

Psychological Maltreatment: An Operationalized Definition and Path Toward Application

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Abstract

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Child psychological maltreatment (PM) is widespread, harmful, and therefore worthy of prevention and intervention (Brassard, Hart, Baker & Chiel, 2019). However, the lack of a single, operationalized definition that is both comprehensive and sufficiently operationalized as to allow for its consistent recognition and application has tremendously limited impactful action (see Baker, Brassard, & Rosenweig, 2021). Without an easy to use and comprehensive definition, child welfare professionals cannot assess for and make determinations about PM in a fair and consistent manner. Parents and others involved in caring for children cannot be clear about what behavior “crosses the line” to PM and is thus important to modify or avoid. Public health entities cannot consistently measure rates of PM to understand how policy changes might be affecting behavior. Policy makers cannot precisely target policy nor gauge the impact of policy changes. Thus, without a definition that is both comprehensive and easy to use, stakeholders can do nothing concrete to meaningfully address PM.

In Table 1, this paper presents a definition of PM that we believe has the potential to serve as a foundation for meaningful action. In this paper, we present the process used to develop this definition, the definition itself with the rationale for various aspects of it, and a pathway for field testing its utility towards the widespread application of the model. The paper also articulates some issues to address in training and application.

Virtually every publication on the subject of PM notes the difficulty of defining, identifying, and measuring PM, a claim also often expressed by practitioners in child protective services. Research on PM often uses one of several instruments or measures that include very few statements denoting the various manifestations of possible PM, focussing instead on hostility towards and rejection of the child (e.g., Parent-Child Conflict Tactics Scale; Strauss et al., 1998).

PM often co-occurs with other forms of maltreatment, but can also occur on its own (Manly, 2005; Vachon, Krueger, Rogosch, & Cicchetti, 2015). The lack of measures that correspond to definitions of PM that are used in the literature limits our understanding of how many children are impacted by PM in the general population. However, one study of a large sample of U.S. military families, using a definition of PM less inclusive than the one we propose herein, found a prevalence greater than 3% of children who experienced psychological abuse in the previous year (Slep et al., 2011). If one measured psychological neglect in combination with psychological abuse, the rates of PM would be notably greater.

The impact of PM is considerable. There is empirical evidence which points to the serious harm emanating from PM to the child and later in adulthood (e.g., Abajobir, et al., 2017a; Abajobir, et al., 2017b; Brassard, 2019; Egeland, Sroufe, & Erickson, 1983; Geoffroy, Pereira, Li, & Power, 2016; Norman et al., 2012; Spinazzola et al., 2014). Yet, our ability to reduce the impact of PM is seriously hampered by the lack of a definition that can be consistently applied in a variety of settings. Instead, we rely on a widely different set of laws and policies, depending on state or country, and which are highly inconsistent in what they include within PM (e.g., Baker & Brassard, 2019) and even more variable set of implementation guidance and practice that often results in PM being overlooked or being swept under the rug because it is considered hard to assess and harder to substantiate and agree upon.

We present our work here as an attempt to address this gap. As well as clarifying what PM actually is, we have sought to define PM in a manner that can be consistently understood and applied across all caregiver-child contexts. Thereby, we to strive to unify an understanding of PM between state, national, and international standards coding (e.g., Diagnostic and Statistical Manual of Mental Disorders, 5th edition; American Psychiatric Association, 2013 and the

International Classification of Diseases, 11th edition; World Health Organization, 2020). We hold that the definition presented here can (and should) also form the basis of for standardised research measures of PM.

Development of the Definition

Foundational Sources

The definition presented herein rests on the important work of others that it has built upon. First, the APSAC endorsed definition of PM (Hereafter, the “APSAC definition”; Brassard et al., 2020) was a critical foundational tool. Not only was the definition of PM presented extremely comprehensive, but the discussion is also clearly contextualized by the empirical literature. This work served as our frame of reference to ensure that the range of caregiver acts and omissions that can constitute PM were well represented in our definition. We chose to differ from this work in two important ways, however. We determined that to make consistent “above the line/below the threshold” decisions about PM, we needed to incorporate some information about the child and the observed or assessed potential impact of the caregiver acts/omissions. The rationale for this will be detailed below. Additionally, we chose to limit our definition of PM to maltreatment that was not part and parcel of other forms of maltreatment. Of course, all forms of maltreatment can have a psychological impact; however, we thought the impact of our work might be greatest if it was not overlapping with physical abuse, sexual abuse, or physical neglect.

Second, we borrowed heavily from the overall approach of Heyman and Slep (2006; 2009; Slep et al., 2015). They developed a multi-component approach — comprising training, assessment, criteria, and the computerized decision tree — known as the FAIR (Field-tested Assessment, Intervention-planning, and Response) system to defining all forms of maltreatment

including PM and subjected their system to a number of field trials (see Heyman & Slep; 2006; 2009; Slep & Heyman 2006). The FAIR system resulted in consistent clinical assessment and decision-making, and this consistency, in turn, led to reductions in subsequent maltreatment (Snarr et al., 2009; Slep et al., 2021). Their definitional criteria were subsequently adopted by all U.S. military services, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (American Psychiatric Association, 2013) and the International Classification of Diseases, 11th edition (World Health Organization, 2020). From this system, we adopted the overall framework, and much of the approach to operationalizing the actual and potential impact of potentially maltreatment acts and omissions. Furthermore, we adopted their approach to focusing on incidents to aid in the consistency of determinations. Finally, we built on their successful implementation experiences to inform our vision for field testing and training that is summarized later in this paper. In so doing, we have also rendered the definitions we propose herein consistent with those adopted by diagnostic and public health systems.

Third, we leaned heavily on the Maltreatment Classification System (MCS) (Barnett, Manly, & Cicchetti 1991; 1993), which is arguably the most widely used coding system for all forms of child maltreatment in research. The system was developed to be both comprehensive and result in consistent classifications. It is rigorous and supports fine-grained classification of different categories of PM (i.e., consistent application), yet requires more training than is typically viable in clinical contexts. Thus, we used this system to ensure that all presentations of PM were reflected and that acts that could be considered other types of maltreatment were omitted from our definition. The Maltreatment Classification System provides operational definitions for Emotional Maltreatment, which for these purposes was considered synonymous with Psychological Maltreatment.

Finally, we referred to Glaser's conceptual framework (Glaser, 2002; 2011) incorporated into England's Guidance.

It is important to note that each of these sources - APSAC definition, FAIR definitions, MCS, and Glaser's conceptual framework were, themselves, based on many other definitions in laws, policies, guidance, published research literature, and used in the research methods of large studies. The breadth of the definitions that fed into the prime sources for our work can be traced in the referent publications for each system and we will not review them here.

The Process Undertaken

We began by determining parameters and guiding assumptions (e.g., we were not going to include other forms of maltreatment). We determined that, consistent with the model used by Heyman and Slep (see Foran et al., 2015), building criteria that focused on presenting incidents was the best approach. This approach is most consistent with how child protective services operate, and although can consider pattern, does not require assessments to go back in time with the same precision and level of detail. Finally, although it is very much the case that PM tends to represent a *pattern* of caregiver behavior, a pattern is not required for it to “cross the line” (e.g., an upset parent shames and humiliates their child in front of peers).

We also determined that to meet the threshold and “cross the line” while supporting consistent use in the field, we adopted the same act plus impact framework that is in the FAIR model (see Slep, Heyman, & Malik, 2015 for a detailed discussion). As will be detailed below, the specific impact operationalizations, which include actual impact and a determination of a high probability of impact from the caregiver act have been found to be necessary in reliably making threshold decisions. Clearly, caregiver behavior exists on continua. These continua of caregiver behavior, and different thresholds for socially-sanctioned caregiving in different

contexts across the globe underscore the utility of considering both caregiver behavior and child impact in the definition of PM. There is generally global agreement on the rights of children to live in safe environments, free from risk of preventable physical and psychological injury (e.g. UNCRC; WAIMH). Thus, the proposed criteria use the impact on the child as the threshold between nonabusive but suboptimal caregiving and PM.

We then determined an overarching definition of PM. We know from past experience, however, that a more detailed operationalized definition is required to achieve consistent decision making and reliable and valid measurement. Thus, we then moved on to develop an operationalized definition. It is critical to note that the operationalized definition must be used in its totality, and when that is done, each possible application of the operationalized definition conforms to the terms of the overall definition. In other words, the overall definition is the arbiter for specific examples in deciding whether they conform. The definition clearly differentiates between suboptimal caregiving and PM, enabling child protective services to intervene, a clinician to treat, and a parent to understand where the limits are. The definition of PM is primarily based on the presence of harmful caregiver behavior. However, impact on the child (as specified below) identifies the threshold of that caregiver behavior. Once the overarching definition was agreed to by the primary authors, it was reviewed by and refined with the authors of the APSAC definition (Brassard et al., 2020).

After the overarching definition was finalized, the primary authors aligned the caregiver acts noted in each of the foundational definitional sources. We sought to be reasonably comprehensive while consistently considering the long-term goal of the definition - promoting consistent decision making. To that end, despite the fact that the categories and examples presented in the operationalized definition under “Caregiver Act” are designed to help explicate

the range of acts and omissions that can constitute PM, situations can arise where a caregiver's behavior is somewhat unique and not covered precisely by an example in a table. In those situations, the overarching definition is the key. We also sought to avoid terms that were especially "grey" in their interpretation, which could lead to inconsistency in application of the definition. As such, the behaviors listed are neither exhaustive nor entirely specific to PM. They are merely examples of caregiver behavior that might be indicative of PM if other criteria are also met. Note that caregiver intent is not considered, as it is extremely difficult to assess intent, harmful impact can occur regardless of parental intent, and reliability in decision-making is much more likely to be achieved with behavior versus intent decisions. Thus, caregiver behavior is the focus of these definitional criteria.

The group then moved on to the impact operationalization. For this, the primary source was the FAIR system (see Slep et al., 2011; Slep, Heyman, & Malik, 2015), as this is the only field-tested approach that has used such criteria. Many elements were taken directly from the system, but we sought to ensure the criteria were comprehensive, and this required a few modifications. For example, we added "social" to the list of qualifying developmental disruptions. This impact operationalization was then reviewed and refined.

The Definition

The definition of PM appears in Table 1, as previously noted. Please note that the overarching definition appears first and is complete on its own. The operationalized definition appears below that and must be considered in totality (i.e., there must be a qualifying act/omission and a qualifying impact). The abbreviated "check box" scoring system appears last to visually summarize this requirement of caregiver act and child impact. Finally, the field trials of FAIR system identified some specific language that appears in this PM definition that requires

their own specified operationalization (e.g., “more than inconsequential fear reaction”) to be used consistently. These are also noted in the table.

The strength of examples of behavior

By using operationalized examples of caregiver behavior, rather than relying on the overall term 'psychological maltreatment', it is easier to convey to professionals, caregivers, and children what the specific nature of the concerning behaviors are. It is much more difficult to take issue with the existence of specific behaviors and therefore with the existence of PM.

Why is the list of acts not inclusive?

It is apparent from even a cursory glance at Table 1 that we have included a great many examples of caregiver acts that might constitute PM. We leaned quite heavily on both the APSAC definitions and the MCS for the language and exemplars that we included, but we remain certain that not all potentially PM acts and omissions are mentioned. Why then do we specify that other acts that are not listed might also meet the definition? This is for two reasons. First, humans are creative. We cannot be certain that any list of actual or potential examples sensitively captures every single way in which a caregiver might psychologically maltreat a child. If the caregiver's behavior is not specified, but is consistent with the overall definition of PM, then it would meet the “Caregiver Act” criterion. Second, and relatedly, the definition is written and formatted to aid in consistent decision making in real world settings. In those settings, it is neither necessary, expedient, nor desirable to note every act a caregiver engaged in that is a distinct act of PM. In our experience with similar systems, it is not possible to capture all possible acts. Examples have emerged in CPS records or implementation of the FAIR system that have not/would not be in existing questionnaires or classification systems. The clinician merely needs to have a strong assessment of a caregiver act that is in the universe of the types of

acts depicted. This is a much simpler and faster task than isolating a specific subtype and example of that subtype in a consistent manner. We recognize that implementation of any definition or classification requires some training and experience with use of the definition. For research purposes, however, one might want to include assessment of multiple psychological maltreatment subtypes to better understand and disentangle typical patterns of PM that occur and how they relate to impact, for example (Vachon, Krueger, Rogosch & Cicchetti, 2015).

Why isn't a pattern of behavior required?

There is agreement that PM rarely occurs as an isolated incident, so why not have the definition require a pattern? This decision came from the experience of the FAIR system. If one requires a pattern in the definition, then the definition excludes rare but extreme examples of isolated incidents. An example would be an absent parent appearing one night to force a young child to watch a beloved pet be hurt or killed while being told it is what they deserve for ruining that parent's life. Even if that is the only contact with that parent, it would be wrong to say that did not constitute PM because it only happened once. Additionally, from the Maltreatment Classification System perspective, definitional criteria for presence/absence of a maltreatment subtype are distinct from other maltreatment dimensions, such as severity, frequency, chronicity, and developmental period of occurrence. Distinguishing dimensions of maltreatment can have research, clinical, and policy implications (Barnett, Manly, & Cicchetti, 1993). Furthermore, if a pattern were required, we would need to specify how much of a pattern is sufficient to be called a pattern. In addition to there being no empirical basis for answering this question, asking a clinician to conduct the assessment necessary to address any rule of this type would sacrifice enormous time for little gain. Instead, the victim carries the evidence of pattern with him or her in the impact of the experience(s). To the extent that there is already a demonstrable impact, that

can denote the significance of a pattern or that the experience of PM in a single instance did not require a pattern to exert an impact. If the clinician thinks that impact is highly likely in the future, that determination is also informed by pattern. We believe that this approach includes what is important about pattern without going into a 'rabbit hole' to describe specifics of patterns in a way that would not result in better information or improved classification.

Why is impact required?

We completely agree with the conceptualization of maltreatment as being entirely a function of the caregiver act/omission. The child does not determine why or how caregiver actions constitute maltreatment. However, because one purpose of this definition is to help systems consistently draw the line and mark the threshold between non-maltreating but suboptimal parenting and maltreating caregiver behavior, the single best way to do that is by including impact. Unlike the parental behavior criterion, in which an unspecified parental behavior that adheres to the overarching definition can be considered to meet that criterion, with impact, the criterion must meet specific characteristics for the definition of PM to be met. That impact is required serves several functions. First, it helps capture situations in which an incident that is reported may seem to an assessing worker not to be an especially egregious caregiver act, but the child's sensitivities or prior history with that caregiver mean that it had demonstrable impact; this consideration for individualizing application of the definition is essential not to overlook. Requiring impact also captures that if a caregiver act is culturally normative, and therefore less meaningful in a specific cultural context than it might be in another, it will likely result in no actual apparent impact and less than a reasonable potential for impact, and thus be determined not to constitute psychological maltreatment. Finally, requiring impact allows the system both to respond flexibly to the needs and situations of each child (caregiver actions that

might deflect a more vulnerable child's developmental trajectory might have no effect on a more resilient child's trajectory, see differential susceptibility or 'Orchids and Dandelions' Boyce, 2019) and to provide consistency in a structured approach. This balance allows the definition to be sensitive to the "fit" of caregiver and child without compromising the reliability with which the definition can be applied.

Why include "reasonable potential" as an impact?

Because impact is a required element of our operationalized definition, it is critical to include reasonable potential for consequences to the child beyond those that are apparent at the moment of assessment. First, there are times when the long-term impact of a caregiver act might be expected to occur at a future developmental stage rather than the current one. For example, if a caregiver berates his 8-year-old daughter, saying she will never get a man because she is ugly and stupid like her mother, then even if there are no apparent sequelae in that moment, it is reasonable to expect that this will affect the girl's self-view and social development in her teen years when she begins to form intimate relationships. Reasonable potential allows for those delayed consequences that seem likely. Second, some caregiver actions are so inherently destructive that even if the impact of them cannot be concretely documented, reasonable people agree the behavior would be expected to be impactful. A further example would be a parent attempting to shoot a child's dog in front of her, but missing; that does not mean that action was not maltreatment. Finally, there are times when it is very difficult to conduct a comprehensive assessment of the impact on the child in part because of the child's age (e.g., infants) or developmental level (e.g., a child with significant speech delays). In these situations, reasonable potential as a threshold ensures that these children have a voice.

Why is some of the language clunky?

An essential aspect of definitional criteria that need to be carefully followed to be applied consistently is that one must refer to the actual criterion each time it is used. This definitional adherence has proved tricky with child maltreatment, where many CPS workers and other professionals have been trained in a “you know it when you see it” approach. Because of this, we are applying a lesson learned from the FAIR field trials and have adopted words and phrases that make a person think twice. This use of language helps cue them. They may think “what does that mean?” That reflection, in turn, means that they read the definitional criteria. Continually pointing back to the overarching definition aids in the consistency of application. Our use of the word “egregious” helps serve this purpose, as do phrases such as, “more than inconsequential fear reaction.” The field trials had allowed for the optimization of language and training to facilitate consistent decision making. We have adopted the optimization we could, and advocate for additional field trials to determine if further optimization can be achieved. Training and implementation procedures also can be useful in clarifying this use of language and application.

Next steps

We argue that this definition of PM represents an advance over prior definitions offered in the literature. This definition builds on systems designed for conceptual comprehensiveness, research rigor, and consistent clinical application in real world settings. That said, this definition is a starting point rather than the last word. A necessary next step will be to field test this definition in a child protection context. That is the most sensible first setting as child protection is where families are rendered “above or below the line” determinations about the presence or absence of maltreatment. In the development of the FAIR system, the two field trials that were conducted were essential to the ultimate success of the definitions and the system through which they were implemented. The authors of the FAIR system classified cases in parallel with the

committees and clinicians making the decisions on the ground. At first, every case classification meeting resulted in a slight wording change to optimize the consistency with which the definitions were interpreted and applied. Tiny changes in wording resulted in improved (or deteriorated) performance of committees and clinicians. The field test was continued until the wording of the definitional criteria could be interpreted correctly by the vast majority of committees and clinicians with very minimal training. This process is critical to a system working in real world settings, where limited resources mean that no newly introduced system can ever take more time to train or implement than the existing system, or successful uptake is unlikely. In contrast to the wording of the definitions themselves, the approach to assessment and actual decision making did not need as much incremental refinement. We applied lessons learned from the FAIR field trials to our work presented herein; however, to understand the performance of these criteria, field trials must be conducted.

We argue that two critical elements must be included in any field trial of these definitions. The first is a structured decision tool. In the FAIR system, all case determinations are arrived at by determining whether the preponderance of the information available suggests that any given allegation is above or below the line for each criterion considered in turn. This threshold is reflected in the check box scoring summary in Table 1. The FAIR trials clearly indicated that deciding each criterion helps limit bias and enhances consistency. Every ongoing dissemination of the FAIR system, therefore, uses a computer-guided decision tree to walk clinicians and committees through the criteria to be considered in order. It is important to note that child welfare system decisions are notorious for their inconsistency in the best of circumstances: Determinations are affected by race, family's income, workers' perceptions of the parents' openness to change, and the amount of time spent investigating (e.g., Alter, 1985;

English et al., 2002; King et al., 2003) as well as common human cognitive biases and heuristics, such as confirmation bias that discounts evidence contrary to first impressions (Munro, 2008). Interrater reliability regarding caseworkers' risk assessments, decisions about foster care placements, and even agreement on substantiation of sexual abuse allegations have been found to be strikingly low ($\kappa = .18$, Baird et al., 1999; $\kappa = .25$, Lindsey, 1992; $\kappa = .20$, Herman, 2005). Given that PM is arguably the most varied and nuanced form of maltreatment, it is especially critical that this structured approach to decision making be adopted. This approach resulted in 90% agreement with master reviewers in the FAIR dissemination trial averaged across all forms of maltreatment, and 90% agreement with master reviewers specifically on child PM (Heyman & Slep; 2009). In addition, they found that the system was not subject to bias due to demographic factors (e.g., officer/enlisted status, military/civilian status, gender; Heyman et al., 2016).

Finally, although we have developed this definition to be of use in real world settings where workers have different education and backgrounds within the same time constraints of current systems, and thus the training burden for this system is not high, training is required. It is critical that workers understand the overarching definition and how the operationalized criteria specify it precisely. Workers need to know how to conduct assessments to garner the information needed to apply the criteria. Furthermore, they need a foundation in child development and mental health that will allow them to apply the impact criteria. Without some background in child development, for example, it is difficult to make a determination that one child's social development has a reasonable potential ultimately to be affected by her parent's actions when another child's likely will remain unaffected. Implementations of the FAIR system have required a 20-minute computer-based training, a 1-4 hour interactive training on the definitions and assessment (length dependent on setting and role), and then supervised initial use with feedback

from trained supervisors for the first few months of implementation. This training was considered to build on a professional background in child development and mental health. As a next step, we intend to produce draft training materials that would be appropriate to test and refine as part of a field trial.

Application

Clinical Contexts

PM is a form of child maltreatment and is subject to mandatory reporting in the USA. We are especially interested in developing a definition and system for its use that will enable child protective systems to become more consistent in the manner in which they address PM. However, this is not to say that involvement in the child protective system is the optimal strategy for many cases of PM. A criminal prosecution is almost always counterproductive as is the immediate separation/protection of the child from the maltreating caregiver(s). We believe that with this operationalized definition, those in clinical contexts and involved in serving and supporting parents and children will be better able to identify and intervene with families at risk for PM.

An obvious starting point for recognising PM is identifying presence of any caregiver behavior which conforms to the overall definition, and which includes those aspects listed. Although it might not rise to the level of PM if impact is not applicable in that case, it clearly indicates potential for PM and should be addressed. There are two further, *indirect*, starting points for finding caregiver behaviors that are consistent with PM:

- I. Parental risk factors strongly associated with PM such as mental health problems, drug and alcohol misuse, inter-parental violence and histories of trauma. Identifying these parental difficulties calls for an exploration of the quality of the adult's

relationship with their children . Identification of these risk factors could also be preventive of actual PM.

- II. Identifying children with difficulties that are associated with PM (see below). A central aspect of pursuing concerns about children's difficulties is the exploration of harmful caregiver behaviors amounting to PM, which may well contribute to or explain the child's difficulties.

Clinicians should assess the child's overall functioning. All domains of functioning are relevant, including physical, emotional, cognitive, behavioral and social, including peer, relationships. Concerns in any of harm in the domains may or may not be attributable to the PM, even if present. If they are, they are regarded as evidence of impact of the PM. Absence of identified harm does not indicate lack of need for a professional response, since harm may not yet have occurred.

The next step is to assess the severity of the PM, which will guide practitioners in the decision regarding how to intervene. Severity is determined both by the intensity of the harmful parent child interactions and the effects on the child. In practice, severity is one of the factors which will determine whether *immediate* child protection by removal of the child is required. This is, in practice, relatively rare.

The aim of intervention when PM is identified is to offer the caregivers help with their own difficulties, support in improving their interactions with their child(ren) by dyadic parent-child work, and a whole family approach. This may also include direct work with the child which may require alleviating acute and severe child mental health difficulties. A particular issue for early attention is ensuring continuation or provision of education for the child.

The nature of interventions will depend on the items within the operationalized

definitions of caregiver behaviors in Table 1 and the contributing factors for the family. The interventions will include attention to contextual problems such as violence, poverty, structural racism, homelessness; mental health interventions – specifically addressing depression and anxiety; direct behavioral change; exploration of underlying motivations, understanding of child development and beliefs about child rearing; capacity to 'mentalise' – awareness of the child's feelings, perceptions, psychological needs. They include both work with the caregiver(s) and with the caregiver and child together.

The interventions should be regarded as time-limited therapeutic assessments of the caregiver(s)' capacity to change, which includes consideration of both risk and protective factors for the family. They often involve agencies other than child protection services and include adult and family mental health services and family support services. If the caregiver(s) do not engage, or if there is insufficient change, more active child protection needs to be considered, including placing the child in an alternative living arrangement. For some children, removal may be deemed inappropriate, possibly due to age, or a less optimal solution. Direct, therapeutic work is then offered to the child to enhance coping with ongoing PM.

Research

One potentially major advance in research on PM would be the development of reliable and valid measures of PM that cover the entirety of the proposed definition. Such a measure, given the nature of the construct, would include assessment of both caregiver acts and child functioning. Efforts to ensure respondents understand the measure would be particularly important, along with efforts to mitigate self-presentation related biases in responding. A starting point might be to further refine the Family Maltreatment measure (Heyman et al., 2020), which includes a section on PM as it was defined in the FAIR system (including act and impact) and

used to assess that variant of PM in a sample of over 50,000 caregivers (Slep, Heyman, & Snarr, 2011). This measure went through several phases of development to optimize validity and could be expanded to make compatible with the more comprehensive list of caregiver acts we include in the proposed PM definition. For use in studies requiring diagnostic interviews, Slep and colleagues (2012) developed such an interview for the FAIR system that could be similarly expanded. In light of the fact that the proposed definition of PM encompasses several caregiver behaviors, as well as impact, it is no longer appropriate for research studies to use selective indicators of PM or to focus only on caregiver acts or child functioning. It is also recommended that research on PM address the frequent co-occurrence of PM with other subtypes of maltreatment (Vachon & Rogosch, 2015). Research that examines a single subtype without recognition of children's experiences of multiple forms of maltreatment is unlikely to advance clarity in the field.

Implications

If this definition of PM, as refined and finalized through a field trial, with accompanying training, assessment, and structured decision-making tools were to be adopted, this would represent a major step forward for children and their families. Rather than a hodgepodge of definitions of PM that are often unclear even to those charged with applying them and completely opaque to parents, there would be one clear definition of PM. This definition would have been tested in field trials and found to be able to be applied consistently and without bias. This would allow parents to more easily understand what types and levels of caregiver behaviors are not to be tolerated. Parents at risk would be more easily identified and supported. Children subject to PM would have those experiences validated and responded to. Systems would be able to have a stable metric to understand how much PM is in their community and make better

informed plans to address it. Researchers could align research on PM with the clinical and child protective systems, which would ensure that knowledge would accumulate more rapidly.

We have existed for decades without a clear, agreed upon definition of PM and children and families have suffered as a result of this vacuum. Although a definition and systems for applying it does not change the world, without such a definition, it has been impossible to make substantial progress.

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Table 1*Definition of Psychological Maltreatment***Overarching Definition**

Psychological maltreatment refers to caregiver behaviors toward, or involving, a child (excluding physical/sexual abuse and physical neglect) which cause or have a strong potential to cause serious harm to a child's emotional, cognitive, social, interpersonal, or physical wellbeing or development.

Psychological maltreatment could reflect a single caregiver act or omission, or could reflect repeated caregiver behaviors.

Caregiver refers to any adult responsible for attending to the needs of a child as defined by the system using these definitions.

Operationalized Definition

A. Non-accidental act or acts (excluding physical and sexual abusive acts) and omissions (excluding physical neglect). *The following are possible examples and not intended as an exhaustive list. Acts/omissions not listed, but similarly potentially or actually harmful, are also eligible.*

Psychological Neglect

- Caregiver uninvolved
- Caregiver unresponsive to child's bids for a response
- Caregiver shows **egregious** lack of affection

Spurning

- Caregiver hostile to child
- Caregiver derogates, denigrates, belittles, insults, humiliates
- Scapegoating/ Caregiver singles child out for blame
- Caregiver rejects child

Developmentally inappropriate interactions

- Imposing developmentally inappropriate standards on the child, Including infantilization and parentification

Inappropriate Discipline

- Excessive discipline though frequency or intensity
- Confining/binding
- Compelling the child to inflict pain on him/herself
- Placing unreasonable limitations or restrictions on child's social interactions

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

Terrorizing/Exposing child to potentially traumatic experiences

- Exposing child to potentially traumatizing domestic violence; deliberate parental self-harm; recognizably dangerous situations
- Threatening violence against or abandonment of the child
- Threatening or perpetrating violence against a child's loved ones, pets, or objects (includes domestic violence).
- Terrorizing child through nonviolent actions or threats

Exploiting/ Using the child to fulfill caregiver needs over the child's

- Compelling the child to take sides in parental disputes.
- Munchausen by Proxy (limited to interactions with the child)
- Grooming for sexual abuse or exploitation

Failures to promote socialization /Corruption

- Encouraging antisocial behavior

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

1. Actual Psychological harm, including either

- a. The act/omission (or pattern of acts/omissions) created or exacerbated a **significant disruption** of the child's physical, emotional, cognitive, social, or interpersonal development
- b. Significant psychological distress (Major Depressive Disorder, anxiety disorders, disruptive behavior disorders, Substance Abuse disorders, or other **psychiatric disorders**, at or near diagnostic thresholds) related to the act(s)/omission(s)
- c. Stress-related somatic symptoms (related to or exacerbated by the acts) that significantly interfere with normal functioning
- d. **More than inconsequential fear reaction**

2. Reasonable potential for harm

- a. The act/omission (or pattern of acts/omissions) carries a reasonable potential for **significant disruption** of the child's physical, emotional, cognitive, social, or interpersonal development
- b. The act/omission (or pattern of acts/omissions) creates reasonable potential for the development of a **psychiatric disorder** (at or near diagnostic thresholds) related to, or exacerbated by, the act(s). The child's level of functioning and the risk and resilience factors present should be taken into consideration.
- c. The act/omission (or pattern of acts/omissions) carries a reasonable potential for **significant disruption** of the child's physical, emotional, cognitive, social, or interpersonal development

Secondary Operationalizations

Egregious: Egregious acts show striking disregard for child's well-being. As such, they are not merely examples of inadvisable or deficient

parenting, but must clearly fall below the lower bounds of normal parenting.

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

More than inconsequential fear reaction:

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

AND

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

1. Persistent intrusive recollections of the incident, including recollections as evidenced in the child's play
2. Marked negative reactions to cues *related to incident*, as evidenced by (a) avoidance of cues; (b) subjective or overt distress to cues; or (c) physiological hyperarousal to cues (NOTE: Perpetrator can be a cue)
3. Acting or feeling as if incident is recurring
4. Marked symptoms of anxiety (any of the following):
 - Difficulty falling or staying asleep
 - Irritability or outbursts of anger
 - Difficulty concentrating
 - Hypervigilance (i.e., acting overly sensitive to sounds and sights in the environment; scanning the environment expecting danger; feeling keyed up and on edge)
 - Exaggerated startle response

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

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

Psychiatric Disorders: Mental disorders as defined by the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), International Classification of Diseases (ICD), Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: 0-5 (DC: 0-5)

Child Psychological Maltreatment — Scoring

-
- Meets criterion A (non-accidental acts/omissions)
- and*
- Meets criterion B (significant impact; check below which criterion met)
 - B.1a (more than inconsequential fear reaction)
 - B.1b (Significant psychological distress)
-

-
- B.1c (Somatic symptoms that that significantly interfere with normal functioning)
 - B.1d (Significant developmental disruption)
 - B.2a (Reasonable potential for psychological harm)
 - B.2b (Reasonable potential for significant disruption of development)
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Note. Words that are bolded in the operationalized definition are further operationalized in the secondary operationalizations section.

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