Child Abuse and Neglect: Role and Obligation of Pediatric Dentist in India

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Abstract

Background: Child abuse is a form of behavior that involves treating someone (child, under the age of 18years) with cruelty or violence resulting in actual or potential harm to the child. It has no boundaries and may occur in any geography, culture, or in any socioeconomic strata. Many studies reveal that there is inadequate knowledge and awareness regarding child abuse recognition and reporting among health workers.

Method: Most of the studies reported that trauma to head and facial region occurs in approximately 50% or more of physically abused children. Therefore Pediatric Dentist has major chance of witnessing the physical abuse in clinical practice. On the same time they are not the authority to make diagnosis of child abuse & neglect, rather identify and report the suspected cases, so that a process for effective protection of the victimized children can be initiated. It is the responsibility of the child protection agency/commission to confirm the crime and do the needful. Hence, the role of pediatric dentist in the identification and reporting of suspected child abuse is crucial. He is expected to practice 4R's: Recognize, Refer (if any), Record and Report

Conclusion: Understanding the peculiar role of Pediatric Dentist in recognizing and reporting child abuse and neglect which ultimately contributes towards making better world for children.

Key Words: *Child abuse, India, Neglect, Obligation, Pediatric Dentist, Role.*

Introduction

Child abuse is a form of behavior that involves treating someone (child, under the age of 18years) [1] with cruelty or violence resulting in actual or potential harm to the child. It is a complex phenomenon and may be exercised by parents, caregivers, relatives or persons responsible for the child and can occur at home or in the organizations, schools or communities, the child interacts with. It has no boundaries and may occur in any geography, culture, or in any socioeconomic strata. ***Journal of Child Abuse and Neglect,*** describes Child Abuse as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, an act or failure to act which presents an imminent risk of serious harm" [2]. The terms child abuse and child maltreatment are often used interchangeably, although some researchers make a distinction between them, separating child maltreatment as neglect, exploitation and trafficking [3]. WHO distinguishes child abuse/maltreatment into five types: physical, sexual, emotional (psychological) abuse; exploitation and neglect & negligent treatment [4] (Table I). While physical and sexual abuse leave some signs, which can be differentiated from an accidental injury, emotional abuse can severely damage a child's mental health and

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social development. Child neglect is a separate entity, where the parent/guardian fails to provide the basic need of a child, although he/she is in a position to do so. Regardless of the types of abuse, the result is serious emotional harm, which can leave deep long lasting scars in children.

Despite long past record of history of child abuse, actual professional investigation on this issue considered to have begun in 1960s, following publication of an article "The Battered Child" by C Henry Kempe and his co-workers [5] . Over time there has been an exponential increase in consciousness among the public for the same, yet studies reveal that there is inadequate knowledge and awareness regarding child abuse recognition and reporting among health workers, specifically dental professionals [6].

India is home to the largest child population in the world [7] and child abuse here is widespread. However, response towards reporting the incidence is inadequate. Fear of social stigma, unfriendly behaviour of police and long judicial process are the deterrents to seek justice [8] . There is neither any provision for training the health workers on child abuse examination, interviewing and care taking, nor any protocol has been developed with regard to documentation and reporting [8]. Therefore the objective of this article is to review the role and obligation of pediatric dentists in identifying the suspected case of child abuse and neglect in India.

Table I: Recognizing child abuse and neglect [10] (Reproduced with permission)

Category	Definition9	Examples of signs the dental team may observe
Physical Abuse	Hitting, shaking, throwing, poisoning,burning or scalding, drowning,suffocating or otherwise causing physical harm to a child;fabricating or inducing illness(formerly known as Munchausen by proxy syndrome).	Bruises;abrasions and lacerations;burns;bite marks;bone fractures;intra-oral injuries.SeeAlso Figures 1 A and 1 B
Emotional Abuse	Persistent emotional maltreatment such as to cause severe and persistent adverse effects on the child's emotional development;conveying to children that they are worthless or unloved ;imposing inappropriate expectations;preventing normal social interaction;seeing or hearing the ill-treatment of another (eg domestic violence).	Interaction with parents,eg parent using threatening or abusive language;poor growth;developmental delay;social immaturity;aggression;indiscri minate friendliness;challenging behaviour.
Sexual Abuse	Forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening; either involving physical contact or non – contact activities (eg involving children in looking at or producing pornographic material	Direct allegation(disclosure);sexually transmitted oral infections;pregnancy;trauma including oral trauma; emotional and behavioural changes.
Neglect	Persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development;failing to provide adequate food, clothing,shelter,failing to protect from danger;failure to ensure access to appropriate medical care.	Failure to thrive;frequent injuries;inappropiate clothing;ingrained dirt;developmnetal delay;behavioural changes, eg withdrawn or attention-seeking; untreated dental disease with repeated episodes of dental pain.

Prevalence

According to World Health Organization(WHO), prevalence of child abuse/maltreatment vary widely by country, depending on country's definition of child abuse, the type of study, the scope & quality of data gathered and the scope & quality of surveys [4]. Despite these limitations, WHO report on international studies reveal that, one fourth of all adults having been physically abused as children; 1 in 5 females and 1 in 13 males were also sexually abused as children [4]. Emotional abuse and neglect were also frequently experienced during childhood. Naidoo.S (2000), accounted that boys had higher prevalence (72%) of child abuse than girls (65%), relations perpetrated approximately 89% of the crimes and majority of the incidents (70%) remain unshared and unreported [11]. Therefore, it is assumed that the actual prevalence of child abuse and neglect would be much higher than the reported prevalence. With regards to site and type of injury observed in child abuse, most of the studies reported that trauma to head and facial region occurs in approximately 50% or more of physically abused children[12] - [17] and most common soft tissue injury in these areas is bruise [18].

In India, Ministry of Women & Child Development, in conjunction with UNICEF conducted a study over 12000 children, and reported the prevalence of child abuse of concern as; physical(66%), sexual(50%) and emotional(50%) [19]. A recent study by the National Commission for Protection of Child Rights (NCPCR), conducted in 7 states of India among 6,632 child respondents, showed that 99% children face corporal punishment in schools [20].

RISK FACTORS

Table II: Risk Factors

Parental Characteristics	Child Characteristics	Environment Characteristics
§ Violence § Poverty § Parental history of abuse § Socially isolated § Low self-esteem § Less adequate maternal functioning	§ Unwanted or unplanned child § More number of children in the family § Child's nature § Child's position in the family § Physically challenged or disabled § Activity level or degree of sensitivity to parental needs.	§ Chronic stress § Problem of divorce § Poverty § Unemployment § Poor housing § Frequent relocation, § Alcoholism, § Drug addiction.

In an attempt to understand the causes of child abuse and neglect, the following risk factors have been identified, which provide an overview on the social and cultural contexts of child abuse and neglect [2] (Table II).

CHILD ABUSE AND PEDIADRIC DENTIST: IS THERE AN OBLIGATION ?

Children of all ages are susceptible to physical abuse, although majority of incidents occur under the age of two years [21]. This may be partly because they cannot comply with the instructions of the abuser, owing to their intellectual development and partly because they are more vulnerable. In contrast, observations affirm that non-physical abuse (sexual, emotional &exploitation) is more common in elderly children and mostly remain unshared and unreported [19] [22].

Physical abuse, as reported mostly involves the head and face region, thus any signs of inflicted injury to these areas can be readily identifiable by the dentists. Additionally, diagnosis of non-physical type of child abuse warrants knowledge on child's cognitive, psychological, social development and behavior. Pediatric Dentists, having adequate understanding on these aspects are in a superior position than general dentists in analyzing the behavioural change of the child

victim as well. Moreover, pediatric dentists have the convenience of spending at least 30-45 minutes with the child, conversing and providing dental treatment, thereby maintaining a cordial relationship with the child and his parents [22]. This makes their role even more critical in the process of diagnosis, both physical and non-physical type of maltreatment so that the general well-being of the child can be facilitated. Therefore, pediatric dentists have a moral and legal obligation to recognize and report the suspected case of child abuse.

Child Abuse and Pediatric Dentist In India: The Role Defined

Pediatric dentist is not the authority to make diagnosis of child abuse & neglect, rather identify and report the suspected cases, so that a process for effective protection of the victimized children can be initiated. It is the responsibility of the child protection agency/ commission to confirm the crime and do the needful. In India, the data on offences or crimes against children as reported by MWCD (Minister of Women and Child Development) is lacking [19]. Notably the only source of data available in India is with the National Crime Records Bureau. Although this data is useful, it constituted a miniscule of the total crime/violence against children. It may be due to the fact that, crimes against children in India are either not recorded, or cognizance is not taken. Moreover, the absence of a comprehensive and common definition of the term 'child' creates confusion and a dilemma. Children have limited protection from physical violence and abuse under the Indian Penal Code 1860 (IPC), and the Juvenile Justice (Care and Protection of Children) Act, 2000 [24]. Hence, the role of pediatric dentist in the identification and reporting of suspected child abuse is crucial. He is expected to practice **4R's** [10].

Recognize

Refer (if required)

Record

Report

RECOGNIZE:

Recognition of child abuse and neglect should be initiated at the reception area while the child is being carried by the parents or family members. Each member of the dental team, irrespective of its position, plays an important role in the identification of abuse. Valuable information provided by the observant receptionist will certainly facilitate the Pediatric dentist to diagnose both the physical and non-physical type of abuse. On the dental chair, child should be assessed for his general & oral health and hygiene, signs of proper nourishment and clothing. Following initial assessment, the indicators of child abuse should be looked for. First one is physical, which includes trauma to head, face, neck and hands [25]. Second indicator is behavioral, which is difficult to judge at first instance, unless not accompanied with physical abuser. Two types of extreme behaviors are observed. Either, child avoids/wary of adult contact, displays passive behavior to avoid conflicts, frightened, afraid to go home, loyal to parent, fear of being punished; or he/she seems overly aggressive, violent, demanding, displaying abusive behavior, exhibit dramatic mood changes and uncooperative [23][26].

Refer For Assessment

This step is optional and is applicable, if pediatric dentist is not in a state to identify a suspected form of abuse, but has an apprehension, specifically for sexual (oro-genital injury) or emotional abuses. She/he is required to refer the case to a Pediatrician/Gynecologist/ Psychologist for a better assessment and further investigations. Physical, radiological and laboratory tests, if required would be carried out by them to confirm the initial impression [29]. If a decision is made to refer the child, it is necessary to discuss his/her concern with the parents and seek consent. A detailed documentation should be made in child's record [10].

Record & Documentation

The next step following recognition is proper documentation of evidences and maintaining a record for future reference. The process begins with an overall assessment of the child in a sequence of History, Physical Examination, Radiological and Laboratory investigation and if required appropriate photographs should also be taken [23].

2a) *HISTORY: (Must be witnessed)*

v Interview the parent/custodian and child

separately, record and document their explanation in their own words, dully signed by interviewer and witness on completion of the documentation.

v Ask; open ended question, non-threatening type and which require descriptive answers.

v Note for any risk factors, difference in history and lack of consistency between severity of the trauma and the story told by parents/custodian. These may point towards abuse.

v Record, when where and how it happened and if any witness is there

v Who lives with the child/ takes care of the child?

v Note history of past injuries, hospitalizations and medical conditions, which might mimic abuse pattern.

v Do not interrogate or attempt to prove an abuse or neglect.

To record the history, five questions need to be asked and five observations to be made.

Table III: Check list for child abuse [21]

Five Questions:	
1)	Could the injury have been caused accidently and if so how?
2)	Does the explanation for the injury fit the age and the clinical finding?
3)	If the explanation of cause is consistent with the injury is this itself within normally acceptable limits of behaviour.
4)	If there has been any delay in seeking doctor's advice, then reasons for this?
5)	Does the story of the accident vary?
Five Observations:	
1)	The general demeanour of the child
2)	The relationship between parent and child.
3)	The child's reaction to other people
4)	The child's reaction to any medical/dental examinations
5)	Any comments made by child and/or parent that give concern about the child's upbringing or lifestyle.

2b*) PHYSICAL EXAMINATION:*

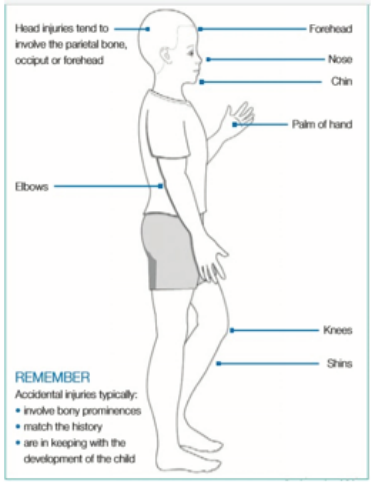
In case of any suspicion, proceed for physical examination in a systemic order starting from extra oral (hand to toe) onto intra oral as,

1) Extra oral: Location and type of injury differentiating the accidental and non-accidental injuries [27] (Figure 1 A and B).

v Triangle of safety

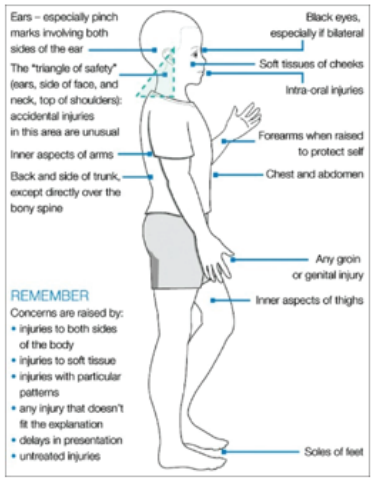
v Trauma on both sides

v Check for ***6 B's – Bruises, Breaks, Bonks, Burns, Bites, Baby blues (Non –accidental)*** (Figure 2)



A

Figure 1A: Typical sites of accidental injury (Reproduced with permission) [27]



B

Figure 1B: Typical sites of non-accidental injury (injuries that should raise concerns) (Reproduced with permission) [27]

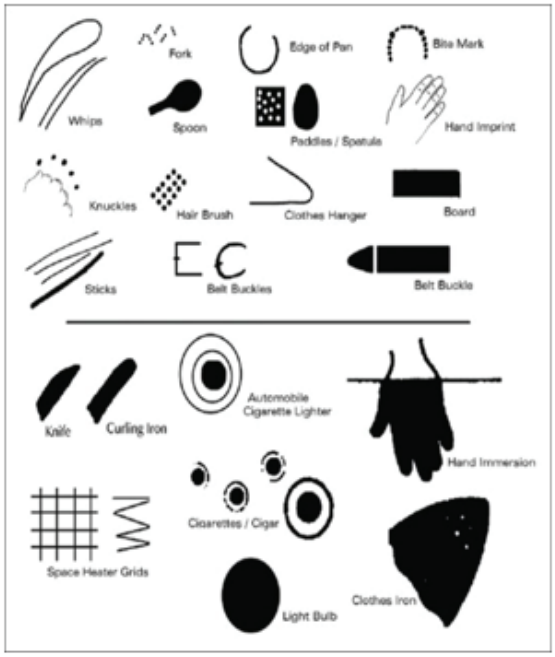


Figure 2: Common patterns of bruise marks (Reproduced with permission) [29]

2) Intra Oral: Soft and hard tissues [2]

v Lacerations or scar marks may present on lip, on labial Frenum from forced feeding, on tongue from forcibly biting down, and sometimes a severe form may present on edentulous ridges.

v Burns marks from heated instruments, or rope marks on the corners of the mouth from a gag being placed over the mouth may present.

v Bruises may present on Palate from forced oral sex called as fellatio (unexplained petechiea or bruises particularly at the junction of the hard and soft palate) or

on edentulous ridge.

v Contusions may present on floor of the mouth.

v Non accidental trauma induced fractured or nonvital teeth, missing or displaced teeth for which there is no obvious explanation.

v Appearance of white slough due to necrotic epithelium caused from caustic substances or scalding liquids.

v Additionally, the child may report with excessive salivation, even drooling, and may have difficulty in swallowing.

v Venereal warts, HIV-associated lesions, or any STDs.

IF DENTAL NEGLECT:

v Untreated, rampant caries.

v Untreated pain, infection, bleeding or trauma in orofacial region

v Delayed seeking of dental help after clear diagnosis.

2c) PHOTOGRAPHS:

American Board of Forensic Odontologists (ABFO) made a standard reference scale ABFO Number 2 used by forensic odontologists for bite mark measurement and photography [30]. Millimeter reference scale may be placed if required close to the area being photographed (Figure 3A and 3B). Images should be captured at a distance of 3-5 feet from the subject [31].

A tag with date and reference number can be added on each photograph.

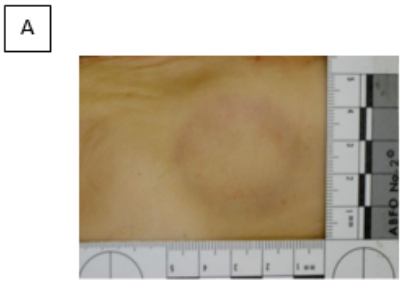
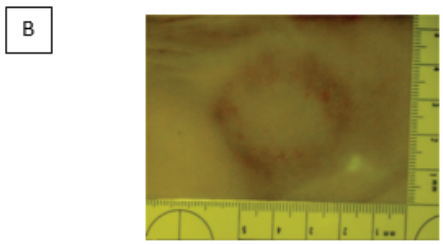


Fig. 3A Visible light image of two-week old bite on arm



Alternate light image of same bite as seen in Fig. 3B

Report

Mandatory reporting mandates certain professionals to report suspected cases of child physical and sexual abuse to appropriate authorities. Designated professionals (including pediatric dentist) are required by law to report all suspected cases of child abuse & neglect and under Juvenile Justice Act (Care and Protection) Act, 2000 (amended 2006) [32], proof is not required. Rather, they are protected by law in case of an erroneous reporting as long as it was in good faith. In contrast, they can be legally penalized in case they fail to report. In India, such provisions have not yet been introduced. But Government of India has launched a Childline (dialing number-1098) which is a 24 hours free phone service and can be accessed by child himself/herself in any distress situation or emergency assistance whenever required. It can also be used by adult on child's behalf. This service responds to call for medical assistance, child protection from abuse, emotional support or any referral services [33]. However, for proper reporting three "Ws" are important. They are: WHY ? WHOM ? and WHAT ? [33][34]

A. WHY to report? (Table IV)

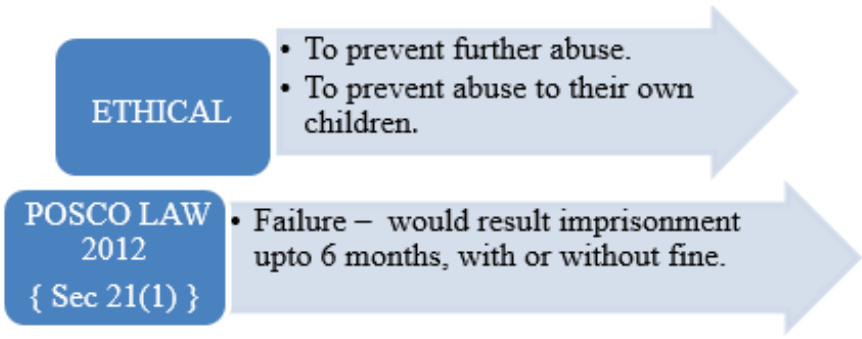


Table IV: Why to Report? [33]

B. WHOM to report? In the absence of 'mandatory reporting', child protection services in India constitute an important decision. Usually the reporting can be done to the police, the local Child Welfare Committee and even to the Child line. Regular follow up to monitor and assess child abuse and development [33].

C. WHAT to report?

1) Name, age, home address of the affected child

2) Observations as documented with signature and date. Also, obtain the signature of a witness to injuries and interview.

3) The name, age and condition of the other children in the same household, if available.

4) Identify the person or persons responsible for abuse or neglect, if known

5) Any other information that you believe may be helpful in establishing the cause of the abuse to the child.

6) Record verbatim the comments made by the child and parent explaining the injury.

Conclusion

Child abuse and neglect is observed in every social, cultural and economic background, both in developed and developing countries. It depends on the person's mental state and attitude, who indulges in this type of abusive behaviour. Although literature reveals that, dental professionals do not have the adequate training and knowledge on recognition and reporting of suspected case of child abuse and neglect, pediatric dentists have the potential to recognize it in their clinical practice, owing to their comprehension on child's cognitive, psychological and social development. However, most of them do not report such cases, probably because they are unaware of their legal responsibility or existence of social barriers which complicate the task, thereby putting the child at risk of further harm. Nevertheless, the country like India, with the existing legal system and the perceptions in the society, the moral of pediatric dentists on this issue is certainly not high. Hence, a change in our attitude and sense of responsibility is required to safeguard children against child abuse and neglect.

Conflicts of Interest: Nil

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Ethical Clearance: This is a review article therefore Institutional Ethics Committee clearance is not required

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