Rhetoric and Reason in Parental Alienation Discourse

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ROADMAP

1. Rhetoric and Reason in Parental Alienation Discourse - MM
2. Gulf between Theory and Practice - JM
3. Beyond Rhetoric: Identifying Abusive and Alienating Behaviors in Practice - BG
Rhetoric and Reason in Parental Alienation Discourse

How Ideas Can Become Persuasive without Evidence and Reason

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Rhetorical Strategies Seek to Persuade Illegitimately

Rhetorical Strategies
1. Exaggerating consensus and ignoring dissent
2. Misrepresenting organizational support
3. Misrepresenting evidence
4. Using labels that assume what must be proven
5. Making opposing arguments appear absurd
6. Insulting opposing thinkers
7. Changing names without changing content
1.a. Exaggerating Consensus

Asserting that alienation is accepted across the world

“Parental alienation (PA) is a serious mental condition that affects hundreds of thousands of children in the United States and comparable numbers in other countries. Mental health professionals (MHPs), family law attorneys, and everyday citizens observe PA on a regular basis” [Lorandos, Bernet, & Sauber, 2013].

“Divorce professionals and members of the lay community have come together to create a groundswell of support for including parental alienation (PA) in ... DSM-5” [Rand, 2013].

PA has been addressed in the U.S., Malta, Germany, the Philippines, India, Israel, Malaysia, Morocco [Dum, 2013], Brazil [Brockhausen, 2013] and other countries.

1.b. Discounting Dissent in the U.S.

Failure to get alienation accepted in any form in DSM-5 [Bernet, 2010].

Opposition to its inclusion by alienation researchers in conjunction with leading child abuse and domestic violence researchers, teachers, and clinicians [Faller, 2010].

Opposition from The American Professional Society on the Abuse of Children [APSAC, 2019].
1.c. Discounting Dissent in the U.S.

NY State *Amicus Brief* Signatories:

Organizations Protesting the Lack of Scientific Foundation for PA and its Misuse in U.S. Courts

The Domestic Violence Legal Empowerment and Appeals Project [DV LEAP, 3/2/19]


1.d. Discounting International Dissent

Memo to the World Health Organization

International opposition contained in the Collective Memo of Concern sent to the World Health Organization from concerned family law academics, family violence experts and research institutes, trauma institutes, child development and child abuse experts [WHO Memo, 4/16/19].
Exaggerating Consensus and Ignoring Dissent in Practice

 Means Ignoring Other Causes

 Dr. Jones’ Opinion

Dr. Jones is a much-used expert for Reunification Therapy. He opines:

In most cases, the child’s resistance is caused by the preferred parent, reflects that parent’s pathology, and is transferred onto the other parent. The charges are deliberately invented out of malice.

He says, “I could give you example after example.”

Exaggerating Consensus and Ignoring Dissent in Practice

 Means Assuming that Removing the Child from the Preferred Parent as a Remedy is Warranted

Evidence contradicts Dr. Jones.

Saini and colleagues report malicious abuse allegation rates in large scale studies of custody disputes that range from 12% to 25% [Saini et al., AFCC Webinar, 6/9/20].

They also report 6% malicious sexual abuse allegations (CSA) for young children.

They conclude that the argument that malicious allegations are common is a “myth.”
Exaggerating Consensus and Ignoring Dissent in Practice

**Cause for Concern Does Not Provide Grounds for Assumptions**

Fabrication rates (12%-25%) raise concern.

But they mean that between 75% and 82% of abuse allegations are **not** malicious.

And 94% of CSA allegations regarding young children are **not** malicious.

The CSA allegations are the ones most likely to be *assumed* to be malicious – they are least likely to have physical evidence.

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**Assumptions Produce Over-Confident Treatment Recommendations**

Dr. Jones’ Opinion

Reunification therapy never fails if judges enforce their orders.

Milchman, Geffner, and Meier’s Question

Is external compliance with court orders the same as internal change?
Exaggerating Consensus and Ignoring Dissent in Practice

Interpreting Reunification following Removal Treatments as Proof of “No Abuse” is Simplistic

Dr. Jones’ Opinion

- If Reunification Therapy fails, then moving the child from the preferred parent to the rejected parent for several months will succeed in repairing the relationship.
- “What other explanation could there be?”

Exaggerating Consensus and Ignoring Dissent in Practice

Abuse Could be the Explanation

Saini and colleagues report a 45% substantiation rate for all types of abuse in custody cases [Saini et al., AFCC Webinar, 6/9/20].

For the most difficult-to-substantiate cases – CSA of young children – they report a 3% substantiation rate [Saini et al., AFCC Webinar, 6/9/20].
Exaggerating Consensus and Ignoring Dissent in Practice

Assuming “Alienation” is the Explanation Ignores Other Explanations for Behavior Change if the Abuse Allegations are True

- Being taken Hostage
- Living in Captivity
- Feeling Terrified

2. Misrepresenting Organizational Support

Claiming that commercial publications of books by professional associations indicate acceptance of PA [Bernet, 2017] – American Bar Association, American Psychological Association. Commercial publication does not indicate endorsement, as disclaimers on the copyright pages state.

“Cherry picking” documents that create the appearance of support and disregarding contradictory documents from the same organization at the same time [Bernet, 2020] – APSAC.

3.a. Misrepresenting Evidence

Ground Zero for Considering Evidence “Scientific”

Scientific evidence requires behaviors that are unique to alienation.

Behaviors proposed to indicate alienation must not overlap with those that indicate other causes of parent rejection – abuse, witnessing domestic violence, insensitive or incompetent parenting [Lubit, 2019; Milchman, forthcoming].

There is no scientific study that demonstrates that the behaviors interpreted as indicating PA are not also behaviors that are also indicative of other causes of parent rejection [Saini, Johnston, Fidler, & Bala, 2012, 2016].

3.b. Misrepresenting Evidence

PA Studies that Claim to Provide Scientific Evidence Do Not

Studies that claim to provide scientific evidence EITHER take the word of parents or children that they were victims of alienation but do not rule out other causes

OR

Rely on the opinions of judges whose opinions are likely to reflect expert opinions

BUT

Expert opinions are vulnerable to ideological biases favoring alienation and disfavoring abuse [Lubit, 2019; Saunders, Faller, & Tollman, 2016].
3.c. Misrepresenting Evidence

**Much of the “Evidence” Consists of Anecdotes**

Anecdotes are self-proclaimed stories.
Increasing the number of stories doesn’t turn them into scientific evidence because they don’t challenge their authors’ narratives.
It doesn’t matter if there are “thousands” of alienation narratives – not one proves that there were no other causes of their victims’ pain and suffering.

3.d. Misrepresenting Evidence

**In Practice, the More Anecdotes, the Better**

Many stories create an appearance of truth.
Many stories create a receptive atmosphere.
Many stories are more persuasive than fewer stories.

**But**

Unchallenged stories can be misleading – especially if there are a lot of them.
3.e. Misrepresenting Evidence

Anecdotes Are Not Evidence

There is no logical difference between

“If you think you were alienated, you were alienated”

and

“If you think you were sexually abused, you were sexually abused.”

3.f. Misrepresenting Evidence

Agreement Is Not Evidence

It doesn’t matter how many people agree that there is evidence for alienation.

Their agreement doesn’t mean they were alienated.

Evidence is not determined by popular vote.
3.g. Misrepresenting Evidence

**Agreement about Nonsense: Alien Abduction Stories**

“Alien abductees” often tell the same stories [Saini & Drozd, 2019]:

- They woke up and couldn’t move. They felt a strange presence. They “lost time.”
- They felt that they were flying. They saw light in the room. They saw a halo around a person they couldn’t see. They felt they left their bodies. They had scars on their bodies they couldn’t explain. They sensed bad things would happen to someone they know and were right. They were visited by the dead.

Their agreement doesn’t mean that they actually had been abducted by aliens.

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3.e. Misrepresenting Evidence

**Talk Is Not Evidence**

Bernet and others have cited the frequency with which PA is discussed as evidence that “it” exists [Bernet, 2020; Bernet, von Boch-Galhau, Baker, & Morrison, 2010].

Evidence of interest is not evidence of existence.

Opponents discuss the ideas they oppose frequently!
3.e. Misrepresenting Evidence

Talk about PA that Indicates Disagreement

Is “alienation” a syndrome?

Is “alienation” a disorder?

Should alienation be included in *DSM-5*?

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4. Labeling PA vs. Describing Alienation

Labeling Assumes What Has to be Proven

Labels are proper nouns – names for identifiable things.

Names allow similar things to be differentiated (e.g., the Brooklyn Bridge vs. the Golden Gate Bridge).

Alienated children cannot be differentiated from abused children.

Labeling alienation with a proper noun assumes what has to be proven: that it can be discriminated from other causes of parent rejection.

Labeling creates realities rather than describing them.
4. a. Labeling PA vs. Describing Alienation

Labels that Create Realities
The Birther Movement
The Deep State
I.Q.

5.a. Making Opposing Arguments Appear Absurd
Reductio Ad Absurdum

Strategies to Attack Evidence that Challenges PA Claims
Misrepresenting empirical results
Making interpretations of results look silly
Using disparaging language to describe conclusions
5.b. Making Opposing Arguments Appear Absurd

*Reductio Ad Absurdum*

**Example: Robb’s (2020) accusations against Meier and Dickson (2017)**

Meier and Dickson concluded that gender disparity against mothers affects some PA decisions.

Robb claims Meier and Dickson do not define “lost custody;” equate “winning” a custody/parenting time decision with losing custody; equate termination of parental rights with decisions that give an additional hour of parenting time to the other parent.

Robb concluded that Meier and Dickson considered an “iota” of change a custody loss. His conclusion makes them look foolish – and biased against fathers.

5.c. Making Opposing Arguments Appear Absurd

*Reductio Ad Absurdum*

**What Meier and Dickson (2017) Actually Did**

They defined “custody loss” as occurring when a court orders a “switch” in sole custody from one parent to the other.

They defined a “win” as occurring when a party got the relief requested and/or defeated the other party’s request. Their example was increased parenting time.

They analyzed “losses” and “wins” separately.

Within each category, they analyzed results by gender, PA allegations, abuse allegations, and the courts’ acceptance (“crediting”) of the allegations.

Their results suggest bias in the courts – recognizing bias is not being biased.

Recognizing misogynistic bias disfavors PA arguments supporting fathers’ claims of false allegations by mothers.
6. Insulting and Demeaning People

*Ad Personam Attacks*

Ignoring ideas and focusing on personal characteristics

Bernet [2020] said that child abuse and domestic violence researchers accused Gardner of being an “adherent” of pedophilia.

Lorandos [2020] claimed Faller’s opposition to PA was caused by Gardner’s testimony against her in a civil lawsuit.

Bernet [2020, p. 302] supported Rand's assertion that feminists and child abuse scholars favor “leading and suggestive interviews when abuse is suspected.” All researchers and major organizations that train forensic interviewers agree that leading interviews are unacceptable.

Using disparaging language to describe the person

Lorandos and Bone [2016, p. 218] described an author’s critique as “true to the ‘Three Premises’ of Idiot America.”

They accused another of intending to mislead [Lorandos & Bone, 2016, p. 217].

7. Changing Names without Changing Content

*From PAS to PAD to PA*

All 3 concepts identify the same factors as indicating alienation.

The factors have not changed since Gardner first proposed them [Gardner, 1986].

PAS was dropped because it did not meet the definition of a medical syndrome (e.g., location within an individual).

PAD was chosen specifically to advocate for inclusion in *DSM-5*, which defines psychiatric diagnoses as mental disorders.

PA was chosen to legitimize inclusion in the sections of *DSM-5* that do not identify mental disorders.

These changes serve advocacy needs, not clinical or scientific ones.
7. Changing Names without Changing Content

**From an Attorney**
“I don’t care what you call it. I know it when I see it.”

**From an Evaluator**
“Alienation is like porn – You know it when you see it.”

*From Milchman, Geffner, & Meier*
“No you don’t. You think you know it when you label it.”

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**PA Rhetoric is Effective**

Now let’s see whether PA allegations are persuasive to courts even when evidence does not warrant it.

Do court decisions favor PA when PA evidence is lacking or minimal or contradicted?

Do court decisions favor PA over abuse evidence?

The following presentations address these issues.
References

A Reference List is provided as a handout. It has all the references on these slides and others contained in Milchman, Geffner, and Meier (2020), which is titled “Ideology and rhetoric replace science and reason in some parental alienation literature and advocacy: A critique”
2. Alienation Theory vs Practice

WHAT HAVE WE SEEN?

THEORY - Extensive alienation literature

In-depth scholarly exchange and theorizing about parental alienation, as in the articles in this Special Issue, adds credibility to the construct, and helps reassure experts and courts that alienation is a research-based, well-considered concept.
BUT . . .

Does practice in actual court cases match the theory and scholarship?

?  

One reason the scholarship supports the credibility of alienation construct is that it rightly acknowledges complexity:

Leading scholarship is converging around the idea that contact resistance is **multi-factorial** – i.e., rarely just one parent’s doing, e.g.:

Bala and Fidler, 58 Fam. Ct. Rev. 576 (2020)

“It is widely acknowledged that [contact resistance] cases are best understood and addressed by relying on a multi-factorial perspective...”
Sullivan and Johnston, 58 Fam. Ct. Rev. 270 (2020)

“Persistent erroneous assumption that an alienating parent is primarily the source of a child’s resistance/rejection of a parent (called the dominant Single-Factor theory of PA) is problematic in applying PA constructs in research and practice.”

“A careful look at a child’s resistance to contact may surface several issues, for example, a history of inadequate parenting by the target parent . . . child snatching, forceful restraint, mouth kissing . . . Intimate partner violence” (275, 280)

Drozd, Olesen & Saini, PARENTING PLAN & CHILD CUSTODY EVALUATIONS, p. 3 (2013)

“The paradigm shift that is proposed here is movement from the approach in which evaluators think of the psychological question in binary terms – as “yes/no” questions. . . [e.g.] “Has this father committed domestic violence?” or “Is this mother alienating?” . . . The authors propose that evaluators shift to an approach that is multidimensional, multilevel, multi-causal, and interactive . . . as “yes/no/both/and”
Bottom line from leading scholarship – multi-factorial analysis:

Assessing children’s contact-resistance requires considering all possible causes:

- Behaviors of the DISfavored parent which may cause child distress (not limited to DV or child maltreatment)
- Developmental issues, such as age-based or situation-based separation anxiety
- Experiences at the disfavored parent’s home (e.g., another partner, new child, etc)
- Behaviors of the preferred parent which may undermine the child’s relationship with the disfavored parent
- Schedule issues, and many more

POLLS

POLL 1. Belief

How many of you agree this multi-factorial approach [all possible causes of a child’s resistance to contact] should be utilized?
POLL 2. Experience

How many alienation cases* have you been involved in?

- 1-5
- 6-10
- 11-20
- More than 20

* IE, alienation alleged and seriously considered in litigation

Poll 3. Multifactorial practice

How often in your cases (involving serious consideration of alienation) are other causes of contact resistance also considered by the court?

[Always; Often; Occasionally; Never]
“SINGLE-FACTOR” CASE EXAMPLE: H v H (CA 2013)

Father convicted and imprisoned for 6 years for felony sexual assault of mother (horrific details caught on tape)

Neutral evaluator found children very afraid of father due to both his DV against mother and his abuse toward them, esp the autistic one (yelling, humiliating, and hitting, leaving bruises)

Trial court said children were only “collateral damage” of father’s abuse of mother, therefore:

Children’s fear was purely result of mother’s presumed alienating conduct (no evidence)

H v H (CA 2013), cont’d

Despite evaluator’s suggestion of father’s serious pathology and need for substantial treatment and rehabilitation before seeing children. . .

• Court ordered immediate reunification with children when father released from prison, before any counseling

• Court said non-reunification not an option – indifferent to children’s feelings

• Reversed on appeal (unpublished) on multiple grounds
Poll 4. Court Treatment

In your experience:

How often, in “alienation” cases where there are multiple factors potentially relevant to children’s rejection, do courts treat alienation as the primary one?

[Always; Often; Occasionally; Never]

Dominant Factor Case Example


- Court found father was “more prone to lose his temper than most people” and “used temper and intimidation to impose his will”
- Court found father had committed two intrafamily offenses involving shaking and throwing the mother
- Older daughter angry at father for witnessing his abuse, his lying about it, and his shaking her during her first visit (over a toothbrush) – refused to visit again
- Court found mother “unintentionally” alienating
- Court awarded joint custody to father to remedy “alienation”
E.J. v D.J., subsequent events

Two years later, father moved for full custody of both children due to older child’s continued resistance to seeing father.

Court told older child that if she did not “learn to like” her father she would “live with the consequences.”

Three months later awarded sole custody of both children to the father.

Older child was cut off from mother; subjected to numerous “treatments” including boarding rehab programs. Multi-year removal from her happy, successful life in high school, competitive chorus, and with friends and sister.

“Treatments” did not improve her feelings toward her father. Ultimately, father let her go back to her mother.

POLLS 5 & 6

5. How often in your cases (where alienation was a serious concern) have courts primarily blamed the preferred parent for a child’s contact resistance? [Always; Often; Occasionally; Never]

6. How often in your cases (where alienation was a serious concern) have courts required the rejected parent to change how they parent [not reunification therapy] in order to receive increased or desired parenting time?

[Always; Often; Occasionally; Never]
POLL 7. Outcomes (fathers)

How often where father was claiming alienation did evaluator (or other neutral) recommend custody or parenting time that favored the “alienated” father

[Always; Often; Occasionally; Never]

Poll 8. Outcomes (mothers)

How often where mother was claiming alienation did evaluator (or other neutral) recommend: custody or parenting time that favored the “alienated” mother

[Always; Often; Occasionally; Never]
Wrap-up

It appears that courts often don’t seriously weigh the different reasons discussed in the literature for children’s contact-resistance.

Even when there are obvious, significant other reasons, e.g., serious abuse (HvH), some courts ignore these in favor of blaming the preferred parent for “alienating.”

We need to ensure that the “other factors” – especially family violence - are addressed as potential primary factors, so the alienation label is not mis-applied to subject children to dangerous or harmful parents. The literature must be applied in court.
Beyond Rhetoric in Cases: Assumptions vs Evidence in Determining Alienating Behaviors vs Domestic Violence/Child Abuse

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KEY ISSUES

Alienating Behaviors are not Child Abuse
Alienating Behaviors are not Domestic Violence
Parental Alienation is not a Condition or Diagnosis but it is an Inappropriate Label
The Issues are the Parental Behaviors: Alienating Behaviors vs Abusive Behaviors
Resist-Refuse Dynamics are not the End Product: The Reasons for the Behaviors are the End Product Assumptions are Problematic; Evidence is the Key
“High Conflict Divorce” vs Abuse

The theory/label/worldview of “High Conflict Divorce” confuses clear cut issues of domestic violence and child abuse by assigning blame for the violence equally to victims and perpetrators and viewing the violence as situationally caused by the “family system” dynamics. It minimizes abuse.

Difficulties/Ethical Issues

Preconceived ideas (divorce/parenting/alienation)
Poor interviewing and investigation
Lack of knowledge of child development or family psychology dynamics
Lack of understanding of victim dynamics and trauma
Lack of understanding of offender behaviors and profiles
Conclusions and recommendations do not match the data or the above issues
“Investigation”/Evaluation Issues

Open minded
  ◦ Don’t make presumptions/assumptions
Neutral in judgment
Review prior information and records
Anticipate problems and options
Alternative hypotheses
Countertransference
BE SUPPORTIVE, NOT JUDGMENTAL

Definitions  (Geffner, 2016)

Distinction between Abuse and Aggression:

Abuse = a pattern of learned behavior; one partner gets his/her needs met at the expense of the other; use of power and coercive control; usually has elements of intimidation, and often produces hurt, fear and trauma. The abusive person is using superior position, privilege, or strength to impose his/her will on another. Control can be directed at the victim’s actions, feelings, and/or beliefs. The context, motivation, and consequences are the keys.

Aggression/Assault = usually physical but can be verbal or sexual, where one person commits an assaultive behavior on the other person. This is usually an isolated event.

Thus, can have abuse without physical aggression, or aggression without abuse. Mutual Abuse would be where both partners are fighting with each other for power and control (not common – 10-15% of cases).
General Incorrect Assumptions Too Often Made by Child Custody Evaluators

- IPV has no correlation with child abuse and unfit parenting
- What happens between the parents does not affect the children
- A parent must facilitate access to their children’s other parent regardless of danger/abusiveness
- Maximum contact with both parents is essential and beneficial to all children

Broad-based, multiple-measured evaluation of all parties

Psychology borrows from the law:
“Parents and other parties are likely to advance their concerns in a forceful and contentious manner” (p. 864)

Multiple methods of data gathering enhance the reliability and validity of opinions, and recommendations (p. 866)
Overview of Evaluation

Phase 1- Pre-eval procedures
Phase 2- Clinical Interview & Testing - Multiple Measures
Phase 3- Observations of Parents and Child(ren)
Phase 4 - Collateral Information
Phase 5 - Interview and Report Findings to Parties
Phase 6 - Presentation to Attorneys

Psychological Testing

Standardized testing of abusive parties is of questionable validity and reliability (Bagby, Nicolson, Buis, Radovanovic, & Fidler, 1999; Bathurst, Gottfried, & Gottfried, 1997; Emery, Otto, & Donahue, 2005).

It can rule in more than rule out.
Use data from psychological testing to generate hypotheses.
What Are We Looking For in Psychological Assessment?

Personality Characteristics
Psychological Functioning, Anger, Hostility
General Attitudes, Power and Control
Parenting Issues
Interpersonal Skills
Trauma Symptoms
Substance Abuse

Issues to Assess for Each Family Member

Violence/Abuse/Intimidation  Trauma/PTSD
Psychological Functioning  Social Skills
Substance Abuse/Dependence  Dominance/Need to Control
Attitudes - Power & Control Psychopathy
                  Parenting Skills Self-Esteem
Gender Role  Anger/Hostility
                     Stereotypes Depression
Communication  Impulsivity
Assertiveness  Fears
Conflict Resolution Skills Empathy
                               Readiness to Change
ADULT PROCEDURES

Each parent can expect approximately 8 hours of testing and evaluation. Approximately 3 hours will be needed for administration of the semi-structured interviews and observations, 2 hours for a home study if conducted, and another 3-4 hours for administration of the following tests:

- MMPI-2, Personality Assessment Inventory (PAI), Trauma Symptom Inventory – 2 (TSI-2) and/or Detailed Assessment of Posttraumatic Stress (DAPS), Parenting Stress Index -4 (PSI-4), Parent-Child Relationship Inventory (PCRI), Personal Problems and Personal History Checklists, Checklists about each child, and Parent/Family Questionnaires. Specific other measures for suicidality, substance abuse, domestic violence, etc. as needed.

- KFD Projective Test; Thematic Apperception Test (TAT), and Sentence Completions.

Sample Measures for Child Custody

- Minnesota Multiphasic Personality Inventory—MMPI-2 (567 True/False) – 1-1½ hrs. (Pearson)
- Personality Assessment Inventory (PAI) - Morey, 1991 (344 items, 4-point Likert scale - 40 minutes (PAR)
- Parenting Stress Index (PSI) Reg or Short Form 4th ed - Abidin, 2012 (120 or 36 items, 5-point Likert scale) – 10-20 minutes (PAR)
- Parent-Child Relationship Index (PCRI) — Gerard, 1994 (78 items, 4-point Likert scale) - 15 minutes, self report by parent, one for each child (WPS)
- Trauma Symptom Inventory – 2 (TSI-2) - Briere, 2006 (120 items, 4-point Likert scale – 15-20 minutes (PAR)
- and/or The Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) – 25 minutes (PAR)
- Suicide Probability Scale (SPS) - Cull & Gill, 1988 (36 items, 4-point Likert scale) - 10 minutes (WPS)
### Additional Sample Measures That Can Be Used

- Millon Clinical Multi-Axial Inventory (MCMI -IV) **[not with victims of abuse]**
- Conflict Tactics Scale (CTS) or Dangerous Scale
- Parent Alliance Measure (PAM)
- Hare Psychopathy Checklist
- Child Abuse Potential Inventory (CAPI)
- Buss-Perry Aggression Questionnaire
- Personal History Checklist, Problems Checklist, and Parenting/Family Questionnaires
- SPECTRA, ACEs/Resilience, SASSI

### Sample Measures to Utilize with Victims of DV/IPV

The Conflict Tactics Scale (CTS; Straus, 1979) and the Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996 - WPS)
- Developed during the past two decades as a tool for measuring the frequency and type of family violence
- Consists of 18 items that measure three different ways of handling conflict in intimate relationships: reasoning, verbal aggression (also known as psychological abuse), and physical violence
- Items are ranked on a continuum from least to most severe, with the first 10 describing acts that are not physically violent and the last 8 describing violent acts
- The last five items make up the “severe violence” index and include acts such as “kicked at” and “used a knife or gun.”

Other measures: DA - Dangerousness Assessment Scale 2 and Rev (Campbell, 2003, revised 2005, update 2018); Index of Spouse Abuse (Coker, Pope, Smith, Sanderson, & Hussey (2001); WEB -Women’s Experiences with Battering Scale (Smith, Earp, & DeVillis, 2002); and Battered Women Justice Project Guides
Procedures for Children

Each child involved will be interviewed if verbal, and usually given some combination of the following:

- DAF/KFD Projective Test
- Sentence Completion and Prokop Divorce Adjustment
- Roberts Apperception Test - 2
- Anxiety & Anger scales
- Children's Depression Inventory - 2
- Trauma Symptom Checklist
- Piers-Harris Self-Concept Scale -3
- Aggression Questionnaire
- Personal History/Problems Checklists

There will be at least 2 play therapy or interview sessions with each child, using techniques such as the Thinking/Feeling/Doing Game or Conversations. Following this, there will be 2 observation sessions, one with each parent and children that includes one structured and one unstructured. Preschool children will be receive the following:

- Play therapy sessions
- Projective Drawings, if old enough

Psychological Assessment of Children and Adolescents

Sample Objective Tests:

- Trauma Symptom Checklist for Children or TSCYC – Briere (PAR)
- Aggression Questionnaire (AQ) - Buss & Warren (WPS)
- Child Anxiety Scale (CAS) or Revised Children's Manifest Anxiety Scale (RCMAS) - Reynolds & Richmond – (WPS)
- Children's Depression Inventory -2 (CDI-2) - Kovacs (MultiHealth Systems or WPS)
- Children’s Inventory of Anger (ChIA)- Nelson & Finch (WPS)
- Piers-Harris Children’s Self-Concept Scale – 3 (PHCSCS-3) - Piers & Harris (WPS)
- Conflict Tactics Scale –Children (CTS-C) – Straus & Hamby (WPS)
- IQ (WISC V), Achievement (WRAT 5, WIAT), Visual-Motor (Bender), Attention (Connors, TOVA) – These only if LD suspected
### Sample Objective Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Domains Assessed</th>
<th>Informant</th>
<th>Ages</th>
<th>Type of Scale</th>
<th>Time Needed</th>
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<td>Trauma Symptoms</td>
<td>Self</td>
<td>9-18</td>
<td>Likert</td>
<td>10 minutes</td>
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<td>Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005)</td>
<td>Trauma Symptoms</td>
<td>Caregiver</td>
<td>3-12</td>
<td>Likert</td>
<td>10 minutes</td>
</tr>
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<td>Aggression Questionnaire (AQ; Buss &amp; Warren, 2000)</td>
<td>Aggression</td>
<td>Self</td>
<td>8 and above</td>
<td>Likert</td>
<td>10 minutes</td>
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<td>Revised Children’s Manifest Anxiety Scale (RCMAS; Reynolds &amp; Richmond, 2009)</td>
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<td>Self</td>
<td>6-19</td>
<td>Yes/no</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Children’s Depression Inventory – 2 (CDI-2; Kovacs, 2012)</td>
<td>Depression</td>
<td>Self</td>
<td>7-17</td>
<td>Likert</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Child Behavior Checklist (Achenbach, 2001)</td>
<td>Behaviors</td>
<td>Caregiver</td>
<td>1 ½-5; 6-18</td>
<td>Likert</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Children’s Inventory of Anger (ChIA; Nelson &amp; Finch, 2000)</td>
<td>Anger</td>
<td>Self</td>
<td>6-16</td>
<td>Likert</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

### Sample Objective Measures (Cont’d)

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Domains Assessed</th>
<th>Inform-ant</th>
<th>Ages</th>
<th>Type of Scale</th>
<th>Time Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piers-Harris Children’s Self-Concept Scale (PHCSCS-3; Piers &amp; Herzberg, 2018)</td>
<td>Psychologi-cal Health</td>
<td>Self</td>
<td>7-18</td>
<td>Likert</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Millon Adolescent Clinical Inventory (MACI; Millon, et al, 1993)</td>
<td>Personality</td>
<td>Self</td>
<td>13-19</td>
<td>T/F</td>
<td>20-25 minutes</td>
</tr>
<tr>
<td>Family Adaptability and Cohesion Evaluation Scale (FACES III; Olson, Portner &amp; Lavee, 1994)</td>
<td>Family Relation-ships</td>
<td>Self</td>
<td>12 and above</td>
<td>Likert</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Child Sexual Behavior Inventory (CSBI; Friedrich, 1997)</td>
<td>Sexual Behavior</td>
<td>Care-taker</td>
<td>2-12</td>
<td>Likert</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
Child Sexual Behavior Inventory (CSBI)

- Children should be between the ages of 2 to 12 years
- Normed on female caregivers
- 38 items are ranked on a 0 to 3 Likert Scale
  - ‘Never’ to ‘At least once a week’
- T-scores between 60 to 64 are potentially problematic
- T-Scores above 65 are significant

CSBI

Items:
- Issues with boundary
- Self-stimulation
- Sexual knowledge

Does not have validity scale
- A raw score of 45 or above on the CSBI Total scale is rare

Scales
- Developmentally Related Sexual Behaviors
- Are these developmentally appropriate?
- Sexual Abuse Specific Items

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Adolescent

Clinical Interviews and Observations
Millon Adolescent Clinical Inventory (MACI)
Adolescent Psychopathology Scale – Short Form (APSSF) – instead of P-H, CDI, RCMAS
Trauma Symptom Checklist for Children (TSCC)
Children’s Inventory of Anger (ChIA)
Aggression Questionnaire (AQ)
Reynolds Adolescent Depression Scale – 2 (RADS-2)
Roberts Apperception Test for Children (RATC) or TAT
Kinetic Family Drawing Task (KFD)
The Forer Structured Sentence Completion/Prokop Divorce Adj. Invent.
Personal Problems Checklist for Adolescents
Personal History Checklist for Adolescents

Sample Projective Measures (Adolescent/Child)

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Domains Assessed</th>
<th>Reporter</th>
<th>Ages</th>
<th>Time Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic Apperception Test (TAT)</td>
<td>General personality</td>
<td>Self</td>
<td>14 and above</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Roberts Apperception Test – 2nd Edition (RATC-2; Roberts, 2003)</td>
<td>General Personality</td>
<td>Self</td>
<td>6 and above</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Prokop Divorce Adjustment Inventory (Prokop, 1986)</td>
<td>Adjustment to divorce; conflicts and attitudes</td>
<td>Self</td>
<td>7 and above</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Sentence Completion (Stoner or Forer)</td>
<td>General personality</td>
<td>Self</td>
<td>7 and above</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Kinetic Family Drawing</td>
<td>General personality</td>
<td>Self</td>
<td>6 and above</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Rorschach (Exner, 1993; RPAS, 2010)</td>
<td>General Personality</td>
<td>Self</td>
<td>6 and above</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

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Modify Structured Clinical Interview

Questions focus upon:

. Family of origin
. School history and work history
. Previous and current relationships
. Parenting history
. Events leading to the separation, and allegations in the present custody dispute
Parental Interviews When a Trauma has Occurred or Been Alleged:

A review of the divorce and any traumatic incident from the parent’s point of view.
Observations of the child’s initial responses.
Information about the child’s current symptoms.
The child’s developmental history.
Information about lost skills following the divorce or trauma.
Their personal reaction to the child’s experience and symptoms.

Clinical Interview

Questions focusing directly on gathering a complete trauma history
Information regarding substance abuse
Cultural issues
History of traumatic or abusive incidents in both the immediate family, as well as within the family of origin for each parent
Clinical Interview (cont’d.)

Unspoken language--may be more important than what is stated overtly

Behavioral observations play a key role in understanding
  ◦ How the interviewee is experiencing the questions may shed some light onto their comfort level in honestly answering the evaluator's inquiries

Many trauma victims and survivors are keenly aware of and tuned into nonverbal gestures and subtle hints of disbelief. This may lead them to attempt to persuade the interviewer in more intense ways about the abuse

Family Violence & Sexual Assault Institute dba Institute on Violence, Abuse and Trauma

INITIAL INTAKE ASSESSMENT-CUSTODY

Client Name: _______________ Date: _____________ DOB: __________
Sex: __ Length of Session(s): ____ Provider: ___________ Atty ___________
Report/Records To: ____________________________________________ Release Obtained: Yes No
*****************************************************************************
1. Judge / Courthouse / Case Number:
2. Significant Family Hx of Parent: (#/ages children, marital history, family origin):
3. Sociocultural Background (religion, ethnicity, affiliated groups, etc.):
4. Education/Work History:
5. Significant Medical History and/or Prior Medical Treatment:
6. Current Medications/Dosage:
7. Prior Mental Health Functioning/Treatment:
8. Current Symptoms and Clinical Findings (Severity: 1-Mild, 2, 3-Severe):
   __Tension ____Fatigue __________Obsessions ___Anxiety ___Headache ___Compulsions
   __Depression ___Dizziness _______Drug/Alcohol Use ___Suicidal Ideation ___Appetite Disturbances
   __Hallucinations ___Sleep Disturbances__Physiological Symptoms ___Delusions ___Nightmares
   ____Sexual Problems ___Homicidal Ideation ____Tics ___Phobias ___Easily Distractible ___Impulsivity
   ___Hyperactivity ___Low Self-Esteem __Intrusive Thoughts ___Hypervigilance ___Avoidance

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9. Substance Abuse History:  
10. Legal History:  
11. Other Background (Client’s strengths/protective factors):  
12. Concerns about the Other Parent:  
13. Current Custody Arrangement:  
14. Requested Custody Arrangement and Rationale:  
15. Relationship History of Parties Involved:  
16. CPS/CWS/DV:  
17. Child(ren)’s History (Educ., Medical, Mental Health, Sociocultural, Substance, etc.):  
18. Impression of Client’s Response to Evaluator:  
   _____ Overly Compliant _____ Cooperative _____ Fearful  
   _____ Suspicious _____ Hostile _____ Apathetic  
19. Physical Appearance:  
   _____ Well-Groomed _____ Presentable _____ Untidy _____ Disheveled  
20. Communication Style:  
   _____ Excessively Talkative _____ Appropriate _____ Under-Productive _____Answers Questions Only  
21. Insight:  
   _____ Little or None  
   _____ Some Insight Into Dynamics Involved  
   _____ Seems to Have Good Intellectual Insight  
22. Motivation:  
   _____ Poor  
   _____ Ill-Defined  
   _____ Good  
23. Affect:  
   _____ Flat _____ Appropriate _____ Concrete _____ Blunted _____ Variable/Depressed  
24. Judgment:  
   _____ Intact _____ Impaired  

Child Interviews Can Provide...  

The child’s story of the event -- through play, if not verbally.  
The meaning the child attaches to the event.  
How the child is coping with the aftermath.  
The child’s coping style.  
The child’s strengths—individual, family and community.
Robert Geffner, Ph.D., ABPP, ABN  
Psychologist/Neuropsychologist/LMFT  
Institute on Violence, Abuse & Trauma

DIAGNOSTIC INTERVIEW FOR CHILDREN & ADOLESCENTS

NAME: __________________ DOB: ______ AGE: ______
SCHOOL: __________________ GRADE: ______
GENDER: ______ ETHNICITY: ______ DATE: ______

FAMILY

How many are there in your family? ________________________________
Who lives in your house with you? ________________________________
How long have you lived where you do? ____________________________
Do you like it there? ________________________________
Where have you lived before this? ________________________________
Where does the rest of your family live (siblings, grandparents)? ______
What do your parents do for a living? _____________________________

Interview (cont’d)

FAMILY/SELF

What are your favorite TV programs? ________________________________
Why do you like them? _________________________________________
What is the earliest memory you can recall? _________________________
How old were you? _____________________________________________
What activities does your family enjoy together? ____________________
What do your parents do when you do things that you shouldn’t? ______
Do you get punished? _______ In what way? _______________________
Do you get along better with your Mom or your Dad? _________
   Mom - What does she do that you like? ________________________
   Don’t like (bugs you)? ________________________________
   Dad” - What does he do that you don’t like (or that bugs you)? ______
   That you like? ____________________________________________
If you had a "magic wand" and could change one thing in your family to make it more like you’d like it to be, what would you change? _______

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Interview (cont’d)

SCHOOL

Do you like school? ____________________________
What is your favorite subject? ____________________________
Why? ____________________________
What school subjects do you not like? ________________
Why? ____________________________
What could be done to help you do better in school? ___________
Who is your favorite teacher? ____________________________
Why? ____________________________
What does he/she do that you like? ____________________________
Who is your least favorite teacher? ____________________________
Why? ____________________________
What does he/she do that you don't like? ____________________________
If you had a "magic wand" and could change your school to be any way you wanted it to be, what changes would you make? ____________________________

Interview (cont’d)

SELF-IMPRESSIONS/RELATIONS WITH OTHERS

What kinds of things are you good at doing? ________________
What kind of pressures are you under now (what gets you uptight)? If you had to describe yourself, would you say that you are mostly:

Shy/not shy     Hard worker/kind of lazy     Quiet/loud
Active/not so active     Good/bad     Happy/unhappy
Smart/dumb     Restless/calm
Worry about things/don't worry
Usually do what you are told/don't do what you are told.

If you could make three wishes, what would they be? ____________
What is the worst thing that you ever did? ________________
What is the worst thing that has happened to you? ________________
What is the best thing that you ever did? ________________
What is the best thing that has ever happened to you? ________________
Interview (cont’d)

What are some things that you do that get you upset or mad? ___
  Why?__________________________
What are some things that others do that get you upset? ______
What do you do when you get mad/angry?_____________________
What are some things that you do that upsets others?___________
If you could be any animal in the whole world, which one would you be?
  Why?__________________________
What kinds of sports/interests/activities do you like?___________
If you could change anything about yourself, what would it be?

What would you like to be when you grow up?______________
  Why?__________________________
What else would you like to tell me about yourself?___________
What else should I have asked but did not? ________________

Review of Records

Did evaluator fully review all relevant records:
  Police Records
  Child Protective Services Records
  School Records
  Medical Records
  Therapist Records
  Other Evaluation Records
  Court Records
  Other
Phase 3- Observations of Parents and Child(ren)

1. Instructions for Parent–Child Observation
2. “Come prepared to play with your child for an hour”
3. Expected baseline parenting behaviors
4. Structured and unstructured
5. Ending of observation process
6. Clean up

Expected baseline parenting behaviors

Observe compliance, noncompliance, inappropriate behavior, indirect questions, interaction, behavior or critical comments, control issues, warmth, touch, eye contact, autonomy

Note ability to use direct instruction, descriptive statements, reflective listening, labeled praise, unlabeled praise, or ignore inappropriate behavior
Creating/Obtaining a Timeline

A Timeline is a chronology of the entire narrative history of the case, in chronological order. It should cover all issues relevant to the child’s best interests, and should include all the information available to the evaluator from records, interviews, and court filings.

Allegations Of Child Abuse

CONFIRMED, FOUNDED, SUBSTANTIATED (20-45%)
PROBABLY TRUE
UNSUBSTANTIATED, UNCONFIRMED, NOT ABLE TO BE PROVEN (30-45%)
PROBABLY NOT TRUE
UNFOUNDED (2-12%) - -
[Misperceived (6-10%), False (2-5%)]

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MISINTERPRETING UNSUBSTANTIATED CPS REPORTS TO MEAN CHILD WAS LYING OR SOMEONE WAS COACHING THE CHILD (i.e., FALSE ALLEGATIONS)

Controversies in Child Sexual Abuse Evaluations

Suggestibility and Programming/Coaching of Children
False Allegations; Substantiation Rates
Parental Alienation vs Abuse
Models to Use; Consensus Statement for Forensic Interviewing
  ◦ APSAC Website vs NICHD/Others
Number of interviews; Types of Questions
Use of Anatomically Detailed Dolls/Drawings
Sexualized Behavioral Symptoms
Assessment Techniques
Psychological Profiles of Victims and Offenders
Is it easy to get a child to make a false report of child abuse by coaching a child?

What if child had a good relationship with the other parent and a secure bond?

How would you do it?

OVERVALUING THE COACHING HYPOTHESIS
Inaccurate Assumptions/Myths

- Ignoring and not investigating new abuse disclosures because of previous court or evaluator findings that abuse did not occur in the past, or because it is a custody case.
- Discounting abuse disclosures because the child displayed a "normal" affect in the presence of the alleged abuser.
- Not taking context and history into consideration in determinations of sexual abuse conclusions.
- Repeated forensic interviews of children automatically produces unreliable or suggestible outcomes.
- Therapists in custody court cases must follow forensic guidelines.

Common Mistakes For Failure to Recognize Child Sexual Abuse

- Focusing on police and medical records to confirm abuse
- Assuming abuse disclosures in child custody cases are false
- Assuming child sexual abuse allegations are due to coaching, suggestibility, or programming, and that it is relatively easy to do this
- Skepticism of new or delayed abuse allegations
- Relying on polygraphs in decision-making

Faller, Geffner, Goldstein, Lyon, Silberg, and others
# The Myth of Johnson’s Typology of IPV

*(Johnson, 2008)*

Not Replicated and Does Not Match Accepted Research or Terminology (e.g., Meier, 2017)

<table>
<thead>
<tr>
<th>Motives of DV</th>
<th>Intimate Terrorism (IT) (Feminist Perspective)</th>
<th>Situational Couple Violence (SCV) (Family Violence Perspective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distinguishing Features</td>
<td>Maintaining general control over one’s partner</td>
<td>Family conflict that is instigated by stress</td>
</tr>
<tr>
<td></td>
<td>Violence rooted in <em>coercive control</em></td>
<td>Violence rooted in <em>conflict</em> or <em>situational stress</em></td>
</tr>
<tr>
<td></td>
<td>Multiple violent and non-violent control tactics</td>
<td>Specific conflicts or situations in which one or both partners act out violently</td>
</tr>
</tbody>
</table>

---

# More details and forms


G. Andrew H. Benjamin, Connie J. Beck, Morgan Shaw, and Robert Geffner


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References


Institute on Violence, Abuse & Trauma (IVAT), San Diego, CA   www.ivatcenters.org

National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV) – Annual Meeting and Think Tank, Aug. 29, 2020, San Diego, CA   www.npeiv.org

International Summit on Violence, Abuse & Trauma, – Aug. 30-Sept. 2, 2020, San Diego, CA   www.ivatcenters.org

Assessing, Treating & Preventing Child, Adolescent & Adult Trauma - April 27-30, 2021, Honolulu, HI
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