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The question posed:

> Is there research available that proves the statement that children, once removed from the alienating parent and placed with the targeted parent, recover soon?

Answer 1: The DSM-5 diagnosis for the pathology is V995.51 Child Psychological Abuse,[1] Confirmed. No discussion about separating the child is initiated without a confirmed DSM-5 diagnosis of V995.51 Child Psychological Abuse.

> The question then becomes, is there research evidence that proves that children, once removed from a psychologically abusive parent, recover normal-range development soon?

That question is based on the premise that there is ever a reason to leave a child with a psychologically abusive parent. We never abandon children to child abuse.

If there is a confirmed DSM-5 diagnosis of V995.51 Child Psychological Abuse made by a mental health professional, this becomes a child protection issue. We never leave the child with an abusive parent.

Answer 2: The presence of Diagnostic Indicator 3 (an encapsulated persecutory delusion evidenced by the child) represents the diagnostic evidence of a shared delusional pathology with the allied parent. The diagnosis of shared delusional pathology is recognized by the ICD-10 and by the DSM-IV TR.[2]

The description of the shared delusional pathology provided by the American Psychiatric Association is:

> **From the APA:** "The essential features of Shared Psychotic Disorder (Folie a Deux) is a delusion that develops in an individual who is involved in a close relationship with another person (sometimes termed the "inducer" or "primary case") who already has a Psychotic Disorder with prominent delusions (Criteria A)" (American Psychiatric Association, 2000, p. 332)[3]

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[1] Pathogenic parenting that is creating significant developmental pathology in the child (diagnostic indicator 1), personality disorder pathology in the child (diagnostic indicator 2), and delusional-psychiatric pathology in the child (diagnostic indicator 3) is a DSM-5 diagnosis of V995.51 Child Psychological Abuse.

[2] The DSM-5 discontinued the shared delusional disorder as a separate category and instead incorporated a shared delusion as a qualifier of the delusional disorder category. The shared delusional disorder remains a diagnosis in the ICD-10 diagnostic system of the World Health Organization: Shared Psychotic Disorder F24.

[3] Regarding the psychotic disorder of the parent with prominent delusions, see Millon's discussion of the psychotic collapse of the narcissistic personality: Appendix 1.

> **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. Individuals who come to share delusional beliefs are often related by blood or marriage and have lived together for a long time, sometimes in relative isolation." (American Psychiatric Association, 2000, p. 333)
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> **From the APA:** "If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear." (American Psychiatric Association, 2000, p. 333)
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> **From the APA:** "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, p. 333)
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> **From the APA:** "Without intervention, the course is usually chronic, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. With separation from the primary case, the individual's delusional beliefs disappear, sometimes quickly and sometimes quite slowly." (American Psychiatric Association, 2000, p. 333)

It is prima facie evident that if one parent is "the inducer" of delusional pathology in the child, then separating the child from the inducer of the pathology will eliminate the child's induced pathology.

> From Cornell University Law School: "Prima facie may be used as an adjective meaning "sufficient to establish as a fact or raise a presumption unless disproved or rebutted."

Separation of the child from "the inducer" is also indicated in two treatment related statements made by the American Psychiatric Association:

> **From the APA:** "If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear." (American Psychiatric Association, 2000, p. 333)
>
> **From the APA:** "With separation from the primary case, the individual's delusional beliefs disappear, sometimes quickly and sometimes quite slowly." (American Psychiatric Association, 2000, p. 333)

Answer 3: It is 100% guaranteed that leaving a child with an abusive parent will <u>not</u> resolve the impact of the child abuse on the child. That again should be prima facie self-evident, that leaving the child with an abusive parent will never be expected to resolve the impact of the child abuse on the child. Leaving the child with an abusive parent is NOT the treatment for child abuse.

So the question is asking, "What is the research evidence proving that separating a child from an abusive parent resolves the impact of the child abuse?" I would reverse that question and ask what is the research evidence to prove that leaving the child with an abusive parent resolves the impact of the child abuse.

There is zero research on either side because no one ever thought that there would need to be research proving that separating children from abusive parents is a good thing. There is zero reason to believe that leaving the child with an abusive parent will resolve the impact of the child abuse on the child, and there is zero research proving that leaving the child with an abusive parent will resolve the child's pathology created by the child abuse.

So at this point, there is zero research evidence on either response option. So let's conduct the research.

Do we leave the child with the abusive parent and measure how soon the child's symptoms resolve when left with a psychologically abusive parent who is creating the child's pathology? Or do we separate the child from the psychologically abusive parent and measure how long it takes for the recovery of the child's normal-range and healthy development?

Let's do the research. Which do we start with, leaving the child with an abusive parent or separating the child from the abusive parent, to see which one of these response options resolves the child's symptoms?

I would recommend that we start with separating the child from the abusive parent and measure outcome, and this is the single-case ABAB research design I suggest in my booklet, Single Case ABAB Assessment and Remedy. I would also suggest, pursuant to Answer 1, that we never leave the child with an abusive parent. It is a child protection issue. The single case ABAB research protocol offers a scientifically based treatment option for the court's consideration regarding the assessment and resolution of attachment-related family pathology.

Separation of the child from a parent is always based on a confirmed DSM-5 diagnosis of V995.51 Child Psychological Abuse made by a knowledgeable mental health professional, based on the following operationalized definition for the diagnosis of Child Psychological Abuse:

> Pathogenic parenting that is creating significant developmental pathology in the child (attachment system suppression; diagnostic indicator 1), personality disorder pathology in the child (five narcissistic personality disorder traits; diagnostic indicator 2), and delusional-psychiatric pathology in the child (an encapsulated persecutory delusion; diagnostic indicator 3) represents a DSM-5 diagnosis of V995.51 Child Psychological Abuse, Confirmed.

The DSM-5 diagnosis of V995.51 Child Psychological Abuse is not based on a theoretical model, it is based solely on the symptoms evidenced by the child. An underlying attachment-based description of the pathology provides the foundations for understanding

the causal origins and symptom expressions of the pathology, but the DSM-5 diagnosis of Child Psychological Abuse is based solely on the child's symptom display.

And all decisions regarding separation are based on a confirmed DSM-5 diagnosis of V995.51 Child Psychological Abuse made by a knowledgeable mental health professional, documented using the Diagnostic Checklist for Pathogenic Parenting for the child's symptoms and the Parenting Practices Rating Scale regarding the targeted parent. The knowledge base necessary for the assessing mental health professional is the foundational work of attachment (Bowby; Ainsworth; Sroufe; Fonagy; Stern), personality disorder pathology (Beck; Kernberg; Millon; Linehan), and family systems therapy (Minuchin, Haley, Bowen, Madanes). This is the professional knowledge base required for professional competence in the assessment, diagnosis, and treatment of attachment related family pathology surrounding divorce.

There is no research until we do the research. The AB-PA pilot program for the Houston family courts will be doing the research. We invite other pilot program and research collaborators. The goal and mission of the AB-PA pilot program for the family courts is to provide the family court system with the highest caliber of professional knowledge and standards of practice surrounding court-involved assessment, diagnosis, and treatment of attachment related family pathology surrounding divorce.

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Appendix 1

Theordore Millon: The Psychotic Collapse of the Narcissistic Personality

Millon. T. (2011). Disorders of personality: introducing a DSM/ICD spectrum from normal to abnormal. Hoboken: Wiley.

From Millon:

"Under conditions of unrelieved adversity and failure, narcissists may decompensate into *paranoid* disorders. Owing to their excessive use of fantasy mechanisms, they are disposed to misinterpret events and to construct *delusional* beliefs. Unwilling to accept constraints on their independence and unable to accept the viewpoints of others, narcissists may isolate themselves from the corrective effects of shared thinking. Alone, they may ruminate and weave their beliefs into a network of fanciful and totally *invalid suspicions*. Among narcissists, *delusions* often take form after a serious challenge or setback has upset their image of superiority and omnipotence. They tend to exhibit compensatory grandiosity and jealousy *delusions* in which they *reconstruct reality* to match the image they are unable or unwilling to give up. *Delusional* systems may also develop as a result of having felt betrayed and humiliated. Here we may see the rapid unfolding of *persecutory delusions* and an arrogant grandiosity characterized by verbal attacks and bombast." (Millon, 2011, pp. 407-408; emphasis added).

"Deficient in social controls and self-discipline, the tendency of CEN narcissists to *fantasize* and *distort* may speed up. The air of grandiosity may become more flagrant. They may find hidden and deprecatory meanings in the incidental behavior of others, becoming *convinced of others malicious motives*, claims upon them, and attempts to undo them. As their behaviors and thoughts *transgress the line of reality*, their alienation will mount, and they may seek to protect their phantom image of superiority more vigorously and vigilantly than ever… *No longer in touch with reality*, they begin to accuse others and hold them responsible for their own shame and failures. They may build a "logic" based on irrelevant and entirely circumstantial evidence and ultimately construct a *delusion* system to protect themselves from unbearable reality." (Millon, 2011, p. 415; emphasis added)