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ABSTRACT

Childhood should be carefree time of life filled with love, with new worlds to explore, and with the joy of mastery of oneself and the environment. For many children it is a dream and not reality. Child abuse and neglect is a social problem prevalent in all countries. In developing countries, most of such instances go unnoticed and undocumented, and the real scenario remains unclear. It is generally accepted that the most effective strategy for management of child abuse in its various forms is prevention. The significance of child abuse is threefold. First of all a pediatric dentist is very likely to see cases. Second, the pediatric dentist is not only morally bound but often legally obligated to report suspected cases. Finally reporting does help. The likelihood that the dentist will see evidence of child abuse is increased by the fact that physical abuse often involve facial and intraoral trauma. As pediatric dentists, our role lies on two scales. Primarily to identify such a case in dental office and report to concerned authorities and secondarily to spread generalized awareness among kids this will help them in a great way. Let us fulfil our duty and make this world a better place.

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INTRODUCTION:

Child Abuse and Neglect (CAN) is defined by the World Health Organization as: Every kind of physical, sexual, emotional abuse, neglect or negligent treatment, commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. This definition consists of 2 meanings: (1) the result of a committed action (physical, sexual, or emotional abuse) or (2) an omission (neglect)¹. The consequence of CAN is real or potential damage to the child's life, health or development, especially for infants (1-4 years), wherein the commission or omission of an action could stake a claim on their future life and health².

Dental neglect can be defined as: Wilful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health for adequate function and freedom from pain and infection. 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 treatment³.

CLASSIFICATION

Physical abuse: It is defined as any act which results in non accidental trauma or physical injury. 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. Physical abuse includes hitting, shaking, suffocating and other ways of inflicting pain or injury to child. Physical abuse can be identified when the history does not coincide with the symptoms present.

Emotional abuse: Emotional abuse is the least understood of all forms of child abuse, yet it is more prevalent and can be the most cruel and the most destructive of all types of abuse. It can seriously interfere with the child's positive development as it attacks the child's psyche and self concept. Rejecting, ignoring, terrorizing, isolating, corrupting are the various types of emotional abuse.

Sexual abuse: It can be defined as the involvement of dependent, developmentally immature children in sexual activities that they do not fully comprehend and therefore to which they are unable

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to give informed consent and/or which violates the taboos of society. Sexual abuse has the potential to interfere with child's normal healthy development, both emotionally and physically. These children experience severe emotional disturbances from their own feelings of guilt and shame¹⁸.

Munchausen Syndrome by proxy: Munchausen syndrome is a psychological disorder in which the patient fabricates the symptoms or injury in order to undergo medical tests, hospitalization, or even medical or surgical treatment. To command medical attention, patients with Munchausen syndrome may intentionally injure themselves or induce illness in them. On the other hand, in cases of Munchausen syndrome by proxy, a parent or caretaker attempts to bring medical attention to themselves by injuring or inducing illness in their children¹⁵.

Intentional drugging or poisoning: It can occur for many different reasons, and involve a variety of toxic substances and have no classic clinical presentation. It is important to remove the patient from the caretaker may be one of the management options under such circumstances¹⁶.

Shaken baby syndrome: It is a form of child abuse where the infant's head is shaken vigorously forward and backward, hitting the chest and shoulders. The classic medical symptoms associated with infant shaking are retinal haemorrhage, subdural or subarachnoid hematomas, and absence of other external signs of abuse, breathing difficulties, seizures and unconsciousness¹⁷.

Among health professionals, dentists are probably in the most favourable position to recognize CAN, because 50% to 75% of reported lesions involve the mouth region, the face, and the neck^{4,6}. Besides, dentists have a continuing relationship with their pediatric patients and their families, as it is often necessary for a given patient to be seen several times a month. This fact gives the dentist an opportunity to observe not only the physical and the psychological condition of the children, but also

their family environment. Often the abuser, usually a parent, delays bringing the child to the hospital, because he or she feels "watched over" by the medical personnel. The same kind of caution is not used with dentists who are expected to provide only a technical service. Despite the opportunities available to dentists in detecting child maltreatment, they seldom report suspected orofacial injuries^{4,5}.

Considering how damaging abuse and neglect can be to child's health, life, and development^{7,8}. Dentists must act to detect, treat, and prevent it. Unfortunately, attitude and lack of knowledge present obstacles to reach this goal.

Considering the importance of a healthy dentition in digestion, knowing the role of the primary dentition in tooth exchange, and being aware of the consequences of infections and toothaches in the child's social life, we should feel it our duty to detect and treat cases of neglect. An awareness campaign, designed to awaken not only physicians and dentists, but parents and society in general, could reduce the frequency of dental abuse and expose it as a real type of abuse⁹.

There is widespread disagreement in the literature about what plays a greater part in influencing the way health and social operators deal with CAN, including such wide ranging factors as character of reporter (age, sex, degree, specialist training, percentage of pediatric patients in the practice, knowledge of, experience with CAN, fear of litigation, patient confidentiality, trust of child protection services, type of maltreatment, and victim). Some investigators consider the characteristics of the professional as the major determinant in his or her predisposition to identify or report such cases; others consider the typology of the case or of the victim as the most important ones.

India is home for 19% of the world's child population, with every fifth child in the world living in India. Forty-two percent of the Indian

population is aged below.¹⁸ Some of the facts in India related to CAN are as follows¹⁰.

- India is country with huge population but birth registration is only just 62%.
- Every second child in India is underweight.
- Every third malnourished child in the world lives in India.
- One thousand one hundred four lakh children are child labours in the country.
- Immunization coverage is very low.
- Decline in the female to male ratio is maximum in 0–6years: 927 females per 1000 males.

Women and children trafficking in India is high, number of missing children in India is about 44,476. Three to five lakh girl children are involved in commercial sex and organized prostitution. This is according to the survey carried out by the ministry of women and child development, government of India in the year 2007 and it was done in 13 states.

In all suspected cases for the detection of both physical and sexual abuse, a careful intraoral and perioral examination is required. In physical abuse, injuries often cause blunt trauma and are inflicted using an instrument (kitchen tools, hands, fingers) or scalding liquids and caustic substances. Abuse may result in contusion of the soft tissues or lacerations of the tongue, buccal mucous membrane, hard and soft palate, gingival mucous membrane, or frenulum. Other clinical evidence includes jaw fracture and avulsed or discoloured teeth. In sexual abuse, the presence of oral or perioral gonorrhoea or syphilis in prepubertal children is pathognomonic. Unexplained erythemas or petechiae in the palate, especially at the junction of the hard and soft palate, can indicate forced oral sex, making the mouth the most frequent place where sexual abuse can be detected in children. Bite marks can also be a sign of both sexual and physical abuse.

Physical abuse

Two out of three children were physically abused, out of 69% children 54.68% were boys. Eighty-eight percent were physically abused by parents and 65% of school going children reported facing corporal punishment (62% in government and municipal school). The states such as Andhra Pradesh, Assam, Bihar, and Delhi have almost consistently reported higher rates of abuse in all forms as compared to other states. In more than 50% of the cases, the site involved is the facial region¹⁰.

Sexual abuse

53.22% children have faced one or the other forms of sexual abuse. States such as Andhra Pradesh, Assam, Bihar, Delhi, reported highest amount of child abuse. 21.90% child respondents faced severe form of sexual abuse. 50% abusers are persons known to the child or in a position of trust and responsibility¹⁰.

Emotional abuse and girl child neglect

Every second reported child was facing emotional abuse, with an equal percentage of affected girls and boys. In 83% of the cases, parents were the abusers. Girls who wished to be a boy was 48.4%¹⁰.

Child labour

Across the world, around 21 million children were involved in child labour in 2004, around 1104 lakh only in India, with it having the world's highest number of working children.

There are many studies that were carried out to assess the perception, knowledge, attitude of dentist regarding CAN. Studies concluded that they did not know much about CAN and they require continuing dental education regarding CAN. As we all know that medical professionals are the one who will come first in contact with the child and parents. They are the one who promote health and they are the preferred one for any kind of trauma or ill health. CAN was first reported in the year 1960 by a

medical professional called Dr. C. H. Kemp. Considering the above-mentioned Indian facts and important role played by the medical professional, we should reassess perception, attitude, knowledge, and experience of medical professionals about CAN¹⁰.

Most of the professionals are aware of their duty to protect child's physical and psychological health. Considering how damaging abuse and neglect can be to child's health, life, and development, medical professionals must act to detect, treat and prevent it. In one of the study, 45–86% dentist were aware of their legal obligations. There are many factors that influence the ability to recognize and report CAN¹².

These include the following.

- Lack of awareness of legal responsibilities and protections.
- Uncertainties about what constitutes CAN. Lack of training in identifying characteristics of children who are victims of CAN.
- Uncertainties regarding the assessment of a patient's problem: Is it abuse or neglect?
- Lack of knowledge and skill in reporting procedures
- Uncertainties regarding the outcome of reporting
- Poor experience or relationships with local authorities.
- Reluctance to interfere in the parent–child relationship.
- Fear of legal involvement.
- Fear of detrimental effects on the individual's practice.

Some of programs to prevent CAN are

1. Family support approaches
 - a) Training in parenting
 - b) Intensive family preservation services
2. Training for health professionals
 - a) Continuing education program
 - b) Providing them diagnostic and treatment guidelines
3. Legal and related remedies
 - a) Child protection services
 - b) Arrest and prosecution policies
4. Community based effort
 - a) School programs
 - b) Prevention and educational campaigns

CONCLUSIONS

- The incidence and prevalence of CAN is underestimated by medical professionals;
- Ninety-two percent of medical professionals agree that protection of child's health is their duty, but 35.5% medical professionals have a poor attitude in perceiving CAN as pathology.
- Most of the medical professional are unable to confront suspected cases even though they may be aware of the medico legal responsibility of their job.
- Child neglect is the least known even though they are most frequently occurring.
- The perception, knowledge, and attitudes of medical professionals in India about CAN display a poor overall understanding of the problem. This gives a clear indication for further formal training and continuing medical educational programs are required.

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