Chapter 28

Child physical violence and the dental surgeon's professional duty: A literature review

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ABSTRACT
This paper aimed to perform a non-systematic review of the literature on physical violence against children, addressing the following factors: indicators of maltreatment and legal aspects, as well as elucidating the importance of the dental surgeon in the diagnosis and the ideal conduct to be taken by him. Thus, through the analysis and discussion of the theoretical basis presented, we seek to establish the current Brazilian panorama on child physical violence. The study is divided into seven exposition topics: the abstract, the introduction, the objectives, the methodology, the literature review, the discussion, and the final conclusion, thus composing the desired content. The following journals were used for the formulation and preparation of the study: Latin American and Caribbean Literature on Health Sciences (LILACS), Brazilian Bibliography of Dentistry (BBO), Scientific Eletronic Library Online (SCIELO), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Portal CAPES. Articles from the last 18 years were used, searching for the following keywords: "abuse", "violence", "child abuse", "orofacial injuries" and "dentistry". Despite the scarcity of underreporting of this violence, it was found that the orofacial region is often the site of multiple injuries from physical violence, making clear the importance of the dental surgeon in identifying and reporting this violence.

Keywords: Abuse, Violence, Child mistreatment, Orofacial injuries, Dentistry.

1 INTRODUCTION

According to the World Health Organization (WHO), violence can be defined as the use of physical force or power, in threat or in practice, against oneself, another person or a group that results in physical or psychological harm and impairs the child's development (WHO, 2002).

Children and adolescents, being individuals in a position of social vulnerability and physically more fragile, constantly have their rights violated and can be subjected to abusive acts. In 2016, the National Denunciation Hotline of the Secretariat of Human Rights of the Presidency of the Republic (SDH/PR) recorded more than 76,000 reports of violations of the rights of children and adolescents, 22.2% (32,040)

of which were physical violence. Moreover, according to the Child and Adolescent Statute, all citizens must notify suspected cases of maltreatment to the juvenile court in order to protect the rights of these individuals (BISS, 2015). Child violence can be divided into four types: 1) physical violence: characterized by physical harm caused by the parents or guardian to the child; 2) sexual violence: when the minor is sexually exploited by the parents or guardian; 3) emotional violence: in which the child is subjected to frequent threats and rejection; 4) neglect: when the parents or the guardian of the child are not able to provide the basic needs of the child or adolescent (BEN, JALES, 2016).

It is known that physical violence damages the child's physical, emotional and intellectual development, in addition to affecting their dignity, safety and well-being (CRESPO, 2011; MALTA et al. 2007), and the reasons that cause them are multiple and complex. Among the causes of violence, the following contributing factors can be highlighted: Low economic income, psychological disorders, parental divorce, reports of drug abuse and alcoholism. (SOUSA et al, 2012). In many cases, the offender justifies it as a disciplinary attitude, and not as aggression, despite the various existing legal mechanisms that aim to protect the victims of this type of punishment (GARBIN, 2016, p.274; RIBEIRO, 2014).

Epidemiological studies indicate that 20.2% to 65.3% of injuries from child maltreatment occur in the head and neck region (FRANZIN et al., 2014; BARRETO et al., 2010; CARVALHO et al., 2009; CAIRNS, MOK, WELBURY, 2005; CAVALCANTI, 2010).

This happens because the head and face, besides being more exposed and accessible regions, are extremely representative in the human being having direct influence on self-esteem and psychological health (COELHO, F. J, 2014; SANTOS, et al. 2014).

Thus, due to their area of expertise, dental surgeons have a favorable position to diagnose them, and thus, to report to the competent authorities any type of child abuse, thus fulfilling their legal, ethical and moral duty required by Article 245 of the Statute of Children and Adolescents - Law 8069/90 (BRAZIL, 1990; FRANZIN, 2014).

Despite the responsibility of dental surgeons in this important social issue, about 65% of health professionals did not receive information about child maltreatment during their academic training (CAVALCANTI, 2009; BOHNER et al., 2012; CARVALHO, et al. 2006; GOMES, et al. 2011). Thus, violence against children tends to be an uncomfortable topic for health professionals due to the lack of experience to recognize and deal with the problem (GONDIM et al., 2011).

Considering the scarcity of studies in the area and the need to explore this topic, this study aims to present epidemiological data on childhood physical violence, highlighting the importance of the role of the dental surgeon in the diagnosis and notification of violence against children, providing subsidies for the professional to make the diagnosis of suspected physical violence and notify the case to the competent authorities.

2 OBJETIVES

The objective of this work was, by means of a non-systematic review of the literature, to present the epidemiological situation of physical violence against children in Brazil and to draw the attention of the dental surgeon to the problem. Aiming at the importance of the dental surgeon in the diagnosis of physical violence against children, the work provides subsidies for the diagnosis of suspected physical violence and for the notification of the case to the competent authorities.

3 METHODOLOGY

This is a non-systematic literature review, based on national and international articles published between the years 2000 and 2018, in addition to data obtained from the Federal Constitution of 1988, the Juvenile Code of 1927, the Juvenile Code of 1979, the Statute of Children and Adolescents, and the Code of Dental Ethics.

The search for articles was carried out in the following databases: Latin American and Caribbean Literature on Health Sciences (LILACS), Brazilian Bibliography of Dentistry (BBO), Scientific Electronic Library Online (SCIELO), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Portal CAPES. Articles in Portuguese and English were selected from the search using the following descriptors: "abuse", "violence", "child abuse", "orofacial injuries" and "dentistry".

Articles indexed from 2000 to 2018 that related to the topic were included. Those that did not fit the period and did not meet the theme were excluded. The sample consisted of 27 national articles and 7 international articles. After careful reading, we evaluated the pertinent subjects, relevance of the study, author, year, objectives, methodology, results, and conclusions. In addition to those selected through the databases, we manually selected, through the bibliographic references of articles already included in the sample, 8 scientific articles of important relevance on the theme, totaling 42 scientific articles.

4 LITERATURE REVIEW

4.1 EPIDEMIOLOGY OF CHILD VIOLENCE

There is great difficulty in identifying and classifying the types of violence that a child or adolescent suffers. This may be related to social tolerance related to certain practices, especially when it comes to physical violence, concealment of abuse by victims and those close to them, in addition to the difficulties in making the differential diagnosis with other etiologies and the lack of notification to the competent entities by health professionals, who, although required by law, do not do so, creating an obstacle to determine the incidence of child and youth abuse (CRESPO et al, 2011).

Due to the underreporting of these crimes, we know that the statistics created from the official numbers may represent the "tip of the iceberg",. It is estimated that only 10% to 30% of the total cases are registered, even in countries where reporting is an action to which the citizen is sensitized (BAZON, 2008, p.324; FALEIROS, MATIAS, BAZON, 2009; ROLIM, 2014).

Table 1 below presents the most prevalent data regarding epidemiology in the articles selected in this review.

Table 1. Epidemiology of child violence

Reference	Number of victims	Physical abuse prevalence	Male gender		Female gender	Fathers and mothers offenders	Prevalence of head and neck injuries
Valente et al., 2015	10.483	6,33%	46,95%		54,05%	NR	NR
Farias et al., 2016	498	59,2%	61,4%		56,4%	43,4%	NR
Costa et al., 2007	1.293	35,18%	NR		NR	NR	NR
Franzin *et al.,* 2014	19.316	7,9%	NR		NR	NR	NR
Gawryszewski et al., 2009	4.085	43,3%	61,4%		48,6%	43,8%	NR
Carvalho et al., 2009	2.073	64,7%	43,9%		56,1%	NR	65,5%
Mascarenhas et al., 2010	518	67,4%	NR		NR	48,1%	NR
Rocha e Moras, 2011	278	93,8%	NR		NR	NR	NR
Barreto et al., 2012	2.225	50,83%	47,82%		52,18%	39,3%	45,54%
Banheiro, 2014	35	NR	60%		40%	NR	61,5%
Martins e de Mello Jorge, 2009	479	NR	46,6%		53,4%	NR	NR

NR: not reported.

In 2007, Costa et al. collected data from the medical records of victims of child maltreatment registered in the Guardianship Councils I and II of Feira de Santana, Bahia, in the period from January 1, 2003 to December 31, 2004. In this period there were 1,293 registers of violence, with (78.1%) occurring at home. The most frequent violence was negligence (56.22%), physical violence (35.18%), by beating (30.31%), in the 2 to 13 years old age group; psychological violence (28.92%) and sexual violence (5.25%), mainly among adolescents. Most reports were made anonymously (30.8%); the aggressors for neglect were the parents; for physical violence, the stepmother and "other aggressors"; for sexual violence, the stepfather, "other relatives/aggressors"; psychological violence was prevalent among all categories of aggressors (COSTA, et al, 2007).

In a logistic regression test conducted in 2009 by Gawryszewski in the state of São Paulo, the records of the Violence and Accidents Surveillance System (VIVA) were used and 4,085 notifications in children under 15 years old were studied. The gender most affected by violence was female, totaling (61.4%). The most frequent age group among girls was from 10 to 14 years old (38.8%), and among the younger boys, those under 5 years old (35.8%). Physical violence accounted for (43.3%) of cases in boys and (28.2%) in girls. The main perpetrators of aggression were parents (43.8%) and acquaintances (29.4%). Most of the aggressors were male (72%). The residence was the place of occurrence of (72.9%) of the cases. Children and adolescents classified or referred to as white accounted for 60.2% of the total victims, while non-whites were 39.8%;

Carvalho et al. (2009) evaluated 2,073 cases of child violence in the city of Salvador-BA, which were reported to the police station specialized in the repression of crimes against children and adolescents

in the municipality. The cases analyzed were registered between the years 1997 and 1999. The sampling process was based on a statistical draw (Epi-Info, v. 1.01, 2000) carried out through a sampling register of occurrences per month. Every month, 75 records that matched the prerequisites were selected for analysis.

In these records, sociodemographic and physical data of the victims, aggressors, and complainants were evaluated. Physical abuse (64.7%) was the most frequent. Bodily injuries occurred in (22.2%) of the cases, most of them concentrated in the head and neck region (65.3%). Among all manifestations of violence, except physical violence, the female gender was the most affected (56.1%). The age subgroup of 11 to 15 years was the most affected, with 45.1% of the total cases, followed by adolescents from 16 to 18 years (29.3%). There was an intense participation of males among the aggressors (71.8%).The reports were made in most cases by the parents of the victim (72.9%). No reports were made by health professionals, reflecting a greater need for their involvement in the problem (CARVALHO et al, 2009).

The cross-sectional and descriptive study coordinated by Martins and De Mello Jorge (2009) about physical violence against minors under 15 years old, which occurred in 2006, analyzed the notifications recorded in the Guardianship Councils of Londrina-PR and services for children and adolescents victimized in the city (Sentinel Program of the Londrina City Hall and De Olho No Futuro Extension Project). There were 479 cases of violence by bodily force and 9 by other means (7 by instruments, 1 by a sharp object and 1 by a corrosive substance). In the former, female victims prevailed (53.4%), with a higher risk at the age of six years (violence coefficient of 12.2 per 1,000). The most frequent aggressor was the father (48.8%) and alcoholism was present in (64.0%) of the cases. Violence by instruments was practiced through strapping (42.9%), wire (28.6%), iron (14.3%) and kitchen instrument (14.3%), with female victims (85.7%), in the age group of twelve years (33.3%), with the father (71.4%) and the mother (28.6%) being the only abusers with alcoholism present in 57.1% of these situations. The victim of sharp violence was male, 13 years old, and the aggressor, unknown, was 15 to 19 years old. The victim of violence by corrosive substance was a 13 year old male adolescent, whose aggressor was the father, and alcoholism was the present situation.

In 2006 and 2007, a survey of emergency care of injuries caused by childhood violence (0 to 10 years old) was carried out through the Violence and Accidents Surveillance System (VIVA) of the Ministry of Health, during 30 consecutive days in the Federal District and in 34 Brazilian cities. Of the 518 children attended, there was a prevalence of male victims (60.6%), aged 5 to 9 years old (52.1%) and black (71.2%). There was a prevalence of aggressions that occurred in the victim's home (55%), with cut/puncture injury (34.2%) and evolution to discharge (68.7%). The most common violence was physical aggression (67.4%), involving beating, sharp objects and firearm. Most abusers were male (48.1%) and the victim's family members were involved in 46.8% of the cases. (MASCARENHAS, et al. 2010).

In 2011, Rocha and Moraes conducted a research to characterize Family Violence against Children enrolled in the Family Medicine Program of Niterói/RJ (27 Family Health teams), selecting, through systematic sampling, 278 children. The prevalence of violence was estimated using the national version of

the Conflict Tactics Scale Parent-Child (CTSPC). Psychological violence occurred in 96.7% of the cases and physical violence in 93.8% of the respondents. The aggressions were subdivided into 3 groups: corporal punishment (93.8%) (slap; hit on the "butt" with objects; hit on the hands, legs, or arms; pinch; shake; slap on the face, head, or ears); minor physical abuse (51.4%) (hit on other parts of the body with objects; punch or kick; throw on the floor), and severe physical abuse (19.8%) (grab by the neck; beat; burn; threaten with knife or gun). Those considered "minor" and "severe" were practiced in 51.4% and 19.8% of the families, respectively. The mother was the main perpetrator of all types of violence, although both parents practiced psychological aggression and corporal punishment. It was concluded that, due to the high prevalence of family involvement in child maltreatment, this problem should be prioritized in the Family Health Strategy.

In the period from July 2008 to May 31, 2012, 2,225 cases of child maltreatment against children aged 0 to 12 years were recorded in the Information System of Notifiable Diseases (SINAN) of the state of Bahia. Physical violence was the most frequent type, totaling 1,131 (50.83%) occurrences, followed by psychological violence (50.57%), sexual violence (43.41%), neglect/abandonment (7.16%), torture (5.66%). The most affected body parts were head/face (402; 45.54%) and genitals/anus (249; 22.01%). Among the victims, 1,161 (52.18%) were female and 1,064 (47.82%) were male (BARRETO et al, 2012).

Franzin et al. (2014) analyzed 19,316 records of reports from the Protection Network for Children and Adolescents at Risk for Violence, from the municipality of Curitiba-PR, in the period between the years 2004 to 2009. Abuse and neglect occur in 88.4% (17,082) of the cases. The prevalence of the types of abuse was calculated over the total sample and distributed (absolute value; %) in descending order: neglect (9,742; 57.0%); physical violence (1,341; 7.9%); sexual violence, (796; 4.7%); psychological violence (574; 3.4%); and, abandonment (190; 1.1%). The most affected age group was between 5 and 14 years old, affecting females and males equally. Physical sequelae (20.2%) affected mainly the head and upper and lower limbs.

The Child and Adolescent Protection Network of Curitiba-PR-Br registered 10,483 cases of child maltreatment in the years 2010 and 2011. From these records, Valente et al. (2015) selected reports of physical injuries occurring in the family environment from the Epidemiology Center of the Municipality of Curitiba. The children and adolescents were aged 0 to 17 years old, totaling 322 cases of physical abuse in the family in 2010. Of these, 57.1% were male and 42.9% female, and 58% had injuries in the head and neck region. There were 342 notifications in 2011, 49% were male and 51% were female, and head and neck injuries accounted for 65% of reported cases. Injury prevalence increased by 6% and head and neck injuries increased by 19% between 2010 and 2011.

In 2016, Barreto et al. conducted a descriptive study of cases recorded in SINAN of violence against children aged 0 to 11 years old residing in the state of Bahia, analyzing the gender of the aggressor and the child's bond with him. Of the 3,981 notifications, it was possible to analyze the gender in 3,045 (76.5%) of the cases. The majority of the aggressors belonged to the male gender (66.8%), in 90.7% of the reports it was possible to evaluate the degree of kinship between the aggressor and the child, and in 39.3%,

at least one of the biological parents was the aggressor, and in 78.1%, the aggressor was known to the child. As for the means of aggression, 50.3% (1,212) used corporal force to practice violence.

In the city of Ribeirão Preto-SP-BR, Farias et al. (2016) conducted a descriptive study of violence in children with data from the Violence and Accidents Surveillance System (VIVA) of the Municipal Health Secretariat from 2006 to 2008. This database is fed from the Notification Forms of Domestic, Sexual and/or other Violence, from the records of violence against children, made in the various health, education and justice services, from non-governmental organizations and from the community of the municipality. An increase of 75.89% (112 to 197) was registered during the period evaluated, being 498 cases of violence against children from 0 to 9 years old, 79.3% of the notifications came from the health area, most of the children were female (56.4%) and aged between two and five years old (more than 60%); male aggressors prevailed (53.6%), and in 43.4% of the cases the violence was perpetrated by parents or relatives, especially the father figure (22.7%). Physical aggression was the most frequent (59.2%) and the place of greatest occurrence was the family home (75.5%).

The only international study found was Bathroom in 2014, conducted at the University of Lisbon in Portugal. Through meta-analysis, it evaluated articles that reported 35 clinical cases of physically abused children who had head and neck injuries. They were aged between nine days and thirteen years (27.19 months in average), 14 were female (40%) and 21 male (60%). In descending percentage order, facial (85.7%), intraoral (25.7%), head (17.1%), and neck (8.6%) lesions were observed. Of the 9 cases in which intra oral injuries were present, there were labial contusions (11.1%) , laceration of the gingiva (11.1%) or alveolar mucosa (11.1%), avulsion (11.1%) or intrusion (11.1%) of the teeth, excoriation of the hard palate (22, 2%), laceration of the bridle (11.1%), excoriation (11.1%), perforation (11.1%) and laceration (11.1%) of the pharynx, laceration of the soft palate (44.4%) and sublingual region (11.1%), oral hemorrhage (11.1%), and, traumatic absence of teeth (11.1%). The evaluation showed the percentage of all injuries: tooth absence due to trauma (2.9%), tooth avulsions (2.9%), tooth intrusions (2.9%), petechiae (2.9%), ecchymoses (8.6%), contusions (40%), lacerations (31.4%) , perforations (11.4%), abrasions (11.4%), hematomas (8.6%), edema (11.4%), scars (2.9%), burns (2.9%), subconjunctival hemorrhages (11.4%), chemosis (5.7%), hyphema (5.7%), oral hemorrhages (8.6%), nosebleeds (8.6%), and finally bloody otorrhea (11.4%). It was concluded that the head and neck region is the focus of several injuries resulting from mistreatment.

4.2 LEGAL ASPECTS

Historically, the fight against child maltreatment is recent. The centuries-old absence of this issue in legislation and political projects is due to social acceptance and even the cultural practice of physically punishing children and adolescents as a punitive method for bad behavior. On October 12, 1927, Brazil's first Juvenile Code was instituted, establishing that only those over 18 years of age could be held criminally responsible and imprisoned (BRASIL, 1927).

At the Constitutional level, this theme was addressed for the first time in 1934, by criminalizing child exploitation, ill-treatment of children and adolescents, and labor for those under 14. The subsequent Constitutions were solidifying and expanding the laws that protected and supported children and families in situations of social vulnerability (BRASIL, 1934).

Later, in 1979, the new Juvenile Code was enacted, which offered protection and surveillance for minors under 18 years old in irregular situations. The "unfit" minors were children in need, delinquent, abandoned, with misconduct, and victims of violence. Those who fit into these categories were removed from their parents or guardians and the State took them under its guardianship (BRASIL, 1979).

In the current Federal Constitution, promulgated on October 5, 1988, there was a major breakthrough with profound changes in the legal status of children and adolescents. The child is now seen as a citizen, no longer considered a potential person, but rather a subject of law, with specific and priority protection needs, essential for his or her development (BRASIL, 1988).

In this context, based on the constitutional principles and standards and on the Convention on the Rights of the Child, adopted by the United Nations General Assembly on November 20, 1989, the Statute of the Child and Adolescent (ECA), Law n. 8069 of July 13, 1990, was drafted and came into force on October 14, 1990 (LOBO, 2006).

The ECA was a revolutionary document in doctrinal and legislative terms due to its universal character. Unlike the Juvenile Code (1979), it broke with the doctrine of the irregular situation of minors and adopted the foundation of comprehensive protection of childhood and adolescence. Thus, according to article 277 of the Constitution, all children and adolescents, regardless of their social or economic condition, must be assured their rights to life, food, health, education, leisure, culture, and freedom. Moreover, the role of child protection is the responsibility of the family, society and the state, i.e., all citizens, who must notify the Guardianship Council of any suspected case of maltreatment.

The Code of Dental Ethics (2012) also provides for the notification of child physical violence in Article 9, item VII, which describes that in the face of child abuse, the conduct to be taken should ensure the patient's health and dignity (ALMEIDA, et al. 2012). It is also noteworthy that failure to notify is considered an administrative offense for teachers and health professionals, constituting the penalty in a fine of three to twenty reference wages, being applied double in case of recurrence (BRASIL, 1990).

According to the Federal Council of Dentistry, the case must be mandatorily notified to the Council of Guardianship. It is not necessary to present evidence and confidentiality is guaranteed. You can appeal to the National Denouncement Hotline (Disque 100) as well as to the Police and/or the Public Prosecution Service. It is suggested that there be no personal interference (CFO).

4.3 INDICATORS OF MALTREATMENT

The diagnosis of child physical violence is complex and should never be based on only one piece of evidence, but rather on a series of physical, psychological and social indicators that the child presents

(CRESPO et al., 2011). In this context, careful observation is the initial point of identification or suspicion of child maltreatment. Thus, it is up to the dental surgeon to analyze the behavior of the child from the moment he enters the dental office, the way he interacts with parents and the dental team and, not least, his dress and general appearance.

According to Loureiro (2013), physical abuse against the minor can trigger negative behavioral patterns in the short and medium term. Psychological indicators such as aggressiveness, difficulty in emotional control, aversion to physical contact, low self-esteem, low school performance, difficulties in social interaction, anxiety disorder, depression and sleep disorders are characteristic of victims of physical violence.

Thus, when there is a suspicion of maltreatment, the surgeon is obliged to register in the medical record (along with a rigorous anamnesis covering the whole historical, social, and biological context of the child) all the signs observed that serve as behavioral indicators of the victimized child, besides those that are physical. Of fundamental importance is the analysis of whether the story told by the child and the guardians justifies the injuries and, if necessary, question them separately; discrepancies or stories that change version a lot, and those incompatible with the observed injuries are important indications of maltreatment.(VELOSO, et al. 2018).

Regarding the clinical examination, not only the face and intraoral region (the dentist's area of expertise) should be inspected, but also hands, arms, ears, neck, and even the scalp. Furthermore, it should be noted that injuries from maltreatment may present themselves in multiple ways according to the etiology of the trauma (ecchymoses, hematomas and lacerations) (LOUREIRO, 2013).

Another aspect to be highlighted is the differentiation between accidental and provoked injuries, a very challenging situation for the dental surgeon due to the similarity between them. For this reason, according to Trindade (2013), the dental surgeon should be aware of the specificities involving provoked injuries, having as a parameter the following physical indicators of injuries caused by violence: lesions in unusual regions in accidental trauma for the child's age; injuries in different stages of healing; injuries not compatible with the child's age; repetitive occurrence of supposed accidents and time elapsed between the accident and the search for medical care.

Also, according to CRESPO et al. (2011), injuries resulting from physical violence can occur in several locations, but the orofacial region is very relevant in these cases, since they correspond to 50% of the occurrences. Table 2 compiles and describes the most recurrent extraoral injuries, according to Menoli et al. (2009) and Veloso et al. (2008). Also, according to Banheiro (2014), Massoni et al., (2010) and Souza et al., (2016), the enteral oral injuries occur in a significant number in children who suffer physical violence, being described in table 3 the most recurrent ones.

Table 2. Most recurrent extraoral manifestations of physical violence

MOST RECURRENT EXTRAORAL MANIFESTATIONS	
Burns	They can be circular and uniform, suggestive of a cigarette butt; in the form of liquid spilled on the child's body, or caused by direct flame (lighter). Burns are injuries that are easy to identify and are classified according to their depth.
Alopecia or bleeding in the scalp	They occur when they suffer hair pulling. Observe the scalp during care, patting the child for signs of lesions .
Bruises	They usually occur in the soft parts of the body. On the face, they have a greater recurrence in the eyes, chin and jaw. They have a linear circumferential pattern and indicate slaps, slaps and punches, or injuries resulting from the use of objects such as belts.
Subdural or retinal hemorrhage	Injuries from beating, shaking, or asphyxiation
Bone fractures	The number of fractures, the history of the accident, and the age of the child are decisive indicators in the diagnosis. Accidental fractures usually occur with children older than five years .
Bruises and ecchymoses	When diagnosing these lesions, the dental surgeon should be aware of the history of the lesion, its number, location, and healing period. Accidental bruising and ecchymosis usually affects the front face of the body and bony eminences.

Source: Menoli et al. (2009) e Veloso et al. (2008).

Table 3. Most recurrent intraoral manifestations of physical violence

MOST RECURRENT INTRAORAL MANIFESTATIONS
Lacerations of the lingual or labial frenum caused by force feeding
Burning of the lips and intraoral mucosa due to hot food or utensils
Scratches and bruises on the labial commissure region indicating gag use
Bruising or lacerations on the lip, indicative of slaps and punches
Fractured, avulsed, or mobile teeth without plausible justification to clarify the injuries
Recurrent bone fractures

Source: Banheiro (2014), Massoni et al., (2010) e Souza et al., (2016).

4.4 CONDUCT OF THE DENTAL SURGEON

Faced with the suspicion of ill-treatment, it is the duty of the dental surgeon to notify the Guardianship Council of the city where the child lives, or the Juvenile Court. The complaint can be made in person, in writing or by telephone, confidentially or not (MASSONI et al., 2010).

To this end, the child's documentation must be duly recorded, including the story told by the child as well as by those responsible, description of the behavior of those involved (child and guardian), detailed description of the lesion (size, location, coloration, healing stage), photographs of the lesions, radiological examination (if necessary) and conduct adopted by the dental surgeon (MENOLI et al. 2009).

5 DISCUSSION

This literature review is undoubtedly important because epidemiological data show that, among the violence practiced against children, physical abuse is the most recurrent. It is common knowledge that physical violence (characterized as a violent and intentional action intended to hurt, cause pain and suffering

to the child, which may or may not leave obvious marks on the child's body) (GAWRYSZEWSKI et al, 2009) impairs the child's development and behavior, often leading to psychological and physical disorders that will accompany the child throughout his or her life.

Although it is the most reported type, physical violence against children is considered only the "tip of the iceberg" (FALEIROS, MATIAS, BAZON, 2009). Another aspect to be mentioned is that, although there is discrepancy about the most affected gender (Farias et al, 2016; Carvalho et al., 2009; Martins and de Mello Jorge, 2009; Valente et al., 2015; Gawryszewski et al., 2009; Barreto et al., 2012; Banheiro et al, 2014), most studies report that child physical violence occurs, in most cases, within the victim's home, being inflicted by fathers, mothers, or family members (Farias et al, 2016; Martins and de Mello Jorge, 2009; Gawryszewski et al., 2009; Barreto et al., 2012; Mascarenhas, 2010;) .

Therefore, there being the habitual coexistence between victims and aggressors, many real cases may be disregarded in the statistics This fact contributes worryingly to the numerical undersizing of this crime, which must be urgently analyzed, faced and disclosed by the competent bodies (Valente et al, 2015; Farias et al., 2016; Costa et al., 2007; Franzin et al., 2014; Gawryszewski et al., 2009; Carvalho et al., 2009; Mascarenhas et al., 2010; Rocha and Moras, 2011; Barreto et al., 2012; Rolim, 2014). Such alarming data also contributes to the determination of a series of vulnerability indicators, in addition to physical and psychological damage and child development (Martins e de Mello Jorge, 2009; Gawryskewski et al., 2009; Mascarenhas, 2010; Barreto et al., 2010; Farias et al., 2016).

According to the legal aspects, it is understood that the fight against child abuse is recent: although child violence and exploitation were addressed in 1927, it was only after the enactment of Law n. 8069 of July 13, 1990, which originated the ECA (1989), that the right of children to protection and support was guaranteed, as well as the right of individuals in situations of social vulnerability.

Although much is heard about child violence in the media, the existence of society's omission and passivity around it is undeniable. This is due to the lack of knowledge of the reporting mechanisms by the general population, the fear of the child to report and the naturalization of physical violence as a disciplinary action, generating the non-recognition of this practice of punishment as a crime (CRESPO et al. 2011; ZAMBON et al. 2012; RIBEIRO, 2014).

Although the works found do not mention data on the involvement of dentists in reports of physical violence, even with the expressive amount of injuries in head and neck region (Carvalho et al., 2009; Barreto et al., 2010; Valente et al, 2015), it is suggested that that omission and passivity may, unfortunately, also be present in the dental field, notwithstanding the professional duty to care for the patient's health and dignity, also in cases of child violence (Article 9 of the Code of Dental Ethics) and the obligation of the same to expose and report such child crime, even in the face of uncertainty about it (VELOSO et al. 2018).

It may be difficult to determine the exact reason for the problem mentioned above, but it can certainly be motivated by the absence or insufficient preparation of the dental surgeon to deal with such

situations. Because of this, this work reinforces the importance of inserting this theme into the dental teaching of Brazilian universities, discussing the social and technical responsibility of the professional who should identify and report physical violence against children immediately to ensure their well-being and proper development. In parallel, and still according to the content presented, it is assumed a scarcity of certain attitude, being much of this due to the little attention provided for the study of such field of defense and guarantee of the child's right (CAVALCANTI, 2009; GONDIM et al., 2011).

Still from that point of view, we add that, although the dental surgeon is able to identify various head, neck and intraoral injuries, there may be ignorance about the parameters related to the identification of injuries that arouse suspicion of physical violence, which should be extensively explored both in educational institutions and in the public health system. Indeed, and to this end, the following aspects comprise characteristic signs of injuries resulting from physical violence: different stages of wound healing, presence of injuries not compatible with the child's age, repetition of supposed accidents, accidental traumas uncommon for the age, incompatibility between the injury presented and the story told, as well as the discordance between the child's report and those responsible, among other means (TRINDADE, 2013).

Finally, it is stated that it is necessary to give due attention to the identification and documentation of injuries related to physical violence, as well as the indicators that the child presents, both through descriptive documents and photos and radiological exams, thus ensuring the correct conduct of the professional and the fulfillment of the duty of the dental surgeon (MENOLI et al., 2009).

6 CONCLUSION

Based on the information and data obtained, it is possible to state that the diagnosis of child physical violence is complex and should be performed based on behavioral, social and physical indicators.

The dental surgeon is in a favorable position to detect child violence, since injuries resulting from abuse often affect the head and neck region. Despite the ethical duty and the remarkable importance of the dental surgeon in this problematic, the absence of the subject in the curricular grid of the graduation course generates great unpreparedness in the class in face of child violence.

Thus, we reinforce the need to debate violence in the academic environment and to alert professionals to the responsibility of seeking sufficient knowledge so that, when exposed to such situations, they can act appropriately, fulfilling their ethical function, notifying the case to the Guardianship Council.

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