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APSAC Monograph on Psychological Maltreatment (PM)

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The American Professional Society on the Abuse of Children (APSAC) “Monograph on Psychological Maltreatment (PM)” is a living document, always a “draft” to be upgraded periodically by the author team in cooperation with experts throughout the world. **Recommendations for strengthening the content and applications of the monograph are most welcome.*

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1 **Statement of Purpose***

2
3 This monograph provides essential information concerning the evolving state of
4 knowledge about psychological maltreatment (PM; also known as mental, emotional, and
5 psychological abuse; psychological and emotional neglect) and its assessment,
6 prevention, and intervention. Specific attention is given to factors that will help advance
7 the work of child protection professionals responsible for gathering information, carrying
8 out evaluations, making determinations, and formulating interventions for suspected PM.

9
10 This monograph is also intended to advance understanding, policies, and practices in
11 child custody determinations, judicial processes concerning the treatment of children, and
12 in the wide range of interventions by families, communities, and their agencies to assure
13 safety and good caregiving for children. Thus, the document offers a vision about the
14 treatment of children and how to respect their rights and promote their well-being. This is
15 consistent with the growing recognition in the United States and internationally that all
16 efforts to serve the best interests of children, including child protection, should be aimed
17 toward and contribute to securing and advancing their well-being.

18
19 The goal for child protection, therefore, should go beyond merely protecting children
20 from harm and extend to promoting wellness. Opportunities for deeper investigation of
21 topics by users of this monograph are made possible through extensive references and
22 appendices.

23
24 **SECTION 1.**
25 **PSYCHOLOGICAL MALTREATMENT:**
26 **DEFINITIONS AND SUBTYPES**

27
28 **Definitions and Forms of Psychological Maltreatment**

29 According to the federal Child Abuse Prevention and Treatment Act (CAPTA, 2010),
30 “*Child abuse and neglect*” means, at a minimum, “any recent act or failure to act on the
31 part of a parent or caretaker, which results in death, serious physical or emotional harm,
32 sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of
33 serious harm.” Child abuse and neglect, also referred to as child maltreatment, includes

* 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, 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 the other 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.

all forms of interpersonal violence against children by caregivers. There is no uniform legal definition of each type of child abuse, including psychological maltreatment (PM), across state child abuse statutes (Baker, 2009; Baker & Brassard, 2019) or in mandated reporter training (Baker & Roygardner, n.d.). State definitions are generally found in one or more of its civil or criminal statutes.

Psychological maltreatment is defined by us “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, and respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another’s needs, and/or expendable” (see Hart, Brassard, Baker, & Chiel, 2017, p. 147, for this quote and related material). The term *psychological*, instead of *emotional*, is used because it better incorporates the cognitive, affective, conative (involving volition; i.e., decision making, acts of will), and interpersonal aspects of this form of child maltreatment (Hart et al., 2011). However, the terms *psychological/emotional maltreatment*, *psychological/emotional abuse and neglect*, and *mental injury* will be used interchangeably throughout this monograph as studies and laws are reviewed.

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 *mental injury* or *emotional abuse*) refer to the impact on the child, not the caregiver acts that may have led to such a result. Some state definitions describe behavioral indicators that a child has been harmed, such as severe anxiety, depression, withdrawal, and aggressive behavior. Only a small number of state laws describe the specific parental behaviors that could cause such outcomes. Thus, legal definitions primarily apply a child-outcome approach and define *PM* as the resulting injury to the child's functioning, without necessarily specifying what caregiver behaviors cause it (Baker, 2009; Baker & Brassard, 2019). In contrast, in this monograph *PM* is defined as “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 as to the type of information that is useful in establishing harm.

The subtypes of *PM* presented here are intended to help professionals analyze cases and are complementary to legal and regulatory definitions of *PM* used in various jurisdictions. 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 subtype.

Table 1. Psychological Maltreatment Definition and Forms.

[†] The range of persons who psychologically maltreat children occurs beyond child caregivers through, for example, peer bullies who act face-to-face with the victim, indirectly through peer communities in schools and other venues, and through electronic social media. Programs of primary prevention, risk reduction, and correction/rehabilitation to overcome existing maltreatment must be successfully framed and implemented to deal with the full range of *PM* occurrence. This issue will be given deserved attention in the next edition of this monograph.

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.¹ 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 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
- (6) 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;²
- (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;
- (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: Hart, S. N., & Brassard, M. R. (1991/ 2001). **Revised Source:** Hart, Brassard, Baker, & Chiel (2019).

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.

The definition of *PM* presented in Table 1 has strong construct validity. Not only is it consistent with other definitions of *PM* (Baily & Baily, 1986; Barnett, Manley, & Cicchetti, 1993; Dunne et al., 2009; Garbarino, Guttman, & Seely, 1986; Glaser, 2002; Heyman & Slep, 2006; McGee & Wolfe, 1991; Sedlak et al., 2010) and cross-culturally valid (Dunne et al., 2009; Lansford & Deater-Deckard, 2012; Rohner, 2016; Rohner & Rohner, 1980) but it has also been used to reliably code both child protection records (Trickett, Mennen, Kim, & Sang, 2009) and the PM content of parent intervention programs (Baker, Brassard, Schneiderman, Donnelly, & Bahl, 2011).

Further, this definition is based on decades of research that documents the damage caused by forms of PM (for reviews see Brassard & Donovan, 2006; Donovan & Brassard, 2011; Hart, Binggelli, & Brassard, 1997; Hart et al., 2011; Rohner & Rohner, 1980; Wright, 2008). New studies, with findings consistent with previous research on the harmfulness of caregiver PM, continue to shed light on the effects of these forms, supporting their construct validity (e.g., Norman et al., 2012). For the history of the empirical identification of these forms, see Brassard and Donovan (2006) and Hart and Brassard (1991). 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 Brassard and Donovan (2006) and Glaser (2002).

SECTION 2. PSYCHOLOGICAL MALTREATMENT IN CONTEXT

1. Nature and Significance of Psychological Maltreatment

Humans are fundamentally psychosocial beings. It is primarily through social relationships and experiences that our basic needs are met, our capacities and identities are formed, and our well-being is promoted. Psychological maltreatment occurs within social interactions. It is expressed in various forms of abuse and neglect, which represent an attack on basic human need fulfillment and which limit, corrupt, distort, and damage

the child's development, functioning, relationships, and health. It is recognized that all forms of child maltreatment are an attack on basic need fulfillment and are insidious because they are most often perpetrated by people upon whom children are dependent and with whom children expect to be safe and supportive (e.g., parents, family, school personnel, peers, coaches, and mentors). In this regard, PM is especially damaging because (a) it promotes and establishes negative self-references (e.g., through messages that the child is unloved and unlovable) that are incorporated into the child's self-concept, (b) the child may develop negative expectations for interpersonal relationships as a consequence, (c) PM behaviors are likely to limit and corrupt social relationships and undermine essential support for well-being, and (d) it can operate continuously at low levels of intensity over the course of daily routines. In these ways, it can be a pervasive characteristic of and influence on the child's daily life, and it can negatively determine a child's developmental path.

2. Guiding Assumptions

The first guiding assumption is that while PM occurs alone, it often co-occurs with or is embedded in other forms, occurrences, and outcomes of child maltreatment. PM as a standalone form of maltreatment could be, for instance, when a parent demeans a child (spurning) without engaging in physical or sexual abuse or physical neglect. A co-occurrence of PM with other forms would be, for example, when a parent physically abuses a child while also making extreme degrading comments to the child. PM's standalone forms, described in Table 1, and their prevalence in the population are clarified in later sections.

While we believe strongly in clear operational definitions that distinguish between the various forms of child maltreatment, it is important to acknowledge that there is a psychological component to most acts of child maltreatment. The present state of knowledge demonstrates that it is the psychological memory and the meaning children make of their maltreatment experiences, including physical experiences (e.g., touch, pain), that are the basis for thoughts, feelings, and actions influencing the course of life (for related background and discussion, see Baddeley, Eysenck, & Anderson, 2014, Davidson, 2000; Lilienfield, Lynn, & Lohr, 2002; Loftus & Ketcham, 1994; Radvansky, 2010; Van der Kolk, McFarlane, & Weisaeth, 1996). In regard to the impact of the psychological meanings associated with physical abuse, it is illustrative to consider the difference between a child receiving a physical blow while playing a sport and having the same physical blow delivered by a parent as an expression of hatred or disgust. If the blow is accompanied simultaneously or previously by statements of derision and threat (e.g., "You deserve to be hit—you are such a rotten kid. You'll be hit like that again any time I feel like it."), the negative impact on the child will be even more powerful and longer lasting than the blow alone. Similarly, physical neglect communicates lack of worth and value, especially when the child compares himself or herself to better-nurtured children. In child sexual abuse, physical force and harm are rare, leaving the psychosocial factors as primary issues of significance (World Health Organization [WHO], 2003). Likewise, child sexual abuse is pervaded by psychological issues of abuse of power, broken trust, and corruption of values, identity, and worth (including exploitation to serve another's interests) and the shaping of developmentally inappropriate thinking, feeling,

1 and behavior. Negative inherent and associated meanings of victimization formed by the
2 child can be exacerbated by statements the perpetrator makes during the sexual abuse
3 (e.g., “This is all you’re good for,” “Here’s how you show you love someone”). It is
4 illustrative that, among the researched effects of sexual abuse, the condition most
5 commonly diagnosed is posttraumatic stress disorder (PTSD) as an interpersonal-trauma-
6 reactive mental health problem (Bahali, Akcan, Tahiroglu, & Avci, 2010). In summary,
7 based on research and expert opinion, it is reasonable to credit the embedded or
8 associated psychological maltreatment aspects of other forms abuse and neglect with
9 being the major contributors to the long-term detrimental effects of victimization.
10 Although the Effects of Psychological Maltreatment subsection in this monograph
11 clarifies the present state of knowledge regarding the particular harm contributions and
12 attributions of PM, continuing research will be needed to further establish the unique
13 outcomes of each of its forms as well as the contribution of each to outcomes when
14 accompanying and interacting with other forms of maltreatment.

15
16 **The second guiding assumption** is that PM is a complex, misunderstood, and often
17 ignored form of child maltreatment that must be directly addressed in child protection if
18 advances are to be made. In particular, because PM often co-occurs with other forms of
19 maltreatment, prevention and correction of other forms will likely be inadequate until the
20 PM components are recognized and fully addressed. For example, being physically
21 abused by a parent creates fear of the threat of future assault and degrades the child’s
22 sense of psychological safety and ability to rely on the parent for comfort and protection.
23 Getting a parent to stop beating a child does not address the co-occurring psychological
24 abuse and the damaged relationship. Until the parents can interact with their children in a
25 way that does not distort or thwart their psychological development, child protection will
26 not be truly or fully achieved.

27
28 **The third guiding assumption** is that preventing PM can advance child protection
29 toward the highly desirable and recommended promotion of good child caregiving and
30 primary prevention (Fiorvanti & Brassard, 2014; Hart & Glaser, 2011; Hart, Lee, &
31 Wernham, 2011). This is particularly important given the limited evidence for
32 intervention effectiveness in modifying the behavior of at-risk and abusive parents. While
33 there are some promising parenting programs, results have been mostly in the areas of
34 reducing risk for abuse rather than in changing established parenting behaviors.
35 Obviously, there is much work to be done and primary prevention seems much more
36 likely to be successful in the long run than tertiary interventions (for recent meta-analyses
37 see Chen & Chan, 2016; Euser, Alink, Stoltenborgh, Bakermans-Kranenburg, & van
38 IJzendoorn, 2015; Lundahl, Nimer, & Parsons, 2006; MacMillan, Wathen, Fergusson,
39 Leventhal, & Taussig, 2009).

40 41 **3. Theoretical Perspectives**

42
43 Most major theories of human development that have relevance for psychosocial
44 functioning inform and are informed by knowledge of PM (Hart et al., 2011). Next, some
45 of the theoretical perspectives of particular relevance for PM are very briefly described.
46

1 **Human needs theory.** Abraham Maslow's (1970) theory of human needs construction
2 has continued to influence and illuminate research and practice regarding the essentials of
3 well-being, happiness, satisfaction (Ryan & Deci, 2000; Sheldon, Elliot, Kim, & Kasser,
4 2001), and resilience (Bernard, n.d.; Ungar, Ghazinour, & Richter, 2013; Werner &
5 Smith, 1992). It postulates basic needs (i.e., physiological, safety, love and belonging,
6 and esteem) and growth needs (i.e., aesthetic and cognitive knowledge, self-actualization)
7 that resonate with our personal and shared understandings of meaning in life. Arguably,
8 the power of PM is in large part due to the fact that it represents direct and indirect
9 assaults on and frustrates human need fulfillment. As an example, terrorizing is an attack
10 on safety needs, and when perpetrated by a caregiver, it limits and degrades fulfillment of
11 love and belonging and esteem needs.

12
13 **Psychosocial stage theory.** Erik Erikson's (1993; Erikson & Erikson, 1998) conception
14 of human development stages continues to provide a fundamental orientation to critical
15 issues of development (i.e., trust vs. mistrust, birth–2 years; autonomy vs. shame and
16 doubt, 2–3 years; initiative vs. guilt, 3–6 years; industry vs. inferiority, 6–12 years; and
17 identity vs. identity confusion, 12–18 years). Success or failure at any stage may promote
18 or interfere with establishment of critical orientations, competencies, and characteristics
19 at that stage and those beyond. For example, a 1-year-old ignored when distressed or
20 subjected to chaotic and threatening caregiver behavior is likely to mistrust the most
21 powerful people in his or her life and to retreat from the risk of pursuing opportunities for
22 autonomy at the next stage.

23
24 **Attachment theory.** The early personal and interpersonal life of the infant and toddler is
25 formed through the interactions/relationships with and attachment to primary caregivers
26 (Ainsworth, 1969, 1989; Bowlby, 1973, 1980, 1982, 1988; Sroufe, 1979). Attachment
27 theory has framed this conceptualization and, with associated research support, has
28 argued that the emotional health and interpersonal functioning of the child, short and long
29 term, are strongly influenced by the quality of the early caregiver-child attachment
30 relationship (see Levy, Meehan, Temes, & Yeomans, 2012, for recent overview). Parents
31 whose responsiveness is contingent, sensitive, and supportive engender a "secure base"
32 of attachment, but psychologically unavailable, hostile rejecting, threateningly chaotic,
33 and unpredictable caregiving is likely to produce children with an avoidant, anxious-
34 ambivalent, or disorganized attachment (Levy et al., 2012). Insecure attachment,
35 especially disorganized attachment, is linked with less optimal adaptation across the
36 lifespan (Cry, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Kochanska &
37 Kim, 2013; Pascuzzo, Moss, & Cyr, 2015).

38
39 **Interpersonal acceptance-rejection theory (IPARTheory).** Rohner and Rohner (1980),
40 in proposing an earlier version of this theory, were among the very first researchers and
41 theorists to knowingly give specific attention to PM. In this theory, "acceptance" includes
42 parental warmth, affection, comfort, care, and nurturance. "Rejection" is expressed in all
43 forms of physical, sexual, and psychological abuse and neglect. Rejection includes both
44 emotional abuse in the forms of parental hostility, aggression, and love withdrawal, as
45 well as emotional neglect in the forms of indifference and the absence of positive
46 behaviors inherent in acceptance (Rohner, 2016). Rejection is related to many child
47 development problems (Hart et al., 1997; Rohner, 2016; Rohner & Rohner, 1980).

Learned helplessness theory. When a human being (or animal) experiences repeated instances of pain, aversive stimuli, or threat in conditions that appear to deny escape, “learned helplessness”—nonresponsive giving up and giving in—may develop and be employed for similar and more general situations. Research originating in the work of Seligman (1972) and by others (e.g., Cole & Coyne, 1977; Hiroto & Seligman, 1975; Peterson & Park, 1998) has established learned helplessness as a viable theory with multiple implications for human development, behavior, and related interventions. Weiner (1986) has produced an attributional conceptualization for learned helplessness, including global-specific, stable-unstable, and internal-external dimensions. Negative physical and mental health outcomes, including depression, have been related to learned helplessness. All forms of PM have the potential to produce learned helplessness because the child is generally dependent on the parent/caregiver and unable to escape the relationship.

4. Prevalence and Incidence

Of all forms of violence[‡] (i.e., maltreatment) against children, PM has the highest levels of incidence and prevalence because it occurs not only in discrete standalone forms but also frequently co-occurs with every other type of maltreatment (see Rady Children’s Hospital, 2012; Vachon, Krueger, Rogosch, & Cicchetti, 2015).

Historically, there have been resistance and reluctance on the part of both the lay public and mental health professionals to recognize PM, which has resulted in difficulty assessing incidence and prevalence. There are several possible factors that contribute to this. It has been argued (e.g., personal email communication, Jody Todd Manly, 6/22/18) that the lack of sufficiently clear demarcation between poor parenting and PM is the “driving factor.” Related to this issue, to greater or lesser degrees, is the likely concern of many persons that if PM were recognized, they would be vulnerable to findings of guilt, resulting in having their children taken from them or being harshly judged by others, or both (see Heyman & Slep, 2009, for exposition; and see Appendix G for guidance in discriminating among good, poor, and emotionally/psychologically abusive/neglectful parenting, Wolfe & McIssac, 2011). Another contributor to denial of PM is the unwillingness or discomfort that could result from labeling one’s own parents, relatives, or close associates as abusive. Additionally, some persons consider parenting strategies that ignore children and their expressed needs, or treat them sternly or roughly, and that may border on or be maltreatment, to be necessary to prepare children to be tough and self-sufficient, that is, able to function in the real world. Also, because PM generally does not involve easily identifiable physical actions or physical wounds as may occur with other types of maltreatment, PM is harder to see, both literally and figuratively. And finally, because most U.S. state statutes focus on mental injury or harm to the child in their definition of PM and omit reference to parental behaviors that are known to cause harm, it can be difficult for case workers to causally link caregiver behavior to mental injury.

[‡] “Violence” in this Monograph is intended to cover all forms of child abuse and neglect or maltreatment in accord with its use in the *U.N. Convention on the Rights of the Child* and in its relevant guiding *General Comment 13*.

1 Most research on the occurrence of PM—and child maltreatment broadly—focuses on
2 incidence: that is, how many new cases occur in a given year. Incidence data are
3 beneficial as they suggest the possibilities for prevention in a given period. The most
4 recent National Incidence Study of Child Abuse and Neglect (i.e., NIS cases known to
5 mandated reporters located in the community) reports incidence rates for emotional
6 abuse and neglect to be 4.1 and 15.9, respectively, per 1,000 children using the
7 endangerment standard (Sedlak et al., 2010). In regard to incidence data, it is important to
8 recognize that these cases underestimate the pervasive presence of psychological
9 maltreatment in a population because the NIS data only represent new cases each year.
10 Given the effects of chronic patterns and the lasting impact of PM on a person's
11 development, it is necessary to consider lifetime prevalence when developing preventive
12 and corrective interventions. However, even prevalence measures are susceptible to
13 underestimation because of under-reporting due to several possible factors. For example,
14 families who refuse participation in phone surveys may have higher rates of
15 maltreatment, survey respondents may not disclose all incidents, and there is likely a
16 failure to recognize PM when occurring with other forms of child maltreatment
17 (Finkelhor, Turner, Shattuck, & Hamby, 2013). Nonetheless, prevalence rates tend to be
18 better estimates of the extent of the problem than incidence.

19 Findings from a recent nationally representative community sample telephone survey
20 indicate a self-reported lifetime prevalence of nearly 26% for emotional abuse—the most
21 prevalent form of child maltreatment as measured by the survey (Finkelhor et al., 2013).
22 In a meta-analysis of 65 studies of adult recall of childhood psychological maltreatment
23 using the gold standard measure, the *Childhood Trauma Questionnaire* (CTQ,
24 Pennebaker & Susman, 2013), Baker and Maiorino (2010) found that approximately 15%
25 of the participants in community samples and 32% in clinical samples had emotional
26 abuse scores at the highest threshold, while approximately 13% of participants in
27 community samples and 19% of participants in clinical samples had emotional neglect
28 scores at the highest threshold. In other studies, self-report data reveal the rate of lifetime
29 psychological maltreatment ranges from 13% to 25% in community samples and 19% to
30 32% in clinical samples, with rates varying depending upon the measure used. A meta-
31 analysis of studies on reports of PM included 46 independent nonclinical samples with
32 over 7 million participants around the world (but predominately in wealthy countries).
33 The authors found an estimated prevalence of 3 in 1000 when informants (i.e.,
34 professionals) reported cases and 363 in 1000 when self-reports were used (Stoltenborgh,
35 Bakermans-Kranenburg, & Ijzendoorn, 2013).

36
37 Clearly, a marked difference exists between self-report and informant prevalence rates,
38 which highlights the challenge in reporting and identifying PM. Informant incidence data
39 appear to underestimate the prevalence by including only the relatively small number of
40 cases that are brought to the attention of police or child protection agencies. In contrast,
41 self-report prevalence data result in higher rates of PM. Though studies suggest that
42 informant-based data tend to underestimate, and self-report studies may overestimate
43 (perhaps due to people labeling isolated incidents as abuse, rather than a chronic pattern
44 of maladaptive interactions), there is a clear problem with the under identification of PM
45 through child protection agencies and in the public eye. In light of discrepancies in
46 definitions and samples used across studies as well as probable underreporting, the
47 prevalence rates estimated from *APSAC Study Guides 4: Psychological Maltreatment of*

1 *Children* (Binggeli, Hart, & Brassard, 2001) continue to be relevant and probably the best
2 available. Therefore, it is reasonable to estimate that between 10% and 30% of
3 community samples experience moderate levels of PM in their lifetime and from 10% to
4 15% of all people (community and clinical samples) have experienced the more severe
5 and chronic forms of this maltreatment (p. 51).

6 7 **5. Effects of Psychological Maltreatment:[§] Impact and Consequences**

8
9 The evolving knowledge base of the known and probable impact and consequences of
10 psychological maltreatment is presently much stronger than generally recognized.
11 In this section, the argument is made that child maltreatment intervention priorities,
12 standards, and systems inadequately appreciate the effects of PM; a sampling of major
13 research markers establishing the seriousness of PM consequences is presented; the
14 emerging case for causality is introduced; and enlightening findings are organized as to
15 their relevance within the broadly applicable framework of the federal (U.S.) Individuals
16 with Disabilities Act as Amended (IDEA).

17 18 **PM's Representation in U.S. State Standards**

19
20 A review of U.S. state statutes makes it is clear that some forms of child maltreatment
21 (CM) are considered more harmful than others. Assumptions about harmfulness can be
22 determined by (a) whether a form is included in a states' child abuse statute, (b) how
23 clearly the relevant caregiver behavior is defined, (c) if harm to the child is assumed or if
24 evidence of harm must be demonstrated to substantiate a case, (d) who is tasked with
25 investigating a screened-in report—child protective services (CPS) alone or with the
26 police, and (e) the consequences to the perpetrator should an allegation be confirmed.

27
28 Using these criteria for seriousness, it is clear that child sexual abuse is considered the
29 most harmful form of CM. Sexual abuse is in all state statutes; caregiver behaviors are
30 clearly described and often in great detail; if caregiver behavior is present, harm to the
31 child is assumed; sexual abuse is investigated by child protective services *and* the police;
32 if substantiated, it is tried in criminal court as a felony; and, if convicted, the caregiver
33 goes to jail and is often listed on a searchable sex offender website and subject to many
34 restrictions and a great deal of stigma.

35
36 Physical abuse is ranked second in seriousness. It is in all state statutes and caregiver
37 behavior is clearly and consistently defined, but harm is not always assumed; further,
38 many states require tissue damage (e.g., bruises, burns or fractures) to substantiate a case

[§] This section of the Monograph draws on the United States (federal) Individuals with Disabilities Act as Amended (IDEA), commonly known as IDEA (see code of federal regulations). This definition incorporates psychological criteria for (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 Association's Diagnostic and Statistical Manual(s) of Mental Disorders* (i.e., DSM-IV-TR; DSM-V) useful to guide determinations of extant or predicted harm related to psychological maltreatment.

1 as physical abuse. It is investigated by CPS unless physical injuries are quite severe or
2 fatal, which triggers police involvement and can result in a felony conviction.

3
4 Using these criteria, neglect is ranked somewhat higher than PM. It is in all state statutes,
5 but the clarity of definitions varies greatly, some including only physical neglect and
6 others including also emotional, supervisory, and educational neglect. Harm is sometimes
7 assumed (e.g., leaving a young child without supervision, leaving child in the care of a
8 sex offender or violent individual) because of the immediate risk of harm, but evidence of
9 harm may be required for more delayed threats to the child's well-being (e.g., ill health
10 left untreated, emotional neglect in the context of adequate physical care). Neglect is
11 investigated by CPS unless it results in a child fatality, and then the police may become
12 involved. The National Incidence Study-4 (Sedlak et al., 2010) found neglect the least
13 reported form by sentinels (qualifying staff from a wide variety of agencies and
14 organizations) aware of its existence. This may indicate that sentinels take it less
15 seriously than other forms of child maltreatment or may take it seriously but have less
16 expectation that it will be effectively addressed if reported.

17
18 While 44 U.S. states include PM in state statutes, PM is not mentioned in the statutes of
19 six states under any of its names or behavioral descriptions (i.e., emotional abuse). States
20 including PM define it variously but often minimally as "mental cruelty" or "emotional
21 harm" with both the caregiver behavior and the harm undefined (Baker & Brassard,
22 2019). Harm is required in most states to substantiate the case and PM is investigated
23 only by CPS.

24
25 Does research support this ranking of CM forms based on harmfulness to the child? In
26 this section we make a strong argument that the answer is no. A critical review of the
27 extensive and growing research literature shows that PM is at least equivalent in harm
28 and in some instances, worse than other forms of CM. The following examples are
29 representative of findings in this review.

30 31 **Major Research Markers Establishing PM's Impact**

32
33 The publication of the *Adverse Childhood Experiences Study* (ACE Study; Felitti et al.,
34 1998) and subsequent publications using this data set, have had immense influence on
35 how seriously child maltreatment is taken by scholars, the health care system, and policy
36 makers in the United States and around the world. The original ACE study of 13,000+
37 adult members of the Kaiser Health Plan in San Diego tied the retrospective report of
38 four forms of child maltreatment (emotional, sexual, and physical abuse and battered
39 mother) and three characteristics of household dysfunction (household substance abuse,
40 household mental illness, incarcerated household member) to a myriad of problems.
41 Related problems included most of the leading causes of death in adults (e.g., ischemic
42 heart disease, cancer), reproductive behavior issues (age of sexual debut, promiscuity,
43 unintended pregnancy, sexually transmitted diseases, father involvement in pregnancy),
44 smoking and early smoking onset, substance abuse (alcoholism, drug abuse), mental
45 health problems (depression, suicide attempts, anxiety, sleep disturbances), general health
46 and social problems (e.g., perpetrating or being a victim of domestic violence), and in
47 later follow-ups, prescription medication use, diseases, and mortality (Anda, Butchart,

1 Felitti, & Brown, 2010; Anda et al., 2007; Anda et al., 1999; Brown et al., 2009; Dietz et
2 al., 1999; Dube et al., 2001; Felitti et al., 1998; Hillis, Anda, Felitti, Nordenberg, &
3 Marchbanks, 2000). Researchers found that each of the seven ACEs conferred increased
4 risk of adverse outcomes over no ACE and there was a dose-response relationship in that
5 more reported adverse childhood events predicted more adverse health outcomes,
6 particularly for those reporting four or more adverse childhood events. They
7 demonstrated that changes in society and life events experienced by birth cohorts (e.g.,
8 living through the Great Depression, the change in woman's rights and work roles) did
9 not reduce or increase the impact of the ACEs by examining four age cohorts with birth
10 dates back to 1900 (Dube et al., 2003).

11
12 The ACE questionnaire and adaptations of it have been used in many studies around the
13 world, replicating and extending the original findings. Some of these studies have been
14 implemented by governments as seen in the Behavioral Risk Factor Surveillance System
15 (BRFSS) surveys conducted by the Centers for Disease Control (CDC), the health
16 departments of five U.S. states (e.g., Campbell, Walker, & Egede, 2016; Font &
17 Maguire-Jack, 2016), and by the World Health Organization (WHO) World Mental
18 Health Surveys administered by countries representing low-, middle-, and high-resource
19 contexts (e.g., Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014; Kessler et al., 2010).

20
21 There are many independent studies of adults using a similar format to that of the ACE
22 study. For example, there are cross-sectional studies linking lifetime ACEs to mental
23 health and health functioning (e.g., Poole, Dobson, & Pusch, 2017), nationally
24 representative samples looking at adults who retrospectively recall ACEs and are
25 administered diagnostic face-to-face interviews (e.g., Harford, Yi, & Grant, 2014), as
26 well as long-term prospective studies following individuals from childhood. The latter are
27 given an ACE questionnaire in adulthood, after which adult outcomes are assessed in a
28 later wave (e.g., Anderson et al., 2018). These studies have found significant independent
29 effects for emotional abuse and neglect.

30
31 Using a design similar to the ACE study, there are many surveys of teens in community
32 and clinical populations asking about current and lifetime child maltreatment and other
33 adversities and assessing current psychopathology or school functioning via either self-
34 report (e.g., Hagborg, Berglund, & Fahlke, 2018; Li et al., 2014) or the clinical
35 assessment/placement setting (e.g., in substance abuse treatment or detention; Cecil,
36 Viding, Fearon, Glaser, & McCrory, 2017; Vahl, van Damme, Doreleitjers, Vermeiren, &
37 Collins, 2016). Some of these studies follow teens into young adulthood (Cohen, Menon,
38 Shorey, Le, & Temple, 2017). They show significant independent effects for emotional
39 abuse and emotional neglect.

40
41 The ACE study program established emotional abuse (i.e., PM) as a significant adverse
42 childhood experience on the same level as physical and sexual abuse and disruptive
43 household experiences in predicting adverse outcomes (Anda et al., 1999). This occurred
44 in the original study, which included only two to three items assessing spurning and
45 terrorizing (e.g., "how often did a parent, stepparent, or adult in the home swear at you,
46 insult you, or put you down?", "how often did a parent, stepparent, or adult in the home
47 act in a way that made you afraid that you would be physically hurt?"). Emotional abuse

1 had the highest odds ratio among the ACEs for depression and lifetime attempted suicide
2 (Dube et al., 2001) and was one of the three highest relative risk ratios for unintended
3 pregnancy (along with physical abuse and mother battering; Dietz et al., 1999).
4 (Witnessing domestic violence is considered PM in the Hart et al., 2019 definition
5 presented in Table 1.) Further, treated as a family climate variable, emotional abuse
6 interacted significantly with other forms of child maltreatment to enhance risk and was
7 related to increased risk as a sole variable as well (Edwards, Felitti, Holden, & Anda,
8 2003).

10 The BRFSS survey (Campbell et al., 2016) found that emotional/verbal abuse and sexual
11 abuse “were the two ACE components that independently affected most of the outcomes
12 investigated in this study, including smoking, risky HIV behavior, obesity, diabetes,
13 coronary heart disease, depression, and disability caused by poor health. This suggests
14 that individual ACE components may exert their effects on risky behaviors and outcomes
15 through different mechanisms” (p. 350). Emotional/verbal abuse also had an independent
16 effect on binge drinking. Unfortunately, emotional abuse was dropped from the WHO
17 ACE survey to make room for items of interest to low- and middle-resource countries
18 (Anda et al., 2010; Kessler et al., 2010).

20 The ACE and ACE-related studies brought significantly increased attention to PM as an
21 important adversity but the methodology of retrospective recall of maltreatment has
22 limitations that may bias findings. A recent systematic review and meta-analysis of 16
23 unique studies with both prospective and retrospective measures of maltreatment found
24 that agreement between the two was poor (Baldwin, Reuben, Newbury, & Danese, 2019).
25 Agreement was higher when the retrospective measure was an interview but type of
26 prospective measure, age at retrospective report, study quality, and sex distribution of the
27 sample did not affect the level of agreement. While there is no guarantee that
28 contemporary evidence of maltreatment is free from errors of omission or commission
29 (see Kobulsky, Kepple, & Jedwab, 2018 for a good discussion of these issues), the
30 research and clinical communities need to be aware that retrospective recall often does
31 not match contemporary evidence of maltreatment. Widom’s (2019) summary is quite
32 cogent:

33 From a scientific perspective, cross-sectional studies based on
34 retrospective reports cannot demonstrate that childhood adversities
35 cause particular outcomes. From a clinical perspective,
36 these new findings do not negate the importance of listening
37 to what a patient says, but they suggest that caution
38 should be used in assuming that these retrospective reports
39 accurately represent experiences, rather than perceptions, interpretations,
40 or existential recollections. (p. 568)

42 **The Case for Causality**

44 The ACE Study has clearly established a strong, consistent, graded relationship between
45 the number of ACEs and adverse health and mental health outcomes (see Anda et al.,
46 2010 for a listing of all of the health-related variables and conditions). However,
47 correlations alone do not establish causality. The ACE Study is retrospective in the

1 assessment of child maltreatment and household dysfunction, omits some important
2 childhood adversities (e.g., physical and emotional neglect), and uses self-report to assess
3 current and lifetime health problems in most of the studies (e.g., Anda et al., 1999;
4 Edwards et al., 2003; Felitti et al., 1998), but not all (Anda et al., 2007; Brown et al.,
5 2009).

6
7 The ACE authors argue that many of Hill's criteria (Hill, 2015) for causality have been
8 met in tying child maltreatment to adverse outcomes (Anda, Felitti, & Bremner, 2006). In
9 making their case, they call on a large body of converging evidence from neurobiology
10 and epidemiology and highlight findings from prospective studies that have measured
11 child maltreatment in childhood (through observations, parent interviews, or CPS
12 reports/substantiations) and adverse effects at later points in time, controlling for
13 potentially confounding factors. Not all of these prospective studies have assessed all
14 forms of child maltreatment, especially older studies. An example is Widom and
15 colleagues' well-known longitudinal study of individuals substantiated for physical and
16 sexual abuse and neglect (Widom, Czaja, Bentley, & Johnson, 2012), which did not
17 include consideration of PM. Prospective studies that have included PM have found
18 significant effects for emotional abuse and emotional neglect consistent with the ACEs
19 study and those using a similar research design. Such studies are described in the section
20 that follows.

21
22 Many factors influence the specific effects of PM on a given child. A child's age or
23 developmental period, or both, may make a child more or less vulnerable to PM. A
24 child's genetic sensitivity to the psychosocial environment (good and bad) makes the
25 child more or less likely to suffer harm from PM than other children, including siblings
26 (Belsky & Pluess, 2013). Children also differ in the degree to which they experience
27 other ACEs or conditions that may intensify the effects of PM (e.g., violent
28 neighborhoods, poor peer relationships) or may counteract PM (e.g., caring and
29 competent teachers, strong learning ability; see for example, Lynch & Cicchetti, 1992;
30 Marriott, Hamilton-Giachritsis, & Harrop, 2014).

31
32 While each child's experience is unique, the research literature is extensive and highly
33 consistent in demonstrating significant correlations between negative child outcomes
34 and the forms of PM listed in Table 1. Across studies, the effects of PM have been
35 found to be immediate and long term as well as broad and narrow in nature. Because
36 these outcomes are found internationally, in both community and clinical samples; in
37 correlational, prospective, and retrospective longitudinal research; in natural experiments;
38 as well as in clinician and biographical accounts, very strong evidence establishes that the
39 damaging correlates or consequences of PM are common among those who experience it
40 and are not limited to particular subgroups.

41
42 Without unethical experimentation, causal relationships cannot be demonstrated
43 unequivocally. However, the literature is approaching the level of evidence needed to
44 indicate a causal link between CM (including PM) and adverse outcomes. Criteria for
45 establishing causation include the strength and consistency of a relationship, specificity
46 of effect, a clear temporal sequence of experienced condition and adverse effect, a dose-
47 response curve, plausibility, well-developed theoretical models of the mechanisms

involved, and the ruling out of all other explanations (Hardy et al., 2016; Hill, 2015; Schaefer et al., 2017). It is the ruling out of other explanations that has proven the most challenging; child maltreatment co-occurs with other adversities and genes influence exposure to adverse environments. This makes genetically sensitive prospective observations studies particularly valuable in efforts to evaluate causality.

One of most powerful studies addressing the issue of causality between childhood victimization (including PM) and adult psychopathology is by Schaefer et al. (2017). They used the genetically informed Environmental Risk (E-Risk) Longitudinal Twin Study of a 2,232 English and Welch same-sex twins born 1994–1995. Representative of United Kingdom newborns in 1990, a little over half of the sample were monozygotic (MZ) twins and half were female. The twins and their parents were interviewed separately at ages 5, 7, 10, 12, and 18 with each co-twin having his or her own interviewer. At each visit, exposure to forms of maltreatment was assessed but emotional abuse and neglect were only assessed at age 18 when youth were asked about poly-victimization since the age of 12 (in addition to maltreatment, this included peer/sibling abuse, crime victimization, and Internet/mobile phone victimization). Harm was defined as internalizing, externalizing, and thought-disorder scores on the *Achenbach System of Empirically Based Assessment* (ASEBA; Achenbach, 2009) as rated by mothers and a teacher. The authors addressed this question: Does victimization in adolescence predict early adult psychopathology controlling for victimization prior to age 12? The answer was “yes.”

Victimization in adolescence predicted increases in psychopathology controlling for pre-existing psychopathology at earlier ages. Co-twin and parent reports of an individual’s victimization history produced the same results, so results were not due to same source bias. The effects of victimization were nonspecific; each type of victimization significantly raised the risk of any type of psychopathology. Child maltreatment (including PM) was more predictive of adverse outcomes than the other types of victimization. There were no consistent patterns of sex differences. Importantly, while MZ twins were more highly correlated in their victimization experiences than dizygotic (DZ) twins, suggesting genetic effects on environmental exposures, twins (both MZ and DZ) discordant for victimization differed significantly in their degrees of psychopathology—the exposed twin had more psychopathology at age 18. This indicated that the association between victimization and psychopathology “could not be fully explained by shared family-wide environmental factors or genetic factors, suggesting the possibility of an environmentally mediated pathway from greater victimization exposure in adolescence to more psychiatric symptoms in early adulthood” (Achenbach, 2009, p. 363). Because of an insufficient number of twins discordant for victimization, they could not test for which specific types of victimization predicted early-adult psychopathology independent of shared family-wide and genetic risk factors.

Domains of Effects

Research that has specifically examined the effects of various forms of PM has linked consequences of PM (i.e., harm) to five broad areas (for reviews see Glaser, 2011; Hart et al., 2017; Wright, 2008). The five areas of harm are derived from the definition of

emotional disturbance in the United States Individuals with Disabilities Education Act (2004). This definition incorporates psychological criteria for major mental disorders and interpersonal, cognitive, emotional, and behavior problems. Professionals assessing children for the possible effects of PM will find the IDEA definition of emotional disturbance particularly useful in guiding determinations of predicted or extant harm related to PM. Application of these definitions can be complemented by consideration of the standards included in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual(s) of Mental Disorders* (i.e., DSM-IV, APA, 1994; DSM-5, APA, 2013).

The IDEA framework** for harm includes the following five categories for which representative research findings are provided to illustrate the range and quality of research support for the form of psychological maltreatment that falls within each category:

i. Problems of intrapersonal (within the individual) thoughts, feelings, and behaviors, such as a general pervasive mood of unhappiness or depression, anxiety, negative self-concept, and negative cognitive styles that increase susceptibility to depression and suicidal thoughts and behaviors (e.g., pessimism, self-criticism, catastrophic thinking, immature defenses).

The link between PM and depression, negative cognitive style, and self-harm is particularly strong, but much of the evidence is based on retrospective recall of maltreatment. For example, the Adverse Childhood Experiences Study (ACE Study; Chapman et al., 2004) found that “childhood emotional abuse posed the greatest risk of the ACEs for both a lifetime history of depressive disorders and recent depressive disorders” (p. 221) with adjusted odds ratios of 2.5 to 3.3 times for men, respectively, and 2.7 to 3.1 times for women.

Depression often evolves out of negative cognitive styles. Van Harmelen, de Jong, Glashouwer, Spinhoven, Penninx, & Elzinga (2010), using the Netherlands Study of Depression and Anxiety (NESDA) (N = 2,981), found that child abuse was associated with negative explicit and automatic self-associations. When compared with child sexual and physical abuse, child emotional maltreatment had the strongest link, and mediated the relationship between child abuse and negative self-association. The same research group found that after controlling for comorbidity (lifetime DSM-IV diagnoses) and clustering of adversities, childhood adversities retrospectively recalled predicted affective disorders better than lifetime negative events (Spinhoven et al., 2010). Emotional neglect was the most powerful predictive form of the childhood adversities and was associated specifically with diagnoses of depressive disorder and social phobia. Moreover, Paterniti, Sterner, Caldwell, and Bisserbe (2017) found that childhood emotional neglect, retrospectively recalled, predicted depression recurrence in a followed sample of patients (N = 238) at a mood disorders clinic.

**As an alternative framework, findings of impact for PM could be organized to fall under *intrapersonal*, *interpersonal*, *learning*, and *health* fields with relevant behavioral expressions respected within those fields. This could reduce confusion that might result from some overlap of these fields across IDEA domains.

1 Norman and colleagues (2012) conducted a systematic review and exhaustive meta-
2 analysis of the international literature on the long-term health consequences of nonsexual
3 forms of child maltreatment in which they included only those studies that measured each
4 form of maltreatment separately. Of the 124 high-quality studies they identified, only 16
5 prospectively identified child maltreatment, the rest obtained cross-sectional reports or
6 asked participants to retrospectively recall their maltreatment experiences. Prospective
7 and retrospective studies were generally consistent in their findings. The authors reported
8 robust evidence that child emotional abuse may be *causally related* (the author's term) to
9 depressive disorders, anxiety disorders, and suicide attempts, approximately doubling the
10 risk for adverse mental health outcomes when mediating variables are taken into
11 consideration.

12
13 As shown in the Norman et al. (2012) review, there is a strong link between child
14 maltreatment and suicidality. There is emerging evidence that this link is causal. Using
15 the E-Risk sample, Baldwin et al. (2019) found that each additional exposure to
16 victimization doubled the odds that “adolescents would experience suicidal thoughts and
17 self-harm and tripled the odds of attempting suicide—and was consistent across different
18 informants and victimization types.” The authors concluded that victimization was
19 “likely a causal factor in suicidal ideation and self-harm” (p. 512) but that family-wide
20 genetic vulnerabilities (e.g., poor emotion regulation, impulsivity) and unsupportive
21 environments also played a major role.

22
23 Other studies link PM with suicidal behavior and non-suicidal self-injury (NSSI). A
24 recent meta-analysis of 15 high-quality international studies using concurrent or
25 retrospective recall of child maltreatment (Liu et al., 2017) found that suicidal behavior
26 and childhood abuse were closely linked both in the total population and in clinical
27 groups. Emotional abuse had the strongest effect among the five subtypes of child
28 maltreatment (it more than doubled the risk), and the effect was strongest in the chronic
29 schizophrenic patients. Using a sample of 5,616 children (average age 11–12 years) with
30 a lifetime history of exposure to maltreatment out of the 14,088 children in the National
31 Child Traumatic Stress Network Core Data Set, Spinazzola et al. (2014) found that
32 children with emotional abuse and neglect exhibited significantly greater baseline
33 problems in the area of internalizing disorders than the other forms of maltreatment,
34 separately and combined. It was the strongest and the most consistent predictor of
35 depression, generalized anxiety disorder, social anxiety disorders, and attachment
36 problems. In a large epidemiological sample of over 14,000 mainland Chinese
37 adolescents from four major regions of the country, all forms of maltreatment were
38 associated with significantly higher risk of non-suicidal self-injury (2.5 to 4 times
39 higher), but when entered simultaneously, physical abuse, emotional abuse, and sexual
40 abuse remained significant (Wan, Chen, Sun, & Tao, 2015). With a much smaller sample
41 of U.S. undergraduates, Croyle and Waltz (2007) found only child emotional abuse and
42 not child sexual or physical abuse, related to NSSIs.

43
44 Justified by the strong cross-sectional relationship between PM and anxiety in two large
45 national samples, one of community high-school students in Kuwait (Al-Fayez, Ohaeri,
46 & Gado, 2012) and one of a child welfare sample in Canada (Tonmyr, Williams,
47 Hovdestad, & Draca, 2011), Banducci, Lejuez, Dougherty, and MacPherson (2017)

prospectively examined the relationship between emotional abuse and anxiety to see if it was moderated by distress tolerance. A sample of over 200 community youth was assessed annually for 5 years with an anxiety measure, the emotional abuse scale of the Childhood Trauma Questionnaire, and a computerized distress tolerance task. They found that youth reporting high levels of PM at baseline also reported high anxiety at baseline and at each subsequent time point. Low-distress tolerance at baseline was associated with greater anxiety but did not predict changes in anxiety over time. Baseline distress tolerance moderated the relationship between childhood emotional abuse and anxiety. Youth with higher emotional abuse and lower distress tolerance had the highest anxiety at each yearly assessment, and they had the highest anxiety symptoms across time. The study illustrated the role PM may play in increasing the odds of chronic anxiety symptoms and identified a target for intervention: increasing tolerance for dysphoric affect.

The strong link of PM to internalizing disorders may result in part from PM's influence on differential brain functioning in ways that are related to increased psychopathology. Looking at a subsample of adults reporting childhood PM, the Netherlands group found a PM-related, reduced medial-prefrontal-cortex volume in a system centrally involved in cognitive and emotional memory processing (van Harmelen, van Tol, van der Wee, Veltman, Aleman, Spinhoven, . . . Elzinga, 2010), hyperactive amygdala responses to emotional face processing (van Harmelen et al., 2013), and hypoactive medial prefrontal cortex functioning. This is interpreted to strongly suggest, along with much other work, that PM "may increase an individual's risk for the development of psychopathology on differential levels of processing in the brain" (van Harmelen et al., 2014, p. 2,026).

ii. Inappropriate types of behaviors or feelings under normal circumstances, 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 and schizophrenia.

Rosenkranz, Muller, and Henderson (2012) examined the degree to which the self-reported experiences of multiple forms of maltreatment were related to severity of substance use problems in a sample of over 200 youth as they began an outpatient substance-abuse treatment program. When considering all forms of maltreatment together, the authors found that only emotional abuse and emotional neglect were significant predictors of substance use problem severity. Consideration of concurrent experiences of interpersonal violence did not change the strength of the relationship. Norman et al. (2012), reviewed above, reported robust evidence that child emotional abuse may be *causally related* to drug use and sexually transmitted diseases/sexually risky behavior, when mediating variables are taken into consideration.

In a systematic review and meta-analysis of studies examining the relationship between child abuse and eating disorders, Caslini et al. (2016) found that child emotional abuse and child physical abuse were significantly associated with both bulimia nervosa and binge eating disorder. All studies used concurrent and or retrospective recall of maltreatment experiences. The authors speculated that emotional abuse might play a key

1 role in eating disorders because of its high prevalence and its influence on “dissociative
2 coping styles, self-control through self-starvation, and emotion regulation” (p. 86).

3
4 All forms of child maltreatment are related to increased reports of dissociative symptoms
5 in both community samples and those with schizophrenia and other psychotic disorders
6 (e.g., Goff, Brotman, Kindlon, Waites, & Amico, 1991; Lange et al., 1999; Mulder,
7 Beautrais, Joyce, & Fergusson, 1998). Some studies using retrospective recall of child
8 maltreatment found that PM is more predictive of such symptoms than other forms of
9 maltreatment. PM was related to increased risk for dissociative symptoms in community
10 samples after controlling for other forms of maltreatment (e.g., Mulder et al., 1998;
11 Teicher, Samson, Polcari, & McGreenery, 2006; Teicher & Vitaliano, 2011).

12
13 Teicher and colleagues (2006) recruited 554 young adults who reported either a happy or
14 an unhappy childhood. They administered measures of child maltreatment and
15 psychiatric experiences. Parental verbal abuse was related to moderate to large effects on
16 measures of depression, anger-hostility, dissociation, and limbic irritability (described as
17 brief hallucinatory events, visual phenomena, automatism, etc.), with greater effects than
18 other forms of maltreatment. The combined exposure to witnessing domestic violence
19 and parental verbal abuse had “extraordinarily large adverse effects, particularly on
20 dissociation” (p. 997). The authors caution that they cannot rule out the possibility that
21 (a) individuals with a high degree of current psychopathology view and report childhood
22 experiences in a more negative light than do individuals without such symptoms and (b)
23 that maltreatment is more common in families with mental illness. They called for more
24 genetically informed studies with twins discordant for various forms of child
25 maltreatment to clarify causality.

26
27 PM was related to vulnerability to “shutdown dissociation” in patients with schizophrenia
28 spectrum disorders (SSD), that is, “shutting down of sensory, motor, and speech
29 systems,” which is likely a “defensive response to traumatic stress” (Schalinski &
30 Teicher, 2015, p. 1). Schalinski and Teicher (2015) examined 75 inpatients with SSD in
31 regard to the timing and type of child maltreatment and other adverse events experienced
32 during each year of childhood and adulthood. The researchers found that ages 13–14
33 were the times of peak vulnerability to dissociative symptoms, and emotional neglect,
34 followed by emotional abuse, was the most predictive of shutdown dissociation
35 symptoms within the past 6 months. (For similar findings on the role of childhood PM in
36 dissociative symptoms in adulthood, see Braehler et al., 2013; Brunner, Parzer, Schuld, &
37 Resch, 2000; Lange et al., 1999; and Mulder et al., 1998.)

38
39 Varese and colleagues (2012) conducted a meta-analysis of patient-control, -prospective,
40 and cross-sectional studies on the relationship between childhood adversities (all five
41 forms of CM, bullying, and parental death) and psychosis. They found an estimated
42 population attributable risk of 33% (16%–47%) with findings similar across all three
43 research designs. All types of adversity were related to an increased risk of psychosis
44 although emotional abuse had the highest odds ratio (3.40), followed by physical abuse
45 (2.95).

Agnew-Blais and Danese (2016) conducted a systematic review and meta-analysis of child maltreatment and poor clinical outcomes in bipolar disorder. Examining the 30 studies that met their selection criteria, they found that patients with a history of childhood maltreatment (a composite of physical, sexual, or emotional abuse; neglect; or family conflict) had significantly greater mania severity; depression severity; greater comorbidity with PTSD, anxiety disorders, substance use disorders, and alcohol misuse disorders; more manic episodes; more depressive episodes; and higher risk of suicide attempt compared with those without such a history. The associations were not due to publication bias, the outside effects of single studies, or study quality. A weakness of the findings was that the studies relied on retrospective recall of child maltreatment and did not control for preexisting childhood psychopathology. However, the authors noted that these findings held even in studies that assessed child maltreatment in a euthymic state (void of mood disorder; important because mood can influence recall of past events) and even in studies in which all participants had familial risk for bipolar disorder such that maltreatment added to the predictive value over and above family history.

iii. An inability to build or maintain satisfactory interpersonal relationships, such as social phobia, impaired social competency, lack of empathy for others, attachment insecurity/disorganization, self-isolating behavior, noncompliance, extreme dependency, sexual maladjustment, aggressive and violent behavior, and delinquency or criminality.

In the area of parent social competency, Bailey, DeOliveira, Wolfe, Evans, and Hartwick (2012) queried a sample of high-risk mothers about their child maltreatment experiences and then observed their parenting and gathered self-reports of parenting competency and stress. Witnessing family violence (a form of PM) and other emotional maltreatment in childhood was significantly related to mothers' observed hostility toward their children, even after controlling for other forms of potentially traumatizing adult experiences.

Parenting competence was also examined in a United Kingdom study of low- and high-risk parents with intellectual disabilities (ID; McGaw, Scully, & Pritchard, 2010). In a sample of 101, the authors found that having a CPS referral and being referred to a specialist parenting group was not associated with IQ, relationship status, parental age, or employment. Instead, it was associated with parental reports of childhood trauma (particularly emotional abuse and physical neglect), parents having additional special needs beyond low IQ and raising a child with a disability.

While PM alone, or in combination with other forms of maltreatment, seems particularly tied to internalizing symptoms, emotional abuse combined with physical abuse (a common co-occurrence) is associated with conduct-related problems such as delinquency and sexual risk behaviors. Berzenski and Yates (2011) demonstrated this in a sample of over 2,000 college students who completed measures of their childhood maltreatment history (neglect excluded) and current psychopathology, dating violence perpetration, substance use, and risky sexual behavior. Latent Class Analysis (a form of structural equation method used to identify unmeasured subclasses within a group) was used to identify patterns of maltreatment experiences. The sample as a whole broke into maltreated and non-maltreated clusters, with the single maltreatment group having four subgroups that corresponded with four types of child maltreatment (i.e., physical, sexual,

psychological, and witnessing domestic violence). Those who experienced multiple forms of maltreatment fell into four subgroups representing the family climate that college students reported being raised in the following contexts: Hostile Home (domestic violence and emotional abuse), Violent Home (domestic violence and physical abuse), Harsh Parenting (physical and emotional abuse), and Sexual Abuse (sexual abuse alone or with any other form of maltreatment). They found that participants who experienced any form of emotional abuse (with or without other forms of maltreatment) reported significantly higher psychopathology than any group that did not. Harsh Parenting was the most strongly related to conduct problems, particularly substance abuse, and especially among young men.

In a prospective study, Vachon et al. (2015) analyzed 27 years of data from the Mt. Hope summer camps established by Dante Cicchetti and his colleagues. The sample consisted of 2,292 children (1,193 maltreated) ages 5–13, most were of low-socioeconomic status, half were boys, and 60% were African American. For those attending camp for more than one year, data from the first year of attendance were used. Forms of maltreatment previously experienced were coded with the Maltreatment Classification System (Barnett et al., 1993) using CPS and all child welfare records as well as maternal interview. Harm was assessed by comparing maltreated children (CPS substantiated) with those not maltreated on children's camp peer reports of disruptive behavior, counselor reports of internalizing and externalizing behavior, and self-reports of depression. The authors found that emotional abuse, neglect, and physical abuse were highly correlated ($r = .82$) with one another and had to be treated as a common factor in analyses. All types of CM were related to significant and equivalent harm. The harm associated with CM was general and not specific in terms of psychopathology. There was no moderation of the relationship between maltreatment and harm by sex or race/ethnicity, indicating that maltreatment had a uniform relationship to adverse psychiatric outcomes in these children. As with the ACE study (and many others), there was a strong dose response effect such that the risk of psychopathology increased with the presence of any type of CM—in addition, the more forms of CM and the more events of CM experienced, the more severe the harm. The authors concluded that all forms of CM are equally harmful with respect to these outcomes and should be treated as such.

iv. 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 intelligence, and school problems due to noncompliance and lack of impulse control.

Most of this literature shows that neglect (emotional and physical) is strongly related to cognitive deficits, but emotional abuse is either not related or less related to learning than other forms of maltreatment, especially after controlling for variables such as poverty. Emotional abuse is related to behavioral problems that affect schooling (see recent reviews by O'Higgins, Sebba, & Gardner, 2017; Romano, Babchishin, Marquis, & Frechette, 2014).

Egeland, Sroufe, and Erickson (1983), in the Minnesota Longitudinal Study of Risk and Adaptation, used frequent home and laboratory observational methods from infancy on to

1 identify child maltreatment in a prospective longitudinal study of 267 mothers prior to the
2 birth of her first child. At 18 months, children with psychologically unavailable
3 caregivers showed anger, noncompliance, and low-positive affect during problem-solving
4 tasks and a significant decline on the Bayley Scales of Infant Development from average
5 at 12 months to well below average at 18 months. In the same sample, they found that by
6 preschool, children with a psychologically unavailable caregiver or one who was
7 hostile/verbally aggressive had more teacher/caregiver reported psychopathological
8 behavior than other high-risk controls. All of the maltreatment groups were significantly
9 more noncompliant, avoidant, and negative with their caregiver and less persistent and
10 enthusiastic in learning (Erickson & Egeland, 1987; Pianta, Egeland, & Erickson, 1989).

11
12 Fay-Stammbach, Hawes, and Meredith (2017) examined the relationship between
13 parental emotional socialization and preschool executive functioning in their study of 58
14 preschool children recruited from child protective services and high-risk families from an
15 early intervention program and 49 community participants without parenting risks. PM
16 was by far the most common form of maltreatment experienced by children in this
17 sample. The authors found that both maltreatment history and mother's emotional
18 socialization practices accounted for unique variance in executive functioning and that
19 the two interacted, indicating that unsupportive emotional socialization practices made
20 the risk of poor executive functioning even worse while supportive practices were
21 protective. The unsupportive emotional socialization practices constitute known forms of
22 PM. These include punitive reactions to negative child emotions (*terrorizing*) and
23 dismissing emotions (*spurning*), not providing comfort for distress/crying (*emotional*
24 *unresponsiveness*), and not helping with or encouraging problem solving
25 (*corrupting/exploiting*).

26
27 Using a cross-sectional survey of South Arabian 12–19-year-old students, Altamimi,
28 Alumuneef, Albuhairan, and Saleheen (2017) found that youth who reported parental
29 psychological abuse were more likely to perform poorly in school than those who were
30 not psychologically abused. The odds ratio was 2.3, comparable with the odds of those
31 physically abused versus not and multiply abused versus not.

32
33 In a 1958 British birth cohort study (N=8,928), psychological and physical neglect in
34 childhood (ages 7 and 11) significantly predicted childhood cognitive functioning
35 problems (math, reading, and IQ), age 42 educational qualifications, and age 50 memory
36 and processing speed scores, controlling for a long list of covariates including mental
37 health (Geoffroy, Pereira, Li, & Power, 2016). Psychological abuse was not related to
38 cognitive functioning and the other forms of abuse (physical, sexual, witnessing domestic
39 violence) were not related after controlling for other confounding variables. All forms of
40 maltreatment were related to more childhood behavioral problems and adult depressive
41 symptoms, controlling for numerous confounding variables.

42
43 Other studies showing a negative effect on learning from neglect, but not necessarily
44 emotional abuse, include the following. A western Australian population-based cohort
45 study linked CPS reports (unsubstantiated, substantiated, out-of-home placements),
46 disability records, and health records for 46,000+ children (Maclean, Taylor, &
47 O'Donnell, 2016). The predictor variables were maltreatment allegations (emotional,

1 sexual and physical abuse, and neglect—*neglect* was not defined so it is unclear if it
2 included both physical and emotional neglect), controlling for other risk factors (e.g.,
3 maternal smoking, maternal mental health contacts of any type), and the dependent
4 variable was low reading achievement on the national third grade reading test (below the
5 10th percentile). After controlling for other risk factors, emotional abuse was no longer
6 significantly related to poor reading, but sexual and physical abuse and neglect were;
7 sexual abuse and neglect were associated with 50% increased odds of low reading
8 achievement. A separate western Australia linkage study of 19,000+ kindergarten age
9 children related all previous CPS reports to performance on an extensive school readiness
10 battery (Bell, Bayliss, Glauert, & Ohan, 2018). All forms of substantiated maltreatment
11 were related to lower readiness as were unsubstantiated physical abuse and neglect.
12 Unsubstantiated emotional abuse and sexual abuse were not related to test scores.

13
14 The E-Risk study found strong support for child maltreatment having a possible causal
15 relationship with poor educational qualifications at age 18 and not being in education,
16 training, or work at that age (Jaffe et al., 2018). Maltreated children were twice as likely
17 to have poor educational qualifications (e.g., no school leaving certificate). After
18 controlling for sex, family SES, parental psychopathology, and IQ at age 5 the
19 relationship was diminished; however, it was still significant. The authors concluded that
20 the relationship between maltreatment and poor educational outcomes was not due to
21 being raised in a poor neighborhood or of having a low IQ. It was also not due to being
22 more vulnerable to psychopathology because one's parents had mental illness with poor
23 educational or occupational prospects as the result. Instead, their findings were consistent
24 with "maltreatment jeopardizes education and employment prospects by increasing the
25 risk of poor mental health in childhood" (p. 1,146). The researchers did not have enough
26 twins discordant for maltreatment to test for the specific effects of each form of
27 maltreatment.

28
29 **v. Physical health problems/adverse biological changes**, such as delays in almost all
30 areas of physical and behavioral development; allergies, asthma, headaches, sleep
31 complaints, and other respiratory ailments; as well as lifestyle risk behaviors in
32 adolescence, including tobacco smoking and risky sexual behavior that increases the risk
33 of HIV and other sexually transmitted diseases; and the increased risk of disease and risk
34 factors for common diseases and health problems and mortality.

35
36 Most of the evidence for these relationships comes from the ACE study and follow-ups
37 previously reviewed (e.g., Anda et al., 2010; Felitti et al., 1998) and other similar studies
38 using retrospectively recalled child maltreatment to predict current or future health
39 behavior. For example, Poon and Knight (2011) used a sample of almost 900 adults aged
40 60 years and older from the National Survey of Midlife Development in the United States
41 to examine the degree to which patient-reported childhood maltreatment was related to
42 sleep complaints in late adulthood. Adverse childhood experiences (emotional and
43 physical abuse, emotional and physical neglect, but not sexual abuse) were recalled at
44 Time 1, and sleep problems as well as current relationship and emotional distress were
45 assessed at Time 2, 9 years later. The authors concluded that childhood emotional abuse
46 was significantly associated with more sleep complaints in old age and that unsupportive

1 interactions with family and friends as well as emotional distress partially explained the
2 association.

3
4 In their related research, Spertus, Yehuda, Wong, Halligan, and Seremetis (2003) studied
5 women participants in a primary care practice (N = 205) to examine the relationship
6 between PM and anxiety, depression, posttraumatic psychological symptoms, and
7 somatic complaints after controlling for other forms of maltreatment and trauma. The
8 authors found that while all forms of maltreatment were significant predictors of mental
9 and physical health complaints, PM (both abuse and neglect) still predicted somatic
10 complaints (as well as anxiety, depression, and posttraumatic symptoms) even when
11 controlling for other forms of abuse and trauma. PM also predicted the number of doctor
12 visits in the past year, showing that it may have an impact on the health care system in
13 terms of increased utilization.

14
15 Prospective studies have identified unexpected health relationships with PM as well. For
16 example, a 21-year follow-up of an Australian sample tracked prenatally into adulthood
17 (N = 2,661 out of an original sample of 7,223), with prospectively substantiated child
18 abuse and neglect for ages 0–14, found that both physical and emotional abuse and
19 neglect were significantly related to a deficit in height after perinatal and family
20 confounding factors were controlled (Abajobir, Kisely, Williams, Strathearn, & Najman,
21 2017). Each additional exposure to emotional or physical abuse and neglect during ages
22 0–14 was related to a 0.03 cm decrease in the height of the young adult.

23
24 An example of how verbal abuse (spurning) is related to adverse child outcomes comes
25 from the Japan Environment and Children's Study, “an ongoing nationwide population-
26 based birth-cohort study designed to determine environmental factors during and after
27 pregnancy that affect the development, health, or wellbeing of children” (Komoria et al.
28 & the Japan Environment and Children's Study Group, 2019, p. 193). Controlling for 16
29 potentially confounding variables (e.g., noisy environment, smoking during pregnancy)
30 in the 79,985 mother–infant pairs with complete data, the authors found that maternal
31 reported verbal abuse by her partner during pregnancy was significantly associated with a
32 hearing referral for the infant after two failed screenings in the first week of life (adjusted
33 odds ratio: 1.44; 95% confidence interval: 1.05–1.98). About 60% of infants failing the
34 initial screening were diagnosed with hearing loss and the remaining 40% with immature
35 auditory development. Physical abuse of mother by partner was not related to hearing
36 referral. The authors proposed multiple causal pathways through which verbal abuse may
37 cause hearing impairment and concluded that “these data suggest that a loud, non-
38 maternal voice experienced in conjunction with maternal tachycardia likely create an
39 environment that is uncomfortable for fetuses and therefore may negatively affect
40 auditory function development in the child during gestation and after birth” (p. 199).

41 42 **Nature of This Review of Impact and Consequences**

43
44 The studies presented in this section are not exhaustive. Rather, they are intended to
45 provide an overview of the breadth and depth of the voluminous research that now exists
46 on the effects of PM, alone or in combination with other forms of child maltreatment, on
47 child and later adult characteristics. As the volume of studies and recent publication dates

1 indicate, researchers across the world from different disciplines recognize the lifelong,
2 multidomain harm associated with childhood PM and include it as a variable in a myriad
3 of studies on risk factors for health and social adaptation across the lifespan. This
4 recognition by the research community has been long in coming, but the evidence on the
5 strong, consistent relationship between childhood PM and adverse outcomes across the
6 lifespan is now indisputable. Nonetheless, many parents, child welfare personnel, health
7 care professionals, judges, educators, and the general public are still unaware of this
8 research and the many ways PM impairs human functioning, especially when it is chronic
9 or severe, or both.

11 **Severity and Developmental Considerations**

13 **Assessing severity of PM** is essential for all levels of decision making. Thus, the first
14 question is whether PM is occurring and the second is, if so, at what level of severity.
15 This information is essential for determining what course of action is required.
16 The legal jurisdiction in which the family resides affects whether the behavior is
17 considered maltreatment under state law/regulations and, if it is, the intervention options.
18 Decision making is discussed in Section 4 (Assessment).

20 In determining the nature of PM severity, consideration should be given particularly to
21 the following:

- 22 (a) Magnitude (i.e., intensity, extremeness), frequency, and chronicity of the
- 23 caregiver behavior,
- 24 (b) Degree to which PM pervades the caregiver–child relationship,
- 25 (c) Number of subtypes of PM that have been or are being perpetrated,
- 26 (d) Salience of the maltreatment for the developmental period(s) in which it
- 27 occurs and the developmental periods that will follow, and
- 28 (e) Extent to which negative child developmental outcomes exist, are developing,
- 29 or are likely.

31 **Impact of PM at developmental periods** varies from child to child. Some forms of PM
32 are more damaging to children when experienced at certain ages or developmental
33 periods than when they occur at other times. Children differ in terms of their exposure to
34 conditions that may exacerbate (i.e., increase magnitude) or counteract (i.e., oppose or
35 mitigate) psychological maltreatment. Some children are genetically more sensitive to
36 their environments (both good and bad) than other children (including siblings), making
37 them more likely to suffer the ill effects from PM (Belsky & Pluess, 2013).

39 The following examples are relevant:

41 The impact of hostile/verbally aggressive parenting (spurning and terrorizing) is
42 particularly strong when experienced during the first 2 years of life through middle
43 childhood. It is uniquely related to conduct problems and anxiety disorders, particularly
44 social phobia, depression, and suicidal behavior (for reviews, see American Professional
45 Society on the Abuse of Children [APSAC], 2010; Brassard & Donovan, 2006; Heyman
46 & Slep, 2009; Wolfe & McIsaac, 2011).

1 The impact of isolating in infancy and toddlerhood is closely tied to emotionally
2 unresponsive parenting (sometimes referred to as psychologically unavailable
3 caregiving). Many of the documented adverse effects of institutional rearing of infants
4 and toddlers are due to isolating and lack of a reliable caregiver, experienced by the
5 infant as life threatening. These circumstances create toxic stress, which adversely shapes
6 early neurological development, threatening healthy development (Shonkoff et al., 2012).

7
8 Psychological unavailability/emotional unresponsiveness/emotional neglect can be
9 devastating in the infant-toddler and pre-school years and again in adolescence. In early
10 life, it is related to dramatic drops in IQ, language delays, attachment disorders, and early
11 onset of internalizing and externalizing problems (Egeland & Erickson, 1987; Egeland,
12 Sroufe & Erickson, 1983). In adolescence, it is related to increases in depression,
13 substance abuse, and suicidality (see Brassard & Donovan, 2006).

14
15 There is considerable research on modeling, permitting, and encouraging antisocial
16 behavior or developmentally inappropriate behavior, and generally on all forms of
17 exploiting/corrupting, and on their relationships to adverse outcomes. There is strong
18 research evidence connecting being raised by a criminal parent to increased risk for
19 antisocial personality disorder (ASPD), independent of genetic contributions to antisocial
20 behavior (Jaffee, Moffitt, Caspi, & Taylor, 2003). A lack of parental monitoring and
21 supervision is strongly related to engaging in antisocial behavior (Sampson & Laub,
22 1994). There is strong research evidence for relationships between psychological control
23 (manipulative parenting) and internalizing problems (Barber, 1996). There is also a solid
24 body of research on the deleterious effects of parental acts that undermine and interfere in
25 the child's relationship with the other parent by inducing the child to behave in an
26 aggressive, cruel, and immoral manner (Harmon, Kruk, & Hines, 2018) as well as on
27 children forced into emotional caretaking of parents (Hooper, DeCoster, White, & Voltz,
28 2011).

29 30 **6. Risk Factors for Psychological Maltreatment**

31
32 Psychological maltreating behaviors are a form of violence against another person and,
33 therefore, can be caused by a number of behaviors and conditions that are known risk
34 factors for violence. In this section, attention is given to risk factors widely recognized to
35 be associated with categories of conditions of risk involving the child, caregiver, family,
36 and community (see Klika & Conte, 2017, and periodic reports of the U.S. Department of
37 Health and Human Services (USDHHS), Administration of Children and Families,
38 Children's Bureau and its embedded National Center on Child Abuse and Neglect
39 (NCCAN) as well as the International Society for Prevention of Child Abuse and Neglect
40 (ISPCAN).

41 42 **Child Factors**

43
44 Child victims are not responsible for the maltreatment they experience but may have
45 characteristics that increase their vulnerability to maltreatment. Features of children that
46 may increase the likelihood that their caregivers will mistreat them include, but are not
47 limited to, high-maintenance and -demand characteristics associated with developmental

age/stage (e.g., infants, toddlers, teens), disability (e.g., physical, cognitive, and emotional), temperament (e.g., unpredictable biological rhythm, negative mood, high-intensity responsiveness, distractibility, resistance to soothing), and behavior (e.g., aggression). Importantly, child characteristics increasing their 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. While children with high-maintenance or -demand characteristics require coping and caring that may challenge the capacities of caregivers, researchers have established that it is possible that these children can be parented in constructive ways, promoting well-being without incurring maltreatment from caregivers.

Caregiver Factors

Caregivers are more likely to perpetrate violence 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, substance abuse; childhood experiences of maltreatment (particularly when combined with genetic vulnerability), including witnessing family violence (e.g., sibling maltreatment, marital/partner violence); beliefs and attitudes that depersonalize children, that consider them property, or set unrealistically high expectations for their development and behavior (these are both risk factors and 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, or responsiveness for a child's good qualities; lack of interest or incapacity to attend to child(ren); parenting while experiencing high stress (e.g., interpersonal, financial, work, health) and low-social support.

Family Factors

At the family level, all human nature, child, and caregiver factors previously mentioned 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 from communities (e.g., school, faith, health services, recreation); insufficient income for basic family needs; high stress, domestic violence, substance abuse, and criminal activity in the home or neighborhood.

Community Environment Factors

At the community level, all risk factors previously cited are relevant as they influence and are influenced by community members, the social norms and the broader psychosocial-physical environment of the community. Community system contributions to violence against children and inadequacy of prevention and corrective responses are increased by

- (a) Low expectations and low levels of support for parenting/childcare, 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 or are not 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.

As can be seen, multiple conditions and factors have been identified as probable or possible contributors to physical, sexual, and psychological violence against children. None of these factors has been established by research as a sufficient cause in itself or as the single most important or consistently primary cause. For example, having been maltreated as a child is a background factor for approximately 30% of adults who maltreat their own children, while the majority of those who have such backgrounds have not been found to be abusers (although a significant minority may provide borderline care to their children, e.g., Egeland, Jacobvitz, & Sroufe, 1988). It is generally accepted that it is the dynamics within and between/among multiple conditions/factors that create the tipping point toward manifest violence.

Seven important points should be recognized here:

- (a) Little research has been done on specific risk factors for PM,
- (b) PM is generally embedded in or associated with all forms and occurrences of maltreatment,
- (c) The existence of any one or set of possible risk factors is insufficient evidence that maltreatment has occurred or will occur,
- (d) The greater the number and magnitude of existing possible contributors or risk factors for violence the greater the likelihood violence (in its various forms, including PM) will occur,
- (e) Knowledge of possible risk factors to maltreatment is most usefully applied to interventions to prevent and correct maltreatment conditions,
- (f) Virtually all recognized possible contributors to violence have an alternative/opposite form that supports nonviolence and other desired human conditions (e.g., sensitive responsive care vs. ignoring), and
- (g) Emphasis by society on promoting positive supportive conditions as an intervention, through an enlightened public health approach, is superior to attempting solely or primarily to suppress negative conditions. Expanded coverage of the last concept is provided in Appendix A, which describes and proposes An Enlightened Public Health Approach for Child Protection consistent with evolving international standards.

7. Psychological Maltreatment in the Context of Child Rights

Child protection systems and associated services need significant transformation (Hart, Lee, & Wernham, 2011). The practice of protecting children from immediate harm, typically after a child has experienced one or more forms of violence or harm, with narrowly focused interventions that have the potential to cause harm as well as good (e.g., Lawrence, Carlson, & Egeland, 2006; Melton, 2005) is no longer considered

1 acceptable. Appendix B offers a discussion of the United Nations' position on advancing
2 the rights of children to be free from all forms of violence, and notably PM. This
3 international perspective provides a broad framework for conceptualizing psychological
4 maltreatment as a form of violence from which all children should be protected as a basic
5 human right.

6 7 8 **SECTION 3.** 9 **ASSESSMENT CONSIDERATIONS**

10 11 **1. Professionals for Whom the Monograph Is Relevant and Associated** 12 **Required Qualifications**

13
14 It is anticipated that professionals using the monograph will have different assessment
15 purposes. Child protective service workers may be focused on assessing whether or not
16 PM is occurring, alone or in the context of other forms of maltreatment, and the degree to
17 which a child is facing immediate risk of harm. Mental health professionals might be
18 conducting an assessment of family functioning to determine child risk, family capacity
19 to change, and intervention needs or to determine the best interests of a child in a clinical
20 or a forensic custody situation. Other forensic assessment purposes might include
21 establishing that an individual has been psychologically maltreated for death penalty
22 mitigation or when there are allegations of institutional abuse in residential settings.

23
24 CPS workers should be thoroughly trained in all forms of maltreatment, normal and
25 abnormal child development, and family dynamics, including knowledge of competent
26 and abusive parenting. Mental health professionals conducting an initial assessment of
27 family functioning should additionally be trained in adult mental health, making it likely
28 that the individual can validly assess the parents' and family's capacity to change and
29 sustain positive change, within a therapeutic intervention (Finkelhor & Lannen, 2015).
30 Such an approach could reduce the need for mandated treatment and possible removal of
31 the child. Should such an assessment or trial intervention, indicate the lack of capacity for
32 positive change, with significant threats to the child's well-being, a forensic^{††} assessment
33 incorporating psychosocial assessment^{‡‡} is warranted.

^{††} *Forensic assessment* for the purpose of this monograph means a psychosocial evaluation that is conducted whole or in part for use in legal proceedings. For example, a psychosocial assessment for forensic purposes would include an evaluation by a CPS worker to substantiate a report of suspected PM, or an assessment by a mental health professional at the request of a juvenile court or family court judge for treatment planning or to determine the best interests of a child.

^{‡‡} *Psychosocial assessment* herein means a systematic process of gathering information and forming a professional opinion regarding whether or not a child has been or is being subjected to PM. Psychosocial assessments are broadly concerned with understanding developmental, familial, cultural (e.g., ethnic/racial, religious), and historical factors that might be associated with PM. The results of psychosocial assessments might be used to assist in legal decision making and in-treatment planning. In the monograph, the terms *assessment* and *evaluation* are used interchangeably and have the same meaning. Some psychosocial assessments are *forensic assessments* as that term is defined in this monograph.

1 A professional conducting a forensic assessment should possess an advanced degree in a
2 relevant mental health discipline or an advanced health services degree with training and
3 substantial experience in mental health. The professional should hold the licensure or
4 credentials required to practice in the relevant jurisdiction. Service providers who meet
5 the experience standards set forth in this section, but who are not licensed or credentialed
6 in a mental health discipline, should be permitted to carry out forensic assessment
7 functions under the supervision of a mental health professional meeting the criteria
8 outlined in this paragraph. The professional should have broad experience in the
9 evaluation and treatment of both adequately functional and troubled children and
10 families. The professional should possess a minimum of two years of experience with
11 abused and neglected children. Two or more years of experience with non-maltreated
12 children are desirable. The professional should also have specialized training in or
13 knowledge of child development and psychological maltreatment. If the professional
14 lacks the experience described in this paragraph, appropriate supervision by someone
15 with such experience is recommended. The professional should have experience
16 conducting forensic interviews and testifying in court. Also needed are familiarity with
17 the forensic implications of interviews with children and adults, appreciation of the
18 importance of evidence-based interviewing and documentation, and training in the use of
19 associated practices (see APSAC, 2012 and the Newlin et al., 2015 articles on forensic
20 child interviewing best practices published by the Office of Juvenile Justice and
21 Prevention).

22
23 The professional should approach the assessment with an open mind regarding what, if
24 anything, might have happened and be prepared to give genuine attention to both
25 confirmatory and disproving evidence.

26
27 In a multidisciplinary team of specialists, it is advisable for one member of the team to
28 assume the responsibility of coordinating the assessment processes, integrating findings,
29 and preparing needed reports. When opinions of team members differ, it is recommended
30 that this should be recognized and clarified in reports.

31 32 **2. Necessity to Consider Psychological Maltreatment in All Investigation** 33 **Stages**

34
35 It is common for maltreated children to experience multiple forms of maltreatment. PM is
36 often accompanied by or embedded in other forms of child abuse and neglect, and it is
37 generally a major contributor to negative outcomes. For these reasons, all stages of child
38 maltreatment investigation should include a consideration of whether PM is present,
39 regardless of the nature of the primary maltreatment concern.

40 41 **3. Assessment and Determination of Psychological Maltreatment**

42
43 The goal of forensic assessment^{§§} is often to determine for a court of law, or according to
44 a regulatory statute, whether maltreatment was or is present. Many jurisdictions also

^{§§} The current version of the monograph focuses particularly on assessment of PM, risk factors, and harm for forensic purposes, reflecting the child protection focus of this document. Well-designed psychosocial evaluations of at-risk and

1 require a determination of the severity of maltreatment and the degree to which harm has
2 or is likely to occur.

3
4 PM can occur during an acute incident, such as when, in a moment of grief, a parent
5 states to a child that the parent wishes that he or she were the one who had died rather
6 than a deceased sibling. A very serious single incident of domestic violence observed by
7 a child would be another example. PM can occur during an extended life crisis, but not be
8 pervasive or reflective of the parent–child interaction prior to that. For example, a father
9 who is depressed and set off balance by long-term unemployment might be hypercritical
10 and psychologically unavailable when interacting with his child, while that was not
11 previously the case. In some cases, PM occurs only when some specific, recurring event
12 occurs. For example, a caregiver who occasionally binge drinks may be emotionally
13 unresponsive or verbally abusive when intoxicated. However, most PM is chronic,
14 regular, and embedded in the child’s daily existence (e.g., a caregiver may level a daily
15 barrage of verbal abuse at a child and psychologically manipulate and control the child).

16
17 To aid professionals assessing suspected PM, we offer a decision-making grid to organize
18 evidence for each of the forms of PM (Part B), common risk factors (Part A), and
19 evidence of harm (Part C). This grid can be found on pages 37–38.

20
21 An alternate and compatible categorical diagnostic strategy has been developed by
22 Heyman and Slep (2006; 2009) and is reproduced in Appendix H. As described by Wolfe
23 and McIssac (2011) it “involves a structured clinical interview, whereby aspects of the
24 allegation or report are recorded in as much detail as possible (e.g., “describe what
25 happened as if you were watching a movie”). Moreover, their protocol provides a
26 systematic assessment of impact on the child, as well as factors that affect the potential
27 for such impact. These details are then provided to a committee or independent panel to
28 evaluate whether or not they fit the criteria for CEM*** (*child emotional maltreatment*,
29 i.e., PM) (for example). In doing so, they adopted a standard of proof based on the
30 “preponderance of the evidence,” which was felt to be the most reasonable safeguard for
31 family members as well as children. As in civil cases, this standard requires only that the
32 investigator determine that it is more likely than not the criterion was met, taking into
33 account the credibility of reporters in making such a decision” (Wolfe & McIssac, 2011,
34 p. 808). The Heyman and Slep protocol is designed to identify any form of maltreatment
35 while the protocol presented here is focused more narrowly on PM.

36 37 **Assessment Techniques and Sources of Information**

38
39 Psychosocial evaluation procedures, such as observations, interviews, questionnaires,
40 records review, and projective techniques, with due consideration of their reliability and
41 validity, can provide clarifying and corroborative information about patterns of

maltreated children intended to inform choices within a broad base of interventions (i.e., clinical assessments) are required in support of the public health and three-tiered approaches championed here. The next version of the monograph will include full coverage of clinical assessment.

*** Alternatively, as in Alaska, the decision can be made by the assessing worker in consultation with his or her supervisor (personal email communication from Amy Slep, 6/1/18).

1 interaction, care, and treatment and their impact on the child. Assessment of the child and
2 caregivers usually include one or more interviews, review of collateral reports and
3 records, and psychological testing (optional). Every attempt should be made to interact
4 respectfully and authentically to increase the likelihood of voluntary involvement in the
5 assessment and any subsequent intervention.

6
7 **The child–caregiver relationship.** When feasible, the professional should observe the
8 child–caregiver relationship. Repeated observations may be necessary to obtain a
9 representative sample of behavior and to recognize patterns of child–caregiver
10 interaction. Assessors should be as alert to positive aspects of the relationship as they are
11 to negative. For infants and young toddlers, direct observation of caregiver–child
12 interaction is essential and should be conducted by a professional trained in how infant
13 behavior reflects past history with the caregiver. Although direct observation of the
14 child–caregiver relationship may be essential and is often useful, such observation is not
15 always necessary to form an opinion regarding psychological maltreatment if there are well-
16 documented collateral reports. In this regard, observations of caregiver–child interactions have
17 their limitations because parents and children may not behave in their usual manner when being
18 observed, although this concern diminishes the longer the duration or greater the frequency of the
19 observation. Moreover, some caregiver–child relationship problems can mask as healthy
20 relationships and require extensive observation, knowledge of enmeshment, and multiple sources
21 of data in order to observe the true nature of the relationship.

22
23 Discriminating between poor or inadequate caregiving and psychologically maltreating caregiving
24 can be challenging. For example, the impact of PM on the child (e.g., behavior problems,
25 anxiety, depression) can result in the worker empathizing with the parents about how difficult the
26 child is and lead to overvaluing or accepting parent behavior as attempts to do their best to deal
27 with these challenges. Therefore, knowledge about optimal versus non-optimal parenting is
28 essential (see Appendix G), and employment of team decision making may be helpful (Heyman
29 & Slep, 2006; Heyman & Slep, 2009).

30
31 The child–caregiver relationship can also be assessed through interviews of the caregiver
32 and the child, review of pertinent records, recorded observations, consultation with other
33 professionals, and collateral reports from siblings, extended family, school and daycare
34 personnel, teachers, coaches, neighbors, and others. It is also important to be aware that
35 even abused children may strenuously campaign to remain with the abusive parent. In so
36 doing, they may deny the occurrence or impact of the abuse, deflect responsibility away
37 from the abusive parent, and assume the blame for any problematic behavior on the part
38 of the parent (Baker & Schneiderman, 2015). Therefore, interviews alone will not be
39 sufficient to determine the true nature of the parent–child relationship. Appendix G
40 provides guidance in distinguishing between good, poor, and psychologically maltreating
41 parenting behavior (see Heyman & Slep, 2009, for exposition).

42
43
44 *Child Characteristics.* Deviance or delay in the child’s functioning, which can be
45 evidence of harm (but can occur for other reasons as well), is assessed through direct
46 observation by the evaluator, testing, the observations of others, and available reports and
47 records (e.g., school, special education, health, juvenile justice, therapy).

Caregiver/Family Competencies and Risk Factors. Evaluation of caregiver competencies and risk factors assists in determining risk factors for psychological 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 (willingness and ability to parent, ability to empathize with the child’s point of view and recognize the child as a worthy and autonomous being). Assessing caregiver state of mind about attachment is very useful in this regard (see Dozier, Peloso, Lewis, Laurenceau & Levin, 2008),
- (2) Personal resources (intelligence, capacity for insight, willingness to change, job skills, social skills, personality variables, self-control, mental health, substance use),
- (3) Social support/resources (marital status, family, friends, financial status, faith and secular community involvement), and
- (4) Life stresses or transitions in the family.

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 opportunity for intervention. The psychosocial conditions jeopardizing a child’s development may not be under the control of a caregiver. 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, existing risk factors for maltreatment still must be considered and interventions addressing these risk factors must 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 experts is required. See Fontes (2005) for a comprehensive discussion. Reader suggestions for expansion of this section are invited.

Assessment of PM at Different Developmental Levels

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. In Table 2, we provide some examples of indicators of the PM subtypes at different developmental levels of the child.

1 **Table 2. Forms of PM by Developmental Level.**

Salient Issues/Tasks at Stages of Development	Infancy: Assistance in the regulation of bodily states and emotion. Attachment.	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 and emotions and store information—predict and make sense of the world. Development of verbally mediated or semantic memory. Development of social relationships beyond family, generalization of expectations about relationships. Moral reasoning.	Adolescence: Peer relationships. Adaptation to school. Moral reasoning. Renegotiation of family roles. Identity issues (sexuality, future orientation, peer acceptance, ethnicity).
<i>Spurning</i>	Ridiculing and hostilely rejecting the child’s attachment behaviors. 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, creating negative self-image by name calling.	Demeaning child’s characteristics to convey extreme disappointment and disapproval. Mocking or devaluing accomplishments.	Refusing to accept changing social roles and child’s needs for greater autonomy and self-direction. Humiliating the child regarding his or her developing physical maturity/body changes, career interests.
<i>Terrorizing</i>	Extreme unpredictability in responding to infant’s cues and basic needs. Violating the child’s ability to manage stimulation and change.	Intimidating, threatening, raging at the child.	Extremely inconsistent commands, extreme punishment for not meeting inappropriate expectations, threatening abandonment.	Threatening public humiliating or ridiculing in public. Extremely inconsistent commands, extreme punishment for not meeting inappropriate expectations, threatening abandonment.
<i>Isolating</i>	Denying the infant consistent patterns of interaction and stimulation. Failure to provide opportunities for stimulation. Leaving infant unattended for hours in a playpen or infant seat.	Punishing the child for wanting social interactions. 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.
<i>Exploiting/Corrupting</i>	Placing the child at risk of developing addictions or bizarre habits.	Reinforcing aggression or sexual precociousness.	Encouraging the child to misbehave, to be antisocial, criminal, or hypersexual. Forcing the child to take care of the parent,	Involving and rewarding the child’s involvement in socially unacceptable behaviors involving

		.	or to act much younger than he or she is to meet the parent's needs.	crime, sex, drugs, and failure to meet social expectations. Relying on the child to fulfill the parent's needs.
<i>Emotional Unresponsiveness</i>	Failing to respond to child's bids for attention and eye contact. Lack of emotional expressiveness, flat affect, and being slow to respond.	Lack of warmth and expression of affection. Failure to engage in the child's daily life.	Failing to protect the child or help the child navigate difficult social interactions. Emotional detachment and lack of involvement in the child's daily life.	Abdicating parental role, displacing child as object of affection.
<i>Mental Health, Medical, and Educational Neglect</i>	Failing to provide or refusing treatment for child's physical health problems, such as failure to thrive, extreme expressions of distress, ear infections, or fevers that have may have severe long-term consequences for the child's development.	Refusing to allow a child to receive reasonable services for special education needs, such as autistic spectrum disorders, disruptive behavior, or physical health problems such as low vision or motor problems.	Refusing to allow a child to receive reasonable services for serious special education needs (disruptive behavior, not learning to read), not ensuring that a child receives an education (not getting a child to school, 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; not ensuring that a child receives an education; ignoring the need for, or failing or refusing to provide treatment for, serious physical health problems.

4. Determination of Extant Harm and Assessment of Danger

Assessment of harm is based on a large research literature that has repeatedly tied forms of caregiver behavior, labeled in this document as psychological maltreatment (PM), with current and future harm to the child. Because of this robust research literature, assessors can have confidence that there is a likely threat to the child's current and future well-being when psychologically maltreating caregiver behavior has occurred.

Child behavior often provides evidence of the impact of the caregiver behavior on the child. One must be cautious, however, of inferring parent behavior from child behavior. Multiple pathways can lead to any particular child behavior. When considering the possibility of PM, the professional should rule out other factors that might cause child behavior problems, such as psychological trauma unrelated to maltreatment, inherited or congenital vulnerabilities, various forms of mental illness that have a strong genetic base, or maltreatment from someone other than a caregiver.

Evidence of harm to the child is observed in two forms: (1) distortion or delay of key age/stage-salient developmental competencies and (2) signs of psychological (particularly emotional), behavioral, and physical distress that is impairing current functioning or likely to impair future development and functioning, or both.

The assessment for possible PM should include consideration of the child's developmental level. The caregiver-child relationship should be considered within a developmental framework that takes into account the primary developmental tasks of the child and the related task responsibilities placed upon the caregiver. For example, one of an infant's primary developmental tasks is to form a secure attachment with an adult caregiver, learning in the process to trust others to provide a stable, loving, nurturing, responsive environment and to believe in one's own ability to solicit that care. A caregiver who is maltreating predominantly rejects or distorts a child's bids for attention (for nurturance, comfort, play, or assistance) and, thereby, negatively shapes a child's sense of self, worthiness, competence, efficacy, and trust in others. Such interference, if severe enough, can be devastating in its impact on a child's cognitive, emotional, and volitional development and the brain networks that underlie those functions.

Professionals may use the list of "Developmental Tasks" contained in Table 2 to assist in this aspect of the assessment process.

Signs of Psychological, Behavioral, and Physical Distress and Their Relationship to Harm

There are multiple, overlapping frameworks that can be used to identify significant distress or harm in a child. As mentioned earlier, IDEA's criteria for *emotional disability* incorporates psychological criteria for major mental disorders, covered at length in the *Diagnostic and Statistical Manual* of the American Psychiatric Association, and other formulations of interpersonal, cognitive, and emotional behavior problems. If a child meets IDEA criteria for *severe emotional disturbance* or a clinical disorder as described

1 in DSM-V, that occurrence can be considered evidence of harm if the disorder is tied to
2 psychologically maltreating caregiver behavior. We prefer the IDEA definition to DSM
3 because it has long been accessible to the entire child-supporting and protection
4 community.

5
6 According to the IDEA (2004), *severe emotional disability* is defined as

7 An inability to learn that cannot be explained by intellectual, sensory, or health
8 factors; an inability to build or maintain satisfactory interpersonal relationships
9 with peers and teachers; inappropriate types of behavior or feelings under normal
10 circumstances; a general pervasive mood of unhappiness or depression; and/or a
11 tendency to develop physical symptoms or fears associated with personal or
12 school problems.

13
14 Assessment of harm is based on the degree to which PM has contributed to existing
15 reductions or distortions of well-being, threatens the child's well-being, or if continued,
16 will significantly or permanently undermine normal development. As examples, children
17 and youth distressed to the point of suicidality or engaging in high-risk, self-destructive
18 behavior are at great danger, as are infants who are ignored, being deprived of the
19 cognitive and social situations needed for adequate brain development.

20
21 Heyman and Slep (2006; 2009) have produced a well-respected approach for assessing
22 harm or its potential in decision making regarding PM that gives more emphasis to
23 traditional DSM criteria. It is excerpted in Appendix H as taken from Wolfe and McIssac
24 (2011).

25 26 **5. Presentation of Findings and Recommendations**

27
28 Professionals conducting a forensic assessment typically prepare reports that contain
29 findings and, sometimes, recommendations. For recording and organizing information
30 and findings regarding risk factors, PM, and harm, worksheets are provided in Section 4
31 of this document. We encourage the use of the worksheets during the data
32 collection/investigation phase of the assessment and to guide the report-writing phase for
33 presenting the results of the investigation. Appendix F provides a checklist/overview of
34 PM risks, types, and harm.

35
36 The report of a forensic assessment should document all sources of information
37 considered by the professional during the assessment. The report should state the reason
38 for the assessment request, the nature of the professional's assessment, and the findings,
39 recommendations for intervention, and the basis for opinions. In appropriate
40 circumstances, the report may set forth the professional's opinion concerning whether a
41 child has or is suffering from psychological maltreatment or other forms of child abuse
42 and neglect. The report may indicate findings consistent with or inconsistent with
43 psychological maltreatment.

44
45 If the professional concludes that PM has occurred or is occurring, the report should do
46 the following:

- 1 (a) State the form(s) of PM,
- 2 (b) Describe specific related occurrences of caregiver behavior that constitute PM,
- 3 (c) Document the severity through reference to intensity/extremeness, frequency,
- 4 chronicity, pervasiveness, multiplicity of forms, counterbalancing positive
- 5 treatment, developmental saliency, and probable short- and long-term effects of
- 6 the maltreatment, and
- 7 (d) Describe the relationship between PM and harm to the child.

8

9 In cases where the assessment is inconclusive, the professional should state the reasons

10 for the inconclusive finding and should indicate whether, in the professional's judgment,

11 the child is at risk of harm. The child or family problems and needs that have been

12 identified, regardless of whether maltreatment is a factor, should be reported to provide

13 guidance toward interventions for securing and advancing the child's well-being.

14

15 Application of this process (assessment, completion of the data grid, completion of the

16 one-page checklist, culminating in the selection of a category that best describes the case)

17 will result in a judgment as to presence of PM. If the judgment is affirmative, the next

18 step is to consider and select appropriate intervention(s), depending on the case (e.g.,

19 prevention services, therapeutic trial of the parents' or family's capacity to change and

20 sustain change, out-of-home placement, supervised visits) based on the local decision-

21 making guidelines and processes (Graham, Dettlaff, Baumann, & Fluke, 2015).

22

23 Promise toward further progress for PM assessment for treatment planning can be found

24 in existing models. For example, see Glaser's thoughtful and nuanced description of child

25 welfare approaches to assessment most likely to lead to effective intervention planning

26 based on her extensive experience with family services in the United Kingdom (Glaser,

27 2011). Assessments from this perspective can address multiple participants and issues

28 (i.e., addressing child symptoms, parenting stressors, as well as parent-child relational

29 interactions). Each level of the family system needs to be considered as a potential target

30 for a coherent pattern of treatment. An analysis of the child's ecological map as it relates

31 to risk factors for maltreatment would ideally be undertaken to identify the proximal and

32 distal risk factors for maltreatment and compromised child well-being.

33

34 6. Assessment Worksheet

35 We offer here a worksheet format for organizing observations and evidence when making

36 a determination of PM. This form can function as a supplement or replacement of other

37 data collection forms (see Appendix E for an example of a completed form).

38

39 Part A. Risk Factors for Psychological Maltreatment.

40 (Refer to Section 2 of this document for a fuller description of these risk factors.)

41

CHILD FACTORS: high maintenance and demand characteristics, disability, temperament, and behavior.	
Evidence	
Source of Evidence	

Disproving Evidence	
Questions	
Conclusion	
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	
Source of Evidence	
Disproving Evidence	
Questions	
Conclusion	
FAMILY FACTORS: large ratio of children to adults, young, unprepared and poor coping of parents; father absence; aberrant substitute parent 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	
Source of Evidence	
Disproving Evidence	
Questions	
Conclusion	
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 of Evidence	
Disproving Evidence	
Questions	

Conclusion	
------------	--

Summary Conclusion About Risk Factors:
--

Part B. Evidence of Psychological Maltreatment.

(Refer to Tables 1 and 2 for fuller descriptions and examples of these PM types.)

SPURNING: (hostile rejecting/degrading) includes verbal and nonverbal caregiver acts that reject and degrade a child.	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusion	
EXPLOITING/CORRUPTING: caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors) or to meet the needs of the caregiver in a manner that undermines the child's own development.	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusion	
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	
Source of Evidence	
Disproving evidence	
Questions	
Conclusion	

EMOTIONAL UNRESPONSIVENESS: caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring, and love for the child) and showing no emotion in interactions with the child.	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusion	
ISOLATING: caregiver acts that consistently or significantly deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home.	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusion	
MENTAL HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT: includes 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	
Source of Evidence	
Disproving evidence	
Questions	
Conclusion	

1
2
3
4
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7
8

Summary Conclusion About Presence of PM:

Part C. Evidence of Harm to Child.

- 1 (Refer to Section 2 of this document.)
- 2

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, immature defenses).	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusions	
Inappropriate Behavior or Feelings under Normal Circumstances: substance abuse and eating disorders, emotional instability, impulse control problems, dissociation and other thinking problems, and more impaired functioning among those diagnosed with bipolar disorder.	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusions	
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 noncompliance and lack of impulse control, and impaired moral reasoning.	
Evidence	
Source of Evidence	
Disproving evidence	
Questions	
Conclusions	
Physical Health Problems: Delays in almost all areas of physical and behavioral development; allergies, asthma and other respiratory ailments, hearing impairments in infancy, sleep problems, and somatic complaints.	
Evidence	
Source of Evidence	

Disproving evidence	
Questions	
Conclusions	
Summary Conclusion of Harm to Child	

1

2

3

4

SECTION 4. INTERVENTION^{†††}

Intervention as used here is a broad concept covering (a) promotion of good conditions in the psychosocial and physical environments that reduce the likelihood of maltreatment, (b) prevention of negative contributors or facilitators of maltreatment and harm, and (c) correction of maltreatment and harm. Some forms of intervention involve official action on the part of government agencies. Examples of official intervention include investigations by child protective service agencies, provision of home visitor services, and juvenile court orders designed to protect children from maltreatment. Some official interventions occur in spite of the objections of caregivers and represent the legal authority of government to intervene in families. Other interventions can be received on a voluntary basis. In addition to official action on behalf of children, intervention includes a wide range of acts by professionals in public and private sectors. Examples of nonofficial interventions include promoting social support networks through faith groups, schools, and recreation programs; providing therapy for children; and referring caregivers to appropriate agencies for support (e.g., parenting education, help accessing resources).

The present state of interventions for child maltreatment and, particularly, for PM leaves much to be desired and deserves greater attention. The United Nations takes a similar position by recognizing the general inadequacy of historical child protection measures and the importance of advancing multi-faceted coordinated approaches to protect children while giving priority to the promotion of child well-being and primary prevention (Hart, Lee, & Wernham, 2011). Changing maltreating relationships once they are established is very difficult (see relevant meta-analyses by Chen & Chan, 2016; Euser, Alink, Stoltenborgh, Bakermans-Kranenburg, & van Ijzendoorn, 2015; Lundahl et al., 2006; Macmillan et al., 2009). In addition to this general inadequacy of maltreatment interventions, there are presently no interventions available designed specifically to target PM. Therefore, this section is intended to provide assistance toward selecting existing interventions that have relevance for PM and to give direction to intervention development that will be more specific to PM. While it is intended particularly to be

^{†††} Christina Fiorvanti is thanked for strengthening this section through her review and advice.

1 aspirational and heuristic in nature, it is hoped that it will be found to be of genuine
2 practical value, Reader recommendations for strengthening this section will be most
3 welcome.

4
5 In our framing of interventions of relevance to PM, we give strong emphasis to the
6 importance of employing a three-tiered child-rights-informed public health approach,
7 with the overarching goal of achieving child and family well-being. We place central
8 importance on psychosocial health and quality interpersonal relationships, and the
9 environments that give rise to and sustain them.

10 11 **1. Three-Tiered System Approach**

12
13 The three-tiered system for the prevention and treatment of PM and promotion of child
14 well-being is conceptualized to include

15 *Tier 1 encompassing universal well-being promotion and violence prevention*
16 *efforts,*

17 *Tier 2 concentration on pointed intervention for at-risk populations, and*

18 *Tier 3 focused on correction where PM has occurred and requires intensive*
19 *targeted intervention due to the failure or insufficiency of the other tiers.*

20
21 Presently, many U.S. states offer some supportive and preventative services to parents
22 with young children. These most commonly include referrals to community supports and
23 subsidized child healthcare and childcare, home visiting, and Early Head Start for low-
24 income families (Hendrikson & Blackman, 2015). Child protection agencies in the
25 United States are generally not directly responsible for or involved in Tier 1 promotion
26 and prevention efforts but rather become active when families have been referred for
27 being at risk or substantiated for maltreatment. Changes in this regard are needed if
28 universal promotion and prevention are to be embraced to advance child well-being
29 through child protection and child welfare missions.

30
31 Toward this end, the organization and management of a three-tiered approach should
32 bring together all relevant sectors of society, including education, social/human services,
33 health care, and law enforcement, with the goal of framing the expectations and manner
34 in which each can best contribute to the common agenda. In so doing, significant respect
35 should be given to the fact that a majority of interventions have relevance, in adjusted
36 forms, at each tier and can be designed to magnify their connected benefits across all
37 tiers. These possibilities might be realized, maximizing the benefits of synergy and
38 fidelity to principles, by establishing an umbrella authority (children's bureau, office of
39 child and family services, department of child development and health) with the
40 responsibility to achieve high levels of coordination and interaction for child and family
41 serving programs (for a review of related issues, see Winters, Magalhaes, & Kothari,
42 2016). Such a program might be constructed within the promising Comprehensive
43 Community Initiative model (CCI; Zaff, Donlan, Jones, & Lin, 2015), in which all
44 members of the community are involved in the planning, implementation, and evaluation
45 of services for families. The CCI model is comprehensive, individualized, and
46 multidimensional, and it involves communication within and across silos to ensure that

1 child and family needs are being met.

2 **2. Public Health Approach**

3
4
5 A public health approach as conceptualized here stresses the following points: no
6 violence (i.e., maltreatment, abuse, neglect, exploitation) against children is justifiable,
7 all violence against children is preventable; proactive prevention deserves first-level
8 priority; families deserve a central position in interventions, basic resources for
9 promoting health and well-being should be secured; the fundamental causes for violence,
10 harm, and health should be determined; and persons and communities should be educated
11 and empowered and should cooperate and collaborate to prevent violence and promote
12 health and well-being (Hart & Glaser, 2011; see Appendix A in this document).

13
14 A public health approach that blends universal and targeted promotion, prevention, and
15 correction efforts shows great promise in reducing all forms of child maltreatment and
16 improving children's lives (e.g., Sanders & Kirby, 2014). This approach is strongly
17 encouraged. It should bring together every relevant sector and be highly coordinated and
18 interactive within communities and nations, as has been encouraged for three-tiered
19 services in the last section, and it should be expressed and evident across service
20 providers and systems (e.g., pediatricians, psychologists, social workers, daycare,
21 schools, and child welfare). Bross and Krugman (in press) have provided guidance for
22 considering the challenges, merits, and child rights relevance of the way forward to end
23 child abuse and neglect through a public health approach.

24
25 Within the public health framework, consideration should be given to programs such as
26 Triple P (Sanders, 2008; Sanders, Turner, & Markie-Dadds, 1998) and Incredible Years
27 (Gardner & Leijten, 2017; Webster-Stratton, 2006). Triple P has shown some
28 effectiveness for most ages and at all levels of intervention. The Incredible Years
29 programs, considered well-supported by evidence, are applicable across the three tiers,
30 particularly for Tiers 2 and 3 and multiple-age levels. The recent data from the Strong
31 Communities for Children program also highlight the effectiveness of broad-based efforts
32 to modify parenting via improving the quality of life for families (McDonnell, Ben-Arieh,
33 & Melton, 2015), which is consistent with a public health approach to child maltreatment
34 prevention. For families with children who are maltreated or are at risk for maltreatment,
35 the evidence-based service planning for child welfare (EBSP) model deserves
36 consideration for adoption by states and to be implemented by child welfare agencies (see
37 Berliner et al., 2014 for the report of the APSAC task force on this issue). Together, these
38 approaches embody the three-tier characteristic of well-being promotion and
39 maltreatment prevention, involving voluntarily received assistance where recognized
40 vulnerability and threat exist, and respectful intervention where maltreatment has
41 occurred (Prinz, 2016).

42 **3. Child Rights Infusion**

43
44
45 The evidence is now overwhelming that preventable conditions, particularly adverse
46 social relationships and chronic stressors, including child maltreatment/violence,

1 significantly increase risk for psychological and behavior problems and likely play a
2 large contributing role in adult health problems, disease, and early morbidity and
3 mortality (Anda et al., 2006; Biglan, Flay, Embry, & Sandler, 2012; Shonkoff, Boyce, &
4 McEwen, 2009). For this reason, it is imperative that governments and professional
5 organizations concerned with child health and well-being apply the spirit, principles, and
6 standards of the United Nations (1989) *Convention* (i.e., Treaty) *on the Rights of the*
7 *Child*, organize child and family policy to respect the Convention, and prioritize universal
8 well-being promotion and maltreatment prevention efforts that are effective in reducing
9 violence and enhancing competence and positive development (see APSAC, 2010). In
10 this regard, the World Association for Infant Mental Health (WAIMH) has given specific
11 attention to emotional (i.e., psychological) health, development, safety, and abuse in its
12 *Position Paper on the Rights of Infants* (WAIMH, 2014/2016).

13
14 The intervention program examples described in the previous subsection and, in fact, all
15 existing programs can be significantly enhanced through infusion of prevailing child
16 rights principles and standards. Therefore, the child rights-respecting characteristics of all
17 programs should be analyzed and upgraded as necessary to achieve the desired
18 enlightened public health approach. If adopted and widely implemented, the three-tier
19 model of public health, informed by child rights, will move the field into a new era of
20 comprehensive evidence-based practices to achieve child well-being. See Appendices A
21 and D for clarification of child rights standards and applications.

22 23 **4. Essential Components for Effective Intervention**

24
25 It is appreciated that community, child welfare, and child protective services agencies
26 must employ in a selective fashion the resources available to them and rely on what is
27 known about effective child maltreatment interventions in general. This monograph is not
28 designed to encourage narrow interventions derived from a single program or any one
29 agency's menu of options but rather to champion informed aspirations for the field. To
30 the extent that there are choices, the following components are considered worthy of
31 consideration in selecting an existing program, enhancing an existing program, or
32 constructing a program to promote child well-being as well as to reduce and correct
33 maltreatment.***

34 35 **What Parents and Caregivers Need:**

- 36
37 • **Knowledge of child development**, with an emphasis on the range of normal
38 behavior and how needs are expressed behaviorally by children, including
39 specific behaviors that generate caregiver concern, such as separation protest or
40 toddler negativism, and to help parents see events through the child's eyes (i.e.,
41 perspective taking, empathy) (Egeland & Erickson, 2003; Erickson, Labella, &
42 Egeland, 2017; Suess, Bohlen, Carlson, Spangler, & Frumentia Maier, 2016).

*** Martha Farrell Erickson, co-creator of STEEP, provided essential expertise and material to help formulate the guidance here. See related references in this monograph and online at momenough.com for more information. Perspectives and recommendations from readers will be appreciated.

- 1
- 2 • **Skills to enable sensitive responses to infant cues and knowledge of why it's**
- 3 **important to do so.** Included should be reassurance that babies can be
- 4 emotionally supported and securely attached if they receive sufficient sensitive
- 5 contingent responses and parents repair ruptured responses (Egeland & Erickson,
- 6 2003; Erickson et al., 2017; Suess et al., 2016; Tronick & Cohn, 1989). Of course,
- 7 children need sensitive responsiveness from caregivers throughout their
- 8 childhood.
- 9
- 10 • **Social support,** not just social connections (which may be either destructive or
- 11 supportive of the parent–child relationship), to promote a healthy parent–child
- 12 relationship with an eye toward both parent and child health, safety, and well-
- 13 being (see Munsell, Kilmer, Cook, & Reeve, 2012; Ozbay et al., 2007; Sperry &
- 14 Widom, 2013; Tomlinson & Wise, 1999).
- 15
- 16 • **Coping strategies** to deal with the stresses, challenges, and opportunities of
- 17 material/financial conditions, employment conditions, marriage/adult
- 18 partnerships, home management, child rearing, family dynamics, and personal
- 19 need fulfillment. This may require access to effective mental health and substance
- 20 abuse treatment as needed to allow caregivers to be psychologically available,
- 21 present, consistent, and reliable for their children’s personal need fulfillment.
- 22
- 23 • **Active reflection in child rearing** to understand how one’s own relationship
- 24 history, experiences of trauma/PM, and upbringing during childhood affect one’s
- 25 current coping strategies, views and values about parenting, and emotional
- 26 regulation and relational behaviors with others, especially with one’s child. In
- 27 STEEP (described in a later subsection), this is called "looking back, moving
- 28 forward." In many relational interventions, this is also referred to as reflective
- 29 functioning (Beach & Kaslow, 2006; Egeland & Erickson, 2003; Erickson et al.,
- 30 2017; Suess et al., 2016).
- 31
- 32 • **Empathy and compassion** for the children. Empathy is the ability to see and feel
- 33 the world as the child—to understand the meanings given to situations and
- 34 behaviors experienced by the child and the child’s related behavioral expressions
- 35 (Egeland & Erickson, 2003; Erickson et al., 2017; Gordon, 2009; Perry &
- 36 Szakavitz, 2011). Compassion is the desire to reduce someone else’s suffering.
- 37 Together they are a powerful force in motivating caregivers to live the golden
- 38 rule, treat others, and particularly children in their care, as they would want to be
- 39 treated and would have wanted to be treated as children (Hart & Hart, in press, a).
- 40 The capacity to reflect on one’s own childhood experiences, both positive and
- 41 negative, increases the ability to understand how one’s child(ren) might be
- 42 thinking and feeling and to respond in kind.
- 43
- 44 • **Permission for and guidance in setting appropriate boundaries for child**
- 45 **behavior.** Caregivers who set firm, consistent, benign, and clear boundaries for
- 46 the behavior of their children create safe, predictable pro-social conditions that

1 promote practical living competency, self-discipline, establishment of identity,
2 and confidence for the child (Cloud & Townsend, 2001; Gardner & Leijten, 2017;
3 Sanders et al., 1998).

- 4
- 5 • **Mutually respectful conflict resolution.** Resolving conflict in a way that
6 maintains the dignity of each party brings both romantic partners and parents and
7 their children closer together, while harsh/disrespectful actions make mutually
8 satisfying resolutions unlikely and degrade the relationship (Kaminski et al.,
9 2008; Goddard, Myers-Walls, & Lee, 2009; Shapiro, Nahm, Gottman, & Content,
10 2011; Shapiro, Gottman, & Carrere, 2000; Shapiro, Gottman, & Fink, 2015).

11 What Children Need:^{§§§}

- 12
- 13
- 14 • **To be connected, be securely attached, and have ready access to one or more**
15 **trustworthy adults** committed to their safety and well-being who will monitor
16 their treatment and progress, and who will proactively and reactively champion
17 their best interests (see Suess, Erickson, Egeland, Scheuerer-Engelsch, &
18 Hartman, 2017; Toth, Gravener-Davis, Guild, & Cicchetti, 2013; for extra-family
19 models see Court Appointed Special Advocate, Guardian Ad Litem, Big
20 Brother/Big Sister, and elementary school counselor programs).
- 21
- 22 • **To have their views heard and considered** to assure that their experiences,
23 needs, and concerns are respected. This includes having their emotions validated,
24 encouraged and accepted, even while limits are set around appropriate and
25 inappropriate ways to convey those emotions. It should be appreciated that
26 children of all ages have the ability to communicate their needs in some manner.
27 (see Farber & Mazlish, 2012; Gibson, 1988; Garbarino & Stott, 1989). The
28 Children's World project provides a well-researched model for surveying children
29 regarding the status of their well-being (Rees & Main, 2015).
- 30
- 31 • **To be involved in identifying, planning, and choosing interventions,** to the
32 extent that the child's developmental status allows, to benefit from the child's
33 knowledge of what is of concern, needed, and has genuine intervention potential
34 (i.e., what will be understood, appreciated, create safety, achieve investment by
35 and for themselves and in the circles of their social ecology (Farber & Mazlish,
36 2012; Gopnik, Meltzoff, & Kuhl, 1999; Percy-Smith & Thomas, 2010).
- 37
- 38 • **To have models for positive relationships and instruction in how to engage**
39 **positively with others,** including learning how to resolve conflicts peacefully,
40 make one's needs known respectfully, and understand one's right to be treated

^{§§§} The degree to which, and manner in which, these prescriptions are applied will be dependent on the child's developmental status and progress trends. Children at every stage of development communicate their needs and are ready for partnerships to satisfy these needs through human relationships.

Comment 13 (United Nations General Assembly, 2011; the right of the child to freedom from all forms of violence and *General Comment 12* (United Nations General Assembly, 2009; the right of the child to be heard) provide support for this section.

with respect as well as one's responsibility to treat others with respect (Goldstein, 1988; Eisenberg, Fabes, & Spinrad, 2007).

- **To have their resilience promoted** through respecting and advancing their talents, strengths, social support, choice-making ability, self-efficacy, and self-respect (Cicchetti, 2013; SearchInstitute, 2019).
- **To know that their living conditions are predictable and carefully monitored and that an alert system is readily available to them when they are in need or under threat**, allowing them the confidence necessary to live fully and joyfully (Markham, 2012).

What Characteristics Intervention Programs Need:

- **Well-being prioritized** – Programs that strengthen child and family well-being and improve family functioning are preferred over programs that focus more narrowly on preventing reoccurrence of maltreatment and satisfying only a basic level of safety (Hart & Glaser, 2011; United Nations General Assembly, 2011).
- **Strength focused** – leading with strengths and building upon the child's and family's existing capacities before addressing challenges and weaknesses (Hart & Glaser, 2011).
- **Individualized** – rather than one-size-fits-all, with regard to both the child and the parents (Hart et al., 2017; Rose, 2016).
- **Preventive and proactive** – providing universal support, screening for early identification of concern, and initiating effective intervention at the first warning sign, instead of waiting until the child meets criteria for diagnosis, the family becomes dysfunctional, maltreatment takes place, and the child is removed from parents' care (Brassard & Fiorvanti, 2015).
- **Ecologically sensitive** – taking into account context, culture, opportunities, and threats in the community or larger society (Dahlberg & Krug, 2002).
- **Trauma informed** – screening for experiences of trauma, maltreatment, and stress within the family, and working from a trauma lens, utilizing one's experiences of trauma to understand one's unique worldview, vulnerabilities, and ways of being in relationships (Cole et al., 2005; DeCandia, Guarino, & Clervil, 2014).
- **Relationship based** – respecting that the relationship between provider and parent is a vehicle for change more than any specific curriculum, and that in a parallel process the provider is empathic and sensitive with the parent just as the parent is expected to be empathic and sensitive with the child (Egeland & Erickson, 2003; Erickson et al., 2017; Suess et al., 2016).

Relationally focused – programs that promote understanding, reflective thinking, and competency in the relationships and interactions between caregiver and child are the most effective interventions (Egeland & Erickson, 2003; Erickson et al., 2017; Toth et al., 2013).

- **Reflection promoting** – meaning that providers examine their own emotions, relationship history, and coping mechanisms to understand what they bring to the working relationship with clients, again in a process that is parallel to what is being asked of parents (Egeland & Erickson, 2003; Erickson et al., 2017; Suess et al., 2016).
- **Parsimonious (sparing, economic, efficient)** – because it is essential to avoid overloading parents with too many expectations as that can lead to defeatism, low morale, and even failure of the program to produce change. Research shows that in some circumstances, fewer services or shorter length of treatment are often more effective than more services or longer length of treatment (Chaffin et al., 2004; Foshee et al., 2004).
- **Partnership/collaboration based** – Involving the family (parents and child) in the development of a service plan can increase effectiveness of the services and engagement by family members. Whenever possible, family members should be offered a choice about which services they would prefer to receive (Dawson & Berry, 2002; Devaney & Byrne, 2015; United Nations General Assembly, 2011).
- **Accessible** – Many factors can act as barriers to accessing high-quality, evidence-based interventions. Services that are provided in the context of integrated care models, such as integrated primary care and school-based health centers, can increase access to intervention, increase family engagement, and reduce stigma (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015; Brassard, Rivelis, & Diaz, 2009; Njoroge, Hostutler, Schwartz, & Mautone, 2016; Rones & Hoagwood, 2000).
- **Evidence based** – programs demonstrated to be effective should be given highest priority. A number of approaches for improving parenting, parent–child relationships, and child symptomatology have been demonstrated to be effective and these programs should be given highest priority (MacMillan et al., 2009).

At the same time, few of the programs have been evaluated specifically for addressing any or all forms of PM that might be present in a family (see Baker et al., 2011, for how well-known group programs fare in addressing PM content), nor have most of these programs been evaluated for caregivers and children in all types of living arrangements or with all types of unique family situations and stressors. Fidelity to evidence-based models is necessary to ensure that implementation of the program does not drift too far from the model that has been studied and found to be effective. However, some intentional adjustment, monitored for effects, may be necessary to ensure optimal fit of

the program in a new setting (i.e., foster care agency) or new population (i.e., parents of children with a disability).

5. Concentration on Relational, Strength-Based, and Promising Primary Prevention Themes

Three intervention themes—relational, assets, and promising primary prevention approaches—are drawn out for particular attention here because of their inherent and recognized constructive potential for preventing PM and promoting well-being.

Relational interventions are especially promising for dealing with PM. It is our position that relational factors (within the psycho-social domain) play a fundamental role in prevention and correction of child maltreatment, including domestic violence, and in promotion of child well-being, arguably most particularly for PM components. Toth and colleagues (2013) have reviewed relevant research and made a strong case for the necessity to make relational factors, past and present, central to maltreatment interventions. While child development knowledge applicable to good parenting behavior is clearly important for the caregiver, truly effective interventions require that specific attention be given to the interactive relational behavior of the caregiver and child, the meanings embedded and expressed, and their need fulfillment purposes. The relational/interpersonal context is where human needs are met or thwarted, where psychologically supportive or destructive interactions occur. It is the primary context for eliminating PM and promoting well-being. Across the various relational interventions reviewed by Toth et al. (2013), the salient elements employed to greater or lesser extent are interpreted to be as follows:

- a home visitor approach;
- working with parents during the early years of their children's lives;
- multiple observations and consultation for play, conflict, and other interactions across months;
- focus on the caregiver–child dyad with priority given to the relational nature of their behavior and interactions;
- exploration and guidance regarding the child's views and needs and the caregiver's views and needs as communicated in behaviors/interactions;
- guidance in understanding and reformulating representations of self, child, and caregiving;
- modeling and direct support for improving the parent–child relationship in its natural context.

In a later section, which provides suggestions for framing PM-sensitive three-tiered programming, some of the relational interventions considered to be effective or promising will be identified. As a resource to encourage further related explorations of relational interventions, Table 3 is presented, to which further related references will be made.

Table 3: Relational Interventions (Fioravanti, C., & Grossman, H., 2018; derived in part from Toth et al., 2013)

NAME & (Ref.)	Theory Base	Main Purposes	Involves	Int. Pattern	Process	Therapist Interventions	Effectiveness	Criteria Met
Child-Parent Psychotherapy CPP (Cicchetti et al., 2006; Toth et al., 2002; Lieberman et al., 2006; Lieberman et al., 2005; Pickreign Stromach et al., 2013).	Attachment, Psychoanalysis, Developmental Psychopathology, Cognitive Behavioral Therapy, Stress & Trauma work, Social learning	Treatment for families of young children who have experienced trauma or abuse and/or to prevent child trauma and maltreatment in high risk families where parent has experienced trauma	Parents & their children birth – 5 years	Weekly 60-minute sessions in clinic or home for ten to twelve months	Observation, clarification and guidance for spontaneous play, conflict & other interactions.	Express voice of child; Encourage parent's understanding of child's thoughts and feelings (needs, wishes, fears); Model appropriate behavior toward child and provide development guidance; Explore the role of parent's experiences on their behavior toward child and their interpretation of child's actions; Facilitate naming and processing of joint trauma through play.	Promotes attachment security in maltreated toddlers; positive self-representation in maltreated preschoolers; decreased behavioral problems & trauma symptoms in preschool children exposed to domestic violence; Promotes sustained security of attachment.	Well-Established Treatment (Toth et al., 2013) Supported by Research Evidence (California Evidence-Based Clearinghouse for Child Welfare)
Attachment and Biobehavioral Catch-Up ABC (Bernard et al. 2012; Dozier, 2003; Dozier et al., 2008)	Attachment	Enhance parental sensitivity, increase child attachment security in families with multiple risks or children in foster care after maltreatment.	Parents and their children approximately 6 months to 24 months of age	Ten joint parent-child sessions in home	Observe parent interactions and teach parent skills for sensitive, contingent responding to their child.	Use of video-feedback throughout sessions. Notice and praise use of the core skills. Encourage parent to provide nurture and sensitive caregiving when child is distressed, follow child's lead when s/he is in calm state, delight in child's actions, and avoid frightening child or behaving intrusively.	Higher rates of secure attachment post-treatment than comparison group receiving developmental education intervention	Well-Supported by Research Evidence (California Evidence-Based Clearinghouse for Child Welfare) Probably Effective Treatment (Toth et al., 2013)

NAME & (Ref.)	Theory Base	Main Purposes	Involves	Int. Pattern	Process	Therapist Interventions	Effectiveness	Criteria Met
Program in Relational Intervention PRI (Moss et al, 2011)	Attachment	To foster improved parental understanding of interactions between parent and child and increase maternal sensitivity	Caregivers and young children	Brief, eight 90-minute sessions	Similar to CP and ABC under play sessions conditions structured by therapist	Immediate video-feedback of play sessions and reflective process	Attachment more likely to shift from insecure or disorganized to secure—particularly for young children	Probably Efficacious Treatment (Toth et al., 2013)
Promoting First Relationships PFR (Kelley et al, 2008; Specker et al, 2012)	Attachment	To improve child-caregiver relationships -- facilitate deeper caregiver understanding of child's needs and emotions as related to child-caregiving relationships	Young maltreated children and their caregivers	Ten-week, home-based intervention	Clarify child's & parents socio-emotional needs behind behavior; encourage reflection & reframing of meaning of child behavior; work dyadically with parent & child	Video-feedback used in reflective process to help parent learn to correctly interpret child cues	Caregivers show improvements in sensitivity and understanding of toddler's social and emotional needs – children show greater competence	Probably Efficacious Treatment (Toth et al., 2013) Promising Research Evidence (California Evidence-Based Clearinghouse for Child Welfare)
Parent-Child Interaction Therapy PCIT (Chaffin et al, 2004; Chaffin et al, 2011; Hakman et al, 2009; Thomas et al, 2011)	Social Learning and Attachment	Reduce physical abuse, address disruptive behaviors, and improve parent-child interactions	Children 2-7 years of age exhibiting disruptive behaviors and/or in physically abusive families and their parents	Twelve to fourteen dyadic sessions, additional as needed depending upon progress	Teach parenting skills, encourage effective alternatives to physical discipline, interrupt coercive cycles between parent and child	Promote positive parent-child interaction skills and consistent discipline through live coaching and in vivo practice using a one-way mirror and microphone in the parent's car	Reduces re-reports of physical abuse, decreases child behavior problems, and increases parental sensitivity.	Probably Efficacious Treatment for maltreated children (Toth et al., 2013) Well-Supported by Research Evidence (California Evidence-Based Clearinghouse for Child Welfare)
Steps Toward Effective, Enjoyable Parenting STEEP (Egeland & Erikson 1993; Egeland & Erikson, 2004; Suess, G., Erickson, M. F., Egeland, B., Schneurer-Engelsch, H., & Hartman, H-P, 2017).	Attachment Theory	Encourage parental sensitivity and better understanding of the quality of the interactions within the caregiver-child dyad	Parents and children, from second trimester through child's second year of life (extended from original STEEP, in families with multiple risk factors for maltreatment	Biweekly home visits from second trimester through child's second year of life	Provides a corrective emotional experience for parent thru her relationship with the facilitator and working with the parent on her own working models of relationships	Use video-feedback of parent-child interaction to encourage parental sensitivity and address parental representations of their own caregivers that interfere with the current parent-child relationship	Mothers were found to have better understanding of child development and greater sensitivity to their child's cues and signals	Promising Treatment (Toth et al., 2013) (Not able to be rated in California Evidence-Based Clearinghouse for Child Welfare)

NAME & (Ref.)	Theory Base	Main Purposes	Involves	Int. Pattern	Process	Therapist Interventions	Effectiveness	Criteria Met
Circle of Security Parenting COOS - P (Cooper et al., 2003; Hoffman, Marvin, Cooper, & Powell, 2006)	Attachment Theory	Promote secure attachment in children in high risk families	High risk families with children under 6 years old- Caregivers ONLY participate in the intervention	Eight 90-minute weekly small group sessions for parents/caregivers	Caregivers watch and discuss video- recorded interactions and are prompted to consider their relationship with their child throughout sessions, keeping the child in mind through discussion about the parent- child relationship, imparting a relational focus.	Parents receive psychoeducation about attachment theory, meet and discuss each individual caregiver's attachment relationship with child, and areas for growth and change in order to promote secure attachment	Change from disorganized to organized attachment in children whose parents received Circle of Security	Promising Treatment (Toth et al., 2013) (Not able to be rated in CEBC Clearinghouse for Child Welfare)
Interpersonal Psychotherapy IPT (Klerman et al., 1984; Weissman et al., 2000) Interpersonal Psychotherapy- Adolescent IPT-A (Moreau et al., 1991; Muñoz et al., 1993; Muñoz et al., 1996)	Relational intervention	Treatment of depression in adolescents and adults in individuals who have experienced maltreatment	Adults (IPT) and Adolescents (IPT- A)	Typically weekly individual sessions for varying lengths for varying lengths (Twelve to sixteen weeks minimum, up to eight months)	Focuses on individuals' current social and interpersonal functioning in relation to mood symptoms. Focuses on one of four problem areas: role transition, interpersonal conflict, grief and loss, or interpersonal deficits. Adaptions have been made for individuals who have experienced trauma.	Address trauma related patterns to help clients understand how these patterns exert a harmful impact on their current relationship in unwanted ways	IPT: clinically and statistically significant reductions in PTSD, improved relationships with immediate family members (most effective in women with PSTD)	IPT: Well-Supported by Research Evidence (California Evidence- Based Clearinghouse for Child Welfare) IPT-A: Promising Research Evidence (California Evidence- Based Clearinghouse for Child Welfare)
Group Attachment Based Intervention GABI (Murphy et al., 2015)	Attachment theory, Trauma informed care	Promote secure parent-child attachment and prevent disorganized attachment relationship in young children and parents whose histories and current contexts	Vulnerable families with infants and toddlers	Parents and children attend group with other families up to three times a week for 120 minutes; Long term treatment	Parents and children start group together with other parent- child dyads and therapists. Therapists support parents' reflective functioning through play interactions.	Gives parents the opportunity to build secure relationships with their children and works towards repairing their own relationship histories	Improved reflective capacities for parents	Clinical trial in process

NAME & (Ref.)	Theory Base	Main Purposes	Involves	Int. Pattern	Process	Therapist Interventions	Effectiveness	Criteria Met
		place them at risk			Parents then separate from their children for parent-only group to explore past experiences alongside current struggles of parenting.			
Play and Learning Strategies - Infant Program: Toddler/Preschool Program PALS I - Infant PALS II - Toddler/Preschool Landry et al., 2006)	Attachment theory, Developmental Guidance	Preventive intervention to facilitate contingent responsive parenting, increase parents' emotional support to children, and help parents to maintain child's focus	PALS I: 5 - 15 months PALS II: 18 months to 4 years	Fourteen 90-minute weekly in-home sessions: Ten home visits with parent-child dyad, Two visits with other caregiver and child, Two sessions of developmental knowledge training	Guided curriculum includes behaviors linking four aspects of responsiveness of mothers to children: Understanding and responding contingently to cues, encouraging child's self-regulation, maintaining child's focus, and building language.	Includes video feedback, planning with mothers how to integrate responsive behaviors into everyday activities	Increased maternal warmth, Improved contingent responses to child and use of redirection	Promising Research Evidence (California Evidence-Based Clearinghouse for Child Welfare)
Multisystemic Therapy for Child Abuse and Neglect MST-CAN (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009; Swenson et al., 2010)	Multiple theories, including Family Systems, Cognitive Behavioral Therapy, Behavior Analysis, and Social Ecology Theory	Intensive treatment for families with an abuse history with the goals of maintaining placement with biological family or reunifying child with parents, reducing maltreatment, improving mental health functioning, and improving parenting	Families of children between the ages of 6 and 17 years with documented report of physical abuse or neglect	Intensive services, from three times per week to daily for six to nine months in home or some other convenient location. 24-hour on-call service available.	Team-based intervention with 3 therapists, crisis caseworker, psychiatrist, and supervisor. Begins with a comprehensive assessment of strengths and needs of individuals and systems within the family. Each problem behavior is assessed to determine the driving factors behind that behavior, which are then targeted by intervention.	Integrates many evidence based treatments to determine the root of negative behaviors in the family, such as functional analysis of the maltreating behavior and Cognitive Behavioral Therapy to target anxiety that is contributing to maltreating behavior. Also incorporates extensive safety protocols.	Reduced child mental health symptoms, Reduced parent psychiatric distress, Fewer parenting behaviors associated with maltreatment, Fewer out-of-home placements and changes in placement, and Increased social support for parents.	Supported by Research Evidence (California Evidence-Based Clearinghouse for Child Welfare)

NAME & (Ref.)	Theory Base	Main Purposes	Involves	Int. Pattern	Process	Therapist Interventions	Effectiveness	Criteria Met
Minding the Baby MTB (Sadler et al., 2013)	Attachment theory, Social Ecology theory, Self-efficacy theory	Home visiting intervention for at risk new mothers and their babies to promote positive health, mental health and attachment	At risk pregnant women and families of young children up to 24 months	Home visiting from pregnancy through the child's second birthday	Interdisciplinary home-visiting team of pediatric nurse practitioner and licensed clinical social worker bridging primary care and mental health to enhance the mother-infant relationship. Clinicians promote secure attachment and strong parent- child relationship, along with health and mental health.	The relationship between the clinician and parent provides the positive relationship interactions of containment, attunement, and acceptance that are necessary for change and subsequent positive impact on the parent-child relationship. Clinicians support and encourage parental reflective functioning.	Lower rates of child protection referrals; More vulnerable mothers were found to be more reflective in their parenting (rather than reactive); Higher rates of secure attachment and lower rates of disorganized attachment in teen mothers	Evidence-Based (Home Visiting Evidence of Effectiveness HomVEE review)

A strengths or “assets” approach deserves inclusion in PM interventions, as previously encouraged for all interventions. Of relevance here would be the Appreciative Inquiry approach (Cooperrider & Whitney, 2010), a powerful organizational

development model for identifying the existing factors within a program or agency that already support a selected goal, in this case children's well-being, and identifying other opportunities or avenues for additional support. For example, it could promote achievement of the external and internal developmental characteristics or assets of a child formulated by the Search Institute or the "Student Support Card," seven factors that influence youth development as constructed by Kaleidoscope Connects. Both of these allow for systems and individual child programs to relate families, schools, and community in identifying and promoting conditions that advance the well-being of children. At a case-specific level, the Appreciative Inquiry model could be employed to identify existing good parenting characteristics, including good intentions and interpersonal behavior, for attention and magnification by caregivers.

The research findings of Gottman and associates in regard to successful marriages provide guidance worthy of consideration toward achieving effectiveness for all interpersonal relationships (Gottman, 2011; Gottman & Silver, 2012; Gottman & DeClaire, 1997). For example, the concept of the "magic ratio" (i.e., five positive to every one negative interpersonal message) for achieving "positive sentiment override" in marriages could be applied by providers in their communication with parents/caregivers, particularly to encourage investment in positive change and expanding of behavior assets supportive of child well-being. In a similar vein, consider the value of magnifying the positive psychosocial behaviors that are the obverse of PM. Child well-being should be enhanced, and PM prevented or reduced if the positive behaviors contrasted with the following PM behaviors are increased proportionately in their ratio relationship.

- ⌘ *Respecting, valuing, promoting self-respect, and self-esteem should be increased; Spurning should be decreased.*
- ⌘ *Assuring/securing safety, sensitive care, and trust should be increased; Terrorizing should be decreased.*
- ⌘ *Assuring/securing social involvement of a respectful caring nature and social support should be increased; Isolating should be decreased.*
- ⌘ *Nurturing and promoting developmentally and socially appropriate expectations for behavior and functioning; Corrupting-Exploiting should be decreased.*
- ⌘ *Attending, listening, sensitive responsiveness, checking understanding, and providing feedback and assistance should be increased; Psychological-Emotional unresponsiveness should be decreased.*
- ⌘ *Monitoring development and needs, cooperating with and enlisting service providers, applying interventions recommended and prescribed by service providers should be increased; Neglect of medical, mental, and educational needs should be decreased.*

Increases in caregiver response patterns toward the "magic ratio" for these positive versus negative (PM) psychosocial behaviors should be possible with sufficient encouragement, practice in simulation and real life, and monitoring by trusted sources, including self through application of technology. There is reason to consider the quite credible visions for technology that can serve humans in the future (Kaku, 2012). It might be possible, eventually in real time, for a person to be informed through technology of his or her

vocalized/physical prosocial to antisocial communication patterns or ratios and to be encouraged to increase the ratio in favor of prosocial statements. A system has already been produced to similarly monitor and guide text messaging to overcome cyberbullying (see Rethink at <http://www.rethinkwords.com>; <https://itunes.apple.com/us/app/rethink-stop-cyberbullying/id1035161775?mt=8>).

Primary prevention components known to be of particular promise have been identified by Finkelhor (personal telephone communication, August 25, 2010). These include the following: raising normative standards for the treatment and care of children; increasing “bystander mobilization” to increase the likelihood persons will intervene on behalf of the best interests of children, and strengthening the agency of children to act in their interests themselves or through others (originally reported in Hart & Glaser, 2011, p. 759). If genuine traction is to be achieved toward an emphasis on primary prevention, strategies that work should be employed. These strategies are highly relevant for PM intervention and can be formulated for inclusion in all tiers. Some related applications are addressed in the next subsection.

6. Suggestions for Framing PM-Sensitive Three-Tiered Programming

We have argued that intervention for maltreatments of all forms should be designed to promote synergy within and across all three tiers. To suggest realistic possibilities in this regard, Hart et al. (2017) have previously described the manner in which the same intervention themes can be included in variant forms across tiers.

For example, a combination of the home visitor (Sweet & Applebaum, 2004; U.S. Department of Health and Human Services and Administration for Children and Families, 2016) and family group conferencing model (Child, Youth & Family, 2014) variations offer promise across all levels. For Tier 1, home visits, education, connection with resources, and encouragement for the prospective parent and other family members could be offered to all families in preparation for and to sustain good child care; for Tier 2, alerts from any family member, including the child, could lead to guided family (and extended family) meetings, planning, action, and evaluation loops; and at Tier 3, a modified Multi-Systemic Treatment approach (Henggeler et al., 1998), including time- and results-limited 24/7 monitoring, planning, and networking with family and community.” (p. 157)

In this subsection some of the interventions of high-PM relevance that have potential for application in a three-tier system are suggested for consideration. This is not intended to be comprehensive in any sense, but rather to illustrate possibilities and to encourage confidence and interest toward further exploration and related applications.

For Tier 1

To promote the well-being of children and prevent violence against them, it is essential to provide ongoing developmental support to promote desired characteristics in those who are or will become parents or otherwise influence children. All facets of the community

1 can cooperate in advancing the psychosocial health and competency of persons who will
2 influence the lives of children. Here, as examples, we suggest strategies to (a) inform and
3 guide the public at large, (b) help families of young children, (c) prepare adolescents to
4 be good romantic partners who avoid psychological, sexual, and physical violence as
5 either a perpetrator or a victim, and (d) prepare children themselves to eventually become
6 good caregivers.

7 **Public information campaigns/programs** are viable channels for promoting Finkelhor's
8 three strategies (raising standards, mobilizing bystanders, and strengthening children's
9 agency) for primary prevention. These could be designed to inform prospective and
10 current parents about children's needs and well-being status, to recognize children's
11 expressions of their needs, parenting/caregiving behaviors that respect those needs and
12 promote well-being (as contrasted with poor parenting or PM behavior), and to establish
13 the expectation that parents will respond sensitively to child needs/expressions with
14 positive interpersonal behaviors obverse to PM. If child well-being is to be seriously
15 promoted, standards or indicators for its existence are essential. High-quality work
16 already underway provides guidance for developing child well-being indicators (see Ben-
17 Arieh, 2007; Huebner, 1994; Kim, Furlong, Ng, & Huebner, in press) that could become
18 widely adopted community standards for the treatment of children. Guidance is available
19 for incorporating child's views in such a campaign, for example by surveying their
20 subjective perspectives on their well-being (See Children's Worlds research; Rees &
21 Main, 2012). The combination of such public information and consensus-building
22 programs should advance recognition and investment for normative standards, encourage
23 good caregiving and vigilance in its regard, and offer respect for the child as a person and
24 partner.

25 **For adults preparing for or already involved in child rearing**, direct services
26 incorporating relational intervention components can shape parents' intentions,
27 capacities, and practices to promote child well-being and combat PM. The Program in
28 Relational Intervention (PRI; Moss et al., 2011) and Steps Toward Effective and
29 Enjoyable Parenting (STEEP; Egeland & Erickson, 1993; Egeland & Erickson, 2004;
30 Suess et al., 2017), alternatives presented in Table 3, are promising interventions
31 applicable at Tier 1. They promote parental understanding, sensitivity, and supportive and
32 satisfying caregiver-child dyad interactions. They also both provide immediate
33 videotaped feedback to parents to enhance their reflective processes in ways that are
34 respectful of their good intentions and potential to learn and improve. There is significant
35 support for prioritizing parent-infant attachment because of the foundations it establishes
36 for the child's future well-being (Benoit, 2004; Colin, 1991; Rees, 2007). These programs
37 are based on related theory, intend to facilitate advances toward this goal, and show
38 promise in doing so.

39
40 **The couple relationships of future parents** are another focal point for Tier 1 attention
41 that can profoundly shape an infant/s or child's experience of family life—his or her
42 health, resilience, and well-being (Shapiro & Gottman, 2005). Adolescents can learn
43 what quality romantic relationships look like and avoid being either a perpetrator or a
44 victim of dating violence through participation in an evidence-based program offered in

secondary school health classes or the regular English high school curriculum. In this regard, programs worthy of consideration include Safe Dates (Foshee & Langwick 2004; 2010), a 9-week health curriculum designed to reduce dating violence, and the Fourth R (Wolfe, Crooks, Hughes, & Jaffe, 2001), a more comprehensive high school English or health curriculum designed to help adolescents form healthy relationships and make better choices in the areas of substance use, sexual relationships, bullying, and violence. Both programs have been implemented in random clinical trials and found to have immediate and lasting positive influences on targeted romantic behavior (Crooks, Scott, Ellis, & Wolfe, 2011; Crooks, Wolfe, Hughes, Jaffe, & Chiodo, 2008; Foshee, Bauman, Arriaga, Koch, & Linder, 1998; Foshee et al., 2004; Wolfe, Crooks, Chiodo, Hughes, & Ellis, 2012; Wolfe et al., 2009).

Programs for children and youth cannot be started too early to help set the stage for them to be good and sensitive caregivers of the children they will eventually influence in parent or other caregiver roles. At school age, relevant programs are available to teach prosocial skills to children and youth in schools (Goldstein, 1988), including the Skill Streaming series (see guides across all the school years by McGinnis, 2011a, 2011b, 2011c), Positive Youth Development (PYD; see Lerner, 2005), Social Emotional Learning (SEL; see Schonert-Reichel & O'Brien, 2012; Elias, 2003; and on the CASEL website, www.casel.org); Prosocial Education (Carlo, 2006; Eisenberg, Eggum, & Di Giunta, 2010), and character education (Berkowitz & Bier, 2005). Empathy capacity, highlighted previously as a central component promoting good caregiving, may be advanced for children as recommended by Perry and Szalvatiz (2011) through the Roots of Empathy (ROE) program for schools (Gordon, 2009), which gives children opportunities to observe infants and develop an understanding of their needs for sensitive and contingent care. There are also effective programs of empathy training for those beyond childhood (see Teding van Berkhout & Malouff, 2016).

For Tier 2 and Tier 3

There are many intervention avenues of promise that can serve both populations at-risk and those experiencing maltreatment. Here, particular attention is given first to public information programs, and then to the formulation and practices of child protective services, and finally to the relational interventions of promise.

Public service campaigns, again, are a promising strategy for creating awareness and sensitivity about the nature, types, and consequences of PM. These campaigns, applicable at all tiers, could be designed to create a shared understanding that PM is not acceptable, promote strategies for enlightened bystanders to intervene in order to discourage and positively redirect PM, and to inform children of the unacceptability and dangers of experiencing such behaviors and ways to respond directly and through supportive others. Toward this end, public awareness-education campaigns should be conducted ... this could include revitalization and expansion through today's social media of the 1988 emotional child abuse campaign of the National Committee for Prevention of Child Abuse, which employed a Spiderman comic book. (Cited by the following: Hart et al.,

2017, p. 156–157), and public service videos such as “But Names Can Hurt Forever” [Northern Wisconsin In-School Telecommunications (NEWIST), 1987].)

Additionally, public media, through the use of experts and panels, could explore the relevance of PM in high-profile cases given attention by the media (e.g., Rand, 2018, on the Menendez murders, British Broadcasting Corporation on the DaddyOfive case). The promising prevention strategies, as identified by Finkelhor, can include campaigns of this nature to raise normative standards in general and particularly for child caregivers and bystanders within or observing childcare whose related constructive actions are desired. They can also sensitize the child to the need for support and strategies for seeking it.

Child Protective Services (CPS) programs of prevention and correction will be advanced by their recognition and appreciation of the nature of PM and by its specific inclusion in statutes, standards, and services. At a minimum, this means that CPS intake/referral stages must solicit information related to PM occurrences and their frequency and magnitude; that investigations must specifically explore PM forms, as they stand alone and associate with other types of maltreatment, to determine their frequency, severity, sources, and facilitators and existing and potential inhibitors; that determinations and their official establishment, including through court processes, must include consideration of PM; and that preventive and corrective interventions, required or encouraged, must include specific consideration of PM. As part of CPS programs or more general public health programs, PM and PM-related harm should be surveyed across population sectors (e.g., child development stage/age; socioeconomic strata; living and service provision settings—family, school, medical, and mental health services, sports/recreation, faith community). In this regard, it is informative that in Maine, where CPS programs employ earlier versions of the PM definitions in this monograph, PM prevalence has been found to be second only to child neglect (Maine Department of Health and Human Services, 2015). This suggests that when CPS attends to the full spectrum of PM types, more cases will be identified. While this may not be seen as a desirable outcome for already overburdened services, it may be reframed to both justify strong encouragement for Tier 1 programs and for assuring that PM experts are more readily available and exert greater influence on interventions at all stages, particularly those employed for at-risk populations.

Relational interventions, all of those reviewed by Toth et al. (2013) and in the larger set described in Table 3, have components that can be applied in originally intended or adjusted forms at all tiers. The majority of the relational interventions were developed for application where maltreatment risk and existence are at issue. Child–parent psychotherapy (CPP), partially derived from Fraiberg’s “psychotherapy in the kitchen” (Fraiberg, Adelson, & Shapiro, 1975), is intended for conditions in which young children are at risk for or have experienced maltreatment. It is recognized to be a particularly effective intervention for promoting high-quality parent–infant relationships in early childhood and to advance secure attachment and decrease behavioral problems and trauma symptoms in children (Toth, Rogosch, Manly, & Cicchetti, 2006). It shares many characteristics with PRI and STEEP, described under Tier 1, and gives particular emphasis to promoting reflective caregiving sensitive to the meanings of the behaviors of

1 caregiver and child in dyadic relations. Among the other relational interventions worthy
2 of consideration are attachment and biobehavioral catch-up (ABC; Bernard et al., 2012;
3 Dozier, 2003; Dozier et al., 2008), well-supported by research, meant for application to
4 infants and toddlers, and circle of security parenting (COS—P; Cooper, Hoffman,
5 Powell, 2003; Hoffman, Marvin, Cooper, & Powell, 2006), judged a promising treatment
6 meant for children under 6 years of age. While both have been shown to advance secure
7 attachment, ABC involves both caregiver and child while COS—P involves only the
8 caregiver. For caregiving involving older children, two interventions deserving
9 consideration are (1) Parent–child interaction therapy (PCIT; Chaffin et al., 2004;
10 Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Hakman, Chaffin, Funderburk, &
11 Silovsky, 2009; Thomas & Zimmer-Gembeck, 2011), which is applicable for children
12 ages 2–7 and employs dyadic caregiver–child sessions, increases parental sensitivity, and
13 reduces re-reports of physical abuse and child behavior problems, and (2) multisystemic
14 therapy for child abuse and neglect (MST-CAN; Henggeler et al., 2009) which is for
15 families with children 6–17 years of age with documented reports of abuse and neglect,
16 employs a multidisciplinary highly intensive team approach, and reduces child and parent
17 mental health and behavioral problems. Both are well supported by research.

18
19 Before closing this section, it is important to comment on the home visitor model, which
20 provides a framework applicable across the tiers. It is capable of incorporating many of
21 the components of relational therapies and could be effective as a gateway to bridge
22 families experiencing needs beyond a particular program’s capacity to one whose design,
23 resources, and practices are a better fit. The home visitor model provides good reasons to
24 be optimistic for future progress in this regard. For example, Prevent Child Abuse
25 America’s (<http://preventchildabuse.org>) Healthy Families America program
26 (<http://www.healthyfamiliesamerica.org/the-hfa-strategy-1>) is recognized for its success
27 in promoting good parenting and preventing child maltreatment for at-risk populations.
28 Home visitor programs, to the extent that they incorporate a relational intervention focus
29 and give attention specifically to PM prevention and to the achievement of
30 relations/behaviors obverse to PM, have the potential to advance psychosocial well-being
31 and both PM prevention and correction. As previously noted, it is important to recognize
32 that interventions appropriate in one tier might be appropriate in another and that
33 establishing continuity and synergy for program components may increase benefits at all
34 levels. The home visitor model is a case in point. In this regard, Martha Davis, senior
35 program officer at the Robert Wood Johnson Foundation, has effectively argued for home
36 visitor services to be made available to all parents/families (Davis, 2016). It is
37 encouraging to note that home visitor programs are freely available for first-time parents
38 in parts of New Mexico and Tennessee .
39

1 **Connecting Links for Interventions Within and Across Tiers**

2 If the three-tier framework is to realize its potential, effective organization and
3 management are imperative. One of the critical components of effective organization and
4 management is the ability to guide parents to services they need or desire or that are
5 required, to improve already acceptable caregiving (Tier 1), prevent poor parenting from
6 becoming maltreatment (Tier 2), and to overcome their PM behavior (Tier 3). Useful
7 guidance is available in this regard (see for example, *Child Protection in Families*
8 *Experiencing Domestic Violence*, Bragg, 2003).

9 Prospectively, a reformulation and expansion of the well infant/baby clinic model could
10 greatly facilitate three-tier service provision and connectivity to available services (see
11 the report of the Congress on the Baby-Friendly Hospital Initiative (World Health
12 Organization, 2016). A recommendation has recently been made by the International
13 Institute for Child Rights and Development to design and establish child/youth well-
14 being clinics to work in concert with parents and community services to monitor,
15 promote, and secure child rights and well-being for all children from conception through
16 adult status. The proposal has been endorsed by a wide body of international child rights,
17 development, and protection experts (IICRD, 2015). It has been argued that health and
18 development centers of this nature might be most effective if they are based in school
19 systems (Hart & Hart, in press b).

20 **7. Toward a Future of Progress**

21
22 Awareness and understanding of PM can play a significant role in achieving a
23 transformation of policy and practice toward well-articulated and synergistic three-tier
24 interventions in the interests of children. PM is nearly ubiquitous in the context of child
25 maltreatment, a primary cause of negative developmental outcomes from maltreatment,
26 and is generally inadequately addressed in current practices. Advances will require a
27 coordinated and concerted effort to train all professionals who work with children and
28 families to recognize psychological maltreatment, respect the human rights of all parties,
29 and be familiar with the three-tier intervention approach put forth here. For direction on
30 system configurations, supports, and changes that may be required in a child protection
31 service system for the system to truly promote effective practice, see Appendix C.

32
33 New programs are being developed and tested all of the time. The best way to find out
34 about new programs is to search various evidence-based registries of effective programs
35 (e.g., California Evidence-Based Clearinghouse for Child Welfare,
36 <http://www.cebc4cw.org/>). No one registry contains every program and all registries
37 include programs that may not be relevant or appropriate for a particular setting or
38 family, so care must be taken. As previously noted, a program may be recognized as
39 effective or evidence-based for a particular problem, setting or particular population and
40 may not be evidence-based for a new setting or population.

APPENDIX A.

An Enlightened Public Health Approach for Child Protection

A child rights public health transformation of child protection has been recommended for international application. The best-fit configuration for achieving this will vary according to national, local, and cultural conditions. However, in any configuration and staging of stepwise progress toward this goal, essential principles and elements deserve incorporation toward the desired future. This is true for each of the major domains of violence against children (i.e., United Nations definition, including physical, psychological, and sexual maltreatment and exploitation) and for all levels/categories of intervention (e.g., promotion of good childcare/treatment), prevention, and correction of violence against children.

A widely acknowledged set of these principles and elements follows, emphasizing that a child rights health approach necessitates that

- Child well-being and “well-becoming” (including safety and thriving) are the primary goals of child protection and that all interventions respect and contribute to these goals.
- Child well-being is conceptualized holistically, and interventions focused on any one of set of child conditions respects influences on the remaining child conditions in both the short and long term.
- A rights-based approach is applied, respecting the best interests, dignity, evolving capacities, perspectives, and agency of the child.
- Every child’s survival and well-being are pursued without prejudicial discrimination.
- Every child’s development is monitored, tracked, and supported toward health and well-being.
- No violence against children is considered justifiable.
- All violence against children is considered preventable.
- Proactive prevention is given first-level priority.
- Families are given a central position in interventions.
- The basic resources for promoting health and well-being should be secured.
- The fundamental causes for violence, harm, and health should be determined.
- Persons and communities should be educated and empowered to cooperate and collaborate, to prevent violence, and to promote health and well-being.
- Child rights education and training should be infused into all preparatory and continuing education for child caregivers and for child protection, legal, and health professionals.

The psychological components of serving and achieving child well-being and of reducing and eliminating psychological maltreatment and other forms of violence are central to the establishment and success of this model. The widely endorsed three-tiered model of child protection would rely heavily on strengthening psychological and psychosocial

1 conditions in its configuration of interventions to deal with three major sectors of the
2 human population:

- 3 (a) general population/all persons,
- 4 (b) at-risk populations displaying characteristics described in the preceding
- 5 Contributions and Causes section, and
- 6 (c) populations in which maltreatment has been/is occurring.

7
8 For each of these sectors, attention would be given to interventions such as the following:
9 advancing understanding and application of child development knowledge, self-
10 regulation, prosocial behavior, empathy, social competency, social support, bystander
11 mobilization, and measures of objective and subjective child well-being (United Nations
12 General Assembly, 2011).

APPENDIX B.

International Definitions

The U.N. Convention on the Rights of the Child uses the word *violence* to subsume all forms of abuse, neglect, exploitation, and maltreatment. Article 19 of the Convention requires State parties to “protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment, or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s), or any other person who has care of the child.” General Comment 13 (U.N. General Assembly, 2011), “*The right of the child to freedom from all forms of violence*,” elaborates that children have the right to be free not only from violence and abuse but also to be free from family and societal neglect—and the right to be invested in and treated with dignity (see Hart et al., 2011, and Bennett, Hart, & Svevo-Cianci, 2009).

General Comment 13 on Article 19, paragraph 4, states that the term violence has been chosen here to represent all forms of harm to children as listed in Article 19, paragraph 1, in conformity with the terminology used in the 2006 United Nations study on violence against children, although the other terms used to describe types of harm (injury, abuse, neglect or negligent treatment, maltreatment and exploitation) carry equal weight. In common parlance the term violence is often understood to mean only physical harm or intentional harm. However, the Committee (*U.N. Committee on the Rights of the Child*) emphasizes most strongly that the choice of the term violence in the present general comment must not be interpreted in any way to minimize the impact of, and need to address, non-physical and non-intentional forms of harm (such as, inter alia, neglect and psychological maltreatment).

Mental violence according to General Comment 13 (IV.A.21): “Mental violence,” as referred to in the Convention, is often described as psychological maltreatment, mental abuse, verbal abuse, and emotional abuse or neglect, and this can include the following:

- All forms of persistent harmful interactions with the child, for example, conveying to children that they are worthless, unloved, unwanted, endangered, or only of value in meeting another’s needs;
- Scaring, terrorizing, and threatening; exploiting and corrupting; spurning and rejecting; isolating, ignoring, and favoritism;
- Denying emotional responsiveness, neglecting mental health, medical, and educational needs;
- Insulting, name calling, humiliating, belittling, ridiculing, and hurting a child’s feelings;
- Exposing a child to domestic violence;
- Placing a child in solitary confinement, isolation, or humiliating or degrading conditions of detention; and
- Psychological bullying and hazing by adults and other children, including via communication and information technologies (ICTS) such as mobile phones and the Internet (known as “cyberbullying”).

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Within the Child Custody/Family Court/Forensic Setting:

1 *Custody Evaluators:* Mental health professionals engaged to conduct custody evaluations
2 as part of a best interests of the child (BIC) evaluation should be trained on the forms and
3 effects of PM so that they can factor that information into their overall evaluation strategy
4 and report. Many states include in their BIC statute whether a parent has been abusive
5 toward a child, however, unless the evaluator has received training specifically in PM,
6 she or he may not be attuned to this sometimes subtler form of maltreatment.

7
8 *Visitation Supervisors:* Mental health professionals tasked with overseeing supervised
9 and therapeutic visitation should receive mandated training on PM so that they can
10 identify it when observed between parents and children and factor that information into
11 their reports to the courts and guidance to child caregivers.

12
13 *Mental Health Providers:* Clinicians appointed by the court (or those who are reporting
14 to the court although not appointed by the court) should receive mandated training about
15 PM so that they can identify it when they observe it and factor PM and associated
16 information into their practices and reports to the court regarding the quality of parent-
17 child relationships.

18
19 *Additional Family Court Considerations:* Family courts vary across states/jurisdictions.
20 In addition to above service categories, they may have personnel dealing with divorce
21 decrees, child support, guardianship, child protection, and criminal and juvenile justice
22 proceedings. The judiciary and all other persons involved in related roles which deal with
23 or create influences on the child should be educated in regard to PM and its implications
24 for fulfilling their responsibilities.

25
26 All mandated reporters should receive training in PM in order to identify it when they
27 observe it. They should know whether it is actionable in their state and be familiar with
28 interventions and resources to recommend to/for caregivers toward improvements.
29
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APPENDIX D.

Application of a Child Rights Public Health Approach in the Three-Tiered System

The opportunities and expectations of Appendix A (An Enlightened Public Health Approach for Child Protection) and Section 2.6 (Intervention: A Three-Tiered Evidence-Based System) within the present document deserve articulation and integration toward maximum synergy, power and efficiency. In practice, this requires something in the way of a community “coordinating framework” to achieve systematic cooperation to promote well-being at the all population or universal level, reduce risk at the targeted vulnerability level, and overcome maltreatment at the specialized adverse experiences level. Such a coordinating framework has been recommended in GC13 (Section 69) to involve all major sectors responsible for securing and advancing child well-being (e.g., government, law enforcement, family, educational, health, social and protection services).

The community-coordinating framework should be grounded in a public health orientation, committed to child well-being as its central goal, and employ child rights respecting principles and strategies toward its ends. If these major components are selected and constructed through highly participatory community involvement, it would provide the most promising base of understanding and investment for planning, development and implementation of programs. Plans and actions for each of the three-tiers could radiate primarily from a common base of either child rights principles or empirically supported intervention themes. Here are some examples of each pattern.

Table 4. Child Rights.

	Tier 1	Tier 2	Tier 3
CHILD RIGHTS: Child Participation	the subjective perspectives of all children are surveyed periodically regarding their well-being and related supporting conditions with findings applied to achieve improvements	children and child teams research (survey and action methods) the physical and psycho-social dangers and threats and support components in their environments, maintaining appropriate levels of anonymity, to guide programs of assistance and intervention	maltreated children are informed of the nature of services and interventions available to them, are consulted in regard to viable options, and are involved in the design and monitoring of interventions to assure that needs and potentials, holistic and beyond the immediate concern, are not put in jeopardy
CHILD RIGHTS: Nondiscrimination	the holistic development and	At-risk children, families, and sectors	potential for perpetrator and

	well-being of all children are periodically evaluated and promoted through expanded and strengthened forms of the “well baby/child clinic” model	are identified/mapped and accountability assured for equity in provision of family assistance	family rehabilitation is evaluated where maltreatment has existed, and determination of intervention is made through blind review by an expert panel
INTERVENTION THEME: Parent Support	all middle school and high school children experience hands-on childcare and parenting preparation (in school/community day care/nurseries)	home visitor programs educating and guiding good childcare practices are provided for all new parents in at-risk circumstances or requesting the services	parenting groups and mutual support are provided for all families where maltreatment exists
INTERVENTION THEME: Social Support	social competency is promoted as a basic skill for all school children	”No Family/Parent Left Out” programs of social networking and support exist in all sectors of the community	family group conferencing is applied for children experiencing maltreatment

Multiple benefits can accrue from application of this model if its potential advantages are intentionally and rigorously pursued. Toward this end, a community coordinating framework could

- (a) be implemented through a center accurately representing critical service and population components of the community,
- (b) work transparently and cooperatively with the community in multiple partnerships, including with parents and children,
- (c) pursue goals and apply practices that have been community generated/selected/approved,
- (d) employ rights and intervention themes in coherent mutually supportive fashion across tiers,
- (e) apply an accountability system of indicators, measures, evaluation, and reporting for goals, interventions, and child outcomes,
- (f) continuously upgrade programs and services on the basis of relevant research and empirical evidence, and
- (g) educate the community in general and child protection service providers specifically in the public health and child rights orientations.

- 1 On a broader scale, there are also efforts to address child abuse and neglect globally.
- 2 Finkelhor and Lannen (2015), for example, have articulated the advantages and
- 3 disadvantages of various efforts to reduce maltreatment of children worldwide.

APPENDIX E.

Assessment Worksheet Case Example

Child is TA, male, age 10, second of five children born to a married couple:

Part A. Evidence of Psychological Maltreatment. (Refer to Tables 1 and 2 for fuller descriptions of these PM types.)

SPURNING: (hostile rejecting/degrading) includes verbal and nonverbal caregiver acts that reject and degrade a child. SPURNING includes the following:	
Evidence	<p>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!”</p> <p>Upon questioning about the family drawing, TA reported that his Dad screams at him and his two younger brothers, calls them names like “dummy,” and “idiot,” and “loser,” all the time, but especially when his Dad’s parents are present. Says his older and younger sister are Dad’s favorites, they can do no wrong, Dad calls them his princesses, tells them they are beautiful, is affectionate to them.</p> <p>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. Says his girls are well behaved. Oldest one, age 11, is a good student. Causes no problems. The youngest is in preschool, “so cute.”</p> <p>Mom says Dad does prefer the girls and is critical of the boys, frequently calling them names.</p> <p>Teacher says TA very tense at school, flinches if touched on shoulder unexpectedly.</p>
Source of Evidence	Child interview, Father interview, Mother interview, Teacher interview, School psychologist interview and notes, review of school record.
Disproving Evidence	
Questions	Is Dad sexually abusing the girls?
Conclusion	Mother, father, and TA all report that father frequently uses degrading language to TA and his brothers and singles them out for markedly worse treatment than their

	sisters receive. Blames them for their poor treatment.
EXPLOITING/CORRUPTING: caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors) and/or to meet the needs of the caregiver in ways that undermine child development.	
Evidence	Dad models the use of verbally abusive behavior toward some and a view of the world as highly threatening, constantly dangerous.
Source of Evidence	Child, mother and father report.
Disproving Evidence	
Questions	
Conclusion	Father models confused, contradictory and paranoid 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	<p>TA says his Dad is scary, has a lot of guns, talks crazy (neighbors are trying to break into the garage, Dad says he will kill them if they put even a big toe on the property).</p> <p>Mom says Dad is combat vet, has nightmares, and thinks people are out to get him. Has put attractive boulders as a barrier in front of house so no one could ram into it as part of an assault and has house booby trapped with trip wires that only the family know about to protect the family home.</p> <p>TA says Dad knows everything that is going on at home, even when he isn't there. At night tells each kid how many times he or she peed, what they said to each other in the house. Finds this spooky.</p> <p>TA says he's worried about Mom. 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, says she says it would be so easy to take a few more sleeping pills.</p> <p>Dad admits to having a big conflict with his next-door neighbor ("that asshole!") and at work. Says of course he has guns, needs to protect his family, make sure his sons know how to shoot. Emphasizes gun safety. Says he has PTSD from combat and is doing the best he can.</p> <p>Mother agrees with what TA reports about Dad. Acknowledges that she has a history of depression and suicidality and is in treatment with a psychiatrist on a</p>

	weekly basis. Has made several suicide attempts but feels she's okay right now. She feels bad about her children's school problems (learning and behavior for the three boys). Does think she is a bad mother.
Source of Evidence	Child interview, maternal interview, paternal interview, 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, current depression) and his father's scary behavior with guns, conflicts with neighbor, defensive stance in anticipation of threats against the family home, and family surveillance is terrorizing.
EMOTIONAL UNRESPONSIVENESS: caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring, and love for the child) and showing no emotion in interactions with the child.	
Evidence	<p>TA says Dad never affectionate, never hugs, never comforts, and never says "I love you." Can't remember him ever doing so.</p> <p>TA says when Mom 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 (might die) and has to go to the hospital with asthma, then she hugged him, held him close.</p>
Source of Evidence	Mother admits that she is not touchy feely type. Her mother wasn't that way.
Disproving Evidence	Mother attentive to health issues, responds quickly to asthma, takes him to appointments, rushes him to hospital when sick.
Questions	
Conclusion	Father is never emotionally responsive or affectionate. Mother is only emotionally responsive 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 the booby traps and his Dad's weird behavior. 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 only socializes with his Dad's brother and parents. Once in a while they see his mother's brother, but the relationship isn't close.
Source of Evidence	Child interview. Maternal interview. Paternal interview.
Disproving Evidence	
Questions	
Conclusion	Home environment and paternal behavior interfering with social interactions with peers and other adults in the community.
MENTAL HEALTH, MEDICAL, AND EDUCATIONAL NEGLECT: includes 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	
Source of Evidence	Maternal interview. Teacher interview. Medical records. School records.
Disproving Evidence	Mother makes sure that the kids receive regular medical checkups, monitors TA's asthma. Has allowed TA and his two younger brothers to be evaluated for special education for learning and behavior problems. Both parents have attended IEP meetings. TA missed over two months in the first grade with asthma but has missed 15–20 days in recent years. Parents allowed 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 indicated.

Summary Conclusion About Presence of PM:

TA exposed to long-standing, chronic PM in the forms of spurning, exploiting/corrupting, terrorizing, emotional unresponsiveness, and isolating.

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

Exploiting/corrupting: Father models confused, contradictory, and paranoid 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, current depression) and his father's scary behavior with guns, conflicts with neighbor, defensive stance in anticipation of threats against the family home, and family surveillance is terrorizing.

Emotional unresponsiveness: Father is never emotionally responsive or affectionate. Mother is only 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.

Part B. Risk Factors for Psychological Maltreatment. (Refer to Appendix F for a fuller description of these risk factors.)

CHILD FACTORS: high maintenance and demand characteristics, disability, temperament, and behavior.	
Evidence	TA diagnosed with severe asthma, learning disability (in all subjects as he is currently 2 years behind grade level, was retained in first grade), and most recently ADHD. Is inattentive and appears depressed. School work erratic makes big mistakes on already mastered work indicating that his mind is elsewhere.
Source of Evidence	
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 responsiveness for child strengths/good qualities; lack of interest or incapacity to express interest in child(ren); high stress and low social support.	
Evidence	<p>Mother has long history of depression and suicidality. Has very low self-esteem. Currently sees a psychiatrist once a week and takes antidepressants and sleeping pills.</p> <p>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.</p> <p>Both parents report a history of child maltreatment.</p>

	<p>Mother reports neglectful mother and absent father and sexual abuse by neighbor. Father reports being placed in foster care at age 5 for neglect, 3 years of foster homes (3), before being adopted by a couple.</p> <p>Mother seems aware of TA's psychological needs, but her own passivity and depression limit her ability to address them.</p> <p>Father shows little empathy or appreciation of TA's psychological needs, little appreciation of TA's good qualities, and no appreciation for how his behavior impacts TA.</p> <p>Neither parent has friends. Social support only from father's parents.</p>
Source of Evidence	Maternal report. Teacher interview. Father interview. 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. Mother seems handicapped in meeting TA's needs, in part, by her depression and 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 criminal activity in the home or neighborhood.	
Evidence	<p>Family has five children all born within 7 years. Mother was age 18 and Dad 20 when they married with Mom pregnant.</p> <p>Family only socializes with father's family (parents and brother and his family), rarely with mother's brother. 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.</p>

Source of Evidence	Maternal report. Paternal report. Child report. State records check.
Disproving Evidence	Both parents are high school graduates (father got GED in military). Father has a good technical job with benefits. Neither parent has a criminal record nor previous CPS report.
Questions	
Conclusion	On one hand, the family has a large number of children to adults with children born close together—a heavy caregiving burden. The family socializes with father’s family and receives some financial and babysitting support but is otherwise socially isolated. On the other hand, 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 (no criminal records), with this being 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 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. Father has 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. Mother seems handicapped in meeting TA’s needs, in part by her depression and history of emotional neglect, and Father by his lack of appreciation of TA’s needs, good qualities, and how his own behavior impacts TA (and the other children). On one hand, the family has a large number of children to adults (5 to 2) with children born close together—a heavy caregiving burden. The family socializes with father’s family and receives some financial and babysitting support but is otherwise

socially isolated. On the other hand, 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, with this being the first CPS report. They live in a well-resourced community with many supports available.

Part C. Evidence of Harm to Child.
(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, immature defenses)

Evidence	<p>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, low mood and little pleasure most days, but adequate appetite and sleep. His IEP recommended continuing social work services for mood and behavior.</p> <p>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.</p>
Source of Evidence	Teacher interview. Social work progress notes. IEP. School psychologist report of triennial evaluation for special education. 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	
Source of Evidence	
Disproving Evidence	

Questions	
Conclusions	
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 noncompliance and lack of impulse control, and impaired moral reasoning.	
Evidence	<p>School problems: TA had severe asthma in first grade and missed more than two 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, and 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.</p> <p>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.</p>
Source 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 schoolwork. 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 respiratory ailments; hearing impairments, and somatic complaints.	
Evidence	TA had severe asthma in first grade and missed over two months of school. While his asthma is now much better

	managed, he still had three emergency hospitalizations in the last calendar year.
Source of Evidence	Medical records. School record.
Disproving Evidence	
Questions	Is good home management of asthma consistent with 3 hospitalizations in the past year?
Conclusions	TA has severe asthma despite access to good medical care. 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 (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, 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 are contributing significantly to his difficulties.

1 APPENDIX F.

2 Checklist: General Overview of PM Risks, Types, and Harm.

RISK FACTORS	PM TYPES	HARM
<p><u>Child Factors</u> High maintenance Disability Difficult temperament Challenging/Disruptive behavior</p> <p><u>Caregiver Factors</u> Psychological disorders Low self-esteem Low impulse control Depression Low empathy Poor coping Substance abuse Abuse history as child Depersonalization of child Unrealistic expectations of child Inadequate parenting knowledge Lack of awareness of impact of own behavior Incapacity to express interest in child High stress Low social support</p> <p><u>Family Factors</u> Large ratio of children to adults Young and unprepared parents Father absence Aberrant father substitute</p> <p><u>Community Factors</u> Low norms and support for parents Infrequent monitoring of child development Poor mobilization of reporters High levels of substance abuse Violence and criminality Poverty</p>	<p><u>Spurning</u> Belittling and hostile Belittling and hostile toward siblings, other parent, kin Shaming for normal emotions Singling out negatively Public humiliation</p> <p><u>Exploiting/Corrupting</u> Encouraging Antisocial behavior, Betraying trust/cruelty to another person, Developmentally inappropriate behavior</p> <p>Manipulation of child's thoughts, feeling, emotions Interfering with cognitive, social, emotional development Other maltreatment that also involves exploiting/corrupting</p> <p><u>Terrorizing</u> Frightening the child Placing child in danger Rigid/unrealistic expectations Threat or violence against child Threat against loved one/objects Prevent access food, light, etc. Preventing sleep, rest.</p> <p><u>Emotional Unresponsiveness</u> Detached and uninvolved Interacting only necessary; Fail express affection, love Emotionally detached Inattentive to the child's needs</p> <p><u>Isolating</u> Confining/unreasonable limitations Restricting communication/ Interaction with the other Placing in a loyalty conflict Unreasonable limitations on social interactions</p>	<p><u>Intrapersonal (Emotional)</u> Anxiety Depression Low self-concept Negative cognitions Suicidal behavior Non-suicidal self-injury</p> <p><u>Inappropriate Behaviors or Feelings Under Normal Circumstances</u> Substance abuse Eating disorder Emotional instability Impulse control Personality disorders Dissociative coping style</p> <p><u>Inability to Build/Maintain Relationships</u> <u>Poor parenting,</u> <u>Hostility</u> <u>Delinquency</u></p> <p><u>Learning Problems</u> Poor executive functioning Academic problems Low achievement Decline in IQ School behavior problems</p> <p><u>Physical Health Problems</u> Infant mortality Delays in development Reduced height Respiratory problems Lifestyle risk behaviors in adolescence including tobacco smoking, substance abuse, and risky sexual behavior that increases the risk of HIV and other sexually transmitted diseases. Somatic complaints Hearing problems</p>

APPENDIX G.

Guidelines for Discriminating Good Positive/Healthy Parenting, Poor/Dysfunctional Parenting, and Emotionally (Psychologically) Abusive/Neglectful Parenting

Source: Wolfe, D. A., & McIsaac, C. (2011, p. 807). Used with permission.

Continuum of parental emotional sensitivity and expression		
Most positive		Most Negative
Positive, Healthy Parenting Style	Poor / Dysfunctional	Emotionally Abusive/Neglectful
<p><u>Stimulation and Emotional Expressions</u> provides a variety of sensory stimulation and positive emotional expressions expresses joy at child's effort and accomplishments</p> <p><u>Interactions</u> engages in competent, child-centered interactions to encourage development friendly, positive interactions that encourage independent exploration</p> <p><u>Consistency and Predictability</u> demonstrates consistency and predictability to promote their relationship</p> <p><u>Rules and limits</u> makes rules for safety and health appropriate safeguards for child's age</p> <p><u>Disciplinary practices</u> occasionally scolds, criticizes, interrupts child activity teaches child through behavioral rather than psychological control methods</p> <p><u>Emotional delivery and tone</u> uses emotional delivery and tone that are firm but not frightening</p>	<p><u>Stimulation and Emotional Expressions</u> shows rigid emotional expression and inflexibility in responding to child seems unconcerned with child's developmental/psychological needs</p> <p><u>Interactions</u> often insensitive to child's needs; unfriendly poor balance between child independence and dependence on parent</p> <p><u>Consistency and Predictability</u> often responds unpredictably, sometimes with emotional discharge</p> <p><u>Rules and limits</u> Unclear or inconsistent rules for safety and health</p> <p><u>Disciplinary practices</u> frequently uses coercive methods and minimizes child's competence uses psychologically controlling methods that confuse, upset child</p> <p><u>Emotional delivery and tone</u> uses verbal and non-verbal pressure, often to achieve unrealistic expectations</p>	<p><u>Stimulation and Emotional Expressions</u> expresses conditional love and ambivalent feelings towards child shows little or no sensitivity to child's needs</p> <p><u>Interactions</u> emotionally or physically rejects child's attention takes advantage of child's dependency status through coercion, threats, or bribes</p> <p><u>Consistency and Predictability</u> responds unpredictably, accompanied by emotional discharge</p> <p><u>Rules and limits</u> Sporadic, capricious exploits or corrupts for parent's benefit</p> <p><u>Disciplinary practices</u> uses cruel and harsh control methods that frighten child violates minimal community standards on occasion</p> <p><u>Emotional delivery and tone</u> frightening, threatening, denigrating, insulting</p>

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APPENDIX H. Heyman and Slep Psychological Harm Diagnostic Criteria

Significant impact on the child as evidenced by any of the following:

(1) Psychological harm, including any of the following:

- a. More than inconsequential fear reaction.
- b. Significant psychological distress (i.e., psychiatric disorders, at or near diagnostic thresholds) related to, or exacerbated by, the act(s).

(2) Reasonable potential for psychological harm, as evidenced by either or the following:

- a. The act (or pattern of acts) creates reasonable potential for the development of a psychiatric disorder (at or near diagnostic thresholds) related to, or exacerbated by, the act(s). Note: The child's level of functioning and the risk and resilience factors present should be taken into consideration.
- b. The act (or pattern of acts) carries a reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development. A significant disruption would involve development that is substantially worse than would have been expected, given the child's developmental level and trajectory evident before alleged maltreatment.

(3) Stress-related somatic symptoms (related to or exacerbated by the acts) that significantly interfere with normal functioning.

5 **Source:** Heyman, R. E., & Slep, A. (2009, p. 812 excerpts); original source: Heyman, R.
6 W., & Slep, A. (2009). *Psychological harm diagnostic criteria*. Family Translational
7 Research Group, State University of New York at Stony Brook, Department of Psychology,
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