

# Family Violence Content in Dental Hygiene Curricula: A National Survey

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*Abstract:* Dental personnel are in an excellent position to recognize suspected abuse of dental patients because 65-75 percent of abuse occurs in the head and neck area. While most dental and dental hygiene curricula include the topic of child abuse, it has previously been unknown if other types of abuse, such as intimate partner abuse, elder abuse, and abuse of disabled persons, are addressed. This study was conducted to determine the extent to which dental hygiene programs have incorporated these family violence topics into the curriculum. Specific data on content, teaching methods, faculty, and resources were collected. Reasons for not including family violence in the curricula, attitudes on mandatory continuing education, and support services available for abuse victims were also examined. A fifteen-item survey was sent to all 229 U.S. accredited dental hygiene programs. Surveys were returned from 173 programs for a response rate of 77.5 percent. Child abuse was taught in most programs (N=122, 70.5 percent), while elder abuse (N=95, 54.9 percent), intimate partner abuse (N=81, 46.8 percent), and abuse of individuals with disabilities (N=80, 46.2 percent) were taught in fewer programs. Reasons for not including family violence in the curricula (N=31, 18 percent) varied. The need is critical for increased curriculum attention in U.S. dental hygiene programs to help stem the epidemic of family violence. Raising dental hygienists' awareness of the problem and potentially increasing the number of reports of and referrals for suspected violence may help more victims.

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Family violence is a general term used to describe various types of abuse and/or neglect of persons either living in the same household or having close familial-like contact even though living in separate domiciles. Family/domestic violence is a problem of epidemic proportions in Western society and affects all socioeconomic levels and ethnic groups.<sup>1-4</sup>

The umbrella term "family violence" includes not only child abuse, but also elder abuse, intimate partner abuse, and abuse of disabled persons. On average, more than three women are murdered by their husbands or boyfriends in this country every day.<sup>5</sup> Between 1976 and 1999, intimate partner homicide accounted for one-third of the murders of women.<sup>6</sup> Nearly one-third of American women (31 percent) report being abused by a current or former partner at some point in their lives.<sup>7</sup> This figure is low since intimate partner violence is underreported to the appropriate authorities.<sup>8</sup> Approximately three children die every day in the United States as a result of child

abuse. If the same number died from polio each day, the public would likely raise an uproar to reverse this trend.<sup>9</sup> In addition, approximately one-half million elderly adults were abused or neglected in the United States in 1996, and many more were exploited.<sup>10</sup> Some believe that elder abuse is as common as child abuse, and that it is also grossly underreported.<sup>1,11,12</sup> Less is known about the incidence of abuse of individuals with disabilities.<sup>13,14</sup>

Family violence may include physical, sexual, economic and/or emotional/behavioral/psychological abuse or neglect. Victims may experience only one type of abuse or a combination. Frequently, economic abuse occurs with the elderly through financial exploitation, which includes taking the victim's money or Social Security checks, forcing the victim to change his or her will to leave the perpetrator all financial assets, and/or coercing the victim to sign over property or money.<sup>1,12</sup> With economic abuse of intimate partners, the victim may be prevented from getting or keeping a job, kept on an allowance, and

prevented from knowing about or having access to family income.<sup>15</sup> Signs and symptoms of these various types of abuse, as well as documentation and reporting procedures, are described thoroughly in the dental literature.<sup>3,12,13,15-22</sup>

It has been estimated that 65-75 percent of abuse involves trauma to the head, neck, and facial structures.<sup>2,9,19,22,23</sup> Therefore, dental personnel are in a unique position to aid in the recognition, documentation, and reporting of suspicions and/or referral of victims for appropriate assistance. Mandated reporters of child abuse in various state statutes may be listed by the specific profession such as “dentists”; by a general term such as “health care providers”; or by requiring “all persons” to report suspected abuse. Dental hygienists in forty states and the District of Columbia, dentists in every state, and health professionals in all states are required by law to report suspected cases of child abuse or neglect.<sup>19,24</sup> As of 1996, states not specifying “dental hygienists” as mandated reporters of child abuse included Alabama, Arkansas, Georgia, Kansas, Massachusetts, North Dakota, Oregon, South Dakota, Washington, and Wisconsin.<sup>19</sup> Reporting of abuse, however, is infrequent among dental professionals.<sup>11,25,26</sup> Some jurisdictions also require health professionals to report elder abuse or abuse and neglect of disabled persons.<sup>10,12,13</sup> Other than the reporting of child abuse, there are no statistics on the reporting of other types of abuse by dental professionals, but it can be assumed to be at least as low as child abuse reporting. Individuals who have been educated in the recognition, documentation, and reporting of abuse, however, are more likely to report suspicions of abuse.<sup>27,28</sup>

Dental professionals give many reasons for not reporting abuse, including reluctance to become involved, lack of education in recognition, time constraints, fear of litigation, belief that abuse is not a dental problem or that reporting might make the situation worse, lack of knowledge in reporting procedures/policies, fear of offending and losing patients, fear of “opening a Pandora’s box,” or belief that even if the incident is reported, it will not help.<sup>16,26,28-30</sup> In 1994, the American Association of Dental Schools (AADS), now the American Dental Education Association (ADEA), passed a resolution recommending that all dental and dental hygiene curricula include information on child abuse.<sup>31</sup> It is an ethical, legal, and moral responsibility for all dental professionals to become educated about and participate in attempts to stem the epidemic of domestic violence.<sup>2,10,12,13,19,21,24,32,33</sup>

Most dental and dental hygiene curricula include the topic of child abuse and neglect, but it has been unknown if all types of family violence are addressed.<sup>34-36</sup> A 1990 study of pediatric dental programs reported that 96 percent included child abuse in the curricula.<sup>34</sup> A 1995 study of U.S. and Canadian dental schools also reported that 96 percent of predoctoral dental education programs included recognition and reporting of child abuse in the curricula.<sup>34</sup> A more recent study, in 2002, found that 100 percent of U.S. and Canadian dental schools include child abuse in the curricula, while only 87 percent include elder abuse.<sup>35</sup> A 1984 study of dental hygiene programs found that 64 percent of the programs included various aspects of child abuse education in the curricula.<sup>36</sup>

The purpose of this study was to determine the extent to which U.S. dental hygiene programs have incorporated the topics of child abuse, elder abuse, intimate partner abuse, and abuse of disabled persons into their curricula. Data on specific topic areas included in the curricula, teaching methods, faculty, and resources used were also collected. Also examined were the attitudes of respondents toward mandatory continuing education in these topic areas as a requirement for relicensure, reasons for not including family violence topics in the curricula, and support services available in the school for abuse victims.

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## Methods

The investigators developed a survey to obtain information on curriculum content in the area of family violence. Items about attitudes and knowledge of family violence were also included. As a pilot test the survey was sent to eight dental hygiene programs. Modifications were made based on the resulting recommendations. Part I of the survey was designed to obtain demographic information including program setting, length and type of program, and degrees/certificates awarded. Part II contained questions on curriculum that required a forced choice response. In spring 2000, a cover letter and the revised fifteen-item survey were sent to all 229 accredited dental hygiene programs. The cover letters were directed to the program directors, with instructions to complete the survey themselves or forward it to the faculty member responsible for teaching the topic. To maximize the survey response rate, a second cover letter

and survey were sent to nonrespondents. Data were then tabulated, and descriptive statistics, including frequency distributions, were used to analyze the information.

## Results

Surveys were returned from 173 programs for a response rate of 77.5 percent. The response revealed that a majority of programs (N=136, 78.6 percent) include family violence topics in the curriculum. Reasons given for not including it included “lack of time,” “lack of faculty expertise,” “topic not on National Board,” and “topic not within the dental hygienist’s scope of practice” (Figure 1).

Child abuse/neglect was part of the curricula in most programs (N=122, 70.5 percent). Elder abuse (N=95, 54.9 percent), intimate partner abuse (N=81, 46.8 percent), and abuse of disabled persons (N=80, 46.2 percent) were taught by fewer programs. Self-abuse and addiction were included by a small number of programs (N=11, 6.4 percent). Curriculum hours of instruction were dependent on abuse category, with the most hours devoted to child abuse (Figure 2). None of the respondents indicated that

too much time was spent on family violence topics, and about one-third (N=63, 36.4 percent) felt that the time spent was too little. Seventy-nine respondents (45.7 percent) felt that the time currently devoted was “just right.”

Of the programs containing family violence in the curriculum, the most common topics included were recognition of abuse (N=143, 82.7 percent), dental neglect (N=134, 77.5 percent), and legal reporting requirements (N=117, 67.6 percent). A variety of other relevant topics were also included in many of the programs (Figure 3).

Support services were available at sixty-five (37.6 percent) programs to assist patients identified as victims of abuse. The support services included a handout with resources for counseling, shelters and other available assistance for abuse victims at fifty (28.9 percent) of the programs, and restroom information with phone numbers of support services at fifteen (8.7 percent) programs. Other support services (N=32, 18.5 percent) included verbal referrals to community counseling centers, legal clinics, on-campus counseling offices, and bulletin boards with posted information.

Many programs (N=81, 46.8 percent) supported mandatory continuing education on family

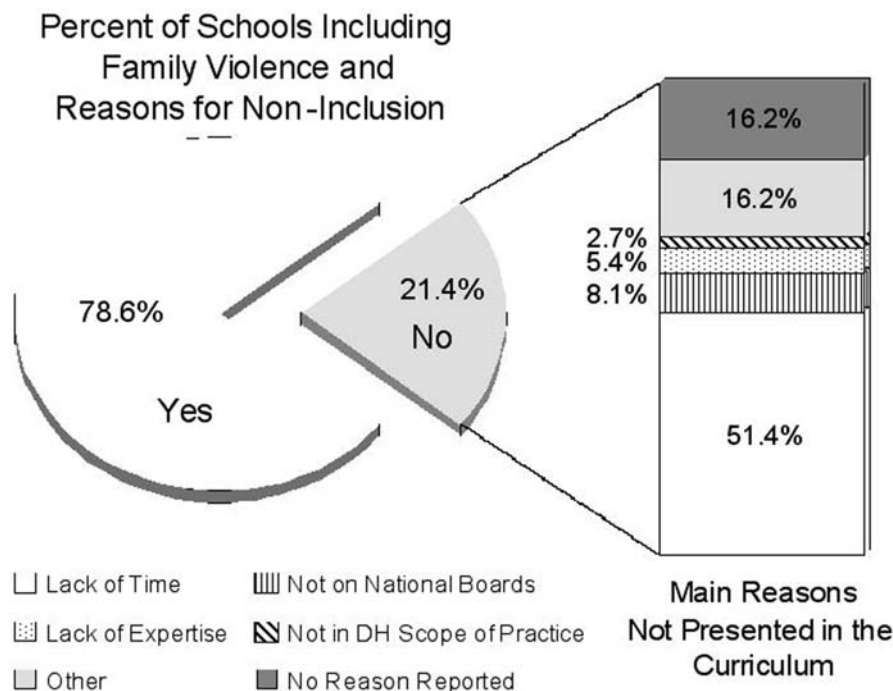


Figure 1. Percent of schools including family violence and reasons for non-inclusion

### Hours of Instruction by Types of Abuse and Category

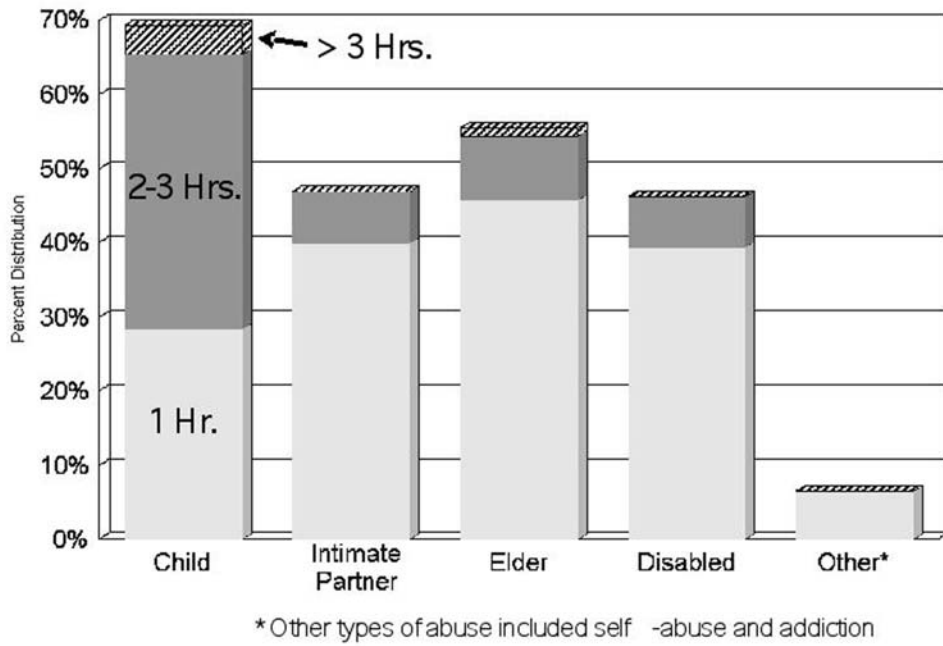


Figure 2. Types of abuse and hours of instruction by category

### Specific Abuse Topics Included

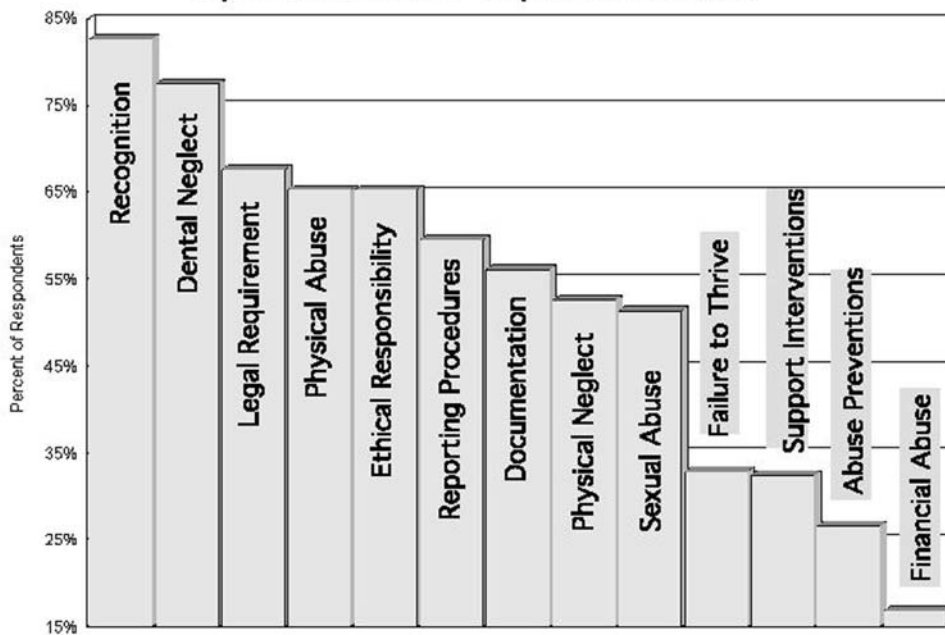


Figure 3. Specific abuse topics included

violence for relicensure of dentists and dental hygienists. Fifty-three respondents (30.6 percent) were opposed to mandatory continuing education, and thirty-seven programs (21.4 percent) were uncertain.

In the programs including family violence in the curriculum, the individual primarily responsible for teaching the topic was a dental hygiene faculty member (N=116, 67.1 percent). Other individuals responsible included abuse specialists from the community (N=13, 7.5 percent), dental faculty (N=8, 4.6 percent), and others (N=4, 2.3 percent). This latter category included P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) Coalition representatives, social work faculty, and dental assisting faculty.

In a majority of the programs (N=131, 75.79 percent), lectures were the primary teaching method, although a combination of methods, including videotape courses (N=4, 2.3 percent), slide-tape courses (N=2, 1.2 percent), and self-study modules (N=1, 0.6 percent) were also used. Faculty used a variety of resources to augment the presentation of family abuse topics, including journal articles (N=61, 35.3 percent), dental hygiene textbooks (N=49, 28.3 percent), videotapes (N=49, 28.3 percent), and the Internet (N=20, 11.6 percent). Other resources included P.A.N.D.A. training materials, state-mandated manuals, and materials provided by the American Dental Association (ADA).

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## Discussion

Over the past several decades, numerous studies have examined the role of dentistry and dental hygiene in recognizing, documenting, and reporting family violence.<sup>1-3,11-13,16-22,26,28</sup> Reporting by dental professionals remains low, but increased knowledge and awareness of the problem result in higher reporting rates among dental professionals.<sup>11,25,26</sup> This study was conducted to determine the extent to which dental hygiene programs have incorporated child abuse, elder abuse, abuse of disabled persons, and intimate partner abuse into the curriculum.

The findings of this study suggest wide variability among dental hygiene programs in their presentation of family violence topics. Although descriptive data are reported, there was much variation in content, hours, and specific topics included in the curriculum. In completing the survey, respondents may have had different interpretations of what subjects constitute family violence. However, the high

response rate provides some level of confidence in interpreting the results.

Child abuse was taught in 71 percent of dental hygiene programs surveyed in 2000. However, this was only a 7 percent increase over the 1984 study, which found 64 percent of programs included child abuse education in the curricula.<sup>36</sup> Although this change is in the right direction, it is important to note that child abuse was taught to dental students in 100 percent of U.S. and Canadian dental schools, and elder abuse was taught in 87 percent of these dental schools.<sup>35</sup>

Although most programs do include family violence topics in the curricula, an unexpected finding was the number of schools not teaching any abuse topics. Since laws in all states require “health care professionals” to report signs of suspected abuse,<sup>10,12,13,19,24</sup> it is difficult to understand why all dental hygiene curricula do not include these topics. It is possible that because some respondents believed the recognition and reporting of abuse were not within the dental hygienist’s scope of practice and/or were not tested on National Boards, it was not included in the curriculum. Lack of knowledge of state laws, designing a curriculum around the National Board, and/or holding the belief that recognition of abuse should be left to social workers, police, or others may also be responsible for this omission.

Insufficient time in the curriculum was another reason given for the failure to include family violence topics. Administrators of dental hygiene programs need to take the initiative to examine the curriculum and eliminate any areas of overlap or repetition that could yield the needed time to address this problem. This topic could also be addressed in a number of different courses without substantially increasing didactic hours. This can be accomplished by requiring students to review the dental literature and research the topic, prepare table clinics, write papers, or make oral presentations in class.

For programs lacking faculty expertise, continuing education courses and volunteer activities at a community shelter may provide sufficient impetus for faculty development in family violence. Performing a literature review of the topic, investigating Internet resources, or discussing this issue with faculty in other programs might raise a faculty member’s knowledge level and awareness of the importance of including family violence topics in the dental hygiene curriculum. Guest speakers from the community are also available and usually eager to speak to students.



Contacts and relationships may be developed through agencies such as child protective services, adult protective services, and P.A.N.D.A.

Many qualities are essential to the development of a caring, empathetic dental hygienist, such as professionalism, ethics, and interpersonal communication skills. Just like family violence issues, these essential qualities are not directly tested on National Board Examinations. However, it is still important to include these areas in the curriculum because these components of professional behavior enable students and practitioners to live up to the behavior outlined in the Code of Ethics of the American Dental Hygienists' Association to "comply with local, state, and federal statutes that promote public health and safety" and to "refer clients to other healthcare providers when their needs are beyond our ability."<sup>33</sup>

It was not surprising to see more curriculum hours devoted to child abuse because considerable emphasis has been placed on this area in the dental literature as well as in the popular media. Reporting of child abuse is also mandatory in all states, which undoubtedly serves as an incentive for including the topic in the curriculum.<sup>1,19,24</sup> In contrast, elder abuse, intimate partner violence, and abuse of disabled persons had fewer curriculum hours. This may be due to lack of knowledge, faculty resources, or available time in the curriculum. It has yet to be determined what the appropriate number of hours should be to provide students with the skills and confidence to report suspected abuse of elderly dental patients. Specific courses in dental hygiene programs as well as continuing education courses in the treatment of geriatric patients could serve as excellent vehicles for the inclusion of elder abuse information.

The most frequently taught abuse topics were recognition of abuse, dental neglect, and legal reporting requirements. Although other topics, such as physical/sexual abuse, ethical responsibilities, and support interventions, were presented in some of the programs, more comprehensive coverage of topics is needed to provide students with the needed skills to recognize, document, and report abuse, to refer patients for needed help, and to communicate with victims in an empathetic, nonjudgmental manner.

Victim support services were available at 38 percent (N=65) of the programs responding to the survey. All programs need to be equipped to manage the situation if the patient discloses to the dental health care provider that suspicious injuries were due to physical abuse. Just as a patient may be referred

to a physician, patients should also be provided with referrals to specialized counseling centers.

Future studies could examine dental hygienists' documentation and reporting practices in relationship to the level of family violence education received in formal programs and/or through continuing education experiences. Other studies could include an analysis of the relationship between curricular content and the presence of support services at the individual programs or the relationship of the states' reporting statutes to the family violence curricular content. Mechanisms to increase the incidence of recognition and reporting could also be studied in an attempt to stem the epidemic of family violence. In addition to determining how many didactic hours or clinical experiences are adequate to prepare competent dental hygiene practitioners, there should be a research focus on the best way to educate students in this area, how to assess student competency, and how to improve consistency among programs.

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## Conclusions

The need is apparent for increased curriculum attention in U.S. dental hygiene programs to prepare dental hygienists to meet future challenges. Barriers for not including family violence in the curriculum need to be overcome if dental hygienists are to become part of the solution to help stem the epidemic of family violence by providing timely and appropriate interventions. Dental hygiene administrators and educators may wish to explore various mechanisms to include child abuse, elder abuse, intimate partner abuse, and abuse of disabled persons in the curriculum. Lastly, an increased focus on family violence continuing education programs for dental hygienists may provide needed education for dental hygienists already in practice.

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