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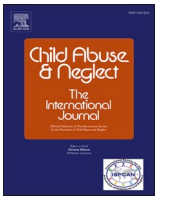

Child torture as a form of child abuse: An exploratory study of investigative aspects among 42 offenders

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ABSTRACT

Background: Torture has traditionally been described in the context of politically motivated abuse. Torture of children in the familial context is a less studied phenomenon, with scholarly articles focused on legal or medical viewpoints. Analysis from a frontline professional's perspective is virtually nonexistent in the literature.
Objective: The present study seeks to identify the common features of child torture and assist law enforcement, medical, and child protection agencies in earlier identification and inform more effective investigative and intervention strategies.
Participants and setting: A convenience sampling method was used to identify and collect cases involving severe child maltreatment consistent with torture. The sample included 42 offenders and 35 victims, representing 20 households.
Methods: Researchers reviewed and extracted data from law enforcement case files, to include investigative, medical, and child protective services (CPS) reports, as well as recorded law enforcement interviews of offenders/witnesses and child forensic interviews. Descriptive and frequency statistics were generated.
Results: Offenders were often female (57 %), most commonly biological mothers (38 %), with a history of violence (57 %). Prior CPS reports were noted in 85 % of cases, less than half of which were substantiated. In over half of the cases (55 %), law enforcement discovered digital documentation of the torture. Over half (54 %) of the victims died as a result of the torture.
Conclusions: This study demonstrated how CT is a distinct form of child maltreatment that is especially severe and pervasive. Recognition, assessment and documentation of the unique constellation of physical and psychological abuse are key to an efficient intervention.

1. Introduction

Frontline professionals and mandated reporters, such as those in law enforcement and child welfare, are generally trained in recognizing child maltreatment (Ho et al., 2017). These professionals play an important role in detection, providing services to victims and their families, and the development of research (Crettenden & Zerk, 2012). Homicide or major crime investigators and child

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protection personnel may be afforded advanced technical training in certain types of child maltreatment, such as physical and sexual abuse. Those who have experience in investigating child abuse typically can recall a case where the abuse or neglect was severe or particularly cruel. Despite anecdotes by seasoned professionals, most are still unfamiliar with child torture (CT) and the specific characteristics that defines and sets it apart (Esernio-Jenssen, 2022; Knox et al., 2014). The seemingly fantastical nature of initial reports or disclosures goes beyond what is typically encountered in child abuse cases, resulting in reports of CT being discounted. In addition, a general lack of awareness and/or minimization of psychological abuse has likely affected professional responses, as this form of maltreatment can be less tangible and not as well understood (Brassard et al., 2019). This difficulty in recognizing CT is further exacerbated by an offender's skill at avoiding scrutiny by people and systems (Knox et al., 2014), affecting the interpretation of evidence that would normally raise concerns of professionals and lead to intervention. It is critical that law enforcement and other professionals develop an understanding of the unique dynamics involved in this type of maltreatment to ensure effective recognition and response.

1.1. Recognizing and defining torture

Torture has traditionally been described in the context of politically motivated abuse and involves the infliction of physical or mental pain and suffering to elicit a confession, punish, intimidate and/or coerce the victim (Office of the High Commissioner for Human Rights, 2022; Quiroga, 2009). A variety of national and international definitions of torture exist with both a humanitarian and legal focus (Allasio & Fischer, 1998; Amnesty International, 1975; Burgers & Danelius, 1988; Stover & Nightingale, 1985; World Medical Association, 2006). Victims of child torture under political conditions are typically refugees, displaced or unaccompanied children, or child soldiers, and the torture often takes place within the context of war or conflict (Alayarian, 2009).

Torture of children in the familial context, however, is a less studied phenomenon. Only a handful of scholarly articles have been published that focus on CT, many of which have a legal or medical focus (Ahan, 2009; Browne, 2014; Den Otter et al., 2013; Deutsch & O'Brien, 2024; Esernio-Jenssen, 2022; Knox et al., 2014; Macy, 2019; Quiroga, 2009; Schlatter et al., 2024; Tiapula & Applebaum, 2011). The studies that provide further insight into CT victims' experiences consist of relatively small sample sizes. Nevertheless, the descriptions of the unique types of severe physical abuse, psychological abuse and neglect inherent in CT were fairly consistent across these studies (Knox et al., 2014; Schlatter et al., 2024). Not only is research on CT lacking, but statutes addressing this offense vary considerably across states or are entirely absent (Deutsch & O'Brien, 2024; Macy, 2019; Tiapula & Applebaum, 2011). Approximately one quarter of states do not have a CT statute, and for those that do, the available charges often do not encompass the magnitude of the abusive acts committed against the child, particularly when the child survives the torture and evidence of severe physical abuse is lacking (Deutsch & O'Brien, 2024; King & Gillespie, 2017; Macy, 2019). Similarly, many states' child abuse statutes do not recognize psychological maltreatment as a separate legal category of abuse (Deutsch & O'Brien, 2024; Macy, 2019). This combination of factors has impacted the ability of medical and legal authorities to effectively recognize and address this problem (Den Otter et al., 2013; Deutsch & O'Brien, 2024).

Prior to Knox et al.'s (2014) seminal article, CT lacked medical definitional criteria that would allow it to be distinguished from other forms of child maltreatment. Through Knox et al.'s (2014) evaluation of 28 victims of extreme child abuse, CT was defined as "a longitudinal experience of at least two physical assaults (or one extended assault), and two or more forms of psychological maltreatment resulting in prolonged suffering, permanent disfigurement/dysfunction or death" (Knox et al., 2014). The abuse typically escalates over time, with offenders often justifying their actions as discipline (Knox et al., 2014; Schlatter et al., 2024). Offenders are commonly female and are often the primary caregiver and parent of the victim (Knox et al., 2014; Schlatter et al., 2024). The high prevalence of female offenders in previous samples is contrary to commonly held views of females' capacity for violence. Women are often viewed as passive and nurturing, so the idea they could actively harm another human being, let alone their own child, is difficult to comprehend, making it more difficult for their violent acts to be detected (Archer, 2000; Pearson, 2021; Robbins et al., 2003; Shelton et al., 2015; Stangle, 2008).

1.2. Differentiating child torture from other types of child maltreatment

Considering the recent emphasis on promoting family integrity and connection for children (Macy, 2019), it becomes critical to differentiate child torture from the most commonly recognized forms of severe child abuse. Over 60 years ago, psychiatrist Brandt Steele, who worked with Henry Kempe in defining "Battered Child Syndrome" and advocated for humanistic interventions for both maltreated children and their abusive parents, had already warned of the importance of early recognition of certain child abuse perpetrators. These offenders, who repeatedly and cruelly hurt children, are extremely difficult, if not impossible, to rehabilitate into safe caregivers, and their infliction of abuse is easily transferred to other children in the family (Steele, 1987). Allasio and Fischer (1998) reiterated Steele's warning, "The term torture needs to be made part of our assessment, and when it exists, it should warn us that removal of a child from the torturer is critical to prevent future abuse of the child" (Allasio & Fischer, 1998, p. 270).

Compared to the frequency of child maltreatment, CT is relatively rare. Among the medical community, it is estimated that 1–2 % of children being evaluated for abuse are victims of torture (Knox & Starling, 2012). However, the true rate of CT's occurrence in the population remains unknown, as the concept is not well understood and only recently defined (Knox et al., 2014). What distinguishes CT from more commonly recognized forms of child abuse is not only the severity of the abuse, but also the pervasiveness, as it can affect all aspects of the victim's daily life. The abuse is often premeditated and also serves as a means to humiliate and obtain submission from the victim (Knox et al., 2014). In contrast, child physical abuse usually results from sporadic, impulsive assaults due to a caregiver's loss of control in response to frustration (Schilling & Christian, 2014). Even though these distinctive characteristics of CT

can seem obvious, cases are frequently misdiagnosed or dismissed by professionals. For example, prior CPS contact has ranged from 45 %–70 % of cases in previous CT studies (Knox et al., 2014; Schlatter et al., 2024). This can be attributed to a lack of awareness of CT as a separate form of abuse and poor coordination between the medical provider, CPS, or law enforcement. Inconsistent or disjointed medical care may also contribute to the lack of recognition of CT, as well as isolation from extended family, teachers, and other members of the community who may be able to identify signs of abuse and intervene. Professionals may also be deceived by the ability of the perpetrators to present as an apparently caring and cohesive family who reports that the child's behavioral issues account for all their problems (Schlatter et al., 2024).

The purpose of this exploratory study was to identify offender, victim, and case characteristics that are common in CT cases (Ahan, 2009; Browne, 2014; Esernio-Jenssen, 2022; Knox et al., 2014; Macy, 2019; Schlatter et al., 2024). The results of this study may assist frontline professionals, such as law enforcement, medical, and child protection agencies, in identifying victims of CT earlier in the investigative process and develop strategies that are effective in resolving these unique cases.

2. Methodology

2.1. Sampling procedure

Due to the exploratory nature of the study, a convenience sampling methodology was utilized to develop a sample of CT cases. Law enforcement case files were assessed by the Federal Bureau of Investigation's (FBI) Behavioral Analysis Unit (BAU)-3 and a Board-Certified Child Abuse Pediatrician based on the following inclusion criteria: (1) the abuse of the victim(s) met the definition of CT in Knox et al. (2014), (2) the victim was less than 18 years of age at the time of the abuse, regardless of age at the time of intervention, and (3) an offender was charged with and/or adjudicated for the abuse/death of the victim, or the offender(s) died by suicide and a death investigation concluded that the decedent(s) was/were responsible for the abuse/death of the victim(s). Cases where the torture exclusively involved sex acts were not considered for inclusion. In those cases, the infliction of pain and suffering is isolated to acts that are in furtherance of the offender's sexual motivation but does not extend to controlling the victim's access to the necessities of life, such as food, water, toileting, clothing, warmth, and schooling (Knox et al., 2014).

Cases previously referred to the BAU by law enforcement were assessed by the research team for inclusion ($n = 12$); additionally, summaries of case files from prior BAU research on maternal filicides and false allegations of child abduction were reviewed ($n = 3$). If inclusion criteria were met, cases were pulled for inclusion in the sample. Lastly, a survey was sent out to all 56 FBI field offices across the United States to identify additional cases that met the above inclusion criteria ($n = 8$). These cases were then assessed for inclusion by the research team. The above sampling procedures yielded a total of 23 cases. Three cases were excluded as they met the physical abuse criteria but lacked evidence of repeated psychological abuse that permeated the child's daily life.

The strategies outlined above resulted in a convenience sample of 35 child victims and 42 offenders within 20 households (i.e., cases). The cases were adjudicated between 1998 and 2021 and represent 12 states. Research procedures were approved by the Institutional Review Board (IRB) of the Federal Bureau of Investigation (FBI). The University of Florida's IRB ceded oversight of the study to the FBI's IRB.

2.2. Source material

Investigative and prosecutive case files consisting of law enforcement and autopsy reports, CPS, medical, and mental health records, as well as court transcripts and sentencing information, were assessed. In addition, recorded law enforcement interviews of offenders/witnesses and child forensic interviews were reviewed. Adult and juvenile criminal history information for the offenders was obtained using the FBI's Criminal Justice Information System (CJIS) and coded using the FBI's National Incident-Based Reporting System (NIBRS) (FBI, 2023). Information related to victim, offender and offense characteristics was extracted from the case files using a 91-question instrument developed by the researchers. Victim characteristics included demographics, educational, medical and mental health histories, duration of abuse, cause of death, and recovery status (i.e., alive or deceased/presumed deceased). Offender characteristics consisted of demographics, relationship to the victim, mental health and criminal histories, current and past intimate partner violence, life stressors, and adjudication outcome. Offense information was comprised of household composition, precipitating events, prior CPS history, physical and digital evidence recovered, methods of torture, and types of injuries. In cases where there were multiple victims and/or offenders, each victim or offender was endorsed individually. Data were not collected for children residing in the household who were not victims of torture. If necessary, investigators who had been assigned to the case were contacted to clarify or provide missing information.

2.3. Analysis

Extracted data were entered into SPSS (Version 29.0). Univariate statistics were performed to establish an understanding of characteristics of CT at the offense, offender, and victim levels. Frequencies were calculated for features of interest, guided by Knox et al.'s (2014) definition of child torture, to determine prevalence of characteristics across cases.

3. Results

3.1. Offender characteristics

Table 1 highlights various demographics of the 42 offenders, to include age, gender, employment/marital status, relationship to the victim, and mental health/criminal history. Of the 42 offenders, 57 % ($n = 24$) were female and 43 % ($n = 18$) were male. The most common relationships to the victim were biological mother ($n = 9$, 21 %), biological father ($n = 6$, 14 %) and adoptive mother ($n = 6$, 14 %). Among the females, 43 % ($n = 18$) were mothers (either biological, step, or adopted) to the victim(s), 50 % of which ($n = 9$) were biological mothers.

Of the 42 offenders, half had a criminal arrest history prior to the incident offense. The most common offenses consisted of "other" B offenses (e.g., criminal contempt, harassment, probation violation; 67 %), assault (52 %), drugs/narcotics (29 %), disorderly conduct (24 %), larceny/theft (24 %), and fraud (19 %). Over half of the offenders had a history of abusing other adults and/or non-tortured children. History of abuse was defined as any emotional, physical, and/or sexual abuse or violence and included behavior that was reflected in the offender's criminal arrest history, as well as other documented abuse in the investigative file. In five cases, the age of the other victims could not be determined. Of the 24 offenders who abused other individuals, 11 (46 %) also exhibited control, domination, and/or manipulation that often mirrored the abuse of the targeted child.

For 25 of the 42 offenders (60 %), the psychiatric history of the offender was available in the case materials. Of the cases where this information was known, 13 offenders (52 %) had been diagnosed with a psychiatric disorder prior to intervention in the torture case. The more common diagnoses fell into the diagnostic categories of depressive disorders (62 %), personality disorders (39 %), and trauma and stressor related disorders (31 %). For 35 offenders, information related to substance abuse was available. Of those, over half had a history of abusing alcohol and/or illegal drugs at some point in their life.

Table 1
Descriptive statistics of child torture offenders and their characteristics.

Child torture offenders ($N = 42$)	*n* (%)
Average age at time of intervention	36.1 years
Age range at time of intervention	21–58 years
Gender	
Female	24 (57 %)
Male	18 (43 %)
Race/ethnicity	
Caucasian	22 (52 %)
Black/African American	8 (19 %)
Other	7 (17 %)
Hispanic/Latino/Mexican American	5 (12 %)
Employment	
Employed	22 (52 %)
Unemployed	16 (38 %)
Marital status	
Married/common law marriage	32 (76 %)
Not married	7 (17 %)
History of violence toward other children and/or adults	24 (57 %)
Reported to be victim of abuse[a] by a co-defendant	12 (29 %)
Female	10 (83 %)
Male	2 (17 %)
Offenders' relationship to victim(s)	
Parent	28 (67 %)
Biological parent	15 (36 %)
Stepparent	4 (9 %)
Adoptive parent	9 (21 %)
Other relationship[b]	14 (33 %)
Criminal history[c]	21 (50 %)
Prior diagnosed mental health disorder	13 (31 %)
Substance abuse history[d]	19 (45 %)

Data presented as *n* (% of total *N)*. Percentages within categories may not add to 100 % as some information was unknown.

[a] Includes both intimate partner violence and physical, sexual, and emotional/psychological abuse perpetrated by non-intimate partners.

[b] Includes parent's intimate partner, relative, roommate or friend.

[c] Offenders may have more than one prior arrest/charge/conviction as a juvenile and/or adult.

[d] Accounts for formal substance use disorder diagnosis and substance abuse outside of official diagnosis.

3.2. Victim characteristics

Table 2 highlights various demographics of the 35 victims such as age, gender, and education history. Male and female victims were similarly represented in the dataset, with 19 (54 %) victims being female and 16 (46 %) victims being male. The largest victim age group was elementary school-aged children (46 %), which included those between five and 11 years of age. Almost three quarters of the victims were age eligible for enrollment in K-12 schooling at the time of intervention, but less than a quarter were enrolled. Of the school-aged victims who were not enrolled in K-12 schooling, 62 % were reported to be homeschooled, although in most cases the homeschooling was inadequate or entirely absent. Similarly, 83 % of victims had a history of disenrollment from a school setting, to include daycare, preschool, and K-12 schooling.

The victim's recovery status (i.e., alive or deceased) and his/her cause of death, if applicable, are also noted in Table 2. Over half of the victims were deceased, presumed deceased or subsequently died of injury complications (54 %). The most common cause of death documented on autopsy reports was blunt force trauma to the head (60 %) or torso (60 %). Table 2 also notes medical and mental health histories of the victims. Chronic medical issues and/or mental health history were either documented in the victim's medical records and/or reported by caregivers. Fifteen victims (43 %) had or were reported to have had a chronic medical issue, defined as a disease or condition that persists over time or is frequently occurring. Reported medical conditions that were supported by medical documentation from a medical professional included facial asymmetry, cerebral palsy, asthma, anemia, and failure to thrive. Other chronic medical issues reported by caregivers/offenders that were not supported by a formal diagnosis included issues with balance, binge eating, chewing/swallowing difficulties, food allergies, low iron, breathing problems, obesity, and speech problems.

Nineteen victims (54 %) had or were reported to have had a mental health issue and/or diagnosis. Common prior diagnoses made by mental health professionals were neurodevelopmental disorders (26 %). It was not uncommon for offenders to report a victim's mental health symptoms in the absence of an official diagnosis, often stemming from maladaptive behaviors surrounding food, attention deficits, aggression/violence, intellectual disability, and/or hair pulling (i.e., trichotillomania). For eight of the 19 victims

Table 2
Descriptive statistics of child torture victims and their characteristics.

Child torture victims ($N = 35$)	n (%)
Age range at onset of abuse[a]	3 months-12 years
Average age at time of onset of abuse[a]	5.5 years
Average duration of abuse	4 years
Average age at time of intervention/death	9.1 years
Gender	
Female	19 (54 %)
Male	16 (46 %)
Race/ethnicity	
Caucasian	17 (49 %)
Biracial	8 (23 %)
Black/African American	6 (17 %)
Other	4 (11 %)
Victim(s) and offender(s) are of different races	18 (51 %)
Mental health issue/diagnosis (reported by caregivers and/or official diagnosis)	19 (54 %)
Chronic medical issue/diagnosis (reported by caregivers and/or official diagnosis)	15 (43 %)
Education: K-12 enrollment	
Age eligible for K-12 schooling at time of intervention/death	26 (74 %)
Enrolled in K-12 schooling at time of intervention/death	6 (23 %)
Not enrolled in K-12 schooling at time of intervention/death	4 (15 %)
Homeschooled	16 (62 %)
History of being disenrolled from school setting (daycare/preschool/K-12)[b]	19 (83 %)
Falsely reported missing by caregivers	3 (9 %)
Recovery/Outcome	
Alive- survived	16 (46 %)
Alive- but later died due to medical complications	3 (9 %)
Deceased	12 (34 %)
Presumed deceased (no remains recovered)	4 (11 %)
Cause of Death ($n = 15$)[c]	
Blunt force trauma to head	9 (60 %)
Blunt force trauma to torso	9 (60 %)
Malnutrition/dehydration/starvation	3 (20 %)
Undetermined	3 (20 %)
Other	2 (13 %)

Data presented as n (% of total N, unless otherwise noted). Percentages may not add to 100 % as some information was unknown.

[a] In five cases, exact age of onset of abuse was unknown, but in three of the five cases the victim's developmental age group was known (e.g., toddler, elementary).

[b] Percentage represents the proportion of children out of those who were ever enrolled in a school setting ($n = 23$).

[c] Category totals add to more than the total number of deceased victims ($n = 15$) as causes of death were not mutually exclusive.

(42 %), the caregivers' reported symptomology was supported by an official diagnosis from a medical professional. Reported mental health conditions that were supported by documentation from a medical professional included developmental delay, attention deficit hyperactivity disorder (ADHD), reactive attachment disorder (RAD), oppositional defiant disorder (ODD), autism spectrum disorder (ASD), and binge eating disorder. Despite being officially documented, it was difficult to ascertain the validity of the diagnoses as the offenders often had direct input into the reporting of symptoms to the provider.

3.3. Offense characteristics

3.3.1. Household composition

The number of individuals within the 20 households, at the time of intervention ranged from one to 16, with an average of six people in the home. In only one case were the victim and the offender the sole individuals living in the home. In 17 cases (85 %), there were multiple children living in the home, which could include both non-tortured children ($n = 14$) and/or multiple torture victims ($n = 6$). In three of these cases, there were multiple tortured children and one or more non-tortured children residing in the household (e.g., a total of four children in the home, with two being victims of torture and two being non-tortured children). The number of torture victims per case ranged from one to six. In four cases (24 %), other children in the home were co-opted into participating in the targeted child(ren). In 18 cases (90 %), multiple adults (two or more) lived in the home, with most being charged in connection with the abuse/death of the victim(s). The range of offenders per case was one to four, with two being the most common (65 %).

3.3.2. Initial agency contacted at time of intervention

At the time of intervention, the first entity to be contacted was most often medical professionals (55 %), followed by law enforcement (40 %) and CPS (5 %). Offenders initiated contact in most cases (75 %), rather than medical professionals or other individuals (e.g., teachers, witnesses, non-offending parents). This initial contact was most often made via a 911 call, typically to request medical assistance for an unresponsive child or law enforcement for a purported missing child.

3.3.3. Prior system contact

In 17 of the cases (85 %), there was a documented prior history of CPS contact and/or investigation. The number of CPS contacts ranged from one to 14 per household ($M = 4.07$, $SD = 4.22$), resulting in 57 total CPS reports across the 17 households. However, the outcome or determination of the 57 reports was only available in 24 of the CPS reports (42 %). One household, where a determination for eight of the 12 reports was unknown, as well as 33 other reports with missing outcomes, were excluded from analysis. Of the remaining reports with known outcomes ($n = 20$), fewer than half of the reports (45 %) were determined to be substantiated by the investigating CPS agency. In three of these cases, CPS contacts were made in multiple jurisdictions. In half of the cases in the sample ($n = 10$), prior calls for service were made to other entities, as well, such as law enforcement or medical services.

3.3.4. Physical & digital evidence of torture

In 90 % of cases, physical evidence that corroborated/was consistent with torture was discovered by law enforcement at or around the residence where the torture occurred (see Table 3). The most common physical evidence included soiling areas (e.g., urine, feces, vomit) induced by the length of the victim's isolation/confinement (50 %), minimal or lack of bedding (44 %), and implements of abuse (39 %). Some of the implements discovered were BB guns, pieces of wood, hangers, whips, and paddles. Many offenders (55 %) also demonstrated some level of forensic awareness by attempting to cover up the offense, including cleaning areas of the home, placing air fresheners to cover up odors, and disposing of items related to the torture. In just over half of the cases, digital evidence was recovered

Table 3
Frequency of the types of physical evidence recovered in child torture cases.

Physical evidence of torture ($N = 18$[a])	*n* (%)
Soiling areas (e.g., urine, feces, vomit)	9 (50 %)
Minimal/lack of bedding	8 (44 %)
Implements of abuse (e.g., BB guns, pieces of wood, hangers, whips, paddles)	7 (39 %)
Other physical evidence (e.g., damage to residence and evidence of repair, doors/door jams removed, offender journals, sound proofing)	7 (39 %)
Locks on food containers (e.g., refrigerators, cabinets)	6 (33 %)
Body fluids (e.g., blood, semen)	6 (33 %)
Alarms/cameras/security equipment	5 (28 %)
Physical restraints (e.g., chains, ropes)	5 (28 %)
Additional locks on points of entry	4 (22 %)
Areas of confinement (e.g., cabinets, closets, crates)	4 (22 %)
Evidence of recent medical intervention (e.g., ice packs, medicines)	4 (22 %)
Reverse locks on exterior/interior doors	3 (17 %)
Use of nails on points of entry	2 (11 %)
Sexual paraphernalia (e.g., pornography, sexual devices)	2 (11 %)
Victim's clothing with evidentiary value	2 (11 %)
Evidence the child was suspended	1 (6 %)

Data presented as *n* (% of total *N*).
[a] In two of the 20 cases in the sample, no physical evidence of torture was recovered at the time of intervention.

by law enforcement on the offenders' device(s) that depicted and/or corroborated the torture of the victim(s). Digital evidence typically consisted of video footage, images, text messages, and/or personal security system footage.

3.3.5. Alleged precipitating events/behaviors

A variety of events and/or victim behaviors were reported by offenders, victims, and witnesses as purported precursors to the abusive acts. These explanations did not necessarily align with the offenders' true motivations. Every case had at least two purported events with the maximum reported being six. The most commonly reported precipitating events and/or behaviors involved alleged victim non-compliance, which included behaviors such as the victim's rule breaking/disobedience (75 %), toileting issues/accidents (55 %), food-related issues (45 %; e.g., stealing food, eating when not allowed, eating too fast), and verbal transgressions (30 %; e.g., talking back, crying, disrespectful tone). Other purported circumstances and/or behaviors surrounding the abuse involved the victim's mental health (20 %; e.g., alleged ADHD or RAD), the victim's medical problems (20 %), fighting/misbehavior (20 %), behavioral problems at school (20 %), traditional discipline methods being ineffective (15 %), alleged problematic sexual behavior (10 %; i.e., developmentally inappropriate or potentially harmful behaviors involving sexual body parts; Chaffin et al., 2008), and religious duty/influence (5 %).

Table 4
Frequency of torture/abuse by type.

Types of torture/abuse ($N = 20$)	*n* (%)
Living/environmental restrictions	20 (100 %)
Solitary confinement/isolation from peers/others	18 (90 %)
Forced position, standing, stretching	16 (80 %)
Restriction of toilet facilities, bathing, personal hygiene	15 (75 %)
Denial of privacy/forced nakedness/withholding of clothing	12 (60 %)
Restriction of sleep/inadequate sleeping arrangements (e.g., no bedding, outside)	12 (60 %)
Isolated in small/overcrowded space	11 (55 %)
Physically bound/restrained (e.g., chains, ropes)	11 (55 %)
Unhygienic living conditions	10 (50 %)
Forced exercise	8 (40 %)
Cold/hot baths/showers (uncomfortable temperatures)	6 (30 %)
Other living/environmental conditions	6 (30 %)
Sensory stimulation deprivation (sound, light, sense of time, etc.)	5 (25 %)
Exposure to extreme temperatures (hot/cold)	3 (15 %)
Suspension	3 (15 %)
Gagged	2 (10 %)
Pharmacological torture (e.g., toxic doses of sedatives, neuroleptics, paralytics)	2 (10 %)
Threats/terrorizing	16 (80 %)
Terrorizing	15 (75 %)
Threat of further torture	8 (40 %)
Threats of death	6 (30 %)
Face/head covered during abuse/torture	6 (30 %)
Threat to loved object/pet	2 (10 %)
Other threats	2 (10 %)
Diet restrictions/forced ingestion	18 (95 %)
Food restriction/contamination	16 (80 %)
Water restriction/contamination	16 (80 %)
Forced ingestion excrement material (urine/feces/vomit)	5 (25 %)
Other diet restrictions	4 (20 %)
Forced ingestion of water/food	4 (20 %)
Forced ingestion other chemicals (e.g., of salt, chili peppers, gasoline)	2 (10 %)
Physical abuse	20 (100 %)
Beaten/kicked/struck with objects	19 (95 %)
Asphyxiation: wet & dry methods (e.g., strangulation, drowning, chemicals)	8 (40 %)
Targeting of genital, anus, breast areas (sexual motivation not required)	8 (40 %)
Falanga (repeated blunt force trauma to feet, hands, or hips)	6 (30 %)
Action to aggravate pain of existing injury	6 (30 %)
Burning (contact, scald, chemical, electrical, etc.)	5 (25 %)
Sexual abuse	5 (25 %)
Psychological abuse/neglect	20 (100 %)
Spurning (emotional rejection/denigration)	18 (90 %)
Medical neglect	14 (70 %)
Educational neglect	8 (40 %)
Forced to perform humiliating acts	8 (40 %)
Mental health neglect	4 (20 %)
Other psychological abuse/neglect	4 (20 %)

Data presented as *n* (% of total *N*).
Note. N represents the number of cases in the sample, which may involve more than one offender and victim, as well as more than one instance of the listed forms of abuse/torture.

3.3.6. Types of torture and injuries

The types of torture were subdivided into categories adapted from Knox et al.'s (2014) research, which consist of living/environmental factors, threats/terrorization, diet restrictions/forced ingestion, physical/sexual abuse, and psychological maltreatment (see Table 4). In all cases, victims were subjected to more than one subtype of abuse, with an average of four subtypes endorsed per case. Notably, it was not uncommon for victims to suffer episodes of strangulation or attempted drowning by offenders (40 %). In 30 % of cases, offenders would also engage in falanga (i.e., repeated application of blunt trauma to the feet, hands or hips; Office of the High Commissioner for Human Rights, 2022) or cover the victim's face/head during the infliction of abuse (30 %). Furthermore, in 40 % of the cases, offenders targeted the genitalia, anus, and/or breast area of the victim's body, typically causing injury. A determination that the offender's motivation was sexual was not required for this type of abuse to be endorsed, but in a quarter of these cases, the purpose of the abuse appeared to be for the offender's sexual gratification. Similarly, the injuries resulting from the torture were categorized based on Knox et al.'s (2014) research and are highlighted in Table 5. The most common were cutaneous injuries (e.g., bruises, scrapes, cuts) and blunt force injuries to the head or torso. Of note, 30 % of the cases involved victims that had injuries to their mouths, such as loose/missing teeth or gum and/or lip injuries.

4. Discussion

This exploratory study aimed to examine offender, victim, and offense characteristics of 42 CT offenders and 35 CT victims within 20 households. Specifically, the authors sought to identify the common elements of CT, expand upon the limited body of research on CT and provide a perspective from a frontline professional.

4.1. Interpretation of results

4.1.1. Offender characteristics

Notably, the current sample prominently featured female offenders, specifically biological, adoptive, and stepmothers, which violates societal beliefs related to females' capacity for extreme predatory violence. Contrary to the expectation that females in the sample were co-opted into the abuse out of fear, duress, or at the direction of a male co-defendant, it was observed that many of these women played an active role in directing and orchestrating the torture in addition to perpetrating it. Additionally, female offenders tended to have more access to and time with victims and other children in the household, as they were responsible for their basic needs, schooling, and monitoring their behavior, underscoring that daily domestic life is interwoven into the child torture environment. Although the experiences of law enforcement, medical professionals and child protection officials expose them to female-perpetrated violence, the notion that females are incapable of the extreme level of violence inherent in CT cases continues to prevail and is perpetuated by societal expectations regarding maternal instincts (Pearson, 2021; Shelton et al., 2015). Female aggression, specifically to a child, is contrary to what we expect of women. However, women have committed crimes against children since antiquity and they have done so for a variety of reasons, many of which reveal clear and rational intent (Stangle, 2008).

Table 5
Frequency of injuries by type.

Types of injuries (N = 20)	n (%)
Cutaneous Injuries (on body's surface)	20 (100 %)
Bruise and/or swelling	18 (90 %)
Scrapes, abrasions, scratches, and floor burns	15 (75 %)
Sharp force injury (e.g., cuts, lacerations, gashes, and tears)	10 (50 %)
Genitals, anus, breast injury (sexual motivation not required)	5 (25 %)
Hair loss from hair pulling, malnutrition, etc.	5 (25 %)
Burns	5 (25 %)
Contact (contact w/ hot object)	3 (15 %)
Scalding (contact w/ hot liquid)	3 (15 %)
Chemical (to include ingestion of corrosive substances)	1 (5 %)
Skeletal Injuries	5 (25 %)
Fractures (leg, arm, rib)	5 (25 %)
Dislocation/Flexion of a limb beyond normal range	1 (5 %)
Blunt Force Injuries	16 (80 %)
Head Injuries	15 (75 %)
Thoracic/Abdominal	15 (75 %)
Limbs	11 (55 %)
Physical Evidence of Medical Neglect	6 (30 %)
Permanent or temporary loss of body part or function	6 (30 %)
Disfigurement	1 (5 %)
Other Injuries	8 (40 %)
Oral injuries (loose/missing teeth; gum, lip injuries)	6 (30 %)
Bite marks; ear injuries	5 (25 %)

Data presented as n (% of total N).
Note. N represents the number of cases in the sample, which may involve more than one offender and victim, as well as more than one instance of the listed injuries.

The themes of violence or antisocial tendencies permeated the lives of these offenders, both past and present, and either as a victim or an offender. This is exemplified by the fact that half of the offenders had been arrested prior to the incident offense, with many being charged with assault. Further, the offenders' violence history was not always reflected in their criminal arrest history, as many offenders had an undocumented history of engaging in violence toward other adults and children. In some cases, violence occurred in the context of their past and/or present interpersonal relationships (to include co-offenders), with some of these relationships being described as mutually combative by the offenders or chronicled as such in police and other reports. In addition, the behaviors exhibited by offenders in these relationships often involved aspects of control, manipulation, and dominance that mirrored their interactions with the CT victim. In one case, there was evidence of multi-generational torture, beginning with a parent torturing her child during childhood, followed by the co-opting of the now adult child (the former child victim) to join in the infliction of torture of her own child. The offenders in this sample were also adept at deflecting suspicion and explaining away situations, exemplified by the fact that the majority of cases involved prior CPS reports that were often unsubstantiated. These past successes with manipulating systems and people likely increased the offenders' confidence that they could continue the abuse undeterred. This may explain why the offenders themselves initiated contact with medical or law enforcement agencies at the time of intervention.

Additionally, the results of this study emphasize that CT is not a crime committed in isolation or outside the purview of others, as those in the household are typically aware the abuse is occurring and may participate themselves. This is illustrated by the fact that, in the current sample, multiple offenders were charged in the majority of cases. Some offenders engaged in digital documentation of the abusive acts andor their role in those acts, despite this seemingly being counter to their best interests. The offender's motivations for this behavior are unknown with a need for further study.

4.1.2. Victim characteristics

Another important takeaway from the current research relates to victim selection. In situations where multiple children were present in the home, the offenders' interactions with each child ranged from positive to abusive to torture. In spite of this, one child seemed to bear the brunt of the offenders' abuse, illustrating the targeted nature of CT that sets it apart from other types of child abuse. The selection of the targeted child(ren) did not appear to be dependent on any specific victim characteristic, such as gender, age, race, birth order, or relationship to the offender. It was common for parents to torture a biological child, emphasizing that the biological connection to a child may not be protective against abuse in child torture cases. The offender's disparate treatment of the children in the household also created conflict among the children themselves, possibly serving as justification for further abuse and facilitating the other children's involvement in the torture of the primary victim. While the current data do not indicate which factors are involved in the selection process, it does not appear to be random. This is borne out in the cases where the targeted victim becomes unavailable (e.g., due to death, removal from home) and the offender's acts of torture shift to another child in the home, suggesting an inherently predatory nature to CT.

Of note, a significant number of victims in these cases had or were reported to have had a chronic medical and/or mental health issue. The reporting of diagnoses was problematic because they were often dependent or based entirely on exaggerated or false statements/or observations by the offender to medical professionals if care was sought. Conversely, the symptomology may have genuinely manifested because of the environmental conditions of the torture. In other words, the offenders were either falsely reporting symptoms to provide a legitimate explanation for their behaviors or were responsible for the development of the mental health issues or medical conditions due to the torture. While these diagnoses and associated behaviors can generally increase parental strain, interestingly, the offenders in the current sample tended to focus more on victim behaviors unrelated to the diagnoses (e.g., rule breaking, noncompliance) when attempting to justify their abusive acts. In reality, the offenders were, knowingly or unknowingly, creating the behaviors they were now punishing.

4.1.3. Offense characteristics

All cases involved victims who were physically abused by the offenders. All but one case involved the victim being beaten, kicked, and/or struck with objects. These objects ranged from common household items such as belts, wooden spoons, and hangers to more obscure items such as a cat-of-nine tails, horse whip, handle of a tomahawk, and BB pellets. The variety of implements used to inflict abuse may reflect the ingenuity these offenders employ to carry out their abusive acts or may simply be explained by how readily available these items were at the time the abusive acts were inflicted. The high prevalence of falanga and targeting of the genitalia, anus, and/or breast areas of the victims suggests that offenders may target areas that are especially sensitive to the infliction of pain and/or areas that are not readily visible, decreasing the possibility of detection. Exposing and/or drawing attention to these areas may also increase the level of humiliation the child feels due to the inherently private and personal nature of those specific areas of the body. This humiliation, along with the other psychological aspects of CT, may contribute to the lack of disclosure.

Similarly, psychological abuse was present in all cases, most often accomplished through spurning, terrorization, and/or medical neglect. Spurning, defined as emotional rejection/denigration (APSAC Taskforce, 2019), was evidenced by offenders purposely excluding a targeted child from family activities or special occasions, name calling, withholding attention, and favoring other children in the home. Offenders would also refer to victims as “Satan,” “evil,” “possessed,” or other similar terms. These acts of psychological abuse were designed to make the victims feel unwanted, alienated from other and/or inherently worthless, extending the offenders' level of control past physical isolation to include emotional isolation, as well. Terrorization, which is used to elicit fear of injury or death by placing the child or the child's loved ones in recognizably dangerous situations (Brassard et al., 2019), was common in this sample and observed in rather unique ways. One method offenders used to terrorize the victims was through covering the victim's face or head. When this behavior is seen in other types of cases (e.g., sexual assault and homicide), it may reflect an offender's feelings of remorse or guilt for their actions (Russell et al., 2018). In the current sample, however, the covering of the face often occurred in

combination with physical abuse and/or was accompanied by position holds, such as requiring the victim to remain motionless. This method caused the victim further distress because he/she did not have the ability to anticipate when the offender would inflict the abuse. In addition, terrorization was also invoked by repeated episodes of strangulation or submersion underwater to temporarily asphyxiate the victim. Depriving the victim of oxygen likely induced fear of death, but also reinforced the victim's belief that the offender had absolute control over whether the victim lived or died.

Despite the severity of the physical and psychological abuse present in these cases, what set them apart were the environmental conditions the offenders placed on the victims to exacerbate their suffering. For example, in all but two cases, there was evidence of the offenders placing the victims in solitary confinement, which isolated them physically and emotionally from others in the home and often coincided with restricting their access to basic amenities (e.g., food, water, toileting, bathing, bedding). In many cases, victims were placed in solitary confinement following instances of physical abuse that resulted in injuries, compounding the psychological impact by forcing them to suffer with untreated injuries alone. This isolation often extended to offenders refusing to allow prosocial activities outside the home, such as attending school, church, and family outings, even when others in the home continued to engage in those activities. This further marginalized the victims from others in the home by increasing their awareness of the disparity of their treatment as compared to others in the home. Of the victims who were previously allowed to attend school, many were removed, or attendance was limited by the offenders in response to suspicions or reports of child maltreatment by others. This offender-precipitated decision was often explained away as being due to philosophical differences or inadequate instruction in public school settings. Yet, in many cases this was just a mechanism to further isolate the child and/or to prevent disclosure or discovery of the torture by those outside of the offender's control. The impact of this experience on the victim's psyche likely exacerbated their sense of despair and helplessness, and further solidified the omnipotent status of the offender.

Similarly, forced positions/exercises were commonly employed by offenders under the auspices of discipline, but these acts were taken to an extreme level. For example, victims were forced to hold unnatural positions or poses for extended periods of time (e.g., holding arms above head with weighted objects, performing wall sits and bear crawls, hanging from an unsafe height by fingertips, and holding plank positions for hours at a time). Forced exercise was often done to the point of the victim's exhaustion or failure and included activities such as running or squats. It should be noted that forced exercises were particularly difficult for many victims due to their lack of stamina stemming from food deprivation, physical injuries, or developmental inability. In some instances, forced physical activities included performance of menial tasks under the guise of “chores”, such as moving rocks from one area of the yard to the other or excessive and repetitive household cleaning. These tasks were sometimes combined with extreme outside temperatures, were completed over extended periods of time, and/or involved unrealistic performance expectations by the offender that further denigrated the victim.

The abuse was often justified by the offenders as being instigated by the victim, despite the victim's response being consistent with developmentally appropriate misbehaviors (e.g., rule breaking, arguments among siblings, minor disobedience) or because of developmentally inappropriate expectations being placed upon the child. While this is commonly seen in fatal child maltreatment cases (Douglas, 2017), it appears to differ in cases of CT, where offenders often purposefully set the victim up for failure or orchestrate the environment so that the child is unable to accomplish what is demanded of them (Knox et al., 2014; Schlatter et al., 2024). For instance, in one case in the current sample, an offender forced a victim to stand against a wall wearing socks, knowing the floor was slippery and would likely cause the child to fall. This “failure” on the part of the victim would then be interpreted by the offender as noncompliance and would result in further torture. The motivation for offenders to engage in this infinite loop of victim-offender interplay may be two-fold. First, the purported failures by the victim can create “a sense of internal badness” on the part of a severely abused victim (Herman, 1992, p. 103) and justify to others why extreme measures in the name of discipline are required, providing plausible deniability for the offender if questioned. Second, the victim's repeated inability to do the impossible strengthens the offender's psychological control on the child resulting in sense of hopelessness and perhaps causing the child to feel deserving of the punishment. The offender's nearly constant monitoring on the victim via surveillance systems, as well as the violation of physical boundaries (e.g., offender watching victim go to bathroom, victim being forced to stand naked in front of others in the home, offender smelling victim's breathe to detect eating without permission), likely resulted in a diminished sense of autonomy, especially as the victims grew older. In some cases, the victims believed that the offender possessed the ability to read their minds, conveying a sense of omnipotence.

4.2. Challenges in child torture detection

Despite the fact that many investigators immediately recognize CT as “very severe child abuse” or the “worst case our agency has ever seen,” it remains largely unidentified as such. Reasons for this are often multidimensional, to include lack of awareness and training in CT, as well as insufficient coordination between law enforcement, medical providers, and the child protection system (Knox et al., 2014, Schlatter et al., 2024). Conversely, professionals may face an oversaturation of child abuse cases, causing them to evaluate a report of abuse as a single act rather than part of the larger, more insidious campaign of torture. Thus, a professional may draw upon the immediate examples that come to mind based on prior experiences with similar conduct, rather than holistically evaluate the case at hand. Similarly, societal differences related to child rearing can lead to disparate evaluations of the graduation from discipline to child abuse to CT.

Perhaps the biggest challenge in CT cases is the connotation of the terminology itself. Traditionally, the term “torture” conjures up images of medieval or barbaric acts of gratuitous violence or politically or militarily motivated conduct. Thus, professionals may be hesitant to label even the most severe cases of child abuse as “torture.” In addition, the existence of torture in the intrafamilial environment implies that the suffering has been prolonged and opportunities for intervention by multiple systems may have been

overlooked. This was observed in the current sample with regularity as professionals interacted with the household during the torture period but remained unaware of the severity of the abuse or the victim's condition. This may be influenced by the fact that physical abuse is often more obvious and considered a higher priority while the psychological abuse inherent in CT, to include spurning, terrorization, isolation, and humiliation, is often overlooked or minimized, contributing to a lack of substantiation in these cases (Brassard et al., 2019). Additionally, the limited statutes codifying psychological maltreatment perpetuates the lack of recognition or equal consideration of this type of abuse (Deutsch & O'Brien, 2024; Macy, 2019). Similarly, CPS workers are traditionally trained to provide family support with the goal of reunification, often through parenting classes, substance abuse courses, and respite care. Nevertheless, this approach may result in inappropriate interventions that do not address the disparate treatment of children in the household or the potential for the offender to continue his or her behavior by targeting a new child even when removal of a previously targeted child occurs.

4.3. Limitations & future directions

The current study has several limitations. Although comparable to previous studies (Knox et al., 2014; Schlatter et al., 2024), the sample size is smaller than ideal. This is largely due to the challenges in CT detection and classification, as well as the lack of a distinct ICD-10 code for CT, which limits the ability to identify potential cases for inclusion. The authors were therefore required to use convenience sampling in order to efficiently acquire cases that fit the inclusion criteria, which limits the generalizability of the results. As awareness increases, retroactive studies of severe child maltreatment cases that could be reclassified as CT may help determine an accurate prevalence rate, creating opportunities to analyze larger sample sizes.

The current research, even with a smaller sample size and the use of convenience sampling methods, is a critical first step in improving the identification of CT among frontline professionals and determining predictive factors of this type of severe abuse. The authors believe that publication of these results, while still exploratory in nature, will increase awareness of the phenomenon and provide clearly endorsable elements leading to more effective recognition and intervention. Additionally, the authors hope that with a clearer definition of CT and the presentation of these fundamental elements, states may adopt comprehensive approaches to analyzing child fatalities similar to Washington state's study (Schlatter et al., 2024), as well as consider introducing or expanding CT statutes to aid in the prosecution of these cases.

It is important to note that cases were identified through law enforcement sources, and thus represent only those that rose to the level of police response, which may account for the high fatality and morbidity rate in the current sample. Similarly, because our sample only consisted of cases where the offender was charged and/or adjudicated for the torture, there is the likelihood that these cases are not representative of all CT cases, to include those in which the torture goes undetected or unprosecuted. As this study was exploratory, the results should be used to inform professionals of the unique aspects of CT that warrant further inquiry. Investigators should exercise caution when applying the results to an individual case and instead consider the totality of the circumstances before classifying a case as CT, as this designation can affect investigative and prosecutive decisions.

In the future, the authors plan to extend this study by increasing the sample size. Research would also benefit from the analysis of CT households both between and within cases to better understand the characteristics that may be typical across cases or those that may be evidence of divergent subgroups. It is also important to study the impact of exposure to CT cases on those involved. Frontline professionals' psychological well-being may be compromised, potentially to the point of them requesting reassignment or leaving their profession altogether (Molnar et al., 2020). Decision makers in a variety of professional environments should be attuned to the presence and effects of vicarious trauma on law enforcement, CPS, child forensic interviewers, and medical professionals, as well as jury members and court personnel exposed during the prosecutive phase (Gewirtz-Meydan et al., 2024; McQuiston et al., 2019; Molnar et al., 2020). Mental health services should be offered and encouraged for personnel engaged in these types of cases both throughout the investigative and legal process and beyond.

4.4. Conclusion

CT perpetrators inflict a severe, multifaceted type of child abuse that includes extreme physical and psychological maltreatment. The torture goes beyond typical polyvictimization in that it includes intense humiliation and terrorization of the targeted child. The unique environmental conditions created (e.g., solitary confinement, forced exercise, position holds and food restrictions), in addition to the victims' perceived omnipotence of the offenders, reflects that CT is distinctly different from other forms of child maltreatment in its premeditation, intent, and ongoing nature. The hallmarks of this severe form of abuse span all facets of the victim's life. The severity, longevity, and pervasiveness of the abuse emphasizes the need for efficient identification and intervention among those charged with the protection of children.

CRediT authorship contribution statement

Joy Lynn E. Shelton: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Barbara L. Knox:** Writing – original draft, Project administration, Methodology, Investigation, Conceptualization. **James E. Hardie:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Taylor E. Burd:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Tia A. Hoffer:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Kristen E. Slater:** Writing – review & editing, Writing – original draft,

Methodology, Investigation, Formal analysis, Conceptualization.

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Data availability

The data that have been used are confidential.

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