What Victims of Domestic Violence Need from the Dental Profession

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Abstract: Most dental schools teach students about domestic abuse, but it is unknown if this information is ever applied in practice. This study was conducted to determine whether domestic violence victims 1) visited dental offices when signs of abuse were present; 2) were asked about their injuries; 3) were given referrals or assistance; and 4) want the abuse recognized by and discussed with the dental professional. A survey was developed and mailed to fifteen shelters. Eleven (73.3 percent) shelters participated, with a total of 112 out of 165 (67.8 percent) surveys returned. Descriptive statistics were analyzed, and an ANOVA test was conducted to determine if a relationship existed between the incidence of abuse and ethnicity. Seventy-six percent of respondents had suffered physical abuse in the head and neck area. Over half of the participants had seen a dentist when signs of abuse were present, yet 88.6 percent were not asked about their injuries. In addition, 69.2 percent responded that they would have liked to have been asked about their injuries. It appears that the dental profession needs to take a more active role in the recognition of domestic violence in their patient populations. Raising dentists and dental hygienists' awareness of the problem and potentially increasing the number of referrals may help more victims.

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The incidence of domestic violence (DV) is at epidemic proportions, with approximately four million women being battered every year in the United States.[1,2] The American Medical Association, the American Dental Association, and three U.S. surgeons general have encouraged health care providers to recognize, treat, and respond appropriately to signs of abuse.[2-6] Unfortunately, few oral health care professionals are knowledgeable about the relationship between head and neck injuries and domestic violence.[7]

Domestic violence is not only a problem in the United States, but also internationally. According to a 2006 worldwide study, women are at a higher risk for violence by an intimate partner than any other perpetrator.[8] While data from different surveys indicate a high prevalence of domestic violence against women in all societies, prevalence studies only show one side of the problem: the seriousness of how widespread it is.

Another side of the problem, one that has received less attention, is that most cases of domestic violence are unreported.[9] Battered women seek help frequently, but as few as 5 percent are correctly identified by the practitioners to whom they turn for help.[1,10-13] Therefore, it seems probable that the incidence of DV is actually more prevalent than the statistics suggest, due to many cases being unrecognized and unreported.[9]

Health Care Professionals and Domestic Violence

With the high percentage of DV injuries occurring in the head and neck area, oral health care professionals have a unique opportunity to play a role in conducting routine assessments for domestic violence because almost two-thirds of all adults in the United States have regularly scheduled dental visits

at least once a year.[14] The routine dental examination involves a close inspection of the patient's head, neck, and oral cavity that might reveal signs of battering.[15,16] Since most patients have positive views of their dentists and trust them, dentists have an opportunity to initiate dialogue with their patients about DV.[17] Despite this unique opportunity, a national survey found only 41 percent of dentists responded that they often or always screen for domestic violence only when a patient had signs of trauma on the head or neck.[7] In the same study, 19 percent stated that they did not screen for domestic violence even when signs of abuse were present, while 87 percent responded that they never screen for signs of domestic violence. Even when individuals in abusive relationships avoid seeking medical attention, dental appointments are often kept.[18] As a result, dentists and allied dental personnel are in an ideal position to identify injuries associated with physical, emotional, and sexual abuse.[18] However, only 6 percent of dentists commonly suspect physical abuse among their patients, compared with 23 percent of physicians and 53 percent of social workers.[19] It is not known what percentage of dental hygienists have suspected or reported physical abuse. Oral health care workers may be less likely than any other health care provider to address DV within their role as health professionals.[20]

Physicians face many barriers in the identification and treatment of domestic violence victims.[21-30] Some of these barriers include lack of education on the part of health professionals and limited time and resources. The attitude and skill of the physician may also be one of the major impediments for delivery of care to patients in violent relationships.[21,28,30] Physicians waver between understanding the impact of violence on patients' lives and frustration due to the inability to remedy what appears to be a hopeless situation.[28,30]

There are other barriers health care professionals face when dealing with domestic abuse.[30,31] Studies of medical staff in emergency departments and primary care physicians in a health maintenance organization found that physicians and other health care professionals felt they were constrained in their interactions with battered women by negative attitudes, including stereotyped views of battered women, feelings of discomfort or powerlessness, fear of offending the patient, and worry about loss of control of the interview.[30,31] Studies that gathered data from battered women suggested other possible barriers, such as health care professionals' lack of sensitivity or seemingly indifferent attitudes toward the victim's situation, battered women's concern for confidentiality, and the embarrassment and humiliation felt about disclosing personal accounts of victimization.[32-35] Other barriers included battered women's fear of retribution from the batterer for seeking help, sociocultural issues, such as racism or classism, and time constraints of the health care professional.[32,33,36]

In addition to physicians, surveys of dentists concerning their awareness, knowledge, and attitudes about abuse have been conducted.[7,37-39] The attitudes, rationale, and behaviors of a national sample of dentists regarding the recognition of domestic violence and the barriers dentists face in the intervention of DV were examined by Love et al.[7] (See Table 1.)

Education about domestic violence could help overcome some of these barriers.[7] In addition to feeling inadequate in identifying suspected abuse victims, oral health care professionals do not know the appropriate actions to take to prevent further abuse or neglect.[37-39] No studies have been conducted to determine what services DV victims want or need from the dental profession.

The authors of an article titled "Changing Dentists' Knowledge, Attitudes, and Behaviors Regarding Domestic Violence Through an Interactive Multimedia Tutorial" developed a tool called "AVDR," an acronym for "asking, validating, documenting, and referring."[40] The four-stage AVDR process involves

Table 1. Barriers dentists said they face in the recognition/intervention of domestic violence, by percentage of total respondents

Barrier	Overall %
Patient was accompanied by partner or children	77
Lack of training in identifying domestic violence	68
Concerned about offending patient	66
Patient's cultural norms and customs	53
Embarrassed to bring up domestic violence	51
Do not have a list of referral agencies	41
Do not have enough time to raise the issue of domestic violence	36
No mandatory reporting requirement	31
Believe patient would not follow up on referral	29
Believe domestic violence is not my business	23
Patient is on welfare	11

Source: Data from Love C, Gerbert B, Caspers N, Bronstone A, Perry D, Bird W. Dentists' attitudes and behaviors regarding domestic abuse: the need for an effective response. J Am Dent Assoc 2001;132:85–93.

the following: 1) *asking* the patient about the injury or incident; 2) providing *validating* messages that battering is wrong and it is not the victim's fault in any circumstance; 3) *documenting* signs, symptoms, or any verbal disclosures that the patient has shown or given in the patient's records in writing and with any pictures; and 4) *referring* victims to a DV specialist, which may include counselors, authorities, or shelters. This process was developed to spell out and simplify the dentist's role in addressing DV. The AVDR intervention can be used when abuse is suspected but not disclosed, and it allows dentists to help their patients without giving the unreasonable expectation that the dentist can *solve* the problem. By providing strategies for assessment and intervention, the AVDR tutorial is a quick and simple way to educate oral health professionals about the importance of recognizing DV among their patients and learning how to help them.

The law is clear when it comes to reporting abuse of children and elders, but domestic violence cases are more complicated because there are different opinions about whether mandatory reporting of domestic violence cases should become law.[41,42] In only a few states are physicians and/or health care workers mandated to report acts of domestic violence to an agency.[42]

Methods

A fourteen-question survey (which appears in the Appendix) was developed and mailed to fifteen domestic violence shelters in the North Texas area. The survey was made available in both English and Spanish. The survey was not pilot-tested due to the difficulty of locating domestic violence victims, the sensitive nature of the survey, and the need to maintain anonymity for the victims. Therefore, the reliability could not be determined. The validity could only be determined for the population surveyed.

Each director of the fifteen shelters was mailed fifteen surveys (for a total of 165 total surveys) and self-addressed stamped envelopes for return of the surveys. The surveys were distributed by either the clinical directors or the counselors in each shelter to women and/or men staying in the shelter or using their resources during the months of May and June 2006.

Descriptive statistics, including percentages, were obtained for the demographic data. The descriptive statistics included the mean age, race, marital status, and gender of each participant. A chi-square test was run to determine whether there was a significant difference between the participant's marital status and abuse. A one-way Analysis of Variance (ANOVA) was used to determine whether the participant's age, race, or gender was statistically significant in determining the likelihood of abuse.

Results

Eleven of fifteen shelters participated in the study, for an institutional response rate of 73.3 percent. Out of the 165 surveys mailed, 112 were returned for an overall response rate of 67.8 percent. Although each shelter was mailed a total of fifteen surveys, some directors noted that they did not have fifteen clients staying at the shelter at that time, therefore reducing the number of participants. All participants were female. The sample was predominantly Caucasian (57.1 percent, N=64), with a smaller number of African Americans (29.5 percent, N=33), Hispanics (7.1 percent, N=8), Native Americans (1.8 percent, N=2), and those from other ethnic groups (4.5 percent, N=5). Of the total 112 respondents, 76 percent (N=85) said they had experienced an abusive head, neck, or mouth injury due to domestic violence, while twenty-seven participants (24 percent) said they never had this type of injury due to domestic violence. Although Caucasian women represented the largest number of overall respondents, only 68.8 percent (N=44) of them reported receiving a head, neck, or mouth injury due to domestic violence. All African American (100 percent, N=33) and Native American (100 percent, N=2) respondents answered that they had had an injury to the head, neck, or mouth due to domestic violence. A one-way Analysis of Variance (ANOVA) found statistically significant differences in abuse rates for different ethnic groups: African Americans and Native Americans had significantly higher abuse rates ($p<.05$) (Figure 1). The mean age for respondents was 35.7 years, with a range from twenty to seventy-two years of age. The majority of respondents were single (42.9 percent, N=48), with 33 percent (N=27) married and 24.1 percent (N=27) divorced. A chi-square analysis found no correlation between age, race, or marital status and the likelihood of abuse involving a head, neck, or mouth injury.

The respondents were asked to check all the injuries they had experienced, and many responded with more than one location and/or type of injury (N=210). This accounts for the number of locations and injuries being higher than the number of partici-

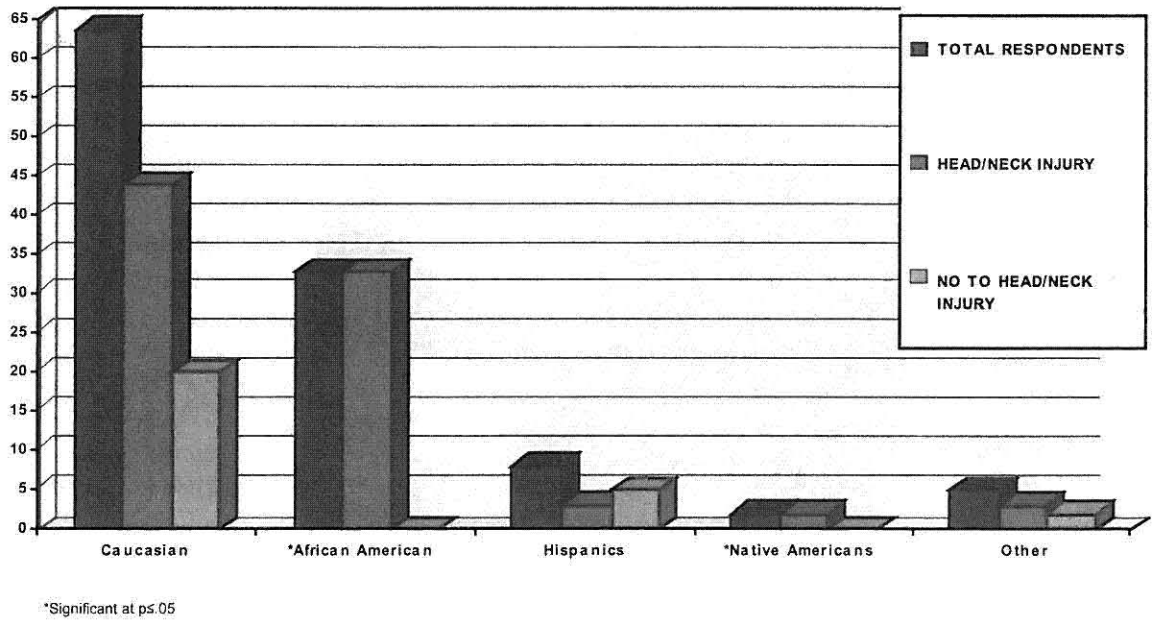

Figure 1. Prevalence of abuse to the head/neck area by ethnicity of respondents in our study

pants. The most common location of injury was the lip (29 percent, N=61). (See Figure 2.) Other common locations included the face (21 percent, N=45), the neck (14 percent, N=30), and the tongue (5 percent, N=11). Other injuries included broken teeth (15 percent, N=32), broken jaw (7 percent, N=14), lost teeth (5 percent, N=11), and other (3 percent, N=6). Other responses included dislocated jaw, black eye, and broken nose.

Dental Experiences of the Respondents

Of the eighty-five respondents who reported a head, neck, or mouth injury, 14 percent (N=12) saw a dentist due to an oral injury caused by abuse. Four respondents had seen a female dentist, and eight had seen a male dentist. Those who had seen a dentist were asked if they were to see a dentist again for an injury, which gender they would prefer. Most said either gender (75 percent, N=9), followed by male (16.5 percent, N=2) and female (8.5 percent, N=1).

All eighty-five respondents who had reported a head, neck, or mouth injury were asked if they had ever needed dental treatment due to an episode of abuse, but were unable to get treatment due to financial reasons. The majority of respondents answered yes (57.6 percent, N=49), while 41.1 percent (N=35) responded no. One respondent did not answer the question.

When the respondents were asked if they had visited a dentist for dental work not related to abuse at a time when signs of abuse were present, 52.9 percent (N=45) answered yes, and 44.7 percent (N=38) answered no. Two respondents did not respond. Of those who had been seen in a dental office when signs of abuse were present, 86.6 percent (N=39) said they were not asked about their injuries. Only 13.3 percent (N=6) said they were asked about their injuries by a dental staff member.

DV Victims' Needs

Respondents who had not been asked about their injuries during a dental visit (N=39) were asked if they would have liked for someone to ask about their injuries. A majority of the respondents (69.2 percent, N=27) answered yes, they would have liked for someone to have asked about their injuries. The remaining 30.7 percent (N=12) responded no for various reasons including fear of embarrassment or fear that more abuse would follow disclosure.

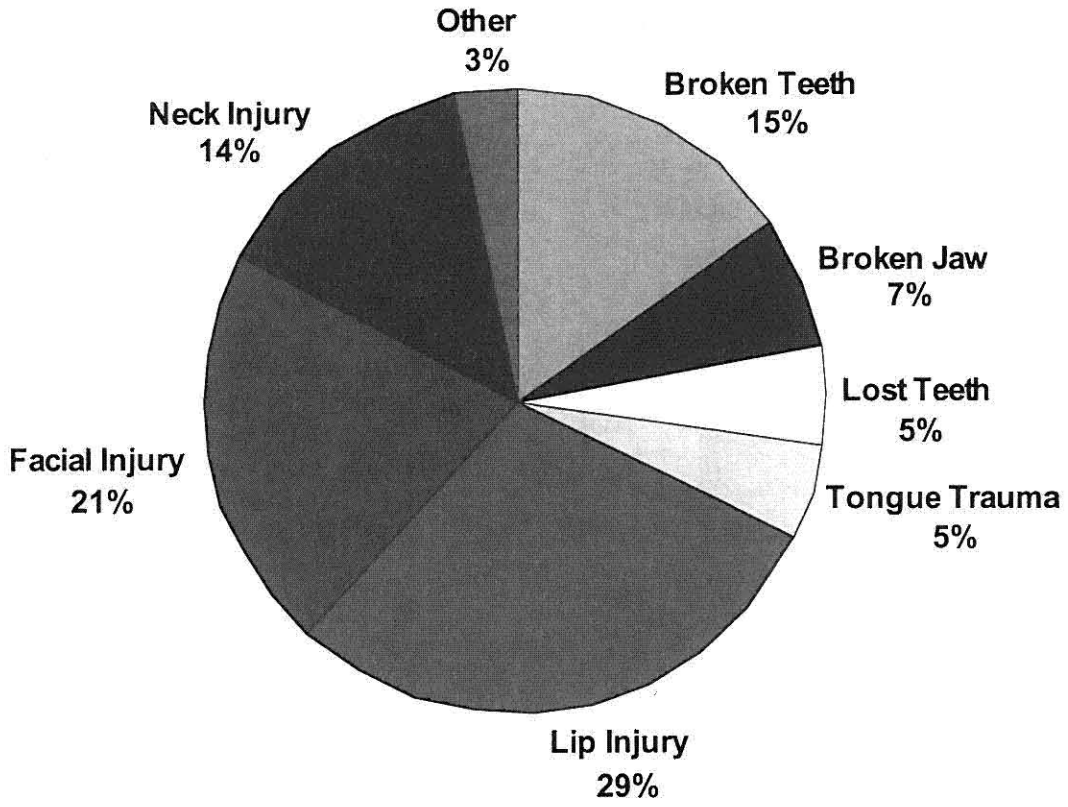

Figure 2. Location/type of injury reported by respondents in our study, by frequency of mention

Three respondents reported that both the dentist and the dental hygienist asked about their injuries; two responded that only the dentist asked, and one responded that only the dental hygienist had asked about the injuries. Of the six respondents asked about their injuries, three respondents said they did not receive any assistance and/or referrals from the dental team, and three did receive assistance and/or referrals. The three respondents who received assistance and/or referrals reported that they had received phone numbers for shelters; two received phone numbers for counselors; one received contact numbers for police; and two responded that they had someone to listen to them. The respondents who were not given any assistance and/or referrals were asked what sort of help they would like to have received and to check all that applied. All three answered that they would have liked someone to listen to them, and two also answered they would have liked shelter information.

Discussion and Conclusions

Currently, there are no published studies reporting whether domestic violence victims have been recognized by dental health care workers and what type of assistance, if any, has been received. The overall objective of this pilot study was to determine whether signs of abuse present on victims of domestic violence were detected by oral health care professionals in the office setting and, if detected, whether assistance and/or referrals were given.

Findings from this study demonstrate that the majority of domestic violence victims were not asked about their injuries by a dental professional when signs were apparent. Although the American Dental Association encourages oral health care providers to recognize and respond to abuse by offering assistance

and/or referrals, our findings were that these professionals are not doing this to the extent that domestic violence victims wish they would.

This study also found that victims of domestic violence who present in dental offices with signs of abuse want the abuse to be recognized by the dental team and want to receive assistance and/or referrals. Since it appears that victims of domestic violence want assistance from dental professionals, screening for abuse, as well as asking questions about the injures, is recommended.

The survey in our study was limited to patients receiving services the day the survey was administered, which may account for the small number of respondents. Therefore, the results of the study may not be applicable to the general population. A future study could be conducted to survey larger numbers of shelters over a longer period of time to provide a larger sample size. The survey could also be used as part of the admitting process for shelters. This would lead to a larger number of participants and in turn could produce a more accurate assessment tool for determining a victim's needs and wants regarding oral health professionals.

Although victims want the abuse to be recognized, dental health care providers face barriers when it comes to domestic violence recognition. These barriers will need to be overcome if dentistry is to be a participant in overcoming this epidemic. Dental and dental hygiene schools should include didactic information on not only how to recognize domestic violence victims but also how to conduct an interview and provide support once the victim has disclosed the abuse. Continuing education courses could benefit those oral health professionals already in practice.

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APPENDIX

The Texas A&M University System Health Science Center
BAYLOR COLLEGE OF DENTISTRY
Oral Trauma/Abuse Survey

Please answer the following.

Age: _____

Gender: Female _____ Male _____

Marital Status: Single _____ Married _____ Divorced _____

Race: Black ____ White ____ Asian ____ Hispanic ____ Other ____

Please answer each question.

1. Have you ever sustained an injury to the head, neck, or mouth as a result of abuse?

   Yes _____ No _____

If NO, you are finished with this survey. Thank you very much. Please return this survey as soon as possible in the self-addressed stamped envelope.

2. If yes, what sort of injury did this involve?
   _____Broken teeth
   _____Broken jaw
   _____Lost teeth
   _____Trauma to the tongue
   _____Injury to the lip
   _____Injury to the face
   _____Injury to the neck
   _____Other, please specify _____

3. Have you ever seen a dentist due to an oral injury caused by physical abuse?
   Yes _____ No _____

   If NO, please go to question number #6.

4. Was the dentist a male or female?
   Male _____ Female _____

5. If you were to see a dentist again, which would you prefer?
   Male _____ Female _____ Either _____

6. Have you ever needed treatment from a dental office due to an episode of abuse but could not get treatment due to financial reasons?
   Yes _____ No _____

7. Have you ever visited your dentist for dental work not related to abuse, when signs of abuse were present?
   Yes _____ No _____

If NO, you are finished with this survey. Thank you very much. Please return this survey as soon as possible in the self-addressed stamped envelope.

APPENDIX *(continued)*

8. Were you asked about your injuries?

   Yes _____ No _____

   If YES, please go to question #10.

9. If **no**, would you have liked someone to ask you about the injuries?
   Yes _____ No _____
   Please explain why you would **not** want someone to ask you about your injuries.
   _____
   _____

You are finished with this survey. Thank you very much. Please return this survey as soon as possible in the self-addressed stamped envelope.

10. If you were asked about the injuries, how did you feel? (check all that apply)
    _____Offended _____Angry ____Relieved
    _____Scared _____Embarrassed ____Other, please specify

11. Who asked you about your injuries? (check all that apply)
    _____Dental hygienist (person cleaning your teeth)
    _____Dentist
    _____Dental assistant (person assisting doctor during procedures)
    _____Receptionist

12. Did you receive any assistance or referrals from any of the members of the dental staff?
    Yes _____ No _____

    If NO, please go to question #14.

13. What sort of assistance did you receive?
    _____Contact phone numbers for shelters ____Contact phone numbers for police
    _____Contact phone numbers for counseling ____Someone to listen to you

14. What sort of help would you have liked to receive?
    _____Contact phone numbers for shelters ____Contact phone numbers for police
    _____Contact phone numbers for counseling ____Someone to listen to you

Please feel free to make any comments below.

Thank you very much for your participation in this important survey.
Please return this survey in the self-addressed, stamped envelope as soon as possible.