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Guidelines for Child Custody Evaluations in Family Law Proceedings

Analysis (Draft) of Proposed APA Child Custody Evaluation
Competence: Guidelines 4 5 6
(authors unknown)
Analysis & Commentary by C.A. Childress, Psy.D. (1/31/21)

DRAFT

206 **Guideline 3. Psychologists ~~endeavor to~~^{cc} identify the child custody evaluation’s stated purpose,**

207 **II. Competence**

208 **Guideline 4. Psychologists ~~aspire to~~^{cc} provide child custody evaluations consistent with the highest**

209 **standards of their profession, and to obtain and maintain the necessary competencies.**

Dr. Childress Comment:

“the highest standards of their profession”

- Bowlby citations – 0
- Minuchin citations – 0
- Bowen citations – 0
- Beck citations – 0
- Millon citations – 0
- Kernberg citations – 0
- Linehan citations – 0
- Van der Kolk citations – 0
- Cicchetti citations – 0
- Tronick citations – 0
- Kohut citations – 0
- DSM-5 & ICD-10 citations – 0
- Principle D Justice: equal access & equal quality
- Standard 2.04: Bases for Scientific and Professional Judgments
- Standard 2.01: Boundaries of Competence
- Standard 9.01: Bases for Assessment
- Standard 3.04: Avoiding Harm
- Duty to protect

“obtain and maintain the necessary competencies.”

The “necessary competencies” for working with high-intensity family conflict surrounding divorce are:

- Attachment (Bowlby and others)
- Family systems therapy (Minuchin and others)
- Personality disorders (Beck and others)
- Complex trauma (van der Kolk and others)

- Child development (Tronick and others)
- DSM-5 & ICD-10 diagnostic systems

233 **Rationale.** Child custody evaluations are a domain of forensic psychology that requires skills, training,

234 knowledge, and competence in the forensic assessment of children, adults, and families. Child custody

Dr Childress Comment:

That is a false, deceptive, and misleading statement. Child custody evaluations require skills, training, knowledge, and competence in the attachment system and attachment pathology during childhood, family systems therapy, personality disorders and their impact on family relationships, complex trauma and the trans-generational transmission of trauma in the distorted parenting that unresolved trauma creates, in thought disorder pathology that is secondary to personality disorders and unresolved trauma, and in child development and the importance of the parent-child relationship context for the neurodevelopment of the brain in childhood – Bowlby – Minuchin – Beck – van der Kolk – Tronick – DSM-5 & ICD-10: the “established scientific and professional knowledge of the discipline.

235 evaluations have a significant impact on people’s lives and involve public scrutiny and trust.

Dr. Childress Comment:

“a significant impact on people’s lives”

There is no excuse for professional sloth or ignorance when the lives of children, their parents, and the court’s decisions affecting their lives hang in the balance.

The “Working Group” is lazy, ignorant, and did not show “proper care” (i.e., negligent) in the development of these Guidelines for Child Custody Evaluations.

- Bowlby citations – 0
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- Bowen citations – 0
- Beck citations – 0
- Millon citations – 0
- Kernberg citations – 0
- Linehan citations – 0
- Van der Kolk citations – 0
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- Principle D Justice: equal access & equal quality
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- Standard 2.01: Boundaries of Competence
- Standard 9.01: Bases for Assessment

- Standard 3.04: Avoiding Harm
- Duty to protect

The “Working Group” fails to even meet basic Standards of professional practice (Standards 2.04, 2.01, 9.01).

236 **Application.** Psychologists continuously ~~strive to~~^{cc} update and augment their existing skills and abilities,
 237 consistent with a career-long dedication to professional development. They recognize that there has

Dr. Childress Comment:

Forensic psychology applies NO knowledge or information from:

- Psychoanalysis: Freud (transference) Kohut (self-objects functions) – developed in the 1930s
- Cognitive-Behavioral: Skinner (Applied Behavioral Analysis & Functional Behavioral Analysis) and Beck (schemas and irrational beliefs) – developed in the 1940s
- Family Systems: Minuchin (cross-generational coalitions) and Bowen (triangles and emotional cutoffs) – developed in the 1970s.
- Attachment: Bowlby (insecure attachments, “goal-corrected” primary motivational system) – developed in the 1970s.
- Complex Trauma: van der Kolk (trauma reenactments, trans-generational transmission of trauma) – developed in the 1990s.
- Child Development: Tronick (breach-and-repair sequence) and others (neurodevelopment in the parent-child relationship context) – developed in the 2000s.

A Checklist of Applied Knowledge was used with the APA’s proposed Guidelines for Child Custody Evaluations (Appendix C), no knowledge from any domain of professional psychology was evident in application.

238 been debate in the literature whether psychologists have an objective basis for determining what
 239 factors to evaluate in a best interests of the child determination or even whether such ultimate issue
 240 opinions about best interests should be offered (e.g. Melton et al, 2018). The child custody evaluator

Dr. Childress Comment:

They have no idea how to operationally define the construct of the child’s “best interests,” they just make it up. There is no definition available for that construct based on the existing knowledge of professional psychology.

The definition of the child’s “best interests” from clinical psychology is that it is ALWAYS in the child’s best interests for the family to make a successful transition to the new separated family structure following divorce, it is ALWAYS in the child’s best interests to repair broken attachment bonds of love and affection to their mother or father.

In the absence of child abuse, parents have the right to parent according to their cultural values, their personal values, and their religious values, and professional psychology does not, and should not, intrude upon that foundational human right of parenting. If there are problems (pathology), we fix it (treatment).

We need a written treatment plan, for that we need a diagnosis. The treatment for cancer is different than the treatment for diabetes, diagnosis guides treatment, and that's true in all of healthcare, including mental health care; diagnosis guides treatment.

The diagnosis of concern is a thought disorder from unresolved trauma in the parent (i.e., narcissistic and/or borderline personality traits) that is being transferred to the child through the aberrant and distorted parenting of this more fragile parent who is psychologically collapsing surrounding the divorce and marital dissolution (ICD-10 F24, a shared persecutory delusion).

From Stahl & Simon: "A critical subject facing those working in the field of family law, whether they're legal professionals or psychological professionals, is the concept of the best interests of the children. Even recognized experts in this concept differ with regard to what it means, how it should be determined, and what factors should be considered in determining what is in the best interest of a child. Thus, this ubiquitous term escapes consensus and remains fundamentally vague." (Stahl & Simon, 2013, p. 10-11)

From Stahl & Simon: "It is defined differently from state to state; and even in Arizona, where there are nine statutory factors associated with the best interest of the child, the meaning behind many of the factors is obscure. Additionally, when psychologists refer to the best interests of children, they are referring to a hierarchical set of factors that may have different meanings to different children with different families and that may be understood differently by psychologists with different backgrounds and different training." (Stahl & Simon, 2013, p. 11)

Stahl, P.M. and Simon, R.A. (2013). *Forensic Psychology Consultation in Child Custody Litigation: A Handbook for Work Product Review, Case Preparation, and Expert Testimony*, Chicago, IL: Section of Family Law of the American Bar Association

They have no idea how to define the construct of the child's "best interests," yet that is supposedly the construct they are somehow assessing. They have no idea what they are doing because they are not applying the "established scientific and professional knowledge of the discipline," i.e., attachment (Bowlby), family systems therapy (Minuchin), personality disorders (Beck), complex trauma (van der Kolk), child development (Tronick), and the DSM-5 and ICD-10 diagnostic systems.

241 ^{cc} ~~seeks to~~ maintain familiarity with the empirical social science research regarding children's psychological
242 and developmental needs, including health impairments, educational needs, cultural or linguistic
243 concerns, other case-specific issues, and the child's best interests. Psychologists ^{cc} ~~strive to~~ gain an

Dr. Childress Comment:

- Bowlby citations – 0
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- Kernberg citations – 0
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- Van der Kolk citations – 0
- Cicchetti citations – 0
- Tronick citations – 0
- Kohut citations – 0
- DSM-5 & ICD-10 citations – 0

244 evolving and up-to-date understanding of the following: parenting; child and family psychopathology;

Dr. Childress Comment:

Parenting:

Patterson – Applied Behavioral Analysis – Functional Behavioral Analysis

Tronick – breach-and-repair

Stern – intersubjectivity, affective attunement

Fonagy – mentalization and boundary violations

Kohut – self-object, self-structure, transmuting internalizations

(Pruter – trauma-informed parenting)

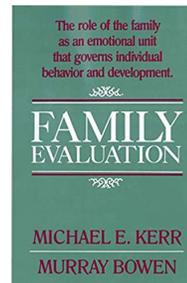
Child and family psychopathology

Family systems therapy

- Kerr & Bowen: *Family Evaluation*
- Minuchin: Structural Family Therapy
- Haley & Madanes: Strategic family therapy

DSM-5 & ICD-10

- DSM-5: V995.51 Child Psychological Abuse
- ICD-10: F24, shared persecutory delusion



245 separation and divorce stress; impact of relationship dissolution and inter-parental conflict and abuse on

Dr. Childress Comment:

Separation and divorce stress:

Personality disorders

- Beck: cognitive therapy with personality disorders
Beck, Freeman, Davis, & Associates (2004). *Cognitive Therapy of Personality Disorders*
- Millon: narcissistic and borderline personality spectrum

Millon (2011): *Disorders of Personality: Introducing a DSM/ICD Spectrum from Normal to Abnormal*

- Kernberg: narcissistic and borderline personality pathology

Kernberg (1975). *Borderline Conditions and Pathological Narcissism*.

- Linehan: DBT therapy with borderline spectrum pathology

Linehan (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*.

246 children; adult development and pathology; forensic psychological assessment; relevant laws and

Dr. Childress Comment:

Conflict & Abuse

- Van der Kolk - Cicchetti – Fonagy – Kohut - DSM-5 V995.51 Child Psychological Abuse

Forensic psychological assessment?

- Forensic? There is no allegation of a crime. There is a family conflict, often an intense and intractable conflict surrounding the child's custody. If the procedures of a "forensic psychological assessment" are inadequate, inappropriate, unethical, and substantially flawed, then they are a bad thing, not a good thing. First establish reliability and validity, operational define the constructs for assessment, then promote the assessment procedure if it is reliable and valid for the intended purpose. It remains unclear what a "forensic psychological assessment" entails (we know it is not brief and focused, so it is assumed to be long and unfocused), it does not assess for child protection factors (that's a separate and distinctly different assessment), and there remain many substantial professional concerns surrounding the practice.

Laws and Regulations

- Like the APA ethics code.
- While court-involved psychologists who work with regularity with court-involved family conflict should be familiar with the surrounding laws and procedures of the court, psychologists are not attorneys and should remain contained within their role as healthcare professionals, not legal professionals.

247 regulations; and the specialized child custody literature (as addressed in Guideline 5). In addition, when

Dr. Childress Comment:

"specialized child custody literature"

NOT at the expense of the "established scientific and professional knowledge of the discipline," i.e., attachment (Bowlby and others), family systems therapy (Minuchin and others), personality disorders (Beck and others), complex trauma (van der Kolk and others), child development (Tronick and others), and the DSM-5 and ICD-10 diagnostic systems.

If there is additional relevant research that meets professional standards of practice, then it should also be considered.

*Note: The construct of “parental alienation” does NOT meet professional standards of practice. All professional use of this construct in any capacity is beneath professional standards of practice. There is the attachment system, there is family systems therapy, there are personality disorders and complex trauma. There is no such pathology as “parental alienation” ever defined.

All “specialized child custody literature” that uses the construct of “parental alienation” as its foundation is irrelevant and beneath professional standards of practice. All “specialized child custody literature” that proposes new forms of pathology unsupported by any research, such as “resist and refuse dynamics” (Daubert and Kelly-Frye the construct, there is no support, it’s the new PAS “junk science offering) are irrelevant and beneath professional standards of practice.

Standard 2.04 is clear on the Bases for Scientific and Professional Judgments

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The “established scientific and professional knowledge of the discipline” is attachment, family systems therapy, personality disorders, complex trauma, child development, and the DSM-5 and ICD-10 diagnostic systems – Bowlby – Minuchin – Beck – van der Kolk – Tronick – DSM-5 & ICD-10.

- 248 making recommendations, psychologists ^{cc} ~~endeavor to~~ remain current and knowledgeable about
- 249 treatments, interventions, and resources to address different dysfunctions as well as the types of
- 250 custody arrangements that promote healthy patterns. Psychologists ^{cc} ~~strive to~~ update routinely their

Dr. Childress Comment:

“treatments, interventions”

- Family systems therapy – Bowenian (Bowen) – Structural (Minuchin) – Strategic (Haley & Madanes)
- Personality disorders – Beck & cognitive therapy – Schema Therapy – Emotion Focused Therapy – DBT
- Solution-focused therapy – de Shazer & Berg
- Pruter: *High Road Workshop, Higher Purpose Parenting*

“the types of custody arrangements that promote healthy patterns”

In the absence of child abuse, parents have the right to parent according to their cultural values, their personal values, and their religious values, and professional psychology does not violate that foundational human right of parenting.

Question: Is our White Northern-European parenting a “healthy pattern” – healthier than Blacks? Healthier than Asians? Healthier than Hispanics or Muslims? It becomes exceedingly dangerous when psychologists self-authorize to judge parents for “healthy patterns” ... what “patterns” and by whose decision?

No. In the absence of child abuse, parents have the right to parent according to their cultural values, their personal values, and their religious values, and professional psychology does NOT intrude into this foundational right of parenting.

If there are problems, we fix them with a written treatment plan, with specified and agreed to Goals, Interventions, Outcome Measures, and Timeframes for goal accomplishment.

251 child custody evaluation practices in accordance with developments in the peer-reviewed literature.

Dr. Childress Comment:

“developments in the peer-reviewed literature”

- Bowlby – attachment
- Minuchin, Bowen, Haley, Madanes – family systems therapy
- de Shazer, Berg – solution-focused therapy
- Beck, Millon, Kernberg, Linehan – personality disorder pathology
 - Schema Therapy – Emotion-Focused Therapy – DBT
- van der Kolk, Courtois, Cicchetti – complex trauma and child abuse
- Tronick, Fonagy, Stern, Kohut – child development

“peer-reviewed”

Peer review is relevant for research studies to ensure appropriate methodology and limitations to the conclusions drawn based on the methodology. Peer-review is not relevant to opinion pieces. One set of Editors for one Journal can hold one set of opinions, they “peer-review” similar opinions and publish those opinions in their journal. Another Journal’s Editors hold a different opinion and peer-review and publish opinion articles that hold a similar opinion as the Editors. This is not peer-reviewed research – the operative words being all three – peer – review – research – not opinions. A peer-reviewed opinion is still an opinion.

There are even-still peer-reviewed journals that publish opinion articles using the construct of “parental alienation.” These are not peer-reviewed research. We need to base our decisions on the current and latest peer-reviewed research. That would be attachment (Bowlby, Ainsworth, Mains, Ruth-Lyons, Sroufe, Fonagy, Tronick), that would be trauma-informed and complex trauma (van der Kolk, Courtois, Perry, Briere). That would be the DSM-5 and ICD-10 diagnostic systems (thought disorders and Mental Status Exams of frontal lobe executive functions).

These forensic psychologists use “peer-reviewed” as a mantra for “we all agree, right?” That’s not what it means. There are three words – peer – reviewed – research... research, not opinions.

How many of the forensic citations in the References to these proposed Guidelines for Child Custody Evaluations are to peer-reviewed research and how many are citations to forensic psychology opinion pieces?

Appendix A: 78% of the forensic reference citations (26/33) are to opinion pieces, and two of the research studies cited were to survey research regarding the opinions of forensic psychologists.

Three words – peer – reviewed – research – not opinions – research.

252 When ~~the specifics of a case are such that~~^{cc} the psychologist does not possess the requisite competency
253 to conduct the custody evaluation, ~~this situation provides~~^{cc} psychologists ~~with an important opportunity~~
254 ~~to~~^{cc} decline involvement and ~~suggest~~^{cc refer to} a more suitable evaluator. Exceptions to this guidance may exist

Dr. Childress Comment:

This is basic, fundamental, standard of practice throughout all of psychology and all of healthcare. If the healthcare provider in any capacity, psychologist, social worker, MD physician, is not competent to perform the service, they decline and refer to someone who is. These are not guidelines, it's an undergraduate group paper made up off the top of their heads. They are simply reciting basic principles of professional practice as if they were special "Guidelines," i.e., if you are not competent, decline the service and refer.

255 when the custody evaluation takes place where no other more appropriate referral source is available or
256 when there are distinctive attributes or qualities of an individual or family (e.g., uncommon culture,
257 clinical condition). In such situations, rather than withdrawing from the case, the psychologist might

Dr. Childress Comment:

Proposed "exceptions" to professional competency

- "no other more *appropriate* referral source is available" – if the custody evaluator feels there is not a "more appropriate" source for the custody evaluation available, then they can make an "exception" to their incompetence and go ahead with the evaluation anyway.
- "distinctive attributes" – if the custody evaluator feels there is something interesting and special about the family situation, then they can make an "exception" to their incompetence and go ahead with the evaluation anyway.

From the APA ethics code, Standard 2.01 Boundaries of Competence

Standard 2.01 Boundaries of Competence

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a **reasonable effort to obtain the competence required** by using relevant research, **training, consultation**, or study.

There are very limited exceptions to professional competence requirements under Standard 2.01(d), i.e., so that services are not denied, with closely related prior training or experience, and IF they make a reasonable effort to OBTAIN the competence required.

Why did the “Working Group” not cite the relevant APA ethics code, Standard 2.01(d). There are no exceptions for competence unless reasonable efforts are made to OBTAIN the competence (such as through training and consultation), and only in cases where the professional has “closely related” professional experience and, if not provided, then no services will be available.

The “Working Group” seems lax in their requirements for professional competence. No mention of Standard 2.04, no mention of required competence in attachment pathology, family systems, personality disorders, complex trauma, or the diagnostic systems of the DSM-5 and ICD-10, just some vague and general statements about parenting and childhood.

258 consider obtaining the appropriate consultation or supervision so that the custody evaluation can

259 proceed where otherwise it could not.

Dr. Childress Comment:

This is improper. They twist the meaning of Standard 2.01(d) to give permission to accept the case, “rather than a strict prohibition to incompetent practice, with a limited qualifier in Standard 2.01(d)

“rather than withdrawing from the case, the psychologist might consider...”

No. If the psychologist does not possess the necessary competence, the psychologist declines the case and makes a referral. In a situation where a referral is not available because the competence is not available in the community, and if the psychologist has closely related knowledge, then the psychologist may accept the case so that services won’t be denied – IF – IF – the psychologist makes a reasonable effort to “obtain the competence required.

They left that part out, the part about “obtain the competence required.” They mentioned the “consultation” part that follows.

They are technically in accord with Standard 2.01(d) – however, why did they not cite it, why did they not reference “reasonable effort to obtain the competence required,” why did they instead give themselves additional latitude not allowed by Standard 2.01(d) to accept cases beyond the boundaries of their competence if they feel that there are no other “appropriate referrals” and if there are “distinctive attributes” (never mentioned in Standard 2.01) that would somehow allow them to accept a case for which they are incompetent.

They should have directly cited the APA ethics code, Standard 2.01(d).

No mention of Standard 2.04. No mention that “psychologists’ work is based upon established scientific and professional knowledge of the discipline,” i.e., attachment, family systems therapy, personality disorders, complex trauma, child development, and the DSM-5 and ICD-10 diagnostic systems.

260 **Guideline 5. Psychologists endeavor to acquire and maintain specialized competencies to address**

261 **complex issues in child custody evaluations.**

Dr. Childress Comment:

“specialized competencies”

Such as:

- Attachment: specialized competency in the nature, functioning, and dysfunctioning of the attachment system in childhood (Bowlby, Ainsworth, Mains, Sroufe, Cassidy, Lyons-Ruth), including the treatment and restoration of damaged parent-child attachment bonds, i.e., the breach-and-repair sequence (Tronick, Stern).
- Intersubjectivity: specialized competency in the neurologically based relationship system of intersubjectivity (Stern, Tronick, Fonagy, Kohut), a psychological connection system mediated by the mirror neuron network (Siegel), called “enmeshment” in the family systems literature (i.e., the loss of psychological boundaries).
- Personality Disorders: specialized competency in the assessment, diagnosis, and treatment of personality spectrum pathology, specifically narcissistic and borderline personality pathology (Beck, Millon, Kernberg). Narcissistic pathology is vulnerable to rejection, borderline pathology is vulnerable to abandonment, divorce involves both rejection and abandonment by the spousal attachment figure. The activation of narcissistic and borderline personality disorder traits and pathology in a parent would be expected by divorce and the marital rejection and perceived abandonment involved. Specialized competency in the assessment, diagnosis, and treatment of narcissistic and borderline personality pathology is required.
- Complex Trauma: Specialized competency in complex trauma (van der Kolk, Courtois, Cicchetti) and the reenactment of unresolved childhood trauma in the current family relationships (called the “transference” by Freud, “schemas” by Beck, and “internal working models” by Bowlby) is required.
- Brain Development: Specialized competency in the neuro-development of the brain across all stages of childhood is necessary since both assessment factors and recommendations will depend on a variety of neuro-developmental stage factors with the child, and in the parent-child relationship and communication bond. When making life-altering recommendations for children, a specialized competency in the stages and issues in the neurodevelopment of the brain in the parent-child relationship is required.
- Thought Disorders: Specialized competency in thought disorders is required because both narcissistic and borderline pathology will collapse into thought disorders (persecutory delusions) when placed under stress, and divorce represents a significant stress to the narcissistic or borderline personality because of the inherent rejection and abandonment involved.

From Millon: Under conditions of unrelieved adversity and failure, narcissists may decompensate into **paranoid** disorders. Owing to their excessive use of fantasy mechanisms, they are disposed to misinterpret events and to construct **delusional** beliefs. Unwilling to accept constraints on their independence and unable to accept the viewpoints of others, narcissists may isolate themselves from the corrective effects of shared thinking. Alone, they may ruminate and weave their beliefs into a network of fanciful and totally **invalid suspicions**. Among narcissists, delusions often take form after a serious challenge or setback has upset their image of superiority and omnipotence. They tend to exhibit compensatory grandiosity and jealousy **delusions** in which they **reconstruct reality** to match the image they are unable or unwilling to give up. **Delusional** systems may also develop as a result of having felt betrayed and humiliated. Here we may see the rapid unfolding of persecutory **delusions** and an arrogant grandiosity characterized by verbal attacks and bombast.” (Millon, 2011, pp. 407-408).

It is a reasonable expectation that psychologists working with court-involved high-intensity family conflict may frequently encounter parental narcissistic or borderline pathology. Specialized competency in the assessment and diagnosis of thought disorder pathology (i.e., delusions) is required.

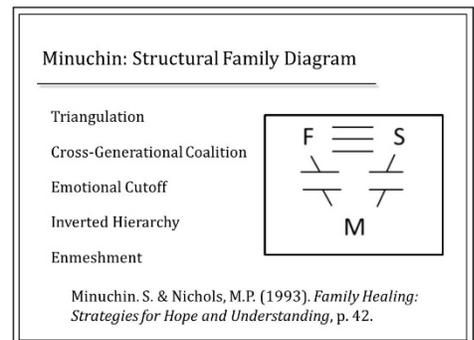
262 **Rationale.** Families requiring custody evaluations are complex and are often characterized by special
263 situations and difficult experiences (Drozd et al., 2016). Some specialized areas of child custody

Dr. Childress Comment:

This is a false statement. The family pathology only appears “complex” to the ignorant. The application of the established professional knowledge from family systems therapy brings clarity to the family dynamics:

Family Systems Description: The child is being *triangulated* into the spousal conflict through the formation of a *cross-generational coalition* with one parent against the other parent, resulting in an *emotional cutoff* in the child’s attachment bond to the other parent. (Bowen; Titelman)¹

Minuchin has a Structural family diagram for exactly the pathology (i.e., *cross-generational coalition* and *emotional cutoff*). In this diagram from Minuchin (1993), the father has formed a *cross-generational coalition* with the son against the mother. The *triangle* pattern is evident, as is the breached parent-child bonds with the mother (called an *emotional cutoff*).



The pathology is not “complex” to anyone who is competent in family systems, it only appears “complex” to ignorance.

An additional problematic feature in the family becomes the addition of parental narcissistic or borderline personality pathology, particularly the pathology of “splitting” (extreme polarization and rigidity of beliefs), which creates the intractable sides in the family and the “loyalty conflicts” (Boszormenyi-Nagy; *Invisible Loyalties*)

The addition of parental personality pathology to the cross-generational coalition and psychologically enmeshed relationship with the child (i.e., the three lines between the father and son in Minuchin’s diagram), requires that the assessing mental health professional have competence in both family systems and personality disorder pathology, that includes competence in the assessment and diagnosis of thought disorders relative to the collapse of a narcissistic or borderline personality surrounding the divorce and spousal conflict.

I notice that Drozd is cited three times for opinion pieces (what makes her opinion special?), which is notable for the number (3 citations) when Bowlby, Minuchin, Beck, van der Kolk, Millon, Kernberg, Cicchetti, Linehan, Bowlby, and Tronick received zero citations combined, yet Drozd’s work is so important that it receives three separate citations.

¹ Bowen, M. (1978). *Family Therapy in Clinical Practice*. New York: Jason Aronson.

Titelman, P. (2003). *Emotional Cutoff: Bowen Family Systems Theory Perspectives*. New York: Haworth Press.

I wonder if she was on the “Working Group”? They won’t release the names and vitae of who was on the “Working Group” or how they were chosen.

Drozd, L. M., Olesen, N. W., & Saini, M. A. (2013). *Parenting plan & child custody evaluations: Using decision trees to increase evaluator competence & avoid preventable errors*. Professional Resource Press.

- Opinion piece – not peer-reviewed research

Drozd, L., Saini, M., & Oleson, N. (Eds.). (2016). *Parenting plan evaluations: Applied research for the family court*. Oxford University Press.

- Opinion piece – not peer-reviewed research

Austin, W. G., & Drozd, L. M. (2012). Intimate partner violence and child custody evaluation, part 1: **Theoretical framework**, forensic model, and assessment issues. *Journal of Child Custody: Research, Issues, and Practices*, 9(4), 250–309.

- Opinion piece – not peer reviewed research

It is a curious set of priorities for the “Working Group” to cite opinions of Drozd (who?) three times (5% of the total citations; 3/61), while Bowlby, Minuchin, Bowen, Beck, Millon, van der Kolk, Kohut, Tronick, receive zero combined.

We need to see the names and vitae of who was on the “Working Group.”

The “Working Group” notes the intention of publishing these proposed Guidelines in the APA’s journal *American Psychologist*. They wouldn’t be doing this to advance their vitae and careers would they, rather than conducting an authentic review of the research and recommendations for the conduct of professional practice?

206 “the document was submitted for posting on the APA website and disseminated through

207 official APA communications channels. The document was also submitted for consideration for

208 publication in the *American Psychologist*.”

Yet there is no “conflict of interest” in developing “Guidelines” for their vitae? Drozd (who?) receives 5% of the overall citations promoting her opinions, while Bowlby, Minchin, Beck, van der Kolk, Millon, Kohut, Linehan, Bowen, receive zero – combined.

264 evaluations are well grounded in scientific literature, while other areas are not as well informed. For

265 example, a child may experience physical challenges requiring unique support services, a parent may be

266 diagnosed with a communication disorder necessitating specialized assessment techniques, or parent-

267 child bonds may reflect a highly a typical interpersonal history.

Dr. Childress Comment:

Or there may be a cross-generational coalition with one parent against the other parent resulting in an emotional cutoff, or there might be a shared persecutory delusion created by the collapse of a narcissistic-borderline parent surrounding the divorce, or it might be a severe attachment pathology in the child as the

result of the trans-generational transmission of unresolved trauma from the allied parent, who is recreating their own trauma reenactment narrative from childhood (called the “transference” by Freud, called “schemas” by Beck, and called “internal working models” by Bowlby).

268 **Application.** Complex issues in child custody evaluations may include, but are not limited to: relocation,
269 attachment, parent-child contact problems, intimate partner violence, child maltreatment (See
270 Guideline 15), effects of substance abuse (See Guideline 16), and mental health. Psychologists ^{cc}strive to
271 understand and evaluate factors affecting the child’s adaptation to relocation, that include, but are not
272 limited to, loss of contact with one parent, level of parental conflict, and difficulty of travel (Austin et al.,
273 2016; Stevenson et al., 2018).
274 Attachment issues with parents (Schore & McIntosh, 2011) and with siblings (Shumaker et al., 2011) are

Dr. Childress Comment:

When they cite attachment, they cite Alan Shore in a forensic journal. They have never read Alan Shore. I have. Here are Shore’s citations on the Reference list for *Foundations*:

Shore, A.N. (1997). Early organization of the nonlinear right brain and development of a predisposition to psychiatric disorders. *Development and Psychopathology*, 9, 595-631.

Shore, A.N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology*, 8, 59-87.

Schore A.N. (1994). *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*. Hillsdale, NJ: Erlbaum.

I’m fairly confident that the “Working Group” members do not understand the work of Alan Shore. This is like a student paper where they needed an “attachment” citation and the only one they know of is from their forensic journals, and Shore’s work sounds scientific and neurological, so they cited that as representing “attachment issues with parents.”

Not Bowlby Volume 1: Attachment. Not Bowlby Volume 2: Separation – Anxiety and Anger. Not Volume 3: Loss. Probably (likely) because they have never read any Bowlby, or any attachment literature. Alan Shore in a forensic journal is their citation for “attachment issues with parents.” This is little more than an undergraduate “group” project (and not a good one). This is far from a professional caliber work product.

Which speaks to the caliber of work product in child custody evaluations.

275 important complex issues for child custody evaluations, with ^{cc}the goal of restoring a healthy attachment bond ~~effort being made to optimize the bond~~

276 with both parents, ^{cc}particularly with young children. Psychologists ^{cc}strive to understand and evaluate

Dr. Childress Comment:

“particularly with young children” – NO, with all children.

The attachment system does NOT stop developing in early childhood, it continues to develop across all the developmental stages of childhood, shifting and changing with the stage and genders involved. The attachment system is a primary motivational system of the brain, like eating or sex. It is the brain system that governs all aspects of love and bonding throughout the lifespan, including grief and loss. The eating system doesn't stop after early childhood and the child learns how to feed themselves, eating remains important across the entire lifespan. Proper nutrition and healthy eating is important throughout childhood. So is love and bonding to mom and dad. Pathology in attachment bonding is bad, very bad, whenever it happens in childhood – not “particularly” – always.

There are four primary parent-child attachment bonds and they differ on the genders of the child and parent; mother-son, mother-daughter, father-son, father-daughter. Two are cross-gender (mother-son, father-daughter), these are the high-affection bonds. Two are same-gender (mother-daughter, father-son), these are the identity bonds.

Mothers are not exchangeable for fathers in the attachment networks of their children, nor are fathers exchangeable with mothers – the father daughter bond is different and serves different functions than does the mother-daughter bond, same for the mother-son and father-son bonds, they are unique to the relationship, and the functions of these bonds change across developmental stages.

“particularly in young children” – NO. In all children throughout the period of childhood. The “internal working models” of attachment (schemas) are developing throughout the childhood period. We NEVER leave a parent child attachment bond untreated and unrepaired. Never. That is the worst possible thing to do (Tronick: “the good, the bad, and the ugly” Still Face:

<https://www.youtube.com/watch?v=apzXGEbZht0&t=11s>)

277 issues of bonding within the existing family dynamics.

278 Parent-child access problems are a complex area of study such that psychologists ^{cc} ~~seek to~~ obtain

279 knowledge of the state-of-the art literature in this topic. The employment of such terms as “parental

Dr. Childress Comment:

“Parent-child access problems” is NOT a defined pathology. What is the diagnosis? Diagnosis guides treatment – including “recommendations” – what is the diagnosis.

It is NOT “complex,” it is simple, you tell me the diagnosis, I'll tell you what to do about it (i.e., the treatment).

If the pathology is a shared persecutory delusion, then the DSM-5 diagnosis is Child Psychological Abuse (V995.51) and the treatment is to protect the child. Is that complex? No, that's simple.

The “state of the art” literature on the topic of thought disorder pathology are the DSM-5 and ICD-10 diagnostic systems. This is the description of a shared delusional disorder from the American Psychiatric Association:

From the APA: “Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person.

If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear. Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs." (American Psychiatric Association, 2000, p. 333)

From the APA: "Course - Without intervention, the course is usually chronic, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. With separation from the primary case, the individual's delusional beliefs disappear, sometimes quickly and sometimes quite slowly." (American Psychiatric Association, 2000, p. 333)

Was that complex? No that was simple. Apply knowledge to solve pathology, ignorance solves nothing.

280 alienation syndrome" and "alienating behaviors" (e.g., Warshak, 2015) to address parent-child contact

Dr. Childress Comment:

The use of the construct of "parental alienation" in a professional capacity is unsupported and beneath professional standards of practice.

281 problems has engendered considerable controversy and confusion, because these terms do not convey
282 the full complexity of these problems. Psychologists ^{cc} ~~strive to~~ understand parent-child contact problems
283 through a suitably thorough investigation of all potential causes, including vulnerabilities of the children
284 and evidence of behavior, vulnerabilities of the parents including healthy and unhealthy attachments of
285 parents and children, and other family dynamics. Competencies may be enhanced by participation in

Dr. Childress Comment:

Including a cross-generational coalition with one parent against the other that is resulting in an emotional cutoff in the child's relationship with the other parent (Minuchin, Bowen, Haley, Madanes), and a shared persecutory delusion created in the child by the allied parent (ICD-10 F24) resulting in Child Psychological Abuse (DSM-5 V995.51) by the allied parent.

Do they consider these possibilities? No. Because they don't know anything about family systems therapy, attachment, personality disorders, complex trauma, child development, and the ICD-10 and DSM-5 diagnostic systems.

286 case supervision, peer consultation, and continuing education, particularly when complex issues

287 unexpectedly arise that are outside the psychologist's scope of expertise when conducting child custody

288 evaluations.

Dr. Childress Comment:

Or competencies may be acquired BEFORE beginning practice with attachment pathology, family systems conflicts, collapsing personality disorders surrounding a divorce, child development decisions, and the assessment of possible thought disorder pathology in the family.

Bowlby – Minuchin – Beck – van der Kolk – Tronick – DSM-5 & ICD-10 diagnostic systems, i.e., “the established scientific and professional knowledge of the discipline” Standard 2.04 Bases for Scientific and Professional Judgments

289 **Guideline 6. Psychologists conducting child custody evaluations ~~strive to~~^{cc} engage in culturally**

290 **competent practice.**

Dr. Childress Comment:

Cultural competence probably should have been Guideline 1.

In the absence of child abuse, parents have the right to parent according to their cultural values, their personal values, and their religious values, and psychologists do not intrude into that fundamental human right of parenting.

Children belong to and unite within themselves and their self-identity, two cultures, two family lineages, two family heritages, and both cultures, both heritages, from the mother and from the father, need to be fully respected by professional psychology.

The cultural orientation and background of the psychologist, will always – always – enter the assessment and recommendation process, it is impossible to avoid our own cultural orientation influencing our perceptions and world-view. All psychologists working with family conflict, particularly surrounding attachment pathology, should receive focused personal work on their cultural and family-of-origin issues relative to love and attachment bonding.

The counter-transference can be high when working with family conflict and attachment pathology (i.e., problems with love-and-bonding in the parent-child relationship). Unmet childhood (or spousal) needs of the evaluator can unconsciously influence perceptions and judgments, as can cultural comfort and discomfort with various parenting and interpersonal styles.

Cultural competence should probably be Guideline 1.

291 **Rationale.** Psychologists encounter unique issues and special considerations when evaluating persons of

292 diverse backgrounds. These issues often reflect such overlapping elements as gender, gender identity,

293 sexual orientation, culture, racial and ethnic minority status, socioeconomic status, ability status,

294 immigration status, religion and spirituality, language diversity, relative assimilation with the dominant

295 culture, and age (Howard & Renfrow, 2014).

Dr. Childress Comment:
A self-evident statement.

296 **Application.** Psychologists consider how culture, broadly defined, influences children and parents and
297 the evaluator’s own values and expectations (Gallardo, 2014). In particular, psychologists ~~strive to~~

Dr. Childress Comment:
A self-evident statement.

298 understand the challenges, strengths, and diverse issues that impact co-parenting, family dynamics, and
299 child adjustment, and that are based in frameworks different from an evaluator’s own background.

Dr. Childress Comment:
This seems a confusing and unfocused statement on cultural competence. Who was the member on the Working Group representing for Cultural psychology? Was the Cultural psychology Division of the APA consulted (Division 45 Society for the Psychological Study of Culture, Ethnicity and Race)? Why not, in two years of “work” (perhaps four years), why not consult with Division 45 on cultural aspects of child custody evaluations?

300 One approach to working with diverse individuals is to consider that a person’s identity is shaped by
301 multiple social and cultural contexts or viewed in biosociocultural contexts (APA, 2017a and Principle E;
302 APA, 2017b). Psychologists ~~aspire to~~^{cc} assess and understand how diversity issues impact the balance of

Dr. Childress Comment:
For Cultural Competence Guidelines, they simply cite the Multicultural Guidelines for the APA.
American Psychological Association (2017b). Multicultural guidelines: An ecological approach to context, identity, and intersectionality. <http://www.apa.org/about/policy/multicultural-guidelines.pdf>

303 status, power, and equality between the parents in multiethnic families and families with diverse
304 identities. In particular, when conducting examinations, interpreting data, and formulating opinions,
305 psychologists consider how the structure and functions of diverse families may differ from cultural
306 stereotypes, especially in areas such as attachment, parenting attitudes, child development, child and
307 partner abuse, family functioning, childrearing practices, gender role including caregiving roles, and

308 disability in children (Saini & Ma, 2012). Psychologists remain aware of their need to relate and work
309 effectively across cultures, bearing in mind that their own explicit and implicit biases could compromise
310 data collection, its interpretation, and the subsequent development of valid opinions and
311 recommendations (APA, 2017b).

Dr. Childress Comment:

“...their own explicit and implicit biases could compromise data collection, its interpretation, and the subsequent development of valid opinions and recommendations”

Wrong, the explicit and implicit biases from the cultural context of the evaluator WILL affect and influence the data collection, its interpretation, and their subsequent development of their opinions and recommendations. Whether or not they are “valid” opinions and recommendations is based on how much influence the evaluator’s explicit and implicit biases from their own cultural context (and personal history) influence their conduct of the assessment and their subsequent interpretation of the data collected.

We are all cultural beings, a product of our cultural surround and development. We cannot see the world except through our eyes shaped by our culture. Multi-cultural competence is more than understanding “them” – it’s understanding me – and the lens from which I view the world – and recognizing that I always see with my cultural biases.

The issue is to recognize them and address them. The “Working Group” should have invited the collaboration of a representative from Division 45 Society for the Psychological Study of Culture, Ethnicity and Race.

312 Cultural considerations may require changes in customary procedures, such as the use of interpreters
313 and test translations. Psychologists ^{cc are} ~~strive to be~~ aware of how these changes may affect the evaluation
314 data they collect.

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