

Challenging Dentists' Role: Identifying and Reporting Domestic Violence

¹C. Stavrianos, ²K. Louloudiadis, ³C. Papadopoulos,

¹N. Konosidou, ¹E. Samara and ¹D. Tatsis

¹Department of Endodontology (Forensic Odontology), Aristotle University, Thessaloniki, Greece

²Department of Preventive Dentistry, Aristotle University, Thessaloniki, Greece

³Department of Forensic Sciences (Forensic Odontology),
University of Glamorgan, Wales, United Kingdom

Abstract: Domestic violence and child abuse has become one of the latest social concerns and this trend can be clearly seen in the increasing number of reported cases. The aim of this case report is to present a case of physically abused child 11 years old. The 11 years old child had facial and oral traumas, in particular bruises and abrasions in the frontal area, the upper lip and the periorbital area about 65% of child abuse injuries involve head, neck or mouth areas. So, dental personnel may be in a good position to note abuse. As dentists, researchers are likely to be in contact with children who have been exposed to family violence the head and face are often easy targets of the abuse. The dental team that is alert to the fact that many children are been abused and that many of these abused children have injuries to the head and around the mouth may be able to identify an abused child and institute steps that might save the child's life.

Key words: Family violence, child abuse, statistics, risk factors, recognition, Greece

INTRODUCTION

Child abuse can be defined as any non-accidental trauma, failure to meet basic needs or abuse inflicted upon a child by the caretaker that is beyond the acceptable norm of childcare in the culture. A child is defined as anyone <18 years of age (Kenney and Spencer, 1995; Kenney, 2000). Family violence includes all language and actions which inflict suffering on one family member from another. Family violence also includes behaviors which force someone to do things they do not want to or prevent them from doing activities that they do want to do (Gelles, 1987; McDowell *et al.*, 1992). A long time research has revealed that many children are affected by exposure to adult domestic violence. Indeed, there are more children victims of family violence than adult victims. In home where violence occurs, children are at high risk of suffering not only physical abuse but also emotional abuse, sexual abuse and neglect. In many family violence situations there are children who witness the fighting and the assaults.

Even when they do not observe the violence, children are usually aware of what is going on. They are aware of the obvious tension, fear and distress. Their home instead of being a place of security is characterized by cruelty and fear (Garbarino *et al.*, 1991; Zuckerman *et al.*, 1995; Stavrianos, 2010; Stavrianos *et al.*, 2010).

CASE REPORT

In this study a case of physically abused child, 11 years old Albanian origin is reported. The child was thoroughly examined and the results of perioral, intraoral and radiographic examination were recorded (Fig. 1 and 2). Finally, photographs were taken yet without the use of the A.B.F.O millimeter scale as it is imposed by the Forensic medicine. The 11 years old child had facial and oral traumas, in particular bruises and abrasions in the frontal area, edema of the upper lip and the periorbital area. There was also a cigarette burn mark on the right temporal area. The panoramic radiograph revealed fracture of the frontal upper alveolar abscess and transposition of tooth #11, 12 and loss of tooth #21, 22. After the dental and medical treatment, the authorities were informed about the case, in order to document it and provide the psychological support of the child as well as the legal issues that aroused by the abuse.

FORMS-STATISTICS-RISK FACTORS OF FAMILY VIOLENCE

Family violence constitutes a triad encompassing:

- Child abuse
- Adult domestic violence or spousal abuse
- Elder abuse



Fig. 1: Multiple extraoral injuries on the face of the 11 years old victim inflicted by abuser's hand; frontal and lateral aspect

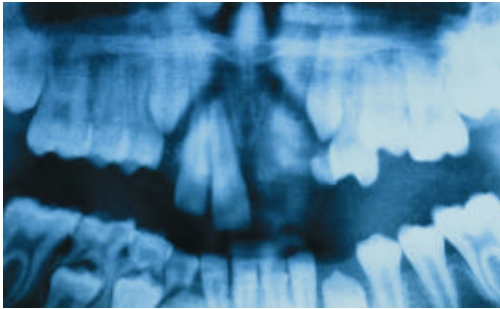


Fig. 2: The panoramic radiograph showed fracture of the maxilla, partial avulsion of the right incisors and avulsion of the left incisors

Studies indicate that child abuse occurs in up to 77% of families in which there is abuse of adults (Gelles, 1987). The numbers of reported cases of child abuse rise annually and there has been a 41% increase between 1988 and 1997. Reasons have been offered for these increased numbers. It has been reported that >70% of child abuse fatalities are caused by injuries to the head and neck. Cameron found that 50% of physical injuries were observed in the head and neck region. Studies have indicated that dentists are nearly 5 times as likely to report suspected abuse when they receive education in this area (Cameron *et al.*, 1966; Kenney and Spencer, 1995; Kenney, 2000). Under the age of 1 year, males are more commonly abused. From age 1-12 years males and females are about equally abused. Above the age of 12 years females are more often abused as they are the victims of sexual abuse.

Abused children and offenders do come from all economic, social, ethnic and cultural backgrounds. Statistics show that a large number of incarcerated youth were victims of child abuse and neglect. About 95% of

victims know their perpetrators as parent, stepparent or sibling. The statistics about family violence are revealing:

- Children are involved in 60% of family violence cases
- More than 3 million children witness acts of family violence each year as it occurs at least once in 2/3 of all marriages
- Up to 50% of all homeless women and children in the U.S. are fleeing family violence
- About 1 in 10 calls made to alert police of family violence is placed by a child in the home
- In 90% of cases children will be in the same or the next room when the violence occurs

In U.S. at least three children die each day as a result of abuse and neglect (Gelles, 1987; Zuckerman *et al.*, 1995; Mouden, 1994, 1996). Some of the factors that may increase the likelihood of child abuse include:

- Family stress and high levels of depression (Klein and Stein, 1971)
- Social disadvantages (Klein and Stein, 1971; Kenney and Spencer, 1995)
- Mental illness of child or parent

Studies indicate that there is a strong link between violence and problems with drugs and alcohol (Gelles, 1987; Zuckerman *et al.*, 1995; Stavrianos and Metska, 2002). Socio-economic background and education do not discriminate in cases of abuse. Well educated families hide the secret of abuse as do those with minimal education (Kenney and Spencer, 1995; Mouden, 1999; Stavrianos and Metska, 2002). Most parents would agree that parenting is often difficult and trying. All parents can feel anger towards their child at some time and even when a crisis in the family setting is often unrelated to the child will it can lead to abuse as the most defenseless member of the family becomes targeted. The difference between abusers and non-abusers is that non abusers find less violent methods to deal with their anger and frustration (Kempe *et al.*, 1962; Kenney and Spencer, 1995; Vale, 1997; Kenney, 2000).

PROTOCOL OF ACTS

Dentists must be cognizant of their responsibilities which include:

- Identification of victims
- Documentation of findings
- Treatment of injuries or conditions
- Assessment of the immediate safety of the patient

Referral to community family violence resources and/or reporting to appropriate agencies (Kenney and Spencer, 1995; Vale, 1997).

SYMPTOMS AND SIGNS (DETECTING IN THE DENTAL OFFICE)

Perhaps because crying or speaking emanates from the mouth, this area is frequently the focus of attack in cases of violent child abuse. Studies have shown that oral or facial trauma occurs in about 50% of physically abused children. Many of these injuries are within the scope of dentistry or easily observed by the dental professional in the course of a routine dental treatment.

It is therefore very likely that a dentist may detect such signs if he or she were astute and knowledgeable of what to look for. When injuries to the head are observed, every child needs to have a quick neurological assessment to assure no significant damage has occurred (Kenney and Spencer, 1995; Vale, 1997). In general, any evidence of severe or repeated trauma to a child suggests the possibility of abuse. This should precipitate not only a particularly thorough oral or physical examination but also a careful history and observation of the child and parents. Usually it is the non-abusive parent who will bring a child in for treatment of an abuse injury. The parent accompanying the child may himself or her self be the target of spousal abuse (Belanger *et al.*, 1986; Stavrianos and Metska, 2002).

GENERAL FINDINGS ON DENTAL EXAMINATION

Before examining the mouth the dental team may note general physical, behavioral findings, signs of sexual abuse and emotional scars that are consistent to child abuse. Any time a child presents with a possible diagnosis of child abuse, a full body examination must be undertaken to document any marks or injuries that may be covered by clothing. It is common for a particular child to have more than one injury. It is very important to state that there are no specific injuries which are diagnostic or pathognomic of child physical abuse (Kenney and Spencer, 1995; Jessee, 1995; Vale, 1997; Kenney, 2000).

The health professional should be aware of the child who seems to have overall reduced care by the parent which might include poor hygiene, inappropriate clothing, the ignoring of a routine health care (including dental care) and educational or nutritional neglect. Cigarette burns, human bites and scalds are obvious signs of child abuse. The abused child may appear unduly aggressive or may be withdrawn, show lack of confidence and have

fear of certain adults (Wagner, 1986; Stavrianos and Chourdakis, 1987, 1989; Stavrianos and Metska, 2002; Stavrianos *et al.*, 2007). A careful and thorough intraoral and perioral examination, radiographic studies, manipulation of the jaws, pulp vitality tests and percussion are necessary in all cases of suspected abuse and neglect. Some authorities believe that the oral cavity may be a central focus for physical abuse because of its significance in communication and nutrition. The injuries present most commonly as blunt trauma with an instrument, eating utensils, hands or fingers or by scalding liquids or caustic substances.

The abuse may result in contusions; lacerations of the tongue, buccal mucosa, palate, gingival alveolar mucosa or frenum; fractured, displaced or avulsed teeth; facial bone and jaw fractures; burns or other injuries. Dental neglect can also be found. This lack of care makes routine eating impossible, causes chronic pain, delays a child's growth or makes it difficult for a child to perform daily activities (Vale, 1997; Kenney, 2000).

DOCUMENTING AND REPORTING CHILD ABUSE

Recognition and reporting any suspected instances of child abuse and maltreatment is the responsibility of every health care provider. As a natural outgrowth of the dental professional's role in recognizing and reporting child abuse the topic has been broadened in recent years to domestic violence that is child, spouse/intimate partner, disabled and elder abuse. About 40 years ago in the U.S. there were 662 cases of child abuse reported to authorities (Kenney, 2006). A survey of dentists in U.S. has showed that the majority were unaware of their legal and social responsibilities to report suspected cases of child abuse. Also in general, pedodontists were more aware of their responsibilities than were general practitioners. From 1993 the ADA has obligated dentists to be familiar with all signs of child abuse and to report suspected cases to appropriate agencies. There has been noted an 80% increase in the reporting rate of dentists since 1992. The reporting is made to the appropriate agency according to law (Vale, 1997).

When one suspects child abuse it is important to document the findings thoroughly. This record of evidence is crucial for whatever legal proceedings may follow. Documentation may involve written notes, photographs and radiographs which must be recorded in the child's dental record. In some countries there are special forms available to report child abuse. When there are signs of bite marks forensic odontologists can assist dentists in the detection and evaluation of bite marks

related to physical and sexual abuse (Mouden, 1998; McDowell *et al.*, 1992; Stavrianos *et al.*, 2010). If the child requires medical attention, referral should be made to the proper resource. Even if immediate medical care is not required if a pediatrician is readily available, the dentist may wish to consult regarding the suspected child abuse prior to reporting. However, the absence of consultation and the dentists' leery of bureaucratic entanglements does not relieve them from the responsibility to promptly report suspected abuse (Vale, 1997). In many countries the dentist is only required to notify the proper authorities not pursue any investigatory aspects of the case. However, the key element for mandated reporters is their reasonable suspicion that based on their training and experience, child abuse has occurred (Kenney and Spencer, 1995).

CONSEQUENCES-IMPACT OF DOMESTIC VIOLENCE ON CHILDREN

Children learn significant messages about behavior and gender roles from parents who are role models. When exposed to family violence, they may incorporate this behavior in their relationships as children and later as adults. How much they will be affected by it depends on the child's age, the frequency of the abuse and how long it has been happening (McDowell *et al.*, 1992; Mouden, 1996; Cameron *et al.*, 1966). The child who lives in a dysfunctional environment where abuse, violence or neglect are the norm cannot predict the behavior of the responsible adults and therefore has no control over its life. The child learns, usually from an early age that using bullying behaviors brings relief from anxiety and thus surviving. Controlling other children through violent behavior means brings a sense of power (control) to the child; he can't predict or control his parents but he can control other (smaller or less physically strong) children. His targets also become useful objects onto which he can freely displace his own aggression. This is known as displacement aggression (Jones, 1982; Krugman and Krugman, 1984; Gelles, 1987; Belanger *et al.*, 1986; Zuckerman *et al.*, 1995).

Where a child is brought up under these conditions, his brain will activate a set of adaptive responses which help him survive. Different children have different adaptive styles. Some use a hyperarousal response and some a dissociative response. In most traumatic events, a combination of these 2 is used. When this threat is repetitive or chronic as in domestic violence these systems in the brain undergo permanent changes. The changes result in emotional, behavioural, social, cognitive

and physical symptoms. These symptoms commonly include relationship problems, impulsivity, inattention, anxiety, aggression, rage and depressed mood and are similar to symptoms of post traumatic stress disorder (Meadow, 1982; Krugman and Krugman, 1984; Finkelhor, 1984; Garbarino *et al.*, 1991).

A child adopting a hyperarousal response may display defiance, easily misinterpreted as willful opposition. These children may be resistant or even aggressive. They often display hyper vigilance, anxiety, panic, aggression, fear or increased heart rate. This type of response is more common in older children, males and in circumstances where trauma involves witnessing or playing an active role in the event (Garbarino *et al.*, 1991; Finkelhor, 1984; Mouden, 1996; Stavrianos and Metska, 2002). The dissociative response involves avoidance or psychological flight, withdrawing from the outside world and focusing on the inner.

Children may be detached, numb and have a low heart rate. Dissociation is more common in young children, females and during traumatic events characterized by pain and inability to escape (Kenney and Spencer, 1995; Stavrianos and Metska, 2002). The child is wholly dependent on their parents and the parents possess in the eyes of their child, a god-like status in the eyes of the child the parent can do no wrong.

Therefore the child can be brought up in inappropriate social models and can say when I was a kid, parents had the right to whip me to make me behave and I turned out okay. As adults, victims will develop hostility, inappropriate sexual behavior, poor self esteem, tendency toward substance abuse, difficulty with close relationship and suffer from long-term disturbances of the psyche. Following their parents' example of family violence to solve conflicts they are teaching the same destructive behavior to their children (Soloman, 1973; Mouden, 1999).

Exposure to domestic violence during the early years affects a child's brain development and it is linked to lower I.Q. measures and long term effects on learning processes and short-term memory. As a result it's more likely to have difficulties at school. Vulnerable children have much less capacity to tolerate the normal demands and stresses of school, home and social life compared to their peers. When faced with a challenge they react with fear or terror, they are psychologically in a state of alarm. Typical children may become vigilant or slightly anxious (Mouden, 1998; Stavrianos and Metska, 2002). Victims may also have a feeling that something is wrong with me and that the abuse is their fault. The parent-child bond can be negatively affected as parents may not be able to

consistently respond to a child's needs. Children often fail to report because of the fear that disclosure will bring consequences even worse than being victimized again. The victim may fear consequences from the family, feel guilty for consequences to the perpetrator and may fear subsequent retaliatory actions from the perpetrator.

Harmful behaviors by the parents include the encouraging of the child to use drugs and/or alcohol and to steal or engage in illegal activities (Gelles, 1987; Zuckerman *et al.*, 1995; Stavrianos and Metska, 2002; Stavrianos *et al.*, 2007). Victims often suffer both physical and emotional pain. Many survivors state that they are hurt and disappointed because the person who abuses them is the person whom they love or have loved and respected. They live in fear because the abuser is always near them and they feel shameful because their dignity is violated. Children in these families usually may want to run away from home (Krugman and Krugman, 1984; Bell, 2001; Stavrianos and Metska, 2002).

DISCUSSION

The crucial factor in the fight against child abuse is early recognition of the problem so that effective intervention can be undertaken (Vale, 1997). Dentists are in an ideal position to recognize maltreated children. An abusive parent or caregiver may take a child to various physicians or hospitals over a period of time for treatment but will visit the same dental office repeatedly so as to avoid suspicion. About 23% of head and neck injuries that were not caused by automobile accidents were a result of domestic violence and that 94% of domestic violence victims had head or neck injuries or both (Stavrianos *et al.*, 1987; Stavrianos and Chourdakis, 1989; Vale, 1997; Kenney, 2000; Stavrianos and Metska, 2002; Stavrianos *et al.*, 2007).

Many child protection agencies already treat childhood exposure to domestic violence as a form of maltreatment that should be reported, investigated and result in state intervention (Misawa, 2001). The Tennessee (USA) Code states that a person reporting harm shall be presumed to be acting in good faith and shall thereby be immune from any liability, civil or criminal that might otherwise be incurred or imposed for such action. Thus, the defendant would absolutely be immune from liability if he reported the harm (Jerrold, 2010). It has been reported that 35% of children who have been abused will be seriously re injured if returned to the parent or guardian without intervention. Indeed, 5% will be killed.

Child abuse is second only to SIDS (Sudden Infant Death Syndrome) as the leading cause of death in children under one year of age. In older children it is second only to accidents (Kenney and Spencer, 1995; Vale, 1997).

CONCLUSION

The evidence of severe and repeated trauma should alert the dentist to identify possible child abuse. The ability of proper identification of suspicious injuries to the head, face, mouth and neck of the child is of great importance for the dentists. History can be the only valid source of information and as legal procedures may follow everything should be written down in a very detail.

Offenders look like ordinary people. Although, it's not accurate or fair to create a profile of child abuser, statements of the general behavior can be made, based on studies of abuse perpetrators. People with a history of child abuse in their own childhood or of abuse against other children, with problems with alcohol or drug abuse, with anger management, especially to poor parenting skills and with poor coping skills, especially related to problem solving and making or having choices. So it is of major importance to realize that all dentists have a unique opportunity as well as ethical obligation to assist in the struggle against child abuse and institute actions that might save children's lives. The comfort level of a given child must be such that they will even disclose it directly. So dental personnel must understand their importance for the stop of pain and death of children's maltreatment by adopting the appropriate knowledge and training so as to recognize and report the signs successfully.

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