

The following is a de-identified extract from a report written by Dr. Childress regarding the professional practices of a psychologist. The full report is 55 pages long. This de-identified extract covers the initial summary orientation to the professional practice issues of concern which were then elaborated on more fully in the body of the report. This extract then skips to the concluding summary of the professional practice issues that are identified and described in more detail in the body of the clinical analysis report.

This extract is for educational purposes only.

Clinical Consultation on Dr. <name>'s Treatment

Date of Report: 10/1/15

Psychologist: Craig Childress, Psy.D.

Scope of Report

The professional consultation of Dr. Childress was sought by <attorney's name>, the attorney representing <parent's name>, regarding materials provided to Dr. Childress. Dr. Childress was requested to provide his clinical opinion regarding the reviewed material, drawing on his professional background, experience, and expertise in child and family therapy, child development, and clinical psychology regarding the information provided to Dr. Childress. The opinions of Dr. Childress contained in this consultation report are based solely on the materials and information provided to him for review, and are dependent upon the accuracy of the provided information. Dr. Childress has not independently interviewed the involved participants in this matter.

Materials Reviewed:

The materials reviewed are listed in Appendix 1

Foundation:

Mental health professions are responsible for knowing all diagnoses in the DSM diagnostic system at a professional level of competence. While they may not be expert in diagnosing and treating all of the varied diagnoses in the DSM diagnostic system, they are nevertheless responsible for knowing the diagnoses and their own professional boundaries of competence, and to know when a particular type of pathology exceeds their boundaries of professional competence and requires a referral to a more expert mental health professional (APA Standard 2.01a).¹ All mental health professions are also responsible for appropriately assessing the mental health pathology at a level "sufficient to substantiate" their "reports and diagnostic or evaluative statements" (APA Standard 9.01).

Failure to possess the necessary professional competence related to a particular form of pathology required to properly assess the pathology would represent a violation of

¹ Ethical Principles of Psychologists and Code of Conduct; American Psychological Association, 2010

Standard 2.01a of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association. In addition, failure to properly assess for relevant pathology “sufficient to substantiate” the “reports and diagnostic or evaluative statements” made by the mental health professional would represent a violation of Standard 9.01 of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association. Violations of either Standard 2.01a or 9.01 which then leads to harm to the client would also become a violation of Standard 3.04 regarding avoiding harm to the client.

All mental health professionals also incur a “duty of care” and a “duty to protect” relative to their patients as part of their professional obligation. The professional duty of care and duty to protect establish the mental health professional’s responsibilities to the client. Among the mental health professional’s duty of care obligations is to provide appropriate treatment and not abandon the client. Appropriate treatment requires that the mental health professional make an accurate diagnosis of the pathology and implement appropriate treatment interventions to resolve the pathology. Termination of treatment needs to be in the best interests of the client and needs to be handled in a professionally responsible fashion that ensures both the continued well-being and the continuity of care for the client. The abrupt termination of treatment for reasons not in the client’s best interest and without ensuring proper continuity of care could represent a violation of the mental health professional’s duty of care and is referred to as “patient abandonment.”

All mental health professional also incur a “duty to protect” their clients from harm. This includes a professional obligation to reasonably identify the emotional and psychological abuse of a child (a DSM-5 diagnosis of V995.51, Child Psychological Abuse Suspected/Confirmed) and to take appropriate steps to protect the child from such abuse. The mental health professional’s obligation under his or her duty to protect may be discharged by making a report of suspected child abuse to the appropriate child protective services agency for additional assessment, or through other actions such as providing parenting skills interventions that are documented in the patient record. Failure to reasonably identify the emotional and psychological abuse of a child and take appropriate child protection actions (which are then documented in the patient record) could potentially represent a failure in the mental health professional’s duty to protect.

Review of Dr. <name>’s Reports:

Dr. Childress reviewed multiple <treatment reports> from Dr. <name> (dated: <dates>) as well as additional documents (itemized in Appendix 1). Dr. <name> was appointed by Court order as the treatment provider for the <family’s name> family on <date> and began treatment on <date>. Dr. <name> withdrew as the treatment provider in <month/year>.

Areas of Clinical Concern:

A variety of clinical concerns arise from the progress reports of Dr. <name> which will be detailed in later sections of this report. Among these clinical concerns are:

APA Standard 2.01a: Dr. <name>'s reports suggest a potential absence of professional competence in recognizing, diagnosing, and treating the various forms of family pathology which are seemingly evident in her progress reports.

Dr. <name>'s questionable professional knowledge and professional competence appears in three domains of pathology, 1) family systems theory and pathology, 2) personality disorder pathology, 3) attachment trauma pathology.

1. Family Systems Pathology: The reports of patient symptoms and family processes contained in Dr. <name>'s Progress Reports and her response to this evident pathology suggests that Dr. <name> may not possess the professionally required level of expertise in recognizing, diagnosing, and treating family systems pathology, which would include:

- Recognizing, diagnosing, and treating a child's triangulation into the family conflict as a result of a cross-generational coalition with one parent against the other parent (Bowen, 1978; Haley, 1977; Minuchin, 1974);
- Recognizing and treating the features of and impact on family relationships of a child's psychological enmeshment with a parent (Minuchin, 1974);
- Recognizing the structural role of an appropriate parent-child hierarchy, and the pathological implications of an "inverted" parent-child hierarchy as being a symptomatic indication of a cross-generational coalition of the child with one parent against the other parent (Minuchin, 1974).

The absence of professional competence in the domain of diagnosing and treating family systems pathology (e.g., Bowen, 1978; Haley, 1977; Minuchin, 1974; Satir, 1972; Madanes, 1981)² would be extremely concerning for a mental health professional who is tasked with diagnosing and treating family pathology.

2. Personality Disorder Pathology: The reports of patient symptoms and her response suggests that Dr. <name> may not possess the needed professional competence in recognizing and diagnosing personality disorder pathology (in particular narcissistic personality pathology) which would include the following:

- Recognizing and diagnosing the projective processes and splitting pathology inherent to the narcissistic personality pathology as defined by

² Bowen, M. (1978). *Family Therapy in Clinical Practice*, Northvale, NJ: Jason Aronson Inc.

Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. Weakland (Eds.), *The interactional view* (pp. 31-48). New York: Norton.

Madanes, C. (1981). *Strategic Family Therapy*. Jossey-Bass Inc., San Francisco,

Minuchin, S. (1974). *Families and Family Therapy*. Harvard University Press.

Satir, V. (1972). *Peoplemaking*. Palo Alto, CA: Science and Behavior Books.

the American Psychiatric Association (2000) and described by Kernberg (1975)³ and others;

- Recognizing distorted cognitive schemas associated with personality disorder pathology that systematically distort perception of interpersonal relationships (Beck, et. al., 2004);⁴
- Recognizing and diagnosing the psychological decompensation of narcissistic personality pathology into delusional belief systems (Millon, 2011).⁵

Professional ignorance in the domain of diagnosing and treating personality disorder pathology (e.g., American Psychiatric Association, 2000/2013; Beck, et al., 2004; Kernberg, 1975; Millon, 2011) would be extremely concerning for a mental health professional who is tasked with diagnosing and treating family pathology created by the psychological decompensation of parental narcissistic personality pathology.

3. Attachment Trauma Pathology: The reports of patient symptoms and her response suggests that Dr. <name> may not possess the level of professional expertise required for recognizing and diagnosing attachment trauma pathology, particularly as manifested in the following pathologies:

- Recognizing the pathology of parent-child boundary dissolution and role-reversal pathology (Kerig, 2005);⁶
- Recognizing, diagnosing, and treating trauma reenactment pathology (Pearlman, Courtois, 2005; Trippany, Helm, & Simpson, 2006; van der Kolk, 1989)⁷

Professional ignorance in the domain of diagnosing and treating attachment trauma pathology (Pearlman, Courtois, 2005; Trippany, Helm, & Simpson, 2006;

³ American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (Revised 4th ed.). Washington, DC: Author.

Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Aronson.

⁴ Beck, A.T., Freeman, A., Davis, D.D., & Associates (2004). *Cognitive Therapy of Personality Disorders*. (2nd edition). New York: Guilford.

⁵ Millon, T. (2011). *Disorders of Personality: Introducing a DSM/ICD Spectrum from Normal to Abnormal*. Hoboken: Wiley.

⁶ Kerig, P.K. (2005). Revisiting the construct of boundary dissolution: A multidimensional perspective. *Journal of Emotional Abuse*, 5, 5-42.

⁷ Pearlman, C.A., Courtois, C.A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress*, 18, 449-459.

Trippany, R.L., Helm, H.M. and Simpson, L. (2006). Trauma reenactment: Rethinking borderline personality disorder when diagnosing sexual abuse survivors. *Journal of Mental Health Counseling*, 28, 95-110.

van der Kolk, B.A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics of North America*, 12, 389-411

van der Kolk, 1989) would be extremely concerning for a mental health professional who is tasked with diagnosing and treating attachment-related pathology involving pathogenic parenting practices that are the product of unresolved parental attachment trauma.

Under Standard 2.01a of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association, psychologists are required to know the boundaries of their professional competence and to limit their practice to within these boundaries of professional competence. Treating family pathology involving the child's triangulation into the spousal conflict through the formation of a cross-generational coalition with one parent against the other parent, the addition of splitting pathology from an allied narcissistic personality parent to the cross-generational coalition of this parent with the child against the other parent, and the potential reenactment of attachment trauma from the childhood of the allied narcissistic parent into the current family relationships through the child's induced pathology, would require professional competence in family systems theory, the recognition and diagnosis of complex personality disorder pathology, and professional competence in recognizing and treating the inter-generational transmission of parental attachment trauma pathology.

Standard 9.01: A consequence of Dr. <name>'s seeming ignorance relative to family systems pathology, personality disorder pathology, and attachment trauma pathology is that she appears to have failed in her professional obligation to conduct an assessment of the family pathology that was "sufficient to substantiate" her "reports and diagnostic or evaluative statements." Dr. <name>'s clinical assessment apparently did not follow-up on prominent clinical leads in the data, including:

- Cross-Generational Coalition: The seemingly evident cross-generational collation of the children with their mother against their father, in which the "stimulus control" (cues and reinforcement) for the children's behavior was not in response to the father's actual behavior but arose from role-reversal features of their cross-generational coalition with the mother in which the children's attitude and behavior toward their father served to stabilize the emotional and psychological pathology of the mother;
- Pathogenic Parenting: The seemingly evident effects of pathogenic⁸ parenting practices by the mother that are inducing significant pathology in the children (e.g., a delusional belief regarding the father's supposed threat potential; a complete suppression of the children's normal-range attachment system motivations relative to their father; narcissistic personality traits in the children's symptom display toward their father; and extreme anxiety symptoms displayed by the children relative to their father), that is resulting

⁸ Patho=pathology; genic=genesis, creation. Pathogenic parenting practices is a clinical and developmental psychological construct denoting the creation of significant child pathology through aberrant and distorted parenting practices.

in the loss for the children of a positive and loving relationship with a normal-range and affectionally available parent (their father).

- **Role-Reversal Pathology:** The potential of a role-reversal relationship (i.e., psychological boundary dissolution and boundary violation) in which the children are being used by the mother to regulate the mother's own anxiety and depression related to the mother's separation fears, fears of abandonment, and distorted threat perception, that has the potential to seriously undermine the children's individuation and development of independent psychological autonomy.

Instead, Dr. <name> appears to have very possibly misdiagnosed the pathology within the family as somehow being caused by the father's parenting practices (i.e., misidentifying the locus of stimulus control for the children's behavior), including such supposedly problematic parental behavior as his calling the children affectionate nicknames and wanting to have a positive and bonded relationship with his children, so that Dr. <name>'s treatment approach was misdirected toward altering the father's normal-range parental behavior rather than on altering the children's defiant disrespect and the mother's seeming psychological control of the children which reasonably appears to be the cause of the children's pathological relationship with their father.⁹

Standard 3.04: Psychologists are prohibited under Standard 3.04 of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association from engaging in activities that would harm their clients. To the extent that Dr. <name>'s seeming ignorance regarding family systems pathology when diagnosing and treating family pathology, of personality disorder pathology when treating the effects of possible parental personality disorder pathology on family relationships, and of attachment trauma pathology when treating a severe disruption to the children's attachment system that appears related to the possible effects of parental attachment trauma being reenacted within current family relationships, may have led to substantial harm done to the client children and father, including being a contributing cause of the children's lost affectionally bonded relationship with their father.

⁹ In the *Journal of Emotional Abuse*, Kerig (2005) writes, "Barber (2002) defines psychological control as comprising "parental behaviors that are intrusive and manipulative of children's thoughts, feelings, and attachments to parents, and are associated with disturbances in the boundaries between the child and the parent." Rather than telling the child directly what to do or think, as does the behaviorally controlling parent, the psychologically controlling parent uses indirect hints and responds with guilt induction or withdrawal of love if the child refuses to comply. In short, an intrusive parent strives to manipulate the child's thoughts and feelings in such a way that the child's psyche will conform to the parent's wishes." (p. 12)

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

Colluding with Inverted Family Hierarchy and Cross-Generational Coalition:

By potentially focusing on the wrong locus of “stimulus control” (cueing and reinforcement) for the children’s pathological relationship with their father, Dr. <name> appears to have actually acted in ways that would collude with the family pathology of the “inverted hierarchy” created by the children’s cross-generational coalition with their mother against their father. Rather than treating the family pathology, the interventions employed by Dr. <name> (such as creating rules governing the father’s appropriate behavior at dinners with his children; i.e., no use of affectionate nicknames for his children, no taking pictures of his children, no talking to his children during dinner, arriving at sessions 10 minutes after his children arrive so as to supposedly not stress his children, not attending his children’s high school graduation) may actually have colluded with and further entrenched the family pathology by supporting the inverted family hierarchy (Minuchin, 1974) and false narrative created within the children’s cross-generational coalition with their mother.

Colluding with False Locus of Stimulus Control for the Children’s Behavior

By not addressing the seemingly proper locus of “stimulus control” for the children’s pathology (i.e., the children’s cross-generational coalition with the mother against the father), Dr. <name> apparently developed an ineffective treatment plan that squandered over a year and a half of potential treatment that could have otherwise been used to resolve the pathology had a more accurate diagnosis and treatment plan been developed.

Dr. <name>’s seeming ignorance of family systems pathology and its treatment, personality disorder pathology and its effect on family relationships, and attachment trauma pathology and its role in creating distorted family relationship pathology, appears to have resulted in her colluding with the pathology rather than treating the pathology, with the effect of further entrenching the children’s pathological relationship with their father and delaying effective treatment for over a year and a half which could otherwise have been provided to the children’s pathology, resulting in a general deterioration of family relationships and the further entrenchment of the family pathology while under her care and as a direct result of her improper diagnosis and improper interventions.

Duty of Care: Mental health professionals incur a duty of care for their patients that obligate the mental health professional to the patient’s well-being. Dr. <name>’s professional handling of the treatment for the <family name> family raise two prominent concerns, 1) financial management decisions that resulted in an excessive interruption in patient care (a 10-month interruption in treatment), and 2) potential patient abandonment in her termination of her treatment with the family.

1. Financial Management: Dr. <name>’s management of fees and financial arrangements appears to have had a severely adverse effect on treatment. It is questionable whether Dr. <name> adequately explained and evaluated the

financial issues surrounding the <family name> family's ability to afford her services. Following an initial round of conjoint father-children sessions (two sessions with each of the children and the father, comprised of one father-daughter session with each child in <month/year> and one father-daughter session with each child in <month/year>), further father-daughter therapy sessions were discontinued because the mother claimed she could no longer afford her share of the financial cost for the children's therapy with their father. Discontinuing the father's therapy with his children because such therapy supposedly imposed a financial hardship on the mother should probably have been more fully considered and explored prior to initiating therapy so as to prevent a seemingly harmful 10-month interruption to therapy as a result of the mother's inability (or unwillingness) to pay her designated share for the father's therapy with the children.

A treatment-related concern is also involved in discontinuing therapy as a result of the mother's withdrawing her financial support for the therapy. If the mother is engaged in a cross-generational coalition with the children against the father that has as its goal the termination of the father's relationship with the children (i.e., the addition of the mother's splitting pathology to a cross-generational coalition with the children), then the mother clearly does not support the restoration of the children's positive relationship with their father. If, however, the ability to conduct therapy is predicated upon the mother providing financial support for the therapy to restore the father's positive relationship with the children, then the easiest way for the mother to undermine and terminate this therapy is to withdraw her financial support, which is exactly what she did.

This dynamic should have been a reasonably anticipated outcome from the recognition of the cross-generational coalition of the mother and children against the father (i.e., the mother's non-support for the father's relationship with the children) and establishing a financial structure for therapy that makes father-daughter therapy dependent upon the mother's financial support for the therapy. Discussion of this treatment-related financial issue should probably have been addressed prior to initiating treatment rather than abruptly discontinuing the father's treatment with his children when the mother was unable (or unwilling) to continue her required financial support for the therapy. Standard 6.04d of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association specifies,

6.04 Fees and Financial Arrangements

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible.

Furthermore, as a result of discontinuing the father-daughter therapy it appears that dinner visits between the father and the children also ceased. In her <date> progress report, Dr. <name> remarks that <name> was "adamant that she does not want to have a relationship with Father, since the dinner visits, which had not occurred since <date>, did not go well." When therapy to restore the father-

daughter relationship was ended by Dr. <name> because the mother withdrew her financial support for the therapy, this apparently also ended the father's sole contact with his children through his scheduled dinner visitations with his children until therapy once again resumed in <month/year>.

In addition, when Dr. <name> ceased therapy because the mother withdrew her financial support for the therapy, Dr. <name> nevertheless continued as the court-appointed treatment provider for the family until therapy eventually resumed ten months later, thus preventing the father from acquiring alternate affordable therapy to restore his positive relationship with his children. As a result of the mother's discontinuing her financial support for the father-daughters therapy, in the three months from <date> to <date> no therapy was conducted, from <date> to <date> only two sessions were conducted, one individual session with the mother and one individual session with the father, and no father-daughters therapy. Therapeutic interventions apparently resumed in <month/year> with various parent and child sessions, but joint father-daughter sessions did not resume until <date> (a ten-month interruption in therapy).

During the 10-month period from <date> to <date> in which Dr. <name>'s served as the court-appointed treatment provider for the family, no joint father-daughter therapy sessions were conducted to restore the father's relationship with his daughters. Regarding "Interruption of Therapy," Standard 10.09 of the Ethical Principles of Psychologists and Code of Conduct states,

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient.

It is questionable whether "paramount consideration" was "given to the welfare of the client/patient" during the ten month interruption in therapy that occurred between the first joint parent-child therapy session and the last joint parent-child therapy session prior to Dr. <name>'s abrupt termination as the treatment provider in <month/year>.

2. **Patient Abandonment:** In <month/year>, Dr. <name> abruptly terminated her role as the Therapeutic Interventionist for the family after having conducted only three sets of joint father-daughter sessions in over a year and a half as the treatment provider, one session with the father and each daughter in <month/year>, one session with the father and each daughter in <month/year>, and one session with the father and each daughter a year later in <month/year>. The reason for Dr. <name>'s abrupt withdrawal as the court-appointed treatment provider is apparently because the father was becoming frustrated with the entirely ineffective therapy of Dr. <name>.

Duty to Protect: Mental health professionals also have a duty to protect their clients from harm. This includes a duty to protect children from emotional and psychological child abuse. Pathogenic parenting involving a role-reversal relationship in which serious developmental and psychiatric pathology is created in the child as a means for the parent to regulate the parent's own emotional and psychological state would reasonably represent a DSM-5 diagnosis of V995.51 Child Psychological Abuse, either at the lower threshold of "Suspected" or the higher threshold of "Confirmed" based on the children's symptom display.

If the mother has formed a cross-generational coalition with the children against the father in which the children evidence:

- Developmental Psychopathology: A severe and complete suppression of the normal-range functioning of their attachment system relative to their relationship with their father;
- Personality Disorder Pathology: Prominent narcissistic personality traits of a haughty and arrogant attitude toward their father, a sense of entitlement relative to their father, a grandiose judgement of their father's adequacy as a person, an absence of normal-range empathy for their father, and splitting pathology in which their father is viewed as entirely bad, worthless, and devalued, whereas their mother is idealized as being the perfect parent;
- Psychiatric Pathology: A delusional belief that their father's normal-range parenting represents a threat to the children, and excessive unwarranted anxiety regarding the supposed threat potential posed to the children by the normal-range parenting practices of the father;

and if, as a result of this induced psychopathology the children lose a relationship with a normal-range and affectionally available parent, the pathogenic parenting of the mother could reasonable represent a DSM-5 diagnosis of V995.51 Child Psychological Abuse, at least at the level of "Suspected" and reasonably at the level of "Confirmed" based on the children's symptom display.

The potential emotional and psychological abuse of the children by the mother's pathogenic parenting practices would then activate Dr. <name>'s "duty to protect" which would need to be discharged, either by filing a suspected child abuse report with the appropriate child protective services agency, or by taking other definitive and affirmative steps to protect the children, which would be documented in the patient record.

It does not appear that Dr. <name> responded to her duty to protect, either because she did not recognize the potential severity of the pathology being evidenced in the family, or because she disregarded her professional obligation to protect the children's emotional and psychological development.

Standard 2.03: Standard 2.03 of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association requires psychologists to

“undertake ongoing efforts to develop and maintain their competence.” With regard to the clinical concerns evidenced in Dr. <name>’s reports, it is questionable whether Dr. <name> fulfilled the requirement of Standard 2.03 to develop and maintain her competence in the relevant domains of family systems pathology, personality disorder pathology, and attachment-related pathology that are directly related to her work as a court-appointed treatment provider in cases of severe family pathology.

Principle B and Standard 4.06: To the extent that the family systems pathology, the personality disorder pathology, and the attachment trauma pathology being expressed within the <family name> family was beyond the boundaries of Dr. <name>’s expertise, resulting in nearly a year and a half of completely failed therapy, she may have also failed to seek appropriate consultation consistent with Principle B and Standard 4.06 requiring that “psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work” (APA ethics code; Principle B).

<Additional Specific Report Data Redacted>

Summary:

Based on the analysis of the clinical data contained in Dr. <name>’s Progress Reports, strong consideration should be given as to whether Dr. <name>’s professional practices were in violation of the following standards of professional practice:

- **Failure in Her Duty of Care:** Patient abandonment regarding both the 10-month interruption in treatment in which Dr. <name> seemingly placed her financial interests ahead of her patient care responsibilities (“with paramount¹⁰ consideration given to the welfare of the client/patient” APA Standard 10.09), and her abrupt termination of therapy when the father became frustrated with her ineffective treatment plan and unresponsiveness to his requests for seeking additional professional consultation.
- **Failure in Her Duty to Protect:** The children appear to be evidencing extremely concerning developmental pathology (severe distortion to the normal-range functioning of the attachment system), severe psychiatric pathology (delusional beliefs regarding the threat potential posed by the father’s normal-range parenting practices), and the children’s deeply disturbing personality disorder pathology (seemingly evidencing grandiosity, entitlement, an absence of empathy, a haughty and arrogant attitude, and splitting). This developmental, psychiatric, and personality pathology appears to be produced by the pathogenic parenting practices of the mother, which is seemingly the direct cause for the children’s loss of a healthy and normal-range affectionally bonded relationship with a normal-range and affectionally available parent (their father). Inducing significant developmental, psychiatric, and personality disorder pathology in children through highly distorted

¹⁰ **Paramount:** more important than anything else. Cambridge Online Dictionary

and pathogenic parenting practices would reasonably meet DSM-5 criteria for V995.51 Child Psychological Abuse, at least at the lower threshold of Suspected, and more reasonably at the higher threshold of Confirmed. Even at the lower threshold of V995.51 Child Psychological Abuse, **Suspected**, this would engage Dr. <name>'s professional obligation under her duty to protect to take an affirmative protective action and document this action in the patient's record. Yet Dr. <name> never addresses this issue in any of her Progress Reports to the Court. Dr. <name> never indicates that she considered this DSM-5 diagnosis, that she provided this DSM-5 diagnosis, or that she took any form of affirmative protective action consistent with her professional duty to protect.

- **Standard 2.01a Professional Competence:** Based on the clinical information contained in Dr. <name>'s Progress Reports and her failed case conceptualization and treatment plan, Dr. <name> does not appear to possess fundamental and basic knowledge in family systems theory, even though she is treating family systems pathology (the triangulation of the child into the spousal conflict through a cross-generational coalition with one parent against the other parent). Dr. <name> also does not appear to possess fundamental professional competence in the diagnosis and treatment of personality disorder pathology required for her role as the court-appointed treatment provider with this family (i.e., the recognition of seemingly narcissistic personality pathology displayed by both the mother and the children). Dr. <name> also does not appear to possess the necessary professional competence in attachment system pathology, particularly the trans-generational transmission of attachment trauma from the childhood of the parent (e.g., disorganized attachment) to the current family relationship (trauma reenactment pathology) which is seemingly evidenced in this family.
- **Standard 9.01 Appropriate Assessment:** Due to her apparent absence of the necessary professional knowledge and professional competence, Dr. <name> appears not to have conducted an appropriate assessment "sufficient to substantiate" the opinions contained in her "recommendations, reports and diagnostic or evaluative statements, including forensic testimony."
- **Standard 3.04 Harm to the Client:** As a result of her lack of professional knowledge and professional competence, her failure in her duty of care, her failure in her duty to protect, and her failure to conduct an appropriate assessment sufficient to substantiate the opinions contained in her recommendations, reports and diagnostic or evaluative statements, including forensic testimony, substantial harm was apparently inflicted on her patients.
- **Standard 10.09 Interruption in Services:** Standard 10.09 requires that "paramount consideration be given to the welfare of the patient/client." The word paramount means "more important than anything else." Dr. <name>, however, appeared to place her own financial interests ahead of her patient care obligations.
- **Standard 3.12 Interruption of Services:** Standard 3.12 of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association requires that,

“...psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as... financial limitations.”

Dr. <name> appears to have failed to plan for or facilitate services during the 10 months of interrupted therapy caused by the mother’s withdrawal of financial support for the father-daughter therapy sessions and Dr. <name>’s decision not to resume therapy until the mother resumed her financial support.

- **Standard 6.04d Fees and Financial Arrangements:** Given the clearly evident pathology in this family, it would have been reasonable to anticipate that the mother might seek to undermine the father’s therapy with the children by withholding her financial support for the father-daughter therapy sessions (which occurred beginning in <month/year>, after only two rounds of father-daughter therapy sessions). The mother’s withholding of her financial support caused a 10-month interruption in treatment. Standard 6.04 states,

“(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible.”

There appeared to be no anticipation, no prior discussion, and no planning for what should reasonably have been an anticipated interruption in the mother’s willingness to financially support the father’s therapy with his daughters.

- **Principle B and Standard 4.06 Consultation:** Dr. <name> directly refused the client’s request that she seek additional professional consultation, and she provided the client with false information that she needed consent of both parents to seek consultation, when that is not true. According to Standard 4.06, professional consultation is always allowed as long as “information that reasonably could lead to the identification of a client/patient” is not disclosed during the consultation.

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