C. A. CHILDRESS, Psy.D.
LICENSED CLINICAL PSYCHOLOGIST, PSY 18857
219 N. INDIAN HILL BLVD., STE. 201 • CLAREMONT, CA 91711 • (909) 821-5398

Date: <date>

Psychologist: Craig Childress, Psy.D.

Scope of Report:

Dr. Childress was asked to review a report by Dr. <name> and provide comment based on Dr. Childress' background, knowledge, and training in clinical child and family psychology, childhood attachment and trauma, parent-child conflict, family conflict, and family systems therapy.

Impressions:

It is generally considered beneath professional standards of practice to make up new forms of pathology without an adequate supporting research base for the pathology.

Dr. <name> relied on a construct[1] used often in forensic court-involved psychology that has no meaning in actual clinical and child psychology, and that lacks adequate research foundation to be considered appropriate for professional clinical practice.[2] In my professional opinion, the analysis and report by Dr. <name> are beneath professional standards of practice in child and family therapy.

I would <u>not</u> accept any of this report or analysis from an intern. I would require that the intern revise the entire report and analysis, entirely withdrawing the use of a new construct (i.e., "parental detachment"/"parental alienation") and requiring the intern to use only standard and established constructs, such as the attachment system (secure and insecure attachment categories), family systems constructs (cross-generational coalition; emotional cutoff), trauma (trans-generational transmission of trauma), personality disorder constructs (absence of empathy; splitting), and behavioral constructs (oppositional-defiant behavior; breach-and-repair sequence; stimulus control of behavior).

None of these standard domains of professional clinical psychology were applied by Dr. <name> in her analysis. The absence of appropriate application of standard and established constructs from professional psychology (attachment system; family systems therapy; the trans-generational transmission of complex trauma; personality pathology in parents; and oppositional-defiant behavior and breach-and-repair sequences in family conflict), represents practice substantially <u>below</u> professional standards of practice.

Furthermore, this practice beneath professional standards by failing to apply relevant constructs from established psychology is further compounded by then applying a construct for a new form of pathology ("parental detachment"/"parental alienation") that has no defined and accepted meaning established in the research literature. This too, represents practice substantially <u>below</u> professional standards of practice.

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[1] Translated as "parental detachment" for this report, also commonly called "parental alienation."

[2] Dr. Childress has reviewed the articles cited by Dr. <name> in the references and Dr. Childress is familiar with all of the citations; they are very weak and insubstantial, and do now warrant consideration relative to the "new form of pathology" (i.e., "parental detachment") in professional psychology.

Comparison 1: Oppositional Defiant Disorder

I would start by noting the DSM-5 criteria for a diagnosis of 313.81 Oppositional Defiant Disorder (ICD-10 F91.3).

DSM-5 Oppositional Defiant Disorder

A pattern angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry /Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

Argumentative/Defiant Behavior

4. Often argues with authority figures, or for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others
7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months

Dr. <name> does not even attempt to differentiate her construct of "parental detachment" from the standard construct of oppositional-defiant behavior, nor does she apply the standard construct of oppositional-defiant behavior and the surrounding research literature to her analysis. This represents a substantial failure in professional practice standards:

1. To not apply standard constructs;

2. To apply constructs that are not supported by the research literature.

Comparison 2: Attachment Pathology

The attachment system is the brain system for love-and-bonding. A disruption to the parent-child bond is an attachment pathology. There are two broad categories of attachment; secure and insecure. There are three categories of insecure attachment; anxious-ambivalent (preoccupied), anxious-avoidant, and disorganized.

Dr. <name> is clearly discussing disrupted parent-child bonding but she fails to apply the constructs from the attachment system and surrounding research literature. Dr.

<name> does not identify which attachment category (secure or insecure; anxious-ambivalent, anxious-avoidant, disorganized) are applicable to the children. To not apply relevant information sets from professional psychology to pathology is considered beneath standards of professional practice.

Instead, Dr. <name> creates new categories for a new form of pathology she is asserting ("parental detachment"/"parental alienation"). Even if she wished to assert a new form of pathology (which is extremely unwise), that does not release her from her standard professional obligation to apply the standard and established knowledge of professional psychology to her analysis. Since she is discussing an attachment-related pathology (a problem in the love and bonding system of the brain), she is required by professional standards of practice to apply the knowledge and information sets from the attachment system to her analysis (diagnosis) of pathology. '

If Dr. <name> then wishes to add additional analysis of her devising, she can anchor this subsequent analysis (diagnosis) within the established constructs she's already described. But first, professional standards of practice require the application of standard and established knowledge sets to pathology and symptom diagnosis. All additional analysis then proceeds from this. Dr. <name>'s analysis therefore falls substantially below professional standards of practice for failing to apply standard information sets to the analysis (diagnosis) of pathology.

Comparison 3: Family Systems Pathology

Similarly to the information sets from the attachment system, Dr. <name> failed to apply the information sets from family systems therapy to understanding family pathology. Family systems therapy is one of the four primary schools of therapy, the others being psychoanalysis (Freud and the couch), humanistic-existential (growth and self-actualization), cognitive behavioral (learning theory and lab animal experiments). Of the four primary schools of psychotherapy, only family systems therapy involves family relationships and family conflict, including how to solve family pathology – all forms.

The principle literature in family systems therapy is:

Salvador Minuchin: *Families and Family Therapy*
Murray Bowen: *Family Therapy in Clinical Practice*
Jay Haley: *Problem Solving Therapy*
Cloe Madanes: *Strategic Family Therapy*
Virgina Satir: *Peoplemaking*

Dr. <name> did not apply any constructs from family systems therapy to her analysis of the family pathology. This does not meet required standards of practice in clinical psychology.

While Dr. <name> may prefer her new constructs, that does not release her from her obligation to apply the standard constructs of professional psychology to her analysis (diagnosis) of pathology.

Comparison 4: DSM-5 Diagnosis (ICD-10)

Standard of practice in clinical psychology is to give a DSM diagnosis for all cases. This could be a DSM-5 diagnosis of "no diagnosis" (V71.09), a rule-out diagnosis, a provisional diagnosis, or a deferred diagnosis, but a DSM diagnosis is made in all cases.

This is to document that an assessment for any significant psychiatric pathology had been conducted and that severe psychiatric pathology was not present, or it is to identify significant psychiatric pathology in the client.

The standard of practice in clinical psychology is that, "If it is not documented in the patient's record, then it didn't happen." If there is no documented DSM-5 diagnosis then Dr. <name> did not conduct an assessment for any severe psychiatric pathology in the family. This is a negligent violation of professional standards of practice of assessment with clients, to not even conduct an assessment for significant psychiatric pathology (such as V995.51 Child Psychological Abuse) in the child or parents.

Dr. <name> may verbally assert after the fact that she did do an assessment for major psychiatric pathology, but since there is no documented evidence that she did so then it did not happen. If it is not documented in the patient record, it didn't happen. The purpose of making a DSM-5 diagnosis in all cases is not to "pathologize" the patient, it is to identify areas of need. The purpose of documenting the DSM-5 diagnosis for all cases (even if it is V71.09 No Diagnosis) is to document that an assessment was done for major psychiatric pathology, and then to document the results.

Conclusion

Dr. <name>'s analysis (diagnosis) of family pathology fails to meet minimum levels for professional standards of practice in clinical psychology.

While Dr. <name> may enjoy her preferred ideas, her personal preference does not exempt her from professional obligations to apply the standard and established knowledge of professional psychology (attachment, family systems therapy, personality pathology, complex trauma, behavioral psychology) to her analysis of family and child symptom information. She did not do this, and thus failed in her fundamental obligation as a psychologist, and so failed her client children and family who were being assessed.

Craig Childress, Psy.D.
Clinical Psychologist, PSY 18857