A Primer on Child Torture for Law Enforcement

David Matsumoto, Ph.D.

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DISCLAIMER – I relied heavily on searches using artificial intelligence to develop this report. I did retrieve all the articles cited below and did a cursory review of them to ensure they were accurately described. Still, I am not an expert in this area and would refer to others who are for confirmation.

Core definition

Domestic child torture (as opposed to international, terrorist-based child torture) is a chronic, multi-domain, coercive system of child maltreatment in which a caregiver or caregiver system targets a child for domination through physical abuse, psychological maltreatment, neglect and deprivation, isolation, and coercive control over the child's daily life. Child torture is different from severe child abuse in not just severity but also system structure. The abuse is typically chronic, organized, escalating, and domination-based rather than impulsive or incident-bound. Caregivers often regulate food, sleep, toileting, movement, isolation, and social access, while also using humiliation, terror, scapegoating, and deprivation. The child's adaptive responses are then used to justify further abuse. The pattern is often partially visible across law enforcement, medical, welfare, and educational systems but is misread because institutions parse incidents rather than recognize systems. It is frequently undercaptured by law because legal frameworks remain oriented toward discrete injuries rather than cumulative coercive harm.

Conceptual Framework in Eight layers

1. Etiologic and vulnerability layer

This layer concerns conditions that may increase family vulnerability, without implying determinism or excuse. Relevant upstream risks in the broader literature include caregiver trauma histories, household dysfunction, substance use, domestic violence, mental illness, instability, and prior system involvement. The Duka et al. (2023) maternal ACEs paper is not a child torture paper but it shows how high caregiver adversity burdens can contribute to later caregiving risk contexts, especially when combined with substance use and instability. The key idea is that child torture does not arise from one variable; it emerges from a risk ecology in which caregiver psychopathology, coercive relationship patterns, prior trauma, social isolation, and household instability may converge.

2. Perpetrator-control layer

At the center is a caregiver or caregiver system motivated by domination, control, punishment, and behavioral regulation, not merely explosive anger. The Knox, Shelton, and Schlatter papers all support the view that torture cases are more systematized and control-oriented than ordinary episodic physical abuse. Browne and Ahan both emphasize custodial/physical control as a defining element of torture**.** Common features include:

- rigid rules and rituals
- punishment framed as "discipline"
- dehumanizing or globally negative narratives about the child
- control of basic necessities

- creation of "set-ups for failure"
- household complicity or multiple offenders in many cases.

The key idea is that the child is treated not as a developing person but as an object to dominate, correct, break, or morally reform.

3. Abuse-system layer

Child torture is a multi-domain abuse system. The domains repeatedly documented across the core papers are:

- physical abuse
- psychological abuse
- deprivation and neglect
- environmental control/isolation.

The Schlatter et al. (2023) paper reported 100% psychological maltreatment, high rates of food deprivation, isolation, medical neglect, and physical abuse findings. The Knox case series found the same pattern. Other papers reinforce the notion that torture includes mental suffering independently of physical injury. No single act defines torture; the diagnosis emerges from the co-occurring pattern across multiple domains.

4. Child-targeting layer

Many cases involve a targeted child, not equal maltreatment of all children in the home. One child may be singled out as "difficult," "bad," "behavioral," "demonic," or otherwise problematic, while siblings may be spared, favored, or even recruited into the abuse dynamic. This selectivity suggests intentionality and relational meaning. The abuse is often not random household chaos; it is frequently directed.

5. Child adaptation and symptom layer

A major insight across the literature is that the abuse system often produces the very behaviors later used to justify more abuse. Children subjected to starvation may hoard, gorge, steal, or hide food. Children subjected to terror and unpredictability may become withdrawn, dysregulated, compliant, anxious, sleepless, or socially odd. These responses are then recoded by perpetrators as proof the child is defective or oppositional. Victim behavior is often adaptive evidence of torture, not evidence against it. Schlatter et al. (2023) specifically documented food hoarding, food gorging, PTSD symptoms, nightmares, insomnia, and other acute behavioral sequelae even after rescue.

6. Detection and forensic discrimination layer

This layer explains how torture is recognized and how it is distinguished from accidents or isolated abuse. Two sub-principles emerge from the literature:

Pattern recognition. Professionals should look for:

- multi-domain abuse
- control of daily life
- isolation
- repeated reports
- medical neglect

- bizarre punishments
- inconsistent or manipulative caregiver narratives.

Mechanism plausibility testing. The burn and injury papers show that forensic evaluation must test whether the caregiver's story is physically and developmentally plausible. Some injuries strongly contradict claimed accidental mechanisms (e.g., the iron burn paper), while some apparently alarming injuries can truly be accidental if the history, scene, and findings align (e.g., climbing in the bathtub paper). Thus, the correct forensic question is not "could this be abuse?" but "does the total pattern of injury, history, development, and context fit accident, isolated abuse, or torture?"

7. System-contact and failure layer

One of the strongest themes across the literature is that victims are frequently seen by CPS, medical providers, schools, or police before torture is recognized. Prior CPS involvement was common in the Knox case series, the Washington case series, the Shelton paper, and the fatality-prevention review. Barriers to recognition include:

- fragmented viewing of incidents rather than patterns
- overreliance on caregiver explanations
- under-recognition of psychological abuse
- failure to connect malnutrition, hygiene problems, "behavior problems," and injuries into one abuse system
- disbelief when disclosures sound extreme
- lack of training on torture as a category
- no unified protocol exists for documenting child torture

Thus, there is a problem of misinterpretation, not absence of evidence.

8. Outcome and justice layer

Victim's end states include:

- severe physical injury
- chronic psychological injury
- developmental impairment
- malnutrition
- disfigurement
- death in some cases

But the legal response often fails to match the clinical reality. Macy, Deutsch/O'Brien, and the Macy chapter show that criminal statutes are often built around discrete assaults, serious bodily injury thresholds, and narrow intent requirements, while child torture is longitudinal, cumulative, and often heavily psychological or deprivation based. Despite the fact that binding, confinement, repeated blows, burns, and forced ingestion can all be considered as evidence of intent to cause suffering, child torture is often clinically obvious but legally undercaptured.

Summary

- Upstream vulnerability may include caregiver trauma, household instability, coercive dynamics, substance use risk contexts

- Perpetrator control orientation involving domination, punishment ideology, dehumanizing child narratives
- Construction of abuse system across multiple domains including physical abuse + psychological abuse + deprivation + isolation
- Targeting
- Victim adaptation involving food behaviors, fear, dysregulation, trauma symptoms, “behavior problems”
- Detection opportunities including school absence, prior reports, injuries, malnutrition, bizarre stories, medical visits
- System failure or intervention because of fragmentation, disbelief, minimization, or multidisciplinary recognition
- Outcomes that involve rescue, chronic disability, or fatality; then legal underfit may still occur

Distinguishing Child Torture from Nearby Concepts

Dimension	Child Torture	Severe Physical Abuse	Neglect	Psychological Abuse / Coercive Control	Accidental Injury
Core nature	Systematic multi-domain abuse + control	Physical violence	Failure to provide needs	Psychological domination	Unintentional injury
Time pattern	Chronic, prolonged	Episodic	Chronic	Chronic	Single event
Structure	Organized system	Unstructured	None	Structured control	None
Intent	Control/domination	Anger/frustration	Omission	Control	None
Scope	Multi-domain	Physical only	Deprivation	Psychological	Physical only
Psychological abuse	Central	Secondary	Indirect	Primary	Absent
Deprivation	Common	Rare	Primary	Sometimes	Absent
Control of daily life	Extensive	Limited	Indirect	Moderate	None
Isolation	Common	Rare	Sometimes	Sometimes	None
Targeting	Often one child	Variable	All children	Variable	N/A
Narrative	Child blamed	Loss of control	Overwhelmed	Justified control	Consistent
Pattern visibility	Fragmented system	Injury-based	Condition-based	Subtle	Clear
Mechanism consistency	Often inconsistent	Sometimes	N/A	N/A	Consistent
Child presentation	Fear, trauma	Injury distress	Neglect signs	Anxiety	Normal
Household dynamics	System	Single offender	Household	Dyadic	Normal

Legal fit	Poor	Strong	Moderate	Weak	None
Fatality risk	High	High	High	Lower	Low
Distinctive feature	System of control	Violence	Absence of care	Domination	Accident

Key Distinctions

Child torture is defined by a chronic, multi-domain system of control over a child's life, combining physical, psychological, and deprivation-based abuse.

Vs. Severe Physical Abuse

Severe physical abuse may be acute, episodic, and anger driven. Child torture is more often chronic, structured, multi-domain, and control centered.

Vs. Neglect

Neglect alone may involve omission. Child torture often uses deprivation actively and coercively, alongside physical and psychological abuse.

Vs. Coercive Control

Coercive control overlaps heavily, but child torture adds a more explicit pattern of sustained maltreatment, suffering, and bodily deprivation, often with visible physical abuse as well.

Vs. Accidental Injury

Accidental injuries can be serious, but they lack the longitudinal pattern, multi-domain abuse, and system context seen in torture. Mechanism plausibility remains essential.

Master List of Documented Abuse and Control Methods

Physical Abuse Methods

Direct violence

- Beating (hands, fists)
- Kicking
- Punching
- Slapping
- Striking with objects (belts, bats, pipes, tools)
- Throwing objects at child
- Shaking
- Strangulation / choking
- Suffocation attempts (plastic bags, covering airway)
- Stabbing or cutting
- Biting

Blunt force / impact

- Slamming into walls or objects
- Impact to head/body
- Dropping or throwing child

Burns and heat injury

- Scalding (immersion burns)
- Contact burns (objects, surfaces)
- Forced exposure to heat sources
- Burning as punishment

Cold exposure

- Forced exposure to cold environments
- Sleeping outside or on cold surfaces
- Cold water immersion

Forced physical exertion

- Forced exercise (pushups, stair climbing)
- Forced prolonged standing
- Forced stress positions (arms extended, holding objects)
- Positioning to induce pain or fatigue

Binding and restraint

- Tying wrists/ankles
- Binding with cords, tape, or restraints
- Suspension or hanging positions
- Restricting movement for long periods

Confinement

- Locked in closets, rooms, bathrooms, cabinets
- Confined to small spaces (boxes, cubbyholes)
- Locked in vehicles or trunks
- Physical imprisonment within home

Injury aggravation

- Withholding care for injuries
- Forcing movement on injured body parts
- Re-inflicting injury

Sexual abuse (subset in some cases)

- Penetration (digital or otherwise)
- Forced exposure
- Sexual humiliation

Deprivation/Neglect (Active and Coercive)

Food deprivation

- Withholding food entirely
- Restricting access to food
- Locking food away
- Punishing attempts to obtain food
- Forcing child to watch others eat

Water deprivation

- Restricting fluids
- Punishing attempts to drink
- Forcing consumption from unsafe sources

Sleep deprivation

- Preventing sleep
- Forcing prolonged wakefulness
- Interrupting sleep as punishment

Toileting restriction

- Denying bathroom access
- Forcing use of buckets/containers
- Punishing toileting accidents
- Controlling bodily functions

Hygiene deprivation

- Denying bathing
- Forcing unsanitary conditions
- Preventing personal care

Medical neglect

- Failure to treat injuries
- Ignoring severe illness
- Delaying or preventing care

Educational neglect

- Removing from school
- Fake "homeschooling"
- Preventing learning or development

Psychological Abuse/Maltreatment

Verbal and emotional abuse

- Name-calling ("evil," "bad," "worthless")
- Insults and degradation
- Constant criticism
- Rejection and spurning

Humiliation and degradation

- Forced embarrassing acts
- Public or family humiliation
- Degrading punishments
- Identity attacks

Terrorization

- Threats of death
- Threats of harm to child or others
- Threats of future punishment
- Exposure to fear-inducing situations
- Fear based control

Emotional neglect

- Ignoring emotional needs
- Withholding affection
- Denying comfort or support

Isolation (psychological + physical)

- Preventing social interaction
- Removing from peers
- Blocking contact with outside world
- Sensory deprivation

Control of identity and autonomy

- Treating child as object/problem
- Denying individuality
- Suppressing autonomy

Coercion and Control Tactics (Core of Torture)

Control of basic life functions

- Food access
- Water access
- Sleep
- Toileting
- Movement within home

Environmental control

- Restricting rooms/areas
- Surveillance (alarms, monitoring)
- Locking doors/containers
- Controlling physical space

Rule systems and rituals

- Arbitrary or impossible rules
- Constantly changing expectations
- Structured punishment systems
- Ritualized discipline routines

"Set-up for failure"

- Tasks child cannot complete
- Punishment regardless of outcome
- No path to success

Dependency creation

- Limiting independence
- Creating reliance on caregiver
- Removing alternatives

Isolation as control

- Removing school access
- Preventing outside contact
- Hiding child from others

Humiliation and Dehumanization Tactics

- Forced ingestion of non-food items (insects, waste)
- Forced consumption of spoiled food
- Forced exposure to bodily waste
- Degrading body positioning
- Denial of clothing or bedding
- Forced nudity or exposure
- Hair cutting as punishment
- Forced observation of others' privileges
- Treating child as less than human

Narrative and Psychological Manipulation

Caregiver framing tactics

- "This is discipline"
- "Child is difficult/defiant"
- "Child has behavioral/mental problems"
- "Child causes the punishment"

Distortion of reality

- Blaming child for abuse
- Mislabeling starvation as eating disorder
- Misinterpreting trauma behaviors as misconduct

System manipulation

- Providing plausible explanations to professionals
- Controlling what others see
- Withholding information
- Using prior reports to normalize situation

Household/Social Control Dynamics

- Multiple perpetrators involved
- Non-offending adults aware but passive
- Siblings coerced into participation
- Targeted child singled out
- Favoritism toward other children
- Household normalization of abuse

Child Adaptive Responses

(Not abuse methods, but critical indicators)

- Food hoarding, gorging, hiding
- Drinking from unsafe sources
- Extreme compliance or fear
- Withdrawal or flat affect
- Hypervigilance
- Trauma symptoms (PTSD, anxiety, insomnia)
- "Behavior problems" caused by deprivation

Are the Perpetrators mostly Women?

The studies show that women are very frequently involved and they are often the primary caregiver (e.g., mother, stepmother, adoptive mother). In some studies (e.g., Knox et al. 2014), female perpetrators were present in every case. But men are also heavily involved and many cases involve multiple perpetrators. Men are often associated with more overt physical violence while women are the primary caregiver and they control food, routines, environment, and access to others, which are exactly the domains torture. In general child abuse, men are more often associated with severe physical violence and fatal injuries (statistically). So the correct interpretation is that women are overrepresented relative to typical physical abuse cases, but not necessarily the majority acting alone.

Abuse Type	**More common perpetrator pattern**
Acute physical assault	Often male
Neglect / deprivation	Often primary caregiver (frequently female)
Coercive control system	Primary caregiver + co-perpetrator
Child torture	Mixed system (often both)

Child torture cases frequently involve female primary caregivers but are most often part of a multi-perpetrator household system in which both men and women contribute to the abuse. Multi-offender households are common. Many cases involve two or more adult perpetrators, both caregivers aware and participating. Siblings may also be coerced and involved at lower levels. Thus, child torture is often a household system, not a single offender.

Operational takeaway for investigators: Do not assume single offender or gender-based pattern. Instead ask: “Who controls the child’s environment, and who participates—directly or indirectly—in the system?” The key variable is not gender—it is control over the child’s daily life, and whoever controls food, access, routines, or isolation plays a central role in torture dynamics.

Is there a Single Target?

Yes; the research literature shows that a "primary target child" is very common and this child receives the most severe abuse. That child was typically labeled as "problematic," "difficult," or "bad." This is often called "scapegoating."

But other children are almost always involved somehow and are affected. They may also be abused, but less severely. They may also be witnesses (trauma exposure), coerced participants (forced to assist), or favored children (used for comparison/control). Thus, one child is usually the main target but other children are often involved somehow.

Why does a Single Main Target Emerge?

The literature suggests several mechanisms:

- Scapegoating: One child is blamed for family stress, behavioral issues, or moral/religious narratives.
- Perceived vulnerability: The child may be younger, developmentally delayed, a step/adopted child, or less protected socially.
- Reinforcement loop: Abuse → child behavior changes → used to justify more abuse

Target selection is not random; the target child is usually selected, labeled, and treated differently over time because torture is an intentional system, not chaotic violence.

Critical Investigative Implication

Don't stop at the "target child." Even if one child is clearly the victim, consider assessing all siblings and all children in the home because they may also be victims, they may be at risk, or they may provide critical information. Most important operational takeaway:

- The presence of a "single target child" is a red flag for a structured abuse system—not evidence that other children are safe.

The pattern in child torture cases mirrors coercive control in domestic violence and scapegoating dynamics in dysfunctional families, where one person absorbs the majority of harm and others are controlled through comparison, fear, or alignment.

Bottom Line

A primary target child is very common but the abuse system almost never involves only that child. The correct model is a targeted victim within a broader household system