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Diagostic Questions to be Answered by Mental Health Assessment Surrounding Child Custody Conflict

To: Parents, attorneys, & mental health professionals

From: Craig Childress, Psy.D.

Re: Diagnostic questions for court-involved custody conflict

When a child rejects a parent surrounding court-involved custody conflict, that is an attachment pathology, i.e., a problem in the love and bonding system of the brain. 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, the diagnostic question to be answered is which parent? 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 diagnosis for each parent.

Risk Assessment

All mental health professionals have duty to protect obligations which become active whenever there is concern for any of three dangerous pathologies, suicide, homicide, or abuse (child, spousal, or elder abuse), and they must conduct a proper risk assessment or ensure that a proper risk assessment be conducted for the danger of concern. 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.

The diagnostic concerns surrounding severe attachment pathology displayed by the child in the context of court-involved child custody conflict is child abuse range parenting by one parent or the other.

- **Child Abuse by Targeted Parent:** Either the targeted parent is abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a two-person attribution of causality).
- **Child Abuse by Allied Parent:** Or the allied parent is 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 secondary gain to the allied parent of manipulating the court's decisions regarding child custody, and to meet the parent's own emotional and psychological needs.

Whenever a child displays severe attachment pathology surrounding child custody conflict, a proper risk assessment for possible child abuse needs to be conducted to the appropriate differential diagnosis for each parent, and the duty to protect obligations are

likely active for all involved mental health professionals, including the currently involved treatment providers.

Clinical Pathology: Possible Persecutory Thought Disorder

The first Rule-Out (R/O)[1] diagnosis is possible child abuse by the targeted parent. If the abuse allegations toward the targeted parent are either 1) not credible, or 2) the outcome findings from a Child Protective Services investigation do not find the abuse allegations against the targeted parent to be supported (i.e., child abuse by the targeted parent is ruled-out), then the differential diagnosis for the child's expressed pathology becomes the potentially distorted and abusive range parenting of the allied parent by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the parent.

If child abuse by the targeted parent is ruled out from a proper risk assessment, then the following DSM-5 diagnoses relative to the allied parent are of concern and should receive a proper risk assessment from the involved mental health professionals:

1. Rule-Out (R/O) V995.51 Child Psychological Abuse, allied parent perpetrator by creating an induced persecutory delusion and factitious attachment pathology in the child for secondary gain to the allied parent.

2. R/O V995.82 Spouse or Partner Abuse, Psychological, using induced pathology in the child as the weapon.

The American Psychiatric Association provides the following definition of a persecutory delusion:

> **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)

In the journal *Family Court Review*, Walters & Friedlander (2016)[2] describe the shared persecutory delusion that often appears in court-involved child custody conflicts,

> **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."

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[1] A Rule-Out (R/O) diagnosis means a considered diagnostic possibility needing further assessment for ruling-in or ruling-out the diagnosis.

[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: "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 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?"

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."

In all cases of court-involved custody conflict, I recommend that a proper risk assessment for child abuse be conducted with the family to the appropriate differential diagnosis for each parent, that will yield accurate answers to the following diagnostic questions:

Targeted Parent Abusive: Is the targeted parent in the family 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

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

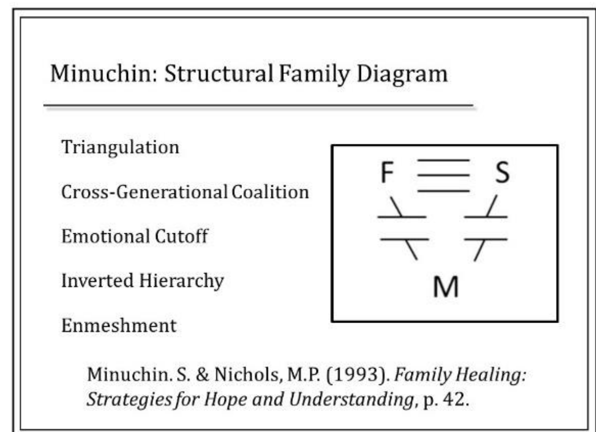
[3] Martin DC. The Mental Status Examination. In: Walker HK, Hall WD, Hurst JW, editors. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Boston: Butterworths; 1990. Chapter 207. Available from: https://www.ncbi.nlm.nih.gov/books/NBK320/

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

- **Persecutory Delusion (shared):** Does the allied parent in the family 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 in the family using the child's induced pathology as a weapon of spousal emotional and psychological abuse of the other parent (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)? ☐ yes ☐ no

Family Systems Pathology

The family systems pathology of concern is the child's possible *triangulation* into the spousal conflict through the formation of a *cross-generational coalition* with the allied parent against the targeted parent, resulting in an *emotional cutoff* in the child's attachment bond to the targeted parent. This family relationship pattern is depicted in a structural family diagram from Minuchin and Nichols (1993).[4] This diagram depicts a cross-generational coalition of a father and son against the mother, resulting in an emotional cutoff in the child's attachment bond to the mother.



Triangulation

The term *triangulation* refers to the child being placed 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 triangular pattern of family relationships is clearly evident in the Minuchin-Nichols diagram. The Bowen Center for Study of the Family[5] describes the construct of triangles within families.

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

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

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 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.” (Bowen Center for Study of the Family)

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. Cloe Madanes (2018),[6] the co-founder of Strategic family systems therapy, 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 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). The grandparent may side the grandchild against a parent. An aunt might side with the niece against her mother. A husband might join his mother against the wife. 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)

Jay Haley (co-founder of the *Strategic* school of family systems therapy), provides the professional definition of a cross-generational coalition:

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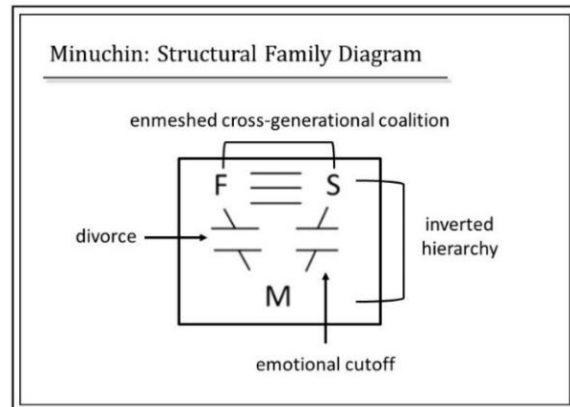
[6] Madanes, C. (2018). Changing relationships: Strategies for therapists and coaches. Phoenix, AZ: Zeig, Tucker, & Theisen, Inc.

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)[7]

Emotional Cutoff

The family systems construct of an *emotional cutoff* (Bowen, 1978; Titelman, 2003)[8] refers to any full-scale breach in a family bond. The child's loyalty to a pathological parent in a cross-generational coalition against the other parent (Haley, 1977; Madanes, 2018) leads to an emotional cutoff in the child's attachment bond to the targeted parent. In the Minuchin-Nichols structural family diagram, the emotional cutoff between the child and parent is depicted as the broken bonding line between the child and the mother, while the broken bonding line between the father and mother represents the divorce.



Inverted Hierarchy

An *inverted hierarchy* is 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 psychological boundary dissolution with the child (i.e., a fused psychological state), and the parent's use of psychological control to manipulate the child to the parent's desired ends. The construct of enmeshed relationships within families is described by Minuchin (1974),

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

[8] 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.

> **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).[9]

Writing in the *Journal of Emotional Abuse*, Kerig (2005)[10] identifies the enmeshed parent-child relationship as a psychological boundary dissolution between the parent and child, and describes the impact of an enmeshed relationship with one parent on the child's relationship with the other parent,

> **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)

Stone Buehler, and Barber (2002)[11] link the family systems constructs of triangulation, cross-generational coalitions, and enmeshment, with parental psychological control of the child.

> **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

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

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

[11] 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.

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).

Based on the clinical concerns surrounding court-involved custody conflict, the following diagnostic questions regarding possible family systems pathology need to be answered by the involved mental health professionals:

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 allied parent against the targeted parent in the family? ☐ yes ☐ no
- **Emotional Cutoff:** Is there an emotional cutoff between the child and the targeted parent in the family (a full breech to the parent-child bond)? ☐ 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 allied parent and child have an enmeshed relationship? ☐ yes ☐ no

Psychological Control of the Child

As described previously by Stone Buehler, and Barber (2002), the pathogenic parenting of concern is the possible psychological control of the child by a highly problematic parent. 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*,[12] 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)[13] define the construct of parental psychological control of the child:

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

[13] 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.

> **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)

Stone, Bueler, and Barber (2002) distinguish between parental psychological and behavioral control of the child,

> **From 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)[14] describe the various methods used to achieve parental psychological control of the child:

> **Soenens & 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)

Diagnosis Guides Treatment

In all of healthcare, diagnosis guides treatment (the treatment for cancer is different than the treatment for diabetes). The term diagnosis means exactly the same thing as identify, the term pathology means the same thing as problem, and treatment means the same thing as 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. It is the professional obligation of all involved mental health professionals to accurately diagnose (identify) the pathology (problem) so that an effective treatment plan can be developed to fix the problem (pathology).

The diagnostic process and the role of consultation is described by the National Academy of Sciences in *Improving Diagnosis in Healthcare* (2015),[15]

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[14] 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.

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 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."

Professional 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. Furthermore, when the pathology is also the spousal psychological 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

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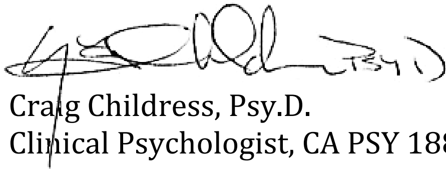
[15] *Improving Diagnosis in Healthcare* (2015). National Academies of Sciences, Engineering, and Medicine; Institute of Medicine; Board on Health Care Services. Available from: https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWElqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI

participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

Documentation of Symptoms

Diagnosis is a pattern-match of symptoms to diagnostic criteria. To accurately diagnose (identify) the problem (pathology), begin by documenting the symptoms with clarity. For the purposes of clarity in diagnosis, I recommend that the clinical opinions of the involved mental health professional regarding the parenting practices of the targeted parent be documented using the *Parenting Practices Rating Scale* (Appendix 1), and that the child's symptoms be clearly identified for diagnostic purposes using the *Diagnostic Checklist for Pathogenic Parenting* (Appendix2) for all cases of court-involved custody conflict involving severe attachment pathology displayed by the child. The pattern of symptoms recorded in these two symptom documentation instruments will accurately identify (diagnose) pathogenic parenting by the allied parent 100% of the time when that problem (pathology) is present and will never misidentify the pathology as being present when it is not. In all cases of court-involved custody conflict involving severe attachment pathology, I recommend that the symptom documentation instruments of the *Diagnostic Checklist for Pathogenic Parenting* and *Parenting Practices Rating Scale* be routinely collected.



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Appendix 1: Parenting Practices Rating Scale

Parenting Practices Rating Scale

C.A Childress, Psy.D. (2016)

Name of Parent: ______________________________ Date: ______________

Indicate all that apply. Do not indicate child abuse is present unless allegations have been confirmed. In cases of abuse allegations that have neither been confirmed nor disconfirmed, or that are unfounded, use Allegation subheading rating not Category rating.

Level 1: Child Abuse

☐ **1. Sexual Abuse**

As defined by legal statute.

- ☐ Allegation: Neither confirmed nor disconfirmed
- ☐ Allegation: Unfounded

☐ **2. Physical Abuse**

Hitting the child with a closed fist; striking the child with an open hand or a closed fist around the head or shoulders; striking the child with sufficient force to leave bruises; striking the child with any instrument (weapon) such as kitchen utensils, paddles, straps, belts, or cords.

- ☐ Allegation: Neither confirmed nor disconfirmed
- ☐ Allegation: Unfounded

☐ **3. Emotional Abuse**

Frequent verbal degradation of the child as a person in a hostile and demeaning tone; frequent humiliation of the child.

- ☐ Allegation: Neither confirmed nor disconfirmed
- ☐ Allegation: Unfounded

☐ **4. Psychological Abuse**

Pathogenic parenting that creates significant psychological or developmental pathology in the child in order to meet the emotional and psychological needs of the parent, including a role-reversal use of the child as a regulatory object for the parent's emotional and psychological needs.

- ☐ Allegation: Neither confirmed nor disconfirmed
- ☐ Allegation: Unfounded

☐ **5. Neglect**

Failure to provide for the child's basic needs for food, shelter, safety, and general care.

- ☐ Allegation: Neither confirmed nor disconfirmed
- ☐ Allegation: Unfounded

☐ **6. Domestic Violence Exposure**

Repeated traumatic exposure of the child to one parent's violent physical assaults toward the other parent or to the repeated emotional degradation (emotional abuse) of the other parent.

- ☐ Allegation: Neither confirmed nor disconfirmed
- ☐ Allegation: Unfounded

Level 2: Severely Problematic Parenting

☐ 7. **Overly Strict Discipline**
Parental discipline practices that are excessively harsh and over-controlling, such as inflicting severe physical discomfort on the child through the use of stress postures, using shaming techniques, or confining the child in an enclosed area for excessively long periods (room time-outs are not overly strict discipline).

☐ 8. **Overly Hostile Parenting**
Frequent displays (more days than not) of excessive parental anger (6 or above on a 10-point scale).

☐ 9. **Overly Disengaged Parenting**
Repeated failure to provide parental supervision and/or age-appropriate limits on the child's behavior and activities; parental major depression or substance abuse problems.

☐ 10. **Overly Involved-Intrusive Parenting**
Enmeshed, over-intrusive, and/or over-anxious parenting that violates the psychological self-integrity of the child; role-reversal use of the child as a regulatory object for the parent's anxiety or narcissistic needs.

☐ 11. **Family Context of High Inter-Spousal Conflict**
Repeated exposure of the child to high inter-spousal conflict that includes excessive displays of inter-spousal anger.

Level 3: Problematic Parenting

☐ 12. **Harsh Discipline**
Excessive use of strict discipline practices in the context of limited displays of parental affection; limited use of parental praise, encouragement, and expressions of appreciation.

☐ 13. **High-Anger Parenting**
Chronic parental irritability and anger and minimal expressions of parental affection.

☐ 14. **Uninvolved Parenting**
Disinterested lack of involvement with the child; emotionally disengaged parenting; parental depression.

☐ 15. **Anxious or Over-Involved Parenting**
Intrusive parenting that does not respect interpersonal boundaries.

☐ 16. **Overwhelmed Parenting**
The parent is overwhelmed by the degree of child emotional-behavioral problems and cannot develop an effective response to the child's emotional-behavioral issues.

☐ 17. **Family Context of Elevated Inter-Spousal Conflict**
Chronic child exposure to moderate-level inter-spousal conflict and anger or intermittent explosive episodes of highly angry inter-spousal conflict (intermittent spousal conflicts involving moderate anger that are successfully resolved are normal-range and are not elevated inter-spousal conflict).

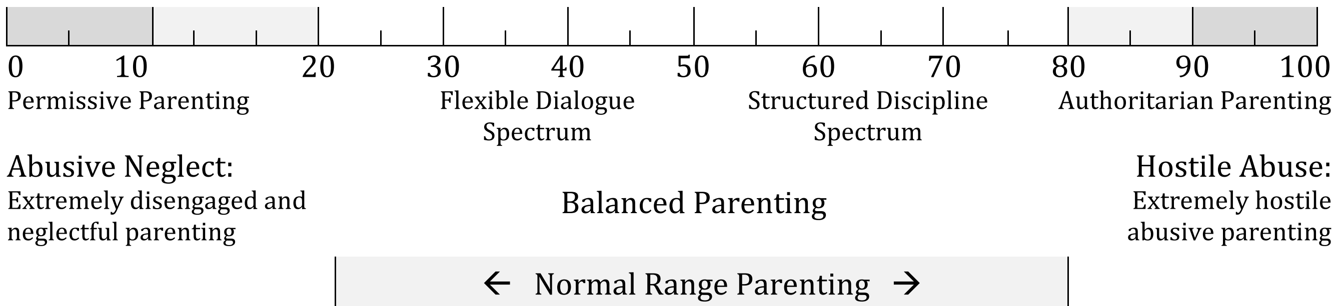
Level 4: Positive Parenting

☐ 18. **Affectionate Involvement – Structured Spectrum**
Parenting includes frequent displays of parental affection and ***clearly structured*** rules and expectations for the child's behavior. Appropriate discipline follows from clearly defined and appropriate rules.

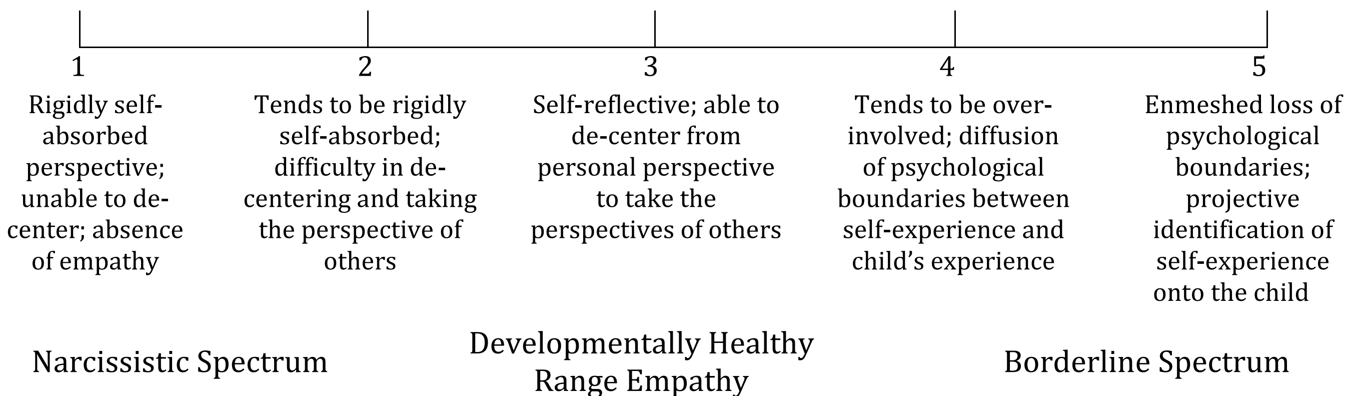
☐ 19. **Affectionate Involvement – Dialogue Spectrum**
Parenting includes frequent displays of parental affection and ***flexibly negotiated*** rules and expectations for the child's behavior. Parenting emphasizes dialogue, negotiation, and flexibility.

☐ 20. **Affectionate Involvement – Balanced**
Parenting includes frequent displays of parental affection and parenting effectively balances structured discipline with flexible parent-child dialogue.

Permissive to Authoritarian Dimension Rating: _______________



Capacity for Authentic Empathy Rating: _____________



Parental Issues of Clinical Concern (CC)

☐ CC 1: Parental schizophrenia spectrum issues

Stabilized on medication? ☐ Yes ☐ No ☐ Variable

☐ CC 2: Parental bipolar spectrum issues

Stabilized on medication? ☐ Yes ☐ No ☐ Variable

☐ CC 3: Parental major depression spectrum issues (including suicidality)

Stabilized by treatment? ☐ Yes ☐ No ☐ Variable

☐ CC 4: Parental substance abuse issues

Treated and in remission (1 yr)? ☐ Yes ☐ No ☐ Variable

☐ CC 5: Parental narcissistic or borderline personality disorder traits

In treatment? ☐ Yes ☐ No ☐ Variable

☐ CC 6: Parental history of trauma

Treated or in treatment? ☐ Yes ☐ No ☐ Variable

Appendix 2: Diagnostic Checklist for Pathogenic Parenting

Diagnostic Checklist for Pathogenic Parenting: Extended Version

C.A. Childress, Psy.D. (2015)

All three of the diagnostic indicators must be present (either 2a OR 2b) for a clinical diagnosis of pathogenic parenting and Child Psychological Abuse (DSM-5 V995.51. Sub-threshold clinical presentations can be further evaluated using a "Response to Intervention" trial.

1. Attachment System Suppression

Present	Sub-threshold	Absent	
☐	☐	☐	The child's symptoms evidence a selective and targeted suppression of the normal-range functioning of the child's attachment bonding motivations toward one parent, the targeted-rejected parent, in which the child seeks to terminate a relationship with this parent (i.e., a child-initiated cutoff in the child's relationship with a normal- range and affectionally available parent).

Secondary Criterion: **Normal-Range Parenting:**

yes	no	
☐	☐	The parenting practices of the targeted-rejected parent are assessed to be broadly normal-range, with due consideration given to the wide spectrum of acceptable parenting that is typically displayed in normal-range families.

Normal-range parenting includes the legitimate exercise of parental prerogatives in establishing desired family values through parental expectations for desired child behavior and normal-range discipline practices.

2(a). Personality Disorder Traits

Present	Sub-threshold	Absent	
☐	☐	☐	The child's symptoms evidence all five of the following narcissistic personality disorder features displayed toward the targeted-rejected parent.

Sub-Criterion Met

yes	no	
☐	☐	**Grandiosity:** The child displays a grandiose perception of occupying an inappropriately elevated status in the family hierarchy that is above the targeted-rejected parent from which the child feels empowered to sit in judgment of the targeted-rejected parent as both a parent and as a person.
☐	☐	**Absence of Empathy:** The child displays a complete absence of empathy for the emotional pain being inflicted on the targeted-rejected parent by the child's hostilityand rejection of this parent.
☐	☐	**Entitlement:** The child displays an over-empowered sense of entitlement in which the child expects that his or her desires will be met by the targeted-rejected parent tothe child's satisfaction, and if the rejected parent fails to meet the child's entitled expectations to the child's satisfaction then the child feels entitled to enact a retaliatory punishment on the rejected parent for the child's judgment of parental failures
☐	☐	**Haughty and Arrogant Attitude:** The child displays an attitude of haughtyarrogance and contemptuous disdain for the targeted-rejected parent.
☐	☐	**Splitting:** The child evidences polarized extremes of attitude toward the parents, inwhich the supposedly "favored" parent is idealized as the all-good and nurturing parent while the rejected parent is entirely devalued as the all-bad and entirely inadequate parent.

2(b). Phobic Anxiety Toward a Parent

Present	Sub-threshold	Absent	
☐	☐	☐	The child's symptoms evidence an extreme and excessive anxiety toward the targeted-rejected parent that meets the following DSM-5diagnostic criteria for a specific phobia:

Criterion Met yes	no	
☐	☐	**Persistent Unwarranted Fear**: The child displays a persistent and unwarranted fearof the targeted-rejected parent that is cued either by the presence of the targeted parent or in anticipation of being in the presence of the targeted parent
☐	☐	**Severe Anxiety Response:** The presence of the targeted-rejected parent almost invariably provokes an anxiety response which can reach the levels of a situationally provoked panic attack.
☐	☐	**Avoidance of Parent:** The child seeks to avoid exposure to the targeted parent due to the situationally provoked anxiety or else endures the presence of the targeted parent with great distress.

3. Fixed False Belief

Present	Sub-threshold	Absent	
☐	☐	☐	The child's symptoms display an intransigently held, fixed and false belief maintained despite contrary evidence (a delusion) regarding thechild's supposed "victimization" by the normal-range parenting of the targeted-rejected parent (an encapsulated persecutory delusion). The child's beliefs carry the implication that the normal-range parenting ofthe targeted-rejected parent are somehow "abusive" toward the child. The parenting practices of the targeted-rejected parent are assessed to be broadly normal-range.

DSM-5 Diagnosis:

If the three Diagnostic Indicators are present in the child's symptom display (either 2a or 2b), the appropriate DSM-5 diagnosis is:

- 309.4 Adjustment Disorder with mixed disturbance of emotions and conduct
- V61.03 Disruption of Family by Separation or Divorce
- V61.20 Parent-Child Relational Problem
- V61.29 Child Affected by Parental Relationship Distress
- V995.51 Child Psychological Abuse, Confirmed (pathogenic parenting; shared persecutory delusion)
- R/O 300.19 Factitious Disorder Imposed on Another (delusional thought disorder and false attachment pathology for secondary gain to the parent)
- R/0 V995.82 Spouse or Partner Abuse, Psychological (allied parent perpetrator using the child as the weapon)

Checklist of Associated Clinical Signs (ACS)

evident	not evident			
☐	☐	ACS 1: Use of the Word “Forced”		
☐	☐	ACS 2: Enhancing Child Empowerment to Reject the Other Parent		
		evident	not evident	
		☐	☐	“Child should decide on visitation”
		☐	☐	“Listen to the child”
		☐	☐	Advocating for child testimony
☐	☐	ACS 3: The Exclusion Demand		
☐	☐	ACS 4: Parental Replacement		
☐	☐	ACS 5: The Unforgivable Event		
☐	☐	ACS 6: Liar – “Fake”		
☐	☐	ACS 7: Themes for Rejection		
		evident	not evident	
		☐	☐	Too Controlling
		☐	☐	Anger management
		☐	☐	Targeted parent doesn’t apologize or take responsibility
		☐	☐	New romantic relationship neglects the child
		☐	☐	Prior neglect of the child by the parent
		☐	☐	Vague personhood of the targeted parent
		☐	☐	Non-forgivable grudge
		☐	☐	Not feeding the child
☐	☐	ACS 8: Unwarranted Use of the Word “Abuse”		
☐	☐	ACS 9: Excessive Texting, Phone Calls, and Emails		
☐	☐	ACS 10: Role-Reversal Use of the Child (“It’s not me, it’s the child who…”)		
☐	☐	ACS 11: Targeted Parent “Deserves” to be Rejected		
☐	☐	ACS 12: Allied Parent Disregards Court Orders and Court Authority		
		evident	not evident	
		☐	☐	Child disregard of court orders for custody
		☐	☐	Child runaway behavior from the targeted parent