

The Dental Assistant's Role in Preventing Family Violence

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Continuing Education Units: 3 hours

This continuing education course will provide information regarding the dental assistant's role in preventing family violence. Through the understanding of what causes family violence and learning the definitions of child abuse and neglect, the dental assistant will also learn the protocol for properly identifying suspected cases of child abuse and neglect. This course will help the dental assistant understand the common symptoms that may mimic abuse and the differences in intervening in family violence cases involving adults. Additionally, the assistant should become very familiar with local and state dental initiatives to prevent family violence.

Conflict of Interest Disclosure Statement

The author reports no conflicts of interest associated with this work.

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Overview

Orofacial injuries resulting from abuse or neglect should be easy to identify in the dental setting. However, many in dentistry have historically been unable or unwilling to properly identify these injuries. The steps in dealing with conditions due to abuse or neglect are easy to learn and even easier to incorporate into the dental practice.

Not only are trained and informed dental assistants a valuable resource for providing dental care, dental assistants must also be aware of the realities of family violence in order to help prevent abuse and neglect. Treatment procedures that involve dental assistants are easily modified to include potential identification of abuse and neglect. The dental assistant's input is valuable in identifying suspected family violence because he or she typically spends more time with the patient than the dentist and as such, can be a confidant for patients who need to talk.

Learning Objectives

Upon the completion of this course, the dental professional should be able to:

- Know the definitions of child abuse and child neglect.
- Understand family violence as a problem affecting all age groups.
- Be familiar with the demographics of child maltreatment victims.
- Understand some of the causes of family violence.
- Help develop a protocol for properly identifying suspected cases of abuse or neglect.
- Recognize some common conditions that may mimic abuse.
- Understand the necessary differences in protocol when intervening in family violence cases involving adults.
- Be familiar with local and state dental initiatives to prevent family violence.

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Glossary

alveolar ridge – Bony ridge of the mandible or maxilla.

cao gao – An oriental folk remedy in which coins are rubbed on the back or chest in the belief that the process will reduce fever.

Ehlers-Danlos Syndrome – A genetic disorder marked by easy bruising, scar formation, and tendency to bleed.

epidermolysis bullosa – A congenital skin disease characterized by the development of blisters, with or without provocation.

hematologic – Pertaining to the blood.

hemophilia - hereditary blood defect characterized by delayed clotting and in turn, difficulty in controlling hemorrhage even after minor injuries.

idiopathic thrombocytopenia purpura – A condition of unknown origin exhibiting purplish spots on the skin or mucosa as a result of decreased numbers of blood platelets.

Menke's Syndrome – An hereditary disorder that in its severe form leads to mental retardation and early death.

mucosa – A mucous membrane, such as that covering the inside of the mouth.

odontology – Study of the anatomy, growth, and diseases of the teeth.

orofacial – Pertaining to the face and surrounding structures.

P.A.N.D.A. – acronym for the **P**revent **A**buse and **N**eglect through **D**ental **A**wareness coalition.

paruli - abscesses in the gum.

pathognomonic – Typical of a particular disease.

perioral – Surrounding the mouth.

petechiae – A small spot on a body surface, such as the skin or mucous membrane, caused by a

very small hemorrhage.

sequelae – A condition that follows, especially one arising from a disease.

Sturge-Weber syndrome – A congenital disorder of unknown cause characterized by facial birth marks and eye irregularities.

Family Violence

Abuse and neglect have traditionally been discussed as affecting children. However, abuse and neglect can affect victims of any age. By definition, family violence can be the maltreatment of children (child abuse or neglect), competent adults (intimate partner violence or domestic violence), and senior citizens (elder abuse or neglect). The phrase “intimate partner violence” (IPV) is the current terminology describing abuse or neglect of those within or outside of a marriage who are above age 18 but not yet elderly. Such abuse also may involve partners of the same gender. At which age maltreatment becomes elder abuse or neglect is somewhat subjective, especially within an aging society focused on staying young. Despite a change in terminology, however, the physical signs of family violence are relatively consistent across the lifespan and may present in similar fashion in victims of any age.

Child Abuse

Defined by state laws, the definition of child abuse varies somewhat from state to state. Statutes typically define child abuse as non-accidental physical, sexual, or emotional injuries or trauma inflicted on a minor child by a parent or other caregiver.¹ Child abuse can take many different forms and can present in different ways in the dental office. Child abuse includes those injuries inflicted by someone who has care, custody, and control of the child; it can include not only parents and guardians but also teachers, day care workers, and baby sitters. It does not include those considered “strangers.”

Data and Demographics

National statistics show that 3.2 million children were reported as abused or neglected in 2007, with almost 25% of those cases substantiated after investigation.² A national study found that one child dies every six hours as a result of child abuse, and young children continue to be at highest risk for such fatalities. In the eight-year period 2001-2007, 10,440 children died in the

U.S. from abuse or neglect.³ More than three-quarters (78.7 percent) of the children who have died were younger than age 4. Of these fatalities, 89 percent were younger than 1 year old.²

Child abuse and neglect know no boundaries. They are not limited to large cities, certain neighborhoods, or specific ethnic groups. Across the nation, cases of child abuse and neglect happen in all socio-economic groups, and victims come from all ethnic groups. Cases also are spread out geographically, with victims in rural as well as urban settings. It is often said that every dental practice sees abused and neglected children. Unfortunately, these children are often not properly identified.

Etiology and Contributing Factors

First and foremost dental care providers must remember that child abusers may love their children very much, even if they do not love their children very well. Abusers often are not motivated by hatred but rather by a warped sense of right and wrong in child rearing.

Child maltreatment undoubtedly can come from a breakdown in the parenting skills of the child's caregivers. Many factors can lead to this failure to parent properly. Child abuse and neglect may be one of many symptoms of a dysfunctional family.⁴ One theory holds that parents' unrealistic expectations for the child and for themselves can contribute to the abuse. Another theory is that the abuser's attitude toward children is based on the conviction that children exist to satisfy parental needs. For these parents, it follows that children who do not satisfy those needs should be physically punished in order to make them behave properly.⁵ Some mothers are simply not satisfied by the unresponsiveness and lack of feedback from an infant.⁶ One young mother's tragic lament shows her self-justifying reasons for abusing her baby: “I've waited all these years for my baby, and when she was born she never did anything for me” and “When she cried, it meant that she didn't love me; so I hit her.”⁵

Other abusers explain the maltreatment of children as a suitable means of parenting. In one notable study, Dietrich et al. interviewed abusers about their feelings subsequent to the abuse. Of those adults interviewed, 62.5 percent

felt justified in injuring the child, 58.9 percent felt no remorse for their actions, and 50.7 percent blamed the victim for the abuse. Combining the three factors studied, fully one-third of the adults interviewed felt justified, blamed the victim, and felt no remorse.⁷

It is well understood that several social factors contribute to child abuse, the most cited of which is substance abuse. Although substance abuse in and of itself does not cause family violence, it may make a bad situation worse. The abuse of alcohol or other drugs can be an indicator of other risk factors, including poverty, unemployment, depression, and feelings of hopelessness. Other common contributing factors are stress, lack of a family support network, and the cyclic problem of abuse as a learned behavior: Abusers are likely to have been abused as children. It has often been said that children who have been abused often grow up to abuse their own children, their spouse and even their parents, a situation referred to as “retribution abuse.”

The Dental Team’s Involvement

Dental healthcare workers should be concerned about the rising incidence of child abuse and the lack of reporting by dental professionals. First of all, dentists in every state are mandated reporters, that is, they are required by law to report suspected cases of child abuse or neglect.¹ Although dental assistants often spend more time with patients than their dentists, few states specifically require assistants to report suspected cases of abuse or neglect. Although state laws mandate such reports only from certain individuals, anyone can make a report.

Some facts about child abuse make it likely that most dental professionals will see it in their practice, even if they don’t always recognize it. About 75 percent of all child abuse cases involve trauma to the mouth, face, or head.⁸ Furthermore, while abusive parents often do not take the child to the same physician (fearing the physician will recognize the abuse), they tend to return to the same dentist.⁹ A 1995 national survey of child protective services (CPS) agencies showed that dentists filed only 0.32% of all reports of suspected child abuse or neglect;¹⁰ no state tracks the number of dental hygienists or dental assistants making reports. Data from various

states show that the vast majority of reports come from teachers, social workers, and “permissive reporters” (those individuals who are not required to report but do so out of concern for the child).

If dental professionals are in the best position to see some injuries from child abuse, why don’t they recognize them? If they suspect the abuse, why don’t they report it?

Clinical Protocol

Every dental office needs a protocol to raise awareness of symptoms of child abuse and neglect (Appendix 1). Evaluate behavior and histories, and conduct a general physical assessment along with the oral exam. The warning signs of abuse should be in the back of every dental worker’s mind each time they see an injured patient. Repeated injuries, multiple bruises, bilateral injuries to the face, or injuries that are inconsistent with the history given may all signal instances of abuse.

Behavior assessment is just one part of the patient evaluation. Dental assistants often spend the most time with a child during a dental visit and may be in the best position to evaluate behaviors. Abused or neglected children may be extremely apprehensive and inordinately fearful of an oral exam. On the other hand, some abuse victims are extremely eager to please; they have learned that less than perfect behavior may result in more abuse. One way to determine if a child’s behavior is appropriate is to judge against personal experience with children of a similar maturity (Note: Maturity is often different from chronological age) in similar circumstances. Share your impressions with the dentist. Combining your evaluation of the child’s behavior with other information in the patient history and with the dentist’s oral exam may lead the dentist to suspect child abuse.

It is always best to obtain histories of an injury from the child and adult separately, although abusers may not want you to be alone with the child. If dental radiographs are indicated, x-raying the child alone provides an opportunity for a private conversation. Caution: Never take radiographs merely as an excuse to have the adult leave the operator. Taking unauthorized or inappropriate radiographs may constitute

technical battery and open the dentist or assistant to liability.

Review the adult's and child's versions of the history and determine if any discrepancies exist in how and when the injuries occurred. Also determine if the injuries are consistent with the explanations. Be sure to have the dentist document in the patient chart any discrepancies in the stories given and note any physical findings that are inconsistent with the history provided.

Accidental Injuries, Predisposing Medical Conditions, and Other Causes that may Mimic Symptoms of Abuse

Be aware that children receive normal bumps and bruises in accidents. Foreheads, chins, hands, feet, elbows, and knees are the most typical sites for accidental injuries in childhood accidents. However, children can get hurt anywhere on their bodies and apparently in an infinite number of ways. Always use clinical judgment to weigh the facts and the presenting symptoms.

As with accidental injuries, many otherwise normal conditions exist that may mimic child abuse injuries. A thorough health history, updated regularly, will help clinicians make a proper diagnosis. Bleeding disorders such as hemophilia and idiopathic thrombocytopenia purpura (ITP) make children more susceptible to bruising. If these patients are not adequately treated through hematologic therapies, they bruise easily and sometime bruise spontaneously.

Conditions that cause discoloration of a child's skin, such as Sturge-Weber syndrome, Mongolian spots (also known as the slate-gray spots of infancy), or even simple birth marks can be confused with abuse injuries. While these types of marks may eventually fade with time, they are essentially permanent discolorations.

Some folk medicine remedies also cause marks similar to abuse. Cao gao, or oriental coin rubbing, can cause extensive bruising to the skin. "Cupping," a practice from Central and South America where hot ceramic cups are placed on the skin to draw out fever, causes round suction marks on skin. A more modern version of cupping involves plastic cups and a hand-operated pump. None of these practices

is meant to harm the child but are felt in some cultures to be suitable therapy for children's illnesses. All clinicians must be familiar with the cultural diversity of their patients and understand these practices.

Other, more rare conditions may also mimic child abuse. Ehlers-Danlos Syndrome, a genetic disorder that affects collagen formation, may present with numerous marks that resemble multiple bruises. Epidermolysis bullosa, an autoimmune disorder, may mimic burns that are healing. Children with Menke's Syndrome may have brittle hair that resembles traumatic hair loss. Again, a good health history helps clinicians differentiate these conditions from abuse injuries.

Common Presentations of Injuries from Abuse

Bruises or welts, however, may indicate abuse. Be concerned about injuries to the face, lips, mouth, and neck as well as any to the ankles or wrists that may be visible in the course of a normal dental visit. Injuries to both eyes or cheeks are always suspicious because accidents are most typically unilateral. (It is rare, although not impossible, to fall down and hit both sides of your face.) Bilateral injuries of abuse also can occur on other easily observable areas of the child's body.

Injuries that form a pattern are also suspicious. A slap with an open hand can leave marks indicative of the abuser's fingers. Note the lines of petechiae indicating the adult's handprint (Figure 1). "Grab-marks" on arms or shoulders may indicate excessive force in punishing a child (Figure 2).

Burns are a common occurrence in life but certain burns should make you think twice about possible abuse. Cigar or cigarette burns on the palms of the hands or elsewhere, or multiple circular burn marks should be a red flag during physical assessment (Figures 3 & 4). Immersion burns by scalding water can produce a sock-like or glove-like pattern on hands and feet (Figure 5). Patterned burns from hot objects such as a radiator, floor furnace, or a hot implement are often easy to identify; the difficulty, however, lies in determining if the burn is accidental or non-accidental.

All these injuries must be considered in light of the fact that all children get hurt from time to time. Important information for analyzing bruises



Figure 1. A “slap mark” from an open handed blow. Note the lines of petechiae indicating the adult’s handprint.



Figure 2. “Grab marks” on a child’s arm.



Figure 3. Cigarette burns to a child’s palm



Figure 4. Multiple cigarette burns across an infant’s face and torso



Figure 5. “sock burns” indicating immersion in scalding liquid

is knowing the color changes that occur during healing. Individual healing may differ markedly, and the appearance of bruises may differ based on the amount of trauma incurred. However, evaluating the color of a bruise may help you determine if the history you have received coincides with the actual date of the injury (Table 1). Clinicians without extensive forensic background are cautioned against trying to date the actual occurrence of trauma. Use the colors of healing as guidelines to assess whether the stated history matches the symptoms seen. Consider that bruises that are still swollen, red, blue, or purple are new. Bruises that present as yellow, green, or brown are older. Be most concerned if the history given contends that the injury happened in the past 24 hours but the marks are obviously many days or weeks old. Delay in seeking treatment is often seen in cases of family violence.

Evaluate dental or facial injuries carefully to determine their cause. Although the injuries of child abuse are many and varied, several types of injuries are common to abuse. Many of these injuries are within the scope of dentistry or easily observed in the course of routine

Time Since Injury	Bruise Coloring
0-1 Days	Swollen, tender, red
1-5 Days	Red, blue, purple
5-7 Days	Green
7-10 Days	Yellow
10-14 Days or longer	Brown
2-4 Weeks	Cleared

Note: Healing times and colorations can vary widely based on age, the patient's general health and the severity of the original injury.



Figure 6. Periorbital and labial contusions from a beating

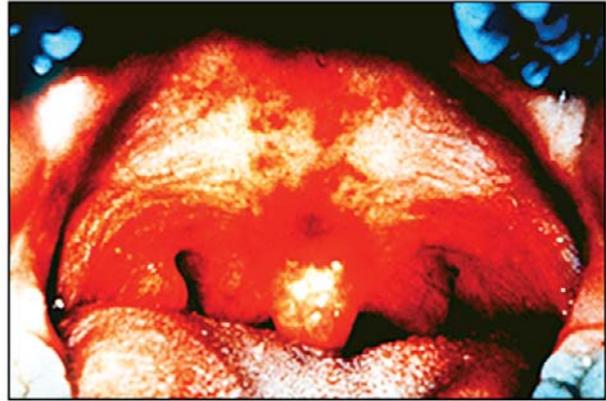


Figure 8. Petechiae of the hard palate resulting from forced oral sex



Figure 7. Bilateral injuries to an infant's face, indicative of physical abuse

dental treatment. Other types of injuries are pathognomonic to child abuse and easily identified by the dentist. Injuries of this type include those that appear simultaneously on multiple body planes¹¹ (Figure 6). Injuries that exhibit patterned marks of implements or the

adult's hand or bilateral injuries to the face (Figure 7) carry a high index of suspicion of abuse.¹²

Even cases of child sexual abuse may exhibit indicators in the perioral region. Oral or perioral lesions of gonorrhea, syphilis, or chlamydia in prepubertal children are indicative of sexual abuse.¹³ In addition, petechiae of the hard or soft palate are sometimes seen in cases of forced oral sex (Figure 8). Other indicators of possible child abuse may include pain or difficulty in walking or sitting, pregnancy in young children, and extreme fear of any dental treatment. Of course, not everyone who is afraid of dental treatment is a victim of child sexual abuse. Because of their history of abuse, however, victims of an oral rape can be terrorized by having something as benign as a mirror or explorer placed in their mouths.

The head and face are often attacked in child abuse because they represent the "self" of the child. Some such injuries of child abuse are a



Figure 9. Missing central permanent incisor from a blow to the mouth

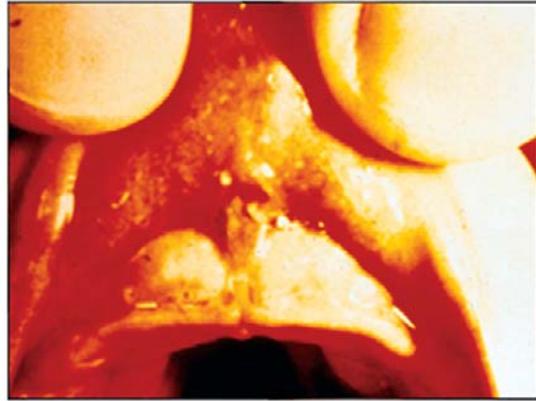


Figure 11. Laceration of the labial frenum from forced feeding



Figure 10. Severe injuries from an open-handed slap to the mouth (note the laceration of the maxillary lip, contusions in the vestibule and subluxation of the central incisor.)



Figure 12. A bite mark first reported as a dog bite (Note the marks of human adult dentition)

matter of convenience: The child's head may be the easiest place for an adult to reach. In other cases, the mouth is often injured due to the abuser's desire to silence a crying child.¹⁴ Surveys of dentists who have reported cases to CPS agencies show a trend in the type of oral injuries encountered in child abuse cases. In a survey of pediatric dentists throughout the nation, the principal dental injuries reported in cases of child abuse included missing and fractured teeth (32 percent of reported cases) (Figure 9), oral bruises (24 percent), oral lacerations (14 percent) (Figure 10), jaw fractures (11 percent), and oral burns (5 percent).^{15,16} Although the sample size of this study was limited, pediatric dentists may be more likely to encounter more child victims due to the focus of their practices.

Even the youngest victims of abuse can have oral injuries. Lacerations and contusions of the oral mucosa, particularly around the anterior alveolar ridge, are seen in cases of forced feeding when the bottle is shoved forcefully against a child's mouth⁵ (Figure 11). In older children, gags used to silence or punish a child can leave bruises at the corners of the mouth.^{17,18}

Always be wary of human bite marks on a child. Human bite marks, which should be easily identifiable by all dental professionals, carry a high index of suspicion of child abuse.¹⁹ Human bites tend to compress the flesh, while animal bites are more likely to tear it (Figure 12). Also be aware of the differences between animal and human dentition and arch forms to properly

identify the cause of a mark. Actual identification of the perpetrator through bite mark analysis is left to experts in forensic odontology.

Every member of the dental team should be able to see most abuse-related bite marks. Forty-three percent of all abuse bite marks are located on the head and neck,²⁰ and 65 percent of these marks can be seen while the child is clothed.²¹ Human bites are painful and represent an assault with a weapon that carries a significant possibility of morbidity or even mortality. Also, the infection potential of the human bite is significant and serious.

Child Neglect

Child neglect also is a huge problem. For every case of child abuse, an estimated ten children are neglected. Unfortunately, children without adequate dental care are seen in dental offices every day. As such, states have provided a definition of child neglect to help differentiate it from simple lack of care.

Although state definitions of neglect vary considerably, all specify acts of omission, including failure to provide adequate care, support, nutrition, shelter, and medical or other care necessary for a child's health and well being.¹ Parents who can't access or finance dental care may not be neglecting their children. However, if resources are available and the child is not receiving proper care, a suspected case of neglect should be reported (Figure 13). According to the American Academy of Pediatric Dentistry, "dental neglect is a willing failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection."²² Because neglect may involve many factors, including money, insurance, transportation, and access to care, deciding to report suspected neglect may take more consideration than a suspected abuse case.

Questions often arise as to when missed dental appointments should raise suspicion of child neglect. Because state statutes provide no guidelines for when these cases should be reported, dental team members must carefully evaluate the seriousness of the child's untreated



Figure 13. Dental neglect as indicated by multiple paruli from gross caries.

condition, the family's resources, and factors affecting access to care before deciding to make a report. Where one case may not need to be reported even after two or three missed appointments, another case may require a report after just a single broken appointment if the child is in imminent danger of serious physical sequelae from lack of care.

Intimate Partner Violence

According to the Centers for Disease Control and Prevention (CDC), Intimate Partner Violence (IPV) is defined as abuse that occurs between two people in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering.

IPV includes four types of behavior:

- Physical abuse is when a person hurts or tries to hurt a partner by hitting, kicking, burning, or other physical force.
- Sexual abuse is forcing a partner to take part in a sex act when the partner does not consent.
- Threats of physical or sexual abuse include the use of words, gestures, weapons, or other means to communicate the intent to cause harm.
- Emotional abuse is threatening a partner or his or her possessions or loved ones, or harming a partner's sense of self-worth. Examples are stalking, name-calling, intimidation, or not letting a partner see friends and family.

As is also found in elder abuse and neglect, the physical and behavioral signs of intimate partner violence are often quite similar to the signs of child abuse and neglect maltreatment.

Reporting

Child Maltreatment

Before making the report, a decision must be made whether a dental professional should visit with the parent or caregiver regarding the child's condition. If it is in the child's best interests to speak with the adult before making a report, the dentist should speak with the adult in private but with another member of the staff present as a witness. In that confidential setting, the dentist should express a concern for children in general and for the particular child specifically, unemotionally stating the requirement to report suspected abuse and neglect and relating the conditions, behavior, or history that raised his or her concerns. Avoid being judgmental. Even if the child is a victim, it may not be at the hands of the adult present, and the maltreatment may be totally unknown to the person receiving the information.

Dentists and dental staff are not the professionals charged with determining whether abuse or neglect has actually occurred. Their responsibility is only to report suspected cases. Dental assistants should talk privately to the dentist and other staff members about conditions or problems they see. It may be beneficial, but is not mandatory, for the dentist to consult with the child's physician to discuss any concerns. The physician may have useful information about the child's condition and medical history.

If a report needs to be made, make the report immediately, or have the dentist make the report immediately. Simply call state or local child protective services (CPS) agency, as dictated by state law. A trained social worker will discuss the case with you and determine necessary action. It should be noted that a call to CPS does not necessarily mean you have to file a report on the specific case. The call can be a professional consultation to help you decide if you need to report. Most importantly, remember that a call to CPS is not an accusation but a request for

help on behalf of a child. If an investigation is warranted, CPS will investigate the case.

Based on its investigation, the CPS agency will determine if a case is "substantiated," meaning that credible evidence was found to indicate abuse or neglect, or if it is "unfounded," which means that insufficient evidence exists to substantiate maltreatment. Even if a case is deemed unfounded, a child may still be at risk. If sufficient evidence was not found, information from the initial inquiry may be useful in future investigations to benefit the child.

Liability is not an issue in reporting suspected abuse or neglect. State laws contain language that protects mandated reporters from criminal and civil liability arising from good-faith reports. Unfortunately, dental workers can still be sued for making a good-faith report. Unless bad faith is proven, however, they cannot be held liable. The reality of modern American society is that anyone can be sued for any reason. Nonetheless, in reporting suspected child maltreatment, such suits generally have no foundation in law.

Privileged communication does not apply to suspected child abuse or neglect cases. The law states that privileged communication between a professional person and his patient does not apply to situations involving abused or neglected children, and does not constitute grounds for failure to report as required.⁹ Information given to the dentist by a patient may be shared with CPS in the investigation of child abuse or neglect, and doctor-patient privilege is not a valid excuse for failing to report a suspected case.

Forty-seven of the states that specify mandated reporting also provide for criminal penalties for failure to report suspected cases.²³ It is important for mandated health care professionals to note that malpractice insurance does not cover criminal acts. Because failure to report can be a crime, injuries resulting from such failure might expose a health care professional to uninsured professional liability.¹

Adults and the Elderly

States that mandate reporting by health care professionals of suspected child abuse and

neglect also mandate reporting of suspected elder abuse and neglect. As with child maltreatment, the definition of elder abuse, or maltreatment of 'endangered adults' varies from state to state.

Most states have requirements for mandatory reporting of institutionalized adults in hospitals, nursing homes, or other long-term care facilities. However, few states require reporting of otherwise competent adults who are victims of intimate partner violence. Mandatory reporting of adults compromises patient confidentiality, creates a less safe situation for victims, and removes individual autonomy. Because the most dangerous situation for an abused spouse is when she/he tries to leave, mandatory reporting can actually increase the risk of serious injury or death.

According to the Family Violence Prevention Fund, only eight states require licensed health care professionals to report suspected "domestic violence" or "intimate partner violence."²⁴ Although a difference of opinion on mandatory reporting of adults certainly exists, it is widely known that mandatory reporting of IPV can put the victim of great risk.

Because of wide variation in statutory language, dental professionals must be knowledgeable about reporting requirements in the state(s) where they work. Even where reporting of suspected IPV is not required, all dental professionals should be educated about other appropriate intervention. Routine inquiry of all women of child-bearing age should be part of the routine intake and recall history. In private, every patient should be asked if they have ever been hit, kicked, punched or frightened by someone important to them. A more succinct question is to ask "how are things at home" known as "HATAH." Sometimes it is sufficient to merely ask the patient if it is safe to go home.

Given a suspicion of physical, emotional or sexual abuse, dental professionals should be prepared to support the victim by stating that no one deserves to be a victim of family violence, that violence is not the fault of the victim, and that resources are available. Everyone in the dental office should be aware of local resources that can include shelters and safe houses. Contact your state Coalition Against Domestic Violence – before the situation

arises, to learn about what is available in your community.

Interventions

State and local programs have had remarkable success in raising awareness about family violence. In 1991, an effort in Massachusetts led to what has become arguably the most successful program to get dentists involved in family violence prevention. In that year, several Massachusetts organizations formed what was then known as the Dental Coalition to Combat Child Abuse and Neglect. The idea spread to Missouri where various dental organizations joined together to form the **Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.)** coalition.

The mission of the P.A.N.D.A. coalitions is to create an atmosphere of understanding in the health care community that will result in the prevention of abuse and neglect through early identification and appropriate intervention for any persons who have been abused or neglected.²⁵ To accomplish that goal, the coalition produced a series of educational programs to present to dentists, hygienists, and assistants, as well as to dental and dental hygiene students. Within its first year, Missouri's P.A.N.D.A. spokesperson traveled the state, making presentations to every dental society, dental study club, and dental hygiene group in Missouri.

P.A.N.D.A.'s success also is spurred on its choice of acronym and mascot. The picture of the P.A.N.D.A. became the backdrop for all of the coalition's programs. The P.A.N.D.A. became a perfect symbol for the coalition's work. It is endangered, just like victims of abuse and neglect. Also, with permanent "black eyes," the P.A.N.D.A. serves as the perfect reminder of the injuries often resulting from abuse (Figure 14).

While the group's early efforts concentrated on dental continuing education seminars, they quickly expanded into a much broader program. At the urging of coalition members, child abuse and family violence prevention were added to the curriculum of the state's dental school and dental hygiene programs. The coalition further refined its presentations for medical seminars, nursing groups, teachers, day care workers, and other lay organizations. As it conforms to the needs of



Figure 14. An endangered animal with two “black eyes”, the P.A.N.D.A. bear is the symbol for the work of the P.A.N.D.A. coalition (Image used with permission of the P.A.N.D.A. Coalition, developed by Delta Dental of Missouri, copyright 1992.)

the various groups it educates, P.A.N.D.A. also continually addresses changes in policy and state laws.

The original coalition was fortunate in one other area that helped ensure its success. In 1992, Missouri was one of only six states that tracked the number of dentists reporting child abuse and neglect. Starting with a minuscule percentage of reports from dentists, the reporting rate by Missouri’s dentists rose 60 percent in the first year of the P.A.N.D.A. educational programs.²⁶ Within the first three years, reporting had climbed by 160 percent.²⁷ At the urging of P.A.N.D.A. coalitions, three additional states now track dentists’ reporting data, and improvements as high as 800 percent have been seen in as little as five years. The ultimate goal of these efforts is to involve more people until eventually fewer cases of family violence need to be reported.

Although dentists are mandated reporters of child abuse and neglect in every state,¹ only 18 states at the time of the 1995 national survey had any formal training protocol for any mandated reporters.¹⁰ This failure leaves dentists and other mandated reporters in the unfortunate position of having no formal training to help diagnose the cases they are required to report. It is not

unusual to find low reporting rates, considering the dearth of education for reporters.

While the increased rate of reporting by dentists is one measure of success, another is the replication of the P.A.N.D.A. program in other state and international settings. Currently, 46 US states have P.A.N.D.A. programs, with varying levels of activity. Coalitions also are in place in Ontario, Canada; Timisoara and Turnu Severin, Romania; Guam; Finland; Israel; Peru, Brazil, and worldwide as part of the U.S. Army Dental Command. P.A.N.D.A.’s founders are working with individuals and organizations in the Canadian provinces of Quebec, Alberta, and British Columbia as well as in Belgium, South Africa, the Federated States of Micronesia, Mexico, India and Papua New Guinea. Other states and nations also are forming coalitions as the P.A.N.D.A. family continues to grow.

Although the P.A.N.D.A. program began by concentrating on children’s issues, the broader issue of family violence affects victims of all ages. As with child abuse injuries, the other forms of family violence (domestic violence and elder abuse) also are most likely to involve injuries to the head and neck.²⁸ Therefore, P.A.N.D.A. has added information on intimate partner violence (variously known as violence against women, spousal abuse, and domestic violence) and elder abuse and neglect to its message. Its mission statement has been refined in many states to reflect that the coalition encourages “appropriate intervention” for suspected family violence victims of any age.

Summary

Abuse and neglect are growing at ever increasing rates in the US. It not only is within the purview of dental practice to identify and report suspected cases, it also is required under state laws. An appropriate child abuse and neglect protocol in the dental practice may be the best defense for children in these unfortunate situations. Discuss family violence at staff meetings. Be aware of the warning signs, know what to consider when you see an injury, and know how to report suspected cases.

When you see a patient who may be a victim, remember that everyone else in the dental office

has seen the same patient and may have useful information. Talk privately among yourselves about what you see and hear. Encourage the dentist to fulfill his or her legal obligation by reporting suspected cases as dictated by state law, and understand that anyone can report child maltreatment, whether specified as a mandated reporter or not. Remember that breaking the cycle of abuse and neglect not only can make your patient happier and healthier, it also may save a life.

Appendix 1

Office Protocol for Identifying and Reporting Suspected Abuse and Neglect

Steps in Identification of Suspected Abuse or Neglect

1. **General physical assessment of the patient.** Although general physical examinations may not be appropriate in the dental setting, be aware of obvious physical traits that may indicate abuse or neglect (e.g., difficulty in walking or sitting, physical signs that may be consistent with the use of force).
2. **Behavior assessment.** Judge the patient's behavior against the demeanor of patients of similar maturity in similar situations.
3. **Health histories.** If you suspect child maltreatment, it can be useful to obtain more than one history, one from the child and one separately from the adult.
4. **Orofacial examination.** Look for signs of violence, such as multiple injuries or bruises, injuries in different stages of healing, or oral signs of sexually transmitted diseases.
5. **Consultation.** If indicated, consult with the patient's physician about the patient's needs or your suspicions.

Steps in Reporting Suspected Child or Elder Abuse or Neglect

1. **Documentation.** Carefully document any findings of suspected abuse or neglect in the patient's record.
2. **Additional witness.** Have another individual witness the examination as well as note and co-sign the records concerning suspected abuse or neglect.
3. **Reporting.** Call the appropriate child or adult protective services (CPS or APS) or law enforcement agency in your area, consistent with state law. Make the report as soon as possible without compromising the patient's dental care. The [state agency] for reporting is _____.
4. **Necessary information.** When making the report, have the following information at hand:
 - name and address of the patient and parents or other persons having care and custody of the child
 - patient's age
 - name(s) of a child's siblings
 - nature of the patient's condition, including any evidence of previous injuries or disabilities; and,
 - any other information you believe might be helpful in establishing the cause of the abuse or neglect as well as the identity of the person believed to have caused such abuse or neglect.

To receive Continuing Education credit for this course, you must complete the online test. Please go to www.dentalcare.com and find this course in the Continuing Education section.

Course Test Preview

1. **State definitions typically include _____ as child abuse.**
 - a. non-accidental physical injury
 - b. sexual abuse
 - c. emotional abuse
 - d. All of the above.
 - e. None of the above.

2. **Child abuse can be committed by any of the following except a _____.**
 - a. stranger
 - b. parent
 - c. guardian
 - d. baby sitter
 - e. teacher

3. **Victims of child abuse are primarily from _____ demographics/groups.**
 - a. poor
 - b. ethnic minorities
 - c. inner city populations
 - d. all socio-economic, ethnic, geographic

4. **_____ is a contributing factor to child abuse.**
 - a. Substance abuse
 - b. Hatred motivation
 - c. Lack of love for the child
 - d. Living in large urban areas

5. **_____ can make a report of suspected abuse or neglect.**
 - a. Physicians
 - b. Dentists
 - c. School
 - d. Neighbors
 - e. All of the above.

6. **Approximately _____ of physical injuries of child abuse are documented as involving head, neck and mouth.**
 - a. 10%
 - b. 25%
 - c. 75%
 - d. 90%

7. **“Normal” conditions that may mimic child abuse include _____.**
 - a. accidental injuries
 - b. Sturge-Weber Syndrome
 - c. slate-gray spots of infancy
 - d. birth marks
 - e. All of the above.

8. **Dentists report approximately _____ cases of child abuse in the United States.**
- 50%
 - 75%
 - 25%
 - Less than 1%
9. **The phrase _____ is the current recognized terminology for the abuse or neglect of those above the age of 18 and not yet elderly.**
- domestic violence
 - intimate partner violence
 - spousal abuse
 - elder abuse and neglect
 - violence against women
10. **Symptoms of child sexual abuse can include _____.**
- oral lesions of sexually transmitted diseases
 - pregnancy
 - pain on walking or sitting down
 - extreme fear of an oral exam
 - All of the above.
11. **_____ is/are the earliest colors that a bruise may typically exhibit.**
- Brown
 - Yellow
 - Red, blue, or purple
 - Green
12. **The face is often injured in child abuse cases because it _____.**
- represents the “self” of the child
 - is easy for an adult to reach
 - may be an attempt to silence a victim
 - All of the above.
 - None of the above.
13. **_____ is/are contributing factors that may keep a child from getting needed dental care.**
- Money
 - Insurance
 - Access to care
 - Transportation
 - All of the above.
14. **If a dental assistant suspects abuse or neglect, it is _____.**
- noted it in the chart and evaluated at the following six-month recall/recare appointment
 - immediately called in to the police with demands that the parents be arrested
 - reported to the proper authorities consistent with state law
 - ignored with the hope that the child doesn't have more serious problems

15. The acronym “P.A.N.D.A.” stands for _____.
- a. Professional Artists, Nutritionists and Dental Assistants
 - b. Preventing All Neglect Directed at Assistants
 - c. Preventing Abuse and Neglect Daily and Always
 - d. Prevent Abuse and Neglect through Dental Awareness

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About the Author

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