Specialized Treatment Program Recommendations
for
Tortured Children

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for
Tortured Children

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Acknowledgments

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Abstract

Children who have experienced tortuous abuse would benefit greatly if they had available to them a specialized treatment program. Currently programs do not exist for tortured children of child abuse. It is anticipated that this research project will serve as a guide for mental health professionals and those who work with child victims of crime. These professionals include, but not limited to, law enforcement, prosecutors, judges and any other professionals who are involved with the welfare of child abuse victims of this type. Evaluations of other program therapies will be overviewed and positive and negative attributes will be discussed. Recommendations will be made on which key elements should be included in the development of specialized treatment programs for child abuse torture victims. Taking a screening tool like the Istanbul Protocol or the Trauma Focused Cognitive-Behavioral Therapy and adapting it to be developmentally appropriate for children herein is a first step to program development. The unique healing needs of tortured children and the key elements that are used in current therapy methods are highlighted in this document that support how they can be developed into a specialized treatment program.

Sara Elizabeth Flynn (Jones)
Under the Supervision of Dr. Amy Nemmetz

Statement of the Problem

Child abuse torture victims experience higher and more sadistic forms of abuse than a “typical abuse” victim. Evidence is based on medical records, police reports, and condition of the child who sustained injury (Knox, 2014). The number of tortured children is a small population
of the total number of abused children. Torture is a specific form of child abuse. As of 2015, research from the Center for Victims of Torture suggest that 44 percent of refugees, assailers and asylum seekers living in the United States have experienced torture. As referenced by Dr. Knox’s research “we define child torture as longitudinal experience characterized by at least two physical assaults and one extended assault, two or more forms of psychological maltreatment, and neglect resulting in prolonged suffering, permanent disfigurement or dysfunction, or death.” (Knox, 2014 p.1).

As quoted in Dr. Knox’s article, “Torture is different from other forms of child abuse, but it currently lacks medical definitional criteria. As opposed to torture, the majority of commonly recognized psychically abusive acts result from a caregiver’s episodic unchecked anger or loss of self-control. Torture is usually prolonged or repeated and includes acts designed to establish the perpetrators’ domination and control over the child’s psyche, actions and access to the necessities of life. It employed elements of both physical abuse and psychological cruelty. 1 to 2% of children being evaluated for abuse present with such unique constellation of physical and psychological injuries which appears to represent torture.” (Knox, 2014, p. 2).

Many children who leave a torture situation, do not have resources and treatment programs specific to a specialization that focuses on tortured victims of abuse. Victims of torture often are referred to cognitive-behavioral therapies or are lumped into treatment programs that rarely focus on their specific issues related to tortuous abuse. Once a child leaves the abusive situation or environment where they had experienced the abusive torture, healing needs to take place. This is not just for physical injuries but for mental healing due to the abusive torture.
According to Urquiza, & Timmer (2012), one aspect of recovery that is vital for abused children is having support and warmth from an important or primary caregiver. Often, a child is tortured by a caregiver(s) or parent(s) or someone that is a primary family member (Knox, 2014, p.3). This means, the child who experienced torture must restart an attachment relationship with someone new or another family member. This can pose a challenge for the child. Often, a child is too apprehensive to form a bond. It is often difficult for them to build trust or even rapport with anyone.

Sometimes, victims experience “trauma bonding”, this is where the abused individual will attach and feel the most connected to the abuser. Sometimes, the victim will find comfort in the ritualistic abuse because they often know what is coming or how things may occur when referencing the type of abuse or the severity of abuse. There is still a connection or some comfort for the victim even if it is abusive, torturous, or hurtful. When victims are quickly and suddenly placed in a safe situation, which is something they are not used to, they may feel anxious and on-edge because they cannot understand or predict the behavior from a new safe, caring and kind caregiver. It feels more unsettling to experience kindness and to have their needs met without reason, explanation, threats or abusive behaviors. In their “normal” environment they are accustomed to feeling scared and hurt; suddenly the abuse stops, and in a way, they lose a sense of self and that common feeling of predictability is gone (Urquiza, & Timmer, 2012).

Currently, society is lacking the capacity to provide focused treatment programs for this specialized group of abused children (Knox, 2014) (Berliner, 2004). The system including the justice system, human services, the foster system and those working with child victims often will place tortured children into treatment programs for “abuse victims”. The system might recommend more frequent talk-therapy sessions. Other specialized programs are needed for this
group of tortured children. Victims need specialized programs so they can successfully heal from their trauma and live productive lives (Berliner, 2004). Rehabilitating these children will take more time, resources, and specialized professionals to help in the healing process.

This research paper analyzes the pros and cons of current treatment programs that are being used for typical abused children, currently. Programs are evaluated with a focus on making recommendations for development for treatment programs which also specialize in tortured victims of abuse. This paper points out components of these programs and provides suggestions for new therapy models. The goal is to focus on key elements of successful programs, combine those elements and investigate those findings to determine if they would be appropriate for a specialized treatment program for children of torturous abuse.

Methods of Approach

Qualitative studies using secondary research will be used in this paper. Resources include articles, and journals. There is not a single treatment therapy that has been developed or used as a model specifically for children of torturous abuse. Tortured children would be a sub-group of abused children and there is a lack of programs for severely abused children available. Any literature used would need to find quality programs that have an impact in the healing process for abused children. The foundational support of current programs will be able to help build elements into other specialized programs that could be developed specifically for tortured victims of child abuse (Knox, 2014, p.1) (Berlinger, 2004) (The Center for Victims of torture, 2019).

Researching treatment programs and therapies that are already being utilized, or those that have been used for abused victims, will be explored. Pros and cons of each program or
therapy model will be compared. Provisions of the information about programs that are used for other populations (refugee survivors for example, methods used at refugee camps) will be utilized (The Center for Victims of Torture, 2019). When completed, additional research will be provided where it is available. Information about the success rates and statistical data will be used to support the growing need for specialized programs for tortured children.

Ideal elements and components based on positive attributes of already developed programs and therapies will be suggested, as well as how those foundational ideas can be included or incorporated into specialized therapies or programs for tortured children (Berliner, 2004).

Anticipated Outcomes

It is anticipated that the outcome of this seminar paper is to create the argument as to why, as a society, there is a need to create specialized treatment programs for tortured child abuse victims. The anticipation is that the foundations of other programs used for healing child abuse victims accompanied with research and literature, can justify why those elements are needed in a specialized program. Analysis here will also show why those current programs do not work for tortured children. This paper highlights ways to enhance those elements for severely abused or tortured children (The Center for Victims of Torture, 2019). This paper will show what key elements of other programs may be more likely to be successful in a specialized treatment program. It is anticipated that this research project will serve as a guide for mental health professionals and those who work with child victims of crime. This includes, but not limited to, law enforcement, prosecutors, judges and any other professionals who are involved with the welfare of child abuse victims of this type.
It is anticipated that some foundational roots of other programs can inspire new programs to be developed for tortured children. This research can be used to inspire growth in the mental health field and can inspire ways to expand programming. This research should be looked at as an educational tool for professionals working with child abuse victims.
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I. Introduction: The History and Important of Developing a Specialized Treatment Program for
Torture Child Abuse Victims

According to Den Otter, Smit, Dela Cruz, Özkalipci, & Oral (2013), children are often targeted as victims of abuse due to their vulnerabilities, size, intelligence levels and direct dependency on adults for survival. As noted by Den Otter et. al (2013), the 2000 report by Amnesty International brought attention to child torture. The report covers reasons for torturous suffering. The range of reasons stretch from politically driven directives to sadistic and sociopathic behaviors and disorders. Quiroga (2009), gives a recent report that looks at the varying cases from the 2000 report by Den Otter et. al (2013). The atrocities that children suffered due to their being abducted was in this report. There were also mentioning’s of over 400 children who were reported missing as well as children who were born to mothers in detention facilities. Many of these mothers and children were killed for political reasons in Argentina. This report covered 133 cases that involved torture of children in Guatemala and Honduras. Testimonies were recorded from 1080 children who were detained and tortured for political reasons during the dictatorship of Pinochet of Chile (Den Otter, et. al, 2013). The report also contains the documentation of 415 cases of tortured children during the Marcos dictatorship in the Philippines. Thousands of street children in Brazil were either killed by the police or forced to fight (Den Otter, et. al, 2013).

On an international level, these testimonies and experiences are expressed in a way that has a citizen of the United States believing that torture is something that happens in other deprived countries. In other words, torture might be something experienced in other areas of the world, so the need for spending the time, energy and resources to develop programs for tortured
children in the United States, might feel like a waste of time and money. This is certainly not true.

The United Nations, adopted the Convention on the Rights of the Child in 1989 which has now been ratified by 193 states, making it the most universally ratified human rights treaty. The committee that supports and develops this treaty had developed and ordered an ongoing global study on the Violence Against Children. One of the primaries focuses of this global study not only introduced evidence of violence against children (including tortures) but also emphasized reason it should be prohibited. This collaboration included the following: United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the Office of the High Commissioner for Human Rights, the International Labor Organization and a wide network of nongovernmental organizations (Den Otter, et. al., 2013).

Politically motivated reasons are often what leads to torture. The idea of torture occurring in the familial context has had little research, interest, or support. This has resulted in the lack of information supporting torturous abuse of children in the familial context. In order to find movement in developing programs that will help with healing and treatment of this sub-group, a focus to develop something that would give professionals the tools needed to start program development would be the first step. Developing protocols and procedures to find a definition that helps guide professionals to start an investigation, would ignite help for the victim. This first step needs to be developed so that professionals can provide resources to the family and victim (Knox, 2014).

It is important that studies such as the Istanbul Protocol study, which was used on adults, can be applied to children of abusive torture. The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,
known as the Istanbul Protocol and was adopted in 1999. This study took adult victims of torturous abuse and developed a guideline, or protocol, that walked medical professionals through ways to properly document and report on the injuries sustained through torturous abuse on adults. This protocol however, only dedicates a small chapter to children victims. Professionally expanding this method and protocol to child victims could certainly improve ways of properly documenting the injuries for children in a quicker way. There must then be litigation that will have power over both national and international courts to impose accountability onto a state for forensic medical documentation (Den Otter, et al., 2013).

The importance of developing a method, or protocol, in handling children who are victims of tortuous abuse, is needed. In the current system, the law defines children as minors. Torture is different from “child abuse” but there is currently no supportive medical definition or criteria to be able to distinguish where the line is between abuse and torture. Torture would be extreme levels of abuse that the child experiences. Things such as position holding (an example would be having the child stand on one foot for long periods of time, or holding something heavy over their head, etc.) withholding food and water, having boiling water thrown on them, multiple bedsores, and broken bones over time (Knox, 2014). Often the person who is tortuously abusing the child is a parent, or other adult or caregiver in the child’s life (Knox, 2014).

Minors depend on their legal guardians or parent to represent them in the legal system and they would need to have this person waive their “Miranda Rights” on their behalf. This crosses into ethical territory and can cross the conflict of interest line for child victims. Studies show that parents or guardians are often the primary suspect in child abuse torture cases, therefore conflict of interest may exist (Knox, 2014), (Den Otter, et al. 2013). By using the Istanbul Protocol for documenting injuries, it would give medical professionals the ability to
temporarily waive those rights for the minor and get protective services and law enforcement involved on the case. Using a tool like the Istanbul Protocol would also help document the torturous physical injuries sustained in a uniform way. If the injuries meet a criteria or protocol procedure, other assistance could be accessed quickly and efficiently with more consistent results.

When discovery of injury occurs, professionals can move forward in the investigation of abuse. Any modification of this protocol when developed to meet the needs of children would also need to be evaluated and put into place so that children are not traumatized. This would be something to consider when comparing a new protocol for children based off of the Istanbul Protocol that focused on adult victims.

It is important that professionals evaluate the Istanbul Protocol before adapting it to child torture victims, because developmentally, medically and psychologically children will present differently than adults. Children will respond differently to treatment programs depending on age, severity of abuse, the onset of abuse, and the availability of warmth, support, protective adults. Other factors that will affect a child would be the environments and the accessibility for the child to have their basic needs met. Children who were born into abuse may not be developmentally able to comprehend the abuse, compared to a healthy adult victim. An adult who was in an abusive situation after their brain was able to be wired and formed without abusive influence will be affected differently (Quiroga, 2009).

When working with child victims, it is important that the child victim is in a safe, child friendly environment where professionals who specialize in child abuse or sexual assault can be present (Knox, 2014). It is important that proper methods of forensic interviewing are handled accordingly and that the age of the child is taken into consideration. A professional should
identify what is developmentally appropriate, the level of abuse the child experienced or perceived, and the overall familial situation of the child (Knox, 2014). It is crucial that Crime Victim Support be accessed and that the protective adult for the child be given resources and support from the state, humans services, and law enforcement so that healing can occur for the child victim. Law Enforcement individuals are typically first on scene and the first ones to recognize torture. Their reports can frequently identify the level of abuse or tortured situations and can make referrals for the child.

It was found that between 1% and 2% of children evaluated for abuse had a unique set of injuries such as multiple fractures, burn injuries, and bed sores. According to police and medical records these injuries are visible and noticed either when an officer arrives on scene or when a child arrives at the hospital. The child’s reactions and behaviors can sometimes indicate the evidence of psychological injuries according to Dr. Knox and Starling (2014).

Dr. Knox and colleagues (2014), researched severe child torture cases; these studies overviewed 28 cases of extreme abuse. The ages in the study ranged from 9 months old to 14.3 years old, with the median being 7.5 years old. Thirty-six percent of the child victims died. Many counties have their own child death committees or a task force that reviews these death cases. The duration of the abuse the child victims experienced ranged from 3 years and 5 months to 8 years (Knox, 2014, p.3).

Ninety-three percent of the victims had commonalities, which fit into the framework of the “how” to define “tortuous abuse” (Knox, 2014, p.3). Directly taken from the research:

“Ninety-three percent of children were beaten and exhibited cutaneous injury; 21% had fractures. There were 25 victims of isolation (89%), as well as 61% who were physically restrained and 89% who were restricted from food or water. All the children were
victims of psychological maltreatment; 75% were terrorized through threats of harm or death to themselves or loved ones and 54% were degraded and/or rejected by caregivers. Nearly all children were medically neglected. Half had a history of prior referrals to CPS. The children in this case series were physically abused, isolated, deprived of basic necessities, terrorized, and neglected. 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.” (Knox, 2014, p.3)

According to Knox (2014), a definition of torture can be intentional infliction of severe pain and suffering without regard to the extent of injury. Abusers will often target children for the purpose of obtaining submission over them. For instance, in a few of Knox’s cases a child would be in confined spaces. Or they might have to complete tasks for the abuser to get food. Abusers will also try to dehumanize the child, as studied by Knox where several children were forced to eat dog food or feces.

A few programs have been utilized to help with treatment in child abuses cases. Many of those therapies are reviewed below. Occasionally, when a case is identified or investigated and severe abuse is suspected, sometimes these known treatment programs will be used. After reviewing these therapies, this paper describes reasons why these methods cannot be solely used for a specialized treatment methodology for tortured children. Key components of the therapies are then highlighted, and suggestions are made on what could be used for an appropriate treatment program for tortured child victims.
II. Literature Review of Programs used for Abused Children

A. Bibliotherapy

Pardeck (1990), introduced the idea of “bibliotherapy” as a method to help children heal through reading. Children’s Literature is used to help victims of child abuse and there is evidence that it is impactful. These children read books and are able to identify with the main character with prompting and emotional support from the therapist. Children are asked to find ideas in the books that support their own experiences and struggles. Sometimes the plot of the book is used to guide the therapists in exploring the child’s experiences. With support from the therapist, children are able to identify different ways the main character solved the issue or got through the problem. The solutions that were identified in the story can be used to further explore the child’s ability to see solutions in their own situation. The child’s feelings about their personal situation can sometimes be revealed when they focus on the main characters’ experiences in the book. Bibliotherapy allows children to find and label their feelings using the support of the literature. They can find that connection and relate to the character or the plot of the story and “not feel alone” (Pardeck, 1990).

Bibliotherapy allows children to work through their personal experiences and find recognition in their abuse and feel supported by the therapist (Pardeck, 1990). This method was an experimental study throughout the 90s and early 2000s but was no longer a popular treatment therapy after it was used on severely abused children. This therapy seemed to do a number of things. One negative impact was it retraumatized some children. In reading about the abuse that the character endured it became difficult for the child to continue this type of therapy. Other children were so neglected and developmentally behind that the method did not work because the children were illiterate. Many times, the literature topics were beyond comprehension for the
child and beyond the child’s understanding of the books. Lastly, it was difficult to find books with such severe levels of abuse and it became difficult to find books that showed positive outcomes for the children in the stories.

One thing Pardeck (1990), points out that therapists need to understand that abused children often have a difficult time forming relationships with people. The “trust” factors are missing or weak, at best. It is not a probable expectation that children will form therapeutic relationships with a psychologist or psychiatrist, due to their severe abuse. When those attachment bonds do occur, it’ll happen over a great deal of time and with a lot of patience. Bibliotherapy would be an innovative option to use as a specialized treatment program for children who are capable of comprehension. Trying to develop trust in a safe adult is going to be crucial. For many children this will be their first time experiencing a positive relationship. Bibilotherapy can start those foundational relationships in an indirect way with a therapist (Berlinger, 2004).

B. Animal Therapies

Simpson et. al (2011) developed a research-based program called Animal Assisted Therapy (AAT) for mentally, physically and sexually abused children. AAT used pets as a tool for therapy. The article mentions the changes in mood of children who are in the presence of a therapy animal. This type of method for therapy helped children feel more comfortable and it allowed children to be able to open up about difficult topics. Animal therapy can also help children form bonds and it can teach children to develop trust and empathy. Some therapists will talk with the child as the child is interacting with the animal. Other therapists will listen to the child's interactions while the child talks with the animal instead of the therapist about difficult things. There is some information provided about the method and ideas and the benefits for using
therapy animals. However, not a lot of research has been found about the success rates of this type of therapy (Simpson, 2011).

The two most common types of animals used for Animal therapy are dogs and horses the latter is known as Equine therapy (Simpson, 2011). What makes using animals successful is that animals have the ability to provide the child consistent responses to their behaviors. Ambiguous responses were sometimes observed when the child interacted with the animal, however children then have the ability to practice adaptive behavior patterns that are learned through animal interactions (Signal, et. al, 2017).

Studies have shown that animals have a calming effect on children when the animal shows affection to the child. This is beneficial to children who have experienced abuse. Some other studies have shown that using dogs can reduce stress and lower the psychological indicators of arousal, such as being able to lower blood pressure, or feelings of loneliness. This helps express feelings and communication skills, improves cognitive functioning, helps with problem solving skills, reduces anger and trauma-like symptoms in children. These provide positive effects to children who use dog interaction therapy (Signal, et al.,2017). Animal therapies downfall when used on child abuse victims is the lack of evidence or support that it would be effective (Signal, et. al., 2017).

C. Parent- Child Attachment Therapies

“Parent-child Attachment Therapy” is also known as “Parent-Child Interaction Therapy”. According to Urquiza, & Timmer, (2012) the Parent-Child Interaction Therapy or PCIT, is commonly practiced for children between the ages of 2 and 7. Therapists identify this time of childhood to be “the formative” years of development. This method focuses on three main components of therapy for children; first, reducing child behaviors, second, improving parenting
skills, and the parent’s reactions, and third, expanding their understanding of trauma. This also improves the quality of the parent-child relationship while focusing on building up trust in that relationship. This therapy would not be recommended or appropriate between the abuser and the child. PCIT would be used for the child and either the other protective parent or their new caregiver (Knox, 2014). This therapy is usually a fourteen to twenty-week course according to Urquiza, & Timmer (2012). In severe cases, PCIT could be developed into a program that is ongoing and continuous. This would allow victims to build trust, along with other needs and skills with the caregiver. In the article about PCIT, there is statistical information that overviews the residual effects in the children who have utilized this therapy. PCIT can maintain positive post-treatment effects for up to six years (Berlinger, 2004). This treatment program was initially developed for behaviorally disruptive kids. Through further research and experiment, it was found to be an effective method to use for evidence-based parenting programs on high risk families, families experiencing domestic violence and with abused children (Berliner, 2004) (Alayarian, 2009).

D. Play-Therapy

Play-therapy is different from regular play, a therapist can help a child address and resolve some of their own experiences, feelings, and abuse using Play-therapy (Play Therapy for Victims of Child Abuse, 2013). Play-therapy is most successful in children between the ages of 3 and 12 years old. It is an appropriate method to use for younger children who view play differently than a pubescent or adolescent child (Play Therapy for Victims of Child Abuse, 2013), (Cattanach, 2008).

Play-therapy is another program that can be used to assist children in being able to process what happened to them. It allows children, in a developmentally appropriate way, to act
out what happened or to express the feelings associated with their abuse. Cattanach (2008), mentions Play-therapy as an option for a program to help abused children. Play-therapy can be a healing method for a child because it accesses the subconscious (Cattanach, 2008).

Play-therapy is commonly used with a therapist when they are working with children, since play-therapy gives the child an out for self-expression and self-knowledge. Play-therapy is used as an outlet for expressing events and feelings and can be used to help a child tell or express a story. Children who may lack the language to express these events and situations may find play-therapy beneficial (Play Therapy for Victims of Child Abuse, 2013).

Play-therapy has been studied and shown to help a therapist connect with children of abuse. Play can help a child relieve feelings and emotions as well as to help foster imagination, critical thinking, creative thinking and encourage exploration play. Play-therapy is a great treatment option when a therapist is working with a child that is struggling with their emotions. It can help children who may not be able to express their feelings or what happened to them. Play-therapy can elevate stress in a child who may not have the language capacities to be able to talk about their feelings, events or things that happened to them (Play Therapy For victims of Child Abuse, 2013). “Research supports the effectiveness of play therapy with children experiencing a wide variety of social, emotional, behavioral, and learning problems, including: children whose problems are related to life stressors, such as divorce, death, relocation, hospitalization, chronic illness, assimilate stressful experiences, physical and sexual abuse, domestic violence, and natural disasters.” (Play Therapy for Victims of Child Abuse, 2013, p.442).

According to Play Therapy for Victims of Child Abuse (2013), Play-therapy is typically a treatment that is used on a child on a weekly basis. The sessions can last anywhere from thirty minutes to roughly fifty minutes. This time interval varies depending on the focus of the child,
the age of the child, the developmental abilities of the child and the severity of the abuse. It also depends on the interactions between the therapist and the child. Research has concluded that it takes an average of twenty sessions for the average child to complete qualitative therapy treatment (Play Therapy for Victims of Child Abuse, 2013). However, a child who has experienced extreme torture would likely take longer since the exposure and abusive episodes were probably severe. If this therapy was specialized and adapted to tortured children, it may result in shorter sessions, or the sessions may occur more frequently. The frequency of this therapy could be a few times a week, perhaps even daily. These sessions could also occur in the child’s home. This method would likely be ongoing for a child who is well receptive to this form of treatment. This therapy would not resolve the abuse issues of a severely abused child, even after twenty sessions and would likely be an ongoing therapy program.

E. Relaxation Therapy

According to The Center for Victims of Torture, many of the victims that are being treated are refugees or people seeking asylum for safety. Relaxation therapy has been used for refugee survivors and at The Center for Victims of Torture. Relaxation therapy is used to give the victim of torture an awareness of self. It helps enhance their body awareness and helps them focus on relaxing their muscles by using relaxation techniques (Berliner, 2004) (The Center for Victims of Torture, 2019). Relaxation therapy was founded to help reduce stress and fear responses in those that use it as a treatment method (The Center for Victims of Torture, 2019).

The Center for Victims of Torture has developed and personalized a program called Services for Survivors of Torture (SOT) (The Center for Victims of Torture, 2019). This program is geared for refugee victims. Some of the practices could be incorporated into a specialized program for tortured children and could be beneficial in their healing journey. SOT
focuses on direct services for survivors, as well as technical assistance for developing skills, and working with trained and skilled professionals. This program helps survivors navigate getting jobs and uses cognitive-behavioral therapy to help them develop personal relationships that they may encounter. The National Capacity Building Project (NCB) at The Center for Victims of Torture recently launched a new brief theoretical and practical overview of Narrative Exposure Therapy (NET). This overview has emerged recently as a promising evidence-based treatment for PTSD in torture survivors. NET helps survivors cope with the symptoms of PTSD (The Center for Victims of Torture, 2019). This program could also be reworked to fit the unique needs of child victims of torturous abuse. For example, in child-development a child will go from playing parallel with peers to playing in cooperative play with another child. This progression occurs naturally over time. Using this with tortured children, it could be supported in a program structured to work through stages or social interactions. First, children would need to feel more comfortable in close proximity to their primary caretaker and potentially getting familiar with a therapist. After the child is comfortable with their primary caretaker, they are slowly introduced to other care team members, as well as other family members. Eventually the goal would be to move therapy sessions from the child’s home or the therapist’s office to other environments or in a safe public space.

F. Trauma Focused Cognitive-Behavioral Therapy

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment program to use on children, according to Films Media Group, film distributor, & PESI, Inc. (2017). CBT for Trauma Treatment: Powerful and Proven Techniques — A Lecture. Place of publication not identified]: PESI, Inc (Firm). Originally this treatment was used for adults but was developed and used on children. This therapy incorporates parents into the therapy sessions with children.
TF-CBT is an evidence-based treatment for children, adolescents, and their nonoffending caregivers. This is designed to address PTSD, depression, and other trauma-related behavioral difficulties. Most children will engage in twelve to sixteen sessions, generally. The US Department of Justice supports this system. TF-CBT uses the acronym PRACTICE.

“PRACTICE stands for Psychoeducation and parenting skills, Relaxation, Affective expression and regulation, Cognitive coping, Trauma narrative development and processing, In vivo gradual exposure, Conjoint parent-child sessions, and Enhancing safety and future development.” (Films Media Group, 2017, 4:49:30).

TF-CBT has three phases in its program. The first phase is the stabilization and skills building phase. This is where the therapist works with the protective parent on parenting skills, providing education and trauma understanding. Therapists will model appropriate parenting behavior to the parent and offer suggestions to help the protective parent with coping skills so they can work with the child who may have difficult behaviors. The second phase is the processing and trauma narration phase. Here the therapist works with the child and slowly exposes them to triggers or traumatic memories. The child works through their traumatic experiences by talking with the therapist, and will sometimes express their trauma using writing or art. The therapist challenges the child and works on their understanding of the events through these media. The therapist will work with the child to understand the events of the abuse so the child can comprehend what that abuse meant. How the child feels emotionally and the consequences of the situation are part of the processing phase. In other words, what happened and why, what is understood about the abusive events? Questions such as “Does that make sense to think about it that way? or “What about looking at it this way?” The child could be challenged by asking,” What should have happened instead?” The third phase is roughly the consolidation
and closure phase. This phase gives the child understanding of their abuse and also the caregiver some tools to better respond to the child. This phase works on safety planning and plans to prevent revictimization. This is a phase of growth and empowerment working through processing the abuse (Ready, et. al., 2015 pp 20-23).

TF-CBT is a structured program that be used as a component in therapy with the child. This structured program would give professionals a baseline on how to move through therapy with the child. An example would be, after a tortured child is discovered and goes through the guideline or screening process, it was discovered that the child would respond best by incorporating Equine therapy (Animal therapy). The psychologist would be able to knowledgeably reference the guide and base the foundation of therapy using horses. With TF-CBT, the therapist could then go through the PRACTICE steps of TF-CBT using Equine therapy as major components and following a guideline for the specialized treatment program. This is a great baseline that could help structure the foundational ideas to personalized therapy and to truly make the specialized treatment program unique to each child victim of torture.

Unfortunately, there is no evidence if this would be successful and there would have to be a testing phase and preliminary study to determine if this would potentially retraumatize children. There is no information that indicates it is used on tortured victims but enough studies have been conducted using this treatment on abused children.

III. THEORETICAL FRAMEWORK

A. Jean Piaget Theory

Jean Piaget, “The Father of Child Development”, and his theory should be considered when making the determination of abuse. Jean Piaget first started researching and publishing his
information in the 1920s. According to Piaget it is important to consider the child’s age, and the child’s cognitive abilities. He also states that the child’s developmental age, the language development of that child, the child’s skill level, and developmental milestones are also important factors. It is important to determine if what is occurring is truly child abuse or parental discipline. Turning to science and theories on child welfare will help determine if child abuse is occurring so a definition can be developed. As a child ages their moral development will grow, and memory recall will expand and strengthen. If abuse is occurring, clearly there is disruption in these developmental areas (Wright, 2019).

Continuing on using Piaget’s Theory, children who have been severely abused and tortured may not have been able to develop the basic skills in recall memory. In their brain development they experienced trauma and this interrupted the brains circuit connections. The child will first go through the stage of recognition, even though it may be basic facial recognition before they are able to grow through the other stages of development. The other stages include, recall recognition and sense of self where they can interpret and discover their autobiographical memory. This shapes their moral development and at that point allows the child to make choices. This allows a child to be able to distinguish between obedience and avoidance of punishment. By age 9 a normal, healthy child can start to recall memory more efficiently, their moral development is heightened, and they can now choose between avoiding disapproval and gaining approval from others (Wright, 2019).

When a professional is working with an abused or tortured child, they must keep in mind that the child’s ability to recall the abuse and to understand that connections might be lacking. Professionals need to understand this must be taken slowly and with purpose to patiently work with the abused child. It is not necessary in the healing process that a child be able to recall all
details of their abuse experience. Compassion and empathy can make a world of difference in the approach of working with an abused or tortured child (Wright, 2019).

B. Children’s Memories/Recall Process/Forensic Interview

During a forensic interview a child may disclose abuse. In an investigation it may be discovered that abuse or torture has occurred requiring the investigator to access mental health services and to start the case documentation for the criminal justice system. Forensic interviewing is crucial in the next steps of healing for that child. A rigorous training procedure needs to be established for professionals who are expected to be the “first initial responders” to a child torture case. Often, the child is abused prior to the age of 9 clueing the investigator that the child will not have developed appropriate language skills. The investigator then may need to set up a forensic interview for that child (Wright, 2019, p. 18). A tortured child is likely neglected emotionally, they may appear to be in pain and scared. The child may not be able make a disclosure verbally that is understood by anyone else. This may impact their ability to make statements in an interview. A tortured child may not have been given the chance to form trust bonds with anyone, so talking to a stranger would be challenging. Due to the child having a lack of positive relationships the forensic interviewing process might be challenging and possibly retraumatizing for the child. Often a tortured child is too young to identify with their feelings or the moral implications of the situation. Their autobiographical stories may be weak or nonexistent. For a tortured child to make sense of the abuse through their underdeveloped lens would be challenging. Professionals need to have the right levels of training and education to understand what the child is trying to express especially with torturous abuse (Wright, 2019).
Typically, with forensic interviewing, a forensic interviewer can make a well-educated guess on the child’s ability to disclose the abuse. This is based on the child’s age where they are developmentally and language skills. However, when working with torture victims, the severity of abuse between the victims will vary and can be unpredictable for a professional. Commonly, a child in a torturous situation is working in their survival brain. For instance, a child will be more concerned about when they will be able to eat and/or if they will be abused. Other worries could include wondering if the abuser will prevent them from sleeping as opposed to a child who is not abused. Living in uncertainty is a stressful situation with abuse and cannot compare to a child who is not abused. A child who is not abused may be interested in what is the latest toy and not worry about being abused. A well-trained forensic interviewer or investigator will need to understand and be more empathetic to the abuse that the child endured. They need to be sharp, patient and trained when they are working with a child (Wright, 2019, p. 33).

C. Social Learning Theory

According to Hammer (2011) Social Learning Theory states that the norms and beliefs of a person form within that persons cultural and social environments. Their social interactions play a major role in what behaviors they express. It could be argued that the abuser learned the abuse from someone else. Mental health services would benefit the abuser as well. It is advised that the abuser be ordered mental health services to prevent recidivism. The focus on this theory is the healing of the abused or tortured child. Aker’s Social Learning Theory can help explain reasons for crime. According to Piquero, (2015) people who are abusers and engage in crime or criminal behaviors will likely repeat that behavior and commit other crimes and abuse. According to this theory it is be believed that a child that is being tortured might grow up and torture someone else. The ACE’s study would support the idea of the Social Learning Theory because both suggested
that a person who is abused/tortured is likely to abuse or torture later on. With intervention and prevention work, there can be a decline in the predictable curve projection of a child who was tortured. The Social Learning Theory states that a person can adapt to their environment. Once a child is removed from the tortuous situation and placed in a safe environment that provides positive relationship’s and can meet the basic needs of the child then the child will adapt to their new environment (Hammer, 2011 p.1-2).

Social Learning Theory gives professional insight and hope that a child in a tortuous situation can successfully be rehabilitated with supportive interventions and not repeat the abuse. However, Social Learning Therapy also indicates that there is a risk that the child would have been affected by the abuse and learned that behavior and then might repeat it on someone else. There are no studies found that show enough qualitative information on torturous child abuse and if positive outcomes after removal occurs. There are no studies found to support if they indeed will repeat these abusive behaviors.

IV. Implications of Trauma and the Impact of Torture

A. ACE’s (Adverse Childhood Experiences)

The more Adverse Childhood Experiences (ACE) a person was exposed, the higher their ACE score, and likely the poorer their health outcomes would be. The Adverse Childhood Experiences study was one of the largest qualitative findings that focused on family dysfunction. This study looked at more than 1700 participants. The study recognized the effects of trauma and identified people who suffered poor health outcomes. The CDC and Kaiser Permanente got together to answer the question of “Why are certain people more susceptible to poor health outcomes compared to others?” (Harris-Burke, 2015). What they found was alarming. They
discovered that when they asked people about their childhood experiences, people who indicated that they endured child abuse, neglect and/or sexual abuse fared worse off and faced more poor health outcomes, compared to their peers that had a lower ACE score (Cronholm, et. al 2015). The study looked at several factors that included home dysfunction, abuse and neglect. The answers to questions asked of the participants would then give them an ACE score. In general, the people who scored 4 or more ACE’s had more poor health outcomes overall.

According to Cronholm (2015) the method used to create an ACE score consistently shows that people with a high ACE scores often express risky behaviors that include substance abuse, multiple sex partners, smoking, early sexual onset activities, pregnancy etc. The ACE scores also showed that there is a correlation between higher mortality rates. Mental health issues, cardiovascular diseases, pulmonary disease and liver diseases which are reasons for causes of death in people who have higher ACE scores (Harris-Burke, 2015).

Naysayers challenged the research and said that it was not true science that people who lived in lower income neighborhoods or lived with an alcoholic. They stated it would make sense to turn to alcohol and drugs to cope with their situations. They stated that this was not science but was interpreted as “bad behavior”. This is exactly where science comes in (Harris-Burke, 2015).

People who are exposed to “high doses of ACEs” (Harris-Burke, 2015), are more likely to suffer from seven out of ten of the leading causes of death in the United States. Childhood trauma highly affects a person, not just through mental health but also their physical health. The exposure to adversity or trauma clinically shows definitive changes to the developing brain. It even affects the way DNA is read and transcribed. This stress DNA can be multigenerational affecting poor health outcomes and increases sensitivity to diseases among decedents. Abuse or
alcoholism can be transferred for several generations as a result of this DNA alteration in the family bloodline. Trauma includes physical, emotional or sexual abuse, as well as, physical or emotional neglect. This study then expanded to examine parental mental illness, substance dependency, incarceration/military deployments, parental separation or divorce, as well as domestic violence.

The important things about ACE’s that must be understood is that most people have an ACE score. The ACE’s study found that 67% of the population had at least one ACE. (Burke-Harris, 2015). For example, consider how the divorce rate has increased over the last decade. Consider how many people has enlisted in the military after 9/11. The ACE study also discovered that 12.5 % or 1 in 8 adults had a score of 4 or more ACEs. It is important to point out that children who are tortured are going to have a high ACE score of four or more. Tortured children would likely be able to be identified on the ACEs questionnaire. A high ACE score could indicate that they had been physically and or sexual abused and/or their abuser was also abusing alcohol or other substances. Possibly the child may have had an incarcerated parent some point. All of this would continue to increase that child’s ACE score. It is incredibly important to get these children into specialized treatment programs so they can build resiliency, be rehabilitated, and lessen the curve and trajectory of poor health outcomes. The more professionals can focus on rehabilitating these victims, the better chance they have to experience fewer poor health outcomes due to interventions and prevention efforts. There is growing evidence that correlates toxic stress and adversity poor health outcomes (Cronholm, 2015) (Boullier, & Blair 2018).
ACE’s and toxic stress can cause permanent damage to the developing brain and alters the functioning of the immune, endocrine and neurological systems in a patient. This predisposes them to the risk of early death or chronic diseases (Boullier, & Blair, 2018).

Humans have the ability to regulate themselves. When people are faced with stressful situations, a response system is activated. This process is called “allostasis” (Boullier & Blaire, 2018). This response is normal and appropriate in the event of a fight or flight situation for safety reasons. When a child frequently experiences situations where their stress response is constantly being activated, it causes changes in brain development. Usually, a normal person is able to recover from a stressful situation and can regulate back to normal levels of functioning. A person in the constant state of stress and trauma cannot regulate back to a normal state of functioning (Boullier, & Blaire, 2018).

From a neurological standpoint, a person in constant state of toxic stress or trauma may have issues with behavior problems, memory, recall, problem solving abilities, concentration, learning and overall poor executive functioning (Boullier, & Blaire, 2018).

Toxic stress can affect the endocrine system by increasing the cortisol production that affects the circadian rhythm (Boullier, & Blaire 2018). Chronic stress also affects the immune system by increasing inflammation, and cardiovascular disease (Boullier, & Blaire, 2018). Having a high ACE score can have short, medium- and long-term health effects, especially on children. Children who are tortured are more at risk of dying at a younger age and due to the effects of trauma can also put them at higher risk for poorer health outcomes (Boullier., & Blaire, 2018).

B. Overview of Previous Torture Case Examples
Knox (2014), emphasized the importance in humbly examining tortured children cases and using those experiences to be able to find commonalities. These cases provide clues in developing prevention programs and to highlight the unique victimizations of tortured children. When looking at the physical and psychological maltreatment that these children endured, it is paramount to find a medical definition that helps these cases stand out. Eleven of the victims examined were male children and seventeen were female children. “Twelve children were Caucasian (43%), ten (36 %) African American, and six (21%) were Hispanic. Forty-five percent of the victims’ siblings had been coerced into participation in the torture and 65% of siblings were abuse victims themselves….” Another interesting set of commonalities in the research looked at the types of physical abuse and injuries: “Ninety-three percent of children had cutaneous evidence of physical abuse at the time of medical intervention or death. Sixty-one percent had been physically restrained by binding. Ninety-three percent of children had been beaten and 21% had fractures. They received no medical care for their physical injuries. The fatality rate was high at 36%.” (Knox, 2014 p.3).

Unfortunately looking at these victims of torture, a common theme was identified involving food. Many of the children were neglected by not given enough food and water for long periods of time. Common themes also included basic needs being used as punishment. Children were prevented the right to use proper toileting facilities, were deprived of food or water and were often isolated from social interactions, family and friends (Knox, 2014). “Eighty-nine percent experienced food deprivation and 79% were fluid restricted. Sixty-four percent were restricted in the performance of normal bodily functions, including toilet access for urination and defecation. The majority of the children (89%) were isolated from people outside the immediate family; 79% experienced solitary confinement. For over half, few individuals
outside the abuser(s) knew of the child’s existence. This social isolation typically involved preventing the child from attending school or daycare. Twenty-nine percent of school-age children were not allowed to attend school; two children, though previously enrolled, were disenrolled by their caregiver and received no further schooling. An additional 47% who had been enrolled in school were removed under the auspice of “homeschooling.” This “homeschooling” appears to have been designed to further isolate the child and typically occurred after closure of a previously opened CPS case. Review of these cases found no true educational efforts were provided to the homeschooled children. Their isolation was accompanied by an escalation of physically abusive events, … Threats of death were made to 32% of the children. Of known mental health outcomes for the surviving children, post-traumatic stress disorder (PTSD) was the most common mental health condition… Twenty of 51 perpetrators were either the biological mother or father (39.2%). Females (31 total) were among the perpetrators in every case. Twelve female perpetrators were biological mothers (38.7%). Stepmothers or girlfriends constituted 19.4%, as did adoptive mothers. Other female relatives (12.9%, 4) and unrelated females (9.7%, 3) were also perpetrators. Among the 20 male perpetrators, eight (40%) were the biological father, five (25%) were stepfathers or mother’s boyfriend, four (20%) were adoptive fathers, one (5%) was another relative, and two (10%) were unrelated males. For all cases, all adults in the home knew of this extreme abuse and participated to some extent in the abusive acts. Unlike other forms of abuse, most perpetrators of torture partially confessed to their crimes; however, they significantly minimized or rationalized their individual involvement.” (Knox, 2014, p.3).

Knox is stating that these children were not allowed to have a childhood. Their childhood was taken away from them and their abuser controlled their environment. The abuser often seems to purposely hurt them, deprive them of their basic needs and dehumanize them. In
Knox’s statistics it was found that 60% were abused by nonbiological relatives. This is a small data set of information; however, appropriate conclusions can be made. For many of these cases the perpetrator seemed to have found a ritualistic form of abuse and continued to perfect the abuse performed on the child.

C. Household Dynamics

Several children came into torturing households through informal family arrangements. These arrangement agreements were outside of court orders, formal legal actions, custody agreements and placement agreements, etc. It was observed that 79% of the primary abusers were not the child’s first degree relative; they included such caregivers as boyfriends, girlfriends, aunts, uncles, grandparents, adoptive parents, and stepparents. Most child victims appeared to be singled out within their family. Another recognized form of abuse is associated with sibling empathy deficits (Hollingsworth, 2007). Other siblings often were coerced to participate in or endorse the abuse of the index child. In this case series, many of the other children in the household were also abuse victims themselves. They generally suffered significantly less abuse than the index child.

The long-term effects of child torture, when identified as a form of child abuse, is understudied and not well known, researched or documented. According to the medical literature researched by Knox, (2014), adult victims of torture often exhibit insomnia, anxiety, depression, PTSD symptoms, phobias, nightmares, panic expressions etc. Aside from torture, when a child experiences polyvictimization (multiple forms of abuse), they suffer from more severe mental health issues and disorders compared to a child with stable family relationships.

V. Recommendations for Developing a Specialized Treatment Program for Tortured Children
A. Implementing Elements that Work in Other Programs

Every child torture case is unique, thus having a single program for those cases would be ineffective. The programming needs to be child centered and adapted to the specific victimization and abusive torture the child endured, including where the child is developmentally. Any program of this nature needs to start by defining the torture abuse situation that meets both medical and legal criteria. When that threshold of criteria is met, the perpetrator can be prosecuted appropriately. A guideline or questionnaire needs to be considered to properly document the injuries sustained. It is essential for the program to have highly trained professionals who understand trauma and child abuse. They must also be empathetic to the child’s fears, and are equipped to handle extreme behaviors due to trauma. Professionals should be able to handle any developmental delays observed in the child. It is important that they make sure the visible physical injuries are handled appropriately and professionally. In other words, professionals need to be aware of body language, facial reactions, and instinctive human emotions. Professionals need to also be aware of their reactions to seeing physical injuries so that they do not emotionally harm or traumatize the child by their reactions.

Children who suffer torture often are healing from broken bones, malnutrition and are in a hospital setting. Medical professionals are going to want to make sure the physical injuries are healed before the child is released or has the opportunity to undergo therapy. Once physical injuries are healed, the cognitive and physical development of the child can then be established further. Once the child is healed enough to undergo therapy, more serious forms of treatment could then occur. The basics need to be met first. Professionals should consider the parent-child attachment and establish how strong the relationship is between the child and caregiver. At that point, the professional is able to build on that relationship. One thing to consider are the language
skills of the child. Professionals need to establish support, resources and care for the family, as well as what can be accomplished in treatment for this child.

Questions that need asking would be: Does this child have the skills to comprehend books and language? If yes, would “bibliotherapy” be a good stepping stone in developing rapport with this child from a therapeutic standpoint? How developmentally behind is this child? Are we working back to basics? Is it more appropriate for the focus to be working on a cry response between child and caregiver? Questions like: Should we try establishing trust, for instance does the child bond with the caregiver, does the child have a sense of safety with the caregiver, etc.? Is the child afraid of animals? If they are not afraid of animals would animal therapy be appropriate for this child to develop a secure relationship? Does this child have mental health concerns and issues or a disorder like autism or something similar? All these factors need to be considered before jumping into a rigorous treatment program. To establish a successful program, a guideline for professionals should be created so they can check off what is established through the questioning processes. Then a treatment program can be established and be unique to that child.

B. Developing a Multidisciplinary Care Team for Tortured Children and the Importance of Training and Education when Working with Tortured Children

The first step in developing a care team is to formulate a medical definition that meets legal statutes. It is important to have a medical definition of torture so that professionals who specialize in child abuse can open up treatment programs and healing for the victim through more appropriate measures. If a baseline definition is given then medical professionals, human services or child protection agencies, and law enforcement officers could better identify and react to these cases from a legal and treatment perspective. Once definitions are established,
appropriate guidelines and protocols unique to that child can be developed. This allows professionals to be able to ask questions, and to make a thorough investigation once they identify that child’s issues. Are there humiliation tactics being used? Are there prolonged times of physical labor or position holding evident? How many days has this child been deprived of food or water? etc. This would allow for proper evaluations, the ability to effectively protect the child victim, and to find a procedure or protocol that is separate and specialized. Legal professionals then could be able to appropriately handle these cases and know systematically how to best handle the perpetrators.

It is essential to also identify any siblings who were abused, witnessed the abuse, or participated in the torture or abusive behaviors. The siblings also need thorough evaluations and need rehabilitative efforts and treatment programs, so they can heal and rehabilitate into society also (Knox, 2014).

Understanding the effects of trauma and abuse needs to be specialized. Child abuse and child torture can be difficult to prosecute because two sides of the law are both activated. These cases are often both civil, as well as criminal matters. In a criminal situation a person has the right to face their accusers but for a child this can be extremely stressful and triggering. In the court room, this is a stressful occurrence for most adults let alone a child. Professionals need to be aware of the emotional capacities of a child who can be more severely abused in an interview or legal situation.

As stated above according to Knox (2014), child torture cases can be both criminal and civil matters. The criminal law side will reflect on the physical and psychological injuries. These injuries are often related to physical abuse and/or sexual abuse. The civil side reflects information that highlights family matters, custody, employment related laws, public health
concerns and safety issues, etc. When considering torture related cases, what establishes the idea of torture is often concerned with details of the specific event. An example of this would be a mass shooting, or natural disaster. The extent of the injury sustained and the pain suffered by the child victim are also relevant (Boullier, & Blaire, 2018).

Being able to recognize the potential of abuse and the warning signs of torture will be crucial in developing programs. A program needs to correct malnutrition issues and to address any trauma concerning food and water deprivation, the program would need to include the rehabilitation of physical injuries. Counseling and psychological care needs particular attention especially to the emotional trauma sustained from the torture that should include grief counseling and bereavement support in child torture case resulting in death. A systematic approach should involve a tough criminal justice response, child protective services, crime victim supportive services, mental health professionals, and rehabilitative support workers. These professionals would all be important to have on a Multidisciplinary team that work with the child. These team members would participate in the parent-child attachment therapies and ideals. This would allow the child to securely attach to a protective caregiver with support from professionals. At that point they can then gear their work and focus around that person and child/family unit.

Many children are reunited with their abusers. However, Knox (2014), states safety plans for victims of child torture should rarely, if ever, involve plans for family reunification. There is too much damage to the child’s mental health that is similar to PTSD. Putting the child back into the situation where they were abused with the person who inflicted the abuse would be devastating to the child victim. After the discovery of abuse the child would be in treatment and starting to heal through counseling. Major setbacks will occur if reunification was ever entertained or established at this point. Based on the evidence and supported by the ACE’s study
reunification with a person who “tortuously abused” a child would set that child back. Recommendations should be made to remove a person of their parental rights. If the abuse occurred from a non-biological parent or other adult then a no contact order must be an automatic condition for the protection of the child. The goal needs to be an ongoing “back to the basic” focus in therapy and treatment programming and would need to support a relationship that embraces the child victim and protective caregiver.

VI. SUMMARY AND CONCLUSION

Using a guideline like the Istanbul Protocol and creating it to be developmentally appropriate for children, would be a great first step in developing a guideline to properly record and document sustained injuries of torturous abuse. Whatever the guideline is called, it needs to be child centered and not focused on adults as stated in the Istanbul Protocol. In order for it to be effective the guidance document(s) would need to be modified to fit the needs of children. This specialized treatment program needs to include professionals, and a Multidisciplinary Team that can support the healing of the child. This can help create the attachment needed between the “new” protective parent/family and the child victim. These professionals should be trained and should understand the specialization of child abuse, neglect and especially tortuous abuse. Clinical questions and evaluations would be needed to support the victim, and the evidence needs to guide the illegal nature of the abuse.

Most cases need testimony or eyewitness accounts of abuse. This is where the forensic investigator can be helpful. Developing a Specialized Treatment Program that can use medical forensic evidence of abuse and can also help get a child into a child-focused specialized treatment therapy the goal of a child focused program. This program would be accessed more
quickly which is vital in the rehabilitation of the child victim. Each child abuse case also would need to have a systematic approach and a guideline that could meet “protocol” from a medical and legal stand point. With this guidance document justice can be served and the child victim can seek services and support. This would give the child victims the opportunity to heal in a treatment program in a time sensitive manner and can support the rehabilitation of the child and the family.

A good start would be to outline the positive aspects of the Istanbul Protocol and determine if those aspects would be appropriate to use for children who are torturously abused. Creating a guideline for children based off the guideline from the Istanbul Protocol for adults is a step in the right direction. However, after investigating this avenue it may not be appropriate to use on children. Emphasis would be on the positive aspects of the Istanbul Protocol as it applies to child abuse vs. adult abuse. Since the TF-CBT is the most current industry standard for child abuse, it may be the best model in which to adapt to tortuous children.

Multidimensional therapies will need to be identified and incorporated into any guidance. When developing the guideline, professionals need to take into consideration currently available therapies of known success. These have been discussed throughout this document. Example questions have been given for each therapy and their pros and cons. This would allow the professional to then select the most appropriate therapies given each individual child’s needs based on answers to these questions. (See pages 27, 31, 40 and 41)

Once an investigation on abuse is open and a Multi-Disciplinary Team is assigned a professional is designated case manager. At that point different therapies can be discussed and the created guidelines discussed herein can be utilized. Establishing a checklist that can determine if abuse has occurred and how severe the abuse is can be overviewed in a single
document. If a tortuous situation of abuse has been identified then a separate set of questions can be asked and trigger a specialized response system. An example question in the guideline could be along the lines of, have you ever been punched? If the child answered yes, they have been punched. Then the next question could be: Have you been punched once or more often? The child states it was more than once, this would constitute the need to access more questions that ask about tortuous abuse so that a specialized program can be centered for that child. In the state of Wisconsin, currently no such list exists and this list would need to be created to help everyone professionally get on the same page. This document stays in the child’s case file and then professionals can reference back to it to adjust objectives and therapies for the child. Protocols need to be created and questions need to be asked so that a child who is a victim of torture can be placed in appropriate therapies that will support healing.

Once this protocol is in place and being implemented other questions will arise and further investigations will need to be made. This guideline can then be finely tuned to address further concerns surrounding cases of tortuous abuse. The specialized treatment program should be continuously investigated, studied and modified, as appropriate, so that it results in the most impact on a child who has been tortuously abused. More detailed definitions of tortuous abuse would be helpful than what is given in this document.

VI. REFERENCES


