

Parent Consultation Information

C.A. Childress, Psy.D.

This information is designed to help parents in court-involved child custody conflict achieve a successful treatment-oriented solution to the child's attachment pathology surrounding divorce.

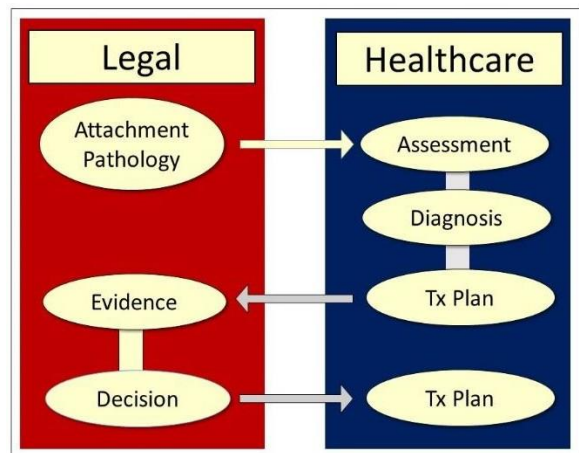
Treatment Not Custody

A clinical psychology approach is through treatment and resolution of the child's attachment pathology being displayed toward a parent. This differs from a "forensic" psychology approach that focuses on the child's custody schedule.

Parents in court-involved child custody conflict will want a treatment plan from clinical psychology (the healthcare system) to restore the child's healthy attachment bonds that have been damaged by the surrounding divorce process. In family conflicts with a pathological parent, the pathogenic¹ parent will seek to drive the family conflict into the courts to put the targeted parent on trial for being a "bad parent"/(bad spouse), in revenge and retaliation for the failed marriage and divorce. This becomes a form of Intimate Partner Violence (IPV),² the emotional and psychological abuse of one spouse-and-parent by the other using the child as the weapon.

The targeted parent will want to move the family conflict out of the courts and over to the healthcare system (clinical psychology) for a diagnosis and treatment plan. Then, once a proper risk assessment for possible child abuse and possible IPV spousal abuse has been conducted and an accurate diagnosis returned with recommendations for treatment, this diagnosis and treatment plan can move back into the court-involved child custody litigation as evidence for the judge's consideration in resolving the family conflict in the courts.

The approach of "forensic" psychology with its focus on child custody is to try to resolve family conflict entirely through the legal system. This is not an effective approach. It results in years of litigation at tremendous financial costs, and only results in severely damaged parent-child bonds that are never resolved. A treatment-oriented approach that moves back-and-forth between the healthcare and legal systems is needed to restore healthy bonds of affection between the child and parent and calm the litigation surrounding parental conflict.



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

² DSM-5 V995.82 Spouse or Partner Abuse, Psychological

The Pathology of Concern

The pathology of concern is that the allied parent has potentially recruited the child into a *cross-generational coalition* against the other targeted parent (targeted for emotional and psychological abuse using the child as the weapon). This family dynamic is depicted in a Structural family diagram from Salvador Minuchin. This is the pathology of concern surrounding high-conflict child custody litigation that is creating the *attachment pathology* displayed by the child toward a parent (i.e., a child rejecting a parent).

Of additional concern is that the allied parent may have a thought disorder, i.e., a *persecutory delusion* from unresolved childhood trauma, that distorts their current thinking and perception of situations, and that this parent is then imposing their persecutory belief system onto the child, creating a *shared persecutory delusion* regarding the other parent. A persecutory delusion is a fixed and false belief in supposed “victimization.” The American Psychiatric Association provides the following definition of a persecutory delusion:

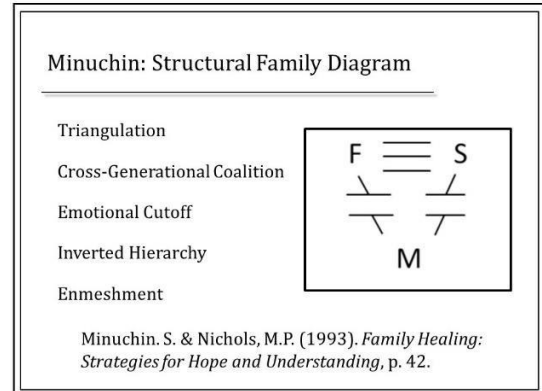
From the APA: “Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way.” (American Psychiatric Association, 2000)

Google malevolent: having or showing a wish to do evil to others.

Creating a shared persecutory delusion in the child that then destroys the child’s attachment bond to the other parent represents a DSM-5 diagnosis of Child Psychological Abuse (V995.51). A child rejecting a parent raises concerns surrounding possible child abuse by the targeted rejected parent. If, however, the parenting practices of the targeted parent are normal-range, then the differential diagnosis become a shared persecutory delusion created by the allied parent’s false beliefs in supposed “victimization”, i.e. a DSM-5 diagnosis of Child Psychological Abuse (V995.51) by the allied parent.

Either way, possible child abuse is a considered diagnosis, either by the targeted parent in creating the child’s attachment pathology, or by the allied parent who has formed a cross-generational coalition with the child against the other parent, and who has created a shared persecutory delusion in the child. When possible child abuse is a considered diagnosis, the diagnosis returned must be accurate 100% of the time. The consequences of misdiagnosing child abuse are too devastating for the child. In all cases of attachment pathology in court-involved custody litigation, a proper risk assessment for possible child abuse needs to be conducted (Appendix 1 Risk Assessment).

The pathology of concern that needs a proper risk assessment is a potential shared persecutory delusion. The American Psychiatric Association describes a shared delusional disorder



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, p. 333)

This is the pathology that needs a proper risk assessment in all cases of court-involved child custody litigation. In the journal, *Family Court Review*, Walters and Friedlander³ highlight this association of court-involved custody conflicts and the potential role of persecutory delusions with a 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.”

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)

Psychological Control

The means by which one parent damages the child’s attachment bond to the other parent is through the manipulative psychological control of the child using a variety of subtle but powerful parenting tactics. 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*,⁴ 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. In Chapter 2, Barber and Harmon define the construct of parental psychological control of the child:

Barber and Harmon: “Psychological control refers to parental behaviors that are intrusive and manipulative of children’s thoughts, feelings, and attachment to parents.

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.
<https://doi.org/10.1111/fcre.12238>

⁴ Barber, B. K. (Ed.) (2002). *Intrusive parenting: How psychological control affects children and adolescents*. Washington, DC: American Psychological Association.

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)⁵

According to Stone, Bueler, and Barber:

From Stone, Bueler, & 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)⁶

Soenens and Vansteenkiste (2010)⁷ describe the various methods used to achieve parental psychological control of the child:

From 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)

Stone, Buehler, and Barber describe the process of psychological control of the child by a parent surrounding divorce,

From Stone, Bueler, & 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

⁵ 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.

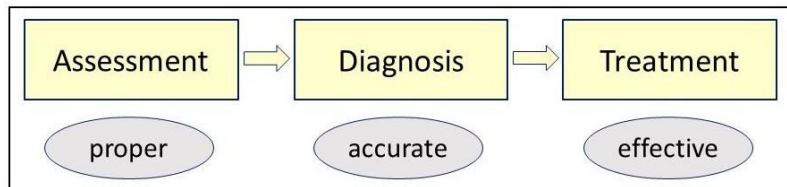
⁶ Stone, G., Buehler, C., & Barber, B. K.. (2002) *Interparental conflict, parental psychological control, and youth problem behaviors*. In B. K. Barber (Ed.), *Intrusive parenting: How psychological control affects children and adolescents*. Washington, DC: American Psychological Association.

⁷ 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.

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)

Diagnosis Guides Treatment

Parents will want a written treatment plan to restore the child's healthy and normal-range attachment bonds that have been damaged surrounding the divorce. To formulate a written treatment plan will need a diagnosis. The treatment for cancer is different than the treatment for diabetes. Diagnosis guides treatment. In order to obtain an accurate diagnosis to guide the development of an effective treatment plan, parents will need a proper assessment of the attachment pathology.



Consultation on Diagnosis

Professional-to-professional consultation on diagnosis is common throughout healthcare. The appellate system in healthcare for a disputed diagnosis is a second opinion.

From Improving Diagnosis: "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." (Improving Diagnosis in Healthcare, 2015)⁸

From Improving Diagnosis: "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." (Improving Diagnosis in Healthcare, 2015)

The assessment for thought disorders and delusions is a Mental Status Exam of thought and perception. The website for the National Center for Biotechnology Information (NCBI) describes the Mental Status Exam of thought and perception from Chapter 207 of Clinical Methods:

⁸ *Improving Diagnosis in Healthcare* (2015). National Academies of Sciences, Engineering, and Medicine; Institute of Medicine; Board on Health Care Services:
<https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWEIqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI>

From Clinical Methods: “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 Clinical Methods: “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.”

Clinical Methods notes that the Mental Status Exam of thought and perception is one of the most difficult to conduct and requires “considerable experience.” I have that considerable experience in conducting a Mental Status Exam of thought and perception (Appendix 2: Dr. Childress Specialized Expertise).

Child Custody & Clinical Psychology

The field of clinical psychology is treatment, not custody. The view of clinical psychology regarding the child’s custody surrounding divorce is that, in the absence of child abuse, each parent should have as much time and involvement with their child as possible. In the absence of child abuse, parents have the right to parent according to their cultural values, their personal values, and their religious values. The question for professional psychology is whether there is child abuse?

The differential diagnosis for attachment pathology surrounding divorce is whether it is the targeted-rejected parent who is abusive, and so is creating the child’s attachment pathology toward this parent, or whether the allied parent has formed a cross-generational coalition with the child against the other parent, and it is the pathology of the allied parent that is creating a shared (induced) persecutory delusion in the child that then destroys the child’s attachment bond to the other parent?

The attachment system is a primary motivational system of the brain that governs all aspects of love and bonding throughout the lifespan, including grief and loss. The attachment system is developing its patterns for love and bonding during childhood through the child’s relationship with both parents. These attachment patterns formed in childhood will then guide the child’s future love and bonding relationships throughout the rest of the child’s life. Childhood is NOT the time when we want to see the worst possible attachment pathology in a child, a complete severing of the parent-child attachment bond. The attachment pathology of a child rejecting a parent needs treatment and resolution.

When severe attachment pathology is present surrounding divorce, a proper risk assessment needs to be conducted for possible child abuse and possible spousal emotional and psychological abuse using the child as the weapon to reach an accurate diagnosis that will guide the development of an effective treatment plan.

Appendix 1: Risk Assessment

Risk Assessments

A risk assessment is conducted when any of three types of dangerous pathology are presented by a client, suicide, homicide, or abuse (child, spousal, elder). 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.).

There are four diagnoses of child abuse in the Child Maltreatment section of the DSM-5,⁹ each of these 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 equivalent in the severity of 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.

A suspicion of child physical, sexual, or neglect abuse is a mandated report to Child Protective Services (CPS) to allow their trained assessment professionals to conduct a proper risk assessment for these types of child abuse, and then to take the proper child protection steps when warranted. Mental health professionals in the community are prohibited from conducting the risk assessment themselves for these forms of child abuse, and they are mandated to refer to Child Protective Services (CPS) to ensure a proper assessment and the proper protection of the forensic evidence if needed.

Psychological child abuse, however, is not a mandated report, it is a “permitted” report to CPS, but not required. Psychological child abuse (i.e., creating severe pathology in the child through aberrant and distorted parenting) is more difficult to assess and diagnose, and typically requires a higher level of training than is available to the CPS professionals who are more focused on child physical, sexual, and neglect abuse.

The assessment for possible child psychological abuse requires a higher level of professional knowledge in attachment pathology, complex trauma, personality pathology, and thought disorders. Since psychological child abuse is not a mandated CPS report, this allows the the involved mental health professionals to conduct the risk assessment for psychological child abuse, thereby allowing CPS to remain focused on identifying the other more overt forms of child abuse.

The professional concern with child psychological abuse is the creation of a thought disorder in the child, an induced persecutory delusion, by the aberrant and distorted parenting practices of the allied parent. A delusion is a fixed and false belief that is

⁹ The DSM-5 diagnostic system is from the American Psychiatric Association. It is a specialty diagnostic system focused solely on psychiatric disorders (as contrasted with the ICD-10 that is both medical and psychiatric diagnostic codes). In its more specialty focus, the DSM-5 offers greater descriptive elaboration on each psychiatric disorder, as well as diagnostic criteria for each disorder. The ICD-10 is the diagnostic coding system, the DSM-5 is the description.

maintained despite contrary evidence. The type of delusion of concern is a potential persecutory delusion, i.e., a fixed and false belief in supposed “victimization.” The American Psychiatric Association provides the 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)

Creating a shared persecutory delusion with a child that then destroys the child’s attachment bond to the other parent represents a DSM-5 diagnosis of V995.51 Child Psychological Abuse. The assessment for thought disorder pathology (delusions) is a Mental Status Exam of thought and perception conducted with the child and allied parent. Obtaining direct observation of the symptoms displayed in the parent-child relationship would confirm the diagnosis from the Mental Status Exam of thought and perception.

The clinical pathology of concern in the family is for possible unresolved trauma with a parent that then distorts their thinking and perception of situations, and that the parent’s persecutory delusion is then imposed on the child through aberrant and distorted parenting practices, creating a shared persecutory delusion (ICD-10 F24) relative to the other parent.

An additional clinical concern is that the allied parent is inducing this thought disorder in the child in order to (intentionally?) destroy the child’s attachment bond to the other parent in vengeful retaliation against the targeted parent for the failed marriage and divorce. Using the child as a weapon of spousal emotional and psychological abuse would represent Intimate Partner Violence (IPV; “domestic violence”), and would warrant a DSM-5 diagnosis of V995.82 Spouse or Partner Abuse, Psychological. By weaponizing the child into the spousal conflict, the allied parent creates such significant pathology in the child that it rises to the level of Child Psychological Abuse (DSM-5 V995.51). Spousal emotional and psychological abuse using the child as the weapon is a second dangerous pathology of concern in the family that warrants a proper risk assessment.

Attachment pathology is only created by problematic parenting (pathogenic parenting), either from the targeted-rejected parent or from the allied parent. Whenever there is significant attachment pathology displayed by a child surrounding divorce, a proper diagnostic risk assessment should be conducted to answer the referral question: Which parent is the source of pathogenic parenting creating the child’s attachment pathology, and what are the treatment implications?

In all cases of a dangerous pathology, including possible psychological child abuse (DSM-5 V995.51 Child Psychological Abuse) and possible spousal emotional and psychological abuse using the child as the weapon (DSM-5 V995.82 Spouse or Partner Abuse, Psychological), a proper risk assessment is required. Mental health professionals have duty to protect obligations.

Appendix 2: Dr. Childress Domains of Specialized Professional Background

Dr Childress Domains of Specialized Professional Background

My vitae in supports the following four domains of specialized expertise in professional psychology:

1. Thought disorders and delusional pathology
2. Child abuse assessment, diagnosis, and treatment
3. The attachment system and attachment pathology
4. Factitious Disorder Imposed on Another (FDIA)

Thought Disorders & Delusions

In support of my specialized expertise in the assessment and diagnosis of thought disorders and delusions are 12 years of experience at a major UCLA clinical research project on schizophrenia where I received annual training in the assessment and diagnosis of delusions and thought disorders using the *Brief Psychiatric Rating Scale* (BPRS) to diagnostic reliability of $r=.90$ to the co-directors of the Diagnostic Unit at the UCLA-Brentwood VA, Dr. Lukoff and Dr. Ventura. The entry on my vitae for this work experience while I was at Dr. Nuechterlein's project at UCLA is:

9/85 - 9/98 Research Associate

UCLA Neuropsychiatric Institute

Principle Investigator: Keith Nuechterlein, Ph.D.

Area: Longitudinal study of initial-onset schizophrenia. Received annual training to research and clinical reliability in the rating of psychotic symptoms using the Brief Psychiatric Rating Scale (BPRS). Managed all aspects of data collection and data processing.

Note that I was trained annually in the rating of delusional and psychotic symptoms using the *Brief Psychiatric Rating Scale* (BPRS). Wikipedia describes the BPRS:

From Wikipedia: "The Brief Psychiatric Rating Scale (BPRS) is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour. The scale is one of the oldest, most widely used scales to measure psychotic symptoms and was first published in 1962... An expanded version of the test was created in 1993 by D. Lukoff, Keith H. Nuechterlein, and Joseph Ventura."¹⁰

The Expanded version cited by Wikipedia links to a professional reference available online from Drs. Nuechterlein, Ventura, and Lukoff,¹⁰ note the date of the revision -

¹⁰ Ventura, Joseph & Lukoff, D. & Nuechterlein, Keith & Liberman, R.P. & Green, Megan & Shaner, Andrew. (1993). Brief Psychiatric Rating Scale Expanded version 4.0: Scales anchor points and administration manual. *Int J Meth Psychiatr Res.* 13. 221-244.

1993. Note where I was from 1985-to-1998, i.e., at Dr. Neuchterlein's UCLA research project being annually trained in the assessment and diagnosis of delusional and thought disorder pathology to an $r=.90$ diagnostic reliability with the co-directors of the Diagnostic Unit at the UCLA-Brentwood VA and authors of the Expanded BPRS, Dr. Ventura and Dr. Lukoff. I have considerable professional training, background, and experience in the diagnostic assessment of thought disorders and delusional pathology,

Child Abuse Pathology

Regarding my background in child abuse pathology, I served as the Clinical Director for a three-university assessment and treatment center for children ages zero-to-five in the foster care system. Our primary referral source was Child Protective Services (CPS). I have personally worked with all four DSM-5 child abuse diagnoses and have led and supervised the multi-disciplinary assessment and treatment of child abuse as the Clinical Director for a three-university treatment center. The entry for this experience on my vitae is:

10/06 - 6/08: Clinical Director

START Pediatric Neurodevelopmental Assessment and Treatment Center
California State University, San Bernardino
Institute of Child Development and Family Relations

Clinical director for an early childhood assessment and treatment center providing comprehensive developmental assessment and psychotherapy services to children ages 0-5 years old in foster care. Directed the clinical operations, clinical staff, and the provision of comprehensive psychological assessment and treatment services across clinic-based, home-based, and school-based services. A three-university collaboration with speech and language services through the University of Redlands, occupational therapy through Loma Linda University, and psychology through Calif. State University, San Bernardino.

Attachment System & Attachment Pathology

I have specialty background in Early Childhood Mental Health, ages zero-to-five initially obtained from training with Dr. Marie Poulsen at CHLA and subsequently extended with professional practice. Early Childhood Mental Health ages 0-to-5 is a restricted sub-specialty domain of practice because it requires extensive knowledge of brain development in infancy through the first five years of life. Early Childhood Mental Health specialization requires understanding the neuro-development for each brain system individually (cognitive, language, sensory-motor, emotional, memory, relationship) as well as how they integrate with each other at each developmental period of maturation in the first year of infancy and beyond into all the subsequent maturational changes.

The period of early childhood is directly the developmental period of the child's early attachment formation to the parent. Within this specialty background, I know two

additional diagnostic systems for early childhood besides the DSM-5, the DC:0-3 which is more attachment sensitive, and the DMIC which is stronger with autistic spectrum disorders. I am also trained in two early childhood attachment therapies, *Watch, Wait, and Wonder* for infants and *Circle of Security* for preschool-age children, and I am Certified in Infant Mental Health from Fielding Graduate Institute.

The attachment system is the brain system that governs all aspects of love and bonding throughout the lifespan, including grief and loss. The attachment system develops its patterns for love-and-bonding during childhood and then we use these internalized patterns for love-and-bonding (attachment) to guide our expectations and our approach to all future love and bonding experiences in adulthood. The clinical domain of attachment and attachment pathology is within the Early Childhood Mental Health specialization, and my clinical experience is with children ages zero-to-five in foster care, which is directly attachment pathology. A child rejecting a parent is a problem in attachment, a problem in the love-and-bonding system of the brain,

Factitious Disorder Imposed on Another

I have specialized professional background and training in the diagnostic assessment of Factitious Disorder Imposed on Another (FDIA: Munchausen by proxy) from three years of training in pediatric psychology from Children's Hospital Los Angeles (CHLA), and my subsequent tenure on medical staff at Children's Hospital Orange County (Choc) as a pediatric psychologist. FDIA is generally thought of as inducing a false medical pathology in the child for secondary gain to the parent from doctor attention given to the supposedly "nurturing" parent (with histrionic/borderline personality associations). As a false medical (or psychiatric) pathology produced in the child by the parent, FDIA is difficult to diagnose by community professionals because it is a false disorder, with frequent changes in providers part of the symptom presentation as the involved professionals cannot determine a cause for the false symptoms and the involved parent keeps changing providers seeking the desired diagnosis ("doctor-shopping").

As a result of the false disorder imposed on the child, parent and child will eventually be referred into the local Children's Hospital for a more expert diagnosis, since the community resources cannot determine the cause of the child's symptoms. When FDIA is suspected by the treatment team at the Children's Hospital, a request is made of the hospital's Psychology Department for consultation on the diagnosis of FDIA, and a pediatric psychologist is sent from the hospital's Psychology Department to evaluate for possible FDIA. As a pediatric psychologist with three years of training from Children's Hospital Los Angeles and tenure on medical staff as a pediatric psychologist at Children's Hospital Orange County, I have relevant training and experience in the diagnostic assessment of FDIA (DSM-5 300.19).

4/02 – 10/06: Pediatric Psychologist

Children's Hospital Orange County – UCI Child Development Center

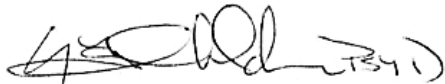
9/00 – 4/02 Postdoctoral Fellow

Children's Hospital Los Angeles

9/99 - 9/00 Predoctoral Psychology Intern – APA Accredited

Children's Hospital Los Angeles

I have professional background and specialized expertise in multiple relevant domains of knowledge, 1) thought disorders and delusions, 2) child abuse pathology, 3) the attachment system and attachment pathology, and 4) Factitious Disorder Imposed on another (DSM-5 300.19). I also am trained in family systems therapy (Bowlby, Minuchin, Haley, Madanes, Satir) from Pepperdine University, and I have worked with court-involved family conflict for the past decade, with professional presentations to the American Psychological Association, the Association of Family and Conciliation Courts, an invited presentation at the Erasmus Medical Center in the Netherlands, and an invited presentation to the Law Society of Saskatchewan. I have a broad array of directly relevant domains of professional background and experience.



Craig Childress, Psy.D.
Clinical Psychologist, CA PSY 18857

Craig Childress, Psy.D.

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Education:

Pepperdine University; 11/00
Psy.D. degree in Clinical Psychology, APA accredited

California State University, Northridge; 6/85
M.A. degree in Clinical/Community Psychology

University of California, Los Angeles; 3/78
B.A. in Psychology, cum laude

Recent Presentations:

- **American Psychological Association.** Empathy, the Family, and the Core of Social Justice. Childress, C.A. & Pruter, D. Paper Presentation at the APA National Convention, Division 24, 8/8/19; Chicago, Il.
- **Erasmus University Medical Center.** Attachment-Based Parental Alienation: Trauma Informed Assessment of Complex Family Conflict. Rotterdam, Netherlands; 2/25/19.
- **Dutch Ministry of Justice.** Invited meeting; 2/27/19.
- **Law Society of Saskatchewan.** Solutions for the Family Court and Professional Psychology; Saskatoon 11/20/18; Regina 11/21/18.
- **Certification Seminars for the Houston Pilot Program for the Family Courts.** Attachment-Based Parental Alienation (AB-PA). 5/22-24/18; Houston, Texas.
- **California Association for Licensed Professional Clinical Counselors (CALPCC).** Parental Alienation Testing, Orders, and Treatment in BPD/NPD Custody Proceedings. April 20, 2018; San Francisco, CA.
- **Legislature Briefing.** Pennsylvania State Legislature; House Children and Youth Committee. Solutions to High-Conflict Divorce in the Family Court. November 15, 2017; Harrisburg, PA (<https://www.youtube.com/watch?v=Ala1KbfsWIM>)
- **Legislature Briefing.** Massachusetts State Legislature. Grandparent and Family Alienation; Hosted by Representative Walsh. 5/31/17; Boston MA.
- **Association of Family and Conciliation Courts (AFCC).** An Attachment-Based Model of Parental Alienation: Diagnosis and Treatment. Childress & Pruter, Presentation at the AFCC National Convention, 6/1/17; Boston, MA.

Professional Affiliations

- American Psychological Association
- Credentialed with the National Register of Health Service Psychologists

Employment History:

6/08 – Current: Private Practice

271 Winslow Way E, 10631
Bainbridge Island, WA 98110

Psychotherapy with adults, couples, children, and families. Specializing in attachment pathology, ADHD, anger and impulse control problems in childhood, childhood trauma, family psychotherapy, marital therapy, and parent-child conflict. Consultation and expert testimony with court-involved family conflict.

10/06 - 6/08: Clinical Director

START Pediatric Neurodevelopmental Assessment and Treatment Center
California State University, San Bernardino
Institute of Child Development and Family Relations

Clinical director for an early childhood assessment and treatment center providing comprehensive developmental assessment and psychotherapy services to children ages 0-5 years old in foster care. Directed the clinical operations, clinical staff, and the provision of comprehensive psychological assessment and treatment services across clinic-based, home-based, and school-based services. A three-university collaboration with speech and language services through the University of Redlands, occupational therapy through Loma Linda University, and psychology through Calif. State University, San Bernardino.

5/03 – 10/06: Clinical Director

Fineman Consulting Group
Fire F.R.I.E.N.D.S. Juvenile Firesetting Intervention Program
Executive Director: Kenneth Fineman, Ph.D.

Through grants from FEMA and the Department of Justice to develop a national model for juvenile firesetting intervention, collaborated with Dr. Fineman in developing a comprehensive clinical psychology assessment protocol for the mental health evaluation of juvenile firesetting behavior.

1/12 – 12/17: Faculty

University of Phoenix; Pasadena Campus; Ontario Campus

Courses taught: Child Development; Assessment and Treatment Planning; Advanced Diagnosis; Models of Psychotherapy; Counseling Psychometrics; Research Methods; Cultural Psychology

1/09 – 9/10: Faculty

Argosy University; San Bernardino Campus

Courses taught: Diagnosis and Psychopathology; Child and Adolescent Psychotherapy; Child Development

4/02 – 10/06: Pediatric Psychologist

Children's Hospital Orange County – UCI Child Development Center
Early Identification and Treatment of ADHD in Preschoolers
Director: James Swanson, Ph.D.

Served as the primary clinical psychologist on a joint CHOC-UCI project for early identification of ADHD in preschool-age children.

4/02 - 9/02: Research Associate

Children's Hospital Los Angeles
Principle Investigator: Ernest Katz, Ph.D.

Multi-site Children's Hospital study, remediation of attention deficits of children with cancer.

9/00 – 4/02 Postdoctoral Fellow

Children's Hospital Los Angeles

Two-year post-doctoral fellowship. Specialty focus: ADHD; spina bifida; early childhood mental health

9/99 - 9/00 Predoctoral Psychology Intern – APA Accredited

Children's Hospital Los Angeles

Rotations: spina bifida, early childhood preschool consultation

9/98 - 9/99 Research Associate

UCLA Neuropsychiatric Institute
Principle Investigator: Elisabeth Dykens, Ph.D.

Area: Cognitive functioning in Williams Syndrome. Test administration and coding of behavioral observation data

9/85 - 9/98 Research Associate

UCLA Neuropsychiatric Institute
Principle Investigator: Keith Nuechterlein, Ph.D.

Area: Longitudinal study of initial-onset schizophrenia. Received annual training to research and clinical reliability in the rating of psychotic symptoms using the Brief Psychiatric Rating Scale (BPRS). Managed all aspects of data collection and data processing.

9/80 – 9/85 Psychiatric Aide

Southern California psychiatric hospitals.

3/74 – 6/78 Crisis Counselor

Los Angeles Suicide Prevention Center

Crisis telephone counselor and supervisor for Los Angeles Suicide Prevention Hotline.

Divorce Training

Certificate Program: Certification in Divorce Mediation. Conflict Resolution Training, Inc. 2/24/16 – 2/27/16. Susan Deveney, Instructor

Early Childhood Training:

Certificate Program: Parent-Infant Mental Health: Fielding Graduate University, 1/14/08; 1/15/08.

Early Childhood Diagnostic System: *DC:0-3R Diagnostic Criteria*: Orange County Early Childhood Mental Health Collaborative.

Early Childhood Diagnostic System: *DMIC: Diagnostic Manual for Infancy and Early Childhood*. Interdisciplinary Council on Developmental and Learning Disorders: assessment, diagnosis, and intervention for developmental and emotional disorders, autistic spectrum disorders, multisystem developmental disorders, regulatory disorders involving attention, learning and behavioral problems, cognitive, language, motor, and sensory disturbances.

Early Childhood Treatment Intervention: *Watch, Wait, and Wonder*: Nancy Cohen, Ph.D. Hincks-Dellcrest Centre & the University of Toronto.

Early Childhood Treatment Intervention: *Circle of Security*: Glen Cooper, MFT, Center for Clinical Intervention, Marycliff Institute, Spokane, Washington.

Recent Seminars Taken

Complex Trauma: Bessel van der Kolk. How the Body Keeps Score: Intensive Trauma Treatment Course – 12-hour PESI seminar, online.

Dialectic Behavior Therapy (DBT): Dialectic Behavior Therapy Intensive Training; 12-hour PESI seminar, online.

Emotion Focused Therapy (EFT): Sue Johnson. Intensive Course in Emotionally Focused Therapy: Attachment-Based Interventions for Couples in Crisis; 12-hour PESI seminar, online

The Bowen Center: Emotional Cutoff: The Bowen Center for Study of the Family: 56th Annual Symposium on Family Theory and Family Psychotherapy. Dr Plimer “*Family Rifts and How to Mend Them: Findings from the Cornell Estrangement and Reconciliation Project*” – three-day symposium, Johns Hopkins University, MD; 11-7/19 – 11-9-19.

Book Publications:

Childress, C.A. (2018). *The Petition to the American Psychological Association*. Claremont, CA: The Childress Institute.

Childress, C.A. (2017). *Assessment of Attachment-Related Pathology Surrounding Divorce*. Claremont, CA: Oaksong Press.

Childress, C.A. (2017). *Strategic Family Systems Intervention for AB-PA: Contingent Visitation Schedule*. Claremont, CA: Oaksong Press.

- Childress, C.A. (2017). *The Key to Solving High-Conflict Divorce in the Family Courts: Proposal for a Pilot Program in the Family Law Courts*. Claremont, CA: Oaksong Press.
- Childress, C.A. (2016). *The Narcissistic Parent: A Guidebook for Legal Professionals Working with Families in High-Conflict Divorce*. Claremont, CA: Oaksong Press.
- Childress, C.A. (2015). *An Attachment-Based Model of Parental Alienation: Foundations*. Claremont, CA: Oaksong Press.
- Childress, C.A. (2015). *An Attachment-Based Model of Parental Alienation: Single Case ABAB Assessment and Remedy*. Claremont, CA: Oaksong Press.
- Childress, C.A. (2015). *An Attachment-Based Model of Parental Alienation: Professional Consultation*. Claremont, CA: Oaksong Press.
- Childress, C.A. (2015). *Essays in Attachment-Based Parental Alienation: The Internet Writings of Dr. Childress*. Claremont, CA: Oaksong Press.

Journal Publications

- Tamm, T., Swanson, J. Lerner, M.A., **Childress, C.** Patterson, B, Lakes, K., Nguyen, A.S., Kudo, M., Altamirano, W., Miller, J., Santoyo, R., Camarero-Morse, V., Watkins, J., Simpson, S., Waffarn, F., Cunningham, C. (2005). Intervention for preschoolers at risk for Attention-Deficit/Hyperactivity Disorder (ADHD): Service before diagnosis. *Clinical Neuroscience Research*, 5 (5-6) 247-253.
- Childress C.A. (2000) *Ethical issues in providing online psychotherapeutic interventions*. *Journal of Medical Internet Research*, 2(1):e5.
- Childress, C.A. (1999). *Interactive e-mail journals: A model for providing psychotherapeutic interventions using the Internet*, *Cyberpsychology and Behavior*, 2(3), 213-221
- Childress, C.A., & Asamen, J.K. (1998). *The emerging relationship of psychology and the Internet: Proposed guidelines for conducting Internet intervention research*. *Ethics and Behavior*, 8, 19-35.

“Parental Alienation” Seminars and Presentations Given:

- Erasmus University Medical Center. Attachment-Based Parental Alienation: Trauma Informed Assessment of Complex Family Conflict. Rotterdam, Netherlands; 2/25/19.
- Law Society of Saskatchewan. Solutions for the Family Court and Professional Psychology; Saskatoon 11/20/18; Regina 11/21/18.
- Certification Seminars for the Houston Pilot Program for the Family Courts. Attachment-Based Parental Alienation (AB-PA) May 22-24, 2018; Houston, Texas.
- California Association for Licensed Professional Clinical Counselors (CALPCC). Parental Alienation Testing, Orders, and Treatment in BPD/NPD Custody Proceedings. April 20, 2018; San Francisco, CA.
- Certification in Attachment-Based Parental Alienation (AB-PA). Provided Basic and Advanced Certification Seminars in AB-PA. November 18-20. Pasadena, CA.

- Legislature Briefing. Pennsylvania State Legislature; House Children and Youth Committee. Solutions to High-Conflict Divorce in the Family Court. November 15, 2017; Harrisburg, PA (<https://www.youtube.com/watch?v=Ala1KbfsWIM>)
- Legislature Briefing. Massachusetts State Legislature. Grandparent and Family Alienation. Hosted by Representative Walsh. 5/31/17. Boston MA.
- Association of Family and Conciliation Courts Annual Convention. An Attachment-Based Model of Parental Alienation: Diagnosis and Treatment. 6/1/17. Boston, MA.
- Keynote Address. Parental Alienation Symposium 2017: Solutions for Professionals and Families. 4/29/17; Dallas, Texas.
- Master Lecture Series; California Southern University. *Treatment of Attachment-Based Parental Alienation*. November 21, 2014; Irvine, CA. (available online at <https://www.youtube.com/watch?v=ezBJ3954mKw>)
- Master Lecture Series; California Southern University. *Theoretical Foundations of Attachment-Based Model of "Parental Alienation."* July 18, 2014; Irvine, CA. (available online at <https://www.youtube.com/watch?v=brNuwQNN3q4>)
- Family Law Reform Conference. Invited Panelist: *Parental Alienation and Domestic Violence*. Hosted by DivorceCorp. November 15-16, 2014; Alexandria, VA.

Professional Association Presentations: Parenting

- Herrejon, E., Feeney-Kettler, K., Kettler, R., **Childress**, C., Kamptner, L., Lakes, K. (2007). *Multi-tiered Early Childhood Model of Service Delivery*. American Psychological Association Convention presentation.
- Marche Haynes, M., Lakes, K., **Childress**, C., Kamptner, L., Lilles, E. (2006). *Do SES, Race/Ethnicity, and Acculturation Predict Parenting Intervention Completion?* Western Psychological Association Convention Presentation.
- Grimes, L., Lakes, K., **Childress**, C., Kamptner, K., Simmons, S. (2006) *Impact of SES and Culture on Parenting Intervention Outcomes*. Western Psychological Association Convention Presentation.
- Kramer, L., Lakes, K., **Childress**, C., Kamptner, L., Grimes, L. (2006) *Parent Behaviors and Corresponding Child Prosocial Behaviors and Conduct Problems*. Western Psychological Association Convention Presentation.
- Lilles, E., Lakes, K., **Childress**, C., Kamptner, L., and Kramer, L. (2006). *Does SES or Ethnicity Predict Parent Use of Physical Punishment?* Western Psychological Association Convention Presentation.

Early Childhood Mental Health Seminars and Trainings Given:

- Early Childhood Intervention with "Behavior Problems" in the Preschool Classroom. San Bernardino Head Start Preschool Teacher Training Series (10/27/06; 11/3/06; 11/17/06).

- Early Childhood Intervention with “Behavior Problems” in the Preschool Classroom. San Bernardino West End SELPA Preschool Teacher Training Series (10/17/06; 11/7/06; 12/5/06).
- Early Childhood Intervention with “Behavior Problems” in the Preschool Classroom. San Bernardino West End SELPA Preschool Teacher Training Series (10/31/06; 11/14/06; 12/12/06).
- Early Childhood Intervention with “Behavior Problems” in the Preschool Classroom (5/5/06). Victorville Head Start. Victorville, CA
- Early Childhood Intervention with “Behavior Problems” in the Preschool Classroom. (11/12/04). National Association for the Education of Young Children Conference, Anaheim, CA
- Functional Behavioral Analysis and Positive Child Guidance with Preschoolers. (5/1/04). Westminster School District. Westminster, CA.
- Functional Behavioral Analysis with Preschool-Age Children - Seminar Series. (3/5/04; 4/2/04). Placentia Yorba Linda School District; School Readiness Coordinators. Yorba Linda, CA
- Functional Behavioral Analysis with Preschool-Age Children - Seminar Series. (2/6/04; 2/13/04; 2/20/04). Irvine Unified School District. Irvine, CA.
- Functional Behavioral Analysis and Positive Behavior Management with Children. (12/3/03). Orangewood Preschool, Irvine, CA
- Early Childhood Working with “Problem Behavior” in the Preschool Classroom (10/31/03). Orange County Head Start; Teachers & Teacher Aides. Bren Events Center, University of California; Irvine, CA.
- Functional Behavioral Analysis and Positive Child Guidance with Preschool-Age Children. (10/17/03). Irvine Unified School District. Irvine, CA.
- Functional Behavioral Analysis with Preschool-Age Children - Seminar Series. (9/26/03; 10/17/03). Orange County Head Start Center Directors and Multi-disciplinary Teams. Orange, CA.

Internet Psychology Seminars and Presentations Given

- **World Health Organization**, 2nd International Symposium on Psychiatry and Internet: Information – Support – Therapy. Invited presentation on *Ethical Issues in Online Psychotherapeutic Interventions*. 4/2002, Munich, Germany.
- **American Association for the Advancement of Science** and the Office of Protection from Research Risks, Conference on the Ethical and Legal Aspects of Human Subjects Research in Cyberspace. Invited paper presentation on *Privacy and Confidentiality Issues in Internet Research*. 6/1999, June. Washington, D.C.
- **American Psychological Association** Convention, Symposium on Using the Internet for Change: Online Psychotherapy and Education. J. Grohol (Chair): *The Potential Risks and Benefits of Online Therapeutic Interventions*. 8/1998; San Francisco, California.