Attachment Pathology in the Family Courts

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The pathology of concern in the family courts is an attachment pathology that potentially rises to the level of child abuse. When a potential child abuse diagnosis is a consideration, the diagnosis returned from the mental health care system for the Court's consideration in its decisions must be accurate 100% of the time. The consequences of an incorrect decision by the Court when a child abuse diagnosis is involved can be severe for the child. Leaving a child with an abusive parent can lead to the destruction of the child's life. When a child abuse diagnosis is among the possible differential diagnoses for the child's symptom display, the diagnosis returned from the mental health care system for the Court's consideration must be accurate 100% of the time.

If there is any question, if there is any dispute about the diagnosis (and the diagnosis is anticipated to be disputed in court-involved family conflict), then get a second opinion, or even a third. When a possible child abuse diagnosis is involved, do whatever it takes to make sure the diagnosis that is returned from the assessment is accurate. The appellate system in healthcare for a disputed diagnosis is second opinion, or even a third. The damage done to the child from a misdiagnosis of child abuse is too severe. When child abuse by a parent is a diagnostic consideration, which it is with severe attachment pathology displayed by a child, then the diagnosis returned from the mental health care system must be accurate 100% of the time.

The pathology of clinical concern for the family is a possible shared persecutory delusion created by the pathogenic parenting of the allied parent, a thought disorder in the allied parent from unresolved trauma that is being imposed on the child, which then destroys the child's attachment bond to the other parent. In this pathology, the allied parent forms a *cross-generational coalition* (Haley)[1] with the child against the targeted parent, resulting in an *emotional cutoff* in the child's attachment bond to the targeted parent. The allied parent is *triangulating* the child into the spousal conflict to use the child as a weapon of spousal revenge and emotional abuse directed at the ex-spouse, i.e., Intimate Partner Violence (IPV), the emotional abuse of the ex-spouse using the child as the weapon. In weaponizing the child into the spousal conflict, the allied parent creates such

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[1] Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. Weakland (Eds.),

> 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)

significant pathology in the child that it rises to the level of a DSM-5 diagnosis of psychological child abuse.

The needed risk assessments for the family pathology surrounding court-involved family conflict are for:

1. Child Abuse: potential child abuse by the targeted parent (to be specified by the assessment), or potential psychological child abuse by the allied parent (DSM-5 V995.51 Child Psychological Abuse)

2. Spousal Abuse: potential IPV emotional abuse of the ex-spouse and parent using the child as the weapon (DSM-5 V995.82 Spouse or Partner Abuse, Psychological)

Whenever child abuse is a diagnostic consideration, the diagnosis returned from the mental health care system must be accurate 100% of the time. The Court needs an accurate diagnosis for its decisions, and the child needs an accurate diagnosis when the potential diagnosis is child abuse by a parent.

There are four DSM-5[2] diagnoses of child abuse in the Child Maltreatment section, and each diagnosis of child abuse 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 do 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.

When a child rejects a parent, the clinical concern is child abuse, the diagnostic questions is, which parent? When the possible diagnosis is child abuse by a parent, both the child and the Court require that a proper risk assessment be conducted that will reach an accurate diagnosis 100% of the time. If the diagnosis is disputed, the appellate system in healthcare is not litigation in the courts, it's second opinion, or even a third opinion from other doctors. All doctors, all psychologists, should be applying exactly the same sets of knowledge (the best) to reach the exactly same conclusions and recommendations (accurate). Standard 2.04 of the *Ethical Principles of Psychologists and Code of Conduct* of the American Psychological Association requires that the established scientific and professional knowledge of the discipline serve as the bases for professional judgments.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline.

[2] 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.

The established scientific and professional knowledge of the discipline surrounding court-involved family conflict is:

- Attachment – Bowlby and others
- Family systems therapy – Minuchin and others
- Personality disorders – Beck and others
- Complex trauma – van der Kolk and others
- Child development – Tronic and others
- Self psychology – Kohut and others
- ICD-10 & DSM-5 diagnostic systems

Diagnosis is a pattern-match of the symptoms to the diagnostic criteria. If there is a disputed application of the diagnostic criteria to a set of symptoms, get a second opinion or even a third opinion if necessary. When the potential diagnosis is child abuse, we must not get it wrong. We must be accurate in our diagnosis 100% of the time. Misdiagnosis hurts people – badly. A misdiagnosis of child abuse is extremely bad.

Misdiagnosis of a shared persecutory delusion has particularly troubling implications. If you believe a shared delusion then you become part of the shared delusion, you become part of the pathology. When the pathology is child abuse, you become part of the child abuse. If the involved mental health professional misdiagnoses the pathology and believes the delusional disorder as if it were real, and if the Court then makes its decisions based on the false beliefs of a pathological parent that are misdiagnosed, then all of them become part of the shared delusion, they all become part of the pathology, they become part of the child abuse. The potential damage from the misdiagnosis of child abuse can be severe, and the potential implications for the involved professionals can be profound. Whe child abuse is a consideration, the diagnosis returned from the mental health system must be accurate 100% of the time.

Attachment Pathology

A child rejecting a parent is an attachment pathology, a problem in the love-and-bonding system of the brain. There are two potential causes, 1) child abuse by the targeted-rejected parent (to be specified by the assessment), or 2) child psychological abuse by the allied parent who is using the child as a weapon of IPV spousal abuse (Intimate Partner Violence; i.e., the emotional abuse of the ex-spouse using the child as the weapon).

A child rejecting a parent is a problem in love-and-bonding. A child rejecting a parent is an attachment pathology, a problem in the love-and-bonding system of the brain. The attachment system is the brain system governing all aspects of love and bonding throughout the lifespan, including grief and loss. It is a primary motivational system of the brain, like other primary motivational systems for eating and sex. A breach in the

attachment bonding between children and their parents is a pathology in a *primary motivational system* of the brain, the love-and-bonding system; the attachment system.

There is no more severe form of attachment pathology than the termination of the child's attachment bond to the parent. There is nothing <u>worse</u> in terms of attachment pathology, for pathology in a primary motivational system of the brain, than a severing of the parent-child attachment bond. That is as bad as attachment pathology in childhood gets, pathology in a primary motivational system of the brain that is developing its patterns to guide love-and-bonding throughout the lifespan during childhood, through relationship bonds with both parents. A child rejecting a parent is the <u>worst</u> possible attachment pathology in childhood.

To understand the severity we can use an analogy to another primary motivational system, the eating system. The worst possible eating pathology is anorexia, the person refuses to eat, their bond to food is completely severed, they starve, and they die. By analogy, a complete severing of a child's attachment bond to a parent represents "anorexia" of the attachment system, the <u>worst</u> possible form of attachment-related pathology. There is nothing worse in terms of attachment pathology, that's as bad as it gets. It is exceedingly important for the healthy development of children that their attachment pathology toward their mothers and fathers be effectively treated and resolved as quickly as is possible.

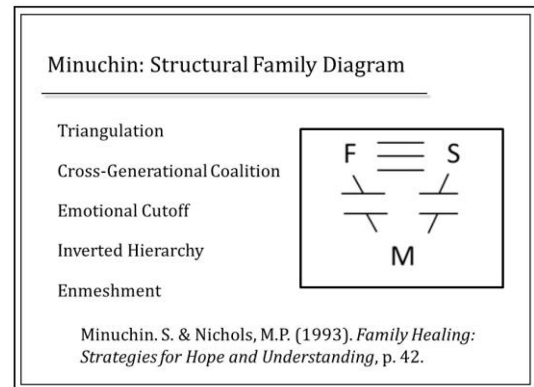
The differential diagnosis for the attachment pathology (i.e., for a child's rejection of a parent) is that either 1) the parent who is the target of rejection is causing the attachment breach through possibly severe maltreatment of the child, or 2) the allied parent is creating the attachment breach through their extremely problematic parenting in forming a *cross-generational coalition* with the child against the other parent. The coalition of the child with one parent against the other parent leads to the *emotional cutoff* in the child's attachment bond to the targeted parent out *loyalty* to the coalition with the allied parent.

The diagnosis of clinical concern is potential Child Psychological Abuse (pathogenic parenting) by the allied parent (DSM-5 V995.51), a thought disorder in the allied parent (a persecutory delusion) that is being imposed on the child, destroying the child's attachment bond to the other parent in spousal revenge and retaliation for the failed marriage and divorce (DSM-5 V995.82 Spouse or Partner Abuse, Psychological). This needs a proper assessment to reach an accurate diagnosis to guide the Court's decisions and the development of an effective treatment plan.

Family Systems Therapy

There are four primary schools of psychotherapy; psychoanalytic (Freud and the couch), humanistic-existential (self-actualization and growth), cognitive-behavioral (B.F. Skinner, rewards and punishment) and family systems therapy (describing how families work and how to fix problems in families). Of the four primary schools of psychotherapy, the appropriate school for developing a treatment plan for resolving family conflict is family systems therapy (Minuchin, Bowen, Haley, Madanes, Satir). Parents and the Court will want an assessment of the family conflict and attachment pathology that applies the constructs of family systems therapy toward resolving the family conflict.

The family systems diagnostic description of concern for assessment would be that the child is being *triangulated* into the spousal conflict through the formation of a *cross-generational coalition* with one parent against the other parent, that is then resulting in an *emotional cutoff* in the child's attachment bond to the targeted parent. This specific pathology is depicted by a Structural family diagram from the preeminent family systems therapist, Salvador Minuchin.



This Structural family diagram depicts the relationship pattern of concern, a *cross-generational coalition* of a father with his son against the mother. The *triangle* pattern to the family relationships is clearly evident in the diagram, i.e., the child becomes "triangulated" into the spousal conflict by the alliance with the father against the mother.

Also evident is a symptom feature called the *inverted hierarchy* in which the child becomes over-empowered by the coalition with the allied parent into an elevated position in the family hierarchy above that of the mother, from which the child becomes empowered (by the allied parent's support) to judge the adequacy of the other parent as if the other parent were the child and the child were the parent. In the Structural family diagram from Minuchin, this symptom feature of the *inverted hierarchy* is reflected in the child's elevated position above the hierarchy line to be with the father in a "co-parenting" role over the mother, who is in the child's relative position, and who's adequacy as a parent is being judged by the child.

> **From Krugman:** "The child is elevated into the parental hierarchy and the system is stabilized through role reversal. The child may thus be either covertly allied with one parent against the other, or parentified and obliged to care for a parent." (p. 139)[3]

The *emotional cutoff* caused by the *cross-generation coalition* is reflected in the broken lines from the child to the mother, and from the father to the mother. An emotional cutoff is created by unresolved trauma in the parent being transferred to the child through aberrant and distorted parenting practices, called multi-generational trauma by Bowen (Bowen; Titelman).[4]

The three lines joining the father and son in the diagram represent a psychologically fused and over-involved relationship called enmeshment (i.e., the psychological control of

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[3] Krugman, S. (1987). Trauma in the family: Perspectives on the Intergenerational Transmission of Violence. In B.A. van der Kolk (Ed.) *Psychological Trauma* (127-151). Washington, D.C.:

[4] 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.

the child), which leads to the *emotional cutoff* in the child's attachment bond to the other parent. In the *Journal of Emotional Abuse*, Kerig notes the intertwined relationship between enmeshment and disengagement within families,

> **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)." (p. 10)[5]

An enmeshed and psychologically over-intrusive parent-child bond is a very destructive psychological relationship for a child to have with a parent, and it is why Jay Haley, the co-founder of Strategic family systems therapy, calls the cross-generational coalition a "perverse triangle," i.e., because it violates the child's psychological self-integrity and boundaries. The psychological boundaries and self-autonomy of the child should always be respected by the parent, but are violated by a cross-generational coalition.

> **From Kerig:** "The breakdown of appropriate generational boundaries between parents and children significantly increases the risk for emotional abuse." (p. 6)

> **From Kerig:** "Rather than telling the child directly what to do or think, as does the behaviorally controlling parent, the psychologically controlling parent uses indirect hints and responds with guilt induction or withdrawal of love if the child refuses to comply. In short, an intrusive parent strives to manipulate the child's thoughts and feelings in such a way that the child's psyche will conform to the parent's wishes." (p. 12)

This is the pathology of clinical concern relative to the family conflict and attachment pathology in the family courts, and this is the family pathology that requires a focused diagnostic assessment.

Psychological Control of the Child

The 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*,[6] 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 of *Intrusive Parenting: How Psychological Control Affects Children and Adolescents*, Barber and Harmon define the construct of parental psychological control of the child:

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

[6] Barber, B. K. (Ed.) (2002). Intrusive parenting: How psychological control affects children and adolescents. 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)[7]

According to Stone, Bueler, and 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)[8]

Soenens and Vansteenkiste (2010) describe the various parental methods used to achieve psychological control over 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)[9]

Stone, Buehler, and Barber (2002) describe the link between psychological control of the child and the cross-generational coalition formed with one parent against the other parent:

> **Stone, Buehler, & Barber:** "The concept of triangles "describes the way any three people relate to each other and involve others in emotional issues between them"

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[7] 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.

[8] 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.

[9] 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.

(Bowen, 1989, p. 306). In the anxiety-filled environment of conflict, a third person is triangulated, either temporarily or permanently, to ease the anxious feelings of the conflicting partners. By default, that third person is exposed to an anxiety-provoking and disturbing atmosphere. For example, a child might become the scapegoat or focus of attention, thereby transferring the tension from the marital dyad to the parent-child dyad. Unresolved tension in the marital relationship might spill over to the parent-child relationship through parents' use of psychological control as a way of securing and maintaining a strong emotional alliance and level of support from the child. As a consequence, the triangulated youth might feel pressured or obliged to listen to or agree with one parents' complaints against the other. The resulting enmeshment and cross-generational coalition would exemplify parents' use of psychological control to coerce and maintain a parent-youth emotional alliance against the other parent (Haley, 1976; Minuchin, 1974)." (Stone, Buehler, & Barber, 2002, p. 86-87)

Diagnosis Guides Treatment

Parents and the Court will need a written treatment plan. Google "mental health treatment plans" and read the first two returns. Those are descriptions of the structure for a written treatment plan. To formulate a written treatment plan will require a diagnosis. The treatment for cancer is different than the treatment for diabetes - diagnosis guides treatment. In order to obtain an accurate diagnosis, parents and the Court will need an appropriate assessment of the attachment pathology.

Appropriate Assessment

An appropriate assessment for the type of attachment-bonding pathology in the family courts involves three components representing a trauma-informed clinical psychology assessment of the child's attachment pathology

- **Trauma-informed**: A "trauma informed" assessment ensures the proper application of information sets from complex trauma and the multi-generational transmission of trauma from a parent to a child.
- **Clinical psychology**: A clinical psychology assessment is focused toward developing a written treatment plan (as contrasted with a "forensic psychology" assessment focused on child custody schedules). Clinical psychology is focused on treatment.
- **Attachment pathology**: The goal of the assessment is on developing a written treatment plan to resolve the children's attachment pathology relative to their parents. This involves the application of information sets surrounding the attachment system in childhood.

Assessment is always directed toward answering a referral question. The recommended referral question for a trauma-informed clinical psychology assessment of child's attachment pathology displayed toward a parent surrounding divorce would be,

> **Referral Question for Assessment**: Which parent is the source of pathogenic parenting[10] creating the child's attachment pathology, and what are the treatment implications?

Obtaining an Accurate Diagnosis

The differential diagnosis for attachment pathology is between severely problematic parenting by the targeted parent (i.e., child abuse) or severely pathogenic parenting by the allied parent (i.e., a cross-generational coalition of the child and parent). A trauma-informed clinical psychology assessment of the child's attachment pathology should address this differential diagnosis. There are three diagnoses that parents and the Court will want returned from the trauma-informed diagnostic assessment of the family surrounding children's attachment pathology:

1.) ICD-10 Diagnosis

The ICD-10 diagnostic system is from the World Health Organization. It is the formal diagnostic classification coding system for all medical and psychiatric diagnoses, from high blood pressure, to cancer, to diabetes, to depression, to ADHD. The ICD-10 diagnostic system is the formal diagnostic system internationally, and in the U.S. it is used as the diagnostic coding system for all medical and psychiatric pathology for insurance billing purposes.

The ICD-10 diagnosis of concern for attachment pathology in the family courts is a possible thought disorder emanating from the allied parent's influence and affecting the child, an ICD-10 diagnosis of F24, a shared persecutory delusion of the child with the allied parent, with the parent as the "primary case" (also called the "inducer"). This is the description of a shared delusional disorder from the American Psychiatric Association:

> **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)

2.) DSM-5 Diagnosis

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. The ICD-10

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[10] Pathogenic parenting: patho=pathology; genic=genesis, creation. Pathogenic parenting is the creation of significant pathology in the child through aberrant and distorted parenting practices.

is the diagnostic coding system, the DSM-5 is the description. Parents and the Court will want the assessment to generate both.

For the pathology of concern, the ICD-10 diagnosis is F24 Shared Psychotic Disorder (a shared persecutory delusion), and the DSM-5 diagnosis for creating a thought disorder in the child that then destroys the child's attachment bond to the other parent would be V995.51 Child Psychological Abuse. These specific diagnoses should be part of the differential diagnoses considered by the assessment.

3.) Case Conceptualization Diagnosis - Family Systems Therapy

The "*case conceptualization*" diagnosis is the organizing framework for the treatment. The treatment approaches available for resolving family pathology are guided by the constructs and principles of family systems therapy, one of the four primary schools of psychotherapy. To develop a written treatment plan we also need a *case-conceptualization* diagnosis from family systems therapy (as contrasted with the "*categorical*" diagnoses of the ICD-10 and DSM-5).

The family systems pathology of concern is that the child is being *triangulated* 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 relationship to the targeted parent.

- **Triangulated**: Child put in the middle.
- **Cross-generational coalition**: the problematic parenting of the allied parent.
- **Emotional cutoff**: a family member rejecting a family member; a child rejecting a parent (caused by "multi-generational" unresolved trauma originating in the parent).

Treatment Considerations

Diagnosis guides treatment. If a thought disorder (shared persecutory delusion) is present, then the DSM-5 diagnosis would be Child Psychological Abuse (V995.51). In all cases of child abuse, the standard of practice and professional duty to protect requires the child's protective separation from the abusive parent. The child's normal-range and healthy development is then recovered and restored. Once the child's healthy development has been recovered, contact with the abusive parent is reestablished with enough safeguards in place to ensure that the child abuse does not resume when contact with the abusive parent is restored.

With regard to treatment for a shared delusional disorder, the American Psychiatric Association twice indicates that a protective separation of the child from the primary case (the "inducer") will resolve the child's delusional beliefs.

> **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**: "Course - 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)

The assessment for a thought disorder pathology is a Mental Status Exam of thought and perception. For more information on the Mental Status Exam of thought and perception, Google the search term "mental status exam" and read the NCBI return, Chapter 207 of Clinical Methods,[11] scroll to the section on Thought and Perception. That is the clinical assessment for a possible thought disorder pathology, i.e., a Mental Status Exam of thought and perception.

Treatment Plan

A treatment plan is structured around four major components – Goals – Interventions – Timeframes - Outcome Measures. For a description of mental health treatment plans, I recommend a Google search for the term "mental health treatment plans" and read the top two returns. The structure for a mental health treatment plan is so standard-of-practice it returns on a simple Google search. The family therapy should be guided by a written treatment plan that follows this standard of professional practice and should include:

- Short- and long-term goals, identified in measurable ways,
- Specified interventions to achieve those goals,
- Timeframes for achieving the treatment goals, with measurable benchmarks,
- Treatment outcome data collection on symptoms and recovery

The type of therapy should be trauma-informed family therapy. The pathology creating the children's attachment pathology involves the trans-generational transmission of trauma (van der Kolk), also called multi-generational family trauma (Bowen). The additional information sets from complex trauma and personality disorders provide valuable additions to the established constructs of family systems therapy. An additional focus on the work of Marsha Linehan surrounding the "invalidating environment" that is created by a pathogenic parent would also be particularly helpful for treatment,

> **From Linehan:** "A defining characteristic of the invalidating environment is the tendency of the family to respond erratically or inappropriately to private experience and, in particular, to be insensitive (i.e., nonresponsive) to private experience… Invalidating environments contribute to emotional dysregulation by: (1) failing to teach the child to label and modulate arousal, (2) failing to teach the child to tolerate stress, (3) failing to teach the child to trust his or her own emotional responses as valid interpretations of events, and (4) actively teaching the child to

[11] Chapter 207 of Clinical Methods: Mental Status Exam https://www.ncbi.nlm.nih.gov/books/NBK320/

invalidate his or her own experiences by making it necessary for the child to scan the environment for cues about how to act and feel." (p. 111-112)[12]

From Linehan: "They tend to see reality in polarized categories of "either-or," rather than "all," and within a very fixed frame of reference. For example, it is not uncommon for such individuals to believe that the smallest fault makes it impossible for the person to be "good" inside. Their rigid cognitive style further limits their abilities to entertain ideas of future change and transition, resulting in feelings of being in an interminable painful situation. Things once defined do not change. Once a person is "flawed," for instance, that person will remain flawed forever." (p. 35)[13]

From Fruzzetti et al: "In extremely invalidating environments, parents or caregivers do not teach children to discriminate effectively between what they feel and what the caregivers feel, what the child wants and what the caregiver wants (or wants the child to want), what the child thinks and what the caregiver thinks." (p. 1021)[14]

Family systems therapy is a primary school of psychotherapy and it is the appropriate school of psychotherapy to apply to resolving family conflict (Minuchin, Bowen, Haley, Madanes, Satir). The case conceptualization for treatment should derive from the application of family systems therapy constructs (i.e., *triangulation*, *cross-generational coalition*, *emotional cutoff*).

Adjunctive Solution-Focused Therapy:

The addition of Solution-Focused Therapy[15] (Berg) will provide an additional important trauma recovery component that will substantially improve prognosis for

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[12] Linehan, M. M. & Koerner, K. (1993). Behavioral theory of borderline personality disorder. In J. Paris (Ed.), *Borderline Personality Disorder: Etiology and Treatment*. Washington, D.C.: American Psychiatric Press, 103-21.

[13] Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford

[14] Fruzzetti, A.E., Shenk, C. and Hoffman, P. (2005). Family interaction and the development of borderline personality disorder: A transactional model. Development and Psychopathology, 17, 1007-1030.

[15] Solution-Focused Therapy Wikipedia: https://en.wikipedia.org/wiki/Solution-focused_brief_therapy:

"SFBT has been examined in two meta-analyses and is supported as evidenced-based by numerous federal and state agencies and institutions, such as SAMHSA's National Registry of Evidence-Based Programs & Practices (NREPP). To briefly summarize:

- There have been 77 empirical studies on the effectiveness of SFBT,
- There have been 2 meta-analyses (Kim, 2008; Stams, et al, 2006), 2 systematic reviews.
- There is a combined effectiveness data from over 2800 cases.

treatment efficacy. Trauma pathology pulls toward an unsolvable past. The present and future orientation of solution-focused family therapy will counteract the pull of trauma toward an unsolvable fixation on the past.

Treatment Goals

Restoring the healthy attachment bonds of children with their mothers and fathers is of high and immediate priority. Healthy and affectionate attachment bonds between children and their parents need to be restored as quickly as possible. The parent-child attachment bond is too important to a child's healthy psychological development to remain unrepaired when damaged, and lost time during childhood can never be recovered. Childhood is once. The goal of psychotherapy is not merely to eliminate pathology, the goal is to achieve healthy child development. The goal of psychotherapy is to achieve a healthy attachment system in the child, with a healthy attachment bond to the mother and to the father – neither parent is expendable, and both are vital to the child's healthy development.

In American Psychologist,[16] the primary journal of the American Psychological Association, Mary Ainsworth, a leading figure in attachment research provides the following description of a healthy attachment bond:

> **From Ainsworth:** "I define an "affectional bond" as a relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other. In an affectional bond, there is a desire to maintain closeness to the partner. In older children and adults, that closeness may to some extent be sustained over time and distance and during absences, but nevertheless there is at least an intermittent desire to reestablish proximity and interaction, and pleasure – often joy – upon reunion. Inexplicable separation tends to cause distress, and permanent loss would cause grief." (p. 711)
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> **From Ainsworth:** "An "attachment" is an affectional bond, and hence an attachment figure is never wholly interchangeable with or replaceable by another,

- Research was all done in "real world" settings ("effectiveness" vs. "efficacy" studies), so the results are more generalizable.
- SFBT is equally effective for all social classes.
- Effect-sizes are in the low to moderate range, the same that are found in meta-analyses for other evidence-based practices, such as CBT and IPT. Overall success rate average 60% in 3–5 sessions
- The conclusion of the two meta-analyses and the systematic reviews, and the over-all conclusion of the most recent scholarly work on SFBT, is that solution-focused brief therapy is an effective approach to the treatment of psychological problems, with effect sizes similar to other evidenced-based approaches, such as CBT and IPT, but that these effects are found in fewer average sessions, and using an approach style that is more benign (Gingerich et al, 2012; Trepper & Franklin, 2012). That is, the more collegial and collaborative approach of SFBT does not involve confrontation or interpretation, nor does it even require the acceptance of the underlying tenets, as do most other models of psychotherapy. Given its equivalent effectiveness, shorter duration, and more benign approach, SFBT is considered to be an excellent first-choice evidenced-based psychotherapy approach for most psychological, behavioral, and relational problems."

[16] Ainsworth, M.D.S. (1989). Attachments beyond infancy. American Psychologist, 44, 709-716.

> even though there may be others to whom one is also attached. In attachments, as in other affectional bonds, there is a need to maintain proximity, distress upon inexplicable separation, pleasure and joy upon reunion, and grief at loss." (p. 711)

A child rejecting a parent is the worst attachment pathology possible in childhood, pathology in a primary motivational system of the brain developing its patterns to guide love-and-bonding throughout the lifespan during childhood, through relationships with both parents. Leaving the worst possible attachment pathology untreated and unrepaired is the worst possible thing we can do. It is always in the child's best interests to have a healthy and normal-range attachment bond to both parents. It is always in the child's best interests for the family to make a healthy and successful transition to a post-divorce separated family structure. Successful treatment that restores a healthy and normal-range attachment bond between children and their parents is always in the child's best interests.

The child unites two families into the fabric of their being, two family lineages, two family heritages, two family cultures are brought together and united in who they are. For a child to reject either parent is for the child to reject half of themselves. Children are not weapons. Children should never be used as weapons in the spousal conflict surrounding divorce. When one parent weaponizes the child into the spousal conflict, we must protect the child. The clinical concern is for a DSM-5 diagnosis of Child Psychological Abuse by the allied parent (V995.51), a thought disorder in the parent imposed on the child. This needs a proper assessment to reach an accurate diagnosis.

When potential child abuse is a considered diagnosis, the diagnosis returned from the mental health system for the Court must be accurate 100% of the time. Do whatever it takes to answer any question that needs to be answered, seek any consultation for information that is needed, conduct any response-to-intervention trial required to achieve an accurate diagnosis, do whatever it takes. Because when child abuse by a parent is a considered diagnosis for the Court's decision, the diagnosis from the mental health care system must be accurate 100% of the time.