Comment on APSAC Guidelines for Child Psychological Maltreatment

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The APSAC is proposing diagnostic criteria for a new pathology label called "child psychological maltreatment" (CPM) that does not exist in any established diagnostic system (DSM-5, ICD-11, DC:0-3). In the DSM-5, the *category* of Child Maltreatment contains four child abuse *diagnoses*, Child Physical Abuse (V995.51), Child Sexual Abuse (V995.53), Child Neglect (V995.52), and Child Psychological Abuse (V995.51). The proper professional-level terminology that the APSAC should use in their diagnostic formulations is child psychological abuse as defined by the DSM-5:

> **From DSM-5:** "Child psychological abuse is nonaccidental verbal or symbolic acts by a child's parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child. (Physical and sexual abusive acts are not included in this category.) Examples of psychological abuse of a child include berating, disparaging, or humiliating the child, threatening the child, harming/abandoning – or indicating that the alleged offender will harm/abandon - people or things that the child cares about; confining the child (as by tying a child's arms or legs together or binding a child to furniture or another object, or confining the child to a small enclosed area (e.g., a closet); egregious scapegoating of the child, coercing the child to inflict pain on himself or herself; and disciplining the child excessively (i.e., at an extremely high frequency or duration, even if not at a level of physical abuse) through physical or nonphysical means."

Nowhere in their discussion of diagnostic criteria for their new pathology label of "child psychological maltreatment" (CPM) did the authors discuss the existing DSM-5 definition of child psychological abuse (V995.51), nor did the authors discuss why the DSM-5 definition of child psychological abuse is inadequate and requires additional extension from the APSAC in its diagnostic definition.

Failure to apply the DSM-5/ICD-11 diagnostic systems as the bases for diagnostic formulations and professional judgments and instead making up new pathology labels ("child psychological maltreatment"; CPM), may represent a violation of Standard 2.04 Bases for Scientific and Professional Judgments of the American Psychological Association ethics code. Standard 2.04 requires all psychologists to apply the established scientific and professional knowledge of the discipline as the bases for professional judgments.

> **2.04 Bases for Scientific and Professional Judgments**
> Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The DSM-5 and ICD-11 diagnostic systems represent the "established scientific and professional knowledge of the discipline" that should be applied as the bases for professional diagnostic judgments (noted is Standard 1.04). But instead of relying on the established scientific and professional knowledge provided by the DSM-5 and ICD-11 diagnostic systems, the APSAC is proposing a new pathology label called "child psychological maltreatment" (CPM) with diagnostic domains identified based on the opinions of the authors.

Maltreatment vs Abuse

Child Maltreatment is a category in the DSM-5 containing four child abuse diagnoses – the term "maltreatment" is a *category* term containing multiple individual "abuse" *diagnoses*. To propose a new pathology label using a category term (maltreatment) for a specific form of child abuse (child psychological abuse) creates confusion. Are the authors discussing all four forms of child maltreatment – physical, sexual, neglect, and psychological in their use of the term "maltreatment"? Or are they only discussing one form of child maltreatment – child psychological abuse? If the authors are discussing only one abuse type, then they should use the professional-level term (DSM-5/ICD-11) for that type of abuse.

Creating new pathology labels such as "child psychological maltreatment" (CPM) with new diagnostic criteria developed by the authors, rather than relying on the established diagnostic systems of the DSM-5 and ICD-11, is beneath professional standards of practice in clinical psychology, and is likely in violation of Standard 2.04 Bases for Scientific and Professional Judgments of the APA ethics code.

Clarity and Misdiagnosis

The reason for formal diagnostic systems like the DSM-5 and ICD-11 is to provide clear diagnostic criteria established by supporting research for clarity in professional-to-professional communication about pathology, and to decrease risks of misdiagnosis from the development of random diagnostic proposals and labels created by varied professionals that can cause substantial harm to the client-public. Making up new pathology labels such as "child psychological maltreatment" (CPM) generates confusion in professional discussion and increases the risks of misdiagnosis by encouraging the use of diagnostic labels that are outside of established diagnostic systems.

Establishing criteria for identifying a pathology as being present or absent involves value judgments about the probability of making two types of diagnostic error – false positive misdiagnoses (when the diagnosis say the pathology is present when it is actually not present), and false negative misdiagnoses (when the diagnosis says the pathology is absent when it is actually present). False positive misdiagnoses are called Type I errors in diagnosis, and false negative misdiagnoses are called Type II errors.

True Positive Accurate Diagnosis as Present The diagnostic criteria accurately identify the pathology is present when the pathology is present	**False Positives** Type I Misdiagnosis The diagnostic criteria misidentify the pathology as being present when the pathology is actually absent
False Negative Type II Misdiagnosis The diagnostic criteria misidentify the pathology as absent when the pathology is actually present	**True Negative** Accurate Diagnosis as Absent The diagnostic criteria accurately identify the pathology is absent when the pathology is absent

As we adjust the sensitivity of the diagnostic criteria to limit making Type I diagnostic errors (false positives), we increase the risk of making Type II diagnostic errors (false negatives), and vice versa. Setting diagnostic criteria thresholds involves balancing the likelihoods of Type I and Type II misdiagnoses with the harm caused by making each type of misdiagnosis. For example, if false positive misdiagnoses cause substantial harm to the patient, then diagnostic criteria thresholds would seek to limit false positives (low Type I misdiagnosis). But the danger then becomes not identifying actual cases of the pathology, i.e., increasing the number of false negative misdiagnoses (high Type II misdiagnosis) to reduce false positives.

Setting diagnostic criteria thresholds involves applying value judgments regarding the relative damage caused by making the different types of misdiagnoses. Is it more important to diagnose as many true-positive cases as possible? If so, then the diagnostic criteria should be set at a lower threshold because it is more acceptable to have many false positive misdiagnoses to ensure that all the true positives are identified. If, on the other hand, it is it more important to limit over-pathologizing normal-range behavior, then the diagnostic threshold would be set higher to reduce the chances of making false positive misdiagnosis (over-identifying the pathology) because it is acceptable to have a higher rate of false negative misdiagnoses (the pathology is present but not diagnosed)?

The APSAC is proposing a new pathology label called "child psychological maltreatment" (CPM) that exists in no established diagnostic system. They propose adding multiple domains to the DSM-5 definition of child psychological abuse (V995.51) for their new pathology label of "child psychological maltreatment" (CPM). No offering is made by the authors as to why the DSM-5 definition of child psychological abuse is inadequate and needs additional extension from the APSAC, and no research data is provided by the authors regarding the probabilities of Type I (false positive) and Type II (false negative) misdiagnoses using their proposed diagnostic criteria.

APSAC Diagnostic Criteria for New CPM Pathology

The proposed diagnostic criteria for the new pathology label of "child psychological maltreatment" replicates portions of the DSM-5 Child Psychological Abuse diagnosis (V995.51), while also adding additional diagnostic domains based on the beliefs of the authors. The following table presents the diagnostic criteria proposal for CPM divided into the criteria that replicate the DSM-5 definition, and those that extend that definition. Concern points are identified for each of the new diagnostic domain proposals.

Proposed New Domains for a Child Psychological Maltreatment Diagnosis	Existing DSM-5 Definition of Child Psychological Abuse
APSAC: Caregiver uninvolved, caregiver unresponsive to child's bids for a response, caregiver shows egregious lack of affection. • Vague; subjective • Cultural bias	APSAC: Caregiver hostile to child, caregiver derogates, denigrates, belittles, insults, humiliates the child, scapegoating, caregiver singles child out for worse treatment than siblings, caregiver rejects child

• No research support	**From DSM-5:** "Examples of psychological abuse of a child include berating, disparaging, or humiliating the child… egregious scapegoating of the child..."
APSAC: Imposing or fostering developmentally inappropriate standards on the child, including infantilization and adultification (e.g., parentification) • Vague; subjective • Cultural bias • No research support	APSAC: Excessive discipline through frequency or intensity **From DSM-5:** "…disciplining the child excessively (i.e., at an extremely high frequency or duration, even if not at a level of physical abuse) through physical or nonphysical means."
APSAC: Placing unreasonable limitations or restrictions on child's social interactions • Vague; subjective • Cultural bias • No research support	APSAC: Confining/binding **From DSM-5:** "…confining the child (as by tying a child's arms or legs together or binding a child to furniture or another object, or confining the child to a small enclosed area (e.g., a closet)
APSAC: Preventing a child from necessities (e.g., sleep, rest, food, light, water, access to the toilet) • Denial of food and water is Child Neglect (V995.52) • APSAC is adding denial of sleep, rest, light, and toilet to child psychological abuse diagnosis.	APSAC: Compelling the child to inflict pain on him-/herself **From DSM-5:** "…coercing the child to inflict pain on himself or herself..."
APSAC: Exposing child to potentially traumatizing interparental violence; deliberate parental self-harm; recognizably dangerous situations • Adding Intimate Partner Violence (IPV) exposure to child psychological abuse diagnosis. • Will require corresponding DSM-5 diagnosis of spousal abuse: o V995.81 Spouse or Partner Violence, Physical	APSAC: Threatening violence against or abandonment of the child, threatening or perpetrating violence against a child's loved ones, pets, or objects (including domestic violence). **From DSM-5:** "… threatening the child, harming/abandoning – or indicating that the alleged offender will harm/abandon - people or things that the child cares about..."

○ V995.82 Spouse or Partner Abuse, Psychological • Exposing the child to dangerous situations is negligent failure in parental supervision (Child Neglect V995.52)	
APSAC: Exploiting/using the child to fulfill caregiver needs over the child's needs • Vague; subjective • Cultural bias • No research support	APSAC: Terrorizing child through violent actions or threats **From DSM-5:** "… threatening the child, harming/abandoning • Violent acts are child physical abuse (V995.54)
APSAC: Caregiver actively subjecting the child to belittling, degrading, and other forms of hostile or rejecting treatment of those in significant relationships with the child • Adding IPV exposure to child psychological abuse diagnosis. • Will require corresponding DSM-5 diagnosis of spousal abuse: ○ V995.81 Spouse or Partner Violence, Physical ○ V995.82 Spouse or Partner Abuse, Psychological	APSAC: Munchausen by proxy (limited to interactions with the child) **From DSM-5:** 300.19 Factitious Disorder Imposed on Another
APSAC: Grooming for sexual abuse or exploitation • Prior to sex abuse, "grooming" behavior is simply friendship. After sex abuse, the prior grooming behavior (forming a friendship) is subsumed under the Child Sexual Abuse diagnosis (V995.53)	
APSAC: Encouraging antisocial behavior • Vague; subjective • Cultural bias • No research support	

Through their new diagnostic label of "child psychological maltreatment", the APSAC is seemingly proposing the addition of the following domains to the existing DSM-5 definition of child psychological abuse (V995.51)

- **Unresponsive Parent:** A parent who is not sufficiently responsive to the child's bids for affection represents child psychological maltreatment (CPM).
- **Adultification:** Placing too many responsibilities onto the child ("adultification") represents child psychological maltreatment (CPM).
- **Social Restrictions:** Restricting the child from peer social interactions for reasons deemed "unreasonable" by the evaluating professional represents child psychological maltreatment (CPM).
- **Deprivation of Needs:** Denying the child sleep, rest, light, and access to the toilet represents child psychological maltreatment (CPM).
- **IPV Exposure:** Subjecting the child to (diagnosed/confirmed) Intimate Partner Violence (IPV) represents child psychological maltreatment (CPM).
- **Role-Reversal:** The parent using the child to meet the parent's emotional needs represents child psychological maltreatment (CPM).
- **Grooming for Sex Abuse:** Forming a friendship with the child (for future sexual abuse purposes; "grooming" the child) represents child psychological maltreatment.
- **Encouraging Misbehavior:** Encouraging the child to engage in antisocial behaviors represents child psychological maltreatment (CPM).

No reason is provided for why these specific symptom features need to be added to the DSM-5 definition of child psychological abuse. No research support is offered for the proposed expansion of the DSM-5 domains for a child psychological abuse definition. The authors did not identify why the DSM-5 definition of child psychological child abuse is inadequate for child protection purposes and requires additional clarification by the APSAC.

For conceptual support for a new diagnostic label of "child psychological maltreatment", the authors of the proposed APSAC guidelines cite to an article by three of the group's advisors, Drs. Slep, Glaser, and Manly.[1]

> **From APSAC Guidelines:** "The overarching definition and subtypes of CPM formulated and operationalized by Slep et al. [17], which include decision-making guides, are adopted in these APSAC Guidelines and presented in Figure 1 for application by professionals evaluating children to determine whether they have or have not been victims of psychological maltreatment.."
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> **From APSAC Guidelines:** "These guidelines are the product of APSAC's Task Force on Psychological Maltreatment, co-chaired by Stuart N. Hart, PhD, and Marla

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

Brassard, PhD. Contributions toward its development have been provided by… Danya Glaser, MD, Jody Todd Manly, PhD, and Amy M. Smith Slep, PhD.

In their article, Slep, Glaser, and Manly (2022) indicate that there is currently no research support for their proposed diagnostic label of "child psychological maltreatment" (CPM), and that clinical trials are still needed to determine the validity and usefulness of their proposed new diagnostic label.

> **From Slep, Glaser, & Manly (2022):** "We discuss the need for field trials to establish the utility of the definition."

Until research ("field trials") is conducted for a new pathology label called "child psychological maltreatment" that adds diagnostic criteria to the DSM-5 definition of child psychological abuse, the guidelines as offered by the APSAC should not be relied on for decision-making surrounding children and families. Of concern surrounding the additional diagnostic domains proposed by the APSAC for their new pathology label of "child psychological maltreatment" (CPM) are prominent professional concerns for cultural bias.

Cultural Bias

Of professional concern is that the diagnostic criteria proposed by the APSAC for a new pathology label called "child psychological maltreatment" (CPM) is culturally biased in favor of Western, Northern-European, humanistic, non-religious values over other cultural values. For example, many cultures encourage older siblings to assume care responsibilities for younger children in large families. This parenting approach, however, may meet diagnostic criteria of "adultification" in the new pathology label of CPM.

> **From APSAC Guidelines:** "Imposing or fostering developmentally inappropriate standards on the child, including infantilization and adultification."

Creating diagnostic criteria based on personal opinions that will pathologize parenting approaches as child maltreatment, making the child subject to removal from the parent's care, should be undertaken with considerable caution for respecting cultural values, parental rights regarding their personal value systems, and differing religious values that guide parenting styles, beliefs, and practices. Child physical abuse involves physical behaviors that often leave demonstrable physical evidence of bruising or injuries. Child sexual abuse involves criteria for physical touch or exposure to states of undress. Child psychological abuse often involves 'soft-sign' parent and child emotional-relational symptoms that can be open to a range of interpretations and values application.

Pathologizing parenting as "maltreatment" warranting a child protection response of separating the child from the parent should be done with considerable caution, and the diagnostic criteria should be conservative. False positive misdiagnoses of over-identifying cultural, personal, and religious values as child psychological abuse should be avoided, and having more false negative misdiagnoses of under-identification are acceptable given the context and concerns. Diagnostic guidelines can be extended once more complete research becomes available on the nature, features, and symptom indicators of child psychological abuse across cultural, personal, and religious contexts.

Being a parent is a fundamental human right, and parents have the right to parent according to their cultural values, their personal values, and their religious values. Overriding these foundational rights of parenting by pathologizing the parenting practices as psychologically abusive (DSM-5 V995.51 Child Psychological Abuse) requires a high-bar of professional certainty in the diagnosis, and needs to protect the legitimate cultural, personal, and religious rights of parents in the selection and application of professional diagnostic criteria to be applied for a diagnosis of psychological child abuse.

Breach & Repair

Forty years of attachment research by Tronick (still-face paradigm) indicates that in healthy parent-child relationships, the parent and child are mismatched in their communication (misattuned; not synchronous with each other) 70% of the time. Psychological damage is not caused by breaches in the parent-child relationship (i.e., by misattunement; conflict), psychological damage occurs from the failure to repair the breach.

> **From Tronick & Gold:** "Moving through messiness turns out to be the way we grow and develop in relationships from earliest infancy through adulthood! This might seem counterintuitive as you might think that in healthy relationships, there is no place for discord. Shouldn't two people in a good relationship always get along? Previous infant research has reflected the assumption that the more synchronous and attuned the interaction, the more optimal, or clinically "normal" the relationship. To many people's surprise, the research revealed that messiness holds the key to strong relationships,.. In typical healthy parent-infant pairs, on average 70% of the interactions were out of sync!" (Tronick & Gold, 2020, p. 37)

> **From Tronick & Gold:** "Does it seem right to you that most relationships are mismatched 70% of the time? We found this again and again. In the field of developmental psychology, this 70-30 split has become famous, with some practitioners referencing it without actually knowing its origin. It comes from our detailed observation of the primary love relationship. In analyzing these videotapes, we discovered that the most important part was not the mismatch but the repair." (Tronick & Gold, 2020, p. 37-38)

> **From Tronick & Gold:** "Repair is where the action is. We came to recognize that repair is the crux of human interactions. Repair leads to a feeling of pleasure trust and security, the implicit knowledge that *I can overcome problems.* Furthermore, repair teaches a critical life lesson: the negative feelings that arise from a mismatch can be changed into a positive feeling when two people subsequently achieve a match. One does not have to get stuck in a negative feeling state." (Tronick & Gold, 2020, p. 38)

> **From Tronick & Gold:** "We came to understand mismatch and repair as a normal and ongoing experience fundamental to our species development as social beings. What a relief to learn that in primary love relationships, humans are in Sync only 30% of the time! That the number is so low should relieve the pressure many people feel to seek perfect harmony in their relationships as adults. As long as there is an opportunity for repair, mismatch in 70% of interactions is not only typical but

conducive to positive and healthy development in relationships. We need the normal messiness in order to trust each other." (Tronick & Gold, 2020, p. 39)

From Tronick & Gold: "We prefer to capture the range of a child's experience with a different set of terms: *the good, the bad, and the ugly. Good stress* is what happens in typical everyday interactions, what we have seen in our videotaped interactions as moment-to-moment mismatch and repair. *Bad stress* is the stress represented in the still face experiment by the caregivers sudden inexplicable absence… *Ugly stress* occurs when the infant has missed out on the opportunity for repeated experiences of repair, as in situations of emotional neglect, and thus cannot handle any sort of bigger stressful event." (Tronick & Gold, 2020, p. 134)

From Tronick & Gold: "Children growing up with insufficient experiences of mismatch and repair are at a disadvantage for developing coping mechanisms to regulate their physiological behavioral and emotional reactions. We use the term *regulatory scaffolding* to describe the developmental process by which resilience grows out of the interactive repair of the micro-stresses that happen during short lived, rapidly occurring mismatches, the caregiver provides "good-enough" scaffolding to give the child the experience of overcoming a challenge, ensuring there is neither too long a period to repair nor too close a mismatch with no room for repair." (Tronick & Gold, 2020, p. 135)

Many cultures are high in expressed emotion in the family, yet these cultures and families nevertheless raise psychologically healthy children because conflicts in the family are successfully repaired. The issue for defining child psychological abuse is not so much the parenting behaviors of criticism or conflict, the psychological/developmental damage occurs to the child from the failure to repair the relationship following the conflict. It is notable that the authors of the proposed new diagnostic label of "child psychological maltreatment" (CPM) cite to none of the attachment research (such as Tronick) for their proposed diagnostic criteria, suggesting they may not be familiar with the attachment research regarding the central neuro-developmental importance of the breach-and-repair sequence in the parent-child bond.

Child Abuse Diagnoses

Typically, mental health professionals are only allowed to assess and diagnose one type of child abuse, psychological child abuse, with the other child abuse diagnoses typically being made by Child Protective Services (CPS) following a mandated report (by the mental health professional or from the community). Because the diagnoses of child physical abuse (V995.54), child sexual abuse (V995.53), and child neglect (V995.52) are made by CPS following specialized forensic interviews, these child abuse diagnoses are not relevant for discussion of diagnostic criteria. A suspicion of possible child physical abuse, sexual abuse, or child neglect triggers a mandated report to CPS for investigation and diagnosis, and their returned diagnosis of founded (substantiated) or unfounded (unsubstantiated) is accepted by mental health professionals as accurate. Mental health professionals are prohibited from assessing for child physical, sexual, and neglect abuse to allow a for a proper specialized forensic child abuse assessment to be conducted by CPS.

Child psychological abuse, however, is not a mandated report to CPS for investigation, meaning that this is the only child maltreatment diagnosis that mental health professionals would be in a professional position of diagnosing. The DSM-5 diagnostic system of the American Psychiatric Association and the ICD-11 diagnostic system of the World Health Organization represent the established scientific and professional knowledge of the discipline that should serve as bases for diagnostic formulations. It is unclear why the APSAC believes the DSM-5 diagnostic definition for child psychological abuse (V995.51) is inadequate and needs extension into a new diagnostic label of "child psychological maltreatment" that includes additional domains of parenting concern.

In the DSM diagnostic system, V-code diagnoses (like child abuse or spousal abuse) represent modifying conditions for the primary DSM-5 diagnosis. Several primary DSM-5 diagnoses warrant the additional V-code diagnosis of child psychological abuse.

- Factitious Disorder Imposed on Another (300.19)

  Historically called "Munchausen syndrome by proxy", Factitious Disorder Imposed on Another (FDIA) is the creation of a false (factitious) pathology in the child for secondary gain to the parent, and represents an additional V-code modifying diagnosis of child psychological abuse (V-995.51) to the primary diagnosis of FDIA (300.19)

- Shared (induced) Persecutory Delusion

  In court-involved custody conflict, a parent creating a shared (induced) persecutory delusion in the child that then destroys the child attachment bond to the other parent represents an additional child psychological abuse modifying diagnosis (V-995.51) to the primary diagnosis of 297.1 Delusional Disorder (shared); persecutory type.

Given the inherent cultural, personal, and religious factors influencing judgments of parenting, considerable diagnostic caution should be exercised in making a child psychological abuse diagnosis from 'soft-sign' symptoms of professional judgment. In defining psychological child abuse for diagnostic purposes, a conservative approach is recommended until additional research can clarify extending any diagnostic criteria into 'soft-sign' diagnostic symptoms.

A conservative approach to diagnosing child psychological abuse (DSM-5 V995.51) would separate concerns into two categories:

- **Confirmed Child Psychological Abuse:** a confirmed diagnosis of child psychological abuse would accompany a DSM-5 primary diagnosis of FDIA or a shared (induced) persecutory delusion.

- **Unconfirmed Child Psychological Abuse:** any clinical concerns that do not represent a confirmed DSM-5 diagnosis of child psychological abuse, that are based on 'soft-sign' symptoms, professional judgments, or reporting of parental behavior of clinical concern, would represent unconfirmed child psychological abuse concerns..

A confirmed child psychological abuse diagnosis would result in a child protection response commensurate with the child protection response for any other child abuse diagnosis. All child abuse diagnoses are equally damaging to the child, they differ only in the type of damage done, not the extent of damage. An unconfirmed child psychological abuse diagnosis that is based on elevated clinical concerns should be diagnostically designated as a rule-out (R/O) possibility still under consideration, and a Response-to-Intervention (RTI) treatment approach should be undertaken to clarify diagnostic issues and clinical concerns.

In clinical practice, a rule-out diagnosis is expected to be resolved as either confirmed or disconfirmed by the six-week point of treatment. If the rule-out diagnosis is rejected based on additional treatment-related experience, then it is dropped from the diagnostic profile. If the rule-out diagnosis is confirmed through additional treatment experience, then it is added to the diagnostic profile. When a rule-out (unconfirmed) diagnosis of child psychological abuse is added to the diagnostic profile as confirmed by a Response-to-Intervention (RTI) trial, then this diagnostic confirmation should include appropriate cultural consultation and second-opinion diagnostic consultation before confirming the child psychological abuse diagnosis from its prior rule-out status.

The Diagnostic Process

The National Academy of Sciences describes the diagnostic process in a paper on *Improving Diagnosis in Healthcare* (2015),[2]

> **From Improving Diagnosis**: "The working diagnosis may be either a list of potential diagnoses (a differential diagnosis) or a single potential diagnosis. Typically, clinicians will consider more than one diagnostic hypothesis or possibility as an explanation of the patient's symptoms and will refine this list as further information is obtained in the diagnostic process." (National Academy of Sciences, 2015)
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> **From Improving Diagnosis**: "As the diagnostic process proceeds, a fairly broad list of potential diagnoses may be narrowed into fewer potential options, a process referred to as diagnostic modification and refinement (Kassirer et al., 2010). As the list becomes narrowed to one or two possibilities, diagnostic refinement of the working diagnosis becomes diagnostic verification, in which the lead diagnosis is checked for its adequacy in explaining the signs and symptoms, its coherency with the patient's context (physiology, risk factors), and whether a single diagnosis is appropriate." (National Academy of Sciences, 2015)
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> **From Improving Diagnosis**: "Throughout the diagnostic process, there is an ongoing assessment of whether sufficient information has been collected. If the diagnostic team members are not satisfied that the necessary information has been collected to explain the patient's health problem, or that the information available is

[2] *Improving Diagnosis in Healthcare* (2015). National Academies of Sciences, Engineering, and Medicine.

https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care?fbclid=IwAR2ht8JZQGHLWElqlBjwqPqx6qtmgc9JYpI8mSRUJaLZFdzljAubk2MkOAI

not consistent with a diagnosis, then the process of information gathering, information integration and interpretation, and developing a working diagnosis continues." (National Academy of Sciences, 2015)

From Improving Diagnosis: "In addition, the provision of treatment can also inform and refine a working diagnosis, which is indicated by the feedback loop from treatment into the information-gathering step of the diagnostic process. This also illustrates the need for clinicians to diagnose health problems that may arise during treatment." (National Academy of Sciences, 2015)

From Improving Diagnosis in Health Care: "Clinicians may refer to or consult with other clinicians (formally or informally) to seek additional expertise about a patient's health problem. The consult may help to confirm or reject the working diagnosis or may provide information on potential treatment options. If a patient's health problem is outside a clinician's area of expertise, he or she can refer the patient to a clinician who holds more suitable expertise. Clinicians can also recommend that the patient seek a second opinion from another clinician to verify their impressions of an uncertain diagnosis or if they believe that this would be helpful to the patient."

Family Courts & Child Psychological Abuse

A primary domain for a child psychological abuse diagnosis is in high-conflict child custody litigation in the family courts. Typically in high-conflict custody litigation, the court's decision-making regarding custody schedules is made more complex because of child attachment pathology toward a parent (i.e., the child rejects or seeks to flee a parent's care). A child seeking to reject, avoid, or flee from a parent represents an attachment pathology, i.e., a problem in the love-and-bonding system of the brain.

The attachment system is a primary motivational system that always motivates the child to bond to a parent. If a child is rejecting, avoiding, or seeking to flee from a parent's care, then child abuse concerns become relevant diagnostic possibilities for the child's symptoms. The only cause of severe attachment pathology (i.e. a child rejecting or seeking to flee a parent) is child abuse range parenting by one parent or the other.

- **Child Abuse by Targeted Parent:** Either the targeted parent is abusing the child in some way, thereby creating the child's attachment pathology toward that parent (a two-person attribution of causality).

- **Child Abuse by Allied Parent:** Or the allied parent is psychologically abusing the child (DSM-5 V995.51 Child Psychological Abuse) by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the parent. (a 3-person triangle attribution of causality)

Since the only cause of severe attachment pathology (a child rejecting a parent) is child abuse range parenting by one parent or the other, in all cases of court-involved child custody conflict involving severe attachment pathology (i.e., a child rejecting a parent), a proper risk assessment for child abuse needs to be conducted to the appropriate differential diagnoses for each parent.

Shared Persecutory Delusion

The child psychological abuse pathology of concern in the family courts is the creation of a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied pathological parent (narcissistic-borderline-dark personality). The American Psychiatric Association provides the following definition for a persecutory delusion:

> **From the APA:** "Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way." (American Psychiatric Association, 2000)

The American Psychiatric Association also indicates that a shared (induced) persecutory delusion can occur "especially in family situations" in which the children adopt the parent's delusional beliefs to varying degrees.

> **From the APA:** "Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person… Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs." (American Psychiatric Association, 2000)

The persecutory delusion that is present in the family courts is described by Walters & Friedlander (2016) in the journal *Family Court Review,*

> **From Walters & Friedlander:** "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated **delusion** about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated **delusion** is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426)

> **From Walters & Friedlander:** "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed **delusion** often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated **delusion** and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426)

Creating a persecutory thought disorder in the child that then destroys the child's attachment bond to the other parent represents a DSM-5 diagnosis of 297.1 Delusional Disorder (shared), persecutory type, and an additional modifying V-code diagnosis of V995.51 Child Psychological Abuse.

Factitious Attachment Pathology

Creating false (factitious) attachment pathology in the child for secondary gain to the pathological parent (narcissistic-borderline-dark personality) also represents a modifying

DSM-5 V-code diagnosis of child psychological abuse. The potential secondary gain to the allied parent for creating psychiatric and developmental pathology in the child includes:

- **Court Manipulation:** manipulating the court's decisions regarding child custody in the allied parent's favor (by deceiving the court regarding the parenting of the other parent through creating false pathology in the child).
- **Spousal Abuse:** the spousal emotional and psychological abuse of the targeted parent using the child, and the child's induced pathology, as the spousal abuse weapon.
- **Regulatory Object:** the pathological narcissistic-borderline-dark personality parent is using the child as a "regulatory object" to meet the allied parent's own emotional and psychological needs.

The ICD-11 diagnostic system defines the diagnostic criteria for FDIA:

> **From ICD-11 FDIA: "**Factitious disorder imposed on another is characterised by feigning, falsifying, or inducing medical, psychological, or behavioural signs and symptoms or injury in another person, most commonly a child dependent, associated with identified deception."
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> **From ICD-11 6D51 FDIA:** "The individual seeks treatment for the other person or otherwise presents him or her as ill, injured, or impaired based on the feigned, falsified, or induced signs, symptoms, or injuries.

In the family courts, the allied parent in the custody conflict is inducing psychological symptoms in the dependent child to deceive the court regarding the normal-range parenting of the targeted parent. The allied parent then presents the child to the court and to mental health professionals as being "injured" by the (normal range) parenting of the targeted parent, and as having an "impaired" attachment bond to the targeted parent based on the child's induced symptoms.

APSAC Discussion of Child Maltreatment

The discussion of child maltreatment generally that includes child physical, sexual, and neglect abuse is not relevant to the diagnostic guidelines for the new pathology label of "child psychological maltreatment" since only psychological child abuse is diagnosed by mental health professionals. The other child abuse diagnoses are identified (diagnosed) by CPS investigation following a mandated child abuse report to CPS. It is stipulated as general understanding that child abuse exists (hence the four DSM-5 diagnosis of child abuse), and that all forms of child abuse are damaging to the child's development.

> **From Bowlby:** "No variables, it is held, have more far-reaching effects on personality development than have a child's experiences within his family: for, starting during the first months of his relations with his mother figure, and extending through the years of childhood and adolescence in his relations with both parents, he builds up working models of how attachment figures are likely to behave towards him in any of a variety

of situations; and on those models are based all his expectations, and therefore all his plans for the rest of his life." (Bowlby, 1973, p. 369).[3]

Examples of Child Psychological Maltreatment

Offering examples for diagnostic criteria that are constructed by the authors to highlight aspects of their new diagnostic label of "child psychological maltreatment" (CPM) is of little value because of potential bias in the construction and presentation of the case symptoms in favor of the diagnostic proposal. Of far more value is actual research supporting the selection of the specific criteria and severity levels of the proposed diagnostic criteria, as well as inter-rater reliability data on rating the symptoms, that will allow for computing the probabilities of Type I and Type II misdiagnoses using the diagnostic criteria for the new pathology label of "child psychological maltreatment" (CPM) proposed by the APSAC.

Until supporting research is conducted for the proposed diagnostic criteria from the APSAC for their new pathology label called "child psychological maltreatment" (CPM), the guidelines as offered by the APSAC appear culturally biased, vague, and unsupported by research, and should not be relied on for decision-making surrounding children. Due to substantial cultural concerns when diagnosing parenting behavior as psychological child abuse based on 'soft-sign' clinical judgment symptoms, a conservative diagnostic approach is recommended until additional research is conducted that will allow for expansion of the relevant domains for diagnosis.

Summary & Conclusions

1) The APSAC proposes a new diagnostic label of "child psychological maltreatment" that does not exist in any established diagnostic system (DSM-5, ICD-11, DC:0-3).

2) No offer is made by the authors as to why the DSM-5 diagnostic definition of child psychological abuse (V995.51) is inadequate and requires additional modifications and extensions into the new domains proposed by the APSAC guidelines.

3) No research support is offered by the authors for the extended definitions contained in their new diagnostic label of "child psychological maltreatment" (CPM).

4) Prominent professional concerns are present that the extended definitions for a new diagnostic label of "child psychological maltreatment" (CPM) are culturally biased.

5) Prominent professional concerns are present that the proposal from the APSAC for a new diagnostic label called "child psychological maltreatment" fails to rely on the established scientific and professional knowledge of the discipline as the bases for professional diagnostic formulations and judgments, in apparent violation to Standard 2.04 Bases for Scientific and Professional Judgements of the APA ethics code (noted also is Standard 1.04).

[3] Bowlby, J. (1973). Attachment and loss: Vol. 2. Separation: Anxiety and anger. NY: Basic.

The APSAC apparently believes they are allowed to make up new diagnostic labels ("child psychological maltreatment"; CPM) based on their personal beliefs. They are not, that is not the way professional healthcare works. If the APSAC is allowed to make up a new pathology label based on their beliefs and definitions (CPM), then everyone is similarly allowed to make up new pathology labels based on their beliefs and their definitions.

Ethical Standards exist for a reason, and Standard 2.04 of the APA ethics code requires all psychologists to apply the established scientific and professional knowledge of the discipline as the bases for professional judgments. The authors of the proposed new diagnostic label of CPM should reflect on the potential negative consequences of violations to Standard 2.04. What bad things could happen if psychologists did not rely on the established knowledge of the DSM-5/ICD-11 diagnostic systems as the bases for their professional judgments, and instead made up new pathology labels based on personal beliefs?

The established diagnostic systems of the DSM-5 and ICD-11 exist for a reason, and all professional-level doctors are expected to rely on these established diagnostic systems as the bases for their diagnostic formulations and professional judgments for legitimate and important professional reasons. As the established scientific and professional knowledge of the discipline, the DSM-5/ICD-11 diagnostic systems should be applied first, before proposing new diagnostic labels for pathology, as the bases for diagnostic formulations and professional judgments. If, after applying the DSM-5/ICD-11 diagnostic systems, some inadequacy is identified in the diagnosis of pathology, then – and only then – can a proposal for a new pathology label be offered based on research support for the new pathology label.

Until the APSAC proposal of a new diagnostic label called "child psychological maltreatment" is in the DSM-5/ICD-11 diagnostic systems, it does not exist as a professional-level diagnosis and should not be relied on for decision-making surrounding children and families. If the APSAC believes that the DSM-5 diagnosis of Child Psychological Abuse (V995.51) is inadequate and needs revision with additional domains of concern, the APSAC can describe how the DSM-5 is inadequate and then can present their research evidence to support their proposal for the added domains of concern.

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