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INTRAFAMILIAL CHILD TORTURE: Making the Case for a Distinct Category of Child Maltreatment

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INTRAFAMILIAL CHILD TORTURE: Making the Case for a Distinct Category of Child Maltreatment

Intrafamilial Child Torture (ICT) is a particularly severe form of child maltreatment with unique family dynamics and devastating outcomes for child victims. No separate diagnostic category exists for ICT. It is not widely recognized or understood by child maltreatment professionals, and there is little research data to help professionals fully understand it or know how to respond. We expect that ICT cases are often misdiagnosed or remain unidentified. We also contend that professional responses to other forms of child maltreatment may not be effective for ICT and may leave tortured children at extreme risk of serious harm. In this paper, we propose a working definition of ICT to raise professional awareness of the condition and to promote adoption of ICT as a distinct category of child maltreatment. In a separate document, we provide a case study of a survivor to demonstrate ICT's severity, dynamics, and deleterious outcomes for child victims.

INTRODUCTION

Intrafamilial child torture, or ICT, is a type of child maltreatment (CM) that, while often including other forms of child maltreatment, manifests its own unique and specific set of family dynamics and outcomes for its child victims. ICT differs from other types of CM largely in the type and extent of parental psychopathology that creates situations of ICT. ICT is also substantially different in the lived experiences of child victims when compared with the experiences of victims of other forms of child maltreatment. We contend that it is necessary to recognize and acknowledge ICT as a separate category of child maltreatment, so that empirically supported practices can be developed to identify, protect, and support its child victims, and to rehabilitate and restructure family integrity, if possible. This should include strategies for effective identification and reporting, investigation, child welfare and criminal litigation, permanency planning, and treatment of child survivors. Because established professional responses to other forms of CM may not be effective for ICT, child-serving professionals must engage in ongoing research, learning, and policy development specific to ICT, as well as to the part other forms of child maltreatment often play in ICT.

The very first academic papers on ICT have already identified systematic failures in reporting (Miller, 2020), in child welfare litigation (Tiapula & Appelbaum, 2011), in criminal prosecution (Browne, 2014; Macy, 2019), and in preventing child fatalities related to ICT (Knox et al., 2014).

This paper is the first in what will be a seven-paper series on ICT. In this initial introduction, we will define ICT and illustrate its essential differences from other forms of child maltreatment. We will explore legal and medical definitions offered by other scholars, and we will propose a new definition to provide a foundation for the development of professional assessment tools in medicine, mental health, and child welfare risk assessment, and to provide a resource to develop criminal law, family law, and legislative definitions. We will describe the more typical forms of child abuse and neglect to contrast them with the distinctive features of ICT. We will also review the causal and contributing factors for other forms of CM and compare these with the contributing and causal factors for ICT. We will argue that significant and distinct child safety considerations make it imperative that ICT be recognized as a separate and distinct category of CM.

What Is ICT? How Does it Differ from Other Forms of Child Maltreatment?

Child maltreatment is a significant social problem of great concern to the numerous professions that serve children and families. Whether practitioners are working in child welfare, child mental health, law enforcement, or simply upholding their duty as professional mandated reporters, all human service professionals may be called upon to respond to child maltreatment at some point in their careers. Most child-serving professionals receive some education regarding physical abuse, sexual abuse, emotional abuse, and neglect. However, they may be less familiar with the emerging research on ICT, including the unique parental pathology, abusive behaviors, and multidimensional harm to children that both define and underpin the dynamics of ICT.

ICT is torture directed against children by their primary caregivers, be they parents or other adult household members. Stories of children being terrorized from ICT have been widely covered in the national news media—none so infamous as the Turpin family from California, who tortured their 12 children for years, until their 17-year-old daughter jumped out of a window and found a way to call 9-1-1 (Hartocollis, 2019). Authorities discovered that the children had been beaten, starved, shackled to furniture with chains, and subjected to other extreme and bizarre abuses. The children had been hidden from the public under the auspices of homeschooling. The horrors of the Turpin family are not an isolated occurrence.

The national media has covered similar cases of the Hart family (CBS News, 2018) and Hana Williams (Stanglin, 2013), both of which ended with child fatalities. In Ohio, there is a pending lawsuit against a county child protective services agency following the torture and death of 2-year-old Harmony Carsey by her mother—a death that her father and paternal grandmother allege could have been prevented (Smathers v. Glass, 2020-Ohio-3264).

A quick Google search of "child tortured by parents" reveals hundreds of cases of children either being rescued from or dying from ICT. Knox et al. (2014) estimated that 1%–2% of children evaluated for abuse may be victims of intrafamilial child torture. However, without accurate identification of ICT and uniform data collection, we cannot determine incidence rates and family demographics associated with ICT. Without a separate diagnostic category for ICT, we presume that many cases remain unidentified or are being documented as some other form of child maltreatment. Establishing ICT as a distinct entity and training professionals to accurately identify it are prerequisites to collecting valid data about incidence and demographics. Moreover, as was true in the evolution of our understanding of both physical abuse and sexual abuse, initial estimates of prevalence may be low, largely because of society's generalized disbelief that parents can inflict such severe harm on their own children, and prevalence rates increased once these conditions were more widely understood and identified. This may be true of ICT as well.

There is almost no comprehensive research on ICT as it is a new category of study in the child maltreatment field. In child maltreatment scholarship, there are 50 years of robust research on physical abuse, sexual abuse, emotional abuse, and neglect. In scholarship on the topic of child torture, there has been a plethora of research and professional attention to politically motivated torture (Goldfeld, 1988; Herman, 1992; Rasmussen et al., 2004; de la Rie et al., 2018), including some studies on child victims of political torture (Cohn et al., 1981; Green, 2007; Alayarian, 2009; den Otter et al., 2013). However, there are only four published, peer-reviewed articles that focus on child torture in families (Knox et al., 2014; Browne, 2014; Macy, 2019; Miller, 2020), all of which have been published in the past 6 years. There are also very brief and isolated medical case studies that describe incidents of possible child torture (Allasio & Fischer, 1998; Tournel et al., 2006).

Early authors have attempted to create the first medical and legal definitions of ICT. We seek to build on these previous definitions to articulate the uniqueness of ICT and to provide a strong impetus to include ICT as a separate and distinct category of child maltreatment. ICT is more than a combination of abuses or typical abuses of

greater severity. As we will illustrate, ICT must be recognized and precisely defined in a way that incorporates the essential components that make it unique, including specific parental psychopathologies, the lived experiences of the children who have been tortured, and the family dynamics underlying this extremely severe form of child maltreatment. This information is essential in the development of assessment tools, treatment plans, and education and training for professionals responsible for protecting these children.

Early Definitions of ICT

Knox and colleagues' seminal article described "domestic, intrafamilial child torture" in two ways—by listing the multiple forms of harm that may be involved and by describing the family dynamics that lead to child torture (Knox et al., 2014). Some of the forms of physical maltreatment listed included beating, binding, gagging, burning, forced position or standing, forced exercise, and asphyxiation (p. 44). Some forms of psychological maltreatment listed were solitary confinement, death threats, food and water restriction, bathroom restriction, sleep deprivation, forced hot/cold environment, and denial of medical and educational services (p. 45). Knox and colleagues experimented with a variety of medical definitions of ICT: "We sought to identify medical criteria distinguishing these cases from other forms of child abuse…" (p. 38). In the abstract of their paper, they stated, "We define child torture as a longitudinal experience characterized by at least two physical assaults or one extended assault, two or more forms of psychological maltreatment, and neglect resulting in prolonged suffering, permanent disfigurement or dysfunction, or death (p. 37). Throughout the remainder of the article, the authors slightly modified the components of the definition. For example, on page 44, the definition no longer allows for a single extended period of assault, and neglect is removed from the definition. In the conclusion of the article, the components changed slightly again, but the gist of the definition remained the same—both physical and psychological harm must be present, neglect is often present, and the consequences for child victims are quite severe and perhaps permanent. Later, the authors provided a longer list of harmful outcomes by stating, "[Intrafamilial child torture] results in severe child trauma, prolonged emotional distress, pain and suffering, bodily injury or disfigurement, permanent bodily dysfunction, and/or death" (p. 48). Knox and colleagues also stated that the family "dynamic of domination and control over the necessities of life is uniquely different from other forms of physical abuse" (p. 47); further, they wrote that family dynamics include the parents' desire "to crush the child's spirit and humanity" (p. 48) and to use intense humiliation and terrorization (p. 44).

They also contended that child torture is more severe than typical poly-victimization (p. 44). The authors provided an example of the differences in family dynamics between physical abuse and child torture, stating that most physical abuse involves a caregiver's episodic, unchecked anger or loss of self-control; and by contrast, child torture involves strategically planned acts of harm "designed to establish the perpetrator's domination and control over the child's psyche, actions, and access to the necessities of life" (p. 38).

Knox et al.'s concept of child torture does include sexual abuse as a form of "physical injury" (p. 44) but does not include cases of sexual torture, which the authors say are best understood as a separate category of abuse, given the torturers' different motivations and relationships to the child (p. 39). None of Knox et al.'s proffered definitions include the family dynamics of ICT, which was likely intentional, given that they are establishing medical criteria to assist child abuse pediatricians who may see a child once and must determine if there is torture, based solely on the child's presentation.

The same year Knox et al.'s article was published, Browne (2014) published a law review article that described child torture by parents. Browne sought to create a legal definition of torture that would give rise to a model legal statute criminalizing non-political torture, such as child torture by parents or domestic partner torture (typically) by men (p. 275). Browne provided a thorough analysis of his process to define torture. He stated that knowledge that one person is torturing another should be enough to convict an offender: the prosecution should not have to prove purposeful intent in the inner workings of the torturer's mind, which would be difficult to do and would create a barrier to convictions. Browne also stated that a torture crime should not require proof of pain and suffering of the victim, because the actions of the torturer are just as wrongful, regardless of whether the victim is more or less resilient, either physically or psychologically. Browne stated that there should be no temporal requirement: a child or wife can be tortured in a short amount of time, and requiring that it be enacted over long periods of time is an unnecessary barrier to convicting the worst offenders. We agree with his legal analysis and conclusions on all three points with respect to criminal litigation. However, as we will show, the dynamics suggested in our definition of ICT do include parameters, perpetrator intent, time span elements, and the physical and psychological impact on victims as important elements of the definition.

Finally, and most important to note, Browne (2014) reasoned that psychological torture alone should be enough to convict an offender of torture. He wrote, "In reality, the distinction between physical and psychological torture is artificial" (p. 288), referencing a neurobiological study that demonstrated that "coercion of any type [physical or psychological], in itself, implies threat, fear, and powerlessness, all of which can and often does impact on brain, spinal cord, and organ integrity and therefore has medical consequences" (Fields, 2008). Browne also quoted Catani et al. (2008), who state that physical and psychological torture have "the same crucial feature: exposing a person to an uncontrollable and unpredictable life-threatening situation of extreme stress" (p. 175). We agree that torture can be purely psychological and incorporate this component in our definition supra.

A 2019 article by Macy and a 2020 article by Miller both adopted Knox et al.'s definitions without analysis. While defining child torture by parents was part of Browne's thesis, it was not the aim of Macy or Miller. Macy called for 14 states to create a crime of child torture, and Miller called for child welfare laws to create targeted responses to ICT, including mandated reporter laws. Miller was the first to consistently use the term intrafamilial child torture or ICT to ensure precision and to avoid confusion with child torture outside the family home or with politically motivated child torture (2018; 2020).

Knox and colleagues' definition was groundbreaking in beginning the study of ICT and attempting the first medical definition. Their description of parental dynamics involving domination, control, and terrorization are essential parts of conceptualizing parental psychopathology in cases of ICT. In 2016, the Journal of Child and Adolescent Trauma published a "Letter to the Editor" from Alexander and Peña (2016), briefly critiquing Knox et al.'s definition. The letter pointed out that although one of Knox et al.'s case examples included repeated sexual abuses against the child within the overall context of torture, the proffered definition of child torture did not mention sexual harm. Knox and colleagues (2016) wrote a "Letter to the Editor" of the same journal in response and acknowledged that "often physical, psychological, and sexual tortures co-occur in these cases" (p. 265).

As thought leaders continue to explore and examine ICT, a scholarly definition must be created that has increased precision and is applicable to an interdisciplinary audience. Such an underpinning general definition is necessary to demonstrate how ICT is essentially and categorically different from other forms of CM and is therefore deserving of its own body of research on etiology and effective interventions. It can also provide a foundation for development of specialized criteria for purposes of

criminal law, family law, child welfare risk assessment, medical diagnosis, and mental health assessment and diagnosis, which are reflected in the earlier papers on ICT reviewed herein.

Writings on Torture That Have Informed Our Definition

In a largely philosophical article, "The Meaning of Torture," Yale scholar and political scientist Paul Kenny (2010) explored the many ambiguities in defining torture. The article argued that there is no need to distinguish between physical and psychological harm in the definition of torture because "[i]n most cases, the infliction of injury to the body elicits a physiological and psychological reaction (p. 146)." Pain is a "multidimensional experience" and includes "an array of psycho-somatic sensations" (pp. 146–147). Suffering can be described as "perceived damage to the integrity of the self" (p. 148) and can be caused by physiological or psychological stressors. Kenny continued by saying, "Suffering, however produced, can in turn lead to feedback effects that people experience as sickness [physical], depression [psychological], and reducing cognitive abilities [neuro-psych, i.e. both physical and psychological]" (p. 149).

Second, Kenny (2010) made several arguments for a distinction between torture and situations where suffering is morally and/or legally permissible (e.g., incarceration), and perhaps incidental rather than essential (e.g., infant circumcision) (p. 143). Third, Kenny distinguished between torture and related concepts such as cruelty or sadism by emphasizing the total physical control a torturer has over his victim. For Kenny, torture involves being physically controlled and having no freedom to leave, little possibility of escaping, and little ability to defend oneself, but these are not necessary components of cruelty and sadism.

Finally, Kenny (2010) arrived at a definition that "torture is the systematic and deliberate infliction of severe pain or suffering on a person over whom the actor has physical control, in order to induce a behavioral response from that person" (p. 154). Kenny's reasoning was helpful in developing a definition of intrafamilial child torture that includes much of the essential nature of torture as a general construct.

Kenny's description of "no freedom to leave" and "little possibility of escape" revisits a theme originally posited by Judith Herman in her 1992 classic treatise, "Trauma and Recovery"—the theme of captivity. In an entire chapter devoted to the subject, Herman stated that, logically, severe interpersonal trauma (e.g., torture) can only occur in conditions of captivity, be it physical captivity, psychological captivity, or

both. She wrote, "Such conditions [of captivity] obviously exist in prisons, concentration camps, and slave labor camps. These conditions may also exist…in families" (p. 74). Further, she stated. "Children are [automatically] rendered captive by their condition of dependency," and "…many survivors of childhood abuse…describe a highly organized pattern of punishment and coercion" (p. 74). These survivors often report punishments similar to those in political prisons. Many describe intrusive control of bodily function, such as forced feeding, starvation, use of enemas, sleep deprivation, or prolonged exposure to heat or cold. Others describe actually being imprisoned: tied up or locked in closets or basements" (p. 99, emphasis added).

We adopt many of Kenny's components of torture, Herman's components of captivity and imprisonment, and Browne's assertions that torture can occur over different periods of time, obviously with longer periods of torture having accumulating and compounding effects. Therefore, we define torture as follows:

> *Torture is the systematic and deliberate infliction of severe pain or suffering, which may last any short or long period of time, on a person over whom the torturer has physical or psychological control and the ability to sustain captivity, in order to induce a desired response from that person.*

The desired ends sought by perpetrators of torture vary, and these objectives define the methods, duration, outcomes, and typologies of torture. We accept the terminology sadistic torture to describe the infliction of pain and suffering when the primary purpose of the torture is the pain and suffering itself. We accept the terminology political torture to describe torture precipitated by a State or other political perpetrator to punish or control the victim or to obtain information important to a political agenda. We therefore define intrafamilial child torture as follows:

> *Intrafamilial child torture (ICT) is systematic and deliberate child maltreatment, occurring within a child's family or household, where the child is physically and/or psychologically captive and not free to leave. The components of torture may include intentional physical abuse, deliberate neglect, planned sexual abuse, or methodical psychological abuse to purposefully direct, shape, and control a child's psychological and moral development and sense of identity and autonomy, to produce in the child subservient beliefs and behaviors in service to the psychopathological needs of the perpetrator(s). While ICT can last any period of time, it often occurs over a protracted period of time in a child victim's life.*

Descriptions of More General Forms of Child Maltreatment

Intrafamilial child torture has many features that are similar to, and in some ways overlap with, other forms of child maltreatment. To fully understand what makes ICT a separate category of CM, it is important to first identify what it is not. It is not "typical" physical abuse, sexual abuse, psychological abuse, or neglect, and it does not occur primarily as a result of the parental factors and environmental influences that give rise to other types of child maltreatment. To illustrate this point, we herein define and describe the other forms and manifestations of child maltreatment recognized in both scholarly literature and practice with children and families:

Child maltreatment is a general term used to refer to a variety of parental or caregiver acts that can result in serious harm to children. In general, the term child abuse refers to parental actions that inflict serious harm on children, while child neglect refers to harm to children because of the culpable failure of parents or caregivers to meet children's most fundamental needs.

Child abuse is normally subdivided into several categories that include the following:

Physical abuse refers to the nonaccidental and active infliction of serious physical injury or harm on a child by a parent or a caregiver. Physical abuse can manifest as bruises, burns, bone fractures, and serious injuries to the brain, internal organs, or genitals. Injuries from physical abuse can result in permanent physical damage, scarring, developmental disabilities, and in some cases, death—particularly in infants and young children.

Sexual abuse is most often defined as the involvement of a child by an adult in sexual activities committed for the sexual stimulation of the abuser and/or to establish and reaffirm power over the child victim. Sexual abuse may include a range of direct physical involvement of a child in adult sexual activities, exposing a child to the sexual activity of others or to sexually explicit materials, and using children as sexual commodities, such as in child prostitution, trafficking, and child pornography. Children may also abuse other children, but the dynamics of youthful perpetrators are not the same as in adult perpetrators. Physical indicators of sexual abuse in children are injury to the genitals or rectal area, including cuts, lacerations, bite marks, stretched rectum or vagina, fissures in the rectum, or swelling and redness of genital tissues. However, in most cases, there is no physical evidence that

sexual abuse has occurred. Child sexual abuse is more often identified by a verbal disclosure by a child, or by a combination of emotional or behavioral indicators that can include sexualized behaviors inappropriate for the child's age and developmental level, aggression, generalized irritability, anxiety and depression, developmentally regressive behaviors, public or excessive masturbation, and inappropriate and seductive behavior toward adults.

Psychological or emotional abuse is a sustained and repetitive pattern of parental actions that lead children to feel unloved, unwanted, and inherently bad and worthless, which deeply compromises a child's emotional development, identity, and self-esteem. Parental behaviors that constitute psychological maltreatment include the following: constant criticism and belittling, threatening, rejecting, withholding of love, support or guidance, and dismissing a child's contributions. Neglectful behaviors such as ignoring children, failing to notice them, withholding attention or affection, and being chronically unresponsive to their needs and communications also qualify as psychological abuse. The experiences of infants in congregate care institutions or orphanages exemplify the effects of chronic psychological maltreatment. These infants often appear withdrawn, they do not cry or attempt to communicate with caregivers, and they often become deeply depressed. Emotionally maltreated children are likely to develop serious mood disorders, attachment disorders, physical illness, and other effects of deep psychological trauma, in addition to significant developmental delays in all domains. Psychological abuse also undermines children's development of strong and trusting attachments, essential autonomy, self-worth, and the capacity for healthy social relationships.

Child neglect is the culpable failure of parents or caregivers to meet their children's most basic physical, nutritional, safety, medical, and emotional needs, thereby placing these children at high risk of serious injury, illness, developmental delay, or death. Severe neglect, such as chronic malnutrition in an infant, or the lack of medical care for serious illness, can be life threatening. More children die from severe neglect than die from physical abuse. The long-term effects of chronic neglect can cause serious and often permanent damage to children, particularly to children under the age of 3. Child neglect is also typically divided into several subcategories that include the following:

Physical neglect often includes improper or infrequent feeding, which leads to malnutrition and dehydration, including the severe malnutrition and grossly impaired physical development associated with the medical finding of "failure to

thrive." Physical neglect also includes failure to clothe children for the weather, lack of physical hygiene, and exposing children to dangerous conditions in the living environment.

Medical neglect includes the failure to provide, in a timely manner, the health care and medical interventions needed to prevent or treat illnesses, disease, injuries, or other medical conditions.

Supervisory neglect includes failure to provide care and supervision for children who are not yet old enough to care for themselves, by leaving them unattended or unsupervised by caregivers who are not competent or willing to meet children's needs, placing them at increased risk of injury.

Educational neglect is the failure of a parent or caregiver to enroll a child of mandatory school age in an appropriate educational setting or otherwise ensure that a child has the opportunity to receive a developmentally appropriate education.

Contributing Factors to Child Maltreatment

For decades, child maltreatment research has attempted to identify the parental, family, and environmental factors that contribute to the various forms of abuse and neglect. Understanding the typical parental and family dynamics of various forms of maltreatment is an important baseline for understanding the unique family and parental pathologies that underlie child torture.

Rycus and Hughes (1998), in the Field Guide to Child Welfare, draw on the seminal work of Brandt Steele (Helfer & Kempe, 1987) by delineating four primary categories of contributing factors to child maltreatment (p. 72). These include parental factors, child factors, environmental stress factors, and a family's lack of resources and supports. A 2019 fact sheet by the Child and Family Research Partnership (CFRP), at the University of Texas at Austin, provides a summary of empirically supported publications in the last 20 years that demonstrate the impact of these family dynamics and contributing factors (Child and Family Research Partnership, 2019). Examples of these factors are provided below.

Parental Factors that underlie child abuse or neglect might include the following: parents' mental illness or emotional disorders (Jakupcevic & Ajdukovic, 2011), maternal depression (Dubowitz et al., 2011), parental substance use disorder (Walsh et al., 2003), parents' inability to regulate strong emotions and lack of self-control

(Henschel et al., 2014), family/partner violence (Cox et al., 2003, parents who lack coping skills for problem solving or managing stress (Cox et al., 2003), young or developmentally immature parents (Sidebotham & Heron, 2006), lack of effective and age-appropriate parenting skills (Cox et al., 2003), lack of knowledge of children's developmental needs or milestones at different ages and unrealistic behavioral expectations for their children (Rycus & Hughes, 1998), trauma or abuse in the parents' own childhoods or lives (Sidebotham & Heron, 2006), and non-biological father figures living in the household (Putnam-Hornstein & Needell, 2011).

Child Factors are often summarized in the concept of child vulnerability. These factors not only increase the likelihood that children will be maltreated but also increase the degree of trauma a child is likely to experience from being maltreated. Vulnerable children include children who are developmentally delayed or have disabilities, children who need unusual or special care, including premature or medically fragile infants or children (Rycus & Hughes, 1998); infants and very young children, where more constant and intensive care is generally required; children demonstrating typical oppositional behavior for their developmental stage, such as learning autonomy or during toilet training (Rycus & Hughes, 1998); or children whose temperaments are intrinsically more challenging to their parents, such as being seen as demanding, not easily satisfied, exhibiting frequent or unrelenting crying, or who are often agitated and irritable (Bagley & Mallick, 2000; Rycus & Hughes, 1998.)

Environmental Stress Factors refer to the impact of ecological factors, such as unsafe, unsupportive, and challenging environments in contributing to child maltreatment. These factors might include unemployment, family poverty (Dubowitz et al., 2011), unstable or unsafe housing or homelessness (Marcal, 2018), community violence and dangerous neighborhoods (Centers for Disease Control [CDC], n.d.), and chronic crises and unabated stress in the family caused or exacerbated by external factors (Rycus & Hughes, 1998).

Lack of Resources and Supports frequently increase the likelihood of an occurrence of child maltreatment. A primary antidote to stress in a family is easy access to resources and interpersonal support (Kim & Maguire-Jack, 2015). The absence of these increases stress and the likelihood of child maltreatment. Many families live in chronically undersupported communities with poor quality schools and lack of access to health care, family planning resources, or health insurance (Jakupcevic & Ajdukovic, 2011); poor relationships with law enforcement; high unemployment and low job opportunity; or absence of formal community-based organizations to help

families meet basic needs. Some families are isolated and lacking supports from extended family, friends, neighbors, or faith communities (Cox et al., 2003; Sidebothom & Heron, 2006).

With the exception of sexual abuse, child abuse and neglect typically result from a confluence of external, environmental factors, and in-family parent and child factors that potentiate each other, exacerbating stress and creating family disruption and instability. An example can illustrate the interconnected contribution of factors from multiple sources in child maltreatment. A single mother may have experienced trauma in her own life and, as result, may struggle with substance abuse that she uses to cope with PTSD from childhood abuse. She may not have access to psychotherapy or substance abuse treatment due to lack of community programs, health insurance, and transportation. Her child may have a disability resulting from her use of substances during pregnancy. She is likely to be overwhelmed by her child's unusual care needs and, without family or community support, may turn to substances to cope. Increased drug use may cause her to lose her job and eventually become homeless because she cannot pay rent without an income. Mother and child may move into a homeless shelter, where she becomes increasingly depressed, resulting in further neglect of her child. Some variation of these interacting factors is commonly identified in many cases of physical abuse and particularly in neglect.

In some cases, a particular factor may be strongly associated with a particular type of child maltreatment. For example, a non-biological father figure living in the home (mother's boyfriend or a stepfather) increases the risk to female children of sexual abuse (Putnam-Hornstein & Needell, 2011). A parent's difficulty regulating strong emotions may lead to episodic outbursts of anger resulting in an incident of physical abuse (Henschel et al., 2014; Knox et al., 2014). Using corporal punishment often leads to physical abuse when it is a parent's primary means of behavioral control, or if a parent is unable to exercise self-restraint to prevent harm to the child.

The Dynamics of Perpetrators in ICT

A primary distinguishing feature of ICT is parents' intention to inflict torture on their children. Parents who torture their children appear to use extreme levels of coercive control, including both physical and psychological abuse intended to gain and retain absolute power and control over all aspects of a child's thoughts and actions, and specifically to serve the perpetrator's own psychopathological needs and desires (See Herman, 1992; Knox et al., 2014; Miller, 2020). They achieve these ends by

intentionally undermining and crushing their child's autonomy, spirit, and humanity (Knox et al., 2014). Parents who torture their children strategically create conditions of captivity and enslavement to make their children completely submissive to their will. Herman posited that these types of perpetrators are psychologically dependent on their child victims to play out the other half of a torturous interpersonal dynamic, totally in service to the perpetrator's perceived well-being (Herman, 1992, p. 75).

A review of Biderman's (1957) "Chart of Coercion," provides helpful insights on the parent-child dynamics in ICT. While this chart was created to explain the dynamics and psychological techniques of political torture, it appears to accurately reflect the documented experiences of ICT survivors. The chart is recreated in Table 1. Notably, of the eight general methods and 39 variants of coercion/torture in Biderman's Chart, not one involves physical torture as it is traditionally defined. All the techniques are a blend of psychological torture that attacks both the body and the mind (See Herman, 1992, p. 108; Fields, 2008, p. 139).

Table 1: Biderman's "Chart of Coercion."

General Method	Effects/Purposes	Variants
1. Isolation	• Deprives victim of all social support of his ability to resist • Develops an intense concern with self • Makes victim dependent upon interrogator [i.e., perpetrator]	• Complete solitary confinement • Complete isolation • Semi-isolation • Group isolation
2. Monopolization of Perception	• Fixes attention upon immediate predicament; fosters introspection • Eliminates stimuli competing with those controlled by captor • Frustrates all actions not consistent with compliance	• Physical isolation • Darkness or bright light • Barren environment • Restricted movement • Monotonous food
3. Induced Debility/ Exhaustion	• Weakens mental and physical ability to resist	• Semi-starvation • Exposure • Exploitation of wounds • Induced illness • Sleep deprivation • Prolonged constraint

		• Prolonged interrogation • Forced writing • Overexertion
4. Threats	• Cultivates anxiety and despair	• Threats of death • Threats of non-return • Threats of endless interrogation and isolation • Threats against family • Vague threats • Mysterious changes of treatment
5. Occasional Indulgences	• Provides positive motivation for compliance • Hinders adjustment to deprivation	• Occasional favors • Fluctuations of interrogators' [perpetrators'] attitudes • Promises • Rewards for partial compliance • Tantalizing
6. Demonstrating Omnipotence	• Suggests futility of resistance	• Confrontation • Pretending cooperation taken for granted • Demonstrating complete control over victim's fate
7. Degradation	• Making cost of resistance appear more damaging to self- esteem than capitulation • Reduces prisoner [victim] to "animal level" concerns	• Personal hygiene prevented • Filthy infested surroundings • Demeaning punishments • Insults and taunts • Denial of privacy
8. Enforcing Trivial Demands	• Develops habit of compliance	• Forced writing • Enforces minute rules

Source: Biderman, A.D. (1957) in the Bulletin of the New York Academy of Medicine. Reproduced with Permission.

Of the 39 variants of torture (column 3), all but two have been documented in cases of intrafamilial child torture (Knox et al., 2014; Miller, 2018; 2019; 2020).

The motivation and intentions of the perpetrators of ICT in Knox et al.'s sample were not analyzed, nor was the precise underpinning psychopathology of these perpetrators identified. However, the behavior and dynamics described suggest characteristics of individuals with psychopathy and personality disorders. These dynamics include the following: extreme physical and psychological cruelty inflicted on victims; fearless domination over others; cold heartedness and lack of guilt; self-centered impulsivity; the repetition of inflicted pain and suffering over extended periods of time; sophisticated thought and planning to maintain control of the child, family, and environment to perpetuate ICT; dismissal of the victim's humanity and autonomy; the use of the child victim as a means to meet the perpetrator's own needs and desires; and blaming the victim's own behavior for the abuse. All point toward deviations in the perception of self and others, a lack of empathy and appropriate emotional response, and problematic interpersonal functioning—all associated with psychopathy and personality disorder (American Psychiatric Association, 2013; Lilienfeld & Andrews, 1996; Lilienfeld & Fowler, 2006; Hare et al., 1990). These individuals are often highly manipulative and skilled at deception, and thus they are not always or easily identified (Woodworth, 2012).

Another important consideration in Knox et al.'s study was the biological relationship of the perpetrator to the child victim(s). As is often true in child sexual abuse, one would expect a higher risk of abuse from perpetrators who were not biologically related to the child victim, e.g., step-parents, romantic/sexual partners of the parent, other unrelated adults living in the family, and primarily males or father figures. While Knox et al. confirmed this pattern in their sample, almost 40% of the perpetrators in their study were either biological mothers or fathers, and women were among the perpetrators in every case identified. However, the sample size in the Knox et al. study was small, and there is some case study and clinical practice data that suggest this number may be much higher.

Additional research is needed to accurately determine the range and scope of psychopathology associated with perpetrators of ICT. However, it is eminently clear that the threats to children in these families can be extreme because of the pathology of the perpetrators, and this must be heavily considered in intervention strategies to ensure children's safety.

Child Safety in Situations of ICT

We have shown ICT to be significantly different from other forms of CM in both its characteristics and its contributing factors. Because of the unique features of ICT,

professional interventions must be modified to effectively protect children who have been tortured and to help them heal. Uniformly, child victims of ICT are at very high to extreme risk of both imminent and long-term, serious physical and psychological harm, often resulting in permanent harmful outcomes in all areas of their development. Interventions in ICT must be rapid and focused on addressing the many immediate threats to children's safety, while also ensuring these children's long-term well-being. Although national child welfare goals of safety, permanence, and well-being are both common and fundamental across all types of child maltreatment, the typical practice models and strategies used in response to other forms of child maltreatment can leave children who have been tortured in unmitigated danger.

In child protective services practice, a child's safety is based on a complex interaction of three intersecting factors: (1) safety threats in the home environment and in the child's relationship with parents, (2) a child's level of vulnerability, based on the child's age, condition, and temperament, and (3) the strengths and protective capacities in the family system that can be applied to support and protect child victims. The challenge in ICT is that parental protective capacities—empathy, concern for the child's well-being, and authentic desire to become an effective parent—are decidedly absent. ICT is not generated by acute, transient, or intermittent family or community stressors, nor is it generated by circumscribed threats to parental capacities and responsibilities, such as drug abuse, spousal abuse, anger control issues, anxiety and depression, all factors that can increase risk of child maltreatment, but which are also recognizable, treatable, and when successfully addressed, can promote re-establishment of family integrity and child safety in their own families.

By contrast, the primary contributor to ICT appears to be the irreductible psychopathology of the parent, including a single-minded need to control the child and a lack of insight or empathy regarding the child's needs—all of which suggest that there is little potential to strengthen parental protective capacities, and certainly not within time frames necessary to meet children's immediate developmental and safety needs. These parental psychopathologies are typically immune to therapeutic interventions other than extreme coercion, and research documents extreme limitations in our expectation for positive change (Hare, 1993; Hare, 1996; Perry, 1997; Stone, 2007; Woodworth, 2012). Taken together, these facts preclude using most of the intervention strategies widely applied to strengthen families and build parental protective capacities in other situations of child maltreatment. In spite of their protestations and verbal commitment to "do better,"

parents who torture appear to have a chronic and all-consuming pathological need to continue abusing the child. Therefore, in spite of interventions intended to strengthen families, children who have been tortured will likely remain at chronically high risk of imminent and long-term, potentially permanent, serious harm if they remain in their abusing families. Ensuring a child's safety in the short run can be seen only as a stopgap measure. In ICT, it is essential that we eliminate the certain long-term risk as well.

Reunification and Family Preservation

The desired outcome in most child maltreatment cases is family strengthening and preservation, with reunification of children when parents can create and sustain a safe and nurturing environment for them. Out-of-home placement can be used as a temporary intervention to keep children safe while services are being provided to strengthen and support their families. However, for reasons outlined earlier, reunification in situations of ICT will rarely be in a child's best interests. Reunification might theoretically be possible if there is a non-offending parent who can develop the capacity to protect the child and keep the offending parent away from the child. As with child sexual abuse, sometimes child victims can remain with their families if the perpetrator is permanently removed, or if other family members can protect the child from the perpetrator's influence. However, in Knox et al.'s sample of 51 perpetrators of ICT, all adults in the home, including biological parents, knew about the extreme abuse being inflicted on the child and had participated to some extent in the abusive acts (2014, p. 39). In ICT, a parent's failure to intervene constitutes a patent failure to protect. Siblings may also become enmeshed in and rewarded for participating in the family's collective torture of the victim. Further research is needed to determine whether, when, and how family preservation might be possible in cases of ICT. But until the broader dynamics in ICT families are better understood, we expect that children who have been tortured cannot and should not be reunited with the parent(s) who tortured them—whether these parents were directly involved or allowed it to happen without protest or protective intervention.

Kinship Care

Kinship care is normally an effective way to provide safety and nurturance for maltreated children, while reducing the degree of separation trauma that can result from out-of-home placement. Although kinship care may be an effective safety intervention for some children who have been tortured, the controlling pathology of ICT perpetrators and their high motivation to continue to abuse the child victim to

meet their own needs may make it more difficult for kinship caregivers to protect the children in their care, especially if it requires them to enforce restrictions against family members. This means that careful assessment, selection, and training of kinship caregivers will be necessary to ensure that they develop and sustain the capacity to both nurture and protect the child, and to determine whether they are sufficiently resilient and committed to resisting attempts by the perpetrator to exert influence or gain access to the child.

Therapy

The first intervention needed by children who have been tortured is a trusting and nurturing relationship with caring, consistent, non-punitive adults. Trust takes time to develop, and children who have been tortured may have more profound disturbances in attachment and emotional resilience than many other maltreated children. Moreover, they may be too vulnerable and too fragile to sustain early therapies that require them to re-live their torture experiences as part of the treatment. The authors suggest that a restorative and permanent family setting is an essential first step. Children cannot, nor should they be expected to, even begin to consider their trauma history until they feel completely safe. This may mean immediate termination of parental rights and permanent placement in a safe, nurturing family home along with the legal protections of guardianship, custody, or adoption. Moreover, the kinds of therapy and their timing are likely to be very different from traditional trauma therapies because of the child's likely developmental and emotional fragility. The best interventions to meet these children's developmental needs have not yet been clearly identified and researched.

Medical intervention for children will also be needed. Child torture can lead to significant physical health problems for child victims, including problems with sleeping, eating, waste elimination, and autonomic functions, such as regulating heart rate, blood pressure, and respiration. Torture has even been shown to cause permanent organ damage (Fields, 2008).

A child who has been tortured will also have special educational needs. In many cases, children who have been tortured are prohibited from attending school as a way to control their environment and to prevent disclosure of their maltreatment. They are likely to have been isolated from other children and may have never learned to relate in a reciprocal manner with other children, or to function in a group setting. Children who have been tortured are also likely to be developmentally delayed in multiple domains. Educational programming may need

to occur within the context of special needs education, and it will be necessary to evaluate a child's developmental level, psychological status, and grade achievement level before making educational programming decisions. Some children who have been tortured may need one-on-one tutoring for a while rather than being assigned immediately to a classroom environment.

Most children will need a holistic and emotionally restorative environment with patient, supportive, and trauma-informed parenting to even begin the healing process. Only after achieving some level of physical and psychological safety should other trauma-related interventions be attempted. In general, early therapeutic interventions should focus on bodily regulation and feeling safe in the body, as described by trauma expert, Bessel van der Kolk (2014). Cognitive and exposure-based interventions should only be used as a later therapy. Some individuals may never be able to handle exposure therapies, even as adults.

Timelines and Requirements in Statute

Children who have been tortured cannot wait. They remain at significant risk of very serious harm until identification and intervention occur. Quick, permanent placement in out-of-home care is typically not considered best child maltreatment practice, because rapid removal and replacement of children can actually exacerbate trauma simply from separation, placement, and resulting impermanence. In most situations of child maltreatment, considerable work should be done to strengthen and support families to promote family stability and reunification. Out-of-home care should be the last resort, used only when a family cannot be helped to provide a safe and nurturing environment for their own children, and when children remain at high risk in their own homes. Federal child welfare legislation (The Adoption Assistance and Child Welfare Act of 1980, PL 96-272) requires that "reasonable efforts" be made both to prevent removal and placement of children and to promote reunification of these children with their families, and there are clear legal time frames within which to make these efforts and decisions. With children who have been tortured, however, the timelines and requirements built into current legislation for other forms of maltreatment pose a threat of continuing serious harm. A different legal category for ICT is necessary to ensure that professionals can act quickly and with conviction to ensure immediate safety for these children, to ensure permanence in a safe and stable family environment and to provide restorative interventions to help these children achieve health and well-being.

In responding to situations of ICT, many aspects of child protective services interventions must be adapted if we are going to meet the unique needs of these children and protect them from ongoing serious, and sometimes fatal, harm. The nature of the caseworker's relationship with family members, the strategies we use for safety and risk assessment, the case plan interventions and services we provide, how we use the legal system, and the kinds of therapeutic interventions we apply may be very different from those that form the primary best practice principles of typical child protection. If we don't recognize and understand ICT as a separate entity with its own principles, mandates, and intervention strategies, we are likely to sustain high levels of risk and trauma for these children, even if we mean well.

Multidisciplinary Collaboration in Responding to Child Torture

A compelling reason to create a new diagnostic category of interfamilial child torture in child maltreatment law and practice is to focus the attention of professionals in all involved disciplines on recognizing and effectively responding to these cases. Unfortunately, the extreme family behaviors that are typical in situations of ICT may seem so bizarre, so outrageous, and so unlikely that professionals might be skeptical and hesitant to believe that children's disclosures are plausible. A thorough understanding of ICT will help them recognize the potential legitimacy of what children are disclosing and realize the extent of the danger these children are in.

Child protective services workers will be the ones most likely to see child torture victims in their caseloads of maltreated children, and these workers must be able to recognize indicators, fully investigate, accurately identify, and appropriately intervene to protect these children. CPS administrators must be responsive to the need for different policies and practices to deal with these cases, and they must have a strong rationale to adjust agency interventions accordingly. Moreover, CPS, as society's designated entity to protect and serve maltreated children, must engage professionals in all involved disciplines to collaborate toward a common goal of immediate and long-term safety for children who have been tortured.

Law enforcement personnel, including investigators of personal crimes, may also encounter these children and their families. An understanding of the parental pathology in ICT can help them structure their investigations and interrogations accordingly. This is equally relevant to forensic interviewers in child protective services agencies or child advocacy centers.

Court personnel, including prosecuting attorneys, judges, and guardians-ad-litem are in a position to ensure children's safety through legal means, provided they accurately recognize ICT and fully understand the risks of leaving children with their abusing families. Mistakes in case disposition can leave children at risk of ongoing serious harm.

Medical providers who evaluate children for other forms of abuse or neglect will be able to do a deeper evaluation of a child's health and safety if they are attuned to the many physical and emotional sequelae of ICT other than visible bruising or fractures.

Therapists in all aspects of mental health, regardless of their specific professional affiliation, must understand the specialized treatment needs of traumatized children, or their usual therapies risk being either ineffective or inflicting additional trauma on these children. Very specific therapies to treat severely traumatized children must therefore be developed and tested.

Other professionals who regularly have contact with children, such as teachers, school counselors, or clergy, if knowledgeable about the indicators of child torture, may be able to sensitively engage children and help them disclose what's happening to them and provide support during referral and intervention.

Creating a separate diagnostic category for ICT is the first step in sensitizing and educating all professionals to keep this extreme form of child maltreatment in the forefront of their thinking throughout the entire continuum of interventions from identification to treatment.

In this paper, we have attempted to raise professional awareness to the existence of intrafamilial child torture as a distinct and extremely dangerous form of child maltreatment. Our ultimate goal is to promote establishment of a separate diagnostic category of ICT to facilitate more accurate and timely identification and development of appropriate treatment interventions for these children. This first paper sets the stage for a more in-depth exploration of the dynamics inherent in ICT and to begin to identify strategies to intervene and treat these highly vulnerable children. This series of papers will be published on the website of the APSAC Center for Child Policy as they are completed.

Going forward, the ICT paper series will cover several additional topics in greater depth. These will include the following: ICT sequelae and treatment for child

victims, psychological abuse and solitary confinement as ICT, psychopathology and personality disorders in ICT offenders, the dangers in promoting family reunification in most cases of ICT, law and law enforcement responses to ICT, and supporting fundamental human rights for ICT victims. These papers will be available from the APSAC Center for Child Policy website (https://www.centerforchildpolicy.org) as they are completed. We will also provide detailed examples of target audiences for this paper series and stress the necessity of a coordinated interdisciplinary response in situations of ICT.

We also provide a comprehensive case study of a child, whom we will call Julie, who experienced and survived extreme ICT in her family. The case study is presented from the child victim's perspective to reaffirm the insidious and far-reaching harm experienced by child victims of ICT. This case study will also be posted on the Center for Child Policy website.

We encourage any professional interested in contributing to an ongoing exploration of ICT and determining what we can do to protect these children to contact us.

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