

C. A. CHILDRESS, Psy.D.

LICENSED CLINICAL PSYCHOLOGIST, PSY 18857

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6/19/19

Dr. <psychologist's name>
<address>,
<address>

Dr. <psychologist's name>,

I am a clinical psychologist. I have been retained by <mother's name> and her attorney as a consultant in clinical psychology to assist them in developing a treatment plan for her family. As part of my consultation to Ms. <mother's name>, I was provided with a variety of reports and documentation surrounding the family conflict. Among the reports I reviewed was your report on the family dated <date>.

Upon reading your report I developed prominent professional concerns as a clinical psychologist regarding the quality of the report and its seeming deficits in meeting professional standards of practice. Pursuant to Standard 1.04 of the APA ethics code, I am contacting you informally through this letter to bring my professional concerns to your attention.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.

Audio Recording Transcript

I have redacted your report in an Appendix to this letter to better indicate the first level of my concern, the excessive use of direct quotes from the transcribed audio recording of the sessions. I redacted blue for direct quotes from the transcript of the audio recording and red for sentences you constructed (Appendix 1). As can be easily seen from the redacted version of your report, your entire History and Symptoms section of your report is merely a transcript of the audio recording without any professional-level interpretation or analysis of the information. This is substantially below professional standards of practice for a History and Symptoms section of a professional report.

The information in the History and Symptoms section of a report should lead to and support your findings, your diagnosis (identification of the problem), and your recommendations provided later in the report. If, however, as in this case, you have simply presented a transcript of the recorded sessions, then it becomes entirely unclear what information you relied on from these recorded transcripts since there are a variety of possible interpretations of the information. How you interpreted this information in making your findings, your diagnosis, and your recommendations is entirely unclear and your findings and recommendations are unsupported by the evidence.

An audio transcript of recorded sessions does not represent professional standard of practice for either collecting or reporting on History and Symptom information in a professional-level report. This leads me to have to prominent professional concerns that your assessment and report are in violation of Standard 9.01a of the APA ethics code.

Standard 9.01a: Foundations for Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings.

Audio recording sessions with the patient and then using solely the directly quoted transcript as the entirety of your History and Symptoms section for the report does not represent “information and techniques sufficient to substantiate” your findings. I have read the transcript of your sessions you reported, and based on the content you reported and my background professional knowledge as a clinical psychologist, I have reached entirely different conclusions about the family processes than you did. It is unclear from your report how you reached your conclusions and recommendations since they are unsupported by the actual data you report in the transcripts.

While you did use one actual test instrument, the MMPI, in my professional view as a clinical psychologist your use of the MMPI was perfunctory and unnecessary, culturally questionable with the family, and not warranted by the surrounding information. The inappropriate and unnecessary (perfunctory) use of a single assessment instrument does not alter the surrounding inadequate assessment techniques and reporting used in your assessment and report.

I do not believe your report for the <family name> family meets professional standards of practice consistent with requirements specified under Standard 9.01a of the APA ethics code. Of glaring note is the complete absence of application to the data set of any constructs or principles from professional psychology from the past 100 years of professional psychology, which would be in violation of Standard 2.04 of the APA ethics code.

Standard 2.04: Application of Scientific Knowledge

2.04 Bases for Scientific and Professional Judgments

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

I am appending a Checklist for Applied Knowledge that I used with your report. As is evident by the findings from this checklist, there is no discernible application of professional knowledge from the scientific research on attachment, on family systems therapy, on personality disorder pathology, on complex trauma, or on the neuro-development of the brain through the parent-child relationship. All of these domains would be relevant to the analysis of the family conflict in the <family name> family and its resolution.

Attachment: A child rejecting a parent is an attachment-related pathology. The attachment system is the brain system governing all aspects of love and bonding throughout the lifetime, including grief and loss. A child rejecting a parent is clearly a problem in the love-and-bonding system of the brain (the attachment system), yet you applied none of the “scientific and professional knowledge” regarding attachment bonding to your work.

The absence of applied knowledge from the scientifically established knowledge of attachment bonding in the parent-child relationship suggests that you may not have the professional training, education, and experience in attachment-related pathology needed to assess, diagnose, and treat attachment bonding problems in the parent-child relationship, which would then be a potential violation of Standard 2.01a of the APA ethics code.

Family Systems Therapy: Family systems therapy is one of the four primary schools of psychotherapy (along with psychoanalytic, humanistic-existential, and cognitive-behavioral) and it is the only school of psychotherapy to address the resolution of current family conflict. Of the four schools of psychotherapy, family systems therapy (Minuchin, Bowen, Haley, Madanes, Satir) would be the appropriate school of professional knowledge to apply in understanding and resolving family conflict. I have appended a description of the family processes of concern related to the < family name > family (the child’s *triangulation* into the spousal conflict through the formation of a *cross-generational coalition* with the allied parent against the targeted parent, resulting in an *emotional cutoff* in the child’s relationship to the targeted parent – Minuchin, Bowen, Haley, Madanes).

In your report, you applied none of the “scientific and professional knowledge” regarding family systems therapy to your work despite – despite – this being a family issue you were asked to assess. This is a deeply disturbing professional oversight suggesting that you may not know family systems therapy, which would then raise, along with the absence of applied knowledge regarding attachment bonding, additional concerns surrounding possible violation of Standard 2.01a of the APA ethics code regarding boundaries of competence. While you may have extensive knowledge in the procedures of conducting court-ordered assessments of family conflict (although tape recording sessions and simply offering the transcript of the recording as your History and Symptoms description is likely beneath professional standards of practice even in that area), you may not have the actual professional level knowledge of the *attachment system* and *family systems therapy* that is needed to conduct appropriate assessments and reach accurate conclusions regarding *attachment-related pathology* in the family.

Personality Disorder Pathology: The mother raised concerns regarding the father’s possible narcissistic personality traits. In my review of the transcript of your session (and from the surrounding family history I am aware of), I too am concerned about the father’s possible narcissistic traits. Of concern is that the eldest

son¹ may be the vehicle who is expressing toward his mother the father's attitudes toward his wife (the mother), leading the 12-year-old child to display the narcissistic traits of his father toward his mother; an attitude of *haughty* and *arrogant* contempt and disrespect for the mother, an attitude of *grandiose entitlement* that allows him to judge of the adequacy of the mother as a parent, an *absence of empathy*, the "*splitting*" pathology associated with both narcissistic and borderline personality pathology, and the father appears to be *exploiting* the son's conflict with the mother as a means of retaliation toward her for the spousal conflict and divorce and to obtain favorable standing in the subsequent custody visitation schedule. These symptoms represent six separate DSM-5 identified symptoms of narcissistic personality disorder displayed by a 12-year-old child.

It is unlikely (impossible) that narcissistic personality disorder is evidenced in a 12-year-old since, prior to the age of adulthood the complex childhood trauma that later creates the symptoms of pathological narcissism show up as insecure attachment symptoms rather than narcissistic personality symptoms (which only consolidate during late adolescence and early adulthood). Far-far more likely is that the father has these attitudes and beliefs toward the mother and is transferring these beliefs to the child by influencing the child's attitudes toward his mother. Yet in your report you dismissed the mother's concerns regarding the father's possible narcissistic personality characteristics as being unfounded, without providing an explanation for this conclusion. A conclusion which, in my opinion based on the child's symptom display, likely is in error. It is your obligation as a psychologist to lay a foundation for your diagnostic statements, and you failed to do that.

Complex Trauma: Attachment trauma in the parent's own childhood is passed on trans-generationally to the children through the distorted parenting practices created by the unresolved childhood trauma of the parent. It is therefore of deep professional concern that you evidenced no application of knowledge from complex trauma (van der Kolk, Courtois) to the data and symptom features for this family. Additionally, within family systems therapy Murray Bowen links the *emotional cutoff* in a family relationship (such as a breach in the parent-child bond) to unresolved multigenerational trauma in the parent that distorts and violates psychological boundaries.²

All indicators in the family data point toward unresolved childhood attachment trauma in the father creating problems in his processing of sadness, grief, and loss surrounding the divorce, leading to his *boundary violations* in the father-son relationship through the development of a *cross-generational coalition* with his son against the mother to divert his spousal anger through the child, which then creates

¹ The eldest son occupies a special family role of loyalty within traditional Chinese culture, which may be influencing the son's loyalty bonding to the father.

² Bowen, M. (1978). *Family Therapy in Clinical Practice*. New York: Jason Aronson.

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

the *emotional cutoff* of the child's relationship to his mother following the divorce. Yet you failed to apply any of this "established scientific and professional knowledge" in your analysis of the family data. This is of deep professional concern, and appears to represent a violation of Standard 2.04 of the APA ethics code. If your failure to apply the knowledge of professional psychology is due to your not knowing the knowledge of professional psychology, then this may also represent an additional violation of Standard 2.01a regarding professional competence.

Standard 2.01a: Boundaries of Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

The complete absence of applied knowledge from any domain of professional psychology (including attachment, family systems therapy, personality disorders, complex trauma, behavioral psychology, psychoanalytic constructs, and neuro-developmental constructs of breach-and-repair and the use of the child as a regulatory object) suggest that you may not know the scientific foundations of professional psychology, which would then represent a potential violation of Standard 2.01a of the APA ethics code regarding boundaries of competence.

In my professional judgement from applying the scientifically established knowledge of professional psychology in these domains, I am of the firm professional opinion that your conclusions about the family were in serious error and that your recommendations will be destructive and harmful for the family.

Standard 3.04a: Avoiding Harm

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

Your possible violation of Standard 3.04a on avoiding harm to the client is of further deep professional concern. Psychologists are not allowed to do things that harm their clients, and the mother is also one of your clients when assessing a family conflict. That your failure to apply the established knowledge of professional psychology to any aspect of your analysis may have led you to erroneous conclusions and harmful recommendations is of serious professional concern.

Of note is that Standard 3.04b makes clear that the "greater good" justification for causing harm is prohibited, and it seemingly becomes problematic how you justify the harm to the mother in your recommendations. You recommended she be entirely cut off from her son (consistent with the father's wishes) which would clearly cause the mother extensive emotional suffering and grief, which is causing harm to the mother. In addition, you also recommended limiting the 10-year-old daughter's contact with the mother (with

no justification provided) which will also cause the mother immense emotional suffering, grief, and loss.

This harm to the mother from your recommendations is foreseeable, and it is preventable by a treatment-oriented set of recommendations that restore family bonding throughout the family, treatment-oriented recommendations that become abundantly available when the scientifically established knowledge of professional psychology is applied (pursuant to Standards 2.04 and 2.01a of the APA ethics code). It appears that your potential violations of professional standards of practice for the application of professional knowledge (Standard 2.04) and possible practice outside the boundaries of your competence (Standard 2.01a) intersected with a professionally inadequate assessment (Standard 9.01a) to create recommendations that were of significant harm to the mother, and to the child, in furtherance of the father's desire to divert his spousal anger toward his wife through the child (i.e., the emotional abuse of the mother using the child as a weapon).

Intimate Partner Violence (IPV)

From my review of both your report and the surrounding family context, I have prominent professional concerns surrounding the father's Intimate Partner Violence (IPV) emotional abuse of his wife (ex-wife) using the child as the weapon. I am deeply concerned that you did not conduct a risk assessment with this family surrounding the differential diagnosis of IPV spousal abuse by the father toward the mother (emotional abuse of the spouse-and-mother using the child as the weapon). If this post-divorce family conflict of the eldest son with the mother represents the father's IPV use of the child as a weapon of spousal emotional abuse (diverting his spousal anger through the child; Minuchin, Haley, Madanes), then your recommendations actually collude with the IPV violence being enacted on the mother.

This is of serious professional concern. I am attaching descriptions of the established professional construct of parental psychological control of the child. That you did not conduct a risk assessment for a differential diagnosis of IPV spousal abuse by the father toward the mother using the child as a weapon is of severe professional concern.

Child Psychological Abuse

The DSM-5 diagnostic system includes a diagnosis of V995.51 Child Psychological Abuse (p. 719). In using the child as a weapon of IPV spousal abuse, the father appears to be creating significant developmental pathology in the child (complete suppression of attachment bonding toward his mother), prominent symptoms in the child of narcissistic personality pathology toward his mother (grandiosity, haughty arrogance, entitlement, absence of empathy, splitting), and a possible persecutory delusion surrounding the child's supposed "victimization" by the normal-range parenting of his mother.

Sufficient concerns exist in the data surrounding the severity of the child's symptoms and the possible IPV use of the child as a weapon of spousal emotional abuse by the father toward the mother, that a risk assessment of possible Child Psychological Abuse was seemingly warranted. Yet none was conducted, and your recommendations appear to collude with the father's potential psychological abuse of the child.

Of deep professional concern is that the father is using the child in a role-reversal relationship as a regulatory object to stabilize his own emotional and psychological collapse in response to the marital failure and divorce, leading to the creation of severe psychopathology in the child. In the scientific literature on attachment pathology, this is called pathogenic parenting (patho=pathology; genic=genesis, creation). Pathogenic parenting is the creation of significant psychopathology in the child through aberrant and distorted parenting practices. At the level evidenced for this family, the father's pathogenic parenting in using the child as a weapon in the IPV spousal emotional abuse of his (ex)-wife would potentially rise to the level of a DSM-5 diagnosis of V995.51 Child Psychological Abuse, in either the category of Suspected or Confirmed. Yet you conducted no risk assessment for the potential differential diagnosis of Child Psychological Abuse. This is of additional deep professional concern.

Duty to Protect

Psychologists have two legally obligating duties, the duty of care and the duty to protect. The duty to protect involves all high-risk pathology, such as suicide, homicide-dangerousness, elder abuse, spousal IPV abuse, and child abuse. When any of these factors are among the differential diagnostic possibilities, a risk assessment is warranted. You did not conduct a risk assessment for either IPV spousal abuse by the father toward the mother (emotional abuse of the (ex)-wife for the marital failure and divorce using the child as a weapon) and you did not conduct an assessment for possible child psychological abuse (pathogenic parenting creating severe pathology in the child). This is of substantial professional concern.



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

Report by Dr. <psychologist name> on <family name> Family

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Redacted Red: original sentences constructed by Dr. <psychologist name>

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EVALUATION PROCEDURES

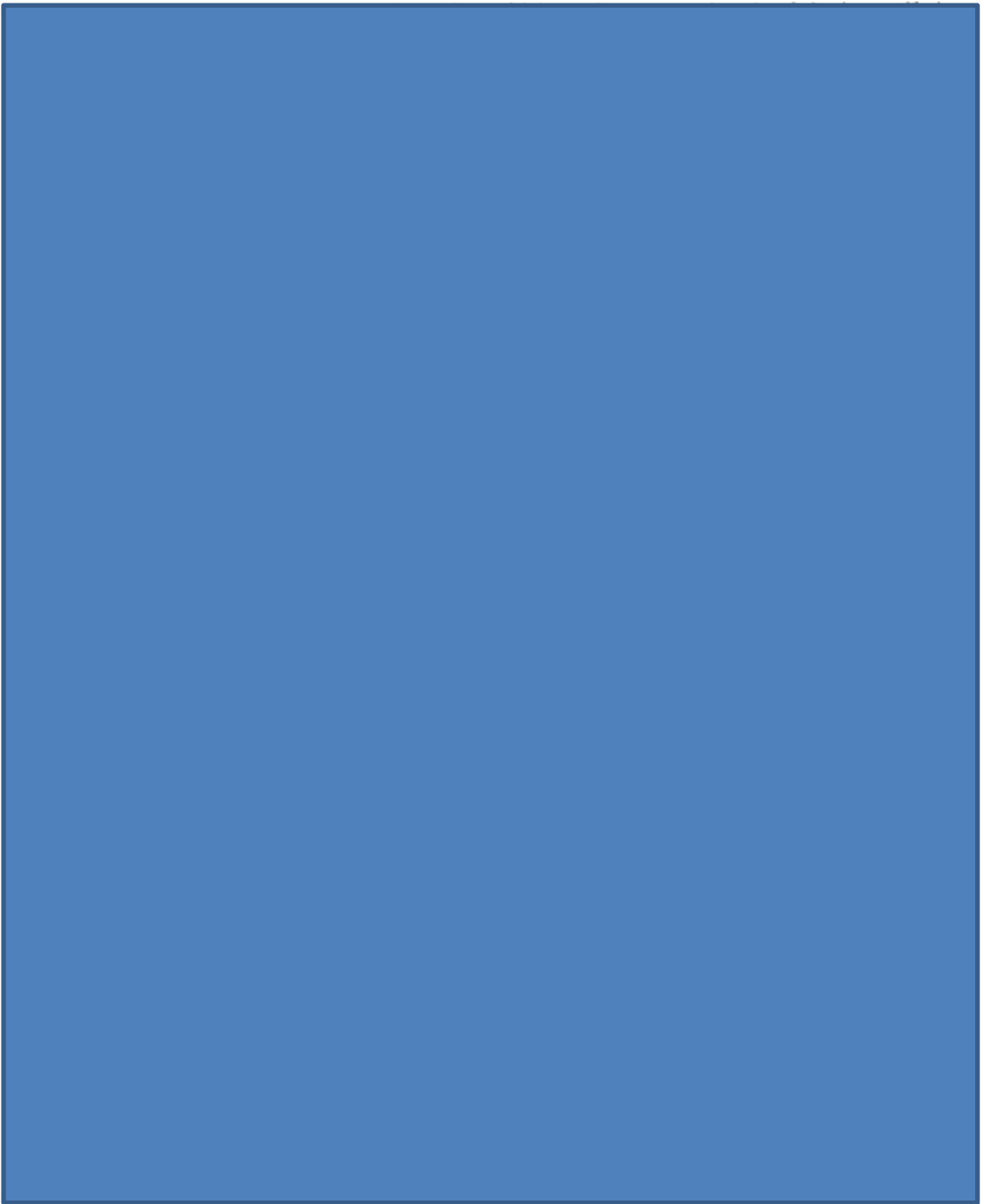
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Psychological Test Results

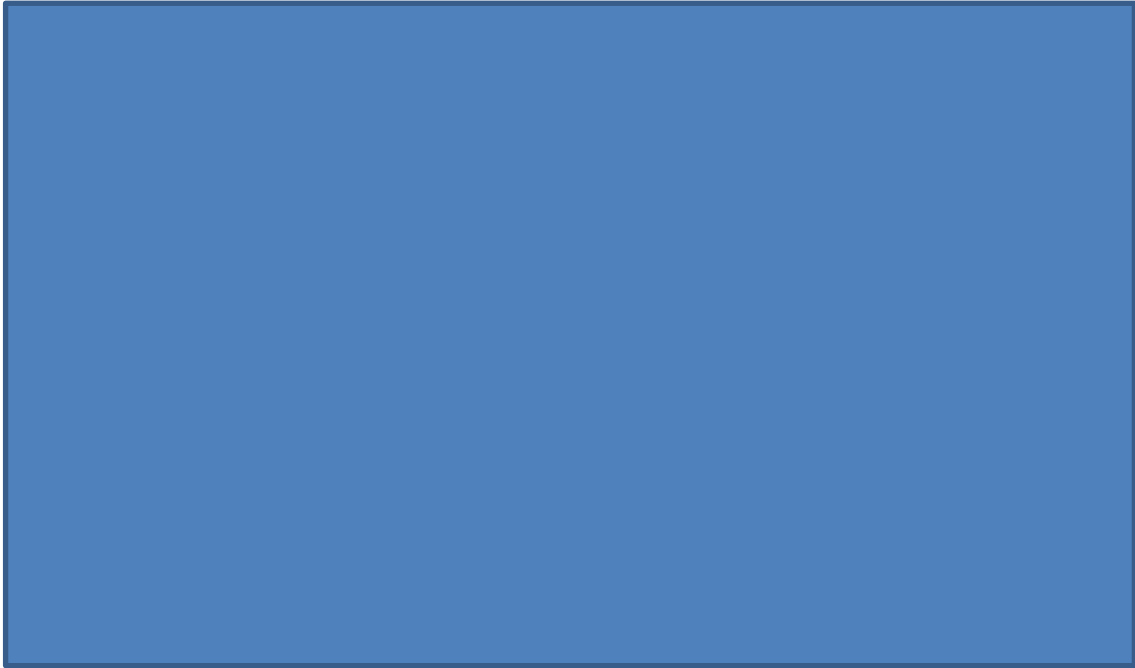
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OPINIONS



Respectfully submitted,



Clinical and Forensic Psychologist
Diplomate American Board of Assessment Psychology
Superior Court Psychiatric/Psychological Panels
(Criminal, Delinquency, Dependency & Competency)
Clinical Professor (Vol.) of Psychiatry & Biobehavioral Sciences
School of Medicine at
Institute for Neuroscience and Human Behavior

Checklist of Applied Knowledge

Checklist of Applied Knowledge in Clinical Psychology

Standards of Practice: Summary Page

Report Reviewed: <psychologist name>, Ph.D.

1. Constructs Used:		Rating
Family Systems Pathology:	No family systems constructs used	deficit
Attachment Pathology:	No attachment pathology constructs used	deficit
Trauma Pathology:	No trauma constructs used	deficit
Personality Pathology:	No personality pathology constructs used	deficit
Neuro-developmental	No neuro-developmental constructs used	deficit
2. Diagnostic Foundations:		
DSM-5 Diagnosis:	No DSM-5 diagnosis	deficit
Case Formulation Diagnosis:	No case formulation diagnosis	deficit
3. Treatment Plan:		
Articulated Treatment Plan:	No organized treatment plan described	deficit
Linked to DSM-5 Diagnosis:	No link of treatment plan to diagnosis	deficit
Linked to Case Formulation	No link of treatment plan to case formulation	deficit
Long-Term Goals	Partial long-term goals (custody)	deficit
Short-Term Goals:	No short-term goals	deficit
Interventions	No interventions to reach goals	deficit
Time-Frames	No time-frames for goal achievement	deficit

1. Family Systems Constructs in Analysis

	1	2	3	4
	No use	Inadequate	Adequate	Full
	No family systems constructs used in analysis	Some but inadequate or inaccurate use of family systems constructs	Some but not complete use of family systems constructs	A full analysis using family systems constructs is provided
<u>Constructs Used</u>			Yes	No
Triangulation			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cross-Generational Coalition			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Emotional Cutoff			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Differentiation of Self			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Multigenerational Transmission ...			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Inverted Hierarchy			<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Attachment Constructs in Analysis

	1	2	3	4
	No use	Inadequate	Adequate	Full
	No attachment related constructs used in analysis	Some but inadequate or inaccurate use of attachment constructs	Some but not complete use of attachment constructs	A full analysis using attachment constructs is provided
<u>Constructs Used</u>			Yes	No
Description of Attachment			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Insecure Attachment Patterns			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Emotional Dysregulation			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Breach-and-Repair Sequence			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Role-Reversal			<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Personality Pathology Constructs in Analysis

	1	2	3	4
	No use	Inadequate	Adequate	Full
	No personality pathology constructs used in analysis	Some but inadequate or inaccurate use of personality constructs	Some but not complete use of personality pathology constructs	A full analysis using personality pathology constructs is provided
<u>Constructs Used</u>			Yes	No
Splitting			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Absence of Empathy			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Emotional Dysregulation			<input type="checkbox"/>	<input checked="" type="checkbox"/>
False "Abuse" Allegations			<input type="checkbox"/>	<input checked="" type="checkbox"/>
Power, Control, & Domination			<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. Personality Pathology Constructs in Analysis

1	2	3	4
No use	Inadequate	Adequate	Full
No personality pathology constructs used in analysis	Some but inadequate or inaccurate use of personality constructs	Some but not complete use of personality pathology constructs	A full analysis using personality pathology constructs is provided
<u>Constructs Used</u>		Yes	No
Splitting		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Absence of Empathy		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Emotional Dysregulation		<input type="checkbox"/>	<input checked="" type="checkbox"/>
False "Abuse" Allegations		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Power, Control, & Domination		<input type="checkbox"/>	<input checked="" type="checkbox"/>

5. Trauma Constructs in Analysis

1	2	3	4
No use	Inadequate	Adequate	Full
No trauma constructs used in analysis	Some but inadequate or inaccurate use of trauma constructs	Some but not complete use of trauma constructs	A full analysis using trauma constructs is provided
<u>Constructs Used</u>		Yes	No
Persecutory Delusion		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Trauma Reenactment Pattern		<input type="checkbox"/>	<input checked="" type="checkbox"/>
PTSD Identified or Implied		<input type="checkbox"/>	<input checked="" type="checkbox"/>
PTSD Criterion 1 Identified		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Phobic Anxiety Identified		<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Neuro-Developmental

1	2	3	4
No use	Inadequate	Adequate	Full
No neuro-developmental constructs used in analysis	Some but inadequate or inaccurate use of neuro-developmental constructs	Moderate use of neuro-developmental constructs	A full analysis using neuro-developmental constructs is provided
<u>Constructs Used</u>		Yes	No
Intersubjectivity		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Co-Construction		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Use-Dependent Development		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Breach-and-Repair Sequence		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Age-Gender Neuro-Maturation		<input type="checkbox"/>	<input checked="" type="checkbox"/>

Standards of Professional Practice: Diagnosis

1. DSM-5 Diagnosis Provided: Yes No

Category of DSM-5 Diagnosis

- Trauma pathology
 - Disruptive/conduct pathology
 - Anxiety pathology
 - Depressive/bipolar pathology
 - Eating disorder pathology
 - Personality disorder pathology
 - Neurodevelopmental
 - Child abuse pathology
 - Spousal-partner abuse pathology
 - Other DSM-5 category
2. DSM-5 Symptoms Reported:
- Trauma pathology
 - Disruptive/conduct pathology
 - Anxiety pathology
 - Depressive/bipolar pathology
 - Eating disorder pathology
 - Personality disorder pathology
 - Neurodevelopmental
 - Child abuse pathology
 - Spousal-partner abuse pathology
 - Other DSM-5 category
3. Case Formulation Diagnosis
- Fully Articulated: A case formulation is clearly presented with a clearly identifiable theoretical orientation articulated.
 - Partially Articulated: A fractured case formulation is presented or clear theoretical foundations are not evident.
 - No Formulation: No organized case formulation is presented beyond symptom identification.
4. Case Formulation Orientation
- Cognitive-behavioral
 - Family systems
 - Humanistic-existential
 - Psychoanalytic (attachment-neurodevelopment)
 - Social Constructionism (cultural, gender, narrative, solution-focused)
 - Religious-spiritual
 - Motivational (recovery)
 - Other organized framework
 - No coherent orientation evident

Standards of Professional Practice: Treatment Plan

1. Articulated Treatment Plan

- Fully Elaborated:** A fully elaborated treatment plan is described that includes short-term, medium-term, and long-range goals that are responsive to the presenting problem and case formulation. The treatment plan identifies the specific steps and interventions used to achieve the treatment goals, with specified time-frame benchmarks for achievement of the treatment goal and its reevaluation. Anchored data procedures are identified for collection of treatment progress measures and treatment outcome assessments.
- Partially Described:** A treatment plan is partially described with many features of a full treatment plan (goals-interventions-outcome) or that is only partially linked to the presenting problem, DSM-5 diagnosis, and case formulation.
- Marginal Description:** The treatment plan is vague and lacks major components of a standard treatment plan, such as missing short and long-term goals, specific interventions to be used, time-frame benchmarks, and measurable outcomes.
- No Treatment Plan:** No coherent or organized treatment plan is described.

2. Treatment Plan Components

	Yes	Partial	No
Links: Linkage to presenting problems	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Linkage to DSM-5 diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Linkage to case conceptualization	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Goals: Long-term goals identified	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Consistent short-term goals identified	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Specific: Specific interventions described for each goal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Measures: Measurable outcomes described	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Time: Time-frame for achieving long-term goal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Time-frame for achieving short-term goal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Treatment Plan Orientation

- Cognitive-behavioral
- Family systems
- Humanistic-existential
- Psychoanalytic (attachment-neurodevelopment)
- Social Constructionism (cultural, gender, narrative, solution-focused)
- Religious-spiritual
- Motivational (recovery)
- Other organized framework
- No coherent orientation evident**

Family Systems Therapy

Constructs Directly Relevant to the <family name> Family

Family Systems Therapy

Family systems therapy is one of the four primary schools of psychotherapy:

Psychoanalytic Psychotherapy: Emerged from the work of Sigmund Freud developing insight into deep unconscious motivations. Individual focus to therapy.

Cognitive-Behavioral Therapy: Emerged from laboratory experiments with animals on the Learning Theory and behavior change principles of reward and punishment. Individual focus to therapy.

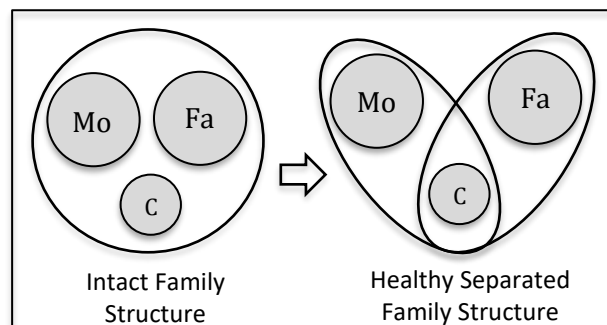
Humanistic-Existential Therapy: Emerged from philosophical roots of existentialism, personal growth, and self-actualization. Individual focus to therapy.

Family Systems Therapy: Describes the interpersonal processes of both healthy and pathological family relationships. Interpersonal focus.

Of the four primary schools of psychotherapy, only family systems therapy deals with resolving the current interpersonal relationships within families. All of the other models of psychotherapy are individually focused forms of therapy. Family systems therapy is therefore the appropriate conceptual framework for understanding and resolving family conflict and family pathology.

Divorce ends the marriage, but not the family. With divorce, the family structure shifts from an *intact family structure* that was previously united by the marriage, to a new *separated family structure* that is now united by the children, through the continuing co-parenting responsibilities and by the continuing bonds of shared affection between the children and both parents.

Families must adapt to various transitions over the developmental course of the family. A central tenet of family systems therapy is that when a family is unable to successfully adapt to a transition (such as a divorce and the transition to a new separated family structure), symptoms emerge within the family (often with the children) to stabilize the family's maladaptive functioning.

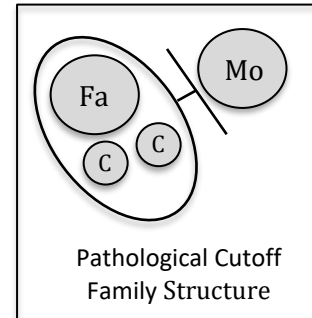


Divorce represents one of the most impactful transitions that any family must navigate; the transition from an intact family structure united by the marriage to a separated family structure united by the children. One of the principle founders of family systems therapy, Murray Bowen, refers to the symptom of one family member rejecting another family member as an “emotional cutoff.” (Bowen, 1978; Titelman, 2003).³

³ Bowen, M. (1978). *Family Therapy in Clinical Practice*. New York: Jason Aronson.

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

Within the principles of family systems therapy, a child's rejection of a parent following divorce represents the symptom of an "*emotional cutoff*" that is the product of the family's unsuccessful transition from its prior intact family structure united by the marriage to the new separated family structure following divorce, a separated family structure that is now united by the child's shared bonds of affection with both parents.



Within the standard and established principles of family systems therapy, the child's rejection of a normal-range parent surrounding divorce represents the child's "triangulation" into the spousal conflict through the formation of a "cross-generational coalition" of the child with the allied parent, that results in an "emotional cutoff" in the child's relationship with the targeted-rejected parent.

Cross-Generational Coalition

A cross-generational coalition is when an emotionally fragile parent creates an alliance with the child against the other spouse (and parent). This coalition between the parent and child provides additional power to the allied parent in the spousal relationship (two against one). However, a cross-generational coalition is also very damaging to the child, who is being used by one parent as a weapon against the other parent in the spousal conflict. In mild cases, the arguing and conflict between the child and targeted parent is high, but they maintain their relationship. In severe cases, the allied parent requires the child to terminate (cutoff) the child's relationship with the other parent out of "loyalty" to the allied parent in their coalition. When this occurs, the emotional and psychological damage to the child is severe.

Children are not weapons, and children should never be used as weapons by one parent against the other parent in their marital-spousal disputes.

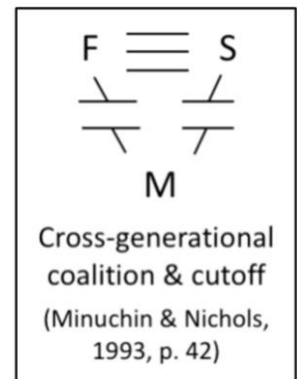
The renowned family systems therapy (co-founder of the *Strategic* school of family systems therapy), Jay Haley, provides the professional definition of a cross-generational coalition:

From Haley: "The people responding to each other in the triangle are not peers, but one of them is of a different generation from the other two... In the process of their interaction together, the person of one generation forms a coalition with the person of the other generation against his peer. By 'coalition' is meant a process of joint action which is *against* the third person... The coalition between the two persons is denied. That is, there is certain behavior which indicates a coalition which, when it is queried, will be denied as a coalition... In essence, the **perverse triangle** is one in which the separation of generations is breached in a covert way. When this occurs as a repetitive pattern, the system will be pathological. (Haley, 1977, p. 37)⁴

⁴ Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. Weakland (Eds.), *The interactional view* (pp. 31-48). New York: Norton.

Most mental health professionals consider Salvador Minuchin or Murray Bowen to be the preeminent family systems therapists. Salvador Minuchin (the founder of *Structural* family systems therapy) provides a *structural* family diagram for the pathology of concern, in his book with Michael Nichols, *Family Healing*.⁵ In this diagram, the triangular pattern to the family relationships is evident, with the child “*triangulated*” into the spousal conflict.

Also evident is a symptom feature called the “inverted hierarchy” in which the child becomes empowered by the coalition with the allied parent into an elevated position in the family hierarchy, from which the child is empowered to judge the parent (as if the parent were the child). In the diagram by Minuchin, this symptom feature of the *inverted heirarchy* is reflected in the child’s elevated position above the hierarchy line with the father, above the mother who is being “judged” by the child.



The *emotional cutoff* caused by the *cross-generation coalition* is reflected in the broken lines from the child to the mother, and from the father to the mother; but that spousal break is divorce. The break in the spousal line reflects the divorce, the break in the mother-son line represents the influence on the child by the allied parent; the cross-generational coalition.

The three lines between the father and son represent the violation of the child’s self-autonomy and psychological integrity (psychological boundary violations; called “enmeshment”). This is a very destructive psychological relationship for a child to have with a parent. It’s why Haley calls it the “perverse triangle.” Psychological boundaries and self-autonomy in a child should always be respected by the parent. Many times, the parent experienced this type of “boundary violation” in their own childhood relationships, and the current psychological violation of the child’s autonomy and psychological integrity represents the “trans-generational transmission” of the parent’s attachment trauma.

In her 2018 book, *Changing Relationships: Strategies for Therapists and Coaches*, the famed family therapist Cloe Manades provides a description of the cross-generational coalition at the start of Chapter 3 on Hierarchies.

From: Madanes, C. (2018). *Changing relationships: Strategies for therapists and coaches*. Phoenix, AZ: Zeig, Tucker, & Theisen, Inc.

Cross-Generational Coalition

In most organizations, families, and relationships, there is hierarchy: one person has more power and responsibility than another. Whenever there is hierarchy, there is the possibility of cross-generational coalitions. The husband and wife may argue over how the wife spends money. At a certain point, the wife might enlist the older son into a coalition against the husband. Mother and son may talk disparagingly about the father and to the father, and secretly plot

⁵ Minuchin, S. & Nichols, M.P. (1993). *Family healing: Strategies for hope and understanding*. New York: Touchstone.

about how to influence or deceive him. The wife's coalition with the son gives her power in relation to the husband and limits the husband's power over how she spends money. The wife now has an ally in her battle with her husband, and the husband now runs the risk of alienating his son. Such a cross-generational coalition can stabilize a marriage, but it creates a triangle that weakens the position of both husband and wife. Now the son has the source of power over both of them.

Cross-generational coalitions take different forms in different families (Madanes, 2009). The grandparent may side the grandchild against a parent. An aunt might side with the niece against her mother. A husband might join his mother against the wife. These alliances are most often covert and are rarely expressed verbally. They involve painful conflicts that can continue for years

Sometimes cross-generational coalitions are overt. A wife might confide her marital problems to her child and in this way antagonize the child against the father. Parents may criticize a grandparent and create a conflict in the child who loves both the grandparent and the parents. This child may feel conflicted as a result, suffering because his or her loyalties are divided.

Psychological Control

Constructs Directly Relevant to the <family name> Family

Psychological Control of the Child

The manipulative psychological control of the child by a parent is a scientifically established family relationship pattern in dysfunctional family systems. In his book regarding parental psychological control of children, *Intrusive Parenting: How Psychological Control Affects Children and Adolescents*,⁶ published by the American Psychological Association, Brian Barber and his colleague, Elizabeth Harmon, identify over 30 empirically validated scientific studies that have established the construct of parental psychological control of children. In Chapter 2 of *Intrusive Parenting: How Psychological Control Affects Children and Adolescents*, Barber and Harmon define the construct of parental psychological control of the child:

“Psychological control refers to parental behaviors that are intrusive and manipulative of children’s thoughts, feelings, and attachment to parents. These behaviors appear to be associated with disturbances in the psychoemotional boundaries between the child and parent, and hence with the development of an independent sense of self and identity.” (Barber & Harmon, 2002, p. 15)⁷

According to Stone, Bueler, and Barber:

“The central elements of psychological control are intrusion into the child’s psychological world and self-definition and parental attempts to manipulate the child’s thoughts and feelings through invoking guilt, shame, and anxiety. Psychological control is distinguished from behavioral control in that the parent attempts to control, through the use of criticism, dominance, and anxiety or guilt induction, the youth’s thoughts and feelings rather than the youth’s behavior.” (Stone, Buehler, & Barber, 2002, p. 57)⁸

Soenens and Vansteenkiste (2010) describe the various methods used to achieve parental psychological control of the child:

“Psychological control can be expressed through a variety of parental tactics, including (a) guilt-induction, which refers to the use of guilt inducing strategies to pressure children to comply with a parental request; (b) contingent love or love withdrawal, where parents make their attention, interest, care, and love contingent upon the children’s attainment of parental standards; (c) instilling anxiety, which refers to the induction of anxiety to make children comply with parental requests; and (d) invalidation of the child’s perspective, which pertains to parental

⁶ Barber, B. K. (Ed.) (2002). *Intrusive parenting: How psychological control affects children and adolescents*. Washington, DC: American Psychological Association.

⁷ Barber, B. K. and Harmon, E. L. (2002). *Violating the self: Parenting psychological control of children and adolescents*. In B. K. Barber (Ed.), *Intrusive parenting* (pp. 15-52). Washington, DC: American Psychological Association.

⁸ Stone, G., Buehler, C., & Barber, B. K.. (2002) *Interparental conflict, parental psychological control, and youth problem behaviors*. In B. K. Barber (Ed.), *Intrusive parenting: How psychological control affects children and adolescents*. Washington, DC: American Psychological Association.

constraining of the child's spontaneous expression of thoughts and feelings." (Soenens & Vansteenkiste, 2010, p. 75)⁹

Research by Stone, Buehler, and Barber establishes the link between parental psychological control of children and marital conflict:

"This study was conducted using two different samples of youth. The first sample consisted of youth living in Knox County, Tennessee. The second sample consisted of youth living in Ogden, Utah." (Stone, Buehler, & Barber, 2002, p. 62)

"The analyses reveal that variability in psychological control used by parents is not random but it is linked to interparental conflict, particularly covert conflict. Higher levels of covert conflict in the marital relationship heighten the likelihood that parents would use psychological control with their children." (Stone, Buehler, & Barber, 2002, p. 86)

Stone, Buehler, and Barber offer an explanation for their finding that intrusive parental psychological control of children is related to high inter-spousal conflict:

"The concept of triangles "describes the way any three people relate to each other and involve others in emotional issues between them" (Bowen, 1989, p. 306). In the anxiety-filled environment of conflict, a third person is triangulated, either temporarily or permanently, to ease the anxious feelings of the conflicting partners. By default, that third person is exposed to an anxiety-provoking and disturbing atmosphere. For example, a child might become the scapegoat or focus of attention, thereby transferring the tension from the marital dyad to the parent-child dyad. Unresolved tension in the marital relationship might spill over to the parent-child relationship through parents' use of psychological control as a way of securing and maintaining a strong emotional alliance and level of support from the child. As a consequence, the triangulated youth might feel pressured or obliged to listen to or agree with one parents' complaints against the other. The resulting enmeshment and cross-generational coalition would exemplify parents' use of psychological control to coerce and maintain a parent-youth emotional alliance against the other parent (Haley, 1976; Minuchin, 1974)." (Stone, Buehler, & Barber, 2002, p. 86-87)

⁹ Soenens, B., & Vansteenkiste, M. (2010). A theoretical upgrade of the concept of parental psychological control: Proposing new insights on the basis of self-determination theory. *Developmental Review*, 30, 74–99.