Consultation: Draft Guidance on Responding to allegations of alienating behaviour

August 2023

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Consultation from Dr. Childress to Draft Guidance from FJC – Part 2

I am a clinical psychologist in the United States. I have six domains of specialized knowledge supported by my vitae relevant to court-involved custody conflict and attachment pathology displayed by the child:

1. Delusional thought disorders

   Twelve years on a major UCLA research study on schizophrenia with annual training in the diagnostic assessment of delusional thought disorders.

2. Attachment pathology

   Early Childhood Mental Health specialization.

3. Child abuse and complex trauma

   Clinical Director for a 3-university assessment and treatment center for children ages zero-to-five in foster care.

4. Factitious Disorder Imposed on Another

   Training and medical staff position as a pediatric psychologist at Childrens Hospitals.

5. Family systems

   Specialized training track from Pepperdine University's doctoral program and

lifelong practice as a family systems therapist

6. Court-involved custody conflict

   Ten years in the family courts as a clinical psychologist and expert consultant to attorneys and their client-parents in custody conflict.

- Dr. Childress Domains of Specialized Expertise & Vitae

  https://drcachildress-consulting.com/wp-content/uploads/2023/01/domains-of-specialized-expertise-1-1-23-2.pdf

I currently serve as a consultant to attorneys and the Court in family law cases of child custody conflict. I have provided consultation on both national and international cases. I have testified as an expert witness in the U.S., Canada, Sweden, and South Africa, and I have been involved in several matters in Great Britain.

I have had an invited meeting with representatives of the Dutch Ministry of Justice when I presented at Erasmus Medical Center in the Netherlands, and I recently had an invited presentation at the University of Novi Sad in Serbia.

I have a Consulting Website that describes more about my court-involved consultation and the pathology of concern in the family courts.

- Dr. Childress Consulting Website

  https://drcachildress-consulting.com/

The FJC draft Guidance describes the professional expertise desired for the family courts:

> **From FJC Guidance:** "Given the complexity of these cases and the often-interacting psychological factors at play in the adults and the children, it is likely that assessments which will assist the court in determining welfare outcomes are those offered by HCPC regulated Practitioner Psychologists with competence in assessing adults and children, e.g., Clinical Psychologists/Counselling Psychologists."

I am a clinical psychologist with competence in assessing adults and children for a variety of pathology, including the attachment pathology in the family courts.

> **From FJC Guidance:** "These assessments should not be undertaken by academic psychologists or psychological researchers in the field of alienation. Only HCPC Registered psychologists have the relevant clinical experience and training to conduct psychological assessments of people and make clinical diagnoses and recommendations for treatment or interventions, whereas, academic psychologists, who should be Chartered, but who are not registered with the HCPC, would not normally have the clinical experience and training in order to complete psychological assessments or make clinical diagnoses."

I am an applied practitioner, a licensed clinical psychologist, not an academic researcher.

My consultation feedback is from the domains of professional clinical psychology recommended by the JFC draft Guidance.

4. Guidance Note for the Family Court on Welfare decisions where findings of alienating behaviours have been made

Diagnosis guides Treatment

There is no such thing as “parental alienation” – “alienation” – or “alienating behaviours” – ignorance solves nothing.

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For all child abuse diagnoses, professional standards of practice and duty to protect obligations require the child’s protective separation from the abusive parent. We always protect the child. The child’s healthy and normal-range development is then recovered, and once stabilized, the child’s contact with the abusive parent is reestablished with enough safeguards in place to ensure that the child abuse does not resume when contact with the abusive parent is restored.

Purpose

This Guidance Note is intended to have particular relevance to judges making welfare decisions where there have been findings of alienation. Whilst there are points of general application for the courts to consider when determining welfare, this Note is not intended to be a comprehensive note of all welfare considerations.

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Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child’s attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no

- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

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> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
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> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Preamble

A finding that a parent has acted to alienate a child from the other parent is usually only one part of the factual matrix. The court should avoid treating a finding of alienating behaviours as an automatic trigger for a change in a child's placement. The court should also examine very carefully all the welfare ramifications for each child if considering making an order for the transfer of a child's care conditional on compliance with a 'time with' order.
Just as with findings of other harmful behaviour such as domestic abuse or child abuse, the fact that a child's relationship has been disrupted by the behaviours of a parent, is a factor to be weighed in the balance. The court should bear in mind the wider factual matrix, which may include associated findings of domestic abuse, alignment or other safeguarding issues, when considering next steps. A judgment in which the court draws together its conclusions on the various elements of the factual matrix will be important in helping those asked to assist the court with welfare options.

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Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the

pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

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- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
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Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross- ☐ yes ☐ no

generational coalition of the child with the one parent against the other parent?

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Guidance

Statements

1. Where the court has made findings of alienating behaviour, and/or other forms of abuse, the court may find it helpful initially to direct statements from the parties in response to its findings of fact judgment. This will help the court understand the parents' level of insight and their willingness to engage in work to address those behaviours and the resultant impact.

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Participation in Child Abuse & Spousal Abuse

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false belief that the child is being malevolently treated in some way)?

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Family Systems Pathology

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The Guardian

2. The child will generally be a party in such complex cases. The Guardian will often be able to help with next steps after the court has delivered its fact-finding judgment. In appropriate cases the Guardian might be available to assist in informing the child in age-appropriate terms of the progress of the proceedings. If the Guardian would be assisted by a direction permitting disclosure of the court's judgment, then a direction could be made to that end. Where a Guardian is appointed the Guardian's analysis might consider external interventions which could be of assistance to the children and parents. The Guardian can be asked to consider the impact of the available interventions in their analysis of alternative welfare outcomes.

Diagnosis guides treatment.

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Interim measures

3. In appropriate cases the court, upon making its findings, may want to look straight away at whether there is any form of intervention that can be adopted more or less immediately to ameliorate or reduce the impact of alienating behaviours on the children and the relationship with the other parent. There are a number of options that may be available and worth considering even if they have been tried before without enduring success e.g.: the safe and managed use of social media (such as Snapchat, Instagram, WhatsApp) or third-party interventions (such as involvement with schools, religious activities etc).

Diagnosis Guides Treatment – Child Protection

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Dialectic Behavior Therapy

Dialectic Behavior Therapy (DBT; Linehan) adapted to family therapy and the pathology in the family courts would be recommended. DBT is a combination of Cognitive-Behavior Therapy (CBT), a major school of psychotherapy with substantial empirical support, with Mindfulness skills training from Eastern meditative traditions. The Cognitive component of CBT would be helpful in correcting any distortions to the child's thinking and perceptions created by the pathogenic parenting of the allied parent, and the Behavioral therapy component of CBT uses Applied Behavioral Analysis which can identify authentic from inauthentic parent-child conflict. The added Mindfulness component of DBT will help with stress reduction for the child who is coping with the family conflict and will facilitate the child's development of self-authenticity.

Another benefit of adapting DBT for family court pathology is that Dialectic Behavior Therapy was developed for the treatment of borderline personality pathology, which is among the spectrum of personality pathologies of concern in the family courts (narcissistic-borderline-dark personality parents), so DBT therapists are trained in relevant personality disorder pathology. Outcome Measures monitoring the child's symptoms of concern should be collected and used to monitor treatment progress and the achievement of treatment goals. The collection and use of Outcome Measures is a standard part of treatment plans in clinical psychology and should be fully familiar to a DBT therapist.

4. Cafcass offer a short-term piece of work under their **Improving Child and Family Arrangements Programme**. Cafcass Cymru are also looking at other programmes to support children. Some local authority areas have public and private professional services available to assist children and families. The process of reporting, accessing and monitoring interventions can take time and can lead to delay. Identifying who will deliver any work with the children and parents must be considered with reference to the children's welfare and the reality of the lives of the family.

With proper training, Cafcass could conduct a proper risk assessment for child abuse to the appropriate differential diagnoses for each parent. If not Cafcass, then referral should be made to qualified and competent mental health professionals who can conduct a proper risk assessment for child abuse to the appropriate differential diagnoses for each parent.

Development of both levels of professional services are recommended, with a second-opinion obtained on the initial assessment, or even a third opinion. When possible child abuse is a considered diagnosis, the diagnosis returned must be accurate 100% of the time.

> **From Improving Diagnosis in Health Care:** "Clinicians may refer to or consult with other clinicians (formally or informally) to seek additional expertise about a patient's health problem. The consult may help to confirm or reject the working diagnosis or may provide information on potential treatment options. If a patient's health problem is outside a clinician's area of expertise, he or she can refer the patient to a clinician who holds more suitable expertise. Clinicians can also recommend that the patient seek a second opinion from another clinician to verify their impressions of an uncertain diagnosis or if they believe that this would be helpful to the patient."

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- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
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Assessments

5. In some cases, the court may be invited to direct a whole family psychological assessment to consider the family dynamics and functioning. Additional expert assessments are not always necessary but when one is considered to be so, the court should be mindful of the need to appoint an expert with the relevant qualifications and expertise to conduct a whole family assessment. The court and the parties should take particular note of the guidance from the President in **Re C (Parental Alienation)** [2023] EWHC 345 (Fam) together with the recent Revised Guidance on Psychologists as Expert Witnesses. The court will also wish to caution itself against appointing experts to assess a family where the expert has a financial interest in the delivery of subsequent services.).

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Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no

- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

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> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
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> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

6. When considering the ambit of an expert assessment, the court should bear in mind the nature, duration, and impact of the disruption in the relationship between the alienated child and parent against the wider factual matrix, to ensure that any assessment is both balanced and comprehensive.

A pilot program for the family courts with university involvement for evaluation research could develop the diagnostic assessment and treatment protocols appropriate for the differential diagnoses involved.

<u>The child's timetable</u>

7. For some children, time and appropriate support can be effective in reversing the harm consequent on alienating behaviours. In some cases, children will have been

alienated from the parent's wider family of the non-resident parent and reparative work may help to re-establish those safe relationships. The court must remain mindful of the child's timetable and the need to manage the court process. Where interventions are found to be outside the child's timetable the court should avoid delay in making difficult final decisions.

Diagnosis Guides Treatment – Child Protection

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If the returned diagnosis from a proper risk assessment is Child Psychological Abuse (V995.51) by the allied parent (i.e., creating shared persecutory delusion and factitious attachment pathology in the child), we always protect the child.

For all child abuse diagnoses, professional standards of practice and duty to protect obligations require the child's protective separation from the abusive parent. The child's healthy and normal-range development is then recovered, and once stabilized, the child's contact with the abusive parent is reestablished with enough safeguards in place to ensure that the child abuse does not resume when contact with the abusive parent is restored.

Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

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correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?”

From Martin: “Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders.”

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), “one of the oldest, most widely used scales to measure psychotic symptoms” (Wikipedia: BPRS).

Parent’s attitude to reparative work

8. An order transferring a child from the care of one parent to the care of another solely on findings of alienation, will be rare. The court should avoid making orders for the transfer of the care of children solely as a sanction for a parent’s refusal to help restore the disrupted relationship. Whilst family courts are often asked to transfer care of a child between parents in the private law family arena, there is a qualitative difference as to the likely impact on a child where the child does not have a positive (or indeed any) relationship with the non-resident parent. The court must similarly consider the consequences for a child’s welfare when considering making an order that would result in a change of placement as a consequence of non-compliance with a ‘time with order’.

Diagnosis Guides Treatment – Child Protection

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If the returned diagnosis from a proper risk assessment is Child Psychological Abuse (V995.51) by the allied parent (i.e., creating shared persecutory delusion and factitious attachment pathology in the child), we always protect the child.

For all child abuse diagnoses, professional standards of practice and duty to protect obligations require the child’s protective separation from the abusive parent. The child’s healthy and normal-range development is then recovered, and once stabilized, the child’s contact with the abusive parent is reestablished with enough safeguards in place to ensure that the child abuse does not resume when contact with the abusive parent is restored.

Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent’s psychological abuse of the child by

validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

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- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no

- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

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The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Welfare the paramount consideration

9. The court must remind itself that the welfare of the child/children remains paramount. A parent from whom a child might be moved is highly likely to perceive the prospect of a transfer of care as punitive. It may affect their presentation in court as well as their mental health. Whilst non-compliance with a court order is a serious matter the court must not conflate non-compliance with welfare. Non-compliance with a court order is not, of itself, a reason for a transfer of care albeit non-compliance and capacity to take up and act on professional support and guidance may be relevant factors in the welfare determination.

Standards of Professional Practice

Diagnosis guides treatment. There is no such thing as "parental alienation" – "alienation" – or "alienating behaviours" – ignorance solves nothing.

Court Orders

Court orders should always be followed. Parents should always follow court orders. Parents should teach their children to always follow court orders.

If a parent teaches their child that disregarding court orders is okay, then a DSM-5 diagnosis of Child Neglect (V995.52) should be considered. Court orders should always be followed.

Diagnosis Guides Treatment – Child Protection

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For all child abuse diagnoses, professional standards of practice and duty to protect obligations require the child's protective separation from the abusive parent. The child's healthy and normal-range development is then recovered, and once stabilized, the child's contact with the abusive parent is reestablished with enough safeguards in place to ensure that the child abuse does not resume when contact with the abusive parent is restored.

Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

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If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
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Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by ☐ yes ☐ no

creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs?

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
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The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

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patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Factors to be weighed in the balance

10. Whilst every case must be considered on its own facts there are a number of potential considerations for the court that must be weighed in the balance when considering welfare after a finding of alienating behaviours. A non-exhaustive list of matters that might impact the child, particularly where their relationship with one of their parents has been disrupted, may include:

Standards of Professional Practice

There is no such thing as "parental alienation" – there is no such thing as "alienation" – there is no such thing as "alienating behaviours" – as defined constructs in clinical psychology.

"parental alienation" = unicorns: both are mythical things.

There are shared delusional disorders. There are factitious disorders imposed on another. There are cross-generational coalitions and emotional cutoffs. There are narcissistic, borderline, and dark personality parents. There is Child Psychological Abuse (DSM-5 V995.51). But there is NO defined pathology in clinical psychology called "parental alienation" – it is mythical thing that people just make up.

The use of the construct of "parental alienation" in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 of the APA ethics code.

2.04 Bases for Scientific and Professional Judgments
Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict is:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others

Apply knowledge to solve pathology. Ignorance solves nothing.

Diagnosis Guides Treatment – Child Protection

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

If the returned diagnosis from a proper risk assessment is Child Psychological Abuse (V995.51) by the allied parent (i.e., creating shared persecutory delusion and factitious attachment pathology in the child), we always protect the child.

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When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

Competence Concerns

No established scientific or professional knowledge from any domain of professional psychology has been applied as the bases for the professional judgments offered in this Guidance. Professional concerns exist that the authors of this Guidance may not know the established professional knowledge of the discipline required to work with the pathology in the family courts.

- **Competence in Delusional Thought Disorders**: ☐ yes ☐ no

  Are the authors of this Guidance competent in the diagnostic assessment and treatment of delusional thought disorders based on their education, training, and experience?

  From Walters & Friedlander: "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426; *Family Court Review*)

From Walters & Friedlander: "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed delusion often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated delusion and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426; *Family Court Review*)

- **Competence in Attachment Pathology**: ☐ yes ☐ no

  Are the authors of this Guidance competent in the diagnostic assessment and treatment of attachment pathology based on their education, training, and experience?

- **Competence in FDIA**: ☐ yes ☐ no

  Are the authors of this Guidance competent in the diagnostic assessment and treatment of a Factitious Disorder (factitious attachment pathology and a delusional thought disorder) Imposed on Another based on their education, training, and experience?

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

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Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no

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Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
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Wishes and feelings of the child

a) Although likely to reflect a desire for the status quo, opportunities for the child to

express their wishes and feelings may offer indications of the viability of reparative work, remaining with the resident parent or moving to live with the non-resident parent or another family member.

Children do not make custody decisions. Asking the child's preference will directly triangulate the child into the spousal conflict and provoke loyalty binds for the child.

The child's beliefs and experiences should be properly considered within the context of the clinical diagnostic assessment for child abuse to the appropriate differential diagnoses for each parent.

It is possible that the child's beliefs and opinions are influenced and compromised by the manipulative psychological control of a pathological (narcissistic-borderline-dark personality) parent. Diagnostic clinical interviewing of the child should be informed with the necessary professional knowledge required for competence.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict is:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others

Psychological Control

Barber, B. K. (Ed.) (2002). Intrusive parenting: How psychological control affects children and adolescents. Washington, DC: American Psychological Association.

Definition

From Barber & Harmon: "Psychological control refers to parental behaviors that are intrusive and manipulative of children's thoughts, feelings, and attachment to parents. These behaviors appear to be associated with disturbances in the psychoemotional boundaries between the child and parent, and hence with the development of an independent sense of self and identity." (Barber & Harmon, 2002, p. 15)

Barber, B. K. and Harmon, E. L. (2002). Violating the self: Parenting psychological control of children and adolescents. In B. K. Barber (Ed.), Intrusive parenting (pp. 15-52). Washington, DC: American Psychological Association.

Behavioral vs. Psychological Control

Stone, Buehler, & Barber: "The central elements of psychological control are intrusion into the child's psychological world and self-definition and parental attempts to manipulate the child's thoughts and feelings through invoking guilt, shame, and anxiety. Psychological control is distinguished from behavioral control in that the parent attempts to control, through the use of criticism, dominance, and anxiety or guilt induction, the youth's thoughts and feelings rather than the youth's behavior." (Stone, Buehler, & Barber, 2002, p. 57)

Stone, G., Buehler, C., & Barber, B. K.. (2002) Interparental conflict, parental psychological control, and youth problem behaviors. In B. K. Barber (Ed.),

Intrusive parenting: How psychological control affects children and adolescents. Washington, DC: American Psychological Association

Methods of Psychological Control:

From Soenens and Vansteenkiste: "Psychological control can be expressed through a variety of parental tactics, including (a) guilt-induction, which refers to the use of guilt inducing strategies to pressure children to comply with a parental request; (b) contingent love or love withdrawal, where parents make their attention, interest, care, and love contingent upon the children's attainment of parental standards; (c) instilling anxiety, which refers to the induction of anxiety to make children comply with parental requests; and (d) invalidation of the child's perspective, which pertains to parental constraining of the child's spontaneous expression of thoughts and feelings." (Soenens & Vansteenkiste, 2010, p. 75)

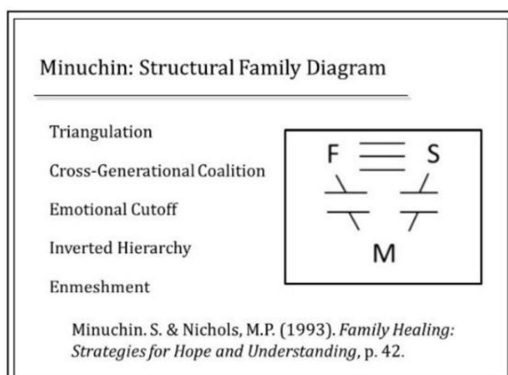
Soenens, B., & Vansteenkiste, M. (2010). A theoretical upgrade of the concept of parental psychological control: Proposing new insights on the basis of self-determination theory. Developmental Review, 30, 74–99.

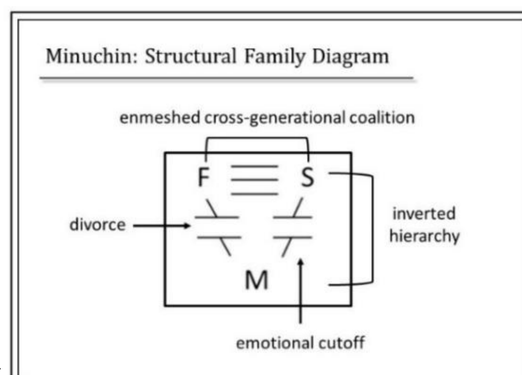
Family Systems & Psychological Control:

Stone, Buehler, and Barber: "The concept of triangles "describes the way any three people relate to each other and involve others in emotional issues between them" (Bowen, 1989, p. 306). In the anxiety-filled environment of conflict, a third person is triangulated, either temporarily or permanently, to ease the anxious feelings of the conflicting partners. By default, that third person is exposed to an anxiety-provoking and disturbing atmosphere. For example, a child might become the scapegoat or focus of attention, thereby transferring the tension from the marital dyad to the parent-child dyad. Unresolved tension in the marital relationship might spill over to the parent-child relationship through parents' use of psychological control as a way of securing and maintaining a strong emotional alliance and level of support from the child. As a consequence, the triangulated youth might feel pressured or obliged to listen to or agree with one parents' complaints against the other. The resulting enmeshment and cross-generational coalition would exemplify parents' use of psychological control to coerce and maintain a parent-youth emotional alliance against the other parent (Haley, 1976; Minuchin, 1974)." (Stone, Buehler, & Barber, 2002, p. 86-87).

Stone, G., Buehler, C., & Barber, B. K.. (2002) Interparental conflict, parental psychological control, and youth problem behaviors. In B. K. Barber (Ed.), Intrusive parenting: How psychological control affects children and adolescents. Washington, DC: American Psychological Association

Family Systems Diagrams – Minuchin & Nichols:





Physical, emotional, and educational needs

b) The child's future relationship with the non-resident parent if there is only indirect contact
c) A total cessation of contact both direct and indirect
d) The impact of continuity or change of schooling/educational arrangements will often need to be considered
e) The practical and physical arrangements for care of the child during and after any change of residence
f) Therapeutic support for the family

Diagnosis guides treatment.

- In the absence of child abuse, parents have the right to parent according to their cultural values, their personal values, and their religious values.
- In the absence of child abuse, each parent should have as much time and involvement with the child as possible.
- In the absence of child abuse, to restrict either parent's time and involvement with the child would damage that child's attachment bond to that parent, thereby harming the child and harming that parent.

If the returned diagnosis from a proper risk assessment is Child Psychological Abuse (V995.51) by the allied parent (i.e., creating shared persecutory delusion and factitious attachment pathology in the child), we always protect the child.

For all child abuse diagnoses, professional standards of practice and duty to protect obligations require the child's protective separation from the abusive parent. We always protect the child. The child's healthy and normal-range development is then recovered, and once stabilized, the child's contact with the abusive parent is reestablished with enough safeguards in place to ensure that the child abuse does not resume when contact with the abusive parent is restored.

The likely effect on the child of any change in their circumstances

g) Different contact arrangements for siblings or possible separation from siblings
h) Separation from the resident parent
i) Contact plans for any new family configuration

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Any harm the child has suffered or is at risk of suffering Risk of the child's living arrangements with the resident parent breaking down

j) Central to the court's evaluation of welfare will be the risk of harm to the child from exposure to continuing alienating behaviours (and disruption to the relationship with the parent) in the resident parent's home weighed against the risk of harm to the child from being uprooted and moved to a parent with whom the child has been reluctant or resistant or refusing to engage
k) Risk of the child's living arrangements breaking down if the child is moved to the current non-resident parent

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How capable each parent (and any other person in relation to whom the court considers the question to be relevant) is of meeting the child's needs

l) A deterioration in the mental health of a resident parent (e.g., where contact with a non-resident parent is imposed) (PD12J)
m) A deterioration in the mental health of a non-resident parent (e.g., after direct contact is suspended or where re-introduction fails)
n) The non-resident parent's capacity to have the child live with them after an interruption in the parent/child relationship

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Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no

- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

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The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
>
> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

The range of the powers available to the court in the proceedings in question

o) The bridging options (e.g., where there is no current relationship between the child

and non-resident parent)

p) Contact with the members of the wider family members of the alienated parent
q) Contingency planning will be important.

Diagnosis guides treatment. The involved mental health professionals should provide the court with 1) an accurate diagnosis of the pathology in the family, and 2) an effective treatment plan to fix the identified (diagnosed) pathology.

When the recommended treatment plan is implemented, it should fix the pathology. That's the obligation of the mental health system.

There are only two possible explanations for failed treatment, 1) misdiagnosis (cancer is being treated with insulin), or 2) incompetent treatment. Because if the diagnosis is accurate and the treatment for that diagnosis is competently delivered, then the treatment should fix the pathology.

For treatment, the Court should receive a written treatment plan with Goals specified in measurable ways, Interventions identified for each Goal, estimated Time Frames for Goal accomplishment, and Outcome Measures to monitor treatment prog. The treatment should reach its Goals in a reasonable amount of time based on the nature of the diagnosis (the treatment for autism is more involved and complex than the treatment for ADHD).

11. Even if on some dimension another care-giving environment may be better than the child's current one, decision-making should assign considerable weight to the value of continuity of "good-enough" care. (See Forslund et al., (2022) **Attachment goes to court: child protection and custody issues**). The court must remain mindful that the trauma of removal and the manner of it must be weighed in balance when considering a fundamental change in the child's living arrangements.

The citation to Attachment goes to court: child protection and custody issues is noted. I have specialty clinical background in Early Childhood Mental Health, with Certification in Infant Mental Health from Fielding Graduate Institute, and a served as the Clinical Director for a three-university assessment and treatment center for children ages zero-to-five in foster care – spot-on attachment and child abuse pathology.

Turn to Tronick and Gold (2020) The Power of Discord for the clinical application of attachment. We always repair. The worst thing we can possibly do, the Ugly, is to leave a breached attachment bond un-repaired.

> **From Tronick & Gold:** "We prefer to capture the range of a child's experience with a different set of terms: *the good, the bad, and the ugly. Good stress* is what happens in typical everyday interactions, what we have seen in our videotaped interactions as moment-to-moment mismatch and repair. *Bad stress* is the stress represented in the still face experiment by the caregiver's sudden inexplicable absence… *Ugly stress* occurs when the infant has missed out on the opportunity for repeated experiences of repair, as in situations of emotional neglect, and' thus cannot handle any sort of bigger stressful event." (Tronick & Gold, 2020, p. 134)
>
> **From Tronick & Gold:** "Children growing up with insufficient experiences of mismatch and repair are at a disadvantage for developing coping mechanisms to regulate their physiological behavioral and emotional reactions. We use the term *regulatory scaffolding* to describe the developmental process by which resilience

grows out of the interactive repair of the micro-stresses that happen during short lived, rapidly occurring mismatches. The caregiver provides "good-enough" scaffolding to give the child the experience of overcoming a challenge, ensuring there is neither too long a period to repair nor too close a match with no room for repair." (Tronick & Gold, 2020, p. 135)Diagnosis guides treatment.

Protecting the child from child abuse is never traumatic for the child**.** Diagnosis guides treatment. If child abuse is misdiagnosed, the consequences to the child are devastating.

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Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

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- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
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> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

The Guardian's role

12. The Guardian may invite the court to make a direction for the local authority to prepare a section 37 report pursuant to the guidance of Wall J (as he then was) in **CDM v CM** [2003] 2 FLR 636 and attaching an ICO. Wall J observed;

"The action contemplated (removal of the children from the residential parent's care either for an assessment or with a view to a change of residence) must be in the children's best interests. The consequences of the removal must be thought through: there must, in short, be a coherent care plan of which temporary or permanent removal from the residential parent's care is an integral part."

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Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

Best Interests of the Child

It is always in the best interests of the child to restore healthy and normal-range attachments to both parents.

It is always in the child's best interests to protect the child from all forms of child abuse, physical (V995.54), sexual (V995.53), neglect (V995.52), and psychological abuse (V995.51). All forms of child abuse are equally devastating for the child, they differ only in the type of damage done, not in the severity of damage done to the child. Psychological child abuse destroys the child from the inside out.

It is always in the child's best interests to fix the pathology (problem) in the family and restore the to the child a normal-range and healthy childhood.

The involved mental health professionals should conduct a proper risk assessment for child abuse to reach an accurate diagnosis that will guide the development of an effective treatment plan to fix the diagnosed (identified) pathology in the family. The court should be presented with the diagnosis (and second opinion confirmation) along with a written treatment plan to fix the diagnosed pathology.

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If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
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Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary ☐ yes ☐ no

gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs?

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
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The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), “one of the oldest, most widely used scales to measure psychotic symptoms” (Wikipedia: BPRS).

13. The Guardian will make a recommendation about whether a move from one parent to another is appropriate and/or practical. The Guardian is not in a position to assist with the mechanics of a move should one be proposed. Cafcass have no authority to take charge of a child or to be practically or physically involved in a transfer of care.

In all cases of child abuse, we always protect the child.

14. In appropriate cases the Guardian may make a referral to the local authority if they consider that a child is at risk and provide the relevant safeguarding information. A local authority may provide a bridging placement for a child to stabilise before a move of residence or to act as a neutral base from which they can build up / develop a relationship with the non-resident parent where there has been an absence of opportunity for them to spend time together. There may be very rare cases where the child is unable to continue to live within the family.

In all cases of child abuse, we always protect the child. Diagnosis guides treatment.

Review

15. Even where the court has conducted its own welfare analysis and carefully weighed in the balance the risks of harm to the child under the various options, the court should keep its decision under careful review consistent with the child’s welfare and a potentially changing landscape.

The standard of practice in clinical psychology is that the written treatment plan provided by professional psychology should include the following:

1. Goals specified in measurable ways,
2. Interventions identified for each Goal,
3. Estimated Timeframes for Goal accomplishment,
4. Outcome Measures to monitor treatment progress and Goal accomplishment.

The court should be provided with an accurate diagnosis and a written treatment plan to fix the identified (diagnosed) pathology in the family.

Conclusion

16. Where a child’s relationship with a parent has been fundamentally undermined, the

welfare decisions will always be difficult. The consequent orders made are not a punishment or admonishment albeit the family are likely to feel them to be so. In the extreme cases the child may lose all contact with a non-resident parent and at the other extreme, experience a change of placement. The court will no doubt wish to ensure that its decision is delivered as sensitively as possible. A short summary of the court's decision in child friendly terms or a letter to the child, may help the child understand and in appropriate cases leave open the option for a relationship with the non-resident parent at a later date.

In healthcare, the diagnosis is always delivered by the doctors (licensed mental health professionals) who are trained in delivering difficult diagnoses. It is the professional obligation of the mental health team to deliver the diagnosis to the family members.

> **From Improving Diagnosis in Health Care: "**The working diagnosis should be shared with the patient, including an explanation of the degree of uncertainty associated with a working diagnosis. Each time there is a revision to the working diagnosis, this information should be communicated to the patient."
>
> **From Improving Diagnosis in Health Care: "**When the diagnostic team members judge that they have arrived at an accurate and timely explanation of the patient's health problem, they communicate that explanation to the patient as the diagnosis."

5. Guidance Note for the Family Court: Understanding hostility and psychological manipulation in cases in which alienating behaviours are alleged

What does hostility look like?

In clinical psychology, child hostility as a symptom is called "protest behavior" and is designed to reestablish bonding that has been breached, or to gain adult caregiver assistance with a developmental task that the child cannot independently master.

> **Recommended Reading:** Tronick and Gold (2020)[1]: *The Power of Discord*
>
> **From Tronick & Gold:** "We prefer to capture the range of a child's experience with a different set of terms: *the good, the bad, and the ugly. Good stress* is what happens in typical everyday interactions, what we have seen in our videotaped interactions as moment-to-moment mismatch and repair. *Bad stress* is the stress represented in the still face experiment by the caregiver's sudden inexplicable absence… *Ugly stress* occurs when the infant has missed out on the opportunity for repeated experiences of repair, as in situations of emotional neglect, and' thus cannot handle any sort of bigger stressful event." (Tronick & Gold, 2020, p. 134)

[1] Tronick, E. & Gold, C. (2020). *The Power of Discord: Why the Ups and Downs of Relationships Are the Secret to Building Intimacy, Resilience, and Trust.* New York : Little, Brown Spark, 2020.

From Tronick & Gold: "Children growing up with insufficient experiences of mismatch and repair are at a disadvantage for developing coping mechanisms to regulate their physiological behavioral and emotional reactions. We use the term *regulatory scaffolding* to describe the developmental process by which resilience grows out of the interactive repair of the micro-stresses that happen during short lived, rapidly occurring mismatches. The caregiver provides "good-enough" scaffolding to give the child the experience of overcoming a challenge, ensuring there is neither too long a period to repair nor too close a match with no room for repair." (Tronick & Gold, 2020, p. 135)

It is easy to assume that a child's negative reaction, in particular their initial reaction, is a stable and pervasive indication of a decision about their desire for a relationship with a parent, or that hostility at some level will be implacable/unchanging. In response to a parental separation children may be expected to experience a wide range of emotions and react with initial anger or resentment due to the situation they find themselves in, and for this to be directed at the parent that they perceive to be at fault for the relationship rupture.

Citation of support from the research is requested for these assertions.

From Ainsworth: "I define an "affectional bond" as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional bond, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief." (p. 711)[2]

From Ainsworth: "An "attachment" is an affectional bond, and hence an attachment figure is never wholly interchangeable with or replaceable by another, even though there may be others to whom one is also attached. In attachments, as in other affectional bonds, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss. (p. 711)

The child responds to grief at separation or loss (Ainsworth, 1989)

From Bowlby: "The deactivation of attachment behavior is a key feature of certain common variants of pathological mourning." (p. 70)[3]

This hostility may include a range of behaviours from refusing to speak to or see a parent, throwing away things that they associate with them, to angry or challenging reactions to that parent, e.g., in response to typical parental boundary setting. It can also include making derogatory remarks about that parent to others, e.g., a teacher, or being critical about them. None of these behaviours can be taken to indicate evidence of exposure to alienating behaviours by the other parent in their own right. It can be helpful to consider the reaction

[2] Ainsworth, M.D.S. (1989). Attachments beyond infancy. American Psychologist, 44, 709-716.

[3] Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss: Sadness and depression. NY: Basic.

to the relationship breakdown around them as a loss reaction, and to consider that observed behaviour may alter over time as this loss is processed by the child.

Citation to supporting research requested for these assertions.

These are statements of opinion that are not supported by professional knowledge or research. The authors seem to be seeking to avoid diagnosing child psychological abuse by the allied pathological parent (narcissistic-borderline-dark personality) and are placing barriers in the way of protecting the child from psychological child abuse by a pathological parent.

Walters and Friedlander (2016) in the journal *Family Court Review*:

> **From Walters & Friedlander:** "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426)

> **From Walters & Friedlander:** "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed delusion often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated delusion and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426)

The American Psychiatric Association describes the pathology of a shared delusion that can develop in families, with the children adopting the parent's delusional beliefs.

> **From the APA:** "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… Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs." (American Psychiatric Association, 2000)

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary ☐ yes ☐ no

gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs?

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events,

or is there no discernible basis in reality for the patient's beliefs or behavior?"

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

It is important to recognise that there will be situations in which there is no obvious cause or reason that can be identified for a child demonstrating such hostility. The lack of a rationale or explanation may cause there to be concern that the child has been exposed to alienating behaviours/psychological manipulation, but the absence of an identified justification does not in isolation evidence alienating behaviours.

Incompetence

There exists a diagnosis, there exists a causal explanation, it's just that the involved mental health professionals tasked with diagnosing the problem (pathology) are not competent in their understanding and assessment of the pathology.

Google incompetence: inability to do something successfully.

Based on the admission of the authors of this Guidance that they are unable to diagnose the pathology (identify the cause of the problem), the authors appear to be admitting to the incompetence in the mental health support received by the Court.

Perhaps the incompetence in identifying the problem (the inability to diagnose the pathology) is related to ignorance (lack of knowledge or information) of the necessary domains of professional knowledge needed to understand and resolve the pathology in the family courts.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict is:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

If the authors of this Guidance (or involved mental health professionals) are unable to identify what the cause of the problem is (are unable to diagnose the pathology), I would suggest the everyone stop making up new forms of pathology and instead learn the necessary knowledge.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – "alienating behaviours" – there is no defined pathology in clinical psychology of "parental alienation." It is a made

up thing.

"parental alienation" = unicorns; they are mythical things that do not exist.

The use of the construct of "parental alienation" ("alienation") in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 of the APA ethics code.

2.04 Bases for Scientific and Professional Judgments
Psychologists' work is based upon established scientific and professional knowledge of the discipline.

Competence Concerns

Based on their reliance on of a made-up construct ("parental alienation" – "alienation" – "alienating behaviours") and their admission of incompetent diagnosis (failure to successfully identify the pathology), prominent professional concerns exist that the authors of this Guidance may not know the knowledge needed for the pathology they are working with.

Do the authors know the domains of knowledge necessary for professional competence with the pathology in the family courts?

APA Standard 2.01 Boundaries of Competence
(a) 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.

- **Competence in Delusional Thought Disorders**: ☐ yes ☐ no

  Are the authors competent in the diagnostic assessment and treatment of delusional thought disorders based on their education, training, and experience?

  From Walters & Friedlander: "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426; *Family Court Review*)

  From Walters & Friedlander: "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed delusion often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated delusion and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426; *Family Court Review*)

  The assessment of delusional thought disorders is a Mental Status Exam of thought and perception as described by (Martin, 1990).

  From Martin: "Thought and Perception. The inability to process information correctly is part of the definition of psychotic

thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

- **Competence in Attachment Pathology**: ☐ yes ☐ no

  Are the authors competent in the diagnostic assessment and treatment of attachment pathology based on their education, training, and experience?

- **Competence in Trauma Pathology**: Are the authors competent in the diagnostic assessment and treatment of child abuse and trauma pathology? ☐ yes ☐ no

- **Competence in Personality Pathology**: Are the authors competent in the diagnostic assessment of narcissistic, borderline, and dark personality pathology based on their education, training, and experience? ☐ yes ☐ no

- **Competence in FDIA**: Are the authors competent in the diagnostic assessment and treatment of a Factitious Disorder (false attachment pathology) Imposed on Another based on their education, training, and experience? ☐ yes ☐ no

- **Competence in Family Systems Pathology**: Are the authors competent in the diagnostic assessment and treatment of family systems pathology based on their education, training, and experience? ☐ yes ☐ no

Several issues are concerning, 1) the reliance on a made-up pathology of "parental alienation", 2) the failure to apply any established scientific or professional knowledge from professional psychology (i.e., the DSM-5 diagnostic system, the attachment system, child abuse and complex trauma, personality disorder pathology, family systems) as the bases for the professional judgments offered by this Guidance, and 3) the admission that they are often unable to diagnose the cause of the attachment pathology displayed by the child, prominent professional concerns exist that the authors of this Guidance do not know the relevant domains of professional knowledge needed for competence in the pathology on which they are opining, in violation of ethical standards of practice (APA Standard 2.01 Boundaries of Competence).

Apply knowledge to solve pathology. Ignorance solves nothing. There is no such thing as "parental alienation" – "alienation" – "alienating behaviours".

The only thing that causes severe attachment pathology is child abuse by one parent or the other. Less severe parenting produces an insecure attachment in various patterns. The only thing that creates a child rejecting a parent is child abuse range parenting by one parent or the other.

The diagnostic question to be answered is which parent is abusing the child? In all cases

of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Diagnosis in Healthcare

> **From Improving Diagnosis in Health Care: "**The working diagnosis may be either a list of potential diagnoses (a differential diagnosis) or a single potential diagnosis. Typically, clinicians will consider more than one diagnostic hypothesis or possibility as an explanation of the patient's symptoms and will refine this list as further information is obtained in the diagnostic process."

> **From Improving Diagnosis in Health Care: "**As the diagnostic process proceeds, a fairly broad list of potential diagnoses may be narrowed into fewer potential options, a process referred to as diagnostic modification and refinement (Kassirer et al., 2010). As the list becomes narrowed to one or two possibilities, diagnostic refinement of the working diagnosis becomes diagnostic verification, in which the lead diagnosis is checked for its adequacy in explaining the signs and symptoms, its coherency with the patient's context (physiology, risk factors), and whether a single diagnosis is appropriate."

> **From Improving Diagnosis in Health Care: "**Throughout the diagnostic process, there is an ongoing assessment of whether sufficient information has been collected. If the diagnostic team members are not satisfied that the necessary information has been collected to explain the patient's health problem or that the information available is not consistent with a diagnosis, then the process of information gathering, information integration and interpretation, and developing a working diagnosis continues."

> **From Improving Diagnosis in Health Care: "**When the diagnostic team members judge that they have arrived at an accurate and timely explanation of the patient's health problem, they communicate that explanation to the patient as the diagnosis. It is important to note that clinicians do not need to obtain diagnostic certainty prior to initiating treatment; the goal of information gathering in the diagnostic process is to reduce diagnostic uncertainty enough to make optimal decisions for subsequent care (Kassirer, 1989; see section on diagnostic uncertainty).

> **From Improving Diagnosis in Health Care: "**In addition, the provision of treatment can also inform and refine a working diagnosis, which is indicated by the feedback loop from treatment into the information-gathering step of the diagnostic process. This also illustrates the need for clinicians to diagnose health problems that may arise during treatment."

> **From Improving Diagnosis in Health Care: "**Clinicians may refer to or consult with other clinicians (formally or informally) to seek additional expertise about a patient's health problem. The consult may help to confirm or reject the working diagnosis or may provide information on potential treatment options. If a patient's health problem is outside a clinician's area of expertise, he or she can refer the patient to a clinician who holds more suitable expertise. Clinicians can also recommend that the patient seek a second opinion from another clinician to verify their impressions of an uncertain diagnosis or if they believe that this would be helpful to the patient."

When possible child abuse is a considered diagnosis, the diagnosis returned must be accurate 100% of the time. The consequences of misdiagnosing child abuse are too

devastating for the child.

Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
>
> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Crucially, it is when there is no known justification for the hostility/rejection of a parent in combination with evidence of psychological manipulation that it may be determined that the child is in what is sometimes referred to as an 'alienated position' in the family dynamic.

There is no such thing as an "alienated position" – stop making things up.

There exists a diagnosis, there exists a causal explanation, it's just that the authors of

this Guidance (or involved mental health professionals) are not competent in their understanding and assessment of the pathology (the problem).

Competence Concerns

Google incompetence: inability to do something successfully

Based on the admission by the authors of this Guidance that they are sometimes unable to diagnose the pathology, the authors appear to be admitting to their incompetence (by definition of the English language, i.e., failure to do identify the pathology successfully). Perhaps the incompetence (inability to diagnose the pathology) is related to the use of made-up things like "parental alienation" and "alienating behaviours" instead of applying actual knowledge.

I would suggest the authors discontinue their practice on display in this proposed Guidance of simply making up new forms of pathology that have no research or theoretical support, and that they instead rely on the application of the established scientific and professional knowledge of professional psychology as the bases for their professional judgments.

The established scientific and professional knowledge of the discipline required for application with court-involved custody conflict is:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

Based on the reliance by the authors on of a made-up construct ("parental alienation" – "alienation" – "alienating behaviours") and their admission of incompetent diagnosis (failure to do identify the pathology successfully), prominent professional concerns exist that the authors of this Guidance are not competent in the pathology on which they are opining.

Do the authors know the domains of knowledge necessary for professional competence with the pathology in the family courts?

APA Standard 2.01 Boundaries of Competence
(a) 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.

- **Competence in Delusional Thought Disorders**: ☐ yes ☐ no
  Are the authors competent in the diagnostic assessment and treatment of delusional thought disorders based on their education, training, and experience?

  From Walters & Friedlander: "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An

encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426; *Family Court Review*)

From Walters & Friedlander: "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed delusion often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated delusion and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426; *Family Court Review*)

The assessment of delusional thought disorders is a Mental Status Exam of thought and perception as described by (Martin, 1990).

From Martin: "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

- **Competence in Attachment Pathology**: ☐ yes ☐ no

  Are the authors competent in the diagnostic assessment and treatment of attachment pathology based on their education, training, and experience?

- **Competence in Trauma Pathology**: Are the authors competent in the diagnostic assessment and treatment of child abuse and trauma pathology? ☐ yes ☐ no

- **Competence in Personality Pathology**: Are the authors competent in the diagnostic assessment of narcissistic, borderline, and dark personality pathology based on their education, training, and experience? ☐ yes ☐ no

- **Competence in FDIA**: Are the authors competent in the diagnostic assessment and treatment of a Factitious Disorder (false attachment pathology) Imposed on Another based on their education, training, and experience? ☐ yes ☐ no

  Where and how did they acquire this competence?

- **Competence in Family Systems Pathology**: Are the authors competent in the diagnostic assessment and treatment of family systems pathology based on their education, training, ☐ yes ☐ no

and experience?

Based on 1) their reliance on a made-up pathology of "parental alienation", 2) their failure to apply any established scientific or professional knowledge from professional psychology (i.e., the DSM-5 diagnostic system, the attachment system, child abuse and complex trauma, personality disorder pathology, family systems) as the bases for their professional judgments, and 3) their admission that they are often unable to diagnose the cause of the attachment pathology displayed by the child, prominent professional concerns exist that the authors of this Guidance do not know the relevant domains of professional knowledge needed for competence in the pathology on which they are opining, in violation of ethical standards of practice (APA Standard 2.01 Boundaries of Competence).

Apply knowledge to solve pathology. Ignorance solves nothing. There is no such thing as "parental alienation" – "alienation" – "alienating behaviours".

The only thing that causes severe attachment pathology is child abuse by one parent or the other. Less severe parenting produces an insecure attachment in various patterns. The only thing that creates a child rejecting a parent is child abuse range parenting by one parent or the other.

Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional and/or the Court misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true, then the mental health professional and/or the Court become part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by an allied pathological parent, then the mental health professional and/or the Court become participants in the parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion.

When that pathology is also the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon, then the mental health professional and/or the Court become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

Risk Assessment for Child Abuse

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of

thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"

> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Psychological manipulation

Psychological Control

> **From Cui et al:** "Specifically, psychological control has historically been defined as psychologically and emotionally manipulative techniques or parental behaviors that are not responsive to children's psychological and emotional needs (Barber, Maughan, & Olsen, 2005). Psychologically controlling parents create a coercive, unpredictable, or negative emotional climate in the family, which serves as one of the ways the family context influences children's emotion regulation (Morris, Silk, Steinberg, Myers, & Robinson, 2007; Steinberg, 2005)." (Cui et al. 2014)[4]

The manipulative psychological control of the child by a parent is a scientifically established family relationship pattern in dysfunctional family systems. In his book regarding parental psychological control of children, *Intrusive Parenting: How Psychological Control Affects Children and Adolescents*,[5] published by the American Psychological Association, Brian Barber and his colleague, Elizabeth Harmon, identify over 30 empirically validated scientific studies that have established the construct of parental psychological control of children. Barber and Harmon (2002)[6] provide the following definition for the construct of parental psychological control of the child:

> **From Barber & Harmon:** "Psychological control refers to parental behaviors that are intrusive and manipulative of children's thoughts, feelings, and attachment to parents. These behaviors appear to be associated with disturbances in the psychoemotional boundaries between the child and parent, and hence with the

[4] Cui, L., Morris, A.S., Criss, M.M., Houltberg, B.J., and Jennifer S. Silk, J.S. (2014). Parental Psychological Control and Adolescent Adjustment: The Role of Adolescent Emotion Regulation. Parenting: Science and Practice, 14, 47–67.

[5] Barber, B. K. (Ed.) (2002). Intrusive parenting: How psychological control affects children and adolescents. Washington, DC: American Psychological Association.

[6] Barber, B. K. and Harmon, E. L. (2002). Violating the self: Parenting psychological control of children and adolescents. In B. K. Barber (Ed.), Intrusive parenting (pp. 15-52). Washington, DC: American Psychological Association.

> development of an independent sense of self and identity." (Barber & Harmon, 2002, p. 15)

The difference between behavioral and psychological control is described by Stone, Bueler, and Barber (2002),[7]

> **Stone, Buehler, & Barber:** "The central elements of psychological control are intrusion into the child's psychological world and self-definition and parental attempts to manipulate the child's thoughts and feelings through invoking guilt, shame, and anxiety. Psychological control is distinguished from behavioral control in that the parent attempts to control, through the use of criticism, dominance, and anxiety or guilt induction, the youth's thoughts and feelings rather than the youth's behavior." (Stone, Buehler, & Barber, 2002, p. 57)

Soenens and Vansteenkiste (2010)[8] describe the various methods parents use to achieve parental psychological control of the child,

> **From Soenens and Vansteenkiste:** "Psychological control can be expressed through a variety of parental tactics, including (a) guilt-induction, which refers to the use of guilt inducing strategies to pressure children to comply with a parental request; (b) contingent love or love withdrawal, where parents make their attention, interest, care, and love contingent upon the children's attainment of parental standards; (c) instilling anxiety, which refers to the induction of anxiety to make children comply with parental requests; and (d) invalidation of the child's perspective, which pertains to parental constraining of the child's spontaneous expression of thoughts and feelings." (Soenens & Vansteenkiste, 2010, p. 75)

Stone, Buehler, and Barber (2002)[9] provide an explanation for the process of intrusive psychological control of children surrounding divorce,

> **Stone, Buehler, and Barber:** "The concept of triangles "describes the way any three people relate to each other and involve others in emotional issues between them" (Bowen, 1989, p. 306). In the anxiety-filled environment of conflict, a third person is triangulated, either temporarily or permanently, to ease the anxious feelings of the conflicting partners. By default, that third person is exposed to an anxiety-provoking and disturbing atmosphere. For example, a child might become the scapegoat or focus of attention, thereby transferring the tension from the marital dyad to the parent-child dyad. Unresolved tension in the marital relationship might spill over to the parent-child relationship through parents' use of psychological control as a way of securing and maintaining a strong emotional alliance and level of support from the child. As a consequence,

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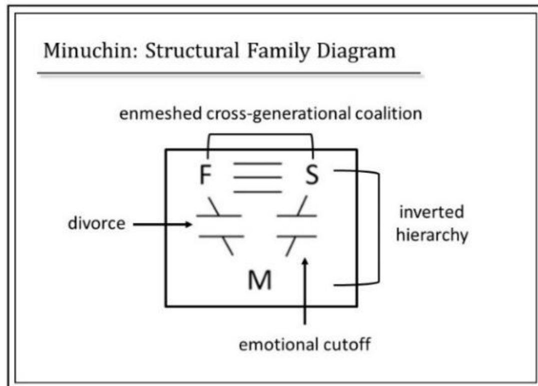
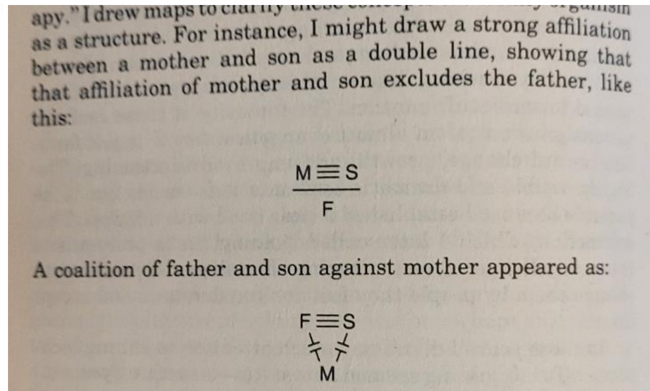
[7] Stone, G., Buehler, C., & Barber, B. K.. (2002) Interparental conflict, parental psychological control, and youth problem behaviors. In B. K. Barber (Ed.), Intrusive parenting: How psychological control affects children and adolescents. Washington, DC: American Psychological Association.

[8] Soenens, B., & Vansteenkiste, M. (2010). A theoretical upgrade of the concept of parental psychological control: Proposing new insights on the basis of self-determination theory. Developmental Review, 30, 74–99.

[9] Stone, G., Buehler, C., & Barber, B. K.. (2002) Interparental conflict, parental psychological control, and youth problem behaviors. In B. K. Barber (Ed.), Intrusive parenting: How psychological control affects children and adolescents. Washington, DC: American Psychological Association.

the triangulated youth might feel pressured or obliged to listen to or agree with one parents' complaints against the other. The resulting enmeshment and cross-generational coalition would exemplify parents' use of psychological control to coerce and maintain a parent-youth emotional alliance against the other parent (Haley, 1976; Minuchin, 1974)." (Stone, Buehler, & Barber, 2002, p. 86-87).




apy." I drew maps to
as a structure. For instance, I might draw a strong affiliation between a mother and son as a double line, showing that that affiliation of mother and son excludes the father, like this:

M ≡ S
F

A coalition of father and son against mother appeared as:

F ≡ S
M

It is well established in law that some parents manipulate their children, and this can include being manipulated to make false allegations in family law proceedings, e.g., *Re H (Children)* [2014] EWCA Civ 733 (Parker J). Examples of such harmful parental behaviour can include a parent reinforcing 'loyalty' and rejection of the other parent with emotional warmth, withdrawing emotional warmth in response to perceived disloyalty/a child wishing to maintain a relationship with the other parent. This can also include engendering a developmentally inappropriate need to protect the emotional fragility of the parent, e.g., through sharing of inappropriate information about the adult relationship or baselessly portraying the other parent as a source of harm to the wellbeing of that parent.

Standards of Professional Practice

Apply knowledge to solve pathology. Ignorance solves nothing.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict is:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

No established scientific or professional knowledge from any domain of professional psychology is evident in application by the authors of this Guidance, in violation of Standard 2.04 Bases for Scientific and Professional Judgments of the APA ethics code.

2.04 Bases for Scientific and Professional Judgments
Psychologists' work is based upon established scientific and professional knowledge of the discipline.

Risk Assessment for Child Abuse

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the ☐ yes ☐ no

family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?)

- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
>
> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Children who have experienced loss arising from parental separation may anticipate the loss of another relationship or threat to the security of that relationship and be motivated by their attachment needs to protect that relationship over their other competing needs. What is often described in these scenarios is a parent struggling to maintain a boundary between their own psychological needs and those of their child – the parent's capacity to prioritise a child's emotional and psychological needs over their own. There may be factors in parent's own psychological functioning which may lead them to actively or inadvertently engage in psychologically manipulative behaviour. Understanding these processes and a parent's capacity to change such behaviour with or without support, may require the assistance of an appropriately qualified psychologist expert.

I am that appropriately qualified expert.

Risk Assessment for Child Abuse

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

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The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

6. Guidance Note for the Family Court: Use of experts in cases in which alienating behaviours are alleged

Use of experts

It is inappropriate for experts to be asked to step into quasi-fact finding or determination of alienating behaviours – as such, the timing of expert evidence and the type of expert evidence needed is crucial. In determining the welfare outcome, when the presence of such harmful behaviours has been identified, it may be necessary to have expert evidence from a Psychologist expert. Determining the appropriate type of psychologist expert should be in accordance with the FJC/BPS 2023 guidance (link below). This updated guidance includes additional guidance in relation to the instruction of psychologist expert witnesses, specifically the scrutiny of their regulation, their qualifications and their access to psychological tests, given in *Re C ('Parental Alienation')* [2023] EWHC 345 (Fam).

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – "alienating behaviours" – "alienating position - there is no defined pathology in clinical psychology of "parental alienation." It is a made up thing.

> "parental alienation" = unicorns; they are both mythical things that do not exist.

The use of the construct of "parental alienation" ("alienation") in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 of the APA ethics code.

> **2.04 Bases for Scientific and Professional Judgments**
> Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict are:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

Competence Concerns

Do the authors of this Guidance know the necessary knowledge of real things, real pathology, needed for understanding and resolving the pathology in the family courts? The authors of this Guidance have yet to apply any established scientific or professional knowledge from established domains of professional psychology as the bases for their professional judgments, and they have acknowledged their incompetence (by definition of the English language, i.e., failure to do something successfully) in identifying the pathology in the family courts.

Risk Assessment for Child Abuse

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child ☐ yes ☐ no

custody, and to meet the allied parent's own emotional and psychological needs?

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events,

or is there no discernible basis in reality for the patient's beliefs or behavior?"

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Given the complexity of these cases and the often-interacting psychological factors at play in the adults and the children, it is likely that assessments which will assist the court in determining welfare outcomes are those offered by HCPC regulated Practitioner Psychologists with competence in assessing adults and children, e.g., Clinical Psychologists/Counselling Psychologists. Although there are differences in their training competencies, both are trained to assess both adults and children (FJC/BPS 2023 guidance (footnote)). It is important that the instructions for psychological evidence when there are allegations of alienating behaviours are not narrowed in focus but have the breadth and scope typical to holistic psychological assessments of parents and children in the family courts. https://www.lawsociety.org.uk/topics/family-and-children/instructing-experts-in-family-and-children-court-proceedings#questions-for-experts

I am a clinical psychologist with specialized professional background, training and experience in six domains of relevant pathology supported by my vitae:

1. Delusional thought disorders

   Twelve years on a major UCLA research study on schizophrenia with annual training in the diagnostic assessment of delusional thought disorders.

2. Attachment pathology

   Early Childhood Mental Health specialization.

3. Child abuse and complex trauma

   Clinical Director for a 3-university assessment and treatment center for children ages zero-to-five in foster care.

4. Factitious Disorder Imposed on Another

   Training and medical staff position as a pediatric psychologist at Childrens' Hospitals.

5. Family systems

   Specialized training track from Pepperdine University's doctoral program and lifelong practice as a family systems therapist

6. Court-involved custody conflict

   Ten years in the family courts as a clinical psychologist and expert consultant to attorneys and their client-parents in custody conflict.

My opinions offered here represent the professional opinions from the domain of clinical psychology which was just noted by the authors as being relevant and important.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – "alienating behaviours" – "alienating position - there is no defined pathology in clinical psychology of "parental alienation." It is a made up thing.

> "parental alienation" = unicorns; they are both mythical things that do not exist.

The use of the construct of "parental alienation" ("alienation") in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 of the APA ethics code.

> **2.04 Bases for Scientific and Professional Judgments**
> Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict are:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

Competence Concerns

Prominent questions are present that the authors of this Guidance may not know the necessary knowledge of real things, real pathology, needed for understanding and resolving the pathology in the family courts.

Risk Assessment for Child Abuse

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false ☐ yes ☐ no

(factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs?

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
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From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

These assessments should not be undertaken by academic psychologists or psychological researchers in the field of alienation. Only HCPC Registered psychologists have the relevant clinical experience and training to conduct psychological assessments of people and make clinical diagnoses and recommendations for treatment or interventions, whereas, academic psychologists, who should be Chartered, but who are not registered with the HCPC, would not normally have the clinical experience and training in order to complete psychological assessments or make clinical diagnoses. There is an inherent risk of confirmatory bias if instructions and assessments are framed solely in terms of allegations of alienating behaviours.

I am a clinical psychologist with specialized professional background, training and experience in six domains of relevant pathology supported by my vitae:

7. Delusional thought disorders

   Twelve years on a major UCLA research study on schizophrenia with annual training in the diagnostic assessment of delusional thought disorders.

8. Attachment pathology

   Early Childhood Mental Health specialization.

9. Child abuse and complex trauma

   Clinical Director for a 3-university assessment and treatment center for children ages zero-to-five in foster care.

10. Factitious Disorder Imposed on Another

    Training and medical staff position as a pediatric psychologist at Childrens' Hospitals.

11. Family systems

    Specialized training track from Pepperdine University's doctoral program and lifelong practice as a family systems therapist

12. Court-involved custody conflict

    Ten years in the family courts as a clinical psychologist and expert consultant to attorneys and their client-parents in custody conflict.

I am not an academic researcher, I am an applied clinician with experience as the Clinical Director for a three-university assessment and treatment center for children ages zero-to-five in foster care.

My opinions offered here represent the professional opinions from the domain of

applied clinical psychology which was just noted by the authors as being relevant and important.

In healthcare, diagnosis guides treatment. But we always land on treatment. We always fix the problem. First, we need to know what the problem is, we need a diagnosis, an accurate diagnosis, to guide the development of an effective treatment plan.

In all cases of severe attachment pathology, we always want to repair the breached attachment bond. Leaving an attachment bond breached and un-repaired is the worst possible thing we can do, i.e., the Ugly of Tronic and Gold (2020; *The Power of Discord*).

> **From Tronick & Gold:** "We prefer to capture the range of a child's experience with a different set of terms: *the good, the bad, and the ugly. Good stress* is what happens in typical everyday interactions, what we have seen in our videotaped interactions as moment-to-moment mismatch and repair. *Bad stress* is the stress represented in the still face experiment by the caregiver's sudden inexplicable absence… *Ugly stress* occurs when the infant has missed out on the opportunity for repeated experiences of repair, as in situations of emotional neglect, and' thus cannot handle any sort of bigger stressful event." (Tronick & Gold, 2020, p. 134)
>
> **From Tronick & Gold:** "Children growing up with insufficient experiences of mismatch and repair are at a disadvantage for developing coping mechanisms to regulate their physiological behavioral and emotional reactions. We use the term *regulatory scaffolding* to describe the developmental process by which resilience grows out of the interactive repair of the micro-stresses that happen during short lived, rapidly occurring mismatches. The caregiver provides "good-enough" scaffolding to give the child the experience of overcoming a challenge, ensuring there is neither too long a period to repair nor too close a match with no room for repair." (Tronick & Gold, 2020, p. 135)

Risk Assessment for Child Abuse

Diagnosis guides treatment. The treatment for cancer is different than the treatment for diabetes. Is there child abuse by the targeted parent or is there child abuse by the allied parent?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – "alienating behaviours" – there is no defined pathology in clinical psychology of "parental alienation." It is a made up thing.

> "parental alienation" = unicorns; they are both mythical things that do not exist.

The use of the construct of "parental alienation" ("alienation") in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 of the APA ethics code.

> **2.04 Bases for Scientific and Professional Judgments**
> Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict are:

- Attachment pathology - Bowlby & others
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- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

Competence Concerns

Prominent questions are present that the authors of This Guidance is not competent in the necessary knowledge of real things, real pathology, needed for the pathology in the family courts.

Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
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Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
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- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

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The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

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Assessments of children should focus on their cognitive, educational, emotional, social, and behavioural development, and comment on any matters of concern. They should comment upon any harm which the children may have suffered in respect of their psychological, intellectual, educational, emotional, social, and behavioural development and assess what the cause of such harm may be and advise on the support services (including therapeutic support) which should be put in place to assist the child.

Risk Assessment for Child Abuse

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Assessments of adults should focus on a parent's psychological functioning/personality and prognosis and any appropriate treatment/support required. A parent's ability to prioritise the child(ren)'s needs above their own, their understanding, insight and acknowledgement of any findings made by the court and the concerns raised by professionals, their ability to make changes in her own behaviours and support the child(ren), their capacity to engage in work to secure a favourable outcome for the child(ren) including any recommended therapeutic intervention or any other necessary intervention or support.

Risk Assessment for Child Abuse

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Conflict of interest

The Family Justice Council (FJC)/British Psychological Society (BPS) guidance for Psychologist expert witnesses (2023) emphasises the importance of the expert being alert to potential conflicts of interest. In particular it notes that:

*"The expert witness's overriding duty is to the Court and to be impartial in their evidence; the impartiality of expert witnesses is essential to their evidence; if the psychologist has a view that is controversial as between experts or that might be derived from partiality, she or he must declare the extent of that interest. This is particularly relevant when a psychologist expert recommends an intervention or therapy that they or an associate would benefit financially from delivering. Whilst this may be experienced as helpful and facilitative to the court, this would be a clear conflict of interest and threat to the independence of their expert evidence."*1

Diagnosis in Healthcare

The National Academy of Sciences describes the diagnostic process in a paper on *Improving Diagnosis in Healthcare* (2015),

> **From Improving Diagnosis**: "The working diagnosis may be either a list of potential diagnoses (a differential diagnosis) or a single potential diagnosis. Typically, clinicians will consider more than one diagnostic hypothesis or possibility as an explanation of the patient's symptoms and will refine this list as further information is obtained in the diagnostic process." (National Academy of Sciences, 2015)

> **From Improving Diagnosis**: "As the diagnostic process proceeds, a fairly broad list of potential diagnoses may be narrowed into fewer potential options, a process referred to as diagnostic modification and refinement (Kassirer et al.,

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2010). As the list becomes narrowed to one or two possibilities, diagnostic refinement of the working diagnosis becomes diagnostic verification, in which the lead diagnosis is checked for its adequacy in explaining the signs and symptoms, its coherency with the patient's context (physiology, risk factors), and whether a single diagnosis is appropriate." (National Academy of Sciences, 2015)

From Improving Diagnosis: "Throughout the diagnostic process, there is an ongoing assessment of whether sufficient information has been collected. If the diagnostic team members are not satisfied that the necessary information has been collected to explain the patient's health problem, or that the information available is not consistent with a diagnosis, then the process of information gathering, information integration and interpretation, and developing a working diagnosis continues." (National Academy of Sciences, 2015)

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The President of the Family Division’s Memorandum on the use of experts in the family court (October 2021) emphasises the rigorous approach to be taken by the family courts in admitting expert evidence and the need for a reliable body of knowledge or experience to underpin the expert’s evidence.

Standards of Professional Practice

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The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

The importance of robust psychological approaches consistent with this memorandum is highlighted in the FJC/BPS guidance. This includes assessments drawing on a range of different sources and methods (to combat biases inherent in any single approach) in order to inform therapeutic recommendations in the opinion given. Recommendations should be consistent with typical current psychological practice and evidence base and flow from a rationale based on recognised assessment methodology. This is a marker of a good quality psychological report. The court should expect a range of options in psychological opinion and recommendations that are:

- Transparent as to the intervention and requisite qualifications needed to effect desired change.
- Interpretable by a wide range of practitioners in the field.
- Deliverable by any suitably qualified practitioners.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – "alienating behaviours" – there is no defined pathology in clinical psychology of "parental alienation." It is a made up thing.

"parental alienation" = unicorns; they are both mythical things that do not exist.

The use of the construct of "parental alienation" ("alienation") in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 of the APA ethics code.

2.04 Bases for Scientific and Professional Judgments
Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The established scientific and professional knowledge of the discipline required for competence with court-involved custody conflict are:

- Attachment pathology - Bowlby & others
- Family systems therapy - Minuchin & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others

- DSM-5 diagnostic system - American Psychiatric Association

Diagnosis in Healthcare

The National Academy of Sciences describes the diagnostic process in a paper on *Improving Diagnosis in Healthcare* (2015),

> **From Improving Diagnosis**: "The working diagnosis may be either a list of potential diagnoses (a differential diagnosis) or a single potential diagnosis. Typically, clinicians will consider more than one diagnostic hypothesis or possibility as an explanation of the patient's symptoms and will refine this list as further information is obtained in the diagnostic process." (National Academy of Sciences, 2015)
>
> **From Improving Diagnosis**: "As the diagnostic process proceeds, a fairly broad list of potential diagnoses may be narrowed into fewer potential options, a process referred to as diagnostic modification and refinement (Kassirer et al., 2010). As the list becomes narrowed to one or two possibilities, diagnostic refinement of the working diagnosis becomes diagnostic verification, in which the lead diagnosis is checked for its adequacy in explaining the signs and symptoms, its coherency with the patient's context (physiology, risk factors), and whether a single diagnosis is appropriate." (National Academy of Sciences, 2015)
>
> **From Improving Diagnosis**: "Throughout the diagnostic process, there is an ongoing assessment of whether sufficient information has been collected. If the diagnostic team members are not satisfied that the necessary information has been collected to explain the patient's health problem, or that the information available is not consistent with a diagnosis, then the process of information gathering, information integration and interpretation, and developing a working diagnosis continues." (National Academy of Sciences, 2015)
>
> **From Improving Diagnosis**: "In addition, the provision of treatment can also inform and refine a working diagnosis, which is indicated by the feedback loop from treatment into the information-gathering step of the diagnostic process. This also illustrates the need for clinicians to diagnose health problems that may arise during treatment." (National Academy of Sciences, 2015)
>
> **From Improving Diagnosis in Health Care: "**Clinicians may refer to or consult with other clinicians (formally or informally) to seek additional expertise about a patient's health problem. The consult may help to confirm or reject the working diagnosis or may provide information on potential treatment options. If a patient's health problem is outside a clinician's area of expertise, he or she can refer the patient to a clinician who holds more suitable expertise. Clinicians can also recommend that the patient seek a second opinion from another clinician to verify their impressions of an uncertain diagnosis or if they believe that this would be helpful to the patient."

Risk Assessment for Child Abuse

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent

Differential Diagnosis for Targeted Parent:

> **Targeted Parent Abusive:** Is the targeted parent abusing the child in some way, thereby creating the child's attachment ☐ yes ☐ no

pathology toward that parent?

If yes, identify the DSM-5 Child Abuse diagnosis involved:

- Child Physical Abuse (V995.54) ☐ yes ☐ no
- Child Sexual Abuse (V995.53) ☐ yes ☐ no
- Child Neglect (V995.52) ☐ yes ☐ no
- Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
- **Factitious Attachment Pathology:** Does the child have a false (factitious) attachment pathology imposed on the child by the pathogenic parenting of the allied parent (DSM-5 300.19 Factitious Disorder Imposed on Another)? ☐ yes ☐ no
- **Spousal Psychological Abuse:** Is the allied parent using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the targeted parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

- **Triangulation:** Is the child being triangulated into the spousal conflict surrounding the divorce? ☐ yes ☐ no
- **Cross-generational Coalition:** Is there a cross-generational coalition of the child with the one parent against the other parent? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and a parent? ☐ yes ☐ no
- **Inverted Hierarchy:** Is there an inverted hierarchy in the family? (Does the child judge the parent's adequacy as if the parent was the child and the child was the parent?) ☐ yes ☐ no
- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

This Guidance is problematic in development and will be problematic in implementation. Following the recommendations of this Guidance will lead to un-diagnosed and un-treated Child Psychological Abuse in the family courts by pathological

parents (narcissistic-borderline-dark personality parents).

The only thing that causes severe attachment pathology is child abuse by one parent or the other. The diagnostic question to be answered is which parent is abusing the child?

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
>
> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

The rating of the delusional thought disorder can be made using item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

Recommendations for interventions deliverable only by the instructed expert or their associates are inconsistent with this. It increases the risk of bias, can limit appropriate oversight of interventions and risks delays as it may create barriers to families accessing appropriate, timely support local to them.

Pilot Program for the Family Courts

For decision-makers surrounding the family courts, I recommend that a pilot program for the family courts be initiated with university involvement for evaluation research, to develop a standardized and agreed upon diagnostic assessment and treatment protocol of the highest professional quality, reliability, and validity for the differential diagnoses of concern.

Differential Diagnosis for Targeted Parent:

> **Targeted Parent Abusive:** Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent? ☐ yes ☐ no
>
> If yes, identify the DSM-5 Child Abuse diagnosis involved:
>
> - Child Physical Abuse (V995.54) ☐ yes ☐ no
> - Child Sexual Abuse (V995.53) ☐ yes ☐ no
> - Child Neglect (V995.52) ☐ yes ☐ no
> - Child Psychological Abuse (V995.51) ☐ yes ☐ no

Differential Diagnosis – Allied Parent:

Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child custody, and to meet the allied parent's own emotional and psychological needs? ☐ yes ☐ no

- **Persecutory Delusion (shared):** Does the allied parent have a persecutory delusion surrounding the other parent, and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)? ☐ yes ☐ no
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- **Enmeshment:** Do the parent and child have an enmeshed relationship? ☐ yes ☐ no

The court should be extremely cautious when asked to consider assessment and treatment packages offered by the same or linked providers.

References:

1. Guidance on the use of Psychologists as Expert Witnesses in the Family Courts in England and Wales (Standards and Competencies) - June 2023 | BPS
2. https://www.judiciary.uk/wp-content/uploads/2021/10/PFD-Memo-Experts.pdf