Symposium Structure

1. Challenging Inadequate Assessments and the 'Discourse of Disbelief' (Dr Rainer Hermann Kurz, UK)

2. Combating psychometric re-victimisation through the assessment of adaptive and ‘maladaptive’ Big 5 personality facets at both ends (Stewart Desson, UK)

3. An Organised Ritualised Crime Abuse Network (ORCAN) in the British Isles? (Dr Rainer Hermann Kurz, UK)
Challenging Inadequate Assessments and the 'Discourse of Disbelief'

Dr Rainer Hermann Kurz (UK)

C.Psychol

ichinendaimoku@gmail.com

‘Only the death penalty is more drastic than removing a child from its parents forever’

(James Munby, President of the Family Division, according to BBC Panorama 13th January 2014)
Background

1 PhD:

2 Book Chapters (& 100+ conference papers):

3 Roles:
• Occupational Psychologist at Assessment Consultancies since 1990
• Member of the BPS Committee on Test Standards (CTS) since 2012
• Science & Practice Convener of BPS DOP since 2016

4 Years Abuse Case Investigation

5 Posters each at the European Psychiatry Congress in Munich (2014), Madrid (2016) and Florence (2017) + 2 at Conference of the European Association of Psychosomatic Medicine (EAPM) 2015 in Nuremberg

https://www.researchgate.net/profile/Rainer_Kurz2
I Personality Assessment & Forensic Psychology

II Case Study A: WAIS and MCMI in ’Child Smuggling’ Case

III Case Study B: ‘Histrionic’ GMC Fitness to Practice Concern

IV Case Study C: ‘Exposing Child Abuse = Borderline Diagnosis’?

V Case Study D: ‘Extreme Abuse Survivor’

IV Health & Care Profession Council (HCPC) Persecutions
General Factor of Competency (Kurz, 2005) and Personality (Musek, 2007)

Alpha & Beta Higher-order Factors (Digman, 1997)

Big 5 Personality Factors (e.g. Norman, 1963; Digman, 1990; Barrick & Mount, 1991)

10 Aspects of Personality (DeYoung, Quilty & Peterson, 2007)


Horney (1950):

**Moving away**
- Excitable
- Skeptical
- Cautious
- Reserved
- Leisurely

**Moving against**
- Bold
- Mischievous
- Colorful
- Imaginative

**Moving towards**
- Diligent
- Dutiful

---

**Hogan Development Survey (HDS) Sub-clinical Scale Themes and DSM Axis 2 Personality Disorders**

### Figure 1.1

**Overlapping Themes from HDS and DSM-IV, Axis 2 Personality Disorders**

<table>
<thead>
<tr>
<th>HDS Themes</th>
<th>DSM-IV Personality Disorders Themes</th>
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</thead>
<tbody>
<tr>
<td>Excitable</td>
<td>Borderline</td>
</tr>
<tr>
<td>Skeptical</td>
<td>Paranoid</td>
</tr>
<tr>
<td>Cautious</td>
<td>Avoidant</td>
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<tr>
<td>Reserved</td>
<td>Schizoid</td>
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<tr>
<td>Leisurely</td>
<td>Passive-Aggressive*</td>
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<td>Bold</td>
<td>Narcissistic</td>
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<tr>
<td>Mischievous</td>
<td>Antisocial</td>
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<td>Histrionic</td>
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<td>Imaginative</td>
<td>Schizotypal</td>
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<td>Diligent</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td>Dutiful</td>
<td>Dependent</td>
</tr>
</tbody>
</table>

Note: *From DSM-IV-R

Conceptual Background

Page 5
Great STORM Topography based on r matrix (N=308) of NEO Big 5 Domain & 7 Personality Questionnaire Great 8 Scores

Kurz (2013)

EAWOP Munster

Slide source: Kurz (2016), SIOP Symposium Discussant ‘Exploring the Psychometric Properties of Personality Derailment Scales’
A revolutionary new perspective on the way we explain human behaviour and define mental health

This controversial new book describes how human behaviour - thoughts, emotions, actions and mental health - can be largely explained if we understand how people make sense of their world and how that framework of understanding has been learned. In this ground-breaking work, Peter Kinderman presents a simple, but radical new model of mental well-being.

Published in the wake of the controversial Diagnostic and Statistical Manual of Mental Disorders, the author challenges notions such as 'mental illness' and 'abnormal psychology' as old-fashioned, demeaning and invalid, and argues that diagnoses such as 'depression' and 'schizophrenia' are unhelpful.

Kinderman believes that one consequence of our current obsession with a medical approach to human well-being and distress is that human problems are too often merely diagnosed and treated, rather than understood. Written by an expert in his field, and accessible to all those interested in and affected by mental health issues, The New Laws of Psychology will change the way we define mental illness forever.

Evaluating Expert Witness Psychological Reports: Exploring Quality


‘Dubious 'experts' are paid to tear families apart

A new report condemns the shoddy standards of psychologists' reports in our family courts.

A study by Professor Jane Ireland, a forensic psychologist, for the Family Justice Council examined 126 psychological reports trawled at random from family court documents. It found that two thirds of them were “poor” or “very poor” in quality.’

‘Another woman was found by a psychologist to be “a competent mother” – so the social workers went to a second witness, who found the same. They then commissioned a third, who at last came up with what they wanted: that the mother had, again, “a borderline personality disorder”. On that basis, her three children were sent for adoption.’

http://www.telegraph.co.uk/comment/columnists/christopherbooker/9150659/Dubious-experts-are-paid-to-tear-families-apart.html

McDowall (2015): Bad Apples, Bad Barrels, Bad Cases

Biases That May Affect Forensic Experts

Forensic assessment tasks present a tall order. Otto (2013) vividly outlined the difficulties faced by forensic clinicians (emphasis in original):

To (in a limited amount of time, using assessment techniques of limited validity, and with a limited amount of information-some of which is provided by persons with an investment in the examiner forming a particular opinion) come to an accurate assessment about the past, current, and/or future emotional, behavioral, and/or cognitive functioning of an examinee as it relates to some issue before the legal decision maker (while ensuring that how one has been involved in the case does not affect one’s decisions).


‘Evaluators perceived themselves as less vulnerable to bias than their colleagues, consistent with the phenomenon called the “bias blind spot”. Recurring situations that posed challenges for forensic clinicians included disliking or feeling sympathy for the defendant, disgust or anger toward the offense, limited cultural competency, pre-existing values, colleagues’ influences, and protecting referral streams.’

Useful information

At last a BREAKTHROUGH!! Read the following article in the "LAW GAZETTE". You can now hit those “SS” people through their pockets! The more times you go to court the harder they will find it to pay for it all! Fight like a tiger and never give up and like countless other mothers (some of whom I have advised) You can WIN and get your children back!

Do not be fooled into cooperating with the “SS” when you are given their promises or those of your legal aid lawyers that if you go along with the “SS” everything will be alright! It WON’T!! All they want from assessments and psycho charlatans is more evidence to win their case so do not give it to them! The “SS” are not police who must be obeyed but they ARE your ENEMIES as long as their stated intention is to take your children into care or for adoption. When your enemy runs out of ammunition you should never send them a fresh case of bullets for them to fire at you!! Only agree to assessments and psychos if ordered to do so by a judge; otherwise refuse unless your children are returned to live with you first! Any other assessment or psychiatric examination cannot be normal or natural.

Lastly never get “conned” into putting your kids into voluntary care because more often than not despite what the law gazette says you may never see them again IF YOU ARE IN THAT SITUATION USE THE LAST PARA OF THE GAZETTE AS PROOF THAT THEY MUST BE RETURNED TO YOU WHEN YOU ASK! And the best of luck to you!

https://forced-adoption.com/
https://forced-adoption.com/contact/
http://forcedadoptions.naa.gov.au/content/overview-forced-adoption-practices-australia
**II Case Study A**

**‘Child Smuggling’**

**GLOBAL FACTORS**

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All 15FQ+ scale values on the Neuroticism vs. Emotional Stability factor of the Big 5 Personality Model are in the ‘Average’ range.

**Area 4: Managing pressure and stress**

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<td>Socially-bold</td>
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Source: Kurz (2015). Politics and the Psychology of Abuse and Cover-up
• DSM-III (1980): Posttraumatic Stress Disorder (PTSD)

• Putnam, F. (1989). Diagnosis and Treatment of Multiple Personality Disorder (Foundations of Modern Psychiatry)

• Herman, J. (1993). Trauma and Recovery. (C-PTSD)

• Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden (1996) SDQ20 Somatoform Dissociation Questionnaire:
  • Q11: ‘I cannot see for a while (as if I am blind)'
  • Q12: ‘I cannot hear for a while (as if I am deaf)'

Only the small secrets need to be protected. The big ones are kept secret by public incredulity. (Marshall McCluhan)
Subject: please help this young adult

hi there i hope you can read this email and reply.

i have been told after an iq test that i am a gifted crossover person and should try to research this. i am not living in the area i took the test in so am not able to get all the help i wanted from the people in the know. cant find this phrase anywhere but i am certainly diagnosed with a learning dissability perhaps similar to an attention defecit child too so can you help me find the information i can read at my leasure please! it is aural delay i experience, by months and years. i go totally deaf you see! even if its about gifts in the verbal (very very high) and perception parts of the iq lot. dont speak the lingo very well you see.

i have moved to ___________________________ now so i hope this is not too far. any information would be helpfull you know. can get a copy of the letter written to my doctor soon and this may give me a little more info.

ok, thanks from <__________>, 25 years old.

Dear <__________>,
Thank you for getting in touch with us. The term we use for ‘crossover’ is twice exceptional and you will probably find lots of information about this if you google the term. I am sending you some of our factsheets that you may find useful, however, most of them relate to children.

All the best, <Advisor>, Education Consultant
National Association for Gifted Children
Tel: 0845 450 0295
Fax: 0870 770 3219
www.nagcbritain.org.uk

Child neglect (at end of case 100% cleared)

Mental Health Issues (‘Delusional’):

– Schizophrenic
– Schizoid
– Paranoid
Method

In-depth Psychometric Assessment

Informal testing for guidance & development:
   Work personality questionnaire
   Abstract reasoning test

Witnessing of interview with Clinical Psychologist

Recovery of IQ reports at age 7, 23 & 25

Commissioning of assessments (5 specialists)

Professional concerns about misdiagnosis

### WISC Results (aged 7)

**General Level of Intellectual Functioning**

*WISC* (Wechsler Intelligence Scale for Children - Revised)

<table>
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<th>WISC Subtests</th>
<th>Score</th>
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<tr>
<td>Information</td>
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<tr>
<td>Similarities</td>
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<tr>
<td>Arithmetic</td>
<td>14</td>
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<tr>
<td>Vocabulary</td>
<td>17</td>
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<tr>
<td>Comprehension (Digit Span)</td>
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</table>

*Full Scale I.Q = 128*

Average score = 10

Range 1 to 10 for these tests

### WAIS III (aged 23)

**General Level of Intellectual Functioning**

*WAIS* (Wechsler Adult Intelligence Scale)

The following standard scores relate to performance to that of adults of similar age and have an average value of 100. Scores of 69 and below are very low; scores 70-79 are low; 80-89 are below average; 90-109 are average; 110-119 are above average; 120-129 are high; and 130 and above are very high.

<table>
<thead>
<tr>
<th>WAIS III Subtests</th>
<th>Score</th>
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<tbody>
<tr>
<td>Verbal Comprehension</td>
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<tr>
<td>Perceptual Organisation</td>
<td>93</td>
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<tr>
<td>Vocabulary</td>
<td>19</td>
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<tr>
<td>Similarities</td>
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<td>Information</td>
<td>12</td>
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<tr>
<td>Comprehension</td>
<td>12</td>
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<tr>
<td>Working memory</td>
<td>84</td>
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<tr>
<td>Perceptual Organisation</td>
<td>93</td>
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<tr>
<td>Arithmetic</td>
<td>6</td>
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<td>Digit Symbol Coding</td>
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**Index Scores**

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<th>Index Scores</th>
<th>Score</th>
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<tr>
<td>Working Memory</td>
<td>84</td>
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<tr>
<td>Processing Speed</td>
<td>76</td>
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</table>

**Full I.Q**

See Text

### WAIS III (aged 25)

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<tr>
<th>IQ/Index Scores</th>
<th>VIQ</th>
<th>PIQ</th>
<th>FSIQ</th>
<th>VCI</th>
<th>POI</th>
<th>WMI</th>
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<tr>
<td>IQ/Index Scores</td>
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<tr>
<td>Percentiles</td>
<td>58</td>
<td>78</td>
<td>68</td>
<td>75</td>
<td>88</td>
<td>25</td>
<td>58</td>
</tr>
</tbody>
</table>

**Verbal I.Q**

107

Percentile: 68

**Performance I.Q**

89

Percentile: 23
## Profile of case

<table>
<thead>
<tr>
<th>Underlying Abilities</th>
<th>Performance</th>
<th>Cognitive* skills (CTOPP)</th>
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</thead>
<tbody>
<tr>
<td><strong>Underlying Abilities</strong></td>
<td><strong>Performance</strong></td>
<td><em><em>Cognitive</em> skills (CTOPP)</em>*</td>
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<tr>
<td>(Wide Ranging Intelligence Test - WRAT)</td>
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<tr>
<td>Non-verbal – WRIT Matrices (Abstract Reasoning)</td>
<td>Spadafore Listening Comprehension</td>
<td>Phono-memory &amp; Working Memory</td>
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<tr>
<td>Verbal</td>
<td>SWR Writing Speed Maths Spelling</td>
<td>Rapid Naming Phono Awareness</td>
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<tr>
<td><strong>Non-verbal – WRIT Diamonds (Spatial Reasoning - Verbally mediated)</strong></td>
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</table>

Tests Used: WRIT, WRAT, CTOPP*, WRAMAL 2, DASH


‘The most judicious course of action is to consider the Millon et al. (1997) study to be fatally flawed. It is noteworthy that none of the three alternatives justifies the use of the MCMI-III in forensic cases. In closing, we reaffirm the conclusions of Rogers et al. (1999): “The MCMI-III does not appear to reach Daubert’s threshold for scientific validity with respect to criterion-related or construct validity” (p. 438). Despite Dyer and McCann’s (2000) spirited defense, fundamental issues regarding validation (construct, criterion-related, and content), forensic applications, and unacceptable error rate argue against the use of its Axis II interpretations as scientific evidence.’

**CAPSULE SUMMARY**

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports.
MCMI-III

- Base Rate cut-offs:
  - 60 Median
  - 75 Significance
  - 85 Prominence
- ‘General Factor of Demoralisation’ (MMPI2) low as indicated by the orange vertical line
- Low scores on Schizoid, Depressive, Histrionic, Borderline, Anxiety, Somatoform, Thought Disorder
- Abuse Survivor
- Stalking
- Crime Report
- Misdiagnosis

Most healthy adults appear ‘Narcissistic’

‘Inter-generational abuse’ & ‘stalking’ victims appear ‘Paranoid’ & ‘Delusional’
III Case Study B
GMC Concern

Fitness to Practice Concern

Concerning Psychiatrist Dr

Submitted by

Complaint Reference Number: E1-1429001124

Original Submission Date: 25/05/2016

A. Dishonesty

A1. Dr claimed that I ‘had an anxious manner and remained unsmiling throughout the interview’ (page 14) during the assessment session on 9th January 2016 – the audio recording and transcript where more than 20 occasions of smiling, laughing or giggling are highlighted in green proof that this is a lie.

A2. Similarly she claimed in the original assessment that I did NOT have a Borderline Personality Disorder but then contradicted herself in the report.

A3. She claimed that changing frequency of therapy from twice to once per week was evidence for ‘impulsivity’ when she actually made the suggestion several times as highlighted in grey in the interview.

B. Unreasonableness – Dr makes the absurd claim that submitting appeals to regain custody of my children is evidence for a ‘disorder’ – this contravenes common sense and legal provisions (see Appendix B, point 16) and must be challenged as otherwise becomes part of ‘case law’.

C. Gross Professional Incompetence - Dr failed to properly gather and provide valid evidence for ‘Borderline Personality Disorder’ and ‘Histrionic Personality Disorder’ which are contradicted by everyday evidence and psychometric personality test results. Salient content is highlighted in yellow with particularly important content underlined. Utterances that appear inappropriate are highlighted in red font.

https://psychassessmentblog.wordpress.com/2016/08/22/psychiatrist-gmc-fitness-to-practice-concern/
### Case Study B

**'Histrionic'?**

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<td></td>
<td></td>
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<tr>
<td>N  Emotional Stability</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>O  Openness to Experience</td>
<td>Open to experience</td>
<td>X</td>
<td></td>
<td></td>
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### NEO Personality Inventory – 3 | Self-report
**UK Working Population - T Score (50+10z)**

<table>
<thead>
<tr>
<th>Raw Value</th>
<th>Normed Value</th>
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<tr>
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<td>116</td>
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<td>125</td>
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</table>

**Domain Scores**

- N Neuroticism
- E Extraversion
- O Openness to Experience
- A Agreeableness
- C Conscientiousness
As shown in the Lumina Mandala (Appendix D) I am a down-to-earth and outcome focussed individual. Both are highly desirable attributes that are priced at the work place.

I am less Extraverted than others making it highly unlikely that I suffer from a ‘Histrionic Personality Disorder’.

I am not ‘inspiration driven’ either which would underpin ‘excitement seeking’ which I have been accused off.
11 July 2016

Dear Ms

Thank you for taking the time to contact the General Medical Council with your concerns. We have carefully considered your concerns and we are sorry to hear of your experience, however we have decided that we will not be taking the matter any further at this time. We are sorry if this is not the outcome that you were hoping for.

About our role

Our role is to ensure that doctors who are registered to practise medicine in the UK are safe to do so. We only take action where we believe we may need to restrict or remove a doctor’s registration to protect patients or the reputation of the medical profession.

The reasons for our decision

Based on the information you have provided, we are unable to identify any concerns that would require us to take any action in relation to the events that you have described. Your complaint relates to a medical report written for court proceedings, and although we recognise that you are unhappy with the report the GMC have no power to change the conclusions Dr __________ has reached as it falls outside of our remit.

When considering your concerns we have sought the advice of a medically qualified member of staff and they agree that the issues raised do not appear to call into question Dr __________’s fitness to practise. The doctor clearly indicated her areas of expertise, what it was that she had been asked to answer and the source of the information that she had used.

The psychiatric assessment was undertaken in a very competent manner, verbatim was collected and noted in the report, proper history was collected and any given diagnosis was explained. Whilst we understand that you disagree with the opinion that was reached by the expert, from the information before us there is no indication that the clinical care provided was deficient.

Our decision is in no way meant to undermine your concerns and we are sorry that we have been unable to assist you further.
9 August 2016

Dear Ms,

Thank you for your email to my colleague, _______. I am responding to you in my role as Complaints and Correspondence officer. I have looked carefully at both your correspondence and the information on our system regarding your complaint. I appreciate how much of an impact the events you have described have had I can see from your letter that this is a matter you feel strongly about. I am sorry that you feel our handling of your concerns has not reached the high levels you are right to expect of us and we did not correctly consider the issues you raised. I hope I can address these points and clarify the reasons for our decision not to open an investigation into Dr _________’s fitness to practise.

Our role as a medical regulator is to make sure that doctors who are on the medical register and licensed to practice medicine, are safe to do so. When complaints are brought to us, we must consider whether they raise fitness to practise concerns about the doctors which would require us to open an investigation and potentially restrict or remove their registration. Our role is not to punish doctors and generally an isolated incident is less likely to point to an on-going risk to current or future patients than where there has been a pattern of poor performance.

The GMC is not a general complaints handling body, and we do not investigate all complaints about doctors even if it appears that there may be issues that should be addressed. Many complaints about doctors, even if they are proved, would not warrant the exercise of our powers to prevent or restrict the doctor from working. Even when someone believes that the doctor’s actions have not met the standards set out in our guidance, this does not necessarily mean that we need to open an investigation into the doctor’s fitness to practise. The decision by our Assistant Registrar (a senior decision maker) was that the concerns you raised did not meet the GMC’s threshold for an investigation to be opened. The GMC issues guidance to the medical profession which sets out the standards they should strive to practise and abide by, however not all breached of that guidance will justify restrictive action on a doctor’s registration.

You have stated that you believe Dr _________’s actions border on criminality; we have no power or authority to take action regarding the law, and we advise anyone with such concerns to contact their local police force. If the police find further issues which may show that the doctor’s fitness to practise is currently impaired, they will make the necessary referrals to us. I apologise that we have not addressed each of your points in detail, however if a complaint is determined to have not met our threshold to open a full investigation we do not consider each issue in the depth you may have been hoping for.

I know you will be disappointed that we have not taken your concerns further and I appreciate how frustrating it can be when these matters have had an effect on your life. I know you may disagree, but we do not believe that the issues you have brought to us suggest that we need to take action on Dr _________’s registration and limit the work she can do. We are therefore not able to take your complaint further at this time.

I hope you find this helpful and I would like to thank you again for writing to us.
8 November 2016

Dear _____ _____,

I'm naturally not satisfied with your conclusion to my complaint submission. After reading the GMC website a few times, I believe that you have not taken appropriate steps to investigate the seriousness of my complaint in order to protect the safety of the public etc etc. It was neither my request for you to CHANGE the conclusions of Dr __________.

Please could you now provide me with the details of all personnel involved in rejecting my submission. I will be submitting a complaint about the handling of my submission to the GMC CEO.

I will be posting a letter to the Head of GMC pointing out that your response does not at all address the points that I'm deeply concerned about.

1. DISHONESTY
2. UNREASONABLENESS
3. INCOMPETENCE

IN MY OPINION all these border on CRIMINALITY and if the GMC refuses to investigate such cases, it is clearly shielding its doctors putting the public at risk.

I look forward to you reply.
9 November 2016

Dear Ms

Thank you for your email. We are sorry that you are unhappy with our decision to close your complaint.

...

A decision to open an investigation can only be made if the concerns raised are so serious that the doctor’s fitness to practise medicine is called into question to such an extent that action may be required to stop or restrict the way in which they can work to protect future patient safety

...

Although we have a legal duty to consider all allegations that are presented to us and whether it is appropriate to open an investigation. As we are not a complaints handling body, we are not legally obliged to address every single allegation made about every doctor within our response. All concerns about registered doctors received into the GMC are carefully considered by a GMC decision maker (Assistant Registrar.) We also have a number of medically qualified colleagues (Medical Case Examiners) who we can refer to for advice on clinical matters. Both the Assistant Registrar and the Medical Case Examiner have thoroughly assessed the information that you provided to us and all of the concerns you have raised, they have not identified any fitness to practise concerns regarding a doctor that would require us to open a GMC investigation. I can confirm that all Medical Case Examiners hold a primary medical qualification and have or still do practise as doctors. We are confident that they have the expertise required to advise on matters such as the ones you have brought to us. The role of the medical case examiners is to advise the GMC on medical matters, they are not public facing and therefore their identity is not required to be disclosed. Decisions made by the Assistant Registrars are made on behalf of the GMC by applying our legal threshold and following our decision making processes and guidance. As such this is not a personal decision. Additionally the decision reasoning of the Assistant Registrar along with any input from a Medical Case Examiner is communicated to you in your closure letter; this explains why they have determined that your complaint does not require GMC action. This being considered there would be nothing further that the Assistant Registrar or Medical Case Examiner would be able to usefully add to you. We are unable to disclose to you the name of the Medical Case Examiner who provided advice on your enquiry, or the Assistant Registrar who made the decision.

...

A decision to close a complaint may be reviewed under our Rule 12 Review Process if there is reason to believe the original decision may be ‘materially flawed’. This is wide enough to cover cases in which we have made an error in our administrative handling of a case, as well as cases in which there has been an error of judgement or reasoning on behalf of the decision-maker. Or is there is new evidence or information received which had it been available at the time of the determination may have led to a different decision. A review will then only be commenced if it is judged necessary either for the protection of the public, prevention of injustice to the practitioner, or otherwise in the public interest. If you are able to provide us, in writing, your reasons for requesting that our decision be reviewed under this criteria then please do send this to addressed to me using the contact details at the bottom of this email and your request will be referred to our review team for consideration.

If you would like to complain about the GMC handling of your complaint (aside from the decision itself) then please feel free to put your complaint in writing to our Complaints Team using the email address below. FPDComplaintsCorresp@gmc-uk.org
Mother of boy (8) relays disclosures indicative of possible emotional, physical and sexual abuse at weekend contact with father to SS.

1st and 2nd Psychiatrist find mother coping well.

SS ‘shop around’ for tame 3rd Psychiatrist (same as in GMC Complaint): ‘Borderline Personality Disorder’ diagnosis.

Judge orders ‘residential treatment’ (!) of Business Owner (!) mother.

4th, 5th, 6th & 7th Psychiatrist refuse to take her as ‘nothing wrong’.

SS commission tame 8th Psychiatrist: ‘Overvalued Sexual Abuse Beliefs’.
Mon 16/05/2016 20:27

<Son>- he was so rough to me
throws me on to the ground
hurt my back
he laughed
took my photos while I was crying
my back still hurts mummy
got sore throat (he has sore throat most of the time)
he keep taking my photos don't like it mummy
he was keep pushing me, hurting me
he was angry with me
I was scared
Don't feel safe there mummy
Don't want to go there anymore
He keeps coming in to bath
Don't want to have bath
Don’t like washing myself anymore

What he told me today regarding things happened in his dad's house weekend just gone.

Mon 20/06/2016 20:52

just saw this
his right under arm
father hit him with gun
E says his dad wouldn't stop
he asked him to stop

E says dad shouted at him saying
if you tell him I will hit you more
with this gun

if u don't say nothing to police,
mum, ss will get u 25 match attacks (cards he collects footballer thing)

Mon 20/06/2016 21:50

it was Saturday

shouts at him Sunday he will
shoot him more with gun all over
his body if he speaks again
1) I went to go visit my mums in the evening as it was a Monday and ____ had been physically injured by <father> so she was obviously distressed. When I got there I decided to talk to him just himself and I as my mum was in the kitchen. ____ then showed me the bruises up his spine because he looked in pain to even move up on the sofa. When I asked what had happened ____ told me that his dad picked him up from a big height and chucked him flat on his back on the floor. He also told me that <father> found the fact ____ was crying and telling him to stop amusing.

2) A second occasion was yet again when ____ came back with physical marks upon his body. When I asked what had happened he told me that his father was chucking ice at him and laughing and yet again finding it amusing that he was causing his son physical pain. ____ stressed to me that it wasn't a joke and that he was in pain and told him to stop. He then went further to tell me his dad actually took photos of him distressed and crying which is nothing other than disturbing.

3) On many other occasions ____ has told me numerous times that his private area was always sore after a weekend at his dads. When I asked if it was ever sore any other time he responded 'no, only after being with my dad'.

4) ____ also always comes back after every weekend extremely skinny and refuses to take a bath. He told me his dad always sends him to bed with no dinner if ____ does the smallest thing such as to 'knock' something. He also refuses to have a bath I can expect because he wishes to hide the physical marks created by his father and also because his esteem is always so low upon returning.
Public needs to hear our story, how social failed to protect my son, they turned their eyes away from any of our serious concerns regarding his abuse all the evidence, signs ignored.

Despite my concerns child been kept handed over to his abuser!

When I used to report answer from ss was ‘but child only tells you’. I have been disbelieved they failed to protect my son instead hand him over to his abuser.

Even they didn't listen child's wish; child often said ; I am scared of my dad, he hurts me if I tell anyone , does mean things to my bum & pipi, sends me to bed with no food in the afternoon .... if I keep secrets he says he will give me money, 25 match attacks but he never does.

He says promise won't do it anymore but he still comes to my bed and sticks his pipi in my bum hurts mummy.

I tell him it hurts he says of course not.
He says it is just a game.
Makes me suck his pipi.
Makes me touch his pipi.
Tells me I am a girl (messing my son's mind up)

Child got to point had enough started to open up to others my boyfriend, his sister, family friend.

Each time child opened up ss said, you were in the room again. Been ignored not believed.

They fail to protect my son from his abuser; been criticised for taking my son to A&E for bleeding bottom ...

Child started to come from dad's house with bruises ... telling me dad says he will hurt him if he speak out

ss ignored. Child been hurt, came back with more physical damage each time when he did speak out. been ignored. Child said dad washes me (don't like it mummy).

Dad takes my naked photos (asked for dad's phone, I-pad, computer check - I have been ignored)

Coming back with sore pipi (when A&E doctor asked he said my dad sucks it).

Told A&E doctor dad says if you speak out will stick my finger...

ss said mum was in the room ignored so far

Only once my son was examined - that was 10 days after him coming back with bleeding bottom. This was 2 years ago. That was already too late. All the other examination by looking from outside . each time when child did speak out ss ignored, said mother was in the room.

My child told me his dad started to put his pipi in his bum. Told this to ss. I have been ignored. Almost each contact he came back with bruises and bleeding bottom. Child said dad rough to me, hurts me; been ignored 

ss handed my son back to his abuser. How come still this boy been handed over to his abuser?

It is unreal! BEYOND MY UNDERSTANDING. ss kept accusing me by saying that I got mental health problem while been put through 8 mental examination almost they were keep trying until they get the result they want (third one privately done by court order says mother has borderline personality disorder rest says mother has NO mental health issues).

When did it become a mental illness being a protective mother trying to protect her child from abuse by standing up for truth & justice?

To weeks ago after police interview I have been forced to hand my son over been treated unfairly. ss wouldn't let me take my child been forced by ss and police to organise my friend to pick my son up. I have been told by senior social worker they had no right to do that without my consent by senior social worker lady. It was a sudden shock to my son. He was very unhappy not going home with mum ......again last week after court my son picked up by dad instead of me I wasn't allowed to have night with my son. My son didn't know nothing what was going on that afternoon. My son taken away from me without no prep, no goodbye ! Another sudden shock to child. All this emotional damage not healthy for child. My son always said his wishes -him wanting to stay with mum and not wanting to have over night contact yet again and again ignored !!!

Last court it was almost week ago, ss served me papers day before in those papers says supervised contact order for both parents - child to go to foster care asap; We we went in to court next day after 40 minutes in court ss changes their mind says child should move to aunty, father can take child to holiday 2 weeks unsupervised ..... 

All this is INSANE!!! Father is known to police. He has a long list of convictions and drug & alcohol addiction .last time been arrested for possession of knife and cannabis.
Bright Side (HPI), Dark Side (HDS) and Inside (MVPI) Profiles of an ‘Extreme Abuse Survivor’

https://lonehorseblog.wordpress.com/2017/09/24/body-centric-healing-of-extreme-trauma/
https://twitter.com/Lone_Horse
Professor Ireland says “I welcome the decision of the HCPC Panel. It has dismissed the case against me. In respect of all bar one of the allegations, it found that there was no case for me to answer and that I did not therefore have to give any response to them. In respect of the one remaining allegation, after hearing my evidence, the Panel decided that the allegation was not well founded and dismissed the entire case. “I have always been and remain deeply committed to high quality and raising standards in the profession.”
Combating psychometric re-victimisation through the assessment of adaptive and ‘maladaptive’ Big 5 personality facets at both ends

S. Desson, J. Golding, A. Towell and S. Benton

2017 Switzerland
1. Summary of my PhD

2. Issue: re-victimisation through pathologizing
   • Solution: no need to pathologize

3. Issue: evaluative bias in psychometrics
   • Solution: value diversity in different ways of being

4. Reframing ‘maladaptive’

5. Helping somebody leave a cult
BF57: A humanistic perspective on psychometrics

From ‘reductionist’, to ‘humanistic’

1. A psychometric that ‘Values Diversity’ in our way of being

2. A psychometric that mitigates ‘Evaluative Bias’

3. A psychometric that measures ‘Maladaptive’ behaviours, ‘Without Pathologizing’
Extraversion vs Introversion

Evaluative Bias

Extravert: Someone who is energized by interactions with others.

Introvert: Someone who runs away from extraverts.
Bias in the ‘Trait Descriptive Adjectives’

The adjectives that describe "Extraversion" include:
- Unrestrained
- Active
- Daring
- Vigorous
- Bold
- Verbal
- Assertive
- Talkative
- Energetic

The adjectives that describe “Introversion” include:
- Unexcitable
- Inhibited
- Untalkative
- Timid
- Withdrawn
- Reserved
- Bashful
- Shy
- Quiet


“When an evaluatively unbalanced set of descriptors such as the Big Five adjectival markers (Goldberg, 1992) is subjected to a simple structure rotation algorithm, the resulting factors almost invariably end up contrasting positive versus negative descriptors (Goldberg, 1992).”


Issue: Big Five Evaluative Bias

• Many adaptive Big Five models have an evaluative bias (Bäckström, Björklund & Larsson, 2014) that can negatively impact an assessment’s user validity
  - how does the user feel about filling in a questionnaire and reading about aspects of their personality in a personalised report?
• Evaluative bias also impacts construct validity
  - has the construct been measured in a comprehensive and balanced way?
Example: impact on user validity and construct validity

- Extraversion being measured in a socially desirable way
  - “I enjoy talking to people”
- Introversion being measured in an overplayed way
  - “I do not speak up in groups”
- Consequence 1:
  - positive aspects of Introversion may not be assessed
  - a more introverted user may feel undervalued
- Consequence 2:
  - negative aspects of overplaying Extraversion, may also not be assessed
  - A more extraverted user may not receive an accurate picture
The Curvilinear Relationship between Extraversion & Sales Revenue

Ambivert employees who scored at the exact midpoint of 4 on a 7-point extraversion scale produced the highest revenue ($208.34/hour). The next highest were Ambiverts who scored between 3.75 and 5.50 ($154.77). Extraverts (measured as scores above 5.5) obtained, $125.19, while Introverts (below 3.75) achieved $120.10.

Source: Grant, 2015

N=340

Fig. 1. Results from a hierarchical regression analysis showing a predicted curvilinear relationship between extraversion and sales revenue over 3 months.

Source: Grant, 2015
Krueger and Eaton (2010) demonstrated the superiority of measuring dysfunction via *continuous traits*

- Criticism of the previous categorical approach
- New Personality Inventory for DSM-5 measures pathological personality traits (not categories)
- Strong convergent validity between PID and Big Five measures on normal populations
Norwegian sample, Thimm, Jordan and Bach (2016, p. 6) found significant correlations based on the 220 item DSM-5 (PID-5) and the 44 item “Big Five Inventory” (BFI)

<table>
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<tr>
<th>PID-5</th>
<th>Big Five</th>
<th>Correlation</th>
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<tr>
<td>Negative affectivity</td>
<td>Neuroticism</td>
<td>with $r = 0.77$</td>
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<tr>
<td>Detachment</td>
<td>Extraversion</td>
<td>with $r = -0.69$</td>
</tr>
<tr>
<td>Antagonism</td>
<td>Agreeableness</td>
<td>with $r = -0.48$</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>Conscientiousness</td>
<td>with $r = -0.41$</td>
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Psychoticism correlated across all five factors as follows:

- Openness        | with $r = 0.26$  |
- Conscientiousness| with $r = -0.41$ |
- Extraversion    | with $r = -0.33$ |
- Agreeableness   | with $r = -0.43$ |
- Neuroticism     | with $r = 0.35$  |
Issue: PID Evaluative Bias

- Four of the five PID dimensions, one end is strongly adaptive and the other strongly maladaptive.
- Challenging this structure, Pettersson, Mendle, Turkheimer, Horn, Ford, Simms and Clark (2014, p. 433) present a persuasive case that
  - “nonevaluative factors, which display maladaptive behavior at both ends of continua, may better approximate ways in which individuals actually behave”.
Pettersson, Mendle, Turkheimer, Horn, Ford, Simms and Clark (2014)

- Successfully applied Peabody’s (1967) method for reducing evaluative bias
- ‘Cracking’ one item out into quadruplets of items for the Multisource Assessment of Personality Pathology (MAPP) instrument
  - two items measuring the low end of each trait, one adaptively and one maladaptively
  - two further items measuring the high end of each trait, again one adaptively and one maladaptively
The Development of the BF57

BF57 developed using three distinct development methods as outlined by Burisch (1986)

- **Inductive** bifurcating of the Big 5 into 10 opposite poles (inspired by Jungian idea) – termed ‘Aspects’ – using factor analysis

- **Deductive** use of conceptually derived constructs and internal consistency reliability estimates to refine items and persona scales

- **Criterion-centric analysis** of scale relationships with performance metrics, including ‘Great 8’ Leadership competencies

Measuring the Big 5 Factors at ‘Both Ends’ – OCEAN – with Jungian Type Overlay

Big Picture Thinking
- Radical
- Conceptual
- Imaginative

Openness to Experience
- Intuition or Sensing

Down to Earth
- Cautious
- Practical
- Evidence Based

Discipline Driven
- Purposeful
- Structured
- Reliable

Conscientiousness
- Judging or Perceiving

Inspiration Driven
- Adaptable
- Flexible
- Spontaneous

Extraverted
- Demonstrative
- Takes Charge
- Sociable

Extraversion
- Extraversion or Introversion

Introverted
- Measured
- Intimate
- Observing

People Focused
- Accommodating
- Collaborative
- Empathetic

Agreeableness
- Feeling or Thinking

Outcome Focused
- Tough
- Competitive
- Logical

Emotional (Risk) Reactors
- Impassioned
- Vigilant
- Responsive
- Modest

Neuroticism

Emotional (Reward) Reactors
- Even-Tempered
- Optimistic
- Resilient
- Confident
Construct VALIDITY - Factor Analysis - N=2,506 at Spark Quality Level

<table>
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<tr>
<th>Factor 1 Neuroticism</th>
<th>Factor 2 Extraversion</th>
<th>Factor 3 Conscientiousness</th>
<th>Factor 4 Open to Experience</th>
<th>Factor 5 Agreeableness</th>
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<td>DD/DD</td>
<td>BPT/DTE</td>
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Note: A Principal Components analysis with Varimax rotation was used. N=2,506. Loadings ≥ ± .40 are shown. IN/EX= Introverted/Extraverted; ID/DD= Inspiration Driven/ Discipline Driven; OF/PF= Outcome Focused/People Focused; DTE/BPT= Down to Earth/Big-Picture Thinking; Riskr=Risk Reactor; Rewr= Reward Reactor.
O Open to Experience
C Conscientious
E Extraverted
A Agreeableness

Outer Layer - 24 Qualities
1st layer on rim - Big Five OCEA(N) terminology
2nd layer on rim - Lumina Spark terminology
Inner Layer - Jungian Terminology
O Open to Experience
C Conscientious
E Extraverted
A Agreeableness
N Neuroticism

Overextended

Outer Layer - Overextended (5th factor)
1st layer on rim - Big Five OCEA(N) terminology
2nd layer on rim - Lumina Spark terminology
Inner Layer - Jungian Terminology
But Emotional Stability can be Overextended too

The 5th Factor from the Big 5
1 2 3 4 5
OCEAN

- Emotional Stability

+ Emotional Stability

RISK REACTORS

REWARD REACTORS
### Raw Correlations of the five dimensions of BF57 with HDS 11 scales

<table>
<thead>
<tr>
<th>O</th>
<th>Excitable</th>
<th>Skeptical</th>
<th>Cautious</th>
<th>Reserved</th>
<th>Leisurely</th>
<th>Bold</th>
<th>Mischief</th>
<th>Colorful</th>
<th>Imaginative</th>
<th>Diligent</th>
<th>Dutiful</th>
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**Note:** N=138; Absolute correlations between 0.3 & 0.4 shaded light grey; Absolute correlations >0.4 shaded dark grey; **. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed)
### Raw Correlations of the five dimensions of Short Spark with HDS 3 factors

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Note: N=138; Absolute correlations between 0.3 & 0.4 shaded light grey; Absolute correlations >0.4 shaded dark grey; **. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).
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<p>| O+ Overextended | .80 |                 |                 |                 |                 |
| O- Overextended | -.71|                 |                 |                 |                 |
| C+ Overextended |     | -.71 |                 |                 |                 |
| C- Overextended |     |     | .59 |                 |                 |
| E+ Overextended |     |     |     | -.70 |                 |
| E- Overextended |     |     |     |     | .69 |                 |
| A+ Overextended |     |     |     |     |     | .84 |
| A- Overextended |     |     |     |     |     |     | -.58 |
| N+ Overextended |     |     |     |     |     |     | .64 |
| Excitable |     |     |     |     |     |     | .84 |
| Skeptical |     |     |     |     |     |     | .84 |
| Cautious |     |     |     |     |     |     | .41 | .57 |
| Reserved |     |     |     |     |     |     |     | .64 |
| Leisurely |     |     |     |     |     |     |     | .55 |
| Bold |     |     |     |     |     |     |     | .58 |
| Mischief |     |     |     |     |     |     |     | .69 | -.41 |
| Colorful |     |     |     |     |     |     |     | .57 |     | -.63 |
| Imaginative |     |     |     |     |     |     |     | .87 |
| Diligent |     |     |     |     |     |     |     |     | .84 |
| Dutiful |     |     |     |     |     |     |     |     | .67 |</p>
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Conclusions

1. The Dark Side/Maladaptive Traits can be modelled as extreme ends of the Big Five

2. However ... sometimes mid range Big Five traits correlate with the dark side/maladaptive
1. Summary of my PhD

2. Issue: re-victimisation through pathologizing
   • Solution: no need to pathologise

3. Issue: evaluative bias in psychometrics
   • Solution: value diversity in different ways of being

4. Reframing ‘maladaptive’

5. Helping somebody leave a cult
Robert Lifton’s (1987) - Mind Control

1. **Milieu control**: environment control
2. **Mystical manipulation**: cult leader reinterprets history
3. **Demand for purity**: makes you vulnerable to guilt, fear, and other manipulation
4. **Cult of confession**: use of shame, guilt and confessing
5. **Sacred science**: dogma with leader having access to absolute truth
6. **Loaded language**: isolate you from real world; restrict thinking
7. **Doctrine over person**: reshape personality
8. **Dispensing existence**: Outsiders unworthy; create phobia of leaving
NRM or CULT?

• NRM - new religious movement

• Or CULT?
An Organised Ritualised Crime Abuse Network (ORCAN) in the British Isles?

Dr Rainer Hermann Kurz (UK)

C.Psychol

ichinendaimoku@gmail.com
Disgraced DJ Jimmy Saville & Savile’s Mate Ray Teret

A lawyer for 169 of Savile’s victims stated that Teret’s conviction represents "the closest the victims of Jimmy Savile will get to a conviction against their attacker".

http://www.express.co.uk/posts/view/371936/I-was-raped-at-13-by-Jimmy-Savile-in-satanist-ritual

Former council leader jailed for two years for ‘appalling’ child pornography offences
The judge said he had to deal with him for downloading 2,844 still images, and 293 movies, of children. He also had to deal with him for the distribution of 23 stills and seven movies. Osbourne had also accessed 152 extreme images, either in still form or as movies, showing “revolting images of deviant sexual practices”, including depiction of sexual behaviour between humans and animals, and depictions of serious violence being inflicted on women.

Kingston council leader quits over child porn arrest

Derek Osbourne has twice served as council leader:

The leader of Kingston borough council has resigned after he was arrested on suspicion of possessing indecent images of children.

Derek Osbourne, 59, was arrested on Tuesday at his home in Kingston and taken to a south London police station. He has been bailed until August.

In a statement, acting leader Liz Green said the Liberal Democrats were “deeply shocked”.

Mr Osbourne was first elected leader from 1997-98, and then again from 2003.
Introduction
‘Disclosure Email’ (Extracts of 1,888 words single paragraph)

Subject: Ill start again with more time please

‘Hello again. Sorry about the rushed mail earlier, ive been locked out of my mailbox for ages.’

‘I witnessed him abuse <child> after he came up behind me in the street where id gone to see my freind after appearing in my street and the town of his own accord and after finding out my friends address from my __________ many months earlier who said he wanted to post me something. that never arrived but an old man turned up asking my friends seven year old where i was..and it started.’

‘I decided not to go the police immediately with my child who would be evidence as the met policeman in <family home town> told me when i was thrown out of _________ house and asked for their aid, that my __________ was dangerous and even if something serious happened to either of us in the future it would be unwise without much more protection to go up in court against him. The problem arose when i reported him later a month after the assault, but instead of being beleived and supported they took us to the hospital for ___checks then removed ___ claiming i was delusional, suicidal, neglectful (__ had some bruises) and unable to be a parent while insisting if i didnt sign a voluntery section 20 they would call the men in white coats. ’

‘There is not way the universe will allow <child> to endure the years i did.’

Subject: RE: Photo Album!
Date: Mon, 17 Sep 2012 00:15:47 +0000

you were right, i’m blown away. i’ve corrected a slide with the date 2012 where it was 2011 in september towards the end on the bed! i simply think that’s a beautiful beautiful present and maybe a new form of therapy? you have such an eye for detail and are very truthful and accurate, truly i can see what absolute care and respect and devotion you have at your disposal towards children and am so privileged that we have the slides all of a sudden. total new one for me and really something you can be proud of too there. hot stuff. many many thanks rainer. i feel quite a bit happier.
Forensic Background

A vulnerable mother who escaped from an intergenerational abuse family was instructed by a clandestine police operation to delay reporting of any sexual assault on her child. An officer explored the death of a couple who had lodged with this family and the ‘disappearance’ of their new born child. The officer was also aware that the mother had reported a teenage pregnancy that succeeded from incestuous rape where the baby also ‘disappeared’, and that the colleague to whom the 14 year old made the disclosure had been found dead a few days later. Three police officers advised the mother to delay reporting until injuries could not be proven as it would be ‘too dangerous to go up alone against the family member’. Police claimed that spotting individuals familiar from her childhood would indicate that the undercover operation was successfully underway.

When the 2 year old was sexually assaulted the mother waited several weeks as per police instruction before reporting the assault. A total of 5 police officers (including a Child Protection Officer) and a Health Visitor created a myth that the mother was ‘delusional’ in flagrant violation of the professional definition of ‘delusion’ provided in the DSM-V (American Psychiatric Association, 2013, p. 819):

‘delusion: a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary.’

Around that time the half-brother’s ex-wife was reportedly found dead.

By this time the child’s nursery teacher’s friend had been found dead outdoors and a close friend died in a house fire.
Arson & Murder?

On 28th December 2010 the toddler’s nursery teacher’s friend was found dead in the river adjacent to King Edward Street, Blaengarw:

It is disconcerting that the police spokeswoman said there are not believed to be any suspicious circumstances surrounding the death. Just a few weeks later on 29 January 2011 a row of cottages overlooking the area where the body was found went up in flames. Reportedly the deceased had been seen in a pub with the ‘Stalker’ and later arguing. The figure was designed for an Appeal Court Submission (thwarted through authority irregularities at the Royal Court of Justice).

In between these two incidents the godmother of the toddler was found dead in her burnt out house across the Irish sea:

Authorities refuse to properly investigate these matters and took the toddler permanently ‘into care’ as mental health professionals considered the mother ‘delusional’. Are authorities (including mental health institutions) in this region infiltrated by ‘vested interests’?


http://www.bbc.co.uk/news/uk-wales-12314741


Kurz (2017). BRIDGEND ‘BEBO’ SUICIDES AND RITUAL VIOLENCE IN WALES. Poster at EPA Conference in Florence
Defamatory calls to police e.g.:
- ‘I saw her shop lifting’
- ‘There was a girl crying in the field’

Defamatory calls to social services e.g.:
- ‘Neglecting child’
- ‘Concerns about mental health’

Physical threats e.g.:
- Driving up the pavement
- Trying to wrestle buggy off mother

Enlisting members of the public / co-conspirators e.g.:
- ‘A rich benefactor would like to pay for the schooling of your child’
- ‘Yes. She is on the bus – she is carrying, ahem, a buggy’
- ‘She is feeding dog food to her child’ (police incident record)

Source: Kurz (2015). Politics and the Psychology of Abuse and Cover-up
On a hiking trail we were intercepted by a police helicopter (!). Someone we had bumped into on the way earlier claimed that I was feeding dog food (!) to my child and that the clothing of my child was unsatisfactory. The police officers checked everything we had and found everything in excellent order. The malicious rumour was obviously completely made up, and I was fully exonerated. These policemen were kind and friendly. They took a liking to us and brought us back to our home as the weather had turned. This story ‘sounds’ unlikely—but is covered through a police record in my files.

In the Council ICD notes (page 10) dated 23rd Nov 2011 this incident was described wrongly as follows: ‘Concerns have been reported by a member of the public that Ms < > was walking on a train track. (Ms < > disputes this, stating that it was her intention to camp over night.). The police suggested that it would not be a good idea and Ms < > was taken back home.’ This example is symptomatic of the level of incompetence and malice the Council employees showed in their biased reporting throughout the whole process (but is difficult to prove where there is no external witness/documentation).’
‘I fairly regularly visited the friend who I had been staying with. On the way I once noticed a man in front of me who then disappeared out of sight. When I took my child out of the buggy the Stalker grabbed my child and sexually abused _____. I was terrified.

I reacted instinctively as follows:

• I tried to minimise the risk of abduction
• I tried to minimise the risk of the ____ being suddenly dropped
• I tried to minimise the risk of injury
• I looked towards the house of my friend to avoid eye contact

The incident felt like a nightmare but later on I found various indications that this was not just a bad dream or hallucination.’
‘There is also the issue that the 1st Psychiatrist (of ________ cultural origin) is linked to her ________ through another ________ family (who now lives in ________). They both know. ________ chanted at age 17 to the ________ with their daughter ‘__________’. ________ disclosed this detail on the evening after the face-to-face session with _________. She previously hinted at this but at the time emphasised that she does not want other individuals to get drawn into the toxic abyss of her dysfunctional family (I find this a hallmark of ________’s wisdom and maturity).’

‘In principle I would be prepared to issue a Letter of Instruction ______ _____ to conduct a document review surrounding the police instruction including a 1h recording of ________’s response thought processes between the assault and the decision to make that phone call to the police, and her 'trauma' of being disbelieved. She said the response of the Authorities was 'the biggest humiliation of all my adult life' - and you know what that means given what other experiences you heard from her.’
Dear Rainer,

That is a brilliant idea.

I am looking forward to a fruitful discussion to see how our contact could benefit each other.

Would Thursday 5th July suit you?

I'll try to give you a call tomorrow or on Friday to look into our diaries.

Regards
Walter

9:38 PM
Security Concerns RK Time Line (as per 14th September 2012)

24/05/2012  ‘Sad news’ email received
24/05/2012  ‘ill start again with more time please’ email received
25/05/2012  I replied and informed a National Faith Leader
25/05/2012  ‘Thank you’ email received
28/05/2012  I offered to come 2h before the Clinical Psychologist session on 7th June
29/05/2012  ‘OK Thank you very much.’ Email received
30/05/2012  I confirmed meeting arrangements
07/06/2012  We met up, I sat at back during Clinical Psychologist session, talked until 7PM

23/06/2012  Fake HSBC email
23/06/2012  Old Computer infected by malware
23/06/2012  Work Computer deliberately infected with Smart Fortress 2012 (worst Spy-Malware available) - ‘targeted approach’ from an identified person trying to ‘befriend’ me

16/07/2012  In the evening call from home to __’s mobile went ‘straight to answering machine’
17/07/2012  In the morning call from home to __’s mobile went ‘straight to answering machine’
17/07/2012  I sent email to solicitor, prompt reply all ok, __ puzzled as phone was on all the time
17/07/2012  Text in the morning from bus about new flat ‘stuck’ – delivered 6pm

31/07/2012  Notes page on i-phone corrupted

29/08/2012  Issue of fake Halifax bank letter featuring my account number

03/09/2012  30 Minute Visit to Surrey Police HQ in Guildford (Female Officer; Sargent joined later)

06/09/2012  During lunch break on terrace (KT6 5QE) – two helicopters circling 12.40-13.10
08/09/2012  When leaving 12.30 Police (surveillance?) van leaves from Cul-de-Sac across road
08/09/2012  When arriving at office 12.45 – a helicopter arrives & circles for 20 minutes

11/09/2012  Working from home - but Broadband stops working at 13.00 (back on 13/09/2012)
14/09/2012  When leaving 8.30 Police estate car leaves from Cul-de-Sac across road
14/09/2012  At school (KT10 __) at 8.35 spot stationary Police bike – speeds off with siren
Three privately organised Disclosure Sessions Autumn 2012 (video-recorded)

Three Disclosure Sessions Summer 2013 covering two ‘Index Incidents’ (video-recorded)

In formal PTSD (Post-traumatic Stress Disorder) assessment session mother rattled off 67 traumas in 10 minutes
In the vicinity of Ms __________ the following three ‘mysterious’ death occurred in the space of 12 months before the attack on the _____:

1. A close friend of the child’s nursery teacher was found dead __________, and ___________ nearby went up in flames a few weeks later
2. The god-______ of the boy died when ____ house burned down
3. The half-brother’s wife died unexpectedly

Criminal intentions to pervert the course of justice can hence not be ruled out.

There was not a single sentence or idea expressed that would be indicative of ‘delusions’ or current personality/character issues/problems.

Problem 1: Omission of Incident Coverage

The whole case revolves around the alleged attack on the _____ - which medically was neither proven nor disproven as 1 month had elapsed which is long enough to heal. The session failed to cover this incident. As a consequence any reporting and interpretation must be based on ‘Collusion’ i.e. repeating the ‘delusions’ claims of the other mental health professionals that this Clinical Psychologist presumably was meant to cross-check ‘independently’.

Allegation 1: Failure to carry out a truly independent assessment in a setting that will decide about the final destiny of a young family – with a completely one-sided case made (up) that is 100% based on ‘denial’ of the crimes Ms _____ reported.

Problem 2: Omission of ‘Giving birth to a baby at 14’ Allegation

I understand that when Ms _____ discussed her own abuse including the pregnancy with police one year before the actual attack happened she was advised to disclose the fact that she had a baby at 14 - that disappeared.

In my view that lack of coverage of these two issues entirely invalidates the session, and - given its pivotal role - the entire court proceedings. They prompt me to make this complaint as I am concerned that those involved in the case proceedings may have been ‘compromised’. This concern is fuelled by the disclosure involving a ‘downstairs neighbour’ (implying a paedophile ‘ring’) in the session I witnessed.

Concern did not meet the HCPC ‘Standards of Acceptance’
Conclusions

Based on observations and questions posed during the assessment, at the present time does not meet the DSM IV Criteria for a Dissociative Disorder. Likewise she does not demonstrate any significant dissociative symptoms. It is to be noted, however, that both self reporting screening instruments demonstrated the equivalent of nil scores. It is highly unusual for even non dissociative people to score so low. If I add to this the observations during the assessment, it is in my opinion possible that her potentially significant dissociative symptoms are categorically cut off from consciousness for the time being. Dissociation is, after all, a means of survival and coping in the world outside through a complete amnesia of emotional and traumatic effects of one’s childhood. From her account, it seems that a significant amount of abuse memories have been processed on her own.

The SCID D differentiates Dissociative Disorders from other psychiatric disorders such as Schizophrenia. No indications of any psychosis were apparent during the assessment. Thus there were no delusions of thought, hallucinations or disorganised thinking and speech or paranoia. presented in a very articulate, emotionally appropriate manner. Her responses and behaviour during the assessment were both honest and open. She was also able to discuss with a realistic appraisal of behaviour. I had no reason to doubt her ability to look after in both the short and longer term.
The DSM-V definition (American Psychiatric Association, 2013, p. 819) remains identical to the DSM-III (p. 765) and DSM-IV-TR (p. 821):

**Delusion** a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary.

A recent UK court custody case quoted ‘Blacks Medical Dictionary’ (Marcovitch, 2010):

‘**Delusions** An irrational and usually unshakeable belief peculiar to some individual. They fail to respond to reasonable argument and the delusion is often paranoid in character with a belief that a person or persona is/are persecuting them. The existence of a delusion, of such a nature as to seriously influence conduct, is one of the most important signs in reaching a decision to arrange for the compulsory admission of the patient to hospital for observation. (See Mental Illness).’

A Google Search on 18/01/2014 did not result in a single entry that quotes the first definition sentence of Black’s Medical Dictionary.

A Google Search on 18/01/2014 brought up 154 entries that quote literally this first DSM Delusion definition sentence.

**Source:** Kurz (2015). Politics and the Psychology of Abuse and Cover-up
Crime Map etc. submitted to:

1. Royal Court of Justice
2. New Scotland Yard
3. SW London Child Abuse Team
4. Surrey Police
5. NHS Clinic
6. Welsh Council
7. Police Force in Wales
8. Police Force in Ireland
9. Operation Midland
10. Operation Conifer (Mike Veal @ Wiltshire Police)

All institutions got ‘excuses’ and continue to deflect their statutory obligations for public safety!
Dear Dr Kurz

Unfortunately at this time I am unable to provide to you the TOR for Op Midland. These are for MPS knowledge only, to allow us to investigate relevant information. It maybe in due course they will become public knowledge but not at this time.

I cannot provide you with the details for CRIS 0405609/13. This is a private matter between the complainant and the police. If you have further information regarding a crime then you can of course make another third party allegation to the correct force area. If you have a complaint about the way police dealt with this allegation I suggest that your best course of action is to report to the local force. If you preferred to make an allegation to the IPCC they will then forward to the relevant force area.

With regards to an alleged linked series of murders I cannot see that there is anything at this stage to link those crimes. If you have a complaint about the way they have been investigated then I think the best way would be to go to the correct force area or the IPCC who will do this for you.

The same applies to the other allegations in respect of the Kingston Police officer and Edward Heath.

I can see that you have a considerable number of grievances with the way that a number of police forces have dealt with differing allegations. Op Midland is not the best way to deal with this. We have logged all your information, but at this time as stated none falls within the TOR for Op Midland.

Kind regards
Sent: 01 November 2016

Dear ______ ________

It was a pleasure talking to you earlier today. Please find attached the ‘leaked’ document seemingly prepared by Psychiatrist Dr Joan Coleman. For ease of reference I also attach the .xls file on which I based the two most relevant EPA conference posters (content copied from an occult network site including some comments publicly identifying Joan Coleman as the author).

I also attach the Nuremberg posters which give a succinct account of the main case I am investigating one of which has two URL links embedded:

Extreme Abuse Dossier (the last few pages of which probably tally with one of the documents you had) which were a subset of a Judicial Review submission (thwarted through fraudulent action of Royal Court of Justice staff!):

https://arsoninformer.files.wordpress.com/2015/06/ead-version-10-09-2013.pdf

Part-redacted report on the suspected Arson-Murder:


The suspected serial abuser, rapist, arsonist and murderer lives in Kingston upon Thames 3 miles from my home.

I got various reports and other materials to back my allegations. If done for Arson-Murder the guy (and his wife!) may ‘sing’ about all sorts of things.

Happy (?) Reading!

Rainer
How do these artefacts relate?
House owner found in hallway ‘on top of roof tiles’
(with broken legs and broken arm)
Low Alpha, High Beta?
1. House owner found ‘on top of roof tiles’ in January 2011
2. At least three officers and 2 fire crews attended the scene
3. Autopsy found that the deceased had broken legs and broken arm
4. Autopsy found that the deceased died of smoke inhalation
5. Authorities refused to order disclosure of Gmail traffic
6. Coroner returned ‘Open Verdict’
7. Half a dozen attempts for proper investigation rebuffed
8. Politicians, RCJ, charities, mental health professionals fail to act
9. Coroner informed via solicitor on Halloween 2014:
   • Suspicion of ‘Arson Murder’
   • Motive
   • ‘Organised Crime’ circumstances
   • Name and address of suspect deposited with solicitor
10. As of 11\textsuperscript{th} November 2017 artefacts remain dispersed across multiple locations unsecured and unexamined – no meaningful action observed – a ‘cover up’?
1. Misdirect target to delay child sexual abuse reporting until injuries cannot be proven
2. 'Bump off' individuals who may scupper plan
3. Orchestrated stalking and defamation campaign to:
   • Get to know target and target environment
   • Intimidate and traumatise target
   • Condition target into ‘freeze’ response
   • Set up authority representatives to be ready to ‘pounce’
   • Facilitate ‘delusional & paranoid’ false diagnosis
4. Carry out ‘unbelievable’ assault
5. Prime ‘professionals’ (associates)
6. Wait for target to attempt a police crime report
7. Suffocate the truth

N>36 ‘professionals’ failed to discharge their duties appropriately
• How many are simply performing inadequately?
• How many are ‘compromised’?