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ORIGINAL ARTICLE

Child torture: A Washington state case series

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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).

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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.

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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%)

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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	

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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.

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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%

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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 &

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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)

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(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.

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REFERENCES

Gonzalez, D., Bethencourt Mirabal, A. & McCall, J.D. (2022) Child abuse and neglect. In: *StatPearls*. StatPearls Publishing.

Hibbard, R., Barlow, J., MacMillan, H., the Committee on Child Abuse and Neglect and American Academy of Child and Adolescent Psychiatry, Child Maltreatment and Violence Committee, Christian, C.W., Crawford-Jakubiak, J.E. et al. (2012) Psychological maltreatment. *Pediatrics*, 130(2), 372–378. Available from: https://doi.org/10.1542/peds.2012-1552

Hillis, S., Mercy, J., Amobi, A. & Kress, H. (2016) Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics*, 137(3), e20154079. Available from: https://doi.org/10.1542/peds.2015-4079

Kairys, S.W., Johnson, C.F. & Committee on Child Abuse and Neglect. (2002) The psychological maltreatment of children–technical report. *Pediatrics*, 109(4), e68. Available from: https://doi.org/10.1542/peds.109.4.e68

Kempe, C.H., Silverman, F.N., Steele, B.F., Droegemueller, W. & Silver, H.K. (1962) The battered-child syndrome. *JAMA*, 181(1), 17–24. Available from: https://doi.org/10.1001/jama.1962.03050270019004

Kimber, M. & MacMillan, H.L. (2017) Child psychological abuse. *Pediatrics in Review*, 38(10), 496–498. Available from: https://doi.org/10.1542/pir.2016-0224

Knox, B.L., Starling, S.P., Feldman, K.W., Kellogg, N.D., Frasier, L.D. & Tiapula, S.L. (2014) Child torture as a form of child abuse. *Journal of Child & Adolescent Trauma*, 9(1), 249–265. Available from: https://doi.org/10.1007/s40653-014-0009-9

Pierce, M.C., Kaczor, K., Lorenz, D.J., Bertocci, G., Fingarson, A.K., Makoroff, K. et al. (2021) Validation of a clinical decision rule to predict abuse in young children based on bruising characteristics. *JAMA Network Open*, 4(4), e215832. Available from: https://doi.org/10.1001/jamanetworkopen.2021.5832

Quiroga, J. (2009) Torture in children. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, 19(2), 66–87.

Schilling, S. & Christian, C.W. (2014) Child physical abuse and neglect. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 309–319. Available from: https://doi.org/10.1016/j.chc.2014.01.001

The Office of the High Commissioner for Human Rights. (1984) *Convention against torture and other cruel, inhuman or degrading treatment of punishment*. United Nations. Available from: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading

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Turner, H.A., Shattuck, A., Finkelhor, D. & Hamby, S. (2016) Polyvictimization and youth violence exposure across contexts. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 58(2), 208–214. Available from: https://doi.org/10.1016/j.jadohealth.2015.09.021

United Nations human rights. (2016) *How can children survive torture?* United Nations. Available from: https://www.ohchr.org/sites/default/files/Documents/Issues/Torture/UNVFVT/HowCanChildrenSurviveTorture.pdf

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