DOMESTIC VIOLENCE IN CHILDREN – WHAT LIES BEHIND THE DOOR??

Harsha Puri[1], Sonali Kadam[2,*], H. R. Umarji[3]

[1]Postgraduate Student, [2]Associate Professor, [3]Professor and Head of Dept.,
Dept. of Oral Medicine and Radiology, Government Dental College and Hospital, Mumbai

***Corresponding Author:**
E mail: sonalikdm863@gmail.com

ABSTRACT

Domestic violence is a devastating social problem that affects every segment of the population. While system responses are primarily targeted towards adult victims of abuse, increasing attention is now focused on the children who witness domestic violence[1]. Many times children suffer silently, and with little support. It is a problem of major public concern and has gained wide attention among paediatricians, dentists, psychiatrists, social workers, forensic pathologists, and professionals. This article reports the oral and dental aspects of physical and sexual abuse and dental neglect and the role of physicians and dentists in evaluating such conditions.

Keywords: *domestic violence, assault*

INTRODUCTION

Domestic violence measured by the National Crime Victimization Survey (NCVS) includes rape or sexual assault, robbery, and aggravated and simple assault committed by a current or former spouse, boyfriend, or girlfriend. In 2000, about 1 in every 200 households acknowledged that someone in the household experienced some form of domestic violence. There is no statistically significant difference in this rate over the prior 6 years. As with other crimes measured using the NCVS, a household counted as experiencing domestic violence was counted only once, regardless of the number of times that a victim experienced violence and regardless of the number of victims in the household during the year.[1-4]

The purpose of this report is to review the oral and dental aspects of physical and sexual abuse and dental neglect and the role of physicians and dentists in evaluating such conditions.

Children's exposure to domestic violence typically falls into three primary categories

- Hearing a violent event;
- Being directly involved as an eyewitness, intervening, or being used as a part of a violent event (e.g., being used as a shield against abusive actions);
- Experiencing the aftermath of a violent event.[5]

Also, Tactics- The types of domestic violence actions perpetrated by abusers include physical, sexual, verbal, emotional, and psychological tactics; threats and intimidation; economic coercion; and entitlement behaviors.[6] Children's exposure to domestic violence also may include being used as a spy to interrogate the adult victim, being forced to watch or participate in the abuse of the victim, and being used as a pawn by the abuser to coerce the victim into returning to the violent relationship.21Some children are physically injured as a direct result of the domestic violence. Some perpetrators intentionally physically, emotion-ally, or sexually abuse their children in an effort to intimidate and control their partner. While this is clearly child maltreatment, other cases may not be so clear. Children often are harmed accidentally during violent attacks on the adult victim. An object thrown or weapon used against the battered partner can hit the child. Assaults on younger children can occur while the adult victim is holding the child, and injury or harm to older children can happen when they intervene in violent episodes. In addition to being exposed to the abusive behaviour, many children are further victimized by coercion to remain silent about the abuse, maintaining the "family secret."[7-10]

Physical abuse

Craniofacial, head, face, and neck injuries occur in more than half of the cases of child abuse.[1-10] A careful and thorough intraoral and perioral examination is necessary in all cases of suspected abuse and neglect. In addition, all suspected victims of abuse or neglect, including children in state custody or foster care, should be examined carefully not only for signs of oral trauma but also for caries, gingivitis, and other oral health problems. Some authorities believe that the oral cavity may be a central focus for physical abuse because of its significance in communication and nutrition.[11]

Oral injuries may be inflicted with instruments such as eating utensils or a bottle during forced feedings, hands, fingers, or scalding liquids or caustic substances.

The abuse may result in: contusions, burns, or lacerations of the tongue, lips, buccal mucosa, palate (soft and hard), gingiva alveolar mucosa, or

frenum; fractured, displaced, or avulsed teeth; or facial bone and jaw fractures[12].

In one study, the lips were the most common site for inflicted oral injuries (54%), followed by the oral mucosa, teeth, gingivae, and tongue. Discoloured teeth, indicating pulpal necrosis, may result from previous trauma.[13,14] Gags applied to the mouth may result in bruises, lichenification, or scarring at the corners of the mouth.[15]

Some serious injuries of the oral cavity, including posterior pharyngeal injuries and retropharyngeal abscesses, may be inflicted by caregivers with factitious disorder by proxy[16] to simulate haemoptysis or other symptoms requiring medical care; regardless of caregiver motive, all inflicted injuries should be reported for investigation. Unintentional or accidental injuries to the mouth are common and must be distinguished from abuse by judging whether the history, including the timing and mechanism of injury, is consistent with the characteristics of the injury and the child's developmental capabilities. Multiple injuries, injuries in different stages of healing, or a discrepant history should arouse a suspicion of abuse. Consultation with or referral to a knowledgeable dentist may be helpful.

Sexual abuse

Although the oral cavity is a frequent site of sexual abuse in children,[17] visible oral injuries or infections are rare. When oral-genital contact is suspected, referral to specialized clinical settings equipped to conduct comprehensive examinations is recommended. The American Academy of Pediatrics statement "Guidelines in the Evaluation of Sexual Abuse of Children"[18] provides information regarding these examinations.

Oral and perioral gonorrhea in prepubertal children, diagnosed with appropriate culture techniques and confirmatory testing, is pathognomonic of sexual abuse[19] but rare among prepubertal girls evaluated for sexual abuse.[20] Pharyngeal gonorrhea is frequently asymptomatic.[21] When oral-genital contact is confirmed by history or examination findings, universal testing for sexually transmitted diseases within the oral cavity is controversial; the clinician should consider risk factors (e.g., chronic abuse, perpetrator with a known sexually transmitted disease) and the child's clinical presentation in deciding whether to conduct such testing. Although human papillomavirus infection may result in oral or perioral warts, the mode of transmission remains uncertain and debatable. Human papillomavirus infections may be sexually transmitted through oral-genital contact, vertically transmitted from mother to infant during birth, or horizontally transmitted through nonsexual contact from a child or caregiver's hand to the genitals or mouth.[22]

Unexplained injury or petechiae of the palate, particularly at the junction of the hard and soft palate, may be evidence of forced oral sex.[23] As with all suspected child abuse or neglect, when sexual abuse is suspected or diagnosed in a child, the case must be reported to child protective services and/or law enforcement agencies for investigation.[22-23] A multidisciplinary child abuse evaluation for the child and family should be initiated.

Children who present acutely with a recent history of sexual abuse may require specialized forensic testing for semen and other foreign materials resulting from assault. If a victim provides a history for oral-penile contact, the buccal mucosa and tongue can be swabbed with a sterile cotton-tipped applicator, then the swab can be air-dried and packaged appropriately for laboratory analysis. However, specialized hospitals and clinics equipped with protocols and experienced personnel are best suited for collecting such material and maintaining a chain of evidence necessary for investigations.[18-20]

Bite marks

Acute or healed bite marks may indicate abuse. Dentists trained as forensic odontologists can assist physicians in the detection and evaluation of bite marks related to physical and sexual abuse.[22] Bite marks should be suspected when ecchymoses, abrasions, or lacerations are found in an elliptical or ovoid pattern. Bite marks may have a central area of ecchymoses (contusions) caused by two possible phenomena: positive pressure from the closing of the teeth with disruption of small vessels or negative pressure caused by suction and tongue thrusting. Bites produced by dogs and other carnivorous animals tend to tear flesh, whereas human bites compress flesh and can cause abrasions, contusions, and lacerations but rarely avulsions of tissue. An intercanine distance (i.e., the linear distance between the central point of the cuspid tips) measuring more than 3.0 cm is suspicious of an adult human bite.[23]

The pattern, size, contour, and colour of the bite mark should be evaluated by a forensic odontologist or a forensic pathologist if an odontologist is not available. If neither specialist is available, a physician or dentist experienced in the patterns of child abuse injuries should observe and document the bite mark characteristics photo-graphically with an identification tag and scale marker (eg, ruler) in the photograph. The photograph should be taken such that the angle of the camera lens is directly over the bite and perpendicular to the plane of the bite to avoid distortion. A special photographic scale was developed by the American Board of Forensic Odontology (ABFO) for this purpose, as well as for documenting other patterned injuries, and can be obtained from the vendor (ABFO No. 2 reference scale, available from Lightening Powder

Co Inc, Salem, Ore). Names and contact information for ABFO certified odontologists can be obtained from the ABFO website (www.abfo.org).[22]

In addition to photographic evidence, every bite mark that shows indentations should have a polyvinyl siloxane impression made immediately after swabbing the bite mark for secretions containing DNA. This impression will help provide a 3-dimensional model of the bite mark. Written observations and photographs should be repeated daily for at least 3 days to document the evolution of the bite. Because each person has a characteristic bite pattern, a forensic odontologist may be able to match dental models (casts) of a suspected abuser's teeth with impressions or photographs of the bite.

Blood group substances can be secreted in saliva. DNA is present in epithelial cells from the mouth and may be deposited in bites. Even if saliva and cells have dried, they should be collected using the double-swab technique. First, a sterile cotton swab moistened with distilled water is used to wipe the area in question, dried, and placed in a specimen tube. A second sterile dry cotton swab cleans the same area, then is dried and placed in a specimen tube. A third control sample should be obtained from an uninvolved area of the child's skin. All samples should be sent to a certified forensic laboratory for prompt analysis. The chain of custody must be maintained on all samples submitted for forensic analysis. Questions regarding evidentiary procedure should be directed to a law enforcement agency. [5,6, 22-23]

Dental neglect

Dental neglect, as defined by the American Academy of Pediatric Dentistry, is the "wilful 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." Dental caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.[22] Some children who first present for dental care have severe early childhood caries (formerly termed "baby bottle" or "nursing" caries); caregivers with adequate knowledge and wilful failure to seek care must be differentiated from caregivers without knowledge or awareness of their child's need for dental care in determining the need to report such cases to child protective services. [14.22-23]

Failure to seek or obtain proper dental care may result from factors such as family isolation, lack of finances, parental ignorance, or lack of perceived value of oral health.[23] The point at which to consider a parent negligent and to begin intervention occurs after the parent has been properly alerted by a health care professional about the nature and extent of the child's condition, the specific treatment needed, and the mechanism of accessing that treatment. Because many families face challenges in their attempts to access dental care or insurance for their children, the clinician should determine whether dental services are readily available and accessible to the children. [22-23]

Possible Symptoms in Children Exposed to Domestic Violence

Sleeplessness, fears of going to sleep, nightmares, dreams of danger;

- Physical symptoms such as headaches or stomachaches;
- Hyper vigilance to danger or being hurt;
- Fighting with others, hurting other children or animals;
- Temper tantrums or defiant behavior;
- Withdrawal from people or typical activities;
- Listlessness, depression, low energy;
- Feelings of loneliness and isolation;
- Current or subsequent substance abuse;
- Suicide attempts or engaging in dangerous behavior;
- Poor school performance;
- Difficulties concentrating and paying attention;
- Fears of being separated from the nonabusing parent;
- Feeling that his or her best is not good enough;
- Taking on adult or parental responsibilities;
- Excessive worrying;
- Bed-wetting or regression to earlier developmental stages;
- Dissociation;
- Identifying with or mirroring behaviors of the abuser.[22-23]

CONCLUSION

Children that are victims of physical violence may present intraoral injuries that range from mild injuries, like ecchymoses in the lips to more severe injuries, such as tooth crown fractures. The dentist and the dental staff must be capacitated to diagnose the different types of oral injuries resulting from child abuse, provide the best treatment possible to the victims and notify the authorities responsible for children's protection of any suspicious or confirmed case of abuse

Referenses:

1. U.S. Department of Justice, Bureau of Justice Statistics. (2002, September). Crime and the nation's households, 2000. Bureau of Justice Statistics Bulletin (NCJ 194107). Washington, DC Edleson, J. L. (1999).
2. Guideline on Oral and Dental Aspects of Child Abuse and Neglect REFERENCE MANUAL V 34 / NO 6 12 / 13
3. 4.27Ganley, A. L., & Schechter, S. (1996).

4. Mouden LD, Bross DC. Legal issues affecting dentistry's role in preventing child abuse and neglect. J Am Dent Assoc 1995;126:1173-80.
5. Schwartz S, Woolridge E, Stege D. The role of the dentist in child abuse. Quintessence Int 1976;7:79-81.
6. Sognnaes RF, Blain SM. Child abuse and neglect. I: Diagnostic criteria of special interest to dentists [abstract]. J Dent Res 1979;58(special issue A):367.
7. Donly KJ, Nowak AJ. Maxillofacial, neck, and dental lesions of child abuse. In: Reece RM, ed. Child Abuse: Medical Diagnosis and Management. Philadelphia, Pa: Lea & Febiger; 1994:150-66.
8. Baetz K, Sledziewski W, Margetts D, Koren L, Levy M, Pepper R. Recognition and management of the battered child syndrome. J Dent Assoc S Afr 1977;32:13-8.
9. Becker DB, Needleman HL, Kotelchuck M. Child abuse and dentistry: Orofacial trauma and its recognition by dentists. J Am Dent Assoc 1978;97:24-8.
10. Cameron JM, Johnson HR, Camps FE. The battered child syndrome. Med Sci Law 1966;6:2-21.
11. Jessee SA. Physical manifestations of child abuse to the head, face and mouth: A hospital survey. J Dent Child 1995;62:245-9.
12. Jessee SA, Rieger M. A study of age-related variables among physically abused children. J Dent Child 1996; 63:275-80.
13. Malecz RE. Child abuse, its relationship to pedodontics: A survey. J Dent Child 1979;46:193-4.
14. Needleman HL. Orofacial trauma in child abuse: Types, prevalence, management, and the dental profession's involvement. Pediatr Dent 1986;8(special issue 1):71-80.
15. O'Neill JA Jr, Meacham WF, Griffin JP, Sawyers JL. Patterns of injury in the battered child syndrome. J Trauma 1973;13:332-9.
16. Skinner AE, Castle RL. Seventy-eight Battered Children: A Retrospective Study. London, England: National Society for the Prevention of Cruelty to Children; 1969.
17. Naidoo S. A profile of the orofacial injuries in child physical abuse at a children's hospital. Child Abuse Negl 2000;24:521-34.
18. Kittle PE, Richardson DS, Parker JW. Two child abuse/ child neglect examinations for the dentist. J Dent Child 1981;48:175-80.
19. Blain SM, Winegarden T, Barber TK, Sognnaes FR. Child abuse and neglect. II: Role of dentistry [abstract]. J Dent Res 1979;58(special issue A):367.
20. McNeese MC, Hebeler JR. The abused child: A clinical approach to identification and management. Clin Symp 1977;29:1-36.
21. AMERICAN ACADEMY OF PEDIATRIC DENTISTRY Ad Hoc Work Group on Child Abuse and NeglectOral and Dental Aspects of Child Abuse and Neglect (RE9920) Pediatrics Volume 104, Number 2 August 1999, pp 348-350
22. Injuries to the head and orofacial region. Dental Traumatology 2010 John Wiley & Sons A/S.