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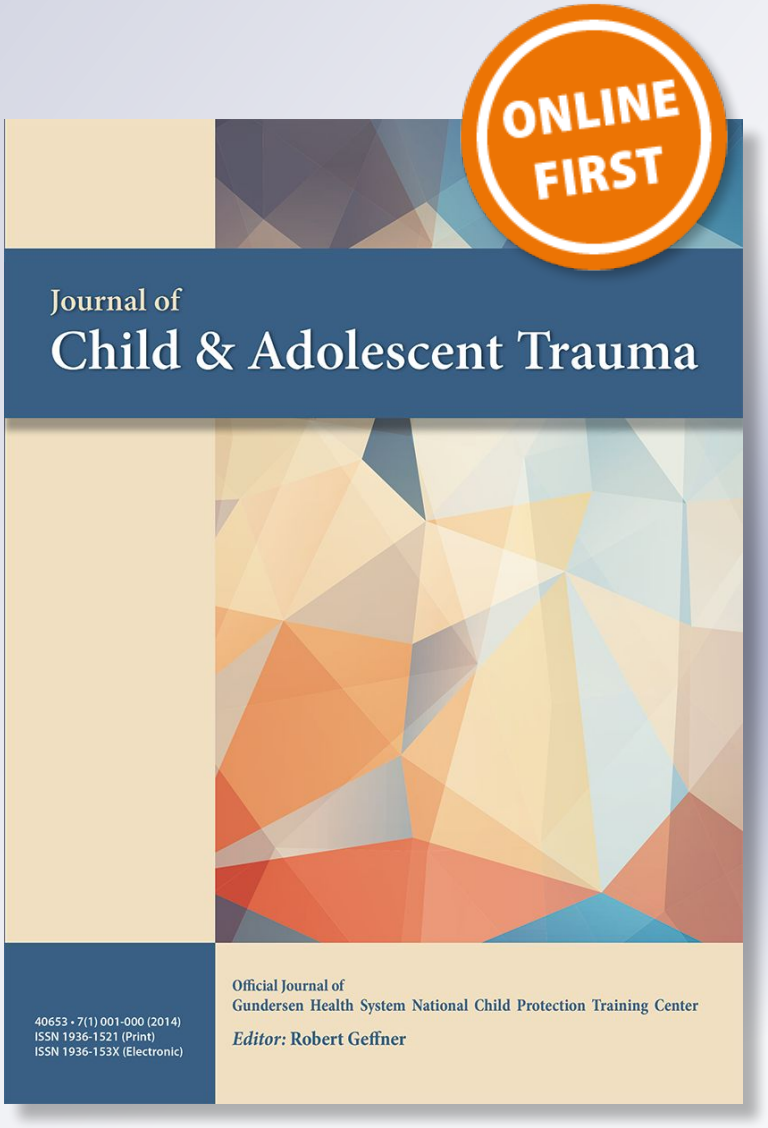

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ORIGINAL ARTICLE

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Abstract This paper describes clinical findings and case characteristics of children who are victims of severe and multiple forms of abuse; and proposes clinical criteria that indicate child abuse by torture. Medical records, investigation records, and transcripts of testimony regarding a non-consecutive case series of 28 children with evidence of physical abuse, neglect, and psychological maltreatment, such as terrorizing and isolation, were reviewed for types of injuries, duration of maltreatment, medical and physical neglect, social and family history, and history of prior Child Protective Services (CPS) involvement. The median age was 7.5 years (9 months to 14.3 years). Thirty-six percent died. Duration of abuse ranged from 3.5 months to 8 years (median 3 years). Ninety-three percent of children were beaten and exhibited cutaneous injury; 21 % had fractures. There were 25 victims of isolation (89 %), as well as 61 % who were physically restrained and 89 % who were restricted from food or water. All of the children were victims of psychological maltreatment; 75 % were terrorized through threats of harm or death to themselves or loved ones and 54 % were degraded and/or rejected by caregivers. Nearly all children were medically neglected. Half had a history of prior referrals to CPS. The children in this case series were physically abused, isolated, deprived of basic necessities, terrorized, and neglected. We define child torture as a longitudinal experience characterized by at least two physical assaults or one extended assault, two or more forms of psychological maltreatment, and neglect resulting in prolonged suffering, permanent disfigurement or dysfunction, or death.

Keywords Non-accidental trauma · Physical abuse · Psychological maltreatment · Neglect · Starvation

B. L. Knox (✉)
Department of Pediatrics, University of Wisconsin School of Medicine and Public Health, American Family Children's Hospital, 600 Highland Ave, H4/428 Clinical Science Center, Madison, WI 53792-4108, USA
e-mail: blknox@pediatrics.wisc.edu

S. P. Starling
Eastern Virginia Medical School, Children's Hospital of The King's Daughters, Norfolk, VA, USA

K. W. Feldman
University of Washington, and Seattle Children's Hospital, Seattle, WA, USA

N. D. Kellogg
University of Texas Health Science Center at San Antonio, San Antonio, TX, USA

L. D. Frasier
Primary Children's Medical Center, University of Utah, Salt Lake City, UT, USA

S. L. Tiapula
National Center for Prosecution of Child Abuse, Alexandria, VA, USA

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Child abuse pediatrics is an evolving field. Prior to Dr. C. Henry Kempe and colleagues analyzing and defining Battered Child Syndrome in 1962 as physically abusive injuries to one or more body systems culminating in serious injury or death (Kempe et al. 1962) these cases were not recognized or, if diagnosed, mishandled by the physician. Kempe's legacy has been to reshape our understanding of child maltreatment. Due in part to this seminal article, physical abuse of children is now diagnosed by clinicians, investigated by social services, and prosecuted in courts. The description of Battered Child Syndrome addressed system-wide failures to recognize child maltreatment.

As the years progressed, other subcategories of child abuse emerged including sexual abuse (Kempe 1978), neglect (Cantwell 1980), emotional abuse (Hart et al. 2011; Hibbard

et al. 2012), abusive head trauma (Christian et al. 2009), medical child abuse (Roesler and Jenny 2009; Rosenberg 1987; Stirling and American Academy of Pediatrics Committee on Child Abuse and Neglect 2007), and intentional child starvation (Kellogg and Lukefahr 2005). Each identified subcategory of child maltreatment included unique clinical features which required specific child assessment, diagnostic, and treatment approaches.

Torture is different from other forms of child abuse, but it currently lacks medical definitional criteria. As opposed to torture, the majority of commonly recognized physically abusive acts result from a caregiver's episodic unchecked anger or loss of self-control. Torture is usually prolonged or repeated and includes acts designed to establish the perpetrator's domination and control over the child's psyche, actions and access to the necessities of life. It employed elements of both physical abuse and psychological cruelty. According to Knox and Starling (2012), 1 to 2 % of children being evaluated for abuse present with such a unique constellation of physical and psychological injuries which appears to represent torture.

Recognition and management of these cases is problematic at multiple levels, including medical care, interventions by Child Protective Services (CPS), and prosecution by the legal system. A recent literature review and commentary notes the lack of a formal medical definition of torture in the context of child abuse (den Otter et al. 2013); this lack of a definition may have reduced the ability of medical and legal authorities to effectively recognize and address this problem. Although torture has been described in the context of politically motivated abuse, the torture of children within a familial context has received little attention. Review of the medical literature yielded only two isolated case reports of torture that were not politically motivated (Allasio and Fischer 1998; Tournel et al. 2006).

Definitions of Torture

Historically, torture in the context of politically or militarily motivated conduct, often by state actors, is a means of extracting information or controlling populations through intimidation and repression (Stover and Nightingale 1985). Definitions of torture have been proposed by Amnesty International (1975), the World Medical Association (1975), and the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (Burgers and Danelius 1988) to address politically motivated conduct and the medical community's response to torture. These definitions include two key components: (1) intentional infliction of severe pain and suffering without regard to the extent of injury, and (2) for the purpose of obtaining submission or dehumanization. Definitions of political torture generally require that perpetrators have physical control over the victim (Stover and Nightingale 1985), inflict severe pain and suffering, to behave systematically and with purpose, and continue or repeat the behaviors over time (Allasio and Fischer 1998). Stover and Nightingale (1985) state:

> The purpose of torture is to break the will of the victim and ultimately to break his or her humanity…through infliction of severe or acute physical pain and mental suffering…and requires that the torturer exert physical control over his or her victim. (p. 4–5)

Campbell (2007) adds: "The act of torture is carried out for the purpose of physically and psychologically 'breaking' an individual" (p. 633). Children also have been documented victims of political torture (Cohn et al. 1981; den Otter et al. 2013; Green 2007; Welsh 2000). However, descriptions of manifestations and definitions specific to intra-familial torture, without political purpose, have not been described (Allasio and Fischer 1998; Tournel et al. 2006).

Exemplary Case Series of Child Abuse Torture

The goal of this case series is to exemplify and thus define child torture within the context of physical and psychological maltreatment inflicted on children by their caretakers. We sought to identify medical criteria distinguishing these cases from other forms of child abuse and present reasons for creating a new subcategory of child maltreatment. This case series also examines perpetrator characteristics and their implications.

Methods

Child abuse pediatricians from five U.S. medical centers selected cases they considered to represent child torture. The sites spanned the country, including Virginia, Texas, Wisconsin, Utah, and Washington State. These cases included a combination of severe physical and psychological maltreatment that occurred repeatedly and caused severe physical and psychological injury. This non-consecutive series included children between ages 9 months and 15-years-old evaluated between January 1, 1995 and August 31, 2012. They did not represent all potential cases from any institution. The medical records were abstracted for age, sex, relationship to perpetrator, details of the child's physical and psychological injuries, reported methods of abuse, the child's abuse disclosures, the duration of abuse, and outcomes of the case. Six major types of psychological maltreatment identified for abstraction included spurning (the emotional rejection/denigration of a child), terrorizing, isolating, exploiting/corrupting, denying emotional responsiveness, and mental health/medical/

educational neglect (Hart et al. 2011; Hibbard et al. 2012). Cases involving primarily sexual torture were excluded from this study based on the authors' experience that the perpetrator(s) motivation and relationship to the child were qualitatively different.

The Institutional Review Boards (IRB) of the University of Wisconsin School of Medicine and Public Health and Eastern Virginia Medical School approved this study prior to data collection. The University of Wisconsin Health Sciences IRB served as the IRB of record for Seattle Children's Hospital and the National Center for the Prosecution of Child Abuse. The remainder of the institutions participating in this study exempted the research.

Results

Twenty-eight cases of extreme child abuse were identified. The children's median age was 7.5 years (range = 9 months-14.5 years). Abuse duration ranged from 3.5 months to 8 years (median = 3 years). Eleven (39 %) children were male and 17 (61 %) female. Twelve children were Caucasian (43 %), 10 (36 %) African American, and six (21 %) were Hispanic. Forty-five percent of the victims' siblings had been coerced into participation in the torture and 65 % of siblings were abuse victims themselves. Ages, physical injuries/outcomes, reported methods of torture, and perpetrator(s) for each case are presented in Table 1. Figures 1 and 2, and their individual case data in Table 1 document the abuse of two children and their injury environments.

All study children in this case series were subjected to more than one form of egregious physical abuse and neglect, and most children were deprived of basic necessities of life (Table 2). Ninety-three percent of children had cutaneous evidence of physical abuse at the time of medical intervention or death. Sixty-one percent had been physically restrained by binding. Ninety-three percent of children had been beaten and 21 % had fractures. They received no medical care for their physical injuries. The fatality rate was high at 36 % (10/28).

Table 3 lists types of psychological abuse(s) and neglect of child victims. Eighty-nine percent experienced food deprivation and 79 % were fluid restricted. Sixty-four percent were restricted in the performance of normal bodily functions, including toilet access for urination and defecation. The majority of children (89 %) were isolated from people outside the immediate family; 75 % experienced solitary confinement. For over half, few individuals outside the abuser(s) knew of the child's existence. This social isolation typically involved preventing the child from attending school or daycare. Twenty-nine percent of school-age children were not allowed to attend school; two children, though previous enrolled, were dis-enrolled by their caregiver and received no further schooling. An additional 47 % who had been enrolled in school were removed under the auspice of "homeschooling." This "homeschooling" appears to have been designed to further isolate the child and typically occurred after closure of a previously opened CPS case. Review of these cases found no true educational efforts were provided to the homeschooled children. Their isolation was accompanied by an escalation of physically abusive events.

Every child included in the study was victim of several of the six major types of psychological maltreatment (as listed in the methodology section). Most of the children were denied emotional responsiveness, in which the caregiver ignored the child's attempts and need for social interaction (den Otter et al. 2013). Threats of death were made to 32 % of the children. Of known mental health outcomes for the surviving children, post-traumatic stress disorder (PTSD) was the most common mental health condition.

Half of all cases reviewed had a prior history of 1 to 15 referrals and/or investigations by CPS. These prior CPS referrals had been investigated for intentional food/fluid restriction, lack of supervision, physical abuse, and neglect. CPS workers often accepted the caretaker(s) attribution that the child was emotionally/behaviorally disturbed or had an eating disorder. If the CPS worker recognized the child to be malnourished, he/she accepted the caretaker's agreement to feed the child and closed the case without follow-up.

A clear timeline of abuse could not be established in all cases. However, for cases in which the timeline was known, the shortest period of time between onset of torture and recognition and intervention was 3.5 months, while the longest period was 8 years. Twenty of 51 perpetrators were either biologic mother or father (39.2 %). Females (31 total) were among the perpetrators in every case. Twelve female perpetrators were biologic mothers (38.7 %). Stepmothers or girlfriends constituted 19.4 %, as did adoptive mothers. Other female relatives (12.9 %, 4) and unrelated females (9.7 %, 3) were also perpetrators. Among the 20 male perpetrators, eight (40 %) were the biologic father, five (25 %) were stepfather or mother's boyfriend, four (20 %) were adoptive fathers, one (5 %) was another relative, and two (10 %) were unrelated males. For all cases, all adults in the home knew of this extreme abuse and participated to some extent in abusive acts. Unlike other forms of abuse, most perpetrators of torture partially confessed to their crimes; however, they significantly minimized or rationalized their individual involvement.

Individual Detailed Case Report

A 14-year-old girl came to the attention of a county social worker who was notified that the child and her siblings had not been attending school. The social worker asked to see the children and was told by their father that they were sleeping. The worker was eventually allowed into the bedroom where she found the girl and her 8 and 5-year-old siblings hiding in

Table 1 Physical injuries/outcomes, reported methods of torture, and perpetrator(s)

Age/sex	Physical injury	Outcome	Reported methods of torture	Perpetrator(s)
9 m (a) female *Sibling to 9 m (b) case*	Starvation; dehydration; contractures of knees and hips	Survived with severe developmental delay and physical disability	Starved; physically restrained; forced to watch parents eat; left home alone for extended periods	Mother & father
9 m (b) female *Sibling to 9 m (a) case*	Starvation; dehydration; contractures of knees and hips	Died	Presented dead on arrival to hospital; starved; physically restrained; forced to watch parents eat; left home alone for extended periods	Mother & father
2y 4 m female	Bilateral periorbital burns with infection; vitreous hemorrhage; head &facial bruising/lacerations; hair loss; dental trauma & avulsed teeth; multiple hand & finger fractures & lacerations	Survived	Chemical burn & blunt trauma to the eyes; blunt trauma to the head & teeth; cuts inflicted by a sharp object; squeezing & striking of hands; hair pulling	Mother's boyfriend & mother
2y 5 m male	Patterned bruises/abrasions face & trunk; liver & pancreas laceration; right lung contusion & pseudocyst; rib fractures; torn upper labial frenulum; cardiac & diaphragmatic bruising	Died	Presented dead on arrival to hospital; multiple beatings over several weeks witnessed by multiple adults; taunted by dangling him over an angry dog	Mother's boyfriend & mother
2y 6 m female	Abusive head trauma & fluid deprivation resulting in SDH[a]; cerebral venous sinus thrombosis & prolonged coma; lacerations/bruises face & head; patterned scars over body; hand burn	Survived with partial blindness and severe PTSD[b]	Multiple witnessed beatings; witnessed being held up while struck in the abdomen; forced to sit immobile under heat lamps for prolonged periods; denied fluids; regularly threatened, cursed, & denigrated	Mother's boyfriend
2y 10 m male	Starvation; dehydration with hypernatremia; bruises/abrasions head and chest; patterned injury on trunk & extremities; pressure ulceration of extremities	Survived	Starved; physically restrained; locked in bathroom; left alone for extended periods; beaten with a brush & belts	Father & father's girlfriend
4y 0 m male	Strangulation-related neck bruises; truncal bruising; genital injury	Survived	Starved; locked in a clothes dryer & tumbled; submerged in freezing water; forced to lick a 9v battery; locked in closet & end table while siblings taunted him; struck with hands & objects	Mother
4y 1 m male	Retinal hemorrhage & optic nerve sheath hemorrhage; Impact subgaleal hemorrhage; acute SDH; scleral hemorrhage; fracture of T1 spine; liver laceration; healing deep partial thickness burns to buttocks, ear, & hands (covered in duct tape); bruises/ abrasions to trunk & head	Died	Found buried in a shallow grave; isolated in house; burned; beaten; shaken; no medical care for 4 days; neck snapped	Paternal aunt & paternal aunt's boyfriend
4y 4 m male	Old subdural hematomas at autopsy; recent impact trauma to scalp; physical signs of starvation	Died	Found dead at home; starved; physically restrained; beaten; spurned	Paternal grandmother
4y 6 m female	Abusive head trauma; 50 % TBSA[c] acute immersion burns; patterned facial contact burns; ulcerating scalp scald burn; binding ulcers of wrists and ankles; intra-oral laceration; neck ligature; diffuse skin scarring	Died	Found dead in bathtub with extensive burns over lower body; older scalp burn treated with alcohol/ulcerating; whipped on soles of feet with a belt; bound by hands & ankles; slept bound, hanging from a closet rod with wrists handcuffed behind her back (see Fig. 1)	Maternal aunt & maternal uncle
5y 4 m female	Abusive head trauma; healed burns; bruises to head, thorax, & extremities; arm ligature marks; perineal laceration	Died	Died in intensive care unit; starved; shaken; bound by wrists & upper arms and kept in a box; forced pushups	Father & stepmother

Table 1 (continued)

Age/sex	Physical injury	Outcome	Reported methods of torture	Perpetrator(s)
			& stair walks; kicked & punched; struck with objects; burned in shower	
6y 11 m male *Adoptive sibling of 7y 0 m*	Bruising over most body surfaces; facial burn; lacerated scrotum	Survived	Chronically starved; hyponatremic seizure from forced water intoxication; history of being cut with knife in the scrotum; adoptive mother reported to school that child had a life-threatening medical condition requiring restrictions of food and water; refeeding syndrome when fed	Adoptive mother
7y 0 m male *Adoptive sibling of 6y 11 m*	Multiple bruises; malnutrition; history of spiral fracture of right femur at 16 months & multiple bruises to face and body; dental trauma & extraction at 20 months	Died	Dehydration documented at autopsy; chronically starved; drank from toilet; clawed through window screen to get snow to drink; bound by hands; adoptive mother reported to school that child had a life-threatening medical condition requiring restrictions of food and water; adoptive mother had CPS acquire the lock that kept him from getting food and water	Adoptive mother
8y 1 m female	Severe non-acute genital injuries (fistula) requiring colostomy	Survived	Starved; consumed own urine, feces and vomit; restrained; beaten; spurned; medical neglect; sexual abuse; kept in closet, car trunk, & cabinets for 4 years; no school or human interactions permitted; ridiculed & spurned by 4 siblings	Mother & stepfather
8y 2 m female	Facial laceration; scars on face & trunk; loop mark bruises of chest, back, & legs; hair cut off	Survived	Withheld food & fed spoiled food; beaten; isolated from siblings & school; scapegoated; made to sleep in hallway; long hair cut off	Mother & maternal grandmother
8y 5 m female	Numerous contusions over body; hair cut off	Survived	Bound to a chair by hands/mouth/legs; long hair cut off; hands burned; beaten for falling asleep	Mother & mother's boyfriend
8y 10 m female	Medical neglect resulting in critical illness & near fatality; significant bruising; malnutrition	Survived	Withheld food and drink; limited toilet access; isolated from family & school; repeated spanking & beating; forced sitting for hours	Stepmother & father
8y 11 m female *Adoptive sibling of 10y 0 m case*	Abusive head trauma; malnutrition; renal failure; scars/bruises/abrasions on head, trunk & extremities; ligatures on wrists and elbows; lip laceration; pressure ulcers over sacrum, lower back	Died	Found dead in a bathroom; starved; restrained by wrists & ankles with duct tape around mouth; isolated from family & school; beaten; no access to toilet; head trauma	Adoptive mother & adoptive father
9y 1 m male	Malnutrition; patterned injury on trunk; laceration of lip, trunk, & extremities; cauliflower ear; burn on left shoulder; ligature injuries of elbows, wrists & ankles; sacral decubitus ulcer; various ages of contusions, lacerations, & abrasions of multiple body surfaces	Died	Found dead on bathroom floor; starved; padlocked in room; bound with electric cords to prevent "getting food from the pantry in the middle of the night"; struck in head with golf club; forced standing for hours; isolated from family & school	Mother & mother's girlfriend
9y 7 m male *Sibling of 10y 8 m case*	Malnutrition; dehydration; bruises	Survived	Food restricted; given caustic substances as "punishment food"; deprived of toilet use/bathing; beaten; medical neglect for severe asthma; withdrawn from school 3 years prior after disagreement with school over food restriction; locked in garage without air conditioning or heat	Maternal great aunt & maternal great uncle (adoptive parents)
10y 0 m female *Adoptive sibling of 8y 11 m case*	Starvation; anemia; patterned lesions on trunk and extremities; lacerated toe; ankle edema	Survived	Starved; restrained by wrists & ankles with duct tape around mouth & neck; chained to the bed; isolated from family & school; beaten with broken shovel pole; no access to toilet	Adoptive mother & adoptive father

Table 1 (continued)

Age/sex	Physical injury	Outcome	Reported methods of torture	Perpetrator(s)
10y 8 m male *Sibling of 9y 7 m case*	Malnutrition; dehydration; bruises	Survived	Food restricted, given caustic substances as "punishment food"; deprived of toilet use/bathing; beaten; medical neglect for severe asthma; withdrawn from school 3 years prior after disagreement with school over food restriction; locked in garage without air conditioning or heat	Maternal great aunt & maternal great uncle (adoptive parents)
11y 8 m male	Extensive scalp burn; 3 disarticulated toes; mummification of fingertips; chronic decubitus ulcers; patterned skin injury; malnutrition; dehydration	Survived with PTSD, depression, loss of digits	Food/water deprivation; confinement in small cubbyhole; forced water intoxication; scalded repetitively; hand restrained behind back while submersed in water; tied by neck to showerhead and forced to stand or strangulate if fell; (see Fig. 2)	3 unrelated caregivers & mother (who was killed by same caregivers)
12y 3 m female	Burn scar; patterned skin injuries	Survived, with suicidal ideation and PTSD	Forced to sleep unclothed on cold garage floor, basement floor, & bathtub as punishment for bedwetting; forced to crawl until hands/feet bled; forced standing on one leg; threatened to kill child & throw away belongings	Father & stepmother
13y 8 m female	Malnutrition; bruises	Died	Found dead by parents; starved; deprived of bathing/toilet; isolated; beaten; parents put garlic, pepper, & vinegar in child's drinks to make them taste bad; paper bag put on head as punishment; child chained; forced positions for discipline; punished for stealing food; "homeschooled" for 3 years, but no education provided; no friend, family, school contact, or medical/mental health care for 4.5 years	Mother & father
14 y 0 m female	Chronic malnutrition; no medical care for 5 years (lost 23 kg); severe dental caries with teeth eroded to gum line	Survived	Withheld food & drink; all bathing & toileting strictly supervised to prevent obtaining water; drank from toilet when possible; forced to sleep on the bare floor beside parents' bed & denied covers; locked in a small unheated room outside the house; hands taped behind her back and head was pushed into the toilet; beaten with a shoe and head slammed into a bed; removed from school to be "home-schooled" after 1st CPS report; books restricted as punishment	Stepmother & father
14y 1 m female	Malnutrition; multiple abrasions; 3 digit fractures	Survived	Withheld food resulting in food scavenging; chronically starved; all access to food in house locked; isolated from family & school; slapped/shoved; forced to sleep naked outdoors without a blanket	Father & stepmother
14y 4 m female	Multiple bruises/lacerations over entire body; 3 extremity fractures; malnutrition	Survived with PTSD	Starved; strangled until unconscious; stabbed with knife; forced to eat roaches/spiders; attempted suffocation by plastic bag duct-taped over her head; struck in head with metal objects & baseball bats	Mother & father

[a] *SDH* subdural hemorrhage; [b] *PTSD* post-traumatic stress disorder; [c] *TBSA* total body surface area

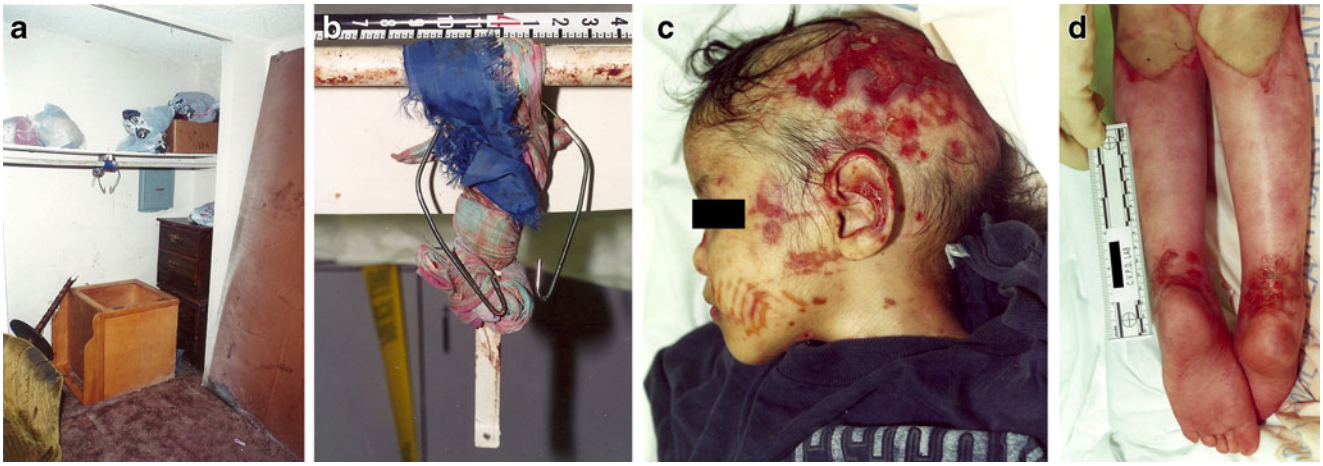

Fig. 1 A 4 6/12 year-old female was found dead in the bathroom. She had 50 % TBSA acute immersion burns and an acute subdural hemorrhage. She had been suspended from a closet rod at night by a bent coat hanger (distant and close up images **a** and **b**) to prevent her scratching her old scalp burn. That burn, a grid-like cheek contact burn and multiple sub-acute facial injuries are seen in her lateral face view (**c**). The back of her legs shows the immersion burns with popliteal sparing. They overlie pressure ulcerations over her heel cords from prior binding with ligatures (**d**)

the closet. The girl was lying in the fetal position in the back of the closet; she had a scalp laceration, bald patches, and dried blood on her head. The social worker called law enforcement, and the child was transported to an academic medical center. At the hospital, the child was emaciated and had multiple varying age lacerations and contusions on her body, a bite mark on her anterior shin, and numerous healed scars on her face, back, and abdomen. X-rays revealed an acute transverse fracture of the right patella, acute fracture of the left 5th metacarpal bone, and a healing fracture of the left 3rd metacarpal bone. It was later determined that the child had pubertal arrest and regression of breast development. On initial history, the child had stated her multiple injuries were self-inflicted, caused by fighting with other teens. However, during the course of her hospitalization, she reported ongoing severe physical and psychological abuse. She reported being forced to eat roaches, spiders, and other insects as a form of punishment and that her family attempted to force feed her a dead mouse. She stated that her father bound her hands behind her back, taped plastic bags over her head and torso, and threatened to drown her in the lake. Her younger sister participated in her abuse by encouraging their father to place more duct tape on her mouth and also encouraged their mother to force the girl's face into soiled toilet water. She reported digital

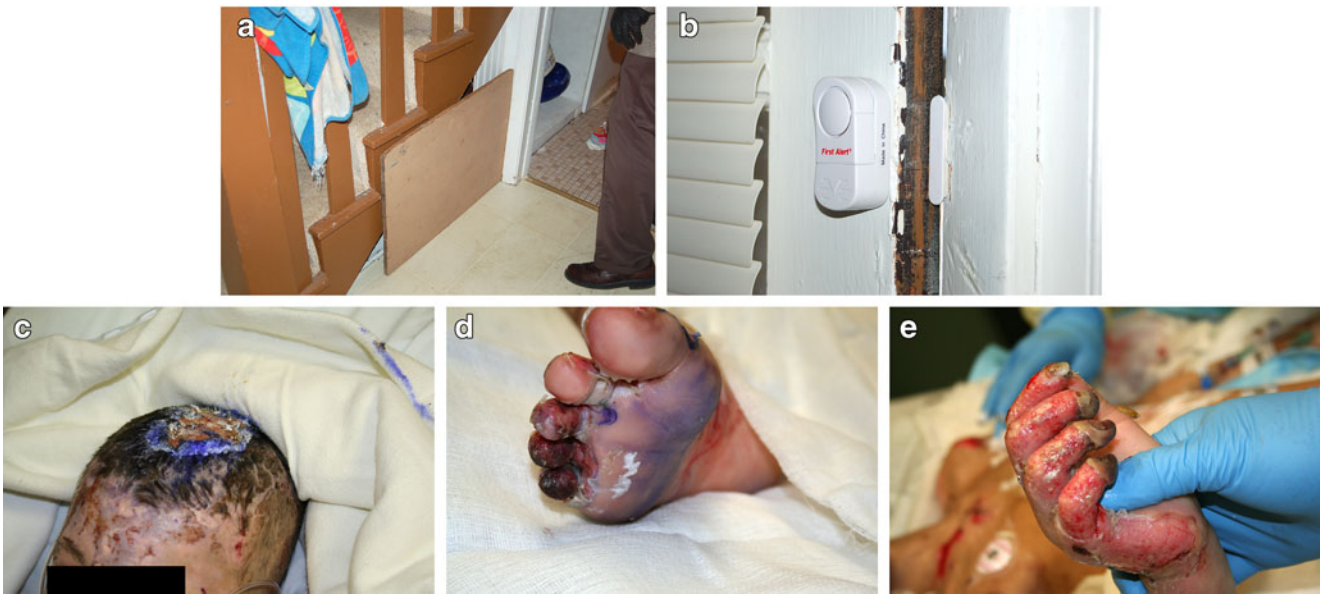

Fig. 2 Law enforcement scene investigation confirmed the 11-year-old child victim's disclosures that he was forcibly confined in a cubbyhole underneath the stairs (**a**) and in closets. A child alarm was placed on the house door to detect his movement and prevent escape (**b**). Scalp pressure injury from chronic confinement, eroded to the bone (**c**); burned and mummified toes, later spontaneously disarticulated (**d**); scalded fingers with mummified tips (**e**)

Table 2 Physical injuries (n=28)

Physical injuries	% Yes	% No	% Unknown
Physical binding	61	21	18
Gagging	25	29	46
Restriction of bodily function	79	27	14
Cutaneous evidence of abuse	93	7	0
Beating	93	7	0
Kicking	36	11	54
Burning, contact	43	54	4
Burning, scald	18	75	27
Striking with objects	79	7	14
Stabbing	7	89	4
Asphyxiation	14	57	29
Forced position or standing	68	14	18
Forced exercise	25	39	36
Fractures	21	6	11
Action to aggravate pain of existing injury	43	29	29
Sexual abuse	21	64	14
Permanent loss body part or function	46	21	32
Death	36	64	0

penetration of her vagina by her father who also repeatedly made her stand naked in front of the mirror while fondling her breasts. Her mother struck her with metal pipes, a skillet, baseball bats, and a glass candle. She also disclosed being stabbed in the abdomen and forearm with a kitchen knife, exposing the bone. No medical care was sought for her injuries. The girl reported she felt certain she would die. Her case had been reported to social services three prior times in the same year, one of which had not been accepted for investigation and the other two were unfounded for abuse. The most recent allegation was unfounded because the child attributed her bruises and lacerations to injuries sustained during a gang altercation.

Discussion

Defining Torture in the Context of Child Abuse

The children in this case series suffered a severe combined type of child abuse including extreme physical and psychological maltreatment (Table 4). Torture goes beyond simple polyvictimization in that it includes an increased severity of both physical and psychological maltreatment. It involves intense humiliation and terrorization (Finkelhor et al. 2011).

In our case series, common characteristics of child torture involved multiple abusive physical injuries, deprivation of essential needs, and denigration or dehumanizing the child. Torture was found to occur over a period of time, often with the knowledge and/or acquiescence of other caregivers and siblings. The role of female perpetrators in all cases is an atypical finding in most cases of child physical abuse. As the level of violence and control in the homes increased, perpetrators increased the isolation of the victims from everyone but their immediate caretakers. The child's entire household either participated in or was aware of the child's abuse. Nearly all children in this case series presented with cutaneous injury. A significant minority (21 %) had fractures. This is different from most forms of physical child abuse, in which fractures are common, but are typically limited to infants and toddlers (King et al. 1988). The children were denied medical intervention until fortuitously they were discovered or near fatal or fatal events occurred.

Based on the commonalities found among these infants and children, we propose defining child torture as a longitudinal period of abuse characterized by at least two physical assaults, and two or more forms of psychological maltreatment (e.g., terrorizing, isolating), resulting in prolonged suffering, permanent disfigurement/dysfunction, or death. Torture usually includes neglect of obvious medical needs that are often the result of their abusive injuries or starvation. Multiple episodes of physical and emotional abuse occur over time or during one prolonged period of abuse. In most cases, the caretaker(s) made concerted efforts to isolate the child from outside contact or observation. Table 4 outlines the definition and provides examples of common forms of assault experienced by child torture victims.

Caregiver Motivation and Dynamics

Definitions of political torture include analysis of the perpetrators' intent to commit torture. Captor/perpetrators are politically motivated and are state actors, thus differ from a child's caretaker in a caregiving setting.

For our subjects, caregiver statements to medical providers, CPS, and police were insufficient or incomplete. Thus, the motivation or intent of the abuser was not analyzed in this case series. The diagnosis of torture in an intra-familial setting is based on the severity, morbidity, and mortality of the physical and psychological maltreatment inflicted on the child. A similar focus on the harm the child has suffered, instead of the perpetrator's intent, has been used in defining other types of child abuse, including Medical Child Abuse, a reframing of Munchausen Syndrome by Proxy (Stirling and American Academy of Pediatrics Committee on Child Abuse and Neglect 2007).

Household Dynamics

Several children came into the torturing households through informal family arrangements. We observed that 79 % of the primary abusers were not the child's first degree relative; they

Table 3 Psychological maltreatment

Psychological maltreatment	Yes	No	Unknown
Threat of death	9 (32 %)	4 (14 %)	15 (54 %)
Threat to loved object or pet	4 (14 %)	2 (7 %)	22 (79 %)
Threat to loved people	4 (14 %)	4 (14 %)	20 (71 %)
Threat of further torture	17 (61 %)	0 (0 %)	11 (39 %)
Terrorizing	21 (75 %)	0 (0 %)	7 (25 %)
Solitary confinement	21 (75 %)	5 (18 %)	2 (7 %)
Isolation from peers or other	25 (89 %)	2 (7 %)	1 (4 %)
Not allowed personal hygiene	18 (64 %)	2 (7 %)	8 (29 %)
Not allowed privacy	14 (50 %)	3 (11 %)	11 (39 %)
Food deprivation	25 (89 %)	1 (4 %)	2 (7 %)
Water deprivation	22 (79 %)	1 (4 %)	5 (18 %)
Sleep deprivation	14 (50 %)	0 (0 %)	14 (14 %)
Exposure hot/cold environment	12 (43 %)	4 (14 %)	12 (43 %)
Spurning	15 (54 %)	0 (0 %)	13 (46 %)
Denied emotional responsiveness	22 (79 %)	0 (0 %)	6 (21 %)
Insulted	12 (43 %)	0 (0 %)	16 (57 %)
Mental health neglect	5 (18 %)	14 (50 %)	9 (32 %)
Medical neglect	23 (82 %)	3 (11 %)	2 (7 %)
Prior CPS history	14 (50 %)	11 (39 %)	3 (11 %)
Educational neglect[a] (n=17)	14 (82 %)	2 (12 %)	1 (6 %)
Homeschooled[a] (n=17)	8 (47 %)	8 (47 %)	1 (6 %)
Never allowed to attend school[a] (n=17)	5 (29 %)	11 (65 %)	1 (6 %)
Sibling also abuse victim[b] (n=23)	15 (65 %)	8 (35 %)	NA
Sibling also an abuser[c](n=20)	9 (45 %)	11 (55 %)	NA

[a] 17 children were old enough to attend school (ages 6 and above)

[b] 23 children had known siblings (three of whom were infants)

[c] 20 children had non-infant siblings capable of acting as an abuser

included such caregivers as boyfriends, girlfriends, aunts, uncles, grandparents, adoptive parents, and stepparents. Most child victims appeared to be scapegoated within their family; this is another recognized form of abuse associated with sibling empathy deficits (Hollingsworth et al. 2007). Other siblings often were coerced to participate in or endorse the abuse of the index child. In this case series, many of the other children in the household were also abuse victims themselves, although generally suffering significantly less abuse than the index child.

Typically, abusers demonstrated little or no remorse for their actions. Many transferred blame for their actions onto others and most perpetrators blamed their victims for precipitating the abuse or causing abuse to be necessary. Perpetrators seemed to utilize a framework of necessary discipline and corporal punishment to justify their abusive acts. In these and other cases we have subsequently evaluated, some perpetrators saw it as a religious duty to discipline their children harshly.

Early identification of perpetrators and their child victims is critical as Steele (1987) finds it "extremely difficult, if not impossible, to rehabilitate perpetrators who torture their offspring" (p. 101). The nature of these crimes and the perpetrator's self-justification argues against any reunification with caretakers and the rehabilitation potential of perpetrators is poor. Safety plans for victims of child torture should rarely, if ever, involve plans for family reunification. Identification of the correct diagnosis should facilitate a safe child protection disposition and appropriate long-term rehabilitative treatment for physical and psychological trauma endured by these victims.

The dynamic of psychological and physical cruelty used to control a child is similar to the dynamic often observed in intimate partner violence. Perpetrators of child torture exercised extreme control over their child victims, inflicting repetitive pain and suffering on these children and dehumanizing them. In some instances torturers may threaten or injure a child's loved ones or objects such as a family pet or favored toy as a means of gaining control over the victim. Denial of necessities, including access to food, water, toilet, and sleep were frequently utilized as punishment by the perpetrators. Family members were coerced into participation in the child's abuse, possibly out of their own fear or an inability to escape the situation.

Effects of Torture

The long-term effects of child torture as a form of child abuse are unknown. The medical literature clearly reflects that adult torture victims have significant physical and psychological sequelae (Goldfeld et al. 1988; Herman 1992). A

Table 4 Definition

Child torture is defined medically as:

- At least two physical assaults, occurring over at least two incidents **or** a single extended incident, which would cause prolonged physical pain, emotional distress, bodily injury, or death

And

- At least two elements of psychological abuse such as isolation, intimidation, emotional/psychological maltreatment, terrorizing, spurning, or deprivation

Inflicted by the child's caretaker(s)

Neglect is usually present, and manifests as failure to seek appropriate care for injuries and/or malnutrition

Resulting in: prolonged emotional distress, pain and suffering, bodily injury/disfigurement, permanent bodily dysfunction, and/or death

Common Abuse Manifestations Include, But are Not Limited to:

- Physical assaults: hitting, kicking, impacting against objects, beating with objects, tying, binding, gagging, stabbing or cutting, burning, breaking bones, exposure to prolonged environmental heat or cold, prolonged forced exercise, forced restraint in or maintenance of an uncomfortable position, forced ingestion of noxious fluids, dangerous materials or excrement, aggravating the pain of prior injuries
- Isolation: removal from school or outside activity, restriction of peer contact, hiding from outsiders, imprisoning alone and/or in tightly confined spaces restricting movement
- Intimidation or emotional/psychological maltreatment: Repeated intimidation or humiliation, cursing, denigration, threatening harm to or harming loved ones, pets or loved objects, spurning, terrorizing
- Deprivation: deprivation of food, water, or sleep, forced to watch while others eat or drink, punishment for seeking basic needs, deprivation of safe and hygienic excretory function, neglect of medical needs, neglect of mental health needs, deprivation of education, deprivation of human contact

Common perpetrator manifestations:

- Typically both adult caregivers are involved in the torture to some extent
- Women figure much more prominently as perpetrators of torture than in other forms of physical abuse
- Siblings are aware of and may be coerced to participate in the abuse, and also may be abused to a lesser degree

psychological syndrome reported in adult torture survivors by Allodi and Cowgill (1982) includes findings of extreme anxiety, insomnia, nightmares, suspicious/fearfulness, as well as somatic symptoms of anxiety and phobias. PTSD is the most commonly diagnosed psychological disorder among adult torture victims (Allodi and Cowgill 1982; Herman 1992). In addition to torture, polyvictimization has been recognized to be associated with worse mental health outcomes in child abuse victims (Finkelhor et al. 2011). By definition, all of our children have suffered polyvictimization as defined by Finkelhor. Although mental health evaluations were not always done or accessible to us, the victims in our case series commonly were diagnosed with PTSD. Formal psychiatric evaluation is recommended for all victims.

Medical Evaluation

In some cases, health care providers had observed the child for caretaker complaints, but failed to recognize the child's injuries or malnutrition or to accurately diagnose abuse as their cause. This subsequently resulted in a continuation of the abuse with severe physical and psychological injury to the child. For example, medical providers frequently based their evaluations solely on the history reported by the perpetrator and failed to consider alternate explanations for malnutrition, such as intentional starvation. The perpetrators' explanations that their children were suffering from behavioral or psychiatric issues causing the starvation were initially accepted by health care practitioners. Many of these children had been bound, confined, or isolated to prevent acquisition of food or water; consequently, these children often attempted to steal or otherwise acquire food or water. They were severely punished if caught. A few children had been brought for medical evaluations with complaints of "excessive hunger and thirst." Physicians evaluating these children did not recognize that the children's behavior represented an appropriate response to their deprivation. As a result, victims suffered ongoing abuse or death.

The victims we saw share some of the characteristics of the child starvation cases described by Kellogg and Lukefahr (2005), including isolation of the child and hidden or missed malnutrition. They were usually kept at home, or if taken where others could observe them, were clothed to cover their degree of malnutrition and their physical injuries. Older children were removed from school under the guise of home schooling. Although home schooling is a valid form of education for many families, these children show no evidence of receiving any education. Their removal from school appears to have been motivated by the need to keep the children hidden. Several children had home visits from protective services or public health nurses or were seen by physicians, but their severe malnutrition was missed. Lack of regularly obtaining and charting growth data appeared contributory.

The evaluation requires a comprehensive, multidisciplinary approach, including scene investigation, careful questioning of the victim, siblings, potential witnesses, and the caregivers. Medical providers must collaborate with police and protective services who can evaluate the scene for evidence of confinement and past injuries. Photographs should be taken to document the availability of sufficient food in the household. Additionally, photographs should also be taken of any objects of value in the home (e.g., mobile technologies, gaming technologies, alcohol, expensive accessories) to document the availability of resources in the home that could have been used to purchase food for the children. Investigators should interview leaders of the perpetrator(s) faith community to determine whether their actions represent idiosyncratic religious beliefs. This could defend against claims that the

perpetrator(s) abuses of the child fell within the range of acts sanctioned by doctrine of faith.

In cases involving starvation, it is important to obtain laboratory studies for dehydration and nutritional status as soon as possible after the child presents for care. If the case enters the court system, serial photographs of the victim from the time of presentation until nutritional recovery are compelling illustrations of the severity of nutritional deprivation, supplementing the growth curves. Likewise, these children's voracious appetites and rapid weight gain after they are allowed food and fluids belie allegations that they suffer from eating disorders, unusual endocrine disorders, or metabolic disorders as a cause of starvation (Kellogg and Lukefahr 2005). Starved children risk re-feeding syndrome if their malnutrition has been prolonged.

The cases we observed reflect systematic attempts by the caregiver(s) to cause physical and psychological pain and suffering to the child. The dynamic of domination and control over the necessities of life is uniquely different from other forms of physical abuse, which usually result from caretaker anger and loss of control (Schmitt 1987). The extent to which these caregivers have created a system of rules, boundaries, and patterns for managing the targeted children is unique. Forced position holding, such as standing with arms stretched out holding phone books for hours, was a common form of discipline. Medical, child protection, or criminal justice professionals often failed to note these rules or rituals or understand their abusive significance. Thus the psychological maltreatment of these children often was overlooked.

When extreme discipline is accepted as the norm by a child, the child may not disclose to a medical provider the abuse they experienced unless specifically asked. Open-ended questions such as "tell me about meal time," "tell me about going to the bathroom," or "what are the rules about sleep or potty" can be very helpful in eliciting otherwise normalized punishments, such as food withholding or forced excrement ingestion. Often disclosures only gradually come forth after the child has been stabilized in a safe setting. Professionals involved in these cases may not be aware of the existence of or recognize the significance of extreme forms of discipline, including limited access to toilet, food, sleep, or other necessities which dehumanize or demean the child.

Fifty percent of the children in this case series had been previously reported to child protective services for maltreatment, including psychological maltreatment and starvation. However, there was poor coordination between the medical providers and the child protection system to identify and manage torture as an unique form of injury. Cases involving withholding of food were not recognized as a form of abuse. Cases of unusual punishment, such as prolonged forced exercise, also were dismissed and not further pursued. Ultimately a medical definition of child torture would provide the medical profession a framework to make an appropriate diagnosis of child victims, allowing earlier intervention by authorities. Medically defining child torture also would invite child protective services, law enforcement, and legal professionals to better recognize the full extent of the injuries suffered by these children, understand the possible outcomes, and allow them to more effectively protect victims and prosecute perpetrators.

We noted that siblings are also frequently recruited to assist in abusing the index child, but also are abuse victims to a lesser degree themselves. At the very least, they sustain the harms of witnesses of violence and abuse (Finkelhor et al. 2009). As such, both their safety and mental health needs also must be considered. Both victims and siblings will likely require therapeutic foster care placement and long-term mental health services (Anda et al. 2006).

The legal landscape for addressing torture varies widely by jurisdiction (Tiapula and Applebaum 2011). Statutes referencing torture reflect a range of legislative responses, including both criminal and civil statutes. Criminal laws prohibit and penalize both physical and sexual torture while civil statutes reference torture in matters of family law, employment law, and public health law. Both physical and sexual torture are explicitly addressed by some states in a range of criminal and child protection statutes and legal precedents, often these include specific provisions related to the extent of the injury or pain suffered by the victim (Tiapula and Applebaum 2011). Thus, medical providers should be careful to document the child's pain and suffering in cases involving child torture. A medical definition of torture might stimulate other states to adopt explicit torture statutes and those with current statues to update them. Emerging recognition of torture as a distinct medical diagnosis would enable legislative responses that reflect the severity of injury. It would enable courts to focus on many of the factors that are often not addressed in existing statutes. For example, medical issues include restraint, isolation, and withholding of necessities and psychological maltreatment. Criminal prosecution and sentencing in cases of child torture reflect the uneven outcomes associated with institutional failures by law enforcement, prosecutors, and the courts to recognize and validate the emotional and psychological injuries linked to torture. Data not available to the current researchers included the prior criminal history of each defendant; a factor often weighed heavily in sentencing outcomes. Another significant factor in sentencing would be the relative culpability of each defendant in cases with multiple perpetrators torturing or participating in the torture of the child victim(s). The criminal sentences the perpetrators received ranged from probation to life in prison.

This series and paper is limited in that it is a select and by no means, inclusive series, of abuse cases. They have been chosen to be illustrative of the phenomenon of torture, but cannot be considered a consecutive case series for statistical analysis. Likewise, the information available to us was that primarily available through our consultations. In particular,

detailed medical and psychiatric follow-up information was usually unavailable to us.

Conclusions

This case series identified specific components common to 28 children and infants who were considered victims of torture. These commonalities indicate that torture can be defined as at least two physical assaults (or a single extended incident) and two or more elements of psychological maltreatment. Neglect is often present, generally manifesting as failure to seek appropriate care for injuries and/or malnutrition. The combination of physical and psychological maltreatment results in severe child trauma, including prolonged emotional distress, pain and suffering, bodily injury/disfigurement, permanent bodily dysfunction, and/or death. Victims of torture were isolated, terrorized, neglected, deprived of basic necessities, as well as physically and psychologically maltreated. Their abuse appears to represent caretaker efforts to crush the child's spirit and humanity. Recognizing early signs of torture, such as malnutrition, injuries suspicious for physical abuse, and lack of emotional responsiveness has significant potential to reduce the significant morbidity and mortality associated with this type of child abuse. The prevention of torture also depends on an effective child protection and criminal justice response requiring education and coordination among medical professionals, child protection workers, law enforcement, and the legal community.

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ORIGINAL ARTICLE

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Child torture: A Washington state case series

Adrienne Schlatter[1] | **Rebecca T. Wiester**[1] | **Alysha D. Thompson**[2] | **Joyce Gilbert**[3] | **Teresa Forshag**[4] | **Kenneth W. Feldman**[1]

[1]Safe Child and Adolescent Network, University of Washington, Seattle Children's Hospital, Seattle, Washington, USA

[2]Psychiatry and Behavioral Medicine, University of Washington, Seattle Children's Hospital, Seattle, Washington, USA

[3]Providence Abuse Intervention Center, Providence ST. Peter, Lacey, Washington, USA

[4]Partners with Families and Children, Spokane, Washington, USA

Correspondence
Adrienne Schlatter, Safe Child and Adolescent Network, University of Washington, Seattle Children's Hospital, 4500 Sand Point Way NE, Seattle, WA 98105, USA.
Email: adrienne.schlatter@seattlechildrens.org

Abstract

Child torture is a worldwide problem, but there is very little research on torture as a form of child abuse. In 2014 Knox et al. reported the first case series on child torture and developed criteria to diagnose child abuse torture. Our objective was to describe additional child abuse torture victims and to determine whether they shared similar patterns, including types of abuse, duration and possible opportunities for early identification. This multi-site case series reviewed 47 children identified as torture victims at three Washington State child abuse programs spanning 15 years. Data was collected through retrospective chart review. Simple descriptive statistics were utilised. Our study found that abuse occurred over months to years. All children experienced psychological maltreatment, 89 per cent had findings of physical abuse. Malnutrition and medical, emotional and educational neglect were common. Majority of torture victims had previously been involved with CPS or had seen a medical provider prior to diagnosis, at which time they had findings of torture, but received no protective intervention. It's important to develop criteria for recognition and early intervention since tortured children experienced sustained, systematic and escalating abuse.

KEYWORDS

child, child abuse, child maltreatment, emotional maltreatment, neglect, physical abuse, torture, torture

Key Practitioner Messages

- Unlike physical abuse, torture is prolonged and includes neglect, physical and emotional abuse.
- There are usually signs and opportunities to identify and intervene for child torture victims at an earlier stage.
- Most child torture victims have both short and long-term outcomes including physical impairments and mental health issues.

INTRODUCTION

Child maltreatment is a serious problem globally causing acute and chronic child issues (Hillis et al., 2016). Battered Child Syndrome was described by Dr Kempe in 1962 beginning the recognition of child abuse by medical providers (Kempe et al., 1962). Since then, the categories of child maltreatment increased to include physical abuse, sexual abuse, neglect, medical child abuse and psychological abuse (Gonzalez et al., 2022). Although, child torture is recognised in war and political conflicts, is not considered a unique form of child abuse (Quiroga, 2009).

Knox et al. (2014) reported 28 victims of child torture by abuse and proposed definitional criteria for torture's diagnosis. This study defined torture as severe combined, longitudinal child maltreatment including both physical and psychological maltreatment (Knox et al., 2014). Abuse often caused prolonged suffering, permanent disfigurement and/or death (Knox et al., 2014).

No additional research has been published describing or validating these findings. However, we continue to see similar victims in Washington State. The objective of this case series was to seek to provide case details confirming torture in an additional set of victims. By this we sought to evaluate whether the Knox diagnostic criteria (Knox et al., 2014) are present in additional abusive torture victims.

METHODS

This descriptive case series identified 47 victims of child torture across Washington state. This multi-site study included four large institutions in Washington State. Each study location obtained approval from their institutional review board. Consent from legal guardians, adult children, and assent from younger children for this retrospective study was waived given circumstances of state involvement, inability to identify current legal caregivers and loss to follow-up. There were concerns that direct interactions with victims might re-traumatise children and adult victims when obtaining consent for the study. Children might not understand what happened to them or associate it with the word torture. The torture perpetrators could not speak in the children's best interests.

All cases were identified by records review and recall through the study child abuse physicians' clinical and medical-legal practices. Cases spanned 15 years, 2006 to 2021. A secure online database utilising Redcap was used to collect case details. The fields in the Redcap database were created based on the previous publication of child torture by Knox et al. (2014). Additional details about previous medical care, Child Protective Services (CPS) involvement and short-term outcomes were collected to answer the study aims. Participating clinicians were asked to enter de-identified details for their cases using Redcap. Descriptive statistics were calculated.

Data was analysed for themes that matched the Knox criteria for child torture. Themes such as types of abuse, torturer details and previous abuse were identified. The objective of the study was to identify common themes between victims to help improve understanding of child torture and identify possible patterns that can help improve early identification.

TABLE 1 Demographics.

	Children ($n = 47$) Families ($n = 34$)[a]	Percentage	Washington state percentages (2020 census)
Sex			
Male	28	60%	
Female	19	40%	
Age at diagnosis (years)			
0–5	17	36%	
6–10	21	45%	
11–15	7	15%	
16–18	2	4%	
Race[b]			
Asian	0/0[a]	0%/0%[a]	9.5%
Native American/Alaska Native	7/2[a]	15%/6%[a]	1.6%
Hawaiian Native/Pacific Islander	1/1[a]	2%/3%[a]	0.8%
Black	10/8[a]	21%/24%[a]	4.0%
White	32/21[a]	68%/62%[a]	66.6%
Mixed	3/3[a]	6%/8.8[a]	10.9%
Ethnicity			
Hispanic Latino	5/4[a]	11%/12%[a]	13.7%
Households with more than one abused child entered the study	7		
2 abuse cases	5		
3 abuse cases	0		
4 abuse cases	1		
5 abuse cases	0		
6 abuse cases	1		

[a]The number of unique households where all tortured children were of the same race.
[b]Some children were identified to be more than one race.

RESULTS

Demographics of victims

Males represented a little over half of tortured children (60%). Median (IQR) age was 7.2 (4.6, 9.6) years. Fifty-three per cent ($n = 25$) of the children had been tortured for more than one year. Black and Native American children were overrepresented compared to Washington Census data (Table 1).

Seven homes had two or more torture victims. Among 34 unique households, 29 (83%) had more than one child, average 2.5. Several siblings were identified as participants in torture and victims themselves. It's unknown how these children came to participate in torture of their sibling(s) and whether caretakers used coercion or violence to enlist them.

Of 47 children, 13 (28%) had mental and behavioural concerns reported by their caretakers. Mental and behavioural concerns included ADHD, oppositional behaviour, suicidal ideation and tantrums, among others. Twelve of 47 children (26%) had one or more caretaker-reported developmental delays. The most common delays identified were speech ($n = 10$), social skills delays ($n = 3$) and gross motor ($n = 2$). It could not be verified whether these were real or caretaker-perceived problems.

Torturer demographics

Among 34 unique households, 12 had a sole adult torturer (35%) and 22 (65%) had a second/assistant adult torturer. In all, 56 adult torturers were identified. Nineteen (30%) were female and 28 (60%) were male. The torturer's most common relationship to the child was mother [11 (20%)], father [10 (18%)] and stepmother [7 (13%)] (Table 2).

Of 34 unique households, 24 (70.6%) had previous Child Protective Services (CPS) involvement. Ten (30%) households either lacked it or previous CPS involvement was unknown. The most common reasons for previous CPS involvement were for physical abuse [14 (41%)] and physical neglect [11 (32%)] (Table 3).

Reason for torture

Thirty-three of 47 victims (70%) had reported reasons or justifications for caretaker torture. Caretakers from 24 (73%) households identified discipline as the torture excuse. Mental and behavioural concerns were second [$n = 5$ (15%)].

TABLE 2 Torture duration and torturer demographics.

Duration of torture	**Total ($n = 47$)**		
<6 months	11 (23.4%)		
6 months to 1 year	8 (17%)		
>1 year	25 (53.2%)		
Unknown	3 (6.4%)		
Torturer	**Total ($n = 56$)**	**Primary ($n = 34$)**	**Secondary ($n = 22$)**
Female	32 (57%)	24 (71%)	8 (36%)
Male	23 (43%)	10 (29%)	14 (64%)
Mother	11 (20%)	9 (26%)	2 (9%)
Father	10 (18%)	5 (15%)	5 (23%)
Stepmother	7 (13%)	4 (12%)	3 (14%)
Adoptive mother	7 (13%)	6 (18%)	1 (5%)
Male partner	6 (11%)	4 (12%)	2 (9%)
Adoptive father	3 (5%)	0	3 (14%)
Foster mother	3 (5%)	1 (3%)	3 (14%)
Stepfather	1 (2%)	0	1 (5%)
Female partner	1 (2%)	1 (3%)	0
Foster father	1 (2%)	0	1 (5%)
Aunt	1 (2%)	1 (3%)	0
Other	6 (11%)	3 (9%)	3 (14%)

TABLE 3 Previous CPS involvement.

Reason for previous CPS involvement	Number ($n = 24$)
Physical abuse	14
Physical neglect	11
Emotional neglect	9
Medical neglect	8
Educational neglect	4
Supervisory neglect	3
Drug use	2
Domestic violence	2
Malnutrition	2
Emotional abuse	1
Unsanitary living conditions	1
Unknown reason	2

TABLE 4 Types of maltreatment.

Type of maltreatment	$n = 47$	Percentages
Psychological maltreatment	**47**	**100%**
Food deprivation	37	79%
Isolation	34	72%
Emotional neglect	29	62%
Intimidation	29	62%
Deprivation	29	62%
Terrorising	26	55%
Water deprivation	23	49%
Threatening with future torture	21	45%
Forced to watch other (eat, recreate, and have privileges)	18	38%
Toileting restrictions	17	36%
Spurning	15	32%
Sleep deprivation	14	30%
Forced chores	13	28%
Scapegoating	12	26%
Solitary confinement	11	23%
Threatening and/or injuring loved ones	9	19%
Threatening with death	8	17%
Denigration	5	11%
Threatening and/or injuring possessions	2	4%
Threatening and/or injuring pets	1	2%
Forced Haircut	1	2%
Exam findings and/or disclosure of physical abuse	**45**	**96%**
Exam findings for physical abuse	**42**	**89%**
Skin injuries (excluding burns)		
All	39	83%
Non-patterned bruising	31	
Scars	22	
Non-patterned bruising	19	
Abrasions	16	
Lacerations	8	
Bites	3	
Other[a]	2	

TABLE 4 (Continued)

Type of maltreatment	$n = 47$	Percentages
Oral injuries	9	19%
Other injuries[b]	8	17%
Burns	8	17%
Fractures/dislocations	5	11%
Abusive head injury	2	4%
Death	1	2%
Disclosure of physical abuse	**25**	**49%**
Cold exposure	20	43%
Other[c]	13	28%
Gagging/strangulation/suffocation	8	15%
Forced exercise or position holding	6	13%
Binding/restraints/locked-in	4	8.5%
Neglect	**42**	**89%**
Medical or dental neglect	30	64%
Emotional neglect	29	62%
Educational neglect	23	49%
Unsafe sleep environment	21	45%
Physical neglect	18	38%
Supervisory neglect	15	41%
Sexual abuse	**7**	**15%**
Other[d]	8	17%

[a]Ulcerations and rashes.
[b]Eye injuries, rhabdomyolysis/renal failure, alopecia from hair pulling and binding injuries.
[c]Waterboarding, forced feeding, forced to eat non-food items, forced chores, water immersion of head and forced showering.
[d]Witnessed sibling physical abuse, forced haircuts, unhygienic living environment, forced to wear diapers.

Other justifications included religious beliefs leading caregivers to believe the child was demonic [2 (6%)], jealousy stemming from the child being a product of a partner's ongoing affair [$n = 1$ (3%)] and lack of resources [$n = 1$ (3%)].

Type of torture

The investigators identified several categories of torture including neglect, physical abuse, emotional abuse and sexual abuse. This information came from histories provided, medical records, physical exam findings, and legal and protective services investigators.

Forty-two children had examination findings concerning for physical abuse (89%). Three of the remaining five disclosed past physical abuse but had no injuries on examination. Therefore, 45 of the children (96%) either had physical exam findings or disclosures of physical abuse. The two remaining children lacked observable injuries but were siblings of index victims who had findings and disclosure of past physical abuse. This does not mean that these children had not been physically abused as history might be lacking.

Among recognisable injuries were five (11%) with fractures, two (4%) abusive head injury, 39 (83%) non-burn skin injuries, eight (17%) burn injuries and nine (19%) oral injuries. Eight had other injuries, including traction alopecia, eye injuries such as subconjunctival haemorrhages, and rhabdomyolysis with secondary renal failure secondary to extensive muscle trauma and fluid deprivation (Table 4).

Among the 47 non-burn skin injuries were 31 (66%) with non-patterned bruises, 19 (40%) with patterned bruises, 16 (34%) with abrasions, eight (17%) with lacerations and three (6%) with bite marks. Five had other skin injuries included rashes, scalp swelling from hair pulling, ulcerations and ligature marks (Table 4).

Twenty-three children (49%) experienced educational neglect. Washington State's legal compulsory age for school enrolment is 8 years. Eighteen of 22 (82%) children 8 years or older experienced educational neglect. Five additional children aged 5–8 years also experienced educational neglect. No children under five were diagnosed as experiencing educational neglect.

Thirty (64%) children experienced medical and or dental neglect. The most common type of medical neglect was failure to seek care for inflicted injuries (67%). Thirteen (43%) lacked a primary care medical provider and 11 (37%) had untreated dental caries. Fourteen (47%) experienced neglect for complex medical conditions.

All children faced psychological maltreatment. Most suffered from more than one type of psychological abuse. Food and water deprivation were most common types of psychological maltreatment (83%). Isolation was the second most common type, affecting 34 children (72%) (Table 4).

Twenty-one children (45%) had both food and water deprivation, 16 (34%) food alone and two (4%) fluids alone. All 47 children had a weight recorded at diagnosis. Among 37 children with food deprivation, the mean weight percentile was 33.3 per cent (CDC percentiles). However, 10 (27%) had weight percentages under the 1st percentile, four (8%) between 1st and 4.99th percentiles and six (5%) between 5th and 9.99th percentiles (Table 5). At discharge and/or follow-up all living children with data had significant weight gains, averaging 0.19 g/day.

Disclosures

Twenty-five of 47 children (53%) made a disclosure of maltreatment. Nine (36%) disclosures occurred before diagnosis of torture. Sixteen (67%) disclosed following their diagnosis. Eight (36%) of the children who did not disclose were under 4 years of age.

Prior medical care

Sixteen (34%) children had been seen by medical providers within 1 year of their diagnosis. Two visits involved a maltreatment diagnosis or concern and one lead to temporary out of home placement. Six of 16 (38%) children who had visits within 1 year had been seen by primary care paediatricians (PCP), seven (44%) had been seen by another provider, and three (19%) by both PCP and another provider. Two additional children were seen within the past 20 months. Several children had been actively followed for poor weight gain despite reported adequate diets. They commonly had histories of eating non-food items or stealing food, in desperation due to their actual starvation. Despite this, food deprivation was not recognised.

Six of 18 children (33%) seen within the past 20 months had signs of maltreatment at prior paediatric visits and nine (50%) had signs of maltreatment at non-PCP visits. Signs included injuries, behavioural concerns, malnutrition, missed visits, poor hygiene, dental caries and neglect concerns. Maltreatment was considered at only one visit due to the child presenting in protective services' custody. Since records for previous visits are not always readily accessible within the medical records, these may be an underestimate of how many children were seen by a medical professional prior to diagnosis.

Outcome of torture

One child died prior to identification and was diagnosed based on history, medical examiner autopsy, police investigation and subsequent CAP review. Of the surviving 46 (98%) tortured children, 23 (50%) were admitted when diagnosed.

TABLE 5 Weights and weight percentiles.

Weight percentiles	All children ($n = 47$)	Percentage	Children with food deprivation ($n = 37$)	Percentage
<1%ile	10	21%	10	27%
1–4.99%ile	3	6%	3	8%
5–9.99%ile	3	6%	2	5%
10–24.99%ile	7	15%	5	14%
25–49.99%ile	9	19%	5	14%
50–74.99%ile	3	6%	2	5%
75–89.99%ile	6	13%	5	14%
90–94.99%ile	0	0%	0	0%
95–98.99%ile	5	11%	5	14%
≥99%ile	1	2%	0	0%

Thirty-one of the surviving children (67%) had sustained temporary injuries related to the torture. Twenty-nine (63%) had complications of malnutrition, including refeeding syndrome, stunted growth, weakness, rickets and anaemia. Fourteen (30%) had permanently impairing physical injuries and 22 (48%) had permanent scars. One child had a serious infection secondary to injuries.

Many displayed early behavioural symptoms commonly reported in torture survivors. Seventeen of the surviving 46 (37%) had food gorging behaviours, 14 (30%) had food hording behaviours and 10 (22%) had food hiding behaviours. Three had oral aversions (6.5%) and two were reported to consume non-food items (4%). Twenty-nine (62%) were reported to have had early psychologic symptoms including 20 (43%) with post-traumatic stress symptoms, 13 (28%) with insomnia, 11 (23%) with nightmares, seven (15%) with social withdrawal, five (11%) with somatic symptoms, five (11%) with specific phobias, and two (4%) with over-trust of strangers. Other symptoms noted included excess thirst, picky eating, increased startle response, developmental delays, depression, anxiety and other behavioural concerns such as inattention or aggression.

Thirty-eight (83%) of the surviving children were referred for mental health care. Of those not referred, all but two were under four years of age. Law enforcement and CPS reports were made in all 47 children. Forty-three (93%) surviving children were removed from their home and placed into kinship care or foster care, two siblings were sent with their non-offending caregiver to a domestic violence shelter, and one was left with the family with ongoing CPS support.

DISCUSSION

Child abuse recognition and research has provided lifesaving impacts for children. Our case series confirms that additional victims of child abuse share the previously published Knox criteria for child abuse torture.

Several medical entities share some aspects of child abuse torture. Child torture is a combination of physical abuse, emotional abuse, child neglect and/or sexual abuse. Medical definitions of child abuse usually intentionally lack caretaker motivations but are based solely on physical and other objective findings or disclosures. However, the usual motivation for torture differs from that of other forms of abuse.

Physical abuse usually results from impulsive assaults due to loss of control in response to child frustrations (Schilling & Christian, 2014). Neglect and emotional abuse can be chronic and can also lead to long-term developmental and emotional outcomes. However, unlike isolated neglect, emotional abuse, and physical abuse, torture usually involves multiple forms of chronic abuse that are systematic and escalating. As opposed to usual child abuse, caretakers lacked remorse and justified their actions as necessary to discipline the child for negative behaviours. Likewise, torture was not simply the result of loss of control. Like Knox and colleagues' case series, these torture victims suffered an array of child maltreatment including physical abuse, psychological abuse and neglect (Knox et al., 2014).

Child poly-victimisation as described by Finkelhor is the intersection of violence and maltreatment of children across multiple settings and by multiple perpetrators (Turner et al., 2016). It can include, but is not limited to, physical abuse, sexual assaults, bullying, online violence and community violence (Turner et al., 2016). However, due to the multiple sites of victimisation, they tend to have multiple assailants, each with their own motivation. Unlike poly-victimisation, child torture involves consistent primary and secondary torturers, who share the intent to cause prolonged mental and physical pain and suffering. Though torture may happen outside of the home, such as in institutions or detention facilities, its usually at the hands of consistent torturer(s) (Quiroga, 2009). Child torture victims can also suffer poly-victimisation if maltreated in other settings.

Torture as defined by the United Nations in its 1984 Convention includes intentional infliction of physical or mental pain and suffering by state or other official actors. The definition includes the torturer's motivation to obtain confessions, punish acts, intimidate or coerce. It is usually directed at 'others' and dehumanises victims from a different culture, class, religion, ethnicity or a conflict enemy (The Office of the High Commissioner for Human Rights. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, 1984). It shares the isolation, confinement and withholding of basic needs with child abuse torture. State or agency torture of children also includes similar motivations (How can Children Survive Torture?, 2016). However, the torturers are extra-familial. Its victims shared many long-term emotional consequences similar to the short-term consequence we observed (How can Children Survive Torture?, 2016).

This case series found that torturers can be biological parents, adoptive parents or foster parents. Primary torturers were commonly female and often the primary caregiver. Abuse was often witnessed and tolerated by other non-offending adults. The couple's full biological children often were spared or enlisted as co-abusers. Often, abuse was targeted at a single child or subgroup of children, described as troubled child(ren).

All but five children had signs of physical abuse on examination. The others all had histories of personal or sibling physical abuse. All children had reported psychological abuse which included food/liquid deprivation, terrorising, spurning, isolation and scapegoating. Psychological abuse often is underrecognised and difficult to detect (Kimber &

MacMillan, 2017). Psychological abuse has long-term impacts on children's mental health (Hibbard et al., 2012). These children often displayed maladaptive behaviours and described feeling unloved (Kairys & Johnson, 2002).

The children overwhelmingly experienced isolation and confinement. Children reported being locked into rooms, closets, outside in the cold or in their homes. Some children reported being bound or tied. Neighbours reported that they often did not know children lived in the home. Children were subject to medical and educational neglect, not attending school or regular medical visits. One of the main barriers to diagnosing and intervening in child torture victims was this isolation. This limited the number of outside individuals who interacted with or observed them. It is therefore imperative that medical providers and CPS understand the characteristics of child torture when evaluating children for abuse or injury.

The children described horrific conditions, including sleeping on floors, in the cold or outside. Children reported being forced to eat unappetising foods or forced to watch other family members eat while being deprived themselves. Many were reported to eat spoiled or frozen food, non-food items or drink from toilets and showers in desperation. Clinicians often would be provided histories of excessive eating and thirst that resulted in caregiver food limitation or starvation of the child. Parents withheld food or locked food away in response to unwanted eating behaviours.

The presentation of these children is often confounding. There can initially be reports of children eating from the garbage or being locked in closets or being subjected to bizarre punishments or suffering degrading rituals. Often, evidence of starvation accompanied by a caregiver history of excess eating and gorging can be seen. However, all these presentations are usually in the context of an apparently caring, organised and well put together family who commonly reports problems with the child's behaviour, accounting for all the problems. These bizarre or inconsistent stories could be considered a sentinel finding of torture, similar to how bruises in pre-mobile infants are sentinels for physical abuse (Pierce et al., 2021). This should then trigger a deeper exploration into the other aspects of torture. This could include further history taking from the child, siblings and family members outside the home, seeking information from school, daycare and church, and an evaluation of all other medical records.

Torture is a disclosure-based diagnosis if injuries are not immediately present. Victim disclosures in this series included forced cold baths, water boarding or ice water immersions. Other children reported forced exercise or position holding as discipline. Some reported having to sleep in places that were cold or not meant for sleeping. It is therefore imperative for physicians to talk with children separately. Questioning about normal activities of daily living and how the child's experiences differ from other family members' are often revealing.

Most children developed acute psychological concerns including PTSD, insomnia, nightmares, anxiety, depression and social withdrawal. Half reported dysfunctional behaviours surrounding food including gorging, hiding, hording, oral aversions, eating non-food items or picky eating following diagnosis. It's therefore important to refer child torture victims for mental health care.

These children constantly endured chronic psychological maltreatment, physical abuse and neglect. The abuse targeted the child's morale and character and was specific to the child's developmental stage. The torture was designed to dehumanise the child and exert control. These children are essentially imprisoned, and their existence denied to the outside world. Only by chance did they come to the attention of others and be rescued from abuse.

As a retrospective study, information was limited to solely what was documented in the children's histories, medical records and by investigators. For example, the way race was collected may have been different at each site. Race of parents was not routinely collected or known for many of the cases. This may be especially relevant for non-biological parents, like foster parents, step patents or adoptive parents.

Data entered for cases came from their initial medical evaluation, subsequent medical visits and information provided to medical providers from law enforcement and CPS agents. Since types of torture were based on the child's disclosures, injuries present on physical exam and information provided to medical providers by government agencies, other information and healed injuries may be missed. The abuse attributes likely underestimate what transpired during torture. Particularly, we observed that questioning about psychologic aspects of torture was often inadequate. Due to their traumatic experiences and to the prolonged and complicated nature of the abuse, these children might not disclose the full extent of their maltreatment during initial hospital evaluations. Among children with known follow-up medical care, many gradually disclosed more aspects of torture as they adapted to and began to trust their new foster parents.

There is a paucity of prior development on the diagnosis and identification of child torture. This is a limitation, as recognition, diagnosis and inclusion of cases relied on this very limited previous research. Continued research on this topic is needed to better understand how to recognise, diagnose and treat children who have experienced torture.

CONCLUSION

The goal for these children is to intervene early; however, missed opportunities were common. Seventy per cent of households in this series had previous CPS involvement. Seventeen of 34 school-aged children (five years and above)

(50%) had been removed from or did not attend school. These critical situations provide opportunities to identify and intervene earlier.

In addition, many children had been seen by healthcare providers within 1 year of their diagnosed torture. Providers need to suspect torture earlier when presented with children that have similar manifestations as the cases described. If presented injuries or malnutrition that are inconsistent with the histories, it is important to consider not only unusual natural diseases, but also torture as a possible diagnosis. If suspected, children should have the opportunity to talk with providers alone, without their caregivers present.

It was common that the extent of the torture was not known until concerned parties including medical providers, social workers, law enforcement and school officials listened to the children and communicated concerns with each other. It could therefore be beneficial to improve communication between involved entities when concerns for torture arise. Intervening earlier might prevent further physical and psychological abuse. For many children with malnutrition, infections, fractures or other injuries, intervening earlier might have prevented life-threatening consequences, permanent disfigurement, and physical and psychological disability.

Although many exhibited acute psychological symptoms, their long-term emotional outcomes remain mostly unknown. Clearly, they have suffered significant trauma physically and mentally and would benefit from ongoing counselling and support. Additional support for subsequent caregivers and foster families of tortured children is warranted to help manage short-term and long-term outcomes of torture.

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CONFLICT OF INTEREST STATEMENT

Some of the authors have provided medical legal consultation and testimony. Drs Schlatter, Wiester, Feldman, Gilbert and Forshag have provided medical legal consultation and testimony.

ETHICS STATEMENT

This study was approved by University of Washington IRB, Seattle Children's Hospital IRB and Providence IRB. Consent was not obtained for this study. Deidentified data from this research are available. This research was not sponsored or funded. No materials from other sources were reproduced. This was not a clinical trial.

ORCID

Adrienne Schlatter https://orcid.org/0000-0002-0057-6355
Alysha D. Thompson https://orcid.org/0000-0002-8494-8573
Kenneth W. Feldman https://orcid.org/0000-0002-9020-5223

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