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Honorable
County of
Family Court Division
?? street
City, State

Dear Judge ——-:

Attached you will find my twenty-one (21) page Amicus Brief addressing why the conventional/traditional therapies typically ordered by the Court to heal a severely damaged or severed parent-child relationship, at the orchestration of the favored parent with whom the child has aligned, usually result in catastrophic failures and frequently produce child safety concerns.[1] This Amicus Brief will further discuss the safe and effective, highly specialized interventions adopted by true specialists in family therapy to treat this dysfunctional family phenomenon which goes by many names but which all—regardless of label—describe the same family dynamics. In the end, "a rose by any other name is still a rose." These interventions were found by peer-reviewed research to be safe and effective. Of particular note, this dysfunctional family phenomenon meets all generally accepted definitions of child psychological abuse. As such, I opine in this Amicus Brief, along with my colleagues, that appropriate remedy should be ordered in accordance with the remedy for any other form of child abuse. (DSM-5: p, 719; Lorandos & Bernet, 2020; Joshi, 2021; Kaplan & Sadock, 2017; Judge and Deutsch, 2017; Clawar & Rivlin, 2013, Miller, 2013; Gottlieb, 2012, 2013; Warshak, 2015, 2018; Reay, 2015; et. al.)

[1] This Amicus Brief assumes that the rejected/resisted parent has not engaged in behaviors that meet the criteria of clinical significance for child abuse or neglect—the behaviors having been assessed according to the scientific method to make accurate clinical findings.

I cite, as follows, a mere fraction of professional and clinical references declaring this family phenomenon of to be a form of child psychological abuse:

DSM-5:

> Child Psychological Abuse" (995.51):
>
> Child psychological abuse is nonaccidental verbal or symbolic acts by a child's parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child … Examples of psychological abuse of a child include berating, disparaging, or humiliating the child; threatening the child; harming/abandoning----or indicating that the alleged offender will harm/abandon-----people or things that the child cares about. (P. 719.)

Demosthenes Lorandos, PhD, JD & William Bernet, MD (2020):

> No expert or professional group has stated the reverse, i.e., that causing severe PA *[parental alienation]* is not a form of child maltreatment. Since PA constitutes significant psychological harm to the child, causing severe PA should be classified as a form of child psychological abuse. (p. 17)

Ashish Joshi, ESQ (2021):

> Parents who are repeat offenders and are simply unable to refrain from a "repeated pattern" of "interfering with or directly undermining the child's important relationships" are upsetting the child's "basic psychological needs." (p. 55)

I cite, as follows, a mere fraction of professionals who recognize the catrasrtrophic failures of conventional/traditional therapies to treat this dysfunctional family phenomenon:

***Clawar & Rivlin** (2013)* labeled the parent with whom the child severely aligns in this family phenomenon as the "brainwashing/programming parent." They affirmed the following in their 2013 book entitled, *Children Held Hostage: Identifying Brainwashed Children, Presenting a case, and Crafting Solutions*, published by the American Bar Association:

> "We have added 300 new cases to our original sample of 700, for a total of 1000 cases . . . Our research continues to confirm that, even under court order, traditional therapies are of little, if any, benefit in regard to treating this form of child abuse." (p. xxvii.)

***Steven G. Miller, MD**,* (2013) describes the severely or pathologically-aligned parent as manifesting "serious co-morbid psychopathology…severe cognitive distortions, profound emotional dysregulation, and extreme or bizarre behavior" (p. 11.) Dr. Miller further affirms the treatment failure of the aligned relationship between the child and favored parent when their relationship had become so enmeshed and eclipsing of the child that the relationship can be characterized as "pathological enmeshment." In his highly regarded and

repeatedly cited chapter entitled, "Clinical Reasoning and Decision-making in Cases of Child alignment, Dr. Miller writes:

> Therapists who insist on a trial of conventional therapy are exceedingly unlikely to succeed ... Such an approach is worse than worthless because while the therapist provides futile treatment, the child, already injured, is deprived of effective intervention– including protection. (p. 16)

Ashish Joshi, ESQ, describes the phenomenon of alienation as an "unhealthy, toxic, and often pathological situation in which a child rejects a parent" (p. 1.) He writes the following in his often-cited 2021 book entitled, *Litigating Parental Alienation:*

> Parties come to court already entrenched in the thick of an embittered alienation struggle. Once the alienation passes this threshold and is entrenched, more aggressive intervention measures are warranted. At this point, traditional therapies almost never work. (p. 55)

Of particular note, it is not primarily the relationship between the child and rejected/resisted parent that requires remedy: it is the relationship between the child and aligned parent, which has become pathologically enmeshed,[2] that actually requires a far greater need for remedy. This relationship is anything but "healthy bonding." The relationship is abusive of the child. Perhaps a more informative way to describe this dysfunctional family phenomenon is to view it as "pathological child alignment" between the child and the favored parent resulting in the child's rejection of or resistance to a meaningful relationship with the other parent due to brainwashing/programming and manipulation by the aligned favored parent.

The purpose for submitting this Amicus Brief is to provide the Court with probative, relevant, admissible information about ineffective and effective treatment in order to assist the trier of facts to resolve competing and contradictory recommendations for treatment of this family phenomenon, which I am referring to as "pathological child alignment."

Of particular note, the issues arising in cases of "pathological child alignment" often elude the understanding of many accomplished, seasoned forensic evaluators and clinicians who nonetheless lack the specialized knowledge and expertise to determine and/or implement appropriate treatment recommendations for this clinical presentation. On the other hand, I trust that my 50+ years of training, education, and experience—in conjunction with my history of having provided testimony to the Courts across the country regarding my

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[2] Pathological enmeshment between child and the favored parent is a severe boundary violation of the child by the alienating parent. This boundary violation presents a severe psychiatric condition for the child in which the alienating parent robs the child of the child's own feelings, opinions, wishes, beliefs, and needs and then imposes those of the alienating parent. The enmeshment strips the child of her/his identity, autonomy, and age-appropriate independence. This is hardly healthy bonding. Pathological enmeshment is played out in three forms that are psychologically harmful to the child: infantilization, adultification, and parentification.

scientifically-informed opinions and recommendations about this family phenomenon—will be informative to the trier of the facts in this case.

Although it is generally assumed that a licensed mental health practitioner is an expert in this family phenomenon and further possesses the specialized knowledge, skills, and experience to properly assess and treat cases of "pathological child alignment," such an assumption is perilously mistaken for a number of reasons.

Firstly, "pathological child alignment" is an extraordinarily complex and counterintuitive clinical presentation. Non-specialists in this clinical presentation typically assess these cases to be merely a parent-child relationship problem. To the contrary, Steven Miller, MD, (2013) affirms:

> Severe cases tend to be clinical in a *medical* sense of the word—the underlying psychopathology is often associated with severe cognitive distortions (including shared delusions and/or other psychotic or quasi-psychotic thinking), profound emotional dysregulation, and extreme or bizarre behavior. If clinicians fail to consider the total clinical picture—including any underlying psychopathology—they may fail to appreciate the severity and complexity of the situation. That, in turn, has major implications for diagnosis, treatment, prognosis, and outcome. (p. 11)

With respect to the favored/aligned parent's psychological functioning, Dr. Miller affirms:

> Such cases are not for the novice. Cases of severe parental alienation often exceed the expertise of highly skilled practitioners unless their special expertise includes treatment of severe child alignment, treatment of severe mental illness, and treatment of personality disorders. Treatment of all three may be necessary to achieve a good outcome or even to prevent catastrophic deterioration. (p. 11)

Dr. Miller's provides the following caveat to the practitioner who is confronted with a decision of whether or not to accept an assignment to assess and/or treat a case of severe or pathological child alignment:

> Clinicians who attempt to manage them without adequate skills are likely to find themselves presiding over a cascade of clinical and psychosocial disasters. (p. 11)

Secondly, just as the medical field consists of various levels of specialization beyond the primary practice level, so does this apply to mental health conditions. As in medicine, it stands to reason that it is not possible for a mental health practitioner to specialize in every mental health condition and phenomenon. Before a mental health practitioner is therefore presumed to specialize in this extraordinarily complex, counterintuitive family phenomenon of "pathological child alignment," the practitioner—like the physician—must provide documentation of her or his skills, knowledge, and experience in the following areas: 1) the philosophical underpinnings of the specialized discipline of family therapy—underpinnings that differ from *every* other form of mental health therapy; 2) specialization in the sub-specialty of pathological child alignment; 3) clinical reasoning and decision making; 4) application of the scientific method to the evidence in the case in order to rule

in the correct diagnosis/findings and to rule out the incorrect diagnoses/findings; 5) knowledge of and experience with the numerous counterintuitive issues arising in cases of pathological child alignment with one parent resulting in the rejection of or resistance to a relationship with the other parent.

I make an explicit point here that I have not evaluated the litigants nor the child(ren) in this case. Nor do I support one litigant over the other. This Amicus Brief is, instead, a generic Brief for the purposes of 1) documenting the reasons for the failure of traditional or conventional therapies to safely and effectively treat the family phenomenon of "pathological child alignment" and 2) assisting the trier of the facts to resolve competing and contradictory recommendations regarding effective treatment for this clinical condition.

Finally, I declare that I was neither compensated nor otherwise received any financial benefit or other benefits for writing this Brief.

Should at the time of the hearing I need to be directly contacted for any clarification or confirmation, my office phone number is (631) 707-0174, and I would be more than happy to telephonically or by other teleconference means, under Oath, opine about relevant questions Your Honor would require of me.

Respectfully signed on letterhead and submitted for the case of **Plaintiff v. Defendant**

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Case NO:

Case Name

Honorable
County of
Family Court Division
One Street
City, State

Declaration of Linda J. Gottlieb, LMFT, LCSW-R

Dear Judge.   :

My name is Linda J. Gottlieb, LMFT, LCSW-R, and I am writing this Amicus Brief documenting the reasons for the recurring failures of traditional or conventional models of therapy to safely and effectively treat the dysfunctional family phenomenon that I am labeling “pathological child alignment.” Pathological child alignment occurs when a parent manipulates and brainwashes a child to join with that parent in a cross-generational, enmeshed alliance to reject, marginalize, humiliate, and dismiss the other child absent a bona fide protective reason. I am further writing this Brief to educate the trier of the facts about the requirements of safe and effective treatment for this family phenomenon.

Safe and effective treatment for a clinical condition is predicated upon developing a “differential diagnosis” of the clinical condition. Given that “pathological child alignment” is exceedingly complex and exceedingly counterintuitive, it is commonly missed and misdiagnosed by many forensic evaluators and mental health practitioners. The catastrophic result of misdiagnosis in these cases is that the treatment typically recommended and ordered is actually contraindicated. “Contraindicated” means forbidden. Of particular note, for example, when this phenomenon is missed, the aligned parent’s psychological abuse of the child is needlessly and unforgivably prolonged. Another significant concern as to why traditional therapies are contraindicated for this clinical condition is their focus on “*that* the child has rejected a parent”—meaning that the *symptom* becomes the target for intervention. Appropriate treatment of this clinical condition requires, instead, focus on “*why* the child has rejected a parent”—meaning that the *cause* of the rejection becomes the target for intervention. Targeting for intervention the cause of a clinical condition is almost always—if not always—the priority for treatment and the standard procedure to address remedy of a clinical condition. Failure to determine and target the cause of the child’s rejection/resistance to the rejected parent is a serious violation of the clinical axiom to “develop a differential diagnosis.”

What other factors contribute to the pervasive misdiagnosis of cases of "pathological child alignment?"

The reality is that misdiagnosis, along with other clinical errors, is a common occurrence in the mental health field in general. According to peer-reviewed research, this is the result of the rampart failure in the mental health community to be informed by science (Bagley, 2009; Baker, McFall, & Shoham, 2009.)

Baker and his colleagues write the following about this in their article entitled, "Current Status and Future Prospects of Clinical Psychology: Toward a Scientifically Principled Approach to Mental and Behavioral Health Care":

> Clinical psychologists' failure to achieve a more significant impact on clinical and public health may be traced to their deep ambivalence about the role of science and their lack of adequate science training, which leads them to value personal clinical experience over research…. Clinical psychology resembles medicine at a point in its history when practitioners were operating largely in the prescientific manner"

What this means with respect to cases of "pathological child alignment" is that mental health practitioners tend to demonstrate a pervasive penchant to unjustifiably rely upon their intuitive reasoning that the child and the aligned parent are truthful, accurate, and reliable reporters—incredibly believing this despite the exceedingly counterintuitive nature of these cases. The result is that these practitioners give unjustified weight to the self-reporting of the child and aligned parent.

Further challenging the reliability of the child's reporting is the substantial peer-reviewed research that finds children to be highly suggestible—such that even an unfamiliar researcher is able to implant in the child false memories (that can even suggest sex abuse.) The taking root of implanted false memories results in as few as three interviews (Bruck & Ceci, 1997; Loftus, 1999, 2000; Shaw, 2017.)

Bruck and Ceci (1997) write the following in their article entitled, "The Suggestibility of Young Children," published in *Current Directions in Psychological Science:*

> When children are repeatedly and suggestively interviewed about false events, assent rates rise for each interview. Subtle suggestions can influence children's inaccurate reporting of nonevents that, if pushed in follow-up questioning by an interviewer who suspected something sexual had occurred, could lead to a sexual interpretation.

One can only imagine the ease with which a parent—upon whom the child is dependent for survival—can implant in the child false, negative memories regarding the other parent and manipulate the child to believe and say anything the favored parent desires.

Further challenging the reliability of intuitive reasoning to assess the truthfulness of the child's and aligned parent's self-reporting is peer-reviewed research that found that humans

are extremely poor lie detectors—being able to distinguish a lie from the truth only 54% of the time. (DePaulo & Bond, 2006)

Further challenging the reliability of intuitive reasoning to assess the truthfulness of the child's reporting is extensive peer-reviewed research that found that lying and deception come naturally and readily to humans—lying and deception being part of our "survival tool box." Because lying is so innate in humans, children can appear quite credible, even when ***relating the most fantastic lie. (Slater, 2013, 2018; Friedman, 2003; et al.)***

Theodore Schaarschmidt (2018) writes the following in his article entitled, "The Art of Lying" published in the *Scientific American*:

> Lying is among the most sophisticated and demanding accomplishments of the human brain… Lying is a major component of the human behavioral repertoire; without it, we would have a hard time coping. Small children love to make up stories, but they generally tell the first purposeful lies about age 4 or five.

We have to teach children not to lie—not an easy accomplishment for any parent!

Further challenging the reliability of intuitive reasoning to assess the truthfulness of the child's and aligned parent's reporting is the "expertise" that the pathologically aligned parent possesses. This expertise is actually the result of their psychological disabilities! Extensive research has found that these parents have a high probability of suffering from one or more personality disorders. (A child who is in the primary care of a parent with a personality disorder has a high probability of developing a personality disorder.) Those who have a personality disorder is an expert at impression management and mimicking normal behaviors—so no surprise that the enmeshed child and pathologically aligned parent so readily fool and deceive even the most seasoned mental health practitioners and non-clinical professionals.

According to the DSM-5, a personality disorder is:

> An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." (p. 645)

Clawar & Rivlin (2013) affirm the following regarding the personality of the aligned parent:

> The programming and brainwashing parent above employed the "*shotgun approach*." It is characteristic of these parents to attack any and all people who even seem to be supportive of the alienated parent. (P. 275)
>
> The effect of the shotgun approach was to cause all parties extensive outlays of money, time, energy, and anxiety. It is part of their socially abusive (and, at times, ***sociopathic****) [bold print mine]* style of operation. The behaviors are generally resistant to change and *usually will not*

> *cease until there are powerful sanctions* (financial and legal) for frivolous litigation and/or custody allocation to the alienated parent. Even then they may not stop. (P. 275)
>
> Escalation takes many forms. **Increasing the pressure on children**, *[bold print min*e] cranking up litigation accelerating rumors, and heightening allegations are just a few examples of what may take place. (P. 276)

Kelly and Johnston (2001) cite the findings as follows of the research and clinical literature regarding the pathology of several aligned parent:

> Both empirical research and clinical observation indicate that there is significant pathology and anger in the parent encouraging the alienation in the child, including problems with boundaries and differentiation from the child, severe separation anxiety, impaired reality testing, and projective identification with the child. It is not a normal parental strategy to encourage the complete rejection of the other parent. Even when there is a history of child abuse, the other parent is mentally built, the child safety is in danger, the average parent will seek different avenues and more rational means of protecting the child. Furthermore, such parents often recognize that their child loves that parent despite the destructive behavior. (p. 258)

Even though intuitive reasoning is known to have an exceedingly high error rate for informing findings, there remains a rampart tendency of mental health practitioners to fail to verify with neutral, corroborative evidence the child's and aligned parent's self-reporting. According to Dr. Miller, when this occurs, the mental health practitioner is violating the clinical axiom to "use proper reasoning." (Miller, 2013)

Given all of the above challenges to findings that are informed exclusively, or almost exclusively, by intuitive reason, the legal and mental health communities tend to give unjustified, excessive "weight to the voice of the child" even without having verified the child's reporting with neutral corroborative evidence. This occurs despite the well-recognized adage that "Self-reporting is highly unreliable." Erroneous and even backwards findings are typically the inevitable result of mental health practitioners' penchant for rejecting science by failing to abide by the clinical axiom to "use proper reasoning.' Erroneous and backwards findings all-too often result in cases of "pathological child alignment." An example of the typical backwards findings is that the aligned parent is deemed to be "healthily bonded" to the child when, in actuality, the aligned parent is pathological enmeshed with the child; conversely, the rejected parent is typically assessed to be have violated the child's boundaries by appearing, uninvited, at the child's games and concerts, although it is the rejected parent who typically maintains appropriate boundaries with the child.

Some of the more common, catastrophic mistakes occurring in the traditional/conventional therapies that are court-ordered to treat "pathological child alignment":

Mistake 1: Failure to abide by the clinical axiom to "determine a differential diagnosis" is a common catastrophic clinical error. It is *never* appropriate for a therapist to treat *any*

condition without first having evaluated the client or clients. It is *never* appropriate to provide generic treatment for "a relationship problem" without first having undertaken an evaluation to assess the child and family dynamics.

Frequently clinicians justify their failure to have undertaken an evaluation to determine the differential diagnosis by stating, "I was not hired to do an evaluation." Therapists who make this claim attempt to equate a routine clinical evaluation (with a small e)—for which an evaluation is *always* required—with a formal Forensic Evaluation (with a capital E). No one should *ever* fall for this common ploy! This erroneous justification is an example of the equivocation fallacy.

When confronted with the clinical presentation of a child who is rejecting a parent, therapists are bound by the standards of clinical practice to determine the *cause* of the child's rejection before implementing a treatment intervention. It is critically important to determine the cause because the treatment for a case in which the child's rejection had been orchestrated by the aligned parent absent a bona fide protective reason is diametrically opposed to the treatment of a case in which the child's rejection was due to bona abuse or neglect on the part of the rejected parent.

An initial step to determine a differential diagnosis is to generate all competing plausible hypotheses to explain the cause of the clinical condition and then to apply the evidence or tests in the case to each hypothesis in order to rule out the incorrect hypotheses and to rule in the correct hypothesis. Rejected parents have a *right* to expect the therapist to undertake an evaluation to determine a differential diagnosis.

Mistake 2: Failure to abide by the clinical axiom to "treat the underlying condition" is a clinical error that portends catastrophic consequences for the child—specifically because this failure results in leaving the child in the care of an abusive parent. In the case of "pathological child alignment" the abuse inflicted on the child by the aligned parent is the "underlying condition" and must therefore be the treatment priority. "Pathological child alignment" is a form of family violence and proper treatment therefore requires an intervention based *upon a child maltreatment and child protection model.* As previously noted, the family dynamics occurring in "pathological child alignment" meet every generally accepted definition of child psychological abuse. Child protection must therefore be the primary focus of the intervention, while the healing of the damaged or severed relationship between the child and the rejected parent is secondarily the focus of intervention.

Ashish Joshi, ESQ (2021) declares the following regarding the priority to rescue the child from past abuse and protect the child from ongoing, future abuse as a result of this dysfunctional family phenomenon:

> The court interventions must first address the safety, permanence, and well-being of the alienated child. In a child abuse and neglect construct, this is often accomplished by providing mental health psychoeducational services to the family and through a temporary or permanent

separation of children from an unsafe or risky environment. (p. 55)

As mandated reporters and as professionals in a case of pathological child alignment we cannot turn a blind's eye to the ongoing abuse perpetuated on the child by the aligned parent.

Mistake 3: Failure to abide by the clinical axiom to "use proper reasoning"—meaning giving undue weight to intuitive reasoning that is not corroborated by analytical reasoning. As noted, the catastrophic outcome of failing to comply with this clinical axiom results in findings that are not merely erroneous but are backwards. In cases of "pathological child alignment," relying upon intuitive reasoning that the child is reporting accurately, truthfully, and freely is a catastrophic mistake. Of particular note, the brainwashing in alienation is likened by the scientific community to the brainwashing in a cult. The pathologically aligned child is not a free agent and can more be expected to report feelings and opinions different from those of the aligned parent than can a cult member report differently than the cult leader. (Joshi, 2021; Lorandos and Bernet, 2020; Warshak, 2015, 2018; Gottlieb, 2012, 2013; Miller, 2013; Clawar & Rivlin, 2013; Rosen, 2013; Reay, 2015, Baker and Fine, 2013; et. al.)

Despite all of the above, giving unjustifiable credence and weight to the voice of the child is the present-day norm in family court proceedings, traditional/conventional therapies, sex abuse evaluations and treatment, and in CPS investigations. Before deciding how much weight—if any at all—should be given to the voice of the child, the evaluator or clinician must first rule out for suggestibility and programming of the child by the aligned parent.

It behooves the practitioner to instead give significant weight to the finding by Clawar and Rivlin (2013) that, of the 1000 children of high parental conflict they had followed, 86% experienced brainwashing/programming by one parent against the other parent at least one time weekly. (p. 420)

Mistake 4: Mirroring, empathizing, and validating the child's feelings and wishes is another contraindicated intervention that is almost always practiced in traditional/conventional therapies. Therapists should not permit—and should certainly not encourage—that the therapy sessions become a forum for the child to:

§ voice fabricated or delusional opinions, which the therapist then requires of the rejected parent to validate and accept (it is never therapeutic to validate delusional thinking);
§ assert alleged grievances against the rejected parent that have no basis in reality;
§ disrespect or denigrate the rejected parent;
§ disrespect or denigrate the therapist;
§ express opinions and feelings disrespectfully or uncivilly;
§ set the agenda for the therapy session;
§ haggle, threaten, cajole, brow-beat, manipulate, etc. in order to get one's way.

Mistake 5: Requiring the rejected parent to apologize for deeds and behaviors that are knowing false or had been accepted as true without neutral corroboration. Apologies backfire and are never accepted: pathologically aligned children reject the apologies as being too little, too late, not genuine, not sincere, all of the above. Apologies often reinforce the child's over-empowerment and the rejected parent's disempowerment. Apologies are humiliating to the rejected parent. Apologies for false allegations of abuse/neglect and for other false allegations only reinforce the Topsy-Turvey family dynamics and undermine healthy family hierarchy. Apologies provide ammunition to the favored parent who declares, "Aha, finally you get a long-overdue apology!"

And imagine the consequences to the rejected parent for having apologized for a false sex abuse allegation—which some traditional therapists have required!

My mentor, Salvador Minuchin, child psychiatrist and a pre-eminent founder of the Family Therapy Movement, declared that there is only one reason a child rejects, maltreats, and/or defies a parent, and the reason is that the child is standing on the shoulders of the other parent, whom Dr. Minuchin referred to as "the aligned parent." Just visualize that metaphor, and it is plainly obvious that the child is empowered over both parents!

The parent who needs to apologize is the aligned parent, but this apology is virtually never requested by traditional/conventional therapists. Apologies need to be given to all family members who have been harmed by the dysfunctional family dynamics orchestrated and engineered by the aligned parent. In her book, *Sex, Love, and Violence,* Cloé Madanes HDL, LIC (1990), addresses the therapeutic necessity of apologies to family healing. She suggests that the apology take the form of a ritual, as a symbol of contriteness and to remediate the harm done by a family member in order for forgiveness to be granted by the harmed family members. Madanes states:

> Rituals are useful in marking the transition from one stage of family life to another or to indicate a transition in a relationship. The drama of the ritual should be commensurate with the severity of the problem presented to therapy... Rituals are particularly indicated when people have to overcome very bad things they have done to each other.... The ritual signifies that the past is over and that this is a new beginning.... The more extreme the problem, the more extreme the ritual that the therapist devises. Rituals are metaphors that bring people together in positive ways. The ordeal is a strategy devised by Milton Erickson to make it more difficult for a person to have a symptom than not to have it. (p. 20)

As with the other co-founders of the family therapy movement, Madanes was particularly concerned about "the abuses of power which typically occur when healthy family hierarchy is disturbed." Madanes described these abuses as "the ruthless striving for personal advantage" (P.18.) In her discussion of various corrective strategies for these abuses, Madanes declared, "The principle is simple: to make the consequence of the violence more unpleasant to the victimizer than to the victim" (p. 19.) Forgiveness by the injured parties, according to Madanes, can be granted only after an appropriate "ritual" by the abusive family member is provided to the injured family members (p.18.)

Mistake 6: Allowing the child to orchestrate the therapy is another serious mistake that undermines the therapy. Because traditional/conventional therapists typically fail to recognize just how overempowered the aligned child is, they counterintuitively endeavor to further empower the already overempowered child by allowing the child to control the therapy. For example, traditional/conventional therapists typically allow the child to:

- choose whether or not to show up for the therapy;
- dictate what can and cannot be discussed in the therapy;
- unilaterally decide to "take a time out" by absconding from the room;
- decide whether or not to talk and participate—or even get out of the aligned parent's car to make an appearance at the therapist's office;
- determine when the session is over;
- make unreasonable demands of the rejected parent and the therapist.

The rejected parent will never be able to resume her or his appropriate status in the family therapy under these "therapeutic" conditions.

Mistake 7: The therapist permits the child to verbally abuse, defy, and sometimes even become aggressive or physical toward the rejected parent. This is anything but therapeutic. In fact, it is normalizing for and permitting the child to engage in antisocial behaviors—just as the aligned parent has permitted and has likely modeled and encouraged. Providing this anti-therapeutic environment—whether intentional or not intentional—is grooming the child to develop an antisocial personality disorder.

When the therapist permits children to verbally abuse, maltreat, and/or defy a parent, it is not therapy: It is therapist-assisted Elder Abuse.

Mistake 8: Failure to comply with the "Patient's Bill of Rights" and the clinical axiom to collaboratively identify appropriate criteria to assess progress and success and to identify estimated targeted dates for goal achievement. Of particular note, goals must include *behavioral changes* on the part of the child and aligned parent, who has caused the damaged or severed relationship between the other parent and their child.

Unfortunately, traditional therapists rarely develop a written treatment plan at all and virtually never one that addresses behavioral changes and timely goal achievement. Imagine a medical provider being given free rein to never provide the patient with her or his diagnosis, never identify treatment procedures, never provide the patient with estimated target dates for the termination of treatment, and to never share and discuss the treatment plan with the patient! Who would ever accept medical treatment under those conditions?!

Yet, the pervasive failure to develop an appropriate, collaborative treatment plan seems to be the modus operandi in mental health treatment and especially in cases of pathological child alignment. Somehow, "Are we there yet?" is never realized in these cases. And yet, for attempting to hold the therapist accountable for compliance with the stipulations in the

“Patient’s Bill of Rights, the rejected parent is often criticized by the professionals in the case and penalized by the Court.

Vague or subjective opinions of *“making progress”* expressed by the therapist, by the aligned parent, or by the child should not be uncritically accepted as progress. *Actions* speak louder than words. Since there have been no behaviors on the part of the rejected parent that meet the criteria of clinical significance for abuse or neglect (or the case would not be one of unreasonable or unjustifiable rejection of a parent,) there must be a plan for speedy resumption of meaningful contact between the child and rejected parent. The treatment plan must therefore incorporate meaningful, measurable steps to restore the rejected parent’s parenting time.

These children will *enthusiastically* welcome their rejected parent back in their lives and behave lovingly towards that parent should their aligned parent convey genuine approval for the child to do so. These children will flip like a light switch to embrace their rejected parent—but only *if and when* the aligned parent releases the child from the loyalty web which that parent had imposed upon them.

Mistake 9: The recommendation to take “baby steps” towards restoring contact between the child and rejected parent is an abysmal, unscientifically-supported recommendation. It is pure speculation, being based on the faulty assumption that the child needs “time to adjust to the rejected parent”—as if that parent is dangerous or can be tolerated only in small doses. The child’s readiness for contact with the rejected parent *is contraindicated by proceeding at a snail’s pace*. The child’s readiness for contact with the rejected parent is, to the contrary, aroused by frequent, intensive, meaningful contact with the rejected parent. Experiences and contact are the greatest antidotes to the disrupted relationship.

Mistake 10: Failure of the therapist to recognize a failed therapy results in prolonging the child abuse and prolonging the suffering of the rejected parent. Should the therapy fail to achieve, in a relatively short period of time, significant behavioral changes—changes that are satisfactory to the rejected parent—then the therapy is a failure! It is worth repeating that, if the aligned parent is genuinely supportive of the child’s relationship with the other parent, the child will immediately appreciate that and enthusiastically welcome the rejected parent back in his or her life. Short of the aligned parent’s genuine and demonstrated support for the relationship between the other parent and their child, conventional/traditional forms of therapy will virtually never be successful—if at all.

Feelings take time to change—and do so typically in response to behavioral changes—so it is incumbent upon the therapist to *require* behavioral changes of the aligned parent. These changes must include to conveying to the child genuine, unequivocal, and demonstrated support for the child’s relationship with the other parent. Failing to require of the aligned parent these behavioral changes is akin to giving antibiotics to a patient with an infection and returning the patient to the germ infested environment that had caused the infection.

It is incumbent upon the traditional therapist to recognize that the aligned parent's environment must be significantly modified in order to facilitate and to expedite the healing of the relationship between the other parent and their child via this form of therapy. Modification by immediate behavioral changes in the aligned parent is the only standard by which to judge the necessity for the child's removal from that parent. I am often asked about how to judge if the aligned parent is genuine when conveying to the child support for the child's relationship with the other parent. I respond that judging is easy: it will be evident in the child's embrace of the rejected parent. The proof is in the pudding, so to speak.

Childhood is not forever, and lost childhood time can never be recouped. Therefore, time is of the essence in requiring of the aligned parent demonstrated, meaningfully behavioral changes. If the aligned parent refuses or fails to make the appropriate changes, then the therapy must be terminated in favor of a higher level of intervention. It is a violation of the standards of clinical practice to continue to provide a knowingly failed treatment.

Mistake 11: Blaming the rejected parent for a failed therapy is a common, disastrous outcome of traditional/conventional therapies and result in misguided and catastrophic recommendations that deflect blame from the therapist, give the aligned parent a pass, further empower the overempowered child, and further humiliate and disempower the rejected parent. The typical recommendations are for the rejected parent to engage in various therapies while other recommendations are contraindicated; these recommendations are devoid of clinical justification. Some of them are to:

- § attend anger management therapy;
- § participate in parent education counseling;
- § take a time out and step back from pursuing a relationship with the child;
- § wait for the child to have a spontaneous epiphany and seek out the rejected parent (something that rarely occurs).

Unforgivably, conventional/traditional therapists typically fail to recognize, and therefore fail to address, the child abuse being inflicted on the child by the aligned parent.

So the reader inquiries: "Are there any elements within the traditional/conventional therapy models that have the potential for success, if so, what would those be?"

First, let us acknowledge, based on all of the above, that pathologically aligned parents are highly resistant to change; have difficulty acknowledging their mistakes (and one cannot fix what one does not perceive to be broken); experience diminished reality testing and likely delusional thinking at least on some level; are emotionally dysregulated, immature, and dependent; and likely suffer from one or more personality disorders. These are hardly characteristics that would lead an aligned parent to voluntarily cooperate with a therapy designed to heal the relationship between the other parent and their child. Nonetheless, courts are initially inclined to order a less intensive intervention—even in the face of clear and convincing evidence that the case is one of severe child alignment. Despite peer-

reviewed research confirming the safety and effectiveness of the more intensive treatment interventions, courts are generally averse to ordering an intervention that requires a no-contact period between the aligned parent and child. This development occurs even when the child's removal from the aligned parent is justified by child protective criteria and the removal is in accordance with child protection protocols. Although I recognize the rationale for the court's initial reluctance ordering a therapeutic intervention that requires the no-contact period, we must bear in mind that, as long as the child remains with the aligned parent, the child is being subjected to psychological abuse.

Therefore—in consideration of: realities; our human tendency to resist change; the erroneous belief that doing nothing is less risky than doing something that is novel and intense;[3] threats by the child, which research demonstrates are not acted upon (Warshak, 2015); the false belief that the child's relationship with the aligned parent is healthy bonding; the *unscientific* claim that the phenomenon addressed in this Amicus Brief does not exist; the false claim that the more intensive treatment interventions have not been peer-reviewed for safety and effectiveness or simply do not work; of any other fantastic speculation about this family phenomenon and how to treat it—I suggest the following short-term, somewhat conventional intervention, but on the condition that the aligned parent *immediately* ceases all psychologically abusive behaviors of the child.

The elements of a short-term modified conventional treatment intervention

Element 1: The aligned parent must be viewed as the primary target for intervention with demands for immediate behavioral changes that include sending the message to the child(ren) of genuine support for their relationship with the other parent. One way to demonstrate this support would be to have the aligned parent write a meaningful letter of support for the relationship and then make a video demonstrating support. Failure by the aligned parent to demonstrate support via behaviors *must* be met with skepticism. Failure of the aligned parent to make these behavioral changes and other changes to free the child from pathological alignment must be met with severe penalties by the court.

Element 2: The aligned parent must *require* the child's relationship with the other parent. It is a charade to claim that "it has been the child's choice" to reject/resist a relationship with the rejected parent." Normal parents do not delegate to the child decision-making over family relationships. The aligned parent cannot claim competency as a parent while simultaneously being unable to get the child to do what the parent states he or she wants the child to do. Either the aligned parent is not a competent parent or otherwise is not being genuine when expressing support for the child's relationship with the other parent.

Element 3: "Process" must be appropriate before content can be addressed. Translation: Feelings and opinions must be expressed civilly and respectfully; the child must accept the

[3] What I mean by "erroneous belief" is that doing nothing *is doing something*. And since there is the high probability that the child is being psychologically abused by the aligned parent, failure to do a removal from that parent is clearly doing something—that is, failing to protect the child.

rejected parent's standing in the family and in the therapy; the child must "grow down" (As Minuchin often declared) and accept his or her appropriate standing in the family hierarchy. In other words, socially and developmentally appropriate behaviors are expected at all times.

Element 4: Contrary to requiring the rejected parent to accept and validate the child's delusional, programmed beliefs about him or her and about the family history, therapy must permit the rejected parent to correct misconceptions, distortions, and outright fabrications about these issues— particularly if there have been false child abuse/neglect allegations reported against the rejected parent. It is crucial to correct false child abuse allegations because, if a child falsely believes having been abused by a parent, the child likely suffers the same risk factors for PTSD and other serious psychiatric disorders *as if the abuse had occurred.*

Falsehoods repeated over time become the child's reality and must therefore be challenged by the rejected parent with the support of the therapist.

Element 5: Challenging the pathological enmeshment is critical to the child's recovery and to long-term functioning across the cognitive, behavioral, psychological, and interpersonal domains. The child must learn to identify and then to protect his or her own boundaries as well as learning how not to violate the boundaries of others. The child must regain capacity for self-direction and self-distinctiveness—functioning had been squashed under the weight of the "psychological incest" imposed on the child by the aligned parent.

Element 6: Although frequently not permitted by traditional therapists (for some reason that remains a mystery to this therapist) memorabilia of the rejected parent's relationship with the child must be utilized in the therapy because is a highly effective tool for correcting the child's "revisionist family history" and for rekindling the child's loving feelings and need for the rejected parent. Cards, videos, photographs etc., that reflect their past life with each together should utilized as a primary intervention. If a picture is worth a thousand words, imagine what a video conveys!

Element 7: Activities outside of the therapy session must commence. Activities are a spontaneous method for facilitating healthy bonding between the child and rejected parent. Activities further restore healthy family hierarchy because the rejected parent assumes and resumes multiple, normal parenting roles with the child, such as that of playmate, encourager, advocate, supervisor, teammate, protector, etc.

Element 8: Because there has been no bona fide abuse or neglect on the part of the rejected parent, there is no justification for failing to swiftly restore the rejected parent's parenting time. This should commence within one month of the initiation of this modified version of a conventional treatment model. It is a counterintuitive issue in cases of pathological child alignment that, when the court imposes contact with rejected parent, children actually embrace the contact. The child's love and need for the rejected parent had not been extinguished; it had only been repressed and is eager and willing to burst through to the

surface given the appropriate environment.

Element 9: Should there not be markedly improved behavioral changes on the part of both the aligned parent and the child in as little as one month's time, we must conclude that the aligned parent is incorrigible, will likely never support the child's relationship with the other parent, is hoping to run out the clock until the child turns 18 years of age, and has not freed the child from the abusive loyalty web. Should this be the case, a more intensive therapy, that includes a no-contact period between the child and aligned parent, is indicated and is probably the only hope to restore healthy family hierarchy and healthy family relationships and to be able to repair the child's relationship with the rejected parent.

I trust that the court will take into consideration the information that I have thoughtfully and painstakingly provided within this Amicus Brief and that the information is helpful to the court in resolving the numerous conflicting and contentious issues that typically arise in cases of pathological child alignement.

Respectfully signed on letterhead and submitted for the case of ***Plaintiff V. Defendant***

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