




*Practice Perspectives*

**Through the Shadows: Exploring Domestic Child Torture**

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**Abstract**

Child torture is a severe form of child maltreatment. Children who are tortured are at high risk of death and/or re-traumatization. It is imperative both legally and ethically that health care providers recognize children who are being tortured in order to develop a safety plan to help prevent further abuse and trauma to the child. This article will define and address the following: child torture, intrafamilial child torture (ICT), common presentations of victims of ICT, risk factors of victims of ICT, and guidelines for healthcare practitioners working in the United States when they assess victims. Additionally, there will be a discussion on the importance of collaborating both on an interdisciplinary (e.g. medical, social workers, child protective case workers, psychology) and multidisciplinary (clinical and legal) level. and the utilization of self-care activities for clinicians, after treating a child who has been tortured.

*Keywords:* Torture, Child Abuse, Severe Child Abuse, Child Torture, Intrafamilial Child Torture

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**Through the Shadows: Exploring Domestic Child Torture**

The World Health Organization (WHO) (2022) defines child maltreatment as “abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence, and commercial or other exploitation which results in actual or potential harm to the child’s health, survival, development, or dignity in

the context of a relationship of responsibility, trust, or power” (para. 1). More than 600,000 children are abused in the U.S. each year (National Children’s Alliance, 2024). Based on seminal research from Knox & Sterling (2012), it is estimated that 1–2% percent of children who are maltreated are suffering from child torture, a severe form of child maltreatment (Knox et al., 2014). Collecting specific statistics related to child torture is not consistently reported at this time, and the United States does not separately identify child torture cases in child fatalities and abuse statistics (National Center for Child Abuse Statistics and Policy, n.d.). In addition to the United States not collecting specific data on child torture, knowing the extent of the problem is further complicated by the fact that not all cases of child abuse are reported (CDC, 2022). In a recent child torture study, 35% of the children tortured had a sole adult torturer, and 65% had a second adult also contributing to the torture. Approximately 70% of these children had a previous Child Protective Services (CPS) investigation. Many torturers reported they used torture as a form of discipline (Schlatter et al., 2024, p.3). Child torture differs from other forms of child maltreatment due to the type and extent of abuse and psychopathology and the lived experiences of the children (Miller et al., 2021). It is imperative, both legally and ethically, that healthcare providers recognize children who are being tortured in order to develop a safety plan to help prevent further abuse and trauma (Knox et al., 2016). This article will define child torture (with a focus on intrafamilial child torture) and discuss common presentations. It will also include assessment suggestions for victims presenting to a medical facility in the United States. Additionally, this article will include the utilization of self-care activities for clinicians treating children who have been tortured.

### **What is Child Torture?**

Both the medical and legal definition of child torture can vary (Deutsch & O'Brien, 2024; National Center for Child Abuse Statistics and Policy, 2020). The most widely accepted medical definition of child torture is “a longitudinal experience characterized by at least two physical assaults or one extended assault, two or more forms of psychological maltreatment, and neglect resulting in prolonged suffering, permanent disfigurement or dysfunction or death” (Knox et al., 2016, p.37). Primary caregiver(s) torturing a child in their care is referred to as intrafamilial child torture (ICT). There is a growing initiative by professionals working with victims of child torture to have ICT become a separate category of child maltreatment due to the consistent psychopathology of the primary caregivers(s) torturing the child in their care (Miller, 2020; Miller et al., 2021). ICT is a severe form of child maltreatment and differs from other forms of child abuse due to the severity, continuous nature, perpetrator intent, and isolation of the child. Perpetrators of ICT use domination to control the child and often limit access to the child’s basic necessities, such as toileting, food, and water (Macy, 2019; Allasio & Fischer, 1998; Knox et al., 2016). Partners with children who are victims of ICT are often victims themselves. The abuser uses dominant techniques to control both the child and the partner (Fontes & Miller, 2022; Miller, 2020; Miller et al., 2021).

ICT is often hard to diagnose because most tortured children do not present to their pediatrician for regular health check-ups (Knox et al., 2016; Schlatter et al., 2024). When a child who has been a victim of ICT presents for medical care at a primary care office or the emergency department, conditions such as cutaneous injuries, burns, and fractures are often discovered. Once the children are discovered, they will often disclose a history of isolation, physical restraints, sexual abuse, restriction of bodily functions, forced exercise, and forced positioning or standing. Further, children or parents may disclose psychological maltreatment consisting of threats of

death or further torture, isolation from others, medical neglect, and being terrorized (Knox et al., 2016).

Medical providers should be diligent in identifying victims of ICT early due to the unique needs of tortured children and their high risk of fatality (Ratnayake, 2020). In the Knox et al., 2016 study, 36% of children who were tortured died due to their injuries, severe neglect, and starvation. A consistent crucial safety priority that healthcare providers need to address when identifying victims of ITC is the development of a safe discharge plan that includes removal from the abuser. A consistent crucial safety priority that healthcare providers need to address when identifying victims of ITC is the development of a safe discharge plan that includes removal from the primary care provider. The perpetrators involved with child torture have unique findings, including the need to control the child and the inability to meet the child's basic needs. Additionally, different than most other forms of abuse, perpetrators of ICT consistently present with psychopathology that is not easily treated in order to have abused children successfully return to the perpetrator(s)' home (Miller, 2020; Fontes & Miller, 2022). These findings are not able to be reversed by using the common interventions for other forms of child maltreatment that focus on the reunification process. Victims of ICT who remain in the home with their abuser will remain at high risk for revictimization and death (Steele, 1987; Miller, 2020).

Children who are victims of child torture are exposed to continuous, intense child maltreatment. Felitti et al. (1998), in their seminal work, identified an association in children between birth and 17 years old between exposure to various forms of traumatic events – referred to as Adverse Childhood Experiences (ACEs) – and negative lifetime consequences. Traumatic events are those that are overwhelming to children and can result in chronic levels of stress and anxiety (CDC, 2024). The frequency and duration of the traumatic experiences are associated with increased risks for adverse physical and mental health outcomes. These traumatic events are often referred to as toxic and are also associated with neurological alterations in a child's developing brain (Hakamata, et al., 2022). In addition to ACEs, there are identified protective factors that can provide opportunities for children exposed to adverse events to defend against the toxic impact on the developing brain. Some protective factors are associated with decreased risk of neurological alterations (Hakamata et al., 2022). Protective and compensatory childhood experiences (PACEs) are primarily separated into useful resources and healthy relationships. Children with social supports, a caregiver or other close relative who provides unconditional love, being part of a supportive group, and/or having a healthy mentor are examples of protective factors that can provide opportunities for children to lessen the impact of traumatic experiences. Some of the healthy resources include living in a safe environment, having a quality education, being provided with an environment for healthy exercise, and being provided with structure and consistent rules (Audage, 2021; Morris & Hays-Grudo, 2023). In addition to assessing for children's ACEs, nurses can also assess for the PACEs in the child's life. If the child is lacking PACEs, they can be included in plans to support the developments of protective factors to provide for the opportunity for positive outcomes as a child is recovering.

### **Why is Child Torture Overlooked?**

Medical providers overlook ICT for many reasons, including the lack of proper training to recognize torture, and the lack of research and training on child torture (Clarysse et al., 2019; Miller, 2020). Also, children who are victims of torture are often isolated from other family, friends, and medical providers. Suppose the child has physical findings on their medical examination. In that case, the perpetrator may explain the medical findings by describing a

behavioral issue and the medical provider will then consider the findings to be related to the behavioral issue and not a result of starvation and torture (Knox et al., 2016). Lastly, many medical providers may feel that the disclosure from the child is “far-fetched” and could not be true, leading them to not report the disclosure (Miller, 2020).

### **What Workup is Suggested When Medical Providers Suspect Child Torture?**

The initial management of a child who has been tortured involves first stabilizing the child and ensuring their safety. Once the patient is stabilized and in a safe environment, the provider is mandated to complete a history and conduct a head-to-toe physical examination. The medical history should be trauma-informed, patient-centered, and culturally sensitive. The physical examination should include a complete skin examination and documentation of all skin lesions, including patterned lesions (Clarysse et al., 2019).

Tortured children of all ages need a skeletal survey upon initial presentation and a repeat skeletal survey in two weeks (Kellogg & Nienow, 2023). Head CT scans are indicated for infants six months and younger who have injuries concerning physical abuse. In addition, any child with altered mental status or signs of neurologic or head injury should have a head CT and/or MRI. The provider also should consider ordering laboratory studies to evaluate bone health (e.g., calcium, magnesium, phosphate, alkaline phosphatase); hematologic disorders (e.g., CBC); coagulation disorders (e.g., PT, PTT, INR); metabolic disorders (e.g., glucose, BUN, creatinine, albumin, protein), liver conditions/injuries (e.g., AST, ALT); pancreatic conditions/injury (e.g., amylase and lipase); and bleeding problems (e.g., von Willebrand antigen, von Willebrand activity, Factor VIII, Factor IX, and platelet function assays). An expanded drug screen and forensic toxicology should also be considered, as many of these children have been given legal and illegal drugs to keep them sedated or as punishment.

The medical provider should request the child’s entire medical record and pay special attention to the child’s growth chart, as many children presenting with torture have been starved. Vitamin levels, IGF-1, and IGFB-3, should be ordered in children who disclose starvation or have a physical exam concerning starvation, as these levels are often low in children who have been starved. If the provider has concerns that the child has had a prolonged period of starvation, the child should be fed slowly, and the child should be monitored for refeeding syndrome (Pulcini et al., 2016). Restricting calories in children who are at high risk for refeeding syndrome can seem cruel and difficult for many providers. However, if the child is fed too quickly, it can lead to metabolic derangements and cardiac arrhythmia.

If the AST, ALT, lipase, and amylase levels are elevated or there is bruising to the abdomen, the provider should consider ordering an abdominal CT to assess for intra-abdominal injuries. CPK should be ordered in children with severe physical abuse or when exercise is used as punishment. If the result is elevated, the provider should monitor for rhabdomyolysis (Table 1). If the clinic or hospital cannot provide the level of care the patient requires at the time of presentation, the provider should follow federal and state laws in coordinating the needed care for the child. If state law supports the process, the child will usually be transferred to another institution that can provide the needed level of care. If transferring a victim of ICT to another facility is not possible, the healthcare team should consult with a child maltreatment specialist (which could be a forensic pediatrician or healthcare practitioners trained in working with children who have been tortured) (Fontes & Miller, 2022; Miller et al., 2021). As with any child maltreatment, healthcare providers are mandated to notify CPS and, in some states, notify police

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directly. Since all healthcare providers are mandated reporters, if there is any suspicion of child torture, they should not delay notifying the appropriate authorities, including waiting for transfer to have another clinic or hospital call in the referral.

**Table 1:**

*Diagnostic and Laboratory Studies for Children who are Tortured*

Skeletal Survey	<ul style="list-style-type: none"> <li>• Order to evaluate for acute and/or healing fractures</li> <li>• All children should receive a skeletal survey upon initial presentation</li> <li>• Repeat skeletal survey in 2 weeks</li> </ul>
Head CT/MRI brain	<ul style="list-style-type: none"> <li>• Order to evaluate for head injury</li> <li>• Children less than 6 months of age</li> <li>• Any child with mental status changes, neurological changes, or concerns about a head injury</li> </ul>
Calcium, Magnesium, Phosphate, Alkaline Phosphatase	<ul style="list-style-type: none"> <li>• Order to evaluate for bone health</li> </ul>
CBC, PT, PTT, INR, von Willebrand antigen, von Willebrand activity, Factor VIII, Factor IX, platelet function assay	<ul style="list-style-type: none"> <li>• Order to evaluate for hematologic disorders</li> </ul>
Glucose, BUN, Creatinine, Albumin, Protein	<ul style="list-style-type: none"> <li>• Order to evaluate for metabolic disorders</li> </ul>
AST, ALT	<ul style="list-style-type: none"> <li>• Order to evaluate for liver conditions/injuries</li> </ul>
Amylase, Lipase	<ul style="list-style-type: none"> <li>• Order to evaluate for pancreatic conditions/injuries</li> </ul>
Expanded drug screen	<ul style="list-style-type: none"> <li>• Order to screen for legal/illegal drugs</li> </ul>
Review the entire Medical Record/Growth Chart	<ul style="list-style-type: none"> <li>• Request to evaluate growth, previous injuries/illnesses</li> </ul>
Vitamin levels, IGF-1, IGF-3	<ul style="list-style-type: none"> <li>• Order to evaluate for starvation</li> </ul>
Abdominal CT	<ul style="list-style-type: none"> <li>• Order if the AST, ALT, amylase, or lipase is elevated or there is bruising to the abdomen</li> <li>• Will assesses for intra-abdominal injuries</li> </ul>
CPK	<ul style="list-style-type: none"> <li>• Order in children with severe physical abuse or when exercise is used as punishment</li> <li>• Screens for rhabdomyolysis</li> </ul>

Suppose a sexual assault has been disclosed or the healthcare provider has concerns that the child may have been sexually assaulted. In that case, the child should receive sexually transmitted infection (STI) testing, including HIV, gonorrhea, chlamydia, trichomonas, hepatitis, and a pregnancy test. Depending on the last known contact with the perpetrator, the provider should consider collecting evidence. The medical provider should consider STI prophylaxis based on the history and their medical facilities protocols.

Since child torture is more severe than other forms of child maltreatment, interventions must vary and be focused on protecting the children and helping them heal. Accordingly, mental health professionals should be consulted, and therapy should begin after the child's physical and psychological safety has been met. Tortured children may continue with many behaviors that are difficult for their guardians, and it may take years for a child to feel safe in their new environment. Many have been isolated and will not know how to interact with adults or children and may even develop eating disorders, such as hoarding food because of starvation, food gorging, or hiding food (Perry, 2013; Schlatter et al., 2023).

Using a multidisciplinary team (MDT) is imperative to improve the understanding, recognition, treatment, and prosecution of child torture. The team should work together to meet the immediate and long-term needs of tortured children, along with discussing the risk factors and protective factors (Miller, 2021). Due to the legal challenges associated with child torture, including the gaps in some states' criminal justice system, the MDT must work together to ensure the children are in a safe environment. In most states, there is further legislation needed to protect children who are tortured (Macy, 2019; Deutsch & O'Brien, 2024).

### **Aftercare for the Medical Provider Caring for a Child Who has Been Tortured**

Healthcare providers who encounter children who are victims of trauma (which includes ICT) are at risk for suffering from compassion fatigue, secondary traumatic stress, and vicarious trauma (Lee et al., 2021; Vang et al., 2020; Xu et al., 2024; Zhang et al., 2018). Although some literature uses the terms of compassion fatigue, secondary traumatic stress, and vicarious trauma interchangeably because they can all result from exposure to traumatic events, the actual exposure of the traumatic experience and impact differs between the experiences (Lee et al., 2021; Nimmo & Huggard, 2013; Peacock, 2023). Figley (1995), in seminal work, identified compassion fatigue as the emotional distress someone experiences when caring for a patient in their workplace who has been exposed to trauma. Further developed and defined, compassion fatigue occurs over time with ongoing exposure to stressful encounters with patients and colleagues, and it affects their ability to be productive in their professional expectations. Furthermore, in the development of compassion fatigue is that healthcare providers' exposure to stress consistently exceeds their ability to restore through healthy lifestyle practices (Zhang et al., 2018). Signs that a provider may be suffering from compassion fatigue may include mood swings, experiencing disconnection of emotions and social relationships, feelings of depression and anxiety, being unable to complete expected tasks in both professional and personal life, impact on sleep, and somatic symptoms (Bhandari, 2022; Peters, 2018).

The seminal work of Figley (1995) also included one of the first definitions of secondary traumatic stress as the result of healthcare providers experiencing overwhelming levels of stress that result in behavioral changes due to learning about a traumatic event experienced by a patient in their care. Some nurses are more vulnerable to developing secondary traumatic stress due to the length of time spent with their patients and family, their empathy, their coping skills, and their frequency of encountering victims of trauma (Arnold, 2020; Xu et al., 2024). The overall symptoms of secondary traumatic stress are similar to post-traumatic stress disorder (except indirectly rather than directly experiencing the trauma) and include having physical, emotional, and social symptoms. A systematic review and meta-analysis conducted by Xu et al., 2024 obtained a pooled prevalence of nurses experiencing secondary traumatic stress by emergency nurses to be 65%—the symptoms experienced by nurses impact both their professional and

personal lives. Nurses who encounter victims of child torture are at greater risk for developing secondary traumatic stress (Children's Hospital of Philadelphia, 2021).

Different from secondary traumatic stress, vicarious trauma was first noted by Pearlman & Saakytne (1995) to describe the negative impact that can occur for individuals working in fields that expose them to encountering victims of trauma and violence frequently. Vicarious trauma typically results in changing how individuals view the world. It can make one more pessimistic and fearful about how one views life. Some individuals who experience vicarious trauma rather than having a negative view can have a positive or resilient response that strengthens their appreciation of what they have in their own lives and appreciation for the work they do (Nimmo & Huggard, 2013; Peacock, 2023; OVC, n.d.).

In addition to some nurses having a positive response to vicarious trauma, other protective factors that may limit or reduce the negative consequences of compassion fatigue, secondary traumatic stress, and vicarious trauma are compassion satisfaction, a supportive work environment, and healthy self-care practices (Lee et al., 2021; Peacock, 2023; Zhang et al., 2018). Compassion satisfaction is a perspective that the work conducted by healthcare providers (which includes nurses) who work with victims of violence and trauma matters, and they have a sense of meaning and purpose (Lee et al., 2021; OVC, n.d.; Peacock, 2023; Zhang et al., 2018). Zhang et al. (2018), in their correlative meta-analysis evaluating the impact nurses' mental health had on the development of either compassion fatigue or compassion satisfaction, found that nurses who have a positive or contented affect and are socially engaged may support the development of compassion satisfaction. Nurses who can maintain a healthy work and personal life balance have the opportunity to be more resilient in managing the emotional tolls of encountering ICT.

Supportive working environments can also promote or minimize the impact of traumatic encounters on nurses. One way to help cope with compassion fatigue is to debrief as a team after seeing a difficult patient. The provider needs to have a safe person and place where they can discuss their feelings. Providers should be encouraged to seek help when they feel like they are suffering after seeing a victim of trauma. Some institutions have found it helpful to debrief after every case of child abuse and neglect, which has allowed their staff to learn more about trauma-informed healthcare environments and has decreased provider burnout (Bennett & Christian, 2023). Included in a supportive environment is to be aware of the symptoms of potential negative consequences from exposures to trauma and violence and provide appropriate referrals to promote health and recovery (Children's Hospital of Philadelphia, 2021; Peacock, 2023; Peters, 2018).

### **Conclusion**

Children who survive child maltreatment, specifically child torture, may experience lifelong physical and psychological consequences. For this reason, anyone who provides care to children must have knowledge of the definition, shared presentations, medical findings, medical workup, and follow-up for children who are tortured. Tortured children need an immediate response by healthcare providers to decrease the physical and psychological effects of torture, along with preventing a child fatality. Due to the potential for negative consequences that healthcare providers may experience as a result of their work with ICT, it is also imperative that they are informed of the potential risks and are supported and provided with the necessary resources.

The authors recommend that further research should be developed for ICT to address the complex needs of undocumented and potentially human-trafficked children who are victims of child torture.

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