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3/15/25

To: APA Ethics Committee

Re: Notice of Ethical Violations Pursuant to Standard 1.05

I am a licensed clinical psychologist in Washington state, Oregon, and California, and pursuant to by obligations under Standard 1.05 of the APA ethics code I am registering formal notice with the APA Ethics Committee as a national committee on professional ethics when I believe there may have been an ethical violation by another psychologist that has caused substantial harm, and will continue to cause substantial harm, to their clients, and that is not appropriate for informal resolution or is not properly resolved in that fashion.

> **1.05 Reporting Ethical Violations**
> If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities.

The ethical concern is for a group of psychologists, and this notice is directed toward specific individuals within this group who appear to be in violation of Standard 2.04 Bases for Scientific and Professional Judgments and Standard 2.01 Boundaries of Competence. This notice of possible ethical violations is directed toward the instructors of a 4-day (8 Module) online training course provided through the Association of Family and Conciliation Courts (AFCC) entitled *Advanced Issues in Family Law: Parent-Child Contact Problems*. Based on my attendance at this course, I believe there may have been an ethical violation of Standard 2.04 Bases for Scientific and Professional Judgments and Standard 2.01 Boundaries of Competence of the APA ethics code by the following psychologists:

Robin Deutsch, Ph.D.

Leslie Drozd, Ph.D.

John A. Moran, Ph.D.

Marsha Kline Pruett, Ph.D.

Matthew Sullivan, Ph.D.

Peggy Ward, Ph.D

These psychologists are the instructors for the 4-day training available through the AFCC (recorded). Along with this formal notice made to the APA Ethics Committee, I have informally notified each of the above-named individuals with individual letters pursuant to my obligations under Standard 1.04, and I have notified the AFCC as an appropriate

institutional authority regarding the apparent ethical violations to Standard 2.04 Bases for Scientific and Professional Judgments and Standard 2.01 Boundaries of Competence. The template for this informal notification of all the instructors is provided in Appendix 1, and their response is provided in Appendix 2.

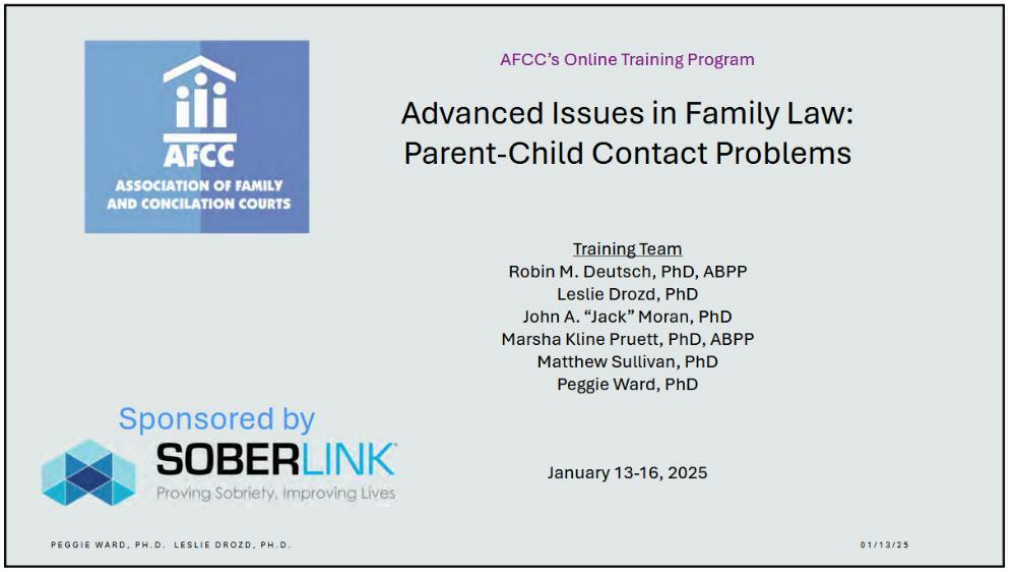
Based on the information provided in their 4-day training course, additional ethical concerns are present for possible violation of Standard 9.01 Bases for Assessment in their professional practice as a consequence of violations to Standards 2.04 and 2.01.

> **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. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

The violation in their broader professional practice of Standard 9.01 Bases for Assessment would represent a consequence of their violations to Standards 2.01 and 2.04.

Foundations of Concern for Ethical Violations

On 1/13/25, 1/14/25, 1/15/25, and 1/16/25, Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, and Dr. Ward collectively presented an 8-Module online training course through the AFCC entitled *Advanced Issues in Family Law: Parent-Child Contact Problems*. This course is recorded and available for review from the AFCC.



In preparing the foundations for my notice to the instructors and subsequently to the APA Ethics Committee, I completed a slide-by-slide Module Analysis for each of the eight Modules taught by the various instructors. These slide-by-slide Module Analyses are appended separately to this notice as Appendices 3-11. The slide-by-slide analyses of each Module generated a set of prominent concerns in various domains, which I then complied into a Catalogue of Concerns for the overall training course, and I am appending this Catalogue of Concerns separately to this notice as Appendix 12.

The Catalogue of Concerns

As I encountered a prominently concerning issue in my slide-by-slide analysis of each Module, I numbered the concern and provided a description of it. Then each additional time that concern arose in my review, I referrenced the Catalogue of Concern number rather than re-describing the concern at the next location. My clinical practice is in the family courts providing second-opinion review of forensic custody evaluations and I find this approach to note-taking in preparation for report writing to be the most efficent. When I'm asked by an attorney to review a forensic custody evaluation, I begin with a line-by-line review of the evaluation (my notes) similar to the slide-by-slide review of each Module that I conducted of the AFCC training course content for this notice to the APA Ethics Committee. These detailed line-by-line reviews then generate a Catalogue of Concern, and my line-by-line notes and the accompanying Catalogue of Concerns then serve as the bases for my opinions contained in my summary and analysis report. I adopted the same approach for this formal notice to the APA Ethics Committee pursuant to my obligations under Standard 1.05 Reporting Ethical Violations of the APA Ethics Code.

Standards 2.04 and 2.01

The foremost concerns for this notice to the APA Ethics Committee are for violations of Standard 2.04 Bases for Scientific and Professional Judgments (Concern 1), and violations of Standard 2.01 Boundaries of Competence in multiple domains (Concern 8).

All psychologists are required[1] by Standard 2.04 of the APA ethics code to rely on the "established scientific and professional knowledge of the discipline" as the bases for their professional judgments. The established scientific and professional knowledge of the discipline relevant to court-involved custody conflict includes the following:

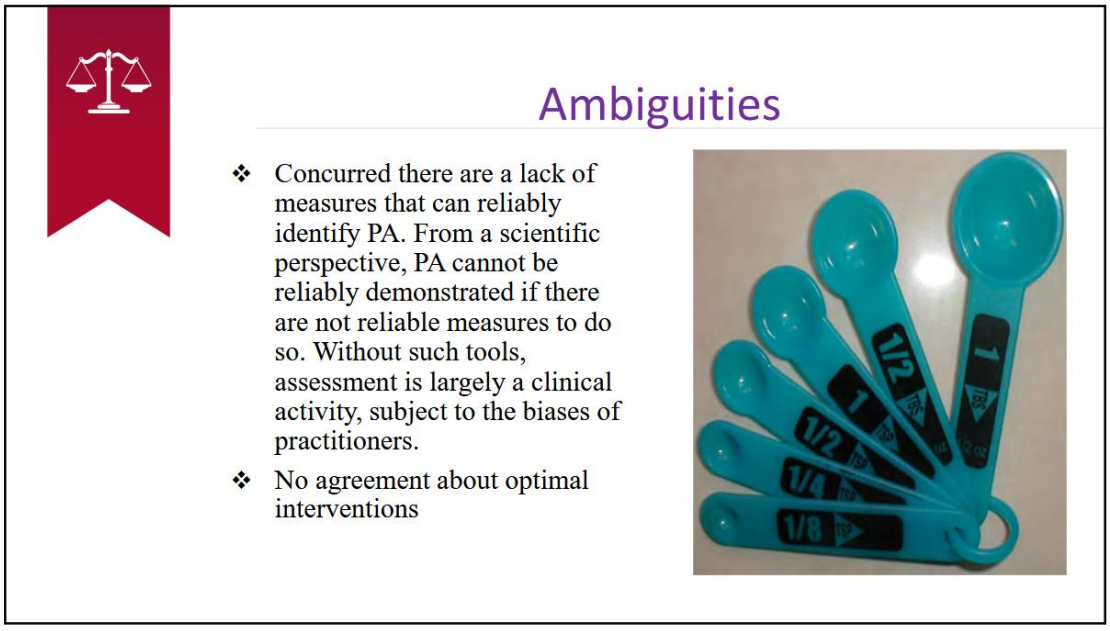
- DSM-5 diagnostic system – American Psychiatric Association
- Attachment – Bowlby, Tronick, & others
- Complex trauma – van der Kolk & others
- Family systems – Minuchin & others
- Personality Pathology – Millon, Linehan, & others
- Psychological control – Barber & others

There is no defined pathology in clinical psychology (and in general society) called "Parent-Child Contact Problems", "resist-refuse dynamic", or "parental alienation" and these made-up pathology labels are not within the scope of the established scientific and professional knowledge of the discipline required by Standard 2.04 for application as the

[11] I note that compliance with the APA ethics code is not optional and is mandatory for all psychologists, including my required obligations under Standards 1.04 and 1.05 when I believe there may have been an ethical violation by another psychologist.

bases for professional judgements. There is no pathology unique to the family courts that exists nowhere else in society, requiring its own unique set of symptom identifiers made up by self-proclaimed "experts" in a new form of pathology. If a pathology exists in the family courts, it exists in the broader society and is only being triggered by the circumstances of divorce (i.e., rejection and abandonment by a spousal attachment figure). If the instructors wish to propose new forms of pathology unique to the family courts that exist nowhere else in society, then they should do so only AFTER applying the established scientific and professional knowledge of the discipline (DSM-5, attachment, complex trauma, family systems, personality pathology, psychological control) in compliance with their required (mandatory) ethical obligations under Standard 2.04 of the APA ethics code.

In Module 4 the instructors note the absence of professional support for the made-up pathology label of "parental alienation" (PA) (Module 4: "From a scientific perspective, PA cannot be reliably demonstrated…").



When I provide second opinion review of forensic custody evaluations in the family courts, I will typically document compliance (and non-compliance) with Standard 2.04 using a *Checklist of Applied Knowledge* (Appendix 13) which provides a structured way to examine for the application of established knowledge from six relevant domains of professional psychology, 1) family systems, 2) attachment, 3) complex trauma, 4) personality disorder pathology, 5) child development, and 6) behavioral psychology using five anchoring constructs from each domain that would be relevant for application with family court pathology. The *Checklist of Applied Knowledge* also examines the two practice domains of diagnosis and the treatment plans. The *Checklist of Applied Knowledge* for the AFCC eight-Module course is provided as Appendix 13 to this notice.

Based on their presentation and course curriculum (Appendices 3-11), no domains of established professional knowledge were applied as the bases for their professional judgments.

- No constructs from family systems were relied on by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.

- No constructs from attachment pathology were evident in application by any instructor (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their professional judgments.

- No constructs from personality pathology were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and judgments.

- No constructs from complex trauma were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.

- No constructs from child development were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.

- No constructs from behavioral psychology were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.

- Diagnostic Formulation: the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) provided no diagnosis for the problem and did not rely on the established knowledge of the DSM-5 diagnostic system as the bases for the opinions and professional judgments.

- Treatment Plan: the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) provided no organized treatment plan or case conceptualization to fix the problem, indicating instead that the pathology is "complex".

  During the 4-day training course, the following pattern of reference citations emerged:

  - Instructor self-citation – 29 references to writings by the instructors

  - DSM-5 – 0

  - Bowlby – 0

  - Tronick – 0

  - Minuchin – 0

  - Bowen – 0

  - Van der Kolk – 0

- Millon – 0
- Linehan - 0

This curriculum content for a 4-day, eight-Module, training course in "Advanced" issues simply represents the instructors' self-promotion of personal beliefs about the pathology in the family courts using made-up pathology labels of their own devising that lack scientific and research support for their use as the foundations for professional judgments.

Given the lack of applied knowledge from any relevant domain of professional psychology, and prominent clinical concerns with the curriculum taught, professional concerns arise that the instructors are not competent in the necessary domains of professional knowledge in multiple domains based on their education, training, and experience, in violation of Standard 2.01 Boundaries of Competence (Concern 8). Based on a review of the course curriculum (Appendices 3-11), the following concerns are present:[2]

Delusional Thought Disorders: are the instructors competent in the diagnostic assessment of persecutory thought disorders based on their education, training, and experience when the differential diagnosis of concern is a possible persecutory delusion (shared/induced)? ☐ yes ☐ no

- Where and how did the instructors acquire their competence in the diagnostic assessment of persecutory thought disorders?

Factitious Disorder Imposed on Another: are the instructors competent in the diagnostic assessment of factitious disorders imposed on the child (for secondary gain to the narcissistic-borderline-dark personality parent) when the differential diagnosis of concern is a possible factitious attachment pathology imposed on the child by the pathogenic parenting of the allied parent? ☐ yes ☐ no

- Where and how did the instructors acquire their competence in the diagnostic assessment of factious disorders imposed on children?

Attachment Pathology: are the instructors competent in the diagnostic assessment of attachment pathology in children based on their education, training, and experience when the pathology involved a child rejecting a parent, i.e., an attachment pathology? ☐ yes ☐ no

- Where and how did the instructors acquire their competence in the

[2] Note: I am competent in all these domains based on my education, training, and experience supported by my vita (available on request).

diagnostic assessment of attachment pathology in children?

Family Systems: are the instructors competent in the diagnostic assessment of family systems pathology based on their education, training, and experience when the pathology involved a family conflict? ☐ yes ☐ no

- Where and how did the instructors acquire their competence in the diagnostic assessment of family systems pathology?

Personality Pathology: are the instructors competent in the diagnostic assessment of narcissistic-borderline-dark personality pathology based on their education, training, and experience when the pathology potentially involves narcissistic, borderline, and dark personality pathology in a parent? ☐ yes ☐ no

- Where and how did the instructors acquire their competence in the diagnostic assessment of personality disorder pathology?

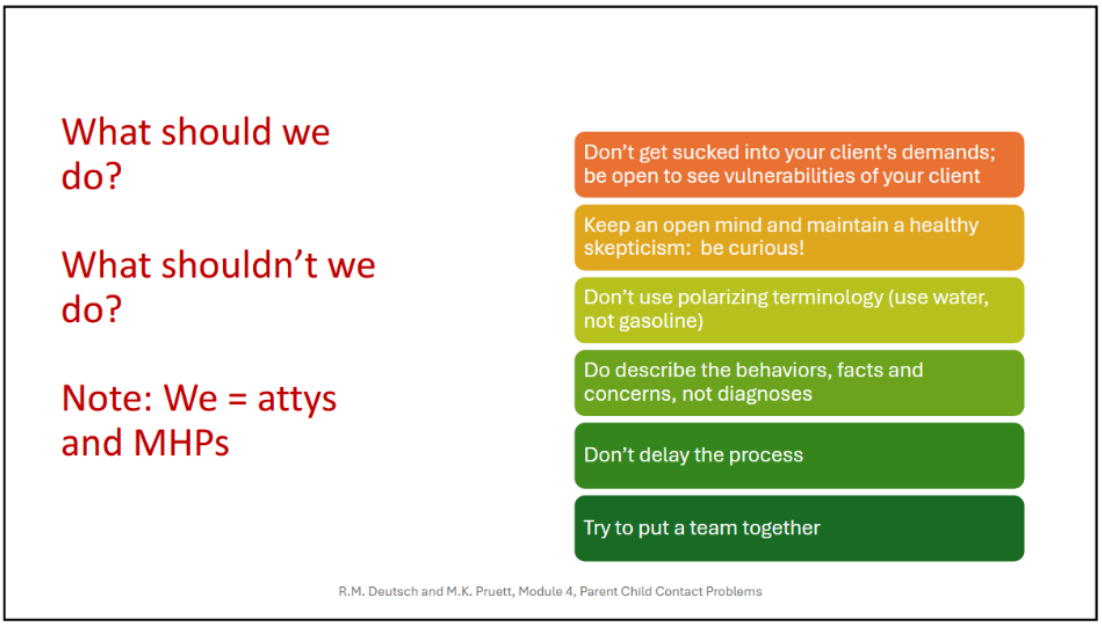
Note: if the instructors need to be educated about the nature of the pathology they are assessing, diagnosing, and treating, then they are not competent with that pathology by their demonstrated need to be educated about it (see also Standard 2.03 Maintaining Competence). The patient should never need to explain the pathology to the doctor, yet prominent professional concerns exist that the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) need to be educated about the pathology they are assessing, (mis)diagnosing, and (mis)treating.

Failure to Apply the DSM-5 as the Bases for Professional Judgments

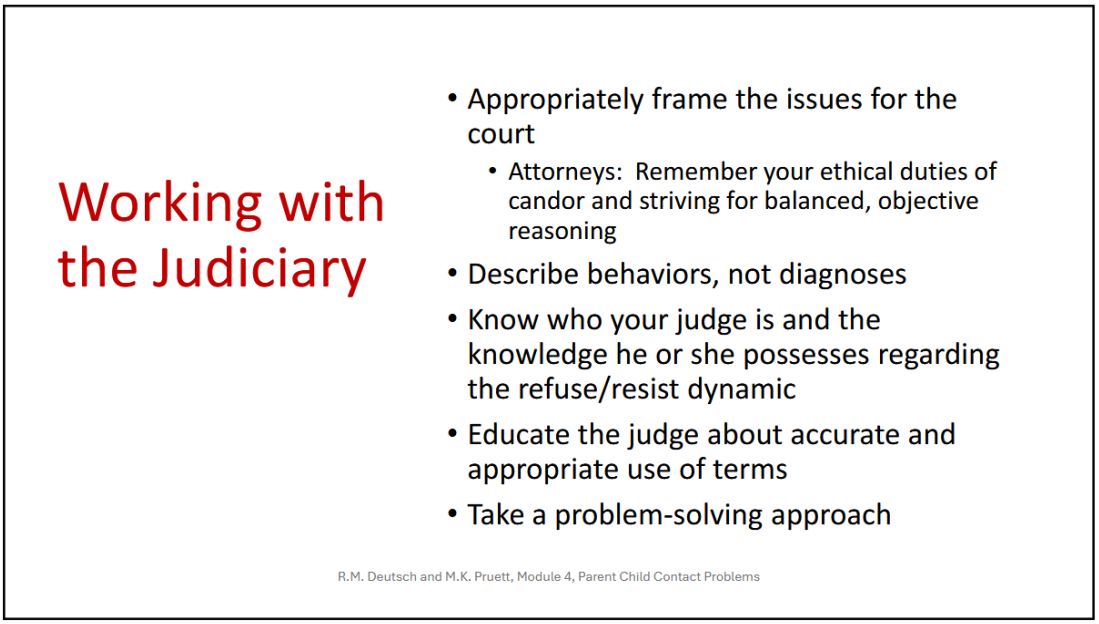
Not only did the instructors fail to apply the DSM-5 diagnostic system (i.e., the established scientific and professional knowledge of the discipline) as the bases for their professional judgments (and instruction), in apparent violation of Standard 2.04 of the APA ethics code, they actually instruct the trainees NOT to apply the DSM-5 diagnostic system as the bases for their diagnostic and professional judgments (Module 4: "Do describe the behaviors, facts, and concerns, not diagnosis" – "Describe behaviors not diagnosis").

Instead, they instruct their trainees to withhold relevant diagnostic information from both the court and from the litigants, thereby hiding the nature of the pathology from the court's understanding, and preventing one litigant (the targeted parent) from fully and properly advocating with the court for a child protection response because the formal DSM-5 diagnosis (i.e., 297.2 Delusional Disorder persecutory type; 300.19 Factitious Disorder Imposed on the Child, V995.51 Child Psychological Abuse, V995.82 Spouse or Partner Abuse, Psychological) has been withheld from the parent-litigants. This intentional withholding of formal diagnostic information from the court's awareness and from the parent-litigants biases the court's decisions in favor of the pathological parent, to the detriment (harm; Standard 3.04 Avoiding Harm) of the targeted parent.

From Module 4:



From Module 4:



Additional Professional Concerns (Concerns 14, 13, 22)

Additional prominent concerns arose from the course curriculum taught by the instructors for possible cultural bias (Concern 14), for bias involving self-promotion of personal interests (Concern 13), and for financial exploitation of a vulnerable population

(Concern 22), with support for these concerns provided in Appendices 3-11 at the locations where these Concerns (14, 13, 22) are cited.

Misdiagnosis of Persecutory Delusion (Concern 20)

Violations to ethical Standards 2.01 Boundaries of Competence and 2.04 Bases for Scientific and Professional Judgments substantially increase the risks for misdiagnosis of the pathology present in the family. Based on the course curriculum presented by the instructors (Appendices 3-11), multiple prominent clinical concerns are present surrounding potential misdiagnosis.

Because the instructors do <u>not</u> rely on the established scientific and professional knowledge of the DSM-5 diagnostic system as the bases for their professional judgments, they seemingly misdiagnose the pathology they are assessing, diagnosing, and treating (Concern 20). The clinical pathology of concern in the family courts includes a possible persecutory thought disorder (DSM-5 297.1), a false (factitious) attachment pathology imposed on the child for secondary gain to the pathological parent (DSM-5 300.19), possible psychological abuse of the child by a pathological (narcissistic-borderline-dark personality) parent (DSM-5 V995.51), and spousal abuse of the targeted parent by the allied parent using the child as the spousal abuse weapon (DSM-5 V995.82).

The persecutory delusion found in the family courts is described by Walters & Friedlander (2016) in the journal *Family Court Review*,

> **From Walters & Friedlander:** "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated delusion about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated delusion is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426)[3]

> **From Walters & Friedlander:** "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed delusion often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated delusion and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426)

The diagnostic assessment for a delusional thought disorder is a Mental Status Exam of Thought and Perception as described by Martin (1990),[4]

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[3] Walters, M. G., & Friedlander, S. (2016). When a child rejects a parent: Working with the intractable resist/refuse dynamic. *Family Court Review, 54*(3), 424–445

[4] Martin DC. The Mental Status Examination. In: Walker HK, Hall WD, Hurst JW, editors. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Boston: Butterworths; 1990. Chapter 207. Available from: https://www.ncbi.nlm.nih.gov/books/NBK320/

> **From Martin:** "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"
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> **From Martin:** "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

Where and how did the instructors acquire the "considerable experience" required to conduct a Mental Status Exam of thought and perception?

Misdiagnosis of Attachment Pathology (Concern 10)

Because the instructors failed to rely on the established scientific and professional knowledge of attachment when assessing, diagnosing, and treating attachment pathology (Concern 10), a violation of Standard 2.04, they are highly likely to misdiagnose the cause of the child's attachment pathology which they are undertaking to assess, diagnose, and treat. Typically, professional competence in attachment pathology is obtained from an Early Childhood Mental Health specialization (ages 0-to-5).[5] It is unclear from their vitae where the instructors obtained their education, training, and experience in the diagnostic assessment and treatment of attachment pathology in children when they are assessing, diagnosing, and treating an attachment pathology in children (a violation of Standard 2.01).

Failure in Duty to Protect (Concern 6)

Despite multiple statements made by the instructors in the course curriculum regarding "safety" issues, the instructors never described professional duty to protect obligations (Concern 6) surrounding the multiple potential abuse considerations present (Concern 3). Of elevated clinical concern is that the instructors never considered or addressed in their course content the potential psychological abuse of the child by the allied narcissistic-borderline-dark personality parent, or the potential spousal psychological abuse of the targeted parent by the allied parent using the child as the spousal abuse weapon.

- **Spousal Psychological Abuse:** that the instructors failed to even consider or discuss the possible spousal abuse of the targeted parent by the allied parent using the child as the spousal abuse weapon (DSM-5 V995.81 Spouse or Partner Abuse, Psychological) is highly concerning regarding their duty to protect obligations.

[5] Note: I have Early Childhood Mental Health specialty based on my education, training, and professional experience.

An additional professional concern regarding the course content provided by the instructors and professional duty to protect obligations is that they failed to discuss mandated reporting requirements for the suspicion of possible child physical, sexual, and neglect abuse, and instead seemed to suggest to their trainees that these trainees should conduct their own assessments for possible abuse, and that the trainees could independently discount the allegations of abuse based on their own judgment if the trainee does not believe the abuse occurred based on the trainee's undefined and potentially problematic assessment (Module 7).

Participation in Child Abuse & Spousal Abuse (Concern 11)

A shared persecutory delusion and FDIA are distinctly unlike other individual child pathologies such as ADHD or autism because of a social extension of the pathology into others (i.e., it is a shared disorder). A prominent professional danger surrounding misdiagnosing a shared persecutory delusion is that if the psychologist believes the shared delusion as if it was true, then the psychologist becomes part of the shared delusion, they become part of the pathology. When that pathology is the psychological abuse of the child by a pathological parent, the psychologist becomes part of the child abuse. When that pathology is also the spousal abuse of the targeted parent by the allied parent using the child as the spousal abuse weapon, the psychologist then also becomes part of the spousal abuse because of their misdiagnosis (Concern 11).

Forensic Custody Evaluations – An Experiment on Human Subjects

The instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) are part of a subspeciality practice called forensic custody evaluators that developed in the 1980s as an experiment in a new "quasi-judicial" role for psychologists in the family courts of advising the courts on child custody schedules. In support of their experimental new quasi-judicial role, this group of psychologists then developed an experimental assessment procedure called a forensic custody evaluation for their new experimental quasi-judicial role they created for doctors (themselves) in the family courts.

Their experiment on children and parents in the family courts of a quasi-judicial role for doctors, and their experimental forensic custody evaluation they developed for this experimental role represents an unregulated experiment on human subjects, in violation of principles contained in the Belmont Report.[6]. Of prominent concern is that these forensic psychologists did not inform the parents or the courts that forensic custody evaluations and a quasi-judicial role for doctors of advising the court on custody schedules represents an experimental procedure (violating the 'informed' part of informed consent for experiments on human subjects, i.e., the children and parents in the family courts). Prominent concerns also arise because the forensic psychologists in the family courts did not provide parents and the courts with an alternative to their experimental approach of

[6] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979). *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. U.S. Department of Health and Human Services

standard community care as usual of a clinical diagnostic assessment of the child's pathology and family conflict, and instead offered parents and the courts ONLY their experimental forensic custody evaluation approach to their own financial gain, and to the substantial harm of parents and children who were denied an accurate diagnosis and effective treatment for the child and family pathology.[7]

This unregulated experiment on human subjects (on the children and parents in the family courts) in a new quasi-judicial role for doctors has been a complete failure, and as a result the lives of thousands of children and their parents have been irrevocably destroyed. A recent independent review of the practice of forensic custody evaluations by the New York Blue-Ribbon Commission on Forensic Custody Evaluations (2021) [8] found that forensic custody evaluations are "dangerous" and "harmful to children," that they "lack scientific or legal value," that their "defective reports" can lead to "potentially disastrous consequences for parents and children," that "the practice is beyond reform", and that forensic custody evaluations should be entirely eliminated from the family courts.

> **From NY Blue Ribbon Commission:** "Ultimately, the Commission members agree that some New York judges order forensic evaluations too frequently and often place undue reliance upon them. Judges order forensic evaluations to provide relevant information regarding the "best interest of the child(ren)," and some go far beyond an assessment of whether either party has a mental health condition that has affected their parental behavior. In their analysis, evaluators may rely on principles and methodologies of dubious validity. In some custody cases, because of lack of evidence or the inability of parties to pay for expensive challenges of an evaluation, defective reports can thus escape meaningful scrutiny and are often accepted by the court, with potentially disastrous consequences for the parents and children… As it currently exists, the process is fraught with bias, inequity, and a statewide lack of standards, and allows for discrimination and violations of due process." (NY Blue-Ribbon Commission on Forensic Custody Evaluations, 2021)
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> **From NY Blue Ribbon Commission:** "By an 11-9 margin, a majority of Commission members favor elimination of forensic custody evaluations entirely, arguing that these reports are biased and harmful to children and lack scientific or legal value. At

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[7] See Standard 3.04 Avoiding Harm.

[8] The Report of the New York Blue-Ribbon Commission on Forensic Custody Evaluations:

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjqoIfZ8ZmBAxUnAjQIHf-TDlUQFnoECBoQAQ&url=https%3A%2F%2Fopdv.ny.gov%2Fblue-ribbon-commission-forensic-custody-evaluations&usg=AOvVaw1Y_JEEyH4zlHjdm9i-xw9t&opi=89978449

A Discussion of the NY Blue-Ribbon Commission Report on Forensic Custody Evaluations is provided by two of the Commissioners available on YouTube:

https://empirejustice.org/training_post/a-discussion-of-the-governors-blue-ribbon-commission-report-on-forensic-cuhstody-evaluations/

worst, evaluations can be dangerous, particularly in situations of domestic violence or child abuse – there have been several cases of children in New York who were murdered by a parent who received custody following an evaluation. These members reached the conclusion that the practice is beyond reform and that no amount of training for courts, forensic evaluators and/or other court personnel will successfully fix the bias, inequity and conflict of interest issues that exist within the system." (NY Blue-Ribbon Commission on Forensic Custody Evaluations, 2021)

In two editions of their book on conducting forensic custody evaluations, *Forensic Psychology Consultation in Child Custody Litigation: A Handbook for Work Product Review, Case Preparation, and Expert Testimony* (Stahl & Simon 2013, 1st ed; Simon & Stahl, 2020, 2nd Ed.),[9], Drs. Stahl and Simon describe the development of this experimental role and assessment procedure of forensic custody evaluations (Stahl and Simon, 2013/2020).

> **From Stahl & Simon 2013:** "As a formal and organized field, forensic psychology has entered its adolescence, but it is far from mature… It was not until 1994 that the APA recognized the importance of formalizing guidelines for child custody evaluations when it published its first set of such guidelines, and it was not until 2010, 16 years later, that these guidelines were revised… These facts serve to illustrate the reality that as an organized field, and as an organized systematic approach to behavioral science, forensic psychology remains in its formative years." (p. 17-18)

> **From Simon & Stahl 2020:** "As a formal and organized field, forensic psychology has entered its adolescence, but it is far from mature… Not until 1994 did the American Psychological Association recognize the importance of formalizing guidelines for child custody evaluations by publishing its first set of child custody evaluation guidelines… This illustrates the reality that as an organized field and as an organized, systematic approach to behavioral science, forensic psychology remains in its formative years." (p. 17)

In the 30+ years of this experiment conducted on children and parents in the family courts, the experimental procedures they rely on still remain in a "formative" phase of development, with no apparent progress for the past ten years. Stahl and Simon (2013/2020) also describe the difference between their experimental custody-focused approach and a standard healthcare approach of diagnosis and treatment provided by clinical psychology,

> **Stahl & Simon 2013:** "Clinical thinking and the clinical mindset are no longer thought to be an appropriate approach to forensic psychological work… We are

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[9] 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

Simon, R.A., & Stahl, P.M. (2020). *Forensic Psychology Consultation in Child Custody Litigation: A Handbook for Work Product Review, Case Preparation, and Expert Testimony* (2nd edition). American Bar Association.

providing a detailed discussion of the differences between forensic and clinical psychology, between the role of the forensic professional and the clinical professional and between forensic thinking and inference making versus clinical thinking and inference making. We strongly disagree with the clinical approach and the purpose of this chapter is to lay out a comprehensive argument in rationale for the use of a scientifically based, empirically driven, and legally informed forensic approach to child custody work." (p. 18)

Stahl & Simon 2013: "FMHP [forensic mental health professional] are not there to help those whom they evaluate" (p. 19)

Simon & Stahl 2020: "When the court appoints a mental health professional to conduct a child custody evaluation and offer advisory recommendations to the court regarding the psychological best interests of the children, the evaluator is in reality, an agent of the state." (p. 18).

Simon & Stahl 2020: "The forensic role is a non-helper role. The evaluating FMHP [forensic mental health professional] is not involved in services that have as a goal the alleviation of suffering or discomfort." (p. 26)

The AFCC Parenting Plan Evaluation Guidelines also describe the difference between the experimental approach of forensic custody evaluation and the standard healthcare approach of clinical psychology (diagnosis and treatment).

From AFCC Parenting Plan Evaluation Guidelines: "Parenting plan evaluations are forensic evaluations for use in developing court orders rather than clinical evaluations. Forensic evaluations involve the application of knowledge and skills from the mental health professions to the resolution of legal matters, whereas clinical evaluations aid in the diagnosis of psychological disorders for mental health treatment. In some jurisdictions, parenting plan evaluations may be mistakenly referred to as a "clinical" evaluation in orders of appointment. This is problematic because, unlike clinical evaluations, forensic evaluations are performed for the express purpose of assisting the parties and courts in reaching legal determinations that affect the rights and liberties of individuals." (AFCC, 2023).[10]

A quasi-judicial role for doctors in custody disputes (i.e., "the application of knowledge and skills from the mental health professions to the resolution of legal matters") is an experimental role for doctors. The assessment procedure they developed for this role of forensic custody evaluations ("parenting plan evaluations") are an experimental procedure they made-up for their experimental quasi-judicial role. Their role and their

[10] AFCC 2022 Guidelines for Parenting Plan Evaluations in Family Law Cases (2023) *Family Court Review*.

https://www.afccnet.org/Portals/0/PDF/Guidelines%20for%20Parenting%20Plan%20Evaluations%20in%20Family%20Law12.pdf?ver=1vnuLMpX0R28H7TzRwPr5g%3D%3D

assessment procedure are an experiment on human subjects, the children and parents in the family courts, without proper oversight.

From my personal experience of providing second-opinion reviews of forensic custody evaluations for the family courts (i.e., "meaningful scrutiny"), I am in 100% agreement with the findings of the NY Blue Ribbon Commission on Forensic Custody Evaluations. Forensic custody evaluations are biased and entirely without scientific or legal value, they cause substantial harm to parents and children in the family courts, and the experimental practice of forensic custody evaluations and a quasi-judicial role for doctors of advising the Court on child custody schedules should be entirely eliminated from the family courts. Courts decide on custody schedules. Doctors diagnose and treat pathology. The experiment in a quasi-judicial role for doctors was, and remains, a complete failure, to the substantial harm of the children and parents in the family courts.

Conflict of Interest

There is currently a conflict of interest within the forensic psychologists. If their experimental quasi-judicial role for doctors with its experimental assessment approach of a forensic custody evaluation (rather than standard healthcare of diagnosis and treatment) is acknowledged as a failure and eliminated entirely from the family courts for being dangerous and harmful to children and lacking in scientific or legal validity, then the current forensic psychologists in positions of authority and influence (such as the instructors for the AFCC course) will need to leave the courts along with their experimental role. There now exists a strong motivation within forensic custody evaluators to cover-up their failed experiment and the substantial harm that has been caused to parents and children as a result.

Parents in the family courts are currently unable to obtain a clinical diagnostic assessment of their family to the differential diagnoses of clinical concern. Yet once professional psychology begins providing diagnostic assessments of the family conflict that identify child psychological abuse (DSM-5 V995.51), i.e., a shared (induced) persecutory delusion and false (factitious) attachment pathology imposed on the child for secondary gain to a narcissistic-borderline-dark personality parent, then this acknowledges that they failed in their duty to protect obligations this entire time. There will be a similar motivation within the forensic psychologists in positions of authority and influence (such as the instructors for the AFCC course) to now cover-up the child abuse in the family courts to hide their prior failure in their duty to protect children from child abuse (DSM-5 V995.51 Child Psychological Abuse) and their parents from spousal abuse using the child as the spousal abuse weapon (DSM-5 V995.82 Spouse or Partner Abuse, Psychological).

Furthermore, once training is initiated in the domains of knowledge required for competence with court-involved attachment pathology and custody conflict (i.e., the diagnostic assessment and treatment of attachment pathology, the diagnostic assessmeten of delusional thought disorders, the diagnostic assessment of factitious disorders imposed on the child, the diagnostic assessment and treatment of narcissistic-borderline-dark personality pathology in a parent, the diagnosis and treatment of child psychological abuse and complex trauma, the diagnostic assessment and treatment of family systems pathology),

this will represent acknowledgement that the forensic psychologists previously were practicing beyond the boundaries of their competence, in violation of Standard 2.01 of the APA ethics code. The patient should NEVER need to educate the doctor about the pathology, the doctor should already know. If the doctor needs to be educated about pathology, then that doctor is not competent with that pathology by their demonstrated need to be educated.

Patients are currently educating the forensic psychologists about the pathology in the family courts. Of note is that I am in a position of educating the instructor forensic psychologists (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) for a supposedly "Advanced" course that merely promoted made-up pathology labels ("parental alienation" – "resist-refuse dynamic" – "Parent-Child Contact Problems") they propose exists ONLY in the family courts and nowhere else in society, requiring its own unique pathology label and diagnostic symptoms developed by self-proclaimed "experts" in these new forms of pathology that are proposed to be uniquely occurring in the family courts.

Of prominent concern regarding substantial conflict of interest and motivated desires to cover-up prior unethical practice and failure in duty to protect obligations is the seeming absence of self-reflection and apparent stonewalling response of the course instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) to informal notification of the ethical concerns surrounding their course content (Appendix 2). Based on the response of the course instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward), they believe they do not need to know or instruct on actual knowledge from professional psychology (i.e., regarding the DSM-5 diagnosis, regarding delusional thought disorders, regarding factitious disorders imposed on the child, regarding the attachment system and attachment pathology, regarding child psychological abuse and duty to protect obligations for the relevant differential diagnoses, regarding narcissistic-borderline-dark personality pathology in a parent damaging family relationships, regarding family systems constructs and principles) and that reliance on made-up pathology labels of their own devising is sufficient. Note Standard 2.03 Maintaining Competence.

The forensic custody evaluators who are in positions of influence are currently disabling the mental health system response to the pathology in the family courts for their own financial and career status gain, and a prominent conflict of interest currently exists. An independent review is needed.

Cover-up of Failure

For the currently broken mental health system in the family courts to be corrected, the failed experiment in a quasi-judicial role for doctors, and their failed forensic custody evaluation approach, needs to be acknowledged to make the necessary corrective changes of returning to standard healthcare practices of diagnosis and treatment. However, the forensic custody evaluators in the family courts are highly motivated from their own financial and career status interests, and its potential loss, to cover-up their failed experiment in a quasi-judicial role for doctors for their own personal financial and career status benefit. An outside and independent review of the experimental practice of forensic custody evaluations in the family courts is needed. Note the extremely harsh findings of the

NY Blue-Ribbon Commission on Forensic Custody Evaluations when such an independent outside review of forensic custody evaluations is conducted.

Licensing Board Review

The oversight function of state licensing boards has been disabled by the influence of prominent forensic psychologists in positions of authority and influence, as evidenced by the fact that state licensing boards have allowed a "dangerous" professional practice that is "harmful to children," and that "lacks scientific or legal value" with "potentially disastrous consequences to parents and children" (NY Blue-Ribbon Commission on Forensic Custody Evaluations, 2021) to continue for 30+ years. Once thesychol failed experiment on human subjects in the family courts of a quasi-judicial role for doctors with its experimental forensic custody evaluation assessment approach is entirely eliminated for being "dangerous" and "harmful to children," self-examination by the Association for State and Provincial Psychology Boards would seemingly be warranted regarding how the state licensing boards were disabled in their oversight role.

I understand the policy of the APA Ethics Committee that ethical concerns should first be submitted to state licensing boards before submission to the APA Ethics Committee. However multiple factors surrounding the current ethical concerns regarding a collective group of psychologists (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) who provide leadership in a highly problematic systemwide practice warrants my current notification of the APA Ethics Committee pursuant to my required obligations under Standard 1.05 Reporting Ethical Violations. Standard 1.04 and 1.05 represent the self-corrective Standards when ethical violations escape formal notice yet are causing substantial harm, or are likely to cause substantial harm, to the client population.

I will follow up this notice to the APA Ethics Committee (a national committee on professional ethics) with notice to the individual state licensing boards for each of the instructors pursuant to the instructions of the APA Ethics Committee to submit ethical concerns directly to state licensing boards. However, this is not expected to have a productive result. The state licensing boards are being disabled in their oversight function by the influence of forensic psychologists on the state licensing boards. There is a conflict of interest in forensic psychologists reviewing other forensic psychologists when they all make the same violations to Standards 2.01, 2.04, and 9.01, and when sanctions for any one forensic psychologist would warrant similar sanctions on all of them. Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, and Dr. Ward represent the leadership within forensic custody evaluators who are teaching a supposedly "Advanced" course promoted by the AFCC. If sanctions or remediation are warranted for Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward, then these same sanctions and/or remediation is warranted for all forensic custody evaluators nationwide.

Once it is recognized that forensic custody evaluations represent a failed experiment on human subjects in the family courts that has proven to be "dangerous" and "harmful to children," questions emerge as to how the oversight functions within professional psychology failed, and Standard 3.04 Avoiding Harm becomes a relevant consideration.

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.

Did the state licensing boards and the American Psychological Association take reasonable steps to avoid harming the children and parents in the family courts (a vulnerable population because of their impaired autonomy in decision-making due to the court's involvement, and their high-need for professional services) when they allowed and promoted an experimental quasi-judicial role for psychologists and the practice of forensic custody evaluations in the family courts? Apparently not if they allowed a "dangerous" practice that "lacks scientific or legal value" that generates "defective reports" that lead to "potentially disastrous consequences for parents and children" (NY Blue-Ribbon Commission on Forensic Custody Evaluations.

> **From NY Blue Ribbon Commission:** "In some custody cases, because of lack of evidence or the inability of parties to pay for expensive challenges of an evaluation, defective reports can thus escape meaningful scrutiny and are often accepted by the court, with potentially disastrous consequences for the parents and children… By an 11-9 margin, a majority of Commission members favor elimination of forensic custody evaluations entirely, arguing that these reports are biased and harmful to children and lack scientific or legal value. At worst, evaluations can be dangerous (NY Blue-Ribbon Commission on Forensic Custody Evaluations, 2021)

The Petition to the APA & No Response

I have previously notified the APA Ethics Committee regarding the ethical concerns surrounding the practices of the forensic custody evaluators in the family courts. In 2018, I wrote a *Petition to the APA* that was signed by 20,000 parents informing the APA of the ethical concern in the family courts. I then hand-delivered this *Petition to the APA* with two parent-advocates, Wendy Perry and Rod McCall, to the corporate offices of the APA in Washington, D.C., and I was told this *Petition to the APA* would be forwarded to the APA Ethics Committee.

I then constructed a website with a clock-timer[11] and linked this website to the online Petition to the APA,[12] and I published the *Petition to the APA* to Amazon.com for documentation and citation purposes. As of 3/17/25, it has been 2,477 days without a

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[11] *Petition to the APA* website: https://apaethicalviolations.com

[12] *Petition to the APA* online location: https://www.change.org/p/the-american-psychological-association-ending-parental-alienation-pathology-for-all-children-everywhere

Petition to the APA on Amazon.com: https://www.amazon.com/Petition-American-Psychological-Association/dp/0996114599

response from the APA Ethics Committee to the *Petition to the APA* signed by over 20,000 parents and hand-delivered to the corporate offices of the APA in 2018.

Given the current opportunity for my direct communication with the APA Ethics Committee, I am again requesting a formal response from the APA Ethics Committee to the 20,000 parents who signed the *Petition to the APA*, with an explanation for the delay in responding to the ethical problems in the family courts. I am also requesting who was on the committee that reviewed the concerns described by the Petition to the APA signed by 20,000 parents in the family courts. I note an entry on the vita of Dr. Deutsch that she chaired an APA "working group" in 2018 on a review of scientific literature for high conflict family relationships. I am also requesting the membership, meeting dates, and report on the finding from this APA working group chaired by Dr. Deutsch. I am attaching my References for my book *Foundations* (Childress, 2015) as the "scientific literature" surrounding high conflict families in court-involved custody litigation (Appendix).

> **From Dr. Deutsch Vita:** Chair, American Psychological Association (APA) Working Group to 2018 Review Scientific Literature for High Conflict Family Relationships with Child Involvement

Response from the Instructors

The response of the instructors (Appendix 2) to my notification of ethical concerns surrounding Standards 2.04 and 2.01 (Appendix 1) appears to lack authentic professional engagement with the ethical issues raised. They appear to merely assert without support or specific responses to the concerns raised that they did nothing wrong. Their united response of vague unsupported and non-responsive assertion appears to be stonewalling the issues because they have no valid and supported response to the ethical concerns raised, which raise serious professional concerns. This apparent stonewalling response and absence of authentic professional engagement with the ethical issues involved seemingly represents the cover-up of wrongdoing noted earlier.

It is also noted from the vita of Dr. Deutsch that she served on the APA Ethics Committee from 2005 to 2008 and was Chair of the APA Ethics Committee from 2007-2008.

> **From Dr. Deutsch Vita:** "Ethics Committee, American Psychological Association Member 2005-2007. Ethics Committee, American Psychological Association Chair 2007-2008"

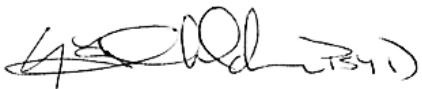
A more detailed and supported defense in response to the ethical concerns raised with great specificity would be anticipated from a former Chair of the APA Ethics Committee. If this is the first time the APA Ethics Committee is learning about the "dangerous" practice of forensic custody evaluations that "lack scientific or legal value" and are harmful to children," why is that? I would offer that the mental health oversight functions are being disabled for parents and children in the family courts for the personal financial and career status benefit of a small group of psychologists (Concern 22: Financial Exploitation of a Vulnerable Population).

Ethical Violations

The following are the potential ethical violations involved in this notice to the APA Ethics Committee pursuant to my required obligations under Standard 1.05 of the APA ethics code when I believe there may have been an ethical violation by another psychologist, in this case a group of psychologists (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, and Dr. Ward; and by extension others) that has caused substantial harm, and which will continue to cause substantial harm to children and parents in the family courts (NY Blue-Ribbon Commission on Forensic Custody Evaluations, 2021).

- Standard 2.04 Bases for Scientific and Professional Judgments
- Standard 2.01 Boundaries of Competence
- Standard 9.01 Bases for Assessment (see Standard 2.04)
- Standard 2.03 Maintaining Competence (see Standard 2.01)
- Standard 3.04 Avoiding Harm (failing to take reasonable steps of conducting a risk assessment for child abuse to the appropriate differential diagnoses for each parent).
- Failure to protect the child from child psychological abuse by a narcissistic-borderline-dark personality parent, i.e., a shared (induced) persecutory delusion and false (factitious) attachment pathology imposed on the child for secondary gain to the pathological parent (DSM-5 V995.51 Child Psychological Abuse; DSM-5 297.1 Delusional Disorder shared/induced, persecutory type; DSM-5 300.19 FDIA, a false/factitious attachment pathology for secondary gain to the parent).
- Failure to protect the targeted parent from psychological spousal abuse by the allied (narcissistic-borderline-dark personality) parent who is using the child, and the child's induced pathology, as the spousal abuse weapon.

I will follow up this notice to the APA Ethics Committee with notifications to each of the instructors individual licensing boards pursuant to the requirements of the APA Ethics Committee, and with notice to the AFCC Board of Directors as an appropriate professional organization pursuant to my obligations under Standard 1.05 of the APA ethics code.



Craig Childress, Psy.D.
Clinical Psychologist
WA 61538481 – OR 3942 – CA 18851

Appendix 1: Standard 1.04 Informal Notification Letter Template for the Instructors

C. A. CHILDRESS, Psy.D.
LICENSED CLINICAL PSYCHOLOGIST
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Informal Notification of Ethical Concerns

Date:

Hello Dr.

I am writing you this letter to notify you informally of my concerns regarding possible ethical violations by you, pursuant to my required obligations under Standard 1.04 nof the APA ethics code when I believe there may have been an ethical violation by another psychologist.

> **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.

I recently attended a four-day training course, *Advanced Issues in Family Law: Parent Child Contact Problems*, with you and other instructors. Based on my attendance and the content presented by you and the other instructors, I believe there may have been an ethical violation to Standard 2.04 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 relevant domains of established scientific and professional knowledge required by Standard 2.04 for application as the bases for professional judgments with the pathology in the family courts includes the following:

- DSM-5 diagnostic system – American Psychiatric Association
- Attachment – Bowlby, Tronick, & others
- Complex trauma – van der Kolk & others
- Family systems – Minuchin & others
- Personality Pathology – Millon, Linehan, & others
- Psychological control – Barber & others

None of this established knowledge from any of these domains of professional psychology was evident in application during any of the eight Modules presented in the training course. Instead, you and the other instructors relied on made-up pathology labels for a proposed pathology unique to the family courts that lack scientific support and clear definitions (“parental alienation” – “resist-refuse dynamic” – “Parent-Child Contact

Problems"). There is no pathology unique to the family courts that does not exist within the general population. The family court context is simply triggering a pathology already existent in the general population into display.

Attachment Pathology

A child rejecting a parent is an attachment pathology (Bowlby, 1969; 1973; 1980; Tronick & Gold, 2020), a problem in the love-and-bonding system of the brain. It is noted that no established knowledge from attachment was relied on by you, or taught to the trainees taking the course, as the bases for professional judgments regarding the assessment, diagnosis, and treatment of attachment pathology (i.e., a child rejecting a parent).

Delusions & Personality Disorder Pathology

The pathology of concern in the family courts is the psychological collapse of a narcissistic-borderline-dark personality parent into persecutory delusions (DSM-5 297.1 Delusional Disorder; persecutory type) triggered by the rejection inherent to divorce that creates a narcissistic injury and triggers abandonment fears in the pathological narcissistic-borderline-dark personality parent. It is noted that no reliance on the established knowledge from the DSM-5 diagnostic system of the American Psychiatric Association (APA, 2013) was relied on or taught as the bases for your professional judgments, and that no application of the established knowledge from personality disorders (narcissistic-borderline-dark personality pathology) was evident in application as the bases for your professional judgments (Beck et al., 2004, Linehan, 1993, Millon, 2011; Paulhus & Williams, 2002).

Factitious Pathology Imposed on the Child

The narcissistic-borderline-dark personality parent uses the child as a regulatory object to stabilize the parent's psychological collapse surrounding the narcissistic injury and abandonment fears triggered by the divorce by creating false (factitious) attachment pathology in the child for secondary gain to the pathological parent (DSM-5 300.19 Factitious Disorder Imposed on Another). The potential secondary gain to the narcissistic-borderline-dark personality parent for creating false pathology in the child includes:

- **Court Manipulation:** manipulating the court's decisions regarding child custody in favor of the allied parent by creating false pathology in the child to deceive the court regarding the normal-range parenting of the targeted parent.

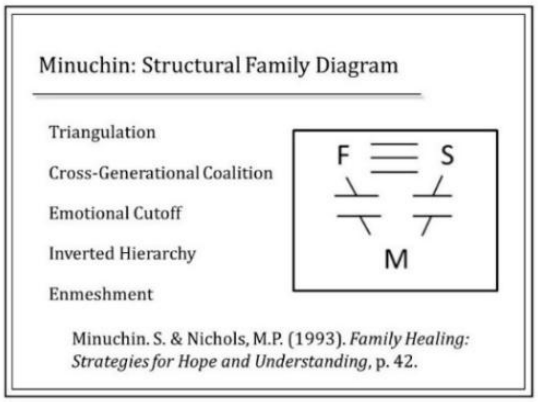
- **Spousal Abuse:** spousal emotional and psychological abuse of the targeted parent (in revenge and retaliation for the failed marriage and divorce) using the child, and the child's induced pathology, as the spousal abuse weapon.

- **Regulatory Object:** the narcissistic-borderline-dark personality parent is using the child as a "regulatory object" to meet the allied parent's own emotional and psychological needs (for narcissistic supply and to allay abandonment fears).

It is again noted that no reliance on the established knowledge from the DSM-5 diagnostic system of the American Psychiatric Association regarding factitious disorders was relied on or taught as the bases for professional judgments.

Family Systems Pathology

The family systems pathology of concern in the family courts is the child's *triangulation* (Bowen, Minuchin) into the spousal conflict through a *cross-generational coalition* (Haley, 1977; Madanes, 2018; Minuchin, 1974) of the allied parent with the child, resulting in an *emotional cutoff* (Bowen, 1978; Titelman, 2003) in the child's attachment bond to the targeted parent, as depicted in this Structural family diagram from Minuchin and Nichols (1993).



While the term "family systems" was used frequently in the course instruction, along with the construct of "enmeshment", it is noted that no mention was made of *cross-generational coalitions* (and their cause), inverted hierarchies (and their cause), emotional cutoffs (and their cause), and the role of enmeshment as a psychological boundary dissolution (and its cause), and no citations were made to any of the established family systems literature (Bowen, Haley, Minuchin, Madanes, Satir, and others).

Euphemisms Hide Child Abuse

The made-up pathology labels of "parental alienation", "resist-refuse dynamic", and "Parent-Child Contact Problems" represent euphemisms for child abuse (DSM-5 V995.51 Child Psychological Abuse; i.e., a shared/induced persecutory delusion & FDIA) that hide the child abuse from view, hide the child abuse from the Court's understanding, and which prevent effective intervention for the child abuse.

It is not an "inappropriate affection dynamic" – it's child sexual abuse.

It is not "Overly Stern Discipline" – it's child physical abuse.

It's not "parental alienation", "resist-refuse dynamic", or "Parent-Child Contact Problems" – it's child psychological abuse.

All mental health professionals have duty to protect obligations. Whenever a mental health professional encounters any of three dangerous pathologies, suicide, homicide, or abuse (child, spousal, and elder abuse), duty to protect obligations are activated and a proper risk assessment for the danger involved needs to be conducted. No discussion of duty to protect obligations surrounding family court pathology was provided in the instruction, suggesting you may be unaware of your professional duty to protect obligations surrounding family court pathology.

Standard 2.01 Boundaries of Competence

Based on the absence of applied knowledge from attachment, delusional thought disorders, personality disorder pathology, factitious disorders, and family systems pathology as the bases of your professional judgments and instruction (a seeming violation to Standard 2.04) and additional troubling content in your training curriculum regarding treatment, I believe that you (and the other instructors) may also be in violation of Standard 2.01 Boundaries of Competence of ethics code for the American Psychological Association regarding multiple domains of necessary knowledge, including: 1) the diagnostic assessment and treatment of delusional thought disorders, 2) the diagnostic assessment and treatment of attachment pathology in childhood, 3) the diagnostic assessment and treatment of factious disorders imposed on the child, 4) the diagnostic assessment and treatment of personality disorder pathology, and 5) the diagnostic assessment and treatment of family systems pathology.

> **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.

Additionally, I would note that if you need to be educated by me about what the pathology in the family courts is at a professional level of description, then you are not competent in the pathology by your demonstrated need to be educated about it, in violation of Standard 2.03 Maintaining Competence of the APA ethics code.

> **2.03 Maintaining Competence**
> Psychologists undertake ongoing efforts to develop and maintain their competence.

Standard 9.01 Bases for Assessment

In addition, if you do not know the required knowledge necessary for competence (a violation to Standard 2.01) and do not apply the established knowledge of the discipline as the bases for your professional judgments (a violation to Standard 2.04), then I am concerned that your opinions contained in your recommendations, reports, and diagnostic or evaluative statements, including your forensic testimony, are NOT based on information and techniques sufficient to substantiate your findings, in violation of Standard 9.01 Bases 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. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

Duty to Protect

Based on the content of the training, I have additional concerns that you (and the other instructors) are routinely failing in your duty to protect obligations on two counts:

- **Child Psychological Abuse:** failure to protect the child from psychological abuse by a narcissistic-borderline-personality parent who is inducing a shared persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the pathological parent (DSM-5 V995.51 Child Psychological Abuse).

- **Spousal Psychological Abuse of the Targeted Parent:** failure to protect the targeted parent from psychological spousal abuse by the allied parent using the child (and the child's induced pathology) as the spousal abuse weapon (DSM-5 V995.51 Spouse or Partner Abuse, Psychological).

As you are aware, all mental health professionals have duty to protect obligations whenever they encounter three types of dangerous pathology, suicide, homicide, and abuse (child, spousal, and elder abuse). Whenever a dangerous pathology is encountered (suicide, homicide, abuse), duty to protect obligations are active and the mental health professional must do three things:

1. **Risk Assessment:** The mental health professional must conduct a proper risk assessment for the danger involved or ensure that a proper risk assessment gets conducted (such as by referring a suicidal patient to the ER for evaluation or making a report to Child Protective Services for the risk assessment of possible child abuse).

2. **Protective Action:** The mental health professional must take an affirmative protective action to ensure everyone's safety (such as referral for additional evaluation and treatment, increased frequency of sessions, or activating surrounding family and social support with proper permissions).

3. **Documentation:** The mental health professional should then document in the patient's medical record the findings from a risk assessment if one was conducted, and the affirmative protective actions taken.

Despite frequent mentions in the course instruction of "safety" being a paramount consideration in court-involved pathology surrounding child custody conflict, no mention or discussion was provided regarding possible psychological child abuse by an allied narcissistic-borderline-dark personality parent, or of the possible spousal psychological abuse of the targeted parent by the allied parent using the child (and the child's induced pathology) as the spousal abuse weapon.

In the absence of discussion regarding the potential narcissistic-borderline-dark personality pathology of allied parent (who you pleasantly label the "favored" parent), and the potential psychological child abuse by the allied parent, and the potential spousal psychological abuse of the targeted parent by the allied parent using the child as the spousal abuse weapon, I am concerned that you (and the other instructors) have biased perceptions (from counter-transference issues surrounding attachment pathology) that favor of the allied and abusive ("favored") parent, to the substantial harm of both the child and the targeted parent.

Failure to conduct a proper risk assessment when a risk assessment is warranted by the symptoms and context may represent a negligent failure in duty to protect obligations.

> **Cornell Law School Definition of Negligence:** "Negligence is a failure to behave with the level of care that someone of ordinary prudence would have exercised under the same circumstances. The behavior usually consists of actions, but can also consist of omissions when there is some duty to act."[13]

Misdiagnosis: Participation in Child Abuse and Spousal Abuse

One of the prominent professional dangers of misdiagnosing a shared persecutory delusion is that if the mental health professional misdiagnoses the pathology of a shared persecutory delusion and believes the shared delusion as if it was actually true, then the mental health professional becomes part of the shared delusion, they become part of the pathology.

When that pathology represents the psychological abuse of the child by an allied pathological parent, then the mental health professional becomes a participant in the allied parent's psychological abuse of the child by validating to the child that the child's false (delusional) beliefs are true when they are, in fact, symptoms of an induced persecutory delusion. In addition, when the pathology is also the spousal psychological abuse of the targeted parent by the allied parent using the child as the spousal abuse weapon, then the mental health professional becomes a participant in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family.

The recommendations from you (and the other instructors) for an "apology therapy" of your own devising (i.e., having the targeted parent apologize to the child for their supposedly malevolent treatment of the child) that is not based in a professional-level diagnosis raise prominent professional concerns that you (and the other instructors) have misdiagnosed a shared (induced) persecutory delusion (because of violations to ethical Standards 2.01 & 2.04) and have become participants in the psychological abuse of the child, and in the psychological spousal abuse of the targeted parent by the allied parent using the child (and the child's induced pathology) as the spousal abuse weapon.

As noted earlier, all psychologists have duty to protect obligations for everyone they work with. It is deeply troubling to consider the possibility that you (and the other instructors) are active participants in the psychological abuse of your child-clients and in the psychological spousal abuse of your parent-clients because of a negligent misdiagnosis of the pathology resulting from a failure to know the necessary knowledge (a violation to Standard 2.01 Boundaries of Competence), a failure to apply the established scientific and professional knowledge of the discipline as the bases for your professional judgments (a violation of Standard 2.04 Bases for Scientific and Professional Judgments), and because you rely on made-up pathology labels (of your own devising) instead.

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[13] Cornell Law School: Negligence https://www.law.cornell.edu/wex/negligence

There are reasons for ethical Standards. There are reasons for Standards 2.01 and 2.04. When mental health professionals practice beyond boundaries of competence and fail to apply the established knowledge of the discipline as the bases for their professional judgments, the risks for misdiagnosis increase substantially. When child abuse and spousal abuse are considered diagnoses, misdiagnosis can result in substantial harm to the client.

Forensic Custody Evaluations

It is noted that you and the other course instructors have long histories of conducting forensic custody evaluations, i.e., an experimental quasi-judicial role in the family courts advising on custody decisions of the Court based on your assessment protocol and judgments. It is noted that the assessment procedure developed for forensic custody evaluations lacks inter-rater reliability data, meaning that two different psychologists can reach entirely different interpretations and recommendations based on exactly the same data. From the psychometric principles of assessment, an assessment procedure (such as a forensic custody evaluation) that lacks reliability (inter-rater reliability for forensic custody evaluations) cannot be a valid assessment for anything (psychometrics of assessment; an assessment procedure must be reliable to be valid).

An independent review of forensic custody evaluations by the New York Blue-Ribbon Commission on Forensic Custody Evaluations found that they "lack scientific or legal value", are "dangerous" and "harmful to children", and that the "defective reports" generated by forensic custody evaluations can have "potentially disastrous consequences for parents and children" in the family courts.

> **From NY Blue Ribbon Commission:** "Ultimately, the Commission members agree that some New York judges order forensic evaluations too frequently and often place undue reliance upon them. Judges order forensic evaluations to provide relevant information regarding the "best interest of the child(ren)," and some go far beyond an assessment of whether either party has a mental health condition that has affected their parental behavior. In their analysis, evaluators may rely on principles and methodologies of dubious validity. In some custody cases, because of lack of evidence or the inability of parties to pay for expensive challenges of an evaluation, defective reports can thus escape meaningful scrutiny and are often accepted by the court, with potentially disastrous consequences for the parents and children… As it currently exists, the process is fraught with bias, inequity, and a statewide lack of standards, and allows for discrimination and violations of due process."
>
> **From NY Blue Ribbon Commission:** "By an 11-9 margin, a majority of Commission members favor elimination of forensic custody evaluations entirely, arguing that these reports are biased and harmful to children and lack scientific or legal value. At worst, evaluations can be dangerous, particularly in situations of domestic violence or child abuse – there have been several cases of children in New York who were murdered by a parent who received custody following an evaluation. These members reached the conclusion that the practice is beyond reform and that no amount of training for courts, forensic evaluators and/or other court personnel will

successfully fix the bias, inequity and conflict of interest issues that exist within the system." (NY Blue-Ribbon Commission, 2021)

Experimenting on children and parents in the family courts (a vulnerable population because of their impaired autonomy in decision-making) with a quasi-judicial role developed by forensic custody evaluators raises prominent professional concerns that need to be properly addressed. It is noted that neither the parents nor the courts were provided with a disclosure that a quasi-judicial role for doctors represents an experimental new role not anchored in standards of healthcare practice, and that the assessment procedure developed for this quasi-judicial role of forensic custody evaluations for the purpose of advising the courts on custody is an experimental assessment procedure. It is also noted at the forensic psychologists in the family courts have withheld from parents and the courts an alternative to their experimental forensic custody evaluations of community practice as usual, i.e., a clinical diagnostic assessment of the pathology.

It is also noted that the intensive 4-day treatment program, *Overcoming Barriers*, developed by many of the course instructors and referenced in the course instruction, represented an experimental treatment for attachment pathology in the family courts that completely failed and is now defunct. There are no intensive 4-day treatments for any form of pathology (ADHD, ODD, trauma, attachment, eating disorders, substance abuse, autism). Professional concerns exist regarding conducting experimental treatments of your own devising on children and parents by court order (i.e., a vulnerable population) without proper research oversight for experimental treatments. The subsequent failure of the experimental 4-day treatment program of *Overcoming Barriers* does not reassure these professional concerns regarding experimenting on parents and children in the family courts without proper research oversight (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research: *The Belmont Report*, 1979)

Module Analysis

To provide clarity to my concerns, I have provided a slide-by-slide Module Analysis for each of the eight Modules in the training (Appendices 1-8; attached separately). This slide-by-slide Module Analysis generated a Catalogue of Concerns for all eight Modules (Appendix 9; attached separately).

With this letter I am making you aware of my concerns that you may have violated Standards 2.04 and 2.01 of the APA ethics code (and possibly 2.03, and 9.01), and with this letter I am discharging my required obligations under Standard 1.04 of the APA ethics code when I believe there may have been an ethical violation by another psychologist.

Craig Childress, Psy.D.
Clinical Psychologist
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OR 3942 – CA 18857

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Appendix 2: Response from Instructors

Re: Dr. Sullivan Standard 1.04

Inbox ×

Dr. Matt Sullivan Sat, Feb 8, 7:23 AM

to me, drrobindeutsch, marsha.pruett@email.smith.edu, leslie@lesliedrozdphd.com, jm@jmphd.com, drpeg

Dear Dr. Childress,

We wanted to acknowledge receipt of your separate emails to each of us to notify us informally of your concerns regarding possible ethical violations by our group as it relates to our recent training on Advanced Issues in Family Law: Parent-Child Contact Problems we conducted from January 12-16, 2025 for the Association of Family and Conciliation Courts. We appreciate that pursuant to your required obligations under Standard 1.04 of the APA ethics code you are informally engaging with us about your concerns. We want you to know we take your concerns seriously and are reviewing what you described in your letter carefully. We appreciate the opportunity to respond to you about them. We will plan to respond to your concerns as a group in the next couple of weeks.

Sincerely,

Drs. Leslie Drozd, Robin Deutsch, John Moran, Marsha Pruett, Matthew Sullivan and Peggie Ward

Appendix 1-8: Module Analyses

appended separately

Appendix 9: Catalogue of Concerns

appended separately

Appendices 1-8: Module Analysis

appended separately

Appendix 9: Catalogue of Concerns

appended separately

Appendix 10: Checklist of Applied Knowledge

AFCC Course “Advanced Issues in Family Law: Parent Child Contact Problems”

Checklist of Applied Knowledge Summary Page AFCC "Advanced Issues in Family Law: Parent Child Contact Problems"			
Constructs Applied:			
	Family systems:	Enmeshment and "family systems" were used but not described or relied on. No reference citations to Minuchin, Bowen, Haley, Madanes	Deficit
	Attachment:	No attachment constructs applied despite teaching about attachment pathology – i.e., parent-child contact (attachment) pathology	Deficit
	Complex trauma:	No complex trauma constructs were applied despite emphasizing "risk" and danger of the pathology.	Deficit
	Personality pathology:	No personality pathology constructs applied despite vignette clearly suggesting borderline (Vulnerable Dark Triad) pathology.	Deficit
	Child development	No child development constructs applied regarding breach & repair (Tronick)	Deficit
	Behavioral psychology	No behavioral constructs applied, no discussion of Applied Behavioral Analysis to identify causes of conflict.	Deficit
Diagnostic Foundations:			
	DSM-5/ICD-11 Diagnosis:	None	Deficit
	Case Formulation Diagnosis:	None: reported the pathology to be "complex"	Deficit
Treatment Plan:			
	Articulated Treatment Plan:	No coherent treatment plan reported	Deficit
	Linked to DSM-5/ICD-11 Diagnosis:	No tx plan linked to a diagnosis	Deficit
	Linked to Case Formulation	Minimal treatment plan ("apology therapy") linked to an inadequate case formulation	Deficit
	Long-Term Goals	No measurable long-term goals: treatment goals offered included throwing a baseball TO a parent instead of AT a parent and making eye contact with a rejected parent.	Deficit
	Short-Term Goals:	No measurable short-term goals	Deficit
	Interventions	No recommended interventions	Deficit
	Timeframes	No timeframes for goal accomplishment	Deficit

Constructs Used as the Bases for Professional Judgments

A *Checklist of Applied Knowledge* was used to evaluate the instructors' use of the established scientific and professional knowledge of the discipline as the bases for their professional judgments. Based on their presentation across all eight Modules, no domains of established professional knowledge were applied as the bases for professional judgments.

- No constructs from family systems were relied on by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.
- No constructs from attachment pathology were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.
- No constructs from personality pathology were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and judgments.
- No constructs from complex trauma were evident in application by by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.
- No constructs from child development were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.
- No constructs from behavioral psychology were evident in application by the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) as the bases for their opinions and professional judgments.
- Diagnostic Formulation: the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) provided no diagnosis for the problem and did not rely on the established knowledge of the DSM-5 diagnostic system as the bases for the opinions and professional judgments.
- Treatment Plan: the instructors (Dr. Deutsch, Dr. Drozd, Dr. Moran, Dr. Kline Pruett, Dr. Sullivan, Dr. Ward) provided no organized treatment plan or case conceptualization to fix the problem, indicating that the pathology is "complex".

Professional Standards of Practice

Of professional note is that the instructors relied extensively on made-up pathology labels of "parental alienation" – "resist-refuse dynamic" – and "Parent-Child Contact Problems" in lieu of applying established knowledge as the bases for their professional judgments.

References

Note 29 reference citations were made to the instructors: zero to Bowlby; zero to Tronick; zero to Minuchin; zero to Bowen; zero to Millon, zero to Linehan; zero to Kernberg; zero to Beck; zero to van der Kolk.

Applied Domains of Knowledge

1. Family Systems Constructs in Analysis

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

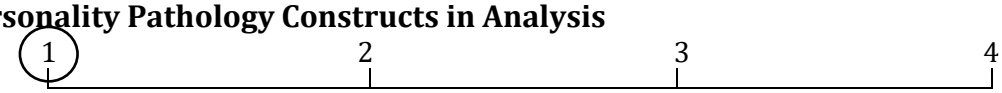
Constructs Used	Yes	No	
Triangulation	☐	☑	
Cross-Generational Coalition	☐	☑	
Emotional Cutoff	☐	☑	
Differentiation of Self	☑	☐	Enmeshment term used
Multigenerational Transmission ...	☐	☑	
Inverted Hierarchy	☐	☑	

2. Attachment Constructs in Analysis

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

Constructs Used	Yes	No
Description of Attachment	☐	☑
Insecure Attachment Patterns	☐	☑
Emotional Dysregulation	☐	☑
Breach-and-Repair Sequence	☐	☑
Role-Reversal	☐	☑

3. Personality Pathology Constructs in Analysis



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

Constructs Used	Yes	No	
Splitting	☐	☑	
Absence of Empathy	☐	☑	
Emotional Dysregulation	☐	☑	
False “Abuse” Allegations	☐	☑	
Power, Control, & Domination	☑	☐	in reference to IPV

4. 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

Constructs Used	Yes	No
Persecutory Delusion ……..	☐	☑
Trauma Reenactment Pattern …….	☐	☑
PTSD Identified or Implied ……	☐	☑
PTSD Criterion 1 Identified ……..	☐	☑
Phobic Anxiety Identified ……..	☐	☑

5. Child Developmental Constructs

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

Constructs Used	Yes	No
Intersubjectivity ……	☐	☑
Co-Construction ……..	☐	☑
Use-Dependent Development ……	☐	☑
Breach-and-Repair Sequence ……..	☐	☑
Age-Gender Neuro-Maturation ……..	☐	☑

Behavioral Psychology

1 — 2 — 3 — 4

No use	Inadequate	Adequate	Full
No behavioral constructs used in analysis	Some but inadequate or inaccurate use of behavioral constructs	Moderate use of behavioral constructs	A full analysis using behavioral constructs is provided

Constructs Used	Yes	No
Applied or Functional analysis……	☐	☑
Behavior chain, stimulus control……..	☐	☑
Cue, trigger, stimulus……..	☐	☑
Target behavior……	☐	☑
Reward, punishment, consequences…	☐	☑

Standards of Professional Practice: Diagnosis

1. DSM-5 ICD-10 Diagnosis Provided: ☐ Yes ☑ No ☐ Partial

   Category of DSM-5 – ICD-10 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
   - ☑ Oppositional/conduct pathology
   - ☑ Anxiety pathology
   - ☑ Depressive/bipolar pathology
   - ☐ Eating disorder pathology
   - ☑ Personality disorder pathology possible personality pathology in a vignette parent
   - ☐ Neurodevelopmental
   - ☑ Child abuse pathology
   - ☑ Spousal-partner abuse
   - ☐ 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 ("it's complex")

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	☐	☐	☑
	Linkage to DSM-5 diagnosis	☐	☐	☑
	Linkage to case conceptualization	☐	☐	☑
Goals:	Long-term goals identified	☐	☐	☑
	Consistent short-term goals identified	☐	☐	☑
Specific:	Specific interventions described for each goal	☐	☐	☑
Measures:	Measurable outcomes described	☐	☐	☑
Time:	Time-frame for achieving long-term goal	☐	☐	☑
	Time-frame for achieving short-term goal	☐	☐	☑

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