Dr. Childress Specialized Expertise

I have six domains of specialized expertise supported by my vita that are directly relevant to the pathology in the family courts (a child rejecting a parent), 1) the attachment system and attachment pathology, 2) delusional thought disorders, 3) child abuse and complex trauma, 4) factitious disorder imposed on another (FDIA), 5) family systems pathology, and 6) court-involved custody confict.

1. Attachment Pathology

A child rejecting a parent is an attachment pathology, i.e., a problem in the love-and-bonding system of the brain, the attachment system.

I have Early Childhood Mental Health specialization (ages 0-to-5) which is the domain of attachment formation. I received my initial training in Early Childhood Mental Health through Children's Hospital Los Angeles, and subsequent training from multiple sources. I am trained in two additional diagnostic systems in addition to the DSM-5 that are relevant to early childhood pathology, the DC:0-3 which is stronger in diagnosing attachment pathology, and the DMIC which is stronger in diagnosing autism-spectrum pathology. I am also trained in two early childhood attachment therapies, Watch, Wait, & Wonder for infants and Circle of Security for preschool age children, and I am Certified in Infant Mental Health through Fielding Graduate Institute.

Child development from ages zero-to-five is the domain of attachment bond formation, particularly during infancy (I am certified in Infant Mental Health from Fielding Graduate Institute). Since the pathology of a child rejecting a parent is an attachment pathology (a problem in love and bonding), I have directly relevant expertise in the attachment system and attachment pathology present in the family courts.

2. Delusional Thought Disorders

I received 12 years of annual training in the diagnostic assessment of delusional thought disorders using the *Brief Psychiatric Rating Scale* (BPRS), "one of the oldest, most widely used scales to measure psychotic symptoms" (Wikipedia BPRS) to r=.90 diagnostic reliability with the Co-Directors of the Diagnostic Unit at the Brentwood-UCLA VA, Dr Ventura and Dr. Lukoff, in my role with a major NIMH clinical research project on schizophrenia (PI: Keith Nuechterlein, Ph.D.). BPRS item 11 Unusual Thought Content is the rating for delusional thought disorders.

Based on 12 years of annual training in the diagnostic assessment of delusional thought disorders, I know what a delusional thought disorder looks like, and I know how to assess for a delusional thought disorder. The pathology of concern in the family courts is the collapse of a narcissistic-borderline-dark personality parent into persecutory delusions surrounding the triggering event of the divorce (i.e., spousal rejection activating a narcissistic injury and the abandonment fears in a vulnerable parent). It is established knowledge within professional psychology that narcissistic and borderline

pathology will collapse into persecutory delusions under stress. Millon (2011)[1] describes the collapse of the narcissistic personality into persecutory delusions, and Barnow et al. (2010) describe the persecutory thought disorders that develop in borderline personality pathology.

> **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." (p. 407-408).

> **From Barnow et al:** "This review reveals that psychotic symptoms in BPD patients may not predict the development of a psychotic disorder but are often permanent and severe and need careful consideration by clinicians. Therefore, adequate diagnosis and treatment of psychotic symptoms in BPD patients is emphasized... In conclusion, we therefore suggest that it is not a cognitive developmental deficit but rather a tendency to construe interpersonal relations as malevolent that characterizes BPD, and this may be shared with certain psychotic disorders." (p. 186-187)[2]

The American Psychiatric Association provides the definition of a persecutory delusion and describes how a shared (induced) persecutory delusion can develop "especially 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

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

[2] Barnow, S., Arens, E. A., Sieswerda, S., Dinu-Biringer, R., Spitzer, C., Lang, S., et al (2010). Borderline personality disorder and psychosis: a review. Current Psychiatry Reports, 12,186-195

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 presence of shared (induced) persecutory delusions surrounding child custody conflict in the family courts is acknowledged by Walters & Friedlander (2016)[3] in the journal, *Family Court Review*:

> **From Walters & Friedlander:** "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426)
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> **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 delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990),[4]

> **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."

I have the "considerable experience" necessary in the diagnostic assessment of delusional thought disorders from 12 years of annual training to r=.90 diagnostic

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[3] 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

[4] 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/

reliability to Drs. Ventura and Lukoff, the authors of the BPRS ("one of the oldest, most widely used scales to measure psychotic symptoms"), while with Dr. Nuechterlein's NIMH clinical research project on schizophrenia.

3. Child Abuse & Complex Trauma

Allegations of child abuse and "trauma" from problematic parenting are common allegations in court-involved custody cases, and the child's symptoms of rejecting a parent (i.e., a directional change in a primary motivational system) prominently implies abusive-range parenting by the targeted parent, with a differential diagnosis of child psychological abuse (DSM-5 V995.51) by the allied parent who is possibly 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.

I have direct professional experience in the diagnostic assessment and treatment of child abuse and complex trauma from my role as the Clinical Director for a three-university assessment and treatment center for children in foster care, with Child Protective Services as our primary referral source. I have personally treated all four forms of child abuse (physical, sexual, neglect, psychological), and I have personally led the treatment teams for all four forms of child abuse that have included CPS social worker involvement. I have substantial direct clinical experience with assessing, diagnosing, and treating child abuse and complex trauma.

4. Factitious Disorder Imposed on Another

The pathology of a Factitious Disorder Imposed on Another (FDIA: DSM-5 300.19) is an uncommon disorder with a characteristic progression in diagnosis. When community doctors cannot identify the cause of the problem (because there is no cause, it is a factitious disorder being imposed on the child), the community doctors will refer the pathology into higher levels of expertise. For medically related FDIA, the child's false pathology eventually reaches the upper levels of the child healthcare system, the local Children's Hospital.

When the physicians at the Children's Hospital suspect FDIA, they will ask for a consult from the Psychology Department at the hospital and a pediatric psychologist will be sent to make the diagnosis of FDIA (once medical causes have been ruled out). I received my pre-doctoral training and two years of post-doctoral training as a pediatric psychologist at Children's Hospital Los Angeles (CHLA), and I then served on medical staff at Children's Hospital Orange County (Choc) as a pediatric psychologist. I have been trained in the diagnostic assessment of FDIA and have clinical experience with the pathology.

The ICD-11 diagnostic system from the World Health Organization provides the following symptom criteria for a diagnosis of factitious disorder imposed on another (ICD-11 6D51):

From ICD-11 6D51 FDIA: "Factitious disorder imposed on another is characterised by feigning, falsifying, or inducing medical, psychological, or behavioural signs and symptoms or injury in another person, most commonly a child dependent, associated with identified deception."

From ICD-11 6D51 FDIA: "The individual seeks treatment for the other person or otherwise presents him or her as ill, injured, or impaired based on the feigned, falsified, or induced signs, symptoms, or injuries.

In the family courts, the allied parent is inducing psychological and behavioral signs and symptoms in a dependent child to deceive the court regarding the normal-range parenting of the targeted parent. The allied parent then presents the child to the court and to mental health professionals as supposedly being injured by the parenting of the normal-range targeted parent, and as having an impaired attachment bond to the normal-range targeted parent based on the induced signs and symptoms – i.e., an ICD-11 diagnosis of 6D51 FDIA, and a corresponding DSM-5 diagnosis of 300.19 FDIA.[5]

Secondary Gain: The potential secondary gain (rewards) to the allied parent for creating false pathology in the child include:

- Court Manipulation: manipulating the court's decisions regarding child custody in favor of the allied parent by deceiving the court regarding the (normal range) parenting of the other parent by creating false pathology in the child.
- Spousal Abuse: the spousal emotional and psychological abuse of the targeted parent using the child, and the child's induced pathology, as the spousal abuse weapon.[6]
- Regulatory Object: the pathological narcissistic-borderline-dark personality parent is using the child as a "regulatory object" to meet the allied parent's own emotional and psychological needs.

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[5] Diagnostic Note: the diagnosis of a shared (induced) persecutory delusion and FDIA would warrant the additional V-code diagnosis of V995.51 Child Psychological Abuse. From Wikipedia FDIA: "Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy); the diagnosis is assigned to the perpetrator; the person affected may be assigned an abuse diagnosis (e.g. child abuse)."

[6] Diagnostic Note: two dangerous pathologies are potentially involved in family court custody conflict 1) possible child psychological abuse by the allied parent creating a persecutory delusion and false (factious) attachment pathology in the child for secondary gain to the parent (V995.51 Child Psychological Abuse), and 2) possible spousal psychological abuse of the targeted parent by the allied (narcissistic-borderline-dark personality) parent using the child, and the child's induced pathology, as the spousal abuse weapon.

5. **Family Systems**

   Pepperdine University, where I received my doctoral education, offered two specialty training tracks from four available options (psychoanalytic, cognitive-behavioral, humanistic-existential, family systems). I received specialty training in Family Systems Therapy from Pepperdine's doctoral program and have worked from a family systems framework throughout my career as a child and family therapist. I am trained and experienced in Bowenian family therapy (Bowen), Structural family therapy (Minuchin), Strategic family therapy (Madanes, Haley), Family of Origin therapy (Framo), and Contextual family therapy (Boszormenyi-Nagy).[7] I also note on my vita the three-day training at the Bowen Center for Study of the Family in 2019 regarding Emotional Cutoffs (i.e., a full breach in a family bond).

6. **Court-involved Custody Conflict**

   I became involved in the family courts around 2010 as I entered private practice (intending on a retirement focus in a different direction: ADHD & complex trauma in children). I became aware of the problematic professional issues in the family courts from my first case in the role of a "reunification therapist" contracted through a minor's counsel when I entered general private practice.

   Based on my clinical experience with that first matter and my substantial professional concerns regarding the quality of mental health services received by parents and children in the family courts, I remained in the family courts as a court-involved clinical psychologist, and I altered the trajectory arc of my practice. I am a court-involved <u>clinical</u> psychologist. My role in the family courts is to provide second opinion consultation and document review of mental health reports.

   In 2015 I wrote my book, *Foundations*,[8] describing the pathology in the family courts in detail across three domains of applied professional knowledge. I described the pathology from the applied knowledge of family systems, from the applied knowledge personality disorder pathology, and from the applied knowledge of attachment pathology in children, and I integrated the description across all three levels. The attachment pathology (trans-generational transmission of attachment trauma) creates the personality pathology in the adult-parent (narcissistic-borderline), which then creates the family systems pathology through the addition of splitting pathology from a narcissistic-borderline parent to a cross-generational

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[7] Bowen provides the overarching family systems model (Bowenian). Minuchin focuses on healthy and unhealthy structures of spousal, parent-child, and sibling units (Structural). Madanes and Haley focus on power dynamics within relationships (Strategic). Framo focuses on the trans-generational transmission of trauma (Family of Origin). Boszormeny-Nagi focuses on loyalty bonds within the family (Contextual).

[8] Childress, C.A. (2015). *An Attachment-Based Model of Parental Alienation: Foundations*. Claremont, CA: Oaksong Press.

coalition, leading to a severe and intractable emotional cutoff in the child's attachment bond to the targeted parent.

I have been involved as an expert consultant and witness in the U.S. and internationally due to my specialized expertise as a clinical psychologist in the family courts. I have an invited presentation in the Netherlands in 2019, following which I was invited for a meeting with the Dutch Ministry of Justice, and I also received an invitation to guest lecture at Maastricht University. In 2023 I was invited to present at the University of Novi Sad in Serbia. In 2024, I presented at the national convention of the American Psychological Association regarding a *Contingent Visitation Schedule* for the family court pathology

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