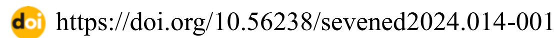
Oral rehabilitation in victims of domestic violence and its relationship with self-esteem and quality of life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Fernanda Paiva Fiedler[1], Bárbara Lídia da Silva Pereira[2], Simone Soares Pedrosa[3], Lurdete Maria Rocha Gauch[4], Davi Lavareda Corrêa[5], Liliane Silva do Nascimento[6], João Pedro Costa Pedrosa[7], Hercules Bezerra Dias[8], Isabelle Rocha Gauch[9], Vania Castro Corrêa[10], Suelen Castro Lavareda Corrêa[11] and Sue Ann Lavareda Corrêa Uchôa[12]

ABSTRACT

Domestic violence is a complex problem that affects people of all ages, races, creeds and social classes, generating several complications for women. Many of the traumas resulting from violence are orofacial, causing physical and functional changes, as well as aesthetic impacts that can aggravate chronic problems, such as depression. This significantly affects the quality of life and social interaction of victims, as psychological complications negatively influence the perception of oral health. This study aims to report the humanized oral rehabilitation of a patient who is a victim of domestic violence, correlate rehabilitation treatment with self-esteem and quality of life, and encourage the interruption of domestic violence. The treatment was carried out at the Integrated Clinic III and IV of the School of Dentistry of the Federal University of Pará (UFPA), following a plan that involved several areas of Dentistry and with the patient's consent. The patient received guidance on oral hygiene and underwent procedures such as scaling, prophylaxis, extractions, endodontic treatments, composite resin restorations, intraradicular retainers, total acrylic resin crowns, and temporary upper partial dentures (PRP). It was concluded that oral rehabilitation significantly increased the patient's self-esteem and quality of life, encouraging her to complete the treatment with crowns and definitive PRPs, in addition to contributing to the interruption of cycles of domestic violence.

Keywords: Oral Rehabilitation, Domestic Violence, Self-Image, Oral Hygiene.

[1] Origin: UFPA
E-mail: fiedlerfernanda1@hotmail.com
[2] Origin: UFPA
E-mail: barbarapereira.cdentista@gmail.com
[3] Origin: Profª. Associate III of FO-UFPA
E-mail: sspedrosa@ufpa.br
[4] Origin: Profª. Associate III of FO-UFPA
E-mail: lrgauch@ufpa.br
[5] Origin: Profª. Adjunct of FO-UFPA
E-mail: davilavareda2@yahoo.com.br
[6] Origin: Associate IV UFPA Full Professor at FO-UFPA
E-mail: dralilianesn@hotmail.com
[7] Origin: Undergraduate student of Dentistry at UFMA
E-mail: joao.pedrosa@discente.ufma.br
[8] Origin: Adjunct Professor of FO-UPFA
E-mail: herculesdias@ufpa.br
[9] General Surgery Resident
E-mail: isabellegauch.uepa@gmail.com
[10] Origin: Profª. Associate III of FO-UFPA
E-mail: vania@ufpa.br
[11] Origin: Brazilian Air Force
E-mail: suelenlavaredam@gmail.com
[12] Origin: São Leopoldo Mandic Research Center
E-mail: sueann.lavareda@yahoo.com.br

INTRODUCTION

According to the WHO (World Health Organization), violence against women is considered a public health problem, as the victims have several physical and psychological disorders, which can directly interfere with their health[1]. According to the Ministry of Women, Family and Human Rights, in 2021, 198,644 complaints of violence against women were registered on the platforms offered by the government[2]. Until May 2022, about 59.51% of the complaints on the platforms had women as victims, and the North region of the country has a large number of complaints. The silence of victims is a dominant factor in the perpetuation of violence[2]. A survey by the WHO, in partnership with the London School of Hygiene and Tropical Medicine and the Medical Research Council, carried out in 80 countries, revealed that 30% of women reported having suffered some form of physical and/or sexual violence by their partner[1].

According to Law 11.340, of August 7, 2006, known as the "Maria da Penha Law", domestic and family violence includes any action or omission based on gender that causes death, injury, physical, sexual or psychological suffering, as well as moral and property damage[3]. It is known that many injuries resulting from violence have a great aesthetic impact, which can intensify chronic problems such as depression, significantly interfering with quality of life and social interaction, according to Article 7, item II[3]. This article defines psychological violence as any conduct that causes emotional damage, diminishes self-esteem, or that harms and disturbs the full development of the victim[3].

This type of violence brings several losses, including high economic costs for the country, whether through medical expenses, impediment to productive work or effects on mental health, becoming a priority in human rights[4]. Although the term "domestic violence" includes people who live in the family environment without necessarily having blood ties, in 70% of cases, the perpetrator is the victim's intimate partner7. Thus, domestic violence is understood as a power relationship between a man and a woman, where the masculine determines the role of the feminine, evidencing gender inequality[6].

There is also a naturalization on the part of some women, who do not recognize violent actions as a violation of their human rights, freedom, right of expression and physical and mental well-being[7]. Aggression causes suffering that goes beyond physical marks, leaving intangible marks[8]. This issue is so critical that, according to the United Nations (UN), 40% of Brazilian women have suffered domestic violence at some point in their lives[9]. Brazil ranks 5th in the ranking of femicide among 83 countries, with a woman being killed every 2 hours in the national territory[9]. Despite fear and constant intimidation, some women are able to abandon their aggressive partner, especially when the aggression intensifies.

About 42% of women who suffered violence reported that physical injuries are the main consequence, often involving the face, such as the lips, the area around the eyes, and teeth[1]. Thus, the dentist plays a crucial role in identifying and reporting violence to the competent bodies, in addition to offering treatment, as health professionals are usually the first to contact the victim[11]. Emotional damage directly affects the victims' self-esteem, with devastating repercussions on their quality of life[12]. In dentistry, the dental surgeon can work in a multidisciplinary team, restoring not only aesthetics, but also function and well-being through oral rehabilitation[13].

Despite this, there are few cases in the literature that demonstrate the role of dentists in the rehabilitation of victimized patients, indicating a still limited role of dentistry in the reintegration of these women into society[14]. Thus, the objective of this study is to describe the rehabilitative dental treatment, with humanized care, adopted for a patient who is a victim of domestic violence, to correlate the results obtained with her self-esteem and quality of life using the Phrase Completion Scale[1]7, in addition to encouraging the interruption of domestic violence.

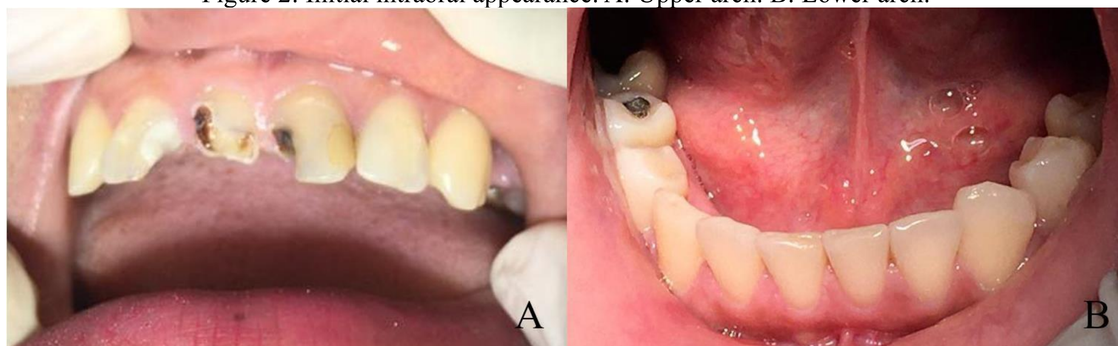
CASE REPORT

Patient L.L.S., a 31-year-old female pheoderma, sought the Faculty of Dentistry of the Federal University of Pará (UFPA), complaining of dissatisfaction with the aesthetics of the anterior teeth, motivated by an "affective misunderstanding" and pain in some elements, which would be repressing her smile and directly interfering with her self-esteem, thus preventing her social life. He had been a smoker for about 10 years and had no history of systemic diseases. Extraoral examination revealed that the vertical occlusion dimension (OLD) was reduced, but the lip support, grooves and commissures were satisfactory (Figure 1A-B).

Figure 1: Initial extraoral appearance. A: Frontal. B: Right Side

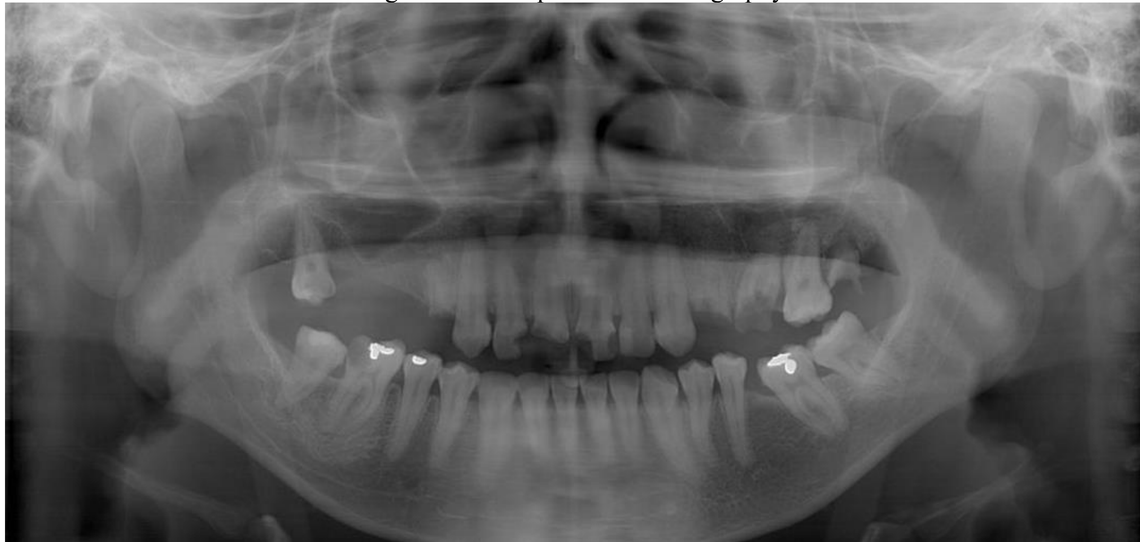
Intraoral clinical examination revealed fractures and caries in teeth 12, 11 and 21; cavities in teeth 23, 17, 38 and 46; extensive restoration in 22 reaching the pulp chamber; residual roots of teeth 14, 26 and 28 and absence of teeth 15, 16, 17, 24, 25, 36 and 48 (Figure 2A-B).

Figure 2: Initial intraoral appearance. A: Upper arch. B: Lower arch.



Periapical and panoramic radiographs showed pulp necrosis of teeth 12, 11, 21, 17 and 46, which was confirmed by negative sensitivity tests (Figure 3).

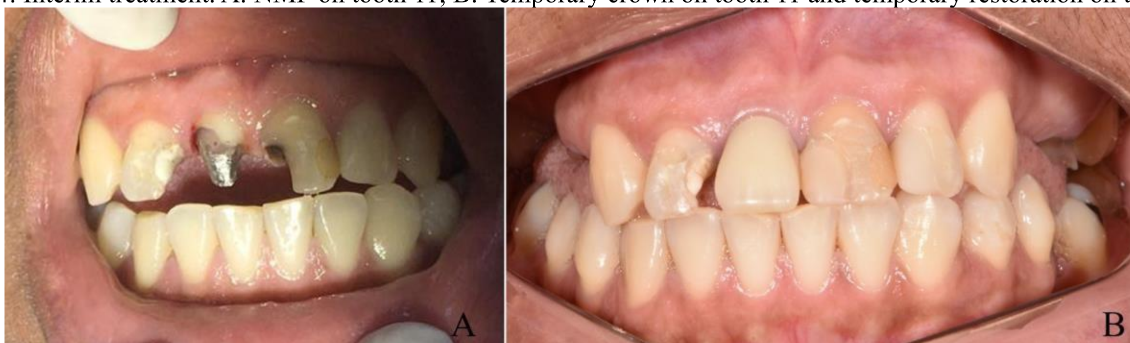
Figure 3: Initial panoramic radiography.



Before the beginning and at the end of the treatment, a questionnaire was applied to the patient, based on the Phrase Completion Scale, which is a standard scale of 11 points (from 0 to 10), which facilitates interpretation, because people are more familiar with this reference, so the objective of the questionnaire was to relate dental treatment with self-esteem and quality of life at the beginning and end of treatment.

The treatment plan was discussed with the specialties of periodontics, surgery, endodontics, dentistry and prosthodontics. The treatment began with periodontal probing, scaling, straightening and corono-root polishing. Then, the cleaning and temporary sealing of the open cavities of teeth 17, 38 and 46 was initiated to reduce contamination in subsequent surgeries to extract the residual roots of teeth 14, 26 and 28. Initially, the endodontic treatment of tooth 11 was performed, due to a painful complaint by the patient, and after the treatment, a fused metal core (MFN) and a temporary crown were made (Figure 4A), in addition to the temporary restoration of tooth 21 (Figure 4B), due to social necessity; Subsequently, endodontic treatments were performed on teeth 12, 21, 22, 17 and 46.

Figure 4: Interim treatment. A: NMF on tooth 11; B: Temporary crown on tooth 11 and temporary restoration on tooth 21.



Study models of the two arches (Figure 5A-B) were made and mounted on the semi-adjustable articulator (ASA) through a facial arch register for the upper model and an interocclusal

register in a centric relationship with Lucia's Jig and a wax slide No. 9 for the lower model (Figure 6).

Figure 5: Study models. A: Upper arch. B: Lower arch

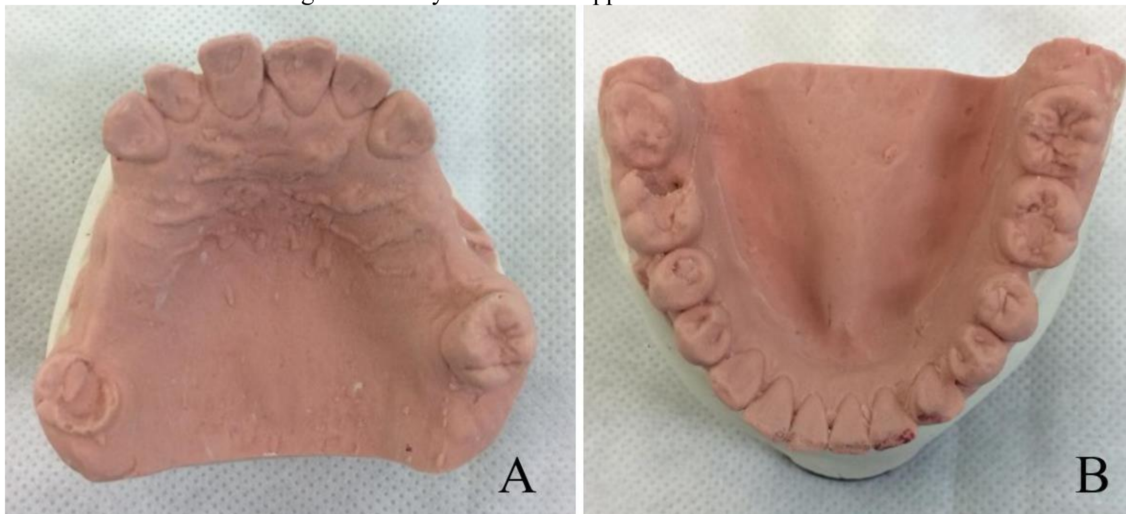
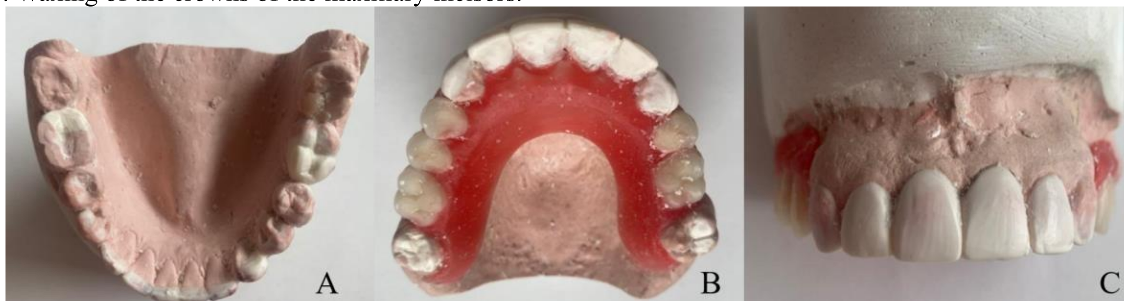


Figure 6: Models mounted on the ASA.

The ASA was sent to the laboratory for wear of the extruded teeth (35 and 46), diagnostic wax-up (teeth 17, 12, 11, 21, 22, 27, 38, 37, 33, 32, 31, 41, 42, 43, 44, 46 and 47) and assembly of artificial teeth in the areas of dental absences (14, 15, 16, 24, 25 and 26) for correction of the occlusion plane and preparation of upper provisional PRP (Figures 7: A, B and C).

Figure 7: Models delivered from laboratory A: Diagnostic wax-up of the lower elements. B: Upper PPR test base and teeth. C: Waxing of the crowns of the maxillary incisors.



Individual trays (acetate) were made for home whitening in a vacuum laminator and the patient used 22% carbamide peroxide gel (Whiteness Perfect, FGM), 1 hour a day for 14 days to whiten her teeth, as well as an office session was also performed, about 1 month and a half later, in order to whiten only the upper canines. using 37.5% hydrogen peroxide gel (Pola Office Plus, SDI).

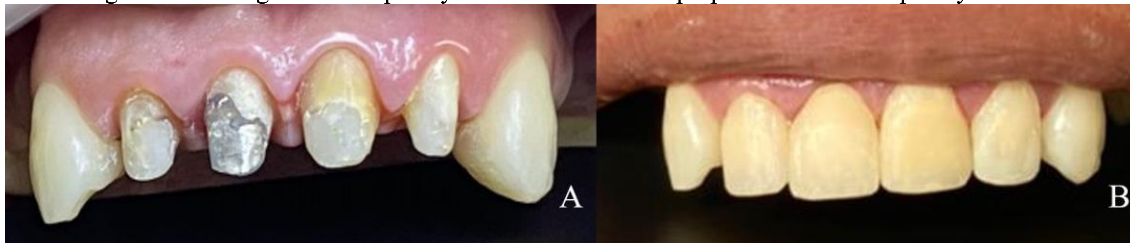
In the first consultations, it was observed that the patient had a very withdrawn profile, extremely silent and easily moved. During each procedure, we can analyze more clearly the patient's behaviors and short excerpts from the patient's reports about her oral condition. During the treatment, she confirmed to us the violence she had suffered under great emotion and anguish, which had made her negligent with her oral health.

The conduits of teeth 12, 21 and 22 were de-obtured under absolute isolation, using glove-gate drills in sequence 2 and 3, leaving 5 mm of obturator material in each conduit; The fiberglass pin test and periapical X-ray were performed to prove the adaptation (21 and 22, nº 0.5 and 12, nº 1; White post DC, FGM); the teeth were conditioned with 37% phosphoric acid (Condaaf, AAF do Brasil) for 15 seconds in the conduit and 30 seconds in the tooth remnant, washed for 1 minute, dried with air jets and an absorbent paper cone inside the conduits, and then the adhesive (Ambar-FGM®) was applied to the teeth and polymerized for 30 seconds after the removal of the excesses. The pins were cleaned with 70% alcohol, silanized (PROSIL, FGM) and cemented with dual resin cement (Allcem® TR, FGM); The cement was applied to the conduits and pins and polymerized for 40 seconds. After 10 minutes, the pins were cut and the teeth were provisionally restored with composite resin (Z250, color A2, 3M/ESPE).

Thus, with the purpose of occlusion stabilization, composite resin reanatomizations (Z250, A2, 3M/ESPE) were performed on teeth 13, 27, 23, 38, 37, 35, 34, 33, 32, 31, and 41 (buccal, incisal/occlusal and lingual/palatal surfaces), using the wall technique made with condensation silicone (Reflex Denso, Yller) on the waxed diagnostic model. Teeth 46 and 17 received direct restoration in fluid composite resin for the base (Master flow, Biodynamics) and then were reanatomized in composite resin (Z250, A2, 3M/ESPE) following the predetermined occlusion plane.

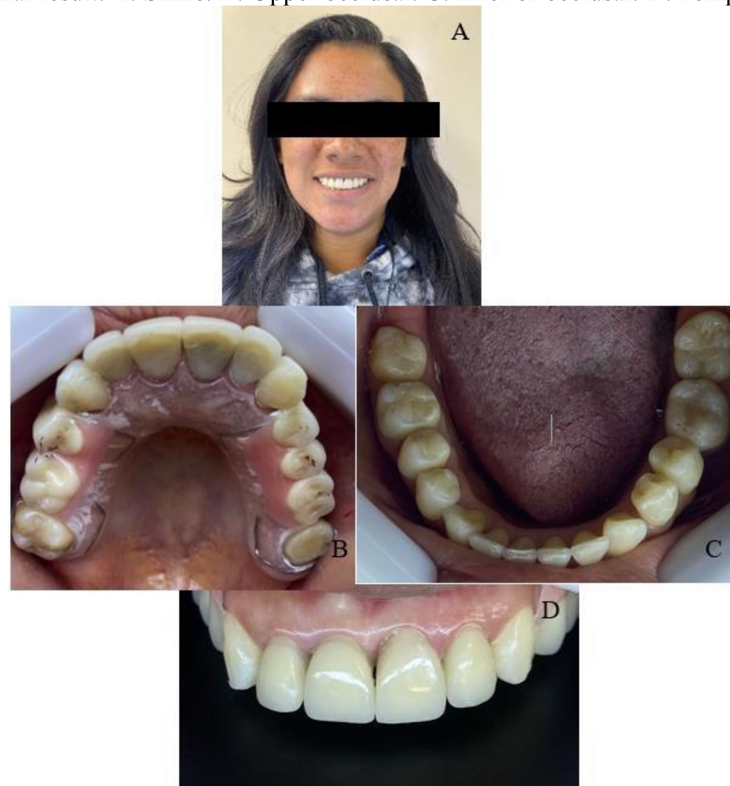
Teeth 12, 11, 21 and 22 were prepared for full crown (drill 3216, 3118, 3216 F and 3118 F) and provisional crowns made using the veneer technique (Biolux teeth, color 60, V 68) in different sessions (Figure 8, A and B).

Figure 8: Making of the temporary crowns. A: Beveled preparations. B: Temporary crowns.



New models were made, mounted on the ASA (facial arch and registration at the usual maximum intercuspation with a No. 9 wax blade) and sent to the prosthesis laboratory to obtain new temporary crowns that would provide greater mechanical resistance and better aesthetic results, in addition to the upper provisional PRP (Biolux teeth, color 60, P6) to complete the occlusion stabilization. The upper arch was molded with two-stroke condensation silicone (Perfil, Coltene) after gingival clearance of teeth 12, 11, 21 and 22 with retractor wire (Ultrapak nº 000, Ultradent) and hemostatic solution (Hemoliq, Maquira) and the lower arch with alginate (Jeltrate Dustless, Dentsply). The temporary crowns were internally sandblasted with 50 micrometer aluminum oxide and silanized (Prosil, FGM); the teeth were conditioned with 37% phosphoric acid, the adhesive (Ambar APS, FGM) was applied and polymerized, and the crowns were cemented with dual resin cement (Ambar TR, FGM). The provisional upper PRP was adjusted and installed (Figure 9: A, B, C, and D).

Figure 9: Final result. A: Smile. B: Upper occlusal. C: Inferior occlusal. D: Temporary crowns



DISCUSSION

Domestic violence is a complex problem that affects people of different ages, races, creeds and social classes, generating a series of complications for women, both physical and psychological[1,16]. Most injuries caused by violence occur on the face, resulting in orofacial traumas that have a significant aesthetic impact on women's lives, and can trigger chronic diseases such as depression[10,11]. These complications significantly interfere with the quality of life and social interaction of the victims, reducing their self-esteem and affecting the perception of their oral health, as reported by the patient in this study[11,12].

The fragility of victims leads to a greater demand for health professionals, whether for psychological, physical or rehabilitative treatments[4,13]. Women who seek primary health care often show signs of violence, such as anxiety, shame, introverted behavior, or bodily injuries[4],[17], and may be more sensitive during procedures in the affected area, which may refer them to the aggressions suffered, as observed in the patient in this study.

In recent years, awareness of domestic violence has grown significantly, showing the impacts of this violence on interpersonal relationships and quality of life of victimized women[1,2]. These women often become invisible in society, either by hiding events from the authorities or by seclusion due to social embarrassment and low self-esteem4,6,12. Therefore, it is crucial to include this theme in the curricula of undergraduate courses, helping dentists to develop a critical awareness that facilitates the identification of violence as members of society13,17.

The training of dentists is essential for them to act as mediating and reliable agents, facilitating the reporting of cases and allowing adequate treatment and proper guidance to deal with violence5,11. Most of the articles that relate violence to self-esteem and were used in this study are from the years 2018 to 202010-12,14,17,19,21, evidencing the need to discuss this topic, which has gained visibility. However, there are still few studies of case reports that demonstrate the clinical protocols adopted in dental fractures and the post-rehabilitation results, clarifying the victim's conditioning in the dental office and their expectations in the face of the new social reality7,10.

The chosen treatment was based on the patient's socioeconomic condition, prioritizing function and, consequently, aesthetics, raising her self-esteem as assessed by the questionnaire based on the Phrase Completion Scale[1]7. An improvement in the patient's social behavior was observed throughout the treatment, becoming less introverted and more sociable[4,10,12], rediscovering her value and raising her self-esteem and quality of life, as shown in the questionnaire.

Rehabilitative treatment with anterior total crowns is indicated in cases of extensive fractures that impair aesthetics[18]. The main limitation found was the financial issue, which prevented the advancement beyond the temporary prostheses, but did not compromise the quality of the treatment.

The face of violence goes beyond what dentistry can change[11,16]. Therefore, it is essential to observe the clinical signs in addition to other factors that may indicate cases of violence, emphasizing the importance of humanized and comprehensive treatment and the construction of a relationship of trust between professional and patient, since the dentist is often the first to contact the victim.

CONCLUSION

This study concluded the importance of humanized dental care in the oral rehabilitation of women victims of violence. In many cases, the dentist is one of the first professionals to come into contact with the patient, and it is essential to identify transgressions, provide guidance on oral hygiene, and oral rehabilitation. Dentistry needs a greater stimulus to address this problem, evidenced by the absence of case reports with humanized care, which hinders decision-making during clinical treatment. In summary, dentists can be fundamental in the reintegration of these women into society, making them visible, restoring their self-esteem, improving their quality of life and encouraging the interruption of the cycle of violence.

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INFORMED CONSENT FORM

TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO

Eu Lídia Lopes, RG nº 6040119, residente à Rodovia do Tapanã, Res. Colcana Rua 2 Nº 223A no bairro Tapanã cidade Belém, Estado PA, declaro por meio deste Termo de Consentimento Livre e Esclarecido ter sido informado(a) sobre os própositos do trabalho intitulado "**Reabilitação oral em vítima de violência doméstica e sua relação com autoestima e qualidade de vida**", acerca dos procedimentos realizados, seu objetivo e riscos e esclarecimentos permanentes e autorizo o uso as imagens e vídeos obtidos durante o meu tratamento odontológico, sejam elas digitalizadas ou impressas. Consinto que estas imagens sejam utilizadas para fins didáticos e científicos, divulgadas em aulas, palestras e outros eventos científicos, assim como seu uso em revistas, livros ou artigos, podendo mostrar ou não meu rosto, o que pode fazer com que eu seja identificado(a), desde de que respeitada as normativas do Conselho Federal de Odontologia.

Concordo voluntariamente em participar deste estudo e poderei retirar meu consentimento a qualquer momento, antes ou durante, sem penalidade, prejuízo ou perda de qualquer benefício que eu possa ter adquirido.

A utilização desse material não gera nenhum compromisso de ressarcimento, a qualquer preceito, por parte do aluno(a).

Belém, 14/06/22.

Lídia Lopes

Assinatura do paciente