Research Article

SPOTTING THE UNSEEN: A NARRATIVE REVIEW OF CHILD ABUSE AND NEGLECT THROUGH DENTAL AND PSYCHIATRIC LENSES

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Abstract

The Centers for Disease Control and Prevention (CDC) define child maltreatment as any act or series of actions, whether through commission or omission, by a caregiver that poses a threat to or harms a child. Child neglect is generally characterized by a continuing failure to fulfill a child's basic physical and/or psychological needs, which can significantly impair the child's development or health. Specifically, dental neglect refers to the willful neglect by a caregiver or legal guardian to prevent the onset of oral diseases and the failure to seek necessary treatment to maintain proper oral health, functionality and freedom from pain and infection. Child maltreatment can be classified into several categories, which may occur independently or in combination. These categories include physical abuse, sexual abuse, emotional or psychological abuse and neglect, physical neglect, human trafficking, medical care and Munchausen syndrome by proxy. Child abuse and neglect are critical issues that extend beyond social contexts to significantly impact healthcare professionals who may encounter abused children. With over half of trauma cases occurring in the head and neck area, dental professionals are uniquely positioned to offer vital insights into instances of abuse and are essential in identifying oral signs indicative of neglect. This makes the detection and reporting of abuse not only a moral duty but also a legal obligation. This review focuses on assessing perioral and intraoral injuries, bite marks, infections, diseases and psychological distress that might indicate potential child abuse or neglect. Additionally, it notes that oral health problems may also be associated with victims of human trafficking. ***ASEAN Journal of Psychiatry, Vol. 25 (7) September, 2024; 1-9.***

Keywords: Child Abuse; Dental Neglect; Sexual Abuse; Physical Abuse; Emotional Abuse; Psychological Abuse; Child Maltreatment

Introduction

The Centers for Disease Control and Prevention (CDC) define child maltreatment as any act or series of actions, whether through commission or omission, by a caregiver that poses a threat to or harms a child [1]. This issue is pertinent across all social, ethnic, religious and professional contexts [2].

Child neglect is generally characterized by a continuing failure to fulfill a child's basic physical and/or psychological needs, which can significantly impair the child's development or health [3,4]. Specifically, dental neglect refers to the willful neglect by a caregiver or legal guardian to prevent the onset of oral diseases and the failure to seek necessary treatment to maintain proper oral health, functionality and freedom from pain and infection. Therefore, when a caregiver repeatedly allows a child to miss essential dental appointments, this behavior aligns with the criteria for neglect [3-5].

The true scope of the problem remains unclear due to the underreporting of many cases. Some studies have indicated that 3%-30% of children have experienced abuse, with the prevalence

of this issue on the rise [6,7]. The majority of maltreatment incidents take place within the family environment, while a smaller proportion occurs in schools and other community settings frequented by children [8].

Child maltreatment can be classified into several categories, which may occur independently or in combination. These categories include physical abuse (such as bruises, burns, fractures, head trauma and abdominal injuries), sexual abuse (involving children in sexual activities to which they cannot legally consent), emotional abuse (actions that undermine a child's self-confidence), physical neglect (failure to provide essential needs like food and clothing), emotional neglect (characterized by a dysfunctional parent-child relationship), medical care neglect (failure to ensure adequate medical care for children) and Munchausen syndrome by proxy (where a caregiver fabricates or induces symptoms in a child) [8]. In summary, child abuse encompasses physical abuse, sexual abuse, psychological abuse and neglect [9]. As a result, children may endure various forms of maltreatment, each of which can negatively impact their emotional, physical and sexual health and development [10].

Maintaining good oral health in children and adolescents enhances their ability to develop physically and psychologically and engage in social activities. Conversely, the presence of orofacial disease raises the likelihood of experiencing pain or discomfort, embarrassment, challenges in cognitive development, decreased self-esteem and restrictions in daily activities [11].

Most current research has primarily focused on the strategies employed by dental professionals in addressing child abuse, with few studies examining the specific signs of abuse relevant to dental practice. This review focuses on assessing perioral and intraoral injuries, bite marks, infections, diseases and psychological distress that might indicate potential child abuse or neglect. Additionally, it notes that oral health problems may also be associated with victims of human trafficking to assist dentists in accurately identifying instances of abuse.

Materials and Methods

Types of child abuse and neglect

Child maltreatment can be classified into several types, which can occur separately or together: Physical abuse (such as bruises, burns, fractures, head injuries and abdominal trauma), sexual abuse (involving children in sexual activities they cannot consent to), emotional abuse (actions that damage a child's self-esteem), physical neglect (failing to provide necessities like food and clothing), emotional neglect (dysfunctional parent-child relationship), medical care neglect (inadequate healthcare provision) and Munchausen syndrome by proxy (inducing or fabricating symptoms in a child) [8]. In summary, child abuse encompasses physical abuse, sexual abuse, psychological abuse and neglect [9]. Consequently, children may face various forms of maltreatment that can adversely affect their emotional, physical and sexual health and development [10,11].

Physical abuse

In over half of child abuse cases, injuries are found in the craniofacial region, including the head, face and neck [12-14]. It is important for all suspected victims of abuse or neglect, including those under state custody or in foster care, to undergo a comprehensive examination by a qualified provider. This examination should occur at some point during their evaluation and focus on identifying signs of oral trauma, dental caries, gingivitis and other oral health issues, which are more frequent among maltreated children compared to the general pediatric population [14,15].

Some experts believe that the oral cavity may be particularly vulnerable to physical abuse due to its important role in communication and nutrition [16]. Oral injuries can be caused by various objects, such as eating utensils or a bottle used during forced feedings, as well as by hands, fingers, scalding liquids, or caustic substances. This type of abuse may lead to contusions, burns, or lacerations of the tongue, lips, buccal mucosa, soft and hard palate, gingiva, alveolar mucosa, or frenum; it can also result in fractured, displaced, or avulsed teeth and fractures of the facial bones and jaw. Naidoo found that the lips are the most common site for inflicted oral injuries (54%), followed by the oral mucosa, teeth, gingiva and tongue [2]. Lacerations of the oral frena in non-mobile infants are often indicative of physical abuse and are frequently associated with other serious physical abuse findings [17]. Dental trauma can cause pulpal necrosis, resulting in gray and discolored teeth [18]. Additionally, the use of gags may lead to bruising, lichenification, or

scarring at the corners of the mouth [19].

Severe oral cavity injuries, such as posterior pharyngeal injuries and retropharyngeal abscesses, may be deliberately caused by caregivers fabricating illness in a child to mimic symptoms such as hemoptysis, which then require medical intervention. Any findings in cases where there is reasonable suspicion of abuse or neglect, regardless of the mechanism, should be reported for further investigation. Accidental or unintentional oral injuries are common and can be differentiated from abuse by assessing whether the history (including timing and mechanism of injury) aligns with the characteristics of the injury and the child's developmental stage. Multiple injuries, injuries at different healing stages, or inconsistent histories should raise suspicion of abuse (Table 1). Consulting with or referring to an experienced dentist or child abuse pediatrician may be beneficial. The American Academy of Pediatrics (AAP) provides further guidance in its clinical report, "The Evaluation of Suspected Child Physical Abuse" [20].

Table 1. Potential indicators and manifestations of physical and emotional abuse.

Physical abuse		**Emotional abuse**	
Extraoral	**Intraoral**	**Lowering a child's self esteem by**	**Indicators**
Ecchymosis (slaps, fits, bites)	Torn labial/lingual freni	Harsh treatment	Significant psychopathology and disturbed behaviors in the child that impair adult functioning, as documented by mental health professionals.
Bruises (Battle's sign)	Abrasions/lacerations of gingival, tongue, palate and floor of mouth	Ignoring	Caregiver's abnormal parenting practices that substantially contribute to these behaviors.
Excoriation/abrasions	Fractures/dislocations/ avulsions/pathologic mobility of teeth	Shouting or speaking rudely	Parent's continual refusal to seek treatment for both the child and themselves.
Lacerations	Fractures of mandible/ maxilla	Name calling and use of abusive language	_
Contusions	Malocclusions (due to previous trauma)	Comparison between siblings and other children	_
Hematomas	_	_	_
Burns (cigarettes, lighters, hot instruments)	_	_	_
Traumatic alopecia	_	_	_

Sexual abuse

The oral cavity is often involved in instances of sexual abuse in children [21], although noticeable oral injuries or infections are uncommon. If oral-genital contact is suspected, it is advisable to refer the child to specialized clinical settings where comprehensive examinations can be performed. Further details on these examinations can be found in the AAP clinical report titled "The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected" as well as in the "Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused" [22,23].

When history or examination findings confirm oral-genital contact, the routine testing for Sexually Transmitted Infections (STIs) in the oral cavity can be debated. Clinicians should consider factors such as chronic abuse or a perpetrator with a known STI and evaluate the child's clinical signs when deciding whether to conduct testing. Detecting STIs in the oral cavity is more accurate if evidence is collected within 24 hours of exposure in pre-pubertal children 24 and within 72 hours in adolescents. Subsequent evidence collection should be performed as clinically necessary. Oral and perioral gonorrhea in pre-pubertal children, confirmed with appropriate cultures and testing, is a definitive indicator of sexual abuse but remains rare [25,26]. The incidence is higher among sexually abused adolescents, with 12% having gonorrhea and 14% Chlamydia [27]. Pharyngeal gonorrhea often presents without symptoms [28]. Although cultures have long been the standard, Nucleic Acid Amplification Tests (NAATs) are now more frequently used because they offer greater sensitivity, are less invasive and are cost-effective [29, 30]. While NAATs have not received Food and Drug Administration (FDA) approval for use in pre-pubertal children or for rectal or oropharyngeal specimens, the CDC recommends them for vaginal swabs or urine as an alternative to cultures in girls. However, cultures remain preferred for urethral swabs or urine in boys and for extra genital sites (pharynx and rectum) in all children [31]. Human Papillomavirus (HPV) infection can cause oral or perioral warts, but the transmission route is unclear. HPV may be spread *via* sexual oral-genital contact, vertically from mother to child at birth, or horizontally through nonsexual contact, such as from the hand of a child or caregiver to the genitals or mouth [32,33]. Unexplained injuries or petechiae on the palate, especially at the hard and soft palate junction, can result from forced oral sex [34]. As with all suspected child abuse or neglect cases, any suspicion or confirmation of sexual abuse should be reported to child protective services or law enforcement for investigation [35]. A multidisciplinary child abuse evaluation for the child and family is recommended when possible [14].

Children who present with an acute history of recent sexual abuse may need specialized forensic testing for the presence of semen and other foreign materials resulting from the assault. Hospitals and child protection clinics that are equipped with established protocols and experienced personnel are ideally suited for the collection of such specimens and for preserving the chain of evidence required for investigations. If a victim reports a history of oral-penile contact, swabs of the buccal mucosa and tongue can be taken using a sterile, cotton-tipped applicator. These swabs should be air-dried and properly packaged for laboratory analysis [14].

Bite marks

Such injuries are typically indicative of physical or sexual abuse. In cases where abuse is suspected, it is essential to consult a forensic pathologist or odontologist [36]. Acute or healed bite marks may signify abuse and the presence of abrasions or lacerations in an oval or circular configuration should raise suspicion of bite marks. Hemorrhagic areas between tooth impressions, which may represent "suck" or "thrust" marks, can suggest instances of physical or sexual abuse. While bite marks can occur anywhere on a child's body, the most common locations include the cheeks, back, sides, arms, buttocks and genital region [37].

It is critical to determine whether bite marks are from an animal or a human. Bites from dogs and other carnivorous animals typically cause tearing of the flesh, whereas human bites compress the flesh, leading to abrasions, contusions and lacerations, but rarely cause tissue avulsions [37]. A suspicious adult human bite can be indicated by an inter canine distance (i.e. the linear distance between the central tips of the canine teeth) that measures more than 3.0 cm [38]. A forensic odontologist should assess the pattern, size, contour and color of the bite mark, which should

be documented through photographs that include an identification tag and scale marker (e.g., a ruler).

In addition to photographic documentation, any bite mark exhibiting indentations should have a polyvinyl siloxane impression taken immediately after swabbing the mark for secretions containing DNA, providing a three-dimensional model of the bite. Written observations and photographs should be repeated daily for a minimum of three days to record the bite's evolution. Given that each individual has a unique bite pattern, a forensic odontologist may potentially match dental casts of a suspected abuser's teeth with impressions or photographs of the bite [38].

Emotional abuse and neglect

Emotional abuse, also referred to as verbal abuse, mental abuse, or psychological maltreatment, encompasses actions or omissions by parents or caregivers that have inflicted or could potentially inflict significant behavioral, cognitive, emotional, or mental harm on a child [39]. Emotional abuse is characterized by the ongoing scapegoating and rejection of a child by their parents or caregivers. In some instances, teachers may also engage in emotional abuse toward students. This form of abuse often includes severe verbal mistreatment and belittling (Table 1).

Human trafficking

Human trafficking is a significant child health concern with medical and dental implications and it is only starting to be addressed in the United States. According to the US Department of State, human trafficking involves the recruitment, harboring, transportation, provision, or acquisition of a person for labor or services through force, fraud, or coercion, with the aim of subjecting them to involuntary servitude, peonage, debt bondage, or slavery [40]. Among these, children most frequently fall victim to sex trafficking, where a commercial sex act is induced by force, fraud, or coercion, or where the individual performing the act is under the age of 18. Sex trafficking is categorized under "commercial sexual exploitation of children," which also includes activities such as pornography and survival sex where sexual activity is exchanged for essential needs like shelter, food, or money [41].

Although children who are victims of human trafficking are often marginalized and isolated from much of society, over one-quarter will still encounter a healthcare professional while in captivity [42]. Trafficking victims face complex psychosocial and physical challenges that influence their perceptions and reactions to situations. Once rescued, they often have complicated health needs, including infectious diseases, reproductive health issues, substance abuse and mental health disorders. Dental problems also feature prominently: In Europe, 58% of trafficked women and adolescents reported experiencing tooth pain [42]. In the United States, more than half (54.3%) of these individuals reported dental issues, with the most common being tooth loss (42.9%) [43].

Child trafficking victims have twice the risk for dental problems due to inadequate nutrition, which can lead to stunted growth and poorly formed teeth, as well as dental caries, infections and tooth loss. For older children, dental issues may originate from their initial environments, where access to or quality of care was limited. Dental problems can also arise during trafficking, as children may experience neglected issues alongside missed preventive care, or even suffer physical abuse or head trauma [42,44].

Dental neglect

Failing to meet a child's basic needs is also considered maltreatment. From a dental standpoint, one major type of maltreatment is dental neglect.

The American Academy of Pediatric Dentistry defines dental neglect as a caregiver's willful failure, despite having adequate access to care, to seek and comply with treatment necessary to maintain a level of oral health that prevents pain, infection and ensures proper function [45]. Untreated dental issues like caries and periodontal diseases can lead to pain, infection and loss of function, which negatively impact learning, communication, nutrition and other activities critical for normal growth and development [46].

Dental neglect may present orally as untreated dental caries, which can be easily recognized by the average observer, as well as ulcers in the oral cavity. Extra-orally, dental issues that directly affect the child can also be evident [47]. Children suffering from dental neglect may also demonstrate behavioral problems, suggesting not only dental issues but also other forms of social isolation. To avoid over-reporting, it's important

to differentiate dental neglect from mere dental caries. There may be inadequacies in oral health care without a neglectful attitude [48]. A history of poor dietary habits and inadequate dental hygiene, along with direct observations, can aid in making an accurate diagnosis [47].

Some children may initially present for dental care with severe early childhood caries, previously known as "infant bottle" or "nursing" caries [14]. It is important to distinguish between caregivers who are knowledgeable yet willfully neglectful in seeking care and those who lack awareness of their child's dental needs when deciding whether to report such cases to child protective services.

In addition to the previously discussed types, there are two uncommon forms of neglect that represent opposite ends of the spectrum concerning medical care. Medical care neglect occurs when caregivers do not provide necessary treatment for infants or children with life-threatening or severe chronic medical conditions. On the contrary, Munchausen syndrome by proxy is a rare disorder in which a caregiver, often the mother, fabricates or induces symptoms or signs of illness in a child. Affected children may present with numerous medical issues or unusual recurrent complaints and fatal cases have been documented [8].

Results

Dentist's responsibility

Dentists are in a strategic position to identify child abuse since many characteristic signs are observable in the craniofacial and oral regions [49]. This makes the detection and reporting of abuse not only a moral duty but also a legal obligation [50]. Additionally, it is noted that offenders often change hospitals and healthcare providers to evade suspicion, yet they tend to consistently visit the same dentist [51].

Reporting child abuse is important to protect children from further harm. Failure to do so risks perpetuating the cycle of abuse, as victims may potentially repeat these abusive patterns with their own children. Reporting is mandated regardless of whether the information was gained in the course of professional duties or through a confidential relationship [51].

Conclusion

In Child abuse and neglect are critical issues that extend beyond social contexts to significantly impact healthcare professionals who may encounter abused children. With over half of trauma cases occurring in the head and neck area, dental professionals are uniquely positioned to offer vital insights into instances of abuse and are essential in identifying oral signs indicative of neglect.

Recognizing child abuse is an urgent responsibility that dentists must embrace, as they can readily identify signs of maltreatment and play a proactive role in assisting victims. It is imperative for all healthcare providers, including dental professionals, to be attentive to the indications of child abuse and to meticulously document suspicious injuries alongside relevant evidence. Injuries inflicted by an abuser's mouth or teeth can leave specific traces that should be carefully noted. Coordinated efforts with pediatric dentists or individuals trained in forensic odontology are necessary to ensure proper testing, diagnosis and treatment.

Most existing research has predominantly concentrated on the approaches dental professionals take toward child abuse, with limited studies addressing the specific signs of abuse in dental practice. This review aims to synthesize pertinent findings to aid dentists in accurately recognizing cases of abuse. By facilitating early detection and reporting, dentists can help prevent further harm to children suspected of maltreatment. When uncertainties arise, seeking consultation from pediatric dentists or those trained in forensic odontology ensures appropriate care.

To enhance the response to child abuse, improved training in dental education is essential, as is the integration of forensic odontologists in clinical settings. Consequently, we encourage the scientific community to place greater emphasis on recognizing various lesions indicative of child abuse, rather than solely focusing on the existing knowledge of dental professionals regarding this subject.

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