Family Violence: Implications for Patients and Practice

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Nurture or nature? Genetics or environment? Which shapes us more? Whichever side of the argument you find more persuasive, we can all agree that every person is a product of experiences in life. That is true for each of us that wants to prevent family violence—defined as abuse or neglect of children, adults or the elderly. It is also true of the survivors we treat in the dental practice. When each member of the dental team learns more about how family violence affects our patients and our practices, we will begin seeing this issue from a much different perspective.

When violence occurs in a home, no one escapes—whether they are physically abused or emotionally affected through witnessing violence. A child's exposure to adult partner violence can include being hit while in a mother's arms or being forced to watch physical assault. Children are also at risk of physical harm by attempting to intervene and stop violence. [i]

The *Adverse Childhood Experiences* study, surveying adult health outcomes of more than 400,000 patients in a managed care system, showed that child maltreatment can have monumental affects on adult health status. A history of child sexual abuse can lead to adult problems of obesity, depression, hypertension, and diabetes. [ii] If we are all products of our experiences, it is no surprise that adverse experiences lead to adverse outcomes later in life.

Dentistry faces two great challenges in dealing with family violence—the magnitude of family violence and the apparent lack of involvement from dental professionals. The size of the family violence epidemic is constantly growing, but is difficult to measure. Recent statistics have shown that the incidence of child abuse and neglect—the only universally reportable forms of family violence—continues to rise. Typical data show as many as three million children each year are reported to child protective service (CPS) agencies in the U.S. Moreover, as many as 4,000 children are fatalities of abuse and neglect each year.

The incidences of intimate partner violence (formerly called domestic violence) and elderly abuse are even larger, although difficult to quantify. Estimates from various sources show that these forms of family violence are each as pervasive as child maltreatment. Dr. Donna Shalala, the former U.S. Secretary of Health and Human Services, put the magnitude of spousal abuse into perspective by stating, that it is "as common as birth in this country because it occurs four million times each year."

Obviously, the size and seriousness of these epidemics are staggering, but dentistry's major involvement has traditionally focused on child abuse and neglect. However, dentistry's commitment to preventing child maltreatment is not commensurate with the epidemic. Although as much as 75% of child abuse injuries occur to the head, neck and face, [iii] few dentists apparently ever recognize or a report a case of child maltreatment.

A 1995 national study of child protective service agencies pointed out several facets of dentistry's involvement in the reporting process. The data on dentists' reporting of child maltreatment must be extrapolated from a small sample because only eight states currently track the number of dentists that make reports. However, in those states, covering 201,944 total reports of child abuse and neglect, only 637 reports came from dentists. This figure represents a reporting rate of only 0.32%. [iv]

Some of the failure to report lies within state legislation and the child protective services bureaucracy. Although dentists and other health care providers in every state are mandated by law to report suspected cases of child abuse and neglect,[v] the survey shows that only 18 states have any protocol for training mandated reporters. This failure leaves mandated reporters with a requirement to report suspected child victims, but no formal training to help diagnose these victims.

Other reasons given for failure to report suspected victims include fear of losing patients from a practice, uncertainty about the diagnosis of abuse or neglect, little confidence in child protective service agencies, and fear of dealing with angered parents. In a national survey of pediatric dentists, seven percent of respondents said they would not report suspected cases of abuse or neglect under any circumstances. [vi] The change in dentistry's attitudes about family violence in the past decades has hopefully improved that grim outlook.

Another stated reason for failure to report is an unwillingness for some practitioners to take dentistry beyond the realm of tooth repair. We sometimes hear the cry that dentists should not get involved with violence prevention issues, but just "stick to dentistry!" [vii] We would hope that stopping violence is as important to dentistry as other community issues such as the prevention of oral disease.

Organized dentistry has developed policies on family violence in recent years. The ADA Principles of Ethics and Code of Professional Conduct states: "Dentists shall be obliged to become familiar with the signs of abuse neglect and to report suspected cases to the proper authorities consistent with state law." It is important to note that the ethical requirement is to help prevent family violence in all age groups. ADA policy also requires the Association to expand educational opportunities on family violence beyond child maltreatment to include women, elders, people with developmental disabilities, the physically challenged and any other person who might be the object of abuse or neglect. Dentistry has been more reluctant to deal with the problems of spousal abuse and elder abuse and neglect. Dentists and dental hygienists must be aware that all forms of family violence may impact their professional practice. As with child abuse injuries, the other forms of family violence are also most likely to involve injury to the head and neck,[viii] so dental professionals are likely to see the victims. Dentists have long been at the forefront of prevention and must extend those efforts to include the prevention of family violence.

Few states require reporting of suspected abuse of competent adults. In the remaining states no other reporting requirement exists—nor should it. All health care professionals must view adult patients as autonomous persons capable of making good decisions about their own lives and their own safety. A mandatory reporting requirement of adult victims can place the victims in a more dangerous, potentially fatal situation. Although few states have a mandatory reporting requirement for intimate partner violence, most states do require other reporting, such as gunshots and stabbings.

When dealing with adult victims, health care professionals must learn that their role is to serve as facilitators by providing information, support, and encouragement. Therefore, dentists and the rest of the health care team must learn to communicate respect for all their patients, support their patients' decisions, and be knowledgeable about available community resources. Every health care provider must develop attitudes that will allow them to assist all victims of family violence—attitudes of urgency, respect, concern, and community.

The Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) program began in Missouri and is now in place in 44 states and 12 international coalitions. The Illinois P.A.N.D.A. program has been in place since 1996. Show concern for every patient's total health and your willingness to help. Dentistry can be at the forefront of preventing family violence. Working together with other health care professionals and community groups, we can make a difference against this exponentially growing problem. Remember the importance of preventing family violence. Your attitudes and actions cannot only protect someone from abuse or neglect, but they may also save a life.

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REFERENCES

i Mitchell, Connie. "How Are Children Impacted by Adult Partner Violence? CDA Journal, April 2004; 32(4): 317-319.

ii Filletti, Vincent. "The Relation Between Adverse Childhood Experiences and Adult Health: Turning Gold into Lead." The Family Violence Prevention Fund's Health Alert, Summer 2001; 8(1): 1-3

iii da Fonesca, MA; Feigal, RJ; ten Besel, RW. "Dental aspects of 1248 cases of child maltreatment on file at a major county hospital." Pediatric Dentistry 1992; 14(3): 152-7.

iv Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, contract reference No. 140759.

v Mouden, LD; Bross, DC. "Legal issues affecting dentistry's role in preventing child abuse and neglect" JADA August 1995; 126(8): 1173-80.

vi Malecz, R.E. "Child abuse, its relationship to pedodontics: A survey." ASDC Journal of Dentistry for Children May-June 1979; 46(3): 193-4.

vii Smith, DM. "Recognizing abuse." (letter) JADA June 1994; 125(6): 659-60.

viii Berrios, DC, Grady, D. "Domestic violence: Risk factors and outcomes." Western Journal of Medicine 1991; 155: 133-5.