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# The dilemma of reporting suspicions of child maltreatment in pediatric dentistry

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Running title: Suspected child maltreatment - a dilemma

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### Abstract

This study examined the factors that lead specialists in pediatric dentistry to suspect child abuse or neglect and the considerations that influence the decision to report these suspicions to social services. Focus group discussions were used to identify new aspects of child maltreatment suspicion and reporting. Such discussions illuminate the diversity of informants' experiences, opinions, and reflections. Focus groups included 19 specialists and postgraduate students in pediatric dentistry. We conducted video-recorded focus group discussions at the informants' dental clinics. All sessions lasted approximately 1.5 hours. We transcribed the discussions verbatim and studied the transcripts using thematic analysis, a method well-suited to evaluating the experiences discussed and how the informants understand them.

The analysis process elicited key concepts and identified one main theme, which we labeled "the dilemma of reporting child maltreatment." We found this dilemma to pervade a variety of situations and divided it in three subthemes: *to support or report, differentiating concern for well-being from maltreatment*, and *the supportive or unhelpful consultation*.

Reporting a suspicion about child maltreatment seems to be a clinical and ethical dilemma arising from concerns of having contradicting professional roles, difficulties confirming suspicions of maltreatment, and perceived shortcomings in the child protection system.

**Key words:** Child abuse, Mandatory reporting, Professional practice, Dentist- patient relations

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## Introduction

Child maltreatment is the term most used in Sweden for child abuse and neglect. It includes any action that results in actual or potential harm to a child's health, development, or dignity. According to the Social Services Act (1), all dental professionals must report any suspicion of child maltreatment. The law states that no diagnosis of abuse or neglect is necessary for filing a report, a suspicion is enough. The obligation to report is unconditional and should be performed without undue delay. A report to the social services initiates a child protection process, so reporting suspicions of maltreatment is important for the welfare of children experiencing maltreatment and for the future of the families being reported.

A study on mandatory reporting in the Swedish Public Dental Service shows that most clinics have guidelines on how to manage suspicions of child maltreatment and that a third of the clinics had filed at least one report with the social services during a 12-month period. It also showed that they were more likely to file a report or contact the social services if they had guidelines to follow (2). In comparison, a majority of Swedish specialists in pediatric dentistry had made at least one report during a 24-month period, with "neglect" most commonly reported (3). Nevertheless, in both specialist and general dentistry, suspicions of maltreatment occur more often than reports are filed with social services (4-11). The same has been found in other professions as well (12-17). Common reasons for dentists and other professionals not reporting their suspicions of maltreatment include lack of knowledge of local child protection systems, uncertainty whether maltreatment has occurred, and also concerns and fears about the possible outcomes of filing a report (5, 6, 10, 12-19).

Studies have found that children exposed to abuse and neglect can suffer from poor subjective oral health, untreated dental disease, lesions in adjacent tissues, oro- facial trauma as well as health problems and health compromising behaviors, and have a documented failure to follow medical treatment regimens (20-27). The factors and circumstances that raise

suspicions of child maltreatment are often unique to the individual situation. How these factors affect management of the case within the practice and the decision to report is not fully understood as previous studies were based mostly upon questionnaires, which often has closed questions and predetermined response options. In the clinical encounter, the origins of maltreatment suspicions that precede a decision to report need more research to understand why dental professionals still sometimes fail to report these suspicions.

This study's objective was to examine what factors cause specialists in pediatric dentistry to suspect child abuse or neglect and to determine what considerations influence the decision to report these suspicions to social services.

## **Material and methods**

To address the gaps in current literature, this study focused on the participants' understanding of their responsibilities regarding child maltreatment. We used focus group discussions to identify new aspects of child maltreatment suspicions and reporting. The groups discussed the topic from various perspectives, soliciting the informants' experiences, opinions, and reflections. To reach meaningful conclusions when discussing delicate matters like child maltreatment, groups should consist of 3-6 people and analysis should include at least 3-4 groups (28). We gave informants little information on the topic before the discussions as too much information might bias their responses and the study's results.

## **Participants and procedures**

During a yearly meeting of the Swedish Academy of Pediatric Dentistry, we invited specialists and postgraduate students in pediatric dentistry to discuss child maltreatment. This was an "existing lists" recruitment strategy (29), a selection process which produced a snowball effect, meaning that individuals who did not sign up at first were informed by other participants. We received 55 statements of interest to participate and, after corresponding by mail, we strategically selected 19 for the study. The groups were homogenous, all working

full time in pediatric dentistry. We did not consider age, gender, experience, or level of education in the selection process. The study included four focus groups. The groups were moderated by one of the authors (TK) who introduced herself as the study's researcher and a dental professional in order to establish a clear relation to the participants.

Group size varied from two to six informants. The small group with two participants was due to late cancellations, a common occurrence in interviewing (29). In this group, the moderator sometimes had to facilitate the discussion by acting as an informant, revealing personal experiences of clinical encounters and opinions. In the other groups, the moderator was more passive and simply made sure that everyone could share their thoughts and opinions.

As with all focus groups, the risk is that the most dominant views may overshadow minority views and that some topics are missed and not brought up. This can indicate that informants forgot about the topics or that they just did not consider them important (29). A theme guide was present, but the informants discussed the topic freely after the moderator introduced it with the open-ended question "*What is child maltreatment?*" This method is used to get informants to reveal the aspects of the topic they find most important. The informants had the opportunity to freely discuss and raise issues or questions on their own. The moderator only asked follow-up questions when necessary or when discussion faded out. Focus group discussions were conducted at the informants' dental clinics and were video recorded. Each group lasted approximately 1.5 hours. Two of this study's authors (TK and IM) transcribed the discussions verbatim.

### **Analysis of data**

We analyzed the transcripts from the focus groups using thematic analysis according to the method of BRAUN AND CLARKE (30). In order to evaluate the participants' experiences and how they understand their situation, the researchers search for themes and patterns across an

entire set of data. The analysis is not directed to theory development but to an interpretation of the reality the participants serve, as well as the possibilities and limits of that reality. Thematic analysis can use a “realist” approach reporting experiences and meaning, or a “constructionist” approach reporting the different discourses operating in the setting. This study used a “contextualist” method, in between realism and constructionism, to interpret how participant make meaning and how the social context influences these meanings. Following BRAUN AND CLARKE (30), our analysis focuses on how the informants understand their professional role within the child protection system and how they manage clinical encounters when they suspect child maltreatment. First, we familiarized ourselves with the data by reading and rereading the transcribed interviews and reviewing the recordings several times. We then began initial coding of the content by summarizing the data and categorizing it into codes that expressed key concepts in the data. Next, we grouped the various codes into themes. To identify a theme, it must satisfactorily answer the question “What is this expression an example of?” (31) and appear as a repeated pattern of interest in the data—though it need not appear verbatim in the transcript (30). We used thematic maps to help us visualize the relation of themes before applying all the themes to the data set as a whole.

Due to the sensitive topic all informants received oral and written information about the study and signed an informed-consent form. They were also informed of their own responsibility to discretion about the topics and cases that were discussed. The Regional Ethical Review Board at Karolinska Institutet in Stockholm approved this study [Daybook no. (Dnr) 2010/1881].

## Results

All informants described child maltreatment as involving a child in need, with descriptions varying from a child with poor oral health, or living without tenderness and love, to a child being exposed to physical violence, forced sex, or other ill-treatment. The analysis process

elicited key concepts and identified one main theme, which we labeled as “the dilemma of reporting child maltreatment.” This dilemma occurred in a variety of situations, and we identified three subthemes: *to support or report*, *differentiating concern for well-being from maltreatment*, and *the supportive or unhelpful consultation* (Fig. 1). These subthemes describe the considerations and dilemmas faced by the informants when deciding whether to report suspicion of maltreatment.

### **To support or report**

The informants interpreted their professional responsibilities in managing suspected child maltreatment with two different roles, the supporter and the reporter. These two roles were not always compatible. In a supporting role, informants presumed that all parents want to do their best to care for their child. The informants’ main focus was to provide dental care in order to prevent negative developments in oral and dental health. To do this, it was important for informants to involve and motivate families to provide dental care and avoid conflicts in order to build a positive working relationship.

I try not to give pointers. Instead, I want to encourage them and say things like “Now you are here and now we will help you and give you advice on how to improve [your child’s oral health]” ... It is rare that I would say something like “You neglect your child.”

I want to help and support these parents because I think, and I hope, that it will help them feel better. I don’t want them seeing me as another authority figure.

This discussion shows that giving support is preferred to reporting because of fear of damaging the working relationship. It also reflects the informants’ uncertainty that making a report would help the family.

On the other hand, in the role of reporter, participants expressed good knowledge of their professional obligations to unconditionally report any suspicion of child maltreatment to the social services.

You can’t confirm maltreatment. We don’t have to know. It is not our job to know. A suspicion is enough.

The general attitude about reporting was that a concern or suspicion of maltreatment is enough, and that that is the standard with which dental professionals must comply.

The reporting dilemma was evident when informants felt they had to choose between providing dental care and their obligation to report suspicions of maltreatment. Informants made their decision whether to report by balancing considerations of the seriousness of dental disease and their perceptions of the urgency of reporting their suspicions. Informants expressed ambivalent feelings toward reporting based on negative preconceptions of the expected consequences of a report. These preconceptions included worries that children would fail to attend treatment after a report and concerns about receiving threats from the family, although few had any experience of threats.

You should, a suspicion is enough

But I feel...

Yet you feel that you need more [concrete evidence of maltreatment]

Then you are afraid to scare the family away. When you see the dental treatment needed you are happy that they are coming at all. You don't want treatment to become more delayed than it already has been because the parents get upset about what we have done.

The discussion above highlights how informants prioritize providing dental treatment over reporting because a report could likely disrupt the dental treatment plan and harm the relationship with the family, as well as concerns there might not be sufficient evidence for a report. This balance between supporting and reporting often created dilemmas that prevented the informants from filing a report despite suspicions of child maltreatment.

### **Differentiating concern for well-being from maltreatment**

When identifying which cases they thought should be reported, the informants used clinical guidelines to differentiate between children with questionable well-being (not amounting to maltreatment) and those potentially experiencing maltreatment. However, these guidelines did

not provide enough guidance to navigate the ill-defined boundaries between concerns for well-being, suspicion of maltreatment, and confirmed maltreatment. The signs and situations that raised informants' suspicions of maltreatment involved experiences either "within their professional competence" or "outside of their professional competence." Informants were mostly likely to decide to report when they could confirm maltreatment from a dental point of view, whereas they often interpreted signs of maltreatment outside of their professional comfort zone as indicating only a child with questionable well-being. The informants considered a history of repeatedly missing appointments, in combination with extensive treatment needs, as dental neglect and within their professional competence.

And this is ... what we have to take action on: caries and no-shows. We don't have anything else ... [just that your child has] a disease and you refuse treatment.

When parents failed to attend treatment with their children despite untreated caries, they confirmed informants' suspicions of maltreatment by dental neglect. Informants viewed this as the only indisputable sign of maltreatment, as both having concrete dental evidence and meeting the available guidelines. However, informants expressed a dilemma in reporting maltreatment when families seemed to provide acceptable compliance with dental treatment but suspicions of dental neglect remained due to progressing caries.

Informants reported that, in theory, it was possible in dental practice to recognize signs of physical abuse, forced sex, and emotional abuse. But in their clinical practice, most of the informants had never had any of these suspicions and none had experience reporting such a case.

There's something you wonder about, but the parents are always there. These things make you stop and think, but there is never anything that is actionable, to my mind [...] Yet, these signs ... you can't pick up on it properly. But the cases will always be in your mind, those children, the way they reacted, every time you raised your hand.

As the excerpt above illustrates, a sudden movement from the dentist, such as a raised hand can make the child react with watchfulness but the reason for the reaction is not easy

interpreted. When the signs were outside of their professional competence, informants became more inclined to simply question the well-being of the child instead of suspecting maltreatment. If they did suspect physical abuse, forced sex, or emotional abuse, the signs were often too vague to file a report with a concrete description of the suspicion. Perceptions of negative parental behaviors raised informants' awareness but were often explained by a "chaotic" life situation due to divorce, illness or stress. These cases involved concerns and suspicions outside of informants' professional comfort zone and were rarely reported.

There are a lot of parents who act like that [angry and dominating], not because you have a child that is maltreated, rather a child who is afraid of situations, and the parents just keep going on, one stupidity after another, and so we discuss with them. You don't believe anything is wrong, it's just parents who can't control themselves. We are quite used to these kinds of conversations, but we don't take more action than that.

Informants often wanted to understand why a child behaved a certain way, and they found the explanation in social difficulties in the family or for example when the family already had contact with the social services. The explanation could also be found in other normal challenges in child rearing. The uncertainty of when these concerns become confirmed maltreatment highlights the dilemma of reporting.

### **The supportive or unhelpful consultation**

To report suspected child maltreatment to the social services, the informants expressed a need for reassurance that their suspicion was adequate. In most situations they consulted with colleagues or other professionals such as child health care providers, school nurses, medical doctors, child psychiatrists, or the social services themselves. Informants expressed differing opinions about who should report maltreatment suspicions. Some thought that the clinical department head should send the report; others thought it was the responsibility of the individual dentist. Most of the informants initially consulted with their clinical department head or a colleague before reporting.

It is never your decision alone, at least not for me. I always discuss the case before reporting.

The statement above describes the importance most informants attached to collegial support. This was further illustrated by one informant who shared a suspected case of physical abuse that was never reported, in part due to lack of support from colleagues.

Consultation with social services was also common. Informants with previous positive experiences viewed these social service consultations as an asset, while those with no or negative experiences were more reluctant.

But you can always call social services if you have reached a point where you feel like, "This is it. I can't go on", but you still don't want to put it into writing [to file the report]. I have sought consultation every time ...

When an informant was uncertain regarding a suspicion or concern, the outcome of feedback from the social services was an important factor in the decision to report. However, in cases of confirmed dental neglect, lack of feedback did not prevent them from reporting. Instead, informants considered this to reflect weaknesses in cooperation in the child protection system.

It was clear that the informants understood that the work load of the social services may prevent them to provide feedback. But it was important for them to know that their report had been received, for maintaining trust in the social services and for their future relations with the family.

We need to build an organization of social workers, medical doctors, dentists and schools // consolidated so that all have the same information. But of course there are ethical principles of confidentiality ... we should not work against each other and mistrust each other in our professions ...

From this statement it is clear that informants found the lack of knowledge of the outcome of a report to be a major issue in reporting, although they blame this on society and the overall organization of child protection, rather than on the social services as an authority.

## **Discussion**

The unspoken dilemma of reporting child maltreatment found in this study sheds new light on child protection procedures in dentistry. Responses showed that reporting a suspicion about child maltreatment was a clinical and ethical dilemma arising from concerns of having

contradicting professional roles, difficulties confirming suspicion of maltreatment, and perceived shortcomings in the child protection system. The study highlights problems that result in fewer reports to the social services than would be expected if the reporting requirements for maltreatment were followed completely.

Maltreatment can be identified through a direct disclosure, by signs or symptoms and through observations of behaviors. All the informants knew of written information and the national clinical guidelines on how to identify maltreatment and manage a suspicion. Still, there were contradictions in all group discussions between the theoretical obligation to report and the cases in which suspicions actually were reported.

In all groups, the discussions focused on cases of suspected or confirmed dental neglect and the management of these situations. The groups did not discuss other forms of child maltreatment to the same extent. However, informants' attitudes on reporting suspicions of any kind of maltreatment were similar to previous studies: it was a last resort when nothing else had had any effect (32, 33). Reporting was not something the informants wanted to do. Before deciding whether to report, they evaluated the situation and assessed concerns and then consulted with colleagues or other professionals with more experience. This kind of consultations, as shown previously, guided their decision and, to some extent, provided reassurance that their suspicion was accurate (10, 11, 15, 34). Reasons for this may include uncertainty of maltreatment, a common barrier to reporting (5, 6, 10, 12-19), and the attitude that the care giver is able to manage the problem without needing to report (12, 15, 33, 35, 36). This was reflected in the informants' focus on dental neglect and general agreement that the professional imperative of dentistry is to treat and prevent oral disease. This is also reflected by the fact that informants often filed a report after maltreatment had been confirmed by dental neglect. This result is magnified by similar results from a questionnaire given to all specialists in pediatric dentistry in Sweden showing that dentists often encounter

extensive dental treatment needs but seldom report maltreatment (3) and similar findings from the United Kingdom (9, 11). The challenge in separating dental neglect from dental caries is known to influence the decision to report a suspicion of maltreatment (37). The informants in this study based their judgment of when to report on how certain they were of their suspicion. They sought greater definition of the boundaries between questionable well-being, suspicions of maltreatment, and confirmed maltreatment. Individual differences between the informants and their interpretations of these borders affected the decision to report. The informants often labeled signs of maltreatment outside of their professional comfort zone as “not maltreatment from our perspective.” These included situations in which negative parental or child behaviors raised concerns about physical, emotional or sexual abuse. Earlier studies also exposed difficulties in managing such cases in general dentistry (6, 13). The dilemma regarding emotional abuse is even more problematic due to difficulties in differentiating between poor parenting and emotional abuse; these reside on a continuum where the boundaries between normal and problematic are poorly defined concerning deficits in parental expressions and sensitivity to the child’s needs (38). Our findings agree with earlier research that has exposed difficulties in confirming suspicions and set thresholds for mandated reporting maltreatment (39, 40). This is not surprising as even experts on child abuse can vary in their assessment of abuse (34, 40, 41)

The dilemma of reporting also arose from uncertainty that a report would actually improve the child’s situation and fear that reporting unnecessarily would damage the care relationship with the family. This was partly due to an expected failure in communication with the social services. The lack of feedback was perceived as a shortcoming in the organization and could be a barrier to report. It is previous shown that the social services in Sweden rarely contact the reporter during their initial assessments (42). Other studies have also observed this view of reporting as potentially negative and a consequent hesitation to

report among dentists (4, 10, 13, 18). Similar findings also appear in studies on different professionals' failure to report (15, 32, 33).

Building relationships with the parents, instead of judging, in order to understand the child's needs and behavior is an approach that accords with being a reflective practitioner (43). According to SCHÖN (1983), the professional's role is double edged, a balance between "helping" and "controlling," which can cause problems, as has been found among child abuse physicians (34) and general practitioners (36). Research among general practitioners has reported them to be reflective in clinical encounters with children of questionable well-being (44). These reflections could be a barrier to reporting because the informants in our study regarded families that had previous or ongoing contact with social services to be vulnerable. A report in such situations was considered to be an additional burden to the family or unnecessary as the family was already receiving social services support. Pediatricians have also expressed this view (15).

Using focus groups instead of individual interviews gave a deep understanding of how the informants consider cases of suspected maltreatment. The group discussions allowed the informants to reflect and discuss delicate issues and topics that might have been overlooked in individual interviews (29). We do not expect the variety in age, gender, experience, and level of education among the informants to have affected the results because child maltreatment is a relatively new subject in dentistry and all informants can thus be considered to have similar educational background in this subject. The level of response we saw from the participants in the groups suggests that they were interested in the topic and perhaps had a higher degree of involvement with cases of maltreatment and reporting than those who were not interested in participating. The selection of informants was based on place of residence and number of informants with possibility to attend on the same day; therefore it was not possible to include all registrations of interest. The discussion in the group with only two original informants did

not differ from the larger groups. The clinical dilemmas expressed and their thoughts and considerations were quite similar to the other focus groups. As the moderator was also a pediatric dentist and participated as an informant in the small group, data collection and analysis could have been influenced by professional preconceptions (45). Therefore the analysis was performed by TK in collaboration with a researcher experienced in qualitative research and with a background in the social sciences (AW) with continuous input and reflection by the other authors (IM and GD). We achieved further credibility of the results by sharing them with the informants and including their thoughts in the final analysis.

Our study found that suspicion of maltreatment occurs more often than a report is filed. Despite knowing that maltreatment should be unconditionally reported and that the threshold for reporting is a suspicion, informants rarely reported an intuition. This is problematic because it is contrary to the rules of the Social Services Act and identifying and reporting suspicions of maltreatment is the first level in the child protection process. Failure to report can therefore prevent or delay help and support to a child. This should be emphasized not only in Sweden but also in an international perspective as several studies, previously discussed, have similar problems in management of suspected child abuse and neglect.

## **Conclusion**

Reporting a suspicion of child maltreatment was a clinical and ethical dilemma for dentists arising from concerns of having contradicting professional roles, difficulties confirming suspicions of maltreatment, and perceived shortcomings in the child protection system.

## **Clinical implications**

It is important to understand that specialists in pediatric dentistry are uncertain about which children that should be reported to the social services and also the consequences of reporting, which can affect their decision to file one. We must acknowledge this dilemma of reporting

when dealing with child maltreatment. Reporting practices for child maltreatment are problematic, despite existing guidelines on how to manage suspected abuse and neglect.

The results indicate a need for more collaboration between professionals in the context of child maltreatment and also educational approaches with focus on the outcome of reporting and how to manage the continuous relations with the family after reporting.

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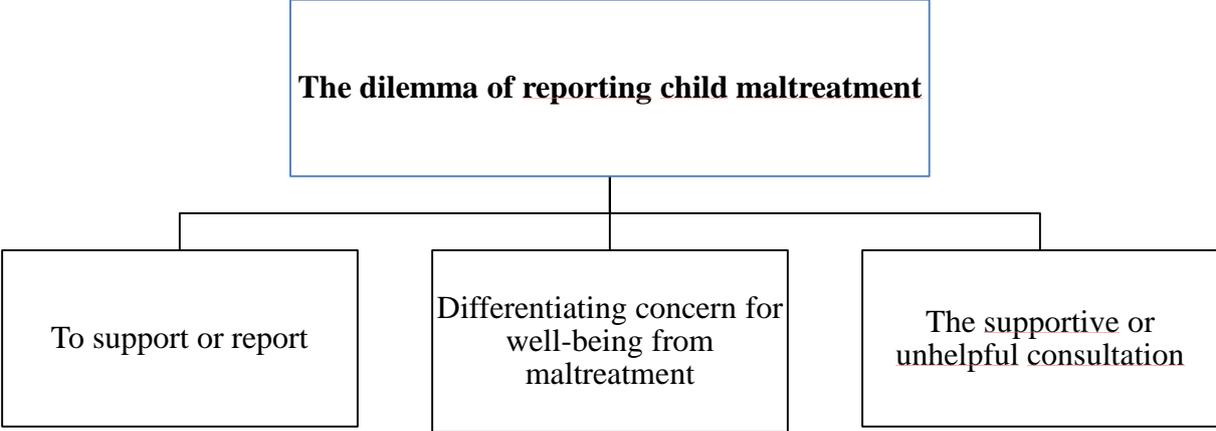
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**Figure legends**



**Figure 1.** The dilemma of reporting suspicions of child maltreatment occurred in a variety of situations, and three subthemes were identified that described the considerations and dilemmas faced by the informants when deciding whether to report or not to the social services.