



## Review

## Domestic violence against children detected and managed in the routine of dentistry – A systematic review



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## ABSTRACT

The domestic violence against children (DVAC) interferes in the psychological development leading to sequels that manifest and persist up to the adulthood. The physical evidences of domestic violence are more easily observed in the orofacial complex, becoming eventually detected by dentists. The present systematic literature review aimed to investigate the perception, knowledge and attitude of dentists towards the detection and management of DVAC cases. A systematic search was performed in 6 databases: PubMed, ScienceDirect, LILACS, SciELO, GoogleScholar, and OpenGrey. Cross-sectional articles assessing the perception, knowledge, and attitude of dentists facing potential cases of DVAC were selected. No restriction of language, time, and publication status was considered. The search resulted in 1.024 articles, of which 18 fit the eligibility criteria. The knowledge for detecting cases of DVAC obtained during the undergraduation course was classified by the dentists (in 39% of the articles) as “insufficient”. When suspecting of cases involving domestic violence, most of the dentists (in 77.75% of the articles) considered reporting to the competent authorities. However, the dentists are not sure about who these authorities are (in 31.25% of the articles). More attention must be given to the Forensic education in Dentistry. Specifically, proper training is necessary to support the dentists on the detection and management of pediatric patients under domestic violence.

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## 1. Introduction

The domestic violence against children (DVAC) may be defined as any attitude (whether by act or omission) that potentially harms the physical and psychological well-being of a child.<sup>1–3</sup> The DVAC includes physical and psychological violence, sexual abuse, and neglect.<sup>2,4</sup> It may be committed in the domestic environment by family members, including persons who assumed the paternal function or any person who has power over the child.<sup>3–5</sup> The DVAC impacts severely in the mental development, leading to sequels that persist up to the adulthood.<sup>3,6,7</sup> Felitti et al.,<sup>8</sup> 1998,

demonstrated that the adverse childhood experiences (psychological and physical), such as child sexual abuse, increase considerably the risk for developing behavioral disorders (e.g. drug abuse, depression, and suicide attempt).

The anatomic region most affected in DVAC cases involving physical manifestations is the face,<sup>9</sup> with an estimated prevalence rate of 58–85%.<sup>10</sup> Coincidentally, the orofacial complex comprehends the region of interest in Dentistry,<sup>1</sup> being examined constantly in the clinical routine. Unknowingly, the dentists may face clinical signs of DVAC on a daily basis. Unfortunately, many dentists complain about the lack of capacity for interpreting suspicious cases and reporting them to the authorities.<sup>11–13</sup> Consequently, the DVAC expands as an underreported social problem.

The present systematic review aims to screen from the scientific literature the current status of the perception, knowledge and attitude of dentists in relation to the DVAC. In parallel, it also

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encourages the participation of dentists in public policies against this important social problem.

## 2. Material and methods

### 2.1. Protocol and registration

This systematic literature review was performed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses PRISMA<sup>14</sup> checklist ([www.prisma-statement.org](http://www.prisma-statement.org)). The research protocol was registered at the International Prospective Register of Systematic Reviews (PROSPERO) (<http://www.crd.york.ac.uk/PROSPERO>) under the registration code: CRD42015026747.

### 2.2. Eligibility criteria

**Focused Question:** Does the dentist know how to detect and manage properly cases of DVAC? The research question was based on the PVO strategy for Systematic Exploratory Review, where P stands for population, context, and/or problem-situation; V stands for variables; and O stands for desirable or undesirable outcomes.

**Inclusion criteria:** Cross-sectional articles assessing the perception, knowledge, and attitude of dentists facing cases of DVAC. No restriction of language, time, and status of publication was applied.

**Exclusion criteria:** Studies exclusively qualitative; studies sampling exclusively undergraduate dentistry students; literature reviews; letters to the editor and/or editorials; case reports; books; and book chapters.

### 2.3. Information sources

A systematic review was performed in the following electronic databases: PubMed, ScienceDirect, LILACS, SciELO, GoogleScholar, and OpenGrey. In order to avoid any selection bias, the “Grey Literature” was verified through GoogleScholar and OpenGrey searches. Only the first 200 GoogleScholar results were assessed, excluding patents and citations.

### 2.4. Search

The MeSH (Medical Subject Headings) terms used were “attitude”, “domestic violence”, “dentistry”, “child”, “knowledge”, “diagnosis”, and “perception”. Entry Terms were also used in order to retrieve all the studies using synonyms for “children”. The Boolean operators (AND and OR) were used to combine the descriptors (Table 1). This research was performed in April 15th, 2015.

The articles retrieved were imported in Mendeley Desktop 1.13.3 (Mendeley™ Ltd, London, UK) software packages to search for duplicates.

### 2.5. Study selection

The selection process was completed in 2 phases. Titles and abstracts were assessed systematically for eligibility by two examiners, which were not blind for the name of authors and journals. Whenever the title and abstract of the studies did not present enough information, full texts were obtained and assessed. The studies were analyzed completely also in case of presenting eligible title but no abstract.

The full texts of the studies considered eligible in this phase were downloaded and read to verify the presence of every inclusion criteria. In specific cases, the authors of studies potentially eligible were contacted by email and asked about the missing information. The rejected studies were registered separately, displaying the

reasons for exclusion.

### 2.6. Risk of bias and study quality in each study

The quality of the methodology used in the studies included was evaluated by independent reviewers (authors), according to the PRISMA<sup>14</sup> recommendation. The evaluation was founded on the description of the information provided in each study. At this point, the review was performed blindly, masking the names of authors and journals. It avoided any potential bias and conflicts of interests during the analysis. The risk of bias and study quality was assessed for each article using an adapted checklist.<sup>15</sup> This checklist was based in 9 criteria expressed as questions (Q) made to each study, namely: Q1) Were the objectives, methodology, results, and conclusion described clearly in the abstract? Q2) Were the objectives mentioned clearly in the full-text version? Q3) Were the ethical criteria mentioned in the text? Q4) Was the study type mentioned in the text? Q5) Was the sample size reported in the text? Q6) Was the sample selected randomly? Q7) Were the inclusion and exclusion criteria mentioned in the text? Q8) Were the results presented clearly and objectively? Q9) Were the study limitations discussed in the text? Based on the answers for these questions, each study received a score translated in quality: low quality (0–4 points), moderate quality (5–7 points), and high quality (8–10 points).

### 2.7. Data extraction of the included articles

The full-texts of the studies pre-selected were revisited and their data were extracted standardly. The information extracted and recorded from the studies were: the authorship; the year of publication; the country in which the study was developed; the sample size, age, and gender; the experience of the dentists interviewed (quantified in years); the method of interview; the results regarding the perception, knowledge and attitude of dentists; and the main outcome of the study.

### 2.8. Data analysis of the included articles

This step comprehended the descriptive analysis of the studies selected and the verification of homogeneity in the methodology and outcomes. In case of homogeneity, a meta-analysis was planned. The final product of the data analysis was presented in the format of a dissertation.

### 2.9. Risk of bias across studies

The assessment of the risk of bias across the studies was only planned if a methodological homogeneity was verified between the studies, enabling (or not) a meta-analysis.

## 3. Results

### 3.1. Study selection

The systematic search resulted in 1,024 studies in the first selection phase. Eight hundred ninety-nine studies remained after removing duplicates. Eight hundred eighty-two were excluded subsequently for different reasons, remaining 17 studies. Three studies were added from expert sources. Two studies were excluded for not distinguishing the dentists from the other populations sampled. The final sample consisted of 18 studies (Fig. 1).

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