I want everyone to listen closely, especially all mental health people. I am going to walk through the diagnosis. This is diagnosis, not a theory. It is diagnosis of a mental health pathology identified by the American Psychiatric Association (DSM-5) and by the World Health Organization (ICD-10).

In diagnosis, there are a series of steps. I am going to walk everyone through the diagnostic steps. This is not a theory… it is diagnosis. Standard diagnosis of psychiatric pathology identified by the American Psychiatric Association (DSM-5) and by the World Health Organization (ICD-10).

Step 1: Presenting Problem

All assessment and diagnosis begins with the presenting problem. Is the patient complaining about a sore throat? Or abdominal pain? Depression? What? What is the presenting problem that is requiring professional involvement and diagnosis?

Presenting Problem: the child is presenting as being "victimized" by a parent and is rejecting their attachment bond to this parent.

Differential Diagnosis: The belief is true (the child is being "victimized" by the parent) or the belief is false (the child has a persecutory belief).

True Belief: If true, then this would likely be a DSM-5 diagnosis of child abuse. It is hard to imagine a case where a child was authentically being "victimized" by a parent that was not also child abuse.

False Belief: If the belief is false, how false? A false belief in "victimization" would represent a persecutory belief. The differential diagnosis for a persecutory belief is whether it represents a persecutory delusion.

The American Psychiatric Association defines a persecutory delusion as:

Persecutory Type: delusion that the person (or someone to whom the person is close) is being malevolently treated in some way.
Does the child believe that he or she is being "malevolently treated in some way" by the parent? Yes. Is that belief true? No. Then it is a persecutory belief. The next diagnostic question is whether it is a persecutory delusion?

The Brief Psychiatric Rating Scale (BPRS) is widely considered to be the gold standard for assessing psychotic-range symptoms. The preeminence of the BPRS for rating psychotic symptoms is widely recognized.

From Wikipedia "The Brief Psychiatric Rating Scale (BPRS) is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored. The scale is one of the oldest, most widely used scales to measure psychotic symptoms and was first published in 1962."

BPRS: Differential Diagnosis
Item 11 on the BPRS Unusual Thought Content is the item rating for delusional-range pathology. Ratings of 4 or higher are considered delusional. The key symptom feature

discriminating between a persecutory belief and a persecutory delusion is the person's degree of conviction that the false belief is true.

From BPRS Instructions: "Delusions are patently absurd, clearly false or bizarre ideas that are expressed with full conviction. Consider the individual to have full conviction if he/she has acted as through the delusional belief were true."
Has the child acted as though the persecutory beliefs regarding the parent are true? Yes, the child is refusing contact with the parent because of the persecutory beliefs. Then the child has "full conviction."

BPRS Rating 3 Mild: "Content may be typical of delusions (even bizarre), but without full conviction."
The child has full conviction, so the rating is higher than a 3 (Mild)

BRPR Rating 4 Moderate: "Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief abut past delusional circumstances."
Does the child's persecutory belief cause "functional impairment."? Yes, it is damaging normal bonded attachment relationships in the family. The child's rating is higher than a 4 (Moderate)

BPRS Rating 5 Moderately Severe: "Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking."

Note diagnostically, that the OR emphasizes that either one OR the other (preoccupation or functional impairment) can be present to meet criteria.

Does the child evidence some preoccupation with the persecutory beliefs OR are some areas of functioning disrupted by the persecutory belief? Yes. Some areas of the child's functioning are disrupted (family relationships). The child's false belief in persecution meets criteria for a rating of 5 Moderately Severe delusion.

The child is evidencing a **Moderately Severe** persecutory delusion.

How does a child acquire a persecutory delusion toward a normal-range parent?

Differential Diagnosis: Shared Delusional Disorder with the allied parent.

The American Psychiatric Association description of a shared delusional disorder:

"Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person. Individuals who come to share delusional beliefs are often related by blood or marriage and have lived together for a long time, sometimes in relative isolation… Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs." (APA, 2000, p. 333)

Confirm Shared Delusion with Allied Parent

Present the allied parent with the evidence that the child is not being maltreated, abused, or "victimized" by the targeted-rejected parent. Normal parents will be happy with this news. A parent with a persecutory delusion ("someone to whom the person is close"; i.e., the child) will continue to insist that the child is in danger from the other parent when this belief is not true.

Has the allied parent acted as through the false belief in the child's supposed "victimization" is true? Yes, the parent seeks to protect the child from contact and involvement with the other parent. Then the allied parent has full conviction and the BRPS rating is at least a 4 Moderate.

Does the allied parent evidence some preoccupation with the false belief in the child's "victimization"? Yes, the allied parent is actively engaged in efforts to "protect the child" from "victimization" when there is no "victimization" present, it is a persecutory delusion. The rating for the allied parent is at least a 5 Moderately Severe persecutory delusion.

From the American Psychiatric Association: "Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs." (APA, 2000, p. 333)

The child's diagnosis is a shared delusional disorder (ICD-10 F24 Shared Psychotic Disorder)

Creating a persecutory delusion in the child toward the other normal-range parent that then destroys the child's bonded relationship to that parent is a DSM-5 diagnosis of V995.51 Child Psychological Abuse.

BPRS Rating 6 Severe: "Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking."

If the child or parent evidence "much preoccupation" OR if there are many areas of functioning disrupted by the persecutory delusion, then the BPRS rating is a 6 Severe.
This is not a "theory" – it is the American Psychiatric Association and the BPRS ("one of the oldest, most widely used scales to measure psychotic symptoms").

Diagnosis. Step-by-step.

Failure to properly assess and diagnose pathology would represent professional malpractice (Standard 9.01a)

Failure to properly assess and diagnose child abuse would be a failure in the professional's duty to protect the child.

Diagnosis. American Psychiatric Association BPRS.

Craig Childress, Psy.D
Clinical Psychologist, PSY 18857