2 Clinical Reasoning and Decision-Making in Cases of Child Alignment

Diagnostic and Therapeutic Issues

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A Lost Opportunity

The Jones family is referred by a family court to a psychotherapist for "reunification therapy" following a contentious divorce and custody dispute. The therapist, a clinical psychologist, has been in practice for 20 years. The parents have been divorced for 7 years. The mother, Anne, has physical custody of the 13-year-old daughter, Dawn, but shares legal custody with the father, Bruce. After the divorce the father had "liberal visitation," including overnights. Dawn spent one-third of her time with him. Three years ago the mother told the father that Dawn was afraid of him and no longer wished to see him. Subsequently, Dawn and the father did not see each other and the father went to court to seek physical custody.

After a 2-day trial, the judge found the mother guilty of contempt for violating the court-ordered parenting plan, writing, "The mother frequently disparaged the father in front of the child, blocked the child's access to the father, blocked the father's access to the child, and made false allegations of threats, abuse, and neglect. The mother falsely told the child the father wanted to kill them." Nonetheless, citing Dawn's low opinion of the father and their lack of recent contact, the judge declined to reverse custody and, instead, ordered "reunification therapy."

The therapist begins by conducting individual 45-minute interviews. The mother is poised and calm. She tearfully reports "verbal abuse" by her former husband. Asked why Dawn does not wish to see her father, she replies, "Because he's abusive. Now that she's older, she can finally stand up to him." The mother says she encourages Dawn to visit her father but Dawn declines. The father presents as anxious and intense. He reports that before seeking custody he

tried to see Dawn but was "thwarted at every turn." He emphatically denies having been abusive.

He states that his former wife has a personality disorder. He claims she is "unstable" and "a master manipulator." Citing the judge's findings, he relates that she told Dawn he had threatened to kill them. Of this, he says, "She made it up out of thin air." He offers to provide eyewitnesses to establish this but the therapist says that is not necessary. The father asks whether the therapist might wish to review Dawn's psychotherapy records to verify his account—including his previously good relationship with Dawn—but the therapist declines, explaining it might compromise her objectivity.

The father asserts that if Dawn remains with her mother the situation will become worse. "The main problem is not that Dawn doesn't see me," he says. "That's a big problem but it's not the main problem. The main problem is that Dawn is being abused by her mother. That's why I tried to get custody."

Dawn arrives holding her mother's hand. She says she wants her mother present for the interview. The therapist agrees. Asked why she is there, she replies, "So you can tell the court I don't want to see my father." Dawn describes her father as "not a good man." Asked to be more specific, she says he is "mean," gave her "time-outs," and "yelled a lot." Her mother confirms this. Dawn describes her mother as "an excellent parent," adding, "She always makes me do my homework."

The therapist's assessment is mixed alienation and estrangement (i.e., that the case is a hybrid). She bases that on three observations. First, the court found the mother had disparaged the father and blocked access, suggesting alienation. Second, she notes the father's intensity during the interview and his criticisms of the mother, suggesting estrangement. Third, she believes the father's desire for custody suggests a need for power and control, another negative. She concludes that, except for her relationship with her father, Dawn is generally doing well as evidenced by her cheerful demeanor, strong bonds with her mother, and good grades in school.

The therapist's treatment plan consists of weekly 45-minute sessions with Dawn and her father. She also plans occasional joint sessions with Dawn and her mother. The goals are to facilitate communication, improve the parenting skills of both parents, and create cognitive dissonance in Dawn so she will see that the mother's harsh portrayal of the father is not entirely accurate. To achieve

these goals, she plans to use a combination of family therapy and psycho-education.

During the first 6 months, the therapist strives to form a therapeutic alliance with each person. She refrains from taking sides, tries to mediate disputes, and teaches communication techniques such as mirroring, validating, and empathizing with each other's statements. "So it upsets you when I ..." "That makes sense to me because ..." "I can imagine how you must feel." Dawn refuses to use those techniques and rejects the psycho-education, saying, "I know what happened!" The therapist urges the father to "apologize for something" so Dawn will see he can admit his faults. The father does that but wonders if he has sent the wrong message.

After 12 months, Dawn still refuses to see her father except in the therapist's office. Those sessions do not go well. Dawn is focused on the father's alleged abuse of the mother. Turning to the therapist, she says, "He abused my mother! I don't want to see anyone who abused my mother!" The father asks the therapist how to handle this. At the therapist's suggestion, he tells Dawn he is sorry she feels that way. Dawn becomes enraged. Later, privately, the father expresses frustration over the lack of progress. The therapist counters that there *has* been progress, as the father now sees Dawn once a week whereas before he didn't see her at all. The father contends that the mother has continued to undermine his relationship with Dawn. The therapist points out that the father has not witnessed that first hand but concedes he "may be right." Since the therapist is no longer optimistic about changing the mother's behavior, she proposes to work with the father on his parenting skills.

Meanwhile, both Dawn and the mother accuse the therapist of not believing them when they relate negative things about the father. In subsequent sessions, Dawn refuses to speak. The therapist admits to a "treatment failure" and suspends treatment entirely. The father, disappointed with this outcome, wonders whether a different approach might have been more effective.

Introduction

Few mental health problems are more difficult to sort out or more resistant to treatment than the triad of a severely alienated child, a severely determined alienating parent, and a severely rejected targeted parent. Many treatment recommendations entail modest modifications of conventional psychotherapy

techniques. That is not surprising since most therapists are trained to treat relationship problems and thus view parental alienation (PA) as a relationship problem.

While PA certainly *is* a relationship problem (or set of problems), severe cases are often associated with serious co-morbid psychopathology, particularly on the part of the alienating parent. Therefore, treatment of the relationship problems per se, while necessary, is seldom—if ever—sufficient. Effective intervention invariably requires treatment of both the alienation and any co-morbid condition (such as mental illness or a personality disorder). Moreover, one must develop a treatment plan for each individual client: the child (who is locked in a delusion); the alienating parent (who is likely to have one or more co-morbid conditions); and the targeted parent (who probably requires coaching and emotional support).

Thus, 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.

Such cases are not for the novice. Cases of severe 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 severe personality disorders. Treatment of all three may be necessary to achieve a good outcome or even to prevent catastrophic deterioration.

To further complicate matters, clinicians who treat PA do not yet have the benefit of large, well-designed clinical trials to guide them. Thus, clinicians who practice in this area cannot always base their treatments on hard scientific data—they are often not there.

What *should* clinicians do? One alternative is to rely on experience and intuition. While that is common practice it is not a good solution unless the clinician has extensive experience, outstanding intuition, and sophisticated clinical skills (including a thorough understanding of certain advanced clinical principles). Otherwise, cases of severe alienation are likely to be highly counterintuitive. Clinicians who attempt to manage them without adequate skills are likely to find themselves presiding over a cascade of clinical and psychosocial disasters.

But how can clinicians base their practices on sound scientific principles if there are few clinical trials and a paucity of outcome data? The answer is that clinicians may need to use first principles—fundamental clinical rules and concepts that can be applied to almost any clinical problem. To apply first principles, however, one must be thoroughly familiar with them. In addition, one must have a sophisticated understanding of clinical reasoning (with the possible exception of compassion, there is no more important quality in a clinician)

yet studies show that many mental health practitioners lack adequate training to properly apply scientific principles (Baker, McFall, & Shoham, 2009; Begley, 2009; Mischel, 2009; Tavris, 2003).

The purpose of this chapter, then, is to review some of those principles and to provide both a conceptual framework and conceptual tools for mental health professions who work with severely alienated children and their families.

General Approach to the Client or Patient

During the past six decades, a large body of research has shed new light on the cognitive processes that underlie clinical reasoning and medical decision-making (Croskerry, 2009b; Elstein, 1976; Eva, 2005; Graber, 2008; Hall, 1967; Kahneman, 2011; Kassirer, Wong, & Kopelman, 2010; Kassirer, 1989; Mark, 2012; Meehl, 1954; Norman, 2005; Norman & Eva, 2010; Nurcombe, 2012). Clinical problem-solving is now conceptualized as a series of distinct but integrated phases. Through a process of logical elimination, competing hypotheses are mentally tested then either discarded or retained.

Perhaps surprisingly, research shows that both expert and novice clinicians approach problems in remarkably similar ways (Elstein, 2009). Almost immediately, they begin to gather information. Simultaneously, they generate hypotheses in an attempt to explain the problem. This usually begins within seconds of a clinical encounter. Despite the often-repeated advice (given especially to students) to gather copious amounts of data and consider a wide variety of possibilities, that is not necessarily what experts do. Typically, experts engage in a mental pruning process that quickly discards unlikely hypotheses and focuses on the most promising ones (Elstein & Bordage, 1988). Such streamlining is necessary owing to the limits of short-term memory, which can only deal with 5 to 10 items at a time (Kassirer et al., 2010; Mark, 2012; Miller, 1994). As data gathering continues, clinicians determine the differential diagnosis, which is a list of diagnostic possibilities. Ideally, competing hypotheses are ranked both in order of likelihood and order of importance, so that the remote possibility of a life-threatening problem might warrant greater consideration than the high probability of a minor one.

Along the way, clinicians employ a variety of cognitive strategies—some conscious, some unconscious—to make sense of the data. Their approaches fall on a cognitive continuum with intuitive reasoning at one end and analytical reasoning at the other (Hamm, 1988). They draw upon associative memory in an attempt to match presenting signs and symptoms with cases they have seen, heard, or read about in the past. Ideally, they also employ two types of logical inference: deductive logic (i.e., if the premises are true the conclusion must be true) and inductive logic (i.e., based on findings or observations there is a certain probability that the conclusion is true) (Fiedler, Walther, Freytag, & Nickel, 2003). At some point they arrive at a working diagnosis and, eventually, a final diagnosis.

Unfortunately, the above process is error prone. The good news is that the errors tend to be predictable and, at least in theory, preventable. The bad news is that some of the most serious and common errors arise from fundamental flaws in human thinking that are deeply ingrained. These are "hard-wired" as a result of natural selection and are notoriously difficult to eradicate or even modify. Since one can seldom correct a problem one does not recognize, it is important for clinicians to be aware of these limitations and pitfalls. Clinicians who deal with PA may be particularly susceptible to such errors because of the emotional and complex nature of the subject.

Such errors can be divided into two groups: cognitive errors and clinical errors. Cognitive errors are thinking errors. They often reflect deep-rooted tendencies for humans to reason in erroneous ways. Clinical errors are deviations from good clinical practice. Many clinical errors arise because of cognitive errors, others because of insufficient information, others because of inadequate understanding of scientific principles. Strategies to reduce clinical errors have recently received much attention (Croskerry & Nimmo, 2011; Norman & Eva, 2010).

Perhaps surprisingly, lack of knowledge is one of the least common clinical errors, except among novices (Graber, Franklin, & Gordon, 2005; Norman & Eva, 2010). Most clinical errors arise from inadequate data collection, faulty interpretation of the data, flawed reasoning, or lack of understanding of scientific principles (Graber, Gordon, & Franklin, 2002).

An expert's primary advantage is in having a large number of previous cases in memory. This leads to better pattern recognition, which in turn permits the expert to match the current case with a mental template. In general, that is an asset but it can also be a liability because it can lead to misdiagnosis by stereotyping. This is particularly relevant to the diagnosis and management of severely aligned children since many alienating parents have learned to manipulate professionals by mimicking a self-serving stereotype.

When experts place too much emphasis on intuition and not enough on logical analysis their judgments may be no better than those of novices. Similarly, expert judgment is often surpassed by simple algorithms or decision rules (Dawes, Faust, & Meehl, 2002; Grove & Lloyd, 2006; Grove & Meehl, 1996). For that reason it might be helpful to review the essential elements of a proper, systematic clinical evaluation.

Data Gathering

Clinical History

Medical textbooks invariably stress the need to obtain an adequate history. That is particularly true for clients with mental health problems since, in most cases there are no diagnostic tests to supplement the history.

History taking can be problem-focused, comprehensive, or in between. The history must include pertinent positives and negatives. If the patient is

a poor or unreliable historian, one may need to use special techniques to elicit and clarify key points (e.g., to refocus the patient's attention, explain terminology, or clarify questions). While a review of interviewing techniques is beyond the scope of this chapter, a sophisticated understanding of those techniques—including forensic techniques—is essential when dealing with PA because the provided history is likely to include intentional misrepresentations. Wise practitioners will address this by cross-checking the provided history with collateral source information. Indeed, it is a fundamental principle of forensic psychiatry and forensic psychology that evaluators must obtain adequate collateral source information (American Academy of Child & Adolescent Psychiatry, 2011). Likewise, one must seek and clarify any discrepancies or inconsistencies. These forensic points are critical because a wrong diagnosis (e.g., misdiagnosing alienation as estrangement) can have devastating effects on outcome.

Physical Examination

Except for psychiatrists, many mental health practitioners believe they are neither qualified nor expected to perform a physical examination as part of their assessments. That is not quite correct. While those who practice in non-physical domains are not expected to "lay on hands," much can be learned from educated observation. Indeed, simple observation is a key component of any physical examination. What is the client's general appearance? What about speech, demeanor, and body language? Is there psychomotor agitation or psychomotor retardation? Is there evidence of emotional distress? Are there abnormalities on mental status examination? Such observations amount to a de facto physical examination. They can be just as relevant to a psychotherapist as to an internist or surgeon.

Diagnostic Testing

To be useful, a diagnostic test must have good validity. Unfortunately, some commonly used tests do not meet that standard. For example, many therapists use projective drawings in their practice. While such techniques can be useful for eliciting information, identifying issues and facilitating discussion, it is important to distinguish between using them as an adjunct to assessment and/or psychotherapy and using them for diagnostic testing. When used for testing, such techniques have strikingly poor validity. As one group of experts put it (Hunsley, 2003), "Until hypotheses based on projective drawings are formulated in a manner that can be subjected to scientific scrutiny and are supported in rigorous studies, there can be no basis to the claims for the validity of these approaches." Nevertheless, despite the lack of scientific support, projective tests (such as the Draw-a-Person test and the Rorschach inkblot test) remain in widespread use. This raises troubling questions because tests with poor validity can be exceedingly misleading.

Treatment

After making a working diagnosis, even if only a symptom (e.g., "emotional distress"), clinicians address treatment. If urgent treatment is indicated (e.g., crisis intervention) that must be provided. If there are multiple problems, clinicians must address each of them. Therapeutic considerations include the type, dose, and frequency of treatment. For psychotherapists, that means the type, length, and frequency of sessions. One must also consider whether ancillary services are required, such as a parenting coordinator or accompanied visits.

The treatment plan must also take into account the severity of each problem. The treatment of severe alienation is very different from that of mild alienation. A 45-minute weekly outpatient session with the alienated child and the rejected parent is grossly inadequate for severe cases, particularly if the child continues to live with the alienating parent (in which case the prognosis is poor regardless of the duration and frequency of office-based sessions—indeed, reversal of custody, limiting contact with the alienating parent, and/or other interventions are generally required to achieve a good outcome). Some children may require treatment in a non-office setting such as a retreat (Warshak & Otis, 2010). Some may need to be moved to neutral ground such as a boarding school (Sullivan & Kelly, 2001). Some are trapped in a cult-like situation and may require treatment similar to the "deprogramming" of cult victims (Baker, 2007; Clawar & Rivlin, 1991; Warshak, 2001).

Another consideration is that in severe cases conventional psychotherapy is typically ineffective and can make things worse (Warshak, 2001). The abysmal failure of conventional therapy in this setting is related to at least four factors:

1. At least initially, the therapist is likely to have an adversarial relationship with some family members, including the alienating parent and the alienated child (or children).
2. It is likely that the alienating parent and child (or children) are there reluctantly, either by court order or other outside pressure. They are likely to be poorly motivated and deeply determined to undermine both the therapy and the therapist.
3. There is usually co-morbid psychopathology, particularly in the alienating parent. Several authors have observed an increased prevalence of personality disorders, such as antisocial and borderline personality disorders, among severely alienating parents (Baker, 2007; Neff & Cooper, 2004). Antisocial personality disorder is notoriously resistant to treatment. Borderline personality disorder, though treatable, requires highly specialized treatment such as dialectical behavioral therapy; conventional therapy often makes things worse (Klosko & Young, 2004; Linehan, 1993; Paris, 2010). It is therefore not surprising that alienating parents who have antisocial, borderline, or related personality disorders are resistant to treatment for PA, particularly if one understands that such individuals may not react well to "looking in the mirror."

4. If the psychotherapy is focused on improving the relationship between the child and the targeted parent it may fail to address the primary underlying problem, which in severe PA is the alienating parent's problematic thinking, emotional instability, and harmful behavior. In severe cases, the alienating parent is too determined, too disturbed, and too delusional to respond to treatment—conventional or otherwise. Therapists who insist on a trial of conventional therapy (e.g., to "see for myself") are exceedingly unlikely to succeed.

But, some might say, "Why not give it a try?" While there is certainly a place for therapeutic trials in clinical practice, this is not one of them. Such trials are only appropriate when the potential benefits outweigh the potential risks. They are not appropriate when the treatment will almost certainly be futile, the upside potential is negligible, and a delay might be devastating. 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.

Why, then, do some clinicians provide predictably futile treatment? For one thing, many practitioners—including some putative experts—lack the clinical expertise to manage severe, complicated cases. For another thing, many clinicians are overconfident (Berner & Graber, 2008; Croskerry & Norman, 2008; Dawson, Connors, Speroff, Kemka, Shaw, & Arkes, 1993; Friedman et al., 2005). Additionally, some clinicians believe (with little scientific justification; see note 4) that most cases are hybrids (i.e., a combination of alienation and estrangement) and therefore (borrowing a principle from marriage counseling) focus on the parent who is most able to change, which is usually the targeted parent. That leaves the harmful effects of the alienating parent unopposed. Finally, when swift, bold, decisive action is indicated—such as removal of a severely alienated child from a toxic home environment—many clinicians lack the temperament to support such action. By nature, they are timid clinicians. When they encounter severe or complex problems timid clinicians tend to do little or nothing. This can lead to a paradox in which higher-risk patients are less likely to receive essential treatment than lower-risk patients (Ko, Mamdani, & Alter, 2004).

On the positive side, many practitioners *do* have both the clinical sophistication and the temperament to manage such cases effectively. But one must match the practitioner with the problem. To assist with that, a variety of potentially effective strategies and techniques are presented elsewhere in this book.

Regardless of which treatments are selected, providers have their work cut out for them. Along the way, they will need to rely on a number of fundamental clinical principles, or axioms. Presented in three groups—general, diagnostic, and treatment—12 of the most important are discussed in the following section.

Clinical Axioms

An axiom is a rule or principle that is self-evident—so obviously true it requires no proof. Clinical practice is governed by several such axioms. Based on centuries of experience, they reflect well-established principles and practices that transcend all clinical disciplines and all clinical situations. The purpose of this section is to review some of the most important, with special reference to severe alignment. These are illustrated in Table 2.1. Note that there is much overlap between axioms.

General Axioms

Axiom 1: Consider the Total Clinical Picture

Clinical findings must be viewed in context. Incomplete information can be misleading. Snap judgments can be catastrophic. In dealing with severe alignment, clinicians must consider the total clinical picture. One common error is to fail to distinguish between the *fact* that a child has rejected a parent and the *reason* the child has rejected that parent. Those who make this error tend to focus on the *strength* rather than the *cause* of the rejection. If the reason for the rejection is that the alienating parent has taught the child to believe things that are untrue—or worse, has caused the child to become delusional—those are critical findings, particularly if the child's prior relationship with the rejected parent was good. A co-morbid psychiatric disorder, previous psychotherapy records, and other collateral source information can provide essential data. All of these things are part of the total clinical picture. Failure to consider the total clinical picture is a very serious clinical error, which is why it is listed first.

Axiom 2: Gather Adequate Evidence

This axiom pertains to both diagnosis and treatment. It requires clinicians to obtain adequate diagnostic data and to understand the scientific data upon which they base their treatments. For either purpose, clinicians must carefully consider both the amount and quality of any evidence. In assessing child alignment, for example, a second-hand report ("Jane said her husband hit her") should generally be given less weight than a first-hand report ("I saw him hit her"). Because some parties may not be reliable historians, collateral source information can be critical. Likewise, circumstantial evidence can be critical (and powerful).

As for treatment, evidence-based practice (EBP) does *not* mean one must have research or a clinical study upon which to base decisions. EBP merely means that clinicians should use the best available evidence (Evidence-Based Medicine Working Group, 1992). Sometimes that means expert consensus, rational extrapolation, or use of first principles. With respect to PA, EBP does *not* mean that therapists should withhold potentially helpful treatment simply because there are no randomized clinical trials (RCTs) on point. For instance, a

Table 2.1 Application of the 12 axioms to clinical problem-solving

Axiom		*Comments*	*Examples of questions that clinicians should ask*
1	Consider the total clinical picture	Consider all aspects of a problem.	What was the prior relationship between the child and the rejected parent? Is the favored parent manipulating the child? Is there credible evidence that the rejected parent is abusive or neglectful? How cooperative is each parent with respect to both therapy and co-parenting? How credible are their stories? Are there discrepancies or inconsistencies? Does either parent breach court orders? Is there psychopathology?
2	Gather adequate evidence	Obtain sufficient high-quality evidence.	Do I have an in-depth understanding of this family? Do I have enough high-quality evidence? Do I need additional collateral source information? Have I overlooked disconfirmatory evidence? Have I overlooked circumstantial evidence?
3	Use proper reasoning	Always employ metacognition (thinking about thinking).	Have I used both System 1 and System 2 (intuition and analytic reasoning)? Have I displayed any biases? Have I followed the laws of logic and probability? Have I found a plausible explanation rather than the correct explanation?
4	Consider the natural history of the disease, disorder, or condition	Consider the clinical course with and without treatment.	What is the prognosis with and without intervention? What will happen if I do little or nothing? If either parent has psychopathology, is that likely to improve or get worse? Is the alienating parent likely to follow court orders?
5	Have a high index of suspicion	Consider atypical presentations, uncommon conditions, and/or intentional misrepresentation.	Could this be an atypical presentation? Is there evidence of intentional misrepresentation? Has the child been programmed? Am I being unduly influenced by the force and conviction of the child's statements? Could this parent be a high-functioning borderline?

6	Develop an adequate differential diagnosis	Rank competing diagnoses for both probability and importance.	What are the possibilities? I need to rank them.
7	Consider severity	Grade severity using a sliding scale and consider whether problems are getting better or worse.	Is the child's alienation mild, moderate, or severe? Is the parent's behavior mild, moderate, or severe? Is the behavior pathological, e.g., delusional, bizarre, or extreme? Am I guilty of severity neglect?
8	Analyze the evidence	Analyze the evidence with respect to amount, quality, strength, and weight. Seek confirmatory and disconfirmatory evidence. Seek direct and circumstantial evidence. Explain any discrepancies and inconsistencies. Obtain additional evidence if necessary.	What is the evidence for alienation? What is the evidence for estrangement? If both are present what are their relative contributions? Are the parents' behaviors causally connected to the child's alignment? Have I confused the strength of evidence with the weight of evidence?
9	Determine treatment priorities	Consider whether urgent treatment is required Determine the timing of various treatments.	What is the highest priority: to stop any ongoing abuse/alienation of the child or to restore the child's relationship with the targeted parent? How likely is the alienating parent to change his/her behavior? Do I need to protect this child? Do I need to inform the court?
10	Conduct a risks/ benefits analysis	Consider the risks and benefits of each treatment option, including the pros and cons of doing little or nothing.	What are the risks and benefits of: reversing custody; permitting the alienating parent to continue to alienate/abuse the child; failing to act promptly; failing to treat the parent's psychopathology; relying on office-based therapy?
11	Provide timely, appropriate treatment	Provide urgent treatment when indicated.	Is this a child in crisis? Is this a family in crisis?

Table 2.1 Continued

Axiom	*Comments*	*Examples of questions that clinicians should ask*
	Use scientific treatments.	How effective is weekly psychotherapy in a case this severe? If ineffective, what else is required?
12 Treat the underlying condition	Treat the root cause(s) of any problem(s) if feasible.	What is the primary problem? Is there more than one? Does either parent require treatment for a mental illness and/or personality disorder? Does the child have any psychopathology that requires treatment, such as pathological splitting or shared delusions? Does the child believe any false allegations? If so, what should be done about that? Can the child be deprogrammed if he/she continues to live with the alienating parent?

clinician might be reluctant to use psycho-education because there are no RCTs to establish its effectiveness, yet there is strong theoretical support and promising empirical data (Fidler & Bala, 2010; Warshak & Otis, 2010). Given what Kelly has called the "bleak prospects for the children's own future psychosocial well-being" in markedly alienated children (Kelly, 2010), clinicians are not only permitted but encouraged to consider new approaches to therapy—provided they are firmly rooted in science.

Axiom 3: Use Proper Reasoning

Clinicians have a variety of reasoning tools. These include: deductive logic (i.e., if the premises are true the conclusion must be true); inductive logic (i.e., inferring conclusions from observations based on probabilities); multivalent logic (i.e., placing variables on a continuum and assigning degrees of truth or "grading the gray"); approximate reasoning; probabilistic reasoning; rational extrapolations; and others. Through metacognition—thinking about thinking—clinicians should select the most appropriate cognitive tools.

Axiom 4: Consider the Natural History of the Condition

Clinicians must understand the usual clinical course of the condition(s) in question, both with and without treatment. As an illustration, consider the natural history of a severely alienated child whose custodial parent is an active alienator with borderline personality disorder (BPD). Some people, ignoring both the increased risk for BPD in children of borderline parents (Paris, Nowlis, & Brown, 1988) and the increased risk of suicide among those with BPD (Linehan et al., 2006), claim children are "resilient," a platitude that is true of some but certainly not all children. Moreover, children of borderline parents are at significant risk of developing BPD and/or other serious psychiatric disorders (Macfie, 2009; Stepp, 2012; Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012). Individuals with BPD have a lifetime risk of *completed* suicide of up to 10% (and the risk of *attempted* suicide is much higher) (Soloff & Chiappetta, 2012). Since the risk in the general population is about 1% (Minino, Murphy, Xu, & Kochanek, 2011), the risk with BPD is about 10 times higher. If a patient is at risk of developing a condition that can increase suicide risk by 1,000%, most people (even laypeople) would understand that those who deal with PA should take vigorous measures to prevent that from happening. Why would any clinician fail to do that? The most likely reason is failure to recognize the risk owing to failure to consider the natural history of PA in a child whose alienating parent has BPD.

Diagnostic Axioms

Axiom 5: Have a High Index of Suspicion

For serious problems, it is not enough to make the correct diagnosis *most* of the time; clinicians need to make the correct diagnosis *almost all* of the time. To

do that, clinicians must have a high index of suspicion with respect to uncommon conditions, atypical presentations, and intentional misrepresentations. Regarding the latter, professionals must identify and clarify any inconsistencies or discrepancies. When clinicians *do* make diagnostic errors, they should be "no fault" or unavoidable errors—not errors due to inadequate data gathering or faulty thinking.

Axiom 6: Develop an Adequate Differential Diagnosis

One of the most common causes of diagnostic errors is failure to *think* of the diagnosis. With respect to child alignment, any competent therapist knows to consider alienation versus estrangement; what distinguishes superior clinicians is their ability to recognize atypical presentations and identify co-morbid conditions.

Axiom 7: Consider Severity

All clinical problems should be classified by severity. This should be done in two ways. First, one must ask whether the condition is *inherently* severe (e.g., a heart attack or anorexia nervosa). Second, one must assess severity *compared with others* who have the condition. While that might seem obvious, failure to do so is a common problem. That is particularly unfortunate with respect to PA because techniques that are often helpful in mild alienation can be harmful in severe cases (e.g., Imago relationship therapy (Hendrix, 2008), in which mirroring, validating, and empathizing can reinforce a child's delusions and encourage a targeted parent to "validate" them).

Axiom 8: Analyze the Evidence

Clinicians must carefully analyze each piece of evidence. The single most common cause of clinical errors—for both novice and experienced clinicians—is failure to interpret the evidence correctly. Here are four caveats. First, clinicians must distinguish between the *strength* of the evidence and the *weight* of the evidence. Though the two terms are often used interchangeably, as used here the strength of evidence is defined only by how dramatic it is—regardless of its truth. For instance, an allegation that a parent has sexually abused a child is very strong but, in itself, conveys nothing about its truth. In fact, according to the laws of logic, the stronger the statement, the less likely it is to be true (since extraordinary claims require extraordinary evidence). By contrast, the weight of evidence refers to how true and valid it is. Unfortunately, humans are hard-wired to pay more attention to strength than to weight. Clinicians must compensate for this by carefully weighting each piece of evidence. Second, clinicians must consider both confirmatory evidence and disconfirmatory evidence. That is critical because, in general, disconfirmatory evidence is more powerful (Nurcombe, 2012). Third, unless they see it with their own eyes, some

therapists are reluctant to conclude that an alienating parent is continuing to alienate. That is unfortunate because circumstantial evidence can be extremely powerful. Fourth, clinicians must distinguish between a plausible diagnosis and a correct diagnosis. One of the hallmarks of a weak clinician is to accept a plausible diagnosis—one that is coherent and "explains things"—without verifying that it is, in fact, the right diagnosis. Indeed, studies show that many clinicians have great confidence in their incorrect conclusions (Berner & Graber, 2008; Croskerry & Norman, 2008).

Treatment Axioms

Axiom 9: Determine Treatment Priorities

Clinicians should give explicit thought to treatment priorities. Consider, for example, a family in which the child is severely alienated, the alienating parent is incorrigible, and the targeted parent has not seen the child in a year. What is the top priority—to stop the ongoing alienation or to "reunite" the child with the targeted parent? Since PA is a form of child abuse—specifically, psychological and emotional abuse (Baker, 2007; Kelly & Johnston, 2001; Warshak, 2010)—there is expert consensus that, at least in severe cases, preventing further abuse is an even higher priority than getting the child to spend more time with the targeted parent. As Warshak (2010) observed, "Our society's standard of care regarding abused children is to prioritize protecting them from further abuse." And yet, those who treat such families often focus more on restoring the child's relationship with the targeted parent than on stopping the ongoing abuse. That is a major error. The priority is to prevent further child abuse.

Axiom 10: Do a Risks/Benefits Analysis

Clinicians must carefully weigh risks versus benefits. One of the most common mistakes is to fail to consider the risk of doing nothing. In fact, doing nothing is doing something. Summarizing the research on this, Hallinan (2009) wrote:

> As a general principle, people feel more responsible for their *actions* than they do for their *inactions.* If we are going to err at something, we would rather err by failing to act. That's because we tend to view inaction as a passive event—we didn't *do* anything. And since we didn't do anything, we feel less responsible for the outcome that follows.

With respect to alienation, such thinking may explain why some clinicians fail to intervene despite obvious reasons to do so. If they are uncertain about risks versus benefits, they are likely to opt to do nothing. If that decision is based on a proper risk/benefit analysis it may be reasonable. If it is based on vague intuition rather than rational analysis it may be a serious error.

Axiom 11: Provide Timely, Appropriate Treatment

When treating progressive conditions, timing can be critical. Unfortunately, with respect to severe PA—which tends to be progressive—prompt intervention is not always provided. All too often, months and years pass with little effective treatment—even for children in crisis. In some cases, the clinicians may lack the training or experience to provide urgent intervention. Even if knowledgeable, timid clinicians may lack the temperament to provide swift, bold intervention (e.g., to confront a persistent alienator or recommend a change of custody). Since psychological and emotional abuse of a child can cause lifelong problems, permitting months or years to pass without effective intervention can be a tragic mistake.

Axiom 12: Treat the Underlying Condition

Sometimes it is not feasible to treat the underlying condition. That said, this is one of the most important principles in medicine. Consider, for instance, a patient with a long-standing cough. If the cause is a curable cancer, it can be a fatal mistake to simply prescribe cough medicine. Similar principles apply to PA. Consider a 10-year-old boy whose mother has convinced him (falsely) that his father wants to physically hurt him. Under such circumstances it would be normal behavior for the boy to reject the father and align with the mother. For therapy to have any chance of success, one must treat the underlying condition (i.e., disabuse the boy of his mother's false allegations). Nonetheless, many therapists violate this fundamental axiom. Rather than recognizing that it is mandatory to treat the underlying condition—or at least to arrange for it to be treated—they either ignore it or make token gestures, with predictably poor results. Meanwhile, they attempt to work with the targeted parent to improve his or her parenting skills. Strong parenting skills on the part of a targeted parent, however, are exceedingly unlikely to neutralize the toxic effects of a determined alienator.

While some would say there's an exception to every rule, only rarely would there be a legitimate reason for a clinician to violate any of the above axioms. And yet some clinicians do violate them—frequently. What accounts for that? One possibility is that such clinicians rely on intuition, which can be misleading. A second possibility is that they are susceptible to cognitive biases that can compromise rational thinking. A third possibility is that they rely on clinical aphorisms that lack scientific rigor. These and related problems are discussed in the following section.

Heuristics and Biases

All clinical disciplines rely on mental shortcuts known as heuristics. Typical heuristics include rules of thumb, clinical aphorisms, and conventional wisdom. They also include certain intuitive judgments. Used properly, heuristics can be useful. They permit experts to make quick, efficient judgments that are usually accurate. They work well under most, but not all, circumstances. By

definition, however, a heuristic is a rule of thumb, not a true rule. There are exceptions to every heuristic. When heuristics fail, they can lead to serious clinical errors (McDonald, 1996). Thus, heuristics are always associated with biases (Tversky & Kahneman, 1974).

As in other clinical disciplines, the mental health professions have a substantial heuristic-based component. That is not necessarily bad—again, heuristics can be useful—but it can be problematic if clinicians attempt to solve complex clinical problems with simplistic heuristic thinking. It is one thing to employ heuristics as an aid to decision-making; it is another thing to rely on them in place of sound scientific reasoning.

With respect to clinical issues there are two types of heuristics: cognitive and clinical. Cognitive heuristics, also called judgment heuristics, are hard-wired, deep-rooted, inherent patterns of human thinking. They are largely unconscious and account for intuitive reasoning. Clinical heuristics are essentially aphorisms. They are rules of thumb that serve as touchstones for problem-solving. In addition to heuristic-related biases, there are other cognitive biases that are unrelated to heuristics. Several of the most important heuristics and biases are presented in the following section. They are illustrated in Table 2.2.

Table 2.2 Heuristics, biases, and metacognition

Heuristic	*Definition and comments*	*Sample applications*
The availability heuristic	Making a judgment based on how readily information can be recalled from memory.	Have I seen or heard about a recent case that is unduly influencing my judgment in this matter?
The representativeness heuristic	Making a judgment based on similarity, i.e., on a stereotype.	Am I stereotyping? How well does this case fit the typical pattern? Are there aspects that don't fit?
The affect heuristic	Making a judgment based on an emotion or feeling—can lead to "emotional reasoning."	Does it make me feel better to think this is estrangement, not alienation? Do I find the rejected parent off-putting because she is anxious and/or assertive? If I feel uncomfortable, is that rational or irrational? Am I engaging in emotional reasoning? What do the facts say?
Anchoring effect	A phenomenon by which judgment is unduly influenced by initial information; often accompanied by inadequate adjustment when new information becomes available.	After reading the guardian *ad litem* report I believed the rejected father was a victim of alienation engineered by the mother, but four credible sources say that is not true. My evidence now supports the mother but I'm having trouble believing it. Am I anchored to the GAL report? Have I failed to make adequate adjustments?

Table 2.2 Continued

Heuristic	*Definition and comments*	*Sample applications*
Confirmation bias	A tendency to focus on evidence that might *confirm* a hypothesis while neglecting evidence that might *refute* it.	Have I been paying too much attention to information that supports my initial impressions? Am I neglecting evidence that might refute those impressions?
Premature closure	Making a diagnosis or other decision before obtaining and/or considering sufficient information.	Do I have enough high-quality information to provide a proper opinion? What else could be going on? Don't jump to conclusions!
Framing errors	Presenting identical information in a way that will lead to a different conclusion, depending on how it is presented.	The court framed this as a problem between the child and the rejected mother. It ordered "reunification therapy." Maybe that's a framing error. Maybe I should re-frame the problem as child abuse by the father. Maybe it's more important to protect the child from the father than to reunite the child with the mother.
The fundamental attribution error	Concluding that a behavior is dispositional when in fact it is situational.	The mother is angry. Is she an angry person in general or is she angry because of the situation?
Base rate neglect	Failure to adequately consider the pre-test or prior probability that a hypothesis is correct when considering new evidence. Giving too much weight to clinical findings and not enough weight to prior probability.	The mother presented well but often denigrated the father in front of the child. The father had a good prior relationship with the child. Thus, the prior probability of alienation is high. That information will be critical when interviewing the child.
The ecological fallacy	As used clinically, giving too much weight to group/epidemiological data and not enough weight to an individual patient's clinical findings.	Some people claim most cases of child alignment are hybrids. Even if that is true, I should not assume this case is a hybrid. Group data should only be used for hypothesis generation, not hypothesis confirmation.

Cognitive Heuristics

Human thought is not always analytical. For the most part, people do not make decisions by carefully weighing (or weighting) evidence and processing it in accordance with the laws of logic, probability, and statistics. The human brain is not well wired for that. Rather, they draw conclusions based on intuitive

judgments. Such judgments rely on cognitive templates that permit humans to make quick, efficient, reasonably accurate decisions. As previously noted, these templates are known as cognitive heuristics.

To qualify as a cognitive heuristic, the mental shortcut must involve attribute substitution, an unconscious process by which a difficult question is simplified by substituting an easier one (Kahneman & Frederick, 2002). For instance, if asked to determine whether an individual is a fit parent, an evaluator might substitute an easier question such as: "How did that parent act in an interview?" or "Do I like that parent?" Although attribute substitutions make questions easier to answer, they introduce substantial error. Interviewing skills might not reflect parenting skills. Consequently, all heuristics entail a trade-off between simplicity and accuracy. Here are 10 cognitive biases, including three cognitive heuristics:

The Availability Heuristic

The availability heuristic holds that many judgments are based on the ease with which information comes to mind (Tversky & Kahneman, 1973). For example, a clinician who once saw a rare disease might be predisposed to diagnose that disease in the future. Availability can be a good thing—it is an important part of expert reasoning—but it can also cause errors (Mamede et al., 2010). Like other heuristics, this one is more appropriate for hypothesis generation than hypothesis refinement.

The Representativeness Heuristic

The representativeness heuristic maintains that people commonly base judgments on superficial similarity (Kahneman & Tversky, 1972). It is occasionally called the similarity heuristic. Clinicians make extensive use of this heuristic. In most cases that is a plus because it permits them to match findings in a new case with exemplars stored in memory. However, because it relies on stereotyping, it is more likely to be accurate in simple cases than complex ones (Elstein & Schwarz, 2002). If relevant differences are not appreciated then reasoning by representativeness can fail. When that happens, expert decisions are often no better—and can be worse—than decisions by lay people (Borak & Veilleux, 1982).

The Affect Heuristic

The word "affect" means emotion or feeling. The affect heuristic states that emotions can affect judgment (Slovic, Finucane, Peters, & MacGregor, 2002), which can lead to emotional reasoning. If one has a "warm and fuzzy" feeling about something, one is likely to have a lower perception of risk and a higher perception of benefit. The affect heuristic can undermine rational decision making: a custody evaluator might be influenced by a vague feeling that one

parent is more appealing than the other; a therapist might side with the favored parent and alienated child because it "feels better" to please two people than one; a therapist may elect to do nothing because that produces less anxiety than being proactive.

Anchoring Effect

Anchoring occurs when thinking is unduly influenced by initial information and there is inadequate adjustment when new information becomes available. In theory, one should be able to correct for an anchor by overriding it with logical thought. In reality, most people are unable to override a strong anchor (Epley & Gilovich, 2006). This has tremendous implications for clinical practice.

Anchoring, while no longer considered a heuristic per se because it does not involve attribute substitution, can lead to both diagnostic and treatment errors. With respect to diagnosis, subjects who skillfully manage first impressions can create powerful anchoring effects that are highly resistant to new evidence. With respect to treatment, consider a therapist whose goal is to restore 50/50 parenting time for a targeted parent who has joint physical custody. The therapist recommends a "phase-in period" starting with a single, weekly, 3-hour visit. While that might seem reasonable the downside is that the children and the alienating parent can become anchored to the brief weekly visits and become even more resistant to longer, more frequent visits. This is an example of how treating severe PA as a typical relationship problem can do more harm than good.

Confirmation Bias

Confirmation bias is a tendency to focus on evidence that would help *confirm* an existing belief while neglecting evidence that might *refute* it. A type of "tunnel vision," it is difficult to avoid even if one is aware of it. If one is focused on confirmatory evidence, one is less likely to seek contradictory or disconfirmatory evidence. This is a tremendous problem because, as mentioned earlier, disconfirmatory evidence tends to be more powerful than confirmatory evidence. A study involving psychiatrists found that the tendency for less-experienced clinicians to seek confirmatory over disconfirmatory evidence was associated with "poor diagnostic accuracy"; indeed, psychiatrists who focused on confirmatory evidence made a wrong diagnosis 70% of the time (Mendel et al., 2011). This bias can be extreme—it is not uncommon for clinicians to ignore multiple pieces of disconfirmatory evidence while focusing on a single piece of confirmatory evidence. Clinicians who initially suspect estrangement are likely to show confirmation bias in favor of estrangement; those who initially suspect alienation are likely to show confirmation bias in favor of alienation. All clinicians must consciously compensate for that.

Premature Closure

Premature closure refers to finalizing a diagnosis before gathering and considering sufficient evidence (jumping to conclusions). Premature closure is related to both anchoring and confirmation bias. These biases tend to reinforce each other and, in concert, can lead all but the most careful clinicians astray. Paradoxically, perhaps due to overconfidence, experienced clinicians may be more susceptible to this error than less-experienced clinicians (Eva & Cunnington, 2006).

Framing Errors

Framing errors occur when people draw different conclusions from identical information, depending on how that information is presented (Tversky & Kahneman, 1981). One example is the leading question. "When your dad gave you that gift, did you consider it a bribe?" Other examples abound. Assume, for instance, that a 10-year-old boy has barely seen his mother in 2 years and a court has concluded the problem is PA. Further assume that the alienating parent is an obsessed alienator (Darnall, 1998). If the court refers the boy for "reunification therapy," the mere fact that the court used that term can radically alter the therapist's approach—both consciously and unconsciously. Consider, for instance, how that wording might influence the therapist's priority setting. What is the first priority? Is it to restore contact between the boy and the rejected parent or is it to stop the alienating parent's destructive and abusive behavior? Common sense mandates that the first priority should be to prevent further child abuse. If that was the judge's intention he did not convey it—quite the opposite—in which case the term "reunification therapy" represents a framing error.

Additionally, the phrase "reunification therapy" entails a second framing error because it focuses on the child's relationship with the targeted parent (a laudable goal) but fails to address the need to deprogram the child (which is essential). Without all three directives from the court—to prevent further child abuse, deprogram the child, and restore the child's relationship with the targeted parent—one or more of these goals may be overlooked.

The Fundamental Attribution Error

The fundamental attribution error refers to a situation in which an observer incorrectly assigns a dispositional, characterological, or internal cause rather than a situational or external cause to a behavior (Ross, 1977; Ross & Anderson, 1982). For instance, just because a person is angry about a specific situation does not mean he or she is an angry person in general. Unfortunately, and to an extreme degree, the human brain is hard-wired to give too much weight to dispositional factors and not enough to situational factors. Therefore, because they can feel perfectly natural, incorrect judgments about people's disposition and character can be made with great confidence (Forgas, 1998).

Base Rate Neglect

When considering new evidence about a hypothesis, clinicians must know or estimate the prior probability of that hypothesis before they can determine the updated or posterior probability. That is required by the laws of probability. Failure to properly consider prior probability is known as base rate neglect (Tversky & Kahneman, 1982). Humans have a striking hard-wired tendency to neglect prior probability. For that reason, base rate neglect runs rampant in every field, even forensic practice (Mossman, 2000). Clinicians who make this mistake give too much weight to clinical findings and too little weight to prior probabilities.

Suppose, for example, one needs to distinguish whether a child is alienated or has been abused. The child is a 12-year-old girl who has rejected her father, claiming he mistreated her at a party. A psychologist is asked to investigate. Before interviewing the girl, he speaks with four adult witnesses who report the father did *not* mistreat the girl. Unless the psychologist doubts the credibility of those witnesses, the prior probability of mistreatment (at least on that date) would be low. If, during an interview, the girl describes the alleged mistreatment—vividly and tearfully—the psychologist, being human, might be inclined to believe her. To do so, however, he would have to discount four credible eyewitness reports, which would represent egregious base rate neglect. He would also have to confuse the strength of the evidence with the weight of the evidence, as previously discussed.

The Ecological Fallacy

Another cognitive error is the ecological fallacy (Piantadosi, Byar, & Green, 1988). That involves the use of group data to draw conclusions about individual people. Originally, the term was applied to the interpretation of data in research studies in which some epidemiologists assumed, incorrectly, that certain characteristics of groups were true of individuals in those groups (Robinson, 1950). An analogous mistake can be made in clinical reasoning whereby clinicians assume that characteristics of a group (e.g., in a published study) necessarily apply to their own individual patients. Clinicians who make this fallacy give too much weight to epidemiological data and too little weight to case-specific clinical findings. In that sense, it is roughly the opposite of base rate neglect.

It is important to recognize this fallacy when reading the literature. For example, one author has stated that rejected parents, "appear to be the more influential architect of their own alienation" (Johnston, 2003).[1] Others have claimed that, in their experience, most cases of child alignment are hybrids (i.e., a combination of alienation and estrangement [Friedlander & Walters, 2010]). Even if these statements are true—and that has certainly not been established except, perhaps, in certain subgroups—one cannot use such information to make a diagnosis in any individual case, except in accordance with Bayes' rule (discussed later), which places strict constraints on how such data can be used.

Clinical Heuristics

In contrast to cognitive heuristics, clinical heuristics are task- or domain-specific rules of thumb. In effect, they are clinical aphorisms. Some are reasonably reliable; others are deeply flawed. One useful heuristic is Occam's razor which is used in every scientific field. It holds that the simplest solution to a problem is usually correct. Some useful heuristics describe the characteristics of alienated children (Gardner, 1999; Kelly & Johnston, 2001). Other useful heuristics address the characteristics of alienating parents, such as Darnall's description of obsessed alienators—parents who wish to destroy the child's relationship with the other parent—and, tellingly, may repeatedly violate court orders to do so (Darnall, 1998). Another useful heuristic is Baker's finding that severe alienators tend to have personality disorders (Baker, 2007). Other heuristics provide valuable advice regarding the treatment of PA (Kelly, 2010; Warshak, 2010; Warshak & Otis, 2010). On the other hand, flawed heuristics are also common. Because their use can cause great harm, the remainder of this section will discuss 10 flawed heuristics that should *not* be used.

A 10 doesn't marry a 1 Although there is a grain of truth to this quip, most people understand that it should not be used for serious decision-making. Astonishingly, that understanding is not universal and this pseudo-heuristic is used by some professionals. "He married her; there must be something wrong with him!" To apply this to a case of severe alienation is to assume that the targeted parent must have done something to deserve the child's rejection simply because, in the past, he or she married a spouse who later became an alienating parent. To believe that shows a poor understanding of psychopathology, as many people with serious mental disorders, including sociopaths and borderlines, can convincingly mimic normal behavior and, particularly when courting or being courted, can be deceptively charming.

He says this; she says that. The truth is probably in the middle This is the famous "He says/She says." If used as a heuristic, it is not only unreliable, it is unconscionable. Such thinking makes it impossible for a victim of false allegations to receive a fair assessment since the victim's true account is likely to be given as much weight as the victimizer's false account (possibly less weight if other biases are at work, which they often are). Those who make false allegations know this and can easily manipulate professionals who are naïve enough to employ this type of fallacious reasoning. "If I sling enough mud something will stick."

If we turn this over to an expert, he or she will figure it out This may or may not be true. Even among experts, the errors reviewed in this chapter are common. Blind faith in this dictum by those in the legal arena can be catastrophic, especially if a court "punts" and the putative expert is given too much authority with too little oversight.

How parents behave in a clinical evaluation is diagnostic Despite much research to the contrary, there is a widespread misconception that a clinical interview has high validity. In fact, research has shown striking limitations regarding information obtained through interviewing (Griffin & Tversky,

2002). Some claim, for example, that if a parent is anxious and intense in an interview, he or she is probably like that when parenting. Such thinking entails the fundamental attribution error. The key question is not whether the parent is acting that way, but rather, why. If the parent is anxious and intense owing to rejection by his or her own child, the observed affect may not be diagnostic. From a psychological perspective, that parent is having a normal fight or flight reaction. Failure to recognize that—to view the behavior as dispositional rather than situational—is a serious but very common error (see Sauber & Worenklein in this volume).

A parent who criticizes the other parent when speaking with a therapist or custody evaluator probably criticizes the other parent in front of the children This, too, entails the fundamental attribution error. Consider a targeted parent who is seeking physical custody of an alienated child. In court, that parent has the burden of proof to show that the custodial/alienating parent is unfit. There is no way to do that without criticizing the other parent. If the targeted parent does explain the reasons for seeking custody (e.g., that the child is being abused by the other parent), a professional who employs this misleading heuristic would hold that against the targeted parent—as if the criticisms were mere name-calling. That puts the targeted parent in a no-win double-bind.

Both parties always contribute This faulty heuristic implies that all cases of alignment are due to a combination of alienation and estrangement (i.e., are hybrids). It also assumes that a targeted parent must have done something to deserve or warrant rejection. This is an example of how alignment issues can be counterintuitive to those who lack adequate clinical understanding. Obviously, it is possible for both parents to be deficient (although if the targeted parent has done something to warrant rejection the term "alienation" should not be used). That does not mean that most cases are hybrid. Furthermore, even if it were true, it would be inappropriate to assume that any individual case is a hybrid. Imagine the firestorm if such a heuristic—that both parties always contribute—were still applied to victims of domestic violence or rape (which, in many parts of the world, it is).

If a child is adamant about a memory, there must be some truth to it This baseless belief flies in the face of massive research on false memories (Bruck & Ceci, 1999; Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010; Loftus, 1997; Loftus & Pickrell, 1995; Schacter, 2001; Tavris & Aronson, 2007). False memories are remarkably easy to implant. They can feel every bit as real as true memories so children who have been programmed are often adamant that they "remember" events that did not happen. To quote Loftus and Pickrell (1995):

> [Research] on memory distortion leaves no doubt that memory can be altered via suggestion. People can be led to remember their past in different ways, and they can even be led to remember entire events that never actually happened to them. When these sorts of distortions occur, people are sometimes confident in their distorted or false memories, and often go on to describe the pseudo-memories in substantial detail.

Note that this excerpt refers to adults. Children, of course, are even more susceptible.

Performance in school usually indicates how a child is doing in general There is no credible evidence to support this premise. In fact, the opposite can be true because some children who live in a toxic home find a safe haven in school. There is certainly no evidence that academic or social success protects the victims of PA from lifelong dysfunction due to trust issues, intimacy issues, esteem issues, anger issues, impulse issues, boundary issues, and the like.

Children are resilient; time heals all wounds This implies that most children suffer no long-term harm from PA. That is dangerously incorrect. For one thing, as illustrated by the literature on post-traumatic stress disorder, time does not heal all wounds—even in adults. In addition, it fails to account for severity. Naturally, children who sustain only mild alienation may experience only mild long-term effects. By contrast, it is well documented that those who suffer from severe alienation can suffer severe long-term effects (Baker, 2007). It also represents a striking example of the ecological fallacy. At most, the statement is true of some children in the general population. One cannot use such group data to conclude that any individual child is resilient. Anyone who doubts this need only recall that suicide is a leading cause of death among adolescents (Nock et al., 2008). Furthermore, many alienating parents have BPD, and the children of borderline parents have a significantly increased risk of developing BPD themselves (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012). Since BPD is associated with up to a 10% lifetime risk of suicide, it should be clear that this flawed heuristic entails a potentially life-threatening clinical error.

When a man seeks full custody, it is because he wants power and control This is Paleolithic logic. While it is reasonable to question whether anyone who seeks custody might be doing it for the wrong reasons it is neither fair nor ethical nor accurate to assume that, especially based on gender.

Clinicians are sometimes told: "Trust your gut." That, of course, means to trust one's intuition. While there are times when that is good advice, it can lead to bad judgments when intuition is not coupled with proper analytical reasoning. That is particularly important for clinicians who manage pathological alignment because, as discussed earlier, such cases can be highly counterintuitive. For that reason, the next section will further explore the respective roles of intuition and analytical reasoning in clinical practice.

The Dual Process Theory of Reasoning

Human thought falls on a continuum from intuitive to analytical (Hamm, 1988). This understanding is now codified as dual process theory, which has recently emerged as the dominant theory of human cognition (Croskerry, 2009a, 2009b; Croskerry & Norman, 2011; Evans, 2008, 2010; Pelaccia, Tardif, Triby, & Charlin, 2011). It provides a powerful new tool for understanding clinical problem-solving and, at least in theory, preventing clinical errors.

The theory posits that, in effect, the human brain has two distinct "processors"—one intuitive, one analytical. Each has a different "personality," with different strengths and weaknesses. Each interacts with and influences the other. And each is essential to competent clinical practice.

The purpose of this section is threefold: (1) to present an overview of this influential new theory, (2) to explain its relevance to clinicians who deal with child alignment issues, and (3) to illustrate how it can be used to improve metacognition.

System 1 and System 2

Current terminology refers to the two systems as System 1 and System 2. System 1 operates at an unconscious level. Relying on cognitive heuristics, it is responsible for intuition. It is fast but unreliable. It relies on pattern recognition and stereotyping—not logic. It is impulsive and prone to emotional reasoning. It has an inborn component and a learned component. The learned component handles certain aspects of expert reasoning, namely those that, through repetition, are learned so well they become automatic.

System 2 operates at a conscious level. Almost entirely learned, it is responsible for analytical thought. It is rule-based and logical. It is relatively resistant to emotional influences, makes few errors, and is quite reliable (though its performance can be impaired by stress or fatigue). System 2 has two roles: one is to handle analytical tasks, the other is to monitor System 1 and correct any errors (i.e., to perform a rational override). System 2 is lazy, however, and may not bother to correct System 1 unless it is employed consciously and deliberately. It might seem that System 2 is superior to System 1 but that is not the case. Each is skilled at different things. Both are necessary for optimal reasoning.

Relevance to Child Alignment Issues

Consider a case of child alignment that has been referred to a custody evaluator. First—unconsciously—the evaluator would begin by deploying System 1 for preliminary data gathering, initial hypothesis generation, and pattern recognition. Next—consciously—the evaluator would deploy System 2 for additional data gathering, data analysis, hypothesis testing, logical inference, probability assessments, and other analytical tasks. If there is conflicting evidence, for instance, if each parent is telling a different story (which is usually the case), System 2 would be required for logical analysis. Note that System 1 is most appropriate for hypothesis generation; System 2 is generally required for hypothesis confirmation (Elstein & Schwarz, 2002). Simple cases can often, but not always, be diagnosed by System 1 pattern recognition. Complex cases require System 2 as well.

Bayes' Rule

Bayes' rule, also known as Bayes' theorem, is a simple mathematical equation that defines the relationship between a hypothesis and the evidence for that

hypothesis. It governs conditional probability—the probability of one thing given another thing—and dictates how to combine and integrate new evidence to update one's belief in a hypothesis. Clinically, the hypothesis is often a possible diagnosis and the evidence is often a clinical finding. Each piece of clinical information should be combined in accordance with Bayes' rule. Because it is a mathematical equation, Bayes' rule implies that clinicians who have the same information should reach the same conclusions (Elstein & Schwarz, 2002).

Suppose one needs to determine whether a child is alienated. The usual approach would be to interview the parties, note various findings, and use intuition to make a diagnosis. The problem with that approach is that intuition can be unreliable, and most people (including clinicians) are poor statistical thinkers and do not assess probabilities well (Kahneman, 2011; Tversky & Kahneman, 1971). A better approach is to use Bayes' rule to determine the probabilities. This requires clinicians to understand that each clinical finding is, in effect, a diagnostic "test" much like a blood test or an X-ray. It also requires clinicians to assess the accuracy of each finding. That is done by estimating the sensitivity and specificity of each piece of evidence.[2] Fortunately, great precision is not required. Few physicians know the precise sensitivity or specificity of most tests but they do know the general range (e.g., very poor, poor, fair, good, or excellent). For clinical purposes, that is usually sufficient.

Additionally, and critically, Bayes' rule requires clinicians to estimate the prior probability of the condition. As previously noted, failure to do so is known as base rate neglect, a serious clinical error. Prior probability is determined or estimated by taking into account everything that is already known before considering any new evidence. Without all three parameters—sensitivity, specificity, and prior probability—it is impossible to make proper use of *any* clinical finding. With those parameters, one can calculate what is known as the post-test or posterior probability. Although the calculations are simple they are beyond the scope of this chapter but have been published elsewhere (Miller, in press).

Case Presentation

You have been asked to evaluate a 14-year-old boy who is strongly aligned with his father and overtly hostile toward his mother. There are no allegations of abuse or neglect. According to the father, the boy simply wants no contact with his mother.

You have already interviewed both parents. The father seemed credible. He was poised and articulate. The mother had some negatives. She was anxious and defensive. She accused the father of "brainwashing" the boy. Your intuition tells you the mother has weak parenting skills and you believe that is why the boy rejected her. Indeed, you believe the probability of estrangement is about 95% and the probability of alienation is only 5%.

However, in a 2-hour interview, you find that the boy meets all five of the criteria for PA that appear in Table 2.3 (for C4, the child meets C4-A, not

Table 2.3 Alienation criteria for the evaluation of a strongly aligned child

Criterion	*Description*
C1	The child manifests unreasonable negative beliefs, feelings, and/or behaviors about the rejected parent, such as anger, hostility, hatred and/or fear, that are significantly disproportionate to the child's actual experience with that parent *and* there is a consistent pattern of denigration for which the child provides only weak, trivial, frivolous, and/or absurd reasons.
C2	The child expresses views about the parents that suggest pathological splitting, such as a marked lack of ambivalence and/or reflexive support for the favored parent in almost any conflict or discussion.
C3	The child engages in cruel or unkind treatment of the rejected parent *and* there is little or no expression of guilt or remorse regarding that mistreatment.
C4	The child's use of language suggests that the child's opinions have been unduly influenced by the favored parent, as evidenced by the choice of words, syntax, or other parameters.
Either	
C4-A	The child expresses opinions, relates incidents, or otherwise criticizes the unfavored parent in a way that is either age-inappropriate or implausible and that closely resembles the beliefs and attitudes of the favored parent.
Or	
C4-B	*In addition to meeting C4-A*, the child, without prompting by the evaluator or anyone else, volunteers or spontaneously claims that he or she is expressing his or her own negative views or feelings about the rejected parent and has not been influenced by anyone else.
C5	Through actions or language, the child expresses either animosity toward, or rejection of, the friends and/or extended family of the unfavored parent *and* the child had a good prior relationship with those individuals.

C4-B). These criteria have been modified from those described by Gardner, Kelly & Johnston, and others (Gardner, 1999; Kelly & Johnston, 2001).

Before interviewing the boy, you believed the probability of PA was only 5%. Now that he meets these five criteria what is your updated belief?

Case Discussion

To use Bayes' rule, one must assess the accuracy of each criterion. In practice, the most common way to express accuracy is through sensitivity and specificity. For the sake of discussion, assume the sensitivities and specificities in Table 2.4.

It is important to note that since C1 contains some essential features of PA (it is a *sine qua non*) one cannot use this model unless the child meets C1. It also serves to screen out so-called hybrid cases.[4]

Table 2.5 presents the results using Bayes' theorem. It provides the probability of PA for a child who sequentially meets all five criteria (using C4-A, which is less powerful than C4-B).[5] The posterior probabilities do not have to be

Table 2.4 Estimated sensitivities and specificities of the criteria for children

Criterion	*Sensitivity (%)*	*Specificity (%)*
C1	94	94
C2	80	85
C3	80	85
C4-A	80	85
C4-B	40	95
C5	60	75

These assumptions are based on expert input and are intended to be conservative (i.e., they are considerately lower than the mean estimates by a group of more than 20 experts and are thus weighted against PA [Miller, in press]).[3]

Table 2.5 Posterior probabilities of child alienation using conservative assumptions and sequential calculations

Criterion	*Posterior probabilities of child alienation for each criterion for various prior probabilities (%)*				
	Prior probability 5%	*Prior probability 10%*	*Prior probability 25%*	*Prior probability 50%*	*Prior probability 75%*
C1	45.19	63.51	83.93	94.00	97.92
C2	81.47	90.27	96.53	98.82	99.60
C3	95.91	98.02	99.33	99.78	99.92
C4-A	99.21	99.62	99.87	99.96	99.98
C5	99.67	99.84	99.95	99.98	99.99

The decimal places are helpful only for higher prior probabilities. For instance, it is useful to distinguish between 99.98% and 99.99% because rounding the latter to 100% would be misleading. The use of decimal places does not imply clinical precision to those decimal places.

calculated sequentially (they can be done in any order) but are presented sequentially to simplify the illustration. To provide perspective, the table includes calculations for prior probabilities of 5%, 10%, 25%, 50%, and 75%. As mentioned previously, the calculations have been published elsewhere.

As these figures illustrate, even with a prior probability of only 5%—an extremely skeptical prior probability (meaning heavily weighted against the hypothesis)—if a child meets all five criteria the posterior probability of PA is greater than 99%. The other columns are equally informative.

For most people, including most experts, these results are extremely counterintuitive and may be difficult to accept. Mathematically, however, they are irrefutable. If one accepts the assumptions regarding accuracy then one *must* accept the conclusions regarding probability. A similar approach should be taken when interviewing the parents, evaluating collateral source information, and so on. When considering the total clinical picture, clinicians should estimate the accuracy of each piece of evidence and combine that evidence using Bayes' rule.

That is not controversial. The failure by many clinicians to apply proper Bayesian methods to clinical problems has been noted by some of the most prominent psychologists of modern times, including Paul Meehl (Meehl & Rosen, 1955), Arthur Elstein (Balla, Iansek, & Elstein, 1985), Scott Lilienfeld (Lilienfeld, 2011), Daniel Kahneman (Kahneman, 2011), and Amos Tversky (Tversky & Kahneman, 1982). It runs rampant through every clinical discipline and is a major problem in the diagnosis and treatment of child alignment.

Analysis of the Clinical Vignette

Obviously, the therapy did not go well. That should not be surprising because the therapist, however well-intentioned, made a multitude of mistakes. While space does not permit a detailed discussion, here are some examples.

Biases The therapist displayed all 10 cognitive biases described in this chapter. Five of the most egregious were: representativeness errors (stereotyping); anchoring errors; confirmation bias; framing errors; and fundamental attribution errors.

Violations of clinical axioms The therapist violated each and every clinical axiom in this chapter. Five of the most serious violations were: failure to consider the total clinical picture; failure to consider the natural history of the condition; failure to properly consider severity; failure to set proper treatment priorities; and failure to treat the underlying condition(s).

The last example is particularly instructive. The mother did not merely badmouth the father; she told the child the father threatened to kill them. Common sense dictates that no amount of competent parenting by the father would reverse that type of malignant programming—particularly since the child lived with the mother. And yet, rather than focusing on the mother's behavior, the therapist proposed to work on the father's parenting skills. Meanwhile, the child continued to believe the father had abused the mother. Seen in that light, the treatment plan was not only inadequate, it was dangerous.

Errors in reasoning There were errors in logic, probability, and general reasoning including:

1. Failure to properly employ deductive logic. For instance, the mother falsely told the child the father threatened to kill them. That was severe emotional abuse. Severe emotional abuse is severe child abuse. Therefore, the mother had engaged in severe child abuse. And yet, the therapist focused on the child's relationship with the father.
2. Failure to properly use inductive logic. For instance, since the mother had abused the child in the past, and since the mother continued to abuse the child in the present, there was a high probability that, without effective intervention, the mother would continue to abuse the child in the future.

3. Failure to make appropriate use of circumstantial evidence.
4. Overreliance on intuitive/emotional reasoning.
5. Underuse of analytical/rational reasoning.

Other errors Other instructive errors include:

1. Inadequate assessment of the child's psychological and emotional state. Based on only two pieces of information—the child's cheerful demeanor and grades in school—the therapist concluded that, except for her relationship with the father, the child was "doing well." That assessment should not have been based on such meager information. Children who live in a toxic home often find a "safe haven" in school.
2. Enabling the alienating parent. The treatment plan was a tremendous "victory" for the mother. It assured that the child would have minimal contact with the father; that contact would be confined to the therapist's office; and that the mother could continue to alienate the child. The net result was to empower and embolden both the mother and the child to act out against the father. The proper approach would have been for the therapist to engage in non-punitive limit-setting.
3. Use of inappropriate techniques. The therapist's use of "mirroring, validating, and empathizing" was ill-advised. It is not appropriate to ask a parent who has been the victim of false allegations to mirror and validate a child's delusions regarding those allegations. This is an example of how a technique that is helpful in one setting (couples counseling) can be harmful in another setting (severe PA).
4. Ineffective use of cognitive dissonance. The therapist expected the child to have positive experiences with the father that would be dissonant with her previous low opinion of him. That can be a useful technique but it can also backfire. For one thing, it assumes that future experiences will be positive. In this case, the experiences were not positive. For another thing, there are several ways to reduce dissonance. One is to change one's beliefs. That is what the therapist hoped for. Another is to reject the information and defend those beliefs. That is what actually happened. Therapists who use cognitive dissonance must do so with great care and skill.
5. Inadequate treatment. To provide only one example, weekly 45-minute sessions were grossly inadequate.

The above comments are not comprehensive. Astute readers will recognize numerous other errors.

Conclusion

This chapter has presented some concepts, principles, and techniques that may be useful to clinicians who deal with severe child alignment. To briefly summarize:

- In recent years there has been a revolution in the field of clinical reasoning and decision-making. One advance has been a better understanding of heuristics and biases. This is reflected in dual process theory, which focuses on the relative roles of intuitive and analytical thinking.
- There has been a shift toward evidence-based practice. It is unacceptable for clinicians to employ unscientific methods that produce suboptimal outcomes.
- There is greater awareness of the need to employ Bayesian principles. Clinicians who violate Bayes' rule often make inaccurate judgments.
- Clinicians must engage in metacognition—they must think about thinking.

In expert hands, the methods in this chapter can be powerful tools for dealing with alienation, estrangement, and related problems. They can also be applied to other clinical situations.

Notes

1 This, incidentally, represents a misuse of the word "alienation." By definition, if the rejected parent played the more influential role then the primary problem is estrangement, not alienation.

2 Sensitivity refers to how accurate a test (or finding) is at detecting patients who actually have a condition. It is the true positive rate. Specificity refers to how accurate a test is at detecting patients who do not have the condition. It is the true negative rate. (Specificity is the inverse of the false positive rate which equals 100 minus specificity.)

3 These estimates were derived from a review of the clinical literature, a survey of over 20 mental health professionals with extensive experience in the area of child alienation and estrangement, and other expert input. For each criterion, the estimates are considerably lower than the mean and close to or lower than the lowest estimates from any expert. For C1, the mean sensitivity and specificity were 96% and 95%, respectively. However, though considered plausible, they have not been validated in a clinical trial and must therefore be considered provisional. A clinical trial to further validate them is in progress. For now, they are offered only as an illustration of how to apply Bayesian reasoning to clinical problem solving.

4 Through its stringent requirements, C1 eliminates the vast majority of cases in which estrangement is playing a clinically significant or causative role. For a hybrid to slip through the C1 filter the estrangement component would have to be both mild and minor. Otherwise, the rejected parent's conduct would have to be severe enough to warrant strong rejection yet mild enough that the child cannot provide a plausible explanation for the rejection. In the absence of undue influence from the favored parent, that combination is neither likely nor common.

Since all parents have flaws, one can always find something wrong with a rejected parent. Advocates of the hybrid hypothesis tend to neglect the relative contribution of each component (thus violating axioms 1, 7, 8, and possibly 12). They tend to call the case a "hybrid" even if the rejected parent has played only a minor role (which is a form of severity neglect). Also, they sometimes misuse the word "alienation" which, by definition, cannot be used if there is clinically significant abuse or neglect. That said, this model provides for a degree of mild estrangement in that each of the criteria has a significant false positive rate (equal to 100 minus specificity). Similarly,

it provides for the possibility that a rejected parent might have suboptimal parenting skills or that a child might be biologically vulnerable.

This model is not intended to take the place of clinical judgment. Rather, it is intended to inform clinical judgment. When considering the possibility of a true hybrid, clinicians must consider the total clinical picture.

5 Mathematically, the combined sensitivity and specificity of C4-A is only two-thirds as powerful as that of C4-B. For those familiar with Bayesian methodology, the former has a positive likelihood ratio (true positives/false positives) of 5.3, the latter of 8.0.

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