

Knowledge, Attitude, and Practice Regarding Child Abuse and Neglect among Dental Practitioners

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Abstract

Background: Child abuse and neglect (CAN) is a prevalent and growing public health problem. Dentists are in a strategic position to identify and report cases of CAN as common signs of child abuse are in the orofacial region. Proper knowledge and awareness are required for early identification and intervention to prevent untoward consequences.

Methodology: A cross-sectional observational study using a predesigned three parts questionnaire was conducted among general and specialty practitioners in branches of dentistry of Dakshina Kannada district, Karnataka to assess the knowledge, awareness, and behavioral practice towards child abuse and neglect. The data extracted were tabulated, statistically analyzed and results calculated based on percentages using SPSS.

Result: The participants in the current study demonstrated sufficient knowledge of the signs and symptoms of child physical abuse, actions that should be taken in suspected cases, circumstances in which to report such cases, and the legal authorities to which they should be reported. Most of the participants desired for further training such as courses or workshops on examining, diagnosing, and reporting cases of child abuse.

Conclusion: - The study suggests that dental practitioners need an effective education to increase their knowledge and awareness on CAN for its precocious identification and diagnosis as an assay for early intervention.

Keywords- Child abuse, child neglect, reporting, child maltreatment, knowledge.

Introduction

Child abuse and neglect is an augmenting element affecting the community in the present scenario. Since face and oral cavity are often the prime focus of child abuse it becomes the authority of dentists to acquire knowledge to diagnose and report child abuse and neglect cases. WHO estimates that nearly 3 in 4 children

of age 2–4 years regularly suffer physical punishment and/or psychological violence at the hands of parents and caregivers.¹

The short and long-term consequences of victims of CAN have been well documented. Well-established empirical evidence shows a ‘graded’ relationship between the number of unfavorable childhood maltreatment exposures and the occurrence of depression, poor academic performance, and even suicidal ideation among youth.²

Studies have reported that orofacial trauma is present in approximately 50 to 75 percent of all reported cases of physical child abuse.³ This high frequency of

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oro-facial lesions associated with child abuse place the dentist in the front line to individualize and to intercept an abused child.

As per the available literature, only 1% of child abuse cases were reported by dental professionals which draws attention to reasons behind underreporting. Analysis of research from different parts of the world has indicated that healthcare providers fail to report suspected cases of abuse, mainly due to a lack of knowledge. As Dentists are in a unique position that allows them to identify and report abuse cases, their knowledge and attitudes are essential factors in fulfilling this obligation. To the best of our knowledge, studies have not been conducted in this area to investigate the recognition and reporting of child abuse by dentists. Thus a questionnaire-based study was conducted among dentists practicing in Dakshina Kannada district to assess their knowledge, attitude, and practice regarding child abuse and neglect.

Methodology

The study was conducted among general dentists and specialty practitioners of Dakshina Kannada district, Karnataka, India to evaluate the knowledge, attitude, and practice regarding child abuse and neglect. Ethical approval was obtained from the Institutional Ethical Committee of KVG Dental College & Hospital, Sullia. (IECKVGDCH/ FR07/2019-20)

Validity and reproducibility test of the questionnaire were conducted with five faculty members of the institution to evaluate understanding, validate the content and attribute scores to each question accordingly-

- 0 (I did not understand anything),
- 1 (I understood just a little),
- 2 (I understood it in part),
- 3 (I understood almost everything, but had some doubts),
- 4 (I understood almost everything),
- 5 (I understood it perfectly and had no doubts).

Scores 0, 1, 2, and 3 were rated as insufficient understanding, and scores 4 and 5 as sufficient understanding, as suggested by Conti et al.⁴ One

question was eliminated, two were corrected and the remaining were found to be appropriate. The finalized questionnaire written in English consisted of three sets of questions- the first set included 14 questions related to knowledge (table1), the second set included 2 questions related to the attitude of the dentist(table2) and third set included 5 questions related to practice they followed. (table 3). 20/21 questions in the study were dichotomous questions formulated as a statement using the yes-no format and 1 multiple-choice questions.

Demographic data including age, gender, clinical experience were also included. Written informed consent was obtained from the participants after explaining the nature and purpose of the study. Data were analyzed by descriptive analysis using percentages from responses to each question.

Results

A total of 125 responders participated in the study. Data collected from completely answered 105 proforma were subjected to analysis. The incompletely answered questionnaires (n=20) were excluded from the data [response rate was found to be 84%].

Demographic characteristics:

70 % of the subjects were female, the most frequent age was 30-49 years (67%) with greater frequency in the working experience of 10 -15 years of dental practice (48 %). Most of the respondents (72 %) were general practitioners and the remaining 28% were divided between pediatric dentists (8 %) and other specialties (20 %).

Knowledge on child abuse

Results about the level of training and self-education regarding CAN and related items revealed adequacy. 94.28% of the participants agreed on the importance of the role of dentists in diagnosing and reporting child physical abuse cases. 70.47% agreed that craniofacial, head, face, and neck injuries make up more than half of child abuse cases. 87.61% agreed with documentation of CAN in patient record is mandatory. Regarding psychosomatic complaints by the child and physical appearance as poor nutritional status and growth, untidy appearance, untidy clothes a lower proportion of participants were able to correctly identify the signs.

(63.80%, 44.76%& 11.42% respectively). On the signs (of child abuse 85.71% of the participants were able to recognize appropriately. A larger proportion of dentists(95.23%) knew that reporting physical abuse cases to legal authority is important and 63.80% were aware of the legal procedures involved in reporting of CAN.

The attitude of dentists on CAN

The attitudes of the participants are illustrated in Table 2. 36.19% thought that knowledge obtained on child physical abuse at the BDS curriculum was

sufficient. 86.66% opined that further training is required on how to examine, diagnose, and to report suspected cases of child physical abuse.

The practice followed by the dentists

Only 8.57% of the practitioners had suspected physical abuse among patients. A higher proportion of dentists (82.25%) believed that children of employed mothers are more prone to get abused. A very low percentage (5.71%) reported cases of child abuse to Child protective services. Causes of underreporting were fear of legal involvement(25.25%) or lack of response from participants.

Table.1-KNOWLEDGE QUESTIONS-

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Sl. No.	Questionnaire	Results
		Yes
1.	Dentists have an important role in diagnosing and reporting child physical abuse cases?	94.28%
2.	Craniofacial, head, face and neck injuries make up more than half of child abuse cases?	70.47%
3.	Documentation (signs/symptoms, laboratory evidence, radiographs, photo documentation and videotapes/ audiotapes) of abuse in the patient record is mandatory?	87.61%
4.	Self-documentation of signs/symptoms of abuse in the patient record is mandatory?	89.52%
5.	A child psychosomatic complaint is an indicator of child abuse?	63.80%
6.	Poor nutritional status and growth is an indicator of child abuse?	44.76%
7.	Untidy appearance, untidy clothes is an indicator of child abuse?	11.42%
8.	Avoiding eye contact is an indicator of child abuse?	84.76%
9.	Bite-marks, swollen lips or severely decayed teeth in your patient be related to child abuse?	85.71%
10.	Ecchymosis, abrasions or lacerations found in an elliptical, horseshoe-shaped or ovoid pattern should be suspected as bite marks?	85.71%
11.	All bite marks should not be suspected as child abuse?	74.28%
12.	Unexplained injury, infection (gonorrhoea) or petechiae of the palate may be a result of forced oral sex?	71.42%
13.	Reporting physical abuse cases to a legal authority is important?	95.23%
14.	Awareness of reporting a suspicious case of child physical abuse and the legal procedures involved?	63.80%

Table.2-ATTITUDE QUESTIONS-

Sl. No.	Questionnaire	Results
		Yes
1.	The amount of knowledge obtained on child physical abuse at your BDS curriculum was sufficient?	36.19%
2.	Whether further training is required on how to examine, diagnose and to report suspicious cases of child physical abuse (e.g. courses, workshops)?	86.66%

Table.3-PRACTICE QUESTIONS

Sl. No.	Questionnaire	Results
		Yes
1.	In your clinical practise, have you ever seen a suspicious case of physical abuse among your paediatric patients?	8.57%
2.	Children of employed mothers are more prone to get abused ?	82.25%
3.	Child abuse is reported more among children studying in rural areas?	59.04%
4.	Child abuse is seen more among children below the age of 5?	64.76%
5.	Reported any child abuse cases, if diagnosed?	5.71%
5.1	If yes, to whom did you report?	
	a) Child protective service	66.66%
	b) Law enforcement agency	33.33%
5.2	If No, reasons for non-reporting?	
	a) Fear of legal involvement	25.25%
	b) Fear of losing patients and subsequent income	3.03%
	c) Suspicions are often difficult to confirm	18.18%
	d) Inadequate training on how to manage child abuse	21.21%
	e) No response	32.32%

Discussion

The present study sought to assess the knowledge, attitudes, and practice of dentists in identifying and reporting cases of child physical abuse as part of an effort to propose and plan future programs and policies for undergraduates. Regarding knowledge about child physical abuse, participants in the present study correctly identified the signs and symptoms of it. Studies have quoted that head, face, and oral cavity are the areas of central focus for physical abuse, due to exposure and accessibility.⁵ In accordance, 70.47% of participants in our study were aware that craniofacial, head, face and neck injuries make up more than half of child abuse cases. Similar studies conducted by M. Mogaddam et al. (50%)⁶/ Al-Dabaan et al.⁷ in Saudi Arabia(73%) and Thomas et al.⁸ in the USA (56%,) revealed that dentists' knowledge of the signs and symptoms of child physical abuse is insufficient in comparison.

In suspected cases of abuse, the actions to be followed by the practitioner were to ask the child and parents about the observed signs, document the signs and symptoms in the child's file, and check the consistency of the parents' and/or child's explanations with the clinical finding. A substantial percentage of participants (87.61%) in our study were aware of the formalities. 76% of the participants in the study by M. Mogaddam et al.⁶ said that they would document the signs and symptoms and their suspicions in the child's file.

To suspect a case of child abuse it is essential to have basic knowledge of signs and symptoms and how to diagnose them. The results in this study show that the knowledge of the respondents about the indicators of child abuse was satisfactory except for the untidy appearance and clothes of the child which showed a low percentage of 11.42%.

The majority of respondents knew signs of physical violence in form of bite-marks, swollen lips, ecchymosis, abrasions, or lacerations(85.71%). Awareness of reporting (95.23%) was also found to be adequate. In another study conducted to assess the knowledge, attitude, and behavior of dentists nearly 76.8% correctly identified the indicators of child abuse.⁹ As per the response from the participants in our survey, though many of them were able to identify, the need for education on detecting physical signs is realized. It is

important to realize that all dental professionals have a unique opportunity and a legal obligation to assist in the struggle against child abuse.²

Attitude

36.19% of dentists stated that the amount of knowledge obtained on child physical abuse at the BDS curriculum was not sufficient and 86.66% felt the need for further training to examine, diagnose and report suspected cases of child physical abuse (e.g. courses, workshops). When professional hygienists were provided post-educational training in identifying and reporting child abuse, post-test questioning indicated that 100% felt they would be able to make a report of child abuse if it was suspected and 96% reported that they knew how to make a report.¹⁰ These findings support the importance of courses and workshops to better understand the need to diagnose, document, and builds up the confidence to report cases of child abuse.

Practice:

Dental professionals have an ethical obligation to report suspected child abuse and neglect. Only 8.57% of dentists in our study had suspected physical child abuse cases in their clinical practice and 5.71% of them reported such cases.

The most common feature of emotional neglect is the absence of normal parent-child attachment and a subsequent inability to recognize and respond to an infant's or child's needs.² Similarly participants of our study (82.25%) noticed CAN among children of employed mothers rather than homemakers. 59.04% of the respondents agreed that reports of child abuse is common in children studying in rural areas. In a 30-year follow-up on a prospective investigational study of physical health outcomes in abused and neglected children, it was found that childhood abuse increased the risk for several adult physical and psychosocial problems.¹⁰

When asked with the participants about whom to report the suspected child abuse cases, the majority of them answered to report it to the Child Protective Service(66.66%) followed by Law Enforcement Agency(33.3%).

91.43% of dentists didn't report suspected cases and the greater response was in favor for the fear of legal involvement. Professionals in the field of child protection say that "it is better to over-report than under-report potential abuse".¹⁰ Reports should be made to local protective services or law enforcement agencies, or through the National Child Abuse helpline, and should include the name, age, and address of the child, the nature and extent of his or her injury, the person believed to be responsible for the abuse or neglect, and any evidence of previous abuse or neglect. Although child safety protocols are vigilant by the government, this study has identified a definite need to address the subject of ignorance regarding the right authority to report CAN case in dental practitioners.

Conclusion

Child abuse and neglect is alarming and since the face and oral cavity are the central focuses of child abuse it is the responsibility of the dentist to acquire knowledge and diagnose such cases. Consequences of abusive behavior toward the child can lead to difficulties in the physical development of the child, health-related issues, psychological signs such as anxiety, depression, insomnia, and fear. Other effects could be a lack of interest in social activities, difficulty in building healthy relationships at work, and home. The magnitude of the problem is larger than estimated. Raising awareness of the warning signs of abuse and educating health care workers, especially dentists, on diagnosis and reporting cases of suspected abuse, would empower them to play an active role in the prevention of child abuse and the protection of vulnerable children.

Ethical Clearance- Taken from K.V.G. dental college and hospital ethics committee

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