The Responsibility of Dentists in Identifying and Reporting Child Abuse

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Citation

C Stavrianos, I Stavrianou, P Kafas, D Mastagas. *The Responsibility of Dentists in Identifying and Reporting Child Abuse*. The Internet Journal of Law, Healthcare and Ethics. 2006 Volume 5 Number 1.

Abstract

The purpose of this article is to review the forms of child abuse and neglect with their clinical signs, together with a step-to-step guide for identification of suspected cases and the role of physicians, such us dentists in evaluating such conditions. The importance of an early recognition is based on the effective intervention. All members of dental team have a unique opportunity and legal obligation to assist in identifying and reporting child abuse. This special opportunity exists because a high proportion of abused children suffer injuries to the face and head, including the oral and perioral regions.

However, physicians receive minimal training in oral health and dental injury and disease usually may not detect dental aspects of abuse or neglect, as readily as they do with symptoms and signs involving other areas of the body. Therefore, physicians and dentists are encouraged to collaborate to increase the prevention, detection and treatment of these conditions.

INTRODUCTION

Maltreatment syndrome includes child abuse and child neglect. 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 our culture. Abuse may cause serious injury to the child and may even cause death. [1, 2]

Child neglect referred to a failure of providing necessary items such as food, clothing, shelter, education, or medical care when reasonable able to do so, or failure to protect a child from conditions or actions that endanger the child's physical or mental health, when reasonable able to do so. [3] Maltreatment syndrome is considered when a child is treated in a way that is unacceptable for certain culture at a given time. [3] Such acts include physical, sexual, or emotional abuse, as well as physical neglect, inadequate supervision and emotional deprivation. [4]

Abuse can range from habitually humiliating a child to refusing the necessary care and from excessively shaking a child to rape. [5]

These behaviors are serious crimes, both as misdemeanors and felonies, punishable by arrest and imprisonment. [2,6]

Dentists should be aware that physical or sexual abuse may result in oral or dental injuries or conditions that sometimes can be confirmed by laboratory findings. Furthermore, injuries inflicted by one's mouth or teeth may leave clues, regarding the timing and nature of the injury, as well as the identity of the perpetrator. Dentists are encouraged to be knowledgeable about such findings and their significance and to meticulously observe and document them. When questions arise or when consultation is needed, a pediatric dentist or a dentist with formal training in forensic odontology can ensure appropriate testing, diagnosis and treatment. [7]

As dentists would probably have more chances to see those cases of hypodermal bleeding in faces, abrasions and mandibular fractures. Therefore we have to keep in mind the possibility of abuse.

FORMS OF CHILD ABUSE

Physical abuse: The most usual form. Any physical or mental injury or threatened injury on a child, inflicted by a person responsible for the child's care, other than by accidental means; any physical or mental injury that cannot reasonably be explained by the history of injuries.

Sexual abuse: When a child under 15 years old is the victim of criminal sexual conduct or threatened criminal sexual conduct by a parent, guardian, caregiver, or sibling. When a

child is engaged in prostitution or when is the subject of pornographic materials.

Mental injury-Emotional abuse: Emotional abuse frequently occurs as verbal abuse (constantly yelling at insulting and criticizing a child), or as excessive demands on a child's performance, which result in a negative self-image on the part of the child or disturbed behavior. Emotional, also, includes the withholding of love and affection. Mental injury, usually the result of emotional abuse, is an injury to the psychological capacity or emotional stability of a child.

Munchausen's syndrome by proxy: This syndrome describes children that are victims of parentally fabricated or induced illness. These children are usually under 6 years and exhibit signs and symptoms fabricated by the parent or the caretaker. Of interest and concern to the dentist would be noted rashes or abrasions caused by the caretaker rubbing the skin or applying caustic substances. [2,3]

It is worth noting that these types of abuse are more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well and a sexually abused child also may be neglected. [2,4]

CAUSES OF DEATH

- Intracranial injuries such us subdural haematoma, subarachnoid bleeding, brain contusion.
- Traumatic shock such us widespread hypodermal or intramuscular bleeding.
- Suffocation from oronasal block, chocking, or drowning.
- Weakness from malnutrition.
- Pneumonia. 1,2,4

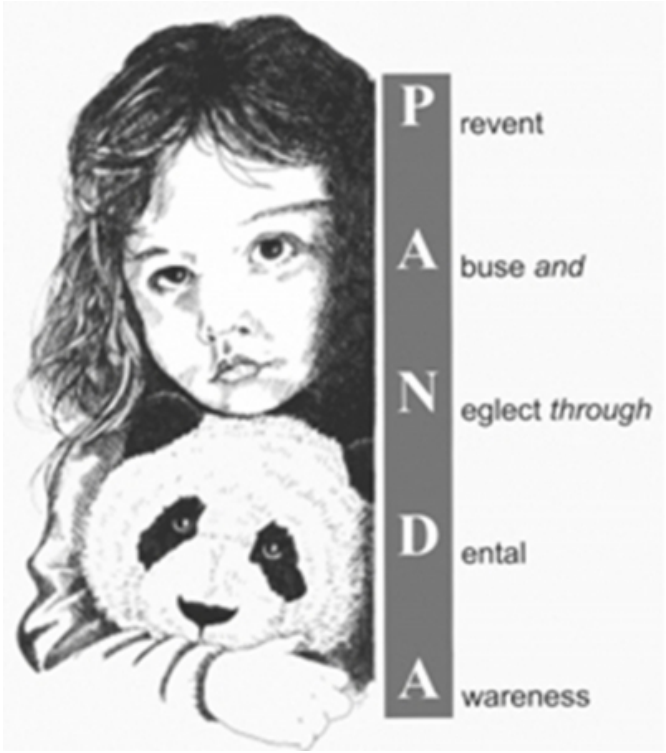
HISTORICAL TRENDS

Unfortunately, child abuse is an old story. It has existed and flourished throughout history, in all cultures and ethnic backgrounds, in all its forms. [3,8,9] There are numerous cases of abused and neglected children in the modern and ancient history. [3] In ancient Greece and Rome, the law allowed deformed children and unwanted female infants to be exposed and left to die. [2,10] The reasons in those stories were social, financial, political, religious, medical and sexual.

In 1874 a church group in New York City took a child named Mary Ellen from a home in which she was being abused. The child was removed from her home thanks to the help of the Society for the Prevention of Cruelty to Animals (SPCA) on the grounds she was a member of the animal kingdom who deserves to be protected. This case led to the formation of the first Society for the Prevention of Cruelty to Children in U.S. [2] The Children's Aid Society was formed in 1891, with Kelso as founding president. He was instrumental in getting the government in 1893 to pass the first bill in Canada to protect children. [6,8,10] The medical profession's first involvement in child abuse historically begins in 1946 with Caffey, [11] a pediatric radiologist, who observed that children with subdural haematoma sometimes also exhibited abnormal changes in long bones, indicative of previous trauma. In 1955, Wooley [12] showed that long bone trauma was inflicted willfully by parents or siblings. In 1962, Kempe [8] coined the term “Battered Child Syndrome”, a clinical condition in which fracture of any bone, subdural haematoma, failure to thrive, swellings, bruises and/or sudden death was at variance with the reported history. In recent years a notable educational program is the Prevent Abuse and Neglect through Dental Awareness (PANDA) Coalition, organized by Lynn Douglas Mouden (Fig.1).

Figure 1

Figure 1: PANDA is an acronym for Prevent Abuse and Neglect through Dental Awareness.



PANDA, which began with the model program in Missouri in 1992, is now in 34 states in the United States and has 2

coalitions in Romania. [10,13] New York State, for example, requires all dentists to complete a two-hour course in the identification and reporting of child abuse as a condition of a relicensure. [4] Not only in America, but also in Japan have been made efforts in the urgent move to tackle this problem. On 20 November 2000, The Prevention of Child Abuse Law was brought into effect. This new law has set a limit to parental authority and has boosted the authority of the child consultation centres, making it possible to enter a house and investigate or to seek help from police. It has also made it compulsory, especially for teachers, child welfare officers, and doctors, to report any risk of abuse to a child consultation centre. [1]

STATISTICS

The numbers of reported cases seemed to rise annually. It has reached epidemic proportions in the US, and is an international issue as well. So, what was once considered to be a private issue has now become a public responsibility. [2,10]

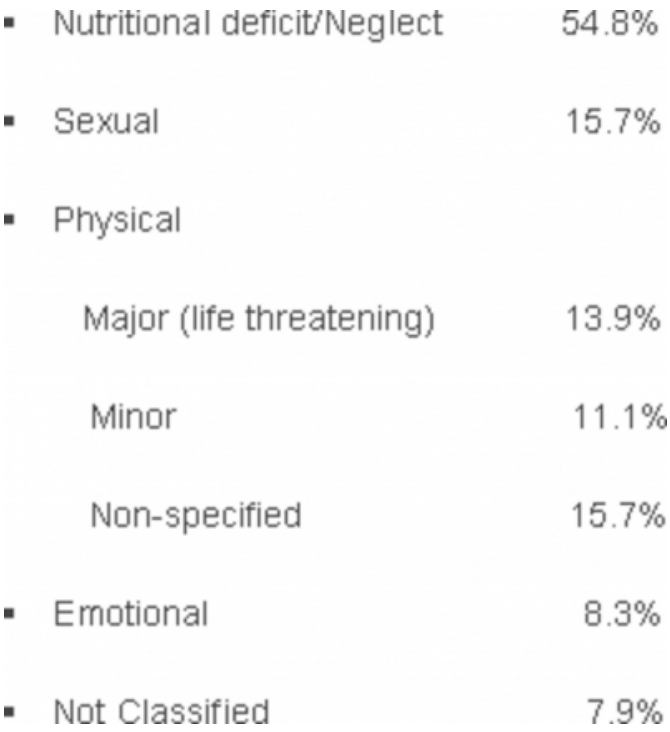
The chairman of the Missouri Dental Association's Council on Dental Health Education noted an 80% increase in the reporting rate of dentists, since the PANDA program has been incepted in 1992. [10,13] In 1997, over 3 million children were reported for child abuse and neglect to child protective service (CPS) agencies in the United States. This figure represents a 1.7% increase over the number reported in 1996. Child abuse reporting levels have increased 41% between 1988 and 1997. At least three children die each day as a result of abuse and neglect. According to the US Administration for Children and Families, an estimated 903,000 children were victims of maltreatment in 2001. [4,14,15]

Reasons for these increased numbers include family crises stemming from economic problems, rising unemployment, increased rates of teenage pregnancies, drug and alcohol abuse, the high rate of divorces and separations and also an increased awareness of mandated reporters. It has been reported that 70% of child abuse fatalities are caused by injuries to the head and neck. Under the age of one year, males are more commonly abused. Above the age of twelve, females are more often abused as they are the victims of sexual abuse. [2] Persons ages 12 to 19 experienced all crimes at rates significant higher than other age groups. Abused children do come from all economic, social, ethnic and cultural backgrounds. [2,5,12,16]

Thirty five percent 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. [3] Child abuse only comes second in SIDS (Sudden Infant Death Syndrome) as the leading cause of death in children less than one year of age, while in older children only comes second to accidents. [4] While the number of substantial maltreatment has increased dramatically, it is important to note that many of these children come to the attention of child welfare authorities for preventative intervention before they have been severely harmed. For every child seen who is abused, probably ten more children have been neglected. [4,5]

Figure 2

Frequency of Types of Abuse



RISK FACTORS

Child abuse can occur in all cultural, ethnic, and income groups, in rich households and poor ones. About 95% of victims know their perpetrators. Offenders look like ordinary people. [5] While it is not accurate or fair to create a ‘profile' of child abuser, we can make general behavior statements, 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. [4,5] Children born prematurely have been shown to have three times a greater risk of being abused. [2] Children who generally have poor

general hygiene are clothed inappropriate for the weather or suffer from medical or educational deprivation, all indicate a child at risk. Culture, religion and inappropriate social models may play a part. Risk assessment is based on outcomes of actual cases. It is important to know that in order to protect a child going to be adopted, mental health, penal records of both parents and authentication of these documents are required. [2,4,10]

Child maltreatment can undoubtedly be considered a breakdown in the parenting skills of the child's caregivers. One theory holds that parents' unrealistic expectations for the child and for themselves can contribute to the abuse. Another theory is based on the conviction that children exist to satisfy parental needs. Some mothers are simply not satisfied by the unresponsiveness and lack of feedback from an infant. Other abusers explain the maltreatment of children as a suitable means of parenting. [17] The survey of Japanese Society of Legal Medicine showed that cases involving a biological mother often tend to be triggered by her mental problem, a child's intellectual handicap or her lack of affection toward her own child. On the other hand, many cases involving a father occurred during times he was stressed by his family troubles or a child's continuous crying. Recently financial worries, bad residential environments and children's defiant attitudes have been added to the contributing factors of abuse. [1]

Families in which abuse may be more likely were: [3,5]

- Families who are isolated and have no friends, relatives, church or other support systems.
- Parents who were abused as children.
- Families who are often in crisis.
- Parents who abuse drugs or alcohol.
- Parents who are very critical or with great expectations of their child.
- Parents who are very rigid in disciplining their child.
- Parents who show too much or too little concern for their child.
- Parents who feel they have a difficult child.
- Parents who are under a lot of stress, with lack of confidence or depressed.
- Teenager parents and unmarried mothers.
- Children with mental problems.

IDENTIFYING

It has been observed that, to avoid suspicion, 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. [15,18] The history may be the single most important source of information. Because legal proceeding may follow, the history should be recorded in detail. Abuse or neglect should be considered when the history reveals the following:

- History of multiple injuries.
- The family offers an explanation that is not compatible with the nature of the injury.(i.e. if the dental injuries resulted from a fall, one would usually expected to also find bruised or abraded knees, hands, or elbow). 4
- Delay in seeking care for the injury.
- The family avoids discussing about the injury. 3
- The parent refuses to cooperate with the planned course of treatment or refuses to be separated from the child.
- The parent takes the child from office to office or from one hospital emergency room to another, so as to avoid the chances of recognition.
- Refusal to consent to diagnostic studies for the child. (In US the law allows photos or x-rays may be taken without parental consent if abuse is reasonable suspected).
- Parent behaves inappropriate to the child's condition; either overly concerned or generally apathetic.
- Parent persists in presenting symptoms unrelated to the obvious condition of the child. 2

Of great importance is considered to be the victim's and the abuser's behaviour. The abused child may appear unduly aggressive or may be withdrawn. He may exhibit a sudden behaviour change apparent to the family or health provider. He/she may commence stuttering, bedwetting or having

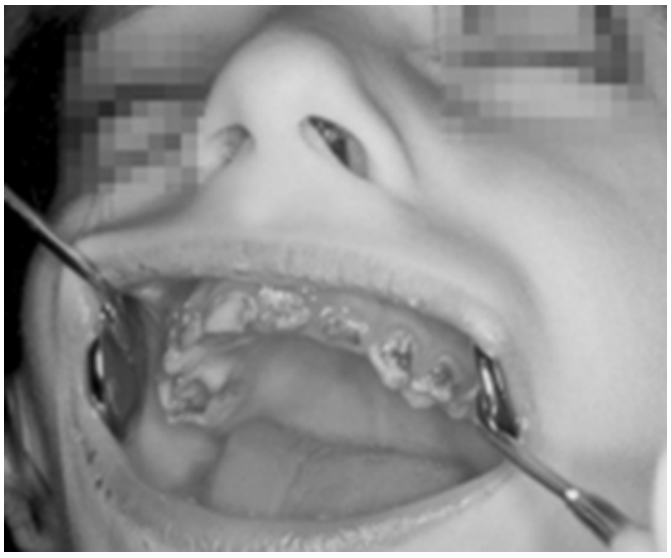
nightmares (perhaps a sign of sexual abuse).

Abusers tend not to trust others and are reluctant to furnish information about the child's injuries. They may be overly critical of the child, seldom touch or look at the child and interact inappropriately. They trend to keep the child unduly confined and often fail to present the child for routine care. [2] A parent who continually breaks dental appointments also requires counselling and support, with the eventual requirement of submitting a report if the child is not treated. [5,19]

Certain injuries and conditions, such us: welts, burns, lacerations and abrasions, skeletal injuries, injuries caused by twisting injuries, or internal injuries are often seen in abuse and neglect (Fig.2). [19]

Figure 3

Figure 2: Neglect is the failure to provide for a child's basic needs. This can include the failure to provide medical or dental care.

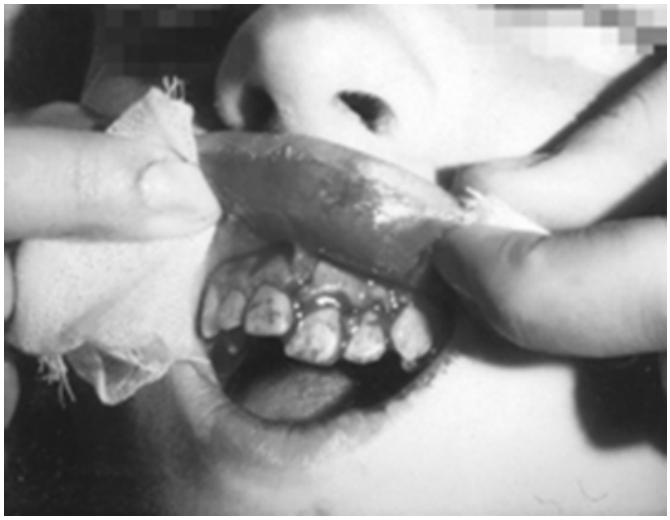


Moreover, if the injury resembles an identifiable object such as, a belt buckle, strap, electrical cord or hand, it should raise immediate suspicion. [15] Fractures of bones, in the absence of an adequate history, should be suspicious. [2,15] Multiple, of varying colours bruises(important in determining when the injury happened) [4] or abrasions anywhere on the body of an infant, a ruptured or perforated tympanic membrane should raise immediate suspicion. [2] A radiological study showed signs of old as well as new fractures, a pattern of repeated trauma that need to be further investigated. Whenever bruise occurs on both sides of the mouth or face at once or if there is scarring of the lips, abuse should be suspected. [4]

Injuries to the face may include trauma to the eyes, ears and nose, as well as to the oral cavity (Fig.3). [4]

Figure 4

Figure 3: Child abuse injury in maxillary area apparently with partial avulsion of the left incisors, caused by heavy blow to upper lip.

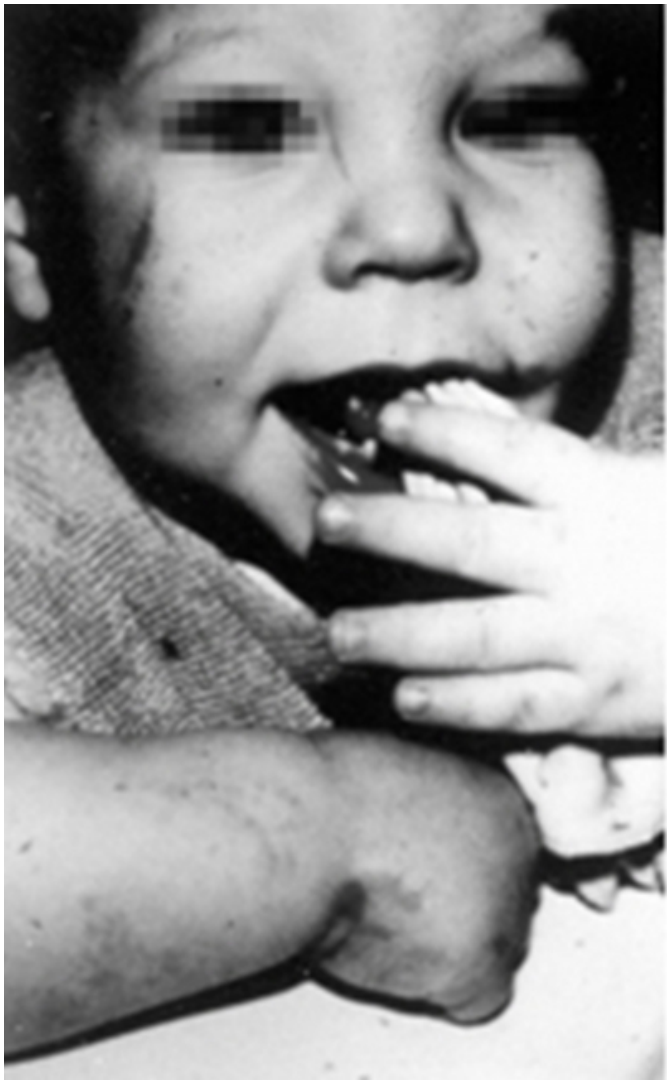


A radiologist should be involved when any skull fracture or facial fracture is suspected in the infant or child. Single or multiple healed fractures of the long bones or of the rib cage may be pathognomonic for abuse. Burns are common child abuse injuries. Bald or sparse spots on the scalp indicate malnutrition or hair pulling. The eyes should be carefully observed for bilateral periorbital ecchymosis/haematoma, which should be considered non accidental. [2]

Bite marks should be suspected when ecchymoses, abrasions or lacerations are found in an elliptical or ovoid pattern. Furthermore, injuries inflicted by one's mouth or teeth may leave clues regarding the timing and nature of the injury, as well as the identity of the perpetrator (Fig.4). [2,7,16,20,21]

Figure 5

Figure 4: Multiple bite marks on victim's face and hand (Courtesy by A.B.F.O.).



Any intraoral soft tissues injuries of the infant or very young child must make one highly suspicious of abuse. [2] Many authors report that lesions in which the oral mucosa is torn away from the gingiva may be the most common injury to the face, and may occur in as many as 50% of child abuse cases. [4] In 1966, Cameron noted that the combination of the split upper lip plus laceration of the alveolar ridge soft tissue frequently with an incisor missing, is considered almost pathognomonic of child abuse in England. [2,22]

Early resorption of the roots of the maxillary primary central incisors indicates possible early trauma to these teeth. [4]

Typical oral lesions: bruises, lacerations, abrasions or fractures-Tears of the labial or lingual frenula-Oral mucosa torn from gingiva-Loosened, fractured or avulsed teeth-Darkened and/or nonvital teeth-Previously missing teeth-Trauma to the lip-Trauma to the tongue-Other soft tissue injuries-Fractures of jaws and associated structures-General neglect of the mouth. [2,4]

Oral injuries may be inflicted with instruments such us eating utensils or a bottle during forced feedings. The abuse may result in contusions, burns, or lacerations of the tongue, lips, buccal mucosa, palate, gingival alveolar mucosa or frenum; fractured, displaced, or avulsed teeth; or facial bone and jaw fractures. In older children, gags used to silence or punish a child can leave bruises at the corners of the mouth. A slap or a blow to the child's mouth to silence the child may injure the labial frenum. [2,4,23,24]

A child presenting with fractured or missing teeth, multiple root fractures or unusual malocclusions, in the absence of adequate explanation, call for a careful case review. When a child presents with current dental trauma and also has one or more dark teeth unrelated to caries, it is probable that the child has experienced previous trauma.

The presence of oral or perioral gonorrhea, syphilis, or chlamydia in prepubertal children is pathognomonic of sexual abuse. Unexplained injury or petechiae of the palate, particularly at the junction of the hard and soft palate, may be evidence of forced oral sex.

When these signs appear repeatedly or in combination we should take a closer look at the situation and consider the possibility of child abuse. [2,25,26,27,28,29]

WHAT IS NOT CHILD ABUSE?

When a child's problem is thought to be child's abuse and it is not, considerable harm may be done to the child, the parents and the doctor-patient relationship. [2,4]

1. Children fighting.
2. Reasonable force used by a peace officer.
3. Sexual activities between minors (both under the age of 14).
4. Pregnancy does not if it self constitute the basis of a reasonable suspicion of sexual abuse.
5. Past abuse of a child who is an adult at the time of disclosure.
6. Material substance abuse, which refers to any positive toxicology screen at birth.
7. Sudden infant death syndrome (SIDS).

8. Self injuries.
9. The Mongolian Spot, a discolouration that occurs over the lower back and buttocks, back of the legs and/or shoulders of the child.
10. Cao gio, a finding caused by rubbing or scratching the child's skin with a coin, producing a dramatic ecchymosis that is usually localized in the intracostal spaces of the back or parallel to the spine.
11. Moxibustion or cupping produces circular burn-like Lesions on the skin of the child. 2,5

It is important to gain an understanding of any medical conditions, which result in such suggested/apparent instances of physical abuse, such as osteogenesis imperfecta, skeletal abnormalities, and leukaemia or blood duscrasias. [4,5,15,30]

There are injuries such us fractured or avulsed teeth, which are common in the young child who walks or is learning to walk, which can confuse the health professional. [2]

The most common injury that occurs when a pre-school child falls is a front tooth is moved into the jaw. [2,4]

INTERVIEWING

Another key step in recognizing and reporting abuse is conducting and documenting interviews with the child and parents. In order to gain child's trust, a key is to provide a safe, predictable and loving environment for these children. In our interactions with children, we can be attentive, respectful, honest and caring. Children often fail to report because of the fear, that disclosure will bring consequences even worse than being victimized again. They also have a feeling that something is wrong with them and that the abuse is their fault. We should tell them that, violence is not their fault and give an opportunity to talk, while reinforcing that they are not alone. Once a child has built the courage to tell about the abuse, it is vitally important for the child to feel that he/she is believed and that someone is getting help. [18,19,24] If possible, we should interview the child with a witness present, but without family members in attendance, so the child may speak freely without fear of reprisal. We should use open-ended, non-threatening questions that require a descriptive answer rather than just a “yes” or “no” answer. Do not suggest answers for the child or press the child for answers to questions he or she is unwilling to answer. Establish a trusting environment for the child and try to use his or her own words and terms, while discussing the situation. Young children do not usually fabricate stories of abuse. Then we should interview the parent separately from the child, ideally with a witness present and find out if the child's explanation is consistent with the parent's explanation. However, the ideal situation is that the oral healthcare professionals make an effort to gain as much information as possible, as well as the confidence of the parent. [5,31]

DOCUMENTATION

It is recommended that a second staff member witness and assist in the documentation of evidence. Written records should include the child's name, age and address as well as the name and address of the parent or whoever brought the child in for care. Also record the name of any staff member assisting in the examination. [2] Documentation may involve written notes, photographs and radiographs, videotapes or audiotapes. [4] Photographs and radiographs of suspicious injuries can be taken without the parent's consent in most states of the US, when abuse is suspected. Drawing the injuries on an anatomic diagram in the child's chart is recommended. Ideally, photographs should be taken with a 35mm camera with a macro lens. Both close-up and distant photographs should be taken. [2] It is important that the critical photographs include a ruler or scale held adjacent to the injury and on the same plane as the injured surface. [4] Proper documentation is a key to moving from suspecting abuse is taking place to taking action to protect the child. Complete and accurate descriptions must be recorded in the child's dental record. Begin with the size, shape, colour, location and radiographic description of the injury. Identify the number of injuries present at each site. Sketch the injury and the body part where it is located, if necessary. Detail the child's behaviour alone and as they interact with their parent, if it appears suspicious. Document all aspects of your interviews with the child and parent. Record verbatim the comments made by the child and parent explaining the injury. And sign and date the chart, and obtain the signature of a witness to the injuries and interviews. [4,5,10]

REPORTING

If the child requires medical attention, referral should be made to the proper resource. [4] If the presence and appearance of the injury does not relate to the history of the injury and the explanation of its cause by both the child and the care-giver, suspected abuse must be reported. Reporting suspected abuse is not an accusation of abuse by the

reporter. It is a call for help for the child and for the abuser. Abuse is a problem that requires treatment. In every jurisdiction of United States, health professionals are mandated by law to report suspected cases of child abuse [2] and a penalty is provide for failure to report. In addition, to criminal liability for failure to report, the practitioner could also face a civil lawsuit if there subsequent injury to the child. Considering the legal obligation to report and the statutory protection provided for the reporter, there would seem to be a greater risk from failing to report than from reporting. [4] Reports may be made to the local law enforcement agency or to the local child protective service. When reporting, the reporter should have ready:

1) A statement of concern and reasons for suspecting abuse, including any documented evidence, and

2) The names, addresses and phone numbers of all involved parties. The immediate and initial report should be made by telephone. The reporter should then follow up with a written report as required. Health care professionals who see children should have the telephone number of the reporting agency available. [2,32,33,34]

Unwillingness to report: The most common reason is uncertainty about the diagnosis, fear of litigation, unfamiliarity with symptoms, possible effect on the practice, reluctance to believe one could inflict cruelties on one's offspring and uncertainty about the reliability of the child's account of the injury. [4] A wonder that can prevent a dentist from reporting is, if the child will be taken away from home, but we should all now that this happens, only when the child's life is really in danger.

We should all consider that, according to a 1996 report from the US Department of Health and Human Services, over 50 percent of reports came from “mandated reporters”, including educators, law enforcement, medical professionals, and care providers.

Dentists should be aware that when a person not in medicine or dentistry takes the stand in a child abuse case, their testimony is regarded as heresay, whereas a medical or dental professional's testimony is not heresay. [2,10,15,20,30]

CONSEQUENCES

Victims often suffer from both physical and emotional pain. They are hurt and disappointed because the person that abuses them is the person whom they love or have loved and respected. Their inability to trust contributes to secrecy and non-disclosure. They live in fear because the abuser is always near them and they feel shameful because their dignity is violated. This constant humiliation will destroy a child's belief in his/her self and severely affect his/her self-esteem. But, often young victims may not recognize their victimization as abuse. [2,5,13,18] The child in a dysfunctional environment where abuse, violence or neglect are the norm; as the subject of abuse, the child cannot predict the behaviour of the responsible adults and therefore has no control. The child learns, usually from an early age that, using bulling behaviours brings relief from anxiety. He can't predict or control his parents, but he can control other (smaller or less physically strong) children. Where a child is brought up under these constant conditions, those areas of the brain which deal with interpersonal, behavioural and social skills simply fail to develop normally. The child who is physically punished, especially if regularly-and parents who hit their children, often repeat the hitting, especially if it has the desired effect, which it frequently appears to in a short term. Post Traumatic Stress Disorder (PTSD) is a normal and natural emotional reaction to a deeply disturbing and shocking experience. Many supposed mental illnesses are probably symptoms of PTSD, resulting from abusive experiences in childhood and should more properly be regarded as psychiatric injury. Exposure to violence is linked to compromised brain development and lower I.Q. measures. Many women and men, who have been subjected to severe physical or sexual abuse during childhood, suffer from long-term disturbances of the psyche. A large number of incarcerated youth were victims of child abuse and neglect. Children who have been abused build-up a lot of hurt and anger inside, which could lead to psychological and social problems. It is too often the case that “the abused becomes the abuser”-as child abuse is a cycle that begins with a child being abused and continues until the child is an adult, abusing his or her own children. [2,7,13,31,34,35]

RESPONSIBILITY

All dentists should be able to recognize the signs and symptoms and be familiar with the reporting laws of their respective country. It is an absolutely crucial factor in the fight against child abuses, the early recognition of the problem so that effective intervention can be undertaken. [3]

It is important to realize, that all dentists have a unique opportunity and ethical obligation to assist in the struggle against child abuse and that's because a high proportion of abused children suffer injuries to the face and head, including the oral and peri-oral regions. These injuries may

be observed during the course of dental treatment and in some cases even before the child is seated in the dental chair. [3] Dental professionals can be expected to perform their duty to help protect our children, only after receiving appropriate education about their role in identifying and reporting suspected cases of maltreatment. Dentists must become more aware of their moral, legal, and ethical responsibilities in recognizing and reporting child abuse and neglect. All dental professionals need to understand the seriousness of the problems of child maltreatment and realize that children do not just get hurt in abuse and neglect-they often die as a direct result of their maltreatment. Dentistry must do its part to help stop the pain, suffering, and death that result from children maltreatment; it has been said that victims of child abuse and neglect fall into only two categories-those who lived through it and those who did not. [5,6,10]

DENTIST'S RESPONSIBILITY OUTLINED BY THE AMERICAN DENTAL ASSOCIATION

- To observe and examine any suspicious evidence that can be ascertained in the office.
- To record, per legal and court rules, any evidence that maybe helpful in the case, including physical evidence and any comments from questioning or interviews.
- To treat any dental or orofacial injuries within the treatment expertise of the dentist, referring more extensive treatment needs to a hospital or dental/medical specialist.
- To establish/maintain a professional therapeutic relationship with the family.
- To become more familiar with the perioral signs of child abuse and neglect and to report suspected cases to the proper authorities, consistent with state law. 36

CONCLUSIONS

The intend of this article is to show every dental professional that a thorough understanding of their involvement in this issue can lead to a feeling of acceptance-an acceptance that we can do something to stop this awful epidemic.

Because a majority of the physical trauma to children occurs in the face and neck area, dentists are ideally positioned to detect possible abuse.

Crying or speaking emanates from the mouth, this area is frequently the focus of attack in cases of violent child abuse. The dentist's mission involves knowing the signs of child abuse and neglect and fulfilling the legal and moral obligation to prevent further abuse by documenting the injuries and reporting the matter to the police or social welfare agency. The practitioner should remember that incorrect or irresponsible accusations of child abuse can have a devastating effect upon the life of an innocent individual. Child abuse is a complex problem with many causes.

As members of the dental profession, we should realize that we find ourselves in a unique position to observe symptoms of child abuse. Providing the proper training to the dentists, we give them the power to participate actively in a process that may help to save the lives of otherwise helpless children.

Infants and children are helpless to the abusive adult. Their physical injuries can range from mild to extreme and may result to their death. Cruelty to children won't end until there is a major change of attitude towards them. If abused is suspected, then it must be reported! The ultimate goal is to save children's lives.

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