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Professional Analysis of "Impact of Parental Conflict Tool"

Date: 5/22/17

Client: Miriam Fox

Psychologist: Craig Childress, Psy.D.

Scope of Report

The professional consultation of Dr. Childress was sought by Miriam Fox regarding materials provided to Dr. Childress. Dr. Childress was requested to provide his clinical opinion regarding the reviewed material, drawing on his professional background, experience, and expertise in child and family therapy, child development, and clinical psychology regarding the information provided to Dr. Childress. The opinions of Dr. Childress contained in this consultation report are based solely on the materials and information provided to him for review and the principles of professional psychology.

Materials Reviewed:

Impact of Parental Conflict Tool (Cafcass)

Professional Analysis:

A search was performed in both the general professional literature and then specifically in the *Mental Measurements Yearbook* (a professional guide and review of published assessment instruments) regarding the *Impact of Parental Conflict Tool* in order to review the instrument's psychometric properties of:

- The underlying theoretical foundations for the instrument's development;
- The operational definitions used in the instrument's application;
- The empirical studies demonstrating inter-rater reliability;
- The empirical studies supporting the construct validity, content validity, concurrent validity, or predictive validity of the instrument.

Based on this review of the professional literature, there appears to be no information in the professional literature which would support the psychometric properties of this assessment instrument.

Construct Validity

According to Brown (1996), the validity of an assessment procedure is defined as "the degree to which a test measures what it claims, or purports, to be measuring" (Brown,

1996, p. 231).¹ There are a variety of different types of validity that can be established for an assessment instrument or procedure, such as the ability of the assessment procedure to predict an outcome (predictive validity), the general agreement of professional opinion that the assessment questions adequately sample a domain (content validity), or the underlying theoretical foundations that support an assessment procedure (construct validity).²

Based upon the review of the *Impact of Parental Conflict Tool* and the principles and constructs of professional psychology, there does not appear to be any underlying foundational principles that were used in the development of the questions used in the *Impact of Parental Conflict Tool*. Instead, the questions appear to represent a haphazard set of questions without a clear rationale for why these specific questions are used. Neither is a cutoff score reported for determining clinical concern based on responses to this arbitrary set of questions, nor is a rationale provided for why such a cutoff score should be used (if one exists).

Construct Validity: Attachment-Based “Parental Alienation” (AB-PA)

An attachment-based model for the family pathology traditionally called “parental alienation” in the popular culture specifies a set of three diagnostic indicators for the family pathology traditionally called “parental alienation,” as well as providing the foundational rationale for the presence of these three definitive diagnostic indicators of AB-PA (Childress, 2015).³

The three diagnostic indicators of AB-PA are:

1.) Attachment System Suppression

The attachment system NEVER spontaneously dysfunctions. The attachment system ONLY becomes dysfunctional in response to pathogenic parenting (patho=pathology; genic=genesis, creation). Pathogenic parenting is the creation of significant pathology in the child through aberrant and distorted parenting practices.

2.) Narcissistic Personality Traits

Five specific narcissistic personality traits are evidenced in the child's symptom display. These are the "psychological fingerprint" evidence of the psychological control of the child by a narcissistic or borderline personality parent. A parent cannot psychologically control a child without leaving "psychological fingerprint" evidence of the parent's control of the child in the child's symptom display.

¹ Brown, J. D. (1996). *Testing in language programs*. Upper Saddle River, NJ: Prentice Hall Regents.

² Drummond, R. J., & Jones, K. D. (2010). *Assessment procedures for counselors and helping professionals* (8th ed.). Boston, MA: Pearson.

³ Childress, C.A. (2015). *An attachment-based model of parental alienation: Foundations*. Claremont, CA: Oaksong Press.

3.) Encapsulated Persecutory Delusion

The child evidences a fixed and false believe (a delusion) that the child is supposedly being "victimized" by the normal-range parenting of the targeted-rejected parent. This symptom represents the child being incorporated into a false trauma reenactment narrative of the narcissistic/(borderline) parent that is in the pattern: "abusive parent"/"victimized child"/"protective parent"

The presence of all three of these symptom indicators in the child's symptom display represents definitive diagnostic evidence for the pathology of AB-PA (attachment-based "parental alienation") as defined and described in *Foundations* (Childress, 2015). No other pathology in all of mental health will produce this specific pattern of child symptoms other than AB-PA as described in *Foundations*.

Analysis of AB-PA and the "Impact of Parental Conflict Tool"

The symptoms used in the *Impact of Parental Conflict Tool* identify some of the symptoms described in an attachment-based model of "parental alienation (AB-PA), but do so in an apparently haphazard approach that does not appear to represent a conceptual understanding for how and why these symptoms emerge from the pathology.

Question 1: The child describes one parent entirely negatively, the other entirely positively.

This symptom indicator appears to represent the psychological symptom of "splitting" (an extreme polarization of perception) that is associated with both narcissistic and borderline personality pathology. The evidence of "splitting" in the child's symptom display would be indicative of the psychological control of a child by a narcissistic and/or borderline personality parent.

AB-PA: This symptom corresponds to diagnostic indicator 2a-5 on the *Diagnostic Checklist for Pathogenic Parenting* (Appendix 1).

Question 2: The reasons given for the dislike of one parent may appear to be justified, but investigation shows them to be flimsy and exaggerated.

This symptom appears to represent the encapsulated persecutory delusion identified in AB-PA; i.e., the child evidences a fixed and false belief that is maintained despite contrary evidence that the child is being "victimized" by the normal-range parenting of the targeted parent.

AB-PA: This symptom corresponds to diagnostic indicator 3 on the *Diagnostic Checklist for Pathogenic Parenting*.

Question 3: The child proffers the opinion of wanting less contact with one parent in a way which requires little or no prompting.

This symptom appears to represent the suppression of child's attachment bonding motivations toward a normal-range and affectionally available parent.

AB-PA: This symptom corresponds to diagnostic indicator 1 on the *Diagnostic Checklist for Pathogenic Parenting*.

Question 4: The complaints have a quality of being rehearsed or practiced.

This is not a defined symptom in established professional psychology and would appear to be extremely difficult to objectively assess. This symptom indicator is likely to be highly prone to bias from the assessor since it is unclear how a “rehearsed or practiced” response can be reliably differentiated from an authentic response.

AB-PA: No corresponding symptom.

Question 5: The child seems to show little or no concern for the feelings of the parent being complained about.

This symptom appears to represent an absence of empathy that is associated with narcissistic personality pathology (DSM-5 diagnostic criterion 7). The absence of empathy in the child’s symptom display would be indicative of the psychological control of a child by a narcissistic personality parent who represents the “primary case” for the absence of empathy being displayed toward the targeted-rejected parent.

AB-PA: This symptom corresponds to diagnostic indicator 2a-3 on the *Diagnostic Checklist for Pathogenic Parenting*.

Question 6: Comments are inappropriate in view of the child’s age / developmental stage.

This is not a defined symptom of pathology in established professional psychology and would appear to be extremely difficult to assess. While there are developmental guidelines for stages of cognitive development (such as Piaget), these developmental stages would seemingly be difficult to apply in a specific case relative to specific comments made by the child about a parent. While a child in the developmental period of “concrete operational thinking” (ages 7-12 years old) who evidences “formal operational thinking” (adolescence through adulthood) may be unusually advanced in terms of cognitive thinking, no research evidence exists that this advanced cognitive development represents psychological control by a parent. This symptom indicator is also likely to be highly prone to bias from the assessor since it is unclear how a broad variation in child development should be measured relative to the child’s “comments.”

AB-PA: No corresponding symptom.

Question 7: The child’s anxiety and reactive behaviour to the contact are disproportionate to the risk identified.

This symptom appears to represent the excessive anxiety sometimes associated with AB-PA in which the child’s anxiety symptoms meet DSM-5 diagnostic criteria

for a Specific Phobia, but of the unrealistic and bizarre type of a “mother phobia” or “father phobia” (neither of which actually exist within forms of pathology).

AB-PA: This symptom corresponds to diagnostic indicator 2b on the *Diagnostic Checklist for Pathogenic Parenting* (which would provide a more precise symptom definition).

Question 8: Siblings provide a highly consistent responses when it is probable that due to age, position within the family, individual characteristics their wishes and feeling could be expected to differ.

This is not a defined symptom of pathology in established professional psychology and appears to be a bizarre symptom for any form of pathology. If people have a similar experience, then their descriptions are likely to be similar. Similarity in sibling perception is not a symptom of any established psychopathology. (Note: grammatical errors in sentence construction also suggest a degree of professional sloppiness that is of concern given the importance of the assessment).

This CAFCASS symptom may be trying to access the Shared Psychotic Disorder (DSM-IV TR) quality of the pathology (AB-PA diagnostic indicator 3) but is seemingly doing so in a strange and unreliable way. The DSM-IV Diagnostic Criteria for a Shared Psychotic Disorder (Appendix 2) identify that shared delusional beliefs can occur in “family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent’s delusional beliefs” (American Psychiatric Association, 2000, p. 333).⁴

AB-PA: No corresponding symptom.

Question 9: The rejected parent had a good relationship with the child prior to separation.

This is not a defined symptom of pathology in established professional psychology and would appear to be extremely difficult to assess. A prominent issue with assessing this question is whose report to believe if there are differing perceptions reported. In addition, change over time is not a symptom of any established psychopathology and change over time can be due to changing events and changing circumstances separate from parental influence on the child by an allied parent. Proximity of symptom development to a life change may provide some suggestive evidence of a possible causal linkage, but it is suggestive at best.

AB-PA: No corresponding symptom.

⁴ American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (Revised 4th ed.). Washington, DC: Author.

Question 10: Emotional warmth from the resident parent directly correlates with the child remaining resistant to contact

This is not a defined symptom of pathology in established professional psychology and it would appear to be extremely difficult to assess and reliably document a correlation of this kind.

This symptom appears to be seeking to document either the possible psychological control of the child, the possibility of an enmeshed parent-child bond with the allied (“resident”) parent, or the possibility of a role-reversal relationship in which the child is being used as a “regulatory object” to meet the needs of the allied (“resident”) parent. It may also be trying to seek one aspect of possible manipulative parental reinforcement by the allied parent of the child’s induced rejection of the other parent. It is unclear, however, how this symptom could be reliably assessed and documented.


AB-PA: No corresponding symptom.

Conclusion

The *Impact of Parental Conflict Tool* appears to be a haphazard collection of symptoms that employs no underlying organizational conceptual framework in guiding the development or use of the questions (i.e., no construct validity).

If a professional-level assessment and documentation of the pathology traditionally called “parental alienation” is sought, it is recommended that the symptom criteria of AB-PA (both the three definitive diagnostic indicators of AB-PA and the 12 Associated Clinical Signs) be assessed and documented using the *Diagnostic Checklist for Pathogenic Parenting* (Appendix 1). The three symptom features of AB-PA as identified in the *Diagnostic Checklist for Pathogenic Parenting* all represent standard and established mental health symptoms that are fully within the scope of practice for assessment by all mental health professionals (i.e., attachment system suppression, personality disorder traits, delusional belief systems), and the conceptual organizing framework for the origins of the three diagnostic indicators (and 12 Associated Clinical Signs) of AB-PA are fully described and elaborated from entirely within standard and established constructs and principles of professional psychology (Childress, 2015).

If some reason argues for the continued use of the apparently haphazard assessment approach offered by the *Impact of Parental Conflict Tool*, then it is recommended that the *Diagnostic Checklist for Pathogenic Parenting* be added to provide greater clarity to the child’s symptom features. In addition, when assessing the pathology surrounding AB-PA (an attachment-based model of “parental alienation”), it is recommended that the parenting practices of the targeted-rejected parent be documented using the *Parenting Practice Rating Scale* (Appendix 3).



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

Appendix 1: Diagnostic Checklist for Pathogenic Parenting

Diagnostic Checklist for Pathogenic Parenting: Extended Version

C.A. Childress, Psy.D. (2015)

All three of the diagnostic indicators must be present (either 2a OR 2b) for a clinical diagnosis of attachment-based “parental alienation.” Sub-threshold clinical presentations can be further evaluated using a “Response to Intervention” trial.

1. Attachment System Suppression

Present	Sub-Threshold	Absent	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The child’s symptoms evidence a selective and targeted suppression of the normal-range functioning of the child’s attachment bonding motivations toward one parent, the targeted-rejected parent, in which the child seeks to entirely terminate a relationship with this parent (i.e., a child-initiated cutoff in the child’s relationship with a normal-range and affectionally available parent).

Secondary Criterion: **Normal-Range Parenting:**

yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	The parenting practices of the targeted-rejected parent are assessed to be broadly normal-range, with due consideration given to the wide spectrum of acceptable parenting that is typically displayed in normal-range families.

Normal-range parenting includes the legitimate exercise of parental prerogatives in establishing desired family values through parental expectations for desired child behavior and normal-range discipline practices.

2(a). Personality Disorder Traits

Present	Sub-Threshold	Absent	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The child’s symptoms evidence all five of the following narcissistic/(borderline) personality disorder features displayed toward the targeted-rejected parent.

Sub-Criterion Met

yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	Grandiosity: The child displays a grandiose perception of occupying an inappropriately elevated status in the family hierarchy that is above the targeted-rejected parent from which the child feels empowered to sit in judgment of the targeted-rejected parent as both a parent and as a person.
<input type="checkbox"/>	<input type="checkbox"/>	Absence of Empathy: The child displays a complete absence of empathy for the emotional pain being inflicted on the targeted-rejected parent by the child’s hostility and rejection of this parent.
<input type="checkbox"/>	<input type="checkbox"/>	Entitlement: The child displays an over-empowered sense of entitlement in which the child expects that his or her desires will be met by the targeted-rejected parent to the child’s satisfaction, and if the rejected parent fails to meet the child’s entitled expectations to the child’s satisfaction then the child feels entitled to enact a retaliatory punishment on the rejected parent for the child’s judgment of parental failures
<input type="checkbox"/>	<input type="checkbox"/>	Haughty and Arrogant Attitude: The child displays an attitude of haughty arrogance and contemptuous disdain for the targeted-rejected parent.
<input type="checkbox"/>	<input type="checkbox"/>	Splitting: The child evidences polarized extremes of attitude toward the parents, in which the supposedly “favored” parent is idealized as the all-good and nurturing parent while the rejected parent is entirely devalued as the all-bad and entirely inadequate parent.

2(b). Phobic Anxiety Toward a Parent

Present	Sub-Threshold	Absent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The child's symptoms evidence an extreme and excessive anxiety toward the targeted-rejected parent that meets the following DSM-5 diagnostic criteria for a specific phobia:

Criterion Met	yes	no
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- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent Unwarranted Fear: The child displays a persistent and unwarranted fear of the targeted-rejected parent that is cued either by the presence of the targeted parent or in anticipation of being in the presence of the targeted parent |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe Anxiety Response: The presence of the targeted-rejected parent almost invariably provokes an anxiety response which can reach the levels of a situationally provoked panic attack. |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoidance of Parent: The child seeks to avoid exposure to the targeted parent due to the situationally provoked anxiety or else endures the presence of the targeted parent with great distress. |

3. Fixed False Belief

Present	Sub-Threshold	Absent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The child's symptoms display an intransigently held, fixed and false belief regarding the fundamental parental inadequacy of the targeted-rejected parent in which the child characterizes a relationship with the targeted-rejected parent as being somehow emotionally or psychologically "abusive" of the child. While the child may not explicitly use the term "abusive," the implication of emotional or psychological abuse is contained within the child's belief system and is not warranted based on the assessed parenting practices of the targeted-rejected parent (which are assessed to be broadly normal-range).

DSM-5 Diagnosis

If the three diagnostic indicators of attachment-based "parental alienation" are present in the child's symptom display (either 2a or 2b), the appropriate DSM-5 diagnosis is:

DSM-5 Diagnosis

309.4 Adjustment Disorder with mixed disturbance of emotions and conduct

V61.20 Parent-Child Relational Problem

V61.29 Child Affected by Parental Relationship Distress

V995.51 Child Psychological Abuse, Confirmed (pathogenic parenting)

Checklist of Associated Clinical Signs (ACS)

evident	not evident																												
<input type="checkbox"/>	<input type="checkbox"/>	ACS 1: Use of the Word "Forced"																											
<input type="checkbox"/>	<input type="checkbox"/>	ACS 2: Enhancing Child Empowerment to Reject the Other Parent																											
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<input type="checkbox"/>	<input type="checkbox"/>	"Listen to the child"																											
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<input type="checkbox"/>	<input type="checkbox"/>	ACS 4: Parental Replacement																											
<input type="checkbox"/>	<input type="checkbox"/>	ACS 5: The Unforgivable Event																											
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<input type="checkbox"/>	<input type="checkbox"/>	ACS 8: Unwarranted Use of the Word "Abuse"																											
<input type="checkbox"/>	<input type="checkbox"/>	ACS 9: Excessive Texting, Phone Calls, and Emails																											
<input type="checkbox"/>	<input type="checkbox"/>	ACS 10: Role-Reversal Use of the Child ("It's not me, it's the child who...")																											
<input type="checkbox"/>	<input type="checkbox"/>	ACS 11: Targeted Parent "Deserves" to be Rejected																											
<input type="checkbox"/>	<input type="checkbox"/>	ACS 12: Allied Parent Disregards Court Orders and Court Authority																											
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Appendix 2: DSM-IV TR Diagnostic Criteria for a Shared Psychotic Disorder

Information Regarding the Diagnosis of a Shared Psychotic Disorder

DSM-IV TR Diagnosis (selected text: emphasis added):

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (Revised 4th ed.). Washington, DC: Author.

Shared Psychotic Disorder

“The essential features of Shared Psychotic Disorder (Folie a Deux) is a delusion⁵ that develops in an individual who is involved in a close relationship with another person (sometimes termed **the “inducer”** or “the primary case”) who already has a Psychotic Disorder with prominent delusions (Criteria A).” (p. 332)

“Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes⁶ the delusional system on the more passive and initially healthy second person. Individuals who come to share delusional beliefs are often related by blood or marriage and have lived together for a long time, sometimes in relative isolation. If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear. Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in **family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent’s delusional beliefs.**” (p. 333)

Associated Features and Disorders

“Aside from the delusional beliefs, behavior is usually not otherwise odd or unusual in Shared Psychotic Disorder. Impairment is often less severe in individuals with Shared Psychotic Disorder than in the primary case.” (p. 333)

Prevalence

“Little systematic information about the prevalence of Shared Psychotic Disorder is available. This disorder is rare in clinical settings, although **it has been argued that some cases go unrecognized.**” (p. 333)

Course

“Without intervention, **the course is usually chronic**, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. **With separation from the primary case, the individual’s delusional beliefs disappear,**⁷ sometimes quickly and sometimes quite slowly.” (p. 333)

⁵ Definition of Delusion: Oxford Dictionary (<http://oxforddictionaries.com/>) Delusion: an idiosyncratic belief or impression that is firmly maintained despite being contradicted by what is generally accepted as reality or rational argument, typically a symptom of mental disorder; MedlinePlus Medical Dictionary (U.S. National Library of Medicine & National Institutes of Health; www.nlm.nih.gov/medlineplus/mplusdictionary.html) Delusion 2: a false belief regarding the self or persons or objects outside the self that persists despite the facts and occurs in some psychotic states

⁶ Childress comment: The term “inducer” and the phrase “gradually imposes” seemingly suggest the cause of the Shared Psychotic Disorder.

⁷ Childress comment: The statements that “If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear” and “With separation from the primary case, the individual’s delusional beliefs disappear” seemingly suggest treatment recommendations.

DSM-IV TR Diagnostic Criteria

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (Revised 4th ed.). Washington, DC: Author.

Diagnostic criteria for 297.3 Shared Psychotic Disorder

- A. A delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion.
- B. The delusion is similar in content to the person who already has the established delusion
- C. The disturbance is not better accounted for by... (p. 334)

Diagnostic criteria for 297.1 Delusional Disorder (emphasis added)

- A. **Nonbizarre** delusions (i.e., **involving situations that occur in real life**, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.
- B. Criterion A for Schizophrenia has never been met. Note: Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme.
- C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and **behavior is not obviously odd or bizarre**.
- D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type (the following types are assigned based on the predominant delusional theme):

Erotomantic Type: delusions that another person, usually of higher status, is in love with the individual

Grandiose Type: delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person

Jealous Type: delusions that the individual's sexual partner is unfaithful

Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way

Somatic Type: delusions that the person has some physical defect or general medical condition

Mixed Type: delusions characteristic of more than one of the above types but no one theme predominates

Unspecified Type

Appendix 2: Parenting Practices Rating Scale
(for documenting the parenting practices of the targeted-rejected parent)

Parenting Practices Rating Scale

C.A Childress, Psy.D. (2016)

Name of Parent: _____ Date: _____

Name of Rater: _____

Indicate all that apply.

Child Abuse Ratings: Do not indicate child abuse is present unless allegations have been confirmed. In cases of abuse allegations that have neither been confirmed nor disconfirmed, or that are unfounded, use Allegation subheading rating not Category rating.

Level 1: Child Abuse

- 1. Sexual Abuse
As defined by legal statute.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 2. Physical Abuse
Hitting the child with a closed fist; striking the child with an open hand or a closed fist around the head or shoulders; striking the child with sufficient force to leave bruises; striking the child with any instrument (weapon) such as kitchen utensils, paddles, straps, belts, or cords.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 3. Emotional Abuse
Frequent verbal degradation of the child as a person in a hostile and demeaning tone; frequent humiliation of the child.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 4. Psychological Abuse
Pathogenic parenting that creates significant psychological or developmental pathology in the child in order to meet the emotional and psychological needs of the parent, including a role-reversal use of the child as a regulatory object for the parent's emotional and psychological needs.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 5. Neglect
Failure to provide for the child's basic needs for food, shelter, safety, and general care.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

- 6. Domestic Violence Exposure
Repeated traumatic exposure of the child to one parent's violent physical assaults toward the other parent or to the repeated emotional degradation (emotional abuse) of the other parent.
 - Allegation: Neither confirmed nor disconfirmed
 - Allegation: Unfounded

Level 2: Severely Problematic Parenting

- 7. **Overly Strict Discipline**
Parental discipline practices that are excessively harsh and over-controlling, such as inflicting severe physical discomfort on the child through the use of stress postures, using shaming techniques, or confining the child in an enclosed area for excessively long periods (room time-outs are not overly strict discipline).
- 8. **Overly Hostile Parenting**
Frequent displays (more days than not) of excessive parental anger (a 6 or above on a 10-point subjective scale).
- 9. **Overly Disengaged Parenting**
Repeated failure to provide parental supervision and/or age-appropriate limits on the child's behavior and activities; parental major depression or substance abuse problems.
- 10. **Overly Involved-Intrusive Parenting**
Enmeshed, over-intrusive, and/or over-anxious parenting that violates the psychological self-integrity of the child; role-reversal use of the child as a regulatory object for the parent's anxiety or narcissistic needs.
- 11. **Family Context of High Inter-Spousal Conflict**
Repeated exposure of the child to high inter-spousal conflict that includes excessive displays of inter-spousal anger.

Level 3: Problematic Parenting

- 12. **Harsh Discipline**
Excessive use of strict discipline practices in the context of limited displays of parental affection; limited use of parental praise, encouragement, and expressions of appreciation.
- 13. **High-Anger Parenting**
Chronic parental irritability and anger and minimal expressions of parental affection.
- 14. **Uninvolved Parenting**
Disinterested lack of involvement with the child; emotionally disengaged parenting; parental depression.
- 15. **Anxious or Over-Involved Parenting**
Intrusive parenting that does not respect interpersonal boundaries.
- 16. **Overwhelmed Parenting**
The parent is overwhelmed by the degree of child emotional-behavioral problems and cannot develop an effective response to the child's emotional-behavioral issues.
- 17. **Family Context of Elevated Inter-Spousal Conflict**
Chronic child exposure to moderate-level inter-spousal conflict and anger or intermittent explosive episodes of highly angry inter-spousal conflict (intermittent spousal conflicts involving moderate anger that are successfully resolved are normal-range and are not elevated inter-spousal conflict).

Level 4: Positive Parenting

- 18. **Affectionate Involvement – Structured Spectrum**
Parenting includes frequent displays of parental affection and *clearly structured* rules and expectations for the child's behavior. Appropriate discipline follows from clearly defined and appropriate rules.
- 19. **Affectionate Involvement – Dialogue Spectrum**
Parenting includes frequent displays of parental affection and *flexibly negotiated* rules and expectations for the child's behavior. Parenting emphasizes dialogue, negotiation, and flexibility.
- 20. **Affectionate Involvement – Balanced**
Parenting includes frequent displays of parental affection and parenting effectively balances structured discipline with flexible parent-child dialogue.

