DOI: http://dx.doi.org/10.17921/2447-8938.2019v21n1p58-64

Dentist's Behavior Regarding Children and Adolescents Maltreatment

Conduta do Cirurgião-Dentista Frente à Suspeita de Maus-Tratos Contra Crianças e Adolescentes

Ana Lídia Soares Cota*[a]; Andreza Maria Correia de Queiroz[b]; Mariana Maria Castro Jatobá Remígio[b]; Daniel Alves Reis[a]; Daniela do Carmo Kabengele[a]

[a]University Center Tiradentes, Postgraduate Program in Society, Technologies and Public Policies. AL, Brazil.
[b]University Center Tiradentes, Dentistry Course. AL, Brazil.
*E-mail: ana.cota@uol.com.br
Received: 31/07/18
Approbed: 21/12/18

Abstract

Child abuse is a serious violation of the child's basic rights and the precocious diagnosis of maltreatment cases and early intervention are important for the protection of the involved individuals. Most of the lesions involve the mouth, craniofacial regions, and neck. Therefore, dentists are in an exceptionally favorable position to recognize child abuse. Thus, the aim of the present study, through an integrative review, to guide dentists in the identification and report of children and adolescents' maltreatment. A review of the literature was performed from secondary sources such as manuals, official documents and articles from scientific journals published in the electronic databases "Scientific Electronic Library Online (SciELO) and "Latin American and Caribbean System on Health Sciences Information " (LILACS). Based on the critical analysis carried out, it is concluded that it is an ethical, legal and moral duty of these healthcare professionals to recognize signs and behaviors indicative of any kind of child neglect, violence (physical, sexual and / or psychological abuse). The suspected or confirmed cases must be reported to the competent organs, aiming at the interruption of violent episodes and ensuring the inclusion of minors in policies that promote their full and healthy development.

Keywords: Dentists. Child Abuse. Domestic Violence.

Resumo

Os maus-tratos contra crianças e adolescentes representam uma grave violação dos seus direitos básicos, sendo importante o diagnóstico precoce dos casos de violência e a intervenção precoce para a proteção dos indivíduos envolvidos. Uma vez que a maioria das lesões decorrentes das agressões envolvem a boca, regiões craniofaciais e pescoço, os cirurgiões-dentistas apresentam uma posição estrategicamente favorável para reconhecer o maltrato infantil. Desta forma, o objetivo do presente trabalho é, por meio de uma revisão integrativa, orientar os cirurgiões-dentistas na identificação e denúncia de maus-tratos contra crianças e adolescentes. Foi realizada uma revisão da literatura a partir de fontes secundárias como manuais, documentos oficiais e artigos de periódicos científicos publicados nas bases de dados eletrônicas "Scientific Eletronic Library Online" (SciELO) e "Literatura Latino-Americana e do Caribe em Ciências da Saúde" (Lilacs). Com base na análise crítica realizada, observou-se que é dever ético, legal e moral desses profissionais de saúde o reconhecimento de sinais e comportamentos indicativos de qualquer tipo de violência infantil (negligência, abuso físico, sexual e/ou psicológico), seguido da denúncia dos casos suspeitos ou confirmados junto ao Conselho Tutelar, visando a interrupção de episódios violentos e a garantia da inclusão dos menores em políticas de promoção de seu desenvolvimento pleno e saudável.

Palavras-chave: Odontólogos. Maus-Tratos Infantis. Violência Doméstica.

1 Introduction

The definitions for violence against children and adolescents vary according to the cultural and historical views on child care, the rights and the fulfilment of social rules[1]. According to the World Health Organization [2], the abuse and negligence in dealing with individuals up to 18 years of age are considered maltreatment against children, including all types of physical ill-treatment and/or emotional, sexual abuse, carelessness, negligence and commercial exploitation or another type, resulting in actual or potential harm to health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

The theme maltreatment has gained visibility, broadcasted often on the national news, and the State has been investing in the formulation of an agenda of policies and programs in various areas of public action, to confront the phenomenon[3], since the attacks tend to cause traumas and losses, often irreversible[4]. Being a victim of maltreatment when child can cause brain changes that increase the risk of behavioral, physical and mental health problems, as well as becoming the victim and/or perpetrator of other forms of violence in adolescence or adult life[2].

In Brazil, on 13th of July 1990, the Child and Adolescent Statute was created (ECA - Law number 8.069/90), with the aim of ensuring them the fundamental rights of the human person and determine the duty of family, community, society in general and the public to ensure priority with the effectuation

of the rights to life, health, nutrition, education, sport, leisure, the professionalization, culture, dignity, respect, freedom and family and community life. ECA, in article 5, stipulates that "no child or adolescent will be the object of any form of negligence, discrimination, exploitation, violence, cruelty and oppression, punished in the form of law any attempt, by action or omission, to their fundamental rights" [5].

Despite the legislation reject the maltreatment against the child and adolescent, in 2014, the legislature, through an excess of zeal, it was clear when the drafting of law no. 13.010, called *Lei da Palmada* or the Law of Menino Bernardo[6]. On the occasion, it was added to ECA, article 18-A, which emphasized that children and adolescents should be educated without the use of physical punishment or cruel or degrading treatment, as correction justification or discipline.

In this context, in spite of the legislation establishing the requirement of the protection and guarantee of rights for children and adolescents, violence against such population groups is still considered a serious public health problem, because it requires awareness and effective participation of society as a whole, in particular health professionals, because they are often in contact with victimized patients, assuming a strategic position in reducing the impact that any type of abuse can result in the development of the mistreated individual and with views to the prevention of the problem, monitoring and the victims' protection[7-9].

Since some studies have shown that around 67% to 75.5% of physical injuries present in cases of child abuse affect the region of the head, face and neck,[10.11] the surgeon dentist has a prominent position in the recognition and protection of victims. However, a national survey[3] found that 71.2% of the dental surgeons had never identified situations of ill-treatment in their professional practice. And among those who did, 83.1% have not notified such occurrences. The inability of the professional to identify them was attributed to the absence or inadequacy of the approach to the subject in the undergraduate and/or in professional trainings, to the clinical conduct based on the biomedical model and the naturalization of violence against children and adolescents. From these findings, there appeared the guiding question of the issue addressed in this article: "What is the ideal dental surgeons' behavior in a situation of suspicion or confirmation of child violence"?

It is essential that these professionals be educated and instructed both to the recognition of the main signs associated to situations of violence as to the procedures regarding the notification of cases. Considering their social role in combating the perpetuation and the underreporting of cases of child violence, the objective of this paper is, by means of an integrative review, with a descriptive approach, guiding the surgeon-dentists in the identification and report of maltreatment committed against children and adolescents.

2 Development

2.1 Methodology

A literature review of secondary sources was performed such as manuals, official documents and articles in scientific journals. For the bibliographic survey of articles, a search was carried out in electronic databases "Scientific Electronic Library Online (SciELO) and "Latin American and Caribbean Literature in Health Sciences (LILACS), using the following descriptors: *"Odontologia", "Cirurgião-Dentista", "Odontólogo", "Maus-tratos" e "Violência".* The inclusion criteria established for the selection of the articles were: Publications in English, full texts that portraited the theme of study and articles published in the period from 2000 to 2018.

2.2 Classification of maltreatment and identification of victims

The diagnosis of maltreatment is based on the recognition of behavioral indicators and the physical signs and symptoms common to the maltreated children and adolescents[8]. In a general way, the suspicion of violence against children and adolescents appears at the moment that the anamnesis is carried out or during the physical examination of the patient. Therefore, an assessment must be done carefully, considering the set of information collected, which will determine the diagnosis of aggression[12].

The questions during the interview should be exempted from any connotation of accusation or censure, although the intentions of confirmation of ill-treatment and to protect the child from new attacks should always be present. For this reason, it is suggested that, in cases of suspicion, whenever possible, the victim is questioned separately from the suspect. Finally, the professional should not forget that all data should be carefully recorded on the records, once the public power may request copies of the documentation of the patient[1.15].

So that the surgeon-dentist identify potential victims and perform a proper intervention, it is necessary that he or she recognizes the main types of maltreatment: neglect, physical, sexual and psychological abuse. Negligence involves the omission of basic care and protection to the child or adolescent before avoidable situations, having consequently the non-compliance for the physical and emotional needs concerns. In this case, food, medicine, clothing, health and hygiene conditions for attending school are not provided. The neglected child can be presented in several forms: appearance of poor body hygiene, dirty clothes, diaper dermatitis, skin lesions of repetition, clothing not suitable to the local climate, malnutrition, lack of food, persistent food mistakes or restrictions due to parents' ideologies, inadequate medical treatments (non-compliance with the vaccination schedule), do not follow medical recommendations, irregular attendance to the monitoring of chronic pathologies, frequent hospitalizations, disorders of growth and development without organic cause, repeated accidents, irregular attendance at

school, inadequate schooling to age, non-participation of parents in schoolwork and long periods of time without activities[1,13,14].

It is believed that among the maltreatments, neglect is revealed with greater frequency in dental scope, mainly by the presence of non-treated tooth infections that occur when parents or guardians, having information and access to care, do not seek and/or follow with the treatment necessary to ensure an adequate level of oral health to the minor[14.15].

Moreira *et al*.[3] highlight that the negligence in oral health can be an indicator of domestic violence. Children and adolescents in situations of this kind may present non-treated pathologies, episodes of pain, infection, trauma, among other consequences, affecting their quality of life. However, such identification must be defined with caution, due to the socioeconomic difficulties of the population, which leads to questioning the existence of intentionality. Thus, one should always consider the circumstances that led to the omission of those responsible for the cares to the victim. In this sense, two criteria are necessary to characterize the negligence: chronicity (repeated and continuous occurrence of some indicator) and omission (a responsible person must have ceased to meet any need of the minor)[1.16].

The Brazilian Federal Constitution in force determines that it is the duty of the family, society and the State to save children and adolescents from all exploitation, violence, cruelty and oppression (Article 227)[17]. Economic difficulties should not be convincing arguments for the family to cease to provide the care that young people need. This behavior - omission - can be considered 'pattern' or even normal, upon observing the care that other families, in a situation of poverty, dispense with their children[1]. On the other hand, it is highlighted that it is up to the professionals who deal with children and adolescents greater attention about this process. Such a change would allow an understanding about the situations experienced by families, as well as would allow to have a logic of individual guilt for greater accountability of public spheres, charging its share of responsibility. That it, it would be up to the State and the public policies a greater assistance in the realization of these rights, since the negligent caregivers would also be considered as neglected by the policies of assistance[18].

Physical abuse is reported as any act of non-accidental violence, in that parents, guardians, relatives or people close to the child or adolescent make use of physical force with the objective of correcting, educating, reproving, leaving evident marks or not of aggression. The suspicion of this type of abuse must start from the identification of lesions in different parts of the body, especially in the region of the head and neck, lesions in different stages of healing, circular lesions in the neck (choke) or on wrists and ankles (bonds), bruises in areas usually protected by clothing, lesions that resemble marks of objects (fork, knife and buckle), burns in the shapes of objects (iron boards, cigarette smoke) and lack of hair (due to tugs)[14,19].

In general, it is the most recognizable form of aggression, with clinical conditions in which the explanation for the marks on the body is not consistent with the type and severity of lesions detected[8]. Thus, during the dental care, the surgeon-dentist should investigate the incompatibility of the history of the trauma with the existing lesions (the lesion is related to an accidental fact or attitude of the child herself which does not correspond with the severity of the condition), the discrepancy between the reports of the victim and the responsible, and the occurrence of alleged accidents of a repetitive and/or with frequency above the expected, usually related to the alleged hyperactivity, bad character and disobedience of the minor[1].

In addition to the detailed anamnesis, an extra accurate and intraoral exam must be carried out, analyzing if the patient presents lacerations of labial and lingual frenulum, burns, bruises, ecchymoses or scars on her lips, gums and/or tongue, fractured tooth, avulsed tooth or with color change (suggestive of dentoalveolar trauma). Moreover, under the legal point of view, it is salutary that the professional describe the lesions in accordance with the region, the size and the appearance, documenting, whenever possible, with photos and x-rays[14].

A fact that needs to be thoroughly associated with the moment of the diagnosis is that cultural aspects, values and taboos may also influence the identification of this type of maltreatment. In Brazil, culturally, but unfortunately, violence against young holds alarming statistic, because 63% of the children and adolescents have already suffered some type of physical abuse[20]. The use of physical punishment or other expressions of violence are still frequently used instruments in the education of their children. Consequently, this trivialization of physical violence makes abusive practices, many times, be regarded as normal attitudes of discipline, even by health professionals[3].

Most cases, the caregiver/abuser offers explanations about the act of hitting or spanking as a form of education, being that they are often motivated by social difficulties, emotional disarray and feeling of guilt for the problems[19]. It is believed that physical violence with the intent to educate the child or adolescent is usually directed to other parts of the body, such as the buttocks and lower limbs. However, when physical abuse with the aim of aggression, humiliation and rebuke of the individual, the head and neck region are the most affected ones. This is justified by the fact that the face is a symbol of the identity of the human being, so attacking the face is a way to suppress him or her, diminishing the dignity, placing the victim in a situation of inferiority in front of the abuser. In addition, this region is visually of greater range and more vulnerable because there is no protection of clothing, as occurs in the limbs and trunk[15].

Sexual abuse is referred to as the abuse of power, by means of which the victim is used for sexual gratification of an adult or another child, by means of physical force, coercion or psychological intimidation [14]. The identification of this

type of violence, in general, is done through the account of the aggression, since, in most cases, evident physical injuries are not found.

Before the spontaneous report of the victim, her or his testimony should deserve all the credibility, since she or he would hardly expect to be able to produce a false history of sexual abuse. A complete physical examination must be carried out, with special attention to areas usually involved in sexual activities. Clinical signs such as hyperemia, edema, bruises, scratches, cracks, breaks, bleeding, sexually transmitted diseases, pregnancy[1] and bite marks of adult in children should also be investigated, since they are generally associated with some form of sexual abuse[16].

Within dental scope, dental surgeons must be attentive to the detection of behavior changes associated to intrabuccal signs that may be indicative of sexual abuse, such as the presence of petechiae (red spots caused by hemorrhage of blood vessels) and erythema in hard and soft palate (forced oral sex)[14]. However, whenever there is doubt before the suspicion, it is wise to seek aid with other professionals, in order to prevent injuries [15] that go unnoticed or be wrongly diagnosed.

Children are not prepared physically, cognitively, emotionally or socially to face a situation of sexual abuse[19]. This violence brings, in addition to the systemic consequences, also from social, emotional and behavioral order. Thus, the suspicion may also arise from the observation of the victims of learning and relationship difficulties, run away from their home, psychosomatic complaints, sudden changes in behavior, phobias, nightmares, compulsive rituals, self-destructive or suicide behavior, early erotization, isolation constant crying or sadness, irritability and aggressiveness, aversion or distrust of adults, among others[1.14].

It is known that, in about 80% of the cases of sexual violence, the abuser is a parent or person with some affective bond with the family of the victim. So, constantly, there is denial of the fact, not admitting the possibility of abuse with the aim of protecting the aggressor or for fear of breaking the family nucleus. False accusations can also occur, especially between couples in a situation of dispute, with the objective to prevent the coexistence of a parent with the minor. In these cases, it is much more difficult to diagnose, because the suspicion of abuse may be one of the reasons for the marital separation[1.21.]

Psychological abuse is related to any action or omission that causes damage to self-esteem, the identity or biopsychosocial development of the victim, changing the formation of his or her personality and his or her way of facing life. Attitudes of hostility, devaluation of the individual, continuous insults, intimidation, emotional abandonment, rejection, discrimination, excessive charges and humiliating punishments may result in the victim behavior indicative of abuse, such as isolation and passivity, agitation and crying, constant irritation and aggressiveness, insecurity and childishness, obesity or malnutrition by anxiety, and disorders of sphincter control (enuresis, fecal scape)[1,14,22].

It is worth noting that the psychological violence tends to occur concomitantly with other types of maltreatment and in any socioeconomic level of society. Although there is no specific psychological profile for the perpetrators, some common characteristics have been found in families who commit this type of abuse: high number of children, unwanted pregnancy, adolescent mothers without psychosocial support or in isolation, inexperience or ignorance in attention to children, psychiatric history, toxicomanias, lack of financial resources, and support from the family, history of domestic violence and family breakdown. However, where there is a clinical indication and there is a possibility, one should think of a psychological family, avoiding future problems of social adequacy of children and adolescents[1].

2.3 Notification of cases

Violence is a relationship that is established in the family environment or in the children's day-to-day and, when characterized, it is necessary that is denounced, seeking resolutive and civilized ways to stop this situation[22]. The notification of the occurrence or suspicion of abuse is a means of guarantee of rights and social protection of children and adolescents, working as a fundamental tool for epidemiological surveillance and the definition of public policies of prevention and intervention[9.14]. However, there is little relevance given to the notification of violence in dental clinics, a fact which affects the reality experienced in the country and stops abruptly the efforts for the elimination of this disease[7].

In Brazil, epidemiological data on child abuse are poor, and there is no reliable national statistics on the subject, but only sparse records of individual services or researchers, which do not reflect the current reality, making it difficult a better deal with the problem[16]. On the one hand, there is not in the country, the establishment of technical standards and routines for the guidance of health professionals facing the problem of violence, which contributes to the difficulty of these professionals to diagnose, record and notify the cases. On the other hand, the pact of silence in homes also collaborates to this ignorance, a space socially sacralized and considered free from violence, but that, in fact, is a privileged place for the practice of maltreatment[1].

Article 13 of ECA establishes that the cases of suspected or confirmed physical punishment, cruel or degrading treatment and child maltreatment against child or adolescent must be communicated to the Tutelary Council of its location, without prejudice to other legal arrangements. Article 262 complements that while Guardianship Councils are not established, the tasks assigned to them shall be exercised by the judicial authority[5]. In these cases, the notifications shall be forwarded to the Court of childhood and youth, Family Court, the Public Prosecutor or to any other judicial authority existing

in the locality where the victim resides. In addition to these, the service *Disque Denùncia Nacional de Abuso e Exploração Sexual Contra Crianças e Adolescentes*[Compliante Reporting Line for Abuse and Sexual Exploration against Children and Adolescents also receives complaints from all types of violence by means of the number 100. The user performs a toll-free number and can report cases of suspected and/or confirmed child abuse, having his or her identity preserved by anonymity[7.14.]

It is, therefore, noticed that the locations are well established where the notifications of maltreatment should be performed . But a crucial point of this flowchart is the determination over which the obligation of the denunciation falls to. Thus, according to article 245 of ECA, the doctor, teacher or responsible for establishment of the health care and basic education, pre-school or nursery, who fail to communicate to the competent authority in the cases where there is cognizance, involving suspected or confirmed abuse against children or adolescents, the same will suffer penalty of three to twenty salaries of reference, applying twice in case of recurrence[5].

In this sense, it is evident that the surgeon-dentist, while responsible for establishment of attention to health, is obliged by law to report cases of suspected or proven cases of child abuse and may be penalized in cases of omission. In practice, several reasons are alleged by the dental surgeons to justify the non-notification of cases, such as the lack of professionals, the uncertainty in the diagnosis, the fear of retaliation and the ignorance of the notification procedure and the penalties that are applicable in the case of non-referral to the competent bodies[18.23].

Regarding the inadequate professional training, Chaim and Goncalves[23] underline that the matter should be addressed in a special way, being integrated in the curricula of the Dentistry Schools, as part of the curriculum to be developed in the years of graduation, regardless of the subject to be liable for the task. In addition, it is supposed that the curricular proposals of graduate courses built in interdisciplinary axes promote the exchange of knowledge and professional experience as compared to the social demands that are entered in the thematic policies and that challenge the effectiveness of health management. In this understanding, the Ministries of Health and Education of Brazil encourage the deployment of residences and graduate degrees in interdisciplinary character to which the policy guidelines, which govern the reorientation of the health care model, to achieve results that transform the health indicators of the population[3].

In the United States of America, the Dentistry School address the topic of child abuse in the curricular content of undergraduate courses and class associations develop continuing education courses, aiming at training and the improvement of its professionals[8]. However, in a recent survey with pediatric dentists in the city of João Pessoa-PB, only 54.8% of respondents reported interest for training on the theme[24].

In our country, the National Examination of Students' performance (ENADE) is one of the ratings that comprise the national evaluation system of Higher Education (SINAES) and aims to evaluate and monitor the process of learning and academic performance of students in relation to the content provided in the curriculum guidelines of the respective undergraduate course, as well as their skills for adjustment to the demands arising from the development of knowledge and skills to understand issues external to the specific sphere of the chosen profession, linked to the Brazilian and world reality and to other areas of knowledge. In 2016, the theme maltreatment was approached in an interdisciplinary way on the specific component of test aimed at graduates of the course of Dentistry. The question presented a case in which the professional suspected of sexual abuse of a 6-year-old child, upon observing in his or her oral cavity a lesion compatible with the signals of a sexually transmitted disease. The applicants were asked to point the presumptive diagnosis of the lesion and the proper conduct of the professional before the event, reinforcing the need for the matter to be discussed and debated throughout their academic training.

Regarding the uncertainty in the diagnosis of maltreatment, Santos *et al*.[24] indicate the need for the elaboration of a protocol for pattern that can guide the conduct of the surgeon-dentist in cases of child abuse. Many times, the professionals fear harm the patient and his or her family upon notifying a doubtful case. The Brazilian Society of Pediatrics[1] clarifies that, even in cases of suspicion, the notification shall be made based on the anamnesis and careful physical exams; because the complainant is not a police action, but a tool that aims to trigger an action of the victim protection and support for the family. The Tutelary Council has no competence to apply judicial measures[7]. One should take into consideration that the responsibility of realistic analysis of the situation is not liable to the surgeon-dentist, but the authorities, which should make the necessary steps, previously, the solicitation of judicial measure[23].

Concerning the fear of retaliation, the professional may possibly be questioned as to how to proceed with the family of the victim. Should the surgeon-dentist warn it about the probable notification? It is ethically advisable that occurs a conversation with the family, explaining that the center will be eligible for competent help, including support in the process of care that will happen after the complaint. After performing the notification by the professional, the Tutelary Council has the obligation to continue to ensure the confidentiality of the situation[1.22]. It is true that, in these cases, the surgeon-dentist, due to believing that the aggressors are those that could cease existing aggression or to prevent imminent aggression, must not omit himself or herself. Even though the same is only considered a provider of health service, before the exercise

of the profession, there is the citizen, and as duty, whenever possible, he or she should try to put an end to the painful situation faced by the children and young patients[25].

According to Chaim and Goncalves[23], some professionals consider as a possible conduct a conversation about the situation of abuse with parents or guardians and, subsequently, not obtaining favorable responses, the communication of the fact to the competent authorities. The authors emphasize that the dentists who act this way, perhaps, balance their conscience, considering the criterion of dialog, as originally proposed, as a reasonable conduct prior to referral to the competent authorities. However, what seems to be a sensible attitude, can be considered an excuse in relation to the case, because it offers other opportunities enough to change the abuser's behavior.

Moreira *et al*.[3] highlight that knowledge of the registration document of notification increases the chance of identification of maltreatment by the dental surgeons. The State Department of Health must have a specific sheet for the notification of a network of services of the *Sistema Único de Saúde* (SUS) [Acronym standing for Single Health System], which should be available in the municipalities so that the professionals can register their complaints. This document should be completed in two counterparts (one remains at the Health Unit and the other will be sent to the Tutelary Council) and included the identification and characterization of the victim, the family, the aggressor, the type of violence, location, name of the professional and health unit that notified[22]. In cases when the sheet is not available, it is suggested that the professional make a report as complete as possible and send it to the Tutelary Council[1].

The omission of the health professionals when faced with a case of abuse against children or adolescents has also been justified by the unfamiliarity of the applicable penalties. In Brazil, the surgeon-dentist has the legal, ethical and moral duty, as a citizen, to notify suspected or confirmed cases to the competent authorities, based not only on the guidelines of ECA, but also in the Dental Code of Ethics, which stipulates in Article 9 that the violation of the fundamental duties of the professional to ensure the health and dignity of the patient characterizes ethics violation [26]. However, it should be noted that despite the professional to be in a privileged position in the identification of suspected or confirmed cases of violence, its Code of Ethics is still outdated regarding the discussion of this problem, not existing in any of its lines the obligation of notification of the same[7]. Thus, considering the above, there is a need for the Federal Council of Dentistry to discuss more deeply into the subject, creating, from that, the addition of a specific article in the code which regulates the exercise of the profession[23].

3 Conclusion

The coping with the occurrence of maltreatment committed against children and adolescents permeates, especially, the attitude of the dental surgeon in the exercise of his or her profession. It is the ethical, moral and legal duty the recognition of signals and behavior indicative of violence associated with the confidential complaints of suspected cases to the competent bodies. The protection to the victims requires an interdisciplinary and multiprofessional intervention, with the adoption of strategies aimed at the interruption of violent episodes and to guarantee the inclusion of minors in policies to promote their full and healthy development.

References

1. Sociedade Brasileira de Pediatria. Guia de atuação frente a maus-tratos na infância e na adolescência. Rio de Janeiro: CLAVES/ENSP/Fiocruz; 2001.
2. World Health Organization. Global status report on violence prevention. Geneva: WHO; 2014.
3. Moreira GAR, Rolim ACA, Saintrain MVL, Vieira LJES. Atuação do cirurgião-dentista na identificação de maus-tratos contra crianças e adolescentes na atenção primária. Saúde Debate 2015;39:257-67. doi: 10.5935/0103-1104.2015S005235
4. Brasil. Ministério da Saúde. Caderneta da criança: passaporte da cidadania. Brasília: MS; 2016.
5. Brasil. Lei 8.069/90, de 13 de julho de 1990. Estatuto da Criança e do Adolescente. Brasília: MEC; 1990.
6. Brasil. Lei 13.010, de 26 de junho de 2014. Altera a Lei no 8.069, de 13 de julho de 1990 (Estatuto da Criança e do Adolescente), para estabelecer o direito da criança e do adolescente de serem educados e cuidados sem o uso de castigos físicos ou de tratamento cruel ou degradante, e altera a Lei no 9.394, de 20 de dezembro de 1996. Brasília: MEC; 1996.
7. Almeida AHV, Silva MLCA, Musse JO, Marques JAM. A responsabilidade dos profissionais de saúde na notificação dos casos de violência contra crianças e adolescentes de acordo com seus códigos de ética. Arq Odontol 2012;48(2):102-15.
8. Alves PM, Cavalcanti AL. Diagnóstico do abuso infantil no ambiente odontológico: uma revisão da literatura. Publ UEPG Cienc Biol Saúde 2003;9(3/4):29-35.
9. Garbin CAS, Dias IA, Rovida TAS, Garbin AJÍ. Desafios do profissional de saúde na notificação da violência: obrigatoriedade, efetivação e encaminhamento. Ciênc Saúde Coletiva 2015;20(6):1879-90. doi: 10.1590/1413-81232015206.13442014.2015S005235
10. Fonseca M, Feigal R, Ten Bensel R. Dental aspects of 1248 cases of child maltreatment on file at a major county hospital. Pediatr Dent 1992;14(3):152-7.
11. Naidoo S. A profile of the oro-facial injuries in child physical abuse at a children's hospital. Child Abuse Neglect 2000;24(4):521-34. doi: 10.1016/S0145-2134(00)00114-9
12. Macdonald RE, Avery DR. Odontopediatria. Rio de Janeiro; 2001. Guanabara-Koogan; 1991.
13. Pires ALD, Miyazaki MCOS. Maus-tratos contra crianças e adolescentes: revisão da literatura para profissionais da saúde. Arq Odontol 2005;12(1):42-9.
14. Losso EM. Maus-tratos infantis - o papel dos cirurgiões-dentistas na proteção das crianças e adolescente. Curitiba: Universidade Positivo; 2015.

15. Martiniano SG. Abuso e negligência contra crianças e adolescentes: aspectos de interesse para o cirurgião-dentista. Araruna: Universidade Estadual da Paraíba; 2016.

16. Massoni ACL, Ferreira AMB, Aragão AKR, Menezes VA, Colares V. Aspectos orofaciais dos maus-tratos infantis e da negligência odontológica. Ciênc Saúde Coletiva 2010;15(2):403-10.

17. Brasil. Constituição (1988). Constituição da República Federativa do Brasil. Brasília, DF: Senado Federal; 1988.

18. Calza TZ, Dell'aglio DD, Sarriera JC. Direitos da criança e do adolescente e maus-tratos: epidemiologia e notificação. Rev SPAGESP 2016;17(1):17-27.

19. Nunes AJ, Sales MCV. Violência contra crianças no cenário brasileiro. Ciênc Saúde Coletiva 2016;21(3):871-80. doi: 10.1590/1413-81232015213.08182014.2015S005235

20. Lira K, Hanna N. O que dizem as crianças? Uma consulta sobre violência a partir da percepção de crianças e adolescentes. Rio de Janeiro: Instituto Igarapé; 2016.

21. Luna GLM, Parentel LEO, Moreira DP, Vieira LJES. Notificação de maus-tratos contra crianças e adolescentes: o discurso oficial e a práxis. Rev Enferm UERJ 2010;18(1):148-52.

22. Brasil. Ministério da Saúde. Série A, n. 167. Notificação de maus-tratos contra crianças e adolescentes pelos profissionais de saúde. Brasília: MS; 2002.

23. Chaim LAF, Gonçalves JR. A responsabilidade ética e legal do cirurgião-dentista em relação à criança maltratada. Rev ABO Nac 2006;14(1):19-24.

24. Santos CAO, Lacerda MC, Caldas ATL, Souza INNS, Silva AS, Silva CAM, *et al*. Violência contra crianças e adolescentes: conhecimentos dos odontopediatras da capital paraibana - estudo piloto. Rev Odontol Univ Cid São Paulo 2016;28(3):223-9.

25. Sales-Peres A, Silva RHA, Lopes-Júnior C, Carvalho SPM. Odontologia e o desafio na identificação de maus-tratos. Odontol Clín-Cient 2008;7(3):185-9.

26. Conselho Federal de Odontologia. Código de Ética Odontológica. 2012. Disponível em cfo.org.br/wp-content/uploads/2009/09/codigo_etica.pdf.