

Practice Parameters for Child Custody Evaluation

ABSTRACT

These practice parameters are presented as a guide for clinicians evaluating the often delicate and complex issues surrounding a child custody dispute. The historical basis of child custody and the various judicial presumptions that have guided courts are reviewed. The differences between performing child custody evaluation and engaging in traditional clinical practice are emphasized. Issues that are common to all child custody disputes are presented, including continuity and quality of attachments, preference, parental alienation, special needs of children, education, gender issues, sibling relationships, parents' physical and mental health, parents' work schedules, parents' finances, styles of parenting and discipline, conflict resolution, social support systems, cultural and ethnic issues, ethics and values, and religion. In addition, special issues that complicate custody evaluations are discussed, including infants in custody disputes, homosexual parents, grandparents' rights, parental kidnaping, relocation problems, allegations of sexual abuse, and advances in reproductive technology, such as frozen embryos, oocyte donation, and artificial insemination. An outline is provided that describes the complete evaluation process, from assessing referrals and planning a strategy through conducting clinical interviews, writing the report, and testifying in court. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(10 Supplement):57S-68S. **Key Words:** child custody, forensic psychiatry, joint custody, court, parenting, practice parameters, guidelines.

Because evaluating the needs of children and adolescents in child custody disputes is complicated and requires specialized knowledge and techniques, practice parameters can be helpful to clinicians and, ultimately, the families they evaluate. These parameters take into account that well-meaning, ethical, and competent clinicians may approach this work in different ways. However, certain methodologies and clinical and ethical boundaries have emerged over time and are presented in these parameters. The recommendations in these parameters are basic principles that should be considered by clinicians who perform custody evaluations and consult with judges and attorneys. Just as competent clinicians may vary in their approaches to evaluation, diagnosis, and treatment, qualified forensic evaluators may differ in their methods.

Although these parameters are not meant to be followed exactly, they contain principles that should be followed when performing child custody evaluations, which are often complicated.

LITERATURE REVIEW

Medline searches were conducted in 1993 and 1996 for the term "child custody" in the titles of articles. Therefore, only papers primarily concerned with child custody have been cited.

Historical Development

Approximately one in two marriages in the United States ends in divorce, affecting about 1,000,000 children per year. Approximately 10% of divorces involve custody litigation. Thousands of children, therefore, are at the center of often protracted legal battles.

A number of authors stress the importance of understanding the historical basis of the custody dispute (Derdeyn, 1976) and evaluating the clinician's role of undertaking a comprehensive evaluation, rendering a readable, helpful report, and, if necessary, testifying in court. Haller (1981) stresses the importance of preparing a strategy for the evaluation and warns against evaluations that assess or support only one party to the dispute. Benedek and Benedek (1980) discuss the role of the expert and the importance of clinician education in the specifics of child custody evaluation. Benedek and Schetky (1985) discuss child custody assessment and the "best interests" presumption. Weithorn (1987)

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provides a comprehensive legal context for the clinician and Ackerman (1994) provides a guide for psychologists that includes pertinent information for child and adolescent psychiatrists and other clinicians. Nurcombe and Partlett (1994) provide an excellent overview of child custody and the role of the clinician. In a section on ethical issues, they stress the importance of the evaluator functioning as an expert and not as an advocate or adversary.

During the 1970s, joint custody, in which both parents are granted equal rights to and responsibility for their children, was touted as almost a panacea for the negative impact of divorce on children. Many saw this arrangement as a way to avoid protracted litigation and its presumed deleterious effects on families. Steinman et al. (1985) describe factors that might predict which joint custody arrangements succeed and which fail. Although their statistics (one third of joint custody families live successfully, one third have difficulties, and one third fail) may not be accurate, her observations make sense: joint custody arrangements can work reasonably well if the divorced parents are psychologically healthy, able to set aside their anger, frustration, and disappointment with each other, and willing to tolerate each other's style of parenting. Atwell et al. (1984) review the psychological and interpersonal effects of joint custody on children, and Tibbits-Kleber et al. (1987) discuss the history and legislative ramifications of joint custody plans. They catalog the advantages and disadvantages of joint custody and outline the role of the clinician in counseling and evaluating families regarding this custody option. They rightly differentiate the needs (or rights) of parents who seek joint custody from the overriding needs and interests of the children who must live with the arrangement.

Several organizations have published standards and guidelines for evaluating child custody disputes: The American Psychiatric Association Task Force on Clinical Assessment in Child Custody (1981), the American Psychological Association (1994), and the American Association of Family and Conciliation Courts (1994). The standards of the American Psychiatric Association and the American Psychological Association provide excellent reference sections that list guidelines from other organizations.

The examination and handling of child custody disputes mirrors the social forces and mores of the times (Mason, 1994). Beginning in ancient Rome and continuing until well into the 19th century, children were considered property and, therefore, awarded to the father, because women were accorded very few legal rights. In the 1800s, the courts adopted the concept of *parens patriae*, a moral (and then legal) duty to protect those citizens who are unable to protect themselves. As natural philosophy evolved into psychology and child development, and as psychoanalytic concepts elu-

cidated the importance of childhood experiences, the courts became increasingly concerned with protecting family members. Courts in Great Britain and the United States became more involved in family disputes, especially when children were at risk (Weithorn, 1987). In short, family law as it is practiced today is a relatively recent phenomenon (Derdeyn, 1976).

Judges have used different conceptual models over the years in their decisions regarding children in custody disputes. Kelly (1994) describes the history of how parents and courts have made decisions regarding custody and access. Recognizing the findings from psychoanalysis on the importance of the mother-infant relationship, the courts adopted the "tender years" doctrine, which held that in deciding a custody dispute, courts should assume that young children need to be with their mothers.

Although the tender years presumption was not uniformly defined, judges across the country, in their custody decisions, spoke of the special relationship between a child and his or her mother. Except in extreme cases of maternal unfitness, courts generally awarded custody of young children to the mother. In cases with children older than 7 years of age, however, fathers often sought and gained custody.

The tender years presumption predominated well into the 20th century, and many would argue that judges unofficially cling to it today. Nevertheless, the prevailing legal test in all states is "the best interests of the child" (*Finlay v. Finlay*, 1925). In general, however, "best interests" means that judges must determine which arrangement best fulfills the needs of the specific children involved. The argued benefit of this approach is to place the judicial magnifying glass on the children, making them the most important part of the process. The concept represents the full embodiment of *parens patriae*.

However, the best interests concept remains an ambiguous one. In practice, it refers to whatever fosters the positive development of the child, but it can be interpreted by judges in a variety of ways, ranging from financial suitability to psychological attachment. It has been argued that the "best interests" concept perpetuates the adversarial system by inviting parties to dispute what constitutes a child's best interests. In addition, as Goldstein, Solnit, and Freud (1973) argue, the use of the word "best" creates the impression that there is a good solution, and the courts must recognize what it is. These authors have postulated an alternative judicial presumption, which, they argue, goes beyond the "best interests" dictum. The concept of the "least detrimental alternative" suggests that all children in custody disputes are harmed to some extent, and the best solution is that which seems to harm them the least.

Many have argued that families are better served by mediation rather than litigation. Some families voluntarily

submit to mediation. In certain jurisdictions, mediation is mandatory. Miller and Veltkamp (1995) argue that mediation may help to protect the best interests of children. Emery, Matthews, and Kitzmann (1994) have found that fathers are more satisfied and more compliant with child support orders 1 year after mediation than 1 year after litigation.

The courts, meanwhile, hearing litigated cases not settled successfully, have turned to clinicians to assist in the determination of best interests. In their review of the court records of 282 disputed child custody cases, Kunin, Ebbesen, and Konecni (1992) have found that only two factors directly affect judges: child preference and the recommendations of the evaluator. Assuming that the psychological well-being of a child is as important — if not more so — than the economic well-being, courts routinely ask psychiatrists, psychologists, and social workers for their opinions about custody and rely heavily on these opinions.

THE ROLE OF THE EVALUATOR

Performing a forensic evaluation expands and complicates the clinician's familiar role of diagnosing and treating psychiatric illness and raises the important issues of competence, agency, and ethics. It is extremely important for the clinician to understand the differences in roles and to keep these roles separate. Wearing "two hats" — therapist and forensic evaluator — with a family is inappropriate and complicates both the therapy and the evaluation (Bernet, 1983).

Competence as a forensic specialist (Gindes, 1995) is crucial because a well-trained clinician with a background in evaluation, diagnosis, and treatment must demonstrate additional important skills, including an engaging interview style, an understanding of family and interpersonal dynamics, a breadth of knowledge of child and adult developmental issues, and familiarity with family law and legal process in the local jurisdiction. The clinician should have obtained continuing education on divorce and custody, should know when to consult with a colleague or mentor, should be aware of local laws and court procedures, and should maintain integrity and sensitivity to ethical issues.

Treating clinicians are advocates or agents for children and, ideally, are partners with parents or guardians in the therapeutic alliance. In contrast, the forensic evaluator, although guided by the child's best interests, has no duty to the child or his or her parents. The forensic evaluator reports to the court or attorney involved rather than to the parties being evaluated. Therefore, the aim of the forensic evaluation is not to relieve suffering or to treat the child but to provide objective information and informed opinions to help the court render a custody decision. Forensic evaluators must be mindful of this role and convey this, in full, to all parties before beginning the evaluation.

Ethical issues are frequently encountered in forensic evaluations. The potential evaluator must consider whether he or she has biases or prior involvement with any of the parties involved in the case that might alter the professionalism of the evaluation. The evaluator must have sufficient time to complete the evaluation in a timely manner and adequate scheduling flexibility to work with the judicial system. Although the fees for forensic evaluations are usually higher than for clinical treatment, fees should not be exorbitant but should be within the community standard. The evaluator, in almost all circumstances, should not refer any of the parties to himself or herself for treatment after the custody evaluation to avoid a conflict of interest.

AREAS FOR ASSESSMENT

A number of issues are common to many, if not all, custody disputes and frequently arise during the evaluations. If these issues are not raised by the families, the clinician should initiate discussion about them. Collecting data on these issues provides a sound basis for the evaluator's opinions and recommendations.

Continuity and Quality of Attachments

The assessment of the quality of the attachments between the parents and the children is the centerpiece of the evaluation. In the opinion of most courts, the concept of "the best interests of the child" has as much to do with the parent-child relationship as with the validity of each parent's plans for the child. The evaluator should assess the parent-child connections, recognize and protect the opportunities for the child to maintain continuity with attachment figures, and consider how these attachments should enter into the forensic recommendations (Rutter, 1995).

Preference

The child's stated preference of where he or she would rather live also may be an issue (Alexander and Sichel, 1991; Schowalter, 1979). Judges tend to give more weight to stated preference when the child is 12 years of age or older. Small children infrequently volunteer a preference. When they do, the evaluator should assess its meaning and whether the child came to this opinion freely or was rehearsed or heavily influenced by a parent (Yates, 1988).

Parental Alienation

There are times during a custody dispute when a child can become extremely hostile toward one of the parents. The child finds nothing positive in his or her relationship with the parent and prefers no contact. The evaluator must assess this apparent alienation and form a hypothesis of its origins and

meaning. Sometimes, negative feelings toward one parent are catalyzed and fostered by the other parent; sometimes, they are an outgrowth of serious problems in the relationship with the rejected parent. This phenomenon, which some have called a "syndrome," whereas others have objected to that characterization, has been addressed by Benedek and Schetky (1985) and by Dunne and Hedrick (1994). Courts have great difficulty interpreting these dynamics and turn to evaluators for guidance.

Child's Special Needs

The clinician should evaluate the child's physical and mental health, noting the presence of chronic conditions that require special care. The clinician also should assess the ability of each parent to understand and respond constructively to the child's disorder. For example, how well can each parent provide special care, such as at-home behavioral and environmental intervention for attention-deficit hyperactivity disorder (ADHD) or physically challenging conditions such as blindness? Do the parents frequently argue about choice of physicians, treatment, and ongoing care? What or whom is the source of the conflicts?

Education

The child's educational needs should be assessed, as well as parental conflicts about the child's education. Contentious issues may require sorting by the evaluator. The evaluation should address each parent's educational plans for the child and whether these plans accommodate special educational needs. Is one parent more sensitive to and realistic about these special needs than the other?

Gender Issues

The evaluator may be called on to provide an opinion about the impact of the child's or parent's gender on the custody decision. Attorneys or parents may attempt to use gender considerations to bolster their case, for example, making the argument that a daughter should stay with a mother and a son should stay with a father. Such conclusions are not supported by adequate studies and raise the controversial issue of separating brothers and sisters after divorce (R.E. Emery, personal communication). Because each family is unique, it is inappropriate to quote a particular developmental study as support for a particular point of view for a specific family. More to the point is each parent's relationship with the children and his or her sensitivity to the gender role-model needs of the child. For example, how is a single mother planning for her son to interact with adult males as he develops?

Sibling Relationships

The evaluator should assess the sibling relationships and each parent's sensitivity to them. Commonly, siblings going through divorce and a child custody dispute lend emotional support to each other, even if they do not frequently discuss the conflict. Children often are quite willing to state that they wish to remain with each other. Separation of siblings is rarely recommended as a solution to custody disputes, and judges are loathe to order it unless the peculiarities of a case warrant it.

Parents' Physical and Psychiatric Health

The evaluator should note each parent's health status, including any physical ailments or unhealthy habits, such as cigarette smoking, that could have adverse consequences for the child. Although parental smoking, for example, has been an issue in a number of custody cases, evaluators should assess the parent's insights and choices, as well as impact on the child.

The evaluator should assess whether either parent abuses drugs or alcohol. Sometimes, one parent accuses the other of drug or alcohol abuse, and it often is impossible for the evaluator to determine the truth. In other cases, the evaluator's clinical skills allow the child to reveal the presence of substance abuse. The clinician must then determine the impact of possible parental substance abuse on the child.

Another common issue arises when one parent has (or is alleged to have) a psychiatric illness. Herman (1990a, 1990b) emphasizes that the issue is not a diagnosis per se but, instead, is the effect of psychiatric impairment on the parent-child relationship. Malmquist (1994) argues that only when issues of parental fitness are raised in a custody dispute should a parent's psychiatric records be released. This approach is echoed in a Task Force Report published by the American Psychiatric Association (1991). Malmquist also points out that both judges and clinicians vary in their handling of records of prior psychiatric treatment.

Parents' Work Schedules

The evaluator must assess how each parent views his or her work and how it interfaces with time spent with the child. Commonly, couples have settled on an arrangement early in the child's life in which one parent spends more time with the young child at home. A history of this arrangement should not automatically weigh favorably for one parent and especially should not be a sole determinant of custody. The clinician should assess how each parent's work schedule impacts meeting the child's development needs. The evaluator should assess the child-care plans put into effect by each

parent. How have they worked for the child? What are each parent's attitudes toward child care?

Parents' Finances

The evaluator should consider the financial situations of each parent and how this might affect the child. Frequently, the financial details of the divorce are separated from the custody issue by the court and are not investigated to any great degree by the clinician. Nevertheless, he or she should have general knowledge of the family's financial circumstances to assess how these will affect the child.

Styles of Parenting and Discipline

The evaluator should assess each parent's parenting style to determine how good a fit there is between each parent and the child. Parenting styles may become obvious during the joint parent-child interviews. Sometimes, however, parenting style is difficult to assess except through what one parent charges about the other. Inferences should be fully explored whenever possible.

Assessments of parenting styles also may include each parent's opinion about the child's connection with the other, as well as each parent's prediction of how these relationships would change after the custody dispute. The evaluator might uncover parental jealousies or distortions or, alternatively, positive and generous points of view about the child's relationship with the other.

The evaluator should inquire about each parent's philosophy and practice of discipline. A litigating parent usually exaggerates the harshness or permissiveness of the other parent's manner of disciplining. The clinician must wade through the inevitable distortions to determine which disciplinary approaches seem most helpful to the child.

Conflict Resolution

The evaluator should examine how family members resolve conflicts. The clinician may observe major or minor disputes — especially between siblings — and witness how each parent attempts to resolve the problem. Even during play sessions, dynamics may emerge that mirror how conflict is handled in common family scenarios.

Social Support Systems

The evaluator should take into account social supports — grandparents, other family members and friends, and the child's own social network — whose availability to the child depends on the custody arrangement. What would the impact be on the child if these supports were or were not readily available? If a parent has a psychiatric illness or other disability, can that parent make use of supports that would enhance the his or her relationship with the child?

Cultural and Ethnic Issues

Cultural issues should be noted, especially if the litigating parties come from different cultural backgrounds. Cultural differences — once appealing to each of the parents — can become yet another contentious issue in a divorcing family. The evaluator should assess the availability of cultural and ethnic influences and their importance to the growth and development of the child.

Ethics and Values

The evaluator should consider how the parents' ethics and value systems affect the child. The parents' values may be similar or glaringly different. The evaluator must guard against imposing his or her own values on each parent. When one party's ethics are clearly suspect, however, as in someone with antisocial tendencies or personality disorder, the evaluator's task is to advise the court about how this pattern of behavior will affect the child.

Religion

Religion is frequently a contentious issue in child custody disputes. When parents of different religions marry and then divorce, conflict develops about which religion the child will adopt. Conflict can be particularly acute when the religions are quite different, such as Jewish and Catholic. In some families, conflict centers on whether there should be any religious training or exposure at all. Religion is an emotional venue in which parents frequently act out. For example, the child is taken to one house of worship with the mother and another with the father. The evaluator must assess the significance of the religious issue within the context of the family. It may be helpful to point out that children can be exposed to more than one religion as they grow without detriment, but ongoing parental conflict over this issue can cause harm.

SPECIAL ISSUES IN CHILD CUSTODY DISPUTES

Infancy

When an infant is the focus of a custody dispute, applying the "best interests" standard to the case may be difficult because of the difficulty of assessing accurately the child's attachment to each parent. The evaluator should nevertheless assess the parents' attachment to the child and the appropriateness of each parent's plan for the child considering his or her developmental needs.

Social Phenomena

A number of social phenomena affect child custody disputes. Herman (1990a, 1990b) writes that these phenomena complicate an already difficult process, requiring the expertise

and sensitivity of a qualified clinician. Such issues include homosexual parents, stepparents' and grandparents' rights, parental kidnapping, relocation problems, allegations of sexual abuse, and advances in reproductive technology, such as frozen embryos, oocyte donation, and artificial insemination. These issues perplex judges and jurists, who are increasingly likely to seek guidance from clinicians.

Homosexuality. It is estimated that several million parents in the United States are homosexual. In the past, homosexuality was an automatic impediment to gaining custody, and in parts of the country, it still is. Hutchens and Kirkpatrick (1985) express judicial concerns regarding parental homosexuality and stress the importance of educating the court about social science research in this area. Kleber et al. (1986) and Pennington (1987) found no detriment to children having lesbian mothers, whereas Bozett (1987) found that children of homosexual fathers may be distressed by their father's gay identity.

Grandparents. Grandparents have been exercising their political clout for the last 25 years and now are able to sue for custody — even against natural parents — throughout the country. Angell (1985) discusses reasons the courts have been reluctant to grant this right to grandparents, and Derdeyn (1985) reviews pertinent case law.

Child Sexual Abuse. Allegations of child sexual abuse are a common component of child custody disputes. Various authors, including Green (1986), debate the extent of false allegations arising during such disputes. Whatever the frequency of false allegations, sexual abuse charges do arise and additionally complicate the evaluator's work. The allegations — whether true or not — place the child at emotional risk (Bresee et al., 1986). Penfold (1995) opines that, under such circumstances, the evaluator must testify with caution, humility, and a mind open to all possibilities.

Reproductive Technology. Advanced reproductive technologies have introduced additional complexity into the arena of custody disputes. For example, in a custody dispute over frozen embryos, it is difficult to evaluate the right of a divorcing woman to have the embryos implanted and, therefore, born against the husband's right *not* to be forced into fatherhood. Kermani (1992) argues that regardless of the type of reproductive technology, the principle of the best interest of the "child" must prevail. Because reproductive technologies are complex and evolving rapidly, unless the clinician has significant training or experience in this area, it may be best for him or her to seek the opinion of an expert in this field.

CLINICIANS AS EXPERT WITNESSES

Judges, jurors, and attorneys assume that a clinician, legally considered an expert witness, possesses the skills necessary to

perform an adequate custody evaluation. These parties should be made aware that evaluators need specialized knowledge and skills to perform the complex work of forensic psychiatry.

The evaluator should be familiar with legal and ethical considerations, working with attorneys, and preparing for court (Appelbaum and Gutheil, 1991). The evaluator should know basic family law and legal procedures in his or her state, including the statutory and case law criteria that the courts use to determine custody. The evaluator also should know if there is a presumption in favor of joint custody or if joint custody can be awarded at all; if lawyers are usually appointed for the children; and if family-relations clinics are available to the courts. The additional knowledge allows the evaluator to communicate effectively with professionals outside of the more familiar world of mental health. And, without adequate knowledge of the legal system, evaluators may find the courts an intimidating workplace.

A colleague or mentor who is well acquainted with forensic work can be an invaluable aid and can enhance the evaluator's competence and confidence when performing complex and emotionally charged evaluations.

Unless a child has his or her own attorney or guardian ad litem, protection can come only from the court. The court, however, may be too distracted by other issues to see that every child's interests are protected. Furthermore, judges vary in their sensitivity to the needs of a child in litigation and in understanding and appreciation of psychiatry.

The legal system, with its adversarial approach to settling disputes, is alien to most clinicians and can be challenging and even frightening. The clinician must bear in mind that the custody evaluation is an opportunity to communicate behavioral and psychological findings to those in the legal system. The successful evaluator can bring the worlds of psychiatry and the law together in the service of the child.

THE EVALUATION PROCESS

The child custody evaluation, with certain exceptions, is composed of several phases: preparing strategy, performing the clinical evaluation, writing the report (except when told not to), and sometimes, testifying in court (Herman, 1992; Nurcombe and Partlett, 1994). Before beginning the process, the evaluator should decide whether to accept the case and then formulate a strategy for conducting the study. After the study is completed, the evaluator writes the report and may, depending on the vagaries of the case, prepare to testify in court. Although the evaluation may take 1 to 3 months, it may be more than 1 year before the court hears the case. Each of the phases of the child custody evaluation includes a number of important steps and opportunities for choices by the clinician. These are described in the outline section below.

DEVELOPMENT OF THESE PARAMETERS

Conflict of Interest

As a matter of policy, some of the authors of these practice parameters are in active clinical practice and may have received income related to treatments discussed in these parameters. Some authors may be involved primarily in research or other academic endeavors and also may have received income related to treatments discussed in these parameters. To minimize the potential for these parameters to contain biased recommendations due to conflict of interest, the parameters were reviewed extensively by Work Group members, consultants, and Academy members; authors and reviewers were asked to base their recommendations on an objective evaluation of the available evidence; and authors and reviewers who believed that they might have a conflict of interest that would bias, or seem to bias, their work on these parameters were asked to notify the Academy.

Scientific Data and Clinical Consensus

Practice parameters are strategies for patient management that are developed to assist clinicians in psychiatric decision-making. These parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. The validity of scientific findings was judged by design, sample selection and size, inclusion of comparison groups, generalizability, and agreement with other studies. Clinical consensus was obtained through extensive review by the members of the Work Group on Quality Issues, child and adolescent psychiatry consultants with expertise in the content area, the entire Academy membership, and the Academy Assembly and Council.

These parameters are not intended to define the standard of care nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. Considering inevitable changes in scientific information and technology, these parameters will be reviewed periodically and updated when appropriate.

OUTLINE OF PRACTICE PARAMETERS FOR CHILD CUSTODY EVALUATION

I. The forensic evaluation.

A. The referral process.

1. Referrals come from a parent, a child's or a

parent's attorney, a judge, a judge's clerk, or a family relations officer. Referrals coming from a noncustodial parent, who wants the child interviewed during visitation, should be refused. It is unethical, and usually illegal, to interview a child without the permission of the custodial parent.

- a. Cases for complete evaluation should be accepted only if the evaluator is court-appointed or agreed on by both parties. The psychiatrist should conduct the evaluation as a neutral, impartial advocate for the best interests of the child to maximize credibility with the court.
 - b. The clinician may work for one party to act as a consultant, to review documents, or to critique the evaluation of the court's expert. Evaluators in this category should not claim to be neutral. If the evaluator has seen only one parent, opinions should not be given on ultimate custody or on the parent not seen.
 - c. If contacted initially by a parent, the clinician should explain the basis for accepting the case, avoid discussing details of the case with that parent, and ask to speak with the parent's lawyer.
2. When discussing the referral with lawyer(s) or the court, the clinician should clarify the questions they want the evaluation to answer and determine whether he or she can legitimately provide an opinion. The clinician should provide his or her credentials, consider whether time, distance, and court scheduling allow him or her to perform the evaluation, and make sure that there are no conflicts of interest. Even the perception of a conflict of interest in the court harms the expert's credibility in the case and reputation in general. Potential conflicts include the following: being the therapist for any family member; being the therapist for one of the attorneys or his or her family member; or having a social or professional relationship with one of the parents, such as being on the same hospital staff or attending the same house of worship. As soon as the evaluator becomes aware of a possible conflict of interest, lawyers on both sides should be alerted, during a conference call, if feasible. Sometimes, neither side may object to a specific situation if the evaluator is responsible about reporting and monitoring it.
 3. The structure and payment of fees should be considered and discussed carefully. If the evaluation is being performed on a private basis, a

full or partial retainer may be requested at the start. Some clinicians prefer the fee to be paid intermittently during the course of the interviews. It might not be possible at the start to determine the number of sessions required to complete the evaluation or whether a deposition or court testimony will be required later. The clinician may charge by the hour (estimating the number of sessions anticipated) or with a flat fee. The fee should cover all clinical interviews, document reviews, telephone consultations, preparation of the final written report, and all meetings with attorneys. Requesting the fee in full at the start of the evaluation eliminates unnecessary distraction later on, because tensions and emotions often run high during custody disputes. Court time should be billed separately and in advance of testimony, because it often is unclear at the start of the evaluation whether testimony will be required.

B. Structuring the evaluation.

1. Request legal documents from both sides, reading not for the truth of the contents but, instead, for insight into what the parties are charging and counter-charging. Evaluators should read medical, educational, or psychiatric records that could provide information on the parenting of the children. Parents' records should be obtained when parental mental health is an issue.
 2. Decide which parties to interview and for how many sessions. Parties include parents, child(ren), each parent with the child(ren), and stepparents or potential stepparents.
 - a. Consider interviewing extended family, friends, neighbors, and alternative caregivers, such as baby-sitters. Inform all interviewees that because of the forensic nature of the evaluation, they automatically waive their rights of confidentiality and privilege. Collateral interviews may uncover objective information about issues relating to the child or alliances that develop within a household during a custody dispute. Grandparents, for example, may be unduly influencing a parent, fueling additional conflict. Interviewing the grandparent(s) may provide insight into this phenomenon.
 - b. Consider whether a visit to one or both homes would be helpful.
 - c. Decide which other professionals familiar with the parties should be contacted, including therapists (for children or parents) and school personnel.
- #### C. Interviewing parents.
1. Consider meeting with the parents together, if they are willing, to gain insight into their relationship. Honor their objection if they refuse.
 2. At the start of each first session, explain to the parent that confidentiality and privilege are waived because of the legal nature of the process. Parents must be told that what they talk about during sessions and telephone calls, and what they write in letters to the evaluator, may be referenced or quoted. Also, their right of privilege, which would normally prevent an expert from testifying about the sessions in court, is waived. Some clinicians ask parents to sign informed consent. Evaluators should document that waiver was explained to and accepted by the parents. Also, the evaluator should remind parents that his or her role is to provide the court with an opinion — *not* a custody decision.
 3. Be comprehensive. The clinician must see a parent a sufficient number of times to render an informed opinion. If one parent is seen more than the other, be prepared to explain the reason. Give each parent enough time to express his or her point of view and schedule extra time when necessary.
 4. In the first session, have each parent explain what is going on — as if the clinician has no prior knowledge of the case. Consider what the parent focuses on rather than whether an event or charge is true. Obtain the following:
 - a. Description and history of the marriage and separation.
 - b. Each parent's perception of his or her relationship with the children.
 - c. Each parent's understanding of and sensitivity to any special needs of the children.
 - d. Each parent's specific plans for the future if custody is awarded.
 - e. Each parent's history, including family of origin, social, and psychiatric or psychotherapeutic experience, if any.
 5. Note whether the parent is focused on the child or instead spends most of the session attacking or being distracted by the other parent.
 6. Other sessions should focus on the developmental history of the child and the schedule or usual routine of the child. The evaluator should explore any allegations parents make against each other. Parents can be asked how they have con-

tributed to the conflict and what they actually like in the other.

7. It is not necessary to render a *DSM-IV* diagnosis in a custody dispute. The process is an evaluation of parenting, not a psychiatric evaluation. However, some clinicians give diagnoses, if appropriate, after obtaining a complete psychiatric history and recording results of a mental status examination.
 8. In most cases, psychological testing of the parents is not required. Psychological tests, such as the Minnesota Multiphasic Personality Inventory, the Thematic Apperception Test, or the Rorschach, were not designed for use in parenting evaluations. Their introduction into a legal process leads to professionals battling over the meaning of raw data and attorneys making the most of findings of "psychopathology" but may have little use in assessing parenting. When the psychiatric health of a parent or child is a legitimate issue, the evaluator may request psychological testing of each parent to help support an opinion and provide relevant data. This may add to the degree of certainty of the parenting assessment. Certain tests have been advanced as having specific utility in assessing variables specific to a custody evaluation. These include the Bricklin Perception of Relationships Test (Bricklin, 1995) and the Ackerman-Schoendorf Scales for Parent Evaluation of Custody (Ackerman, 1994). Use of these tests is controversial at present. Their role in a custody evaluation should be adjunctive and they should never take the place of a comprehensive evaluation.
 9. In general, the clinician should refuse to listen to tape recordings made by one parent of the other, especially if the tape was made secretly. When such a request is made, the clinician can explore the parent's motivation for recording the tape and requesting that the evaluator listen. Evaluation sessions do not need to be audiotaped or videotaped.
- D. Interviewing the child(ren).
1. The clinician should interview the child early in the course of the evaluation. Interviews with children should consider diagnoses when appropriate, level of attachment with adult figures, expressed preferences, and evidence of indoctrination by parents.
 2. If possible, siblings should be seen together at first. This arrangement allows them to be supportive of each other and helps lessen anxiety.
 3. Each child should be seen at least one or two times alone. Arrange for the child to be brought by each parent at least once.
 4. Explain to the child the purpose of the evaluation and the role of the clinician. Even a 3-year-old has heard of "the judge" and can understand that the clinician's role is to help the judge figure out where everyone in the family will live. Explore the child's perception of the family's situation and what he or she thinks is going to happen.
 5. The clinician should develop a warm, comfortable relationship with the child using age-appropriate materials for communication. For younger children, a dollhouse can be emotionally evocative, helping the clinician access the child's inner world. The child also can be asked to draw a family or use puppets to tell a story.
 6. Children as young as 3 years of age usually can be interviewed alone if they can separate from the parent. Occasionally, even a precocious 2½-year-old may be seen alone.
 7. In general, evaluators should be cautious about asking the children, especially young children, where they prefer to live. Some states, however, require the evaluator to ask about a child's preference. If the child volunteers a custodial preference, explore the context for the preference. Are there indications that the child has been coached? What does the child believe life would be like with each parent?
- E. Interviewing parents and child(ren).
1. The joint session of the parent and child should be unstructured and should occur after the child's initial visit to the office. This session also might be conducted as a home visit. The evaluator should allow the parent and child to interact as they prefer. Some evaluators ask each parent and a child of appropriate age to perform a task together. This can show how they work together and how responsive to the child the parent can be.
 2. The clinician should allow for and discuss parental anxiety over being "graded."
 3. The clinician should look for patterns of interaction, ease of the relationship, signs of anxiety, ability of the parent to respond to child's lead, patterns of discipline, and approval and enhancement of the child's self-esteem.
- F. Interviewing others.
1. Interview any stepparent(s) or potential stepparent(s) at least once. Ask about the relationship with the children. Look for sensitivity to the chil-

- dren's needs and realistic assessment of future problems.
2. Consider interviewing other important caregivers, such as a primary baby-sitter, but in general, keep interviews with collateral sources limited. The most important people to see are the immediate family.
 3. It may be critical to talk to the child's and parents' therapists, with consent. Avoid seeking a forensic opinion. Instead, obtain the therapist's impressions of the child and the parents. The forensic evaluator, when speaking to therapists, should be mindful of respecting the therapeutic relationship and should intrude as minimally as possible.
- II. The written report.
- A. In the preparation of the report (Herman, 1992; Nurcombe and Partlett, 1994), the evaluator puts weight on a number of factors that will enter into the final recommendations. These factors can serve as a framework against which the clinical material can be placed. The factors include the following:
 1. Continuity. Which arrangement seems to offer the most stable and permanent situation for the child?
 2. Preference. How has any stated preference of the child been taken into account? Why has the evaluation agreed or disagreed with preference?
 3. Attachment. What is the quality of the relationship between the child and each parent?
 4. Sensitivity and respect. How attuned to the child is each parent and how well does each respect the child?
 5. Parent-child gender. What, if any, is the impact of gender in the parent-child relationship?
 6. Physical and mental health of each parent.
 7. Level of conflict between the parents and the impact on the child.
 - B. Before writing the report, the evaluator should consider the impact of various outcomes on the family and recognize that after divorce, no outcome is optimal.
 - C. The report should be free of technical jargon, because it is designed to assist professionals who are not clinicians.
 - D. The report should be concise but detailed enough to provide necessary information and to hold the interest of those who read it.
 - E. It may be helpful to put the report in the form of a letter, addressed to the referral source, as a reminder to the clinician that it will be read by a responsible person.
 - F. Begin the report with a brief summary of how the case was referred and the questions that were to be addressed by the evaluation.
 - G. List individuals seen and the dates and lengths of sessions. List collateral sources of information, such as telephone interviews with therapists and reviews of legal documents.
 - H. Some clinicians begin the report with their conclusions; others save the final opinions and recommendations until the end. This is a matter of personal preference. However, the conclusions should be explicit and easily located within the report.
 - I. Discuss information derived from the clinical interviews with the various parties and consider including direct quotations. Present clinical impressions of the parties along with the process from the interviews. Present the strengths and weaknesses of the parties.
 - J. Avoid inflammatory statements or comments that could be interpreted as a value judgment.
 - K. *DSM-IV* diagnoses are not necessary. If parties are given diagnoses, the clinician should explain the ramifications (if any) of the diagnosis for custody. Otherwise, providing a diagnosis confuses the court and provides fodder for attorneys.
 - L. A "Conclusions and Recommendations" section should contain the formulation of the case with specific and detailed recommendations for custody, visitation (if that is an issue), and any other comments or recommendations. For example, the evaluator might recommend therapy or additional evaluation for the child(ren) or for the parents before or after the litigation is over.
 - M. The report should be neat, readable, and free of spelling and grammatical errors.
 - N. The reader should be able to see how the clinician reached his or her conclusions and the data in support of them. What makes it clear that one parent should have custody? Why, if both parents are equally fit, does the expert ultimately choose one over the other? Or, what factors lead to the conclusion that joint custody is in the best interest of the child?
 - O. The final report should be released simultaneously to all parties due to receive it. The clinician should be willing to meet with each parent and the attorneys to explain the contents of the report. Often, the clinician can help parents understand and accept the recommendations.
- III. Courtroom Testimony.
- A. General principles.
 1. Although the parents might reach a settlement after the evaluation, the case eventually will be

heard by a judge. The actual trial might take place 1 year or more after the evaluation. The evaluator must refresh his or her memory about the family if much time has elapsed. An update of the evaluation may be necessary.

2. Offer to meet with both attorneys before testimony. (Usually, only the "friendly" attorney will want to do this.) Use this time to discuss the direct and cross-examinations. The testifying clinician should be aware of his or her biases. If unfamiliar with courtroom routine, consult with an experienced colleague before testifying.
 3. Bring all materials to trial. On cross-examination, the attorney may want to compare notes to the final, typed report, looking for errors and inconsistencies.
 4. Be familiar with courtroom procedure. If this is a first experience with expert testimony, it may be useful to observe a trial even briefly to get a feeling for the experience.
 5. Dress appropriately and conservatively. Appearance affects credibility.
- B. Pitfalls and warnings.
1. Respectfully disagree when appropriate, but avoid arguing with attorneys or the judge.
 2. Avoid jargon and arcane medical terms unless they are clearly defined.
 3. If a lawyer correctly points out an error or omission, acknowledge it with grace and do not take it personally.
 4. It is not necessary to answer every question posed. Sometimes, an attorney will ask a question that cannot be answered properly as framed or is designed as a trap. In this case, explain to the judge why the question cannot be answered as posed.
 5. Do not instantly answer an attorney's question on direct or cross-examination. Allow yourself time to formulate answers and for the opposing attorney to object.
 6. Delays and postponements are common and often unavoidable. Be flexible and willing to accommodate.
 7. After testimony has been given, leave the courtroom.

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