anxiety, depression, or disruptive behavior disorders, can assess outcomes using the occurrence of current or past IPD or IPV in parents as covariates, to see whether presence of CAPRD affects treatment outcome. Further treatment studies may contrast the treatment of the parental relationship problem in addition to treatment of the child, as compared to treatment of the child alone. In adults with major depression, the presence or absence of IPD has been shown to affect treatment outcomes and has led to recommendations for couples therapy in addition to individual therapy or medications if IPD is present.[49] Finally, screening for parental distress or maltreatment may be accomplished preventively during well-child checkups. If there are relational problems involving the parents, randomization to couples therapy or treatment as usual and tracking child mental health outcomes could test whether changing this risk factor may prevent onset or progression of child mental health problems.

With regard to clinical practice, CAPRD can be used to identify several different responses that a child might have to interparental conflict, interparental violence, or parental efforts to triangulate a child into taking his or her side against the other parent. Children faced with these parental difficulties may develop or have exacerbated psychological symptoms, physical reactions, an internal conflict, or an unwarranted behavioral rejection of a relationship with a parent. Unlike the more familiar *DSM-5* diagnoses that focus solely on symptoms exhibited by children, CAPRD identifies the context, often the precipitating cause, of the child's symptoms. Identifying this contextual component to the child's presentation can lead to a more comprehensive treatment plan. Prevention programs may well target reduction of exposure of the child to interparental conflict as a way of minimizing a variety of adverse outcomes for children.

CAPRD, like other conditions included in the section on "Relational Problems" in the *DSM-5*, purports an additional paradigm for mental health practitioners to consider. This section tries to define reliably common environmental

contexts of key relationships that appear to lead to or exacerbate a variety of adverse mental health outcomes. Coding this context in a standardized and reliable manner is one method of helping to understand heterogeneity among individually based disorders. For example, a child suffering from major depression in the context of CAPRD may have a different illness from a child who is depressed within a calm and supportive home environment. Coding CAPRD when it is present may help to distinguish differential outcomes for children with similar symptom constellations. Although CAPRD is new and not yet well understood, it deserves the attention of mental health professionals who work with children, adolescents, and families. &

CG Clinical Guidance

- "Child affected by parental relationship distress" is novel terminology for a mental condition in the *DSM-5*. This term may be used for four troublesome family circumstances that are distinct but interrelated.
- A child might experience anxiety or depression when exposed to intimate partner distress (e.g., frequent arguing) between the parents, or posttraumatic symptoms when exposed to intimate partner violence (e.g., physical abuse) between the parents.
- A child might develop somatic or psychological symptoms in the context of an intense loyalty conflict (trying to maintain affection for both parents, who are in conflict with each other), or false memories in the context of parental alienation (gravitating to one parent and wrongly believing that the rejected parent is dangerous).

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REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC: American Psychiatric Association; 2013.
2. Flint J, Greenspan RJ, Kendler KS. How Genes Influence Behavior. New York: Oxford University Press; 2010.
3. Caspi A, Sugden K, Moffitt TE, *et al*. Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. Science. 2003;301:386-389.
4. Goodyer IM. Genes, environments and depressions in young people. Arch Dis Child. 2015;100:1064-1069.
5. Teicher MH, Samson JA. Childhood maltreatment and psychopathology: a case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. Am J Psychiatry. 2013;170:1114-1133.
6. Wamboldt M, Kaslow N, Reiss D. Description of relational processes: recent changes in DSM-5 and proposals for ICD-11. Fam Process. 2015;54:6-16.
7. Beach SRH, Wamboldt MZ, Kaslow NJ, *et al*., eds. Relational Processes and DSM-V: Neuroscience, Assessment, Prevention, and Intervention. Washington, DC: American Psychiatric Press; 2006.
8. Foran HM, Beach SRH, Slep AMS, *et al*., eds. Family Problems and Family Violence: Reliable Assessment and the ICD-11. New York: Springer Publishing; 2012.
9. Beach SRH, Whisman MA. Relationship distress: Impact on mental illness, physical health, children, and family economics. In: Foran HM, Beach SRH, Slep AMS, *et al*., eds. Family Problems and Family Violence: Reliable Assessment and the ICD-11. New York: Springer Publishing; 2012:91-100.
10. Snyder DK. Manual for the Marital Satisfaction Inventory–Revised. Los Angeles, CA: Western Psychological Services; 1997.
11. Whisman MA, Snyder DK, Beach SRH. Screening for marital and relationship discord. J Fam Psychol. 2009;23:247-254.
12. Snyder DK, Heyman RE, Haynes SN. Evidence-based approaches to assessing couple distress. Psychological Assessment. 2005;17:288-307.
13. Gilmour GA. High-Conflict Separation and Divorce: Options for Consideration. Ottawa, ON, Canada: Department of Justice Canada (2004-FCY-1E); 2004.
14. Johnston JR, Roseby V. Parental alignments and alienation among children of high-conflict divorce. In: Johnston JR, Roseby V, Kuehnle K, eds. In the Name of the Child, 2nd ed. New York: Simon and Schuster; 2009:193-220.
15. Lorandos D, Bernet W, Sauber SR. Overview of parental alienation. In: Lorandos D, Bernet W, Sauber SR, eds. Parental Alienation: The Handbook for Mental Health and Legal Professionals. Springfield, IL: Charles C Thomas; 2013:5-46.
16. Felitti VJ, Anda RF, Nordenberg D, *et al*. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14:245-258.
17. Copeland W, Shanahan L, Costello EJ, Angold A. Configurations of common childhood psychosocial risk factors. J Child Psychol Psychiatry. 2009;50:451-459.
18. Foran HM, Whisman MA, Beach SR. Intimate partner relationship distress in the DSM-5. Fam Process. 2015;54:48-63.
19. Swindle R, Heller K, Pescosolido B, Kikusawa S. Responses to nervous breakdowns in America over a 40-year period: mental health policy implications. Am Psychol. 2000;55:740-749.
20. Beach SRH, Fincham FD, Amir N, Leonard KE. The taxometrics of marriage: is marital discord categorical? J Fam Psychol. 2005;19:276-285.
21. Whisman MA, Beach SRH, Snyder DK. Is marital discord taxonic and can taxonic status be assessed reliably? Results from a national representative sample of married couples. J Consult Clin Psychol. 2008;76:745-755.
22. Whisman MA, Sheldon CT, Goering P. Psychiatric disorders and dissatisfaction with social relationships: does type of relationship matter? J Abnorm Psychol. 2000;109:803-808.
23. Cummings EM, Davies PT. Effects of marital conflict on children: recent advances and emerging themes in process-oriented research. J Child Psychol Psychiatry. 2002;43:31-63.
24. Cummings EM, Davies PT. Marital Conflict and Children: an Emotional Security Perspective. New York: Guilford Press; 2010.
25. Sternberg KJ, Lamb ME, Greenbaum C, *et al*. Effects of domestic violence on children's behavior problems and depression. Dev Psychol. 1993;29:44-52.

26. Straus MA, Gelles RJ, Steinmetz SI. Behind Closed Doors: Violence in the American Family. Garden City, NY: Anchor/Doubleday; 1980.
27. Crooks CV, Jaffe PG, Bala N. Factoring in the effects of children's exposure to domestic violence in determining appropriate postseparation parenting plans. In: Hannah MT, Goldstein B, eds. Domestic Violence, Abuse, and Child Custody: Legal Strategies and Policy Issues. Kingston, NJ: Civic Research Institute; 2010:22-1–22-25.
28. El-Sheikh M, Cummings EM, Kouros CD, Elmore-Staton L, Buckhalt J. Marital psychological and physical aggression and children's mental and physical health: direct, mediated, and moderated effects. J Consult Clin Psychol. 2008;76:138-148.
29. Wamboldt MZ, Weintraub P, Krafchick D, Berce N, Wamboldt FS. Links between past parental trauma and the medical and psychological outcome of asthmatic children: a theoretical model. Fam Systems Med. 1995;13:129-149.
30. Bernet W, Freeman B. The psychosocial assessment of contact refusal. In: Lorandos D, Bernet W, Sauber SR, eds. Parental Alienation: The Handbook for Mental Health and Legal Professionals. Springfield, IL: Charles C Thomas; 2013:47-73.
31. Bowen M. Family Therapy in Clinical Practice. Northvale, NJ: Jason Aronson; 1978.
32. Minuchin S. Families and Family Therapy. Cambridge, MA: Harvard University Press; 1974.
33. Ceci SJ, Crotteau-Huffman ML, Smith E, Loftus EF. Repeatedly thinking about a non-event: source misattributions among preschoolers. Conscious Cogn. 1994;3:388-407.
34. Bernet W, ed. Parental Alienation, DSM-5, and ICD-11. Springfield, IL: Charles C Thomas; 2010.
35. Walker LE, Shapiro DL. Parental alienation disorder: why label children with a mental diagnosis? J Child Custody. 2010;7:266-286.
36. Bernet W, Baker AJL. Parental alienation, DSM-5, and ICD-11: Response to critics. J Am Acad Psychiatry Law. 2013;41:98-104.
37. Heyman RE, Slep AMS, Eckardt Erlanger AC, Foran HM. Intimate partner maltreatment: definitions, prevalence, and implications for diagnosis. In: Foran HM, Beach SRH, Slep AMS, Heyman RE, Wamboldt MZ, eds. Family Problems and Family Violence: Reliable Assessment and the ICD-11. New York: Springer Publishing; 2013:1-14.
38. Whisman MA, Beach SRH. Relationship distress: assessment, definition, and implications for mental health diagnosis. In: Foran HM, Beach SRH, Slep AMS, Heyman RE, Wamboldt MZ, eds. Family Problems and Family Violence: Reliable Assessment and the ICD-11. New York: Springer Publishing; 2013:71-78.
39. Festinger L, Carlsmith JM. Cognitive consequences of forced compliance. J Abnorm Soc Psychol. 1959;58:203-210.
40. Clawar SS, Rivlin BV. Children Held Hostage, Identifying Brainwashed Children, Presenting a Case, and Crafting Solutions, 2nd ed. Chicago, IL: American Bar Association; 2013.
41. Klosinski G. Psychological maltreatment in the context of separation and divorce. Child Abuse Negl. 1993;17:557-563.
42. Gardner RA. Recent trends in divorce and custody litigation. Academy Forum. 1985;29:3-7.
43. Gardner RA. Differentiating between parental alienation syndrome and bona fide abuse-neglect. Am J Fam Ther. 1999;27:97-107.
44. Drozd LM, Olesen NW. Is it abuse, alienation, and/or estrangement? A decision tree. J Child Custody. 2004;1:65-106.
45. Baker AJL, Schneiderman M. Bonded to the Abuser: How Victims Make Sense of Childhood Abuse. Lanham, MD: Rowman and Littlefield Publishers; 2015.
46. Bancroft RL, Silverman JG, Ritchie D. The Batterer as Parent: Addressing the Impact of Domestic Violence on Family Dynamics, 2nd ed. Thousand Oaks, CA: Sage Publications; 2011.
47. Wamboldt M, Cordaro A Jr, Clarke D. Parent-child relational problem: field trial results, changes in DSM-5, and proposed changes for ICD-11. Fam Process. 2015;54:33-47.
48. Heyman RE, Smith Slep AM, Foran HM. Enhanced definitions of intimate partner violence for DSM-5 and ICD-11 may promote improved screening and treatment. Fam Process. 2015;54:64-81.
49. Whisman MA. Marital adjustment and outcome following treatments for depression. J Consult Clin Psychol. 2001;69:125-129.