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Practice Guidelines

The Investigation and Determination of Suspected Psychological Maltreatment of Children and Adolescents

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APSAC PRACTICE GUIDELINES[1] FOR THE INVESTIGATION AND DETERMINATION OF SUSPECTED PSYCHOLOGICAL MALTREATMENT OF CHILDREN AND ADOLESCENTS

1. Statement of Purpose[2]

These guidelines are written to provide front-line child protection workers with the information and tools to understand what psychological maltreatment (PM) is, to detect it in all its forms, to understand how it relates to other types of maltreatment, and to determine the nature and degree of its existence. They can also provide guidance to child welfare agencies and family or criminal courts for cases where PM may be an issue.

2. Nature and Significance of Psychological Maltreatment

Humans are psychosocial beings. Beyond basic survival needs for food, water, shelter, temperature control, and physical health, human needs are primarily psychological in nature: to be safe from danger; to be loved and cared for; to love and care for others; to be respected as a unique and valued individual; and to have a say in one's life [1, 2, 3]. These needs are fulfilled for the most part through social experiences. The degree and manner in which these needs are met determines, to a large extent, a person's evolving capacities, identity, and behavior. These psychological needs are so vital to the health and well-being of the individual that having them met should be considered a basic right [4], and in fact, they have been identified as foundational for human rights [5, 6]. Psychological maltreatment (PM) occurs when the child's attempts to have these

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[1] *These guidelines are the product of APSAC's Task Force on Psychological Maltreatment, co-chaired by Stuart Hart, Ph.D. and Marla Brassard, Ph.D., Contributions toward its development have been provided by (in alphabetic order) Amy J. L. Baker, Ph.D., Marla Brassard, Ph.D., Zoe Chiel, and Stuart N. Hart, Ph.D. They represent the most essential elements necessary to guide consideration of suspected psychological maltreatment and are an abbreviated form of the more comprehensive APSAC Monograph "Psychological Maltreatment of Children"* (Brassard, Hart, Baker, & Chiel, 2017; *available online at www.apsac.org), which benefitted from the feedback provided by the APSAC Board and attendees at the meetings on guidelines at the annual colloquium, and from additional guidance provided from leading researchers on psychological maltreatment by (in alphabetic order) Susan Bennett, MD ChB FRCP DTM&H DRCOG DCH Dip Psych, Susan Bissell, Ph.D., Martha Erikson, Ph.D., Danya Glaser, M.D., Jody Todd Manly, Ph.D., Amy Slep, Ph.D., and David Wolfe, Ph.D.*

[2] *Statement of Caution Regarding Use of APSAC Publications: It is negligent, even reckless for a judge, attorney, guardian, counselor or other professional to cite or otherwise mischaracterize this or any APSAC publication on psychological maltreatment as endorsing or even lending credence to a diagnosis or finding of "parental alienation." To find that a parent has committed psychological abuse of a child in an effort to interfere with that child's relationship with the other parent requires direct evidence of the parent's behavior such as significant denigration, efforts to undermine the relationship of that child with the other parent and/or, efforts to get the child to make false allegations of abuse or other extremely damaging behavior by the other parent. A child's avoidance of a parent is not sufficient evidence of psychological abuse by either parent. Professionals seeking guidance on these issues may, as a starting point, wish to review APSAC's 2016 Position Statement on "Allegations of Child Maltreatment and Intimate Partner Violence in Divorce/Parental Relationship Dissolution" and other relevant publications.*

psychological needs met are thwarted, distorted, or corrupted.

PM, also known as mental, emotional, and psychological abuse and neglect, occurs in the social context of interactions among persons. PM is expressed in various forms of abuse and neglect. All forms of child maltreatment are an attack on basic need fulfillment and are insidious because they are often perpetrated by people upon whom children are dependent and who children expect to be safe and supportive (e.g., parents, family, school personnel and peers, recreation/sports coaches/mentors). PM, however, is particularly widespread and destructive. Of all forms of child maltreatment, PM is the most common because it is embedded in or associated with every other type of maltreatment as well as existing in its own discrete forms. PM is especially damaging for many reasons. PM directly endorses negative beliefs about the child (e.g., through messages that the child is unlovable or defective) that are likely to be incorporated into the child's sense of self. This negative self-concept increases the child's vulnerability to depression and may corrupt the child's expectations for social support and relationships, which are essential for well-being. Additionally, PM results in psychological states (e.g., humiliation) known to lead to violence [7]; produces psychological trauma associated with psychopathology [8]; and can be so pervasively and insidiously destructive as to deserve the label “soul murder” [9].

3. Psychological Maltreatment Definitions and Forms

According to the Federal Child Abuse and Treatment Act of 2010 [10, 11], *Child abuse and neglect* means, at a minimum, “any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.” Child abuse and neglect, also referred to as child maltreatment, includes all forms of violence against children. There is no uniform legal definition of each type of child abuse, including psychological maltreatment (PM), across state child abuse statutes [12], which are found in one or more of civil or criminal statutes.

The term *psychological* is used because PM is (a) a symbolic, sometimes verbal, communication from the perpetrator to the child and (b) unless the child dies immediately from maltreatment, the most prominent lasting features, central meanings, and impact of the victim’s maltreatment experience are mental, affecting the thoughts and feelings the child has in response to the abuse or neglect. The major psychological domains affected are thinking (cognitive), feeling/emotion (affective), and from these, impulse or will to action (conative/volitional). Human beings are constantly searching for meaning and understanding. As developmentally possible, they interpret what is being done to them and around them, which then shapes efforts to have their needs met [13, 14, 15].

PM includes acts of commission (e.g., verbal attacks on the child by a caregiver) and acts of omission (e.g., emotional unresponsiveness of a caregiver). Most of the state legal definitions of PM (often labeled in state laws as “emotional abuse” or “mental injury”) refer to the impact on the child as opposed to the caregiver behaviors. In contrast, these guidelines define PM as caregiver behavior that is likely to harm or has harmed a child

(see Table 1). From a child protection perspective, evidence of harm is not always required to substantiate PM. However, because a number of states require evidence of child harm, guidance is provided here about that as well.

The subtypes of PM presented here are intended to help professionals analyze cases and to complement and illuminate legal and regulatory definitions of PM. A child's maltreatment experiences may be categorized by one or more of these forms and may not necessarily fit simply or fully within any one category.

Table 1: Psychological Maltreatment Definition and Forms[1]

Psychological maltreatment is defined as *a repeated pattern or extreme incident(s) of caretaker behavior* that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable. Its subtypes and their forms follow.

SPURNING embodies verbal and nonverbal caregiver acts that reject and degrade a child, including the following:
(1) belittling, degrading, and other nonphysical forms of hostile or rejecting treatment;
(2) shaming and/or ridiculing the child, including the child's physical, psychological, and behavioral characteristics, such as showing normal emotions of affection, grief, anger, or fear;
(3) consistently singling out one child to criticize and punish, to perform most of the household chores, and/or to receive fewer family assets or resources (e.g., food, clothing);
(4) humiliating, especially when in public;
(5) any other physical abuse, physical neglect, or sexual abuse that also involves spurning the child, such as telling the child that he or she is dirty or damaged due to or deserving sexual abuse; berating the child while beating him or her; telling the child that he or she does not deserve to have basic needs met.

TERRORIZING is caregiver behavior that threatens or is likely to physically hurt, kill, abandon, or place the child or child's loved ones or objects in recognizably dangerous or frightening situations. Terrorizing includes the following:
(1) subjecting a child to frightening or chaotic circumstances;
(2) placing a child in recognizably dangerous situations;
(3) threatening to abandon or abandoning the child;[1]
(4) setting rigid or unrealistic expectations with threat of loss, harm, or danger if they are not met;
(5) threatening or perpetrating violence (which is also physical abuse) against the child;
(6) threatening or perpetrating violence against a child's loved ones, pets, or objects, including domestic/intimate partner violence observable by the child;

(7) preventing a child from having access to needed food, light, water, or access to the toilet;
(8) preventing a child from needed sleep, relaxing, or resting;
(9) any other acts of physical abuse, physical neglect, or sexual abuse that also involve terrorizing the child (e.g., forced intercourse; beatings and mutilations).

EXPLOITING/CORRUPTING are caregiver acts that encourage the child to develop inappropriate behaviors and attitudes (i.e., self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors). While these two categories are conceptually distinct, they are not empirically distinguishable and, thus, are described as a combined subtype. Exploiting/corrupting includes the following:

(1) modeling, permitting, or encouraging antisocial behavior (e.g., prostitution, performance in pornography, criminal activities, substance abuse, violence to or corruption of others);
(2) modeling, permitting, or encouraging betraying the trust of or being cruel to another person;
(3) modeling, permitting, or encouraging developmentally inappropriate behavior (e.g., parentification, adultification, infantilization);
(4) subjecting the observing child to belittling, degrading, and other forms of hostile or rejecting treatment of those in significant relationships with the child such as parents, siblings, and extended kin;
(5) coercing the child's submission through extreme over-involvement, intrusiveness, or dominance, allowing little or no opportunity or support for child's views, feelings, and wishes; forcing the child to live the parent's dreams, manipulating or micromanaging the child's life (e.g., inducing guilt, fostering anxiety, threatening withdrawal of love, placing a child in a double bind in which the child is doomed to fail or disappoint, or disorienting the child by stating something is true (or false) when it patently is not);
(6) restricting, interfering with, or directly undermining the child's development in cognitive, social, affective/emotional, physical, or cognitive/volitional (i.e., acting from emotion and thinking; choosing, exercising will) domains, including Caregiver Fabricated Illness also known as medical child abuse;
(7) any other physical abuse, physical neglect, or sexual abuse that also involves exploiting/corrupting the child (such as incest and sexual grooming of the child).

EMOTIONAL UNRESPONSIVENESS (ignoring) embodies caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring, and love for the child) and showing little or no emotion in interactions with the child. It includes the following:
(1) being detached and uninvolved;
(2) interacting only when absolutely necessary;
(3) failing to express warmth, affection, caring, and love for the child;
(4) being emotionally detached and inattentive to the child's needs to be safe and secure, such as failing to detect a child's victimization by others or failing to attend to the child's basic needs;
(5) any other physical abuse, physical neglect, or sexual abuse that also involves emotional unresponsiveness.

ISOLATING embodies caregiver acts that consistently and unreasonably deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home. Isolating includes the following:
(1) confining the child or placing unreasonable limitations on the child's freedom of movement within his or her environment;
(2) placing unreasonable limitations or restrictions on social interactions with family members, peers, or adults in the community;[2]
(3) any other physical abuse, physical neglect, or sexual abuse that also involves isolating the child, such as preventing the child from social interaction with peers because of the poor physical condition or interpersonal climate of the home.

MENTAL HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT embodies caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs of the child. This includes the following:
(1) ignoring the need for, failing, or refusing to allow or provide treatment for serious emotional/behavioral problems or needs of the child;
(2) ignoring the need for, failing, or refusing to allow or provide treatment for serious physical health problems or needs of the child;
(3) ignoring the need for, failing, or refusing or allow or provide treatment for services for serious educational problems or needs of the child;
(4) any other physical abuse, physical neglect, or sexual abuse that also involve mental health, medical, or educational neglect of the child.

Note 1: Please see cautionary note on page 1 of this document for information on appropriate use of these definitions.

Note 2: Caregiver abandonment of a child is one of the most severe forms of PM. While it is specifically identified as a type of terrorizing in this document, it also embodies significant components of emotional unresponsiveness, spurning, and isolating.

These PM subtypes have strong construct validity. For the history of the empirical identification of these forms, see [16,17]. For a comprehensive review of other definitional systems of PM, the degrees to which they overlap and differ with this definition, and the empirical support for each subtype at each developmental period, see [18, 19].

4. Prevalence

The pervasiveness of PM can be determined by the number of new cases each year (i.e., incidence) or the percentage of a population that has experienced PM at any point in time

(i.e., prevalence). Prevalence rates tend to be better estimates of the extent of the problem. In light of underreporting as well as discrepancies in definitions, data sources (i.e., self vs. other report), and samples used across studies, the prevalence rates estimated from *The APSAC Study Guides 4: Psychological Maltreatment of Children* [20] are relevant and probably the best available (see also [14]). That is, between 10% and 30% of community samples experience moderate levels of PM in their lifetime, and from 10% to 15% of all people have experienced the more severe and chronic forms of this maltreatmen**t.**

5. Effects of Psychological Maltreatment[3]

Psychological maltreatment effects can be acute, long-term, and broad or narrow in nature [14, 15, 20]. The particular forms and degrees of harm experienced are dependent on the type of PM and related factors, such as the magnitude, frequency, and chronicity of PM maltreatment and other co-occurring forms of maltreatment as well as the risk and protective factors of and surrounding the child. For example, a child who is frequently or intensely spurned (i.e., belittled, degraded, or overtly rejected) may come to believe s/he deserves such treatment and is wholly unworthy of love or respect, leading the child to forego any challenge or opportunity where s/he might be evaluated or to deal with humiliation through substance abuse, suicide, or homicide.

Domains of Effects

Research that has specifically examined the unique effects of various forms of PM has linked consequences to five broad areas (for reviews, see [14, 15, 17, 22]). These include the following:

Problems of intrapersonal (within the individual) thoughts, feelings, and behaviors, such as anxiety, depression, negative self-concept, and negative cognitive styles that increase susceptibility to depression and suicidal thoughts and behaviors (e.g., pessimism, self-criticism, catastrophic thinking, and immature defenses); *Emotional problems and symptoms,* such as substance abuse and eating disorders, emotional instability, impulse control problems, borderline personality disorder, and more impaired functioning among those diagnosed with bipolar disorder; *Social competency problems and anti-social functioning,* such as social phobia, impaired social competency, lack of empathy for others, attachment insecurity/disorganization, self-isolating behavior, non-compliance, extreme dependency, sexual maladjustment, aggressive and violent behavior, and delinquency or criminality; *Learning problems and behavioral problems* in academic settings, such as impaired learning despite adequate ability and instruction, academic problems and lower achievement test results, decline in IQ over time, lower measured

[3] This section of the guidelines draws on the United States federal Individuals with Disabilities Act as Amended (IDEAA), commonly known as IDEA (see code of federal regulations). This definition incorporates psychological criteria for the following: (a) major mental disorders and (b) interpersonal, cognitive, and emotional behavior problems. Professionals assessing children for possible psychological maltreatment will find these definitions of severe emotional disturbance and the standards included in the *American Psychiatric Associations Diagnostic and Statistical Manual(s) of Mental* Disorders (i.e., DSM-IV-TR; DSM-5) useful to guide determinations of extant or predicted harm related to psychological maltreatment.

intelligence, school problems due to non-compliance and lack of impulse control, and impaired moral reasoning; and *Physical health problems,* such as delays in almost all areas of physical and behavioral development; allergies, asthma, and other respiratory ailments; as well as lifestyle risk behaviors in adolescence, including tobacco smoking and risky sexual behavior that increases the possibility of HIV and other sexually transmitted diseases.

These outcomes have been found in a wide range of settings in the United States and around the world and in different types of research studies. The damaging correlates or consequences of PM are common among those who experience it and are not limited to particular subgroups of children and youth.

Severity of PM

Assessing severity of PM is essential for all levels of child welfare decision making and is vital for determining what course of action is required. The legal jurisdiction in which the family resides affects whether the behavior is considered maltreatment under state law/regulations and, if it is, helps frame the intervention options.

In determining the level of severity of PM, consideration should be given particularly to the following: (a) Intensity/extremeness, frequency, and chronicity of the caregiver behavior; (b) Degree to which PM pervades the caregiver-child relationship: (c) Number of subtypes of PM that have been or are being perpetrated; (d) Influences in the child's life that may buffer the child from PM or its consequences (e.g., does the maltreating caregiver also provide nurturance to the child—does the non-maltreating caregiver provide nurturance to the child?); (e) Salience of the maltreatment for the developmental period(s) in which it occurs and the developmental periods that will follow; and (f) Extent to which negative child developmental outcomes exist, are developing, or are likely.

6. Risk Factors for Maltreatment Important for Assessment and Decision Making

Some of the multiple conditions and factors that have been identified as probable or possible contributors to and/or causes of psychological, physical, and/or sexual violence against children are described next. None of these factors has been established by research as a sufficient cause in itself or as the single most important or reliable primary cause. All are important to consider when evaluating risk and designing interventions.

Child factors. Child victims are not responsible for the maltreatment they experience, including PM, but may have characteristics that increase their vulnerability to maltreatment. These include, but are not limited to, high maintenance and demand characteristics associated with developmental age/stage (e.g., infants, toddlers, and teens), disability (e.g., physical, cognitive, and/or emotional), temperament (e.g., unpredictable biological rhythm, negative mood, high intensity responsiveness, distractibility, and resistance to soothing), and behavior (e.g., aggression). Additionally, child characteristics that increase vulnerability and susceptibility to maltreatment may be the consequences of previous maltreatment. The lack of power and personal agency of

most young children, and the limited ability of some children to acquire social support, may also increase vulnerability to victimization.

Caregiver factors. Caregivers are more likely to perpetrate violence/maltreatment, including PM, against children if they have one or more, and especially many, of the following features: young, unprepared caregivers; psychological disorders; low self-esteem, low-impulse control, depression, low empathy, poor coping skills, and substance abuse; childhood experiences of maltreatment (particularly when combined with genetic vulnerability), including witnessing family violence (e.g., sibling maltreatment and marital/partner violence); beliefs and attitudes that depersonalize children, consider them property, or set unrealistically high expectations for their development and behavior (these are risk factors and can be expressed as forms of PM); limited reflective capacity for dealing with their own experiences of victimization; inadequate knowledge about child development and parenting; lack of awareness, appreciation, and/or responsiveness for child's strengths/good qualities; lack of interest or incapacity to express interest in child(ren); parenting while experiencing high stress (e.g., interpersonal, financial, work, and health), and low social support.

Family factors. At the family level, all human nature, child, and caregiver factors mentioned above are also relevant as they exert influence singly, in interaction with, and as a part of the child's social ecology. Additionally, family system vulnerability is increased by a large ratio of children to adults (including single parent households); father absence; presence of an aberrant parent substitute; low connection to or support from the extended family and communities (e.g., school, faith, health services, and recreation); insufficient income for basic family needs; high stress, domestic violence, substance abuse, and/or criminal activity in the home and/or neighborhood.

Community environment factors. Community system contributions to violence against children and inadequacy of prevention and corrective response are increased by (a) Low expectations and low levels of support for parenting/child care, child development, child health, child well-being, and child rights, and for periodic monitoring of child development and well-being; (b) Mandated reporters not recognizing and/or taking appropriate action; (c) High levels of occurrence and low levels of intervention for substance abuse, violence, and criminal activity; and (d) Poverty, which exacerbates other conditions cited.

7. Consideration of Psychological Maltreatment in Investigations

It is common for maltreated children to experience multiple forms of maltreatment (i.e., to experience poly-victimization). PM is often accompanied by or embedded in other forms of child abuse and neglect, and it is the major contributor to negative non-physical outcomes. For these reasons, all stages of child maltreatment investigation should include a consideration of whether and how PM is present, regardless of the nature of the primary maltreatment concern. To that end, we have developed a data-gathering instrument in the form of three inter-related worksheets (see a completed example in Tables 3–5).

Additional examples can be found in the *APSAC Monograph on Psychological Maltreatment* [14], which and also provides downloadable blank forms.

8. Assessment and Determination of Psychological Maltreatment

Orientation Toward Assessment

As noted, this document is written primarily for the front-line child protection worker. However, child protection takes place in a broad context of multi-disciplinary team responsibility. This means, for example, that in some cases part of the investigation may involve additional assessment by mental health or medical professional, particularly if assessment of harm is needed and is not readily available from records (i.e., medical, school, or daycare) and interviews with collaterals (see Table 3).

All professionals should approach the assessment with an open mind regarding what, if anything, might have happened and be prepared to give genuine attention to information that suggests/confirms PM exists (i.e., confirmatory evidence) as well as information that suggests/confirms it did not (i.e., disproving evidence). PM can occur during an acute incident, such as when, in a moment of grief, a parent states to a child that the parent wishes that he/she were the one who died rather than a deceased sibling. A very serious single incident of domestic violence would be another example. PM can occur during an extended life crisis but not be pervasive or reflective of the parent–child interaction outside of that context. For example, a parent who is depressed and set off balance by a bitter custody battle might terrorize a child by communicating directly or indirectly that the other parent is unsafe, unloving, or unavailable when that is not the case. In some cases, PM occurs only when some specific, recurring event occurs, such as substance abuse by a caregiver. However, most PM is chronic, regular, and embedded in the child's daily existence (e.g., a caregiver may direct a daily barrage of verbal abuse at a child and/or persistently psychologically manipulate and control the child).

The goal of assessment for suspected PM is to determine, according to prevailing standards (e.g., the *Guidelines*, a regulatory statute, or criteria recognized by a court of law), whether maltreatment was or is present. Many jurisdictions also require a determination of the severity of maltreatment, the capacity of caregivers to change in a positive direction, and the degree to which maltreatment is likely to continue to occur.

Assessment Techniques and Sources of Information

Psychosocial evaluation procedures such as observations, interviews, questionnaires, and records review can provide clarifying and corroborative information about patterns of interaction, care, and treatment and their impact on the child. Every attempt should be made to interact respectfully and authentically to increase the likelihood of voluntary involvement in the assessment and any subsequent intervention.

The child-caregiver relationship. When feasible, the professional should observe the child-caregiver relationship. Repeated observations may be necessary to obtain a representative sample of behavior and to recognize patterns of child–caregiver interaction and should be conducted by someone familiar with the developmental stages of children.

Some parents may not behave in their usual manner when being observed, although this is less of a concern the longer the duration of the observation or greater the frequency of repeated observations. The challenge of discriminating between poor or inadequate caregiving and psychological maltreating caregiving can be challenging (see [14, 15, 21] for further guidance).

The child-caregiver relationship can also be assessed through interviews of the caregiver(s) and the child, review of pertinent records, consultation with other professionals, and collateral reports from siblings, extended family, school and daycare personnel, teachers, coaches, neighbors, and others. It is important to be aware that even abused children may strenuously campaign to remain with the abusive parent. In so doing, they may deny the occurrence or impact of the abuse, deflect responsibility away from the abusive parent, and assume the blame for any problematic behavior on the part of the parent. Therefore, interviews alone will not be sufficient to determine the true nature of the parent–child relationship.

Child characteristics. Deviance or delay in the child's functioning, which can be evidence of harm (but can occur for other reasons as well), are assessed through direct observation by the evaluator, testing, the observations of others, and available reports and records (e.g., school, special education, health, juvenile justice, and therapy).

Caregiver/family competencies and risk factors. Evaluation of caregiver competencies and risk factors assists in determining risk factors for maltreatment (but not PM per se) in developing potential supports and a prognosis for improvement in the child–caregiver relationship, and in identifying issues and opportunities to address in treatment. Relevant areas of functioning include the following: (1) Caregiver's perspectives on child rearing and the particular child in question (e.g., willingness and ability to parent, ability to empathize with the child's point of view, and ability to recognize the child as a worthy and autonomous being); (2) Personal resources (e.g., intelligence, job skills, social skills, personality variables, self-control, mental health, and substance use); (3) Social support/resources (marital status, family, friends, financial status, and faith and secular community involvement); and (4) Life stresses or transitions in the family.

Developmental Considerations for PM

Caregiver PM behaviors will likely manifest differently depending upon the age and developmental level of the child. For example, isolating an infant will not occur the same way as isolating an adolescent. Table 2 provides some examples of indicators of the PM subtypes at different developmental levels of the child.

Consideration of Societal and Cultural Context

A family's community context and immediate social and economic circumstances should be taken into consideration when evaluating caregiver behavior, stressors, and sources of positive support and opportunities for intervention. The psychosocial conditions jeopardizing a child's development may not be under the control of a caregiver. For example, homelessness, poverty, and living in a violent neighborhood can have an

adverse impact on quality of care and child development. While caregivers are not responsible for conditions over which they have no control, interventions attending to these risk factors must still be planned and implemented.

Professionals should be knowledgeable about and sensitive to cultural, social class, and ethnic differences in caretaking styles and customs. If the evaluator is not familiar with the cultural context of a particular child and the family, consultation with appropriate resources is required. See [14] for a detailed description of the assessment process and a variety of case examples.

Table 2. Forms of PM by Developmental Level (*Examples are offered for guidance but are not exhaustive*)

Developmental-Level Task Issues	***Infancy*** *Assistance in the regulation of bodily states and emotion.* *Attachment to caregivers.*	***Early Childhood*** *Development of symbolic representation and further self-other differentiation.* *Problem-solving.* *Pride.* *Mastery.* *Gender identity.*	***School-Aged*** *Development of self-control: use of language to regulate impulses, regulate emotions, store information, and predict and make sense of the world.* *Development of verbally mediated or semantic memory.* *Development of social relationships beyond family and generalization of expectations about relationships.* *Moral reasoning*	***Adolescence*** *Peer relationships.* *Adaptation to school.* *Moral reasoning.* *Negotiation of family roles.* *Identity issues (sexuality, future orientation, peer acceptance, and ethnicity)*
Spurning	Ridiculing and hostilely rejecting the child's attachment behaviors, and mocking the infant's spontaneous overtures and natural responses to human contact so as to prevent the formation of a sense of safety and security.	Excluding the child from family activities, rejecting and mocking the child's bids for attention and affection, denigrating the child, and creating a negative self-image by name calling.	Demeaning/degrading child's characteristics, conveying extreme disappointment and disapproval, and mocking accomplishments.	Refusing to accept changing social roles and child's needs for greater autonomy and self-direction, humiliating the child regarding his/her developing physical maturity/body changes, and career interests.
Terrorizing	Acting in an extremely unpredictable way in responding to infant's cues and basic needs, and violating the child's ability to manage stimulation and change.	Intimidating, threatening, and raging at the child.	Making extremely inconsistent commands, meting out extreme punishment for not meeting inappropriate expectations, and threatening abandonment.	Threatening public humiliation, ridiculing in public, making extremely inconsistent commands, meting out extreme punishment for not meeting inappropriate expectations, threatening abandonment.

Isolating	Denying the infant consistent patterns of interaction and stimulation, failing to provide opportunities for stimulation, and leaving infant unattended for hours in a playpen or infant seat.	Punishing the child for wanting social interactions, and teaching the child to fear social interactions.	Prohibiting or encouraging fear in the child regarding normal social interactions, especially with peers.	Preventing the child from participating in social activities outside the home.
Exploiting/ Corrupting	Placing the child at risk of developing addictions or bizarre habits.	Reinforcing aggression or sexual preciosity, and encouraging addictions or aggression.	Encouraging the child to misbehave, to be anti-social, criminal, or hyper-sexual, and forcing the child to take care of the parent or to act much younger than he/she is to meet the parent's needs.	Involving and rewarding the child's involvement in socially unacceptable behaviors involving crime, sex, drugs, and failure to meet social expectations; and relying on the child to fulfill the parent's needs.
Emotional Unresponsiveness	Failing to respond to child's bids for attention and eye contact, lack of emotional expressiveness, and flat affect and being slow to respond.	Lacking warmth and expression of affection, and failing to engage in the child's daily life.	Failing to protect the child or help the child navigate difficult social interactions, being emotionally detached, and not being involved in the child's daily life.	Abdicating parental role and displacing child as object of affection.
Mental Health, Medical, and Educational Neglect	Failing to provide or refusing treatment for child's physical health problems, such as failure to thrive, extreme expressions of distress, ear infections, and fevers that may	Refusing to allow a child to receive reasonable services for serious special education needs, such autistic spectrum disorders, disruptive behavior, or physical health problems such as	Refusing to allow a child to receive reasonable services for serious special education needs (e.g., disruptive behavior or not learning to read), not ensuring that a child receives an education (e.g., not getting a child to school or not providing an alternative at home).	Ignoring the need for, or failing or refusing to allow or provide treatment for, serious emotional/behavioral problems or needs of the child, such as cutting, suicidal ideation and behavior, substance abuse;

	have severe long-term consequences for the child's development.	low vision and motor problems.		not ensuring that a child receives an education; ignoring the need for, or failing or refusing to provide treatment for, serious physical health problems.

Worksheet for Evidence of Psychological Maltreatment

Tables 3–5 provide examples of how data might be entered in an organizational framework to facilitate assessment of PM. The data entered are from the case of a child (referred to as "TA"), who is male, age 10, and second of five children born to a married couple. Downloadable blank forms can be found in the *APSAC Monograph on Psychological Maltreatment* [14].

The first worksheet (Table 3) is to organize evidence of PM categorized by subtype (e.g., spurning); the second (Table 4) is to record evidence of risk factors (e.g., child, family, and community), which is important for the assessment of risk and for treatment planning; and the third (Table 5) is for evidence of harm categorized by the areas identified in the research literature (e.g., learning and behavior problems at school).

Table 3. Evidence of Psychological Maltreatment Worksheet

Refer to Tables 1 and 2 for fuller descriptions of these PM types

SPURNING: (hostile rejecting/degrading) verbal and nonverbal caregiver acts that reject and degrade a child.	
Evidence	On a family drawing as part of an interview for a tri-annual evaluation for special education, TA drew himself as a bug with his father screaming at him, "I will crush you, you little cockroach!" Upon questioning about the family drawing, TA reported that his dad screams at him and his two younger brothers, calls them names (such as "dummy," "idiot," and "loser") all the time, but especially when his dad's parents are present. He says that his older and younger sisters are his dad's favorites, they can do no wrong, Dad calls them his princesses, he tells them they are beautiful, and he is affectionate toward them. Dad says his boys do poorly in school, get into trouble, mess with his things, and don't do what he says so he does criticize them. They deserve the treatment they receive. He says that his girls are well behaved, the oldest one (age 11) is a good student and causes no problems, and the youngest one (in preschool) is "so cute." Mom says Dad does prefer the girls and is critical of the boys, frequently calling them names.

	Teacher says TA is very tense at school and flinches if touched on his shoulder unexpectedly.
Source(s) of Evidence	Child interview, father interview, mother interview, teacher interview, school psychologist interview and notes, and review of the school record.
Disproving Evidence	
Questions	
Conclusion	Mother, father, and TA all report that the father frequently uses degrading language to TA and his brothers and singles them out for markedly worse treatment than their sisters receive. He blames them for the poor treatment.
EXPLOITING/CORRUPTING: caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors)	
Evidence	Dad models the use of verbally abusive behavior toward some and a view of the world as highly threatening and constantly dangerous.
Source(s) of Evidence	Child, mother, and father reports.
Disproving Evidence	
Questions	
Conclusion	Father models verbal abuse and a confused, contradictory, suspicious, and fearful view of the world as highly dangerous.
TERRORIZING: caregiver behavior that threatens or is likely to physically hurt, kill, abandon, or place the child or child's loved ones/objects in recognizably dangerous or frightening situations.	
Evidence	TA says his dad is scary, has a lot of guns, talks crazy (e.g., Dad says neighbors are trying to break into the garage and he will kill them if they put even a big toe on the property). Mom says Dad is a combat vet, has nightmares, and thinks people are out to get him. He has put attractive boulders as a barrier in front of house so no one could ram into it as part of an assault. He has house booby

	trapped with trip wires that only the family know about to protect the family home. TA says he's worried about Mom. He says Mom says she is a terrible mother, they would be better off without her, especially when one of them gets in trouble at school; and she says it would be so easy to take a few more sleeping pills. Dad admits to having a big conflict with his next-door neighbor ("that asshole!") and at work. He says of course he has guns, needs to protect his family, make sure his sons know how to shoot. He emphasizes gun safety; he says he has PTSD from combat and is doing the best he can. Mother agrees with what TA reports about Dad. She acknowledges that she has a history of depression and suicidality and is in treatment with a psychiatrist on a weekly basis. She has made several suicide attempts but feels she's okay right now. She feels bad about her children's school problems (e.g., learning and behavior for the three boys). She does think she is a bad mother.
Source(s) of Evidence	Child interview, maternal interview, paternal interview, and home visit.
Disproving Evidence	
Questions	
Conclusion	TA's parents place him in frightening or chaotic circumstances. His mother's realistic threats of suicide (given her previous attempts and current depression) and his father's scary behavior with guns, conflicts with neighbor, and defensive stance in anticipation of threats against the family home are terrorizing for him.
EMOTIONAL UNRESPONSIVENESS: caregiver acts that ignore the child's attempts and needs to interact (e.g., failing to express affection, caring, and love for the child) and that show no emotion in interactions with the child.	
Evidence	TA says Dad is never affectionate, never hugs, never comforts, and never says, "I love you." He can't remember Dad ever doing so.

	TA says when Mom is not in bed (which she is much of the time), she will sometimes call him a pet name, but she never hugs or comforts him even when he broke his arm from a fall on his bike, except when he is really sick (i.e., might die) and has to go to the hospital with asthma, then she hugged him and held him close.
Source(s) of Evidence	Mother admits that she is not the touchy feely type. Her mother wasn't that way either.
Disproving Evidence	
Questions	
Conclusion	Father is never emotionally responsive or affectionate. Mother is emotionally responsive only when he is so sick that he might die.
ISOLATING: caregiver acts that consistently deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home.	
Evidence	TA says he never brings friends home because of his dad's hoarding and booby traps and his dad's weird behavior. He doesn't want to be embarrassed in front of his friends. His siblings do not bring friends home either for the same reason. He plays with his friends outside in the cul-de-sac and the open fields behind the development. Family socializes only with Dad's family. Once in a while they see Mother's siblings, but the relationship isn't close.
Source(s) of Evidence	Child interview, Maternal interview. Paternal interview.
Disproving Evidence	
Questions	
Conclusion	Home environment and paternal behavior are interfering with social interactions with peers and other adults in the community.
MENTAL HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT: unwarranted caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs for the child.	
Evidence	Mother reports that she is attentive to health issues, responds quickly to asthma, takes him to appointments,

	rushes him to hospital when sick so this was initially placed under disproving evidence. However, when the pediatrician reviewed the case, this was moved to confirming evidence. The pediatrician stated that there was medical neglect as TA would not have had all of his emergency room visits and hospitalizations if he were taking his medication as prescribed—the number of visits is out of the expected range, taking severity into account. TA missed over two months in the first grade with asthma but has missed 15–20 days in recent years.
Source of Evidence	Maternal interview, teacher interview, medical records, and school records.
Disproving Evidence	Mother states that she makes sure that the kids receive regular medical checkups, and the medical records confirm this. The school reports that the mother has allowed TA and his two younger brothers to be evaluated for special education for learning and/or behavior problems. Both parents have attended IEP meetings. Parents allowed the two older boys to receive social work services at school.
Questions	
Conclusion	Parents address the mental health, physical, and educational needs of their children when the environment demands that they do so, but there is little indication of proactive efforts. TA's asthma is not controlled, and the pediatrician attributes this to poor home management of his condition leading to many repeated hospital visits for a potentially life-threatening condition and missed school days.

Summary Conclusion About Presence of PM:
TA is exposed to long-standing, chronic PM in the forms of spurning, exploiting/corrupting, terrorizing, emotional unresponsiveness, isolating, and medical neglect of asthma.

Spurning: The mother, father, and TA all report that the father frequently uses degrading language to TA and his brothers and singles them out for markedly worse treatment than their sisters receive. He blames them for the poor treatment.
Exploiting/corrupting: The father models a confused, contradictory, and suspicious/fearful view of the world as highly dangerous.

Terrorizing: TA's parents place him in frightening or chaotic circumstances. His mother's realistic threats of suicide (given her previous attempts and current depression) and his father's scary behavior with guns, conflicts with neighbor, and defensive stance in anticipation of threats against the family home are terrorizing to him.

Emotional unresponsiveness: The father is never emotionally responsive or affectionate. The mother is emotionally responsive only when TA is so sick that he might die.

Isolating: Home environment and paternal behavior interfere with social interactions with peers and other adults in the community as TA is too embarrassed to bring his friends to his house.

Mental health, medical, and educational neglect: Parents respond to the mental and physical health needs of TA and his siblings when there are demands from the environment (e.g., medical crisis or school requests), but there is no evidence of proactive efforts to prevent a crisis, such as with TA's asthma and TA's (and his brothers) mental health and behavior problems.

Table 4. Risk Factors for Psychological Maltreatment Worksheet

CHILD FACTORS: high maintenance and demand characteristics, disability, temperament, and behavior.	
Evidence	TA diagnosed with severe asthma, a learning disability (in all subjects as he is currently 2 years behind grade level and was retained in first grade), and most recently ADHD. He is inattentive and appears depressed; his schoolwork is erratic; he makes big mistakes on already mastered work, indicating that his mind is elsewhere.
Source(s) of Evidence	Medical records, school records, and teacher interview.
Disproving Evidence	
Questions	
Conclusion	TA has severe asthma and multiple psychological disabilities, which place increased demands for care on his parents.
CAREGIVER FACTORS: psychological disorders, low self-esteem, low-impulse	

control, depression, low empathy, poor coping, substance abuse, childhood experiences of maltreatment, beliefs and attitudes that depersonalize children, unrealistically high expectations, inadequate knowledge about child development and parenting, lack of awareness, appreciation, and/or responsiveness for child strengths/good qualities; lack of interest or incapacity to express interest in child(ren); high stress and low social support.	
Evidence	Mother has long history of depression and suicidality. She has very low self-esteem. She currently sees a psychiatrist once a week and takes antidepressants and sleeping pills. Father has anger control/interpersonal problems, PTSD from combat experiences and likely maltreatment as child, and may have thinking problems. TA's teacher reported that after a parent–teacher conference he said that he's worried that the streetlights outside his house are bugged, that he's being spied upon. Both parents report a history of child maltreatment. Mother reports neglectful mother and absent father and sexual abuse by neighbor. Father reports a history of distressing foster care prior to adoption after his mother was declared unfit. Mother seems aware of TA's psychological needs, but her own passivity and depression limit her ability to address them. Father shows little empathy or appreciation of TA's psychological needs, little appreciation of TA's good qualities, and no appreciation for how his own behavior impacts TA. Neither parent has friends. Social support is only from the father's parents.
Source(s) of Evidence	Maternal report, teacher interview, father interview, and home visit.
Disproving Evidence	Both parents attend parent–teacher conferences held at night. Mother attends all IEP meetings during the day and participates and follows up on intervention suggestions made by the school and physicians.
Questions	

Conclusion	Both parents have mental health problems. Both parents have a history of maltreatment. However, both parents seem invested in parenting and in their children. The mother seems handicapped in meeting TA's needs, in part, by her depression and the father by his lack of appreciation of TA's needs, good qualities, and how his own behavior impacts TA (and the other children).
FAMILY FACTORS: large ratio of children to adults, young, unprepared and poor coping of parents; father absence; aberrant substitute-father presence; low connection to or support from the community and extended family; high stress, domestic violence, substance abuse, and/or criminal activity in the home and/or neighborhood.	
Evidence	Family has five children all born within 7 years. Mother was age 18 and Dad 20 when they married with Mom pregnant. Family socializes only with the father's family, rarely with the mother's siblings. Mother reports that they attended the Methodist church when TA and his older sister were preschoolers, but Mother thinks the parishioners thought they were weird and rejected them so they stopped going. Neither parent has friends.
Source(s) of Evidence	Maternal report, paternal report, child report, state records check.
Disproving Evidence	Both parents are high school graduates. Father has a good technical job with benefits. Neither parent has a criminal record or previous CPS report.
Questions	
Conclusion	There is a large number of children born close together––a heavy caregiving burden. The family socializes with the father's family and receives some financial and babysitting support but is otherwise socially isolated. However, both parents are high school graduates, formed their family as adults, and are in a position to provide for their children. Ostensibly, the family has been law abiding, and this is the first CPS report.
COMMUNITY FACTORS: low norms and low levels of support for parenting/child care, child development, child health, child well-being and child rights, periodic monitoring of child development and well-being; poor mobilization of observer response; high levels of occurrence and low levels of intervention for substance abuse, violence, and criminal activity; and poverty.	
Evidence	

Source(s) of Evidence	Observation of school and home/neighborhood. Parental report.
Disproving Evidence	Family lives in a middle-class neighborhood with good schools and social services. The father has a good technical job with benefits.
Questions	
Conclusion	No community risk factors.

Summary Conclusion About Risk Factors:

TA has severe asthma and multiple psychiatric disabilities, which place increased demands for care on his parents. Both parents have significant mental health problems and histories of maltreatment. However, both parents seem invested in parenting and in their children. The mother seems handicapped in meeting TA's needs, in part, by her depression and history of emotional neglect and the father by his lack of appreciation of TA's needs, good qualities, and how his own behavior impacts TA (and the other children). There is a large number of children born close together—a heavy caregiving burden. The family socializes with the father's family and receives some financial and babysitting support but is otherwise socially isolated. However, both parents are high school graduates, formed their family as adults, and are in a position to provide for their children. Ostensibly the family has been law abiding, and this is the first CPS report. They live in a well-resourced community with many supports available.

Table 5. Evidence of Harm to Child Worksheet

Refer to Section 3 of this document.

Problems of Intrapersonal Thoughts, Feelings, and Behavior: anxiety, depression, negative self-concept, and negative cognitive styles that increase susceptibility to depression and suicidal thoughts and behaviors (e.g., pessimism, self-criticism, catastrophic thinking, and immature defenses).	
Evidence	The school psychologist reported that when evaluated, TA scored very high on a measure of childhood depression, with items endorsed and follow-up interview indicating very low self-esteem, thoughts of suicide but no plan, and low mood and little pleasure most days but adequate appetite and sleep. His IEP recommended continuing social work services for mood and behavior. Mother says she thinks he is depressed. His mother and teacher independently report that he has very low self-

	esteem. Teacher says he gives up easily on school tasks the minute he makes a mistake or experiences frustration. His mother says he will say that he would be better off dead when he gets in trouble at school or gets a bad report card or if problems erupt at home.
Source(s) of Evidence	Teacher interview, social work progress notes, IEP, school psychologist report of triennial evaluation for special education, and maternal interview.
Disproving Evidence	
Questions	
Conclusions	TA has depressed mood, negative cognitive style, negative self-concept, and low motivation that are impairing his ability to function. The preponderance of the evidence is that multiple forms of PM are contributing significantly to his difficulties.
Emotional Problems and Symptoms: substance abuse and eating disorders, emotional instability, impulse control problems, borderline personality disorder, and more impaired functioning among those diagnosed with bipolar disorder.	
Evidence	TA has been diagnosed with ADHD, and his symptoms include impulsive behavior such as many bike and climbing accidents, blurting out answers, not staying seated when it's expected, and butting into games and conversations.
Source(s) of Evidence	School records, medical records, teacher interview, and parental report.
Disproving Evidence	
Questions	
Conclusions	TA has problems with impulse control consistent with his ADHD diagnosis.
Learning Problems and Behavioral Problems: problems in academic settings, such as impaired learning despite adequate ability and instruction, academic problems and lower achievement test results, decline in IQ over time, lower measured intelligence, school problems due to non-compliance and lack of impulse control, and impaired moral reasoning.	

Evidence	School problems: TA had severe asthma in first grade and missed more than 2 months. His teachers found him immature and silly in his play with peers. He was retained because he had not learned the alphabet, was fidgety, and confused directions. When repeating first grade with better attendance, his learning problems persisted; he was labeled learning disabled and started receiving resource room help. He made some progress but was still behind despite average ability. By age 10, he worked slowly and did not finish assignments. He appeared off task most of the time unless an adult was working with him directly. His mistakes on simple material were so great that it was clear his mind was elsewhere. The school recommended an outside evaluation for ADHD, and he was so diagnosed. Stimulants were recommended but couldn't be taken because of his asthma medication.
Source(s) of Evidence	School records.
Disproving Evidence	
Questions	
Conclusions	TA shows significant learning problems and impaired ability to attend and concentrate despite average ability, attending a good school system, and receiving special educational services addressing learning, mood, and behavior problems. His responses on some learning tasks and behavior in the classroom show that his mind is elsewhere, not on his school work. The preponderance of the evidence is that multiple forms of PM by both parents are contributing to TA's depressed inability to concentrate and therefore inability to learn at school.
Physical Health Problems: high infant mortality rates; delays in almost all areas of physical and behavioral development. Allergies, asthma, and other child maltreatment are also associated with the foregoing effects as well as respiratory ailments; deviant adrenocortical responding and amygdala reactivity; white matter tract abnormalities; hypertension; and somatic complaints.	
Evidence	TA had severe asthma in first grade and missed over 2 months of school. While his asthma is now better

	managed, he still had three emergency hospitalizations in the last calendar year, which is inconsistent with good home management of the condition.
Source(s) of Evidence	Medical records and school record.
Disproving Evidence	
Questions	
Conclusions	TA has severe asthma despite access to good medical care. Pediatrician attributes this to poor home management of the condition. The preponderance of the evidence is that multiple forms of PM by both parents are contributing to TA's ongoing respiratory distress.

Summary Conclusion of Harm to Child:

TA shows significant learning problems (i.e., he is 2 years behind grade level) and impaired ability to attend and concentrate despite average ability, attending a good school system, and receiving special educational services addressing learning, mood, and behavior problems. His response on some learning tasks, making mistakes when he has previously mastered material, shows that his mind is elsewhere and not on his schoolwork. TA has depressed mood, thoughts of suicide, negative cognitive style, very low self-esteem, and low motivation that are impairing his ability to function in normal developmental activities. TA has severe asthma despite access to good medical care. The preponderance of the evidence is that multiple forms of PM and poor home management of his condition are contributing significantly to his difficulties.

8. Nature of Guidelines

These guidelines were designed to be as brief as possible to facilitate their use by front-line professionals. As such, they provide essential information abstracted from the more comprehensive *APSAC Monograph on Psychological Maltreatment* (available online at www.apsac.org; see [14]). Users of these guidelines should find significant added value in the monograph (which includes, for example, a detailed description of the assessment process, case examples, guidance for case- and system-wide interventions, and information useful for testifying in court) and in the chapter on psychological maltreatment of children published in the most recent edition of the *APSAC Handbook on Child Maltreatment* (see [15]).

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