

**DEVELOPING AN OPTIMAL PSYCHOLOGICAL ASSESSMENT PROCEDURE FOR
DETERMINING PRIMARY CARE AND RESIDENTIAL PLACEMENT OF CHILDREN
IN A DIVORCE DISPUTE**

by

HENK JOHAN SWANEPOEL

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SUPERVISOR: Professor E.M.Q. Mokhuane

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PLAGIARISM DECLARATION

I declare that the thesis hereby submitted to the University of Limpopo, for the degree Doctor of Philosophy in Clinical and Applied Psychology has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Henk Johan Swanepoel

████████████████████

Date

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DEDICATION

With gratitude I want to thank my wife, Jenny and my children; Reynhardt and Gillian. Your continued support, patience, understanding, encouragement and above all your belief in me was my inspiration.

Thank you to my parents for giving me the guidance and providing the foundation of who I am today.

ABSTRACT

This study aims at developing an optimal psychological assessment procedure for determining primary residence allocation for children whose parents are divorcing. The research consisted of two studies: the first study focused on “translating” 13 identified legal constructs formulated by Justice King for safeguarding the best interests of children and the identification of suitable psychometric instruments that can be used to determine how effectively a particular family is functioning. These 13 legal constructs were converted into psychological constructs by three independent clinical psychologists. Following this a psychological assessment procedure for children and parents within a divorce context was developed incorporating the newly developed psychological constructs.

The 2nd phase consisted of a sample of 39 families (26 families in the experimental group and 13 families in the control group). Six months later after primary placement the families were followed up in order to determine the psychological “health” of the families concerned using the Rosenberg Self-esteem Scale (RSE); Index of Family Relations (IFR); Eyberg Child Behaviour Inventory (ECBI) and the Family Assessment Device (FAD). The means obtained from both the experimental and control groups were compared using the MANOVA analysis.

The results from the RSE concluded that the self-esteem of children in the experimental group, improved significantly to those in the control group. The IFR indicated that families in the experimental group had improved significantly at resolving family problems. According to the ECBI the children in the experimental group with behavioural problems improved significantly after primary placement. In all children in the control group did not improve significantly. The Family Assessment Device therefore indicated significant family cohesion. In summary the results indicate that the families in the experimental group were functioning at a higher level in comparison to the control group six months after primary placement.

Key words: *child, parent, parental responsibilities and rights, forensic psychology, contact, care, psychological assessment, primary placement, divorce, best interests of a child*

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CHAPTER 1

INTRODUCTION

The survival of a species always takes precedence over any other inherent priority and the human race is no exception. One tangible consequence of the instinct for survival is the manner in which society takes care of its offspring: Children are the future of any nation and this is reflected in the United Nations' Convention on the Rights of the Child (1989) and the South African Constitution (1994), the South African Children's Act of 2005 and the Divorce Act of 1979.

The Divorce Act of 1979, highlights the responsibility of the Court as the upper guardian of all children within its jurisdiction, to ensure the welfare of minors or dependent children when their parents get divorced. The post-apartheid Constitution set the stage for significant changes in family law with a special emphasis on the rights and best interests of children. These are embodied in the Children's Act of 2005. However, the "best interests" of a child has to be established, *ad hoc*, in each individual case of divorce and judged on merit. This entails an "objective assessment" within the framework of the specific circumstances that pertain to each case (Gardner, 1989; Roos & Vorster, 2003; Gould & Martindale, 2009). The best interests of the minor refer to his/her welfare in its widest sense, which includes economic, social, moral and religious considerations. Emotional needs and the ties of affection must also be considered and in the case of older children their wishes should not be ignored (Tredoux, Foster, Allan, Cohen & Wasserman, 2005). The question, however, is how should this assessment be done and, perhaps even more importantly, who should do this "objective assessment" to guide and assist the Court?

1.1 Orientation to the Study

1.1.1 The Psychologist as Part of the Legal Process

The involvement of psychologists in legal proceedings has increased steadily over a century ago when psychologists were first required to assist the Courts in matters that required the interface between psychology and law (Gould, 1999; Gudjonsson, 1991; Roos & Vorster, 2003; Gould & Martindale, 2009). Since the 1970's, there has been an increasing trend in South Africa for legal professionals to make use of psychologists in legal proceedings, and currently it is a common trend to rely on the expert knowledge of the psychologist to assist the Courts (Louw & Allan, 1998; Roos & Vorster, 2003; Gould, 2004).

The psychologist working within the psycho legal field is faced with a most demanding and highly responsible task that has to be undertaken with the utmost social responsibility and justice, while maintaining the standards of ethics of the psychology profession. Tredoux, et al., (2005), report that after the process of assessment has been completed psychologists will typically submit a written report that summarises the information gathered during the assessment and outlines their professional opinion on the matter at hand, such as in a divorce.

1.1.2 The Psychologist Involved in Divorce Matters

After a psychological assessment has been done and a report has been presented to the Court, the Court has to decide which of the parents is better equipped to promote the child's physical, moral, emotional and spiritual welfare. In this respect a psychologist may typically attempt to advise the courts regarding the most desirable child custody arrangement for a particular family. However, psychological assessment in terms of determining who is the best parent to take custody of child is fraught with difficulties and these have been highlighted by various authors namely Gould and Bell (2000), Kaliski, (2006), Robinson, (2006) and Gould and Martindale, (2009) who indicate that to date

there is no standardised procedure for these evaluations and no single, sovereign approach to conducting primary residence evaluations for children. It is thus evident that few guidelines exist for custody and visitation assessment methods, especially in determining what is in the best interest of a child?

1.1.3 The Best Interests of the Child: A Vague And Undefined Concept

According to Roos and Vorster, (2003); Davel and Skelton, (2007) the principle of the “*best interests of the child*” remained a vague and undefined concept for some considerable period of time and in advising the Court psychologists largely had to rely on their individual training, experience and clinical judgment. However, the situation has been significantly alleviated through a judgment delivered by the Honourable Mr. Justice King in the matter of *McCall v McCall*, 1994 (3) SA 201 (CPD). In his attempt to legally describe the “best interests of the child” he identified 13 variables to serve as criteria. These are as follows:

- a) *The love, affection and other emotional ties which exist between parent and child, and the parent’s compatibility with the child;*
- b) *The capabilities, character and temperament of the parent, and the impact thereof on the child’s needs and desires;*
- c) *The ability of the parent to communicate with the child and the parent’s insight into, understanding of and sensitivity to the child’s feelings;*
- d) *The capacity and disposition of the parent to give the child the guidance which he/she requires;*
- e) *The ability of the parent to provide for the basic physical needs of the child, the so-called “creature comforts” such as food, clothing, housing and other material needs – generally speaking, the provision of economic security;*
- f) *The ability of the parent to provide for the educational wellbeing and security of the child, both religious and secular;*

- g) *The ability of the parent to provide for the child's emotional, psychological, cultural and environmental development;*
- h) *The mental and physical health and moral fitness of the parent;*
- i) *The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo;*
- j) *The desirability or otherwise of keeping siblings together;*
- k) *The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration;*
- l) *The desirability or otherwise of applying the doctrine of same-sex matching;*
- m) *Any other factor relevant to the particular case, which is before the court.*

The above-mentioned variables, from a legal perspective, quite clearly established an unambiguous and tangible basis for determining the child's "*best interests*" within the context of divorce. It is, however, also evident that these variables, have yet to be defined and "operationalised" from a psychological perspective in order for them to be utilised by psychologists in their attempt to assist the Court. This necessitates a careful definition of the variables, from a psychological perspective, as well as establishing a relatively standardised clinical procedure for the measurement the constructs related to the best interests of the child. Based on the aforementioned one of the objectives of the present study is to translate the construct of the best interest of the child from a psychological perspective and to develop an assessment procedure to evaluate the best interests of the child from including the evaluation of the parents with regard to the most appropriate placement for the child.

1.2 Statement of the Problem

The research statement is phrased in a series of questions.

- How can the "*best interest of the child*" construct be translated from a legal perspective to a psychological perspective?

- What are the specific psychological instruments that could be used to effectively measure *parental effectiveness, parental emotional stability, the children's preference of a parent and a family's health*?
- How will children adjust who have been exposed to the defined assessment procedure six months after primary residence placement?

1.3 Aim of the study

Considering the foregoing, the current research will set out to investigate the “*best interest of the child*” construct and translate it from a legal perspective to a psychological perspective. This construct will then be integrated and implemented as a psychological assessment procedure to determine primary care and residential placement of children in a divorce dispute. Lastly, the adjustment of the children who have been exposed to the assessment procedure six months after primary residence placement will be determined.

1.4 Motivation for the study

From the preceding points, it seems that South Africa has no clear psychological guidelines for the assessment of “*the best interests of the child*”. However, from a legal perspective the Honourable Justice King began the impetus to investigate the meaning of the best interests of the child from a legal perspective. This sets the tone for further translation of the legal constructs regarding “*the best interest of the child*” into psychological concepts, therefore the development of the assessment procedure for the determination of primary residence placement for children whose parents are involved in a custody dispute.

1.5 Definition of Terms

It is imperative to understand certain terminology used in this study to avoid misunderstandings or disagreement. The following relevant definitions will be used:

- a) **'Contact'** - (previously referred to as 'Access') in relation to a child means maintaining a personal relationship with the child. If the child lives with someone else contact implies communication on a regular basis with the child in person including the following:
 - i. visiting the child;
 - ii. being visited by the child; or
 - iii. communication on a regular basis with the child in any other manner including through the post or by telephone or any form of electronic communication.

- b) **'Care'** - (formerly known as 'custody') relates to the control and supervision of the daily life and person of the child (comfort; maintenance; education; protection; physical, emotional and religious needs).

- c) **'Child'** - in this context refers to a person who has not yet attained the age of 18 years.

- d) **'Divorce Action'** - means an action by which a decree of divorce or other relief in connection therewith is applied for, and includes
 - i. an application *pendent lite* of an interdict for the interim custody of, or access to, a minor child of the marriage concerned or for the payment of maintenance; or

- ii. an application for a contribution towards costs of such action or to institute such action, or make such application, *in forma pauperis*, or for the substituted service in process, or the edictal citation of a party to such action or application.
-
- e) **'Family Advocate'** – A suitable and qualified person who is admitted to practise as an advocate in terms of the Admission of Advocates Act 74 of 1964 and who the Minister of Justice and Constitutional Development deem suitable for appointment as a family advocate by reason of his/her involvement in or experience of the adjudication or settlement of family matters.
 - f) **'Family Counsellor'** – A suitable and qualified person to assist the family advocate with an enquiry. A family counsellor shall take office for a period of 3 years or such shorter period as the Minister determines at the time of his/her appointment.
 - g) **'Guardianship'** – In the broader sense 'guardianship' is equated with parental authority which is largely determined by common law and can be described as the sum total of the rights and obligations that parents enjoy in relation to their child(ren) and include guardianship and care. Guardianship is typically used to describe that portion of parental authority which relates to the control and administration of the child's estate, and the capacity to assist or represent him/her in legal proceedings. Guardianship provides for a parent to consent to the following:
 - i. Adoption of a child
 - ii. Removal of the child from the country by a parent or by any other person
 - iii. The application for a passport by either parent in which the minor child is to be specified as a child of the passport holder

- iv. The alienation or encumbrance of immovable property or anything belonging to the child
 - h) **'Joint Legal Custody'** – Control over the child's daily life and person is vested with both parents and restrains either parent from assuming a dominant role in the child's upbringing. The child does, however, have a primary residence with one parent who deals with the daily decisions regarding the child.
 - i) **'Marriage'** – A marriage is recognised in terms of South African law or customary law or concluded in a system of religious law subject to specified procedures and any reference to a husband, wife, widower, widow, divorced person, married person or spouse must be construed accordingly.
 - j) **'Minor'** – Minority status is given to those individuals aged between 0 to 18 years of age, while a major is any individual over the age of 18. Any person who is not a major is a minor. Section 17 of the Act lowered the age of majority to 18 years (Davel & Skelton, 2007).
 - k) **'Parent'** – in relation to a child, includes the adoptive parent of a child but excludes the following:
 - i. the biological father of a child conceived through rape of or incest with the child's mother;
 - ii. any person who is biologically related to the child by reason only of being a gamete donor for purposes of artificial fertilisation; and
 - iii. a parent whose parental responsibilities and rights in respect of the child have been terminated.

- l) **'Parental Responsibilities and Rights'** – in relation to the child, means responsibilities and the rights to the control of the daily life and person of the child (thus comfort; maintenance; education; protection; physical, emotional and religious needs)

- m) **'Shared Parenting'** – The child(ren) have two homes. The parents share the care of the child(ren) where the daily care is rotated on an equal basis between the parents. The principle is also referred to as shared residency.

- n) **'Sole Custody'** – The High Court may grant sole custody to either parent which entails that a parent with sole custody has all the powers of appointing by testamentary disposition any person to be vested with sole custody of the child.

- o) **'Sole Guardianship'** – Sole guardianship is granted to one parent where the other parent has consented to it or by court order, where the parent has shown no interest in the child or has failed to provide any financial support, or where the parent has shown no interest in performing his/her duties as a guardian. The sole guardian may consent for the child without reference to the other parent. (Family Law Legislation Vol. ii, 1994; Roos & Vorster 2003; Fakier, 2006; Davel & Skelton, 2007).

- p) **'A Psychological Healthy Family'** – A psychological healthy family can be defined as a family where the children have good self-esteem; the severity, or magnitude of problems that family members have in their relationships with one another are minimal, conduct-problem behaviours including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing, lying, are minimal; both parent and children are able to show more tenderness and would be more concerned about one another's welfare; parents are able to show more nurturance towards the child; effective controlling problem behaviour are present; verbal messages are clear in content and direct in the

sense that the person spoken to, is the person for whom the message is intended; the families' ability to identify relevant and appropriate problems which might threaten the cohesion is of a high standard; the family has a clear set of rules and consequences and the overall health of the family is optimal.

Within the Children's Act, 2005 the terms 'custody' and 'access' in any law, and in the common law, must be construed to also mean 'care' and 'contact' (Davel & Skelton, 2007).

Section 18(1)(a) provides that a parent who has parental rights and responsibilities in respect of a child has the responsibility and right to 'care' for the child. Section 1 of the Act defines the meaning of the right and responsibility of providing 'care' for the child (Davel & Skelton, 2007). The Children's Act, 2005 will be discussed later in this chapter.

The term 'care' replaces the term 'custody' in family law. Section 1(2) prescribes that any reference to the term 'custody' in any other law or in the common law, must be construed to mean 'care' (Davel & Skelton, 2007).

'Contact' replaces the term 'access' in family law. It involves maintaining a personal relationship with the child, either through visits or through mail by postal service or electronic means or by telephone or cell phone communication.

The terminology change signals a shift from the outdated concept of parental power over children to the concept of parental rights and responsibilities for children. The shift recognises the autonomy of the child as a human being with the full spectrum of human rights which the parents are responsible for upholding and protecting. The child has the right to 'care' from the parent and the parent has the right and responsibility to provide 'care' for the child (Davel & Skelton, 2007).

Section 1(2) provides that where 'custody' and 'access' are assigned a meaning elsewhere in law, they must henceforth be interpreted also to have the meaning 'care' and 'contact'. These terms have frequently been pronounced upon by the courts in a way that has assigned a meaning to them. These precedents will still have relevance, but future case law will have to refashion the concepts to fit into the new definitions of care and contact (Davel & Skelton, 2007).

1.6 Study Outline

Chapter 2 explains the Court's position as the upper guardian of all children within its jurisdiction. Also included in this chapter are the new Children's Act of 2005 and its consequences.

Chapter 3 focuses on the legal safeguards formulated by The Honourable Mr. Justice King's ruling regarding the 'best interests of the child' with specific reference to psychological application of this construct.

Chapter 4 deals with the theoretical aspects of the concept of parental responsibilities and rights in terms of child rearing highlighting the optimal development of the child and the environment the child has to live in during the period of post divorce.

Chapter 5 explores the interaction between psychology and the law and its relationship. The culmination of the two worlds is merged in the discussion about forensic psychology and the high levels of ethics pertaining to the field.

Chapter 6 deals with specific reference to children in the context of divorce. The role and application of the psychologist in the assessment process is explored.

Chapter 7 describes the process of how the comprehensive assessment procedure was developed in dealing with children in divorce.

Chapter 8 discusses the research design and methods utilised in this study.

Chapter 9 deals with the results of the study.

Chapter 10 presents a discussion on the study.

Chapter 11 deals with the conclusion and recommendations pertaining to the study.

CHAPTER 2

THE LEGAL CONTEXT OF THE NEW CHILDREN'S ACT

2.1 Introduction

The Divorce Act of 1979 highlights that the Court assumes the position of upper guardian of all children within its jurisdiction, but the post-apartheid Constitution (1994) paved the way for significant changes in family law with a special emphasis on the Rights of Children which includes their best interests. These were embodied in the new Children's Act of 2005.

In this chapter the development and eventual birth of the new title of the Children's Act of 2005 will be discussed. This will be followed by a mapping of the legal perception and approach with regards to the child during the process of divorce. An extensive explanation of the previous Divorce Act application up to the actual re-birth or review of the Children's Act of 2005 will be done in the form of the preamble of the act.

2.2 The Legality of Divorce and the Minor Child

The law is a given set of rules that regulates human behaviour. These rules are recognised as binding on society at large, and are enforced and punished by the state if breached (Roos & Vorster, 2003; Tredoux et al., 2005).

There are two kinds of laws namely; those that prescribe how people ought to behave and interact with others, thus the laws that regulate behaviour and natural laws that describe how people usually behave (Roos & Vorster, 2003; Kaliski, 2006). The fact that members of a society consider themselves bound by legal rules and adhere to them can be explained by the theory of social contract, which states that members of society sacrifice their freedom to do as they please in exchange for the order and protection

provided by the state. The state, by implication and application of the law, restrains the freedom of each individual, but by doing so protects every individual from the actions of others (Roos & Vorster, 2003; Tredoux et al., 2005; Kaliski, 2006).

Although the law can be divided into a number of fields of study, this study will be written within the context of *family law* which falls within the context of civil law (Roos & Vorster, 2003). Civil cases occur when the subjective rights of persons (legal subjects), rather than the interests and safety of the community at large, are infringed. The context of civil law in this study will be family law which entails the legal rules regarding marriage, matrimonial property, the consequences of the dissolution of marriage, and the relationship between parents, children and guardians (Neetling, Potgieter & Visser, 1996; Roos & Vorster, 2003; Tredoux et al., 2005).

When a marriage has come to an end and is going to be dissolved by means of a divorce a court may grant a decree of divorce on the grounds of the irretrievable breakdown of the marriage and that the relationship between the parties to the marriage has reached such a state of disintegration that there is no reasonable prospect of restoration of the marriage (Family Law Legislation Vol. ii, 1994; Kaliski, 2006; Davel & Skelton, 2007).

According to Divorce Act 70 of 1979, before a decree of divorce shall be granted the safeguarding of interests of dependent and minor children if any, must be satisfactory or are the best that can be effected in the circumstances. This route is followed because the Court is deemed the upper guardian of all dependent and minor children (Family Law Legislation Vol. ii, 1994).

As the upper guardian of dependent and minor children, the legal perspective dictates in order to safeguard the interests of dependent and minor children the Divorce Act 70 of 1979 states: that an enquiry can also be investigated by the family advocate in terms of section 4(1)(a) or (2)(a) of the Mediation in Certain Divorce Matters Act, (1987) and

provide the court with a report and recommendations before granting a decree of divorce (Family Law Legislation Vol. ii, 1994; Davel & Skelton, 2007).

Family Law Legislation Vol. ii, (1994) referring to the Divorce Act 70 of 1979; also states that a court granting a decree of divorce may with reference to the maintenance of a dependent child, or the marriage, or the custody or guardianship, or access to a minor child of the marriage make any order which it may deem fit; and may in particular, if in its opinion it would be in the interests of the said minor child, grant to either parent sole guardianship (which shall include the power to consent to the marriage of the child) or the sole custody of the minor; and the court may order that on the predecease of the parent to whom the sole guardianship of the minor is granted, a person other than the surviving parent shall be the guardian of the minor, either jointly with or to the exclusion of the surviving parent (Divorce Act 70 of 1979).

The court may also appoint a legal practitioner to represent a child at the proceedings and may order the parties or any one of them to pay the costs of the representation (Divorce Act 70 of 1979; Pruett, & Hoganbruen, 1998; Davel & Skelton, 2007).

The Divorce Act 70 of 1979 further states; that if any enquiry is instituted by the family advocate in terms of section 4(1)(a) or (2)(a) in the Mediation in Certain Divorce Matters Act, (1987), the court can consider the report and recommendations referred to in the said section 4(1). For the purposes of subsection (1) the court may order any investigation, for instance a psychological evaluation which it may deem necessary to be carried out and may order any person, for instance a psychologist, to appear before it and may order the parties or any one of them to pay the costs of the investigation and appearance (Family Law Legislation Vol. ii, 1994). This investigation as requested by the office of the family advocate has to solely serve the interests of the minor child or children (Davel & Skelton, 2007).

A maintenance order or an order regarding the custody or guardianship of, or access to, a child made in terms of Divorce Act 70 of 1979 may at any time be rescinded or varied. Provision is made that if an enquiry is instituted by the family advocate in terms of section 4(1)(b) or (2)(b) the Mediation in Certain Divorce Matters Act, 1987, such an order with regard to the custody or guardianship of, or access to, a child shall not be rescinded or varied or, in the case of an order with regard to access to a child, not be suspended before the report and recommendations of the family advocate referred to in the said section 4(1) have been considered by the court (Family Law Legislation Vol. ii, 1994).

The above stated process was the prescribed and followed legal route for the legal profession, however given the post-apartheid changes in the 1990's, the drafting of a new Constitution for a democratic South Africa set the stage for tremendous changes in family law; divorce principles and concepts. This led to a comprehensive review of the Child Care Act and to say the least, had vast effects on how the interests of children were dealt with during divorce matters (Davel & Skelton, 2007). For the purposes of this study it is important for the reader to understand these changes of the Child Care Act because this study was conducted in the context of the changes. The next section addresses the post-apartheid sculpting of the Act in the attempt to serve the best interest of children.

2.3 The New South African Constitution and the Bill of Rights Embodied In the Child Care Act no. 38 of 2005: Children's Act

2.3.1 The Title of the New Act

The drafting of a new Constitution for South Africa, as well as the ratification of international instruments such as the United Nations Convention on the Rights of the Child (1989) and the Hague Convention on Abduction and Adoption (1993) paved the way for the revisitation of the Child Care Act (Davel & Skelton, 2007).

The Bill of Rights in the South African Constitution places a range of obligations on the state regarding the promotion, protection, and realisation of children's rights. With the exception of the right to vote, children are entitled to all the rights contained in the Bill of Rights. These include the rights to equality; dignity; life; freedom and security of the person, property, housing; health care services; sufficient food and water; social security; education; just administrative action, and the rights to arrest and detention (Davel & Skelton, 2007).

In addition to the aforementioned rights, an additional range of rights are provided for extra protection for children in certain areas. These include the rights to identities, names and nationality; family care or parental care or appropriate alternative care when removed from the family environment; basic nutrition; shelter; basic health care services and social services; protection from maltreatment, neglect, abuse or degradation; protection from labour inappropriate for their age and exploitative labour practice, detention except as a last resort and then only for the shortest appropriate time, separately from adults and in conditions that take into account the child's age; access to legal representation at the state's expense in civil proceedings if substantial injustice would otherwise result; protection against being used in armed conflict and protection during times of armed conflict (Davel & Skelton, 2007).

Section 7(2) of the Bill of Rights obliges the state to respect, promote, protect and fulfil children's rights and to refrain from any action which would infringe children's rights. The obligation to protect children obliges the state to adopt measures to prevent third parties from infringing children's rights. The state's duty to fulfil children's rights places an obligation on the state to proactively adopt measures and allocate adequate budgets to ensure that the conditions and services necessary for the fulfilment of these rights are available (Davel & Skelton, 2007).

Davel & Skelton, (2007) explains that because of Section 7(2) of the Bill of Rights together with extensive investigation; collaboration and consultation the new Children's Bill (No. 38 of 2005: Children's Act, 2005) was to all involved parties satisfactory and was promulgated and put into use in June 2006. The final title given to the Children's Act, 2005 reads as follows:

To give effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children; to define parental responsibilities and rights; to make further provision regarding children's courts; to provide for the issuing of contribution orders; to make new provision for the adoption of children; to provide for intercountry adoption; to give effect to the Hague Convention on Intercountry Adoption; to prohibit child abduction and the given effect to the Hague Convention in International Child Abduction; to provide for surrogate motherhood; to create certain new offences relating to children; and to provide for matters connected therewith.

This was found to be indeed a long title, but according to Davel and Skelton (2007), this long title of the Act aims to give a description of what is contained in the act.

The Children's Act, 2005 consists of 22 Chapters and 315 Sections; but only certain chapters have been accepted. Currently the following chapters are referred to in the Children's Act, 2005 as indicated in table 2.1.

Table 2.1: Chapters of the Children's Act, 2005

Chapter	Content
1	Interpretation, objects, application and implementation of act
2	General principles
3	Parental responsibilities and rights
4	Children's courts
7	Protection of children
9	Child in need of care and protection
10	Contribution order
15	Adoption
16	Inter-country adoption
17	Child abduction
18	Trafficking in children
19	Surrogate motherhood
20	Enforcement of act
21	Administration of act
22	Miscellaneous matters

However, for the purposes of this study only Chapters 1 to 3 will be discussed because the principle of the best interests of the child and parental responsibilities and rights are referred to in these chapters and applies to this current study. The next section will deal with the new Children's Act, 2005 where the preamble is addressed, in other words the shift from the past to the present, thus apartheid legislation to post-apartheid legislation.

2.4 Act no. 38 of 2005: Children's Act, 2005

In the Government Gazette, Vol. 492, Cape Town, 19 June 2006, No. 28944, it was notified that the President had assented to the Act No. 38 of 2005: Children's Act, 2005. The preamble reported the following.

2.4.1 Preamble

The Constitution establishes a society based on democratic values, social justice and fundamental human rights and seeks to improve the quality of life of all citizens and to free the potential of each person; and whereas every child has the rights set out in section 28 of the Constitution; and whereas the state must respect, protect, promote and fulfil those rights. The protection of children's rights leads to a corresponding improvement in the lives of other sections of the community because it is neither desirable nor possible to protect children's rights in isolation from their families and communities; and the United Nations has in the Universal Declaration of Human Rights proclaimed that children are entitled to special care and assistance (No. 28944 Government Gazette, 19 June 2006, Act No. 38, 2005 Children's Act, 2005).

The need to extend particular care to the child has been stated in the Geneva Declaration on the Rights of the Child, in the United Nations Declaration on the Rights of the Child, in the Convention on the Rights of the Child and in the African Charter on the Rights and Welfare of the Child and recognised in the Universal Declaration of Human Rights and in the statutes and relevant instruments of specialised agencies and international organisations concerned with the welfare of children. It is reported to be necessary to effect changes to existing laws relating to children to afford them the necessary protection and assistance so that they can fully assume their responsibilities within the community as well as that the child, for the full and harmonious development of his/her personality, should grow up in a family environment and in an atmosphere of happiness, love and understanding (4 No. 28944 Government Gazette, 19 June 2006, Act No. 38, 2005 Children's Act, 2005).

Davis, Cheadle and Haysom (1997), as well as Davel and Skelton (2007), state: that preamble to acts have become popular in South Africa since the first democratically elected government took office in 1994.

The power of the preamble lies in the distinction it makes between the past and the present, especially within the context of the future of family law. The context is created by the preamble which indicates a set of value-based commitments upon which the legislation is premised (Davel and Skelton, 2007).

The preamble to the Children's Act is transformative in character as it aims to improve the situation of children through ensuring state responsibility for their care and protection, within the milieu of their own families and communities (Davel & Skelton, 2007). The one and most important concept of the new act is to integrate the past with the present within the context of the best interests of the child, which forms a sole and only premise part of the Children's Act. In the light of the aforementioned, the main principle described in the Children's Act is, without distinction the concept of the "best interests of the child", which will be discussed in the next chapter.

2.5 Conclusion

Thus chapter aimed to translate the terminology change regarding the preparations and eventual change to the new or amended Child Care Act. The initial process of divorces and related prescriptions as to how legal professionals in the past were dictated to execute the law to serve the interest of the child were described. However, post-apartheid challenges and changes led to the mapping and eventual implementation and change of the new Children's Act, 2005.

This was done with the distinction between the past and the present, thus preamble based on the set of value-based commitments upon which the legislation is premised. This led to the Children's Act transformation to improve the situation of children through ensuring state responsibility for their care and protection (Davel & Skelton, 2007).

CHAPTER 3

THE BEST INTERESTS OF THE CHILD

3.1 Introduction

The use of the “best interests” doctrine represented a 20th century shift in public policy. This doctrine forms part of *parens patriae*, which is Latin for "parent of the nation." In law, it refers to the upper guardian or parent of any child or individual who is in need of protection. It has replaced the “Tender Years Doctrine” which rested on the basis that children are not resilient, and almost any change in a child's living situation would be detrimental to their well-being (Kaliski, 2006; Gould & Martindale, 2009).

This chapter aims to report and elaborate on the best interests doctrine and its application in the new Children’s Act, 2005. This principle dictates that the premise of court decisions in a divorce process concerning a child has to be led by the best interests of that child, which forms the core of this study. Identifying and serving the best interest of the child is however a difficult concept to determine by any means, but in any event has to be identified and recommended to ensure that any child or children can function effectively post divorce. The chapter will then proceed to explore if the best interest of the child is a right, standard or both. The chapter concludes with the new Act’s reference which gives weight to the opinion of the child to be heard.

3.2 Best Interests of Child Standard According To Act No. 38 of 2005: Children's Act, 2005

Roos and Vorster, (2003); Tredoux et al., (2005) propagate that the best interests of the child has for some time been an established common-law principle articulated in a number of private law disputes. It has been termed ‘the golden thread’ that runs through

the law relating to children and governs the legal professionals and others involved in such matters. Since the new Act's application, the principle has gradually been extended far beyond private law disputes by judicial decisions and international law (Martindale & Gould, 2005; Davel & Skelton, 2007).

Although there was agreement that whether the court uses its common-law or statutory powers, the standard in determining issues involving children is the *best interests of the child*, the content and the scope of the standard did, however, create problems in practice as the best interests of the child standard was perceived as being vague and undetermined (Davel, 2006; Davel & Skelton, 2007).

It would appear the best interests of the child were creating difficulties as it was seen as a diffuse concept by legal experts whose implementation was cumbersome. Based on the misgivings of legal experts regarding this concept it became necessary to redefine the principle of the best interest as a standard.

The principle of the best interests of a child standard according to Act no. 38 of 2005 is encapsulated as follows:

(1) Whenever a provision of this Act requires the best-interests-of-the-child standard to be applied, the following factors must be taken into consideration where relevant:

(a) The Nature of the Personal Relationship between The Child and the Parents

- (i) the child and the parents, or any specific parent; and
- (ii) the child and any other caregiver or person relevant in those circumstances;

Here we note that a parent maybe a biological one, a guardian or any person who stand loco parentis. In this section 'parent' includes any person who has parental responsibilities and rights in respect of a child.

(b) The Attitude of the Parents, or any Specific Parent, Towards the Child

- (i) the attitude of the parent or guardian is important to be considered and;
- (ii) the exercise of parental responsibilities and rights in respect of the child;

(c) The Material Circumstances and Emotional Maturity of the Parents / Caregiver

This refers to the capacity of the parents, or any specific parent, or of any other caregiver or person, to provide for the needs of the child, including emotional and intellectual needs;

(d) Changes in the Child's Circumstances

The Act considers the change in the child's circumstances including the likely effect due to any separation from

- (i) both or either of the parents; or
- (ii) any brother or sister or other child, or any other caregiver or person, with whom the child has been living;

(e) Factors Affecting Contact with Parents / Guardian and extended family members

Here the Act considers practical difficulties that the child may encounter including the expense of a child having contact with the parents, or any specific parent. It also

considers both the material aspects in terms of the expense for the child to maintain personal relations and direct contact with the parents (in the case of divorce) or any specific parent on a particular basis. Irrespective of these difficulties the child needs to have contact with parents unless otherwise specified.

(f) The Need of the Child To Be Taken Care of and to make Contact with Family

This document expresses the following:

- i) the need of the child to remain in the care of both or either of his/her parents his/her parent, family and extended family; and
- (ii) to maintain a connection with his/her family, extended family, culture or tradition;

(g) The Child's Developmental Stage

It is important to consider the age of the child, the level of maturity and the stage of development because each developmental stage presents its own needs and challenges which the child has to navigate and overcome some of those challenges to successfully negotiate issues pertaining to his or her development. The document states that the following should be given due consideration:

- (i) age, maturity and stage of development;
- (ii) gender;
- (iii) background; and
- (iv) any other characteristics of the child.

(h) Promotion and Nurturing of the Child's Innate Abilities and Disabilities if any which may be Temporary or Permanent

- i) It is important to provide the child with physical and emotional security
- ii) to promote and nurture his intellectual abilities,
- iii) to provide a secure environment and to be sensitive to his emotional, social and cultural needs in order to promote his or her overall development;

(i) Children with Disabilities

Any child who has a disability needs to be taken care of and be provided with the means to make it easier for him or her to adapt and adjust to the social environment.

(j) Children Suffering from Chronic Illness

These children have to get the necessary medical attention and care from parents or extended family members and be provided with the necessary resources for their survival and well-being.

(k) Stable Family Environment

The Act pronounces that it is important to consider the following:

- i) the need of a child to be brought up within a stable family environment and,
- ii) where this is not possible, in an environment resembling as closely as possible a caring family environment;

(l) Protection from Harm

According to the Act parents, family members and extended family members may not subject a child to any physical or psychological harm caused by:

- (i) subjecting the child to maltreatment , abuse, neglect, exploitation or degradation or;
- ii) exposing the child to violence or exploitation or other harmful behaviour; or
- (ii) exposing the child to maltreatment , abuse, degradation, ill-treatment.

(m) Family Violence

According the Act children have to be protected from family violence involving the child or a family member of the child.

(n) Protection from unnecessary Legal Action

It is imperative that the child is not exposed from an uncalled or unnecessary legal action where possible legal action could be minimise by using conflict resolution strategies.

3.3 The Concept of the Best Interests of the Child

Although there was agreement that whether the court uses its common-law or statutory powers, the standard in determining issues involving children is the *best interests of the child*, the content and the scope of the standard did, however, create problems in practice as the best interests of the child standard was perceived as being vague and undetermined (Davel, 2006; Davel & Skelton, 2007).

Van Zyl (1997); Roos and Vorster (2003); Kaliski, (2006), Davel and Skelton (2007) argue that different professionals involved in matters relating to children have different perspectives on the concept of best interests of the child. The interpretation of this concept is influenced by various factors such as historical background and cultural, political, economic and social conditions, to name but a few (Davel & Skelton, 2007).

The question, however, of what exactly a child's best interests are, is according to Davel and Skelton (2007), a factual question that has to be determined according to the circumstances of each case. Over the years the judiciary laid down guidelines in this regard. In the matter of *Van Deijl v Van Deijl*, during a dispute of custody and guardianship, it was held that in deciding on the best interests of the child regard must be given to the following considerations:

The interest of the minor means the welfare of the minor and the term welfare must be taken in its widest sense to include economic, social, moral and religious considerations. Emotional needs and the ties of accession must also be taken into account and in the case of older children their wishes in the matter cannot be ignored (Davel & Skelton, 2007).

In another attempt to determine what exactly a child's best interests are, Roos and Vorster as well as Davel and Skelton (2007), refer to the case of *French v French*, 1971 (4) SA 298 (W). In this matter the court set out in order of importance four categories or variables of considerations to determine the best interests of the child:

- a) *The primary test is how the sense of security of the child will be preserved.*
- b) *The suitability of the custodian parent is to be tested by enquiring into his/her character, into religion and language in which the children are to be brought up, and also into the fitness of the proposed custodian to guide the moral, cultural and religious development of the child.*

- c) *Material considerations relating to the child's well-being will be considered.*
- d) *The wishes of the child will be considered, with young children as a constituent element in the enquiry as to where they will attain a sense of security, and with more mature children a well-informed judgement, albeit a very subjective judgement, of what their best interests really demand.*

Roos and Vorster (2003; 2009); Kaliski (2006); Davel and Skelton (2007) and Gould and Martindale (2009) report that in determining what is in the best interests of the child the court must decide which of the parents is better equipped to promote the child's physical, moral, emotional and spiritual welfare. Although founded on the above-mentioned concepts, for a long time the concept of the 'best interests' of the child still remained a vague and undefined concept (Roos & Vorster, 2003; Davel & Skelton, 2007).

Some progress was made in defining this concept when the Custody Act of 1970, Michigan Law, determined ten factors to be considered in custody cases. These factors form the basis of the 'best interests' of the child in the South African context as set out by The Honourable Mr. Justice King in the reported case of *McCall v McCall*, 1994 (3) SA 201 (CPD).

In this matter The Honourable Mr. Justice King formulated a comprehensive list of criteria which courts can use as a standard on the facts of the specific case to determine what custody arrangements will best serve the interests of the child concerned.

3.3.1 Criteria as set out by The Honourable Mr. Justice King is the following:

- a. *The love, affection and other emotional ties which exist between parent and child, and the parent's compatibility with the child*

- b. *The capabilities, character and temperament of the parent, and the impact thereof on the child's needs and desires*
- c. *The ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings*
- d. *The capacity and disposition of the parent to give the child the guidance which he/she requires*
- e. *The ability of the parent to provide for the basic physical needs of the child, the so-called 'creature comforts' such as food, clothing, housing and other material needs – generally speaking, the provision of economic security*
- f. *The ability of the parent to provide for the educational well-being and security of the child, both religious and secular*
- g. *The ability of the parent to provide for the child's emotional, psychological, cultural and environmental development*
- h. *The mental and physical health and moral fitness of the parent*
- i. *The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo*
- j. *The desirability or otherwise of keeping siblings together*
- k. *The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration*
- l. *The desirability or otherwise of applying the doctrine of same-sex matching*
- m. *Any other factor relevant to the particular case, which is before the court.*

Before the Children's Act was enacted, South African legislation did not provide any list of criteria such as the one set out by The Honourable Mr. Justice King in order to deal with a child's best interests (Roos & Vorster, 2003; Kaliski, 2006). According to Davel and Skelton (2007), when comparing the list in the Act with the list provided in *McCall v McCall*, 1994 (3) SA 201 (CPD), it is evident that the list in the Act adheres to the principle of non-discrimination (e.g. desirability of same-sex matching and the question whether a parent could provide 'creature comforts' fell away).

The ability of the parent to communicate effectively with the child is not mentioned in the Act (though it is specifically mentioned in *McCall v McCall*, 1994 (3) SA 201 (CPD), but It could be argued that effective communication could be seen as a prerequisite to the ability to address a child's emotional and intellectual needs. The child's preference is not mentioned in this list, but it can be argued that the child's participation is catered for (Hasday, 2004; Davel & Skelton, 2007).

The most remarkable difference seems to be that the list provided by the Act is not an open-ended one, as was the case in *McCall v McCall*, 1994 (3) SA 201 (CPD), where a court could consider 'any other factor which is relevant'. This may prove to be a limitation in practice, but judicial officers can and should use their inherent discretion to consider other factors where relevant (Davel & Skelton, 2007). The literature, however, indicates that the variables provided by The Honourable Mr. Justice King created a frame of reference regarding the best-interests-of-the-child principle (Tredoux et al., 2005; Kaliski, 2006).

When considering the concept of "best interests of the child" some confusion seems to centre around the question as to whether the "best interests" refers to a "standard" as set out in the Children's Act or a "right" that can be claimed by the child, or both.

3.4 The Best-Interests of the child: A Right, or a Standard or Both?

The best interests of the child principle as discussed in Section 8 (Act No. 38 of 2005: Children's Act, 2005) states the following:

(1) The rights which a child has in terms of this Act supplement the rights which a child has in terms of the Bill of Rights.

- (2) *All organs of state in any sphere of government and all officials, employees and representatives of an organ of state must respect, protect and promote the rights of children contained in this Act.*
- (3) *A provision of this Act binds both natural and juristic persons, to the extent that it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.*

The above-mentioned section (section 8(1)) articulates the principle that the Act supplements Chapter 2 of the Constitution (South African Law Commission, Project 110, Review of the Child Care Act (Dec 2002) part 1, par. 3.4, p. 16 in Davel & Skelton, 2007). Section 8(2) confers a positive duty on all officials and employees of organs of state to respect, promote and protect children's rights. Section 8(3) makes the Act applicable to all legal subjects, that is both natural and juristic persons, depending on the nature of the right or duty concerned (Davel & Skelton, 2007).

Section 9 refers to the best interests of the child as paramount (Act No. 38 of 2005: Children's Act, 2005) and states:

In all matters concerning the care, protection and well-being of a child the standard that the child's best interests is of paramount importance, must be applied.

As already indicated by Davel and Skelton (2007), the paramountcy of the best interests of the child standard is firmly established in international law (Section 28(2): Interim Constitution (1993)). The Constitutional Court raised this standard to a principle of paramountcy and this approach has been followed by the courts in many instances, for example, to justify an expansive interpretation of the High Court's review jurisdiction of a protection order in terms of the Domestic Violence Act, in maintenance matters; matters regarding the law of succession; in decisions on medical experimentation ; in decisions regarding a child's participation in religious activities in a particular church; and with

regard to the rights of unaccompanied foreign children (Domestic Violence Act, 1998; Davel & Skelton, 2007).

According to Davel and Skelton (2007), the best interests of the child should either be considered as a right, or a standard or both, and the effect thereof in practice should be taken into account. Every child has the right to have his/her best interests considered to be of paramount importance in every matter concerning him/her. This clearly means that the child is afforded a specific right, which guarantees the paramountcy of his/her best interests (Roos & Vorster, 2003; Gould & Martindale, 2009).

Like other specific rights of children the “best interests” right is a fundamental right endorsed in the Bill of Rights in Chapter 2 of the Constitution. This right, like all the other fundamental rights, has vertical and horizontal applications. This right, like any other fundamental right, is not an absolute right, because the Constitution itself provides for the limitation of fundamental rights. Lastly, this right, like all the other rights, will have to be demarcated and balanced with the rights of various other persons and groups (Davel & Skelton, 2007).

Children’s rights and the implications they raise, as stated by Davel and Skelton, (2007), need to be seen in terms of necessarily challenging, undermining or conflicting with the rights of others or their authority. In fact, this sensitive demarcation of rights is not exclusive to child law, but takes place in many other areas, for example neighbour law and labour law to mention but a few (Davel & Jordaan, 2000; 2005; Davel & Skelton, 2007).

In answering the question whether “best interests” are a standard or a right, it would seem that both apply. The Children’s Act lists 14 factors that must be considered to achieve greater consistency and clarity in applying the standard to all matters concerning children. Section 9 echoes the Constitution and endorses the paramountcy of this standard. It is thus clear that each and every child also has the right to have the

best interests of the child standard considered and applied as being paramount (van Zyl, 1997; Davel & de Kock, 2001; Davel & Skelton (2007).

Bearing in mind the context of the child's rights and best interests, the new Children's Act, 2005, also provided a more visible and direct approach to the child's opinion. The concept is especially important in the context of custody evaluations as many a time the child also has a need or opinion regarding primary care that can and should not be ignored. Although not the primary point of focus in this study, it is deemed relevant to briefly refer to this as reported in the new Act.

3.4.1 A Child's Right to Express His/her Opinion

The new Act allows for the child to participate in rulings about him or her, which is a major difference to previous legislation. Section 10 in the Act is referred to as 'Child Participation' (Children's Act, 2005), which states the following:

Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way, and views expressed by the child must be given due consideration.

A child's right to express his/her opinion freely and to participate in matters concerning him/her is also firmly entrenched in international law: Article 12 of the Convention on the Rights of the Child (CRC): resolution 44/25 of 20 November 1989. The CRC obliges state parties to ensure that a child has the right to express his/her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child, also in the context of divorce (Convention on the Rights of the Child (CRC): resolution 44/25 of 20 November 1989, Article 12(1)).

Article 12 of the CRC has been identified as one of the four core articles providing the convention with the 'soul' since it recognises that children are active legal subjects – the bearers of fundamental human rights with views and feelings of their own (Robinson & Ferreira, 2000). There are two ways children can be allowed, in the words of the Convention, to 'express their views freely' in matters that affect them, namely by means of participation and representation (Hodgkin & Newell, 1998). 'Participation' would refer to all the rules that allow the child to be heard directly, without or with intermediary. It includes rules that require children to be consulted about their opinion, or enable children to become parties to legal actions, so that they have the right to participate in proceedings and/or demand a certain remedy (Edwards in Davel, 1999).

'Representation' is used to indicate the rules that allow children to instruct attorneys, to seek legal advice or to have other kinds of adult representation in legal proceedings (Davel, 2006; Davel & Skelton, 2007).

Article 12 is clear on a number of issues around a child's right to express his/her opinion freely:

- a) The right concerns a child who is 'capable of forming his/her own views'. No lower age limit is set on children's rights to express their views freely.
- b) The right implies that there are no boundaries or areas in which children's views have no place.
- c) The right is to be assured in relation to 'all matters affecting the child' and should thus apply even in matters that may not be specifically covered by the Convention, whenever these matters have a particular interest for the child or may affect his/her life.
- d) That the views of the child must be given 'due weight in accordance with the age and maturity of the child' implies an obligation to listen to and take the views of children seriously. In deciding how much weight should be given to a child's view

in any particular matter, the two criteria of age and maturity must be considered. Once again the Convention rejects specific age barriers.

- e) Children should be heard in a very broad scope of decisions, that is, in '[a]ny judicial and administrative proceedings affecting the child'. There is an increasingly recognised need to adapt courts and other formal decision-making bodies to enable children to participate (Zaal & Skelton, 1998). This could include innovations such as more informality in the physical design of courtrooms, the clothing of the judges and lawyers, separate waiting rooms, the video-taping of evidence and the special preparation of child witnesses (Hodgkin & Newell, 2002).
- f) States are left with the discretion as to how the child's views should be heard, but where procedural rules suggest that this be done through a representative or an appropriate body, the obligation is to transmit the views of the child.

The African Charter on the Rights and Welfare of the Child (ACRWC), entrenches the right of the child to be heard in Article 4(2), which stipulates that in all judicial and administrative proceedings affecting the child who is capable of communicating his/her own views, an opportunity shall be provided for the views of the child to be heard directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate laws (African Charter on the Rights and Welfare of the Child, 1999).

Article 4(2) should be read with Article 7 because the latter makes provision for every child capable of communicating his/her views to express these freely in all matters and to disseminate them subject to the restrictions of domestic law (African Charter on the Rights and Welfare of the Child, 1999; Davel & de Kock, 2001; Davel & Skelton, 2007).

Although the right to be heard provided for in terms of the ACRWC could seem more restricted than the scope of the right in the Convention in some ways, the former is

more specific in that it provides for the child to be heard 'directly or through an impartial representative as a party to the proceedings'. By doing so it goes further than the Convention as it specifies how children would be heard, which is a fundamental right and thus included in the Children's Act, 2005. (African Charter on the Rights and Welfare of the Child, 1999; Chirwa, 2002).

3.5 Conclusion

This study aims to effectively and accurately determine the best interest of the child by means of a psychological procedure, but the concept of the best interests of the child remained vague for a very long time. Many attempts were made to define or explain this principle, which was not effective or comprehensive enough. The Children's Act, 2005 however identified the best interests of the child standard which correlates largely with a ruling by The Honourable Mr. Justice King made in the case of *McCall v McCall*, 1994 (3) SA 201 (CPD). This list of criteria was formulated which courts can use as a standard on the facts of the specific case to determine what custody arrangements will best serve the interests of the child concerned.

This chapter also indicated that the best interests of the child is both a standard as well as a right and this led to many new additions to the Act, especially the child's ability to voice an opinion. The next chapter explains the concept of parental responsibilities and rights as referred to in the Children's Act, 2005.

CHAPTER 4

PARENTAL RESPONSIBILITIES AND RIGHTS

4.1 Introduction

Chapter 3 in the Act and was traditionally called 'Parental Authority' or 'Parental Power' and is now referred to in the Act as 'Parental responsibilities and Rights'. Chapter 3 of the Act governs the acquisition and the loss of parental responsibilities and rights not only by parents but also by other persons. It also governs elements of the content and exercise of parental responsibilities and rights, and miscellaneous matters such as the presumption of paternity in respect of children born out of wedlock, the position of children born of a voidable marriage, the position of a child who born as a result of artificial fertilisation as well as parenting plans.

This chapter in the Act is thus a very important part of this investigation because recommendations regarding parental responsibilities and rights collectively refer to the environment that child will live in post divorce. Therefore this concept as referred to and discussed in the Children's Act, 2005 will be discussed in this chapter.

4.2 Parental Responsibilities and Rights in the Children's Act of 2005 (Section 18)

According to Davel and Skelton (2007), in terms of the common law, parental authority consisted of guardianship, custody and access. It was automatically conferred on both parents of a 'legitimate' child (that is, the child born of parents who were married to each other at the time of his/her conception or birth or at any intervening time) and the concept that is now acceptable internationally on the mother of an 'illegitimate' or extramarital child (that is, a child born out of wedlock).

Prior to the coming into operation of the Guardianship Act 192 of 1993 on March 1994, only the father of a legitimate child was the child's guardian. Section 1(1) of the Guardianship Act abolished this common-law rule and conferred equal, concurrent powers of guardianship on both parents of a legitimate child (Guardianship Act 192 of 1993; Davel & Skelton, 2007).

This Act replaces the terms 'parental power' and 'parental authority' with 'parental responsibilities and rights'; 'custody' with 'care'; and 'access' with 'contact' as mentioned earlier in this chapter. This change is in keeping with modern trends as reflected in some local sources and in many foreign jurisdictions. It is also in keeping with the United Nations Convention on the Rights of the Child (Convention on the Rights of the Child: resolution 44/25 of 20 November 1989). This to say the least had a vast effect in current correspondence; psycho legal reports, hall way discussions and court rulings. To date many legal professionals still find the vocabulary shift difficult.

This Act further does not use the terms 'legitimate', 'extramarital' and 'illegitimate' in respect of the child's status. Instead it uses the child's father's marital status as the defining feature, and imposes new criteria for the acquisition of parental responsibilities and rights by unmarried fathers (Davel & Skelton, 2007).

Section 1(1) of the Act defines marriage in broad terms that include civil, customary and religious marriages. Furthermore, in terms of section 13(2) of the Civil Union Act 17 of 2006, civil unions are also covered by the term 'marriage' (except in so far as the Marriage Act 25 of 1961 and the recognition of Customary Marriages Act 120 of 1998 are concerned (Marriage Act 25 of 1961; Customary Marriages Act 120 of 1998; Civil Union Act 17 of 2006).

4.2.1 Description of Parental Responsibilities and Rights

(1) A person may have both full or specific parental responsibilities and rights in respect of a child.

(2) The parental responsibilities and rights that a person may have in respect of a child include the responsibility and the right to

- (a) care for the child;
- (b) maintain contact with the child;
- (c) act as guardian of the child; and
- (d) contribute to the maintenance of the child.

(3) Subject to subsections (4) and (5), a parent or other person who acts as guardian of a child must

- (a) administer and safeguard the child's property and property interests;
- (b) assist or represent the child in administrative, contractual and other legal matters; or
- (c) give or refuse any consent required by law in respect of the child, including consent to
 - (i) the child's marriage;
 - (ii) the child's adoption;
 - (iii) the child's departure or removal from the Republic;
 - (iv) the child's application for a passport; and

(4) Where more than one person has guardianship of a child, each is competent, subject to subsection (5), any other law or any order of a competent court, to exercise independently and without the consent of the other any right or responsibility arising from such guardianship.

(5) Unless a competent court orders otherwise, the consent of all the persons that have guardianship of a child is necessary in respect of matters set out in subsection (3)(c).

Section 18 came into operation on 1 July 2007. This section partly codifies the legal rules regarding parental authority and recasts them in respect of parental responsibilities and rights. Section 18(1), for example, recasts the common-law principle that all the components of parental authority need to vest in the same person. Thus, section 18(1) provides that a person may have full parental responsibilities and rights, or he/she may have only specific elements of parental responsibilities and rights (Davel & Skelton, 2007).

In terms of section 1(1) of the Act, 'parental responsibilities and rights' refer to the responsibilities and rights cited in section 18. Section 18(2) defines parental responsibilities and rights non-exhaustively to include caring for the child; maintaining contact with the child; acting as the child's guardian; and contributing to the child's maintenance. The first three elements roughly match the components of parental authority, namely custody, access and guardianship (Review of the Child Care Act Report (Project 110) (2002) 7.3 p. 6). At common law, the fourth component of parental responsibilities and rights, that is, contributing to the child's maintenance, exists quite independently of parental authority (Cronje & Heaton, 2004).

In terms of the common law, custody referred to a person's capacity to physically have the child with him/her and to control and supervise the child's daily life, which included caring for the child; supporting and guiding the child; and assuming responsibility for the

child's upbringing, health, education, safety and welfare (Davel, 2006; Davel & Skelton, 2007).

The Act replaces the term 'custody' with 'care'. In terms of section 1(1), 'care' encompasses many of the elements that 'custody' entailed, but 'care' also includes the duty of support and elements of what was traditionally called 'access' and is now known as 'contact' (Davel & Skelton, 2007).

Section 18(2)(b) also lists 'contact' as a separate parental responsibility and right. The content of 'contact' corresponds to the common-law concept of 'access', for it refers to maintaining a personal relationship with the child and communicating with the child on a regular basis (Davel & Skelton, 2007).

As will be explained below, the meaning of 'guardianship' more or less corresponds to the narrow meaning the term had at common law.

'Maintenance' is not defined in the Act and thus retains its common-law meaning, mainly encompassing items like food; clothing; accommodation; medical care and a suitable education (Cronje & Heaton, 2004).

At common law, the term 'guardianship' had a wide and narrow meaning. In the narrow sense it referred to the capacity to administer a minor's estate on his/her behalf, and to assist the minor in legal proceedings and the performance of juristic acts. In its wide sense it also included custody (Schafer in Clark, 1988; Hutchison, van Heerden, van der Merwe & Visser, 1991; van Heerden, Cockrell & Keightley, 1999; Robinson in Davel & Jordaan, 2000; Cronje & Heaton, 2004; Davel & Skelton, 2007).

Section 18(3) of the Act essentially codifies the narrow meaning of the term by obliging a guardian to administer and safeguard the child's property and property interests,

assist or represent the child in administrative, contractual and other legal matters, and give or refuse any consent that is legally required in respect of the child (Davel & Skelton, 2007).

Section 18(3)(c) contains a non-exhaustive list of the juristic acts for which consent is legally required in respect of a child. The acts that are listed in section 18(3)(c) more or less correspond to those for which section 1(2) of the Guardianship Act of 1993 required the consent of both parents of a legitimate child. However, the scope of section 18(3)(c)(iii) of the Act is wider than that of section 1(2)(c) of the Guardianship Act. While section 1(2)(c) of the Guardianship Act applied only to the removal of the child from the Republic, section 18(3)(c)(iii) of the Act extends to the child's departure from the Republic. Section 18 (3)(c)(v) of the Children's Act, on the other hand, is narrower than section 1(2)(e) of the Guardianship Act, for, unlike section 1(2)(e) of the Guardianship Act, section 18(3)(c)(v) of the Act does not apply to any right to immovable property which belongs to the child (Davel & Skelton, 2007).

Subsections (4) and (5) of section 18 recast and extend the scope of the rule on equal, concurrent powers of guardianship that was contained in section 1(2) of the Guardianship Act. Like section 1(2) of the Guardianship Act, subsections (4) and (5) of section 18 of the Children's Act allow any guardian of a child to exercise any responsibility or right arising from his/her guardianship independently and without the consent of the other guardian(s), but they subject this general rule to an exception. Comparing the provisions of the Act to those of section 1(2) of the Guardianship Act, the exception in the Act appears to be more extensive than that which appeared in the Guardianship Act (Davel & Skelton, 2007).

In terms of the Act, a guardian's power to act independently is subject not only to the requirement of joint consent for the juristic acts that are listed in section 18(3)(c) and to any order of a competent court, but also to 'any other law'. However, it is submitted that nothing turns upon this difference, as it is self-evident that guardians could only exercise

their powers of guardianship on the terms of the Guardianship Act independently if independent exercise did not violate the provisions of any other law (Davel & Skelton, 2007).

4.2.2 Parental Rights of Mothers

Section 19 explains parental responsibilities and rights of mothers and states the following:

- (1) The biological mother of a child, whether married or unmarried, has full parental responsibilities and rights in respect of the child, if*
 - (a) the biological mother of a child is an unmarried woman who does not have guardianship in respect of the child; and*
 - (b) the biological father of the child does not have guardianship in respect of the child, the guardian of the child's biological mother is also the guardian of the child.*

- (2) This section does not apply in respect of a child who is the subject of a surrogacy agreement.*

Section 19 came into operation on 1 July 2007. Broadly speaking, section 19(1) is in line with the common-law rule that a woman acquires parental authority over her child when she gives birth to the child. This rule applied regardless of whether the child was born in or out of wedlock. Section 19(1) recasts that rule by conferring full parental responsibilities and rights on the 'biological mother' of a child, regardless of whether or not she is married (Davel & Skelton, 2007).

The act does not define the term 'biological mother'. In the absence of surrogacy or artificial fertilisation using a donor's ovum, the phrase clearly refers to the child's birth mother. In the case of surrogacy, section 19(3) expressly excludes the application of section 19. Section 297(1)(c) furthermore specifies that the surrogate mother has no parental responsibilities or rights in respect of the child. Thus, even if the surrogate mother's ovum was used and she qualifies as the child's 'biological mother' because she contributed biological material to the child, she does not acquire parental responsibilities and rights in respect of the child (Davel & Skelton, 2007).

The legal consequences are the same in the case of artificial fertilisation of a married woman in the absence of surrogacy (Davel & Skelton, 2007). The married woman is regarded to be the child's biological mother and she clearly acquires full parental responsibilities and rights in terms of section 19(1) (Davel & Skelton, 2007).

4.2.3 Parental Rights of Married Fathers

Section 20 refers to parental responsibilities and rights of married fathers and states that the biological father of a child has full parental responsibilities and rights in respect of the child

(a) if he is married to the child's mother; or

(b) if he was married to the child's mother at the time of

(i) the child's conception; or

(ii) the child's birth; or

(iii) the child's conception and birth

Section 20 came into operation on 1 July 2007. This section is in keeping with the common-law rule which conferred parental authority on all fathers of legitimate children. As pointed out earlier, the Act does not use the terms 'legitimate' or 'extramarital' or 'illegitimate'. Instead it refers to married or unmarried fathers. The premise of the common-law rule that a father acquires parental authority by virtue of being married to the child's mother or having been married to her at the time of the child's birth or conception or at any intervening time has, however, been left unchanged (Davel & Skelton, 2007).

4.2.4 Parental Rights of Unmarried Fathers

In section 21 parental responsibilities and rights of unmarried fathers are explained as follows:

(1) The biological father of a child who does not have parental responsibilities and rights in respect of the child in terms of section 20, acquires full parental responsibilities and rights in respect of the child

(a) if at the time of the child's birth he is living with the mother in a permanent life-partnership; or

(b) if he, regardless of whether he has lived or is living with the mother,

(i) consents to be identified or successfully applies in terms of section 26 to be identified as the child's father or pays damages in terms of customary law;

(ii) contributes or has attempted in good faith to contribute to the child's upbringing for a reasonable period; and

(iii) contributes or has attempted in good faith to contribute towards expenses in connection with the maintenance of the child for a reasonable period.

(2) This section does not affect the duty of a father to contribute towards the maintenance of the child.

(3) (a) If there is a dispute between the biological father referred to in subsection (1) and the biological mother of a child with regard to the fulfilment by that father of the conditions set out in subsection (1)(a) or (b), the matter must be referred for mediation to a family advocate, social worker, social services professional or other suitably qualified person.

(b) Any party to the mediation may have the outcome of the mediation reviewed by a court.

(4) This section applied regardless of whether the child was born before or after the commencement of this Act.

Section 21 of the Act came into operation on 1 July 2007. It contains one of the major reforms in the law of parent and child. The section is based on the premise that if a child's unmarried father meets certain requirements, he acquires exactly the same parental responsibilities and rights as the child's mother (Davel & Skelton, 2007).

At common law the father of a child who was born out of wedlock had no parental authority over the child. He could, however, approach the High Court for an order awarding parental authority or elements of parental authority to him on the ground that the order was in the best interests of the child (Davel & Skelton, 2007).

As the issue of the legal position of the father of a child born out of wedlock became increasingly contentious, the need for legislation became apparent. The South African Law Commission embarked on an investigation with a view to drafting legislation on the

issue. Its eventual recommendations essentially merely confirmed the common-law position (Father's Rights of his Illegitimate Child (Project 38) (1994).

These recommendations formed the basis of the Natural Fathers of Children Born out of Wedlock Act 86 of 1997. The Natural Fathers of Children Born out of Wedlock Act did not afford the father any automatic rights in respect of his child but empowered the High Court, on the father's application, to grant the father guardianship and/or custody and/or access if this was in the best interests of the child (Natural Fathers of Children Born out of Wedlock Act 86 of 1997; Davel & Skelton, 2007).

According to Davel and Skelton (2007), the Act repealed the Natural Fathers of Children Born out of Wedlock Act and replaced it with a new set of rules which, inter alia, automatically confers parental responsibilities and rights on certain unmarried fathers. In terms of section 21(4) of the Act, the new rules apply retroactively to children who were born before the coming into operation of the Act.

One of the main reasons for the need for law reform was that the denial of automatic responsibilities and rights (apart from the duty of support) to all fathers of children out of wedlock most probably infringed the Constitution of the Republic of South Africa, 1996 – especially the equality clause and the children's rights clause (van der Vyfer & Joubert 1991; van Heerden et al., 1991; Kruger & Robinson in Robinson, 1997; Davel & Jordaan, 2000; Cronje & Heaton, 2003; van Schalkwyk in Davel, 2005; Davel & Skelton, 2007). Many arguments were raised in favour of and against granting automatic responsibilities and rights to fathers of children born out of wedlock (Davel & Skelton, 2007).

Suffice it to say that even though section 21 of the Act does not confer full parental responsibilities and rights on all unmarried fathers, its provisions probably satisfy most advocates of automatic responsibilities and rights for unmarried fathers, while those who argue that fathers and mothers should not have equal responsibilities and rights

because mothers still bear a disproportionate childcare burden, are left dissatisfied (Davel & Skelton, 2007).

In terms of section 21(1)(a), an unmarried father automatically acquires full parental responsibilities and rights in respect of his child if he lives with the child's mother in a permanent life partnership when the child is born. Regardless of whether or not he has ever lived with the child's mother, he also acquires full parental responsibilities and rights if he meets the requirements that section 21(1)(b) sets. These requirements are that he must consent to being identified or successfully apply to be identified as the child's father or pay damages in terms of customary law; and he must contribute or have attempted in good faith to contribute to the child's upbringing and maintenance for a reasonable period. As section 21(1)(b) uses the connecting word 'and' in respect of the requirements in subparagraphs (i), (ii) and (iii), the father must meet all those requirements to qualify for automatic parental responsibilities and rights (Davel & Skelton, 2007).

A father who falls outside the categories mentioned in section 21(1) can acquire parental responsibilities and rights by entering into a parental responsibilities and rights agreement with the child's mother in terms of section 22, or by having guardianship and/or contact and care assigned to him by the court in terms of section 23 or 24 (Davel & Skelton, 2007). The present discussion focuses only on section 21(1).

At least two phrases in section 21(1) may present difficulties. They are 'permanent life partnership' in 1(1)(a) and 'reasonable period' in 2(1)(b)(ii) and (iii). Neither phrase is defined or explained in the Act. Conventionally, a life partnership refers to living together outside marriage in a relationship which is analogous to, or has most of the characteristics of a civil marriage (Cronje & Heaton, 2004). Davel and Skelton (2007) state that prior to the coming into operation of the Civil Union Act, the phrase 'permanent life partnership' was used to describe many unions that could qualify as 'civil unions' in terms of the Civil Union Act (2006).

The Civil Union Act came into operation on 1 December 2006. It inter alia allows same-sex and heterosexual couples to enter into a marriage or civil partnership which has the same consequences as a marriage in terms of the Marriage Act 25 of 1961. It further equates any reference to 'marriage' and to 'husband', 'wife' or 'spouse' in any law other than the Marriage Act of the Recognition of Customary Marriages Act 120 of 1998 to a reference to 'civil union' and 'civil union partner' respectively (Davel & Skelton, 2007).

At present the phrase 'permanent life partnership' refers to only those permanent life partnerships that fall outside the scope of the Civil Union Act. When such a life partnership can be said to be permanent is, of course, an issue that does not admit of a ready answer. The phrase was first employed in the South African courts in *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC) where it was used in relation to a same-sex permanent life partnership. It has subsequently also been used in relation to a heterosexual permanent life partnership (Davel & Skelton, 2007).

When a father has contributed or has attempted in good faith to contribute towards the child's upbringing and/or maintenance for a 'reasonable period', it is likewise not a straightforward matter, for the point at which a period becomes 'reasonable' is a relative matter on which the child's parents' views may differ vastly. In terms of section 21(3)(a) of the Act, a dispute between the child's parents as to whether they are in a permanent life partnership or whether the father has contributed or attempted in good faith to contribute to the child's upbringing and/or maintenance for a reasonable period, must be referred for mediation (Davel & Skelton, 2007).

According to Davel and Skelton (2007), Section 21(3) governs disputes between a child's unmarried biological parents as to whether the father meets the conditions for acquiring full parental responsibilities and rights in terms of section 21(1). Section 21(3)(a) stipulates that the dispute 'must' be referred for mediation to a family advocate;

social worker; social service professional or other 'suitably qualified person' which can also include a psychologist. The use of the word 'must' indicates that the parents may not approach the court as a first resort for the resolution of their dispute. They first have to mediate their dispute. It should, however, be borne in mind that the Act does not diminish the High Court's powers as upper guardian of all minors (Davel & Skelton, 2007). It can thus be seen that the Act is more 'user friendly' as the immediate legal route of applications or a paper war is avoided, and replaced by a more interactive mediatory route. This option is also much more cost effective, which invariably serves the interest of children.

In section 22, parental responsibilities and rights agreements are described as follows:

(1) Subject to subsection (2), the mother of a child or other person who has parental responsibilities and rights in respect of a child may enter into an agreement providing for the acquisition of such parental responsibilities and rights in respect of the child as are set out in the agreement, with

(a) the biological father of a child who does not have parental responsibilities and rights in respect of the child in terms of either section 20 or 21 or by court;

(b) any other person having an interest in the child's care, well-being and development.

(2) The mother or other person who has parental responsibilities and rights in respect of a child may only confer by agreement upon a person contemplated in subsection (1) those parental responsibilities and rights which she or that other person has in respect of the child at the time of the conclusion of such an agreement.

(3) A parental responsibilities and rights agreement must be in the prescribed format and contain the prescribed particulars.

(4) Subject to subsection (6), a parental responsibilities and rights agreement takes effect only if

(a) registered with the family advocate; or

(b) made an order of the High Court, a divorce court in a divorce matter or the children's court on application by the parties to the agreement.

(5) Before registering a parental responsibilities and rights agreement or before making a parental responsibilities and rights agreement an order of court, the family advocate or the court concerned must be satisfied that the parental responsibilities and rights agreement is in the best interests of the child.

(6)(a) A parental responsibilities and rights agreement registered by the family advocate may be amended or terminated by the family advocate on application

(i) by a person having parental responsibilities and rights in respect of the child;

(ii) by the child, acting with leave of the court; or

(iii) in the child's interest by any other person, acting with leave of the court.

(b) A parental responsibilities and rights agreement that was made an order of court may only be amended or terminated on application

(i) by a person having parental responsibilities and rights in respect of the child;

(ii) by the child, acting with leave of the court; or

(iii) in the child's interest by any other person, acting with leave of the court.

(7) Only the High Court may confirm, amend or terminate a parental responsibilities and rights agreement that relates to the guardianship of a child.

Section 22(1) covers members of the child's present and/or former extended family (such as a grandparent, aunt, uncle, sibling and a present and former step-parent), and the present and/or former permanent life partner of the child's biological parent (Davel & Skelton, 2007).

Before registering a parental responsibilities and rights agreement or making it an order of court, the family advocate or court must be satisfied that the agreement is in the best interests of the child. The family advocate or court must therefore apply the best interests of the child standard as set out in section 7 of the Act (Davel & Skelton, 2007).

Section 23 refers to assignment of contact and care to an interested person by court order. The section reads as follows:

(1) Any person having an interest in the care, well-being or development of a child may apply to the High Court, a divorce court in divorce matters or the children's court for an order granting to the applicant, on such conditions as the court may deem necessary,

(a) contact with the child; or

(b) care of the child.

(2) When considering an application contemplated in subsection (1), the court must take into account

(a) the best interests of the child;

(b) the relationship between the applicant and the child, and any other relevant person and the child;

(c) the degree of commitment that the applicant has shown towards the child;

(d) the extent to which the applicant has contributed towards expenses in connection with the birth and maintenance of the child; and

(e) any other fact that should, in the opinion of the court, be taken into account.

(3) If in the course of the court proceedings it is brought to the attention of the court that an application for the adoption of the child has been made by another applicant, the court

(a) must request a family advocate, social worker or psychologist to furnish it with a report and recommendations as to what is in the best interests of the child; and

(b) may suspend the first-mentioned application on any conditions it may determine.

(4) The granting of care or contact to a person in terms of this section does not affect the parental responsibilities and rights that any other person may have in respect of the same child.

As reported above, sections 23 and 24 deal with court-ordered assignments of care, contact, and guardianship. These sections apply to all children, regardless of the marital status of their parents (Davel & Skelton, 2007).

Section 24 refers to assignment of guardianship by order of court, which states the following:

(1) Any person having an interest in the care, well-being and development of a child may apply to the High Court for an order granting guardianship of the child to the applicant.

(2) When considering an application contemplated in subsection (1), the court must take into account

(a) the best interests of the child;

(b) the relationship between the applicant and the child, and any other relevant person and the child; and

(c) any other fact that should, in the opinion of the court, be taken into account.

(3) In the event of a person applying for guardianship of a child that already has a guardian, the applicant must submit reasons as to why the child's existing guardian is not suitable to have guardianship in respect of the child.

Section 24 deals with an application to court for assignment of guardianship to someone who does not have guardianship. As in the case in respect of an application for court-ordered assignment or contact of care in terms of section 23, the application may be by anyone who has an interest in the child's care, well-being and development (de Villiers, 1993; Davel & Skelton, 2007).

Section 25 refers to certain applications regarded as intercountry adoption. The Act states that when an application is made in terms of section 24 by a non-South African citizen for guardianship of a child, the application must be regarded as an intercountry adoption for the purposes of the Hague Convention on Intercountry Adoption and Chapter 16 of this Act (Donnalioia, 2005; Davel & Skelton, 2007).

Section 25 attempts to close the door on the practice of approaching the South African High Court for an order awarding sole guardianship of a South African child to a foreigner who plans to remove the child from South Africa with a view to adopting the child in a foreign country (Duncan, 1998; Davel & Skelton, 2007).

4.2.5 Paternity Claims

Section 26 addresses a person claiming paternity. This is dealt with in the following manner:

(1) A person who is not married to the mother of a child and who is or claims to be the biological father of the child may

(a) apply for an amendment to be effected to the registration of birth of the child in terms of section 1(4) of the Births and Deaths Registration Act, 1992 (Act 10 No. 51 of 1992), identifying him as the father of the child, if the mother consents to such amendment; or

(b) apply to a court for an order confirming his paternity of the child, if the mother

(i) refuses to consent to such amendment;

(ii) is incompetent to give consent due to mental illness;

(iii) cannot be located; or

(iv) is deceased.

(2) This section does not apply to

(a) the biological father of a child conceived through the rape of or incest with the child's mother; or

(b) any person who is biologically related to a child by reason only of being a gamete donor for purposes of artificial fertilisation.

Davel and Skelton (2007) explains that Section 26 of the Act authorises amendment of the registration of a child's birth in terms of section 11(4) of the Births and Death

Registration Act 51 of 1992, to reflect the paternity of the man who is or claims to be the child's 'biological father'.

In section 27 the assignment of guardianship and care is addressed in the following manner:

(1) (a) A parent who is the sole guardian of a child may appoint a fit and proper person as guardian of the child in the event of the death of the parent.

(b) A parent who has the sole care of a child may appoint a fit and proper person to be vested with the care of the child in the event of the death of the parent.

(2) An appointment in terms of subsection (1) must be contained in a will made by the parent.

(3) A person appointed in terms of subsection (1) acquires guardianship or care, as the case may be, in respect of a child

(a) after the death of the parent; and

(b) upon the person's express or implied acceptance of the appointment.

(4) If two or more persons are appointed as guardians or to be vested with the care of the child, any one or more or all of them may accept the appointment except if the appointment provides otherwise.

A regular request during psychological evaluations as part of a divorce dispute includes termination, extension, suspension or restriction of parental responsibilities and rights. These aspects are dealt with in section 28:

(1) A person referred to in subsection (3) may apply to the High Court, a divorce court in a divorce matter or a children's court for an order

(a) suspending for a period, or terminating, any or all of the parental responsibilities and rights which a specific person has in respect of a child; or

(b) extending or circumscribing the exercise by that person of any or all of the parental responsibilities and rights that person has in respect of a child.

(2) An application in terms of subsection (1) may be combined with an application in terms of section 23 for the assignment of contact and care in respect of the child to the applicant in terms of that section.

(3) An application for an order referred to in subsection (1) may be brought

(a) by a co-holder of parental responsibilities and rights in respect of the child;

(b) by any other person having a sufficient interest in the care, protection, well-being or development of the child;

(c) by the child, acting with leave of the court;

(d) in the child's interest by any other person, acting with leave of the court; or

(e) by a family advocate or the representative of any interested organ of state.

(4) When considering such application the court must take into account

(a) the best interests of the child;

(b) the relationship between the child and the person whose parental responsibilities and rights are being challenged;

(c) the degree of commitment that the person has shown towards the child; and

(d) any other fact that should, in the opinion of the court, be taken into account.

Section 28 deals with the court-ordered limitation, suspension, circumscription or extension of the parental responsibilities and rights a person has. Davel and Skelton (2007) state that the court that may make an order in this regard is the High Court, a divorce court dealing with a divorce matter, and the children's court within whose area of jurisdiction the child is ordinarily resident.

In section 29 court proceedings are discussed:

(1) An application in terms of sections 22(4)(b), 23, 24, 26(1)(b) or 28 may be brought before the High Court, a divorce court in a divorce matter or a children's court, as the case may be, within whose area of jurisdiction the child concerned is ordinarily resident.

(2) An application in terms of section 24 for guardianship of a child must contain the reasons why the applicant is not applying for the adoption of the child.

(3) The court hearing an application contemplated in subsection (1) may grant the application unconditionally or on such conditions as it may determine; or may refuse the application, but an application may be granted only if it is in the best interests of the child.

(4) When considering an application contemplated in subsection (1) the court must be guided by the principles set out in Chapter 2 to the extent that those principles are applicable to the matter before it.

(5) The court may for the purposes of the hearing order that

(a) a report and recommendations of a family advocate, a social worker or other suitably qualified person must be submitted to the court;

(b) a matter specified by the court must be investigated by a person designated by the court;

(c) a person specified by the court must appear before it to give or produce evidence; or

(d) the applicant or any party opposing the application must pay the costs of any such investigation or appearance.

(6) The court may, subject to section 55,

(a) appoint a legal practitioner to represent the child at the court proceedings; and

(b) order the parties to the proceedings, or any one of them, or the state, if substantial injustice would otherwise result, to pay the costs of such representation.

(7) If it appears to a court in the course of any proceedings before it that a child involved in or affected by those proceedings is in need of care and protection, the court must order that the question whether the child is in need of care and protection be referred to a designated social worker for investigation in terms of section 155(2).

Part 2 of the Act refers to co-exercise of parental responsibilities and rights (sections 30 to 32). Section 30 addresses the concepts of co-holders of parental responsibilities and rights which include:

(1) More than one person may hold parental responsibilities and rights in respect of the same child.

(2) When more than one person holds the same parental responsibilities and rights in respect of a child, each of the co-holders may act without the consent of the other co-holder(s) when exercising those responsibilities and rights, except where this Act, any other law or an order of court provides otherwise.

(3) A co-holder of parental responsibilities and rights may not surrender or transfer those responsibilities and rights to another co-holder or any other person, but may by agreement with that other co-holder or person allow the other co-holder or person to exercise any or all of those responsibilities and rights on his/her behalf.

(4) An agreement in terms of subsection (3) does not divest a co-holder of his/her parental responsibilities and rights and that co-holder remains competent and liable to exercise those responsibilities and rights.

4.2.6 The Rights of the Child to be Heard and his/her Rights to be Considered

Section 31 refers to major decisions involving the child in the following manner:

(1) (a) Before a person holding parental responsibilities and rights in respect of a child takes any decision contemplated in paragraph (3) involving the child, that person must give due consideration to any views and wishes expressed by the child, bearing in mind the child's age, maturity and stage of development.

(b) A decision referred to in paragraph (a) is any decision

(i) in connection with a matter listed in section 18(3)(c);

(ii) affecting contact between the child and a co-holder of parental responsibilities and rights;

(iii) regarding the assignment of guardianship or care in respect of the child to another person in terms of section 27; or

(iv) which is likely to significantly change, or to have an adverse effect on, the child's living conditions, education, health, personal relations with a parent or family member or, generally, the child's well-being.

(2) (a) Before a person holding parental responsibilities and rights in respect of a child takes any decision contemplated in paragraph (b), that person must give due consideration to any views and wishes expressed by any co-holder of parental responsibilities and rights in respect of the child.

(b) A decision referred to in paragraph (a) is any decision which is likely to change significantly, or to have a significant adverse effect on, the co-holder's exercise of parental responsibilities and rights in respect of the child.

Section 31 came into operation on 1 July 2007. As South Africa has ratified the United Nations Convention on the Rights of the Child it must comply with the obligations the Convention imposes on state parties (Davel & Skelton, 2007).

These obligations include giving every child who is capable of forming his/her own views the right to express those views freely in all matters that affect him/her and to have them given due weight, taking the child's age and maturity into account (van Zyl, 1997; Davel & Skelton, 2007). The child's own views is also often seen as a controversial point during evaluations for determining parental responsibilities and rights and primary residency allocation of children involved in a divorce dispute (Roos & Vorster, 2003; Kaliski, 2006; Tredoux et al., 2005). Sections 10 and 31(1)(a) of the Act are in keeping with those obligations in so far as proceedings, decisions and other matters under the act are concerned (Davel & Skelton, 2007).

Section 32 addresses the concepts of care of the child by a person not holding parental responsibilities and rights. These are described by the Act as follows:

(1) A person who has no parental responsibilities and rights in respect of a child but who voluntarily cares for the child either indefinitely, temporarily or partially, including a caregiver who otherwise has no parental responsibilities and rights in respect of a child, must, whilst the child is in that person's care

- (a) safeguard the child's health, well-being and development; and*
- (b) protect the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation, and any other physical, emotional or mental harm or hazards.*

(2) Subject to section 29, a person referred to in subsection (1) may exercise any parental responsibilities and rights reasonably necessary to comply with subsection (1), including the right to consent to any medical examination or experiment regarding the child if such consent cannot reasonably be obtained from the parent or guardian of the child.

(3) A court may limit or restrict the parental responsibilities and rights which a person may exercise in terms of subsection (2).

(4) A person referred to in subsection (1) may not

- (a) hold him- or herself out as the biological or adoptive parent of the child; or*
- (b) deceive the child or any other person into believing that that person is the biological or adoptive parent of the child.*

The above mentioned section dealt with the various shapes and forms parental responsibilities and rights can take as referred to in the new Children's Act. Another behaviourally constructive addition to the Act, which directly involves the parents in decisions regarding the involved minor child or children, is the principle of the parenting plan. Parenting plans forms part 3 of the Act and includes sections 33 to 35.

4.3 Parenting Plans

a) Definition

Section 33(1) was promulgated on 1 April 2010, but Davel and Skelton (2007) point out that in section 1(1) of the Act a definition of a 'parenting plan' is not provided. Based on the content, one could deduce that a parenting plan refers to an agreement in which co-holders of parental responsibilities and rights make arrangements on the way in which they will exercise their respective responsibilities and rights.

Currently, however, when a dispute regarding children arise during a divorce, a 'parenting plan' along with divorce correspondence is required in South Africa. Stahl (1994) is in agreement with Gould and Martindale (2009) that a parenting plan allows parents to avoid future conflicts arising from a lack of guidelines in dealing with responsibilities relating to the children. Without specific agreements around these responsibilities disputes can arise and litigation may be needed to resolve these issues (Lincoln, 1986; Kline, 1999; Gould & Martindale, 2009).

The provision for a parenting plan aims to acknowledge that both parents have full parental rights and responsibilities in respect of the minor child, in accordance with the Children's Bill, and that both parents shall act as co-holders of such parental rights and responsibilities in terms of the Children's Bill. In this plan the parents also agree to discuss all major decisions regarding the health; medical care; education; religious upbringing; general welfare; living conditions; personal relations with friends and family members of the minor child; any decision affecting contact between the minor child and a co-holder of parental rights and responsibilities; any decision which may change significantly or have a significant adverse effect on the co-holder's exercise of parental rights and responsibilities, and including all aspects as stipulated in Section 31 of the Children's Bill and shall make all such decisions jointly giving due consideration to any

views and wishes expressed by the minor child and any co-holder of parental rights and responsibilities (van Dorsten, 2002; Davel & Skelton, 2007; Gould & Martindale, 2009).

b) Contents of Parenting Plans

Section 33 refers to the contents of parenting plans states the following:

- i. The co-holders of parental responsibilities and rights in respect of a child may agree on a parenting plan which specifies the exercise of their respective responsibilities in respect of the child.*
- ii. If the co-holders of parental responsibilities and rights in respect of a child are experiencing difficulties in exercising their responsibilities and rights, those persons, before seeking the intervention of a court, must first seek to agree on a parenting plan which specifies the exercise of their respective responsibilities and rights in respect of the child.*
- iii. A parenting plan may determine any matter in connection with parental responsibilities and rights, including:*
 - (a) where and with whom the child is to live;*
 - (b) the maintenance of the child;*
 - (c) contact between the child and*
 - (i) any of the parties; and*
 - (ii) any other person; and*
 - (d) the schooling and religious upbringing of the child.*

iv. *A parenting plan must comply with the best-interests-of-the-child standard as set out in section 7.*

v. *In preparing a parenting plan as contemplated in subsection (2) the parties must seek*

(a) the assistance of a family advocate, social worker or psychologist; or

(b) mediation through a social worker or other suitably qualified person.

A more comprehensive discussion about parenting plans is provided in the next chapter together with continuous issues relating to it.

c) Formalities of Parenting Plan

Section 34 of the Act deals with the formalities of a parenting plan in the following manner:

i. *A parenting plan must be in writing and signed by the parties to the agreement; and*

ii. *subject to subsection (2), may be registered with a family advocate or made an order of court.*

iii. *An application by co-holders contemplated in section 33(1) for the registration of the parenting plan or for it to be made an order of court must be in the prescribed format and contain the prescribed particulars; and*

iv. *be accompanied by a copy of the plan.*

v. *An application by co-holders contemplated in section 33(2) for the registration of a parenting plan or for it to be made an order of court must be in the prescribed format and contain the prescribed particulars; and be accompanied by a copy of the plan; and a statement by a family advocate,*

social worker or psychologist contemplated in section 33(5)(a) to the effect that the plan was prepared after consultation with such family advocate, social worker or psychologist; or a social worker or other appropriate person contemplated in section 33(5)(b) to the effect that the plan was prepared after mediation by such social worker or such person.

vi. A parenting plan registered with a family advocate may be amended or terminated by the family advocate on application by the co-holders of parental responsibilities and rights who are parties to the plan.

vii. A parenting plan that was made an order of court may be amended or terminated only by an order of court on application

(a) by the co-holders of parental responsibilities and rights who are parties to the plan;

(b) by the child, acting with leave of the court; or

(c) in the child's interest, by any other person acting with leave of the court.

viii Section 29 applies to an application in terms of subsection (2).

d) Refusal to Exercise Parental Responsibilities and Rights

In section 35 the refusal of access or refusal to exercise parental responsibilities and rights are referred to by stating the following:

i. Any person having care or custody of a child who, contrary to an order of any court or to a parental responsibilities and rights agreement that has taken effect as contemplated in section 22(4), refuses another person who has access to that child or who holds parental responsibilities and rights in respect of that child in terms of that order or agreement to exercise such access or such responsibilities and rights or who prevents that person from exercising such access or such

responsibilities and rights is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding one year.

- ii. A person having care or custody of a child whereby another person has access to that child or holds parental responsibilities and rights in respect of that child in terms of an order of any court or a parental responsibilities and rights agreement as contemplated in subsection (1) must upon any change in his/her residential address forthwith in writing notify such other person of such change.*
- iii. A person who fails to comply with paragraph (a) is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding one year.*

The “parenting plan” principle thus acknowledges the need for behavioural intervention and regulation in order to resolve unnecessary disputes regarding children on a pre and post divorce level.

4.4 Conclusion

The chapter aimed to illustrate that the new Children’s Act, 2005 not only changed the manner in which legal professionals communicate, but also seems to assume a more constructive and interactive approach towards the process of divorce. The principle of parental responsibilities and rights is a new positioning towards caring for a child and refers to married couples, unmarried parents; guardians; permanent life parents and individuals not related to a child. Quite clearly the Act aims to serve the interests of the child as widely as possible.

The Act seems more ‘user friendly’ as the traditional legal route of applications or a paper war are seen as a second option, and the emphasis is placed on a more interactive mediatory process. This option is also much more cost effective, which also serves the interest of children.

With the new Act reviewed and discussed, it is now important to shift the focus to the role and function of the psychologist within the legal context.

CHAPTER 5

THE PSYCHOLOGIST IN THE LEGAL CONTEXT

5.1 Introduction

In this chapter an attempt will be made to gain some perspective on the role and function of psychology and the psychologist within the legal context.

5.2 The Interface between Psychology and the Law

It is of significance that the legal profession was in the business of studying and modifying human behaviour centuries before the psychology profession even came into existence (Roos & Vorster, 2003; Coombes, Morgan, Tuffin & Johnson, 2004; Cronje & Heaton, 2004; Tredoux et al., 2005). Over the past approximately 2500 years the legal profession has been actively involved in ruling and shaping human behaviour through creating and applying legislation in civil and criminal cases (Ewing, 1985; Gudjonsson, 1991; Fox, 1997, 1999; Gould, 1998; Roos & Vorster, 2003; Tredoux et al., 2005). Law makers and judges attempted to understand human nature and to legislate and judge accordingly (Borum, & Grisso, 1995; Gudjonsson & Haward, 1998; Gould & Stahl, 2000; Brodsky, Caputo & Domino, 2002; Roos & Vorster, 2003; Tredoux et al., 2005).

The ancient Greeks and Romans emphasised the 'free will' of human beings that allowed the individual to direct his/her behaviour according to the basis of intent. This acknowledged the individual's capacity for evil, which was deemed a prerequisite in the determination of innocence or guilt (*mens rea*). The practice of finding someone technically guilty, but granting a pardon if personal circumstances justified it, existed in England in the Middle Ages. Insanity was a recognised defence during the 16th century and the so-called 'wild beast test' a century later. In this respect Judge Tracy (1724), stated that a man so 'deprived of understanding and memory and not knowing what he

is doing, no more than an infant, than a brute, or a wild beast; such a one is never the object of punishment' (Tancredi, Lieb & Slaby, 1975, p76).

The defence of insanity was further clarified in 1843 when the legal definition of this diagnosis was spelled out by the court (in the well-known M'Naghten case) as 'labouring under a defective reason from disease of the mind as to not knowing the nature and the quality of the act [done]; or, if he did know it, that he did not know he was doing what was wrong'. In this case special status was also given to experts and physicians to assist in determining the diagnosis of insanity (Toch, 1961; Nicholas & Coleridge, 2000). This was the forerunner to the present-day principle of criminal capacity in South African law (Gould, & Stahl 2000; Brodsky, Caputo & Domino, 2002; Tredoux et al., 2005; Gould & Martindale, 2009).

In Italy in the 1880s, a number of criminologists and lawyers gave evidence in the defence of people who had participated in a crowd riot. The central theme was that crowds transformed the psychology of participants (van Ginneken, 1992), with implications for legal culpability. This is a principle also accepted in social psychology referred to as mob psychology. In South Africa, in the 1980s, numerous psychologists testified in legal cases of collective violence, arguing in similar vein that people are psychologically transformed in crowd situations (Foster, 1990).

At Harvard University, in the early 1900s, in his book *On the witness stand*, Hugo Munsterberg boldly advocated the applicability of psychology to the law and criticised lawyers for not embracing psychological research (Ogloff, 2002). In the late 19th century, Europe a number of German and French psychologists were called to testify in various court cases. (Tredoux et al., 2005).

Today psychologists are increasingly being called upon to render their contribution in the legal field where their expert opinion often serves as a significant and even decisive factor in the development and outcome of various legal proceedings (Ackerman, &

Ackerman, 1997; Burman & Derman, 2002; Gould & Martindale, 2009). These contributions are important and often directly affect the lives of the individuals involved, especially children involved in divorce disputes (Roos & Vorster, 2003; Tredoux et al., 2005).

5.3 Forensic Psychology

The term forensic psychology can broadly be defined as the application of psychological knowledge to the legal field. When a psychologist embarks on getting involved in a legal process or doing an evaluation for legal purposes, he or she enters the field of forensic psychology (Keilin & Bloom, 1986; Hess & Weiner, 1999; Roos & Vorster, 2003; Kaliski, 2006). In practice, thus, a trained psychologist assists the legal profession or the courts in the deeper understanding of human behaviour and human psychological functioning in order to facilitate a legal outcome (Roos & Vorster, 2003; Kuo, Hall & Levy, 2010).

Prior to the 1970s, psychologists in South Africa contributed to court proceedings primarily in their capacity as psychometrists or members of local forensic teams in psychiatric hospitals (Louw & Alan, 1998). Today psychologists are at times expert witnesses in both criminal and civil proceedings and may be instructed by the defence, the prosecution or the court to render such service (Melton, Petrila, Poythress & Slobogin, 1997; Roos & Vorster, 2003; Tredoux et al., 2005).

Since the 1970s, there has been an increasing trend in South Africa for legal professionals to make use of psychologists in legal proceedings, even though the field of forensic psychology remains poorly defined (Louw & Allan, 1998; Tredoux et al., 2005). However, the role of the psychologist in a psycho-legal context continues to be that of a professional expert who strives to maintain an objective and impartial stance (Grief & DeMarris, 1989; Louw & Allan, 1996; Tredoux et al., 2005; Gould & Martindale, 2009).

Gudjonsson (1995), conducted a survey of 525 members of the British Psychological Society who had prepared a court or tribunal report in the preceding five years, regardless of whether they had testified. He established that the majority of the reports had been prepared for civil proceedings, followed by family, matrimonial and juvenile proceedings and then criminal proceedings. The majority of referrals came from attorneys. The respondents' reports indicated that the main issues were post-traumatic stress disorder, other compensation issues (e.g. head injury cases), followed by childcare matters.

Louw and Allan (1998), carried out a similar survey of 75 psychologists engaged in forensic work in South Africa. They concluded that South African psychologists were involved in a relatively low volume of forensic work and submit a high number of written reports, compared to the number of instances of courtroom testimony. In addition, most of the forensic work in which South African psychologists became involved, was in the area of civil litigation, although a high proportion also reported involvement in criminal litigation. The most common forensic area in which participants frequently worked was that of personal injury cases, but the single activity that constituted the largest portion of forensic activity, was child custody work. Louw and Allan (1998) also found that the majority of respondents received referrals directly from attorneys (Tredoux et al., 2005).

Gudjonsson (1995), provides examples of the many aspects a psychologist might be requested to express an expert opinion on. These include questions about the following:

- mental state and incapacity
- psychological and/or social functioning
- neuropsychological functioning
- personality profiling
- witness reliability
- interrogative suggestibility and disputed confessions

- malingering
- competence to stand trial
- moral development and reasoning
- post-traumatic stress disorder
- attitude of offenders towards their crime
- sexually motivated criminal behaviour
- anger and dyscontrol problems
- deception

Allan and Louw (2001), as well as Tredoux et al. (2005), point out that psychologists may also be asked to provide an expert opinion on an individual's ability to benefit from psychological treatment or their potential risk to others.

In South Africa, psychologists may also be asked to provide expert opinion regarding criminal responsibility of defendants, insanity or mental illness (Allan & Louw 2001; Mental Health Care Act, 2002; Criminal Procedure Act, as amended in 1998). For example, within South African courts, psychologists have offered the opinion in several murder cases that the perpetrator was suffering from 'sane automatism' or 'temporary non-pathological criminal incapacity' at the time of committing the offence (Allan & Louw, 2001; Roos & Vorster, 2003).

In the cases of *S v Nursingh* 1995 (2) SACR 331 (D); *S v Wiid* 1990 1 SACR 561 (A); *S v Moses* 1996 1 SACR 701 (C), the perpetrators were acquitted largely on the basis of the psychological diagnosis that they had been in an intense dissociative state at the time of committing the murders (Tredoux, et al., 2005).

The use of expert psychological evidence in court can thus influence the outcome of a case and impact directly or indirectly on the individuals involved and on society more broadly. For example, in criminal cases, psychological evidence could help to determine

criminal responsibility, the type or length of sentence, and, in civil cases, influence determination of financial compensation and child custody. Expert forensic psychological evidence can also shape case law and determine the types of psychological evidence that are admissible in court (Melton, Petrila, Poythress & Slobogin, 1997; Bone & Walsh, 1999; Nicholas, 2000; Tredoux et al., 2005).

After this more general overview of the field of forensic psychology it now seems necessary to turn to the role of the psychologist in cases of divorce and dealing with the children concerned.

5.4 The Role of the Psychologist during Divorce and dealing with Children

Among the various roles played by the psychologist in both the clinical and forensic arenas, conducting child custody evaluations during a divorce requires a certain role definition in order to execute this endeavour effectively. Melton (1983); Louw & Allan (1998) and Franklin (2008) indicate that the aims, objectives and practices of forensic work are different from those required of the mental health professionals working in purely clinical settings. Consequently, mental health professionals must depart from the 'therapist as witness' approach and engage more fully with their specialist role as expert witness.

There is a world of difference between fulfilling a therapeutic versus a forensic role. As reported, the psychologist who becomes involved in a custody dispute is entering the foreign land of the legal system, which is not a supportive role, but rather, adversarial in nature. Most South African psychologists who perform child custody evaluations have originally been trained as psychotherapists. Most who enter the field have done so with a sincere desire to help people and alleviate their pain and suffering. Psychotherapists train for years to develop the necessary skills to respond empathically and form good treatment alliances with patients, as well as conduct interventions that will assist patients in overcoming their symptoms or conflicts (Carson & Bull, 1995).

While it is important to retain a sense of compassion when conducting a custody evaluation, neutrality and detachment must also be maintained, even when faced with strong expressions of anger, despair, disavowal of responsibility and projection of blame. In addition to suppressing outward expressions of empathy, custody evaluators must also resist the therapeutic and even human urge to be confrontational when they see harmful behaviour being directed by parents toward children or outrageous or sadistic behaviour being directed by one parent against the other. Being overly empathic or confrontational will take custody evaluators out of their neutral role and may compromise objectivity, as well as parents' or attorneys' views of the impartiality of the evaluator (Carson & Bull, 1995).

Greenberg and Shuman (1997), described some of the irreconcilable conflicts between therapeutic and forensic roles. In custody evaluations during a divorce the goal is not to be helpful in a therapeutic sense. Rather, the purpose is to gather information as objectively as possible, so as to provide information to the court to aid in the determination of a legal question, namely, a custody plan which is in the child's best interests. Custody evaluators must be able to live without the gratification frequently experienced in a therapy relationship, such as the feedback that patients value the efforts being made to try to help them.

The role of the psychologist during a divorce evaluation is more similar to that of a detective than a therapist or may be viewed as akin to a professional poker player who keeps his cards close to his vest, carefully not revealing his hand until the end of the game. Henderson, (2003) and Kuehnle (1996), have described the psychologist conducting the custody evaluation role as being like an "impartial scientist." We must, of necessity, be sceptical and questioning about any information provided, as it is not unusual for parents (and sometimes children) to deny problems, as well as exaggerate, distort, or fabricate information. For example, custody litigants' defensiveness and tendency to be non-disclosing about their problems have been well-documented (Hoffman & Pincus 1989; Bathurst, Gottfried, & Gottfried, 1997).

Maintaining this forensic role is often quite difficult. During the evaluation process, custody evaluators are consistently exposed to parents who are often still experiencing great turmoil, sadness or rage about the breakup of their marriage and loss of the family unit. Many of these parents are in the throes of depression and anxiety about the present state of their lives. Because of this critical difference between clinical assessment and forensic assessment it cannot be presumed that instruments popular with the clinician are suitable in the forensic sphere (Martindale, 2001; Franklin, 2008; Gould & Martindale, 2009).

The psychologist's role should be an impartial assessor acting in the child's best interests of the child and making a set of recommendations to the court that reflects a best effort at bringing all parties, lawyers included, to a point of agreement. (Saayman & Saayman, 1989).

Table 5.1 below summarises some key differences in roles between the psychologist as psychotherapist and the psychologist as expert witness (Tredoux et al., 2005).

Table 5.1: Difference between professional roles: Lawyers, psychologists as therapists and psychologists as forensic experts

	Psychologist as therapist	Psychologist as forensic expert
Aim of the work.	Psychologist consulting with a client for therapeutic purposes; To facilitate the client's personal growth or development.	Psychologist conducting an evaluation for the court; To assist the court to make a decision based on the child's best interests.
Confidentiality.	Process should be confidential but notes can be subpoenaed by the court.	The process is not confidential at any point and clients are advised of this.
Data collection process.	To develop as full an understanding of the client's perception of issues as possible so as to assist the client in	To gain as much accurate information as possible in order to assist the court in making a decision in the child's best

	making his/her own life choices.	interests.
Implicit underlying model of work.	Enabling personal growth.	Pragmatism in the service of the child's interests.
Implicit value system.	Empowerment.	Workable long-term solutions.

The advisory position that the psychologist assumes during the divorce proceedings must eventually provide the trier of fact with a rational and scientific foundation for the interpretations, conclusions and recommendations offered to the court. The objective must always be kept in mind: providing pertinent information about the family system to the court.

While denigration, criticisms based on personal values and reprimands are counterproductive, so is excessive concern for the emotional comfort of the litigants. Psychologists involved in the divorce process must recognise that they are obligated to articulate what data gathering methods were utilized, what data was obtained, how that data bears upon the criteria that are collectively referred to as the best interests standards, as discussed in earlier chapters, the logical nexus between the data and the opinions and, finally, the recommendation offered. The psychologist is thus expected to provide an advisory report which should be scientifically formulated in order to provide the best possible specialized knowledge for the family, the attorneys and the court. This necessitates an elaboration on the current trend of divorces in South Africa.

5.5 The Divorce rate in South Africa and its Impact on the Divorced Couple's Children

Tredoux et al., (2005), reports the conventional image of children growing up in a household with both biological parents, who are married to each other, does not reflect reality for many children. Where it does, the situation is likely to change or be disrupted

for at least some part of those children's lives (Ackerman & Ackerman, 1997; Ackerman & Kane, 1998, 2004; Tredoux et al., 2005).

South African data indicates that significant numbers of children are affected by divorce. The divorce rate in 2002 was 5.26 per 1000 married couples. While not all divorces involve children, clearly many do. In 2002, the parents of 31 370 children were divorced, while in 2001, the figure was 37 803 children (Statistics South Africa, 2011).

Preller (2009) reports that the trends in divorces from 1999 to 2008, based on the published data on divorces, indicate that the number of granted cases has been fluctuating between 37 098 and 28 924 per annum. The distribution of couples divorcing by population group shows that there were more divorces among the African population group compared to the other groups. Despite the general fluctuations, the proportions of divorces from the mixed and the African groups have been increasing, whilst those of the white group have been declining in the past ten years. (Statistics South Africa, 2011; myDigitalLife, 2010).

The 2008 data reveals that there were more female (50.6%) than male (37.8%) plaintiffs. However, there were significant differences among population groups. Among African plaintiffs, more husbands (43.5%) than wives (41.1%) initiated the divorce. This is in sharp contrast to the other population groups, particularly among the white (58.0%) and the coloured (57.9%) group where most divorces were initiated by women. Even though a high proportion of the plaintiffs did not indicate the type of occupation they were engaged in at the time of divorce, the highest percentage of wives (19.8%) were in clerical and sales occupations whereas husbands (14.9%) were in managerial and administrative occupations. Very few plaintiffs were in farming and related occupations (Statistics South Africa, 2011 & Mydigitallife, 2010).

The 2008 divorce cases mainly resulted from first marriages. As far as divorced husbands and wives remarrying, the pattern was quite similar regarding the genders. Slightly fewer (76.4%) husbands were from first marriages compared to 77.1% of wives. Approximately 9.0% of both husbands and wives were second-time divorcees. About 2.0% of husbands and wives were getting divorced for at least the third time (Statistics South Africa, 2011; Mydigitallife, 2010).

The median age at divorce in 2008 was 41 for men and 38 for women. African men had the highest median age (43) at divorce. Women from the mixed and Indian/Asian group had the lowest median age (36) (Statistics South Africa, 2011; Mydigitallife, 2010).

The median duration of marriage in 2008 was 9 years. The largest number of divorces (7859 or 27.2%) lasted five to nine years. This group is followed by marriages that lasted less than five years (6143 or 21.2%). Thus, almost half (48.4%) of the 28 924 divorces in 2008, were from marriages that lasted less than 10 years. As the duration of marriages increased, the number of divorces decreased. Irrespective of the population group of the divorcees, the distribution of divorces continues to be skewed towards earlier years of marriage (Statistics South Africa, 2011; Mydigitallife, 2010).

Table 5.2: Number of published divorces in South Africa from 1999 to 2008

Number of published divorces in South Africa (1999 – 2008)						
	Number					
Total	African	Coloured	Indian/Asian	White	Mixed	Unspecified
37 098	6 823	3 938	1 976	14 785	357	9 219
34 145	7 623	3 365	1 746	15 211	444	5 756
34 045	7 860	3 872	1 672	14 718	470	5 453
31 370	7 050	3 581	1 525	14 171	365	4 678
31 566	7 657	3 911	1 508	12 639	532	5 319
31 768	8 965	3 300	1 648	12 437	594	4 824
32 484	8 672	3 568	1 635	11 582	538	6 489
31 270	9 113	3 451	1 676	11 079	613	5 338
29 639	9 055	3 558	1 715	9 935	865	4 511
28 924	10 110	3 057	1 802	9 481	902	3 572

(Preller, 2009)

With reference to divorces involving couples with children, 26 947 children (younger than 18 years old) were involved in divorce during 2008. It is observed that 16 370 (56.6%) of the 28 924 divorces had children younger than 18 years. This implies an average of between one and two children per divorce (Statistics South Africa, 2011; Mydigitallife, 2010). Table 5.2 refers to the number of published divorces in South Africa from 1999 to 2008.

The statistical figures stated above indicate high numbers of divorces where, by implication, children need to be placed in the optimal family context, post divorce. The court then turns to the psychologist as an adviser as to how these children's interests

can best be served. There are three key situations in which the psychologist might become involved in decisions about custody and placement of children in South Africa (Tredoux et al., 2005). These are:

- a) where parents have been married and are in the process of divorce or legal separation and cannot reach agreement as to the custody of the children
- b) there is a dispute among the child's caregivers about where the child should be placed
- c) there is concern from outsiders (for example, a member of the public or a child-protection agency) about what is appropriate placement for the child – especially in cases where child abuse or neglect is suspected.

In practice, according to Tredoux et al., (2005), these situations may overlap – for example, where one parent alleges, during a divorce proceeding, that the other parent has neglected or abused the child (the first and the third situation in the list above is thus applicable). The factual situation is that a physical placement or custodial placement has to be made as no 'King Solomon's sword' is possible. Therefore, the consulting psychologist has to consider certain requirements before custodial decisions are made. This will be dealt with next.

5.6 Custodial Decisions Regarding Children

There is no single, sovereign approach to conducting child residency evaluations. Psychologists should adapt their custody assessment to the relevant referral question and the particularities of a given case. However, all professional work should be based on and follow the current best-practice guidelines, as well as reputable publications in the field. Nonetheless, despite the diverse issues involved, there are several important

factors that should at least be briefly considered if the assessment is to be well-grounded in evidence regarding child adjustment.

In this light, Stahl (1994), identifies four factors or issues for consideration.

- i. The bonds between child and parents
- ii. The nature of the co-parental relationship
- iii. The level of parental dysfunction and parenting capacity
- iv. The importance of devising a parenting plan. Each of these factors has implications for the child's well-being.

Stahl's (ibid) broad approach is one of finding the most ideal fit between the specific needs of the child and the parents' capacity to provide for those needs. He considers this to be the essence of a custody evaluation.

In this decision-making process, Brandt, Dawes, Africa and Swartz (2004) highlight the behavioural concepts of attachment and development regarding the child in the divorce process, which is the psychologist's specialized field. While little psychological research specifically addresses the issue of what the universal 'best interests of the child' are, there are several important findings and theories regarding child development which are relevant to decisions regarding a child's residency. To begin with, the notion of attachment is a foundational concept in understanding children's needs and interests. Several eminent mental health professionals have established the importance of the bond between a young child and his/her significant caregiver, showing its relation to the child's well-being, both in childhood and in later life (Ainsworth, 1969; Bowlby, 1951, 1969).

According to these theories, children need a warm, intimate relationship with an available and stable mother figure or, what Goldstein and colleagues have called, a 'psychological parent' who provides for their physical and emotional needs (Goldstein, Freud & Solnit, 1973). This continuous, emotionally responsive contact, especially during the first three years of life, is associated with healthy gains in physical,

intellectual, emotional and social development. In contrast, the absence of this relationship could contribute to several mental health problems, ranging from difficulties in forming intimate relationships to extreme antisocial behaviour (Tredoux et al., 2005).

Over and above this basic need of children, several other conclusions reached by attachment theorists are also important. Firstly, while a healthy attachment with one stable caregiver is essential for children's development, children are capable of establishing and maintaining several different attachments at any one time (Ainsworth, 1973). Moreover, while the amount of time spent in close contact with the caregiver is clearly important, it is ultimately the quality rather than the quantity of care which determines the nature of the attachments children form with these caregivers (Ainsworth, 1969; Rutter, 1972). Children, therefore, need a degree of continuity in their physical and psychological environments, a stable base from which to experience the world. If this is adequately provided by at least one reliable person, they are likely to grow up emotionally stable and healthy (Lategan, 1991; Tredoux et al., 2005).

Finally, although it has often been assumed that children belong with their (biological) mothers, attachment theory argues that children need a stable 'mother figure' only. Other factors aside, the caregiver's sex and biological relationship to the child are not a given; instead, it is the nature and quality of the relationship which is important for the child's development. It is therefore important to recognise that someone other than a child's biological mother, for example, a father or other maternal substitute, can provide the necessary emotionally responsive, continuous care that young children, in particular, need if they are to get a good emotional start in life (Tredoux et al., 2005; Gould & Martindale, 2009).

With regards to factors related to development, Tredoux et al., (2005), indicates that, apart from the considerable attention that has been given to the importance of attachment and its possible disruption following divorce, scholars such as Judith Wallerstein have shown convincingly that divorce is not just a legal event but part of an

ongoing process (Wallerstein & Blakeslee, 1996; Wallerstein & Kelly, 1980). Divorce is a period of disruption of a marriage that can have a variety of consequences for both the adults and children concerned.

Few children emerge from a divorce situation emotionally unscathed (Hetherington, Bridges & Insabella, 1998; Tredoux et al., 2005). Research supports a developmental perspective namely, that the implications for children will differ, depending on their age and stage of development. Some research indicates that preschool children are particularly vulnerable, while other research highlights the effect on those in middle childhood. A more plausible argument, supported by Wallerstein and Blakeslee's (1996), is that the effects are different depending on the age of the child, both when the change in custody or residency occurs and also at later stages as the child continues to process the effect of this change on his/her life (Tredoux et al., 2005).

Certain risks associated with divorce, such as difficulties with intimate relationships, may, of course, manifest more potently during adolescence although this does not mean, for example, that five-year-olds do not have their own difficulties to face or that these difficulties are any less significant than those of older children (Lewis, 1996; Tredoux et al., 2005; Gould & Martindale, 2009).

Although divorce has been shown to have a number of negative consequences for children, the evidence also clearly shows that living in an environment where there are ongoing, high levels of conflict between parents is one of the most damaging experiences to which children can be exposed (Wallerstein & Blakeslee, 1996; Hetherington et al., 1998). In such situations, parental separation or divorce can have a positive influence on child development outcomes (Tredoux et al., 2005).

In addition, research shows that the impact of factors such as the stress of marital discord or economic hardship (consequent upon divorce) is mediated by the caregiver's response to the stressors and the disruption that surrounds divorce (Hetherington et al.,

1998). Therefore, where parents can find ways to cope effectively with the divorce and custody arrangements and provide ongoing child-sensitive parenting, children are less likely to suffer many of the potentially adverse effects of changes in custody (Wallerstein, 1987). Just as in other circumstances, the principle remains that children need a stable, available parent who can serve as a buffer against divorce and its consequence (Wallerstein & Kelly, 1980; Wallerstein, 1987).

Several broad principles have been discussed above as being of importance in decision-making concerning children's custody and placement. In addition, although researchers do not always agree on exactly which factor should be ranked as most important, Tredoux et al., (2005) identify the basic key factors that should be taken into account.

Firstly, the risk of sexual or physical abuse of a child by a parent (or his/her parent) is a crucial consideration. The parents' psychological stability or mental health is another important consideration, in particular where a condition such as substance abuse impairs the parent's/parents' capacity for child rearing. A related issue is each parent's ability to separate the child's needs from his/her own. A self-absorbed caregiver is not likely to be psychologically available to a needy child, particularly during the stress of the divorce process and its aftermath (Tredoux et al., 2005).

Tredoux et al., (2005), reports that all parents are likely to struggle to a greater or lesser extent with the divorce process, and as a consequence, their psychological availability will be compromised. Such a temporary and understandable state should be distinguished from a long-standing behaviour pattern that exists independently of the stress of divorce. In the latter regard, objective psychometric testing and collateral follow-up is crucial (Roos & Vorster, 2003; Tredoux et al., 2005).

Mental health professionals generally have a strong preference for keeping siblings together and considering the geographical distance between divorcing parents (Newark,

1993; Ackerman & Ackerman, 1997; Keilin & Bloom, 1986; Tredoux et al., 2005). In contrast, other factors should not be fundamental considerations, namely, keeping a young child and his/her mother together, parents' financial sufficiency, same-sex parent and child together, and each parent's religious orientation. Issues such as the parents' comparative socio-economic status and/or the extent to which the individual parents contributed to the breakdown of their relationship, should only be considered in terms of their present and future impact on the children's well-being. Several of these factors propagate maintaining the integrity of the child's needs and interests above those of the adults who are in dispute about residency of the child (Tredoux et al., 2005).

Finally, it is also generally agreed that it is essential to take the views of the children, particularly those of teenagers, into account (Folberg, 1984; Ackerman & Ackerman, 1997; Jameson, Ehrenberg & Hunter, 1997; Keilin & Bloom, 1986, Tredoux et al., 2005).

In order to arrive at custodial decisions regarding children, a process of evaluation must be followed. There seems, though, to be conflict in the professional field regarding this process. This will now be discussed.

5.7 Disagreement on and Lack of Research on the Process of Custody Evaluation

Gould & Martindale (2009), emphasize that conflict exists concerning the process of evaluation during a divorce dispute, primarily over how to conduct custody evaluations. One opinion argues that child custody evaluations are clinical exercises, limited to testing and in-office clinical interviews. The other opinion stresses the need to conduct child custody evaluations as forensic evaluations are conducted as 'forensic evaluations'. Child custody evaluations utilize a five pronged methodology, including semi-structured interviews, psychological tests, direct behavioural observation and extensive collateral record review and collateral interviews (Austin 2000 & 2002; Austin & Kirkpatrick, 2004; Gould, Kirkpatrick, Austin, & Martindale, 2004; Gould, 1998 & 2006; Heilbrun, 2001; Heilbrun, Warren, & Picarello, 2003; Otto, Buffington-Volkam & Edens,

2003). Those who encourage the use of conventional forensic methods and procedures find support among the major professional organizations that have published guidelines or standards as well as among workshop providers who offer training in child custody evaluations through organizations such as the American Academy of Forensic Psychology, the American Psychological Association, and the Association of Family and Conciliation Courts. Judging from a review of the literature and the contents of workshops offered, there seems to be little question that the movement toward a scientifically informed model of custody evaluations has taken hold (American Psychological Association. (1994; Bow & Quinnell, 2002; Kirkland, 2002; Kirkpatrick, 2004; Tippins & Whittmann, 2005).

Those who continue to endorse the older clinical model (Calloway & Lee, 2002; Trubitt, 2004) are failing to meet their ethical responsibility to provide forensic services at the highest level of professional competence because of the potential impact that a psychologist's opinion may have on the decision-making process in a custody trial. Gould & Martindale (2009) stress that those who rely solely upon clinical methodology and clinical judgment and fail to utilize reliable and relevant forensic methods and procedures may be conducting themselves in a manner inconsistent with the ethical obligation of their profession and undermining the credibility of all psychological experts who serve the Court (Tippins & Whittmann, 2005; Weissman & DeBow, 2003).

There is an emerging awareness of the critical distinction between providing expert witness testimony based upon information drawn from forensic methodology as opposed to relying only on clinical judgment (Shuman & Sales, 1998). Clinicians entering the world of custody evaluations encounter references to a controversy concerning the use of clinically versus scientifically formed methods. The concern about clinical judgment used in a forensic context is reflected in several recent articles. Summarizing the controversy, Shuman & Sales, 1998, make the following points:

- While some expert testimony by people with scientific degrees is derived from research, the accuracy of which can be validated, much other expert testimony advances opinions derived from judgment in which accuracy rests on the experts' non-validated theories and skills.
- These untested opinions are commonly referred to as “clinical” judgments and are defined by their reliance on personal experience rather than on statistically analyzed data drawn from valid and reliable research.
- Use of the term “clinical” refers to a method or approach of making judgments or decisions.
- The growing literature on human judgment and decision making helps explain the inherent unreliability of clinical judgment and decision making.
- Expert judgments that are clinically derived are as susceptible to error as lay judgments and involve the use of strategies in arriving at decisions that contribute to the error rate.
- Clinical judgments and opinions offered in the Court are just as flawed as any other clinical judgment.
- The extent to which a scientist or practitioner is relying on personal experience and personal biases in drawing inferences that go beyond the data, he/she is engaging in clinical decision making, despite his/her scientific training.

Together with the conflict in the field of the process of custody evaluation as indicated above, Tredoux et al., 2005 report that far less research has been conducted on divorce and residency in South Africa than in North America and Europe. In addition, most South African studies are in the form of postgraduate theses, such as the current study. Nevertheless, what is available, highlights several key areas which have implications for how local mental health professionals and lawyers make decisions regarding children's placement (Tredoux et al., 2005).

Two separate studies have explored factors related to children's post-divorce adjustment, both concurring with international findings that parental well-being and

parenting practices are significant predictors of children's well-being (Bezuidenhout, 2000; Mudie, 1987). Mudie (1987) found that competent parenting by the custodial parent, frequent contact with the non-custodial parent, and general continuity of relationships are all essential to children's healthy psychological adjustment. In addition, she found stable socio-economic status to be a protective factor for children. Bezuidenhout's (2000) study also demonstrated the importance of the parents' emotional stability as well as their parenting capacity. Both authors also refer to the fundamental role of children's age and development stage in determining their needs and best interests.

Other South African studies have examined the criteria used by professionals to shape their custody recommendations. Findings from a recent study of psychologists' reports to the court, support the conclusion that they employ a child-centred approach that places particular importance on the child's basic and development-related needs (Brandt et al., 2004). In a related investigation, Africa, Daws, Swartz & Brandt (2003) studied the child-custody recommendations of social workers in the Family Advocate's Office. While attention was given to the needs of the child, these professionals placed the greatest emphasis on the nature and level of parental involvement in the care of the child, both prior and subsequent to the divorce. This indicates that they were mainly concerned with the role the parents played in the child's life and the extent to which they observed their parental responsibilities towards the child. The high level of importance ascribed to the adequacy of each adult's parenting capacity, might reflect the counsellors' concern to avoid the danger of continued or future parental neglect. The differences in emphasis might well be the fact that the Family Advocate's Office sees a population different from that served by psychologists in private practice (Tredoux et al., 2005).

The disagreement amongst professionals, as well as the lack of research on the process of custody evaluation, thus necessitated the need for the present study.

5.8 Conclusion

This chapter indicated that forensic psychology and the forensic psychologist within the legal context, plays an imperative advisory role. It was also shown that historically the courts allowed the field of psychology to guide rulings and judgments from the bench. The forensic psychologist, however, does not provide therapeutic support in this legal context, but investigates, explores and reports on matters to supply a holistic psychological synopsis to the legal profession. The role of the forensic psychologist is thus one of being an objective evaluator.

As was also reported, the divorce rate in South Africa is very high and thus asks for constant input from the psychologist to guide the court on custodial placements. In this light the psychologist, being a behavioural scientist, has to apply his or her specialised knowledge to assist families via the legal process. Literature, however, indicates huge disagreement amongst psychology professionals on how the process of custodial evaluation should be conducted. It also appears that South Africa lacks research on the process of custody evaluations and this necessitated the need for the present study.

CHAPTER 6

THE PROCESS OF PSYCHOLOGICAL ASSESSMENT WITHIN THE DIVORCE CONTEXT

6.1 Introduction

The forensic psychologist may assume various roles in the court room, one being the role of expert evaluator. This context asks for a systematic and comprehensive approach to a legal matter where scientific methods are applied. In this chapter the aim is to explain the process of psychological assessment with regards to divorce. The ethics associated with this process is also explored.

6.2 The Phases of Assessment

Tredoux et al., (2005); Kaliski (2006), Gould and Martindale (2009) are in agreement that the psychologist conducting an assessment for court purposes has to follow a planned structure. As the context of this investigation is psychological assessment during a divorce process, this structured assessment process for the court can be divided into three phases:

- a) *Pre-assessment*
- b) *Assessment*
- c) *Post-assessment*

Each of the three phases places different demands on the psychologist involved in the legal case and raises specific professional, ethical and practical issues (Tredoux et al., 2005). The following section will discuss these three phases of psychological assessment in psycho-legal or forensic activities, especially within the divorce context.

6.2.1 Pre-assessment phase

This phase involves issues surrounding conflicts of interest, confidentiality, informed consent and the gathering of information.

(a) Conflict of interest

During this stage of psychological assessment, the psychologist has to determine whether there is no conflict of interest concerning the matter he or she is involved in. In any forensic evaluation objectivity is of paramount importance and conflict of interest may jeopardise the psychologist's objectivity. A typical example would be where a psychologist has assessed or treated a client and is subsequently asked to provide an expert psychological opinion for a legal case (Louw & Allan, 1998; Martindale & Gould, 2004; Gould & Martindale, 2009). Multiple relationships of this kind are ill-advised because they compromise the objectivity of the expert opinion, jeopardise any existing therapeutic relationship and potentially violate the ethical requirements for informed consent and confidentiality (Tredoux et al., 2005).

The Professional Board for Psychology with reference to *Rules of Conduct* pertaining specifically to the profession of psychology (2006) explains the concept of multiple relationships under *Rule 18* which states:

(1) A multiple relationship occurs when a psychologist fulfils a professional role with respect to a person or organisation and at the same time

(a) fulfils or fulfilled another role with respect to the same person or organisation;

(b) is in a relationship with a person or organisation closely associated with or related to the person or organisation with whom he or she has the professional relationship; or

(c) promises to enter into another relationship in the future with that person or organisation or a person or organisation closely associated with or related to that person or organisation.

(2) A psychologist shall refrain from entering into a multiple relationship if that multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence or effectiveness in performing his or her functions as psychologist or cause a risk of exploitation of or harm to the person or organisation with whom the professional relationship exists.

(3) If a psychologist finds that, owing to unforeseen factors, a potentially harmful multiple relationship has developed, he or she shall attempt to resolve the problem with due regard to the best interests of the client concerned and maximum compliance with these rules.

(4) In the circumstances referred to in subrule (3), the psychologist shall assist the client in obtaining the services of another professional, and shall not enter into any professional or other relationship with such client until at least twenty-four months have elapsed after termination of such multiple relationship: Provided that where a client is emotionally or cognitively vulnerable to influencing by such psychologist, no such relationship shall be established between the psychologist and the client.

(5) When a psychologist is required by law, institutional policy or other circumstances to fulfil more than one role in judicial or administrative proceedings, he or she shall, at the outset, clarify the role expectations and any exceptions to the requirement of confidentiality. (Professional Board for Psychology: Rules of Conduct pertaining specifically to the profession of psychology, 2006)

According to Scherrer, Louw, and Moller, (2002) as well as Tredoux et al., (2005), the Professional Board of Psychology in South Africa has been confronted with numerous complaints where psychologists have conflicted a clinical relationship with a psycho-legal or forensic one and have presented 'therapeutic evidence' as if it were psycho-legal or forensic assessment evidence. To avoid allegations of competing obligations, psychologists should only agree to appear as expert witnesses if they have no prior

social, therapeutic relationship with the client, or no personal interest in the outcome of the case. This will enhance the likelihood that the psychological opinion delivered will be impartial (Cumes, & Lambiase, 1987; Roos & Vorster, 2003; Tredoux et al., 2005).

If there is no conflict of interest, then the psychologist should consider the instruction received carefully. The onus is on the referrer (frequently the lawyer or advocate) to ask clear and specific questions, although the psychologist may need to be consulted regarding the appropriateness and refinement of the instruction (Tredoux et al., 2005).

The psychologist must be clear about the legal issue at hand and the psychological evidence being requested. Once the instructions have been clarified, the psychologist should consider whether psychology, as a discipline, has a sufficient body of theoretical and empirical knowledge to address the questions and instructions and whether this knowledge would serve as expert evidence in the case (Roos & Vorster, 2003; Martindale, 2005; Tredoux et al., 2005).

Psychologists are advised to inform the referral source (often the attorney) that their findings may not necessarily concur with the legal strategy perused by the lawyers (Tredoux et al., 2005). For example, the attorney might refer the client, who is a party in a divorce custody dispute, with hope that the findings from the psychologist will favour his/her client, only to receive feedback after the psychological assessment that the client cannot receive parental rights and responsibilities, or the child's best interests will not be served to primarily reside with the said client.

If the psychologist accepts the referral, then it is recommended that written instructions are obtained from the referral source at the outset, including the evaluation, a written agreement on fees and a reasonable time-frame for the delivery of the report (Gudjonsson & Haward, 1998; Kirkland & Kirkland, 2001).

Another important part of the psychological assessment deals with issues pertaining to concepts of confidentiality and informed consent. This will be discussed next.

(b) Confidentiality and informed consent

It is commonly known and accepted that a professional interaction between a psychologist and a client involves some form of confidentiality, but the psycho-legal or forensic context asks for a different format to confidentiality. During forensic psychological assessment confidentiality and informed consent play a vital role as the matter might, and probably will, proceed to trial, which could potentially expose the contents of the case to the public (Wall & Amadio, 1994; Roos & Vorster, 2003; Tredoux et al., 2005).

As with any professional interaction with a client, the psychologist must ensure that the individual undergoing the assessment has given informed consent for the assessment to go ahead (Roos & Vorster, 2003; Tredoux et al., 2005; Vorster 2011). According to Ackerman (1999), the individual undergoing the assessment for court should be informed about the nature, purpose and scope of the assessment, including the nature of psychometric tests or observational methods to be employed, the duration of the assessment, the limits of confidentiality, who will have access to the report and how the report may be used, and where appropriate, the psychologist's duty to warn third parties if the individual threatens to harm others or him/herself. In other words, the informed consent must cover all aspects of the assessment and the expert testimony process (Roos & Vorster, 2003; Tredoux et al., 2005; Gould & Martindale, 2009).

It is also imperative that the psychologist understands the nature of the respective relationships with the client and the attorney. This has a significant bearing on confidentiality (Halon, 1990; Tredoux et al., 2005). The psychologist must make it clear to the client that a forensic relationship does not carry a confidentiality clause and that all clinical and other information may be communicated to the court and to the lawyers in a written report. The client should be aware that this report may be presented and interrogated in the public domain (i.e. courtroom setting) and that details may be reported in the popular or public press, over which the psychologist and the client have

no control. This publicity can have unforeseen personal consequences for the client and other people connected to the case (Roos & Vorster, 2003; Tredoux et al., 2005). Currently this principle of confidentiality and informed consent is frequently practiced by lawyers from the Office of the Family Advocate. Many clients referred from the Office of the Family Advocate, for instance, have already been informed about the above-mentioned confidentiality principle and have also signed a consent form at the state office, agreeing that the report can be delivered directly to the family advocate (Tredoux et al., 2005).

Unlike attorneys, health professionals including mental health professionals in South Africa do not enjoy legal privilege, with the result that refusal to respond to a subpoena to disclose information in court can lead to charges of contempt of court (Tredoux et al., 2005; Kaliski, 2006).

A psychologist called as a witness by the court is expected to act like any other witness and should not offer an expert opinion, even though he/she may be pressurised to do so in court (Roos & Vorster, 2003). In the light of the above, Tredoux et al., (2005), state that no psychologist can be forced to act as an expert witness, although a psychologist may be subpoenaed as a witness to the facts presented in court and in some instances clinical notes may be subpoenaed.

Once the psychologist has determined that the conflict of interest does not exist and informed consent has been obtained, the psychologist can proceed to start gathering background information as indicated below.

(c) Background information

The collection of the background information is of paramount importance in order to create a thorough psycho-legal picture of the case. This process begins with the gathering of background information pertinent to the legal case, for this context the

divorce matter. Ackerman (1999) recommends that psychologists request and review the following records prior to assessment:

- *Arrest and conviction records;*
- *Mental health and psychological reports;*
- *Agency reports (e.g. social services);*
- *Hospital/medical records;*
- *Statements and affidavits;*
- *Pertinent records (e.g. school reports);*
- *Legal correspondence and documentation.*

It is also of vital importance that the psychologist should be familiar with the latest theoretical and empirical evidence in the field and might need to do an up-to-date literature search (Tredoux et al., 2005; Gould & Martindale, 2009). Peer-group review meetings can also assist with access to current and relevant information (Shapiro, 2000).

Gathering background information in various ways may help the psychologist to prepare for appropriate questioning and assessment. Lawyers also need to ensure that they provide the psychologist with all the required background material and that they obtain the client's written consent for the psychologist to access collateral information (e.g. hospital and/or school records) or to conduct interviews with key collateral informants (Skeem, Douglas & Lilienfeld, 2009). The psychologist needs to take legal advice and/or consent concerning contact with collateral informants to ensure that the witnesses for the opposing party are not contacted or interfered with. In some circumstances the psychologist may be asked to attend the whole trial prior to giving evidence. This should only be done with the consent of the presiding magistrate or judge (Tredoux et al., 2005).

When the background investigation has started, the psychologist can proceed to the assessment phase of the evaluation.

6.2.2 Assessment phase

a) The clinical interview

Literature indicates many methods of psychological assessment and techniques for gathering psychological information. In essence, every forensic matter will ask for a unique style of evaluation because the content will differ from case to case. The approach adopted by the psychologist will depend not only upon the specific instructions or questions to be addressed but also upon the psychologist's training, experience, theoretical orientation and personal preferences (Gudjonsson, 1995).

According to Maloney and Ward (1976), psychological assessment is not a specific procedure (either actuarial or clinical) but a general process where actuarial, clinical, or any other types of data or observations are used in a hypothetical-deductive process of problem-solving. As such, it cannot be structurally reduced to a set of specific tests; however, this study aims to create a relative optimal assessment procedure for a particular context of psychological evaluation, namely the divorce context.

An expert psychological opinion may be based on a variety of information sources and methods of data collection (Melton, Petrila, Poythress & Slobogin, 1997). Typically data-gathering methods include some combination of clinical interview, psychometric testing, observational methods, interviews with informants and background material, which are eventually integrated to form the expert opinion (Gudjonsson & Haward, 1998).

Louw and Allan (1998) surveyed 72 South African psychologists regarding the assessment techniques they employed in psycho-legal or forensic evaluations, and found that 71 used some form of interview in the overwhelming majority of assessments, and that almost all employed some form of psychological testing or technique in the majority of assessments.

It would be highly irregular for a psychological opinion to be offered without the psychologist having interviewed the client directly or performed some form of structured testing (Weithorn, 1987; Emery, Otto & O'Donohue, 2005; Tredoux et al., 2005). Unfortunately, all too often in the case of divorce deliberation, one of the parents is frequently not interviewed but opinion given as to their parental fitness, nevertheless. This also often results in complaints being lodged with the Professional Board against a psychologist who is, more often than not, found guilty of unethical practice (Wassenaar, 2002). Tredoux et al., (2005), furthermore reports that, in essence, a trained psychologist as a behavioural scientist who is involved in a psycho-legal or forensic assessment, should know that one party's subjective description of a divorce matter is indeed purely subjective and, therefore, before a recommendation about the best interests of a child can be made, the other parent must at least also be interviewed.

Ackerman (1999) and Gudjonsson (1995) state that, for court purposes, the clinical interview should be tailored to the psychological questions that need to be addressed in the report and may typically cover the following:

- *social-demographic and biographical information;*
- *social and family history;*
- *client's account of the problem;*
- *history of the problem;*
- *medical and psychiatric history;*
- *substance abuse history;*
- *legal history;*
- *mental state examination.*

The emphasis and scope of the clinical interview will depend on the psychological questions being addressed. Psychological opinion inevitably involves some degree of clinical judgement which necessarily has a subjective element (Tredoux et al., 2005). However, Vorster (2003; 2011) refers distinctly to the clinical interview the psychologist conducts and states that the observations are made from a trained and informed

perspective and can thus not be seen as similar or compared to general public observations.

Martindale and Gould (2004); Gould and Martindale (2009), as well as Tredoux et al. (2005) state that the discipline of psychology attempts to improve the reliability and validity of its assessments by employing standardised methods, usually in the form of psychometric tests. Other standardised tools include diagnostic interview schedules, clinical and behavioural checklists, home visit observations of parental and caregiver-child interactions, and risk assessment tools. Given the paucity of appropriately standardised psychological tests, South African psychologists are increasingly relying on interviews and scheduled observational methods due to the limited psychometric norms for the South African context (Tredoux et al., 2005).

As a trained psychologist one specific skill unique to the field is the ability to conduct psychometric tests. The forensic context asks for a detailed approach with the highest levels of objectivity towards psychometric testing which will be highlighted below (Campbell, 1992).

b) Psychometric testing

As mentioned previously, psychologists usually employ psychometric tests as an integral part of their assessments. However, they rarely if ever use psychometric tests or other standardised tools in isolation; in addition, most of these tools require some degree of skilled, subjective interpretation (Gould & Lehrmann, 2002; Roos & Vorster, 2003; Tredoux et al., 2005).

Tredoux et al., (2005) and Gould & Martindale (2009) clearly indicate that psychologists are trained not to report psychometric test results in isolation from other pertinent clinical information and will typically interpret test results in light of information gathered using other data-gathering methods (e.g. clinical interview, behavioural observations and collateral follow-up). For example, it would be considered bad practice for a

psychologist to report psychometric evidence about a client's intelligence without considering the influence of his/her educational and employment history, cultural background and medical history (Tredoux et al., 2005; Gould & Martindale, 2009; Vorster, 2011).

According to Malloney and Ward (1976), the ultimate meaningfulness and usefulness of test data are fundamentally dependent on a clinical consideration and integration of that data with other test data and non-test data by a person skilled in the process of assessment.

Psychological assessment is thus considered to be a part of the evaluative process and tests are tools that can be employed in this process. The classic and current view is that psychometric tests should not stand on their own, or be reported de-contextually, and it may well be difficult to maintain this position in court, particularly under cross-examination (Campbell, 1992; Craig, Bivens & Olson, 1997; Roos & Vorster, 2003; Tredoux et al., 2005; Gould & Martindale, 2009).

The court will frequently want to understand and interrogate the reasoning underlying an assessment and psychologists may be obliged in some circumstances to discuss psychometric test results and test construction in detail, which could get very technical (Gould, 1998; Tredoux et al., 2005). It is thus, again, of vital importance that the psychologist working in the forensic context be up to date about all spheres of the field of psychology. In this light the principle of psychometrics testing should be looked at more carefully.

c) What is psychometric testing?

Groth-Marnat (1997), Roos & Vorster (2003) and Tredoux et al., (2005) explain that psychometric testing is a method of assessment that is uniquely employed by psychologists. The vast majority of psychometric tests should be administered and interpreted only by qualified psychologists. Psychometric testing involves the systematic

measurement of individual differences along specified traits or dimensions. Hundreds of psychometric tests have been developed to measure a wide variety of psychological variables. Roos and Vorster (2003) and Tredoux et al., (2005) report that these include tests of

- *intelligence;*
- *neuropsychological functioning;*
- *personality;*
- *mental state/diagnosis;*
- *attitudes and beliefs;*
- *social functioning and competence to stand trial;*
- *interrogative suggestibility;*
- *malingering;*
- *various other psychologically relevant characteristics.*

Psychometric tests are designed to evaluate psychological variables in a systematic fashion and are intended to eliminate or reduce the biases and errors inherent in subjective judgement and the confounding influence of extraneous factors (Butcher, 2002). Psychometrics are designed to maximise the objectivity of assessment through standardised administration, scoring and interpretation (Meehl, 1997).

Standardisation is intended to increase the reliability of measurement and ensure comparability of results across time and between and within individuals (Maloney & Ward, 1976). Standardisation ensures that a test is always administered, scored and interpreted in the same way, regardless of who is taking or administering a test. A good psychometric test according to Roos and Vorster (2003) as well as Tredoux et al., (2005) will have a test manual that describes the following:

- *test development;*
- *reliability and validity of the test;*
- *procedures for administration;*

- *scoring and interpretation; and*
- *norms*

Norms of psychometric tests are very important because they allow for comparison of the subject's scores with designated populations. They thus provide a measure for determining how the subject performs relative to a comparison group with similar characteristics. This provides a basis for giving meaning to individual scores. Standardisation of interpretation is ensured through the utilisation of empirically derived norms which allow for the interpretation of individual scores. They are used to evaluate an individual's performance in relation to a particular reference group (Gudjonsson & Haward, 1998; Galatzer-Levy, Baerger, Gould & Nye, 2002; Roos & Vorster, 2003; Tredoux et al., 2005).

The individual taking the test needs to be sufficiently similar to the reference group for the norms to be relevant. For example, it would be problematic to evaluate females' performance on a test against male norms. Psychometric tests differ according to the quality and detail of their normative samples. Tredoux et al., (2005), indicate that some tests provide national norms whereas others provide norms only for specific subgroups for example, prisoners or psychiatric patients.

Some tests provide different sets of norms (e.g. national norms and subpopulation norms) with which to compare an individual's scores. The psychologist must therefore be sure to select the most appropriate norms for comparison. For example, the Wechsler Adult Intelligence Scale has norms for different age groups, and many tests have separate norms for males and females. Inappropriate use of norms obviously undermines the validity of the test results and the expert's opinion based on those results (Groth-Marnat, 1997; Tredoux et al., 2005). The latter is a particularly salient issue in South Africa due to the unavailability of diverse tests normed for the multicultural South African population. Very few tests have been standardised for the diverse South African population. Language, cultural and ethnic variations make the

usage of psychological tests in South Africa a highly disputed and contentious issue (Louw & Allan, 1996).

Measurement of psychological variables is far more problematic than in the physical sciences because psychological variables tend to be complex, difficult to define, and intangible (Maloney & Ward, 1976). This leaves scope for error even when standardised tests are employed. Standardised tests might rely on subjective judgment to some extent, resulting in possible disagreement by psychologists about the meaning of particular test scores or profiles (Butcher, 2002).

Indeed, even the most highly regarded psychometric tests have 'confidence intervals' for test scores that specify the probability that a score falls within specific parameters. For example, the Wechsler Adult Intelligence Scale provides such confidence intervals for IQ scores, which means that psychologists who use it could, for example, state that they are '95 per cent certain that a person's score falls between low average and high average' (Groth-Marnat, 1997).

Gudjonsson, (1995) and Tredoux et al., (2005), however, maintain that a good psychometric test can undoubtedly guide the psychologist to make recommendations which can serve the best interests of a child in divorce matters. The question, however, is what constitutes a good psychometric test?

d) A good psychometric test

A number of recommendations have been made about the criteria that should be met before psychometric tests are used to form an expert opinion in court (Groth-Marnat, 1997; Tredoux et al., 2005). Heilbrun (1992), recommends that a psychometric test should be based on sound theoretical principles and have solid empirical evidence regarding its utility. A test manual that describes test development (e.g. how norms were obtained), psychometric properties of the test and procedures for administration, scoring and interpretation should be provided.

Psychometric properties should be scrutinised to ensure that the test has adequate reliability (i.e. consistency of measurement, e.g. over time) and validity (i.e. whether it measures what it purports to measure) so as to justify its use in court (Gudjonsson & Haward, 1998). The latter two concepts are statistically complex as is their empirical determination. It is conventional to express both validity and reliability in terms of an index number that ranges from 0 (poor) to 1 (perfect). Reliability should typically be above 0.7, but it is not possible to give a single criterion for validity, as it tends to be measured in multiple ways. Certainly the preponderance of validity scores reported for the test should be above 0.5.

A psychometric test should only be used if it is relevant to the legal issue or psychological construct underlying the legal issue, and should only be used for the purpose for which it was designed and validated (Heilbrun, 1992). Pope, Butcher and Seelen (2000) warn psychologists against interpreting a test to fit a particular legal theory.

Furthermore, psychometric tests should be administered to individuals who are sufficiently similar to the normative group on which the test was standardised (Gudjonsson, 1995). A highly salient issue in South Africa is that the majority of psychometric tests have been developed and validated in Western countries (usually North America and the United Kingdom), which raises questions about whether they could be validly applied cross-culturally to an African context, particularly where there might also be language, cultural and ethnic variations (Louw & Allan, 1996; Wallis, 2004).

Non-South African standardised tests should be used with great caution in South African courts and preferably with standardised or well-known or generally used psychometric tests (Tredoux et al., 2005). Where they are used, the psychologist would need to declare the limits of the inferences drawn from such usage explicitly. For instance, the *South African Wechsler Intelligence Scale (SA-WAIS III)* has been

standardised on white and coloured population groups and exists in English and Afrikaans versions. There are no indigenous-language versions, e.g. Xhosa, Zulu and Sotho versions. As a result, testees with these primary languages are tested in English or Afrikaans (Tredoux et al., 2005).

The *Minnesota Multiphasic Personality Inventory-2* (MMPI-2) and *Millon Clinical Multi-axial Inventory III* (MCM-III), for instance, are not standardised for the South African context, but are valuable instruments serving to indicate tendencies towards psychopathology. These tests have been in use for several decades and assess DSM-related personality disorders and clinical syndromes internationally, which is valuable in assessing personality styles in divorce contexts (Millon, 1983; Millon, Millon, Davis & Grossman, 1997).

McCann, Flens, Campagna, Collman and Lazzaro (2001), advise the clinician to integrate non-South African-standardised test results with other data such as other tests and background data. For instance, in addition to using the *MCM-III* to evaluate the parenting ability of a person, other collateral sources as well as other tests should also be included. This indicates that a battery of tests could assist the clinician to arrive at fairly accurate personality traits which can also assist in making a recommendation to the court in divorce proceedings (Millon, 1987; McCann et al., 2001 & Tredoux et al., 2005).

Consistent with the above-mentioned, various neuropsychological measures have not been standardised either within the South African context at all, despite their widespread usage by forensic psychologists. Where psychologists do use such tests in clinical or forensic practice, they need to state the limits of their inferences very clearly and be open to cross-examination as to their use of such 'invalidated' tests (Tredoux et al., 2005).

This issue is compounded by the fact that often attorneys employ 'opposing' expert witnesses who quickly alert their contracting attorney to the fact that the assessment

instruments used are not standardised and validated on South African samples (Tredoux et al., 2005).

The position of the Professional Board for Psychology to the use of tests that have not been validated in South Africa is specific. The Board has issued a list of 'approved' tests for use within South African contexts (HPCSA, 2003, 2007) although many of these have not been validated within South Africa. The Board specifically states:

[I]t needs to be noted that even though a test may be classified as a psychological test, the onus rests on the test user to ensure that the test is valid for the purposes for which it is being used; appropriate norms are consulted; and where that tests have been developed in other countries are concerned, appropriate research studies need to be undertaken to investigate whether the test is culturally biased and special care should be taken when interpreting the results of such test (HPCSA, 2003).

Thus, the onus for deciding the validity of the test rests on the practitioner. Psychologists should also be guided in this respect – see Chapter 2.4 of the Employment Equity Act (1998), which states:

Psychological testing and similar assessments are prohibited, unless the test is scientifically valid and reliable, can be applied fairly to all employees, and is not biased against any employee or group.

It is thus imperative for the clinician to apply psychometric tests that would serve the purpose of the evaluation, such as a divorce context, and ensure that the interests of the child are served (King & Trowell, 1992; Groth-Marnat, 1997; Tredoux et al., 2005; Gould & Martindale, 2009). As reported earlier, psychometric testing is unique to a psychologist practice, but the correct use of the test remain an important aspect, especially in the forensic context.

e) *How should a psychometric test be used?*

Pope et al., (2000) recommend that a psychometric test should be employed only if the psychologist has sufficient expertise and up-to-date training. Psychologists will typically gain competence in the principles of psychometric testing and the use of certain psychometric instruments by virtue of their generic training. However, some psychometric tests require specialist training, and such training may sometimes be listed as a prerequisite in the test manual (Groth-Marnat, 1997; Tredoux et al., 2005; Kaliski, 2006).

Lack of the recommended training can be challenged in court and may undermine the credibility of evidence based on the test results (Roos & Vorster, 2003). Pope et al., (2000) also warn against the use of obsolete versions of the tests, outdated norms or modified forms of administration that have not been adequately researched.

Psychologists should strictly adhere to the standardised test procedures specified in the test manual (Heilbrun, 1992). Pope et al., (2000) recommend that psychologists avoid the administration of psychometric tests without close and continuous monitoring (e.g., they should avoid asking the client to complete a self-report questionnaire at home). The psychologist should always take note of the response style (e.g. faking good or faking bad; random responding) of the individual taking the test, as this might bias the results (Millon, 2006).

Some psychometric tests have built-in validity indicators or measures (such as the 16PF and MCMI-III) of response style which help to determine whether the results could be invalid, and these should always be reported (Butcher, 2002 & Millon, 2006). Pope et al., (2000) caution against making interpretations or inferences about scores on an invalid test profile and also recommend that psychologists note any factors that could undermine the validity of the test (e.g. visual problems, language barriers).

Ackerman (1999), notes that it may be difficult to meet all the above criteria in every situation and recommends that the psychologist always be prepared to defend the use of the test, whilst also acknowledging the possible effects of any shortcomings.

The forensic use of psychometric tests can become a crucial part of any legal battle and might even sway a case in a specific direction. Often this is done by referring to the raw psychometric data. This, of course, brings about an important ethical issue which is discussed next.

f) The release of raw data and test materials in the forensic context

A more general issue regarding structured psychometric testing in the forensic context relates to the release of raw data and test materials to non-psychologists. Ackerman (1999) points out that psychologists have an ethical and contractual duty to maintain the integrity of the psychometric tests they employ. Psychologists are often pressurised to hand over their clinical notes, including raw test materials, to 'opposing' attorneys. In this regard the Ethical Code of Professional Conduct (HPCSA, 2006, 2009) in its chapter 'Assessment Activities' states the following under rule 54, 'Release of test data':

(i) A psychologist may release test data to another psychologist or another qualified professional by virtue of informed written consent by the client concerned.

(ii) A psychologist shall not release test data to a person who is not qualified to use such information, except

(a) as required by law or a court order;

(b) by virtue of informed written consent by the client concerned; and

(c) to the client concerned; and

(iii) A psychologist may refrain from releasing test data referred to in subparagraph (2) to protect his or her client from harm.

In essence, the rule implies that psychologists should not, for several reasons, disclose raw test data, answer sheets, or test questions to non-psychologists or lawyers. The raw data could be misused or misinterpreted by non-qualified individuals (Tredoux et al., 2005; Vorster, 2011). If parties in a legal case request access to raw test data, the psychologist should arrange for it to be sent in confidence to another appropriately qualified psychologist acting on behalf of the party concerned (Butcher, 2002).

It should also be noted that there is a profound distinction in practice with regard to patients seeking clinical psychology services for psycho-legal activities. People consulted for forensic purposes are *not* considered clients, but should be viewed as testees (Weschler, 2003; Tredoux et al., 2005). The referral source is seen as the client, implying that the testee and the client can at times be the same person, but at other times not.

It is mandatory to appreciate that psychometric tests are merely one component of the process of a psychological assessment and examination. Findings and recommendations are most certainly not based solely on the psychometric raw test data. Releasing raw psychometric test data (without discussing the context in which the test data was obtained with the psychologist) is fraught with serious problems and is inevitably harmful to a client or the person being examined (Tredoux et al., 2005).

Artefacts within the test data can be incorrectly interpreted, as the test performance of the testee during the test situation does not appear from the test data, and would be unknown to the person attempting to interpret the data. For example, during the test situation it could be observed that the testee's test attitude was simply to complete the test as soon as possible and without due consideration. This would influence the interpretation of the raw test data (Tredoux et al., 2005; Vorster, 2011).

The raw test data could be in conflict with the clinical presentation of the person being evaluated. The psychologist should then be able to interpret what happened during the administration of the test that might have had an impact on the test data. Releasing raw

test data to a testee is harmful and inappropriate. A testee is invariably unable to appreciate the importance of raw data and might very well, due to a complete lack of knowledge and understanding of raw test data, attach significance to insignificant data and vice versa. There is no single circumstance in which divulging raw test data to a testee is appropriate and releasing it to a testee is inherently harmful to him/her (Tredoux et al., 2005).

It is more appropriate and prevalent practice in psycho-legal activities that parties' respective psychologists, involved in specific forensic evaluations, perform their own individual evaluations and, on request, consider raw test data. Expert meetings are also prevalent in practice during which test data is accessed, considered and debated. Expert minutes of points of agreement or disagreement are then recorded for the purpose of court procedures (Tredoux et al., 2005; Kaliski, 2006).

Test material is copyrighted and should not be copied or disclosed to individuals who have not purchased the test. Disclosure of raw data and test materials potentially place them in the public domain and this could compromise the validity of the test and its future use (Ackerman, 1999; Tredoux et al., 2005; Gould & Martindale, 2009).

After the assessment phase has been completed, the psychologist is in the position to prepare and execute the final phase of the assessment, the post-assessment phase, which is an integration and discussion of the whole assessment process. This is dealt with next.

6.2.3 Post-assessment phase

a) Report writing

The post-assessment phase involves the compilation of a written report which is the product of the integration of all the information gathered during the assessment phase. This is usually the most complex and time-consuming part of the assessment process.

Psychologists typically submit a written report that summarises the information gathered during the assessment and outlines their professional opinion on the matter at hand. It is important to list all the contacts, dates and sources of information used in the preparation of the report, highlight any important omissions and qualify opinions in light of any missing data (Shapiro, 2002; Tredoux et al., 2005).

All data relevant to the legal issue should be reported (Ackerman, 1999). The report will form the foundation of the expert's evidence in court, including cross-examination. The psychologist must therefore be prepared to justify every line in the report and should prepare thoroughly for any challenges that might arise during cross-examination. The psychologist must bear in mind that the opposition may instruct another expert psychologist to testify and advise them in court about lines of cross-examination (Gudjonsson & Haward, 1998).

Psychological reports vary in length and the extent of inclusion of data. In South Africa there is an alarming trend for psychologists to prepare over lengthy and detailed reports of up to 100 pages. They run the risk here of including erroneous information not relevant to the legal question confronting the court. These reports often include highly private, irrelevant, clinical material. Such disclosure could well be challenged on ethical grounds. It is forgotten that the report is a summative statement and not a clinical case history (Tredoux et al., 2005).

There is, however, no single acceptable format for writing a forensic report. Everybody has his/her own preferences, which makes it difficult to agree on a standard format. Styles also often change with each written report. A well-written psychological report helps the reader to understand the individual. Forensic reports differ from career counselling reports and ordinary psychological reports in the sense that the approach the psychologist uses, is different (Naylor, Vorster, Cronje & Donaldson, 2003).

b) Clinical guidelines for report writing:

- Never step out of your field of expertise. An opinion which might appear to be 'common sense' is, nevertheless, not an 'expert' opinion, unless it falls within one's field of expertise.
- Avoid sweeping statements.
- Avoid emotionally charged language.
- Be very careful not to misinterpret other expert opinions.
- Never denigrate the opinions of other experts. What is offered by any forensic expert is an 'opinion' only, not a fact. Each expert is entitled to his/her own opinion and will be given an opportunity to defend the premise(s) on which that opinion is based.

Key issues useful in report: Jameson et al., 1997 identified core characteristics of a good assessment report:

- (i) The reason for the report must be clearly stated, and the report should be structured systematically in order to address the articulated questions.
- (ii) Evidence must be systematically marshalled and weighed, sources of all information must be clearly stated and a clear distinction made between evidence collected and the professional's opinion.
- (iii) Triangulation of data: wherever possible, more than one perspective should be obtained on all issues. Where the opinion of only one party (or other person interviewed) on a particular issue is gleaned, this should be clearly stated.
- (iv) Collateral information: due consideration must be given to the possibility of informants' bias in favour of, or against either party.
- (v) Writing should be clear, concise and accessible and the use of jargon should be minimised. Where it is necessary to use technical terms, these must be explained clearly.
- (vi) The report must be long enough to provide a comprehensive picture of all factors which might affect the child's best interests.

(vii) The primary audience for the report will be the court. In all likelihood the report will be read by the parties in the divorce matter and sometimes by the child (regardless of whether the expert believes that the child should be permitted to read the report). The tone of the report should be dispassionate and fair. It should be written with due regard to the feelings of those who will read it and with consideration of how the tone of the report can assist in optimising future relationships among the parties, in the child's best interests.

c) *Essential requirements of psychological reports*

According to Gould and Kirkpatrick (2001), the report of the psychological evaluation would in essence, therefore, meet the following requirements:

- *The summary and conclusions should relate directly to the legal issues of the case.*
- *The relationship between psychological factors and the legal issues should be described.*
- *The findings should reflect standard psychological practice.*
- *Research that supports the expert's conclusions should be noted.*
- *The recommendations should be practical.*
- *Experimental recommendations should reflect services available in the community.*
- *Implementation of the recommendations should be possible within the framework of the legal system.*
- *Recommendations should be clearly stated without the use of professional jargon.*

After a report has been submitted, the legal experts decide on its usability, especially with the aim of providing more weight to a case. The forensic psychologist, however, knows that more often than not, a report will not see the inside of a court room because this same report usually leads to a settlement between parties, many times during a divorce dispute. However, when the report does go to court, the psychologist will have to defend its content. This process will be discussed next.

d) Giving evidence in court

Providing testimony in court is dreaded by many psychologists and many refuse to get forensically involved in any matter, purely to avoid appearing in court. The stigma of a torture chamber of cross examination can be blamed for this.

The psychologist testifying in court on a particular case, or a report he/she has written, is usually done within the context of being an expert witness. It also has to be noted that, according to court rule, the mere fact that a psychologist is a qualified professional, does not automatically imply that he/she is an expert. The court has to decide if the psychologist is an expert and it then duly appoints such person. Being viewed as an expert or not is usually not determined by the psychologist's curriculum vitae, but by the court's opinion of the psychologist's level of expertise and knowledge.

As discussed earlier in this chapter, the psychologist's task as expert witness can be described as 'formulating a scientific opinion which will assist the trier of fact (i.e. judge) in rendering a final decision' (van Dorsten, 2002). The following general guidelines for the expert psychologist testifying in court are provided by van Dorsten (2002).

- *Have a thorough knowledge of your case.*
- *Know your report.*
- *Familiarise yourself with all collateral information, e.g. reports from other experts.*
- *Familiarise yourself with all literature relevant to your case.*

- *Keep yourself up-to-date with all scientific and research developments relevant to your case.*
- *Have an in-depth knowledge with regard to your psychometric test battery (its application, reliability, validity, standardisation, strengths, weaknesses, limitations, etc.)*

During a trial van Dorsten (2002) notes that a psychologist might be required to express an expert opinion which might include the following:

- *mental state and capacity;*
- *psychological and/or social functioning;*
- *neuropsychological functioning;*
- *personality ;*
- *witness reliability;*
- *interrogative suggestibility and disputed confessions;*
- *malingering;*
- *competence to stand trial;*
- *best interests of a child;*
- *parenting ability;*
- *moral development and reasoning;*
- *post-traumatic stress disorder;*
- *attitude of offenders towards their crime;*
- *sexually motivated criminal behaviour;*
- *anger and dyscontrol problems;*
- *deception.*

During a trial the psychologist should be able to defend his or her conclusions logically, using explanations which are understandable to non-psychologists, especially in the context of a divorce where two opposing parents will go to extreme lengths to win primary care of a child (Gould & Kirkpatrick, 2001). Literature and experienced clinicians

encourage novice psychologists to be as thorough as possible in their assessments and reports because then the process of providing evidence can be quite a pleasant one.

6.3 Conclusion

The chapter aimed to explain the complex but systematic process of psychological assessment. The psychologist, especially the forensic psychologist, has to be on his/her guard during each step of assessment, from the first step of accepting an instruction right through to handing in a report and testifying on its content. This chapter also made an attempt to indicate that the process of psychological evaluation is an ethical one which can easily be used against the practitioner due to the smallest of mistakes.

The next chapter will deal with the instruments used to develop a comprehensive assessment procedure for dealing with children in divorce.

CHAPTER 7

INSTRUMENTS USED TO DEVELOP A COMPREHENSIVE ASSESSMENT PROCEDURE FOR DEALING WITH CHILDREN IN DIVORCE

7.1 Introduction

This chapter deals with the assessment methods and instruments applied in this study. These methods and instruments will be discussed on two levels. The first part focuses on the methods and instruments which were utilised in the process of the experimental psychological assessment (in the present study) and the second deals with the instruments which were used to assess the effectiveness of this procedure. The clinical interview always forms an integral part of the assessment procedure.

7.2 13 Statements of the Best Interest Principle based on Justice King's Legal Constructs and a list of Family health Instruments

Three identified clinical psychologists were presented with the document entitled "*13 Statements of the Best Interest Principle based on Justice King's Legal Constructs and a list of Family Health Instruments*" where each of the 13 variables as set out by Justice King's variables were formulated into statements of a psychological nature (Annexure C). In the same document the psychologists also had to identify suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in a system, is functioning.

This document was designed by the researcher specifically for the purposes of this study. The design process is fully described in chapter 8.

7.3 The Clinical Interview

The clinical interview with adults, as well as children, is a vital part of psychological assessment, even when using other formalised tools, which could employ either a structured or an unstructured format. Such assessment evaluates areas of behaviour, such as general appearance and behaviour, mood and affect, perception, comprehension, orientation, insight, memory and content of communication (Boon & Draijer, 1991; Steinberg, 1994; Vorster, 2003).

Ackerman (1999) and Gudjonsson (1995), stress that, for court purposes, the clinical interview should be tailored to the psychological questions that need to be addressed in the report. It would be highly irregular for a psychologist to offer a psychological opinion without having interviewed the client directly.

The emphasis and scope of the clinical interview will depend on the psychological questions being addressed. Psychological opinion inevitably involves some degree of clinical judgement which necessarily has a subjective element (Gudjonsson, 1995; Ackerman, 1999; Roos & Vorster, 2003) and the fact that all human perception is subjective, has been accepted by social and clinical psychology since at least the first half of the twentieth century.

Vorster (2003, 2011), pointed out that, although the psychologist is subjective in his/her perception, he/she has been educated to see and hear from within a trained frame of reference and to do so in an orderly and a systematic fashion. The clinical interview in any psychological assessment thus remains a prerequisite and structured clinical observation and reporting, as such, is an integral part of forensic assessment.

The clinical interview has been expanded increasingly over the past few decades to focus explicitly not only on the individual assessed but also on the relationship between individuals as well. Within the context of forensic assessment, this is of special significance when looking at the relationship between parents and children.

Gudjonsson, 1995; Ackerman, 1999; Roos & Vorster, 2003 indicate that a description of the style of interaction between parent and child, as part of an evaluation process during a divorce, is of crucial importance. Thus a careful and accurate description of the parent-child relationship can assist the court greatly in determining a child's "best interests" when it comes to awarding primary custody and access.

Of particular value in this respect seems to be the diagnostic procedure developed by Vorster (2003, 2011) which he termed the "Interactional Pattern Analysis (IPA).

7.4 Interactional Pattern Analysis (IPA)

The IPA, a structured clinical procedure that is used to describe behavioural patterns systematically, has been extensively researched in the South African context since the 1970s. The IPA provides a detailed analysis of the style of interaction based on observational behavioural patterns (Vorster, 2003, 2011). In order to describe the observed behavioural patterns, certain key variables serve to form the basis of the procedure as described by Vorster (2011). The various variables are outlined below:

7.4.1 Definition of the relationship

As people interact with others in the environment, types of relationships emerge in which individuals are either leading, following, continuously struggling for control or behaving as equals in the relationship, for example, between parents and child. Thus, through interactions, people are constantly defining relationships. Any relationship can be defined by participants as either parallel (between equals); complimentary (with a leader and a follower); or symmetrical (continued power struggle) (Hayley, 1963; Vorster, 2003).

7.4.2 Emotional distance

In all relationships, also those between family members, individuals maintain a certain emotional distance. Emotional distance is determined by verbal and non-verbal behaviour. An individual who talks freely and openly and shares intimate personal details and is transparent in interaction with someone else is maintaining a close emotional distance. The closeness can further be underscored by aspects such as eye contact and an open body posture. The principle of reciprocity dictates that the tempo at which the participants move closer to each other in a relationship should be more or less the same from both sides.

7.4.3 Clarity of self-presentation

This variable of the IPA relates to how 'visible' an individual is experienced during interaction. The individual may talk too fast, or have poor pronunciation which hampers hearing or understanding what he/she is saying. In this light the variable, clarity of self-presentation, has important implications for the quality of an individual's interpersonal relationships, especially those between parents and child. The quality of a relationship can thus be clearly explained by means of the clarity of self-presentation. If someone succeeds in presenting a clear picture of him-/herself, possibilities of rewarding interpersonal experience are opened up.

7.4.4 Potential for eliciting rejection or acceptance

As people interact with others, the interpersonal manoeuvres can be divided into one of two categories: those that elicit acceptance and those that elicit rejection. Thus people literally create either a caring, loving environment or a hostile, rejecting one. If a child, or any person as it were, lives in a caring or accepting environment, constructive growth will be fostered, but if a person lives in hostile social surroundings or is being rejected, it will undoubtedly have significant implications for his/her mental health.

7.4.5 Confirmation

An individual experiences confirmation if a message is received from the environment that he/she is a special or an exceptional individual and appreciated as such. Such a message of confirmation may stem from the fact that the particular individual has excelled in some achievement and this achievement is then favourably commented on by someone else, e.g. a parent reacting to a child's school report. Receiving or not receiving confirmation from the social environment has important implications for the individual's sense of worth and emotional well-being.

7.4.6 Control

An individual can either be in relative control of his/her own circumstances and environment, or overwhelmed by the impact of the environment. This is very similar to the concepts of internal or external locus of control. Punctuating oneself as in control, or as a helpless victim, has important implications for one's sense of self-worth and mental health.

7.4.7 Effectiveness of expression of needs

Whether an individual expresses his/her needs effectively within an interpersonal context, has important consequences for that individual's self-actualisation and ultimately, mental health. Not expressing any needs at all may be just as ineffective as expressing needs in an over-demanding and prescriptive manner.

7.4.8 Degree of interpersonal flexibility or rigidity

An optimally functioning individual should express appropriate behaviour within particular contexts which necessitate a certain degree of flexibility in style. For example, a parent has to be flexible in adjusting to the child's needs in order to understand and respond to his/her needs appropriately.

7.4.9 Linear or circular approach

In their approach to the environment, individuals can exhibit either a linear or a circular stance, i.e. act as if behaviour were either a one-sided phenomenon or as if it were circular and interactive. Typically, individuals with a linear approach to the environment, do not recognise their 'share' in interactive processes but often blame others for that which is not acceptable to them in their relationships. As such, ineffective, and often destructive, interactional patterns are perpetuated in a particular relationship such as a parent-child relationship to the detriment of the mental health of the participants, especially the child.

7.4.10 Skill to meta-communicate

The term meta-communication means to communicate about communication and is a skill that is of paramount importance when it comes to maintaining a harmonious relationship. This skill is especially important in attempts at resolving interpersonal conflict, where the parties involved can adopt a "helicopter view" to reflect on their own actions and communication in order to resolve the conflict between them.

7.4.11 Adequacy of problem-solving skills

Coping with environmental demands on a day-to-day basis obviously necessitates a degree of skill in solving a great variety of problems that may range from the ability to boil water to disciplining a child effectively. It is thus extremely important to observe how an individual manages his or her environment, for example, how a parent deals with unexpected environmental problems when addressing a child.

Utilising the abovementioned variables to describe patterns of interaction between individuals systematically and vividly have proved to be very valuable within the clinical context and a significant correlation between an individual's IPA-profile and degree of mental health has been demonstrated empirically (Van den Berg, 2008). It was,

therefore, decided to include the Interactional Pattern Analysis as a diagnostic procedure in the present study. In addition to this procedure, use was made of a number of measuring instruments which will be set out below.

7.5 Clinical Instruments used for Determining Primary Placement

7.5.1 Millon Clinical Multiaxial Inventory (MCMI-III)

The MCMI-III is a diagnostic assessment procedure which assesses DSM – TR (2000) related personality disorders and clinical syndromes (Millon, Millon, Davis & Grossman, 1997). The test was developed by Theodore Millon, Carrie Millon, Roger Davis and Seth Grossman in such a manner that the results, in the form of different scales, reflect personality disorders as indicated by the American Psychiatric Association's classification system. Based on Millon's theory of personality, the MCMI-III is a self-report instrument designed to help the clinician assess psychopathology (Millon, et al., 1997).

The MCMI-III is described by Millon et al., (1997) as a valuable, informative and useful test for highlighting potential problematic areas of personality. It assists in understanding and helping clients who would otherwise not be classified as having a personality disturbance and not in need of psychological service. Different personality styles are indicated by personality scales in the test. The presence of an individual's personality on a basic personality scale is indicated by basis scores. When a specific scale or scales has/have a basis score of 75 and more, the specific personality style measured by the scale/s can be ascribed to the individual that is being assessed. The test is designed for individuals of 18 years and older with a Grade 8 reading/educational level. The administration time is approximately 25 minutes (175 true/false items). The scoring options are hand scorable or by Bureau Service scoring (Millon et al., 1997).

The MCMI-III also incorporates items and scales to provide insight into 14 personality disorders and 10 clinical syndromes.

7.5.1.1 The Millon Scales according to Millon et al., (1997):

- *Clinical Personality Pattern Scales: Axis II disorders (e.g. schizoid, histrionic, and narcissistic);*
- *Severe Personality Pathology Scales: schizotypal, borderline and paranoid;*
- *Clinical Syndrome Scales: Axis I disorders (e.g. bipolar, post-traumatic stress);*
- *Severe Syndrome Scales: Thought disorder, major depression and delusional disorder;*
- *Modifying Indices and a Validity Index: correction scales and validity indicator;*
- *New: Grossman Facet Scales.*

The modifying indices consist of 4 scales – *the Validity Scale (V), the Disclosure Scale (X), the Desirability Scale (Y) and the Debasement Scale (Z).*

These scores are used to determine a testee's response style, such as whether he/she was keen to present him/herself in a positive light (indicated by an elevation on the Desirability Scale) or exaggerated the negative aspects of him/herself (indicated by the Debasement Scale). It is also used to measure whether the testee was open in the assessment, or if he/she was unwilling to disclose details about him/herself (the Disclosure Scale). The scores are compared against one another to gain an understanding of the testee's response style. For instance, elevated scores on the Disclosure and Desirability Scales suggest a 'cry for help' response style.

The *Disclosure Scale* is the only scale in the MCMI-III in which the raw scores are interpreted and in which a particularly low score is clinically relevant. A raw score above 178 or below 34 is considered not to be an accurate representation of the testee's personality style as either over- or underdisclosed.

The *Validity Index* consists of just three questions in which a response of 'True' is extremely unlikely, such as, 'I was on the front cover of several magazines last year'. While consisting of only 3 questions, the scale is very sensitive to random responding. A score of 2 or 3 on this scale would render the test invalid.

For the *Personality and Clinical Syndrome Scales*, scores of 75-84 are taken to indicate personality trait, or (for the Clinical Syndromes Scales) the presence of a clinical syndrome. Scores of 85 or above indicate the *persistence* of a personality trait or a clinical syndrome.

The MCMI-III differs from the previous edition, the MCMI-II in the following ways: 90 items were revised or replaced; one new Personality Scale (Depressive) was added; one new Clinical Syndrome Scale (PTSD) was added; new Noteworthy Responses sections were added for childhood abuse and eating disorders; the Axis I scales, specifically Alcohol Dependence, were improved; the item-weighting scheme was changed; and there are fewer items per scale and less item overlap among scales. The normative sample for the MCMI-III instrument consists of males and females representing a wide variety of diagnoses (Millon et al., 1997).

Millon et al. (1997) note that the MCMI-III is applied in the following areas:

- *To assess Axis I and Axis II disorders based on the DSM classification system, identifying the personality disorders that underlie a patient's presented symptoms;*
- *To assist in designing appropriate and efficient experimental programmes;*
- *To provide valuable information on issues such as the individual's potential for violence, the possible risk of escape, and probable reaction to authority in correctional settings;*

- *To support classification in forensic settings (custody and criminal);*
- *To provide an empirical foundation for a clinician's expert testimony.*

The validity and the reliability of the MCMI-III have already been researched in several ways and are satisfactory (Millon et al., 1997; Blais, Holdwick, McLean, Otto, Pollack, & Hilsenroth, 2003).

However, McCann, Flens, Campagna, Collman and Lazzaro (2001) raised certain criticisms against the use of the MCMI-III in custody evaluations. Here are concerns that the MCMI-III might overpathologise individuals during custody evaluations. McCann et al., (2001) responded by completing a peer-reviewed study that refutes these allegations. Their findings provide an empirical foundation to support continued use of the MCMI-III in child custody evaluations for those clinicians who feel that this instrument provides useful diagnostic information in such contexts. They indicate that the MCMI-III can be useful to screen for various personality disorders and clinical syndromes that may have an impact on parenting and visitation within a custody evaluation context (McCann et al., 2001; McCann, 2002).

The use of the Millon Clinical Multiaxial Inventory-III (Millon, 1994; Millon, Davis, & Millon, 1997) in child custody proceedings has been controversial. Some have argued that the clinical nature of the instrument renders it inappropriate for use in child custody evaluations, which have been conceptualised by some as non-clinical types of examinations (Ackerman, 1995; Ackerman & Ackerman, 1997). Moreover, because norms for the MCMI-III were developed in clinical settings, they have been viewed by some as inappropriate in child custody cases because they supposedly lead to the MCMI-III narrative report, producing interpretations that over-pathologise individuals being evaluated in child custody disputes (Otto & Butcher, 1995). A significant issue that appears to underlie these concerns is whether the MCMI-III is diagnostically accurate in child custody settings.

There are indeed several reasons to view child custody evaluations as clinical in nature, such as the highly conflicted and contentious nature of marital dissolution and the need to consider the possible presence of psychopathology and its potential impact on parenting. In addition, the MCMI-III was designed for use with 'individuals who evidence problematic emotional and interpersonal symptoms *or* who are undergoing professional psychotherapy *or* a psycho-diagnostic evaluation' (Millon, Davis, & Millon, 1997:6; emphasis added). Child custody disputes certainly fit in the realm of 'individuals who . . . are undergoing . . . a psychodiagnostic evaluation' and the revised MCM-III manual has also endorsed use of the instrument in child custody evaluations (Millon, Davis, & Millon, 1997; McCann et al., 2001).

Despite the fact that McCann and Dyer (1996) recommended the use of the MCMI-II instead of the MCMI-III in forensic settings because of scant validity data in the original edition of the MCMI-III manual (Millon, 1994), there have been recent advances in the literature which outdate this recommendation and which now support validity of the MCMI-III and its use in forensic evaluations (Craig, 1997, 1999; Craig & Bivens, 1998; Craig, Bivens, & Olson, 1997; Davis & Hays, 1997; Davis, Wenger, & Guzman, 1997; Dyce, O'Connor, Parkins, & Janzen, 1997; Dyer, 1997; Dyer & McCann, 2000). Moreover, the MCMI-III manual has been revised and the most recent edition includes a more expanded and detailed validity study which supports use of the MCMI-III in forensic assessments (Millon, Davis, & Millon, 1997; McCann et al., 2001).

Rogers, Salekin and Sewell (1999), have recently criticised forensic use of the Millon Inventories by asserting that neither the MCMI-II nor the MCMI-III has been validated against DSM-IV or legal criteria and that both supposedly have poor convergent and discriminant validity. However, Dyer and McCann (2000) cite several methodological shortcomings of the Rogers et al., (1999) study, including arbitrary reversal of predictor and criterion, an incomplete review of the literature that failed to consider the most current edition of the MCMI-III manual, inaccurate statements about content validity of the MCMI-III, misleading criticisms about the use of the MCMI-III for evaluating legally relevant issues and serious errors in the multitrait-multimethod procedures employed by

Rogers et al., (1999) that render their findings meaningless (McCann et al., 2001). Therefore, while forensic application of the Millon Inventories in forensic settings is a topic of debate, there remains substantial support for continued use of the MCMI-III in many types of forensic evaluations (Dyer, 1997; Dyer & McCann, 2000; Craig, 2005), especially in child custody evaluations (McCann et al., 2001).

As stated in the previous chapter, the Millon Clinical Multiaxial Inventory III (MCM-III) is not standardised for the South African context, but is still a valuable instrument in indicating tendencies towards psychopathology (Craig & Weinberg, 1993; Millon, Millon, Davis & Grossman, 1997). This test is part of the Professional Board for Psychology's list of 'approved' tests for use within the South African context (HPCSA, 2003).

A test which is, however, standardised for some of the South African population. is the Sixteen Personality Factor Questionnaire.

7.5.2 The Sixteen Personality Factor Questionnaire (16PF)

The 16PF is a multiple-choice personality questionnaire which was scientifically developed over several decades of research by Raymond Cattell and his colleagues. Beginning in the 1940s, Cattell used the new techniques of factor analysis (based on the correlation coefficient) in an attempt to try to discover and measure the fundamental traits of human personality scientifically (Cattell, 1946).

In addition to the 16 primary traits, these researchers also found five higher-level 'second-order' traits of personality now known as the 'Big five', which have become popularised by other authors in recent years. From early in his research, Cattell found that the structure of personality was multi-level or hierarchical, with both primary and secondary level traits (Cattell, 1946, 1957).

The sixteen primary factors were a result of factor-analysing hundreds of measures of everyday behaviour to find the fundamental traits behind them. Later, five global (or

second-order) factors were discovered by factor-analysing these sixteen primary traits. Thus, the 16PF test gives scores on both the second-order global traits which provide an overview of personality at a broader, conceptual level, as well as on the more-numerous, precise primary traits, which describe the richness and complexity of each unique personality (Cattell & Schuerger, 2003).

Cattell also found that there was a third-order level of personality organisation that contained two overarching, top-level factors (Cattell, 1957), but it seems that little time was spent on defining this most abstract level of personality organisation (Cattell & Schuerger, 2003).

The test has been exposed to decades of scientific, empirical research, and is an integral part of Cattell's comprehensive theory of individual differences. The 60-year research on this test has found it to be useful in predicting behaviour in a range of settings and to provide an in-depth, integrated picture of the individual's whole personality. For example, it is commonly used in schools and colleges, clinical and counselling settings, in career counselling and employee selection and development and in basic personality research as well as forensic contexts (Ackerman, 2001; Cattell & Schuerger, 2003; Lipman, 2004; Genis, 2008).

Ackerman (2001) and Cattell and Schuerger (2003), report that research has indicated that the test is useful in predicting a wide variety of behaviour traits, such as *creativity, academic success, cognitive style, empathy and interpersonal skills, leadership potential, conscientiousness, self-esteem, frustration tolerance, coping patterns, marital compatibility, and job performance* (Ackerman, 2001; Cattell & Schuerger 2003). The versatility of the sixteen primary factors in the 16PF can be described as follows:

- i. Factor A (Warmth) measures a person's emotional orientation toward others – the degree to which contact with others is sought and found rewarding as an end in itself. This is sometimes known as a person's 'affiliative tendency'. High scorers like and need to be with others. They rarely like to be alone, and may indicate that spending large amounts of time alone is very difficult or

demotivating for them. They need and want high levels of interpersonal contact and have a 'the more, the merrier' approach to life. Low scorers are more interested in tasks or ideas than in people interaction. They might like and value other people, but don't enjoy 'small talk' or superficial social interactions. They are more prone to spend longer periods of time in solitary activities and to enjoy that. They might or might not be shy, but simply don't tend to find social interaction rewarding.

- ii. Factor B (Reasoning) measures a person's way of thinking and reasoning. It is correlated with what we conventionally think of as intelligence or problem-solving ability, but low scorers should not be thought of as lacking in intelligence. It's better to think of them as having a different kind or style of intelligence – as being 'street smart' as opposed to 'book smart'. High scorers are mentally quick and absorb new information rapidly and efficiently. As a result, they are usually easily bored by mundane or routine tasks and often have a high need for intellectual challenge. They mostly enjoy mental complexity or difficulty and might enjoy formal or academic learning contexts. Low scorers are most comfortable with familiar, well-known tasks in which they can draw heavily on past experience and can utilise a concrete style of learning by doing. They might be very effective hands-on learners but often need more time to assimilate and adjust to new information. They might find mental complexity aversive or unpleasant and might prefer practical, experiential learning contexts.
- iii. Factor C (Emotional Stability) measures a person's proneness to mood swings or 'ups and downs' in his/her emotional life. High scorers are less likely to experience wide variations in mood, and are more emotionally stable or 'steady as she goes' in their emotional experience. Low scorers more characteristically experience a wider range of emotional fluctuations – peaks and valleys on the 'roller coaster' of life. As a result, high scorers are usually better able to manage stress in a positive, proactive way – to remain solution-focused under stress or to 'keep their cool' in a crisis. However, for the same reason, some others might

experience or perceive them as unduly stoic or 'above it all' in a fashion that could be seen as either reassuring or annoying, depending on the perceiver's own personality and needs. Low scorers typically struggle more with stress, yet might also experience a richer and fuller emotional life (the bitter as well as the sweet). In some cases, low scorers can be strong advocates for others because of their capacity to empathise with the 'underdog' – they know from experience what it means to struggle. (A high proportion of effective counsellors score on the low side of Factor C for this reason.)

- iv. Factor E (Dominance) measures a person's place on the 'pecking order' of interpersonal assertiveness. It is a measure of dominance versus submissiveness in an interpersonal context. It is also a measure of the extent to which a person likes to be in control of situations involving other people. High scorers enjoy being in control and value power. They are often seen as 'natural leaders' by others (but might, if scores are excessive, strike others as domineering or autocratic if their control orientation is not moderated by other factors). It is common for high scorers to use competitive terms like 'mastering' a subject or 'conquering' a problem; a positive correlate is tenacity and force of will. High scorers tend to like competition and to think of interpersonal situations in primarily competitive terms. Low scorers make few demands on others and instead like to accommodate the needs and wishes of other people, sometimes making insufficient room for their own to be expressed. They dislike conflict, enjoy pleasing others, and like cooperativeness and harmony-seeking. They might not enjoy or seek leadership roles, and if placed in such roles, might not be seen as 'conventional' or 'strong' leaders; they lead, not by the force of their will or personality but by other traits such as positional authority and responsibility.
- v. Factor F (Liveliness) measures a person's natural exuberance or energy level. Thinking of the same factor in a different way, it provides a measure of deliberateness and caution (low scores) versus impulsivity and lack of inhibition (high scores). High scorers are usually uninhibited, playful, adventurous types

who enjoy being the centre of attention. They might become bored easily and like to jump from one thing to another. As a result, they are at their best in 'generalist' work roles that allow them to wear many different hats and to move from one activity to another without investing too deeply in any one of them. As a result, they need to watch their tendency to over-generalise ('jack of all trades, master of none') and may need to strengthen their ability to maintain interest and attention in the face of difficulty or complexity. 'Variety is the spice of life' is a high F slogan. In extreme cases, high F types can be seen as rather fickle, self-focussed, or superficial by others who have a different pattern of traits. Low scorers are usually deliberate, cautious, careful, focussed, and serious-minded types. Their sense of humour is more of the wry, subtle form, and even if they have a dry wit, others are likely to perceive them as sober, serious, even perhaps rather dour people. They usually like to 'dig deep' into what interests them, having longer attention spans than high F types, and so are at their best in 'specialist' work roles that allow them to become technical experts in a chosen field of endeavour. However, they need to watch their tendency to overspecialise ('learning more and more about less and less') and may need to strengthen their ability to deal well with more casual, superficial interactions and roles. In extreme cases, low F cases can be seen as rather dull, plodding, or one-sided (monomanically devoted to a single cause, issue, value, or role) by others who have a different pattern of traits.

- vi. Factor G (Rule Consciousness) measures a person's orientation to rules, procedures, and social expectations. To a considerable extent, it is a measure of ethical and moral responsibility and dutifulness. High scorers are usually highly ethically driven and responsible, although the reverse is not always the case: low scorers are not necessarily irresponsible or unethical, but are, at a minimum, prone to think of ethics in unconventional terms. High scorers are more rule- or principle-governed, while low scorers are more results-governed. Thus, a high scorer is likely to stick to the rules even if this means that a desired result cannot be obtained. 'I'd rather be right than President' is a high G dictum. High scorers'

dutifulness and moral conventionality make them desirable in the eyes of most employers, which is why factor G correlates with employer ratings of workers to a stronger degree than any other personality factor. However, very high scorers might be unnecessarily rigid or unbending about rules or ethical principles. Low scorers are prone to think that rules are made to be broken (or at least bent) if this is what it takes to achieve a desired result. This does not necessarily translate into unethical behaviour (though very low scorers are statistically likely to strike others as ethically challenged or, in the extreme case, even rather conscienceless), but it does suggest a different kind of focus – one in which outcomes, not rules, are the major emphasis.

vii. Factor H (Social Boldness) measures social initiative-taking and, to a lesser extent, a general orientation toward risk-taking of any sort. ‘Shyness’ versus ‘social boldness’, in contrast to ‘shyness’, is one way to think of this factor, but risks other than social ones are also in view in this factor. High scorers are social initiative-takers who are comfortable with such activities as networking, self-marketing, introducing themselves to others, small talk, and ‘schmoozing’. As a result, nearly all sales and marketing professionals are high H types. These types show more ‘courage’, social and otherwise, and in the extreme show a high need for thrill-seeking or ‘living on the edge’. Most people who engage in ‘extreme sports’, for instance, are high H types. Low scorers are more likely to be shy and to find social initiative-taking aversive and difficult. They prefer a small number of close relationships to a large number of more superficial ones and probably do not enjoy meeting new people in large-group contexts. They may show a more general pattern of risk aversion and timidity, and probably enjoy more quiet, ‘safe’ pursuits.

viii. Factor I (Sensitivity) is a complex factor that is difficult to summarise in a single phrase. It has to do with two related qualities: objectivity versus subjectivity, and tough-mindedness versus tender-mindedness. High scorers are generally emotionally sensitive, empathic, aware of feelings, and prone to making

decisions on a more personal or subjective basis (focussed on personal values or the needs of others). As a result, they do well in roles that call for interpersonal sensitivities and an emphasis on 'feeling' issues. (Note that these qualities are not necessarily related to extraversion versus introversion; a person may be very focussed on others' needs and yet not be drawn to superficial sociability.) However, they might, especially in the extreme, lack objectivity, and have a difficult time seeing the dark side of something about which they care deeply. Others might see them as 'thin-skinned' or 'wearing their heart on their sleeve.' Low scorers are generally objective, analytical, logical, and prone to making decisions on a more impersonal basis (focussed on cause and effect or rational consequences). As a result, they do well in roles that call for analytical logic or impersonal objective reasoning (which are more likely to involve working with things, ideas or data rather than with human beings and their needs and problems). However, they might, especially in the extreme, lack sensitivity, and seem to have an 'emotional blind spot' – lacking an emotional vocabulary or the ability to sense their own needs and feelings, as well as those of others. Others may see them as 'armour-plated' or 'having ice in their veins'.

- ix. Factor L (Vigilance) has to do with the balance between trust and scepticism. Erik Erikson views learning how to be appropriately trusting of others (but not excessively or indiscriminately) as the first major challenge people face when growing up. High scorers are more careful, vigilant, wary or sceptical about trusting others and are less likely to assume that others' motivations are trustworthy or benign. They are more likely to 'read between the lines' in evaluating others – which means that they are less likely to be taken in by those who have a hidden agenda, but also that they are more likely to imagine a hidden agenda when, in fact, none exists. Very high scores are associated with a tendency to blame or suspect others without reason. Low scorers are more prone to taking others at face value and to trust others' motives, sometimes in excessive or unrealistic ways. The positive side of low scorers is their natural tendency to feel a sense of 'connectedness' with others and to 'give others the

benefit of the doubt' in dealings with them. The negative side, especially with extreme scorers, is a certain naivety or gullibility in dealing with others – a tendency to be taken in by those who are not worthy of trust. Some professions – those that require scepticism or an ability to read between the lines – require higher L scorers than others. Examples of professions that reward higher than average L scorers are Internal Revenue Service (IRS) auditors, police detectives and insurance underwriters.

- x. Factor M (Abstractedness) has to do with practicality versus creativity, or literal-detail orientation versus imaginative big-picture orientation. Think of a camera with two different lenses: a close-up lens that reveals fine details, and a telephoto lens that shows how elements in a scene are associated with one another. Low scores are like the close-up view, high scores are like the wide-angle view. High scorers are generally creative, imaginative and insightful. Often, they are abstract or theoretical in orientation (focussed on ideas, not their practical implementation). Their focus is generally strategic (the 'thousand-year view'), but in their ideophilia they could miss or under-attend to details and could lack practicality. Under stress they tend to obsess about specific details (which they would usually not notice). The absent-minded-professor image is that of a very high M person. Low scorers are very much in touch with practical realities, live by them, make decisions on a literal and factual basis. They tend to be focussed on here-and-now results and outcomes and ask 'how', not 'why'. Their focus is generally tactical (this hour, this day, this week), but on the negative side they could be blind to wider meanings and implications, could be overly literal or even nitpicky about details and could generally miss the forest for the trees. Under stress they tend to 'catastrophise' about imagined negative future possibilities (which they would usually not consider).

- xi. Factor N (Privateness) has to do with self-disclosure and, consequently, how easy a person is to get to know, as well as how well s/he keeps private matters confidential. Low scorers are more forthright; high scorers are more discreet.

High scorers are careful and selective about self-disclosure (when, where, and with whom they share information). They are slower to open up to others and, as a result, may strike others as hard to get to know. 'I respect her/him, but I really don't know her/him' is something that others might often say about high N types. These people tend to do well in roles that require caution about the disclosure of information (such as a diplomat, a payroll clerk or a human resource professional) or that require political 'savvy'. Low scorers are 'what-you-see-is-what-you-get' or 'shoot-from-the-hip' types who are quick to disclose information and are much less selective about when, where and with whom they share. They strike others as more open and forthright, but might be more politically naïve or might not keep secrets well. People usually know exactly where they stand, but might not trust them with confidential or private information.

- xii. Factor O (Apprehension) has to do with apprehension in two senses. One is a general proneness to worry; the other a propensity to self-doubt and self-blame (intra-punitivity), being hard on oneself, selling oneself short, treating oneself stringently or harshly. High O persons tend to be merciless self-critics. While this suggests high performance standards (and, indeed, high O types are often also high on factor G and, to a lesser extent, Q3), it also suggests a general tendency toward self-blame that is not necessarily productive. High scorers are also prone to experiencing such states as worry and guilt. Low O persons are self-assured, self-confident and rarely worry about themselves. They are certain of their capabilities and invest little energy in introspection of a self-evaluative sort. However, with very low scores these positive traits could turn into complacency, blindness to areas of required self-improvement, arrogance or even denial of one's true faults (so-called 'anxiety binding'). In general, low O persons might profitably learn to be a bit harder on themselves and high O persons might learn to cut themselves some slack. While our current culture tends to favour low O persons, Raymond Cattell strongly emphasises the adaptive value of high O, which includes a tendency to project blame inward rather than outward (the latter usually being more destructive, at least to others).

xiii. Factor Q1 (Openness to Change) has to do with a person's orientation to change, novelty and innovation. The Chinese word for change literally means 'dangerous opportunity'. Low scorers are more attuned to the danger side (and hence tend to resist change), while high scorers are more oriented to the opportunity side (and hence tend to seek out change). High scorers like change, respond positively to it, seek it and want to 'boldly go where no one has gone before'. They are quick to jump on the change bandwagon and tend to become bored, frustrated or demoralised by situations that provide insufficient change. In the extreme, they can be 'change junkies' who see change for change's sake, who needlessly reinvent the wheel or who are intolerant or dismissive of tradition, convention and stability. Low scorers like the known, the tried and true and the time-tested. At least initially, they tend to be sceptical of change, or respond negatively to it, avoid needless change, like things as they are and say, 'if it ain't broke, don't fix it'. They are guardians of stability and constancy and tend to be threatened, frustrated or demoralised by situations that provide excessive change. In the extreme, they could drag their feet about change or seem reactionary to others.

xiv. Factor Q2 (Self-reliance) has to do with the propensity to seek group support – or to strike out on one's own. Nicholas Lore divides the vocational world into 'tribals' (those who like to be 'a bee in the hive') and 'lone wolves' (those who like to do a one-man or one-woman show). This captures factor Q2 well. High scorers like to solve problems on their own – in the extreme, they 'ask for help when the request is pried out from between their cold, dead fingers' – and prize self-reliance. They like to act independently and might be attracted to entrepreneurial roles or to individual contributor roles for this reason. They might find it hard to delegate or run the risk of overly isolating themselves, being seen as 'not a team player' in a culture that consists of more low Q2 types. Low scorers like group support and group consensus, think in terms of collaborative, team-based action and might have a hard time acting alone or independently. They might be attracted to

'corporate' roles in which there are high levels of social support for what they do and in which team outcomes, not individual outcomes, are emphasised.

xv. Factor Q3 (Perfectionism) is another complex factor that encompasses more than one core element. Part of this factor has to do with 'task orientation' versus 'process orientation'. Another has to do with a 'structure-seeking' versus 'structure-avoidant' tendency. A third has to do with image management. Think of cross-country driving. One person's goal might be to get to the destination as quickly and efficiently as possible (the high Q3 style); another's might be to enjoy the trip, taking the scenic route, stopping along the way whenever the mood strikes (the low Q3 style). Thus, the idea of 'the destination versus the journey' is one way to differentiate between high and low scorers. High scorers are more organised, systematic, methodical, goal oriented, focused on conventional achievement (including outward status markers of success and image), like high levels of structure and tend to have steady work habits oriented around starting tasks promptly, working first and playing second and taking deadlines seriously. When taken to excess, these traits might degenerate into rigidity, inflexibility and an inability to handle the unexpected or to stop and smell the roses. High scorers lose efficiency as the amount of environmental structure decreases. Low scorers are more flexible, adaptable, spontaneous, emergent and process oriented. They are often less focussed on achievement as an end in itself and might care less about what 'the Joneses' think. They are better starters than finishers and tend to work in 'feast-or-famine' spurts, mixing work and play and treating deadlines flexibly. When taken to excess, these traits may degenerate into procrastinating, drifting, waffling and an inability to hold oneself accountable. Low scorers lose efficiency as the amount of environmental structure increases.

xvi. Factor Q4 (Tension) is about patience or impatience in response to environmental delays, stresses and demands. A good informal test for a person's Q4 score is to watch their behaviour in a crowded grocery store when the 'express lane' is crawling along at molasses-in-February speed. High scorers are

'always on the go', 'fidgety', constantly busy, efficiency-minded and driven to make things happen. Delays frustrate them, producing impatience, tension and irritability, but they also get things done. Low scorers are patient, relaxed, placid – 'don't worry, be happy', *hakuna matata*. They take life in stride, which means less stress but also less of a sense of internal urgency, hence, less done.

The 16PF can be linked to following 'Big Five' personality factors by way of the second-order factors:

- *Extraversion on the 'Big Five' = high A, high F, high H, low N, low Q2*
- *Openness on the 'Big Five' = high A, high I, high M, high Q1*
- *Agreeableness on the 'Big Five' = low E, low H, low L, low Q1*
- *Conscientiousness on the 'Big Five' = low F, high G, low M, high Q3*
- *Negative Emotionality on the 'Big Five' = low C, high L, high O, high Q4*

Thus, the 16PF factors can be thought of as 'facets' of the more global 'Big Five' dimensions. Deviations from the expected patterns above are psychologically meaningful and interesting; for instance, I am high G but low Q3 (likely to follow rules or follow through with tasks that have ethical implications, but not otherwise).

The validity of the factor structure of the 16PF Questionnaire (the 16 primary factors and 5 global factors) has been supported by more than 60 published studies (Cattell & Krug, 1986; Conn & Rieke, 1994; Hofer & Eber, 2002). Research has also supported the comprehensiveness of the 16PF traits: all dimensions on other major personality tests (e.g., the NEO Personality Inventory, the California Psychological Inventory, the Personality Research Form and the Myers-Briggs Type Indicator) have been found to be contained within the 16PF scales in regression- and factor-analytic studies (Conn & Rieke, 1994; Cattell, 1996).

The test has also been translated into over 35 languages and dialects and is widely used internationally (Cattell, 1996). It has taken a long time to standardise the 16PF for South Africa but norms were eventually finalised as stipulated in Table 7.1.

Table 7.1: Norm groups of the 16PF as described by Prinsloo (1991)

<u>Description of Group</u>	<u>Subgroup</u>	<u>N</u>	<u>Standard Score</u>
First-year university students	Females	899	Stens
First-year university students	Females	912	Stens
General population (age \pm 20)	Males	1342	Stens
Rural population (age \pm 35)	Females	105	Stens
Administrative personnel	None	8239	Stens
Graduate workers	Females	111	Stens
Branch managers at banks	Males	111	Stens

The student norms are based on the data obtained from administering the questionnaire to a sample of university students. Both males and females from English and Afrikaans universities were tested. The norm table for the general population (males) was the result of testing an available group of young males, the majority of whom (70%) had completed Grade 12, and whose ages varied between 18 and 20. The norm table for the females from the rural environment was obtained from a limited sample coming from a comparatively small local area (Prinsloo, 1991).

The administrative personnel were published with acknowledgement to the manpower department as well as the South African Transport Services. The graduate females contain figures for a small, selected group tested during the course of selection procedures. The norm group of bank personnel were employed in either of two divisions, bank services or a financing department. Their ages ranged from 30 to 62, the average being 42.38 years (standard deviation = 7.1). All had a Grade 12 qualification (Prinsloo, 1991).

The latest edition of the 16PF currently in South Africa is the Fifth Edition which is based on the norm groups for the South African version of the 16PF5 on two groups, namely a sample of first-year university students ($N = 2\,538$) in 2005, as well as a group of working adults ($N = 478$) in 2007 (Institute for Personality and Ability Testing, 2009).

The 16PF is also known to be used within the forensic context and is often nationally, as well as internationally, used for custody evaluations (Ackerman, 2001; Lipman, 2004; Genis, 2008). The 16PF is well-established as a sound, effective measure of psychological functioning in the area of child custody evaluations (Weiner, Friedheim & Goldstein, 2003; Ackerman, 2006; Gould & Martindale, 2009; Siegel, 2010). Genis (2008) found that the 16PF is a popular choice of test in the forensic context in South Africa as it is one of the few tests standardised for the South African context.

In contrast to the successful standardisation attempts of the 16PF, other tests were less successful, like the projective tests and projective drawings. Projective tests are mainly applied to explore the underlying dynamics of personality, such as internal conflicts, dominant drives, interests and motives (Cramer, 1991, 2004). These projective techniques will be discussed next.

7.5.3 Thematic Apperception Test (TAT)

The TAT is a widely internationally used projective test. It was developed by the American psychologists Henry A. Murray and Christiana D. Morgan at Harvard during the 1930s. According to Melville scholar Howard P. Vincent, the TAT 'came into being when Dr. Henry A. Murray, psychologist and Melvillist, adapted the implicit lesson of Melville's [Moby Dick] "Doubloon" chapter to a new and larger creative, therapeutic purpose' (Cramer, 1991, 2004; Narron, 2005).

After World War II, the TAT was adopted more broadly by psychoanalysts and clinicians to evaluate emotionally disturbed patients. Later, in the 1970s, the Human Potential

Movement encouraged psychologists to use the TAT to help their clients understand themselves better and stimulate personal growth (Westen, 1991).

This test was developed for the purpose of assessing an individual's perception of interpersonal relationships. The TAT is a projective psychological test. Historically, it has been among the most widely used, researched and taught of such tests. Its adherents claim that it taps a subject's unconscious to reveal repressed aspects of personality, motives and needs for achievement, power, intimacy and problem-solving abilities (Bergin, & Garfield, 1983; Holmstrom, Silber, & Karp, 1990).

The TAT is a projective test which is administered to individuals 10 years and older (Narron, 2005). It is popularly known as the picture interpretation technique because it uses a standard series of provocative, yet ambiguous, pictures about which the subject is required to tell as dramatic a story as possible for each picture presented, including

- *what has led up to the event shown;*
- *what is happening at the moment;*
- *what the characters are feeling and thinking; and*
- *what the outcome of the story is going to be.*

If the subject, particularly a child or an individual with low cognitive abilities omits an element/elements, the evaluator may ask the subject about it directly.

There are 31 picture cards in the standard form of the TAT. Some of them show male figures, some females, some both male and female figures, some of ambiguous gender, some adults, some children and some show no human figures at all. One card is completely blank. Although the cards were originally designed to be matched to the subject in terms of age and gender, any card may be used with any subject.

Most practitioners choose a set of approximately nine or ten cards (mostly cards 1, 2, 3, 4, 6BM/GF, 7BM/GF, 8BM, 10 & 13MF), using either cards that they feel are generally

useful, or that they believe will encourage the subject's expression of emotional conflicts relevant to their specific history and situation (Cramer, 2004). Genis (2008), found that the TAT is a popular choice of test in the forensic context in South Africa. In this study the TAT analysis is based on *Systems Theory*.

The 31 picture cards included in the TAT are used to stimulate stories or descriptions about relationships or social situations and can help identify *dominant drives, emotions, sentiments, conflicts and complexes*. The cards include specific subtests for boys, girls, men and women. The TAT is a widely used projective test and is useful as part of a comprehensive study of personality and in the interpretation of behaviour disorders, psychosomatic illnesses, neuroses, and psychoses.

As the subject is not required to do any reading, no reading or educational level is required for one to complete the test. The administration time varies because a clinician can decide which of the 31 picture cards to use. The test is hand scorable and widely used in the assessment of children, adolescents and adults. It can be used for diagnostics, research, or therapy. The TAT is also widely used in child custody evaluations (Cooley, Robinson, Shaver, & Wrightsman, 1999), Ackerman, 2006; Jafee, Crooks & Poisson, 2003; Quinnell & Bow, 2001; Weiner, Friedheim & Goldstein, 2003; Gould & Martindale, 2009).

The TAT is a projective test in that, like the Rorschach test, its assessment of the subject is based on what he/she projects onto the unambiguous images. Therefore, to complete the assessment, each story created by a subject must be carefully analysed to uncover underlying needs, attitudes and patterns of reaction. Although most clinical practitioners do not use formal scoring systems, several formal scoring systems have been developed for analysing TAT stories systematically and consistently.

Another widely used projective test, especially with children, is the Children's Apperception Test (CAT).

7.5.4 The Children's Apperception Test (CAT)

The Children's Apperception Test (CAT), is a projective personality test used to assess individual variations in children's responses to standardized stimuli presented in the form of pictures of animals (CAT-A) (McCoy, 2005; Murphy, 2004). This test is a projective personality measure for children aged 3-10 years.

The CAT, developed by psychiatrist, L. Bellak, and psychologist, S. Bellak, and first published in 1949, is based on the TAT. The examiner summarises and interprets the stories in light of certain common psychological themes (Bellak, 1954).

In creating the original CAT, animal figures instead of the human figures were used because it was assumed that children from 3 to 10 years of age would identify more easily with drawings of animals. The original CAT consisted of ten cards depicting animal (CAT-A) figures in human social settings. Then Bellak later developed the CAT-H, which included human figures (Bellak, 1954). In this study the CAT-A was used.

Like the TAT, the CAT is a type of personality assessment instrument known as a projective test. The term projective refers to a concept Sigmund Freud coined. In Freud's theory, unconscious motives control much of human behaviour. Projection is a psychological mechanism by which a person unconsciously projects inner feelings onto the external world, then imagines those feelings are being expressed by the external world toward him-/herself (Bellak, 1954; Bellak & Abrams, 1993).

As opposed to cognitive tests, which use intellectual and logical problems to measure what an individual knows about the world, projective assessments such as the CAT are open-ended and designed to encourage free expression of thoughts and feelings, thereby revealing how an individual thinks and feels (Bellak, 1954).

The CAT is used to assess personality, level of maturity, and, often, psychological health. The theory is that a child's responses to a series of drawings of animals or

humans in familiar situations are likely to reveal significant aspects of his/her personality. Some of these dimensions of personality include a *level of reality testing and judgment, control and regulation of drives, defences, conflicts and level of autonomy* (Murphy, 2004; McCoy, 2005).

The CAT, which takes 20-45 minutes to administer, is conducted by a trained psychologist in a clinical, research or educational setting. The test may be used directly in therapy or as a play technique in other settings. After carefully establishing rapport with the child, the examiner shows the child one card after another in a particular sequence (although fewer than ten cards may be used at the examiner's discretion) and encourages the child to tell a story – with a beginning, middle and end – about the characters. The examiner might ask the child to describe, for example, what led up to the scene depicted, the emotions of the characters and what might happen in the future (Bellak, 1954; McCoy, 2005; Murphy, 2004).

In a projective test such as the CAT, there are no right or wrong answers, so there is no numerical score or scale for the test. The test administrator records the essence of each of the stories told and indicates the presence or absence of certain thematic elements on the form provided. Each story is carefully analysed to uncover the child's underlying *needs, conflicts, emotions, attitudes and response patterns*. The CAT suggest a series of ten variables to consider when interpreting the results. These variables include the *story's major theme, the major character's needs, drives, anxieties, conflicts, fears, as well as the child's conception of the external world* (Murphy, 2004; McCoy, 2005).

Although responses in projective tests are believed to reflect personality characteristics, many experts have called into question the reliability, validity, and hence, usefulness of these tests as diagnostic techniques.

Quinnell and Bow (2001), Weiner, Friedheim, Goldstein (2003), Ackerman (2006) and Gould and Martindale (2009) report that the CAT is generally included in the test battery for child custody evaluations. Weiner, Friedheim & Goldstein (2003) report that the CAT

is widely used in forensic contexts, especially within custody evaluations, but it should be used as part of a larger battery of tests. In relation to the aforementioned, Murphy (2004), McCoy (2005), Kuo, Hall and Levy (2010) endorse the use of the CAT to indicate children's conflicts in divorce situations.

The CAT, as well as other projective measures, has been criticised for its lack of a standardised method of administration, as well as its lack of standard norms for interpretation. Studies of the interactions between examiners and test subjects have found, for example, that the race, gender and social class of both parties influence the stories told, as well as the way the examiner interprets them (Bonthuys, 2002; Murphy, 2004; McCoy, 2005).

In addition to questioning the general reliability and validity of all projective tests, some experts maintain that cultural and language differences among children tested might affect CAT test performance and produce inaccurate test results. Nevertheless, it should be borne in mind that psychological tests such as the CAT, which should be administered only by well-trained professionals, are but one element of a child's psychological assessment. These tools should never be used as the sole basis for a diagnosis. A detailed review of psychological, medical, educational, or other relevant history, is required to lay the foundation for interpreting the results of any psychological measurement.

Projection, like in the TAT and CAT, is also applied in the analysis of drawings. These projective drawings are also commonly used in the clinical community, as discussed in the next section.

7.5.5 Kinetic Family Drawing Test (KFD)

Tharinger and Stark (1990) and Groth-Marnat (1997) describe figure-drawing as a projective diagnostic technique which instructs an individual to draw a person, an object

or a situation so that cognitive, interpersonal or psychological functioning can be assessed. The Kinetic Family Drawing Test, developed in 1970 by Burns and Kaufman, requires the testee to draw a picture of his/her entire family. Children are asked to draw a picture of their family, including themselves, 'doing something'.

This picture is meant to elicit the child's attitudes toward his/her family and the overall family dynamics. The KFD is sometimes interpreted as part of an evaluation for child abuse.

Interpretations of all projective tests should be made with caution and their limitations considered. It is generally a good idea to use projective tests as part of an overall test battery. There is little professional support for the use of figure drawing so the examples that follow should be interpreted with caution. In particular, with reference to forensic situations, the use of the KFD and other projective tests may be unethical or illegal depending on the jurisdiction of the country (Tharinger & Stark 1990; Anastasi & Urbina, 1997).

Despite the flexibility in administration and interpretation of figure drawings, these tests require skilled and trained administrators familiar with both the theory behind the tests and the structure of the tests (Anastasi & Urbina, 1997; Groth-Marnat, 1997).

The examiner might then ask the child questions about the drawing, such as *what is happening* and which *family member* is represented by each figure in the picture. Certain characteristics of the drawing are noted upon analysis, such as *the placement of family members*, the *absence of any members*, whether *the figures are relatively consistent with reality* or altered by the child, the absence of *particular body parts*, *erasures*, *elevated figures* and so on (Tharinger, & Stark, 1990; Groth-Marnat, 1997; Kline, 1999; Reynolds, 1998).

The KFD was developed as an extension of the Family Drawing Test (Burns, 1987; Tharinger & Stark, 1990). The kinetic aspect refers to the instructions given to the child to draw his/her family members *doing* something.

The KFD is similar to other psychometric projective techniques such as the Draw-A-Person Test (DAP) developed by K. Machover, and the House-Tree-Person (HTP) technique developed by J.N. Buck (Groth-Marnat, 1997; Kline, 1999; Reynolds, 1998). The KFD and the DAP are extensively used by forensic psychologists during custody evaluations (Genis, 2008; Skeem, Douglas & Lilienfeld, 2009).

The KFD is a paper-and-pencil projective test used for children and adolescents. It covers a broad range of the frequent areas of distress and consists of a projective drawing, followed by a series of projective questions relating to the action between the figures, figure characteristics, position, distance, barriers, style and symbols. The KFD has been used extensively within the South African context and is also accepted within the forensic context (Potgieter, 1987).

Numerous articles caution against the use of projective drawings as these tests present no normative data or empirical research, including validity and reliability. Studies from the literature reviewed showed there were no adult norms that can be referenced and interpretations are speculative and subjective. Handler and Habenich's (1994) review of studies emphasized single KFD signs and the use of a single interpretation for each of a series of signs. They emphasized need for more sophisticated studies that utilize a holistic, integrative approach to interpretation. These researchers also discuss the existence of significant age, race, and culturally related differences in KFD performance and stresses the need for more detailed normative data in these areas. These authors go on to state that 'the KFD technique has not been subjected to adequate critical research and evaluation'. '[T]he KFD still remains primarily a clinical instrument with inadequate norms and questionable validity (Shapse, 2007).

Despite the criticisms and shortcomings of the KFD, its use, together with the Draw-A-Person Test, is advocated by various researchers such as Potgieter (1987), Groth-Marnat (1997), Reynolds (1998), Kline (1999) and Vass (2002), especially within the South African context.

7.5.6 Draw a Person Test (DAP)

The Draw a Person Test is a psychological projective technique used for the assessment of the self perception of children and adolescents (Goodenough, 1926).

Developed originally by Florence Goodenough in 1926, this test was first known as the Goodenough Draw a Person Test. The use of this test is explained in her book, *Measurement of intelligence by drawings*. Harris (1963) later revised and extended the test and it is now known as the Goodenough-Harris Drawing Test. According to Chapman & Chapman (1969) and Jaynes, (2000), the test is 'routinely administered as an indicator of schizophrenia', and that, while not all schizophrenic patients have trouble drawing a person, when they do, there is clear evidence of a disorder which might manifest in signs such as a patient's neglect to include 'obvious anatomical parts like hands and eyes', with 'blurred and unconnected lines', ambiguous sexuality and general distortion. There has been no validation of this test as an indication of schizophrenia and Chapman and Chapman (1969), in a classic study of illusory correlation, argued that in the scoring manual indicators of paranoia, such as large eyes may have been generated from the naive beliefs of undergraduates.

Test administration involves the administrator requesting children to make three individual drawings that of a man, a woman and the self, on three separate sheets of paper. No further instructions are given and the child is free to make the drawings in whichever way he/she would like. There is no right or wrong type of drawing, although the child must make a drawing of a whole person each time with a head, body, upper and lower limbs. The test has no time limit however, children rarely take longer than about 10 or 15 minutes to complete all three drawings. Harris (1963) provides scoring scales which are used to examine and score the child's drawings. The test is completely non-invasive and non-threatening to children – which is part of its appeal (Williams, Wiener & MacMillan, 2005).

The use of a non-verbal, non-threatening task to evaluate children is intended to eliminate possible sources of bias by reducing variables like primary language, verbal

skills, communication disabilities and sensitivity to working under pressure. However, test results can be influenced by previous drawing experience, a factor that may account for the tendency of middle-class children to score higher on this test than lower-class children, who often have fewer opportunities to draw. To assess the testee for emotional problems, the administrator uses the Draw-a-Person Screening Procedure for Emotional Disturbance (SPED) to score the drawings. This system comprises of two criteria for evaluation. For the first type, eight dimensions of each drawing are evaluated against the norms for the child's age group. For the second type, 47 different items are considered for each drawing.

The purpose of the test is to assist professionals in inferring children's cognitive development levels with little or no influence of other factors such as language barriers or special needs. Any other uses of the test are merely projective and are not endorsed by Harris (Ter Laack, de Goede & Aleva, 2005). The KFD and the DAP are widely used by forensic psychologists during custody evaluations of children (Genis, 2008; Skeem, Douglas & Lilienfeld, 2009).

As with the KFD, one has to caution against using the DAP on its own with its limited normative base, empirical research, validity and reliability (Shapse, 2007), but these projective drawings are still widely used in the clinical community.

Another well-known test used for children assessments is the Bene-Anthony Family Relations Test which will be discussed below.

7.5.7 Bene Anthony Family Relations Test

The Bene-Anthony Test (also known as the Family Relations Test) is used by psychologists who work with children to explore their emotional attitudes towards their family. It consists of a set of boxes, each with a slot at the top, on the front of which is a picture that represents a member of the family. A number of cards contain statements which detail positive and negative attitudes towards family members. The child is presented with the cards and places them in the slot of the appropriate family member.

When the cards have all been dealt with, it is possible to sum up the cards for each person and to draw up a graph comprising four areas. Any scores which vary from the expected set can be seen at a glance. The questions attempt to ascertain how the child believes others in the family feel about him/her, as well as how the child feels about the other members of the family (incoming and outgoing feelings). Both of these may have positive and negative valence (Geddis, Turner & Eardley, 1977; Parkin, 2001).

The test consists of a series of cardboard figures representing people of various ages, from grandparents to a baby in a pram. The child selects figures to represent the important persons in his/her emotional life. A series of positive and negative statements are read to the child, who can 'mail' them into a box representing any figure the statement fits (Geddis, Turner & Eardley, 1977; Parkin, 2001).

According to Lund (1983), Parkin (2001), Lund, Garcia and Stachan (2010), this test is also very useful and an aid to evaluating children's feelings in divorced family conflict. The Bene-Anthony Family Relations Test is not standardised for the South African context but literature indicates that it is a valuable instrument in evaluating children, especially in the divorce context. This test is part of the Professional Board for Psychology's list of 'approved' tests for use within South African contexts (HPCSA, 2003).

Another test which is often used in assessing children is the Duess Test.

7.5.8 Duess Test

Düss developed the Duess Test in 1940. This test is a projective test for young children. It consists of ten short, incomplete stories which children must complete. The test was revised by Düss (1946) and is described as indispensable for the correct understanding of some children. With its help one could sometimes unearth subtle psychological

factors not revealed by other methods (Düss, 1946; Tognazzo, Zanettin & Ongaro, 1975).

After the stories have been told to the child, he/she is asked what the end of the story might be. In this way, the child can complete the story in any way he/she likes. The test should not be applied rigidly and should not be scored like a test. One could modify the original stories and could even add new ones to adapt them to the original case. The Dues Test is often an interesting starting-point for further talks with a child (Tognazzo, Zanettin & Ongaro, 1975).

The Dues Test can be administered only to young children and the cut off age is 11 years. It is expected of the child to project him-/herself into the story and identify his/her own situation with that in the fable. In this way emotional complexes may be elicited, but, as with other tests, one should be careful not to view the child as if he/she were an adult neurotic, or read too much abnormality into the responses.

Examples of the fables are:

FABLE 1

“A father bird and a mother bird and their little baby bird are asleep in their nest on the branch of a tree. Suddenly there is a big storm . It breaks the branch of the tree and the nest falls to the ground. The father bird quickly flies to one tree, the mother bird to another tree. What will the baby bird do? He knows how to fly a little”.

Düss (1946), Miller and Veltkamp (1986) as well as Hodges (1991) suggest the usefulness of fables in assessing children whose parents are involved in the process of custody allocation.

7.6 Clinical Instruments Used To Determine Family Health

7.6.1 Family Assessment Device (FAD)

The FAD (Appendix D) was developed by Epstein, Baldwin and Bishop (1983). It is a 60-item questionnaire, designed to evaluate family functioning according to the McMaster Model. This model describes structural, occupational and transactional properties of families and identifies six dimensions of family functioning:

- (i) Affective responsiveness;*
- (ii) Affective involvement;*
- (iii) Roles;*
- (iv) Problem-solving;*
- (v) Communication;*
- (vi) General functioning;*
- (vii) Behaviour control.*

'Affective responsiveness' and 'Affective involvement' measure whether or not family members show tenderness, concern and affection for one another; that is, nurturance. Examples of items in these subscales include 'We express tenderness' and 'We cry openly' (Epstein et al., 1983; Sells, 2004).

The FAD 'Roles' subscale focuses on whether the family has a clear set of rules and consequences, whether parents clearly assign roles and tasks to the children clarifying roles and hierarchy and whether parents are able to maintain and accept a position of authority (Epstein et al, 1983). Examples of these items include, '*We discuss who is to do the chores in the house*', '*We make sure members take the family responsibilities*'.

Epstein et al., (1983), report that the FAD 'Problem-solving' subscale evaluates a family's ability to identify relevant and appropriate problems which threaten the cohesion in the family. Examples of items include, 'We resolve most everyday problems around the house' and 'We usually act on our decisions regarding problems' (Epstein et al., 1983).

Sells (2004), reports that the 'Communication' subscale defines the quality of exchange of information among family members. The focus is on whether or not verbal messages are clear in content and direct in the sense that the person spoken to, is the person for whom the message is intended. Examples of items in this subscale include, 'We are frank with each other' and 'We come right out and say what we think without hinting'.

The FAD 'General functioning' subscale as referred to by Epstein at al., (1983) measures the overall health or pathology of a family. Examples of items in this subscale include, 'We don't get along well together', 'We cannot talk to one another about the sadness we feel'.

Sells (2004), states that the 'Behaviour control' subscale measures how effective parents are in controlling problem behaviour and setting up rules and consequences. Examples of items in this subscale include, '*We have rules about hitting people*', and '*We have parents who control behaviour problems*'.

The FAD responses are scored using a 4 point scale coded as follows:

- | | |
|-------------------------------|-----|
| (i) <i>Strongly agree</i> | = 1 |
| (ii) <i>Agree</i> | = 2 |
| (iii) <i>Disagree</i> | = 3 |
| (iv) <i>Strongly disagree</i> | = 4 |

7.6.1.1 Reliability and Validity Studies

The FAD has been used previously in South Africa in other related studies (Lewis, 1996; Evans, 1997; van Breda, 1997). The FAD's reliability, according to Fischer and Corcoran (2000), demonstrates a fairly good internal consistency with alphas for the subscale ranging from .72 to .92. Regarding validity, Fischer and Corcoran (2000) suggest that the FAD demonstrates good, concurrent and predictive validity.

Family adjustment was evaluated by means of the index of family relations which is discussed next.

7.6.2 Index of Family Relations (IFR)

The IFR (Appendix E) was developed by Fischer and Corcoran (2000). It assesses the severity or magnitude of family problems sprouting from personal and social dysfunction in the area of family adjustment. The IFR characterises the severity of family relationship problems in a global manner and it could thus be regarded as a measure of intra-familial stress (Hudson & Acklin, 1980; Grief & DeMarris, 1989; Hamilton & Orme, 1990).

Grief and DeMarris (1989) and Hamilton and Orme (1990) state that the IFR is used at intake for screening, initial problem-assessment and service or experimental planning, as well as at intervals during intervention to monitor progress and for programme evaluation. The IFR can be used in individual and familyfocussed clinical settings and intervention programmes (Hudson & Acklin, 1980; Corcoran & Fischer (2000).

The IFR is also used as a measure of a person's family environment and can be used to help the person deal with problems in relating to the family as a whole. (Hudson &

Acklin, 1980; Grief, & DeMarris, 1989; Hamilton & Orme, 1990; Corcoran & Fischer (2000).

The IFR is a 25-item scale designed to measure the extent, severity or magnitude of problems that family members have in their relationships with one another. The reading level for the IFR is Grade 5 or higher. The testee responds to all items on the test by selecting one response from a 7-point scale which are the following:

- (i) 1 = None of the time
- (ii) 2 = Very rarely
- (iii) 3 = A little of the time
- (iv) 4 = Some of the time
- (v) 5 = A good part of the time
- (vi) 6 = Most of the time
- (vii) 7 = All of the time

Examples from the IFR are: *'I can really depend on my family.'* *'Members of my family argue too much.'* *'Other families seem to get along better than ours.'* *'I feel left out of my family.'*

Scoring of the IFR produces a score ranging from 0 to 100. A low score indicates the relative absence of the problem being measured and a higher score indicates the presence of a more severe problem. The cutting score of 30 is the score at which clients may have a clinically significant problem. Scores above 70 may indicate severe stress or the possibility of violence. IFR scores should always be considered in relation to all other client data and information.

The IFR has been used previously within the South African context (van Leeuwen, 1990).

7.6.2.1 Reliability and Validity Studies

The reliability of the IFR has a mean alpha of .95, indicating excellent internal consistency, and an excellent (low) Standard Error of Measurement of 3.65. The validity of the IFR has good construct validity, correlating poorly with measures with which it should not correlate, and correlating well with measures with which it should correlate (Fischer & Corcoran, 2000).

The importance of parental report is also an important part of family effectiveness which was assessed by means of the Eyberg Child Behaviour Inventory.

7.6.3 Eyberg Child Behaviour Inventory (ECBI)

The ECBI was developed by Eyberg (1999) and designed to assess parental report of conduct and behavioural problems in children and adolescents ages 2-16. The ECBI (Appendix F) measures the number of difficult-behaviour problems and the frequency with which they occur (Eyberg & Pincus, 1999).

According to Boggs, Eyberg, & Reynolds (1990) and Achenbach (1991), the ECBI is one of the most widely used parenting-rating scales and measures a wide range of problem behaviour traits, including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying. The instrument takes five minutes to complete and five minutes to score. It is a 36-item instrument designed to measure conduct-problem behaviour in children and adolescents. Each behaviour trait is rated on two scales: A seven-point Intensity scale assesses how often the behaviour currently occur in the home or school setting (1 means 'never', 4 means 'sometimes', and 7 means 'always') and a problem scale (Yes/No) identifies whether the child's behaviour is problematic for the parent or teacher (Eyberg & Pincus, 1999; Fischer & Corcoran, 2000).

7.6.3.1 Reliability and Validity Studies

Studies have indicated that the ECBI has good reliability and validity (Boggs, Eyberg & Reynolds, 1990; Eyberg & Pincus, 1999). The reliability of the ECBI, according to Fischer and Corcoran (2000), is high and the internal consistency excellent, with an alpha of .93 for intensity and .91 for problems. Furthermore, it has good concurrent and known-group validity, which correlates significantly with independent observations of children's behaviour, temperamental characteristics of the child. It also distinguishes conduct-disordered children from non-clinical children (Boggs, Eyberg, & Reynolds 1990; Phala, 1997; Fischer & Corcoran, 2000). The ECBI has also been used previously within the South African context (Lategan, 1991).

General self esteem of the child is effectively measured with the Rosenberg Self-Esteem Scale.

7.6.4 The Rosenberg Self-Esteem Scale (RSE)

The RSE (Appendix G) was developed by Morris Rosenberg in 1965. This scale attempts to achieve a uni-dimensional measure of global self-esteem (Sekhute, 1994). It was designed using a Guttman scale, which means that the items were to represent a continuum of self-worth statements ranging from statements that are endorsed even by individuals with low self-esteem, to statements that are endorsed only by persons with high self-esteem.

Rosenberg (1965) scored his 10-question scale used a 4 response coding scale, namely:

(i) *Strongly agree* = 1

- (ii) *Agree* = 2
- (iii) *Disagree* = 3
- (iv) *Strongly disagree* = 4

The first item included questions 1 through to 3 and received a positive score if two or three of its questions were answered positively. Questions 4 and 5 and questions 9 and 10 were aggregated into two other items that were scored positively. If both questions in the item had positive answers. Questions 6 through 8 counted individually, formed the final three items. For the negatively worded RSE questions, responses that expressed disagreement and, were hence consistent with high self-esteem, were considered positive or endorsed (Rosenberg, 1965; Robinson, Shaver & Wrightsman, 1999).

Since its development, the scale has been used with a wide variety of groups and one of its greatest strengths is the amount of research that has been conducted on it. Rosenberg (1965) demonstrated that his scale was a Guttman scale by obtaining high enough reproducibility and scalability coefficients. Multiple studies have been conducted to investigate the validity and reliability of the RSE (Sekhute, 1994; Grobler, 1998; Fischer & Corcoran, 2000; Schmitt & Allik, 2005).

7.6.4.1 Reliability and Validity Studies

The RSE has been used previously within the South African context (Grobler, 1998; Sekhute, 1994). Robinson, Shaver and Wrightsman (1999), Schmitt and Allik (2005), and Martín-Albo, Núñez, Navarro and Grijalvo (2007) point out that this scale has a reliability according to the Guttman scale coefficient of reproductability of .92, indicating excellent internal consistency. According to Fischer and Corcoran (2000), the RSE demonstrates excellent construct, concurrent, predictive and known-group validity. It

correlates significantly with other measures of self-esteem and it also correlates in predicted directions with measures of depression and anxiety.

7.7 Conclusion

The tests and instruments applied in this study were discussed in this chapter including their strengths and weaknesses.

The next chapter will deal with the research design and method utilised in the present study.

CHAPTER 8

RESEARCH METHODS

8.1 Introduction

Having reviewed the literature on divorce and the current legal concepts involved in child custody, this chapter describes the methodology for the two studies.

Each of the two studies will be dealt with separately.

8.2 Phenomenology as a Research Method

For the first phase of the study phenomenological research was applied. Phenomenological enquiry has increasingly become popular in recent years, however it is still one of the most philosophically and theoretically complex research traditions, many aspects of which remain poorly understood (Wilding & Whiteford, 2005). It began as a philosophical movement in the work of Brentano whose seminars were attended by Freud and Husserl, and was later expanded and transformed in various directions by pioneers of philosophy such as Heidegger, Sarte, Merleau-Ponty, and numerous other thinkers (Chessick, 2002).

Phenomenology comes from the Greek words *phaimomenon* and *logos* and it means “the study of human experience and the way in which things are perceived as they appear to consciousness” (Langdrige, 2007, p.10). Phenomenology is used to study and learn about phenomena that are difficult to observe or measure (Wilding & Whiteford, 2005). Phenomenology, as Chessick (2002, p.1) propose, attempts to capture the intrinsic nature of one’s experience exactly as it occurs to a person and without any exaggeration, explanation, extrapolation, interpretation, interference, or attribution to any theory, for example what it feels like to experience dizziness, grief, hunger or pain.

Phenomenological inquiry focuses on what people experience and how they interpret the world (Patton, 1990). Phenomenologists focus on how people put together the phenomena they experience in such a way as to make sense of the world, and in so doing, develop the world view (Patton, 1990). The purpose of a phenomenological research is to produce a clear, precise and systematic description of the meaning that constitutes the activity of consciousness (Berelson, 1952; Valle, King & Halling, 1989). According to Valle et al., (1989), phenomenological research provides a deeper and clearer understanding of what a phenomenological description different from other kinds of descriptions is that phenomenological descriptions aim at explaining lived experience (Van Manen, 1997). According to Van Manen (1997), a good phenomenological description is an adequate clarification of some aspects of the live world. Phenomenology embraces a post-positivism stance which asserts that there can be no all-embracing explanation or generalisation about experience and that research can only describe and every description should be regarded as valid (Neuman, 2000).

A newer review of phenomenology suggests that phenomenology is not a philosophical system, but rather a practise that attempts to get at the truth of matters (Moran, 2000). In Husserl's words it is an attempt to direct attention to the things themselves, to revive our contact with the actual lived world and the living subjects (Chessick, 2002).

The phenomena with which psychology is concerned are ideas or acts of conceiving. This, according to Luijpen, (1996) implies that every psychological phenomenon is characterised by intentional existence of an object or a tendency toward an object. This thinking brought about the notion of intentionality which is too often cited as the main discovery of phenomenology (Kockelmans, 1967). Every psychic act is intentional in the sense that it is directed towards an object. The intentional object is described as always imminent, it is something unreal or insubstantial, though it may be said to exist, it exists in itself to the extent that the thinker has it as his intentional object (Chessick, 2002). Intentionality involves a pair of correlates of which one is real and the other is

not real, for example: seeing and what is seen, presenting and what is presented, loving and what is loved, willing and what is willed (Langdrige, 2007).

The discussion that follows is about the key concepts in phenomenology and these include: intentionality, what is experienced (*noema*) and the way it is experienced (*noesis*), *epoche*, phenomenological reduction, imaginative variation, and essences.

The focus of intentionality is according to Langdrige (2007), in the way consciousness is turned out on to the world as it intentionally relates to objects in the world. It is this consciousness of the world or the relationship between a person's consciousness and the world that is the object of study for phenomenological psychologists (Langdrige, 2007), Moustakas (1994), asserts that knowledge of intentionality requires that we be present to ourselves and to things in the world and we should also recognise that the self and the world are inseparable components of meaning. Kockelmans (in Moustakas, 1994, p.29) points out that "consciousness in itself cannot be anything other than openness, directedness to other, in this way consciousness appears to be not pure interiority, but should be understood as a going-out of itself".

According to Langdrige (2007), phenomenological psychology does not concern itself with understanding cognitions or looking inside people to try and understand what is happening inside their heads as it is done in traditional mainstream psychology. Instead, the intentional correlation lead to a focus on the experiences of things in their appearance and the way in which they appear to us as we focus our attention on them in consciousness. Every intentionality is therefore comprised of *noema* (what is experienced) and the *noesis* (the way it is experienced) (Moustakas, 1994). The *epoche*, also called bracketing, is the Greek word used by Husserl, which means the processes by which we attempt to abstain from our presuppositions that we have about what we are investigating (Langdrige, 2007). It is an act through which it becomes possible to stand aside from one's subjective experience and world view to more objectively understand a given phenomenon (Wilding & Whiteford, 2005). In the *epoche*, our prejudgements, biases, and preconceived ideas about things are set aside

(Valle et al., 1989). In *epoche*, all commitments with reference to previous knowledge and experience are invalidated, inhibited and disqualified (Schmitt, 1996).

Wilding and Whiteford (2005), mention that within phenomenology, as with other qualitative approaches, there is no methodological tenet. Instead, the data itself should guide the nature and form of the study for the researcher. This reflective and holistic stance, as Wilding and Whiteford (2005) put it, allows the words of the research participants to speak for themselves, thus providing the best possible basis for new understanding to emerge. By allowing the data to speak for itself, the researcher becomes a naïve inquirer to the process of research (Wilding & Whiteford, 2005). Husserl (in Langdrige, 2007), argued that human existence was characterised by a natural attitude which is our basic way of experiencing the world with assumptions in operation. According to Husserl, in this natural way there is no time to critically examine our experience but instead we simply get on with life and live it through the natural attitude (Valle et al., 1989).

This natural attitude tends to also be used by the researchers, particularly mainstream psychology researchers, who simply adopt quantitative methods and little critical awareness of the way in which this will simply present experience through the natural attitude rather than revealing what is hidden beyond the natural attitude. Application of phenomenological method seeks that we understand the assumptions at play in a persons' lived experience (Langdrige, 2007). The aim of *epoche* therefore is to enable the researcher to describe the things themselves and attempt to set aside natural attitude or assumptions we have about the world. *Epoche* is what makes a distinction between Husserlain and Heideggerian phenomenology. Although Husserl suggested a process of *epoche* or bracketing, Heidegger maintained that such a 'transcendental' act is not possible (Wilding & Whiteford, 2005). Heideggerian phenomenology suggests that we acknowledge and place on the foreground our own particular horizon of understanding in approaching phenomena. Heideggerian phenomenology acknowledges that researchers bring pre-understandings to their work and although attempts are made to identify these, to put them aside to see research phenomenon in

fresh eyes, there is an understanding that they are actually never transcended (Wilding & Whiteford, 2005). Such subjectivity should not be seen as an indicator of poor research, but 'pre understandings' should be celebrated because they enable rather than constrain the researcher (Hasselkus, 1997).

8.2.1 Phenomenological Reduction

The process of bracketing and re-bracketing is the manner in which one moves from the natural attitude towards the transcendental attitude. This process of adopting the transcendental attitude is called 'reduction' (Valle et al., 1994). Phenomenological reduction continues the process started with the *epoche*' (Langridge, 2007). It is called 'reduction' because it literally reduces the world as it is considered in the natural relative to the world of pure phenomena. In the reduction one does not deny the existence of the natural world, but rather one puts in abeyance one's belief that the world is independent of each individual person (Valle et al., 1994).

Schmitt (1996), mentions that ultimately, through this process of phenomenological reduction, we derive a textural description of meanings and essences of phenomena, the constituents that comprise the experience in the consciousness from the vantage point of an open self.

For the purpose of translating the formulations obtained from Justice King's principle of *the best interest of the child* a phenomenological approach incorporating the key concepts of description, reduction, equalisation as previously explained in the study. Using the emic perspective means refraining from imposing the researcher's beliefs on the data.

8.3 Justification of this study

As indicated earlier in the study the variables defining the *best interests of the child* have only been stipulated from a legal perspective. It is, however, evident that these constructs have yet to be translated from a legal perspective to a psychological perspective in order for them to be utilised by a psychologist in an attempt to assist the Court.

This will necessitate a careful analysis of the constructs, from a psychological perspective. Literature clearly indicates the no sovereign assessment procedure exists in primary care placement of children during a divorce process. One of the objectives of the present study is to establish an optimal psychological assessment procedure for determining primary care and residential placement of children in a divorce dispute.

8.4 Research Context and Setting

This research is set within the context of the divorce of the parents where a family forms part of a process whereby the court has to decide which parent is the most effective custodial parent. The effect of divorce is undoubtedly a difficult transition for the child in the middle of the emotional battle. Numerous studies have shown that the effects of divorce on children alter the psychological mindset of a youth. The typical reasons for such alterations revolve around the fear of change, a fear of abandonment and the possibility of losing attachment to a parent (Lund, 1983 & Mudie, 1987; Denzin, & Lincoln, 2005).

The research setting of this study was conducted at the researcher's offices in Centurion, Gauteng, South Africa where a review of the parent's abilities and histories were done to determine which parent is best suited to care for the child. Although *the*

best interests of the child are paramount in this evaluation, the review of a parent's ability to care for their child is often enshrouded in emotional squabbles and debilitating circumstances.

8.5 Pilot Study

8.5.1 Aim of the Pilot Study

The first aim was to ensure that the instructions on the document entitled "*13 Statements of the Best Interest Principle based on Justice King's Legal Constructs and a list of Family health Instruments*" are clear and the essence of the 13 legal statements are not diluted, but carry the same meaning.

The second aim was also to identify suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in a system, is functioning, i.e. the psychological health of a particular family system.

8.5.2 Recruitment of participants

The document was given to three psychologists who are not on the register at the Office of the Family Advocate, but who had experience with custody evaluations.

8.5.3 Procedure

The three psychologists' role was to indicate if they understood the instructions and indicate if the 13 statements were confusing or lacked clarity. If so they were requested to point out exactly the problem areas.

In addition to the three psychologists an advocate of the Pretoria Bar was also used as a participant whose role was to assess if the instructions in the document are clear and the legal constructs are carried through as proposed by Justice King.

8.5.3.1 *Assessing Equivalence*

The results from the three psychologists suggested that the language used for the instructions was simple and straight forward and the requirements were easy to follow. An advocate from the Pretoria Bar, who also worked as an ad hoc family advocate, served as an “external judge” to ensure that the instructions and legal constructs contained in the document entitled “*13 Statements of the Best Interest Principle based on Justice King’s Legal Constructs and a list of Family health Instruments*” were adequately communicated. The advocate together with the researcher agreed that the level of agreement between the three psychologists and the independent advocate should be at least 80% or greater.

8.5.4 **Analysis of data**

The procedural steps used were as follows:

- (a) The three participants read the instruction.
- (b) All the statements were read one at a time.
- (c) The statements that were not clear were highlighted.
- (d) Meanings were formulated spelling out the approximate meaning of each statement, but this did not depart from the original meaning.
- (e) After the meanings were identified independently by each of the participants a meeting was held to discuss the findings and to compare the findings.
- (f) Any discrepancies found necessitated going back to the original description by justice King in order to validate the meaning.

- (g) This was done to see if there was anything that was not accounted for.
- (h) A re-examination was done for aspects that were not accounted for.
- (i) To verify the meaningfulness and accuracy the advocate then rechecked the document to see if it does not depart from the legal meaning put forward by Justice King.

8.5.5 Results of the Pilot Study

After all of the statements were revised as stipulated above using Collaizzi's (1978) principles the three psychologists and the advocate indicated that there was agreement with regard to the clarity of the instructions. However it was suggested that the instructions should be put in the present tense rather than in the past.

The adaptations to the document were made taking into consideration the comments from both the three psychologists and the advocate. For further clarity on the instructions the assistance of a language editor was utilized who has experience in editing research documents and also has a background in psychology.

The results from the three psychologists and advocate were triangulated. *Triangulation* requires that research should find convergence among sources. Different sources of information were triangulated by examining evidence from sources and using it to build a coherent justification for themes.

The revised document was then presented to both the three psychologists and the advocate for their final consideration. The agreement between the psychologist and the advocate was 80%.

The final agreement on the directions read as follows:

“In the following statements you will be presented with various legal concepts describing the “Best Interests of a Child” as identified by Justice King. Your task is to please define and explain each numbered statement from a psychological point of view and to identify a possible procedure (psychometric or clinical) that would be suitable to evaluate this statement based on your experience. Lastly please list 8 (eight) suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in this system, is functioning, i.e. the psychological health of a particular family system”.

8.5.6 Conclusion

Based on the 80% level of agreement between the three psychologists and the advocate the instructions appear to be clear and acceptable.

8.6 Study 1

8.6.1 Research methods for Study 1: The Translation of Justice King’s Legal Statements to Psychological Constructs

The qualitative approach was utilized for the purposes of this study, due to paucity of psychological research, in the area of *the best interests of the child* and the legal constructs embedded in Justice King’s guidelines on divorce. It is difficult to quantify the *best interest of the child* therefore a qualitative approach seems to be the best method of enquiry.

The aim of this study is to translate of the 13 legal statements set out by The Honourable Mr Justice King for the allocation of custody in divorce cases. The aim was also to identify suitable psychometric instruments that may be used to determine how

effectively a particular family, as well as the children are functioning, namely the psychological health of a particular family.

8.7 Research Questions

The research questions are summarised as follows:

- How can the legally defined *best interests of the child* be translated into psychological constructs?
- What psychometric tests and/or clinical procedures can be used to evaluate these constructs to develop an assessment procedure which serves as the basis for making recommendations for primary care and residential placement?
- What psychometric instruments can be used to determine how effectively a particular family, as well as the children are functioning?

8.8 Research Design for Study 1

8.8.1 Aims of the Study

- a) To translate the 13 legal statements of Justice King into psychological constructs which will assist in the assessment of children and adults in cases of divorce in order to determine the suitability of the parents for custody purposes.
- b) To identify the available psychometric tests and clinical procedures that may assist in the evaluation of parents and children for primary residence placement.
- c) To identify suitable psychometric instruments that can be used to determine how effectively a particular family, as well as the children are functioning.

8.8.2 Recruitment of Participants

The researcher phoned the manager of the Family Advocate's Office in Pretoria introducing himself as a doctoral student in psychology currently interested in conducting research with the aim to translate the 13 statements defining *the best interests of the child* according to Justice King into psychological constructs. Furthermore the researcher would like to identify available psychometric tests and clinical procedures which may probably assist in the evaluation of both parents and children for primary residence placement.

Thereafter, the researcher made an appointment with the office manager at the Office of the Family Advocate in Pretoria and made a request to provide names of clinical psychologists involved in custody evaluations. The aims of the study were explained as set above.

Based on the explanation of the study as mentioned previously the office manager felt that the study was of importance within the context of divorce and allowed the researcher to have access to names and contact details of psychologists who are currently used by the courts for custody evaluations. The manager provided a list with the names of social workers and psychologists. The researcher chose the six psychologists whose names appeared on the list as possible participants. They were telephonically invited to participate in the study. The aims of the study were explained to them.

Thereafter a consent form was sent to the six psychologists together with the aims of the study (Appendix A & B). After the submission of the consent form by three psychologists the researcher forwarded them with the document entitled, "*13 Statements of the Best Interest Principles based on Justice King's Legal Constructs and a list of Family Health Instruments*" (Appendix C).

The number of psychologists selected for the study was based on availability however if saturation of data is not reached a possibility exist for recruiting more psychologists with experience from other sources if available.

8.8.3 Selection Criteria

- a) Each psychologist should have at least 8 to 10 years' experience as a clinical psychologist;
- b) Have at least five years' experience within the context of child custody evaluations. Participants need to describe the processes for psychological assessment including the tests and clinical procedures based on their experience with the requested instruments;
- c) Be proficient in both English and Afrikaans;
- d) Participate voluntarily in the study.

8.8.4 Procedure for Study 1

Study 1 focused on a qualitative translation of 13 identified legal constructs as set out by The Honourable Mr Justice King for the allocation of custody in divorce cases as well as identifying suitable psychometric instruments that can be used to determine how effectively a particular family, as well as the children are functioning.

8.8.4.1 Materials

The document entitled “13 *Statements of the Best Interest Principles based on Justice King’s Legal Constructs and a list of Family Health Instruments*” (Annexure C) was handed to the three identified psychologists personally by hand. They were not given instructions as the instructions were reported on the document.

The experience of the participants served as the material for the identification of psychometric tests and clinical procedures which could be used in custody evaluations.

8.8.4.2 Translation of the document entitled “13 Statements of the Best Interest Principles based on Justice King’s Legal Constructs and a list of Family Health Instruments”

The three psychologists had to translate each of the legal statements individually. They were fully briefed on the aims of the study. They were requested to analyse each item with reference to the suitability of the language used by Justice King. If not suitable, to substitute the legal language with appropriate psychological language or constructs. Thereafter they were requested to recommend suitable psychological tests for both adults and children including psychometric and clinical procedures which could be used to capture the construct of *the best interests of the child* requirements. The selected psychometric tests should have standardised norms locally or internationally and be popular in the clinical community.

On completion of the task, they were requested to send back the completed document to the researcher.

8.8.4.3 Participants

The first psychologist had 23 years’ experience as a clinical psychologist and 10 years’ experience within the context of child custody evaluations. The second psychologist had 17 years’ experience as a clinical psychologist and 11 years’ experience within the context of child custody evaluations and the third psychologist had 9 years’ experience as a clinical psychologist with 8 years’ experience within the context of child custody evaluations.

8.8.5 Analysis of Data

For the purpose of this study, the structured method devised by Colaizzi (1978) was used. Spinelli (2005) mentions that even though this method provides an approach he believes to be containing the key methodological characteristics of phenomenological research in general, he stresses the importance of noting that there exists no one phenomenological means to enquiry.

Spinelli (2005) writes, that an assumption of a method is a fallacy and he asserts that each phenomenological researcher employs unique descriptive approaches derived from phenomenological methods. Again Colaizzi argues, “each particular psychological phenomenon, in conjunction with the particular aims and objectives of a particular researcher, evokes a particular descriptive method” (In Spinelli, 2005, p.136). The researcher felt comfortable with Paul Colaizzi’s method of data analysis as outlined by Spinelli (2005).

The procedural steps were as follows.

- a) *Step 1: Reading the translated legal statements* - The researcher photocopied all the scripts from the three psychologists. The documents were then carefully read and re-read in order for the researcher to acquaint himself with them. *The rule of description* was applied at this stage. The rule of description urges the researcher to remain initially focused on the immediate and concrete impressions and to maintain a level of analysis with regard to these experiences which takes descriptions rather than theoretical explanations or speculations as its point of focus. The researcher read through the scripts one at a time. The “*translation*” of the relevant legal constructs into psychological constructs were carefully documented, compared and integrated by the researcher.
- b) *Step 2: Extracting significant statements*: In this step the researcher returned to each individual document and extracted phrases or sentences using a highlighter. Several transcriptions contained meaningfully similar statements, and

such repetitions were eliminated. Statements that contained particular specifics were transposed to more general statements. Unique statements that appeared nowhere in the researcher's transcribed descriptions were not excluded but they were included in the list and were presented in the final statement. This is in accordance with the rule of horizontalization or the equalisation rule. This rule urged the researcher to avoid placing any initial hierarchies of significance or importance upon items of his descriptions, instead to treat each item as having equal value. This rule therefore, enabled the researcher to examine translations with far less prejudice and with much degree of adequacy.

- c) *Step 3: Formulating meanings:* Here, the researcher extracted the meanings contained in each significant statement. This movement from what is said to what is meant, is according to Spinelli (2005), the most unsafe interpretive part of the phenomenological research process and requires the researcher's creative insight to both remain true to the participant's statements while at the same time seeking to draw out of its embedded, often implicit meaning.
- d) *Step 4: Exhaustive descriptions and formulation of statements:* In this step, all of the formulated meanings were integrated so that an exhaustive description of the investigated phenomenon and a clear a statement of identification of its formal structure could be generated.

The various psychometric instruments and/or clinical procedures suggested by the three psychologists were compared and those instruments and/or procedures, in respect of which all three clinicians were 80% or higher in agreement, were utilised to form an assessment battery.

To verify the accuracy of the themes, psychometric instruments and/or clinical procedures, the researcher had a meeting with two senior clinical psychologists who specialize in forensic psychology and each construct and correlated theme together with the suggested psychometric instruments and/or clinical procedures were discussed. An average percentage of agreement of 80% or greater was deemed necessary for each theme, psychometric instruments and/or clinical procedure to be accepted.

Following the above, the researcher then created an assessment procedure (a battery of tests and clinical procedures) to form the basis for custody recommendations. The newly formulated assessment procedure was then used to evaluate the families in the sample and to make recommendations regarding their custody and primary residency.

As reported above, the three psychologists were also requested to identify suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in this system, is functioning. The researcher also created an assessment procedure (a battery of tests and clinical procedures) to form the basis for determining how effectively a particular family system is functioning. This newly constructed assessment procedure was then used in Study 2 to quantitatively compare the families in an experimental and control group design.

8.9 Research Methods for Study 2 – Quantitatively Comparing The Experimental And Control Group

Quantitative research and investigation of the world have existed since individuals first started recording events or objects that had been counted. In the social sciences, quantitative research refers to the systematic empirical investigation of quantitative properties and phenomena and their relationships. The objective of quantitative research is to develop and employ mathematical models, theories and/or hypothesis pertaining to statistical phenomena (Neumann, 2006).

The process of measurement is central to quantitative research because it provides the fundamental connection between empirical observation and mathematical communication of quantitative relationships (Kuhn, 1961, Firebaugh, 2008; Hunter & Leahey, 2008).

8.9.1 Quasi-Experimental Research Design

A quasi-experiment research design is applied in this study. This necessitates the researcher to give an explanation of the method. This is a method of measure used to estimate the causal impact of an intervention on its target population. Quasi-experimental research designs share many similarities with the traditional experimental design or randomized controlled trial, but they specifically lack the element of random assignment to treatment or control. Instead, quasi-experimental designs typically allow the researcher to control the assignment to the treatment condition, but using some criterion other than random assignment (e.g., an eligibility cutoff mark). In some cases, the researcher may have no control over assignment to treatment condition (Neumann, 2000, 2006).

Quasi-experiments are subject to concerns regarding internal validity, because the treatment and control groups may not be comparable at baseline. With random assignment study participants have the same chance of being assigned to the intervention group or the comparison group. As a result, differences between groups on both observed and unobserved characteristics would be due to chance, rather than to a systematic factor related to treatment (e.g., illness severity). Randomization itself does not guarantee that groups will be equivalent at baseline. Any change in characteristics post-intervention is likely attributable to the intervention. With quasi-experimental studies, it may not be possible to convincingly demonstrate a causal link between the treatment condition and observed outcomes (Jones, Langrall, Thornton, & Nisbet, 2002).

The prefix “quasi” means, in essence, “sort of.” So a quasi-experiment is a “sort of” experiment. Specifically, a quasi-experiment is a study that includes a manipulated

independent variable but lacks important controls (e.g., random assignment), or a study that lacks a manipulated independent variable but includes important controls (Jones, et al., 2002; Neumann, 2006).

8.9.2 Research Questions

The research question for Study 2 is as follows:

- How are the two groups (experimental and control) functioning in terms of their psychological health six months after the initial assessment?

8.10 Research Design for Study 2

8.10.1 Aim of the Study

The aim of the study is to determine the psychological health of parents and children who have undergone the initial assessment with regard to primary custodial placement six months later.

8.10.2 Hypothesis

There are two hypotheses of the study namely, the primary and the secondary hypothesis.

8.10.2.1 Primary Hypothesis

Children placed in primary custody on the basis of a newly established psychological assessment procedure using the following as measures: (a) a clinical interview; (b) an

interactional pattern analysis; (c) the Millon Clinical Multiaxial Inventory; (d) the 16 Personality Factor Questionnaire; (e) the Thematic Apperception Test; (f) the Children's Apperception Test; (g) the Bene-Anthony Family Relations Test; (h) the Duesse Test; (i) the Kinetic Family Drawing; (j) the Draw-A-Person Test will on follow up be more psychologically healthy.

8.10.2.2 Secondary Hypothesis

On follow up six months later using the Family Assessment Device; Index of Family Relations; Eyberg Child Behaviour Inventory and the Rosenberg Self-Esteem Scale as measures; it is hypothesized that the following changes will occur in the experimental group: (a) the children's self-esteem will improve; (b) the severity, or magnitude of problems that family members have in their relationships with one another, will decrease; (c) conduct-problem behaviours including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing, lying, in children will decrease; (d) both parent and children will be able to show more tenderness and would be more concerned about one another's welfare; (e) the parent will be able to show more nurturance towards the child; (f) effectively controlling problem behaviour; (g) verbal messages are clear in content and direct in the sense that the person spoken to, is the person for whom the message is intended; (h) the overall health of the family will improve; (i) improvement in the families' ability to identify relevant and appropriate problems which might threaten the cohesion and the family will have a clear set of rules and consequences as compared to those in the control group.

8.10.3 Recruitment of subjects

The sample consisted of families involved in a divorce dispute who were referred by the Office of the Family Advocate in Pretoria (Refer to item 8.7.3). The request from the office manager that the researchers assesses the families (parents and children) and make recommendations regarding custodial placement of the children.

8.10.3.1 Inclusion Criteria

The participants for the sample were selected based on the following inclusion criteria:

- The participants must participate voluntarily in the study.
- Both parental parties must be present for the evaluation.
- Both parents must provide written, informed consent for the participation of the family in the study.
- The entire family must be proficient in either English or Afrikaans.
- The children must be between the ages of two and sixteen years.
- Both biological parents, as well as the involved children have to consent to a follow-up evaluation after six months.

8.10.3.2 Exclusion Criteria

If one of the parents in exclusion of the other is not accessible for example due to imprisonment or death the family was excluded.

The prospective participants were given the telephone numbers of the researcher to make contact and an appointment was set for the initial interview. During the first interview the researcher made the couples comfortable and thereafter explained the aim of the study as indicated under item 8.9.1. The parents were given an opportunity to raise any questions or concerns regarding the aim of the study and the procedures to be followed including the time span of subsequent interview and assessment procedures. If the parents were satisfied with the explanation of the study including the procedure to be followed there were provided with a consent form (Appendix D). They were requested to send back the signed consent form within a period of 14 days after the initial interview.

All families referred by the Family Advocate, who met the above inclusion criteria were considered as possible subjects for the study.

8.10.3.3 Subjects

A sample of convenience was used for the purposes of this study as they were recruited from the family advocate and families were chosen as they came in. Every second family sent by the family advocate had a chance of being selected to the study as either the control or experimental group.

An attempt was made to obtain a total of 50 families consisting of 25 families for the experimental group and 25 families for the control group. However, several families refused to participate in the assessment process six months later as most of these families were often dissatisfied with the legal outcome of their case where the recommendation by the psychologist were not adhered to by the court.

Therefore, when the Court followed the recommendations made, the particular family automatically fell into the *experimental group*. The *control group* consisted of those cases where the Court did not accept the recommendations.

The researcher eventually had 26 families in the experimental group and 13 families for the control group. To all intents and purposes both the *experimental and control group* were the same in exception that subjects chosen for the *control group* were those that the court did not follow the recommendation by the psychologist. However, neither of the two groups, the *experimental and control* knew their allocations.

8.10.3.4 Ethical Considerations

There were a number of ethical considerations that are of importance to this investigation.

- a) The first requires the researcher to obtain permission from the University of Limpopo Research, Ethics and Publications Committee to conduct the investigation.
- b) The second requires the researcher to ensure that voluntary participation is obtained from all the participants in the investigation.
- c) The third requires the researcher to ensure that all participants provide informed consent with regard to their participation in the investigation.
- d) The fourth requires the researcher to ensure that the anonymity of participants is maintained throughout the investigation.
- e) The fifth is of the utmost importance. It requires the researcher to maintain the highest level of confidentiality throughout the investigation.
- f) The sixth is equally important. It requires the researcher to ensure that no harm comes to the participants of the investigation.

The researcher complied with all the above mentioned ethical considerations for the study to be approved by the University of Limpopo.

8.10.3.5 Materials

Four questionnaires were used to determine the psychological health of the families. The first is the *Family Assessment Device (FAD)* (Appendix D) which was developed to evaluate family functioning in six dimensions namely, affective responsiveness; affective involvement; roles; problem-solving; communication; general functioning and behaviour control. The FAD demonstrates a good internal consistency with alphas for the subscale ranging from .72 to .92. Regarding validity the FAD demonstrates good, concurrent and predictive validity (Fischer and Corcoran (2000)).

The second instrument used was the *Index of Family Relations (IFR)* (Appendix F) which assesses the severity or magnitude of family problems sprouting from personal and social dysfunction in the area of family adjustment. The reliability of the IFR has a mean alpha of .95, indicating excellent internal consistency, and an excellent (low) Standard Error of Measurement of 3.65. The validity of the IFR has good construct validity (Fischer & Corcoran, 2000).

The third instrument used was the *Eyberg Child Behaviour Inventory (ECBI)* (Appendix G) which was used to assess parental report of conduct and behavioural problems in children and adolescents. Studies have indicated that the ECBI has good reliability and validity. The reliability of the ECBI is high and the internal consistency excellent, with an alpha of .93 for intensity and .91 for problems. It has good concurrent and known-group validity, which correlates significantly with independent observations of children's behaviour, temperamental characteristics of the child (Boggs, Eyberg, & Reynolds 1990; Fischer & Corcoran, 2000).

The fourth and last instrument, *The Rosenberg Self-Esteem Scale (RSE)* (Appendix H) was developed to measure of global self-esteem. This scale has a reliability coefficient of reproductability of .92, indicating excellent internal consistency. According to Fischer and Corcoran (2000), the RSE demonstrates excellent construct, concurrent, predictive and known-group validity. For a full exposition of these instruments refer to item 7.5 in Chapter 7.

8.10.3.6 Test Administration

All questionnaires were administered individually. The psychometrics were conducted in a private room at the researcher's offices in Centurion or at the residence of the families in the following order The Rosenberg Self-Esteem Scale (RSE), Index of Family Relations (IFR); Eyberg Child Behaviour Inventory (ECBI) and the Family assessment Device (FAD).

The researcher made sure they are comfortably seated and the room temperature is adequate with no disturbance. Each tests' prescribed administration procedures were followed.

8.10.4 Procedure for Study 2

After obtaining informed consent from the subjects, the study was explained to the subjects as a study whose aim is to determine appropriate psychological assessment procedure for custody evaluation and primary placement of the child. This involves an initial assessment for each member of the family and custody placement of their offspring. Thereafter, six months later, another assessment will be conducted to determine the psychological health of the families.

The families were reassured with regard to confidentiality that it will be maintained and their names will be substituted for numbers. The information will be locked in a cupboard and the person who might have access to the information is the supervisor of the study who also has to adhere to the confidentiality clause.

The same three psychologists referred to in study 1 also had to identify measuring instruments which will be suitable to assess the functioning of the families and children to determine their level of psychological health. These instruments also had to assess for general functioning, including self-esteem of the children; problem-solving within the family; communication; severity or magnitude of family problems; conduct and behavioural problems in the children; aggression; stealing and lying and social competencies of children reported by parents. The instruments also had to give an indication of the children's friendships and functioning at school. Again the task was to identify measuring instruments which are known and accepted within the clinical community. This acceptance was determined by standardisation and popular use in the context of assessing families and children. Based on the recommendations by the clinicians, the researcher created a battery of tests for assessment.

Data regarding the functioning of the families were followed up six months after custody placements have been effected. The researcher either travelled to the families involved, or the families were evaluated at the researcher's consulting rooms in Centurion. The involved children, as well as the custodial and non-custodial parent, were evaluated individually pertaining to the child's functioning as well as that of the primary residential family.

Six months after the initial assessment of the families in the research sample and custody placements had been effected, families in both the experimental and control groups were followed up and assessed by means of this assessment battery. The families in the experimental and control groups were then compared to determine if the hypothesis was proven.

The researcher travelled to 27 families. Most of the families (25) resided in Gauteng, but two relocated to North West Province and two resided in Limpopo. The remaining 12 families were willing to be evaluated at the consulting rooms in Centurion. This follow-up assessment did not take up as much time as the assessment procedure for primary care did. The researcher could evaluate the parents in 1 to 2 hours and the child/children in 1 to 2 hours.

8.10.5 Analysis of Data

Based on the measuring instruments scoring keys, the researcher scored the data. This raw data was submitted to a qualified statistician for analysis. The data was analysed by means of Multivariate Analysis of Variance (MANOVA). With the assistance of a qualified statistician, the data was compared for differences between the mean scores of the experimental group and those of the control group. Simple effects of significant

data interaction in each group was also tested. The nature of the data interaction was established by examining the difference between the groups (Lohnes, 1971).

The two groups (experimental and control) were compared by means of Multivariate Analysis of Variance (MANOVA) using the SAS JMP® computer programme. During this comparison process the mean scores of both the experimental and the control group were compared to determine if the groups differed six months after residential placement. In the cases where a significant change occurred, a test of simple effects was conducted. This implies that the significant data interaction in each group was tested to determine if the variable being evaluated, e.g. self-esteem, changed significantly in this particular group (Dunteman, 1984).

The MANOVA statistical analysis was calculated using with the SAS JMP® computer programme with the assistance of a qualified statistician. This programme will be discussed next.

8.10.5.1 Computerised Analysis Used In This Study

The JMP® computer programme was originally written in 1989 for Macintosh. It is a computer programme that was first developed by John Sall and others to perform simple and complex statistical analysis. It dynamically links statistics with graphics to interactively explore, understand, and visualise data (Jones & Sall; 2011). It was later released for Microsoft Windows in 1993 and Linux in 2005. JMP® provides a comprehensive set of statistical tools as well as design of experiments and statistical quality control in a single package. It can work with a variety of data formats, such as text files, Microsoft Excel files, SAS datasets, and ODBC-compliant databases. JMP® allows for custom programming and script development (Jones & Sall; 2011).

SAS refers to a software package which is used in the JMP® environment. This can greatly extend the usefulness of applied statistics. At present SAS JMP® is widely used

in corporate and academic environments for statistical analysis which is also the main reason why it was utilised in this study (Khattree & Naik, 1999; Jones & Sall; 2011).

The results and discussion will be presented in the next chapter.

CHAPTER 9

RESULTS OF THE TWO STUDIES

9.1 Introduction

To orientate the reader this chapter firstly presents the results of the two studies namely, study 1 dealt with the translation of legal constructs embedded in the *best interests of the child* description of Justice King, into psychological constructs, clinical procedures and test battery for the assessment of children whose parents are divorced and have to be placed with a suitable parent. The participating psychologists also had to identify suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in a system, is functioning.

Secondly, study 2 of the study dealt with the evaluation of families and their children six months after divorce to assess the adjustment after divorce.

9.2 Study 1: Psychological Translation of the Legal Construct of the Best Interest of the Child

The purpose of the study was to translate or capture the 13 legal constructs embodied in *the best interest of the child* as endorsed by Justice King into psychological constructs. These legal constructs are as follows:

- a) *The love, affection and other emotional ties which exist between parent and child, and the parent's compatibility with the child;*
- b) *The capabilities, character and temperament of the parent, and the impact thereof on the child's needs and desires;*

- c) *The ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings;*
- d) *The capacity and disposition of the parent to give the child the guidance which he/she requires;*
- e) *The ability of the parent to provide for the basic physical needs of the child, the so-called "creature comforts" such as food, clothing, housing and other material needs – generally speaking, the provision of economic security;*
- f) *The ability of the parent to provide for the educational wellbeing and security of the child, both religious and secular;*
- g) *The ability of the parent to provide for the child's emotional, psychological, cultural and environmental development;*
- h) *The mental and physical health and moral fitness of the parent;*
- i) *The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo;*
- j) *The desirability or otherwise of keeping siblings together;*
- k) *The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration;*
- l) *The desirability or otherwise of applying the doctrine of same-sex matching;*
- m) *Any other factor relevant to the particular case, which is before the court.*

Inclusion Criteria for the Participants: Three psychologists were selected for the purposes of this study and the *inclusion criteria* used is as follows:

- a) Each should have at least 8 to 10 years' experience as a clinical psychologist;
- b) Have at least five years' experience within the context of child custody evaluations;
- c) Be proficient in both English and Afrikaans;
- d) Participate voluntarily in the study.

The aforementioned purpose is to put the reader into perspective.

Three psychologists independently ‘translated’ the legal statements developed by Mr Justice King into psychological constructs or statements. Secondly the three psychologists also independently listed their recommendations in respect of psychometric instruments for the measuring of the degree of healthy family functioning. The results obtained from these procedures will now be presented below.

9.3 The results obtained in Study 1 - Translation

The results of the “13 Statements of the Best Interest Principle based on Justice King’s Legal Constructs and a list of Family Health Instruments” are arranged according to the 13 statements embodied in the legal construct of the best interest of the child.

This is followed by the findings of the psychometric instruments that can be used to determine how effectively a particular family system is functioning.

The results obtained from psychologist 1 are indicated in Table 9.1 below.

Table 9.1: Results obtained from psychologist 1

Statements as listed by the Honourable Mr Justice King	Psychological construct equivalent for statements as listed by His Honourable Mr Justice King	Suggested Psychometric instruments	Suggested clinical procedures
<p>Statement 1</p> <p>The love, affection and other emotional ties which exist between parent and child, and the parent’s compatibility with the child.</p>	<p>Empathy and congruence in the family.</p> <p>Closeness between family members.</p>	<p>CAT;</p> <p>TAT;</p> <p>Bene-Anthony Family Relations Test;</p> <p>DAP;</p>	<p>Interactional analysis;</p> <p>Clinical interview.</p>

		KFD; DUESS; 16PF5; MCMII-III.	
Statement 2 The capabilities, character and temperament of the parent, and the impact thereof on the child's needs and desires.	Parental insight, empathy and impulse control.	16PF5; MCMII-III; TAT.	Interactional analysis.
Statement 3 The ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings.	Parent's ability to communicate effectively with the child. Congruent and age appropriate awareness of the child's needs.	16PF; TAT; CAT; Bene-Anthony Family Relations Test; MCMII-III; DAP; KFD; DUESS.	Interactional analysis.
Statement 4 The capacity and disposition of the parent to give the child the guidance which he/she or she requires.	Parental insight into the developmental needs of the child and the ability to provide.	16PF; TAT; MCMII-III.	Interactional analysis.
Statement 5 The ability of the parent to provide for the basic physical needs of the child, the so-called 'creature comforts', such as food, clothing, housing and the other material needs – generally	Parent's understanding of the child's developmental needs as well as the ability to provide. Maslow's needs theory.	16PF; MCMII-III; TAT.	Interactional analysis.

speaking, the provision of economic security.			
Statement 6 The ability of the parent to provide for the educational well-being and security of the child, both religious and secular.	Parent's capacity to give the child guidance appropriate to the child's developmental needs and level.	TAT; 16PF; MCMI-III.	Clinical interview. Interactional analysis.
Statement 7 The ability of the parent to provide for the child's emotional, psychological, cultural and environmental development.	Parental insight as well as the individual level of emotional stability.	TAT; Bene-Anthony Family Relations Test .	Clinical interview. Interactional analysis.
Statement 8 The mental and physical health and moral fitness of the parent.	Emotional stability and mental fitness should be an indicator.	MCMI-III; TAT.	Clinical interview.
Statement 9 The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo.	Child's emotional stability and perception of his environment. The awareness of the needs of the child and the child's own awareness of his/her own needs.	CAT; Bene-Anthony Family Relations Test; DAP; KFD; DUESS.	Clinical interview.
Statement 10 The desirability or otherwise of keeping siblings together.	Closeness of siblings.	CAT; Bene-Anthony Family Relations Test; DAP;	Clinical interview.

		KFD; DUESS.	
Statement 11 The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration.	The needs of the child to be considered or to be taken into consideration.	Bene-Anthony Family Relations Test; CAT/TAT; DAP; KFD; DUESS.	Clinical interview. Interactional Analysis.
Statement 12 The desirability or otherwise of applying the doctrine of same-sex matching if so desired.	Cohesion in the family. Parental and sibling closeness will indicate possible same sex matching.	Bene-Anthony Family Relations Test ; TAT/CAT; KFD; DUESS.	Clinical interview. Interactional Analysis.
Statement 13 Any other factor relevant to the particular case which is before the court.	Consideration of any other factors relevant to the child's need placed before the court.	Bene-Anthony Family Relations Test ; TAT/CAT; KFD; DUESS.	Clinical interview. Interactional Analysis.

Table 9.2: Results obtained from psychologist 2

Statements as listed by His Honourable Mr. Justice King:	Psychological construct equivalent for statements as listed by His Honourable Mr. Justice King:	Suggested Psychometric instruments	Suggested clinical procedures
<p>Statement 1</p> <p>The love, affection and other emotional ties which exist between parent and child, and the parent's compatibility with the child.</p>	<p>Emotional closeness between parent and child.</p>	<p>CAT; Bene-Anthony Family Relations Test.</p>	<p>Interactional analysis. Clinical interview .</p>
<p>Statement 2</p> <p>The capabilities, character and temperament of the parent, and the impact thereof on the child's needs and desires.</p>	<p>General psychological health of a parent as well as parental awareness and insight.</p>	<p>16PF; TAT; MCMI-III.</p>	<p>Interactional analysis.</p>
<p>Statement 3</p> <p>The ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings.</p>	<p>Parental empathy and unconditional acceptance referring to an awareness of the child's developmental needs. The parent must also illustrate the ability to place him/herself in the shoes of the child.</p>	<p>16PF; MCMI-III; TAT .</p>	<p>Clinical interview .</p>
<p>Statement 4</p> <p>The capacity and disposition of the parent to give the child the guidance which he or she requires.</p>	<p>The inherent personality traits of the parent to guide the child. Effective parental communication and awareness. Insight into the</p>	<p>16PF; TAT; MCMI-III.</p>	<p>Interactional analysis. Clinical interview .</p>

	child's developmental and physical needs.		
Statement 5	Maslow theory of basic and survival needs for example food, shelter and clothing. Parent's understanding of and sensitivity to the child's needs. The parent should also be acutely aware of the child's general welfare.	16PF; MCMI-III; TAT.	Interactional analysis. Clinical interview .
Statement 6	Maslow second hierarchy of social needs. Parent's capacity to give the child appropriate guidance physically as well as emotionally.	16PF; MCMI-III; Bene-Anthony Family Relations Test; TAT.	Interactional analysis. Clinical interview .
Statement 7	Emotional needs of Maslow. Appropriate child rearing methods.	16PF; MCMI-III; TAT; Bene-Anthony Family Relations Test.	Interactional analysis. Clinical interview .
Statement 8	Personality constructs and traits. Adequate mental health of the parents. The parental diagnostic profile will be able to provide insight into the level of functioning.	16PF; MCMI-III; TAT.	Clinical interview .

<p>Statement 9</p> <p>The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo.</p>	<p>Stability of the child's existing environment with regards to both internal stability as well as external.</p>	<p>Bene-Anthony Family Relations Test; CAT/TAT; DAP; KFD; DUESS.</p>	<p>Interactional analysis. Clinical interview .</p>
<p>Statement 10</p> <p>The desirability or otherwise of keeping siblings together.</p>	<p>Sibling cohesion, are they close that they cannot be separate or not.</p>	<p>Bene-Anthony Family Relations Test; CAT/TAT; KFD.</p>	<p>Interactional analysis. Clinical interview .</p>
<p>Statement 11</p> <p>The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration.</p>	<p>The child's preferences and situational analysis should be considered.</p>	<p>Bene-Anthony Family Relations Test; CAT/TAT; DAP; KFD. DUESS</p>	<p>Interactional analysis. Clinical interview .</p>
<p>Statement 12</p> <p>The desirability or otherwise of applying the doctrine of same-sex matching.</p>	<p>The attachment and bond between parent and child should be the guiding factor. Sibling and parental closeness will dictate same sex matching or not.</p>	<p>Bene-Anthony Family Relations Test ; TAT/CAT; KFD.</p>	<p>Interactional analysis. Clinical interview .</p>
<p>Statement 13</p> <p>Any other factor relevant to the particular case which is before the court.</p>	<p>Any other factors relevant to the child's needs.</p>		<p>Clinical interview .</p>

Table 9.3: Results obtained from psychologist 3

<p>Statements as listed by His Honourable Mr. Justice King:</p>	<p>Psychological construct equivalent for statements as listed by His Honourable Mr. Justice King:</p>	<p>Suggested psychometric instruments</p>	<p>Suggested clinical procedures</p>
<p>Statement 1</p> <p>The love, affection and other emotional ties which exist between parent and child, and the parent's compatibility with the child.</p>	<p>Parental empathy, unconditional acceptance.</p> <p>The emotional closeness and bonding between child and the parents compatibility with the child.</p>	<p>16PF;</p> <p>MCMIII/MMPI-2;</p> <p>TAT/CAT;</p> <p>CAT ;</p> <p>Bene-Anthony Family Relations Test;</p> <p>DAP;</p> <p>KFD;</p> <p>DUESS.</p>	<p>Interactional analysis.</p> <p>Clinical interview.</p>
<p>Statement 2</p> <p>The capabilities, character and temperament of the parent, and the impact thereof on the child's needs and desires.</p>	<p>Parental compatibility.</p> <p>Personality characteristic of the parent and the impact thereof on the child's needs and wishes.</p>	<p>16PF;</p> <p>MCMIII/MMPI-2;</p> <p>TAT.</p>	<p>Interactional analysis.</p> <p>Clinical interview.</p>
<p>Statement 3</p> <p>The ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings.</p>	<p>Parental empathy and unconditional acceptance.</p>	<p>16PF;</p> <p>MCMIII/MMPI-2;</p> <p>TAT/CAT;</p> <p>Bene-Anthony Family Relations Test;</p> <p>DUESS.</p>	<p>Interactional analysis.</p>
<p>Statement 4</p> <p>The capacity and disposition</p>	<p>Personality traits. Parental</p>		

of the parent to give the child the guidance which he or she requires.	empathy and unconditional acceptance of the child. The inherent awareness insight into the child's developmental and physical needs.	16PF; TAT; MCMIII/MMPI-2.	Interactional analysis.
Statement 5 The ability of the parent to provide for the basic physical needs of the child, the so-called 'creature comforts', such as food, clothing, housing and the other material needs – generally speaking, the provision of economic security.	Maslow's hierarchy of basic biological needs. Parental stability and understanding of the child's developmental needs.	16PF; MCMIII/MMPI-2; TAT.	Interactional analysis. Clinical interview.
Statement 6 The ability of the parent to provide for the educational well-being and security of the child, both religious and secular.	Maslow's social needs. Parent's capacity to give the child guidance in both educational as well as religious matters. Help child to self-actualise.	16PF; MCMIII/MMPI-2; TAT.	Interactional analysis. Clinical interview.
Statement 7 The ability of the parent to provide for the child's emotional, psychological, cultural and environmental development.	Maslow's emotional needs. Parent's ability to provide for the basic physical needs of the child.	Bene-Anthony Family Relations Test ; 16PF; DUESS; KFD.	Clinical interview.
Statement 8 The mental and physical health and moral fitness of the parent.	Emotional insight, therefore are they able to understand the child and to understand the proceedings of court?	16PF; MCMIII/MMPI-2; TAT.	Interactional analysis. Clinical interview.

	The ability to adapt to changing circumstances.		
Statement 9 The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo.	Parent's awareness of developmental needs of the child .	Bene-Anthony Family Relations Test .	Interactional analysis. Clinical interview.
Statement 10 The desirability or otherwise of keeping siblings together.	Sibling closeness as well as an outspoken preference..	Bene-Anthony Family Relations Test ; CAT/TAT; DAP; KFD; DUESS.	Interactional analysis. Clinical interview.
Statement 11 The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration.	The child's expressed need of indicated parental preference.	Bene-Anthony Family Relations Test ; CAT/TAT; DAP; KFD; DUESS.	Clinical interview
Statement 12 The desirability or otherwise of applying the doctrine of same-sex matching.	Family / sibling cohesion. Parental and sibling closeness will guide same sex matching.	Bene-Anthony Family Relations Test; TAT/CAT; KFD; DUESS.	Interactional analysis. Clinical interview.
Statement 13			

Any other factor relevant to the particular case which is before the court.	Consideration of any other factors or information relevant to the child's need.		Interactional analysis. Clinical interview.
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9.4 Study 1: Integration of the results

Phenomenological analysis of the questionnaire was semantically done to arrive at the themes as suggested by Collaizzi (1978) and Mokhuane (1996). Statement 1 - according to Justice King refers to: "The love, affection and other emotional ties which exist between parent and child, and the parent's compatibility with the child". The theme was found to be "*Emotional closeness between parent and child*"

This statement was psychologically translated by the three psychologists to suggest *emotional closeness and bonding between child and the parents* as the guiding theme. The three psychologists also suggested that empathy of the parent and unconditional acceptance of the child also has to be considered.

Parental compatibility, empathy and insight were identified as themes in statement 2 where the child's needs and wishes are primarily acknowledged. Triangulating the level of thematic agreement in statement 3 shows high agreement that the parent's ability to communicate effectively with the child in an congruent and age appropriate fashion is a requirement where the child's needs can be optimally acknowledged. *Personality traits, parental awareness regarding child's developmental and physical needs* overlapped as themes in statement 4.

The three psychologists 'unilaterally agreed on the theme in statements 5, 6 and 7 referred to *Maslow's hierarchy of needs*. *Parental stability, understanding of the child's developmental and educational needs* is highlighted. *Maslow's social and emotional needs* are also affirmed by all three. The level of thematic agreement with statement 8 suggested *parental adaptability to changing circumstances*. Statement 9 was

considered and agreed with the theme *determination of the stability of the child's existing environment with regards to both internal and external stability*.

With regards to statement 10 the theme of *sibling closeness* as well as an *outspoken preference* was unanimously agreed by the three psychologists. Statement 11 highlighted the thematic agreement of the three psychologists that the *child's preferences and situational analysis* should be considered. The theme of *family* as well as *sibling cohesion* dictated that level of agreement with statement 12, but also referred to *parental and sibling closeness* when it comes to same sex matching.

The last statement, number 13 seems to match thematically with consideration of *any other factors or information relevant to the child's needs*.

9.4.1 Psychometric tests and clinical procedures suggested by all three psychologists

The above results obtained from the suggestions, as obtained from the 3 psychologists were integrated based on level of agreement of the 80% or more. If one specific test or clinical procedure were not indicated by all three of the involved psychologists it was not included. The results were compiled by listing only those procedures and psychometrics instruments in respect of which all three were in agreement of 80% or more, as reported in Table 9.4.

Table 9.4 Psychometric instruments and/or clinical procedures suggested by the three psychologists

The Clinical Interview
Interactional Analysis
Millon Clinical Multiaxial Inventory (MCMI-III)
Thematic Apperception Test (TAT)
16 Personality Factor Questionnaire (16PF)
The Children's Apperception Test (CAT)
Bene-Anthony Family Relations Test
Duess Test
Kinetic Family Drawing (KFD)
Draw-A-Person Test (DAP)

The above-mentioned procedures and tests were utilised as a test battery that served as the basis on which the families in the sample were assessed and recommendations for custody were made.

Secondly the three psychologists also independently listed their recommendations in respect of psychometric instruments for measuring the degree of healthy family functioning. The results obtained from these procedures will now be presented below.

9.5 The results obtained in Study 1 – Identification of the psychometric instruments for measuring the psychological health of families

During Study 1 the three psychologists independently listed their recommended psychometrics instruments for determining the degree of healthy family functioning. These are listed in the following tables:

Table 9.5: Results obtained from psychologist 1

Instruments/Questionnaires: Family Assessment Device (FAD) Family Apperception Test (FAT) Index of Family Relations (IFR) Eyberg Child Behaviour Inventory (ECBI) Child Behaviour Checklist (CBCL) Family Assessment Checklist (FAC) The Ackerman-Schoendorf Scales for Parent Evaluation of Custody (ASPECT) The Rosenberg Self-Esteem Scale (RSE)

Table 9.6: Results obtained from psychologist 2

Instruments/Questionnaires: Family Assessment Device (FAD) Index of Family Relations (IFR) Eyberg Child Behaviour Inventory (ECBI) Children's Depression Inventory (CDI) Darlington Family Assessment System (DFAS) Child Behaviour Checklist (CBCL) North Carolina Family Assessment Scale (NCFAS) The Rosenberg Self-Esteem Scale (RSE)

Table 9.7: Results obtained from psychologist 3

Instruments/Questionnaires: Family Assessment Device (FAD) Index of Family Relations (IFR) Adolescent Substance Abuse Subtle Screening Inventory (SASSI) Adult-Adolescent Parenting Inventory (AAPI) Beck Depression Inventory II (BDI-II) Eyberg Child Behaviour Inventory (ECBI) Family Assessment Form (FAF) The Rosenberg Self-Esteem Scale (RSE)

9.5.1 Psychometric tests suggested by all three psychologists

The results were compiled by listing only those psychometrics instruments in respect of which all three psychologists were in agreement of 80% or more, as reported in Table 9.8:

Table 9.8: Psychometric instruments suggested by the three psychologists

Instruments/Questionnaires: Family Assessment Device (FAD) The Rosenberg Self-Esteem Scale (RSE) Index of Family Relations (IFR) Eyberg Child Behaviour Inventory (ECBI)
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9.5.2 Psychological Instruments used six months later after placement of primary residency

The above-mentioned psychometric instruments were used as a test battery towards determining how effectively a particular family system, as well as the children in this

system, are functioning. These instruments, namely Family Assessment Device (FAD); The Rosenberg Self-Esteem Scale (RSE); Index of Family Relations (IFR) and the Eyberg Child Behaviour Inventory (ECBI) were utilised six months after placement of the children in primary residency – some placements in accordance with the recommendations made (experimental group) and some placements not in accordance with the recommendation made (control group).

9.6 Phase 2 – Results: Placement Of Children

Over a period of 4 years a total of 39 families referred by the Office of the Family Advocate were evaluated by means of the newly created procedure and test battery and recommendations for placement were made.

FAMILY 1

Table 9.9 Results on the respective psychometric instruments and/or clinical procedures in family 1:

Psychometric test / procedure	Mother	Father	Child
The clinical interview.	Orientated for time; place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time place and person. Incongruent presentation Logical presentation of history. Symmetrical role maintained.	Orientate for time place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Demonstration of appropriate discipline.	Poor levels of empathy. Demonstration of poor discipline.	Comfort in the presence of the mother.

	Maintained a parent-child role definition.	Did not maintain a parent-child role definition.	Uncertainty in the presence of the father.
MCMII-III	Profile valid. Compulsive personality.	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality; Aggressive personality.	
TAT	Awareness of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	Poor understanding of how others present their issues. Limited affect. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	
16PF	Valid profile. High Factor B; High Factor C; Low Factor F.	Valid profile. Low Factor B; Low Factor C; High Factor E; Low Factor G.	
CAT			Closest to the mother figure. Fear of the father figure. Striving to be safe in a structured environment.

FRT			<p>Positive feelings towards the mother.</p> <p>Neutral affections allocated to the father.</p>
Duess Test			<p>Experience safety and nurturance in the maternal context.</p> <p>Wishes to be in the care of the mother.</p>
KFD			<p>Child drawn closest to the mother in interaction.</p> <p>Experience the father as busy and angry.</p>
DAP			<p>Feelings of uncertainty in the child.</p> <p>Anxiety.</p> <p>Aggression and frustration projected.</p>

Family 1: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the mother as the primary caregiver shown by the results of the CAT, FRT and KFD. One of the wishes evident from the Dues test was for the child to be in the care of the mother. The psychometric tests also indicated that the mother was the more emotionally stable parent as she scored a high Factor C on the 16PF, as opposed to the father's low score. The high MCMI score of the father on the narcissistic scale indicated low empathy which was confirmed by the IPA. His TAT interpretation showed poor environmental awareness, as opposed to the mother, who presented as empathic as indicated by the TAT, IPA and MCMI. The recommendation was made that primary care be awarded to the mother. This recommendation was accepted by the Court. The family formed, therefore part of the experimental group.

FAMILY 2

Table 9.10 Results on the respective psychometric instruments and/or clinical procedures in family 2:

Psychometric test / procedure	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Low levels of empathy. Difficulty maintaining	High levels of empathy. Demonstration of	Comfort in the presence of the

	discipline. Parent-child role definition one of equals.	appropriate discipline. Maintained a parent-child role definition.	father. Uncertainty in the presence of the mother.
MCMIII-III	Profile valid. Significant high desirability. Histrionic personality; Narcissistic personality.	Profile valid. No significant scores.	
TAT	Poor understanding of complexity of others. Limited affect. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. Low Factor C; High Factor E; Low Factor I.	Valid profile. High Factor C; Low Factor N; Low Factor Q1.	
CAT			Closest to the father figure. Mother figure experienced as distanced. Frustrated with the environment.

FRT			<p>Positive feelings towards the father.</p> <p>Neutral to negative feelings demonstrated towards the mother.</p>
Duess Test			<p>Experience safety and nurturance in the paternal context.</p> <p>Wishes to be in the care of the father</p>
KFD			<p>Child drawn in interaction with the father. Experienced mother as socializing with friends.</p>
DAP			<p>Feeling of uncertainty with anxiety in the child.</p>

Family 2: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as the primary caregiver as seen from the CAT, Duess and FRT. The psychometric profile of the father seemed to be more emotionally stable as no significant scores were elevated on the MCMI and the high Factor C on the 16PF

compared to the mother’s psychometric results indicating a low Factor C and an elevated narcissistic scale score.

The mother’s awareness of demands was also poor as opposed to that of the father. The child also seemed to experience the father as more involved as indicated by the IPA. The recommendation was made that primary care be awarded to the father. The recommendation was accepted by the Court. This family formed part of the experimental group too.

FAMILY 3

Table 9.11 Results on the respective psychometric instruments and/or clinical procedures in family 3:

Psychometric test / procedure	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Demonstration of poor discipline awareness. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline awareness. Maintained a parent-child role definition.	Comfort in the presence of the father. Uncertainty and anxiety in the presence of the mother.

MCI-III	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality.	Profile valid. No significant scores.	
TAT	Poor understanding of complexity of others. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	Awareness of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. Low Factor B; Low Factor C; Low Factor E; High Factor F; High Factor I.	Valid profile. High Factor B; High Factor C; Low Factor F; Low Factor Q1; Low Factor Q4.	
CAT			Closest to the father figure. Poor acknowledgement of the mother figure. Anxiety regarding adult interaction.
FRT			Positive feelings towards the father.

			Negative feelings associated with the maternal context.
Duess Test			Comfort, involvement, safety and nurturance in the paternal context present. Wishes to be in the care of the father.
KFD			Projection indicates pleasant interaction of father and child. Mother negated.
DAP			Feelings of uncertainty in the child. Power strivings in the child.

Family 3: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver. This was confirmed by the CAT, FRT, KFD and Duess. The interactional analysis indicated comfort and positive interaction with the father. The mother presented psychometrically with emotional instability as seen on the Low Factor C on the 16PF and low levels of empathy as

indicated in the elevated score on the narcissistic scale of the MCMI score. This was also indicated by the interactional analysis.

The father seemed to be stable based on his psychometric profile as no significant elevations were evident in the MCMI score and the high Factor C on the 16PF. He was also constructive in engaging with the environment as indicated by the TAT which was not the case with the mother. The recommendation was made that the primary care be awarded to the father, but the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 4

Table 9.12 Results on the respective psychometric instruments and/or clinical procedures in family 4:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	<p>Orientated for time, place and person.</p> <p>Incongruent presentation</p> <p>Illogical presentation of history.</p> <p>Complimentary role maintained.</p>	<p>Orientated for time, place and person.</p> <p>Incongruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role maintained.</p>	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role maintained.</p>
IPA	<p>Poor levels of empathy.</p> <p>Poor demonstration of discipline awareness.</p> <p>Maintained an equal parental-child role definition.</p>	<p>High levels of empathy.</p> <p>Sufficient ability to maintain discipline.</p> <p>Complimentary parent-child role definition.</p>	<p>Comfort in the presence of the father.</p> <p>Uncertainty in the presence of the mother.</p>

MCI-III	Profile valid Histrionic personality Compulsive personality	Profile is valid No scores were significantly elevated	
TAT	Impulsive in dealing with demands from the environment. Poor emotional investment in relationships. Poor moral standards. Self-centredness. Denial of aggression and depression. Poor understanding of social causality.	Good understanding of complexity of others. Good capacity for emotional investment in relationships. Strong moral standards. Good understanding of social causality.	
16PF	Valid profile. Faking bad. Low Factor C; Low Factor E; High Factor F; Low Factor G.	Valid profile. Low Factor F; High Factor G; Low Factor Q1.	
CAT			Closest to the father figure. Mother figure experienced as absent. In need of a structured environment.
FRT			Positive feelings towards the father. Negative feelings

			towards the mother.
Duess Test			Nurturance received in the paternal context. Wishes to be in the care of the father and in the father's context.
KFD			Child drawn in care of the father. Experienced mother as ill and hospitalized.
DAP			Feeling of uncertainty in the child. Comfortable with gender identity.

Family 4: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as the primary caregiver. The FRT, KFD and CAT indicated nurturance from the paternal relationship. The one major wish expressed from the Duess test was also to be in the care of the father. The presenting style of both parents was the same, but the father could maintain discipline and empathy in the interactional analysis while the mother could not.

As far as the father's psychometric profile is concerned he appeared to be more emotionally stable as no scores were elevated on the MCMI and no significant Factor C on the 16PF. The TAT interpretations showed an awareness of circularity and environmental demands. The mother's psychometric tests indicated elevations in the MCMI scores and a low Factor C in the 16PF. The TAT interpretation also indicated poor awareness of demands and a rigid stance towards the environment. The recommendation was made that primary care be awarded to the father and the recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 5

Table 9.13 Results on the respective psychometric instruments and/or clinical procedures in family 5:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline awareness. Maintenance of a parent-child role definition.	Poor levels of empathy. Good demonstration of discipline awareness. Maintenance of a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.

MCI-III	Profile valid. Dependent personality.	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality.	
TAT	Good understanding of complexity of others. Aware of environmental demands. Developed capacity for emotional investment in relationships. High moral standards. Integrated understanding of social causality.	Aware of environmental demands. Poor emotional investment in relationships. Poor moral standards. Self-centred and low in empathy. Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. Low Factor E; High Factor I; Low Factor L; Low Factor N.	Invalid profile.	
CAT			Primary attachment with the mother figure. Fear for and intimidation by the father figure.
FRT			Positive feelings towards the mother.

			Negative feelings associated with the paternal context.
Duess Test			Experience safety and nurturance in the maternal context. Wishes to be in the care of the mother and protected from the father.
KFD			Projection indicated pleasant interaction between mother and child. Father seen as angry and intimidating.
DAP			Feelings of uncertainty with the child.

Family 5: Recommendation and placement

The evaluation from the psychometric tests and the clinical procedures indicated that the child experienced the mother as the primary caregiver as seen in the closeness projected in the KFD and CAT. Nurturance and care were indicated in the FRT scores obtained and the interactional analysis of the child and both parents showed closeness to the mother rather than to the father. The mother also appeared to have sufficient

empathy coupled with appropriate disciplinary abilities in the interactional analysis. The father presented with symmetrical elements, low empathy and poor disciplinary abilities as seen in the interactional analysis.

The father's 16PF profile was invalid, in addition with low levels of empathy, as seen in the elevated score on the MCMI. The mother presented psychometrically as dependent submissive, but her levels of nurturance and empathy as seen in the TAT interpretations indicate a close relationship with the child. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family was allocated to the experimental group.

FAMILY 6

Table 9.14 Results on the respective psychometric instruments and/or clinical procedures in family 6:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Demonstration of poor discipline abilities. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline abilities. Maintained a parent-child	Comfort in the presence of the father. Comfort in the presence of the

		role definition.	mother, but seemed to be a relationship of equals.
MCMII-III	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality.	Profile valid. Significant high desirability. Compulsive personality.	
TAT	Poor understanding of complexity of others. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. Low Factor C; Low Factor E; Low Factor I; High Factor O.	Valid profile. High Factor C; High Factor G; Low Factor H; Low Factor Q1.	
CAT			Closest to the father figure. Poor acknowledgement of the mother figure. Anxiety regarding parental interaction.

FRT			<p>Positive feelings towards the father.</p> <p>Negative feelings associated with the mother.</p>
Duess Test			<p>There is involvement and nurturance in the paternal context.</p> <p>Wishes to be in the care of the father.</p>
KFD			<p>Projection indicated pleasant interaction of father and child.</p> <p>Mother projected as distant.</p>
DAP			<p>Feelings of uncertainty within the child.</p>

Family 6: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as the primary caregiver. This was seen in the positive fatherly projection in the CAT and KFD. The FRT showed that the father was perceived as positive and the mother as negative and the child’s wishes on the Duess indicated that he would like to be in the care of the father. Both parents presented appropriately,

but the interactional pattern analysis indicated paternal closeness and empathetic understanding of the child.

This was confirmed by the father's high Factor C in the 16PF and circular awareness of interaction in the TAT interpretation. The MCMI scores showed an inclination of the father being compulsive in behaviour as opposed to the mother's low levels of empathy as observed in the elevated narcissistic score. Her emotional stability in dealing with the environment was also questioned as she had a low Factor C in the 16PF and the TAT results were negative. The recommendation was made that primary care be awarded to the father. This recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 7

Table 9.15 Results on the respective psychometric instruments and/or clinical procedures in family 7:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Poor demonstration of discipline ability. Parallel parent-child role	High levels of empathy. Sufficient ability to maintain discipline. Complimentary parent-	Comfort in the presence of the father. Discomfort in the

	definition.	child role maintained.	presence of the mother.
MCMII-III	Profile valid Significantly high on desirability Histrionic personality Compulsive personality	Profile is valid Significantly high on desirability	
TAT	Impulsive in dealing with environmental demands. Poor emotional investment in relationships. Poor moral standards. Self-centredness. Denial of aggression and depression. Poor understanding of social causality.	Good understanding of complexity of others. Good capacity for emotional investment in relationships. Strong moral standards. Good understanding of social causality.	
16PF	Valid profile. Low Factor C; High Factor E; High Factor I; High Factor Q1.	Valid profile. High Factor F; High Factor H; Low Factor L.	
CAT			Closest to the father figure. Mother figure experienced as absent. In need of a structured environment.
FRT			Positive feelings

			towards the father. Negative feelings allocated to the mother.
Duess Test			Nurturance in the paternal context present. Mother is experienced as absent. Wishes to be in the care of the father.
KFD			Child drawn in care of the father. Experienced mother as absent.
DAP			Feeling of uncertainty within the child.

Family 7: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as caring and positive feelings were directed to him in the FRT results. The child also projected closeness to the father as found in the CAT and KFD tests. The presenting style of the parents differed. The mother presented in an incongruent manner with low levels of empathy and a confrontational stance.

The mother appeared to be emotionally less stable as found with the low 16PF Factor C and poor level of interaction as indicated by the TAT results. Her results indicated 2 elevations on the MCMI, but the father profile showed no elevations. The child also seemed to experience the father as more involved and nurturing whereas the mother was perceived as absent. The recommendation was made that primary care be awarded to the father and the recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 8

Table 9.16 Results on the respective psychometric instruments and/or clinical procedures in family 8:

Psychometric tests / procedures	Mother	Father	
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Poor levels of empathy. Poor demonstration of discipline. Maintained a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid. Compulsive personality;	Profile valid. Schizoid personality;	

		Avoidant personality; Dependent personality; Compulsive personality.	
TAT	Aware of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships. High moral standards. Integrated understanding of social causality.	Aware of environmental demands. Poor emotional investment in relationships. Poor moral standards. Low in empathy. Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. Low Factor E; Low Factor F; High Factor G.	Valid profile. Low Factor C; Low Factor F; Low Factor H; Low Factor L; High Factor Q3.	
CAT			Primary attachment to the mother figure. Father experienced as absent and uninvolved.
FRT			Positive feelings towards the mother. Negative and neutral feelings associated with the paternal context.

Duess Test			<p>Safety and nurturance received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p> <p>Poor reference to the father.</p>
KFD			<p>Projection indicated pleasant interaction between mother and child.</p> <p>Father seen as distanced.</p>
DAP			<p>Feelings of uncertainty within the child.</p> <p>Power strivings in the child.</p>

Family 8: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The FRT, CAT, KFD and Duess results suggest emotional closeness and safety with the maternal context. This tendency was present in the interactional pattern analysis where the mother could maintain an empathetic position, but the father indicated low levels of empathy. The mother presented as more stable as indicated with the one elevation on the MCMI score

in comparison with the father who seemed to be overly withdrawn, dependent and avoidant as evident from his MCMI test results. Emotional instability with the father was also indicated based on the low Factor C in the 16PF and TAT results. The recommendation was made that primary care be awarded to the mother. This recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 9

Table 9.17 Results on the respective psychometric instruments and/or clinical procedures in family 9:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Illogical presentation of history. Symmetrical in presentation.	Orientated for time, place and person. Congruent presentation Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a complimentary parent-child role definition	Poor levels of empathy. Poor ability to maintain discipline. Poor parent-child role definition	Comfort in the presence of the mother. Uncertainty and anxiety in the presence of the father.
MCMI-III	Profile valid.	Profile is valid.	

	Histrionic personality.	Significant high score on desirability. Narcissistic personality; Aggressive personality; Compulsive personality.	
TAT	Controlled and patient in dealing with environmental demands. Good emotional investment in relationships. High moral standards. Appropriate acknowledgement of aggression and depression. Good understanding of social causality.	Poor awareness of environmental demands. Poor understanding of complexity of others. Limited affect. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	
16PF	Valid profile. High Factor C; High Factor G; High Factor O; Low Factor Q1.	Valid profile. Faking good. Low Factor C; High Factor E; High Factor I; High Factor Q3.	
CAT			Closest to the mother figure. Father experienced as dominating and aggressive. In need of a structured environment.
FRT			Positive feelings towards at the

			<p>mother.</p> <p>Negative feelings allocated to the father.</p>
Duess Test			<p>Nurturance received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p>
KFD			<p>Child drawn close to the mother.</p> <p>Experienced father as intimidating and angry.</p>
DAP			<p>Feeling of uncertainty within the child.</p> <p>Comfortable with gender identity.</p>

Family 9: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver as found in on the KFD and CAT projection. Positive feelings were directed to the mother in the FRT results as opposed to the negative feelings directed to the father. The presenting style found in the interactional pattern analysis of the parents differed as the father appeared to be confrontational, low in empathy and aggressive, whereas the mother was more

empathic. The mother’s psychometric profile appeared more emotionally stable as seen in the high Factor C score on the 16 PF, and in the psychological test such as the TAT she was found to be constructive when dealing with the environment. This was also confirmed by the MCMI results. The father had a low Factor C in the 16PF test indicating emotional instability, which was confirmed by the MCMI elevated narcissistic and aggressive scales and poor dealing with the environment as shown in the TAT analysis. It was recommended that primary care be awarded to the mother, and the recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 10

Table 9.18 Results on the respective psychometric instruments and/or clinical procedures in family 10:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Not orientated for time place and person. Incongruent presentation. Illogical presentation of history. Symmetrical role definition.	Orientated for time place and person. Congruent presentation. Logical presentation of history. Complimentary role definition.	Orientated for time place and person. Congruent presentation. Logical presentation of history. Complimentary role definition.
IPA	Poor levels of empathy. Demonstration of poor discipline. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline. Maintained a parent-child role definition.	Comfort in the presence of the father. Uncertainty and fear in the presence of the mother.
MCMI-III	Profile valid.	Profile valid.	

	<p>Significant high desirability.</p> <p>Narcissistic personality;</p> <p>Compulsive personality;</p> <p>Delusional traits.</p>	<p>Compulsive personality.</p>	
TAT	<p>Poor awareness of environmental demands.</p> <p>Poor understanding of complexity of others.</p> <p>Limited affect.</p> <p>Poor capacity for emotional investment in relationships.</p> <p>Poor moral standards.</p> <p>Poor understanding of social causality.</p>	<p>Aware of environmental demands.</p> <p>Good emotional investment in relationships.</p> <p>Good moral standards.</p> <p>Good self-esteem.</p> <p>Acknowledgement of aggression and depression.</p> <p>Good understanding of social causality.</p>	
16PF	<p>Valid profile/</p> <p>Low Factor B;</p> <p>High Factor I;</p> <p>High Factor L;</p> <p>Low Factor Q4.</p>	<p>Valid profile.</p> <p>High Factor B;</p> <p>High Factor C;</p> <p>High Factor Q3.</p>	
CAT			<p>Closest to the father figure.</p> <p>Fear of mother figure.</p> <p>Striving to be safe in a structured environment.</p>
FRT			<p>Positive feelings towards the father.</p> <p>Neutral feelings towards the mother.</p>

Duess Test			Safety and nurturance received in the paternal context. Wishes to be in the care of the father.
KFD			Child drawn closest to the father in interaction. Experienced mother as busy.
DAP			Feeling of uncertainty within the child. The child has anxiety. Frustration projected.

Family 10: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as the primary caregiver as perceived in the closeness and comfort present during the interactional pattern analysis. The CAT, KFD, FRT and Duess results indicated closeness to the father. The psychometrics also indicated that the father was the more emotionally stable parent with the high Factor C on the 16PF coupled with warm responses on the TAT interpretation. The MCMI results also indicated emotional stability as opposed to the mother who presented with emotional instability in the MCMI scores and TAT responses. Her presentation also indicates poor empathy in the interactional pattern analysis. The recommendation was made that primary care be awarded to the father, but the recommendation was not accepted by the Court. The family formed part of the control group.

FAMILY 11

Table 9.19 Results on the respective psychometric instruments and/or clinical procedures in family 11:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Demonstration of appropriate discipline abilities. Maintained an equal parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline awareness. Maintained a complimentary parent-child role definition.	Comfort in the presence of the father. Uncertainty and anxiety in the presence of the mother.
MCMI-III	Profile valid. Significant high desirability. Narcissistic personality.	Profile valid. No significant scores.	
TAT	Aware of environmental demands. Poor understanding of complexity of others. Poor capacity for emotional investment in relationships.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self esteem.	

	Poor moral standards. Poor understanding of social causality.	Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. High Factor A; Low Factor C; High Factor H; High Factor I; Low Factor O.	Valid profile. High Factor A; High Factor C; High Factor E; Low Factor O.	
CAT			Closest to the father figure. Poor acknowledgement of the mother figure. Anxiety regarding adult interaction.
FRT			Positive feelings towards the father. Negative feelings associated with the maternal context.
Duess Test			Involvement, safety and nurture received in the paternal context. Wishes to be in the care of the father.
KFD			Projection indicated pleasant interaction of father and child.

			The mother seemed busy and distanced.
DAP			Feelings of uncertainty within the child. Escape into fantasy by the child.

Family 11: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as the primary caregiver. The projections on the KFD, CAT, Dues and FRT tests showed paternal preference. The interactional pattern analysis indicated high levels of paternal empathy, but low levels of maternal empathy were indicated in the mother-child relationship. The mother presented less stable psychometrically as seen in the elevated narcissistic scale in the MCMI scores, poor TAT responses and low Factor C on the 16PF. The father appeared to be more stable based on his psychometric profile with no significance in the MCMI and warm responses to the TAT responses. The recommendation was made that primary care be awarded to the father, but the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 12

Table 9.20 Results on the respective psychometric instruments and/or clinical procedures in family 12:

Psychometric tests / procedures	Mother	Father	Child
The clinical	Orientated for time, place	Orientated for time, place	Orientated for time,

interview	and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Poor demonstration of appropriate discipline awareness. Maintained a parent-child role definition.	High levels of empathy. Demonstrated the ability to maintain discipline. Parent-child role definition one of equals.	Comfort in the presence of the father. Uncertainty in the presence of the mother.
MCMI-III	Profile not valid.	Profile valid. Significant high desirability. Histrionic personality.	
TAT	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. High Factor A; Low Factor C;	Valid profile. High Factor C; High Factor E;	

	High Factor E; High Factor H; Low Factor I.	Low Factor L; Low Factor Q1.	
CAT			Closest to the father figure. Mother figure experienced as distanced. Frustrated with the environment.
FRT			Positive feelings towards the father. Neutral to negative feelings allocated to the mother.
Duess Test			Safety and nurturance received in the paternal context. Wishes to be in the care of the father.
KFD			Child drawn in interaction with the father. Experienced mother as absent.
DAP			Feeling of uncertainty with anxiety in the child.

Family 12: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicated that the child experienced the father as the primary caregiver as indicated by the CAT, FRT and Duesse test results. In the KFD interpretation the father was also projected as closest to the child, this was confirmed by the results of the IPA. Although the presenting style of both parents seemed to have been more or less the same, the mother had difficulty maintaining discipline.

It appeared that the psychometric profile of the father seemed to be more emotionally stable in comparison with that of the mother. She provided an invalid MCMI profile and a low Factor C on the 16PF test. The recommendation was made that primary care be awarded to the father, but the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 13

Table 9.21 Results on the respective psychometric instruments and/or clinical procedures in family 13:

Psychometric tests / procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy.	Poor levels of empathy.	Comfort in the presence of

	Demonstration of appropriate discipline. Maintained a parent-child role definition.	Demonstration of poor discipline awareness. Did not maintain a parent-child role definition.	the mother. Uncertainty and anxiety in the presence of the father.
MCMII-III	Profile valid. No significant scores.	Profile valid. Significant high desirability. Narcissistic personality.	
TAT	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	Aware of environmental demands. Poor understanding of complexity of others. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	
16PF	Valid profile. High Factor A; High Factor E; Low Factor O.	Valid profile. High Factor A; Low Factor C; High Factor H; High Factor I; Low Factor O; Low Factor Q2.	
CAT			Closest to the mother figure. Poor acknowledgement of the father figure. Anxiety regarding adult interaction.

FRT			<p>Positive feelings towards the mother.</p> <p>Negative feelings associated with the paternal context.</p>
Duess Test			<p>Involvement, safety and nurturance received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p>
KFD			<p>Projection indicated pleasant interaction between mother and child.</p> <p>The father was negated.</p>
DAP			<p>Feelings of uncertainty within the child.</p> <p>Power strivings in the child.</p>

Family 13: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicate that the child experienced the mother as the primary caregiver. The interactional pattern analysis indicated high levels of empathy with the mother, but low levels of empathy with the father. The child was also anxious in the presence of the father. This was confirmed by the child's test results which also indicated closeness with her mother as seen in the CAT, FRT, Duess and KFD test. The mother presented psychometrically

more stable as there were no elevations in the MCMI while the father seemed to be less stable in his psychometric profile as seen in the low Factor C in the 16 PF and the narcissistic traits on the MCMI. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 14

Table 9.22 Results on the respective psychometric instruments and/or clinical procedures in family 14:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Sufficient ability to maintain discipline. Complimentary parent-child role definition.	Poor levels of empathy. Poor demonstration of discipline. Maintained an equal parent-child role definition.	Comfort in the presence of the mother. Uncertainty in the presence of the father.
MCMI-III	Profile valid. Compulsive personality.	Profile is valid. Narcissistic personality.	
TAT	Aware of environmental demands. Good understanding of	Poor awareness of environmental demands. Poor emotional investment	

	<p>complexity of others. Good capacity for emotional investment in relationships. Strong moral standards. Good understanding of social causality.</p>	<p>in relationships. Good moral standards. Self-centeredness. Denial of aggression and depression. Poor understanding of social causality.</p>	
16PF	<p>Valid profile. Low Factor E; Low Factor H; High Factor I; Low Factor L.</p>	<p>Valid profile. Low Factor B; Low Factor C; High Factor H; Low Factor I; Low Factor M.</p>	
CAT			<p>Closest to the mother figure. Father figure experienced as absent.</p>
FRT			<p>Positive feelings towards the mother. Negative feelings allocated to the father.</p>
Duess Test			<p>Nurturance received in the maternal context. Wishes to be in the care of the mother and in the mother's context.</p>
KFD			<p>Child drawn in the care of the mother. Experienced father as</p>

			distanced.
DAP			Feeling of uncertainty within the child. Comfortable with gender identity.

Family 14: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicate that the child experienced the mother as the primary caregiver. The child's psychometrics (CAT, FRT, KFD) confirmed the close relationship with the mother. His one wish identified in the Duesse test was also to be in the primary care of the mother. The interactional pattern analysis indicated high levels of empathy with the mother and low empathy with the father. The latter was confirmed by the elevation on the narcissistic scale on the MCMI results.

The mother presented psychometrically more stable as was obvious in the reaction to the TAT interpretation while the father seemed to be less stable in his psychometric profile as seen in the low C Factor on the 16PF and poor responses on the TAT protocol. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 15

Table 9.23 Results on the respective psychometric instruments and/or clinical procedures in family 15:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintenance.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintenance.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Poor levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid. Dependent personality; Compulsive personality.	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality.	
TAT	Aware of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships.	Poor awareness of environmental demands. Poor emotional investment in relationships. High moral standards. Self-centred and low in empathy.	

	High moral standards. Integrated understanding of social causality.	Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor A; Low Factor E; High Factor I; Low Factor L; Low Factor N.	Valid profile. High Factor B; Low Factor C; Low Factor E; Low Factor H; Low factor Q4.	
CAT			Primary attachment to the mother figure. Experienced distance in the relationship with the father figure.
FRT			Positive feelings towards the mother. Negative and neutral feelings associated with the paternal context.
Duess Test			Safety and nurturance received in the maternal context. Wishes to be in the care of the mother.
KFD			Projection indicated pleasant interaction between mother and child.

			Father seen as absent.
DAP			<p>Feelings of uncertainty with the child.</p> <p>Infantile dependency needs present in the child.</p>

Family 15: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The CAT, FRT and KFD tests confirmed the closeness, whereas the father was shown as absent (FRT). It also became clear in the Dues test that the child wished to be in the primary care of the mother. Both parents presented appropriately, but the interactional pattern analysis indicated low empathy with the father (which was confirmed by the narcissistic elevation in the MCMI), but the mother demonstrated effective empathetic abilities which was confirmed by the TAT responses. Emotional instability with the father was also indicated in the low Factor C in the 16PF results. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 16

Table 9.24 Results on the respective psychometric instruments and/or clinical procedures in family 16:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Demonstration of poor discipline. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline. Maintained a parent-child role definition.	Comfort in the presence of the father. Comfort in the presence of the mother, but it seemed to be a relationship of equals.
MCMI-III	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality.	Profile valid. Significant high desirability. Compulsive personality.	
TAT	Aware of environmental demands. Poor understanding of complexity of others. Poor capacity for emotional investment in relationships.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of	

	Poor moral standards. Poor understanding of social causality.	aggression and depression. Good understanding of social causality.	
16PF	Valid profile. Low Factor C; Low Factor E; Low Factor I; High Factor O.	Valid profile. High Factor G; Low Factor H; Low Factor Q1.	
CAT			Closest to the father figure. Poor acknowledgement of the mother figure. Anxiety regarding parental interaction.
FRT			Positive feelings towards the father. Negative feelings associated with the mother.
Duess Test			Involvement and nurturance received in the paternal context. Wishes to be in the care of the father.
KFD			Projection indicated pleasant interaction between father and child. Mother projected as distant.

DAP			The child indicates feelings of uncertainty
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Family 16: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver. One of the Dueses wishes predominantly expressed was also to be in the primary care of the father and this closeness was confirmed by the CAT, FRT and KFD tests. Both parents presented appropriately, but the IPA indicated paternal effectiveness in dealing with the child.

The mother presented psychometrically with low levels of empathy (elevated narcissistic scale in the MCMI) and instability (low Factor C on the 16PF). The father, on the other hand, seemed more stable as was evident from the responses of the TAT and stable scores on the 16PF and MCMI results. The recommendation was made that primary care be awarded to the father. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 17

Table 9.25 Results on the respective psychometric instruments and/or clinical procedures in family 17:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation.	Orientated for time, place and person. Congruent presentation.	Orientated for time, place and person. Congruent presentation.

	Logical presentation of history. Complimentary role maintained.	Logical presentation of history. Complimentary role definition with symmetrical episodes.	Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Sufficient ability to maintain discipline. Complimentary parent-child role definition.	Poor levels of empathy. Poor demonstration of discipline. Parallel parent-child role definition.	Comfort in the presence of the mother. Discomfort in the presence of the father.
MCMI-III	Profile valid. Significantly high on desirability. Compulsive personality.	Profile is valid. Significantly high on desirability. Narcissistic personality; Histrionic personality.	
TAT	Aware of environmental demands. Good understanding of complexity of others. Good capacity for emotional investment in relationships. Strong moral standards. Good understanding of social causality.	Poor awareness of environmental demands. Impulsive in dealing with demands. Poor emotional investment in relationships. Poor moral standards. Self-centeredness. Denial of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor A; High Factor I; Low Factor L; High Factor Q3.	Valid profile. High Factor A; Low Factor B; Low Factor C; Low Factor I; High Factor M.	

CAT			<p>Closest to the mother figure.</p> <p>Father figure experienced as dominating.</p> <p>In need of a structured environment.</p>
FRT			<p>Positive feelings towards the mother.</p> <p>Negative feelings allocated to the father.</p>
Duess Test			<p>Nurturance received in the maternal context.</p> <p>Father is experienced as absent and angry.</p> <p>Wishes to be in the care of the mother.</p>
KFD			<p>Child drawing showed closest to mother.</p> <p>Father was distant.</p> <p>Experienced father as absent.</p>
DAP			<p>Child has feelings of uncertainty.</p> <p>The child experience frustration and anxiety</p>

Family 17: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver and the CAT, FRT and CAT tests indicated fear of the father. The IPA of the parents differed as the mother presented appropriately, but the father presented in a challenging manner. The father's psychometric profile tended towards emotional instability as evident in the low Factor C on the 16PF and the elevation on the narcissistic scale on the MCMI results. The mother's profile on the 16PF and MCMI was more stable as confirmed by the TAT responses. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 18

Table 9.26 Results on the respective psychometric instruments and/or clinical procedures in family 18:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Illogical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of	Poor levels of empathy. Poor demonstration of	Discomfort in the presence of the father.

	discipline. Maintained a parent-child role definition.	discipline. Maintained a parent-child role definition.	Spontaneity and comfort in the presence of the mother.
MCI-III	Profile valid. No significant score.	Profile valid. Compulsive personality.	
TAT	Aware of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships. High moral standards. Integrated understanding of social causality.	Aware of environmental demands. Poor emotional investment in relationships. Rigid moral standards. Low in empathy. Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor H; High Factor I; Low Factor L; High Factor M; Low Factor N; Low Factor O.	Valid profile. Faking good. High Factor C; High Factor E; Low Factor I; Low Factor L; Low Factor N; Low Factor Q1.	
CAT			Primary attachment to the mother figure. Father is experienced as pressurising and impatient.
FRT			Positive feelings towards the mother. Negative and neutral

			feelings associated with the paternal context.
Duess Test			Safety and nurturance received in the maternal context. Wishes to be in the care of the mother. Poor reference to the father.
KFD			Projection indicated pleasant interaction between mother and child. Father seen as distanced.
DAP			Feelings of uncertainty within the child. The child demonstrates power strivings

Family 18: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The CAT, FRT and KFD tests indicate that the child feared the father and safety was experienced with the mother. Both parents presented appropriately, but the IPA indicated high levels of empathy (which was confirmed by the TAT interpretations). The mother’s MCMI results were not elevated. The father seemed to have low empathy (as seen in the TAT responses) and seemed to have compulsive tendencies according to the MCMI results. The

recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 19

Table 9.27 Results on the respective psychometric instruments and/or clinical procedures in family 19:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Illogical presentation of history. Symmetrical in presentation maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a complimentary parent-child role definition.	Poor levels of empathy. Poor ability to maintain discipline. Poor parent-child role definition.	Comfort in the presence of the mother. Uncertainty and anxiety in the presence of the father.
MCMI-III	Profile is valid. Significant high score on desirability. Dependent personality.	Profile valid. Histrionic personality; Narcissistic personality.	
TAT	Aware of environmental	Poor awareness of	

	<p>demands.</p> <p>Controlled and patient in dealing with demands.</p> <p>Good emotional investment in relationships.</p> <p>High moral standards.</p> <p>Appropriate acknowledgement of aggression and depression.</p> <p>Good understanding of social causality.</p>	<p>environmental demands.</p> <p>Poor understanding of complexity of others.</p> <p>Limited affect.</p> <p>Poor capacity for emotional investment in relationships.</p> <p>Poor moral standards.</p> <p>Poor understanding of social causality.</p>	
16PF	<p>Valid profile.</p> <p>High Factor A;</p> <p>Low Factor I;</p> <p>High Factor L.</p>	<p>Valid profile.</p> <p>Low Factor E;</p> <p>High Factor F;</p> <p>Low Factor H.</p>	
CAT			<p>Closest to the mother figure.</p> <p>Father experienced as distant and dominating.</p> <p>In need of a structured environment.</p>
FRT			<p>Positive feelings towards the mother.</p> <p>Negative feelings allocated to the father.</p>
Duess Test			<p>Nurturance received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p>
			<p>Child projected as closest</p>

KFD			to the mother. Experienced father as distant and intimidating.
DAP			Feelings of uncertainty within the child. The child is comfortable with gender identity.

Family 19: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The FRT showed that positive feelings were expressed to the mother which was confirmed by the CAT, KFD and Duesse tests. The presenting style of the parents differed as the father seemed confrontational as indicated by the IPA. The IPA of the mother was appropriate to the context. The mother's psychometric profile appeared more emotionally stable as was evident from the elevated Factor A in the 16PF, elevations in the MCMI and the responses on the TAT. The father presented low in empathy which was confirmed by the TAT and MCMI results. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 20

Table 9.28 Results on the respective psychometric instruments and/or clinical procedures in family 20:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition.
IPA	High levels of empathy. Demonstration of appropriate discipline. Maintained a parent-child role definition.	Poor levels of empathy. Demonstration of poor discipline. Did not maintain a parent-child role definition.	Comfort in the presence of the mother. Uncertainty in the presence of the father.
MCMII-III	Profile valid. Significant high score on the desirability scale. Compulsive personality; Anxiety traits.	Profile valid. Self-defeating personality; Borderline personality.	
TAT	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and	Poor awareness of environmental demands. Poor understanding of complexity of others. Limited affect. Poor capacity for emotional investment in relationships.	

	depression. Good understanding of social causality.	Poor moral standards. Poor understanding of social causality.	
16PF	Valid profile. Low Factor A; High Factor C; Low Factor E; High Factor H; High Factor I.	Valid profile. High Factor B; Low Factor H; High Factor I.	
CAT			Closest to the mother figure. Experienced father figure as absent.
FRT			Positive feelings towards the mother. Neutral and negative affections allocated to the father.
Duess Test			Safety and nurturance received in the maternal context. Wishes to be in the care of the mother.
KFD			Child drawn closest to the mother in interaction. Experienced father as absent.
DAP			Feelings of uncertainty

			and anxiety within the child.
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Family 20: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The CAT, KFD and the FRT results showed closeness with the mother and a wish to be in the care of the mother (Duess test).

The psychometrics also indicated that the mother presented as an emotionally stable parent as was evident from the 16PF high C Factor and favourable responses to the TAT, but the father seemed to be less stable as indicated by the borderline traits on the MCMI results and poor TAT responses.

The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. The family formed part of the experimental group.

FAMILY 21

Table 9.29 Results on the respective psychometric instruments and/or clinical procedures in family 21:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of	Orientated for time, place and person. Congruent presentation. Logical presentation of	Orientated for time, place and person. Congruent presentation. Logical presentation of

	history. Complimentary role maintained.	history. Complimentary role definition, with symmetrical elements.	history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Passive in dealing with the child. Poor levels of empathy. Poor demonstration of discipline. Maintained a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid. Histrionic personality.	Profile valid. Significant high desirability score. Histrionic personality; Narcissistic personality.	
TAT	Aware of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships. High moral standards. Integrated understanding of social causality.	Passive awareness of environmental demands. Poor emotional investment in relationships. High moral standards. Low in empathy. Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. Faking good. High Factor A; High Factor C; Low Factor E; Low Factor Q1.	Valid profile. High Factor B; Low Factor C; High Factor I; High Factor M.	

CAT			<p>Primary attachment to the mother figure.</p> <p>Father is experienced as absent.</p>
FRT			<p>Positive feelings associated with the mother.</p> <p>Negative and neutral feelings associated with the paternal context.</p>
Duess Test			<p>Nurturance received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p> <p>Little reference to the father.</p>
KFD			<p>Projection indicated pleasant interaction between mother and child.</p> <p>Father seen as distanced.</p>
DAP			<p>The child presents with feelings of uncertainty.</p> <p>The child has power strivings.</p>

Family 21: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The FRT results showed that positive feelings were associated with the mother and negative feelings with the father. The mother was indicated as having high as opposed to the father's low empathy on the IPA. The father seemed passive in dealing with the environment as was obvious from the MCMI and TAT and could be emotionally less stable as indicated by the low Factor C in the 16PF results. The father provided poor TAT responses as opposed to the mother's stable 16PF, MCMI and TAT scores. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 22

Table 9.30 Results on the respective psychometric instruments and/or clinical procedures in family 22:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Illogical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition with symmetrical episodes.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Low levels of empathy. Poor demonstration of	High levels of empathy. Demonstration of	Comfort in the presence of the father.

	discipline. Maintained an equal parent-child role definition.	appropriate discipline. Maintained a parent-child role definition.	Uncertainty in the presence of the mother.
MCI-III	Profile valid. Significant high desirability. Narcissistic personality; Histrionic personality.	Profile valid. Significant high desirability. Compulsive personality.	
TAT	Aware of demands, but impulsive. Poor self-esteem. Denial of aggression and depression. Denial towards intimate closeness. Low levels of empathy. Poor understanding of social causality.	Aware of environmental demands. Good self-esteem. Denial of aggression and depression. Comfort with intimate closeness. High levels of empathy. Good understanding of social causality.	
16PF	Valid profile. High Factor A; Low Factor C; Low Factor G; High Factor M.	Valid profile. High Factor C; High Factor E; High Factor L.	
CAT			Closest to the father figure. Fear of the mother. In need of structure and routine.
FRT			Affectionate feelings indicated towards the father.

			Neutral and negative affections indicated towards the mother.
Duess Test			Safety and nurturance received in the paternal context. Wishes to be in the care of the father as the mother was absent and aggressive.
KFD			Projection was closeness with the father. Experienced the mother as busy and intimidating.
DAP			Feelings of uncertainty within the child. Anxiety and frustration projected by the child.

Family 22: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver. The KFD results show that the mother was seen as intimidating whereas closeness and comfort were experienced with the father (CAT, FRT and Duess test). The mother seemed less stable as indicated by the low C Factor on the 16PF, compared to the father who seemed more stable. The mother had low empathy as indicated by the TAT, IPA and elevation in the MCMI narcissistic scale. The father presented more stable with a favourable TAT, MCMI and 16PF results. The recommendation was made that primary care be awarded to the

father, but the recommendation was not accepted by the Court. The family formed part of the control group.

FAMILY 23

Table 9.31 Results on the respective psychometric instruments and/or clinical procedures in family 23:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Demonstration of good discipline. Maintained a parent-child role definition.	Poor levels of empathy. Limited demonstration of appropriate discipline. Maintained a parent-child role definition.	Comfort in the presence of the mother. Uncertainty and anxiety in the presence of the father.
MCMI-III	Profile valid. Significant high desirability. Self-defeating personality; Anxiety traits,	Profile valid. Significant high score on desirability. Dependent personality; Avoidant personality; Anxiety traits; Dysthymic traits.	
TAT	Awareness of environmental demands.	Aware of environmental demands but passive in	

	<p>Good understanding of complexity of others.</p> <p>Good capacity for emotional investment in relationships.</p> <p>High moral standards.</p> <p>Appropriate acknowledgement of aggression and sexuality.</p> <p>Good understanding of social causality.</p>	<p>dealing with them.</p> <p>Poor emotional investment in relationships.</p> <p>High moral standards.</p> <p>Low self-esteem.</p> <p>Low empathy.</p> <p>Denial of aggression and depression.</p> <p>Poor understanding of social causality.</p>	
16PF	<p>Valid profile.</p> <p>High Factor A;</p> <p>High Factor C;</p> <p>High Factor H;</p> <p>Low Factor I.</p>	<p>Valid profile.</p> <p>Low Factor A;</p> <p>Low Factor C;</p> <p>Low Factor F;</p> <p>Low Factor H;</p> <p>High Factor Q4.</p>	
CAT			<p>Closest to the mother figure.</p> <p>Poor acknowledgement of the father figure.</p> <p>Anxiety regarding parental interaction.</p>
FRT			<p>Positive feelings towards the mother.</p> <p>Negative feelings associated with the paternal context.</p>
Duess Test			<p>Involvement and nurturance received in the maternal context.</p>

			Wishes to be in the care of the mother.
KFD			Projection indicated pleasant and close interaction of mother and child. The father was projected as passive and distanced.
DAP			Feelings of uncertainty with underlying anxiety in the child. Power strivings with the child.

Family 23: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The FRT, CAT, KFD and Dues results showed closeness and safety in the maternal context. This tendency was present in the interactional pattern analysis where the mother could maintain an empathic position, but the father indicated low levels of empathy.

The mother presented psychometrically as more stable according to the one elevation on the MCMI in comparison with the father who seemed overly withdrawn, dependent and avoidant from the scores in his MCMI results. Emotional instability with the father was also indicated according to the low Factor C in the 16PF and TAT results. The recommendation was made that primary care be awarded to the mother.

The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 24

Table 9.32 Results on the respective psychometric instruments and/or clinical procedures in family 24:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Illogical presentation of history. Symmetrical role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Poor demonstration of discipline. Maintained an equal parent-child role definition.	High levels of empathy. Sufficient ability to maintain discipline. Complimentary parent-child role maintained.	Comfort in the presence of the father. Uncertainty in the presence of the mother.
MCMI-III	Profile valid. Significant high score of desirability. Narcissistic personality.	Profile is valid. No scores were significantly elevated.	
TAT	Impulsive in dealing with environmental demands. Poor emotional investment in	Good understanding of complexity of others. Appropriate affect. Good capacity for	

	relationships. High moral standards. Self-centeredness. Denial of aggression and depression. Poor understanding of social causality.	emotional Investment in relationships. Strong moral standards. Good understanding of social causality. Appropriate acknowledgement of aggression and sexuality.	
16PF	Valid profile. Faking good. Low Factor C; High Factor F; Low Factor I.	Valid profile. High Factor A; High Factor C; High Factor H; High Factor I; Low Factor L.	
CAT			Closest to the father and stepmother figure. Mother figure experienced as emotional and angry. In need of a structured environment.
FRT			Positive feelings towards the father and stepmother. Negative feelings allocated to the mother.
Duess Test			Nurturance received in the paternal context. Wishes to be in the care of the father and in the father's context.
			Closeness projected with

KFD			the paternal context. Experienced mother as ill and hospitalized.
DAP			Feelings of uncertainty and anxiety in the child. The child is comfortable with gender identity.

Family 24: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver as found in the CAT, Dues and FRT results. The psychometric profile of the father seemed to be more emotionally stable as no significant scores were elevated on the MCMI and the high Factor C on the 16PF results compared to the mother's psychometrics indicating a low Factor C and an elevated narcissistic scale score. The mother's awareness of demands was also poor as opposed to the results of the father. The child also seemed to experience the father as more involved as indicated in the IPA findings. The recommendation was made that primary care be awarded to the father, but the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 25

Table 9.33 Results on the respective psychometric instruments and/or clinical procedures in family 25:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Poor levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition with rigidity.	Discomfort and fear in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid. Significant high desirability. Histrionic personality.	Profile valid. Significant high desirability. Compulsive personality; Narcissistic personality.	
TAT	Awareness of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships.	Aware of environmental demands. Poor emotional investment in relationships. Poor moral standards. Self-centred and low in empathy.	

	High moral standards. Integrated understanding of social causality. Denial of aggression and depression.	Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor A; Low Factor E; High Factor I.	Valid profile. Faking good. Low Factor C; High Factor E; High Factor H; High Factor L; High Factor Q1.	
CAT			Primary attachment to the mother figure. Fear for and intimidation by the father figure.
FRT			Positive feelings felt towards the mother. Negative feelings associated with the paternal context.
Duess Test			Safety and nurturance received in the maternal context. Wishes to be in the care of the mother and be protected from the father.
KFD			Projection indicated pleasant interaction between mother and

			child. Father seen as intimidating by the child.
DAP			The child has feelings of uncertainty with underlying anxiety and suspicion towards the environment.

Family 25: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver as was evident in the closeness projected in the KFD and CAT. Nurture and care were indicated in the FRT results and the interactional analysis showed closeness to the mother as opposed to the father. The mother also presented with sufficient empathetic abilities with appropriate discipline in the interactional analysis. The father presented with symmetrical elements, low empathy and poor disciplinary input as proved in the interactional analysis. The father's 16PF profile was invalid in addition to low levels of empathy as evident from the elevated score on the MCMI results. The mother presented psychometrically as dependent submissive, but her levels of nurture and empathy were high as seen in the IPA and TAT interpretations. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 26

Table 9.34 Results on the respective psychometric instruments and/or clinical procedures in family 26:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Demonstration of appropriate discipline. Maintained a complimentary parent-child role definition.	High levels of empathy. Good demonstration of appropriate discipline. Maintained an equal parent-child role definition.	Comfort in the presence of the father and mother. The relationship of father and daughter seemed to be one of equals.
MCMII-III	Profile valid. Significant high desirability. Narcissistic personality.	Profile valid. Compulsive personality.	
TAT	Passive awareness of environmental demands. Poor understanding of complexity of others. Poor integrated capacity for emotional investment in relationships.	Aware of environmental demands but passive in dealing with them. Good emotional investment in relationships but he seemed to be dependent.	

	<p>High moral standards. Low empathy. Good understanding of social causality. Acknowledgement of aggression and depression.</p>	<p>Good moral standards. Poor self-esteem. Denial of aggression and depression. Good understanding of social causality.</p>	
16PF	<p>Valid profile. High Factor A; Low Factor C; High Factor F; Low Factor N.</p>	<p>Valid profile. High Factor A; High Factor E; High Factor I; Low Factor Q1; High Factor Q3.</p>	
CAT			<p>Closest to the father figure. Poor acknowledgement of the mother figure. Anxiety regarding parental interaction.</p>
FRT			<p>Positive feelings towards the father. Negative feelings associated with the mother.</p>
Duess Test			<p>Involvement and nurturance received in the paternal context. Wishes to be in the care of the father.</p>

KFD			Projection indicated pleasant interaction of father and child. Mother projected as distant.
DAP			Feelings of uncertainty within the child.

Family 26: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver as evident in the closeness and comfort present during the interactional pattern analysis. The CAT, KFD, FRT and Dues results indicated closeness to the father. The psychometrics also indicated that the father was the more emotionally stable parent with the high Factor C on the 16PF scores and favourable responses on the TAT interpretations. The MCMI results also indicated emotional stability as opposed to the mother who presented with emotional instability in the MCMI scores (elevated narcissistic and low Factor C on the 16PF) and TAT responses. Her presentation also spoke of poor empathy in the interactional pattern analysis. The recommendation was made that primary care be awarded to the father. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 27

Table 9.35 Results on the respective psychometric instruments and/or clinical procedures in family 27:

Psychometric test / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Demonstration of appropriate discipline. Maintained a complimentary parental child role definition.	Poor levels of empathy. Poor demonstration of appropriate discipline. Maintained a parent-child role definition with a fair amount of rigidity.	Comfort in the presence of the mother. Discomfort in the presence of the father.
MCMI-III	Profile valid. Significant high desirability. Histrionic personality.	Profile valid. Significant high desirability. Compulsive personality.	
TAT	Awareness of environmental demands. Good understanding of complexity of others. Good capacity for emotional investment in relationships. High moral standards.	Passive awareness of environmental demands Poor emotional investment in relationships. Rigid moral standards. Good self-esteem. Acknowledgement of aggression and depression.	

	<p>Good self-esteem.</p> <p>Acknowledgement of aggression and depression.</p> <p>Good understanding of social causality.</p>	<p>Poor understanding of social causality.</p>	
16PF	<p>Valid profile.</p> <p>Faking good.</p> <p>High Factor C;</p> <p>High Factor G;</p> <p>Low Factor Q1.</p>	<p>Valid profile.</p> <p>Faking good.</p> <p>Low Factor A;</p> <p>High Factor F;</p> <p>High Factor G;</p> <p>Low Factor M;</p> <p>Low Factor Q1.</p>	
CAT			<p>Closest to the mother figure.</p> <p>Poor acknowledgement of the father figure.</p> <p>Anxiety regarding parental interaction.</p>
FRT			<p>Positive feelings towards the mother.</p> <p>Negative feelings associated with the father.</p>
Duess Test			<p>Involvement and nurture received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p>
KFD			<p>Projection indicated</p> <p>pleasant interaction of</p>

			mother and child. Father projected as distant and absent.
DAP			Feelings of uncertainty and anxiety within the child.

Family 27: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver which was also the wish expressed on the Dues results. The CAT, KFD and FRT results indicated a maternal parental preference which was also confirmed in the interactional analysis where the mother demonstrated effective empathetic abilities.

The father seemed to be emotionally less stable as indicated by the low Factor C on the 16PF, heightened narcissistic scale on the MCMI results and poor responses on the TAT interpretation. His low level of empathy was also seen in the interactional pattern analysis. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family was this formed part of the experimental group.

FAMILY 28

Table 9.36 Results on the respective psychometric instruments and/or clinical procedures in family 28:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Poor levels of empathy. Poor demonstration of discipline. Maintained a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid. Significant high score on desirability.	Profile valid. Avoidant personality; Narcissistic personality; Aggressive personality.	
TAT	Awareness of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships. High moral standards.	Aware of environmental demands. Poor emotional investment in relationships. Poor moral standards. Low in empathy. Denial of aggression and	

	Acknowledgement of aggression and depression. Integrated understanding of social causality.	depression. Poor understanding of social causality.	
16PF	Valid profile. Low Factor A; High Factor C; Low Factor Q1.	Valid profile. Low Factor A; Low Factor C; High Factor E; Low Factor O.	
CAT			Primary attachment to the mother figure. Father was experienced as absent and intimidating.
FRT			Positive feelings towards the mother. Negative feelings associated with the paternal context.
Duess Test			Safety and nurturance received in the maternal context. Wishes to be in the care of the mother. Fearful reference to the father.
KFD			Projection indicated pleasant interaction

			between mother and child. Father seen as distanced and intimidating.
DAP			Feelings of uncertainty within the child. Frustration and anxiety are present with the child.

Family 28: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver which was also the wished on the Dues results. The CAT, KFD and FRT results indicated a maternal parental preference which was also confirmed in the interactional analysis where the mother demonstrated effective empathetic abilities. The father seemed to be emotionally less stable as indicated by the low Factor C on the 16PF, heightened narcissistic scale on the MCMI scores and poor responses on the TAT interpretations. His low level of empathy was also seen in the interactional pattern analysis. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family was this formed part of the experimental group.

FAMILY 29

Table 9.37 Results on the respective psychometric instruments and/or clinical procedures in family 29:

Psychometric tests / Procedures	Mother	Father	Child

The clinical interview	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role definition, with symmetrical episodes.</p>	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role maintained.</p>	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role maintained.</p>
IPA	<p>High levels of empathy.</p> <p>Good demonstration of discipline.</p> <p>Maintained a complimentary parent-child role definition.</p>	<p>Poor levels of empathy.</p> <p>Poor ability to maintain discipline.</p> <p>Poor parent-child role definition.</p>	<p>Comfort in the presence of the mother and father.</p>
MCFI-III	<p>Profile valid.</p> <p>Significant high score on desirability.</p> <p>Histrionic personality.</p>	<p>Profile valid.</p> <p>Significant high score on desirability.</p> <p>Depressed personality;</p> <p>Self-defeating personality.</p>	
TAT	<p>Effective dealing with demands from the environment.</p> <p>Good emotional investment in relationships.</p> <p>High moral standards.</p> <p>Appropriate acknowledgement of aggression and depression.</p> <p>Good understanding of social causality.</p>	<p>Poor awareness of environmental demands.</p> <p>Poor understanding of complexity of others.</p> <p>Limited affect.</p> <p>Poor capacity for emotional investment in relationships.</p> <p>High moral standards.</p> <p>Denial of aggression and depression.</p> <p>Poor understanding of social causality.</p>	
16PF	<p>Valid profile.</p>	<p>Valid profile.</p>	

	High Factor F; High Factor G; High Factor H; High Factor N.	Faking good. Low Factor C; High Factor M; Low Factor N; Low Factor Q2; Low Factor Q4.	
CAT			Child seemed closest to the mother figure. Father experienced as emotional and distant. In need of a structured environment.
FRT			Positive feelings towards the mother. Negative feelings associated with the father.
Duess Test			Nurturance received in the maternal context. Wishes to be in the care of the mother.
KFD			Projection was that the child felt closest to the mother. Experienced father as preoccupied.
DAP			The child has feelings of uncertainty. The child is comfortable

			with gender identity.
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Family 29: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. Positive feeling was associated with the mother according to the FRT and KFD results. The CAT and Dues results indicated close relationship with the mother. The father presented with low empathy levels (IPA, elevation in the MCMI depression and self-defeating scale and poor responses on the TAT) and seemed to be emotionally less stable (low C Factor on the 16PF). The mother seemed more stable as indicated by the favourable TAT and 16PF profile and high levels of empathy on the IPA profiles. The recommendation was made that primary care be awarded to the mother. Though the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 30

Table 9.38 Results on the respective psychometric instruments and/or clinical procedures in family 30:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Not orientated for time, place and person. Incongruent presentation. Illogical presentation of history. Symmetrical role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.

IPA	Poor levels of empathy. Demonstration of poor discipline awareness. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline awareness. Maintained a parent-child role definition.	Comfort in the presence of the father. Uncertainty and fear in the presence of the mother.
MCMII-III	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality; Anxiety traits; Bi polar traits; Delusional traits.	Profile valid. Compulsive personality.	
TAT	Poor awareness of environmental demands. Poor understanding of complexity of others. Limited affect. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	Awareness of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. Low Factor B; Low Factor C; High Factor L; High Factor Q4.	Valid profile. High Factor B; High Factor E; Low Factor L; Low Factor Q1.	
CAT			Closest to the father figure. Fear of mother figure.

			Striving to be safe in a structured environment.
FRT			Positive feelings towards the father. Neutral and negative affections allocated to the mother.
Duess Test			Safety and nurturance received in the paternal context. Wishes to be in the care of the father.
KFD			Child drawn closest to the father in interaction. Experienced mother as busy and unpredictable.
DAP			Feelings of uncertainty within the child. Anxiety and frustration projected by the child.

Family 30: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver. The KFD interpretation indicated that the mother was regarded as unpredictable and the CAT, FRT and Duess results proved a fatherly preference. The psychometrics of the father showed one elevation of

compulsion in the MCMI results, but the TAT responses and 16PF profiles seemed stable. The mother, on the other hand, showed tendencies towards psychopathology on her elevations on the MCMI profile and a low C Factor on the 16PF. The recommendation was made that primary care be awarded to the father, but the recommendation was not accepted by the Court. The family formed part of the control group.

FAMILY 31

Table 9.39 Results on the respective psychometric instruments and/or clinical procedures in family 31:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated towards time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical episodes.	Orientated towards time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated towards time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a complimentary parent-child role definition.	Poor levels of empathy. Poor ability to maintain discipline. Poor parent-child role definition.	Comfort in the presence of the mother. Child seemed uncertain and fearful in the presence of the father.
MCMI-III	Profile valid. Significant high score on desirability.	Profile is valid. Significant high score on desirability.	

	Compulsive personality; Anxiety traits.	Depressed personality; Masochistic personality; Dysthymic traits; Substance abuse traits.	
TAT	Controlled and rigid in dealing with environmental demands. Poor emotional investment in relationships. High moral standards. Appropriate acknowledgement of aggression and depression. Poor understanding of social causality.	Passive awareness of environmental demands. Poor understanding of complexity of others. Limited affect. Poor capacity for emotional investment in relationships. High moral standards. Denial of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor B; Low Factor Q1.	Valid profile. High Factor I; High Factor Q3; High Factor Q4.	
CAT			Child seems closest to the mother figure. Father experienced as distant. In need of a structured environment.
FRT			Positive feelings towards the mother. Negative feelings allocated to the father.

Duess Test			Nurturance received in the maternal context. Concerned about the father.
KFD			Projection was that the child felt closest to the mother and worried about the father. Experienced father as preoccupied.
DAP			Feelings of uncertainty and worry in the child. Comfortable with gender identity.

Family 31: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver as indicated by the CAT, KFD, Duess and FRT results. The IPA profile indicated that the father seemed emotionally fluctuating which was confirmed by the depression tendencies in the MCMI results. According to the IPA results he also presented with low empathy whereas the mother tested high on empathy on the IPA profile. The recommendation was made that primary care be awarded to the mother, though the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 32

Table 9.40 Results on the respective psychometric instruments and/or clinical procedures in family 32:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated towards time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated towards time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated towards time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Poor demonstration of appropriate discipline. Maintained a parent-child role definition.	High levels of empathy. Demonstrated the ability to maintain discipline. Parent-child role definition one of equals.	Comfort in the presence of the father and mother.
MCFI-III	Profile valid. Significant high desirability. Compulsive personality.	Profile not valid.	
TAT	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and	

	depression. Good understanding of social causality.	depression. Good understanding of social causality.	
16PF	Valid profile. High Factor A; High Factor C; High Factor H ; Low Factor I.	Valid profile. Low Factor C; High Factor E; Low Factor Q1; High Factor Q4.	
CAT			Closest to the mother figure. Father figure experienced as distanced. Frustrated with the environment.
FRT			Positive feelings towards the mother. Neutral to negative feelings allocated to the father.
Duess Test			Nurturance received in the maternal context. Wishes to be in the care of the mother.
KFD			Child drawn in interaction with the mother. Experienced father as absent.
DAP			Feelings of uncertainty

			with anxiety within the child.
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Family 32: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The FRT results showed that the mother was seen in a positive light which was confirmed by the CAT, KFD and Dues results. The psychometric profile of the mother seemed to be emotionally stable as evident from the high factor C in the 16PF results. The father presented emotionally less stable as proved by the invalid MCMI and low Factor C in the 16PF. The recommendation was made that primary care be awarded to the mother. The recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 33

Table 9.41 Results on the respective psychometric instruments and/or clinical procedures in family 33:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.

IPA	Poor levels of empathy. Demonstration of poor discipline. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline. Maintained a parent-child role definition.	Comfort in the presence of the father. Uncertainty in the presence of the mother.
MCMI-III	Profile not valid.	Profile valid. Significant high desirability. Compulsive personality.	
TAT	Poor awareness of environmental demands. Poor understanding of complexity of other people. Poor capacity for emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of aggression and depression. Good understanding of social causality.	
16PF	Valid profile. High Factor A; Low Factor C; High Factor E; High Factor Q1; High Factor Q3.	Valid profile. High Factor A; High Factor I; Low Factor L; Low Factor Q2.	
CAT			Closest to the father figure. Acknowledgement of the mother figure, but seemed to be intimidated. Anxiety regarding adult interaction.

FRT			<p>Positive feelings towards the father.</p> <p>Negative feelings associated with the maternal context.</p>
Duess Test			<p>Involvement with and safety received in the paternal context.</p> <p>Wishes to be in the care of the father and have limited contact with the mother.</p>
KFD			<p>Projection indicated pleasant interaction of father and child.</p> <p>Mother projected as being busy and distanced.</p>
DAP			<p>Feelings of uncertainty within the child.</p> <p>Underlying aggression present in the child.</p>

Family 33: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver. The CAT, FRT and KFD scores confirmed the closeness with the father and the Duess results proved that the child preferred to be distanced from the mother. The IPA indicated that the father had high

levels of empathy but the mother's IPA profile showed low empathy. Her 16PF profile indicated a low Factor C, indicating emotional instability which was confirmed by the poor responses on the TAT interpretation and the invalid MCMI profile.

The father presented psychometrically more stable as seen in the good TAT responses and valid MCMI and 16PF profiles. The recommendation was made that primary care be awarded to the father. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 34

Table 9.42 Results on the respective psychometric instruments and/or clinical procedures in family 34:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Poor demonstration of discipline. Maintained an equal parental-child role definition.	High levels of empathy. Sufficient ability to maintain discipline. Complimentary parent-child role definition.	Comfort in the presence of the father. Uncertainty in the presence of the mother.
MCMI-III	Profile valid.	Profile valid.	

	Histrionic personality; Narcissistic personality; Compulsive personality.	Compulsive personality.	
TAT	Passive awareness of environmental demands. Poor emotional investment in relationships. Good moral standards. Self-centredness. Denial of aggression and depression. Poor understanding of social causality.	Awareness of environmental demands. Good understanding of complexity of others. Good capacity for emotional investment in relationships. Strong moral standards. Good understanding of social causality.	
16PF	Valid profile. Low Factor A; Low Factor C; High Factor I; High Factor Q4.	Valid profile. High Factor C; High Factor H; High Factor I.	
CAT			Closest to the father figure. Mother figure experienced as absent and angry.
FRT			Positive feelings towards the father. Negative feelings allocated to the mother.
Duess Test			Nurturance and care received in the paternal context. Wishes to be in the care of

			the father and in the father's context.
KFD			Projection to be closest to father. Experienced the mother as distanced.
DAP			Feelings of uncertainty and fear in the child. The child is comfortable with gender identity.

Family 34: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the father as the primary caregiver and feared the mother (CAT, FRT and Dues). The child projected closeness with the father on the KFD interpretation. The IPA indicated a low level of empathy experienced from the mother and high empathy from the father. The mother had a low Factor C on the 16PF profile and elevation on the narcissistic scale on the MCMI scores, confirming the low empathy. The father provided favourable TAT and 16PF results. The recommendation was made that primary care be awarded to the father. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 35

Table 9.43 Results on the respective psychometric instruments and/or clinical procedures in family 35:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical (aggressive) elements.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Poor levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid. Dependent personality; Compulsive personality.	Profile valid. Significant high desirability. Narcissistic personality; Aggressive personality.	
TAT	Good awareness of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships. High moral standards.	Poor awareness of environmental demands. Poor emotional investment in relationships. High moral standards. Self-centred and low in empathy. Acknowledgement of	

	Integrated understanding of social causality.	aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. Low Factor A; High Factor C; High Factor I; Low Factor L; Low Factor Q1.	Valid profile. Faking good. High Factor B; Low Factor E; Low Factor H; High Factor Q3; Low factor Q4.	
CAT			Primary attachment to the mother figure. Experienced distance in the relationship with the father figure.
FRT			Positive feelings towards the mother. Negative and neutral feelings associated with the paternal context.
Duess Test			Care and nurturance received in the maternal context. Wishes to be in the care of the mother. Paternal context seemed to create fear.
KFD			Projection indicated pleasant interaction

			between mother and child. Father seen as absent and intimidating.
DAP			Feelings of uncertainty with anxiety in the child. Infantile dependency traits present in the child.

Family 35: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver. The father was feared as became evident from the FRT, KFD, CAT and Dues results. The IPA indicated high levels of empathy with the mother, which was confirmed by the scores on the 16PF profile and good responses on the TAT interpretation. The father's IPA profile seemed to be aggressive in style, which was confirmed by the MCMI scores, with elevations on aggression and narcissism. His TAT responses also indicated poor empathy. The recommendation was made that primary care be awarded to the mother, but the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 36

Table 9.44 Results on the respective psychometric instruments and/or clinical procedures in family 36:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.
IPA	Poor levels of empathy. Demonstration of poor discipline abilities. Did not maintain a parent-child role definition.	High levels of empathy. Demonstration of appropriate discipline ability. Maintained a parent-child role definition.	Comfort in the presence of the father. Comfort in the presence of the mother, but it seemed to be a relationship of equals.
MCMI-III	Profile valid. Significant high desirability. Narcissistic personality; Compulsive personality.	Profile valid. Significant high desirability; Compulsive personality.	
TAT	Poor awareness of environmental demands. Poor understanding of complexity of others. Poor capacity for emotional investment in relationships.	Aware of environmental demands. Good emotional investment in relationships. Good moral standards. Good self-esteem. Acknowledgement of	

	Poor moral standards. Poor understanding of social causality.	aggression and depression. Good understanding of social causality.	
16PF	Valid profile. Low Factor C; Low Factor E; Low Factor I; High Factor O.	Valid profile. High Factor G; Low Factor H; Low Factor Q1.	
CAT			Closest to the father figure. Poor acknowledgement of the mother figure. Anxiety regarding parental interaction.
FRT			Positive feelings towards the father. Negative feelings associated with the mother.
Duess Test			Involvement and nurture received in the paternal context. Wishes to be in the care of the father.
KFD			Projection indicated pleasant interaction of father and child. Mother projected as distant.

DAP			Feelings of uncertainty within the child.
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Family 36: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experience the father as the primary caregiver. The wish indicated on the Dues test was to be in the care of the father and positive feelings were allocated to the father in the FRT results. The CAT and KFD interpretations showed projections of paternal preference. The mother tested a low Factor C in the 16PF profile and an elevated narcissistic score on the MCMI results with poor TAT responses. The mother tended towards being low in empathy as seen in the interactional analysis. The recommendation was made that primary care be awarded to the father. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 37

Table 9.45 Results on the respective psychometric instruments and/or clinical procedures in family 37:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role

	maintained.	definition with symmetrical episodes.	definition.
IPA	High levels of empathy. Sufficient ability to maintain discipline. Complimentary parent-child role definition.	Poor levels of empathy. Poor demonstration of discipline. Parallel parent-child role definition.	Comfort in the presence of the father. Discomfort in the presence of the mother.
MCMI-III	Profile valid. Significantly high on desirability. Compulsive personality.	Profile valid. Significantly high on desirability. Narcissistic personality; Histrionic personality.	
TAT	Awareness of environmental demands. Good understanding of complexity of others. Good capacity for emotional investment in relationships. Strong moral standards. Good understanding of social causality.	Impulsive in dealing with environmental demands. Poor emotional investment in relationships. Poor moral standards. Self-centredness. Denial of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor A; High Factor I; Low Factor L; High Factor Q3.	Valid profile. High Factor A; Low Factor B; Low Factor C; Low Factor F; Low Factor I; High Factor M.	
CAT			Closest to the mother figure.

			Father figure experienced as dominating. In need of a structured environment.
FRT			Positive feelings towards the mother. Negative feelings allocated to the father.
Duess Test			Nurturance received in the maternal context. Father was experiences as absent and angry. Wishes to be in the care of the mother.
KFD			Child drawing showed closest to mother. Father was distant. Experienced father as absent.
DAP			Feelings of uncertainty within the child. The child has frustration and anxiety.

Family 37: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver which was also the wish

indicated on the Dues test. The CAT, KFD and FRT results indicated a maternal parental preference which was also confirmed in the interactional analysis where the mother demonstrated effective empathetic abilities. The father seemed to be emotionally less stable as indicated by the low Factor C on the 16PF, heightened narcissistic scale on the MCMI and poor responses on the TAT. His low level of empathy was also observed in the interactional pattern analysis. The recommendation was made that primary care be awarded to the mother. The recommendation was accepted by the Court. This family formed part of the experimental group.

FAMILY 38

Table 9.46 Results on the respective psychometric instruments and/or clinical procedures in family 38:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	Orientated for time, place and person. Congruent presentation. Logical presentation of history. Complimentary role maintained.	Orientated for time, place and person. Incongruent presentation. Logical presentation of history. Complimentary role definition, with symmetrical elements.	Orientated for time, place and person. Congruent presentation. Illogical presentation of history. Complimentary role maintained.
IPA	High levels of empathy. Good demonstration of discipline. Maintained a parent-child role definition.	Poor levels of empathy. Poor demonstration of discipline. Maintained a parent-child role definition.	Discomfort in the presence of the father. Spontaneity and comfort in the presence of the mother.
MCMI-III	Profile valid.	Profile valid.	

	No significant score.	Narcissistic personality; Compulsive personality.	
TAT	Good awareness of environmental demands. Good understanding of complexity of others. Developed capacity for emotional investment in relationships. High moral standards. Integrated understanding of social causality.	Aware of environmental demands. Poor emotional investment in relationships. Rigid moral standards. Low in empathy. Acknowledgement of aggression and depression. Poor understanding of social causality.	
16PF	Valid profile. High Factor H; High Factor I; Low Factor L; High Factor M; Low Factor N; Low Factor O.	Valid profile. Faking good. Low Factor C; High Factor E; Low Factor I; Low factor L;	
CAT			Primary attachment to the mother figure. Father was experienced as pressurising and impatient.
FRT			Positive feelings towards the mother. Negative and neutral feelings associated with the paternal context.
Duess Test			Safety and nurturance

			<p>received in the maternal context.</p> <p>Wishes to be in the care of the mother.</p> <p>Poor reference to the father.</p>
KFD			<p>Projection indicated pleasant interaction between mother and child.</p> <p>Father seen as distanced.</p>
DAP			<p>Feelings of uncertainty within the child.</p> <p>The child has power strivings.</p>

Family 38: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver which was also projected in the CAT and KFD interpretations. The wish on the Dues test was to be in the care of the mother and the FRT results showed positive feelings being allocated to the mother and negative feelings for the child to be with the father. The interactional pattern analysis indicated high maternal levels of empathy and good disciplinary input, but the father seemed to be low in empathy. The mother presented psychometrically as more stable as compared to the father as his Factor C on the 16PF profile was low, with poor TAT responses and the high narcissistic score on the MCMI. The recommendation was made that primary care be awarded to the mother, but the recommendation was not accepted by the Court. This family formed part of the control group.

FAMILY 39

Table 9.47 Results on the respective psychometric instruments and/or clinical procedures in family 39:

Psychometric tests / Procedures	Mother	Father	Child
The clinical interview	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role maintained.</p>	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Illogical presentation of history.</p> <p>Symmetrical role maintained.</p>	<p>Orientated for time, place and person.</p> <p>Congruent presentation.</p> <p>Logical presentation of history.</p> <p>Complimentary role maintained.</p>
IPA	<p>High levels of empathy.</p> <p>Good demonstration of discipline.</p> <p>Maintained a complimentary parent-child role definition.</p>	<p>Poor levels of empathy.</p> <p>Poor ability to maintain discipline.</p> <p>Poor parent-child role definition.</p>	<p>Comfort in the presence of the mother.</p> <p>Uncertainty and anxiety in the presence of the father.</p>
MCFI-III	<p>Profile valid.</p> <p>Histrionic personality.</p>	<p>Profile valid.</p> <p>Significant high score on desirability.</p> <p>Dependent personality;</p> <p>Avoidant personality;</p> <p>Narcissistic personality.</p>	
TAT	<p>Controlled and patient in dealing with environmental demands.</p> <p>Good emotional investment in relationships.</p> <p>High moral standards.</p>	<p>Poor awareness of environmental demands.</p> <p>Poor understanding of complexity of others.</p> <p>Limited affect.</p> <p>Poor capacity for</p>	

	Appropriate acknowledgement of aggression and depression. Good understanding of social causality.	emotional investment in relationships. Poor moral standards. Poor understanding of social causality.	
16PF	Valid profile. High Factor A; High Factor C; Low Factor I; High Factor L.	Valid profile. Low Factor C; Low Factor E; High Factor F; Low Factor H; High Factor Q4.	
CAT			Closest to the mother figure. Father experienced as distant and dominating. In need of a structured environment.
FRT			Positive feelings towards the mother. Negative feelings allocated to the father.
Duess Test			Nurturance present in the maternal context. Wishes to be in the care of the mother.
KFD			Child projected as closest to the mother. Experienced father as distant and intimidating.

DAP			<p>Feeling of uncertainty in the child.</p> <p>The child is comfortable with gender identity.</p>
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Family 39: Recommendation and placement

The evaluation from the psychometric tests and clinical procedures indicates that the child experienced the mother as the primary caregiver as seen on the CAT and KFD projection. The FRT showed positive feelings allocated to the mother and negative feelings to the father. The child's wish in the Duesse test was also to be in the care of the mother. The presenting style, as shown in the interactional pattern analysis of the parents differed as the father seemed unassertive with low self-esteem and poor levels of empathy. On the other hand, the mother's levels of empathy were good. The mother's psychometric profile appeared more emotionally stable with no significant lowered C Factor in the 16PF profile, stable TAT responses and one elevation in the MCMI results. Contrary to this the father seemed to be less emotionally stable as indicated by the low Factor C in the 16PF, narcissistic traits in the MCMI results and the poor TAT responses. The recommendation was made that primary care be awarded to the mother, but the recommendation was not accepted by the Court. This family formed part of the control group.

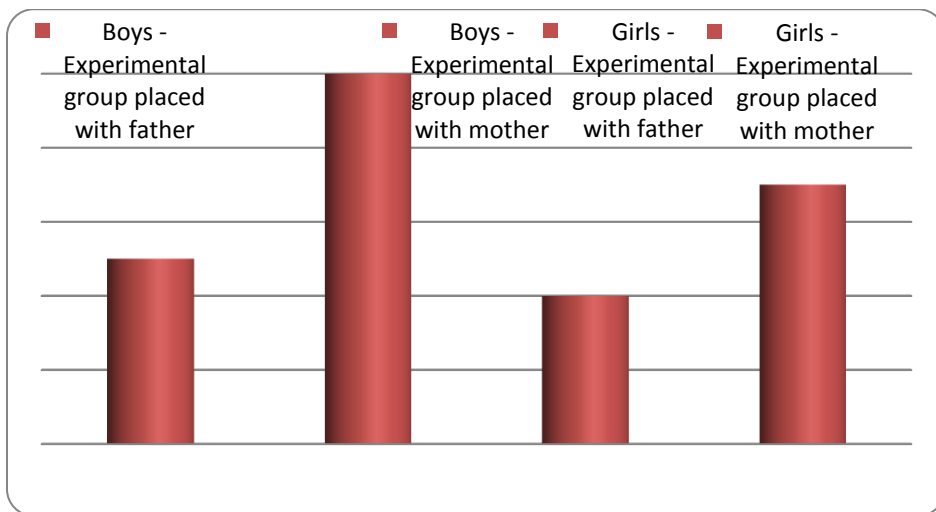
9.6.2 Summary

It is evident from the aforementioned results that a parent with a low Factor C on the 16PF profile, high narcissistic score together with other elevations on the MCMI results coupled with poor responses to the TAT, together with low levels of empathy and poor or inadequate maintenance of disciplinary boundaries in the interactional pattern analysis, led to the recommendation that primary care placement be given to the other

parent. The CAT, KFD, FRT and Dues scores were also clear indicators of the child’s parental preference. The DAP interpretations proved to be of little significance in this regard. The psychometrics thus provided a clear indication for recommendation of primary care placement.

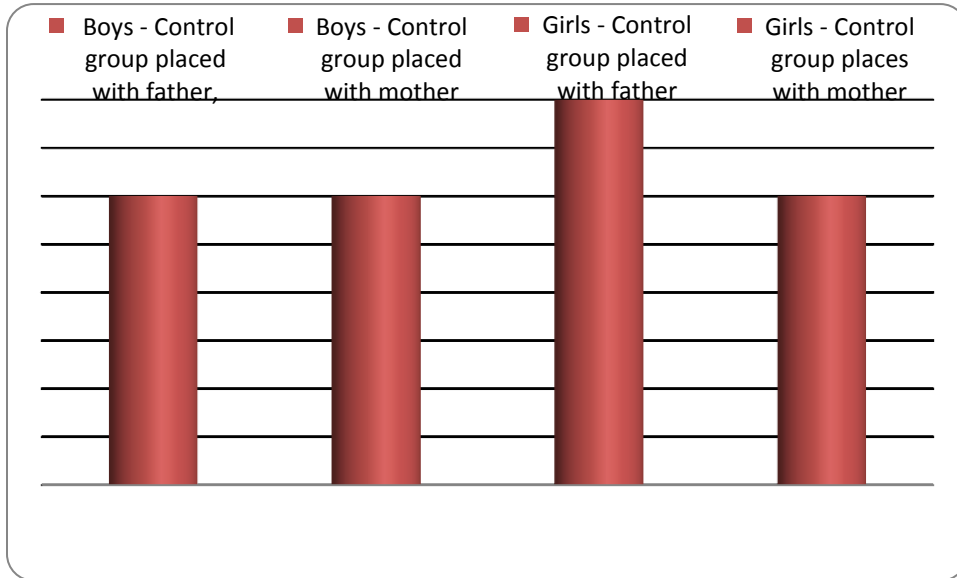
9.7 Distribution of the Residency Placement

Graph 9.1 Residency placement of the children in the experimental group



It is evident from graph 9.1 of the 26 children that in the experimental group, 5 boys were placed with the father and 10 boys with the mother. In the girls experimental group, 4 were placed with the father and 7 with the mother.

Graph 9.2 Residency placement of the children in the control group



Graph 9.2 shows that from the 13 families in the control group, 3 boys were placed with the father and 3 boys placed with the mother. With regard to the girls 4 were placed in residency with the father and 3 with the mother.

Although there was a difference in numbers in the experimental and control groups, valid statistical comparisons could still be made (Neuman, 2009).

Interestingly, the distribution of the residency placement was primarily with the mother, which was in accordance with the old regime of the tender years principle where young children were automatically placed with the mother. However, in this study the sample was too small to make an interpretation in this regard.

The children in the aforementioned placements were followed up and evaluated after six months. The results of the evaluation of the 39 families tested after six months are reported below.

9.8 Results of the Families Tested after Six Months

FAMILY 1

Table 9.48 Results of family 1 tested after six months

Psychometric test	Score
RSE	25
IFR	24
ECBI	71
FAD Affective involvement (AI)	16
FAD Affective responsiveness (AR)	9
FAD Behavioural control (BC)	29
FAD Communication (C)	16
FAD General functioning (G)	25
FAD Problem solving (PS)	17
FAD Roles (R)	15

Family 1: Results of placement of children after six months

The results show that 6 months after primary care placement, the global self-esteem of the child improved: as can be seen on the high score of the RSE scale. The limited occurrence of family problems stemming from personal and social dysfunction in family adjustment and intra-familial stress becomes evident in the low IFR score. It is also clear that, based on the low score obtained from the ECBI score behavioural problems

in the children such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying were not evident. The low FAD (IA, BC and AR) score indicated that the family members showed tenderness, concern and affection for one another. The low score on the FAD (R, PS and G) scores indicates that the family had a clear set of rules and consequences and the family's ability to identify relevant and appropriate problems which threatened the cohesion in the family was effectively addressed. With regard to communication, the verbal messages were clear in content and direct in the sense that the person spoken to was the person for whom the message was intended as seen in the low score in the FAD (C) scale. Overall, the results indicate that this family was healthy (low FAD G).

FAMILY 2

Table 9.49 Results of family 2 tested after six months

Psychometric test	Score
RSE	24
IFR	27
ECBI	61
FAD Affective involvement (AI)	17
FAD Affective responsiveness (AR)	8
FAD Behavioural control(BC)	28
FAD Communication (C)	10
FAD General functioning (G)	20
FAD Problem solving (PS)	17
FAD Roles (R)	18

Family 2: Results of placement of children after six months

The results after six months show general improvement in this family's functioning is evident from the FAD (G) score. The global self-esteem of the child was good (low RSE) and the magnitude of family problems and intra family stress were reported to be

minimal (low IFR). The low ECBI score indicates that the number of difficult-behaviour problems was few and the frequency at which they occurred was rare. In other words, the occurrences of disruptive and annoying behaviour, aggression towards others, non-compliance, temper tantrums, stealing and lying did not seem to be problematic in this family.

The score on AR, R and AI of the FAD shows high levels of nurture in this family, together with a clear set of rules and consequences. The low scores of the FAD PS, BC and C indicate ineffective dealing with problems which might threaten the cohesion in the family.

FAMILY 3

Table 9.50 Results of family 3 tested after six months

Psychometric test	Score
RSE	17
IFR	94
ECBI	143
FAD Affective involvement (AI)	18
FAD Affective responsiveness (AR)	14
FAD Behavioural control (BC)	24
FAD Communication (C)	13
FAD General functioning (G)	37
FAD Problem solving (PS)	14
FAD Roles (R)	22

Family 3: Results of placement of children after six months

The results of family 3 indicate that the child had low levels of global self-esteem as indicated by the high FAD (G).

The high IFR score indicates that the severity of family problems stemming from personal and social dysfunction in the area of family adjustment appeared to be severe.

The high ECBI score shows that the parental ability to deal with behavioural problems in children effectively was not good. Reference was made to problems with aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying were also high, as indicated by FAD BC.

The high score on FAD AI, AR and R shows that the level of nurturance seemed to have lowered and there was confusion regarding a clear set of rules and consequences. FAD PS and C have high elevations indicating poor problem solving and communication. It thus appears that six months after primary care placement the family's health was poor.

FAMILY 4

Table 9.51 Results of family 4 tested after six months

Psychometric test	Score
RSE	27
IFR	27
ECBI	71
FAD Affective involvement (AI)	19
FAD Affective responsiveness (AR)	16
FAD Behavioural control (BC)	26
FAD Communication (C)	16
FAD General functioning (G)	30
FAD Problem solving (PS)	20
FAD Roles (R)	20

Family 4: Results of placement of children after six months

The results of family 4 indicate that the child's global self-esteem is on a good level as seen in the high RSE. Regarding family adjustment, this family did not seem to experience severe family problems stemming from personal and social dysfunction (low

IFR and ECBI). Difficult-behaviour problems and the frequency at which they occurred seem to be limited to the minimum (low FAD BC). This family appeared to show tenderness, concern and affection for one another (high AI and AR). They also had a clear set of rules and consequences, where the custodial parents could clearly assign roles and tasks to the children (FAD R). They were effective in dealing with problems and the exchange of information among family members (low FAD PS and C).

FAMILY 5

Table 9.52 Results of family 5 tested after six months

Psychometric test	Score
RSE	28
IFR	26
ECBI	49
FAD Affective involvement (AI)	16
FAD Affective responsiveness (AR)	13
FAD Behavioural control (BC)	22
FAD Communication (C)	18
FAD General functioning (G)	31
FAD Problem solving (PS)	17
FAD Roles (R)	17

Family 5: Results of placement of children after six months

According to the results it seems that the child had a good global self-esteem (high RSE). The family's ability to deal with family problems was effective and thus reducing the intra-familial stress (low IFR). The parental ability to address behavioural problems in the children such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying was also effective (low ECBI). The FAD AR, AI and BC indicates that a context of nurture with a clear set of rules and

consequences was available (FAD PS). There was clear communication among family members (FAD C); thus the overall health of this family was good.

FAMILY 6

Table 9.53 Results of family 6 tested after six months

Psychometric test	Score
RSE	25
IFR	30
ECBI	51
FAD Affective involvement (AI)	15
FAD Affective responsiveness (AR)	14
FAD Behavioural control (BC)	11
FAD Communication (C)	12
FAD General functioning (G)	21
FAD Problem solving (PS)	10
FAD Roles (R)	10

Family 6: Results of placement of children after six months

The results of family 6 show that the child had good global self-esteem (high RSE) and the magnitude of family problems as well as intra-familial stress was not significant (low IFR). The custodial parents could address behavioural problems in children (low ECBL) effectively. The number of difficult-behaviour problems and the frequency at which they occurred was also very low. The family members showed tenderness and affection (low FAD AI and AR) for one another and maintained family roles (FAD R) by following a clear set of rules and consequences. The custodial parents were also able to maintain and accept a position of authority, causing effective problem-solving (FAD PS and BC). They communicated openly and clearly (FAD C).

FAMILY 7

Table 9.54 Results of family 7 tested after six months

Psychometric test	Score
RSE	25
IFR	26
ECBI	58
FAD Affective involvement (AI)	10
FAD Affective responsiveness (AR)	10
FAD Behavioural control (BC)	11
FAD Communication (C)	9
FAD General functioning (G)	21
FAD Problem solving (PS)	12
FAD Roles (R)	17

Family 7: Results of placement of children after six months

The score on the RSE indicates a high global self-esteem (high RSE). The low IFR score shows that the severity of family problems, relationship problems and intra-familial stress was not significantly high in this family. They acknowledged and addressed behavioural problems (low ECBI), and did not seem to have difficulties with traits like aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying. This family was nurturing on one the hand (FAD AI and AR), but also had a clear set of rules with consequences in place (FAD BC and R). The parents clearly assigned roles and tasks to the children, clarifying roles and hierarchy, with the custodial parents being able to maintain and accept a position of authority (FAD G). They could identify and solve problems (low FAD PS) which threatened the cohesion in the family and communicate clearly to one another (low FAD C). Thus the verbal messages were clear in content and direct in the sense that the person spoken to was the person for whom the message was intended. Consequently this family seemed to be healthy six months after primary care placement.

FAMILY 8

Table 9.55 Results of family 8 tested after six months

Psychometric test	Score
RSE	24
IFR	26
ECBI	48
FAD Affective involvement (AI)	14
FAD Affective responsiveness (AR)	8
FAD Behavioural control (BC)	13
FAD Communication (C)	7
FAD General functioning (G)	15
FAD Problem solving (PS)	9
FAD Roles (R)	12

Family 8: Results of placement of children after six months

The RSE score shows a high global self-esteem for this child (high RSE). It is also indicated that family 8 had a low instance of family problems stemming from personal and social dysfunction in the family adjustment (low IFR). The parental ability and repertoire to address behavioural problems in children, together with expressing tenderness, concern and affection for one another was of a high standard (low ECBL and FAD BC). They had a clear set of rules and consequences in place as this family could identify relevant and appropriate problems which threatened the cohesion in the family (FAD R). The low FAD C shows that they could communicate clearly. Overall, this family could be deemed a healthy family (low FAD G).

FAMILY 9

Table 9.56 Results of family 9 tested after six months

Psychometric test	Score
RSE	24
IFR	19
ECBI	57
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	10
FAD Behavioural control (BC)	11
FAD Communication (C)	11
FAD General functioning (G)	18
FAD Problem solving (PS)	9
FAD Roles (R)	15

Family 9: Results of placement of children after six months

Family 9 shows that the child had a high global self-esteem as seen in the low RSE score. The magnitude of their family problems stemming from personal and social dysfunction was not very high, indicating therefore, low levels of intra-familial stress (low IFR). The low ECBI did not show many complaints of behavioural problems in children and practically no traits of aggression towards others, nor non-compliance, temper tantrums, disruptive or annoying behaviours, stealing lying. They seemed to be close to one another and respect the boundaries and needs of each member (FAD BC). Problem-solving took place effectively (low FAD PS) and communication seemed to be open and transparent (low FAD C). The general functioning of this family was overall healthy (low FAD G).

FAMILY 10

Table 9.57 Results of family 10 tested after six months

Psychometric test	Score
RSE	17
IFR	82
ECBI	194
FAD Affective involvement (AI)	22
FAD Affective responsiveness (AR)	21
FAD Behavioural control (BC)	21
FAD Communication (C)	22
FAD General functioning (G)	37
FAD Problem solving (PS)	19
FAD Roles (R)	29

Family 10: Results of placement of children after six months

The results of this family indicate that the child had a low global self-esteem (low RSE). The severity of family problems stemming from personal and social dysfunction in the area of family adjustment was serious, resulting in heightened intra-familial stress (high IFR). According to the results of the high ECBI score the parental report of, conduct and behavioural problems in the children was disruptive and such instances seemed to be frequent. Apparent presence of traits such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying occurred in this family (high FAD BC and G). The results of the low FAD AI and AR indicated that tenderness, concern and affection for one another was limited and there were no clear rules and consequences (FAD R). It seemed that the custodial parents could not maintain a position of authority (high FAD PS). He/she did not communicate clearly and openly (high FAD C). Health of this family after six months' follow-up was poor (high FAD G).

FAMILY 11

Table 9.58 Results of family 11 tested after six months

Psychometric test	Score
RSE	16
IFR	89
ECBI	102
FAD Affective involvement (AI)	23
FAD Affective responsiveness (AR)	20
FAD Behavioural control (BC)	34
FAD Communication (C)	23
FAD General functioning (G)	42
FAD Problem solving (PS)	19
FAD Roles (R)	30

Family 11: Results of placement of children after six months

After six months the results show that family 11 was not functioning effectively. In this instance the child showed low global self-esteem as revealed in the low RSE. The high IFR proves that the magnitude of family problems was causing intra-familial stress. The custodial parents could not address difficult-behaviour problems effectively and implies the parents have repetitive incidents of aggression towards others (high ECBI). The nurturance seemed poor and the role hierarchy was not clearly defined (high FAD AI, AR and R). Their ability to solve problems was also poor and this might threaten the cohesion in the family (high FAD PS). The level of communication was not direct and bordered on being confusing (high FAD C).

FAMILY 12

Table 9.59 Results of family 12 tested after six months

Psychometric test	Score
RSE	18
IFR	54
ECBI	200
FAD (AI) Affective involvement	24
FAD Affective responsiveness (AR)	19
FAD Behavioural control (BC)	35
FAD Communication (C)	23
FAD General functioning (G)	42
FAD Problem solving (PS)	16
FAD Roles (R)	30

Family 12: Results of placement of children after six months

The results of family 12 indicate that the child had low levels of global self-esteem (low RSE score). The high IFR score indicates that the severity of family problems stemming from personal and social dysfunction in the area of family adjustment appeared to be high.

The high ECBI score shows that the parental ability to deal with behavioural problems in children effectively was not good. Reference was made to problems with aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying.

The level of nurturance: seemed to be lower and there was confusion regarding a clear set of rules and consequences, according to the high FAD scores on AR, AI and R. Problem-solving and communication were not effective (high FAD PS and C). It appears therefore that six months after primary care placement, the family's health was poor (High G).

FAMILY 13

Table 9.60 Results of family 13 tested after six months

Psychometric test	Score
RSE	27
IFR	19
ECBI	43
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	7
FAD Behavioural control (BC)	12
FAD Communication (C)	9
FAD General functioning (G)	17
FAD Problem solving (PS)	6
FAD Roles (R)	12

Family 13: Results of placement of children after six months

The results shows that 6 months after primary care recommendation, the global self-esteem of the child improved in family 13 (high RSE score). The severity of family problems, stemming from personal and social dysfunction in family adjustment and intra-familial stress, decreased, as seen in the low score on the IFR. It is also clear that, based on the results of the ECBI score behavioural problems in the children such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying were not found to be problematic. The low FAD AR and AI indicate that the family members showed tenderness, concern and affection for one another. The family had a clear set of rules and consequences (low FAD R) and their ability to identify relevant and appropriate problems which threatened the cohesion in the family was effectively addressed (low FAD BC). With regard to communication, the verbal messages were clear in content and direct in the sense that the person spoken to

was the person for whom the message was intended (low FAD C). Overall it appears that this family was healthy (low FAD G).

FAMILY 14

Table 9.61 Results of family 14 tested after six months

Psychometric test	Score
RSE	23
IFR	19
ECBI	52
FAD Affective involvement (AI)	12
FAD Affective responsiveness (AR)	8
FAD Behavioural control (BC)	13
FAD Communication (C)	12
FAD General functioning (G)	19
FAD Problem solving (PS)	10
FAD Roles (R)	15

Family 14: Results of placement of children after six months

The results of family 14 after six months show general improvement (low FAD G) in their family's functioning. The global self-esteem of the child was good (high RSE) and the magnitude of family problems and intra family stress was reported to be minimal (low IFR). The low ECBI indicates that the number of difficult-behaviour problems was low and the frequency at which they occurred was rare. In other words, the occurrence of disruptive and annoying behaviour, aggression towards others, non-compliance, temper tantrums, stealing and lying did not seem to be problems in this family.

The AR and AI scores on the FAD show high levels of nurturance: in this family, together with a clear set of rules and consequences in the household (low FAD R). Problem-solving of problems which might threaten the cohesion in the family was

effective: as was the quality of exchange of information among family members (low FAD PS and C).

FAMILY 15

Table 9.62 Results of family 15 tested after six months

Psychometric test	Score
RSE	25
IFR	22
ECBI	46
FAD Affective involvement (AI)	18
FAD Affective responsiveness (AR)	23
FAD Behavioural control(BC)	19
FAD Communication (C)	9
FAD General functioning (G)	13
FAD Problem solving (PS)	10
FAD Roles (R)	10

Family 15: Results of placement of children after six months

The results of family 15 indicate that the child's global self-esteem was on a good level (high RSE). Regarding family adjustment, this family did not seem to experience severe family problems stemming from personal and social dysfunction (low IFR). Difficult-behaviour problems and the frequency, at which they occurred, seemed to be limited to the minimum. This family seemed to show tenderness, concern and affection for one another (low ECBI). They also had a clear set of rules and consequences where the custodial parents could assign roles and tasks clearly to the children (low FAD R). Problems and the exchange of information among family members were dealt with effectively (low FAD PS, C and BC).

FAMILY 16

Table 9.63 Results of family 16 tested after six months

Psychometric test	Score
RSE	28
IFR	19
ECBI	61
FAD Affective involvement (AI)	13
FAD Affective responsiveness (AR)	12
FAD Behavioural control (BC)	30
FAD Communication (C)	15
FAD General functioning (G)	19
FAD Problem solving (PS)	10
FAD Roles (R)	9

Family 16: Results of placement of children after six months

The results of family 16 show that the child had good global self-esteem (high RSE) and that the magnitude of family problems, as well as intra-familial stress, was not significant (low IFR). The parents could address behavioural problems in children effectively, which was indicated by the low score on the ECBI. Difficult-behaviour problems and the frequency with which they occurred were very low. The family members showed tenderness and affection for one another (low FAD AR and AI) and maintained family roles by following a clear set of rules and consequences (low FAD R). The custodial parents were also able to maintain and accept a position of authority, causing effective problem-solving (low FAD PS). They communicated openly and clearly (low FAD C). Based on this family's results, it seems they are effective (low FAD G).

FAMILY 17

Table 9.64 Results of family 17 tested after six months

Psychometric test	Score
RSE	24
IFR	17
ECBI	62
FAD Affective involvement (AI)	10
FAD Affective responsiveness (AR)	20
FAD Behavioural control (BC)	18
FAD Communication (C)	12
FAD General functioning (G)	10
FAD Problem solving (PS)	9
FAD Roles (R)	12

Family 17: Results of placement of children after six months

The score on the RSE indicates a high global self-esteem of the child in family 17 (high score on the RSE). The low score on the IFR shows that the severity of family problems, relationship problems and intra-familial stress was not significant in this family. They acknowledged and addressed behavioural problems, and did not seem to have difficulties with traits like aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying (low ECBI). This family was nurturing (low FAD AR and AI), but also had a clear set of rules with consequences in place (low FAD R). The custodial parents clearly assigned roles and tasks to the children, clarifying roles and hierarchy and the parents were able to maintain and accept a position of authority. They could identify and solve problems which threatened the cohesion in the family and communicate clearly to one another (low BC). Thus the verbal messages were clear in content and direct in the sense that the person spoken to

was the person for whom the message was intended (low FAD C). Consequently this family seemed to be effective six months after primary care placement (low FAD G).

FAMILY 18

Table 9.65 Results of family 18 tested after six months

Psychometric test	Score
RSE	25
IFR	29
ECBI	57
FAD Affective involvement (AI)	19
FAD Affective responsiveness (AR)	12
FAD Behavioural control (BC)	11
FAD Communication (C)	11
FAD General functioning (G)	9
FAD Problem solving (PS)	13
FAD Roles (R)	10

Family 18: Results of placement of children after six months

The low RSE score shows a high global self-esteem for this child. It is also indicated that family 18 had a low instance of family problems stemming from personal and social dysfunction in the family adjustment, as seen in the low score of the IFR. The parental ability and repertoire to address behavioural problems in children, together with the tenderness, concern and affection displayed towards one another, were of a high standard (low ECBI). They had a clear set of rules and consequences (low FAD R) in place as this family could identify relevant and appropriate problems which threatened the cohesion in the family (low FAD PS). They communicated clearly (low FAD C). Overall, this family can be deemed an effective family system (low FAD G).

FAMILY 19

Table 9.66 Results of family 19 tested after six months

Psychometric test	Score
RSE	25
IFR	24
ECBI	69
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	8
FAD Behavioural control (BC)	15
FAD Communication (C)	14
FAD General functioning (G)	11
FAD Problem solving (PS)	10
FAD Roles (R)	13

Family 19: Results of placement of children after six months

Family 19's results show that the child had a high global self-esteem (high RSE). The magnitude of the family problems stemming from personal and social dysfunction was not very high, thus indicating low levels of intra-familial stress (low IFR). The low score on the ECBI shows few reports of behavioural problems in children and practically no traits of aggression towards others, non-compliance, temper tantrums, disruptive or annoying behaviours, stealing or lying. They seemed to be close to one another and respect the boundaries and needs of each member (low FAD AR and AI). Problem-solving was conducted effectively (low FAD PS) and communication seemed to be open and transparent (low FAD C). The general functioning of this family was overall healthy (low FAD G).

FAMILY 20

Table 9.67 Results of family 20 tested after six months

Psychometric test	Score
RSE	27
IFR	19
ECBI	37
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	15
FAD Behavioural control (BC)	14
FAD Communication (C)	16
FAD General functioning (G)	11
FAD Problem solving (PS)	13
FAD Roles (R)	10

Family 20: Results after six months

According to the results it seems that the child in family 20 had a good global self-esteem (high RSE). The family's ability to deal with family problems was effective, reducing the intra-familial stress (low IFR). The parental ability to address behavioural problems in the children such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying was also effective (low ECBI and FAD PS). It seems to be a context of nurturance with a clear set of rules and consequences (low FAD AR and AI). They communicated clearly among themselves (low FAD C). The overall well-being of this family was healthy (low FAD G).

FAMILY 21

Table 9.68 Results of family 21 tested after six months

Psychometric test	Score
RSE	27
IFR	24
ECBI	38
FAD Affective involvement (AI)	13
FAD Affective responsiveness (AR)	12
FAD Behavioural control (BC)	14
FAD Communication (C)	15
FAD General functioning (G)	11
FAD Problem solving (PS)	11
FAD Roles (R)	10

Family 21: Results of placement of children after six months

The RSE score shows a high global self-esteem for this child (high RSE). It is also indicated that family 8 had a low instance of family problems stemming from personal and social dysfunction in the family adjustment (low IFR). The parental ability and repertoire to address behavioural problems in children, together with the display of tenderness, concern and affection for one another, was of a high standard (low ECBL and FAD BC). They had a clear set of rules and consequences in place as this family could identify relevant and appropriate problems which threatened the cohesion in the family (FAD R). The low FAD C shows that they could communicate clearly. Overall, this family could be deemed as a family with healthy interaction dynamics (low FAD G).

FAMILY 22

Table 9.69 Results of family 22 tested after six months

Psychometric test	Score
RSE	17
IFR	86
ECBI	132
FAD Affective involvement (AI)	23
FAD Affective responsiveness (AR)	29
FAD Behavioural control (BC)	32
FAD Communication (C)	27
FAD General functioning (G)	28
FAD Problem solving (PS)	30
FAD Roles (R)	39

Family 22: Results of placement of children after six months

The results of family 22 indicate that the child had low levels of global self-esteem (low RSE score). The high IFR score indicates that the severity of family problems stemming from personal and social dysfunction in the area of family adjustment appeared to be high.

The high ECBI score shows that the parental ability to deal with behavioural problems in children effectively was not good. Reference was made to problems with aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying. The level of nurturance seemed to be lower and there was confusion regarding a clear set of rules and consequences, according to the high FAD scores on AR, AI and R. Problem-solving and communication were not effective (high FAD PS and C). As a result it appeared that six months after primary care placement, the family's functioning can be said to be poor (High G).

FAMILY 23

Table 9.70 Results of family 23 tested after six months

Psychometric test	Score
RSE	24
IFR	22
ECBI	61
FAD Affective involvement (AI)	12
FAD Affective responsiveness (AR)	16
FAD Behavioural control (BC)	9
FAD Communication (C)	12
FAD General functioning (G)	13
FAD Problem solving (PS)	13
FAD Roles (R)	11

Family 23: Results of placement of children after six months

The RSE score of family 23 shows a high global self-esteem for this child (high RSE). It is also indicated that this family had a low instance of family problems stemming from personal and social dysfunction in the family adjustment (low IFR). The parental ability and repertoire to address behavioural problems in children together with the display of tenderness, concern and affection for one another was of a high standard (low ECBL and FAD BC). They had a clear set of rules and consequences in place as this family could identify relevant and appropriate problems which threatened the cohesion in the family (FAD R). The low FAD C shows that they could communicate clearly. Overall this family can be deemed a healthy family (low FAD G).

FAMILY 24

Table 9.71 Results of the family 24 tested after six months

Psychometric test	Score
RSE	19
IFR	82
ECBI	124
FAD Affective involvement (AI)	24
FAD Affective responsiveness (AR)	27
FAD Behavioural control (BC)	23
FAD Communication (C)	29
FAD General functioning (G)	28
FAD Problem solving (PS)	33
FAD Roles (R)	37

Family 24: Results of placement of children after six months

The results of family 24 indicate that the child had low levels of global self-esteem (low RSE score). The high IFR score indicates that the severity of family problems stemming from personal and social dysfunction in the area of family adjustment appeared to be high. The high ECBI results show that the parental ability to deal with behavioural problems in children effectively was not good. Reference was made to problems with aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying.

The level of nurturance seemed to be lower and there was confusion regarding a clear set of rules and consequences, according to the high FAD scores on AR, AI and R. Problem-solving and communication were not effective (high FAD PS and C). Six months after primary care placement this family seemed to be highly ineffective (High G).

FAMILY 25

Table 9.72 Results of family 25 tested after six months

Psychometric test	Score
RSE	24
IFR	20
ECBI	61
FAD Affective involvement (AI)	13
FAD Affective responsiveness (AR)	14
FAD Behavioural control (BC)	23
FAD Communication (C)	18
FAD General functioning (G)	12
FAD Problem solving (PS)	15
FAD Roles (R)	10

Family 25: Results of placement of children after six months

The RSE score shows a high global self-esteem for this child (high RSE). It is also indicated that family 25 had a low instance of family problems stemming from personal and social dysfunction in the family adjustment (low IFR). The parental ability and repertoire to address behavioural problems in children, together with the display of tenderness, concern and affection for one another was of a high (low ECBL and FAD BC). They had a clear set of rules and consequences in place as this family could identify relevant and appropriate problems which threatened the cohesion in the family (FAD R). The low FAD C shows that they could communicate clearly. Overall this family could be deemed as effective (low FAD G).

FAMILY 26

Table 9.73 Results of family 26 tested after six months

Psychometric test	Score
RSE	28
IFR	22
ECBI	50
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	15
FAD Behavioural control(BC)	13
FAD Communication (C)	16
FAD General functioning (G)	11
FAD Problem solving (PS)	12
FAD Roles (R)	9

Family 26: Results of placement of children after six months

The results of family 26 show that the child had good global self-esteem (high RSE) and the magnitude of family problems as well as intra-familial stress were not significant (low IFR). The parents could address behavioural problems in children effectively (low ECBL). The number of difficult-behaviour problems, as well as the frequency at which they occurred, was also very low. The family members displayed tenderness and affection (low FAD AI and AR) for one another and maintained family roles (FAD R) by following a clear set of rules and consequences. The parents were also able to maintain and accept a position of authority causing effective problem-solving (FAD PS and BC). They communicated openly and clearly (FAD C).

FAMILY 27

Table 9.74 Results of family 27 tested after six months

Psychometric test	Score
RSE	25
IFR	26
ECBI	42
FAD Affective involvement (AI)	12
FAD Affective responsiveness (AR)	22
FAD Behavioural control (BC)	18
FAD Communication (C)	17
FAD General functioning (G)	11
FAD Problem solving (PS)	15
FAD Roles (R)	13

Family 27: Results of placement of children after six months

The results of family 27 indicate that the child's global self-esteem was on a good level, as observed in the high RSE. Regarding family adjustment, this family did not seem to experience severe family problems stemming from personal and social dysfunction (low IFR and ECBI). Difficult-behaviour problems and the frequency with which they occurred seemed to be limited to the minimum (low FAD BC). This family seemed to display tenderness, concern and affection for one another (high AI and AR). They also had a clear set of rules and consequences, where parents could assign roles and tasks to the children clearly (FAD R). They were effective in dealing with problems and exchanging of information among family members indicating family health (low FAD PS and C).

FAMILY 28

Table 9.75 Results of family 28 tested after six months

Psychometric test	Score
RSE	25
IFR	22
ECBI	54
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	14
FAD Behavioural control (BC)	12
FAD Communication (C)	12
FAD General functioning (G)	16
FAD Problem solving (PS)	18
FAD Roles (R)	8

Family 28: Results of placement of children after six months

The results show that 6 months after primary care was recommended, the global self-esteem of the child in family 28 improved (high RSE). The severity of family problems stemming from personal and social dysfunction in family adjustment and intra-familial stress, decreased (low IFR score). It is also clear that, based on the low score on the ECBI scores behavioural problems, such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying were not found to be problematic. The low score on FAD AR and AI indicates that the family members displayed tenderness, concern and affection for one another. The family had a clear set of rules and consequences (low FAD R) and the family's ability to identify relevant and appropriate problems which threatened the cohesion in the family, was effectively addressed (low FAD PS). With regards to communication, the verbal messages were clear in content and direct in the sense that the person spoken to was

the person for whom the message was intended as can be observed in the low FAD C score. Overall it appears that this family was healthy in functioning (low FAD G).

FAMILY 29

Table 9.76 Results of family 29 tested after six months

Psychometric test	Score
RSE	16
IFR	45
ECBI	117
FAD Affective involvement (AI)	26
FAD Affective responsiveness (AR)	32
FAD Behavioural control (BC)	36
FAD Communication (C)	28
FAD General functioning (G)	25
FAD Problem solving (PS)	35
FAD Roles (R)	31

Family 29: Results of placement of children after six months

The results collected after six months show that family 29 was not functioning effectively (high FAD G). The child showed low global self-esteem (high RSE) and the magnitude of family problems was causing intra-familial stress (high IFR). The parents could not address difficult-behaviour problems effectively and seemed to experience repetitive experience of aggression towards other family members, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying (high ECBI). Nurture seemed poor (high FAD AR and AI) and the role hierarchy was not clearly defined (high FAD R). Their ability to solve problems was also poor and this might threaten the cohesion in the family (high FAD PS). The level of communication was not direct and bordered on being confusing, as observed in the high FAD C subscale.

FAMILY 30

Table 9.77 Results of family 30 tested after six months

Psychometric test	Score
RSE	17
IFR	76
ECBI	136
FAD Affective involvement (AI)	33
FAD Affective responsiveness (AR)	29
FAD Behavioural control (BC)	37
FAD Communication (C)	35
FAD General functioning (G)	34
FAD Problem solving (PS)	28
FAD Roles (R)	39

Family 30: Results of placement of children after six months

Six months after primary placement of family 30, the results indicated that the family did not function effectively (high FAD G). The child showed low global self-esteem (high RSE score) and the magnitude of family problems was causing intra-familial stress (high IFR score). The parents could not address difficult-behaviour problems effectively and seemed to experience repetitive elements of aggression towards other family members, along with non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying (high ECBI score). Nurture seemed poor (high FAD AR and AI) and the role hierarchy was not clearly defined (high FAD R). Their ability to solve problems was also poor and this might threaten the cohesion in the family (high FAD PS). The high FAD C indicated that the level of communication was not direct and bordered on being confusing.

FAMILY 31

Table 9.78 Results of family 31 tested after six months

Psychometric test	Score
RSE	18
IFR	91
ECBI	121
FAD Affective involvement (AI)	25
FAD Affective responsiveness (AR)	23
FAD Behavioural control(BC)	27
FAD Communication (C)	32
FAD General functioning (G)	33
FAD Problem solving (PS)	27
FAD Roles (R)	25

Family 31: Results of placement of children after six months

The results of family 31 indicate that the child had low levels of global self-esteem (low RSE). The high IFR score indicates that the severity of family problems stemming from personal and social dysfunction in the area of family adjustment appeared to be high.

The high ECBI score shows that the parental ability to deal with behavioural problems in children effectively was not good. Reference was made to problems with aggression towards other family members, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying. Nurture seemed to be lower (high FAD AI and AR) and there was confusion regarding a clear set of rules and consequences (high FAD R), according to the FAD. Problem-solving (high FAD PS) and communication (high FAD C) were not effective as observed in the high score in the FAD C. It appears therefore that six months after primary care placement, the family's health was poor (high FAD G).

FAMILY 32

Table 9.79 Results of family 32 tested after six months

Psychometric test	Score
RSE	12
IFR	92
ECBI	134
FAD Affective involvement (AI)	25
FAD Affective responsiveness (AR)	28
FAD Behavioural control (BC)	25
FAD Communication (C)	29
FAD General functioning (G)	29
FAD Problem solving (PS)	34
FAD Roles (R)	31

Family 32: Results of placement of children after six months

The results of family 32 indicate that the child had a low global self-esteem (low RSE). The severity of family problems stemming from personal and social dysfunction in the area of family adjustment was serious, resulting in heightened intra-familial stress (high IFR). According to the results of the high ECBI score, the parental report of conduct and behavioural problems were areas of concern and seemed to be frequent. Traits such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying were noted in this family (high FAD BC and G). The results of the low FAD AI and AR indicate that tenderness, concern and affection for one another were barely evident and there were no clear rules and consequences (FAD R). It seemed that the parents could not maintain a position of authority (high FAD PS). They did not communicate clearly and openly (high FAD C). The well-being of this family after six months' follow-up was at risk (high FAD G).

FAMILY 33

Table 9.80 Results of family 33 tested after six months

Psychometric test	Score
RSE	24
IFR	26
ECBI	54
FAD Affective involvement (AI)	11
FAD Affective responsiveness (AR)	14
FAD Behavioural control(BC)	11
FAD Communication (C)	13
FAD General functioning (G)	10
FAD Problem solving (PS)	9
FAD Roles (R)	10

Family 33: Results of placement of children after six months

The results show that 6 months after primary care recommendation, the global self-esteem of the child in family 33 (high RSE) improved. The severity of family problems, stemming from personal and social dysfunction in family adjustment and intra-familial stress, decreased (low IFR). It is also clear from the low score on the ECBI instrument that behavioural problems in children, such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying, were not found to be problematic. The low scores on FAD AR and AI indicated that the family members showed tenderness, concern and affection for one another. The family had a clear set of rules and consequences (low FAD R) and their ability to identify relevant and appropriate problems which threatened the cohesion in the family were effectively addressed (low FAD PS). With regard to communication, the verbal messages were clear in content and direct in the sense that the person spoken to was

the person for whom the message was intended, as observed in the low score of low FAD C. Overall, it appeared that this family was healthy and effective (low FAD G).

FAMILY 34

Table 9.81 Results of family 34 tested after six months

Psychometric test	Score
RSE	25
IFR	22
ECBI	66
FAD Affective involvement (AI)	12
FAD Affective responsiveness (AR)	15
FAD Behavioural control (BC)	18
FAD Communication (C)	8
FAD General functioning (G)	14
FAD Problem solving (PS)	12
FAD Roles (R)	10

Family 34: Results of placement of children after six months

Family 34 shows that the child had a high global self-esteem (high RSE). The magnitude of their family problems, stemming from personal and social dysfunction, was not very high, thus indicating low levels of intra-familial stress (low IFR). The low score on the ECBI showed few reports of behavioural problems in children and practically no traits of aggression towards others, nor non-compliance, temper tantrums, disruptive or annoying behaviours, stealing and lying. They seemed to be close to one another and respect the boundaries or needs of each member (low FAD AI and AR). Problem-solving took place effectively (low FAD PS) and communication seemed to be open and transparent as was evident in the low score in the FAD C subscale. The general functioning of this family system was overall healthy (low FAD G).

FAMILY 35

Table 9.82 Results of family 35 tested after six months

Psychometric test	Score
RSE	15
IFR	93
ECBI	171
FAD Affective involvement (AI)	27
FAD Affective responsiveness (AR)	23
FAD Behavioural control (BC)	25
FAD Communication (C)	27
FAD General functioning (G)	29
FAD Problem solving (PS)	31
FAD Roles (R)	33

Family 35: Results of placement of children after six months

The results of this family indicate that the child had a low global self-esteem (low RSE score). The severity of family problems sprouting from personal and social dysfunction in the area of family adjustment was serious resulting in heightened intra-familial stress (high IFR). According to the results of the ECBI (high score), the parental report of conduct and behavioural problems was frequent. Apparent presence of traits such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviour, stealing and lying were observed in this family. The results of the FAD AR and AI show that the display of tenderness, concern and affection for one another was limited and there were no clear rules and consequences. As a result it seems that the parents could not maintain a position of authority (low FAD R). They did not communicate clearly and openly as seen in the high score on the FAD C. The effectiveness of family 35 seems to be poor after six months follow-up (high FAD G).

FAMILY 36

Table 9.83 Results of family 36 tested after six months

Psychometric test	Score
RSE	28
IFR	19
ECBI	66
FAD Affective involvement (AI)	15
FAD Affective responsiveness (AR)	9
FAD Behavioural control (BC)	12
FAD Communication (C)	10
FAD General functioning (G)	11
FAD Problem solving (PS)	11
FAD Roles (R)	10

Family 36: Results of placement of children after six months

The low RSE score shows a high global self-esteem for this child. It is also indicated that family 36 had a low instance of family problems stemming from personal and social dysfunction in the family adjustment (low IFR). The parental ability and repertoire to address behavioural problems in children, together with the display of tenderness, concern and affection for one another, was of a high standard (low ECBI).

They had a clear set of rules and consequences (low FAD R) in place as this family could identify relevant and appropriate problems which threatened the cohesion in the family (low FAD PS). They communicated clearly as was evident from the low score on the FAD C. Overall, this family can be deemed effectively in functioning (low FAD G).

FAMILY 37

Table 9.84 Results of family 37 tested after six months

Psychometric test	Score
RSE	27
IFR	16
ECBI	58
FAD Affective involvement (AI)	14
FAD Affective responsiveness (AR)	23
FAD Behavioural control(BC)	17
FAD communication (C)	19
FAD General functioning (G)	11
FAD Problem solving (PS)	15
FAD Roles (R)	10

Family 37: Results of placement of children after six months

The results show that 6 months after primary care placement the global self-esteem of the child improved as can be seen on the high score of the RSE. The limited occurrence of family problems stemming from personal and social dysfunction in family adjustment and intra-familial stress is seen in the low IFR score. It is also clear that based on the low score of the ECBI, behavioural problems in the children such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying were not found. The low FAD (IA, BC and AR) indicated that the family members showed tenderness, concern and affection for one another. The low score on the FAD (R, PS and G) shows the family had a clear set of rules and consequences and the family's ability to identify relevant and appropriate problems which threatened the cohesion in the family, was effectively addressed. With regard to communication, the verbal messages were clear in content and direct in the sense that the person spoken to

was the person for whom the message was intended as noted in the low score in the FAD (C). Overall it appears that this family is effective in functioning (low FAD G).

FAMILY 38

Table 9.85 Results of family 38 tested after six months

Psychometric test	Score
RSE	15
IFR	86
ECBI	174
FAD Affective involvement (AI)	24
FAD Affective responsiveness (AR)	25
FAD Behavioural control(BC)	27
FAD Communication (C)	23
FAD General functioning (G)	25
FAD Problems solving (PS)	29
FAD Roles (R)	31

Family 38: Results of placement of children after six months

The results of family 38 indicate that the child had a low global self-esteem (low RSE). The severity of family problems stemming from personal and social dysfunction in the area of family adjustment was serious resulting in heightened intra-familial stress (high IFR). According to the results of the high ECBI score, the parental report of conduct and behavioural problems was of concern and seemed to be frequent. Apparent traits such as aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying were present in this family (high FAD BC and G). The results of the low FAD AI and AR indicated that there was a lack of tenderness, concern and affection for one another and there were no clear rules and consequences (FAD R). It seemed that the parents could not maintain a position of authority (high FAD

PS). They did not communicate clearly and openly (high FAD C). After six months follow-up this family did not function effectively (high FAD G).

FAMILY 39

Table 9.86 Results of family 39 tested after six months

Psychometric test	Score
RSE	19
IFR	88
ECBI	167
FAD Affective involvement (AI)	25
FAD Affective responsiveness (AR)	26
FAD Behavioural control(BC)	19
FAD Communication (C)	27
FAD General functioning (G)	28
FAD Problem solving (PS)	25
FAD Roles (R)	31

Family 39: Results of placement of children after six months

The results of family 39 indicate that the child had low levels of global self-esteem (low RSE).

The high IFR score indicates that the severity of family problems stemming from personal and social dysfunction in the area of family adjustment appeared to be high.

The high ECBI shows that the parental ability to deal with behavioural problems in children effectively was not good. Reference was made to problems with aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying.

The level of nurturance seemed to be lower (high FAD AR and AI) and there was confusion regarding a clear set of rules and consequences according to the high FAD R score. Problem-solving (high FAD PS) and communication (high FAD C) were not effective. Consequently six months after primary care placement, the families general level of functioning decreased significantly (high FAD G).

9.9 Comparison of Experimental and Control Groups

With the assistance of a qualified statistician the data gathered in this study was quantitatively analyzed by means of the Multivariate Analysis of Variance (MANOVA). The data was compared for differences between the mean scores of the experimental and the control group. To determine if the difference between the means was statistically significant, a statistical test was conducted and, in this case, the F-test was used. The MANOVA statistical analysis was calculated by means of the SAS JMP® computer programme, with the assistance of a qualified statistician. The results of the respective measuring instruments are reported and discussed below.

9.9.1 Rosenberg Self-Esteem Scale (RSE)

The hypothesis was the following: The Rosenberg Self-esteem Scale will indicate improvement in children's self-esteem (experimental group) six months after custody placement.

A MANOVA test was conducted to test for the difference in the means of the RSE between the experimental and the control group. The results are shown in Table 9.87:

Table 9.87 Comparison of the means of the experimental and the control group as measured by the Rosenberg Self-Esteem Scale.

Group	Mean
Control group	1.66153846
Experimental group	2.55
MANOVA p-value	$p < 0.0083$

As is evident from the above table, the mean scores of the experimental and control groups differed significantly at the level of $p < 0.0083$. It can thus be concluded that the self-esteem of children in the experimental group improved significantly more than that of the children in the control group. These results can be associated with a successful primary residency placement.

9.9.2 Index of Family Relations (IFR)

The IFR hypothesis was the following: the severity, or magnitude of problems that family members have in their relationships with one another, will decrease.

The differences between the mean scores were tested for statistical significance and the results are reported in Table 9.88.

Table 9.88: Comparison of the means of the experimental and the control group (IFR)

Group	Mean
Experimental	2.91384615
Control	6.3375
MANOVA p-value	$p < 0.0001^*$

As can be observed in table 9.88, a significant difference exists at the $p < 0.0001$ level. On the basis of these results it is thus clear that families in the experimental group were successfully better regarding the severity, or magnitude of problems that family members have in their relationships with one another compared to those in the control group six months after primary placement. Again the results can be associated with successful primary placement in the experimental group.

9.9.3 Eyberg Child Behaviour Inventory (ECBI)

In the application of the ECBI, it was hypothesised that after residential placement conduct-problem behaviours including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing, lying, in children will decrease.

The MANOVA was used in SAS JMP to analyse the data and to compare the control and the experimental groups. The results are reported in Table 9.89 below:

Table 9.89: Comparison of the means of the experimental and the control group (ECBI)

Group	Mean
Control	4.0007326
Experimental	2.5123073
MANOVA p-value	$p < 0.0005^*$

It is clear from the above table that the means score of the experimental group and the control group differed significantly at the level of $p < 0.0005$. It can, therefore, be concluded that conduct-problem behaviour, including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing and lying, decreased. This is thus a further indication of effective placement of children in the experimental group.

9.9.4 Family Assessment Device (FAD)

This assessment device has a series of separate subtests (7 sub tests) which were, individually, compared with the results obtained in both the experimental and control group.

9.9.4.1 FAD Affective Involvement (AI)

The first hypothesis for FAD Affective Involvement (AI) stated that both parents and children will be able to show more tenderness and would be more concerned about one another's welfare.

The difference between the means of the experimental group and the control group were compared. The results were as follows (Table 9.90).

Table 9.90: Comparison of the means of the experimental and the control group (FAD AI)

Group	Mean
Experimental	2.76923077
Control	1.67788462
MANOVA p-value	0.0001*

It is clear from table 9.90 that the mean scores of the experimental and control groups differed significantly at the level of $p < 0.0001$. It can be concluded that both parents and children were able to show more tenderness and were more concerned about one another's welfare in the experimental group than those of the parents and children in the control group. These results can be associated with a successful primary residency placement.

9.9.4.2 FAD Affective responsiveness (AR)

The hypothesis for the Affective responsiveness (AR) was that the parent will be able to show more nurturance towards the child.

The MANOVA comparison of FAD affective responsiveness (AR) mean scores are reported in Table 9.91.

Table 9.91: Comparison of the means of the experimental and the control group (FAD AR)

Group	Mean
Experimental	2.71428571
Control	1.48351648
MANOVA p-value	0.0019*

Table 9.91 indicates a significant difference at the $p < 0.0019$ level. On the basis of these results it is clear that families in the experimental group were successfully better in showing nurturance towards the child in comparison with those in the control group six months after primary placement. Again the results can be associated with successful primary placement in the experimental group.

9.9.4.3 FAD Behavioural Control (BC)

The hypothesis for Behavioural Control (BC) was the following: custodial parents will be able to effectively control problem behaviour.

The differences between the mean scores of the experimental group and those of the control group were compared and the results are reported in Table 9.92.

Table 9.92: Comparison of the means of the experimental and the control group (FAD BC)

Group	Mean
Experimental	2.01538462
Control	1.56923077
MANOVA p-value	0.3574

The two groups do not differ significantly. This indicates that the families effectiveness in controlling problem behaviour did not differ significantly between the experimental and control group.

9.9.4.4 FAD Communication (C)

The hypothesis for Communication (C) subscale was that verbal messages will be clear in content and direct in the sense that the person spoken to, is the person for whom the message is intended.

A MANOVA was done to determine the differences between the mean scores of the experimental and control groups and the results are reported in Table 9.93.

Table 9.93: Comparison of the means of the experimental and the control group (FAD C)

Group	Mean
Experimental	2.48351648
Control	1.85714286
MANOVA p-value	0.0029*

It is clear from the above table that the means score of the experimental group and that of the control group differed significantly at the level of $p < 0.0029$ and it can be concluded that verbal messages sent were clear in content and direct in the sense that

the person spoken to, was the person for whom the message was intended. This is an indication of effective placement of children in the experimental group.

9.9.4.5 FAD Problem-solving (PS)

The hypothesis for the Problem-solving (PS) was that there will be improvement in the families' ability to identify relevant and appropriate problems which might threaten the cohesion.

The differences between the mean scores of the experimental group and control groups were compared and the results are reported in Table 9.94.

Table 9.94: Comparison of the means of the experimental and the control group (FAD PS)

Group	Mean
Experimental group	2.62820513
Control group	1.6474359
MANOVA p-value	0.0001*

It is evident from table 9.94 that the mean scores of the experimental and control groups differed significantly at the level of $p < 0.0001$. It can thus be concluded that there was improvement in the experimental families' ability to identify relevant and appropriate problems which might threaten the cohesion compared to the children in the control group. The results can be associated with successful primary residency placement.

9.9.4.6 FAD Roles (R)

The hypothesis with regard to the Roles (R) sub test was that the family will have a clear set of rules and consequences.

The comparison results of the means of the control group and the experimental group are reported in Table 9.95.

Table 9.95: Comparison of the means of the experimental and the control group (FAD R)

Group	Mean
Experimental	2.65811966
Control	1.76495726
MANOVA p-value	0.0001*

From the above in table 9.95, the mean scores of the experimental and control groups differed significantly at the level of $p < 0.0001$. Based on these results, it can be concluded that the experimental families have a clear set of rules and consequences as opposed to the control group families. The results can be associated with successful primary residency placement.

9.9.4.7 FAD General Functioning (G)

The hypothesis concerning the General functioning (G) was that the overall health of the family will improve.

The MANOVA comparison of mean scores of the FAD General Functioning (G) is reported in table 9.96.

Table 9.96: Comparison of the means of the experimental and the control group (FAD G)

Group	Mean
Experimental	2.43786982
Control	1.47337278
MANOVA p-value	0.0149*

As is evident from table 9.96, the mean scores of the experimental and control groups differed significantly at the level of $p < 0.0149$. It can thus be concluded that the overall health of the families in the experimental group improved significantly more than those in the control group. These results can again be associated with a successful primary residency placement.

9.10 Conclusion

In the study the 13 identified statements as set out by The Honourable Mr Justice King for the allocation of custody in divorce cases was qualitatively translated by three independent clinical psychologists. This qualitative analysis of the translation recommended the following psychological assessment procedure:

- The Clinical Interview
- Interactional Analysis
- Millon Clinical Multiaxial Inventory (MCMI-III)
- Thematic Apperception Test (TAT)
- 16 Personality Factor Questionnaire (16PF)
- The Children's Apperception Test (CAT)
- Bene-Anthony Family Relations Test
- Dues Test
- Kinetic Family Drawing (KFD)
- Draw-A-Person Test (DAP)

However, it was found that the DAP interpretations proved to be of little significance in custody evaluations.

The three psychologists independently also listed their recommended psychological tests for determining the degree of healthy family functioning and the integrated outcome was the following:

- Family Assessment Device (FAD)
- The Rosenberg Self-Esteem Scale (RSE)
- Index of Family Relations (IFR)
- Eyberg Child Behaviour Inventory (ECBI)

The aforementioned psychological tests were used as a test battery towards determining how effectively a particular family system, as well as the children in this system, are functioning six months after placement of the children in primary residency.

In this study 39 families were evaluated using the battery of procedures put together as described above. In 26 cases the Court accepted the recommended placements and these families constituted the experimental group. The 13 cases where recommendations were not accepted by the Court became the control group.

The families in the experimental and control groups were then compared and analysed by means of Multivariate Analysis of Variance (MANOVA). The results gave a clear indication that those children placed in the experimental group were psychologically functioning at a statistically significant, healthier level as compared to the control group. The self-esteem of the children in the experimental group significantly improved as well as improvement in the severity, or magnitude of problems. Conduct-problem behaviour, including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing, lying, decreased significantly in the experimental group. Both parent and children in the experimental group could show more tenderness and were more concerned about one another's welfare in comparison to those of the control group. The families in the experimental group were also better at showing nurture towards the child compared to those in the control group. With regard to communication

in the experimental families, the verbal messages were clear in content and direct in the sense that the person spoken to, was the person for whom the message was intended. The experimental families' ability to identify relevant and appropriate problems which might threaten the cohesion was better than that of the families in the control group. A clear set of rules and consequences was established in the experimental group in comparison to that in the control group. The overall health of the families of the experimental group improved significantly more than those in the control group.

The general hypothesis of this study, was thus confirmed which stated that; children placed in primary custody on the basis of a newly established psychological assessment procedure, will on follow-up six months later, be more effectively functioning than those in a control group who were not placed in custody on the basis of the assessment procedure.

CHAPTER 10

DISCUSSION

10.1 Introduction

In an attempt to assist children involved in the destructive process of divorce, this study aimed to provide a comprehensive investigation on divorce and psychological custody evaluations in an attempt to identify an optimal assessment procedure for custody placement.

As a brief overview the aforementioned chapters addressed the following: Chapter 1 orientated the reader as to the importance of the study. Chapter 2 explained the Court's position as the upper guardian of all children within its jurisdiction. This is integrated with the birth of the new Children's Act of 2005 and its consequences. Chapter 3 focused on the legal safeguards of The Honourable Mr. Justice King's ruling regarding the 'best interests of the child' with specific reference to the psychologist's application. Chapter 4 addressed the concept of parental responsibilities and rights which collectively refer to the environment that child will live in post-divorce. Chapter 5 explored the interaction between psychology and the law and its relationship. The culmination of the two worlds is merged in the discussion about forensic psychology and the high levels of ethics pertaining to the field. Chapter 6 dealt with specific reference to children in the context of divorce. The role and application of the psychologist in the assessment process was also explored. Chapter 7 described the process of how the comprehensive assessment procedure was developed in dealing with children in divorce. Chapter 8 explained the research design and the method utilized in this study and chapter 9 reports and discusses the results of the investigation.

Having reviewed the literature on divorce and custody assessment the reader is brought into perspective by mentioning key factors in divorce. According to the United Nations

Statistics Division, Eastern European countries have an average divorce rate of about five out of every 1,000 marriages. Western Europe has slightly lower divorce rates, ranging from two to three out of every 1,000 marriages. Central America has the lowest divorce rates, with only one out of every 1,000 marriages failing (United Nations Statistics Division, 2012).

In South Africa, the published data on divorce indicates that the number of granted cases has been fluctuating between 30 763 and 22 936 per annum over the past decade (2001-2010) (Statistics South Africa, 2011). On average, a South African divorce occurs after nine years of marriage. In spite of the short-term decrease in divorce, there is still a significant overall increase since 1999. South Africa is one of the countries where it is easy to get a divorce (Robinson, 2006).

Literature clearly indicates that during divorce, the most overwhelming emotion felt by children is intense sadness which may persist for some time. They feel sad about the loss of one parent or of the family unit. Children feel abandoned by the parent who has left and frequently fear that they will also be abandoned by the remaining parent. Children are often confused by the divorce as they feel guilty and torn between parents and that they have to choose one or, other parent to love. However, children have the right to love both parents. Fear forms a pre-dominant part of divorce for children as the world is no longer safe and secure or predictable. They have practical fears about who will look after them, or who will take them to school. They may be fearful about caring for and trusting anyone who might leave (Robinson, 2006).

It is thus clear that divorce affects children directly. This is a global problem since thousands of children are affected annually because of divorce, it is therefore of the utmost importance that an optimal procedure be found for placing these children in a manner that will safeguard their best interests.

Protecting children and acting in their best interest is an inherent priority for the human race. The Court, as upper guardian of all children, has to ensure the welfare or serving of the “best interests” of children when their parents get divorced. In South Africa significant changes in family law have been instituted, with a special emphasis on the rights of the child encompassing the best interests of children (Children’s Act of 2005). However the attempt to establish the “best interests” of a child remains a difficult and evasive principle (Roos & Vorster, 2003; Davel & Skelton, 2007).

Literature clearly indicates that in each individual case of divorce, the principle of “best interests” are judged on merit and should entail a scientific or “objective assessment” within the framework of the specific circumstances that pertain to each case (Gardner, 1989; Roos & Vorster, 2003; Gould & Martindale, 2009). The question was asked earlier in this study, how should this assessment be scientifically conducted and who should perform this “objective assessment” to guide and assist the Court to serve the “best interests” of the child? After an extensive review of the literature the answer seems quite clearly to be the psychologist.

In this respect a psychologist may typically attempt to advise the Courts regarding the most desirable child custody arrangement for a particular family to serve the *best interest of the child*. To date there is, however, no standardised procedure for these evaluations and the literature clearly indicates that there is no single, sovereign approach to conducting primary residence evaluations for children (Kaliski, 2006; Gould & Martindale, 2009). It is thus evident that ,not only in South Africa, but also globally, few scientific guidelines exist for custody and visitation assessment methods (Roos & Vorster, 2003; Kaliski, 2006; Robinson, 2006).

In South Africa, the evasive concept of *the best interest of the child* was, however, significantly alleviated through a judgment delivered by the Honourable Mr Justice King in the matter of *McCall v McCall*, 1994 (3) SA 201 (CPD), where he made an attempt to legally describe the “*best interests of the child*” with 13 variables to serve as criteria in

this respect. These statements were identified solely from a legal and not a psychological perspective. It was thus evident that these statements had to be defined and translated from a psychological perspective in order for them to be utilised by a psychologist in an attempt to assist the Court. This necessitated a careful analysis of the constructs, from a psychological perspective, as well to establish a relatively standardised clinical procedure for measuring the parents and children with the intention of primary residence placement of the child with the parent who is emotionally containing the child and at the same time shows affectional consideration to the child's needs. This was the objective of the present study.

During the first of the two phases of this study these 13 statements were qualitatively translated by three experienced psychologists who translated each legal construct into a psychological construct and then identified possible psychometric tests and/or clinical procedures which might be used to evaluate this construct. The identified procedure included the following:

- a) Clinical interview;
- b) An interactional pattern analysis;
- c) The Millon Clinical Multiaxial Inventory;
- d) The 16 Personality Factor Questionnaire;
- e) The Thematic Apperception Test; The Children's Apperception Test;
- f) The Bene-Anthony Family Relations Test;
- g) The Duesse Test; the Kinetic Family Drawing
- h) The Draw-A-Person Test.

The finding however suggest that the DAP interpretations proved to be of little significance during custody evaluations.

In the study 39 families were evaluated using the battery of procedures put together as described above. In 26 cases, the Court accepted the recommended placements and

these families constituted the experimental group. The 13 cases not dealt with on the basis of the recommendations, became the control group.

The three psychologists referred to above were also requested to identify suitable psychometric instruments that could be used to determine how effectively a particular family system, as well as the children in this system, is functioning, that is establishing the psychological health of a particular family system. They identified the following:

- a) the Family Assessment Device;
- b) Index of Family Relations;
- c) Eyberg Child Behaviour Inventory
- d) Rosenberg Self-Esteem Scale

These measures were applied to the 39 families six months after the custody recommendation. The effectiveness / ineffectiveness of this procedure was evaluated by means of exposing the families to these four family assessment instruments.

The families in the experimental and control groups were then compared and analysed by means of Multivariate Analysis of Variance (MANOVA). The results gave a clear indication that those children placed in the experimental group were psychologically functioning at a statistically significant, healthier level compared to the control group. The self-esteem of the children in the experimental group significantly improved ($p < 0,0083$) and there was a significant improvement in the severity, or magnitude of problems that the experimental family members experienced in their relationships with one another ($p < 0.0001$). Conduct-problem behaviour, including aggression towards others, non-compliance, temper tantrums, disruptive and annoying behaviours, stealing, lying, decreased significantly in the experimental group ($p < 0.0005$). Both parent and children in the experimental group could show more tenderness and were more concerned about one another's welfare in comparison to those of the control group ($p < 0.0001$). The families in the experimental group were also better at showing nurturance

towards the child compared to those in the control group ($p < 0.0019$). With regard to communication in the experimental families, the verbal messages were clear in content and direct in the sense that the person spoken to, was the person for whom the message was intended ($p < 0.0029$). The experimental families' ability to identify relevant and appropriate problems which might threaten the cohesion was better than that of the families in the control group ($p < 0.0001$). Clear sets of rules and consequences were established in the experimental group in comparison to that in the control group ($p < 0.0001$). The overall health of the families of the experimental group improved significantly more than those in the control group ($p < 0.0149$).

The general hypothesis of this study, was thus confirmed which stated that; children placed in primary custody on the basis of a newly established psychological assessment procedure, will on follow-up six months later, be more psychologically healthy in terms of their overall functioning than those in a control group who were not placed in custody on the basis of the assessment procedure.

10.2 Contribution to the Field of Psychology - A New Psychological Procedure for the Evaluation of Primary Placement and Contact

Based on the findings of the present study, a "blue print" of how a psychologist should do the evaluation for primary placement and access is herewith tentatively proposed:

Step 1: Clinical interview

The clinical interview is a crucial process in information gathering about one's clients.

- Clinical interviews must be conducted. During the clinical interview with adults, as well as children, observational assessment should evaluate the following areas of behaviour, general appearance and behaviour, mood and affect, perception, comprehension, orientation, insight and content of communication.

These abovementioned factors involve clinical judgement which should guide the psychologist as to how their clients presented themselves. The psychologist in her / his training has been trained to observe what is going on with the client hear what the client is saying, understand the clients presenting problem, put them into a psychological framework including the mental status of the client during the interviewing process. is subjective in his/her perception, he/she has been educated to see and hear from within a trained frame of reference and to do so in an orderly and a systematic fashion.

- A favourable presentation will encompass behaviour including a coherent presentation regarding orientation, comprehension, insight, memory and intact thought processes. The physical demeanour such as whether he is neatly dressed, and maintain mood and affect related to the context. Levels of activity, which can include whether the person is passive, or agitated or not. Thus agitation and tearfulness can therefore be expected, but not bordering on a hysterical level.
- Thus the clinical interview in any psychological assessment remains a prerequisite as this gives the assessor information about the client which is reported.
- Structured clinical observation and reporting, as such, is an integral part of forensic assessment. Therefore psychological opinion that involves clinical judgement, should guide the psychologist as to the appropriateness of presentation.

Step 2: Interactional Pattern Analysis

- Conducting an Interactional Pattern Analysis (IPA) between parents and children has to form part of the evaluation. During this process the parent and child are observed in a playroom setting where a parent needs to maintain a

complimentary role (as a leader and a follower) and not a *parallel role* (relationship between equals) or *symmetrical role* (continued power struggle).

- The *emotional distance* between parent and child should be transparent during the interaction and reciprocity should be present. Therefore a congruent interaction between parent and child is essential since it has important implications for the quality of an individual's interpersonal relationships. The potential to elicit acceptance or rejection has to be determined during the observation as a parent is expected to have the ability to create a caring, loving environment and not a hostile and rejecting one.
- The IPA should also determine if a child experiences validation that he/she is a special or an exceptional individual and appreciated as such by the parent. The level of relative control is also determined by the IPA indicating if the parent or child is a helpless victim or not. The parent and child have to demonstrate the capacity in their relationship to express needs within an interpersonal context as well as effective interpersonal flexibility. A linear or circular approach to the environment is of importance. Typically, parents with a linear approach to the environment do not recognise their 'share' in interactive processes but often blame others for that which is not acceptable to them. It is also important for a parent to be able to monitor his own behaviour especially in terms of maintaining a harmonious relationship. The meta-communication skill is especially important for a parent in his/her attempts at resolving interpersonal conflict, where both parent and child involved in an interaction are able to monitor their own behaviour towards each other, thus adopting a "helicopter view", to reflect on their own actions and communication in order to resolve the existing conflict between them. This is a difficult skill to evaluate during the IPA in the context of primary residency evaluation, but the parents' understanding of and dealing with the child will indicate if a parent has this ability.
- The psychologist has to determine the *adequacy of problem-solving skills* within the parent child relationship as environmental demands on a day-to-day basis

obviously necessitates a degree of skill in solving a great variety of problems that may range from the ability to run a bath to disciplining the child effectively. It is thus extremely important to observe how an individual manages his or her environment, for example, how a parent deals with unexpected environmental problems when addressing a child.

- Utilising the above-mentioned variables systematically to describe patterns of interaction between parent and child will provide the psychologist with insight and understanding regarding the parent child relationship and guide him/her to make the recommendation for primary placement and contact.

Step 3: Psychometric evaluation

- The *Millon Clinical Multiaxial Inventory (MCMI-III)* has to form part of the battery of tests to be used. In this regard the parent should provide a valid profile. If not, he/she was making an active attempt to manipulate the results. Significantly elevated scores in the clinical scales of narcissism, aggression, anti-social and severe pathology scales of schizotypal, borderline or paranoid personalities indicate a pathological approach to the environment which affects parental insight and the ability to enter the child's life world effectively. Effective parents primarily have a valid profile without significant elevated scores on any of the scales.
- The *16 Personality Factor Questionnaire (16PF)* should also provide a valid profile of a particular parent, but low scores on *Factor C* indicate emotional instability which affects parental insight as this person is affected by feelings and impulsively gets upset. This tendency places a question mark on a person's ability to parent effectively.

- The *Thematic Apperception Test (TAT)* should be used to describe the respective parents' personality with specific reference to awareness of environmental demands as identified in *Card 1*. Responses in accordance with healthy stimulus values on *Cards 2, 3, 4, 6 and 7* indicate effectiveness in emotional investment in familial relationships, application of moral standards and understanding of social causality. Appropriate dealing with the intimacy, aggression and sexuality on *Cards 8, 10 and 13* also show a favourable approach to dealing with interactional challenges.
- References to an involved parent and caring behaviour towards the child on *Cards 1, 3, 4, 6, 7, 8 and 10* on the *Children's Apperception Test (CAT)* indicate closeness towards the particular paternal or maternal figure. Furthermore, the loving and nurturing projections on *Card 2, 5 and 9* show the experience of closeness and also from which parent it is received. Repetitive themes in the child's projections on the *CAT* will thus provide an indication from which parent nurture and involvement is primarily received.
- The results of the *Bene-Anthony Family Relations Test (FRT)* will show the psychologist the emotional attitude of the child towards each parent. The psychologist will be able to ascertain how the child believes the respective parents feel about him/her, as well as how the child feels about them (incoming and outgoing feelings). The results will thus be able to indicate where the child's primary parental attachment and nurture lie, guiding a recommendation for primary residence.
- As for the results of the *Duess Test*, the psychologist will gain understanding of the child's emotional complexities regarding parental closeness, which parent causes frustration and wish towards primary residence. These fables are effectively used where the child can complete a storyline and verbalize wishes, thus bypassing possible defences in an attempt not to incriminate any parent.

- The projective interpretation of the *Kinetic Family Drawing (KFD)* will provide the psychologist with a valuable indication as to where the child positions him/herself regarding the parental figures by means of a drawing. It can be hypothesised that, the closer the child draws himself to a parent, the more acceptance and closeness her/she experiences in the relationship with this parent. By implication, if a parent is drawn farther away from the child or even disregarded, it can be hypothesised that the child manoeuvres for distance from this parent which places a question mark regarding primary residence placement with this parent.

Step 4: Collateral information

- Collateral information is important and should be obtained as part of the assessment process. This information should include but not be limited to arrest and conviction records; mental health and psychological reports; hospital/medical records; affidavits; pertinent records such as school reports and legal correspondence. This information should be used to identify patterns of behaviour in the light of pathological or criminal behaviour, for example several protection orders issued, interdicts, unfavourable mental health reports, past personal injuries or statements. Expert reports emphasising that the person is a functional parent acting in the best interest of the child, or interviews with teachers, pastors or therapists will also indicate a trend or pattern in a person's behaviour towards a child. The psychologist should thus be on alert for trends or patterns in behaviour which serve the children's interests or do not serve their interest. This will assist the psychologist regarding recommendation for primary residence.

After the psychologist has completed the above-mentioned steps, he or she will be able to identify which parent presents with or without pathology, which parent can interact

with the child effectively on various levels and the child's preference regarding a parent. The integration of the clinical impressions, specific parental effectiveness as illustrated by the IPA, as well as congruent parent-child relationship also observed from the IPA, non-elevated scores on the MCMI-III and 16PF, interactional healthy projections on the TAT, CAT and KFD and favourable parental allocation on the FRT and Dues test, should, "on the basis of probability", provide a significant chance to the child concerned to benefit from the placement. This integrated view provides the psychologist with a relative scientific perspective regarding the effectiveness of a parent, as well as the child's preference regarding primary residence preference.

The study will be concluded in the next and final chapter.

CHAPTER 11

CONCLUSION AND RECOMMENDATIONS

11.1 Introduction

It is clear from this study that there has been a dire need for the development of an optimal psychological assessment procedure for determining primary residence allocation for children whose parents are divorcing, which was always going to be a daunting task.

It is also clear from this study that an intricate and comprehensive psychological assessment procedure has been developed which is in line with achieving the most important aim, namely what is in *the best interest of the child*.

However, developing an optimal procedure does not guarantee the successful implementation thereof in divorce matters. The success of implementing any developed procedure is completely dependent on the cooperation of each individual involved, especially the parents and the Courts.

11.2 Weaknesses of the study

The first primary shortcoming of the study was that only three clinical psychologists participated in study 1. This sample was identified based on phenomenological research principles which in essence dictate small sizes of participants; however for future research more participants can be included.

Study 1 was conducted from a subjective standpoint and the researcher may have introduced some bias to the data analysis. In an attempt to avoid potential bias, and being consistent with the phenomenological methods, clusters of themes were triangulated with an advocate of the high court as well as a senior clinical psychologist who specializes in forensic investigations.

Identifying participants was not easy because of the sensitive nature of the topic of the study. Which was also the second limitation as the experimental and control groups were not equal in size. Future research can strive for the same number of families to participate in the study.

11.3 Recommendations

The study had strengths in terms of using a sole South African sample. This adds to the limited research pool on this topic in South Africa and Africa.

This study was successful in achieving its three aims, that is, it was successful in translating the “*best interest of the child*” construct from a legal perspective to a psychological perspective; identifying specific psychological instruments that could be used to effectively measure parental effectiveness, parental emotional stability and the children’s preference of a parent and lastly showing how children will adjust who was exposed to the defined assessment procedure six months after primary residence placement.

By identifying psychological guidelines for the assessment of the best interests of the child the children of South Africa can be served better by psychologists, as well as the legal system.

Whereas the present research endeavoured to make some contribution regarding optimal primary placement of children in divorce, the safeguarding of children’s best interests undoubtedly goes beyond the mere placement in itself. In this regard optimal parenting plans are required, but to date very little empirical research has been completed in this respect and, therefore, many generic types and styles of parenting plans exist causing confusion as to the requirements of this research. In this light, it will not serve the child’s interest if he/she is optimally placed but the parents have no proper parenting plan. Optimal placement should be seen as the first step, but an optimal parenting plan needs to be implemented to ensure that the child and the parents are

prepared to adjust to the new context of post-divorce. If not, optimal placement can be nullified if a parent does not know how to assist the child with adjustment to a single parent household including the tensions of the post-divorce context.

Together with the above stated recommendations, optimal parental guidance programmes, especially within the context of divorce are, also required. After divorce the children are subjected to unique challenges and conflicts related to the fact that their parents no longer stay together anymore and there is often antagonism between the parents. Parents should thus be educated and assisted on how to handle the children optimally, especially regarding applying high levels of empathy to the distraught child. These parents should be educated not to yield to the temptation to use the children as “weapons” in their on-going struggles and how to safeguard against this. Optimal parental guidance programmes thus have to be researched empirically and implemented.

11.4 Conclusion

South Africa is in dire need for a psychological procedure to assist the Courts, and more importantly the children during divorce proceedings. This study made a contribution by providing guidelines to psychologists involved in the evaluation for primary residence in order to serve *the best interest of the child*.

It can therefore be concluded that the children in South Africa will be better served by the Courts if they are exposed to this assessment procedure in order to avoid ambiguity.

Finally, it is the overall duty and role of the psychologist to assist the Court in terms of primary placement of the child with the appropriate parent irrespective of the gender of the of the parent, or the child.

12 REFERENCES

- Achenbach, T.M. (1991). *Integrative Guide To The Child Behaviour Checklist*. Burlington: University of Vermont.
- Ackerman, M.J. (1995). *Clinician's Guide To Custody Evaluations*. New York: John Wiley & Sons.
- Ackerman, M.J. (1999). *Essentials Of Forensic Psychological Assessment*. New York: John Wiley & Sons.
- Ackerman, M.J. (2001). *Clinician's Guide To Child Custody Evaluations*. John Wiley & Sons.
- Ackerman, M.J. (2006). *Clinician's Guide To Child Custody Evaluations (3rd Edition)*. New York: John Wiley & Sons
- Ackerman, M.J. & Ackerman, M.C. (1997). Custody evaluation practices: A survey of experienced professionals (revised). *Professional Psychology: Research and Practice*, 28, 137-145.
- Ackerman, M.J. & Kane, A.W. (1998). *Psychological Experts In Divorce Actions (3rd Edition)*. New York: Aspen Law & Business.
- Ackerman, M.J. & Kane, A.W. (2004). *Psychological Experts In Divorce Actions (3rd Edition)*. Cumulative supplement. New York: Aspen Law & Business.
- Africa, A., Daws, A., Swartz, L.S. & Brandt, R. (2003). Criteria used by family counsellors to determine child custody in a family advocate's office. In S. Burman (ed.). *The Face Of The Child: Legal Decisions On Children In The New South Africa*, 122-144. Cape Town: Juta.
- African Charter on the Rights and Welfare of the Child*. November 29, 1999.
- Ainsworth, M. D. S. (1969), Object relations, dependency, and attachment: A theoretical review of the infant mother relationship. *Child Development*, 40, 969-1025.
- Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In: B. M. Caldwell & H. N. Ricciuti (Eds.) *Review of child development research*. Chicago: University of Chicago Press. Pp. 1-94.

Allan, A. & Louw, D. (2001). Lawyers' perception of psychologists who do forensic work. *South African Journal of Psychology*, 31(2), 12-20.

American Psychological Association. (1994). Guidelines for child custody evaluation in divorce proceedings. *American Psychologist*, 49, 677-680.

Anastasi, A. & Urbina, S. (1997). *Psychological Testing*. Upper Saddle River, NJ: Prentice Hall, Inc.

Austin, W.G. (2000). A Forensic Psychology Risk assessment for child custody relocation law. *Family and Conciliation Courts Review*. 38(2). 192-207.

Austin, W.G. (2002). Guidelines for utilising collateral sources of information in child custody evaluations. *Family Court Review*. 40(2). 177-184.

Austin W.G. and Kirkpatrick, H.D. (2004). *Investigative vs. Clinical Emphasis in Child Custody Evaluation*. Routledge

Bathurst, K., Gottfried, A.W. & Gottfried, A.E. (1997). Normative data for the MMPI-2 in child custody litigation. *Psychological Assessment*, 9, 205-211.

Bellak, L. (1954). *The Thematic Apperception Test and the Children's Apperception Test In Clinical Use*. Oxford, England: Grune & Stratton.

Bellak, L., & Abrams, D. M. (1993). *The Thematic Apperception Test, the Children's Apperception Test, and the Senior Apperception Technique In Clinical Use (5th Edition)*. Needham Heights, MA: Allyn & Bacon.

Berelson, B. (1952). *Content Analysis in Communication Research*. Glencoe, Ill: Free Press.

Bergin, A.E. & Garfield, S.L. (1983). *Handbook Of Psychotherapy And Behavior Change*. New York:Wiley & sons.

Bezuidenhout, A. (2000). *Towards Global Social Movement Unionism? Trade Union Responses To Globalization In South Africa*. Unpublished thesis: University of the Witwatersrand.

Births and Death Registration Act 51 of 1992.

Bishop, D.S.; Epstein, N.B. & Baldwin, L.M. (1980). Structuring a Family Assessment Interview. *Canada Family Physician*. Vol 26: 1534–1537.

Bishop, D.S.; Epstein, N.B. & Baldwin, L.M. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy*. Vol 9. No 2. 172-180

Blais, M.A., Holdwick, D.J., Mclean, R.Y.S., Otto, M.W., Pollack, M.H. & Hilsenroth, M.J. (2003). Exploring the psychometric properties and construct validity of the MCMI-III anxiety and avoidant personality scales. *Journal of Personality Assessment* 81(3), 237-241.

Boggs, S.R., Eyberg, S. & Reynolds, L.A. (1990). Concurrent validity of the Eyberg Child Behavior Inventory. *Journal of Clinical Child Psychology*, 19 (1), 75-78.

Bone, M.J & Walsh, M.R. (1999). Parental Alienation Syndrome: How to Detect It and What to Do About It . *The Florida Bar Journal*, 73 (3), p 44-48

Boon, S. & Draijer, N. (1991). Diagnosing dissociative disorders in the Netherlands: A pilot study with the Structured Clinical Interview for DSM-III-R Dissociative Disorders. *The American Journal of Psychiatry* 148 (4), 458-462.

Bonthuys, E. (2002). Gender, race, culture and religion: Outside Legal Subjectivity' , *South African Journal on Human Rights* 18(1): 41-58.

Bow, J. N. and Quinnell, F. A. (2002). A critical review of child custody evaluation reports. *Family Court Review*, 40(2), 164-176

Bowlby, J. (1951). *Maternal Care and Mental Health*. World Health Organization Monograph.

Bowlby, J. (1969). *Attachment. Attachment and Loss: Vol. 1. Loss.* New York: Basic Books.

Borum, R. & Grisso, T. (1995). Psychological Test Use In Criminal Forensic Evaluations. *Professional Psychology: Research and Practice*, 26, 465-473.

Brandt, R., Dawes, A., Africa, A. & Swartz, L. (2004) A thematic content analysis of psychologists' reports in child custody evaluations. *South African Journal Of Psychology*. 34(2):259-282.

Brodsky, S. L., Caputo, A. A. & Domino, M. L. (2002). The mental health professional in court: Legal issues, research foundations and effective testimony. In B. van Dorsten (ed.), *Forensic psychology: From classroom to courtroom*, 17-33. New York: Kluwer Academic/Plenum Publishers.

Burman, S. & Derman, L. (2002). Deciding for children: The family Advocate and the caring professions. In C. Jones-Pauley & S. Elbern (eds.), *Access To Justice: The Role Of Court Administrators And Lay Adjuratory In African An Islamic Contexts*, 161-180.

Burns, Robert C. (1987). *Kinetic-House-Tree-Person Drawings (K-H-T-P): An Interpretative Manual.* New York : Brunner/Mazel.

Butcher, J.N. (2002). Assessment in forensic practice. In B. van Dorsten (ed.) *Forensic psychology: From Classroom To Courtroom*, 65-81. New York: Kluwer Academic/Plenum Publishers.

Calloway, G. & Lee, S.M. (2002). Child based vs Forensic Evaluations. Proceedings of the 5th International Symposium on Child Custody Evaluations and the 5th International Congress on Parent Education and Access Programmes. *Madison, W.I. Association of Family Constellation Courts.*

Campbell, T.W. (1992). Child custody evaluations and appropriate standards of psychological practice. *Michigan Bar Journal*, 71, 278-283.

Campbell, T.W. (1992). Psychotherapy with children of divorce: The pitfalls of triangulated relationships. *Psychotherapy*, 29, 646-652.

Carson, D. & Bull, R. (1995). Psychology in legal contexts: Idealism and realism. In D. Carson & R. Bull (eds.) *Handbook Of Psychology In Legal Contexts*, 3-11. Chichester: John Wiley & Sons.

Cattell, R.B. (1946). *The Description And Measurement Of Personality*. New York: World Books.

Cattell, R.B. (1957). *Personality And Motivation Structure And Measurement*. New York: World Books.

Cattell, H.E.P. (1996). The original big five: A historical perspective. *European Review of Psychology*, 46(1), 5-14.

Cattell, R.B. & Krug, S.E. (1986). The number of factors in the 16PF: A review of the evidence with special emphasis on the methodological problems. *Educational and Psychological Measurement*, 46, 509-522.

Civil Union Act 17 of 2006.

Cattell, H.E. & Schuerger, J.M. (2003) *Essentials of the 16PF*. New York: John Wiley & Sons.

Chapman, L.J. & Chapman, J.P. (1969). Illusory correlation as an obstacle to the use of valid psychodiagnostic signs. *Journal of Abnormal Psychology*, 74, 271-280.

Chessick, R.D. (2002). Psychoanalytic Peregrinations IV: What is Phenomenology? *Journal of the American Academy of Psychoanalysis*: Vol. 30, No. 4, pp. 673-689.

Children's Act of 2005

Chirwa, C. (2002). The merits and demerits of the African charter on the rights and the welfare of the child. *International Journal of Children's Rights*, 10, 157-161.

Civil Union Act 17 of 2006.

Colazzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. Kings (Eds.), *Existential Phenomenological Alternative For Psychology*. New York: Oxford University Press.

Conn, S.R. & Rieke, M.L. (1994). *The 16PF Fifth Edition technical manual*. Champaign, IL: Institute for Personality and Ability Testing.

Constitution of the Republic of South Africa Act 200 of 1994.

Constitution of the Republic of South Africa, 1996.

Convention on the Rights of the Child: resolution 44/25 of 20 November 1989.

Cooley, W.W. and P Robinson, J.P; Shaver, P.R. & Wrightsman, L.S. (eds.) (1999), *Measures of Personality and Social Psychological Attitudes*. Third Edition. Ann Arbor: Institute for Social Research.

Coombes, L., Morgan, M., Tuffin, K. & Johnson, M. (2004). Critical legal psychology. *Critical Psychology, 11*, 30-49.

Craig, R.J. (1997). A selected review of the MCMI empirical literature. In T. Millon (ed.), *The Millon Inventories: Clinical And Personality Assessment*. New York: Guilford.

Craig, R.J. (1999). Testimony on the Millon Clinical Multiaxial Inventory: Review, commentary, and guidelines. *Journal of Personality Assessment, 73*, 290-304.

Craig, J.C. (2005). *New Directions In Interpreting The Millon Clinical Multiaxial Inventory-III (MCMI-III)*. Wiley & Sons.

Craig, R.J., Bivens, A. & Olson, R. (1997). MCMI-III-derived typological analysis of cocaine and heroin addicts. *Journal of Personality Assessment, 69*, 583-595.

Craig, R.J. & Bivens, A. (1998). Factor structure of the MCMI-III. *Journal of Personality Assessment, 70*, 190-196.

Craig, R.J. & Weinberg, D. (1993). MCMI: Review of the literature. In R.J. Craig (ed.), *The Millon Clinical Multiaxial Inventory: A Clinical Research Information Synthesis*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Cramer, P. (1991). *The Development Of Defence Mechanisms: Theory, Research, And Assessment*. New York: Springer Verlag.

Cramer, P. (2004). *Storytelling, Narrative, And The Thematic Apperception Test*. New York: Guilford Press.

Criminal Procedure Act, (1998).

Cronje, D.S.P. & Heaton, J. (2003). *The South African Law of Persons*.

Cronje, D.S.P. & Heaton, J. (2004). *South African Family Law*. 2nd ed.

Cumes, J.W. & Lambiase, E.E.A. (1987). Do lawyers and psychologists have different perspectives on the criteria for the award of custody of a child?" *SALJ* 704-708

Customary Marriages Act 120 of 1998.

Davel, T. (2006). The child's right to legal representation in divorce proceedings' in C. Nagel (ed) *Gedenkbundel vir J Labuschagne*: Butterworths.

Davel, C.J. & de Kock, P.D. (2001). In die kind se beste belang. 34 *De Jure* 272.

Davel, C.J. & Jordaan, R.A. (2000; 2005). *Law of Persons Students' Textbook*. Cape Town: Juta

Davel, C.J. & Skelton, A.M. (2007). *Commentary on the Children's Act*. Cape Town: Juta.

Davis, D., Cheadle, H. & Haysom, N. (1997). *Fundamental Rights In The Constitution Commentary And Cases*. Cape Town:Juta.

Davis, S.E. & Hays, L.W. (1997). An examination of the clinical validity of the MCMI-III depressive personality scale. *Journal of Clinical Psychology*, 53, 15-23.

Davis, R.D., Wenger, A. & Guzman, A. (1997). Validation of the MCMI-III. In T. Millon (ed.), *The Millon Inventories: Clinical And Personality Assessment*. New York: Guilford.

Denzin, Norman K. & Lincoln, Yvonna S. (eds.). (2005). *The Sage Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

De Villiers, B. (1993). The right of children in international law: Guidelines for South Africa. *Stell LR* 289.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). (2000). American Psychiatric Association

Divorce Act of 1979

Domestic Violence Act No. 116 of 1998.

Donnalioia, N. (2005). *Trafficking ion persons in the Republic in South Africa*. Unpublished thesis. University of the Witwatersrand.

Dunteman, G.H. (1984). *Introduction To Multivariate Analysis*. Thousand Oaks, CA: Sage Publications.

Dyce, J.A., O'Connor, B.P., Parkins, S.Y. & Janzen, H.L. (1997). Correctional structure of the MCMI-III personality disorder scales and comparisons with other data sets. *Journal of Personality Assessment*, 69, 568-582.

Dyer, F.J. (1997). Application of the Millon Inventories in forensic psychology. In T. Millon (ed.), *The Millon Inventories: Clinical And Personality Assessment*. New York: Guilford.

Dyer, F.J. & McCann, J.T. (2000). The Millon Clinical Inventories, research critical of their forensic application, and Daubert criteria. *Law and Human Behaviour*, 24, 487-497.

Duncan, W. (1998). Fundamental principles of the Hague convention of 1980 of the Civil aspects of international child abduction. *Hague Conference On International Law*.

Düss, L. (1946). The psychological function of the proper name in the reconstruction of the personality of a schizophrenic,. *Psychiatric Quarterly* , Volume 22, Number 1, 646-666.

Edwards, L. (1999). Hearing the voice of the child: Notes of the Scottish experience. In C.J. Davel (ed.), *Children's Rights in a Traditional Society*. 37-39.

Ehrenberg, J. & Hunter, H. (1997). The best-interests-of-the-child assessment model: Development and outcome. Cape Town:Juta

Emery, R.E., Otto, R.K. & O'Donohue, W. T. (2005). A critical assessment of child custody evaluations: Limited science and a flawed system. *Psychological Science in the Public Interties*, 6 , 1-29.

Employment Equity Act, 1998

Epsein, N.B., Baldwin, M., & Bishop, D.S. (1983). The McMaster Family assessment Device. *Journal of Marial and Family Therappy*. Vol 9. (2) 171-180

Evans, A.C.P. (1997). *A Pilot Study Into The Functioning Of Families With A Member Who's A Hospice Patient To Determine Whether Hospice Patients Require Family Therapy*. Unpublished dissertation: Rhodes University.

Eyberg, S. & Pincus, D. (1999). Eyberg Child Behaviour Inventory & Sutter-Eyberg Student Behaviour Inventory – Revised. *Psychological Assessment Resources*, Odessa, FL: Psychological Assessment Resources.

Ewing, C. P. (1985). *Psychology, Psychiatry And The Law: A Clinical And Forensic Handbook*. Sarasota, FL: Professional Resource Exchange, Inc.

Fakier, Z. (2006). *Children's consent to medical experimental and HIV testing* Unpublished thesis: University of Western Cape.

Family Law Legislation Vol. II (1994). Revision Service No. 8.

Father's Rights of his Illegitimate Child Act (1994).

Firebaugh, G. (2008). *Seven Rules for Social Research*. Princeton University Press.

Fischer, J. & Corcoran K. (2000). *Measures For Clinical Practice: A Sourcebook*. NY, Free Press.

Folberg, J. (1984). *Joint Custody And Shared Parenting*. Washington DC: BNA Books.

Foster, D. (1990). Expert testimony on collective violence. In D. Hansson & D. van Zyl Smit (eds.), *Towards Justice?* (154-172). Cape Town: Oxford University Press.

Fox, D. (1997). Psychology and law: Justice diverted. In D. Fox & I. Prilleltensky (eds.), *Critical Psychology* (217-232). London: Sage.

Fox, D. (1999). Psycholegal scholarship's contribution to false consciousness about injustice. *Law and Human Behaviour*, 23, 9-30.

French v French, 1971 (4) SA 298 (W).

Franklin, D.J. (2008). *Psychology Information and the Law*. Cape Town: Oxford University Press.

Galatzer-Levy, R., Baerger, D. R., Gould, J.W. & Nye, S. (2002). Evaluating the evaluation: How to understand and critique custody evaluations. In R. Brown & L. Morgan (eds.), 2003 Family Law Update, (pp.139-211). Baltimore: Aspen.

Gardner, R.A. (1989). *Family Evaluation In Child Custody Mediation, Arbitration And Litigation*. New Jersey: Creative Therapeutics.

Geddis, D.C., Turner, I.F. & Eardley, J. (1977). *Diagnostic Value Of A Psychological Test In Cases Of Suspected Child Abuse: Archives Of Disease In Childhood*. British Medical Association United Kingdom, 52(9), 708-712.

Genis, M (2008). *A Content Analysis Of Forensic Psychological Reports Written For Sentencing Proceedings In Criminal Court Cases In South Africa*, MA dissertation, University of Pretoria, Pretoria

Goldstein, J.; Freud, A. & Solnit, A.J. (1973). *Beyond the Best Interests of the Child*. New York: Free Press.

Goodenough, F. (1926). *Measurement of intelligence by drawings*. New York: World Books.

Gould, J.W. (1998). *Conducting Scientifically Crafted Child Custody Evaluations*. Thousand Oaks, CA: Sage.

Gould, J.W. (1999). Professional interdisciplinary collaboration and the development of psycholegal questions guiding court-ordered child custody evaluations. *Juvenile and Family Court Journal*, 50(1), 43-52.

Gould, J.W. (2004). Evaluating the probative value of child custody evaluations: A guide for forensic mental health professionals. *Journal of Child Custody*, 1(1), 77-96.

Gould, J.W. (2006). *Conducting Scientifically Crafted Child Custody Evaluations*. Sarasota, FL: Professional Resource Press.

Gould, J.W. & Bell, L.C. (2000). Forensic methods and procedures applied to child custody evaluations: What judges need to know in determining a competent forensic work product. *Juvenile and Family Court Journal*, 38(2), 21-27.

Gould, J.W., Kirkpatrick, H.D., Austin, W. & Martindale, D.A. (2004). A protocol for offering a critique of a colleague's forensic work product. *Journal of Child Custody*, 1(3), 37-64.

Gould, J.W. & Kirkpatrick, H.D.. (2001). *Conducting Scientifically Crafted Child Custody Evaluations*. Continuing Education Workshop Presented At The Annual Convention Of The American Psychological Association. San Francisco.

Gould, J.W. & Lehrmann, D. (2002). Evaluating the probative value of child custody evaluations. *Juvenile and Family Court Journal*, 53(2), 17-30.

Gould, J.W. & Martindale, D.A. (2009). *The Art And Science Of Child Custody Evaluations*. Guilford Press: New York/London

Gould, J.W. & Stahl, P.M. (2000). The art and science of child custody evaluations: Integrating clinical and mental health models. *Family and Conciliation Courts Review*, 38(3), 392-414.

Government Gazette, Vol. 492, Cape Town, 19 June 2006, No. 28944

Greenberg, S. and Shuman, D.W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice*, 28, 50-57.

Grief, G.L. & DeMarris, A. (1989). Single custodial fathers in contested custody suits. *Psychiatry and Law*, 223-238.

Grobler, A. C. (1998). *Some Predictors Of The Mathematics Achievement Of Black Secondary School Children*. Unpublished dissertation: University of the Free State

Groth-Marnat, G. (1997). *Handbook of Psychological Assessment* (3rd Edition). New York: John Wiley & Sons.

Guardianship Act 192 of 1993

Gudjonsson, G. (1991). The trail of psychiatry: Insanity in the 20th century. In K. Herbst & J. Gunn (eds.) *Mentally disordered offender*. Oxford: Butterworth Heinemann.

Gudjonsson, G. (1995). Psychology and assessment. In D. Carson & R. Bull (eds.) *Handbook of psychology in legal contexts*. Chichester: John Wiley & Sons.

Gudjonsson, G. & Haward, L.R. C. (1998). *Forensic Psychology: A Guide To Practice*. London: Routledge.

Hague Convention on Abduction and Adoption, (1993).

Halon, R. L. (1990). The comprehensive child custody evaluation. *American Journal of Forensic Psychology*, 8, 19-46.

- Hamilton, D & Orme, J.G.(1990). *Analysing single-system design data using statistical process control charts*. Council on Social Work Education Annual Program Meeting, *Quantitative Methods in Social Work Symposium*, San Francisco, CA
- Handler and Habenich (1994). A Review of the Literature. *Journal of Personality Assessment*.
- Harris, D. B. (1963). *Children's Drawings As Measures Of Intellectual Maturity*. New York: Harcourt, Brace World, Inc.
- Hasday, J.E. (2004). *The Canon of Family Law*. Stanford Law Review, Vol. 57 p. 825-900.
- Hasselkus, B.R.(1997). Everyday ethics in Dementia day care: narratives of crossing the line. *Gerontologist*. 1997 Oct;37(5):640-9.
- Hayley, J. (1963). *Strategies of Psychotherapy*. New York: Grune & Stratton.
- Heilbrun, K. (1992). The role of psychological testing in forensic assessment. *Law and Human Behavior*, 16, 257–272.
- Heilbrun, Warren, & Picarello, (2003). Use of 3rd party information in Forensic assessment. In I. Weiner and A. Goldstein (ed.). *Handbook of Psychology*. Vol. 11. Forensic Psychology (pp-68-89). Hoboken, New York: Wiley.
- Henderson, P. (2003). Questions on fostering: An anthropologist's perspective. In S. Burman (ed.) *The fate of the child: Legal decisions on children in the new South Africa*, 9-31. Cape Town: Juta.
- Heilbrun, K. (2001). *Principles of forensic mental health assessment*. New York: Kluwer Academic/Plenum.
- Hess, A.K. & Weiner, I.B. (1999). *The Handbook Of Forensic Psychology*. New York: John Wiley & Sons.
- Hetherington, E. M., Bridges, M., & Insabella, G. M. (1998). What matters? What does not? Five perspectives on the association between marital transitions and children's adjustment. *American Psychologist*, 53, 167-184.

- Hodges, W. F. (1991). *Interventions for children of divorce* (2nd. Edition) New York: John Wiley.
- King M and Trowell J (1992). *Children's Welfare and the Law: The Limits Of Legal Intervention*. Sage, London.
- Hodgkin, R. & Newell, P. (1998). *Implementation Handbook For The Convention For The Rights Of The Child*. 145 – 147.
- Hodgkin, R. & Newell, P. (2002). *Implementation Handbook For The Convention For The Rights Of The Child*. New York: John Wiley & Sons.
- Hofer, S.M. & Eber, H.W. (2002). Second-order factor structure of the Cattell Sixteen Personality Factor Inventory (16PF). In B. de Raad & M. Perugini (eds.), 'Big-Five Assessment' (pp.397-404). Cambridge, MA: Hogrefe & Huber publishers.
- Hoffman, A. & Pincus, B.K. (1989). *The Law of Custody*. Durban:Butterworths.
- Holmstrom, R.W., Silber, D.E. & Karp, S.A. (1990). Development of the Apperceptive Personality Test. *Journal of Personality Assessment*, 54 (1 & 2), 252-264.
- HPCSA. (2003b). *List Of Tests Classified As Being Psychological Tests*. Pretoria: HPCSA FORM 207.
- HPCSA. (2006). Professional Board for Psychology: *Rules Of Conduct Pertaining Specifically To The Profession Of Psychology*. Pretoria: HPCSA.
- HPCSA. (2007). *Discussion document: Professional Board for Psychology, Scope of practice*. Pretoria: HPCSA.
- HPCSA. (2009), *Psychology News Letter*. Pretoria: HPCSA.
- Hudson, W.W. & Acklin, J.D. (1980). Assessing discord in family relationships. *Social Work Research and Abstracts*, 16(3). 21-29.
- Hunter, L. & Leahey, E. (2008). Collaborative Research in Sociology: Trends and Contributing Factors. *American Sociologist*, 39, 290-306.
- Institute for Personality and Ability Testing, 2009

Jafee, P.G., Crooks, C.V. & Poisson, S.E. (2003). Common misconceptions in addressing domestic violence in child custody disputes. *Juvenile And Family Court Journal*. 54(4), 57-68.

Jameson, B., Ehrenberg, M.F., & Hunter, M.A. (1997). *Psychologists' Understanding Of The Best Interests Of The Child Criterion In Custody And Access Disputes*. *Professional Psychology: Research & Practice*, 28(3), 253-262.

Jaynes, J. (2000). *The Origin of Consciousness in the Breakdown of the Bicameral Mind*. Mariner Books.

Jones, G. A., Langrall, C. W., Thornton, C. A ., & Nisbet, S. (2002). In L. D. English, M. B. Bussi, G. A. Jones, R. A. Lesh, & D. Tirosh (Eds.), *Handbook Of International Research In Mathematics Education*. Mahwah, NJ: Lawrence Erlbaum Associates. Retrieved December 3, 2006

Jones, B. & Sall, J. (2011). "JMP statistical discovery software". *Wiley Interdisciplinary Reviews: Computational Statistics* 3 (3): 188–194.

Kaliski, S. (2006). *Psycholegal Assessment in South Africa*. Oxford University Press.

Keilin, W.G. & Bloom, L.J. (1986). Child custody evaluation practices: A survey of experienced professionals. *Professional Psychology: Research and Practice*, 17, 338-346.

Khattree, R. & Naik, D.N. (1999). *Multivariate Data Reduction and Discrimination with SAS Software*. SAS Institute. NC

Kirkland, K., & Kirkland, K.L. (2001) Frequency of child custody evaluation complaints and related disciplinary action: A survey of the State and Provincial Psychology Boards. *Professional Psychology: Research and Practice*, 32, 171-174.

Kirkland, K. (2002). The epistemology of child custody evaluation. *Family Court Review*, 40(2), 185-189.

Kirkpatrick, H.D. (2004). A floor not a ceiling: Beyond guidelines – An argument for minimum standards of practice in conducting child custody and visitation evaluations. *Journal of Child Custody*, 1(1), 61-77.

Kline, P. (1999). *The Handbook of Psychological Testing*. New York: Routledge.

Kockelmans, J.J. (1967). Edmund Husserl's phenomenological psychology a historico-critical study. Bobbs-Merrill. Indianapolis.

Kruger, J.M. & Robinson, J.A. in J.A. Robinson (ed.). (1997). *The Law of Children and Young Persons in South Africa*.

Kuehnle, K. (1996). *Assessing Allegations Child Sexual Abuse*. New York: Harcourt, Brace World, Inc.

Kuhn, S.T. (1961). *The Function of Measurement in Modern Physical Science*. Bobbs-Merrill. Indianapolis.

Kuo, A.D., Hall, S.A. & Levy, M.I. (2010). *Child Custody and Divorce: An Overview*. The Guilford Press. New York.

Langdrige, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Harlow: Pearson Education.

Lategan, A. (1991). *Temperamentsverskille By Kinders Met En Sonder Gedragsprobleme*. Unpublished dissertation: Rand Afrikaans University.

Lewis, W.M. (1996). *The Development And Testing Of A Multiethnic, Low Literacy, Family Support Programme For The Primary Prevention Of Child Abuse And Neglect In The Child Under Five Years*. Unpublished dissertation: University of Natal.

Lincoln, N.E. (1986). *Guidelines For Child Custody Evaluation*. Nebraska Psychological Association.

Lipman, J. (2004). Psychometric Profiles of Violent Offenders with Histories of Psychostimulant, Psychosis: A Pilot Study. *International Journal of Forensic Psychology* 1(2), 82-93.

Lohnes, R. (1971). *Multivariate Data Analysis*. John Wiley & Sons, Inc.

Louw, D. & Allan, A. (1996). Forensic psychology in South Africa. *American Journal of Forensic Psychology*, 14(4), 49-61.

Louw, D. & Allan, A. (1998). A profile of forensic psychologists in South Africa. *South African Journal of Psychology*, 28(4), 234-241.

Lund, M.E. (1983). Use of the Bene Anthony Family Relations Test as an aid to evaluating children's feelings in divorced family conflict. *British Association for the Study and Prevention of Child Abuse and Neglect*, Cambridge, England.

Luijpen, W. (1996) *Existential phenomenology*. John Wiley & Sons, Inc.

Lund, M.E.; Garcia, J.A. & Strachan, A.M. (2010). Assessing children's perceptions of Family Relationships: An Interactive Instrument For Use In Custody Disputes. *Journal Of Child Custody*, 7(3), 192-216.

Maloney, M.P. & Ward, M.P. (1976). *Psychological Assessment: A Conceptual Approach*. New York: Oxford University Press.

Marriage Act 25 of 1961.

Marriage Act of the Recognition of Customary Marriages Act 120 of 1998.

Martín-Albo, J.; Núñez, J.L.; Navarro, J.G. & Grijalvo, F. (2007) The Rosenberg Self-Esteem Scale: Translation and Validation in University Students The *Spanish Journal of Psychology*, 10(2), 458-467

Martindale, D. (2001). Cross-examining mental health experts in child custody litigation. *Journal of Psychiatry and Law*, 29(4), 483-511.

Martindale, D.A. (2005). Psychological assessment: Evaluating the evaluations. *The Matrimonial Strategist*, 22(12), 3-5.

Martindale, D.A. & Gould, J.W. (2004). *The Forensic Model: Ethics And Scientific Methodology Applied To Child Custody Evaluations*. New York: John Wiley & Sons.

Martindale, D.A. & Gould, J.W. (2005). A second call for clinical humility and judicial vigilance: Comments on Tippens and Wittman (2005). *A Family Court Review*, 42(2), 253-259.

McCall v McCall, 1994 (3) SA 201 (CPD)

McCann, J.T. & Dyer, F.J. (1996). *Forensic Assessment With The Millon Inventories*. New York: Guilford.

McCann, J. (2002). Guidelines for Forensic Application of the MCMI-III. *Journal of Forensic Psychology Practice*.

McCann, J.T., Flens, J.R., Campagna, V., Collman, P. & Lazzaro, T. (2001). The MCMI-III in Child Custody Evaluations: A Normative Study. *Journal of Forensic Psychology Practice*, 1(2).

McCoy, D. (2005). *The Ultimate Guide to Personality Tests*. Inglewood, CA: Champion Press.

Mediation in Certain Divorce Matters Act, (1987)

Meehl, P.E. (1997). Credentialed persons, credentialed knowledge. *Clinical Psychology: Science and Practice*, 4, 91-98.

Mental Health Care Act, 2002.

Melton, G.B. (1983). In the interest of children: does anybody win? *Law And Human Behaviour*, 10 (4).

Melton, G.B., Petrila, J., Poythress, N.G. & Slobogin, C. (1997). Law and the mental health professions: An uneasy alliance. *Psychological Evaluation For The Courts*, 700-720. New York: Guilford Press.

Melton, G.B., Petrila, J., Poythress, M.G. & Slobogin, C. (1997). *Psychological Evaluations for the Courts: A Handbook For Mental Health Professionals And Lawyers*. New York: Guilford.

Miller, T. W., & Veltkamp, L. J. (1986). Use of fables in clinical assessment of contested child custody. *Child Psychiatry and Human Development* , 16, 274-284.

Millon, T. (1983). *Millon Clinical Multiaxial Inventory manual (3rd ed.)*. Minneapolis, MN: National Computer Systems.

Millon, T. (1987). *Manual for the Millon Clinical Multiaxial Inventory-II (MCMI-II)*. Minneapolis, MN: National Computer Systems.

Millon, T. (1994). *Millon Inventory-III (MCMI-III)*. Minneapolis, MN: National Computer Systems.

Millon, T. (2006). *Personality Subtypes. Institute for Advanced Studies in Personology and Psychopathology.* Dicandrien, Inc..

Millon, T., Davis, R. & Millon, C. (1997). *MCMI-III manual (2nd ed.)*. Minneapolis, MN: National Computer Systems.

Millon, T., Millon, C., Davis, R. & Grossman, S. (1997). *MCMI-III: Millon Clinical Multiaxial Inventory-III. 3rd ed.* NCS Pearson, Inc: Minneapolis.

Mokhuane, E.M.Q. (1996). *Pain Psychological Measurement And Treatment* Dissertation for Doctoral Thesis.

Moustakas, C. (1994) *Phenomenological Research Methods*. Thousand Oaks, CA: Sage, pp. 95-96

Moran, D. (2000). *Introduction to Phenomenology*. Routledge: New York

Mudie, G. 1987. *Determination Of Disputed Custody And Access With Divorce*. Seminar by Gillian Mudie, University of Stellenbosch.

Murphy, P.A. (2004). *The Cult Of Personality: How Personality Tests Are Leading Us To Miseducate Our Children, Mismanage Our Companies, And Misunderstand Ourselves*. Riverside, NJ: Simon & Schuster.

National Coalition for Gay and Lesbian Equality v Minister of Home Affairs 2000 (2) SA 1 (CC)

Narron, M.C. (2005). *Updating the TAT: A Photographic Revision Of The Thematic Apperception Test*. Dissertations Abstract International, p. 568.

Natural Fathers of Children Born out of Wedlock Act 86 of 1997.

Naylor, V., Vorster, C., Cronje, P. & Donaldson, B. (2003). In V. Roos & C. Vorster (eds.), *An Introduction To Forensic Psychology*, 37-58. Pretoria: Verbum Publishers.

Neetling, J.; Potgieter, J.M. & Visser, P.J. (1996). *Neetling's Law Of Personality*. Durban: Butterworths.

Neuman, W.L. (2000). *Social Research Methods.*: Allyn and Bacon (Toronto).

Neuman, W.L. (2006). *Social Research Methods: Qualitative and Quantitative Approaches 6th edition*, Allyn & Bacon.

Newark, N.J. (1993). Specialty guidelines for psychologists in custody/visitation evaluations. *New Jersey State Board of Psychological Examiners*.

Nicholas, L. (2000). An evaluation of psychological reports considered in the amnesty process of the truth and reconciliation commission. *South African Journal of Psychology*, 30 (1) 50-52.

Nicholas , L. & Coleridge, L. (2000). Expert witness testimony in the criminal trial of Eugene de Kock: A critique of the post-traumatic stress disorder (PTSD) defence. *South African Journal Of Psychology*, 30 (1), 33-37.

Ogloff, J.R.P. (2002). *Two steps forward and one step backward*. In J.R.P. Ogloff (ed.), *Taking Psychology And The Law Into The Twenty-First Century* (1-33). New York: Kluwer/Plenum.

Otto, R.K., Buffington-Vollum, J.K. & Edens, J.F. (2003). Child custody evaluations. In A.M. Goldstein (Ed.), *Handbook of Psychology: Vol 11, Forensic Psychology*. New York: Wiley

Otto, R.K. & Butcher, J.N. (1995). Computer-assisted psychological assessment in child custody evaluations. *Family Law Quarterly*, 29, 79-96.

Parkin A. (2001). *The Bene-Anthony Family Relations Test Revisited: Directions In The Assessment Of Children's Perceptions Of Family Relations*. Greenwood Institute of Child Health, University of Leicester, UK.

Patton, M. Q. (1990). *Qualitative evaluation methods*. Thousand Oaks, CA: Sage

Phala, T.M. (1997). *The Adaptation And Standardization Of The Child Behaviour Checklist To The Northern Sotho Speaking Children Between The Ages Of 6-12*. Unpublished Dissertation: University of the North.

Pope, K.S., Butcher, J.N. & Seelen, J. (2000). *MMPI/MMPI-2/MMPI-A in court: Assessment, Testimony, And Cross-Examination For Expert Witnesses And Attorneys*. Washington D.C. American Psychological Association.

Potgieter, R., M. (1987). *Children And Divorce*. Port Elizabeth. University of Port Elizabeth.

Preller, J. (2009) *Children And Divorce*. New York: Guilford Press.

Pruett, M.K. & Hoganbruen, K. (1998). *Joint Custody And Shared Parenting. Research and interventions*. Child And Adolescent Psychiatric Clinics Of North America

Prinsloo, C.H. (1991). *Norms, Means, Standard Deviations And Reliability Coefficients For The Sixteen Personality Factor Questionnaire (Form A)*. Human Sciences Research Council. Pretoria.

Quinnell, F.A. & Bow, J.N. (2001). Psychological tests used in. *Behavioural Science and Law*, 19, 491-501.

Recognition of Customary Marriages Act 120 of 1998

Report on S.A. Father's Rights of his Illegitimate Child (Project 38) (1994).

Review of the Child Care Act Report (Project 110) (2002) 7.3 p. 6.

Reynolds, C.R. (1998). *Comprehensive Clinical Psychology*, Volume 4: Assessment. Amsterdam: Elsevier.

Robinson, J.A. (2006). "The South African Civil Union Act 2006: Progressive Legislation With Regressive Implications?" *International Journal of Law Policy and the Family*.

Robinson, J.P; Shaver, P.R. & Wrightsman, L.S. (eds.) (1999), *Measures of Personality and Social Psychological Attitudes. Third Edition*. Ann Arbor: Institute for Social Research.

Robinson, R. in C.J. Davel (ed.). (2000). *Introduction to Child Law in South Africa*.

Robinson, J.A. & Ferreira, G.M. (2000). Die reg van die kind on gehoor te word: *Enkele Verkennende Perspektiewe Op Die VN Konvensie Oor Die Regte van die Kind*. 154 – 56.

Rogers, R., Salekin, R.T. & Sewell, K.W. (1999). Validation of the Millon clinical multiaxial inventory for Axis II disorders: Does it meet the Daubert standard? *Law and Human Behaviour*, 23, 425-443.

Roos, V. & Vorster, C. (2003). *An Introduction To Forensic Psychology*. Pretoria: Verbum Publishers.

Rutter, M. (1972). *Maternal Deprivation Re-assessed*. Penguin Education: Harmondsworth.

Roos, V. & Vorster, C. (2009). *An Introduction To Forensic Psychology..* Pretoria: Verbum Publishers.

Rosenberg, M. (1965). *Society And The Adolescent Self-Image*. Princeton, NJ: Princeton University Press.

S v Nursingh 1995 (2) SACR 331 (D); S v Wiid 1990 1 SACR 561 (A); S v Moses 1996 1 SACR 701 (C)

Saayman, G.S. & Saayman, R.V. (1989). The Adversarial Legal Process and Divorce: Negative Effects Upon the Psychological Adjustment of Children". *Journal of Divorce*, 12 (2/3), 329-348.

Schafer, L.I. in B. Clark (ed.). (1988). *Family Law Service*. Place:

Scherrer, R., Louw, D.A. & Moller, A.T. (2002). Ethical complaints and disciplinary action against South African psychologists. *South African Journal Of Psychology*, 32, 54-64.

Schmitt, C. (1996). *The Leviathan in the State Theory of Thomas Hobbes..* University Chicago Press.

Schmitt, D.P., & Allik, J. (2005). Simultaneous administration of the Rosenberg Self-Esteem Scale in 53 nations: Exploring the universal and culture-specific features of global selfesteem. *Journal of Personality and Social Psychology*, 89, 623-642.

Section 28(2): Interim Constitution (1993)

Sekhute, K.G. (1994). *An Exploratory Investigation Of Racial Identity And Self-Esteem Among Black University Students*. Unpublished MA dissertation: University of South Africa.

Sells J,S.. (2004). *Intimacy, Differentiation and Marital Satisfaction* .Northern Illinois University.

Shapiro, D. (2000). Ethical issues in forensic psychological evaluation. In B. van Dorsten (ed.), *Forensic psychology: From classroom to courtroom*, 35-64. New York: Kluwer Academic/Plenum Publishers.

Shapse, S.N. (2007). *When a test is not a test: Tests without forensic validity*. HG.org Worldwide Legal Directories.

Siegel, J. (2010). *Development Of Normative Statistical And Interpretive Data For The Sixteen Personality Factors Test (16-PF) On Persons Involved Contested Child Custody Litigation*. Research paper presented to the 25th Annual Meeting of the American College.

Skeem, J.L., Douglas, K.S. & Lilienfeld, S.O. (2009). *Psychological Science In The Courtroom: Consensus And Controversy*. Guilford Press.

South African Children's Act of 2005

South African Law Commission Project 110 .Review of the Child Care Act (Dec. 2002) part 1 par. 3.4 p. 16.

Spinelli, E. (2005) *The Interpreted World: An Introduction to Phenomenological Psychology*. London: SAGE Publications

Stahl, P. M. (1994). *Conducting Child Custody Evaluations*. London: Sage publications.

Statistics South Africa: Marriages and divorces, (2011)

Steinberg, M. (1994). *Interviewers Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)*. Washington, DC, American Psychiatric Press.

Shuman, D.W. & Sales, B.D. (1998). Daubert's wager. *Journal of Forensic Psychology Practice*, 1, 69-77.

Tancredi, L.R., Lieb, J. & Slaby, A.E. (1975). *Legal Issues In Psychiatric Care*. Hagerstown: Harper & Row.

Ter Laack, J., de Goede, M. & Aleva, A. (2005). The Draw-A-Person Test: An Indicator of Children's Cognitive and Socioemotional Adaptation?. *Journal of Genetic Psychology*. Heldref Publications.

Tharinger, D. J.; Stark, K. D.(1990). .A qualitative versus quantitative approach to evaluating the Draw-A-Person and Kinetic Family Drawing: A study of mood- and anxiety-disorder children. *Psychological Assessment: Journal of Consulting and Clinical Psychology*, Vol 2(4), Dec 1990, 365-375.

The South African Divorce Rate Posted by: Bertus, *myDicitalLife* accessed on Feb 10, 2010

Tippens, T.M, & Wittmann, J.P. (2005). Empirical and ethical problems with custody reconedatons: A caal for clinical humility and judicial vigilance. *Family Court Review*, 34(2), 193-222

Toch, H. (ed.). (1961). *Legal And Criminal Psychology*. New York: Holt, Rhinehart & Winston.

Tognazzo, P., Zanettin, D. Ongaro, F. (1975), On the possibility of applying the "Method of Fables" test, by Louisa Duss, to a group of adults. *Bollettino di Psicologia Applicata*, Vol 127-129, Feb-Jun 1975, 89-105.

Tredoux, C., Foster, D., Allan, A., Cohen, C. & Wasserman, D. (2005). *Psychology and Law*. South Africa: Juta and Co. Ltd.

United Nations Statistics Division, (2012).

Valle, R., King, M., & Halling, S. (1989). An introduction to existential-phenomenological thought in psychology. In R. Valle & S. Halling (Eds.), *Existential-Phenomenological Perspective In Psychology*. New York: Plenum Press.

Van Breda, A.D.P. (1997). *The Development Of The Deployment Resilience Seminar*. Unpublished MA dissertation: University of Cape Town.

United Nations' Convention on the Rights of the Child (1989)

Van Deijl v Van Deijl

- Van den Berg, P. (2008). The influence of recalled family, peer, and media influences on body image and eating behaviour as mediated by appearance comparison. Presented at the 35th Annual Convention of the Association for Advancement of Behaviour Therapy, Philadelphia, PA
- Van der Vyfer, J.D. & Joubert, D.J. (1991). *Persone en Familiereg*. Sigma Press: Pretoria.
- Van Dorsten, B. (2002). Forensic psychology. In B. van Dorsen (ed.) *Forensic psychology: From Classroom To Courtroom*, 1-16. New York: Kluwer Academic/Plenum Publishers.
- Van Ginneken, J. (1992). *Crowds, Psychology And Politics*. Cambridge: Cambridge University Press.
- Van Heerden, B. in van Heerden, Cockrell & Keightley (eds). 1999. *Boberg's Law of Persons and the Family*. Sigma Press: Pretoria.
- Van Heerden, B. in Hutchison, van Heerden, Visser, van der Merwe. (eds). 1991. *Wille's Principles of South African Law*. Sigma Press: Pretoria.
- Van Leeuwen, C. (1990). *'n Geldigheidstudie Van Twee Indekse Vir Gebruik In Maatskaplikewerk-Praktyk*. Unpublished Dissertation: Rand Afrikaans University.
- van Manen, M. (1997). *Researching Lived Experience: Human Science For An Action Sensitive Pedagogy*. London, Canada: The Althouse Press.
- Van Schalkwyk, N. in C.J. Davel (ed.), (2005). *Handbook of the South African Law of Maintenance*. Sigma Press: Pretoria.
- Van Zyl, L. (1997). *Divorce Mediation And The Best Interests Of The Child*. Sigma Press: Pretoria.
- Vorster, C. (2003). *General systems theory and psychotherapy: Beyond post modernism*. Satori Publishers: Pretoria.
- Vorster, C. (2011). *Impact – The story of interpersonal therapy*. Pretoria: Satori Publishers.
- Vass, Z. (2002). *Projective Drawings And The Psychopathology Of Visual Expression*. Unpublished master's thesis, University of South Florida.

- Wall, J.C. & Amadio, C. (1994). An integrated approach to child custody evaluation: Utilising the 'best interest' of the child and the family systems framework. *Journal of Divorce & Remarriage*, 21(3/4), 39-57.
- Wallis, T. (2004). Psychological tests do not measure what they claim to measure: A re-evaluation of the concept of construct validity. *South African Journal of Psychology*, 34, 101-112.
- Wallerstein, J. and Blakeslee, S. (1996). *Second Chances: Men, Women, And Children A Decade After Divorce*. New York : Ticknor & Fields.
- Wallerstein, J., and Kelly, J. B. 1980. *Surviving The Break-Up*. New York: Basic Books, Inc. Publishers.
- Wallerstein, J. (1987). *The Unexpected Legacy of Divorce*. New York: Hyperion.
- Wassenaar, D.R. (2002). *Ethical Issues In South African Psychology: Public Complaints, Psychologists' Dilemmas And Training In Professional Ethics*. Unpublished doctoral theses. University of Natal, Pietermaritzburg.
- Wechsler, D. (2003). *Wechsler Intelligence Scale For Children* (4th ed.). San Antonio, TX: Psychological Corporation.
- Weiner, I.B., Friedheim, D.K. & Goldstein, A.M. (2003). *Handbook of Psychology: Forensic psychology*. John Wiley & Sons.
- Weissmann, H.N., & Debow, D.M. (2003). Ethical principles and professional competencies. In A.M. Goldstein (Ed.), *Handbook Of Psychology*. Vol. 11 Forensic Psychology (pp.33-54). New York: Wiley
- Weithorn, L. (1987). *Psychology And Child Custody Determinations*. Nebraska: Lincoln.
- Westen, D. (1991). *Clinical Assessment of Object Relations Using the TAT*. *Journal of Personality Assessment*, 56(1), 56 - 74.
- Williams, S.D., Wiener, J. & MacMillan, H. (2005). *Build-A-Person Technique: An Examination Of The Validity Of Human-Figure Features As Evidence Of Child Sexual Abuse*. *Child Abuse & Neglect* (Elsevier Science).

Wilding, C., & Whiteford, G. (2005). Phenomenological Research an Exploration of Conceptual, Theoretical, And Practical Issues. *OTJR* Vol25(3)

Zaal, N. & Skelton, A. (1998). Providing effective representation for children in a new constitutional era: Lawyers in the criminal and children courts. *SAJHR* 14, 539 -544.

APPENDIX A

UNIVERSITY OF LIMPOPO (MEDUNSA CAMPUS) CONSENT FORM

Letter to Psychologists pertaining to the Aims of the Research Study

Name of the study: DEVELOPING OPTIMAL PSYCHOLOGICAL ASSESSMENT PROCEDURE FOR DETERMINING PRIMARY CARE AND RESIDENTIAL PLACEMENT OF CHILDREN IN A DIVORCE DISPUTE

Dear colleague,

Thank you for your consideration to participate in this doctoral research study. The aims of the study are threefold namely:

- a) To redefine the 13 legal variables of Justice King into psychological constructs which will assist in the assessment of children and adults in cases of divorce in order to determine the suitability of the parents for custody purposes.
- b) To identify the available psychometric test and clinical procedure that may assist in the evaluation of parents and children for primary residence placement.
- c) To identify 8 suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in this system, is functioning, i.e. the psychological health of a particular family system.
- d) If you agree to be a participant you will be required to provide written consent for participation. You will receive a document referring to various legal concepts

describing the “*Best Interests of a Child*” as identified by Justice King. Your task will be to define and explain each numbered statement from a psychological point of view and to identify a possible procedure (psychometric or clinical) that would be suitable to evaluate this statement based on your experience.

- e) Please indicate via the contact details below within the next 6 weeks of receipt whether you are willing to participate in the study.

TEL: (012) 6533196

FAX: (012) 6536821

MOBILE 083 551 7097

E-MAIL: info@henkswanepoel.co.za

Thanking you in advance,

A handwritten signature in black ink, consisting of several overlapping, sweeping lines that form a stylized, somewhat abstract shape.

Henk Swanepoel

APPENDIX B

UNIVERSITY OF LIMPOPO (MEDUNSA CAMPUS) CONSENT FORM

Consent form to Psychologists pertaining to participation in a Research Study

Name of the study: DEVELOPING OPTIMAL PSYCHOLOGICAL ASSESSMENT PROCEDURE FOR DETERMINING PRIMARY CARE AND RESIDENTIAL PLACEMENT OF CHILDREN IN A DIVORCE DISPUTE

I have read the information and heard the aims and objectives of this proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. I know that this study has been approved by the Research, Ethics and Publications Committee of the Faculty of Medicine, University of Limpopo (Medunsa Campus). Am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided that my privacy is guaranteed.

I hereby give consent to participate in this study.

Name of Psychologist

Signature of Psychologist

Date

APPENDIX C

13 STATEMENTS OF THE BEST INTEREST PRINCIPLE BASED ON JUSTICE KING'S LEGAL CONSTRUCTS AND A LIST OF FAMILY HEALTH INSTRUMENTS

In the 13 following statements you will be presented with various legal concepts describing the “*Best Interests of a Child*” as identified by Justice King. Your task is to please define and explain each numbered statement from a psychological point of view and to identify a possible procedure (psychometric or clinical) that would be suitable to evaluate this statement based on your experience. Lastly please list 8 (eight) suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in this system, is functioning, i.e. the psychological health of a particular family system.

1.The love, affection and other emotional ties which exist between parent and child, and the parent's compatibility with the child

Possible measuring procedure (psychometric or clinical)

2. The capabilities, character and temperament of the parent, and the impact thereof on the child's needs and desires

Possible measuring procedure (psychometric or clinical)

3. The ability of the parent to communicate with the child and the parent's insight into, understanding of and sensitivity to the child's feelings

Possible measuring procedure (psychometric or clinical)

4. The capacity and disposition of the parent to give the child the guidance which he/she requires

Possible measuring procedure (psychometric or clinical)

5. The ability of the parent to provide for the basic physical needs of the child, the so-called “creature comforts” such as food, clothing, housing and other material needs – generally speaking, the provision of economic security_____

Possible measuring procedure (psychometric or clinical)

6. The ability of the parent to provide for the educational wellbeing and security of the child, both religious and secular

Possible measuring procedure (psychometric or clinical)

7. The ability of the parent to provide for the child's emotional, psychological, cultural and environmental development

Possible measuring procedure (psychometric or clinical)

8. The mental and physical health and moral fitness of the parent

Possible measuring procedure (psychometric or clinical)

9. The stability or otherwise of the child's existing environment, having regard to the desirability of maintaining the status quo

Possible measuring procedure (psychometric or clinical)

10. The desirability or otherwise of keeping siblings together

Possible measuring procedure (psychometric or clinical)

11. The child's preference if the court is satisfied that in the particular circumstances the child's preference should be taken into consideration

Possible measuring procedure (psychometric or clinical)

12. The desirability or otherwise of applying the doctrine of same-sex matching

Possible measuring procedure (psychometric or clinical)

13. Any other factor relevant to the particular case, which is before the court

Possible measuring procedure (psychometric or clinical)

Please identify 8 (eight) suitable psychometric instruments that can be used to determine how effectively a particular family system, as well as the children in this system, is functioning, i.e. the psychological health of a particular family system.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Your co-operation is highly appreciated!

APPENDIX D

UNIVERSITY OF LIMPOPO (MEDUNSA CAMPUS) CONSENT FORM

Consent concerning participation in a Research Study

Name of the study: DEVELOPING OPTIMAL PSYCHOLOGICAL ASSESSMENT PROCEDURE FOR DETERMINING PRIMARY CARE AND RESIDENTIAL PLACEMENT OF CHILDREN IN A DIVORCE DISPUTE

I have read the information and heard the aims and objectives of this proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. I know that this study has been approved by the Research, Ethics and Publications Committee of the Faculty of Medicine, University of Limpopo (Medunsa Campus). Am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided that my privacy is guaranteed.

I hereby give consent to participate in this study.

Name of participant / volunteer

Signature of participant / volunteer

Date

Statement by researcher

I provided verbal and written information regarding the study. I agree to answer any future questions concerning the study as best as I am able. I will adhere to the approved protocol.

Henk Johan Swanepoel

Signature

Date

APPENDIX E

Family Assessment Device (FAD)

Instructions

This assessment contains a number of statements about families. Read each statement carefully, and decide how well it describes your own family. You should answer according to how you see your family.

For each statement are four (4) possible responses:

Strongly agree (SA) Check SA if you feel that the statement describes your family very accurately.

Agree (A) Check A if you feel that the statement describes your family for the most part. Disagree (D) Check D if you feel that the statement does not describe your family for the most part. Strongly disagree (SD) Check SD if you feel that the statement does not describe your family at all.

These four responses will appear below each statement like this:

41. We are not satisfied with anything short of perfection.

The answer spaces for statement 41 would look like this.

____ SA ____ A ____ D ____ SD _____

For each statement, there is an answer space below.

Do not pay attention to the blanks at the far right-hand side of each space. They are for office use only. Try not to spend too much time thinking about each statement, but respond as quickly and as honestly as you can. If you have difficulty, answer with your first reaction. Please be sure to answer every

statement and mark all your answers in the space provided below each statement.

1. Planning family activities is difficult because we misunderstand each other.

___ SA ___ A ___ D ___ SD _____

2. We resolve most everyday problems around the house.

___ SA ___ A ___ D ___ SD _____

3. When someone is upset the others know why.

___ SA ___ A ___ D ___ SD _____

4. When you ask someone to do something, you have to check that they did it.

___ SA ___ A ___ D ___ SD _____

5. If someone is in trouble, the others become too involved.

___ SA ___ A ___ D ___ SD _____

6. In times of crisis we can turn to each other for support.

___ SA ___ A ___ D ___ SD _____

7. We don't know what to do when an emergency comes up.

___ SA ___ A ___ D ___ SD _____

8. We sometimes run out of things that we need.

___ SA ___ A ___ D ___ SD _____

9. We are reluctant to show our affection for each other.

___ SA ___ A ___ D ___ SD _____

10. We make sure members meet their family responsibilities.

___ SA ___ A ___ D ___ SD _____

11. We cannot talk to each other about the sadness we feel.

___ SA ___ A ___ D ___ SD _____

12. We usually act on our decisions regarding problems.

___ SA ___ A ___ D ___ SD _____

13. You only get the interest of others when something is important to them.

___ SA ___ A ___ D ___ SD _____

14. You can't tell how a person is feeling from what they are saying.

___ SA ___ A ___ D ___ SD _____

15. Family tasks don't get spread around enough.

___ SA ___ A ___ D ___ SD ___

16. Individuals are accepted for what they are.

___ SA ___ A ___ D ___ SD ___

17. You can easily get away with breaking the rules.

___ SA ___ A ___ D ___ SD ___

18. People come right out and say things instead of hinting at them.

___ SA ___ A ___ D ___ SD ___

19. Some of us just don't respond emotionally.

___ SA ___ A ___ D ___ SD ___

20. We know what to do in an emergency.

___ SA ___ A ___ D ___ SD ___

21. We avoid discussing our fears and concerns.

___ SA ___ A ___ D ___ SD ___

22. It is difficult to talk to each other about tender feelings.

___ SA ___ A ___ D ___ SD ___

23. We have trouble meeting our financial obligations.

___ SA ___ A ___ D ___ SD ___

24. After our family tries to solve a problem, we usually discuss whether it worked or not.

___ SA ___ A ___ D ___ SD ___

25. We are too self-centred.

___ SA ___ A ___ D ___ SD ___

26. We can express feelings to each other.

___ SA ___ A ___ D ___ SD ___

27. We have no clear expectations about toilet habits.

___ SA ___ A ___ D ___ SD ___

28. We do not show our love for each other.

___ SA ___ A ___ D ___ SD ___

29. We talk to people directly rather than through go-betweens.

___ SA ___ A ___ D ___ SD ___

30. Each of us has particular duties and responsibilities.
____ SA ____ A ____ D ____ SD _____
31. There are lots of bad feelings in the family.
____ SA ____ A ____ D ____ SD _____
32. We have rules about hitting people.
____ SA ____ A ____ D ____ SD _____
33. We get involved with each other only when something interests us.
____ SA ____ A ____ D ____ SD _____
34. There is little time to explore personal interests.
____ SA ____ A ____ D ____ SD _____
35. We often don't say what we mean.
____ SA ____ A ____ D ____ SD _____
36. We feel accepted for what we are.
____ SA ____ A ____ D ____ SD _____
37. We show interest in each other when we can get something out of it personally.
____ SA ____ A ____ D ____ SD _____
38. We resolve most emotional upsets that come up.
____ SA ____ A ____ D ____ SD _____
39. Tenderness takes second place to other things in our family.
____ SA ____ A ____ D ____ SD _____
40. We discuss who are responsible for household jobs.
____ SA ____ A ____ D ____ SD _____
41. Making decisions is a problem for our family.
____ SA ____ A ____ D ____ SD _____
42. Our family shows interest in each other only when they can get something out of it.
____ SA ____ A ____ D ____ SD _____
43. We are frank(direct, straightforward) with each other.
____ SA ____ A ____ D ____ SD _____
44. We don't hold to any rules or standards.
____ SA ____ A ____ D ____ SD _____
45. If people are asked to do something, they need reminding.

___ SA ___ A ___ D ___ SD _____

46. We are able to make decisions about how to solve problems.

___ SA ___ A ___ D ___ SD _____

47. If the rules are broken, we don't know what to expect.

___ SA ___ A ___ D ___ SD _____

48. Anything goes in our family.

___ SA ___ A ___ D ___ SD _____

49. We express tenderness.

___ SA ___ A ___ D ___ SD _____

50. We confront problems involving feelings.

___ SA ___ A ___ D ___ SD _____

51. We don't get along well together.

___ SA ___ A ___ D ___ SD _____

52. We don't talk to each other when we are angry.

___ SA ___ A ___ D ___ SD _____

53. We are generally dissatisfied with the family duties assigned to us.

___ SA ___ A ___ D ___ SD _____

54. Even though we mean well, we intrude too much into each other's lives.

___ SA ___ A ___ D ___ SD _____

55. There are rules in our family about dangerous situations.

___ SA ___ A ___ D ___ SD _____

56. We confide in each other.

___ SA ___ A ___ D ___ SD _____

57. We cry openly.

___ SA ___ A ___ D ___ SD _____

58. We don't have reasonable transport.

___ SA ___ A ___ D ___ SD _____

59. When we don't like what someone has done, we tell them.

___ SA ___ A ___ D ___ SD _____

60. We try to think of different ways to solve problems.

___ SA ___ A ___ D ___ SD _____

APPENDIX F

Index of Family Relations (IFR)

This questionnaire is designed to measure the way you feel about your family as a whole. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time 2 = Very rarely 3 = A little of the time 4 = Some of the time 5 = A good part of the time 6 = Most of the time 7 = All of the time

1. _____ The members of my family really care about each other.
2. _____ I think my family is terrific.
3. _____ My family gets on my nerves
4. _____ I really enjoy my family.
5. _____ I can really depend on my family.
6. _____ I really do not care to be around my family.
7. _____ I wish I was not part of this family.
8. _____ I get along well with my family.
9. _____ Members of my family argue too much.
10. _____ There is no sense of closeness in my family.
11. _____ I feel like a stranger in my family.
12. _____ My family does not understand me.
13. _____ There is too much hatred in my family.
14. _____ Members of my family are really good to one another.
15. _____ My family is well respected by those who know us.
16. _____ There seems to be a lot of friction in my family.
17. _____ There is a lot of love in my family.
18. _____ Members of my family get along well together.
19. _____ Life in my family is generally unpleasant.
20. _____ My family is a great joy to me.
21. _____ I feel proud of my family.

22. _____ Other families seem to get along better than ours.

23. _____ My family is a real source of comfort to me.

24. _____ I feel left out of my family.

25. _____ My family is an unhappy one.

APPENDIX G

Eyberg Child Behaviour Inventory (ECBI)

Below are a series of phrases that describe children's behaviour.

Please (1) circle the number describing how often the behaviour currently occurs with your child , and (2) circle either "yes" or "no" to indicate whether the behaviour is currently a problem.

How often does this occur with your child?

Never Seldom Sometimes

Often Always Is this a problem for you?

1. Dawdles in getting dressed	1 2 3 4 5 6 7	Yes No
2. Dawdles or lingers at mealtime	1 2 3 4 5 6 7	Yes No
3. Has poor table manners	1 2 3 4 5 6 7	Yes No
4. Refuses to eat food presented	1 2 3 4 5 6 7	Yes No
5. Refuses to do chores when asked	1 2 3 4 5 6 7	Yes No
6. Slow in getting ready for bed	1 2 3 4 5 6 7	Yes No
7. Refuses to go to bed on time	1 2 3 4 5 6 7	Yes No
8. Does not obey house rules on own	1 2 3 4 5 6 7	Yes No
9. Refuses to obey until threatened with punishment	1 2 3 4 5 6 7	Yes No
10. Acts defiant when told to do something	1 2 3 4 5 6 7	Yes No
11. Argues with parents about rules	1 2 3 4 5 6 7	Yes No
12. Gets angry when doesn't get own way	1 2 3 4 5 6 7	Yes No
13. Has temper tantrums	1 2 3 4 5 6 7	Yes No
14. Sasses adults	1 2 3 4 5 6 7	Yes No
15. Whines	1 2 3 4 5 6 7	Yes No
16. Cries easily	1 2 3 4 5 6 7	Yes No
17. Yells or screams	1 2 3 4 5 6 7	Yes No
18. Hits parents	1 2 3 4 5 6 7	Yes No

19. Destroys toys and other projects	1 2 3 4 5 6 7	Yes No
20. Is careless with toys and other objects	1 2 3 4 5 6 7	Yes No
21. Steals	1 2 3 4 5 6 7	Yes No
22. Lies	1 2 3 4 5 6 7	Yes No
23. Teases or provokes other children	1 2 3 4 5 6 7	Yes No
24. Verbally fights with friends own age	1 2 3 4 5 6 7	Yes No
25. Verbally fights with sisters and brothers	1 2 3 4 5 6 7	Yes No
26. Physically fights with friends own age	1 2 3 4 5 6 7	Yes No
27. Physically fights with sisters and brothers	1 2 3 4 5 6 7	Yes No
28. Constantly seeks attention	1 2 3 4 5 6 7	Yes No
29. Interrupts	1 2 3 4 5 6 7	Yes No
30. Is easily distracted	1 2 3 4 5 6 7	Yes No
31. Has short attention span	1 2 3 4 5 6 7	Yes No
32. Fails to finish tasks or projects	1 2 3 4 5 6 7	Yes No
33. Has difficulty entertaining self alone	1 2 3 4 5 6 7	Yes No
34. Has difficulty concentrating on one thing	1 2 3 4 5 6 7	Yes No
35. Is overactive or restless	1 2 3 4 5 6 7	Yes No
36. Wets the bed	1 2 3 4 5 6 7	Yes No

The End

APPENDIX H

Rosenberg Self-Esteem Scale

The scale is a ten item Likert scale with items answered on a four point scale – from strongly agree to strongly disagree.

Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle SA. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.

- | | |
|---|-----------|
| 1. On the whole, I am satisfied with myself. | SA A D SD |
| 2. At times, I think I am no good at all. | SA A D SD |
| 3. I feel that I have a number of good qualities. | SA A D SD |
| 4. I am able to do things as well as most other people. | SA A D SD |
| 5. I feel I do not have much to be proud of. | SA A D SD |
| 6. I certainly feel useless at times. | SA A D SD |
| 7. I feel that I'm a person of worth, at least on an equal plane with others. | SAADSD |
| 8. I wish I could have more respect for myself. | SA A D SD |
| 9. All in all, I am inclined to feel that I am a failure. | SA A D SD |
| 10. I take a positive attitude toward myself. | SA A D SD |