Chapter 28

Child physical violence and the professional duty of the dentist: literature review

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ABSTRACT
The present study aimed to conduct a non-systematic review of the literature on physical violence against creations, addressing the following factors s: indicators of maltreatment and legal aspects, besides elucidating the importance of the dentist in the diagnosis and the ideal conduct to be taken by him. Thus, through the analysis and discussion of the theoretical foundation presented, we seek to establish the current Brazilian panorama on child physical violence. The study is divided into seven topics of exposure: the abstract, the introduction, the objectives, the methodology, the literature review, the discussion, and the conclusion, thus composing the desired content. Is also used for formulation and elaboration, the following researched journals are used: Latin American and Caribbean Literature on Health Sciences (LILACS), Brazilian Dentistry **Bibliography** (BBO), *Scientific Electronic Library Online* (SCIELO), *Medical Literature Analysis and Retrieval System Online* (MEDLINE) and CAPES Portal. Articles from the last 18 years were used, seeking 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 place of multiple lesions resulting from physical violence, making clear the importance of the dentist in identifying and notifying this violence.

Keywords: Abuse, violence, child abuse, 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 practice, against itself, another person, or a group that results in physical, or psychological damage and harms the child's development (WHO, 2002).

Children and adolescents, because they are 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 Complaint Of the Secretariat of Human Rights of the Presidency of the Republic (SDH/PR) recorded more than 76,000 complaints of violations of the rights of children and adolescents, of which 22.2% (32,040) of physical violence. In addition, according to the Statute of the Child and Adolescent, all

citizens must notify suspected cases of mistreatment to the court of minors 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 of the child; 2) sexual violence: the minor is sexually exploited by the parents or responsible l; 3) emotional violence: n to which the child is subjected to frequent threats and rejection; 4) negligence: the parents or guardians 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 impairs the physical, emotional, and intellectual development of children, in addition to achieving their dignity, safety, and well-being (CRESPO, 2011; MALTA et al. 2007), and the reasons for them are multiple and complex. Among the causes of violence, the following factors that contribute to this can be highlighted: low economic income, psychological disorders, divorce from parents, reports of drug abuse, and alcohol consumption. (SOU SA 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 victims of this type of punishment (GARBIN, 2016, p.274; RIBEIRO, 2014).

Epidemiological studies indicate that from 20.2% to 65.3% of injuries resulting from child abuse 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 is because the head and face, besides being more exposed and accessible regions, are extremely representative of humans having a direct influence on self-esteem and psychological health (COELHO, F. J, 2014; SANTOS, et al. 2014).

Thus, due to their area of activity, dentists 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 Art. 245 of the Statute of the Child and Adolescent - Law 8069/90 (BRASIL, 1990; FRANZIN, 2014).

Despite the responsibility of dentists in this important social issue, about 65% of health professionals did not receive information about child abuse during 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 theme, the present study aims to present epidemiological data on physical violence in children l, emphasizing the importance of the role of the dentist in the diagnosis and notification of violence against the child, providing support for the professional to make the diagnosis of suspected physical violence and notify the case to the competent bodies.

2 GOALS

The objective of this study was, through a non-systematic review of the literature, to present the epidemiological situation of child physical violence in Brazil and to draw the attention of the dentist to the problem. Aiming at the importance of the dentist in the diagnosis of child physical violence, the work provides subsidies to carry out the diagnosis of the suspicion of physical violence and for the notification of the case to the competent agencies.

3 METHODOLOGY

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

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

We included the articles indexed in the period from 2000 to 2018 that were related to the theme. And then on-frameworks of the period that did not meet the theme were included. The sample consisted of 27 national articles and 7 international articles. After careful reading, we evaluate the relevant subjects, the relevance of the study, author, year, objectives, methodology, results, and conclusions. In addition to those selected through the databases, 8 scientific articles of important relevance on the subject were manually selected through bibliographic references of articles already included in the sample, totaling 42 scientific articles.

4 LITERATURE REVIEW

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 referring to physical violence, and concealment of abuse by victims and close people, in addition to the difficulties in performing the differential diagnosis with other etiologies and the absence of notification to the competent entities by health professionals, who, although obliged by law, they do not, creating an obstacle to determining the incidence of child and youth abuse (CRESPO et al, 2011)

Due to the underreporting of these crimes, we believe that statistics created from official figures may represent the "tip of the iceberg". It is estimated that only 10% to 30% of all cases are recorded, even

in countries where reporting is an action to which the citizen is sensitized (BAZON, 2008, p.324; FALEIROS, MATIAS, BAZON, 2009; ROLIM, 2014).

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

Table 1. Epidemiology of child violence

Reference	Number of victims	Prevalence of physical abuse	Genus masculino	Female gender	Aggressors' fathers and mothers	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 and 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%
Bathroom, 2014	35	NR	60%	40%	NR	61,5%
Martins and De Mello Jorge, 2009	479	NR	46,6%	53,4%	NR	NR

NR: unreported.

In 2007, Costa et al. collected data from the medical records of victims of child abuse registered in the Tutelary Councils I and II of Feira de Santana, Bahia, from January 1, 2003, to December 31, 2004. During this period, there were 1,293 records of violence, with (78.1%) occurring at home. The most frequent violence was negligence (56.22%), physical violence (35.18%), beating (30.31%), in the ranges of 2 to 13 years; psychological violence (28.92%) and sexual violence (5.25%), especially among adolescents. Most complaints were made anonymously (30.8%); the aggressors for negligence were the parents; for physical violence, the stepmother and "other aggressors"; for sexual violence, the stepfather, "other family members/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, we used the records of the Violence and Accident Surveillance System (VIVA) and studied 4,085 notifications in children under 15 years of age. The gender most affected by violence was female, totaling (61.4%). The most frequent age group among girls was 10 to 14 years (38.8%) and among younger boys, it was that of children under 5 years (35.8%). Physical violence accounted for (43.3%) of the cases in boys and (28.2%) in girls. The main perpetrators of the aggressions were parents (43.8%) and acquaintances (29.4%). Most of the aggressors were male (72%). The residence was the place of occurrence in (72.9%) of the cases. Children and adolescents classified or referred to as white accounted for 60.2% of all victims, while non-white children 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 recorded between 1997 and 1999. The sampling process was based on a statistical draw (Epi-Info, v. 1.01, 2000) carried out through a sample record of occurrences per month. Seventy-five records were selected monthly for the analysis that corresponded to the prerequisites. Sociodemographic and physical data of victims, aggressors, and whistleblowers were evaluated in these records. Physical abuse (64.7%) was the most frequent. Body 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 from 11 to 15 years was the most affected, with 45.1% of the total cases, followed by adolescents aged 16 to 18 years (29.3%). There was intense male participation among the aggressors (71.8%). Complaints were made in most cases by the victim's parents (72.9%). No complaints were made by health professionals, reflecting a greater need for their commitment to the problem (CARVALHO et al, 2009).

The cross-sectional and descriptive study coordinated by Martins and De Mello Jorge (2009) on physical violence against children under 15 years of age, which occurred in 2006, analyzed the notifications registered in the Tutelary Councils of Londrina-PR and services for children and adolescents victimized in the municipality (Sentinel Program of the City Hall of Londrina and Extension Project Of Eye In the Future). 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 corrosive substance). In the first, female victims prevailed (53.4%), with higher risk at the age of six years (coefficient of violence 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. Instrument violence was practiced through brace (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%) the only abusers with alcoholism present in 57.1% of these situations. The victim of violence by the sharp object was a male, 13 years old and the aggressor, unknown, was 15 to 19 years old. Violence by corrosive substance was victimized by a 13-year-old male adolescent, whose aggressor was the father, and alcoholism was the present situation.

In the years 2006 and 2007, a survey of emergency care of injuries caused by child violence (0 to 10 years of age) was conducted through the Violence and Accident Surveillance System (VIVA) of the Ministry of Health, for 30 consecutive days in the Federal District and in 34 Brazilian cities. Of the 518 children who attended, male victims (60.6%), aged 5 to 9 years (52.1%), and blacks (71.2%) prevailed. The aggressions occurred in the victim's home (55%), with cut/puncture injury (34.2%) and evolution to high (68.7%). The most common violence was physical aggression (67.4%), involving beating, sharp objects, and firearms. Most of the abusers were male (48.1%) and the victim's relatives were involved in 46.8% of the cases. (MASCARENHAS, et al. 2010).

In 2011, Rocha and Moraes conducted research to characterize Family Violence against Children registered with the Family Medical 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 cases and physical violence occurred in 93.8% of respondents. The aggressions were subdivided into 3 groups: body joint (93.8%) (spanking; hitting the "butt" with objects; hitting the hands, legs, or arms; pinching; shaking; slapping the face, head or ears); minor physical abuse (51.4%) (hitting other parts of the body with objects; punching or kicking; throwing it to the ground) and serious physical abuse (19.8%) (grabbing by the neck; beating; burning; threatening with a knife or gun). Those considered "minor" and "severe" were practiced in 51.4% and 19.8% of 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, given the high prevalence of family involvement in child abuse, this problem should be prioritized in the Family Health Strategy.

From July 2008 to May 31, 2012, 2,225 cases of child abuse against children aged 0 to 12 years were recorded in the Notifiable Diseases Information System (SINAN) of the state of Bahia. Physical violence was the most frequent type, totaling 1,131 (50.83%) occurrences, accompanied by psychological violence (50.57%), sexual violence (43.41%), neglect/abandonment (7.16%), and torture (5.66%). The most affected body parts were the 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 Network for the Protection of Children and Adolescents at Risk for Violence, in the municipality of Curitiba-PR, between 2004 and 2009. Abuse and neglect occur in 88.4% (17,082) of cases. The prevalence of types of abuse was calculated over the total and distributed sample (absolute value; %) in decreasing order: negligence (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 of age, reaching the female and male genders, similarly. Physical sequelae (20.2%) mainly affected the head and upper and lower limbs.

The Child and Adolescent Protection Network of Curitiba-PR-Br recorded 10,483 cases of child abuse in 2010 and 2011. From these records, Valente et al. (2015) selected reports of physical injuries that occurred in the family environment, from the Epidemiology Center of the city of Curitiba. Children and adolescents were 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% were female, and 58% had lesions in the head and neck region. There were 342 notifications in 2011, 49% were male and 51% female, and head and neck injuries corresponded to 65% of the reported cases. The prevalence of injuries 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 living 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 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 records there was the possibility of assessing the degree of kinship of the aggressor with 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. Regarding the means of aggression, 50.3% (1,212) used body strength 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 Surveillance System of Violence and Accidents (VIVA) of the Municipal Health Department, in the period from 2006 to 2008. This database is fed from the Notification Forms of Domestic, Sexual, and/or other Violence, arising from the records of violence against children, carried out in the various health, education, and justice services, non-governmental organizations, and the community of the municipality. There was an increase of 75.89% (112 to 197) during the period evaluated, with 498 cases of violence against children aged 0 to 9 years, 79.3% of the notifications came from the health area, most of the children were female (56.4%) and were between two and five years old (more than 60%); male aggressors prevailed (53.6%), and in 43.4% of the cases, violence was perpetrated by parents or family members, especially the father figure (22.7%). Physical sections were the most frequent (59.2%) and the place of greatest occurrence was the family home (75.5%).

The only international study found was that of Banheiro, in 2014, carried out at the University of Lisbon in Portugal. Through meta-analysis, he evaluated articles that reported 35 clinical cases of children who were victims of abuse, and who had head and neck injuries. They were between nine days and thirteen years (27.19 months, on average), 14 females (40%), and 21 males (60%). In decreasing percentage order, l and facial (85.7%) intraoral (25.7%) in the head (17.1%), and neck (8.6%)) were observed. Of the 9 cases in which intraoral lesions were present, labial contusions (11.1%), laceration of the gums (11.1%) or alveolar mucosa (11.1%), avulsion (11.1%) or dental intrusion (11.1%) were observed, excoriation of the hard palate (22.2%), laceration of the brake (11.1%), excoriation (11.1%), perforation (11.1%) and laceration (11.1%) of the pharynx, laceration of the soft palate (44.4%) and the sublingual region (11.1%), oral hemorrhage (11.1%), and traumatic absence of teeth (11.1%). The evaluation showed the percentage of all lesions: absence of Dentaria due to traumatism (2.9%), dental avulsions (2.9%), teeth intrusions (2.9%), petechiae (2.9%), bruises (8.6%), contusions (4 0%), 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%), hypnosis (5.7%), hyphema (5.7%), oral hemorrhages (8.6%), nosebleeds (8.6%) and, finally, bloody ostomy (11.4%). It was concluded that the head and neck region is the focus of several injuries resulting from ill-treatment.

LEGAL ASPECTS

Historically, the fight against child abuse is recent. The centenary absence of this issue in political legislation and 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, the first Code of Menores of Brazil was established, 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 first addressed in 1934, criminalizing child exploitation, ill-treatment of children and adolescents, and work for children under the age of 14. Subsequent Constitutions were solidifying and expanded laws that protected and protected children and families in situations of social vulnerability (BRASIL, 1934).

Later, in 1979, the new Code of Minors was promulgated, which offered protection and surveillance for undocumented minors under the age of 18. The "unfit" minors were needy children, offenders, in eventual abandonment, with misconduct, and victims of some violence. Those who fell within these categories were deprived of their parents or guardians and the State started to them (BRASIL, 1979).

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

In this context, based on constitutional principles and norms and 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) was drawn up, Law No. 8069 of July 13, 1990, which entered 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 Code of Minors (1979), it broke with the doctrine of the irregular situation of minors and adopted the foundation of integral protection of childhood and adolescence. Thus, according to Article 277 of the Constitution, all children, and adolescents, regardless of social or economic condition, must have secured 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, that is, all citizens, who must notify the Guardianship Council of any suspected case of ill-treatment.

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 must be taken for the health and dignity of the patient (ALMEIDA, et al. 2012). It is also noticeable that non-notification is considered an administrative infraction for teachers and health professionals, constituting the penalty in a fine of three to twenty reference salaries, applying twice as much in case of recidivism (BRASIL, 1990).

According to the Federal Council of Dentistry, the case should be obligingly notified to the Guardianship Council. It is not necessary to present evidence and secrecy is guaranteed. You can use the National Complaint Dial (Dial 100) as well as the Police Authority and/or public prosecutor. Surgeries not to interfere personally (CFO).

INDICATORS OF MISTREATMENT

The diagnosis of child physical violence is complex and should never be based on only 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 starting point of identification or suspicion of child abuse. Thus, it is up to the dentist to analyze the behavior of the child from the moment she enters the office, the way she interacts with her parents and the dental team, and, not least, her 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, poor school performance, difficulties in social interaction, anxiety disorder, depression, and sleep disorders are characteristic of victims of physical violence.

Thus, because of the suspected mistreatment, the fight between the surgeon and the surgeon recorded in the medical records (together with the rigorous anamnesis covering the whole historical, social, and biological context of the child) all the observed signs that serve as behavioral indicators of the victimized child, in addition to of those physicists. Of fundamental importance is the ana lisand if the story told by the child and those responsible justify the injuries and, if necessary, question them separately; discrepancies or stories that change a lot of versions, and those incompatible with the injuries observed are important indications of ill-treatment. (VELOSO, et al. 2018).

Concerning the clinical examination, not only the face and intraoral region (area of operation of the dentist) must be inspected, but also the hands, arms, ears, neck, and even the hairy choir. In addition, to be repeated for the fact that lesions originating from mistreatment can present in multiple ways according to the etiology of trauma (bruises, bruises, and lacerations) (LOUREIRO, 2013).

Another aspect to be highlighted is the differentiation between accidental and provoked injuries, grand situations challenge the dentist due to the similarity between them. For this reason, according to Trindade (2013), the dentist should be aware of the specificities surrounding the injuries caused, having as parameters the following physical indicators of injuries caused by violence: Injuries in regions uncommon in accidental trauma stored age; wounds in different stages of healing; lEsons not compatible with their age; the repetitive chain of alleged accidents and time elapsed between the accident and the search for medical care.

Also, according to CRESPO et al. (2011), injuries from physical violence can occur in several locations, but the orofacial region has great relevance in these cases since they correspond to 50% of the occurrences. Table 2 compiles and describes the most recurrent extraoral lesions, 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), oral injuries occur in a significant number of children who suffer physical violence being described in chart 3 the most recurrent ones.

Table 2. Extraoral manifestations of more recurrent physical violence

MORE RECURRENT EXTRA-ORAL **MANIFESTATIONS**	
Burns	Are circular and uniform, suggestive of a cigarette butt ; in the form of liquid spilled over the child's body, or caused by direct flame (lighter). Burns are lesions that are easy to identify and are classified according to their depth.
Alopecia or hemorrhage in the hairy choir	They run it when you get your hair. Thebservar of the hairy choir during the care, souring affection in the child looking for signs of the existence of lesions.
Bruises	They usually occur in the soft parts of the body. The face presents greater recurrence in the eyes, mentioning region and mandible. They have a linear circumferential pattern and indicate slaps, blowouts, punches, or injuries resulting from the use of objects such as belts.
Subdural or retinal hemorrhage	Injuries resulting 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 in children older than five years.
Bruises and bruises	When diagnosing these lesions, the dentist should be aware of the history of the injury, its number, location, and healing period. Bruising and accidental bruising usually affect the frontal face of the body and bony eminences.

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

Table 3. Intraoral manifestations of more recurrent physical violence

MORE RECURRENT INTRAORAL MANIFESTATIONS
Lacerations on the lingual brake or lip brake caused by forced feeding
Burns of the lips and intraoral mucosa due to hot food or utensils
Scratches and bruises in the labial commissure region indicate gag use
Bruising or lacerations to the lip, indicative of slaps and punches
Fractured, vested, or with mobility without plausible justification to clarify the lesions
Recurrent bone fractures

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

CONDUCT OF THE DENTIST

Faced with the suspicion of mistreatment, the dentist has to notify the Guardianship Council of the municipality of the child's housing, or the Court of Minors. 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 properly recorded, including the history told by the child and guardians, a description of the behavior of those involved (child and guardians), a detailed

description of the lesion (size, location, staining, healing stage), photographs of the lesions, radiological examination (if necessary) and conduct adopted by the dentist (MENOLI et al. 2009).

5 DISCUSSION

This literature review is undoubtedly important because epidemiological data show that, among the violence against children, physical abuse is the most recurrent. It is common knowledge that physical violence (characterized as a violent and intentional action to hurt, causing pain and suffering to the child, and may or may not leave evident marks on his body) (GAWRYSZEWSKI et al, 2009) impairs the development and behavior of the child, often causing psychological and physical disorders that will accompany him/her in his/her life.

Inbora is the most notified 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 a 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; Bathroom et al. , 2014), most studies report that child physical violence is carried out and, in most cases, within the victim's home, being reported 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, with the usual convivence between victims and aggressors, many real cases can be considered in the statistics This fact contributes in a worrying way to the numerical under dimensioned of this crime, which must be urgently analyzed, addressed, and disseminated 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). This alarming data also contributes to the determination of a series of vulnerability indicators, in addition to physical and psychological damage and child development (Martins and 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: despite the violence and child exploitation being addressed in 1927, only after the sanction of Law No. 8069 of July 13, 1990, which originated the ECA (1989), was the right of the child to be protected and protected, individuals in situations of social vulnerability.

Although much has been heard about child violence in the media, the existence of the omission and passivity of society around it is undeniable. This is due to the lack of knowledge of the mechanisms of notification by the population in general, the fear of the child in denouncing 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).

And the studies found do not mention data on the involvement of dentists in complaints and physical violence, even with the significant amount of injuries in the 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, despite the professional duty to ensure the health and dignity of the patient, also in cases of child violence (article 9 of the Code of Dental Ethics) and mandatory for it to expose and denounce such child crime, even in the face of uncertainty about it (VELOSO et al. 2018).

It is also difficult to determine the exact reason for the problem mentioned above, but for sure, it may be motivated by the absence or insufficient preparation of the dentist for the address of such situations. As a result, this work is important to insert this theme within the dental teaching of Brazilian universities, discussing the social and technical responsibility of the professional and must identify and denounce physical violence against children immediately to ensure their well-being and good development of it. At the same time, and still, according to the content presented, a scarcity of a certain attitude is assumed, and much of this is due to the little attention provided to the study of such a field of defense and guarantee of the child's right (CAVALCANTI, 2009; GONDIM et al., 2011).

Still from that point of view, the growth of the dentist can identify several head, neck, and intraoral lesions, there may be no knowledge about the parameters related to the identification of the lesions that arouse suspicion of physical violence, which should be extensively explored both in educational institutions and in the public health system. The following aspects include 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 alleged accidents, accidental trauma uncommon for injuries age, incompatibility between the lesion presented and the story told, as well as the disagreement between the report of the child and guardians, among other means (TRINDADE, 2013).

Finally, it is affirmed that it is necessary to give due attention to the identification and documentation of injuries related to physical violence, b, and m as to the indicators that the child presents, both through descriptive documents and photos and radiological examinations, thus ensuring the correct conduct of the professional compliance with the duty of the dentist (MENOLI et al., 2009).

6 CONCLUSION

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

The dentist presents himself in a favorable position to detect child violence since often injuries from ill-treatment affect the head and neck region. Despite the ethical duty and the remarkable importance of the dentist in this problem, the absence of the theme in the curriculum of the undergraduate course generates great unpreparedness in the class in the face of child violence.

Thus, the need for debate and violence in the academic environment is reinforced and to alert the professional about the responsibility of seeking sufficient knowledge so that, when exposed to such situations, he can act appropriately, fulfilling his ethical function, notifying the case to the Guardianship Council.

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