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Recognizing and Reporting Child Abuse in the Dental Office

Michael Florman, DDS and Edo Lavi, DMD
3 CONTINUING EDUCATION CREDITS

COURSE OBJECTIVES

Upon completion of this course, participants will have developed a clearer understanding of how to identify signs of child abuse during patient visits to the dental office. Topics include defining child abuse, the long term effects of abuse, detection of child abuse, how to report child abuse and the dentist's specific obligations in this regard.

COURSE SPONSOR

Benco Dental is the course sponsor. Benco's ADA/CERP recognition runs from November 2000 to December 2003. Please direct all course questions to the director: Dr. Rick Adelstein, 3401 Richmond Rd., Suite 210, Beachwood, OH 44122. Fax: (216) 595-9300. Phone: (216) 591-1161. e-mail: toothdoc@core.com

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Upon completion of the course, each participant scoring 80% or better (correctly answering 27 of the 34 questions) will receive a certificate of completion verifying three Continuing Dental Education Units. The formal continuing education program of this sponsor is accepted by the AGD for FAGD/MAGD credit. Term of acceptance: September 1, 1994 to December 31, 2003. Please contact your state dental board for your state's continuing education requirements.

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Your feedback is important to us. Please complete the brief Course Evaluation survey at the end of your booklet. Your response will help us to better understand your needs so we can tailor future courses accordingly.

Why Take This Course?

DUTY—The ADA made it an ethical obligation for its members to become familiar with the signs of child abuse and report them.

CE CREDITS—Fulfill your continuing education requirements. Successful completion of this course earns you 3 Continuing Dental Education Units.

HIGH VALUE—Continue your education without traveling, taking time away from work and family, or paying high tuition, registration and materials costs.

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Who Should Take This Course?

All Dentists
Dental Hygienists
Dental Assistants



ACCEPTED NATIONAL PROGRAM
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Recognizing and Reporting Child Abuse in the Dental Office

Each year, an estimated 1.5 million U.S. children are physically assaulted. Countless more are the victims of emotional maltreatment and neglect. More than 65% of reported injuries inflicted by child abusers occur on the head, neck or face.

The frequency with which dentists, hygienists, and auxiliaries see young patients for diagnosis places them in a uniquely strategic position for the detection of child abuse. While the detection of dental care neglect is an obvious responsibility for dental team, other types of child abuse may also present themselves in the dental office and the dental team should be familiar with them. In the absence of extensive training in every aspect of child abuse prevention, detection, and reporting, the dental team is in grave

danger of missing the opportunity to intervene on behalf of the abused. Consequently, there is a tremendous moral responsibility on dentists, hygienists, and auxiliary to be educated in this topic.

Over the past decade, the ADA and related governing bodies have recognized the need for serious child abuse education. In November 1993, the ADA's House of Delegates made it an ethical obligation for its 140,000 members "to become familiar with the perioral (around the mouth) signs of child abuse and to report suspected cases to the proper authorities" by incorporating guidelines in its Principles of Ethics and Code of Professional Conduct. The ADA's House of Delegates also urged the ADA, and state and local dental societies, to help their members fulfill their

ethical obligation regarding child abuse. Developing resource material and training courses for dentists was a chief goal.

The heightened awareness of the role of the dentist, hygienist, and auxiliary in combating child abuse resulted in increased education for dental students, as well as dental professionals. An ADA survey showed that the percentage of

dentists who had completed training in dental school or in continuing education courses related to recognizing signs of child abuse increased from just under half of dentists in 1994 (47.5%) to 61% in 1997. In addition, the percentage of dentists who reported that they had ever seen signs of child abuse increased from 15.5% of all dentists in 1994 to 16.8% in 1997.

Recent advances in child abuse education for dental practitioners have been highlighted by the legal requirement of child abuse education for state licensure, and the formation of organizations and programs specifically targeting the role of the dentist in the fight against child abuse. In at least 42 states, a program called P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) is seeing increasing success. In Missouri, for example, the reporting rate by dentists of suspected abuse or neglect of children increased 160 percent after only the third year of the P.A.N.D.A. program. In 1998, the ADA sponsored the Dentists C.A.R.E. (Child Abuse Recognition and Education) Conference to provide current education for dental professionals, by increasing awareness of the epidemic of child abuse and family violence, and offering guidelines for the reporting of suspected abuse. Dentists are currently mandated reporters of suspected child abuse in all 50 states.



DEFINING ABUSE

Most manifestations of abuse will include psychological, physical, social, and legal components. In his keynote address at the Dentists C.A.R.E. (Child Abuse Recognition and Education) Conference in 1997, the president of Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse), A. Sidney (Sid) Johnson III, defined child abuse as any act (non-accidental or trauma) that endangers or impairs a child's physical or emotional health or development. He noted that in Massachusetts, the definition was more specific: any child suffering physical or emotional injury which causes harm or substantive risk of harm to the child's health or welfare including sexual abuse or neglect, or any child who is determined to be physically dependent upon an addictive drug at birth. Mr. Johnson outlined some of the many forms that child abuse can take, including physical abuse, emotional abuse and neglect, health care neglect (medical and dental), physical neglect, sexual abuse, failure to thrive, safety neglect, intentional poisoning and Munchausen Syndrome by proxy (fabricated or induced illness by parent). He also identified some of the risk factors within the child's environment that can contribute to the abusive dynamic, including stress, lack of a support network, substance/alcohol abuse, learned behavior (many abusers were previously victims) and other forms of family violence in the home such as spousal or elderly abuse. Understanding the elements

of abuse enables the practitioner to better identify and manage an abusive situation.

LONG TERM EFFECTS OF CHILD ABUSE

The physical scars of abuse are only a small representation of the permanent emotional marks that are left on the abused child. Some of these psychological markings can be the clue that leads us to search for physical signs and establish a definitive impression of the child's trauma. The emotional effects of abuse can be severely debilitating, and constitute abuse by themselves, irrespective of physical findings. An abused child is more likely to exhibit personality defects, including withdrawal, fears, depression, sadomasochistic tendencies, passive-aggressive tendencies and failures to adjust to any situation.

Some clues to the possibility of abuse can be gleaned from analyzing trends in the child's performance in school. Scholastic difficulties, poor adjustment in school, distractibility, poor school attendance, lack of progress to the upper grades, truancy, and school dropouts are warning signs that should be examined in assessing an abusive situation. The scholastic ramifications of abuse usually present along with social symptoms. Abused children are at high risk for delinquency, juvenile crimes, thefts, sex crimes, robbery and murder. They tend to leave home and identify with street gangs. A life of depression and associations with socially maladjusted groups are a volatile recipe for

severe substance abuse, and disillusionment with life in general. Teenage pregnancies are common in female victims. Disturbances in emotions and sleep, phobias and sexual difficulties are also common. Children who have been sexually abused often fail to build lasting relationships, and are prime candidates to become "child abusers" themselves.

The suffering of abused children eventually taxes society as a whole as the children grow up and exert the by-products of their painful upbringing. Its impact causes enormous financial stress on the welfare and health care systems. It is estimated that in the United States, the annual cost of caring for children seriously injured through maltreatment is \$500 million. Experts predict that violence toward children will continue to rise and to have a significant impact on the social system. It thus behooves every member of society to be vigilant about pursuing the signs of abuse early in the development of the child.

DETECTION

Detection of child abuse in the dental office can begin well before the patient is seated. The dentist, hygienist, and staff should be educated to get a visual impression of the child as he enters the reception room. The appearance of the child's clothing can offer certain clues. Clothes that are not appropriate for the climate or occasion are suspicious. Failure to provide adequate clothing for protection from rain, cold or snow may constitute child neglect. Overdressed children

should be examined particularly closely, as long sleeves and high-necked shirts or scarves during hot summer months may be worn to cover signs of physical abuse.

Some indications of abuse can be gleaned from the patient history. Unexplained injuries or injuries that are inconsistent with the explanation are suspicious. One should also observe the guardian's attitude towards the child's injuries. A parent who delays seeking care or was present at the time of the injury, but absent at the examination, raises suspicion. As a rule, if a child accuses someone of abuse, it most likely is true.

In the waiting room, symptoms of dysfunctional interaction between the child and the parent or guardian can be observed. As the patient approaches the dental chair, gross physical assessment of the child includes observation of the child's gait and overall mannerism. An abused child might carry himself in a manner that is withdrawn or

fatigued. Signs of malnutrition should also be searched. Small posture, rounded shoulders, flat chest, a protuberant abdomen, tired eyes and thinning of hair are typical signs of malnutrition. Physical problems, such as a limp, difficulty in climbing into the dental chair, pain upon manipulation in the chair, poor posture or abnormal positioning of the limbs should be observed.

In the dental chair, a quick but systematic examination can reveal many signs of abuse. The head can be observed for symmetry and cleanliness. Abnormalities of the eyes and ears, including unequal pupils, deviated gaze, periorbital ecchymosis, or other signs of physical abuse can be noted. The patient's face, neck and throat should be examined for bruises, scars, abrasions, lacerations, or ecchymosis. Practitioners should note whether the bruises are in various stages of resolution, indicating trauma on different occasions. Bruises that are recent in nature will have a more vivid pronounced color (red-blue), while those that

are resolved appear more faded (brown-green-yellow). The exposed skin surfaces of the child can sometimes exhibit marks of recognizable objects, such as belt marks, hand slap marks, bite marks, electric cord marks and burn marks. Such marks are rarely accidental.

Upon oral examination, the dentist can look for unusual hard and soft tissue presentations other than rampant decay. This stage of abuse detection is critical, and the responsibility for this exam falls squarely on the dentist. A variety of the oral-facial injuries occur in 50% or more of abused children. Soft tissue signs include torn frenum, deviated or scarred tongue, and scars of the lips and mucosa. Dentally fractured, missing, displaced, or discolored teeth can result from physical abuse.

Inflicted burns are a rare, but very serious form of abuse. The hand is a common target of abuse and cigarette burns. Cigarette burns are very obvious as are radiator burns and the "glove or stocking" burn where the child is placed or held in scalding water, leaving a well-demarcated burn. Also sometimes seen is lye-burn, caused by ingestion of household cleaning products, which have not been locked up or forced in a child's mouth.

Finally, physical indicators of sexual abuse include oral lesions indicative of sexually transmitted diseases, bruising of the hard palate, pregnancy in teens, difficulty walking or sitting, and fear of oral exam.

REPORTING CHILD ABUSE

It is possible that the limiting factor in child abuse prevention is not the diagnosis, but the reporting of abuse. Some dental practitioners feel that their demographic population is immune from child abuse, and there-



fore give their patients the benefit of the doubt. Statistically, however, studies have shown that abuse happens in every neighborhood, in all ethnicities and socioeconomic classes. Often the dentist will feel that it is not their place to intervene with familiar patients as they might jeopardize the child further, or damage their own practice and reputation.

Dentists, hygienists, and assistants should realize that there are now several organizations geared towards handling the multifaceted aspects of child abuse detection and reporting. Most experts in the field support the use of interdisciplinary teams to assess children suspected of abuse in which the entire dental team work together with pediatricians, mental health care givers, social work and law enforcement. The complexity and range of issues call for this kind of collaboration.

Organizations such as P.A.N.D.A. are designed to aid in this difficult process. Coalition members generally include the state dental directors, dental insurance companies, the state dental association, the state social services agency, the state dental hygiene association, the state pediatric dental association and dental schools. This coalition is networked together so that any one agency in the coalition can be contacted by the dentist or hygienist, and the resources will be properly coordinated to maximally protect the child from further abuse without compromising the dentist's role in the process. ▶

Self-Test

- 1. How many U.S. children per year are estimated to be physically assaulted per year?**
 - A. 1 million
 - B. 1.5 million
 - C. 2 million
 - D. 2.5 million
- 2. What percent of reported injuries inflicted by child abusers occur on the head, neck or face?**
 - A. Under 20%
 - B. Over 20% but under 40%
 - C. More than 65%
 - D. More than 90%
- 3. What year did the ADA's House of Delegates make it an ethical obligation for its members "to become familiar with the perioral (around the mouth) signs of child abuse?"**
 - A. 1965
 - B. 1970
 - C. 1993
 - D. 1998
- 4. The percentage of dentists who reported that they had ever seen signs of child abuse from 1994 to 1997 was?**
 - A. 15.5% to 16.8%
 - B. 25.5% to 26.8%
 - C. 35.5% to 36.8%
 - D. 45.5% to 46.8%
- 5. At least how many states have a program called P.A.N.D.A (Prevent Abuse and Neglect through Dental Awareness)?**
 - A. 40
 - B. 42
 - C. 44
 - D. 46
- 6. Dentists are currently mandated reporters of suspected child abuse in how many states?**
 - A. 46
 - B. 47
 - C. 49
 - D. 50
- 7. Most manifestations of abuse will include:**
 - A. a psychological and social component
 - B. a physical component
 - C. a legal component
 - D. A and B
 - E. all of the above
- 8. Sidney (Sid) Johnson III defined child abuse as any act (non-accidental or trauma) that endangers or impairs a child's physical or emotional health or development.**
 - A. True
 - B. False

9. Which risk factor is not one that Sid identified, but that can contribute to the abusive dynamic?
- stress
 - lack of a support network
 - substance/alcohol abuse
 - learned behavior
 - none of the above
10. Which of the following is not in the list of personality defects an abused child is more likely to exhibit?
- withdrawal and fears
 - depression and sadomasochistic tendencies
 - passive-aggressive tendencies with the ability to adjust to any situation.
 - none of the above
11. Which clue to the possibility of abuse can be gleaned from analyzing trends in the child's performance in school?
- scholastic difficulties and poor adjustment in school
 - distractibility and lack of progress to the upper grades
 - poor school attendance and dropping out of school
 - all of the above
12. Abused children are not at high risk for:
- delinquency
 - juvenile crimes
 - thefts
 - sex crimes
 - none of the above
13. Abused children are likely to have which disturbance(s)?
- emotional
 - sleep
 - phobias
 - sexual difficulties
 - all of the above
14. Children who have been sexually abused often fail to build lasting relationships, and are prime candidates to become "child abusers" themselves.
- The first statement is true, the second statement is true
 - The first statement is true, the second statement is false
 - The first statement is false, the second statement is true
 - The first statement is false, the second statement is false
15. It is estimated that in the United States the annual cost of caring for children seriously injured through maltreatment is:
- \$100 million
 - \$200 million
 - \$300 million
 - \$400 million
 - \$500 million
16. TRUE or FALSE: Experts predict that the number of incidences of violence toward children should stay the same as it has throughout the last decade.
- True
 - False
17. Which of the following regarding detection of child abuse by looking at the child's clothing are not a good indicator to constitute child neglect?
- Clothes that are not appropriate for the climate
 - Clothes that not appropriate for the occasion
 - Clothes that are not fashionable
 - Clothes that are not providing protection from the rain
 - all are indicators
18. TRUE or FALSE: Unexplained injuries or injuries that are inconsistent with the explanation are suspicious.
- True
 - False
19. TRUE or FALSE: A parent who delays seeking care for a child injury, or who was present at the time of the injury but absent at the examination, raises suspicion.
- True
 - False
20. If a child accuses someone of abuse, should you take it as the truth?
- Yes
 - No
21. TRUE or FALSE: Symptoms of dysfunctional interaction between the child and the parent or guardian can be observed in the waiting room or as the child approaches the dental chair.
- True
 - False

22. Which of the following should not be used when evaluating gross physical assessment?
- unusual gait or posture in dental chair
 - types of clothing
 - overall mannerism
 - energy levels
 - bruises and or pain upon manipulation
23. Which of the following is not indicative of malnutrition in children?
- small posture, rounded shoulders
 - flat chest, protuberant abdomen
 - irregular gait, trouble climbing into the dental chair
 - tired eyes, thinning of hair
24. When evaluating the child's head, one should look for symmetry. Cleanliness is not important.
- The first statement is true, the second statement is true
 - The first statement is true, the second statement is false
 - The first statement is false, the second statement is true
 - The first statement is false, the second statement is false
25. Abnormalities of the eyes and ears include:
- unequal pupils
 - deviated gaze
 - periorbital ecchymosis
 - A and B
 - all of the above
26. The patient's face, neck and throat should be examined for:
- bruises and abrasions
 - scars
 - lacerations
 - ecchymosis
 - all of the above
27. The exposed skin surfaces of the child can sometimes exhibit marks of recognizable objects, such as belt marks, hand slap marks, bite marks, electric cord marks and burn marks. These marks are rarely accidental.
- The first statement is true, the second statement is true
 - The first statement is true, the second statement is false
 - The first statement is false, the second statement is true
 - The first statement is false, the second statement is false
28. Soft tissue signs of child abuse include:
- torn frenum
 - deviated or scarred tongue
 - scars of the lips and mucosa
 - A and C
 - all of the above
29. Inflicted burns are a rare but very serious form of abuse. Burns to the hand are common.
- The first statement is true, the second statement is true
 - The first statement is true, the second statement is false
 - The first statement is false, the second statement is true
 - The first statement is false, the second statement is false
30. Which is not a physical indicator of sexual abuse in children?
- oral lesions indicative of sexually transmitted diseases
 - bruising of the soft palate
 - pregnancy in teens
 - difficulty walking or sitting
 - fear of oral exam.
31. TRUE or FALSE: The limiting factor in child abuse prevention is not the diagnosis, but the reporting of abuse.
- True
 - False
32. TRUE or FALSE: Statistically, studies have shown that child abuse happens in every neighborhood, in all ethnicities, and all socioeconomic classes.
- True
 - False
33. TRUE or FALSE: There is only one main organization designed to aid dentists with child abuse issues, named P.A.N.D.A.
- True
 - False
34. What is Munchausen Syndrome?
- fabricated or induced illness by a parent
 - bruises localized to the head or neck
 - mental state of parent or guardian inducing harm in child
 - none of the above

Recognizing and Reporting Child Abuse in the Dental Office

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Overall rating 1 2 3 4

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1. (A) (B) (C) (D)
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