Association of Professionals Solving the Abuse of Children
apsac.org

In partnership with THE NEW YORK FOUNDLING
nyfoundling.org

Practice Guidelines 2025 Updated Edition

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

Author: APSAC Taskforce **Title:** The Investigation and Determination of Suspected Psychological Maltreatment in Children and Adolescents **Publication Date:** 2025
Publisher: Association of Professionals Solving the Abuse of Children
Retrieved from: https://www.apsac.org/guidelines

APSAC PRACTICE GUIDELINES*
FOR THE INVESTIGATION AND DETERMINATION OF SUSPECTED PSYCHOLOGICAL MALTREATMENT OF CHILDREN AND ADOLESCENTS

1. Statement of Purpose

The purpose of these guidelines is to provide guidance to child protection professionals evaluating children and their circumstances to determine whether they have or have not been victims of psychological maltreatment. It is our belief that these guidelines are compatible with and will illuminate many existing state child protection laws and guidelines. It is appreciated that use of these guidelines must conform to law and regulation within the jurisdictions of application. We believe that a full spectrum of professionals interested in the safety and well-being of children should be familiar with these guidelines and the broader conceptualization of psychological maltreatment and interventions in the *APSAC Monograph on Psychological Maltreatment* [1].

2. APSAC's Statement of Caution Regarding Use of this Publication

It is negligent, even reckless for a judge, attorney, guardian, counselor, or other professional to cite or otherwise mischaracterize this or any other APSAC publication on psychological maltreatment as endorsing or even lending credence to a diagnosis or finding of "parental alienation." A child's avoidance of a parent is not sufficient evidence of psychological abuse by the other parent. Professionals seeking guidance on these issues may, as a starting point, wish to review APSAC's 2016 Position Statement "Allegations of Child Maltreatment and Intimate Partner Violence in Divorce/Parental Relationship Dissolution" and 2022 Position Statement "Assertions of Parental Alienation Syndrome (PAS), Parental Alienation Disorder (PAD), or Parental Alienation (PA) When Child Maltreatment Is of Concern" (available at www.apsac org).

3. Nature and Significance of Psychological Maltreatment

Humans are psychosocial beings. All human needs have associated psychological meanings and implications and the majority of 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 [2, 3, 4]. All human 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 needs are so vital to the health and well-being of the individual that having them met should be considered a basic right [5] and, in fact, they have been identified as foundational for human rights [6, 7]. Psychological maltreatment occurs when the child's psychological needs are rejected, denied, neglected, thwarted, distorted, or corrupted; psychological maltreatment also occurs when the fulfillment of basic survival needs is denied or corrupted.

Child maltreatment can be cruelly damaging, whether blatant to subtle in form, when it is perpetrated by people upon whom children are dependent and whom children expect to be safe and supportive (e.g., parents, family, school personnel, recreation/sports coaches, faith leaders, mentors). Child psychological maltreatment (CPM) is particularly widespread and destructive. Of all forms of child maltreatment, CPM is the most common because it is embedded in or associated with every other type of maltreatment and, importantly, also exists in its own discrete forms. CPM is especially damaging for many reasons; CPM conveys negative beliefs about the child's worth (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 low self-esteem, rejection sensitivity, and depression. In addition, when the child is used primarily for the fulfillment of others' needs, this behavior adversely affects the child's sense of intrinsic self-worth and expectations for social support and relationships, which are essential for well-being. Also, CPM results in negative psychological states (e.g., humiliation, shame) known to lead to violence [8], produce psychological trauma associated with psychopathology [9], and be so pervasively and insidiously destructive as to deserve the label "soul murder" [10].

[*] *These guidelines are the product of APSAC's Task Force on Psychological Maltreatment, co-chaired by Stuart Hart, PhD, and Marla Brassard, PhD. Contributions toward its development have been provided by (in alphabetical order) Amy J. L. Baker, PhD, Marla Brassard, PhD, Zoe Chiel, Stuart N. Hart, PhD, Danya Glaser, MD, Jody T. Manly, PhD, and Amy M. Smith Slep, PhD. 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 et al.,* 2019, *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 alphabetical order) Susan Bennett, MD, ChB, FRCP, DTM&H, DRCOG, DCH, Dip Psych, Susan Bissell, PhD, Martha Erikson, PhD, Danya Glaser, MD, Jody Todd Manly, PhD, Amy Slep, PhD, and David Wolfe, PhD. The operational definitions discussed are detailed in Slep et al.'s 2022 paper (see [11]).*

4. Psychological Maltreatment Definitions and Manifestations

According to the Federal Child Abuse and Treatment Act of 2010 [12, 13], *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 child psychological maltreatment (CPM), across state child abuse statutes [14] which are found in one or more civil or criminal statutes.

State laws often label CPM as "emotional abuse" or "mental injury." In these Guidelines, the term "psychological" is used because (a) CPM is a symbolic, sometimes verbal, communication from the perpetrator to the child and (b) the most prominent lasting effects of the victim's experience of CPM are psychological. The major psychological domains affected are thinking (cognitive); feeling/emotion (affective); social, interpersonal, and physical well-being and development; and from these, impulse or will to action (conative/volitional).

Most of the U.S. state legal definitions of CPM refer to the impact on the child as opposed to the caregiver behaviors, while in some states evidence of harm is not always required to substantiate CPM [14]. In these Guidelines, CPM includes caregiver behaviors toward or involving a child that cause or have a strong potential to cause serious harm. CPM occurs in both acts of commission (e.g., verbal attacks on the child by a caregiver) and acts of omission (e.g., emotional unresponsiveness of a caregiver). The definition of CPM in Figure 1 is conceptualized in these Guidelines first as an overarching definition and then operationalized to capture the criterion and various manifestations of CPM.

The operationalized definition of psychological maltreatment developed by Slep et al. [11] specifies that for criteria to be classified as CPM, caregiver behavior toward or involving a child must be consistent with the overarching definition. Several categories are described with illustrative exemplars of caregiver acts and omissions that have caused actual harm or have the reasonable potential for harm to the child. Consideration of harm (or risk of harm) takes into account cultural practices as well as child sensitivities, vulnerabilities, and development. Thus, procedures can be individually tailored to families' particular situations. That is, the same behavior that in one family context would constitute CPM may not in another, based on the child's developmental level and culture and customs within the family. This approach to including both caregiver behavior and harm criteria is consistent with the Field-tested Assessment, Intervention-planning, and Response (FAIR) system [15, 16, 17], which has demonstrated reliability, utility, and a fit with constraints of real-world systems when used by U.S. military services and a statewide system. This approach has also been shown to clarify thresholds between suboptimal parenting and caregiving behavior that can be reliably determined to constitute psychological maltreatment.

Figure 1 excludes physical abuse, sexual abuse, and physical neglect from the definition of CPM. This was done so that the decision-making model for CPM determinations would be clearly appreciated as bringing added value to existing state standards and not overlap those

standards. The exclusion refers to CPM embedded in these other forms[1] (i.e., the degrading, terrorizing, exploiting, corrupting, and emotional unresponsiveness inherent in physical abuse, sexual abuse and physical neglect). However, when any of these other forms are present and CPM, as defined in Figure 1, is also present, they are each and all actionable in child maltreatment determinations. For example, if physical abuse is accompanied by repeated perpetrator statements that the victim is evil, a failure, or an embarrassment deserving to be beaten, such statements can be dealt with as CPM.

Applying the overarching definition and subtypes in Figure 1 entails four steps: (1) determining whether the case meets the overarching definition, (2) comparing the caregiver behaviors of concern against the acts/behaviors described in Criterion A, (3) assessing whether there are harms or risks of harm as described in Criterion B, and (4) ensuring the case meets criteria for CPM by referencing the Check Box section. A child's maltreatment experience(s) may be categorized by one or more of the forms described in Criterion A.

[1]Although (by Figure 1 definition) PM embedded in other forms of maltreatment is not to be included in decisions about whether a child has been a victim of psychological maltreatment, appreciation of its existence may be quite valuable in formulating interventions. The power of PM is partly explained by the fact that human beings are constantly searching for meaning and understanding, as is developmentally possible. Child victims of PM interpret the psycho-social nature of what is being done to them and around them, including experiences of physical and sexual abuse and physical neglect, which then shapes their understanding of self and others and their efforts to have their needs met [1, 18, 19, 20].

Figure 1. Child Psychological Maltreatment Definition

OVERARCHING DEFINITION

Psychological maltreatment refers to caregiver behaviors toward or involving a child that cause or have a strong potential to cause serious harm to a child's emotional, cognitive, social, interpersonal, or physical well-being or development. Psychological maltreatment could reflect a single caregiver act or omission or could reflect repeated caregiver behaviors. *Caregiver* refers to any adult responsible for attending to the needs of a child as defined by the system using these definitions.

OPERATIONALIZED DEFINITION

There are two components to the operational definition: Criterion A, which refers to the acts of the caregiver, and Criterion B, which refers to the harm or potential harm to the child.

CRITERION A: Non-accidental act or acts by caregiver (excluding physically and sexually abusive acts) and omissions (excluding physical neglect). **The following seven categories of caregiver behaviors are possible examples and are not intended as an exhaustive list.** Acts/omissions that are not listed but are similarly (potentially or actually) harmful are also eligible.[2]

1. **Psychological neglect**
   a. Caregiver uninvolved
   b. Caregiver unresponsive to child's bids for a response
   c. Caregiver shows egregious lack of affection

2. **Spurning**
   a. Caregiver hostile to child
   b. Caregiver derogates, denigrates, belittles, insults, humiliates the child
   c. Caregiver singles child out for worse treatment than siblings/Scapegoating
   d. Caregiver rejects child

[2]The acts identified here as illustrative exemplars were selected to represent caregiver acts/behaviors included in previous APSAC Guidelines (see Appendix), the Maltreatment Classification System, FAIR, and Glaser's conceptual system for psychological maltreatment [11]. Emphasis was given to acts that could be reliably assessed as to their occurrence and were of value in "above the line/below the threshold" decisions. Inclusions are not exhaustive of categories or types falling within categories of acts/behaviors.

3. Developmentally inappropriate interactions

a. Imposing or fostering developmentally inappropriate standards on the child, including infantilization and adultification (e.g., parentification)

4. Inappropriate responses to perceived misbehavior/discipline

a. Excessively intense or frequent discipline (regarding corporal punishment, see footnote[3])

b. Confining/binding

c. Compelling the child to inflict pain on him-/herself

d. Placing unreasonable limitations or restrictions on child's social interactions

e. Preventing a child from necessities (e.g., sleep, rest, food, light, water, access to the toilet)

5. Terrorizing/Exposing child to potentially traumatic experiences

a. Exposing child to potentially traumatizing interparental violence; deliberate parental self-harm; recognizably dangerous situations

b. Threatening violence against or abandonment of the child

c. Threatening or perpetrating violence against a child's loved ones, pets, or objects (including domestic violence).

d. Terrorizing child through nonviolent actions or threats

6. Exploiting

a. Caregiver actively exposing the child to belittling, degrading, and other forms of hostile or rejecting treatment of those in significant relationships with the child

b. Munchausen by proxy (see *APSAC Practice Guidelines Munchausen by Proxy: Clinical and Case Management Guidance*)

c. Grooming for sexual abuse or exploitation (see *APSAC Practice Guidelines Forensic Mental Health Evaluations When Child Maltreatment Is At Issue* and *Forensic Interviewing of Children*)

7. Corruption/Failures to promote socialization

a. Encouraging antisocial behavior

[3] Corporal punishment, even when intended as discipline, includes psychological maltreatment in forms such as fear induction, rejection, humiliation and threat-based compliance.

CRITERION B: Significant impact on the child involving any of the following:

1. **Actual psychological harm,[4] including any of the following:**
   a. Significant disruption of the child's physical, emotional, cognitive[5], or social development created or exacerbated by the caregiver's act/omission (or pattern of acts/omissions)
   b. Significant psychological distress (e.g., major depressive disorder, anxiety disorders, disruptive behavior disorders, substance abuse disorders, or other psychiatric disorders, at or near diagnostic thresholds) related to the caregiver's act(s)/omission(s)
   c. Stress-related somatic symptoms related to or exacerbated by the caregiver's act(s)/omissions(s) that significantly interfere with normal functioning
   d. More than inconsequential fear reaction related to the caregiver's act(s)/omission(s)
2. **Reasonable potential for harm**
   a. The act/omission (or pattern of acts/omissions) carries a reasonable potential for significant disruption of the child's physical, emotional, cognitive or social development
   b. The act/omission (or pattern of acts/omissions) creates reasonable potential for the development of a psychiatric disorder (at or near diagnostic thresholds) related to, or exacerbated by, the act(s). The child's level of functioning and the risk and resilience factors present should be taken into consideration.

KEY WORD/PHRASES OPERATIONALIZED: Below are expanded definitions of key words and phrases.

Egregious: Egregious acts show striking disregard for child's well-being. As such, they are not merely examples of inadvisable or deficient parenting, but must clearly fall below the lower bounds of normal parenting.

Threatening: Verbal or nonverbal acts perceived by victim or witness as signifying that victim's physical integrity was at risk at the time or would be in the future.

Significant disruption: Given the child's developmental level or trajectory evident before alleged maltreatment, child's current development/functioning is substantially worse than would have been expected.

[4] Advances are continuously being made in revealing the nature of harm associated with and due to psychological maltreatment; these should be factored into application of this model as they become available. Section 5, "Effects of Psychological Maltreatment," illuminates this reality.

[5] Includes academic functioning.

Stress-related somatic symptoms: Some victims show impact through physical, rather than psychological, symptoms. Stress-related somatic symptoms are physical problems that are caused by or worsened by stressful incidents. Such somatic symptoms can include, but are not limited to, aches and pains, migraine, gastrointestinal problems, or other stress-related physical ailments.

More than inconsequential fear reaction: The child must demonstrate both

(A) Fear (verbalized or displayed) of bodily injury to self or others AND

(B) At least one of the following four signs of fear or anxiety lasting at least 48 hours:

(1) Persistent intrusive recollections of the incident, including recollections as evidenced in the child's play

(2) Marked negative reactions to cues related to incident, as evidenced by avoidance of cues; subjective or overt distress to cues; or physiological hyperarousal to cues (NOTE: Perpetrator can be a cue)

(3) Acting or feeling as if incident is recurring

(4) Marked symptoms of anxiety such as difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance (i.e., acting overly sensitive to sounds and sights in the environment; scanning the environment expecting danger; feeling keyed up and on edge), or exaggerated startle response.

5. Prevalence

The pervasiveness of CPM can be determined by the number of new cases each year (i.e., incidence) or the percentage of a population that has experienced CPM at any point in time (i.e., prevalence). Prevalence rates tend to be better estimates of the extent of the problem. In regard to psychological neglect in particular, a meta-analysis estimated the worldwide prevalence to be 18.4 % [21]. The larger existing body of available international research reveals a large variation within and across countries [22]. In regard to psychological abuse, based on self-reports it has been estimated to be 363 in 1000 (36.3%) and, when informant reports were used, only 3 in 1000 (.3%) [23]. This difference is likely due to jurisdictions not including CPM in their abuse laws or using different definitions and thresholds, informant reports focusing only on severe cases and/or to the abuse being known only within the family. The WHO Global Health Observatory data repository lists the global lifetime prevalence for both genders for child emotional abuse as 36.3%.

6. Effects of Psychological Maltreatment

Psychological maltreatment effects can be acute, long-term, and broad or narrow in nature [18, 19, 17]. The particular forms and degrees of harm experienced are dependent on the type of CPM and related factors, such as the magnitude, frequency, and chronicity of CPM maltreatment and other co-occurring forms of maltreatment, as well as the risk and protective factors present. For example, children who are frequently or intensely spurned (i.e., belittled, degraded, or overtly rejected) may come to believe they deserve such treatment and are unworthy of love or

respect. This may lead children to forego any challenge or opportunity in which they might be evaluated or cause children to manage their sadness, fear, anger, shame, and humiliation through substance abuse, self-harm including suicide, and violence toward others including homicide.

The scientific evidence that physical and psychological violence, especially during childhood, is harmful to children and can have lasting effects across the lifespan is overwhelming. All forms of child maltreatment are related to increases in the risk of psychopathology, poor health, and poor adaptive functioning across the lifespan [e.g., 24, 25]. Risk increases in a clear dose-response fashion, and multiple forms of maltreatment exposure have an even greater impact than is predicted by the sum of the forms experienced [e.g., 25, 26]. Experimental studies with animals and nationally representative, genetically informed prospective studies of humans from birth provide the strongest evidence of harm because all or most alternative explanations for adverse outcomes can be controlled or ruled out [e.g., 27]. These gold-standard studies are supported by a vast international literature using prospective, concurrent, and retrospective designs with community and clinical populations that show consistent harmful effects on individuals throughout the lifespan. The likelihood of harm is increased as children experience multiple types of maltreatment because CPM is generally accompanied by (i.e., embedded in or associated with) other forms of maltreatment.

Internalizing problems

All forms of child maltreatment are associated with significantly great likelihood of depression, anxiety, suicidality, and non-suicidal self-injury [28, 29, 30]. This finding holds even when using genetically informed designs [28] that control for other partly heritable risk factors for these conditions (e.g., poor emotion regulation, impulsivity, low self-esteem). The uniquely greater impact of psychological (i.e., emotional—the term used in many studies) abuse and neglect on depression is well established [31, 32, 33, 34, 35, 36]. This is also true for suicidality [37, 48, 39, 40]. Psychological abuse promotes low self-esteem, shame, hopelessness, and impaired interpersonal relationships.

Social anxiety and rejection sensitivity are more strongly related to psychological maltreatment [41, 42] than to other forms of child abuse and neglect. CPM can cause intense fear of being evaluated and rejected by friends, family, and acquaintances. When a caregiver swears at and mocks a child, threatens to hit or abandon them, tells them they are worthless, or takes minimal interest, a child constructs a self-image that leads them to expect similar treatment from others.

Anti-social behavior

Conduct disorders (e.g., physical violence, stealing) are linked to co-occurring psychological (i.e., emotional) and physical abuse [e.g., 33, 43, 44, 45]. Substance abuse has been specifically tied to psychological abuse and neglect over and above other forms of child maltreatment [e.g., 33, 44, 46, 47].

Thought disorders

Thinking problems, such as dissociation, hallucinations, and diagnosed psychosis, have also been specifically tied to psychological abuse and neglect over and above other forms of child maltreatment, all of which increased risk of psychosis [48, 49, 50, 51, 52. Trauma symptoms

seem to play a role in impaired reality testing as childhood trauma appears to increase risk for psychosis independently of genetic vulnerability [53].

Cognitive/Learning problems

CPM in the form of psychological neglect is related to significant declines in cognitive functioning in early life [54]. Co-occurring psychological and physical neglect is tied to low-cognitive functioning, including poor academic achievement across the lifespan, and low-educational qualifications in adulthood [e.g., 24, 55, 56, 57, 58].

Physical health problems

Health problems, such as reduced adult height, are significantly predicted by childhood psychological and physical abuse [59]; hearing impairments by verbal abuse, but not physical abuse, of mother while an infant is in utero [60]; and eating disorders by psychological and sexual abuse [e.g., 61, 62]. Psychological abuse is specifically linked to diagnosed asthma in young adulthood [63] and psychological abuse and neglect, to headaches [64, 65, 66].

7. Risk Factors for Maltreatment Important for CPM 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 maltreatment 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 CPM, 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, 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 CPM, against children if they have one or more of the following features: young, unprepared caregivers; mental ill-health; low self-esteem, low-impulse control, low empathy, poor coping skills; substance misuse, criminal activity; childhood experiences of maltreatment, including witnessing family violence (e.g., sibling maltreatment and caregiver 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 CPM); 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 a 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. The family is the most important part of the child's social ecology. Family system vulnerability is increased by a large ratio of children to adults (including single parent households); presence of an aberrant parent substitute; low connection to or support from the extended family; social isolation from the community (e.g., school, faith, health services, and recreation); poverty; and domestic violence.

Community environment factors. Living in low-socioeconomic environments is a well-recognized risk factor for child maltreatment, especially psychological (and physical) abuse and neglect. The risk is mediated by low expectations for how children should be treated and low levels of support for parenting/child care, and high levels of substance abuse, violence, and criminal activity and low levels of intervention.

8. Consideration of Psychological Maltreatment in Investigations

It is common for maltreated children to experience multiple forms of maltreatment (i.e., poly-victimization). CPM 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 CPM 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* [1], which provides downloadable forms.

9. Assessment and Determination of Psychological Maltreatment

Orientation Toward Assessment

As noted, these Practice Guidelines are written for the front-line child protection worker and other professionals dealing with suspected child maltreatment. Often, 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 professionals, particularly to determine whether significant impact on the child has occurred (attributable to CPM) or if there is reasonable potential for harm (see Figure 1, Criterion B above) and is not readily available from records (i.e., medical, school, or daycare) and interviews with collateral sources.

All professionals should approach the assessment with an open mind regarding what, if anything, might have happened and be prepared to seek information that suggests or confirms CPM exists (i.e., confirmatory evidence) as well as information that suggests or confirms it does not (i.e., disproving evidence). CPM can occur as an acute incident, such as when, in a moment of grief, a caregiver states to a child that the caregiver wishes that the child were the one who had died rather than a deceased sibling. A very serious single incident of domestic violence would be another example. CPM can occur during an extended life crisis but not be pervasive or reflective of the caregiver–child interaction outside of that context. In some cases, CPM occurs only when some specific, recurring event occurs, such as substance abuse by a caregiver. However, in other

cases, CPM 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 CPM 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 review of records can provide clarifying and corroborative information about interaction, care, and treatment and their impact on the child. Every attempt should be made to interact respectfully and to behave in a manner that increases 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 caregivers 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 task of discriminating between poor or inadequate caregiving and psychological maltreating caregiving can be challenging (see [1, 19, 67] 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; coaches; neighbors; and others. It is important to be aware that even abused children may strenuously campaign to remain with the abusive caregiver. In so doing, they may deny the occurrence or impact of the abuse, deflect responsibility away from the abusive caregiver, and assume the blame for any problematic behavior on the part of the caregiver. Therefore, interviews alone will not be sufficient to determine the true nature of the caregiver–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), is 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). To evaluate the impact criterion of the CPM definition, the assessor will need to determine whether evidence exists for (a) a significant disruption of the child's physical, emotional, cognitive, social, academic, or interpersonal development, (b) significant psychological distress (i.e., major depressive disorder, anxiety disorders, disruptive behavior disorders, substance abuse disorders, or other psychiatric disorders at or near diagnostic thresholds) related to the act(s)/omission(s), (c) stress-related somatic symptoms (related to or exacerbated by the act(s)/omission(s)) that significantly interfere with

normal functioning, and/or (d) more than inconsequential fear reaction in the child. Alternately, any parental behavior that has reasonable potential for these forms of harm to the child would also meet criteria for the definition [11].

Caregiver/family competencies and risk factors. Evaluation of caregiver competencies and risk factors assists in developing potential supports and in identifying issues and opportunities to address if the family is referred for treatment. In this context, treatment would involve a time-limited trial of the caregiver's capacity to change and sustain change for improvement in the caregiver-child relationship. Relevant areas of functioning that treatment or intervention would most likely include are as follows: (1) Caregiver's perspectives on child-rearing and the particular child in question (e.g., willingness and ability to parent, recognizing the child's needs, 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, self-control, mental health, and substance use); (3) Social support/resources (e.g., marital status, family, friends, financial resources, and faith and secular community involvement); and (4) Life stresses or transitions in the family.

Developmental Considerations for CPM

Caregiver CPM behaviors will likely manifest differently depending upon the age and developmental level of the child. For example, isolating, which could be a form of psychological neglect or inappropriate response to perceived misbehavior/discipline, will not occur in the same ways for infants and adolescents. Similarly, the impact criteria require assessment of the child's developmental competencies and needs. Examples of indicators of the CPM subtypes at different developmental levels of the child are provided in Table 2, Forms of CPM by Developmental Level, in the *APSAC Monograph on Psychological Maltreatment* [1].

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 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. However, cultural practice may nevertheless be harmful. See [1] for a detailed description of the assessment process and a variety of case examples.

10. A Case Example

Here, a case example is presented for the suspected psychological maltreatment of a boy, identified as T.A., at age 10, who was the second of five children born to a married couple. The school psychologist called in a report to CPS after an interview with T.A. for a tri- annual evaluation for special education. T.A. drew himself as a bug with his father screaming at him,

"I will crush you, you little cockroach!" During questioning, T.A. reported that his dad screams at him and his two younger brothers, calls them names (such as "dummy," "idiot," and "loser") all the time. He says that his older and younger sisters are his dad's favorites, they can do no wrong.

Additionally, findings are provided for the application of Figure 1's Psychological Maltreatment Definition. Worksheets to organize findings for suspected child psychological maltreatment are available in the *APSAC Monograph on Psychological Maltreatment* [1] in clean form (Assessment Worksheet, pp. 41–46) and as applied in detailing the T.A. case (Appendix E. Assessment Worksheet Case Example, pp. 75–84).

Caregiver Behaviors

Spurning: Mother, father, and T.A. all report that the father frequently uses degrading language to T.A. and his brothers and singles them out for markedly worse treatment than their sisters receive. He blames them for the poor treatment.

Terrorizing: T.A.'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.

Psychological Neglect: Father is never emotionally responsive or affectionate. Mother is emotionally responsive only when T.A. is so sick that he might die.

Summary Conclusion About Caregiver CPM Behaviors: T.A. is exposed to long-standing, chronic CPM in the forms of spurning, terrorizing/exposing child to potentially traumatic experiences, and psychological neglect.

Risk Factors

Child Factors: T.A. has severe asthma and multiple psychological disabilities, which place increased demands for care on his parents.

Caregiver Factors: 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 to have difficulty in meeting T.A.'s emotional needs, in part, by her depression and the father by his lack of appreciation of T.A.'s needs, good qualities, and how his own behavior impacts T.A. (and the other children).

Family Factors: 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.

Summary Conclusion About Risk Factors: T.A. 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 to have difficulty in meeting T.A.'s needs, in part, related to her depression and history of emotional neglect and the father by his lack of appreciation of T.A.'s needs, good qualities, and how his own behavior impacts T.A. (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. The family has been law abiding, and this is the first CPS report. They live in a well-resourced community with many supports available.

Evidence of Harm

Internalizing Problems: T.A. 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 CPM are contributing significantly to his difficulties.

Cognitive Learning Problems: T.A. 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 CPM by both parents are contributing to T.A.'s depressed ability to concentrate and therefore inability to learn at school.

Physical Health Problems: T.A. has severe asthma and, despite good health care, has had repeat hospitalizations. An interview with the ENT indicted that poor home management was the likely reason for the severity of his condition.

Summary Conclusion of Harm to the Child: T.A. 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. T.A. 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. T.A. has severe asthma despite access to good medical care. The preponderance of the evidence is that multiple forms of CPM are contributing significantly to his difficulties.

Determination Based on the Psychological Maltreatment Definition (Figure 1, pp. 5–8)

T.A. meets criterion A (non-accidental acts/omissions)

A.1 Psychological neglect: The father is never emotionally responsive or affectionate. The mother is emotionally responsive only when T.A. is so sick that he might die.

A.2 Spurning: The mother, father, and T.A. all report that the father frequently uses degrading language to T.A. and his brothers and singles them out for markedly worse treatment than their sisters receive. The father blames the boys for his poor treatment of them.

A.5 Terrorizing/Exposing child to potentially traumatic experiences: T.A.'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.

T.A. meets criterion B (significant impact)
B.1b Significant psychological distress: T.A. 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.

B.1c Somatic symptoms that significantly interfere with normal functioning: T.A. has severe asthma (several hospitalizations a year) despite access to good medical care. The ENT stated that poor home management was the likely cause of the severity of his asthma.

B.1d Significant developmental disruption: T.A. 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.

11. Nature of Guidelines

The APSAC Guidelines were designed to be as brief as possible to facilitate their use by frontline professionals assessing and making determinations of whether or not a child has experienced psychological maltreatment. As such, they provide some essential information abstracted from the more comprehensive *APSAC Monograph on Psychological Maltreatment* (available online at www.apsac.org; see [1]). Users of these guidelines should find significant added value in the monograph (which includes, for example, 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 [19]).

APPENDIX

Psychological Maltreatment Definition and Forms (This is Table 1 from 2019 Practice Guidelines, *The Investigation and Determination of Suspected Psychological Maltreatment of Children and Adolescents,* and provided as an historical resource [67])

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. It's 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 do 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;

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; and

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, they 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, 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. It 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;

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. Original Source: See [18 & 19] for historical Hart & Brassard references. Revised Source: Brassard et al. (2019) [1].
*Caregiver abandonment of a child is one of the most severe forms of PM. Even though it is specifically identified as a type of terrorizing (no. 3) in this Appendix, it also embodies significant components of emotional unresponsiveness, spurning, and isolating.

References

[1] Brassard, M. R., Hart, S. N., Baker, A. J. L., & Chiel, Z. (2019). *APSAC Monograph on Psychological Maltreatment*. American Professional Society on the Abuse of Children. https://www.apsac.org

[2] Maslow, A. (1970). *Motivation and personality*. Harper & Row.

[3] Sheldon, K. M., Elliot, A. J., Kim, K., & Kasser, T. (2001). What is satisfying about satisfying events? Testing 10 candidates' psychological needs. *Journal of Personality and Social Psychology, 80*(2), 325–339. https://doi.org/10.1037/0022-3514.80.2.325

[4] Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68–78. https://doi.org/10.1037/0003-066X.55.1.68

[5] Adler, M. (1981). *Six great ideas.* Macmillan.

[6] Pappas, A. M. (1983). Introduction. In A. M. Pappas (Ed.), *Law and the status of the child: Volume 1* (pp. xxvii–xxiv). United Nations Institute for Training and Research.

[7] Hart, S. N., & Pavlovic, Z. (1991). Children's rights in education: An historical perspective. *School Psychology Review, 20*(3), 345–358.

[8] Pinker, S. (2002). *The blank slate: The modern denial of human nature*. Penguin Putnam.

[9] Van der Kolk, B. A. (1988). The biological response to psychological trauma. In F. M. Ochbert (Ed.), *Post-traumatic therapy and victims of violence* (pp. 25–38). Brunner/Mazel.

[10] Shengold, L. (1989). *Soul murder*. Fawcett-Columbine.

[11] Slep, A. M. S., Glaser, D., & Manly, J. T. (2022). Psychological maltreatment: An operationalized definition and path toward application. *Child Abuse & Neglect*, *134*, 105882. https://doi.org/10.1016/j.chiabu.2022.105882

[12] Child Abuse Prevention and Treatment Act, 42 U.S.C. 5101 et seq. (1974).

[13] Child Abuse Prevention and Treatment Act as amended by PL 11-320, CAPTA reauthorization act of 2010, 42 U.S.C. 5116 et seq. See also 45 CFR 1340; 1974.

[14] Baker, A. J. L., & Brassard, M. R. (2019). Predictors of variation in state reported rates of psychological maltreatment: A survey of U.S. statutes and a call for change. *Child Abuse and Neglect, 96*. https://doi.org/10.1016/j.chiabu.2019.104102

[15] Heyman, R. E., & Slep, A. M. S. (2006). Creating and field-testing diagnostic criteria for partner and child maltreatment. *Journal of Family Psychology, 20*(3), 397–408. https://doi.org/10.1037/0893-3200.20.3.397

[16] Owen, D. J., Knickerbocker, L., Heyman, R. E., & Smith Slep, A. M. (2009). Families, violence, and abuse. In J. H. Bray & M. Stanton (Eds.), *The Wiley-Blackwell handbook of family psychology* (pp. 729–741). Wiley Blackwell. https://doi.org/10.1002/9781444310238.ch52

[17] Slep, A. M., Heyman, R. E., & Foran, H. E. (2015). Child maltreatment in DSM-5 and ICD-11. *Family Process, 54*(1), 17–32. https://doi.org/10.1111/famp.1213

[18] Hart, S. N., Brassard, M. R., Davidson, H. A., Rivelis, E., Diaz, V., & Binggeli, N. (2011). Psychological maltreatment. In J. Myers (Ed.), *The APSAC handbook on child maltreatment: 3rd edition* (pp. 125–144). Sage.

[19] Hart, S. N., Brassard, M. R., Baker, A. J. L., & Chiel, Z. A. (2017). Psychological maltreatment of children. In J. Conte & B. Klika (Eds.), *The APSAC Handbook on Child Maltreatment: 4th edition* (pp. 145–162). Sage.

[20] Hart, S. N., & Brassard, M. R. (1987). Psychological maltreatment: Progress achieved. *Development and Psychopathology, 3*, 61–70.

[21] Stoltenborgh, M., Bakermans-Kranenburg, M. J., Alink, L. R. J., & van Ijzendoorn, M. H. (2014). The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. *Child Abuse Review, 24*(1). https://doi.org/10.1002/car.2353

[22] Stoltenborgh, M., Bakermans-Kranenburg, M., Alink, L. R. A., & Ijzendoorn, M. (2012). The universality of child emotional abuse: A meta-analysis of worldwide prevalence. *Journal of Aggression, Maltreatment, and Trauma, 21*(8), 870–890. https://doi.org/10.1080/10926771.2012.708014

[23] Kobulsky, L. M., Kepple, N. J., & Jedwab, M. (2018). Abuse characteristics and the concordance of child protective service determinations and adolescent self-reports of abuse. *Child Maltreatment*, *23*(3), 269–280. https://doi.org/10.1177/1077559518771743

[24] Strathearn, L., Giannotti, M., Mills, R., Kisely, S., Najman, J., & Abajobir, A. (2020). Long-term cognitive, psychological, and health outcomes associated with child abuse and neglect. *Pediatrics*, *146*(4), e20200438. https://doi.org/10.1542/peds.2020-0438

[25] Vachon, D. D., Krueger, R. F., Rogosch, F. A., & Cicchetti, D. (2015). Assessment of the harmful psychiatric and behavioral effects of different forms of maltreatment. *JAMA Psychiatry, 72*(11), 1135–1142. https://doi.org/10.1001/jamapsychiatry.2015.1792

[26] Teicher, M. H., Samson, J. A., Polcari, A., & McGreenery, C. E. (2006), Sticks, stones, and hurtful words: Relative effects of various forms of childhood maltreatment. *American Journal of Psychiatry*, *163*(6), 993–1000. https://doi.org/10.1176/ajp.2006.163.6.993

[27] Schaefer, J. D., Moffitt, T. E., Arseneault, L., Danese, A., Fisher, H. L., Houts, R., Sheridan, M. A., Wertz, J., & Caspi, A. (2017, Dec 12, epub). Adolescent victimization and early adult psychopathology: Approaching causal inference using a longitudinal twin study to rule out non-causal explanations. *Clinical Psychological Science, 6*(3), 352–371. https://doi.org/10.1177/2167702617741381

[28] Baldwin, J. R., Arseneault, L., Caspi, A., Moffitt, T. E., Fisher, H. L., Odgers, C. L., Ambler, A., Houts, R. A., Matthews, T., Ougrin, D., Richmond-Rakerd, L. S., Takizawa, R., & Danese, A. (2019). Adolescent victimization and self-injurious thoughts and behaviors: A genetically sensitive cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry, 58*(5), 506–513. https://doi.org/10.1016/j.jaac.2018.07.903

[29] Humphreys, K. L., LeMoult, J., Wear, J. G., Piersiak, H. A., Lee, A., & Gotlib, I. H. (2020). Child maltreatment and depression: A meta-analysis of studies using the Childhood Trauma Questionnaire. *Child Abuse and Neglect*, *102*, 104361. https://doi.org/10.1016/j.chiabu.2020.104361

[30] Infurna, M. R., Reichl, C., Parzer, P., Schimmenti, A., Bifulco, A., & Kaess, M. (2016). Associations between depression and specific childhood experiences of abuse and neglect: A meta-analysis. *Journal of Affective Disorders, 190*, 47–55. https://doi.org/10.1016/j.jad.2015.09.006

[31] Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*, 217–225. https://doi.org/10.1016/j.jad.2003.12.013

[32] McGee, R. A., Wolfe, D. A., & Wilson, S. K. (1997). Multiple maltreatment experiences and adolescent behavior problems: Adolescent perspectives. *Development and Psychopathology, 9,* 131–149. https://doi.org/10.1017/s0954579497001107

[33] Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLOS Medicine, 9*(11). https://doi.org/10.1371/journal.pmed.1001349

[34] Paterniti, S., Sterner, I., Caldwell, C., & Bisserbe, J. C. (2017). Childhood neglect predicts the course of major depression in a tertiary care sample: A follow-up study. *BMC*

Psychiatry, *17*(1), 113. https://doi.org/10.1186/s12888-017-1270-x

[35] Paul E., & Eckenrode, J. (2015). Child psychological maltreatment subtypes and adolescent depressive symptoms. *Child Abuse and Neglect, 47*, 38–47. http://dx.doi.org/10.1016/j.chiabu.2015.05.018

[36] Spinhoven, P., Elzinga, B. M., Hovens, J. G., Roelofs, K., Zitman, F. G., van Oppen, P., & Penninx, B. W. (2010). The specificity of childhood adversities and negative life events across the life span to anxiety and depressive disorders. *Journal of Affective Disorders*, *126*(1), 103–112. https://doi.org/10.1016/j.jad.2010.02.132

[37] Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association, 286*(24), 3089–3096. https://doi.org/10.1001/jama.286.24.3089

[38] Liu, J., Fang, Y., Gong, J., Cui, X., Meng, T., Xiao, B., He, Y., Shen, Y., & Luo, X. (2017). Association between suicidal behavior and childhood abuse and neglect: A meta-analysis. *Journal of Affective Disorders, 220*, 147–155. https://doi.org/10.1016/j.jad.2017.03.060

[39] Seff, I., & Stark, L. (2019). A sex-disaggregated analysis of how emotional violence relates to suicide ideation in low- and middle-income countries. *Child Abuse & Neglect, 93*, 222–227. https://doi.org/10.101016/j.chiabu.2019.05.008

[40] Wang, Y-R., & Cao, F-L. (2019). Suicidality among young adults: Unique and cumulative roles of 14 different adverse childhood experiences. *Child Abuse and Neglect, 98*, 104183. https://doi.org/10.1016/j.chiabu.2019.104183

[41] Shähar B., Doron, G., & Szepsenwol, O. (2015). Childhood maltreatment, shame-proneness and self-criticism in social anxiety disorder: A sequential mediational model. *Clinical Psychology and Psychotherapy*, *22*(6), 570–579. https://doi.org/10.1002/cpp.1918

[42] Talmon, A., Dixon, M. L., Goldin, P. R., Heimberg, R. G., & Gross, J. J. (2021). Neurocognitive heterogeneity in social anxiety disorder: The role of self-referential processing and childhood maltreatment. *Clinical Psychological Science, 9*(6), 1045–1058. https://doi.org/10.1177/21677026211004452

[43] Berzenski, S. R., & Yates, T. M. (2011). Classes and consequences of multiple maltreatment. *Child Maltreatment, 16*(4), 250–261. https://doi.org/10.1177/1077559511428353

[44] Jung, H., Herrenkohl, T. I., Lee, J. O., Klika, J. B., & Skinner, M. L. (2015). Effects of physical and emotional child abuse and its chronicity on crime into adulthood. *Violence and Victims, 30*(6), 1004–1018. https://doi.org/10.1891/0886-6708.VV-D-14-00071

[45] Maughan, B., Pickles, A., & Quinton, D. (1995). Parental hostility, childhood behavior, and adult social functioning. In J. McCord (Ed.), *Coercion and punishment in long-term perspectives* (pp. 34–58). Cambridge University Press.

[46] Abajobir, A. A., Najman, J. M., Williams, G., Strathearn, L., Clavarino, A., & Kisely, S. (2017). Substantiated childhood maltreatment and young adulthood cannabis use disorders: A pre-birth cohort study. *Psychiatry Research, 256*, 21–31. https://doi.org/10.1016/j.psychres.2017.06.017

[47] Skinner, M. L., Hong, S., Herrenkohl, T. I., Brown, E. C., Lee, J. O., & Jung, H. (2016). Longitudinal effects of early childhood maltreatment on co-occurring substance misuse and mental health problems in adulthood: The role of adolescent alcohol use and depression. *Journal of Studies on Alcohol and Drugs, 77*(3), 464–472. https://doi.org/10.15288/jsad.2016.77.464

[48] Abajobir, A. A., Kisely, S., Scott, J. G., Williams, G., Clavarino, A., Strathearn, L., & Najman, J. M. (2017). Childhood maltreatment and young adulthood hallucinations, delusional experiences, and psychosis: A longitudinal study. *Schizophrenia Bulletin, 43*(5), 1045–1055. https://doi.org/10.1093/schbul/sbw175

[49] Brunner, R., Parzer, P., Schuld, V., & Resch, F. (2000). Dissociative symptomatology and traumatogenic factors in adolescent psychiatric patients. *The Journal of Nervous and Mental Disease*, *188*(2), 71–77. https://doi.org/10.1097/00005053-200002000-00002

[50] Schalinski, I., & Teicher, M. H. (2015). Type and timing of childhood maltreatment and severity of shutdown dissociation in patients with schizophrenia spectrum disorder. *PLOS ONE, 10*(5), e0127151. https://doi.org/10.1371/journal.pone.0127151

[51] Teicher, M. H., & Vitaliano, G. D. (2011). Witnessing violence toward siblings: An understudied but potent form of early adversity. *PLoS ONE, 6*(12), e28852. https://doi.org/10.1371/journal.pone.0028852

[52] Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*(4), 661–671. https://doi.org/10.1093/schbul/sbs050

[53] Marchi, M., Elkrief, L., Alkema, A., van Gastel, W. Schubart, C. D., van Eijk, K. R., Luykx, J. J., Branje, S., Mastrotheodoros, S. Galeazzi, G., van Os, J., Cecil, C. A., Conrod, P. J., & Boks, M. P. (2022). Childhood maltreatment mediates the effect of the genetic background on psychosis risk in young adults. *Translational Psychiatry, 12*, 219. https://doi.org/10.1038/s41398-022-01975-1

[54] Egeland, B., Sroufe, L. A., & Erickson, M. (1983). The developmental consequences of different patterns of maltreatment. *Child Abuse & Neglect, 7*(4), 459–469. https://doi.org/10.1016/0145-2134(83)90053-4

[55] Bell, M. F., Bayliss, D. M., Glauert, R., & Ohan, J. L. (2018). School readiness of maltreated children: Associations of timing, type, and chronicity of maltreatment. *Child Abuse & Neglect, 76,* 426–439. https://doi.org/10.1016/j.chiabu.2017.12.001

[56] Colich, N. L., Rosen, M. L., Williams, E. S., & McLaughlin, K. A. (2020). Biological aging in childhood and adolescence following experiences of threat and deprivation: A systematic review and meta-analysis. *Psychological Bulletin*, *146*(9), 721–764. https://doi.org/10.1037/bul0000270

[57] Geoffroy, M. C., Pereira, S. P., Li, L., & Power, C. (2015, 2016). Child neglect and maltreatment and childhood-to-adulthood cognition and mental health in a prospective birth cohort. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*(1), 33–40/E3.

[58] Maclean, M. J., Taylor, C. L., & O'Donnell, M. (2016). Pre-existing adversity, level of child protection involvement, and school attendance predict educational outcomes in a longitudinal study. *Child Abuse & Neglect, 51*, 120–131. https://doi.org//10.1016/j.chiabu.2015.10.026

[59] Abajobir, A. A., Kisely, S., Williams, G., Strathearn, L., & Najman, J. M. (2017). Height deficit in early adulthood following substantiated childhood maltreatment: A birth cohort study. *Child Abuse & Neglect, 64*, 71–78. https://doi.org/10.1016/j.chiabu.2016.12.010

[60] Komoria, K., Komorib, M., Eitokua, M., Muchangaa, S. M. J., Ninomiyad, H., Kobayashib, T., Suganumaa, S., & the Japan Environment and Children's Study (JECS) Group. (2019). Verbal abuse during pregnancy increases frequency of newborn hearing screening referral: The Japan Environment and Children's Study. *Child Abuse & Neglect 90*, 193–201. https://doi.org/10.1016/j.chiabu.2019.01.025

[61] Caslini, M., Bartoli, F., Crocamo, C., Dakanalis, A., Clerici, M., & Carrà , G. (2016). Disentangling the association between child abuse and eating disorders: A systematic review and meta-analysis. *Psychological Medicine, 78*, 79–90. https://doi.org/10.1097/PSY.0000000000000233

[62] Gioia, F., Boursier, V., Franceschini, C., & Musetti, A. (2022). The effects of childhood emotional and physical maltreatment on adolescents' disordered eating behaviors: The mediating role of borderline personality features. *The Journal of Nervous and Mental Disease*, *210*(11), 831–837. https://doi.org/10.1097/nmd.000000000000155672

[63] Abajobir, A. A., Kisely, S., Williams, G., Strathearn, L., Suresh, S., & Najman, J. M. (2017). The association between substantiated childhood maltreatment, asthma, and lung function: A prospective investigation. *Journal of Psychosomatic Research, 101*, 58–65. https://doi.org/10.1016/j.jpsychores.2017.08.003

[64] Anto, M., Jaffee, S., Tietjen, G., Mendizabal, A., & Szperka, C. (2021). Adverse childhood experiences and frequent headache by adolescent self-report. *Pediatric Neurology, 121*, 51–55. https://doi.org/10.1016/j.pediatrneurol.2021.04.004

[65] Tietjen, G. E., Brandes, J. L., Peterlin, L., Eloff, A., Dafer, R. M., Stein, M. R., Drexler, E., Martin, V. T., Hutchinson, S., Auroroa, S. K., Recober, A., Herial, N. A., Utley, C., White, L., & Khuder, S. A. (2010). Childhood maltreatment and migraine (Part II). Emotional abuse as a risk factor for headache chronification. Headache, *Headache, 50*, 32–41 https://doi.org/10.1111/j.1526-4610.2009.01557.x

[66] Tietjen, G. E., Karmakar, M., & Amialchuck, A. A. (2017). Emotional abuse history and migraine among young adults: A retrospective cross-sectional analysis of the Add Health dataset. *Headache, 57*(1), 45–59. https://doi.org/10.111/head.12994

[67] American Professional Society on the Abuse of Children (2017, revised 2019). *Practice guidelines: The investigation and determination of suspected psychological maltreatment of children and adolescents*. https://apsac.org