Consultation: Draft Guidance on Responding to allegations of alienating behaviour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 Childress to Draft Guidance from FJC:

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The FJS draft Guidance describes the professional expertise desired for the family courts:

> **From JFS 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 JFS 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.

1. Introduction and scope of the Guidance

'Parental alienation' has for some time been a vexed and highly emotive concept with polarised opinion in the research literature, and one which has gained significant publicity and political attention internationally. It is also an allegation which the family courts in England and Wales are increasingly asked to consider and act on.

Standards of Professional Practice

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

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 ethics code for the American Psychological Association (APA).

> **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 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

Application of DSM-5

When the established scientific and professional knowledge of the DSM-5 diagnostic system is applied to the attachment pathology that arises in high-conflict custody litigation in the family courts, the pathology of concern is a shared (induced) persecutory delusion and false (factitious) attachment pathology being imposed on the child by the pathogenic parenting of an allied narcissistic-borderline-dark personality parent for secondary gain to the pathological parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs.

Creating a shared (induced) persecutory delusion in the child that then destroys the child's attachment bond to the other parent is a DSM-5 diagnosis of V995.51 Child Psychological Abuse. An additional dangerous pathology of concern is the possible spousal emotional and psychological of the targeted parent by the allied parent using the child's induced pathology as the weapon (DSM-5 V995.82 Spouse or Partner Abuse, Psychological).

Risk Assessment

All mental health professionals have duty to protect obligations. A proper risk assessment is required whenever a mental health professional encounters any of three types of dangerous pathology, suicide, homicide, or abuse (child, spousal, or elder abuse). The type of risk assessment depends on the type of danger involved, such as a suicide risk assessment when the client expresses suicidal thoughts (i.e., an assessment of prior history, current plan, recent loss, means, etc.), or a risk assessment for possible spousal abuse when that is the concern.

There are four diagnoses of child abuse in the Child Maltreatment section of the DSM-5, each of these child abuse diagnoses warrants a proper risk assessment; Child Physical Abuse (V995.54), Child Sexual Abuse (V995.53), Child Neglect (V995.52), Child Psychological Abuse (V995.51). All of these child abuse diagnoses are equally severe in the damage they cause to 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.

Severe Attachment Pathology

The only possible cause of severe attachment pathology displayed by a child (i.e., a child rejecting a parent) is child abuse range parenting by one parent or the other. Other less severe forms of problematic parenting produce an insecure attachment that has different symptom characteristics other than a severing of the parent-child bond. The only possible cause of severe attachment pathology (i.e., a child rejecting a parent) is child abuse range parenting by one parent or the other.

- **Targeted Parent Abusive:** Either the targeted parent is abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality),
- **Allied Parent Abusive:** Or the allied parent is psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality).

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.

Diagnostic Assessment of Thought Disorders

The clinical concern is the possible creation of a shared (induced) persecutory delusion and false (factitious) attachment pathology imposed on the child as a result of the allied parent's distorted and pathogenic[1] parenting practices, as described by Walters and Friedlander (2016)[2] in the journal *Family Court Review*,

[1] Patho=pathology; genic=creation. Pathogenic parenting is the creation of significant pathology in the child through aberrant and distorted parenting practices.

[2] Walters, M. G., & Friedlander, S. (2016). When a child rejects a parent: Working with the intractable resist/refuse dynamic. *Family Court Review, 54*(3), 424–445.

> **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 provides the definition for a persecutory delusion and indicates that a shared persecutory delusion often occurs in family situations,

> **From the APA:** "Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way." (American Psychiatric Association, 2000)
>
> **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)

The assessment for a possible delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),[3]

> **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?"

Family Systems Pathology

When the construct of "parental alienation is used by the general public, the family systems pathology of concern is the child's *triangulation* into the spousal conflict through the formation of an enmeshed *cross-generational coalition* with the allied parent against the targeted parent, creating an inverted hierarchy and *emotional cutoff*

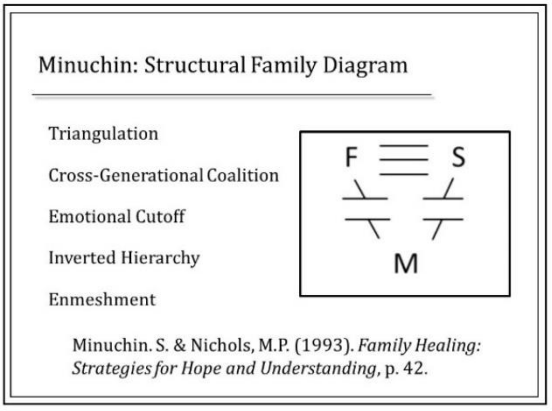
[3] Martin DC. The Mental Status Examination. In: Walker HK, Hall WD, Hurst JW, editors. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Boston: Butterworths; 1990. Chapter 207. Available from: https://www.ncbi.nlm.nih.gov/books/NBK320/

in the child's attachment bond to the targeted parent.

This family relationship pattern of triangulating the child into the spousal conflict is described by Stone, Buehler, and Barber (2002),[4]

> **From 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).

The family dynamic of the child's cross-generational coalition with an allied parent against the targeted parent and the resulting emotional cutoff in the child's attachment bond to the targeted parent is depicted in a Structural family diagram from Minuchin and Nichols (1993).[5]



Triangulation

The term *triangulation* refers to putting the child in the middle of the spousal conflict, which then turns the two-person spousal conflict into a three-person triangle of conflict involving the child. The Bowen Center for Study of the Family[6] describes the construct of triangles within families.

> **From Bowen Center:** "A triangle is a three-person relationship system. It is considered the building block or "molecule" of larger emotional systems because a triangle is the smallest stable relationship system. A two-person system is unstable because it tolerates little tension before involving a third

[4] 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.

[5] Minuchin. S. & Nichols, M.P. (1993). Family healing: Strategies for hope and understanding. NewYork: Touchstone.

[6] Bowen Center Triangles: https://www.thebowencenter.org/triangles

person. A triangle can contain much more tension without involving another person because the tension can shift around three relationships. If the tension is too high for one triangle to contain, it spreads to a series of "interlocking" triangles". Spreading the tension can stabilize a system, but nothing is resolved."

Cross-Generational Coalition

A *cross-generational coalition* is when a parent creates an alliance with the child against the other spouse/parent. This coalition between the allied parent and child against the other parent provides additional power to the allied parent in the spousal conflict (two against one). However, a cross-generational coalition is also extremely damaging to the child who is being used by one parent as a weapon against the other parent in the spousal conflict.

In mild cases, the arguing and conflict between the child and targeted parent is high, but they maintain their relationship. In severe cases, the allied parent requires the child to terminate (cutoff) the child's relationship with the other parent out of loyalty (Boszormenyi-Nagy & Spark, 1973)[7] to the allied parent in their coalition. When this occurs, the emotional and psychological damage to the child is severe. Jay Haley (co-founder of the *Strategic* school of family systems therapy), provides the professional definition of a cross-generational coalition:

> **From Haley:** "The people responding to each other in the triangle are not peers, but one of them is of a different generation from the other two… In the process of their interaction together, the person of one generation forms a coalition with the person of the other generation against his peer. By 'coalition' is meant a process of joint action which is *against* the third person… The coalition between the two persons is denied. That is, there is certain behavior which indicates a coalition which, when it is queried, will be denied as a coalition… In essence, the perverse triangle is one in which the separation of generations is breached in a covert way. When this occurs as a repetitive pattern, the system will be pathological." (Haley, 1977, p. 37)[8]

Cloe Madanes (2018),[9] the co-founder of Strategic family systems therapy along with Jay Haley, describes the development of cross-generational coalitions within families,

> **From Madanes**: "Cross-Generational Coalition. In most organizations, families, and relationships, there is hierarchy: one person has more power and responsibility than another. Whenever there is hierarchy, there is the possibility of cross-generational coalitions. The husband and wife may argue over how the wife spends money. At a certain point, the wife might enlist the older son into a coalition against the husband. Mother and son may talk disparagingly about the father and to the father, and secretly plot about how to influence or deceive him. The wife's coalition with the son gives her power in relation to the husband and limits the husband's power over how she spends

[7] Boszormenyi-Nagy and Spark (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy.* Harper & Row.

[8] Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. Weakland (Eds.), *The interactional view* (pp. 31-48). New York: Norton.

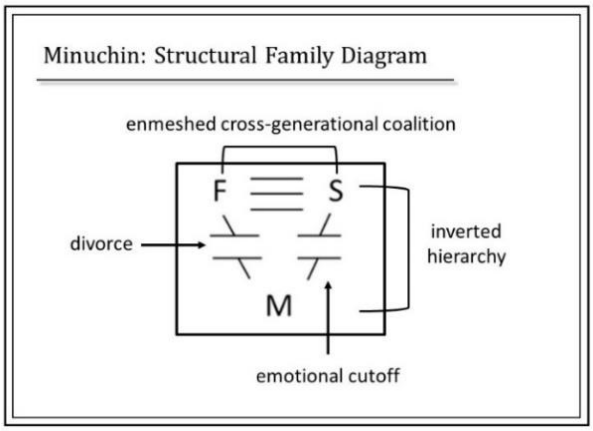
[9] Madanes, C. (2018). Changing relationships: Strategies for therapists and coaches. Phoenix, AZ: Zeig, Tucker, & Theisen, Inc.

money. The wife now has an ally in her battle with her husband, and the husband now runs the risk of alienating his son."

From Madanes: "Cross-generational coalitions take different forms in different families (Madanes, 2009)… These alliances are most often covert and are rarely expressed verbally. They involve painful conflicts that can continue for years. Sometimes cross-generational coalitions are overt. A wife might confide her marital problems to her child and in this way antagonize the child against the father… This child may feel conflicted as a result, suffering because his or her loyalties are divided." (Madanes, 2018)

Emotional Cutoff

The family systems construct of an *emotional cutoff* refers to any full-scale breach in a family bond. The child's loyalty to a pathological parent in their cross-generational coalition against the other parent (Haley, 1977; Madanes, 2018) leads to an emotional cutoff (Bowen, 1978; Titelman, 2003)[10] in the child's attachment bond to the targeted parent.



Inverted Hierarchy

An *inverted hierarchy* in when the child becomes over-empowered by the coalition with the allied parent into an elevated position in the family hierarchy, above that of the targeted parent, from which the child is empowered by the coalition with the allied parent to judge the adequacy of the targeted parent as if the parent was the child and the child was the parent.

Enmeshment

The term *enmeshment* refers to a parent's dissolution of psychological boundaries with the child in which the child's identity and the parent's identity merge into one. Minuchin (1974)[11] describes the construct of enmeshed relationships within families,

From Minuchin: "Enmeshment and disengagement refer to a transactional style, or preference for a type of interaction, not to a qualitative difference between functional and dysfunctional… Operations at the extremes, however, indicate areas of possible pathology. A highly enmeshed subsystem of mother and children, for example, can exclude father, who becomes disengaged in the extreme." (Minuchin, 1974, p. 55)

[10] Bowen, M. (1978). *Family Therapy in Clinical Practice*. New York: Jason Aronson.

Titelman, P. (2003). *Emotional Cutoff: Bowen Family Systems Theory Perspectives*. New York: Haworth Press.

[11] Minuchin, S. (1974). *Families and Family Therapy*. Cambridge, MA: Harvard University Press

Writing in the *Journal of Emotional Abuse*, Kerig (2005)[12] identifies the psychological boundary violations that occur between parents and children, and the impact of the enmeshed relationship with one parent on other family relationships,

> **From Kerig:** "Examination of the theoretical and empirical literatures suggests that there are four distinguishable dimensions to the phenomenon of boundary dissolution: role reversal, intrusiveness, enmeshment, and spousification." (Kerig, 2005, p. 8)
>
> **From Kerig:** "Enmeshment in one parent-child relationship is often counterbalanced by disengagement between the child and the other parent (Cowan & Cowan, 1990; Jacobvitz, Riggs, & Johnson, 1999)." (Kerig, 2005, p. 10)

Standards of Professional Practice

Standard 2.04 of the APA ethics code requires the application of the "established scientific and professional knowledge of the discipline as the bases for professional judgments.

> **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 should be applied first. If, after the application of established knowledge, some aspect of the pathology remains unexplained, then new forms of pathology (such as "parental alienation") can be proposed, but only after the application of established knowledge.

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.

There are reasons for ethical Standards. Unethical practice hurts people – a lot. The failure to apply the established scientific and professional knowledge of the discipline as the bases for professional judgments will lead to misdiagnosis of the pathology.

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 misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was true (and so does not inform the Court of the child psychological abuse in the family), then both the mental health professional and the Court become part of the pathology of the shared delusion. When the pathology represents the psychological abuse of the child by an allied pathological parent, then the mental health professional and the inadequately informed Court become participants in the pathological 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.

This guidance does not aim to explore the research literature into the concept of 'parental alienation', the socio-political context in which such allegations arise or to give an historical

[12] Kerig, P.K. (2005). Revisiting the construct of boundary dissolution: A multidimensional perspective. *Journal of Emotional Abuse*, 5, 5-42.

account. These are important and it is likely that these debates will continue, and our understanding evolve. However, in the meantime it is necessary to consider how such allegations are responded to by the courts and professionals in the wider family justice system. For this reason, the focus has been to provide practical guidance as to how allegations of alienating behaviours are responded to; recognising that they are allegations that can arise at different points in the litigation journey and are likely to be made alongside other allegations of harmful behaviour including domestic abuse or child abuse.

Differential Diagnosis for Severe Attachment Pathology

The only possible cause of severe attachment pathology displayed by a child (i.e., a child rejecting a parent) is child abuse range parenting by one parent or the other. Other less severe forms of problematic parenting produce an insecure attachment that has different symptom characteristics other than a severing of the parent-child bond. The only possible cause of severe attachment pathology (i.e., a child rejecting a parent) is child abuse range parenting by one parent or the other.

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

- **Targeted Parent Abusive:** Either the targeted parent is abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality),
- **Allied Parent Abusive:** Or the allied parent is psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the Court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality).

It is hoped that this guidance will contribute to increased understanding, good practice, and ultimately good welfare outcomes for children. The guidance includes sections on the Litigation Journey, Case Management, Welfare decision, understanding hostility and psychological manipulation in cases in which alienating behaviours are alleged and the use of experts.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – or "alienating behaviors" and the use of those constructs in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is violation of Standard 2.04 Bases for Scientific and Professional Judgments of the APA ethics code.

Risk Assessment for Child Abuse

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

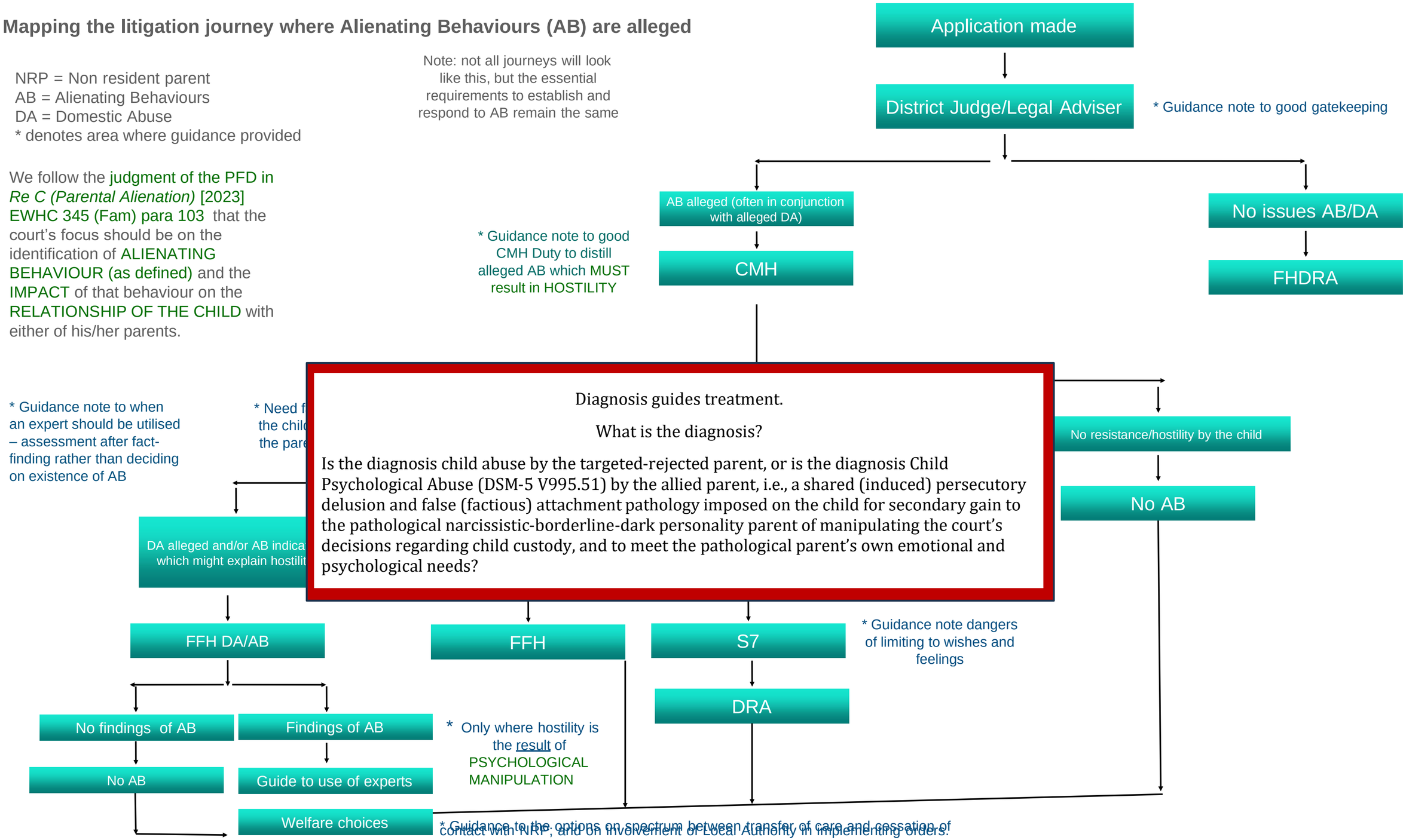
	Targeted Parent Abusive: Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality)?	☐ yes ☐ no
	Allied Parent Abusive: Or is the allied parent psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the Court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality)?	☐ yes ☐ no

Mapping the litigation journey where Alienating Behaviours (AB) are alleged

NRP = Non resident parent
AB = Alienating Behaviours
DA = Domestic Abuse
* denotes area where guidance provided

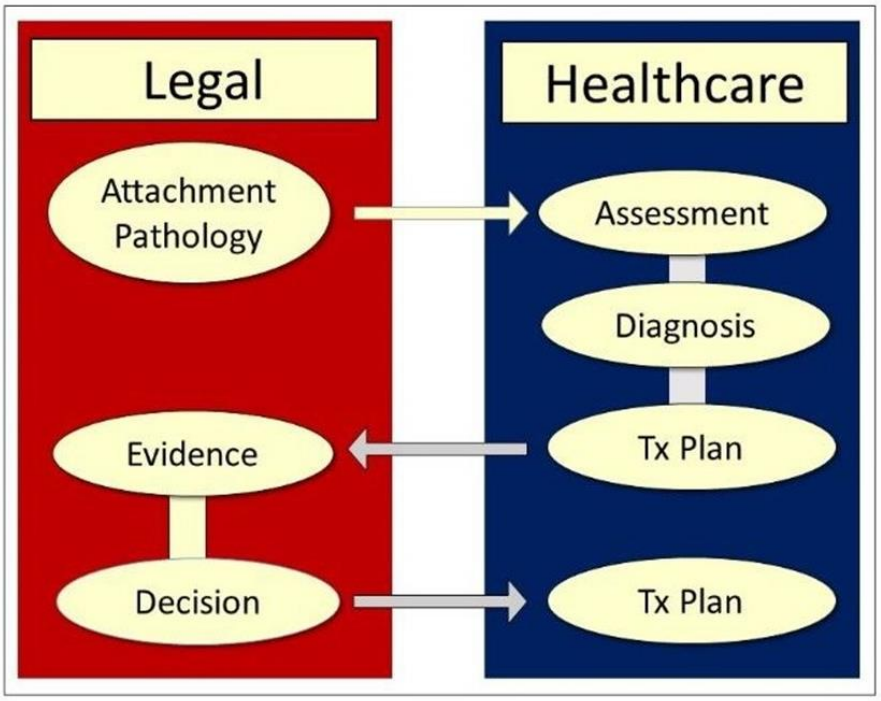
We follow the judgment of the PFD in *Re C (Parental Alienation)* [2023] EWHC 345 (Fam) para 103 that the court's focus should be on the identification of ALIENATING BEHAVIOUR (as defined) and the IMPACT of that behaviour on the RELATIONSHIP OF THE CHILD with either of his/her parents.

Note: not all journeys will look like this, but the essential requirements to establish and respond to AB remain the same



When a child displays severe attachment pathology surrounding court-involved custody conflict, two separate societal systems are involved, the legal system surrounding the custody conflict, and the healthcare system surrounding the pathology. Both systems need to perform their respective functions, interacting efficiently to the tasks of each system.

Doctors should not be deciding on custody. Judges should not be diagnosing the cause of pathology.



3. Case Management Guidance Note for the Family Court: Cases in which alienating behaviours are alleged

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.

> "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:

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- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

Psychological Control

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*,[13] 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)[14] 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 development of an independent sense of self and identity." (Barber & Harmon, 2002, p. 15)

The difference between behavioral and psychological control of the child is described by Stone, Bueler, and Barber (2002),[15]

> **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)

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

[14] 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.

[15] 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.

Soenens and Vansteenkiste (2010)[16] 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)[17] provide a description of 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, 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).

Alienating behaviours

Sir Andrew McFarlane P observed in **Re C ('Parental Alienation'; Instruction of Expert)** [2023] EWHC 345 (Fam) that the disruption or undermining of a parent/child relationship is often encapsulated in the term 'parental alienation' or alienating behaviours. A court would need to be satisfied that three elements are established before it could conclude that alienating behaviours had occurred:

Professional Standard of Practice

[16] 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.

[17] 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.

There is no such thing as "parental alienation." There is no such thing as "alienating behaviours." These are made-up constructs without scientific or research support or agreed-upon definition.

"Alienating behaviours" = 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
- DSM-5 diagnostic system - American Psychiatric Association

Application of Knowledge vs Lack of Knowledge

Do the authors of this Guidance know the established scientific and professional knowledge of the discipline of professional psychology needed for professional competence in working with the attachment pathology in the family courts? Are the authors relying on problematic (made-up) constructs because they do not know the actual established knowledge needed for professional competence?

> **Google ignorance:** lack of knowledge or information

a) the child is refusing, resisting, or reluctant to engage in, a relationship with a parent or carer;

Attachment Pathology

A child who is refusing, resisting, or reluctant to engage in a relationship with a parent represents an attachment pathology, i.e., a problem in the love-and-bonding system of the brain. The attachment system is a primary motivational system of the brain that governs all aspects of love-and-bonding throughout the lifespan (Bowlby; Ainsworth, and others). A child rejecting a parent is an attachment pathology.

> **From Bowlby:** "No variables, it is held, have more far-reaching effects on personality development than have a child's experiences within his family: for,

starting during the first months of his relations with his mother figure, and extending through the years of childhood and adolescence in his relations with both parents, he builds up working models of how attachment figures are likely to behave towards him in any of a variety of situations; and on those models are based all his expectations, and therefore all his plans for the rest of his life." (Bowlby, 1973, p. 369).[18]

The only cause of severe attachment pathology (i.e., a child rejecting a parent) is child abuse range parenting by one parent or the other. Other less severe forms of problematic parenting produce an insecure attachment that has different symptom characteristics other than a severing of the parent-child bond.

In all court-involved custody conflict involving severe attachment pathology displayed by the child (i.e., a child rejecting a parent; "refusing, resisting, or reluctant" to bond to a parent), 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 to the parent 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 ☐ yes ☐ no

[18] Bowlby, J. (1973). Attachment and loss: Vol. 2. Separation: Anxiety and anger. NY: Basic.

V995.82 Spouse or Partner Abuse, Psychological)?

b) the refusal, resistance or reluctance is not consequent on the actions of the non-resident parent towards the child or the resident parent; and

Resist-Refuse and Induced Delusional Thought Disorders

Writing in the journal *Family Court Review*, Walters & Friedlander (2016) describe the refusal and resistance of the child to be with the targeted parent (an attachment pathology) as being caused by a shared persecutory delusion created by the distorted parenting of a pathological parent,

> **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)."

Diagnosis Guides Treatment

Diagnosis guides treatment, the treatment for cancer is different than the treatment for diabetes.

> Diagnosis = identify
>
> Pathology = problem
>
> Treatment = fix it

- We must first *diagnose* what the *pathology* is before we know how to *treat it*.
- We must first *identify* what the *problem* is before we know how to *fix it*.

Is the diagnosis child abuse by the targeted-rejected parent, or is the diagnosis Child Psychological Abuse (DSM-5 V995.51) by the allied parent, i.e., a shared (induced) persecutory delusion and false (factious) attachment pathology imposed on the child for secondary gain to a pathological (narcissistic-borderline-dark personality) parent of manipulating the Court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs?

The treatment and judicial response to child abuse by the targeted parent is different than the treatment and judicial response to child abuse by the allied parent. In all cases of severe attachment pathology surrounding child custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Assessing Delusional Thought Disorders

The assessment for a possible 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?"

The definition of a persecutory delusion is provided by the American Psychiatric Association,

> **From the APA:** "Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way." (American Psychiatric Association, 2000)

The American Psychiatric Association describes the development of a shared delusional disorder that occurs within a family context,

> **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)

Creating a shared (induced) persecutory delusion in the child that then destroys the child's attachment bond to the other parent, as described by Walters and Friedlander (2016) in the journal *Family Court Review*, is a DSM-5 diagnosis of V995.51 Child Psychological Abuse and a child protection response is warranted.

Response to Child Abuse

In all cases of child abuse, we always protect the child. In all cases of severe attachment pathology displayed by the child, a proper risk assessment for child abuse needs to be conducted. If a child abuse diagnosis is returned from a proper risk assessment, then professional standards of practice and duty to protect obligations require the child's protective separation from the abusive parent.

In response to all dangerous pathology (suicide, homicide, or abuse), the professional response begins with a Safety Plan to ensure everyone is safe in the situation. Then, once everyone's safety has been ensured, a treatment plan is developed for the diagnosis with Goals identified in measurable ways, Interventions specified for each Goal, estimated Time Frames for achieving the Goal, and Outcome Measures to monitor treatment progress and goal accomplishment.

Once the Safety Plan is enacted and the child is protectively separated from the abusive parent, the child's healthy and normal-range development is then recovered through the written treatment plan. When the child's recovery has been 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.

Diagnosis guides treatment. What is the diagnosis guiding the decision-making of the mental health professionals and the Court?

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 to the parent 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

c) the resident parent has engaged in behaviours that have directly or indirectly impacted on the child, leading to the child's refusal, resistance, or reluctance to engage in a relationship with the other parent.

Standards of Professional Practice

Making up new forms of pathology is professionally inappropriate. This Guidance would not meet the ethical requirements for clinical psychologists required by 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.

The established scientific and professional knowledge from clinical psychology required for application with court-involved custody conflict as the bases for professional judgments 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

The only cause of severe attachment pathology is child abuse range parenting by one parent or the other. 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

Either parent could demonstrate alienating behaviours. Such behaviours can include (but are not limited to) one parent:

Standards of Professional Practice

There is no such thing as "parental alienation." There is no such thing as "alienating behaviours." These are made-up constructs without scientific or research support or

agreed-upon definition.

> "Alienating behaviours" = 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.

No Established Diagnostic Criteria for "Alienation"

What is the research support for the "alienating behaviours" listed by the authors of this Guidance? I will challenge that the authors are simply making up this list of behaviours from their imagination (and the imagination of others) without research support. Citation support to the research is requested for the assertions made about "alienating behaviors."

If the diagnostic criteria (i.e., the behaviours) may or may not be present, and with no set number of diagnostic behaviours needing to be present for the pathology to be identified (diagnosed), then the diagnostic description for the pathology is entirely arbitrary and subjective in both its development and its application and is entirely worthless as a diagnostic model.

> Ex: For a diagnosis of ADHD, six of nine identified symptoms must be present. For a diagnosis of Major Depressive Disorder, five of eight symptoms of a depressive episode must be present. The symptoms and the diagnostic criteria for a diagnosis of ADHD and Major Depressive Disorder are derived from the relevant research on the respective pathologies.

There is no research support for the selection of these symptoms chosen as "alienating behaviours," and without establishing a set number of specified symptoms needed for the diagnosis of "alienation," the proposed diagnostic model for "parental alienation" is not even a diagnostic model. It is arbitrary and subjective in both its development and its application.

Ethical Standards of Professional Practice

The child's life hangs in the balance of the Court's decision. The Court and the children deserve the highest caliber of professional services. Child abuse by one parent or the other is a considered diagnosis based on the child's display of severe attachment pathology. When possible child abuse is a considered diagnosis, our diagnosis must be accurate 100% of the time. Misdiagnosing child abuse is too devastating for the child.

In all cases of severe attachment pathology surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to return an accurate diagnosis, in order to develop an effective treatment plan to fix the pathology in the family and restore a normal-range and healthy childhood to the child.

The use of the construct of "parental alienation" ("alienation" - "alienating behaviours") 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
- DSM-5 diagnostic system - American Psychiatric Association

The failure of the authors to apply established scientific and professional knowledge from any relevant domain of professional psychology as the bases for their professional judgments, raises professional concerns that the authors of this Guidance may not know the established scientific and professional knowledge of the discipline necessary for professional competence in working with the attachment pathology in the family courts.

> **Google ignorance:** lack of knowledge or information

Apply knowledge to solve pathology. Ignorance solves nothing. The children and the courts deserve the highest caliber of professional services.

- repeatedly or constantly criticising or belittling the other.

Citation requested to the research support for this criterion behaviour.

How is "repeatedly" defined? How is "criticism" or "belittling" defined, i.e., what are the operational definitions for diagnostic purposes? Or is this diagnostic criterion subjectively defined by each evaluator?

Psychological Control

Parental psychological control happens in a myriad of manipulative ways that do not involve speaking negatively about the other parent.

> **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)

Evidence of Abuse

It is unrealistic to require that the private parenting behavior of a pathological parent be directly observed when that parent is alone with the child. Making it a requirement to observe parenting behaviors when the parent is alone with the child will prevent the diagnosis of Child Psychological Abuse since the pathogenic parenting episodes are rarely presented to others. There are no witnesses to the psychological abuse of the child (i.e., to the psychological murder of the child's bond to the other parent) except

the abusive parent and the child. Psychological abuse leaves no outside bruises or marks, its impact is in the specific child symptoms created by the child abuse.

The pathology is a psychological murder, the death in the child's relationship with a parent. Which parent is the perpetrator? There is no eyewitness to the murder of the relationship except the perpetrator and victim. The perpetrator of the psychological murder denies the crime, and the victim cannot speak. But there is other evidence, there are fingerprints on the murder weapon, there is DNA at the crime scene, there are telephone records placing the perpetrator at the crime scene at the time of the murder.

To require eye-witness evidence to convict on the murder is unrealistic to achieve, since only the perpetrator and victim are at the scene of the crime. If the victim can't speak, for example if the victim is under the psychological control (Barber) of the pathological parent, that leaves only the perpetrator to speak. Child abuse leaves symptoms of the child abuse. Diagnosis involved identifying the symptoms in a pattern-match to diagnostic criteria, professionals need to diagnose the child abuse and protect the child.

It is unrealistic to require an eyewitness to diagnose physical abuse when the child presents with bruises and broken bones without a credible explanation. Psychological abuse will be evident in the pathology created, in the specific symptoms created in the child – i.e., a shared persecutory delusion and Factitious Disorder Imposed on Another; either and both of which are a DSM-5 diagnosis of Child Psychological Abuse (V995.51).

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

The National Academy of Sciences describes the diagnostic process in a paper on *Improving Diagnosis in Healthcare* (2015),[19]

> **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,

[19] *Improving Diagnosis in Healthcare* (2015). National Academies of Sciences, Engineering, and Medicine; Institute of Medicine; Board on Health Care Services; Committee on Diagnostic Error in Health Care; Erin P. Balogh, Bryan T. Miller, and John R. Ball, Editors

https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWElqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI

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)

Diagnosis guides treatment. An accurate diagnosis is needed to guide the development of an effective treatment plan. If we treat cancer with insulin, the patient dies from the misdiagnosed and mistreated cancer. The only cause of severe attachment pathology is abusive range parenting by one parent or the other, the diagnostic question is, which parent?

Instead of applying the established scientific and professional knowledge of the discipline toward the goal of making an accurate diagnosis of the pathology in the family, the authors of this Guidance appear to be proposing a new form of pathology from their imagination, with arbitrary and subjective diagnostic criteria.

The allied parent criticizing the other parent is not how the shared persecutory delusion is created. The other parent is discussed often, but in critical ways by the child to the allied parent. The allied parent does not criticize the other parent, the allied parent elicits the criticism of the other parent from the child through directive and motivated questioning, and then the allied parent offers "support" for the child's expressed grievances, entering the coveted role as the supposedly "protective" parent.

> **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)

Does the child have a persecutory delusion? Does the allied parent share this persecutory delusion? That would be a shared persecutory delusion. Creating a shared persecutory delusion in the child that then destroys the child's attachment bond to the other parent is a DSM-5 diagnosis of V995.51 Child Psychological Abuse.

The assessment for a delusional thought disorder is a Mental Status Exam of thought and perception.

> **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?"

- unjustifiably limiting or restricting contact or undermining contact.

Citation requested to the research support for this diagnostic criterion.

What is the difference between "justified" limitations and restrictions on contact and "unjustified" limitations and restrictions on contact? Is this arbitrarily and subjectively determined by each evaluator?

How is "undermining contact" defined for diagnostic purposes, or is this also arbitrarily and subjectively determined by each evaluator?

Standards of Professional Practice

Making up new forms of pathology is not professionally appropriate. All professionals should apply the established scientific and professional knowledge of the discipline – first.

The established scientific and professional knowledge of the discipline required for application 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

- forbidding discussion about the other parent.

Citation requested to the research support for this criterion behavior.

Are these merely criterion behaviors from someone's imagination?

Pathogenic Parenting

That is not how the shared persecutory delusion is created (Barber; psychological control). The other parent is discussed often, but in negative and critical ways by the child to the allied parent. The allied parent does not criticize the other parent, the allied parent elicits the criticism from the child by directive and motivated questioning, and then the allied parent merely offers "support" for the child's expressed grievances.

The allied parent presents as simply "listening to the child's" grievances that were manipulatively elicited by the parent through motivated and directive questioning with the child.

Do the authors of this Guidance know the necessary established scientific and professional knowledge of professional psychology needed for professional

competence in working with the attachment pathology in the family courts.

> **Google ignorance:** lack of knowledge or information

Psychological Control

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*,[20] 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)[21] 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 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),[22]

> **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)[23] 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

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

[21] 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.

[22] 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.

[23] 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.

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)[24] provide an description for the process of 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, 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).

Standards of Professional Practice

Making up new forms of pathology ("parental alienation" – "alienation" – "alienating behaviours") is professionally inappropriate and degrades the quality of professional services received by children and the Court. 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 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.

The established scientific and professional knowledge of the discipline required for application 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

[24] 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.

- DSM-5 diagnostic system - American Psychiatric Association

Apply knowledge to solve pathology.

- creating the impression that the other parent dislikes or does not love the child, or has harmed them or intends them harm.

Citation requested to the research support for this behavioral criterion.

Persecutory Delusion

Creating the impression in the child is called "inducing," - and inducing a false belief that the other parent has harmed the child or intends to harm the child is the definition of creating a shared (induced) persecutory delusion in the child.

> **From the APA:** "Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way." (American Psychiatric Association, 2000)

Walters and Friedlander describe the shared delusion that presents in the family courts,

> **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 American Psychiatric Association describes the development of a shared delusion in family situations, with the child 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)

Professional Competence

The symptoms proposed by the authors of this Guidance appear to be randomly developed from the personal imagination of the authors in an effort to create a new form of pathology ("parental alienation" – "alienation" – "alienating behaviours").

The absence of applied professional knowledge by this proposed Guidance raises the question, do the authors of this Guidance even know the necessary established scientific and professional knowledge of the discipline needed for professional competence in working with the attachment pathology presenting in the family courts?

> **Google ignorance:** lack of knowledge or information

Apply knowledge to solve pathology. The established scientific and professional knowledge of the discipline needed for professional competence in working with the attachment pathology in the family courts 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

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 ☐ yes ☐ no

V995.82 Spouse or Partner Abuse, Psychological)?

- denying emotional responsiveness to the other parent or spurning, terrorising, isolating, corrupting, or exploiting them.

Citation requested to the research support for this feature.

These appear to be random symptoms developed from the personal imagination of the authors. These parenting behaviors also sound like potentially abusive range parenting, and this spectrum of concerns would warrant a proper risk assessment for possible child abuse be conducted to the appropriate diagnoses of concern.

- Terrorising: Concerns that a parent may be terrroising the child should receive a proper risk assessment for possible Child Psychological Abuse (V995.51).
- Isolation: Isolating the child may be a feature of child abuse to isolate the child from reporting and from rescue. Any concerns for the child's well-being involving child isolation should receive a proper risk assessment for possible child abuse.
- Corruption: Concerns that a parent may be corrupting the child should receive a proper risk assessment for possible child abuse, dependent upon the nature of the "corruption" concerns involved.
- Exploitation: Concerns that a parent may be exploiting the child should receive a proper risk assessment for possible child abuse.

How are these various terms operationally defined for diagnostic purposes? Or are they arbitrarily and subjectively defined by each evaluator?

This Guidance Note will use the terms 'non-resident parent' and 'resident parent' when referring to alienating behaviours. While it is accepted that either parent can engage in alienating behaviours, for the sake of brevity this Note will assume the allegations are made against a resident parent. The court must however remain mindful that examples of a non-resident parent engaging in alienating behaviour can and do occur.

Citation to the research support is requested for the statements about prevalence and frequency of the "alienating behaviours" displayed by each party in the family courts. Or are these prevalence estimates for "alienating behaviours" merely statements from the imagination of the authors?

Standards of Professional Practice

There is no such thing as "parental alienation." There is no such thing as "alienating behaviours." These are made-up constructs without scientific or research support or agreed-upon definition.

"Alienating behaviours" = unicorns: both are mythical things.

The use of the construct of "parental alienation" in a professional capacity is substantially beneath professional standards of practice in clinical psychology, it degrades the quality of mental health services received by children and the courts, and it is in violation of Standard 2.04 Bases for Scientific and Professional Judgments of the APA code.

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

If the authors wish to propose a new form of pathology called "parental alienation" – "alienation" – "alienating behaviors" – it still remains incumbent upon them to first apply the established scientific and professional knowledge. If the authors still need to create a new form of pathology after the application of established professional knowledge, then they can make their new pathology proposal.

However, to make up new forms of pathology ("parental alienation" – "alienation" – "alienating behaviours") and NOT apply the established knowledge from professional psychology would seemingly represent negligent professional practice.

Google negligence: failure to take proper care in doing something.

Apply the established scientific and professional knowledge first.

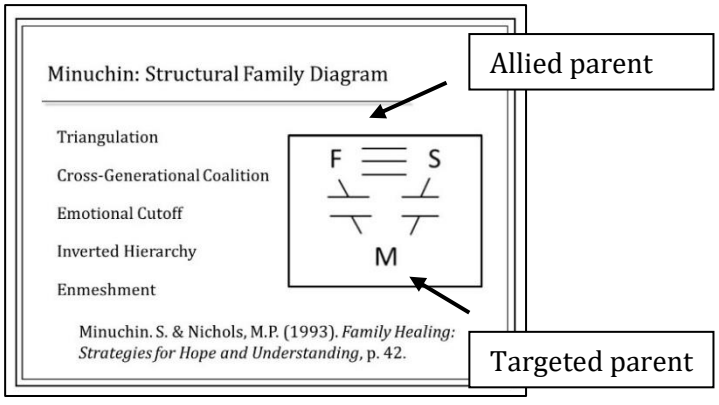
The established scientific and professional knowledge of the discipline required for application with court-involved custody conflict is:

- 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

Terminology for Parents – Family Systems

In family systems therapy (Minuchin, Bowen, Haley, Madanes, Satir, and others), the traditional terms used to designate the parents are the "allied" parent who has formed a *cross-generational coalition* with the child against the "targeted" parent (i.e., the allied parent is in an alliance with the child against the other parent, who is the target for the generated hostility of the child.

This family system pathology is depicted in a Structural family diagram from Minuchin and Nichols (1993).



This Guidance Note will be of assistance to the court at whatever stage of the proceedings the issue of alienating behaviour is to be considered.

Standards of Practice

There is no such thing as "parental alienation." There is no such thing as "alienating behaviours." These are made-up constructs without scientific or research support or

agreed-upon definition.

The proposed "alienating behaviours" are without a professional-level definition that would allow for their diagnostic identification, they are arbitrary and subjective in their development and in their practical application because they do not exist in actual clinical psychology.

"Alienating behaviours" = unicorns: both are mythical things.

The proposed "alienating behaviours" are without research support and are constructions of the imagination of the authors.

Citations are requested to the research support for the proposal of "alienation" or the offered "alienating behaviours."

The Burden of Proof

Whilst alienating behaviour can be subtle and insidious, a parent alleging alienating behaviours must discharge the burden of establishing that such behaviour has occurred.

This will be nearly impossible to prove since the proposed "alienation" (the induction of a shared delusion) occurs out of view of other people. This Guidance will allow Child Psychological Abuse to continue un-diagnosed and un-treated.

Eyewitness evidence is not necessarily needed for a murder if there is fingerprint evidence on the murder weapon found at the crime scene, DNA evidence indicting the perpetrator, evidence of motive and opportunity, and large amounts of circumstantial evidence.

A child rejecting a parent is an attachment pathology that requires a diagnosis as to its cause. Diagnoses aren't proven, diagnoses are given based on a pattern-match of the symptoms to the diagnostic criteria. Diagnosis of pathology is the domain of doctors and the healthcare system.

Attachment pathology is a healthcare issue for the doctors to diagnose and treat. In healthcare, diagnosis always guides treatment. The treatment for cancer is different than the treatment for diabetes. The treatment for child abuse by the targeted parent is different than the treatment of child psychological abuse by the allied parent.

Is the diagnosis child abuse by the targeted parent, or is the diagnosis child psychological abuse by the allied parent?

Diagnosis of Pathology

Diagnosis is a pattern-match of the symptoms to the diagnostic criteria.

The National Academy of Sciences describes the diagnostic process in a paper on *Improving Diagnosis in Healthcare* (2015),[25]

> **From Improving Diagnosis**: "The working diagnosis may be either a list of potential diagnoses (a differential diagnosis) or a single potential diagnosis.

[25] *Improving Diagnosis in Healthcare* (2015). National Academies of Sciences, Engineering, and Medicine; Institute of Medicine; Board on Health Care Services; Committee on Diagnostic Error in Health Care; Erin P. Balogh, Bryan T. Miller, and John R. Ball, Editors

https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWElqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI

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)

The only cause of severe attachment pathology is child abuse by one parent or the other. All mental health professionals have duty to protect obligations. In all cases of severe attachment pathology surrounding court-involved custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

- **Targeted Parent Abusive:** Either the targeted parent is abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality),
- **Allied Parent Abusive:** Or the allied parent is psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality).

The assessment for a possible 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?"

Professional Duty to Protect

Professional duty to protect obligations are legally obligating duties placed on the involved mental health professionals. Failing to conduct a proper risk assessment when a dangerous pathology is encountered (suicide, homicide, abuse) would represent a negligent failure in professional duty to protect obligations.

> **Google negligence:** failure to take proper care in doing something.
>
> **Cornell Law School Definition of Negligence:** 'Negligence is the failure to behave with the level of care that a reasonable person would have exercised under the same circumstances. Either a person's actions or omissions of actions can be found negligent. The omission of actions is considered negligent only when the person had a duty to act (e.g., a duty to help someone because of one's own previous conduct).[26]

The negligent failure would be in the mental health professional's duty to protect the child from child abuse by failing to use reasonable care in their assessment.

Was a proper assessment conducted for a possible persecutory thought disorder (shared) in the family? Was a proper risk assessment for child abuse conducted to the appropriate differential diagnoses for each parent?

Risk Assessment

There are four diagnoses of child abuse in the Child Maltreatment section of the DSM-5, each of these child abuse diagnoses warrants a proper risk assessment; Child Physical Abuse (V995.54), Child Sexual Abuse (V995.53), Child Neglect (V995.52), Child Psychological Abuse (V995.51). All of these child abuse diagnoses are equally severe in the damage they cause to 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.

Whenever there is concern for possible child abuse from anyone for any reason, a proper risk assessment for child abuse needs to be conducted to the appropriate concerns.

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.

When possible child abuse is a considered diagnosis, our diagnosis must be accurate 100% of the time. Misdiagnosing child abuse is too devastating for the child. The decision of the Court will have a life-changing impact on the child. Misdiagnosing child abuse will destroy the child's life.

When child abuse is a considered diagnosis, as it is in all cases of severe attachment

[26] https://www.law.cornell.edu/wex/negligence

pathology displayed by a child, the Court (the legal system) should refer the question to the doctors (the healthcare system) for a diagnosis, and the doctors need to do whatever is required to ensure that the diagnosis they return is accurate.

There are ways for doctors to do that once the doctors set themselves the task to do that. However, the continued use of made-up new pathologies like "parental alienation" degrades the quality of mental health services provided to children and the Court.

Apply knowledge to solve pathology.

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

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

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

Evidence of alienating behaviours

Where alienating behaviours are alleged, the court should require those making the allegation to identify the evidence upon which they rely.

Diagnoses should be made by qualified and competent mental health professionals who are trained in the diagnostic assessment of 1) attachment pathology, 2) child abuse and trauma, 3) delusional thought disorders, 4) Factitious Disorder Imposed on Another, and 5) family systems pathology.

Failure to possess the required professional knowledge necessary for competence would represent practice beyond the boundaries of competence in violation of Standard 2.01 Boundaries of Competence of the APA ethics code.

> **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.

Legal System – Healthcare System

The Court should not be asked to diagnose subtle and sophisticated psychopathology based on evidence presented at trial.

With due respect to the Court's legitimate authority in custody matters, neither is the Court competent by its education and training for the diagnosis of complex family psychopathology, i.e., a complex interaction of attachment pathology, delusional thought disorders, parental personality pathology, and factitious disorders imposed on the child. Courts should decide on matters of the law's application. Doctors should decide on matters of diagnosis of psychopathology.

The legal system is an adversarial system. The diagnosis returned from professional psychology will likely be disputed by one party or the other. The appellate system in healthcare for a disputed diagnosis is second opinion. In all cases of court-involved attachment pathology, a second (or even third) opinion consultation should be sought by the involved mental health professionals at the time of the initial diagnostic assessment.

The National Academies of Science, Engineering, and Medicine recommend second opinion consultation to improve diagnoses in Health Care,

> **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."[27]

Developing a standardized diagnostic assessment and treatment protocol would also help considerably in reducing (eliminating) the fighting among professionals surrounding the child's diagnosis and treatment.

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
- **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 ☐ yes ☐ no

[27] National Academies of Sciences, Engineering, and Medicine; (2015). *Improving Diagnosis in Healthcare* (2015). Institute of Medicine; Board on Health Care Services; Committee on Diagnostic Error in Health Care; Erin P. Balogh, Bryan T. Miller, and John R. Ball, Editors

https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWElqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI

V995.82 Spouse or Partner Abuse, Psychological)?

Alienation involves an act or acts by a parent, that must be evidenced, resulting in the psychological manipulation of the child and the child's unjustified rejection of the other parent. Such behaviours must be evidenced just as other acts of abuse are evidenced.

The evidence needed for conviction of murder is not necessarily having an eyewitness to the murder.

The diagnosis of child physical abuse is often made based on the child's physical symptoms of bruising and broken bones without a credible explanation. Psychological child abuse will produce specific child symptoms.

Diagnosis in Healthcare

Diagnosis is made by doctors in the healthcare system based on a pattern-match of the symptoms to the diagnostic criteria. When child abuse is a concern surrounding court-involved custody conflict, two systems are involved, the legal system and the healthcare system.

The family pathology involved is complex. Identifying the problem (diagnosing the pathology) in the family is the role of the doctors in the healthcare system. A child rejecting a parent is an attachment pathology. What is the cause of the child's attachment pathology? This is a diagnostic question.

The evidence of psychological child abuse is found in the child's symptoms. Does the child have a shared persecutory delusion with the allied parent and a false (factitious) attachment pathology? There is only one possible cause of a child having a shared persecutory delusion and factitious attachment pathology, pathogenic parenting by the allied parent.

The targeted parent cannot produce a delusional thought disorder or factious attachment pathology toward themselves. There is no pathway for that to happen. The only explanation for a delusional thought disorder and factitious attachment pathology displayed by the child is a shared (induced) persecutory delusion and a Factitious Disorder Imposed on Another for secondary gain to the pathological parent.

There are multiple ways that the pathology in the family can be diagnostically determined, 1) by a direct Mental Status Exam of thought and perception conducted with the allied parent and child, 2) from a Response-to-Intervention (RTI) trial with treatment designed to resolve the provisional diagnosis, 3) through an Applied Behavioral Analysis that identifies the cue structure for the child's resistant behavior.

The National Academies of Science, Engineering, and Medicine describe the diagnostic process in health care,

> **From Improving Diagnosis in Healthcare: "**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 Healthcare: "**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 Healthcare: "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 Healthcare: "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 Healthcare: "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."

Routine second and even third opinion (telehealth) consultation can also improve the accuracy of diagnosis.

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, as it is in all cases of severe attachment pathology, the returned diagnosis 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.

When possible child abuse is a consideration, it is vital to the Court's decision-making that the returned diagnosis from healthcare be accurate 100% of the time. There are two parties in litigation, both have their concerns. 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

The behaviour of a child is not evidence of the behaviour of an adult, so the behaviour of a child should not be used to evidence adult behaviours.

That is an incorrect statement. The child's symptoms bear the imprint of their cause.

The diagnosis of concern is a shared (induced) persecutory delusion created by the

pathogenic parenting (psychological control – Barber) of the child by a pathological (narcissistic-borderline-dark personality) parent. The pathology of the child is being created (induced) by the parent's distorted parenting behavior.

The child's symptomatic behavior IS evidence of the pathogenic parenting that created that specific pattern-set of symptoms.

- The diagnosis of concern is a shared (induced) persecutory delusion.

  If a persecutory delusion is present in the child and is also shared by the allied parent, there is only one possible cause – the pathogenic parenting of the allied parent is creating a shared (induced) persecutory delusion.

- The diagnosis of concern is a Factious Disorder (a false attachment pathology) Imposed on Another – DSM-5 300.19.

  If a Factitious Disorder Imposed on Another (a factious attachment or anxiety pathology) is present in the child, there is only one possible cause – the pathogenic parenting of the allied parent who is creating a Factitious Disorder Imposed on Another (DSM-5 300.19).

Either diagnosis, a shared (induced) persecutory delusion or FDIA, separately or together, represents a DSM-5 diagnosis of V995.51 Child Psychological Abuse.

The act of psychological child abuse will not be observed directly, it is done in private and in a variety of manipulative ways. The pathological parent (narcissistic-borderline-dark personality) is highly manipulative, and the hidden parental interactions with the child cannot ever be adequately documented except by their consequence of false symptoms.

> **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)

This Guidance, if followed, will prevent the diagnosis of Child Psychological Abuse by a pathological parent who is creating an induced persecutory delusion and factitious attachment pathology in the child for the secondary gain to the pathological parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs.

Diagnosis Guides Treatment

The only thing that causes severe attachment pathology (i.e., a child rejecting a parent) is child abuse by one parent or the other. The child's attachment pathology by itself indicts the parenting of one parent or the other as being abusive.

Less severely problematic parenting creates a different pattern of symptoms (insecure attachment in various patterns) but does not create a complete severing of the parent-child bond. The only thing that causes a complete severing of the parent-child attachment bond is abusive parenting by one parent or the other. The diagnostic question to be answered is, which parent is abusing the child?

Saying that the child's symptoms are not proof of the parental cause for that behavior is not accurate.

- **Targeted Parent Abusive:** Either the targeted parent is abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality), Document what the abuse is, put it on a treatment plan and fix it. Then restore a healthy attachment bond.
- **Allied Parent Abusive:** Or the allied parent is psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality). Diagnose the Child Psychological Abuse, put it on a treatment plan and fix it. Then restore a healthy attachment bond.

Breach and Repair

We always restore a healthy attachment bond.

> **Recommended Reading:** Tronick and Gold (2020)[28]: 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)

The worst possible thing we can do is leave a breached attachment bond un-repaired – the Ugly of Tronick and Gold. In healthcare, diagnosis guides treatment. The treatment for abusive-range parenting by the targeted parent is different from the treatment for abusive-range parenting by the allied parent.

Consultation in Healthcare

The doctors, the clinical psychologists in the healthcare system, should diagnose what the pathology in the family is. The diagnostic assessment should be to the differential diagnosis appropriate for each parent. If the diagnosis is disputed, which it likely will

[28] 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.

be, then obtain a second opinion on the diagnosis from another qualified psychologist, or even a third opinion.

Since the diagnosis is likely to be disputed, rather than consecutively seeking second (and third) opinions which delays decision-making and creates professional disputes, obtaining the second (and third) opinion should be sought concurrently with the initial diagnosis. Doctor-to-doctor professional consultation on complex pathology occurs all the time in healthcare. Second opinion consultation should occur routinely in the assessment and diagnosis of attachment pathology in the family courts.

> **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."[29]

When possible child abuse is a considered diagnosis, our diagnosis must be accurate 100% of the time. Misdiagnosing child abuse is too devastating for the child. The goal is to protect all children from all forms of child abuse all of the time.

That can be done, once that becomes the goal.

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.

- **Targeted Parent Abusive:** Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality)?
- **Allied Parent Abusive:** Or is the allied parent psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality).

[29] National Academies of Sciences, Engineering, and Medicine; (2015). *Improving Diagnosis in Healthcare* (2015). Institute of Medicine; Board on Health Care Services; Committee on Diagnostic Error in Health Care; Erin P. Balogh, Bryan T. Miller, and John R. Ball, Editors

https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWElqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),[30]

> **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."

A rating for the delusional thought disorder can be made using Item 11 Unusual Thought Content of the Brief Psychiatric Rating Scale (BPRS),[31] "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia: BPRS).

All potential risk factors, such as domestic abuse, must be adequately and safely considered when looking at the nexus between the behaviour of a parent and a child.

The authors of this Guidance appear to have an agenda related to mixing issues of child abuse with issues of alleged spousal abuse. There is a bias in the development of this Guidance in favor of the pathological parent.

This Guidance should not be followed.

Spousal Abuse Concerns

The spousal abuse ("domestic abuse") of concern for the attachment pathology that develops surrounding divorce is the potential emotional and psychological abuse of the targeted parent by the allied parent using the child and the child's induced pathology as the weapon.

- **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

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).

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[30] Martin DC. The Mental Status Examination. In: Walker HK, Hall WD, Hurst JW, editors. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Boston: Butterworths; 1990. Chapter 207. Available from: https://www.ncbi.nlm.nih.gov/books/NBK320/

[31] Brief Psychiatric Rating Scale (BPRS). Available from: https://www.researchgate.net/publication/284654397_Brief_Psychiatric_Rating_Scale_Expanded_version_40_Scales_anchor_points_and_administration_manual

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.

- **Targeted Parent Abusive:** Is the targeted parent abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a 2-person attribution of causality)?
- **Allied Parent Abusive:** Or is the allied parent psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs (a 3-person triangle attribution of causality)?

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 fact that a child is resistant to spending time with a parent, does not automatically mean that the child has been exposed to alienating behaviours from the other parent. The court should remain mindful that a child might withdraw from a relationship with a parent for a variety of reasons e.g.: a new adult relationship; parental separation; loyalty to the other parent; rigid parenting; abusive parenting; or differing parenting styles.

This is not a true statement.

Attachment Pathology

Problematic parenting creates an insecure attachment in three categories, with three sets of different attachment displays, 1) insecure anxious-ambivalent (high protest; caused by inconsistent parental availability), 2) insecure anxious-avoidant (low protest; caused by an overwhelmed parent who withdraws further if the child makes demands), and 3) disorganized attachment (caused by abusive range and chaotic parenting).

The attachment system is a primary motivational system of the brain. It is a "goal-

corrected" motivational system, meaning it ALWAYS maintains the goal of forming a secure attachment bond to the parent. In response to problematic parenting, the attachment system changes HOW it tries to form an attachment bond to the parent, but it always tries to form a secure attachment bond to the parent.

With disorganized attachment, the child evidences no organized strategy to form an attachment bond to the parent. A child rejecting a parent would be considered a disorganized attachment, i.e., the child has no organized strategy to form an attachment bond to the parent. A disorganized attachment is created by abusive-range parenting. The diagnostic implications of a child rejecting a parent are that the parent is somehow abusively maltreating the child, thereby causing the child's rejection of that parent.

Alternatively, however, the allied parent may be creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the pathological (narcissistic-borderline-dark personality) parent of manipulating the court's decisions regarding child custody, and to meet the pathological parent's own emotional and psychological needs.

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 diagnosis 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

The family systems pathology of concern is for the child's *triangulation* into the spousal conflict through the formation of an enmeshed *cross-generational coalition* with the allied parent against the targeted parent, resulting in an inverted hierarchy and *emotional cutoff* in the child's attachment bond to the targeted parent.

- **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

A child might align themselves with another child or adult or demonstrate attachment behaviour to protect the relationship with their resident parent. Alignment and attachment issues can result in resistance, reluctance and refusal without any alienating behaviours perpetrated by an adult.

These are simply personal opinions founded in imagination and are not grounded in any established scientific or professional knowledge from any domain of professional psychology.

Anything can cause anything. When there is concern, a proper assessment of that concern is warranted. When there is concern about possible child abuse, as there is when a child rejects a parent, then a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

> **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)

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

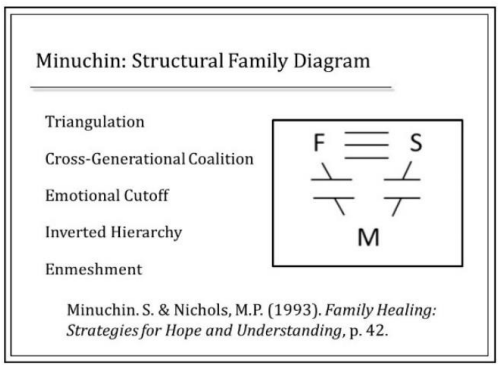
Differential Diagnosis – Allied Parent:

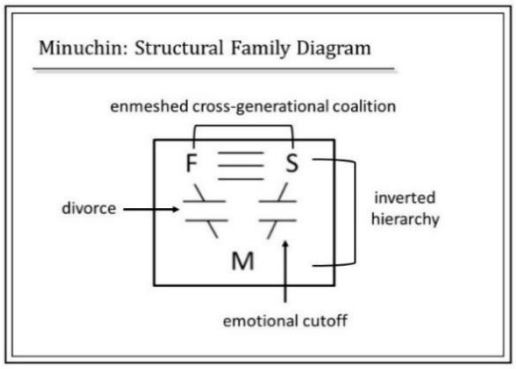
Allied Parent Abusive: Is the allied parent psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for the secondary gain of manipulating the court's decisions regarding child 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).

Robust Case Management

First steps

Where the alleged behaviour is mentioned in the original application or response, the legal adviser or judge triaging the case will need to consider the nature, seriousness and complexity of the issues raised in deciding whether the matter can be retained by the magistrates for case management under the allocation rules.

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).

Where on initial scrutiny of the allegations it appears that one or more of the three elements (described above) is absent, or a court has already considered the allegations to be lacking in any solid evidential base, the matter may remain with the magistrates. The magistrates must thereafter keep allocation under review in accordance with the allocation guidelines.

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?"
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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).

Where, after careful analysis of the information provided to the court in the documents, it appears that the three elements of alienating behaviour (described above) may be present, the case **must** be transferred for case management and determination by a judge.

Standards of Professional Practice

There is no such thing as "parental alienation." There is no such thing as "alienating behaviours." These are made-up constructs without scientific or research support or agreed-upon definition.

> "Alienating behaviours" = 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.

These are opinions from imaginings without support from the application of professional-level knowledge from any domain of professional psychology.

> **Google ignorant:** lack of knowledge or information

Apply knowledge to solve pathology.

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Whilst allegations of alienating behaviours might be raised in the original application or response documents, the allegations might be raised for the first time at any stage in proceedings e.g., at the first case management hearing, or at a subsequent point, as a reason for the breakdown in child/parent relations.

Risk Assessment

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

Whenever the Court encounters a child custody case involving severe attachment pathology displayed by the child, the Court should order that a proper risk assessment be conducted to the appropriate differential diagnosis 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

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- **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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It is incumbent on the court to case manage robustly to avoid, whenever possible, alienating behaviours being raised as an issue for the first time late in proceedings. Where alienating behaviours are raised after the initial stage in proceedings it is important that the case is allocated/re-allocated to a judge to ascertain if there is a solid evidential base necessitating judicial determination of the issue. Allegations of alienating behaviours must be allocated to a District Judge/Circuit Judge for case management and trial. It will be important for the court to identify carefully whether what has been described by a party or professional as alienating behaviour, is capable of meeting all three elements or has no realistic prospect of doing so. If, at a later stage in the proceedings, the court is persuaded that there is an issue of alienating behaviour which it would be relevant, proportionate, and necessary to determine, earlier case management decisions must be reviewed accordingly.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – or "alienating behaviors" – it is a made-up thing.

The use of "parental alienation" in a professional capacity is substantially below professional standards of practice in clinical psychology and is in violation of Standard 2.04 Bases or Scientific and Professional Judgments of the APA ethics code.

> Alienation = unicorns; they are both mythical things of the imagination.

This is Guidance for how the Court should deal with unicorns. The Court should remain focused on real things. A shared (induced) persecutory delusion is a real thing. Child Psychological Abuse (DSM-5 V995.51) by a pathological narcissistic-borderline-dark personality parent is a real thing.

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Case management hearings

The initial case management hearing may be the first opportunity for the court to consider the basis on which the allegation of alienating behaviour is made and to give directions accordingly.

Standards of Professional Practice

There is no such thing as "parental alienation" – "alienation" – or "alienating behaviors" – it is a made-up thing.

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The safeguarding letter from Cafcass should have been provided by the time the first case management hearing takes place. The letter will include a summary of the issues and the parties' positions. It provides an opening for identifying and examining the issues.

In all cases of severe attachment pathology displayed by the child surrounding child custody conflict, Cafcass should conduct a proper risk for child abuse 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
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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, ☐ yes ☐ no

and does the child share this persecutory belief (a fixed and false belief that the child is being malevolently treated in some way)?

- **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 court may wish to direct a schedule of incidents relied upon. Where a course of conduct is asserted, a narrative statement may be necessary.

1. *Is the first element evidenced? Is there evidence the child is refusing, resistant, or reluctant to engage with a parent, and if not, how can it be obtained?*

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Google ignorant: lack of knowledge or information

Apply knowledge to solve pathology. In all cases of severe attachment pathology displayed by the child surrounding child custody conflict, Cafcass should conduct a proper risk for child abuse to the appropriate differential for each parent.

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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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- **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

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If alienating behaviour is raised, the court should ascertain whether it is accepted that the child has rejected the non-resident parent. If the child/children is/are spending time with

the non-resident parent, the assertion of alienation is unlikely to be made out. The court should look for evidence of children being reportedly unwilling to see, stay or remain with the non-resident parent and the reasons given for the child's refusal or resistance. Consider whether statements or reports are required from the parties or third parties as to the child's rejection of the parent.

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In some instances, the court may direct Cafcass or a social worker to meet with the child/children to determine the child's perspective. In cases where the child's view is unclear/unknown and where there are no specific allegations of alienating behaviours or abuse that might justify the child's resistance to see, stay or remain with a parent, consider directing a Section 7 report with a specific direction for an enquiry as to those issues. It may be appropriate to direct Cafcass/Social services to have regard to their own guidance to assist the court on whether this is a case where there is evidence relevant to a finding that alienating behaviours have or have not occurred. Cafcass have a series of practitioner tools

that can be used to assist in identifying support for children where the parent/child relationship has been disrupted. Cafcass are not, however, arbiters of fact. The court and Cafcass must remain mindful that children can form negative views about a parent without influence or manipulation from the other parent.

Risk Assessment & Duty to Protect

In all cases of severe attachment pathology surrounding child custody conflict, a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent. All mental health professionals have duty to protect obligations. To not conduct a proper risk assessment when possible child abuse is a considered diagnosis based on the child's symptoms would represent negligent malpractice, i.e., failure in the professional's duty to protect obligations.

As the front-line organization encountering possible child abuse, Cafcass can perform this role with the proper training in the diagnostic assessment of delusional thought disorders (a Mental Status Exam of thought and perception) and attachment pathology. Enlisting second (or even third) opinion consultation on all assessments, can improve diagnostic reliability and validity, consistent with the National Academies of Science, Engineering, and Medicine recommendations for consultation,

> **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."

If Cafcass does not have the necessary competence in the diagnostic assessment of delusional thought disorders and attachment pathology, then referral should be made to mental health professionals who do possess the competence in the necessary professional domains of knowledge needed to conduct a proper risk assessment for child abuse.

Competence Needed

1. The diagnostic assessment of delusional thought disorders.
2. The diagnostic assessment of attachment pathology.
3. The diagnostic assessment of Factitious Disorder Imposed on Another.
4. The diagnostic assessment of family systems pathology.
5. The diagnostic assessment of child abuse and complex trauma.

Differential Diagnosis for Targeted Parent:

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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 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?"
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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 court should be cautious about ordering a stand-alone 'wishes and feelings report' as the court may be better able to assess the child's perspective with a contextual report that carefully examines the child's position.

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

The child's views may be manipulated. The child's views should be considered within the context of the differential diagnosis of concern.

2. Is the second element evidenced? The child's reluctance, refusal or resistance is not consequent on the actions of the non-resident parent towards the child or the resident parent.

In all cases of severe attachment pathology surrounding child 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

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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.

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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).

Children who show resistance or unwillingness to maintain or build a relationship with a parent who has been abusive towards them or towards the other parent, may be found to have a justified response to that parent. The allegation of alienation will thus fail. Any abuse the children experienced or observed against others might have occurred during the course of the relationship between the parents, or it might have occurred after the separation.

A child rejecting a parent due to child abuse is a serious trauma and treatment for the trauma created by child abuse needs to be undertaken.

The rejection of a parent is not "justified" – it is trauma - it is severely pathological child response to a severely pathological parenting, i.e., the child abuse. The damage to the child will be considerable. The conceptualization that any pathology is "justified" is a misunderstanding of the situation.

In all cases of severe attachment pathology surrounding child custody conflict, a proper risk assessment needs to be conducted to the appropriate differential diagnosis 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
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- 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 ☐ yes ☐ no

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?

- **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?

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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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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).

What is the form of the behaviour alleged against the resident parent? Is there a pattern of behaviour alleged?

The form of behaviour alleged against the allied parent is the creation of a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child through parenting techniques of manipulative psychological control and influence.

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)

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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Are there other forms of abusive behaviour alleged that require/necessitate investigation including against the non-resident parent?

In all cases of severe attachment pathology surrounding child 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

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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?"
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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).

3. *Is the third element evidenced? One parent has engaged in behaviours that have directly or indirectly impacted on the child, leading to the child's refusal, resistance or reluctance to engage in a relationship with the other parent.*

In all cases of severe attachment pathology surrounding child 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

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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?"
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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 court will need to examine carefully what is alleged. The court will require evidence of manipulation of the child for this third element to be established. The burden of proving such allegations will fall to the person making the allegations. As with other forms of abuse the abusive behaviour must be evidenced. How can it be evidenced? Is there independent evidence e.g., witness statements; police, school, or medical reports; a s7 report?

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

Burden of Proof

The "burden" of proving the diagnosis is the professional obligation of the licensed mental health professional conducting the evaluation, and any consultants involved on the matter.

When possible child abuse is a considered diagnosis, the returned diagnosis must be accurate 100% of the time. Misdiagnosing child abuse is too devastating for the child and will destroy the child's life.

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
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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 ☐ yes ☐ no

against the other parent?

- **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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Possible directions

Are schedules needed as well as narrative statements?

Should case management directions await the formal joinder of the child?

Should the child/ren be joined as a party?

Consider approaching Cafcass for agreement to join the child and appoint a guardian.

Consider the appointment of NYAS.

Is a fact-finding hearing relevant, proportionate and necessary?

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

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

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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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- 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 ☐ yes ☐ no

300.19 Factitious Disorder Imposed on Another)?

- **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?"
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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).

If the facts underpinning a child's relationship with a parent are in issue, or where the child

is alleged to have been exposed to abuse directly or indirectly, the court will need to consider whether a fact-finding hearing is relevant and necessary for determination of the welfare issues. Some matters may already be established (e.g., by admissions or in criminal proceedings).

Systems & Roles

Legal professionals are not qualified to diagnose pathology based on their training and education. Psychologists are not qualified to render decisions of law based on their training and education. There are two separate systems, the legal system concerned with custody and the healthcare system concerned with pathology. Each needs to function within their role and coordinate their functioning across systems.

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

When possible child abuse is a considered diagnosis, the returned diagnosis must be accurate 100% of the time. Misdiagnosing child abuse is too devastating for the child and will destroy the child's life.

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

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

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- **Emotional Cutoff:** Is there an emotional cutoff between the child and a 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 factual matrix surrounding a case of alleged alienation is one for the court alone. In the same way that the court must, at the first opportunity, gather evidence and list a fact-finding hearing where other forms of abuse are alleged, the court must gather the evidence and make findings in relation to alienating behaviours.

Systems & Roles

Legal professionals are not qualified to diagnose pathology based on their training and education. Psychologists are not qualified to render decisions of law based on their training and education. There are two separate systems, the legal system concerned with custody and the healthcare system concerned with pathology. Each needs to function within their role and coordinate their functioning across systems.

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Psychiatric Disorders

A delusional thought disorder is a psychiatric disorder of subtly and complexity. The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of thought and perception.

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A Factitious Disorder Imposed on Another (i.e., a factitious attachment pathology imposed on the child by the pathogenic parenting of the allied parent) is a psychiatric disorder of subtly and complexity (DSM-5 300.19).

Attachment pathology is a developmental psychopathology created by pathogenic parenting. Diagnosing the cause of attachment pathology requires a high level of professional understanding.

Professional competence in the diagnostic assessment of psychopathology is essential when conducting a diagnostic assessment of psychopathology. Diagnosis is not done at trial. Diagnoses are made through clinical evaluations by licensed professionals who are

educated and trained for the task.

When the child is displaying severe attachment pathology (i.e., developmental psychopathology) surrounding court-involved custody conflict, two social systems are involved, 1) the legal system applying the legal statutes to the evidence to reach a decision on the child's custody and visitation schedule, and regarding possible child protection needs, and 2) the health care system applying diagnostic criteria to the symptom evidence to reach a diagnosis and treatment plan to fix the problem (pathology) in the family, with professional duty to protect obligations.

The two systems must work together, each to their role, education, training, and specialization, to reach an accurate diagnosis and effective treatment plan to restore the child's normal-range and healthy development.

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

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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 ☐ yes ☐ no

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?

- **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."

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Failure to grasp this nettle risks cases being delayed and the costs of experts wasted. Effective case management can reduce the risk of delay and multiple hearings.

A clinical diagnostic risk assessment for possible child abuse to the differential diagnoses of concern can be completed within four to six weeks.

When child custody cases enter the courts and severe attachment pathology is part of the presentation, a proper risk assessment for child abuse should be routinely conducted as soon as possible to return a diagnosis to guide the Court's decision-making surrounding the child.

Participation in Child Abuse & Spousal Abuse

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The court should be mindful that a fact-finding hearing will only be required where it is relevant to the ultimate issues to be determined and where such a hearing is both necessary and proportionate. The court must be mindful that allegations of alienating behaviours are sometimes raised as a response to allegations of domestic abuse. The court must carefully examine what/why and when the allegations of alienating behaviours were first reported to be an issue.

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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
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- **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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Consider carefully what evidence the trial court will need by way of police disclosure, medical records, social work records, school records, telephone records. Try and ensure that orders for disclosure are as focused as possible on alleged alienating behaviours and their impacts on the child. The court may wish to review the evidence disclosed by third parties at a further case management hearing to ensure that the trial court has before it all necessary and relevant evidence, proportionate to the issues. If a course of conduct is alleged then critically examine the period, and the events likely to be relevant to disclosure. The court should be mindful that a child may be impacted by exposure to events that took place a long time ago. The significance of an event may become greater, not lesser, over the passage of time.

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Schedules of findings sought - where domestic abuse and controlling and coercive behaviours are alleged, PD12J governs the proceedings. It will be usual to invite both sides to consider what findings they are seeking against the other and for the court to consider the relevance of those to the issues in the case before directing a fact-finding hearing. Schedules of findings sought may be appropriate. Where a pattern of behaviours is relied upon the court may direct a narrative statement alongside a summary of the types of behaviours alleged, the period over which they occurred and the impact on parent and child, and may choose 'sample' elements to be tried to evidence the pattern alleged.

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.

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
- DSM-5 diagnostic system - American Psychiatric Association

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In order to consider and determine whether alienating behaviours are a factor and have impacted the adult/child relationship, the court should consider a parent's assertions of the same at the earliest opportunity with reference to the chronology of the parent child relationship and any alternative possible causes of the breakdown.

In all cases of severe attachment pathology displayed by the child surrounding court-involved custody conflict, a proper risk 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?

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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),

> **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."

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List a pre-trial review to consider the evidence.

What interim orders, if any, should be made in relation to the child's relationship with the non-resident parent whom the child is rejecting?

A clinical diagnostic risk assessment for child abuse to the appropriate differential diagnosis can be returned in four to six weeks.

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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Fact-finding Hearings

Alienating behaviours present themselves on a spectrum with varying impact on individual children, and the appraisal of this requires a nuanced and holistic assessment. The court's role is to analyse the behaviour of the adults in the context of the children's unique experiences, their resilience and vulnerability. The court should remain mindful that for an allegation of alienating behaviours to be made out, all three elements must be established.

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.

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.

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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:

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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
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Default Findings

The court must be cautious when invited to agree a default finding that a parent who fails to establish allegations of domestic abuse or abuse of the child has therefore engaged in alienating behaviour. The absence of an alternative explanation does not lead automatically to an explanation in terms of alienation. The court must remain alive to the distinction between a parent who is opposed to contact, and a child who is implacably opposed to contact; a parent who is engaging in alienating behaviour and children who have aligned themselves with a parent or sibling or are demonstrating an attachment strategy. Failed or false allegations of abuse against a non-resident parent will not constitute alienating behaviour unless there is evidence that the subject child has been manipulated (on the basis of those false/failed allegations) into an unjustified resistance or reluctance to engage with the allegedly abusive parent.

Standards of Professional Practice

These are personal opinions that are not based on the application of any professional knowledge from any domain of professional psychology.

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Differential Diagnosis for Targeted Parent:

Targeted Parent Abusive: Is the targeted parent abusing the ☐ yes ☐ no

child in some way, thereby creating the child's attachment pathology toward that parent?

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

- Child Physical Abuse (V995.54) ☐ yes ☐ no
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Family Systems Pathology

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Next steps

Where the court has made findings of any form of abuse, including, but not limited to, domestic abuse, sexual violence or alienating behaviours, the court will need to consider whether further or other evidence is needed for the court to conduct a proper welfare evaluation.

Diagnosis guides Treatment

If the diagnosis is child abuse, 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.

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The court must not direct the instruction of an expert unless such evidence is both necessary and proportionate to the issues under consideration. The court must consider the type of expert evidence required, always remembering that 'alienation' is not a syndrome capable of being diagnosed. The use of an expert at this stage would be to help the court decide on welfare outcomes. Separate guidance has been prepared to assist the court on the appointment of experts and welfare outcomes.

Standards of Professional Practice

The construct of "alienation" cannot be diagnosed because it is not a real thing, it is a made-up pathology with no agreed upon definition.

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<u>Costs</u>

The costs of an expert will be considerable. Where the child has been joined as a party (as will usually be the case) all parties will be required to contribute to the costs, save where the court conducts an assessment of each parties' means and concludes that the adult parties are unable to contribute by reason of their impecuniosity.

A clinical diagnostic risk assessment could be conducted in approximately four to six weeks for a cost of around $2,500 USD – or for around $5,000 USD with a concurrent second opinion. With one assessing professional and two consultants (one hired by each party), the cost would be around $7,500 USD (dependent on the costs to the respective parties for the expertise of the consultants).

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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).