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Violence against children: an opportunity for detection in dental consultations

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Abstract: **Introduction:** Violence against children is a public health issue that can be detected during dental consultation, since it is estimated that 65% of injuries occur on the face and neck. In Argentina, the bibliography and experiences recorded from Dentistry are scarce, so this work arises from the need to have a tool that makes the problem visible and facilitates its approach. **Objectives:** Make recommendations for detection and addressing of child abuse from dental consultation through the development of a theoretical-practical Guide. **Materials and Methods:** A bibliographic review of studies linking child abuse to dental care was conducted. Based on this, a Guide was prepared that has epidemiological information, theoretical and legal framework, and recommendations for the detection and addressing of physical abuse, sexual violence and neglect. **Results:** Pediatric dentists are uniquely positioned to detect signs of child abuse during consultations. **Conclusions:** It is crucial that healthcare professionals, including dentists, are trained to identify and act on signs of child abuse.

Key words: Child abuse, Pediatric dentistry. Child abuse, dental care.

Violencia hacia las infancias: una oportunidad de detección en la consulta odontológica

Resumen: **Introducción:** La violencia hacia las infancias es un problema de salud pública que puede ser detectado en consultas odontológicas, ya que se estima que el 65% de las lesiones ocurren en la cara y el cuello. En Argentina la bibliografía y las experiencias registradas desde la Odontología son escasas, de modo que este trabajo surge de la necesidad de contar con una herramienta que visibilice la problemática y facilite su abordaje. **Objetivos:** Realizar recomendaciones para la detección y abordaje de las violencias a las infancias a partir de la consulta odontológica mediante el desarrollo de una Guía teórico-práctica. **Materiales y Métodos:** Se realizó una revisión bibliográfica de estudios que vinculan el maltrato infantil con la atención odontológica. A partir de ello, se elaboró una Guía que posee información epidemiológica, marco teórico y legal, y recomendaciones para la detección y abordaje de maltrato físico, psicológico, violencia sexual y negligencia. **Resultados:** Los odontopediatras están en una posición única para detectar signos de violencia infantil durante las consultas. **Conclusiones:** Es crucial que los profesionales de la salud, incluyendo odontólogos, estén capacitados para identificar y actuar ante signos de violencia infantil.

Palabras clave: Maltrato infantil, Odontopediatría. Maltrato a los niños, atención odontológica.

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Violência contra crianças: uma oportunidade de detecção na consulta odontológica

Resumo: **Introdução:** A violência contra crianças é um problema de saúde pública que pode ser detectado em consultas odontológicas, pois 65% das lesões ocorrem na face e no pescoço. Na Argentina, a bibliografia e as experiências registradas na Odontologia são escassas, por isso este trabalho surge da necessidade de contar com uma ferramenta que torne o problema visível e facilite sua abordagem. **Objetivos:** Fazer recomendações para detecção e enfrentamento da violência contra crianças a partir de consultas odontológicas por meio da elaboração de guia teórico-prático. **Materiais e Métodos:** Foi realizada uma revisão bibliográfica de estudos que vinculam os maus-tratos infantis ao atendimento odontológico. Com base nisso, foi elaborado um Guia que contém informação epidemiológica, enquadramento teórico e legal, e recomendações para a detecção e abordagem do abuso físico, violência sexual e negligência. **Resultados:** Os odontopediatras estão em uma posição única para detectar sinais de violência infantil durante as consultas. **Conclusões:** É fundamental que os profissionais de saúde, incluindo dentistas, estejam treinados para identificar e agir diante dos sinais de violência infantil.

Palavras-chave: Maus-tratos infantis, Odontopediatria. Maus-tratos a crianças, atendimento odontológico.

Introduction

Violence against children constitutes a social and public health problem of great magnitude that must be addressed by every healthcare provider. In the context of dental care, it is important to highlight the privileged role of Pediatric Dentistry in the early detection of abuse and neglect, as some studies suggest that approximately 65% of injuries are located on the face and neck[1].

It is essential that healthcare teams have both theoretical and practical tools to ensure a timely and appropriate approach to this issue, avoiding the worsening of the situation either through delayed detection or inadequate interventions.

Based on this need, an extensive literature review was conducted, revealing the limited theoretical production available in Argentina that links violence with pediatric dental care. To organize the collected information and provide a practical intervention proposal, a Guide was developed with the objective of contributing to the detection and management of violence against children. This Guide was created through an interdisciplinary effort (social work and pediatric dentistry, with contributions from pediatric medicine and psychology) and aims to serve as an incentive for future research.

Materials and Methods

A bibliographic review was conducted, both online and in libraries, during 2022 and 2023. The search focused on three types of sources. First, official international, national, and local reports with current statistics on violence against children and adolescents. Second, manuals and books by leading experts on the subject were identified to define core theoretical categories and appropriate approaches. Finally, dental articles were identified that raised awareness of the problem based on case reports or systematized oral indicators associated with violence. The review included Spanish- and English-language texts, selecting twenty-seven documents in total, the majority of which were Latin American and Spanish.

Development and Discussion

The narrative review is presented in the form of a Guide, structured as follows: The first section provides an epidemiological and theoretical framework. The second section systematizes oral and behavioral indicators that may raise suspicion of a situation of violence. The third section offers an intervention proposal that includes conducting a preliminary assessment to determine the most appropriate lines of action. This Guide was developed within the framework of a public healthcare setting, and it aims to serve as a tool to be used and adapted according to the characteristics of each country and institution.

PART I

Epidemiological Data

Global, national, and local statistics reveal similar trends regarding the number of reported cases of violence against children, highlighting the high prevalence of this problem.

At the global level, UNICEF reported that, based on data from 30 countries, six out of ten children and adolescents are subjected to some form of violent treatment[2]. Likewise, the World Health Organization (WHO) has documented that children with disabilities are at a greater risk of suffering abuse[3]. In Latin America, UNICEF estimates that there are at least six million severely abused children, of whom eighty thousand die each year as a result of violence2. For this reason, child abuse is recognized by the WHO and PAHO as a public health problem.

At the national level, in Argentina, the program "Las Víctimas contra las Violencias" (Victims Against Violence) from the Ministry of Justice and Human Rights, through consultations made via the 137 helpline and a WhatsApp line between October 2020 and September 2021, gathered the following data[4]:

- Out of a total of 15,118 consultations registering 20,520 victims, 9,989 were children and adolescents.
- Regarding reports of domestic violence, 1 in 10 originated from police stations, hospitals, or other institutions. Reports from hospitals represented 0.5% for domestic violence and 0.9% for sexual violence.
- The majority of child victims (6 out of 10) were female, and the gender gap widened with age.
- Among all reported cases, 61 victims had disabilities, nearly half of whom (47.6%) were female adolescents.
- In cases of domestic violence, eight out of ten children and adolescents were assaulted by their father or mother. In cases of sexual violence, seven out of ten victims were abused by someone within their close social environment. Among perpetrators with family ties, four out of ten child victims were abused by their father or stepfather, and three out of ten by their uncle, grandfather, and/or brother.

At the City of Buenos Aires level, the Council for the Rights of Children and Adolescents reported in 2022 that 62% of its interventions corresponded to situations of violence. Of this total, 40% involved children and adolescents who were

witnesses of domestic violence, 31% were due to physical abuse, 18% to psychological abuse, 17% to neglect, and 19% to sexual abuse[5].

Theoretical Framework: General Aspects of Violence Against Children and Adolescents

The World Health Organization (WHO) defines child maltreatment as:

"...all forms of physical and emotional ill-treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power."[6]

How can we recognize when we are facing a situation of violence?

According to this initial definition, at least two components must be present: the existence of an unequal power relationship (whether due to age, gender, ethnicity, social class, etc.) and the presence of actual or potential harm. This means that violent acts are not necessarily aggressive in nature; rather, they encompass various mechanisms aimed at subjugating the other person. Based on this perspective, the concept of violence allows us to understand the unequal power relations in which these acts occur, with child maltreatment being one of its manifestations.

Expanding this concept further, child maltreatment includes what is done (acts of commission), what is not done (acts of omission), and what is done inadequately (negligent acts). Therefore, we adhere to the conceptualization proposed by Dr. Díaz Huertas, who defines child maltreatment as:

"The non-accidental action, omission, or negligent treatment that deprives the child of their rights and well-being, threatens or interferes with their proper physical, psychological, and/or social development, and whose perpetrators may be individuals, institutions, or society itself."[7]

Currently, the following types of violence against children can be identified:

Physical abuse:

Any act or omission that causes actual or potential physical harm to a child or adolescent, including hitting, shaking, burning, or biting.

Emotional or psychological abuse:

An attack carried out by an adult on the development of the child's personality and social competence through a pattern of psychologically destructive behavior, manifested in five forms: rejection, isolation, terrorizing, ignoring, and corruption."[8]

Sexual violence:

The involvement of dependent and developmentally immature children or adolescents in sexual activities that they do not fully comprehend, to which they are unable to give consent, or that violate family taboos or social roles."[9]

These activities may or may not involve physical contact, since the exposure of the naked body or parts of it to a child or adolescent is also considered a violent act.

According to Baita and Moreno[10], the following actions constitute sexual violence:

- The use of a child and/or their naked body for the production of pornographic material, even if there is no direct contact

between the adult and the victim.

- Touching the child's genitals, anal area, and/or breasts, either over or under clothing.
- Making the child touch the adult's genitals, anal area, and/or breasts (in the case of female offenders), over or under clothing.
- Oral–genital contact from the adult to the child.
- Oral–genital contact from the child to the adult.
- Genital contact without penetration, such as rubbing against the child's body or any part of it with the purpose of achieving sexual arousal and possibly orgasm.
- Vaginal and/or anal penetration with fingers and/or objects.
- Sexual intercourse.

Regarding sexual violence, it is important to consider the following aspects:

- The aggression may be intrafamilial or extrafamilial, though most cases occur within the family environment.
- A large percentage of sexual assaults do not cause visible or permanent physical injuries, which makes their evaluation complex.
- Silence is a transversal characteristic of sexual violence, as the abuser often employs threats or coercive strategies that inhibit disclosure by the child.
- The disclosure of sexual assault may occur accidentally (through play, drawings, or physical injuries) or intentionally, through the child's report.
- According to Sorensen and Snow10, it is possible for a child to retract their disclosure. This does not mean that the abuse did not occur.
- Sexual assault is a form of violence, but it does not always involve physical violence.
- The disclosure of sexual violence causes a rupture in the family's equilibrium, generating a crisis that must be supported, particularly focusing on strengthening the non-offending protective caregiver.

Neglect and Physical Abandonment

This type of violence is related to the caregivers' failure to meet basic needs such as hygiene, nutrition, clothing, healthcare, and supervision, even when they have the means to do so. It is important to highlight that Law No. 114 of the City of Buenos Aires11, in its Article 26, establishes that the lack of material resources is not a valid reason for separating a child from their family group. Instead, the State must guarantee public policies that ensure the proper development of both the child and their family.

Common indicators include malnutrition, poor hygiene, lack of regular medical check-ups, delayed response to domestic accidents, and school absenteeism.

Munchausen Syndrome by Proxy

This occurs when a caregiver (often the mother, usually with medical knowledge) induces or fabricates symptoms in a child, leading them to undergo unnecessary and often invasive diagnostic procedures.[12]

Witnessing Parental Violence:

Research has shown that children who witness intimate partner violence exhibit the same traumatic symptoms as those who have experienced direct abuse or sexual assault. They also tend to internalize violent relational patterns, normalizing them over time.[13]

Prenatal Maltreatment:

Defined as: "Any act, whether intentional or negligent, that affects the developing fetus at any stage of gestation by any person involved in the pregnancy."[12] This includes behaviors by the mother, whether voluntary or involuntary, as well as physical violence against the pregnant woman, sometimes reflected in the absence of prenatal care.

Sexual Exploitation:

Involves the commercial exchange of goods or benefits (tangible or intangible) in return for sexual favors, where an adult takes advantage of the child's socio-emotional vulnerability.

Child Labor Exploitation:

Refers to productive activities performed by children and adolescents in hazardous conditions and without fair remuneration. These activities often impede schooling and hinder both physical and psychological development.

Grooming;

Defined as sexual harassment of minors through the internet or social networks, which may involve the exchange of photos or videos and attempts to arrange in-person meetings by the adult.

Institutional Maltreatment:

Any legislation, program, or institutional practice, whether through action or omission, by public or private entities or professionals operating under institutional protection, that violates the basic rights of children, with or without direct contact. This includes the lack of timely protective measures and bureaucratic delays that put minors at risk.[15]

PART II

Four key stages are proposed during dental care in order to organize the indicators that should be considered for the detection of violence. It is important to clarify that these stages are not necessarily linear and may occur at different points throughout the care process.

Detection During Dental Care

First Stage: Development of the Clinical Record

"Every diagnosis depends on a thorough medical history; this is especially true for child abuse, as the history can significantly increase the clinician's index of suspicion."[16]

For this reason, the following guidelines are proposed for the development of the Clinical Record[14]:

- Record and/or update personal information of the child and accompanying adult.
- Conduct a complete anamnesis of the child, including past and current medical history.
- Prepare a detailed odontogram to detect

current lesions or variations in oral condition during treatment, including signs affecting mucosa and skin.

- Collect and document all relevant clinical information, as well as any observations that draw attention. Record every physical finding—type, number, location, and size of lesions—and document them thoroughly using diagrams or sketches. Anamnesis, together with radiographs and photographs, will assist in accurate diagnosis and provide essential evidence for reporting cases.[16]
- If caregivers do not authorize photographs, this must be clearly stated in the clinical record.

Second Stage: Extraoral Examination

a) Observation of the child's general condition:

- Personal hygiene.
- Clothing: Is the child wearing warm clothes in hot weather?
- Emotional state: Withdrawal, excitement, fear, or sudden behavioral changes over time.
- Behavior: Hesitation or flinching when moving or sitting down.
- Accompanying adult: Nature of the relationship and manner of interaction with the child; explanation provided for the dental visit; any delay in seeking care (especially in emergency cases)

b) Proceed with the examination of the head, face, neck, ears, and skin.

Table 1 presents a description of the lesions that may be found outside the oral cavity.

Table 1. *Description of Lesions That May Be Found Outside the Oral Cavity*

Lesion	Manifestation
Hematoma, contusions	Usually located in non-prominent areas, such as the ears and cheeks.
Burns	Well-defined marks caused by burns, either cigarette-shaped or due to immersion in hot liquids.
Gagging marks	Perioral hematomas or bruising adjacent to the mouth.
Blow (impact injury)	Multiple fractures, or lesions with the shape of the object or instrument that caused the impact; parallel lines compatible with a belt or electrical cord.
Binding/strangulation marks	Ligature marks or parallel lines caused by tying; may be found around wrists, ankles, or neck.
Hair pulling; alopecia	Petechiae on the scalp or pain upon palpation of the scalp.
Bite marks	Elliptical or ovoid pattern on the skin, unlike animal bites, which are triangular. Human bite marks can be distinguished as child or adult based on intercanine distance: normally 2.5–4 cm. The canine impressions are the most prominent part of the bite. Intercanine distances less than 2.5 cm suggest bites produced by children, with a central area of ecchymosis caused by (1) rupture of small vessels due to positive pressure at closure or (2) negative pressure from suction and tongue compression (American Board of Forensic Odontology, March 2015).
Ocular lesions	Scleral hemorrhage: mild bleeding visible in the white of the eye. Ptosis: drooping of the upper eyelid, partially or completely covering the eye.

Sources used for the preparation of this table: Dubowitz e Lane S/R[9]; Morales Chávez, 2008[1]; American Board of Forensic Odontology, março de 2015[17].

Third Stage: Intraoral Examination

After the external assessment, conduct a thorough inspection of the oral cavity. Table 2 presents lesions that may serve as potential indicators of neglect, sexual abuse, or physical abuse.

It is important to emphasize that, in order to confirm the suspicion of any type of abuse, complementary tests and a preliminary evaluation must be carried out through interviews that contextualize the indicators. In other words, most of these indicators are nonspecific and cannot be interpreted in isolation. It is recommended to pay attention to the evolution of the lesions, as this can serve as an additional indicator.

Table 2. *Lesions That May Be Indicators of Neglect, Sexual Abuse, or Physical Abuse*

SEXUAL VIOLENCE	
Condition / Lesion	Description and Diagnostic Considerations
HPV (Human Papillomavirus)	Viral infection transmitted sexually or during childbirth. Diagnosis is based on the observation of papillomatous, verrucous, or hyperplastic lesions affecting skin and mucosa. Given the wide variety of HPV types, complementary testing is required to determine the specific type. Transmission occurs through direct contact, orogenital relations, or autoinoculation. In children, the mode of transmission remains controversial, but the most evident routes are direct contact and prenatal or perinatal transmission. The presence of HPV raises a high suspicion of sexual violence.
Gonorrhea	Bacterial infection transmitted sexually. Oral symptoms include sore throat or burning sensation, possibly accompanied by lymphadenopathy, tonsillitis, oral or perioral lesions, and/or white spots in the mouth. Diagnosis is confirmed through urine or site-specific sampling. A confirmed diagnosis strongly suggests sexual abuse.
Syphilis	Bacterial infection transmitted sexually or congenitally. In the primary stage, a painless ulcerated papule (chancre) may appear in the mouth or genital area. Oral lesions such as flat condylomas and mucous patches may also occur. Diagnosis is made through serologic testing (VDRL) and confirmed with treponemal tests (FTA-ABS, etc.). If congenital transmission is ruled out, sexual abuse should be suspected.
Herpes Simplex Virus (Type 1 and 2)	Viral infection transmitted sexually or through autoinoculation. Type 1 causes oral, facial, and hand ulcers, and may produce vulvovaginitis via self-inoculation. Type 2 is mainly associated with sexual transmission. Confirmation and typing are performed through viral culture and identification. This infection is considered the most nonspecific indicator regarding suspicion of sexual violence.
HIV (Human Immunodeficiency Virus)	Viral infection transmitted sexually, through blood, or vertically during pregnancy, childbirth, or breastfeeding. Oral lesions are recurrent and include xerostomia, gingivitis, periodontitis, aphthous ulcers, oral warts, candidiasis, leukoplakia, and Kaposi's sarcoma. Diagnosis is confirmed by serologic testing. Acquired HIV infection in a child should raise strong suspicion of sexual abuse.
PHYSICAL ABUSE	
Condition / Lesion	Description and Diagnostic Considerations
Burns	Lesions on the tongue or oral mucosa resulting from forced intake of hot food or caustic substances.
Trauma	One of the most specific indicators of physical abuse. – Lateral luxations, fractures, or dislocations of upper incisors with internal lip marks, or avulsions caused by blows. – Torn lingual frenulum, which may also indicate sexual aggression. – Torn upper labial frenulum caused by forcibly covering the child's mouth while crying, often accompanied by perioral hematoma. – Fractured, displaced, or devitalized teeth. – Aesthetic or functional occlusal alterations suggesting maxillary or mandibular fractures, along with color changes. – Radiographic findings may include anterior root fractures, periapical rarefactions, or pulpal obliterations.
Lacerations	Caused by forced insertion of objects such as utensils or pacifiers.
NEGLECT	
Condition / Lesion	Description and Diagnostic Considerations
Negligent behaviors	– Delayed medical consultation after domestic accidents. – Repeated interruption of dental treatment without justifiable cause. – Lack of school attendance. – Absence of regular health check-ups. These factors may result in severe harm or place the child's development at risk.

Sources used for the preparation of this table: Morales Chaves, M., 2008[1]; Molina Gomez, A., 2009[18]; Indart, J, 2009[12]; Syrjänen S., 2010[19]; Gavillon N, *et al*., 2010[20]; Castellsagué X, *et al*., 2009[21], Gamboa M., Guerra ME, 2013[22], Jonathan Hr, *et al*, 2012[23]

Fourth Stage: Active Listening and Observation of Behavioral Indicators

During dental care, the professional may observe behavioral aspects of the child that should also be considered as possible manifestations of violence. The narratives provided by the patient and the accompanying adult are valuable for identifying inconsistencies in the explanations of events, as well as for contributing relevant information to the preliminary evaluation.

It is important to reiterate that emotional and behavioral indicators are sufficient grounds to initiate an evaluation, but they do not necessarily confirm the existence of abuse.

For this purpose, the frequency of the manifestations, as well as how, where, and with whom they occur, and their potential risk, should all be carefully considered.

Possibility No. 1

The child or adolescent may exhibit the following behaviors (see Table 3).

These symptoms may be reported either by the patient or by their family or caregiver.

It is essential to first explore how both the child and their family explain these behaviors, without asking closed-ended questions (yes/no) or making judgments about their responses.

Possibility No. 2

The family observes that the child presents sexualized behaviors that draw their attention.

These behaviors should be evaluated by an interdisciplinary team composed of Pediatrics, Psychology, and Social Work professionals, since they may be related to the child's maturational stage or developmental process.

Children with disabilities must also be considered, as they may engage in actions linked to self-stimulation, which can be associated with disinhibitory factors inherent to their condition.

However, it is crucial to remember that

Table 3. *Behavioral Indicators*

Age Group	Indicadores comportamentais
Preschool age	Ansiedade, pesadelos, oscilações entre comportamento retraído e muito impulsivo, medo, agressividade, depressão, enurese/encoprese, transtorno de estresse pós-traumático.
School age	Pesadelos, medos, queixas somáticas, hiperatividade, baixo rendimento escolar, comportamentos regressivos, transtorno de estresse pós-traumático.
Adolescence	Fugas de casa, uso de substâncias, abuso de álcool, ideação suicida, tentativas de suicídio, automutilação, comportamentos autoagressivos, queixas somáticas, condutas antissociais, promiscuidade/prostituição, transtorno de estresse pós-traumático.

Quadro extraído de Baita y Moreno, 2015; p.80[10]

disability constitutes a vulnerability factor that may increase the risk of maltreatment.

Given that some children with disabilities may have difficulty expressing or recounting experiences of abuse, it is recommended to pay special attention to changes in behavior or emotional expression that evolve over time.

Possibility No. 3. Disclosure by the child or adolescent.

This is the most significant indicator in cases of abuse. Therefore, establishing a trust-based relationship between the professional and the child is key to fostering an environment that encourages disclosure.

Within this context, a patient may have shared an account of abuse with a family member or caregiver, who in turn communicates it to the professional.

The first intervention upon such disclosure (and prior to the preliminary evaluation) should focus on the following principles:

- Do not question the validity of the child's account — believe them.
- Listen carefully — do not overwhelm the child with questions.
- Record verbatim statements from the child or accompanying adult in the clinical record.
- Avoid making promises that cannot be fulfilled.
- Acknowledge and value the child's courage in speaking up.
- According to the child's age, explain that actions will be taken to prevent the abuse from recurring and provide reassurance.
- Do not confront the child's account with the alleged offender.
- Determine whether the alleged offender lives with the child.

The pediatric dentist's attitude during the interview must always reflect active listening toward both the child and the accompanying adult.

A private setting should be provided, and information should be conveyed using clear, age-appropriate language in a gentle and empathetic tone.

Professionals should listen without confrontation or judgment, and avoid punitive or evaluative attitudes.

When interviewing a child or adolescent, it is recommended to ask open-ended questions and not insist when the child does not wish to respond.

It is crucial not to confront the child's account with the alleged aggressor, as this could worsen the abuse if protective measures have not yet been established.

PART III

This section provides recommendations for conducting a risk assessment, which will guide the intervention strategies to be implemented.

At the end of this article, an Annex will

include a proposed Clinical Record format that summarizes these guidelines and allows for the documentation of observations and interventions carried out.

Preliminary Evaluation

Considering the institutional limitations of monovalent dental hospitals (such as the lack of an on-call mental health unit or inpatient care), a preliminary evaluation is proposed when abuse is suspected.

This evaluation aims to determine the level of risk and possible approaches to intervention.

The preliminary evaluation should be conducted interdisciplinarily with the services of Pediatrics/Medicine, Psychology, and Social Work, based on the indicators identified.

If a pediatric dentist has doubts regarding what was observed or reported, or if there is a suspicion to assess, they may call upon any of these departments to determine how to proceed:

- Should the family be interviewed? When and how?
- Should the child or adolescent be interviewed? By whom, and when?
- Is a pediatric consultation required?
- Are complementary studies necessary to confirm a diagnosis?

When a child has already disclosed abuse prior to the evaluation, the adult who first heard the disclosure becomes a key source of information.

In such cases, the interviewer should inquire:

- What did the child say?
- When and under what circumstances?
- How did the adult react?
- How did the child react to the adult's reaction?
- Were there subsequent disclosures?
- If so, were they spontaneous or the result of questioning by the adult?
- Has the child spoken to or shown anything to other individuals (e.g., babysitter, grandparents)? If so, direct contact with these individuals may be helpful.

Risk Assessment

At this stage, the goal is to determine the degree of risk based on the indicators and interviews conducted.

For this purpose, the indicators suggested by the UNICEF and Argentine Ministry of Education Guidelines on Child Maltreatment (2011)[24] and Sexual Abuse (2013)[25] are used (Table 4).

The presence of most of these indicators determines a HIGH-RISK situation, requiring immediate action to ensure the child's protection.

Intervention in High-Risk Situations: Protection of the Child

If a high level of risk is determined, the child or adolescent must not leave the hospital,

Table 4. *Risk Assessment — Suggested Indicators*

Child Maltreatment	Sexual Violence
• Severity of injuries that have endangered or could have endangered the child's life.	• Intrafamilial sexual abuse.
• Injuries inflicted on a child under three years of age.	• Chronicity and frequency of abuse.
• Child in a situation of abandonment, without protective adults.	• Perpetrator's access to the child.
• Chronic maltreatment and/or neglect.	• Characteristics and conditions of the child.
• Child's vulnerabilities, such as chronic illness, motor difficulties, or intellectual disabilities.	• Relationship between the aggressor and the child.
• Parents with traits that hinder their protective capacity (e.g., psychotic structure, drug dependence, alcoholism) and lack of extended family support.	• Characteristics of the parents or primary caregivers.
• padres que tienen rasgos que reducen sus posibilidades de protegerlos adecuadamente (como estructura psicótica, drogodependencia, alcoholismo) y sin red familiar ampliada de apoyo.	• Family environment conditions surrounding the child.

health center, or private practice until an intervention strategy has been coordinated with the Emergency Unit of the Child Protection Agency.

This process depends on the legislative framework of each country, which defines the specific protection agency and its mode of intervention.

In Argentina, the responsible bodies are the Council for the Rights of Children and Adolescents in the City of Buenos Aires, and the Local Protection Services in the provinces.

The intervention strategy will depend on the health and safety condition of the child or adolescent:

- If there are strong reasons to suspect sexual assault within the previous 72 hours, it is essential to ensure immediate medical care to prevent unwanted pregnancy and sexually transmitted infections. In Argentina, the "*Protocol for Comprehensive Care of Victims of Sexual Assault*"[26] (Ministry of Health of Argentina, 2015) is in place. Therefore, referral to a Pediatric Emergency Department should be made through emergency transfer (SAME) or accompanied by a non-offending protective adult.

- If urgent medical attention is required due to physical injuries or if a more comprehensive evaluation is necessary, referral should be made through emergency transfer (SAME) to the nearest pediatric hospital emergency unit.

- If the offending adult is the one accompanying the child to the appointment, it must be clearly explained that the patient cannot leave the facility until the Child Protection Agency determines the discharge procedure. The child must not remain in the same physical space as the offending adult while awaiting this decision.

It is of vital importance that private dental offices maintain a referral network with public health institutions to consult or refer cases when necessary. The private practice setting presents unique challenges that require carefully coordinated interventions to ensure timely protection of children.

Important: Involving the Child Protection Agency's Emergency Unit enables the development of the most appropriate protection strategy for the child in urgent situations.

This may include filing a report with the police or requesting security forces to intervene at the facility if needed.

Intervention in Low/Moderate-Risk Situations: Situation Modification

Low-risk situations present a wide range of intervention options aimed at ending the abuse and repairing the harm through intersectoral coordination.

It is recommended that Psychology and Social Work professionals conduct follow-up of the situation in coordination with the Child Protection Agency corresponding to the child's place of residence.

Conclusion

The pediatric dentist plays a crucial role in the detection, intervention, and support of children and adolescents who experience abuse. Their clinical expertise and trust-based relationship with patients make them key actors in promoting the protection and well-being of children facing situations of violence.

This work proposes that, by integrating dentistry into the multidisciplinary approach to child abuse, the healthcare system's capacity for response can be strengthened, fostering a safer environment for all children.

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Abbreviations and Symbols

NNyA: children and adolescents

UNICEF: United Nations International Children's Emergency Fund

WHO: World Health Organization

Etc.: etcetera

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