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Comparison of Knowledge, Clinical Judgment, and Perceived Barriers in Reporting Child Abuse and Neglect Between Pedodontists and Other Dental Practitioners: A Questionnaire-Based Cross-Sectional Study

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Abstract

Dentists are in a strategic position to identify child abuse and neglect because orofacial injuries and behavioural signs may be detected during routine dental visits. However, recognition and reporting may be limited by inadequate knowledge, uncertainty in clinical judgment, and perceived professional barriers. This study aimed to compare knowledge, clinical judgment, formal training, and perceived barriers related to reporting child abuse and neglect between pedodontists and other dental practitioners. A questionnaire-based cross-sectional study was conducted among 200 dental practitioners, divided into two groups: pedodontists (n=100) and other dental practitioners (n=100), the latter comprising general dental practitioners (n=45) and non-pedodontic specialists (n=55). A structured 29-item questionnaire assessed demographic profile, formal training in child-abuse recognition/reporting, knowledge related to legal and clinical aspects of reporting, clinical judgment in three case scenarios, and perceived barriers to reporting. Data were coded and entered in Microsoft Excel and analysed using SPSS version 25.0. Categorical variables were summarized as frequency and percentage, while continuous summary scores were presented as mean ± standard deviation. Comparisons between groups were performed using the Pearson Chi-square test for categorical variables, Fisher's exact test where indicated, and the independent samples t-test for mean knowledge and clinical judgment scores, with a p-value <0.05 considered statistically significant. Pedodontists demonstrated higher correct responses than other dental practitioners across all knowledge items, with values ranging from 74.0% to 91.0% and 49.0% to 72.0%, respectively. Appropriate clinical judgment was also higher among pedodontists in all three scenarios, with percentages of 93.0%, 80.0%, and 86.0%, compared with 71.0%, 65.0%, and 69.0% among other practitioners ($p<0.05$). Formal training in child-abuse recognition/reporting was reported by 64.0% of pedodontists and 28.0% of other dental practitioners

($p<0.001$). Perceived barriers were common in both groups but consistently more frequent among other practitioners, particularly uncertainty regarding suspicious injuries, inadequate training, fear of legal consequences, concern about harming the relationship with the child's family, and time constraints. In conclusion, pedodontists demonstrated better knowledge and clinical judgment regarding child abuse and neglect reporting than other dental practitioners, while lower training exposure and greater barriers among other dental practitioners indicate the need for stronger educational preparation and clearer reporting protocols across dental practice.

Keywords: Child abuse, Child neglect, Pedodontists, Dental practitioners

Introduction

Child abuse and neglect remain major public health concerns with significant physical, emotional, and developmental consequences. Dental professionals may be among the first healthcare providers to observe signs of maltreatment because injuries frequently involve the head, face, and oral cavity, and because recurrent untreated dental disease may raise concerns about neglect [1,2]. In addition to detecting these indicators, dentists are expected to document findings appropriately, ensure the child's immediate safety, and follow relevant reporting procedures where required [3,4].

Despite this important role, under recognition and underreporting of suspected abuse persist in dental practice. Previous studies have shown that dentists often face uncertainty in identifying suspicious clinical signs, lack confidence in differentiating abuse from accidental injury or hardship, and hesitate to report because of fear of legal consequences, fear of damaging relationships with families, and lack of clarity about whom to contact[5-8]. These barriers are often amplified by inadequate undergraduate or continuing professional training [9,10].

Pedodontists may be expected to have stronger preparedness than other dental practitioners because their training and routine practice are centered on children and adolescents. However, even within pediatric dentistry, reporting-related uncertainty and practical barriers may remain [4,11]. Comparative assessment between pedodontists and other dental practitioners is therefore useful in identifying specific gaps that may inform educational and institutional interventions.

The aim of the present study was to compare pedodontists and other dental practitioners with respect to formal training, knowledge, clinical judgment, and perceived barriers related to reporting child abuse and neglect.

Materials and Methods

Study Design and Participants

This questionnaire-based cross-sectional study included 200 dental practitioners. Sampling method used was convenience sampling. Participants were divided into two groups: pedodontists (n=100), comprising specialists in Pediatric and Preventive Dentistry, and other dental practitioners (n=100), comprising general dental practitioners (n=45) and non-pedodontic dental specialists (n=55). The non-pedodontic specialists included endodontists, orthodontists, prosthodontists, periodontists, oral and maxillofacial surgeons, oral medicine and radiology specialists, public health dentists, and oral pathologists.

Study Instrument

Data were collected using a structured 29-item questionnaire via Google Forms. The questionnaire included items on demographic characteristics, training exposure, knowledge, clinical judgment, and perceived barriers related to reporting child abuse and neglect.

Demographic items included age group, gender, specialty, and years of clinical experience. One item assessed whether the respondent had received formal training in child-abuse recognition or reporting. Knowledge was evaluated using eight items covering mandatory reporting under Indian law, ensuring child safety and documenting findings, photographic documentation, confidentiality, caregiver consent, action in uncertain cases, withdrawal of reports, and legal protection for good-faith reporting.

Clinical judgment was assessed using three case-based scenarios involving possible neglect or reportable concern.

Perceived barriers were assessed using 11 items related to uncertainty about clinical signs, uncertainty regarding suspicious injuries, inadequate training, difficulty recognizing behavioural cues, lack of reporting protocol, uncertainty regarding whom to contact, fear of legal consequences, concern about harming relationships with families, discomfort initiating discussions about abuse, perception that it was not the dentist's role, and time constraints.

Ethical Considerations

The questionnaire stated that participation was voluntary and anonymous. No patient or personal identifying data were collected, and submission of responses implied consent.

Statistical Analysis

Data were coded and entered in Microsoft Excel and analysed using SPSS version 25.0. Categorical variables were summarized as frequency and percentage, while continuous summary scores were presented as mean ± standard deviation. Comparisons between pedodontists and other dental practitioners were performed using the Pearson Chi-square test for categorical variables. Fisher's exact test was considered where expected frequencies were small. Mean knowledge and clinical judgment scores were compared using the independent samples t-test. A p-value <0.05 was considered statistically significant.

Results and Discussion

The present study found a consistent pattern across all major domains: pedodontists demonstrated better knowledge and clinical judgment regarding child abuse and neglect reporting, whereas other dental practitioners reported lower training exposure and more barriers to action. These findings suggest that specialty-specific pediatric training may meaningfully influence preparedness for safeguarding responsibilities within dental practice.

The participant profile indicated that the study population was predominantly young. Among pedodontists, the largest age category was 26-30 years (36.0%), followed by 31-35 years (24.0%), 21-25 years (18.0%), 36-40 years (12.0%), and >40 years (10.0%). A similar age distribution was seen among other dental practitioners, with 32.0% aged 26-30 years and 22.0% aged 31-35 years.

Females constituted 62.0% of pedodontists, whereas the other practitioner group was evenly divided between males and females. In terms of experience, less than 5 years of experience was the most common category in both groups, particularly among pedodontists (42.0%). This predominantly early-career profile may partly explain the strong influence of training exposure observed in the findings.

Within the non-pedodontists group, general dental practitioners formed the largest subgroup (45.0%), followed by endodontists (14.0%), orthodontists (12.0%), prosthodontists (8.0%), periodontists (7.0%), oral and maxillofacial surgeons (5.0%), oral medicine and radiology specialists (4.0%), public health dentists (3.0%), and oral pathologists (2.0%). This distribution is

relevant because regular exposure to child patients and to safeguarding-focused training likely varies across these specialties. (Fig 1)

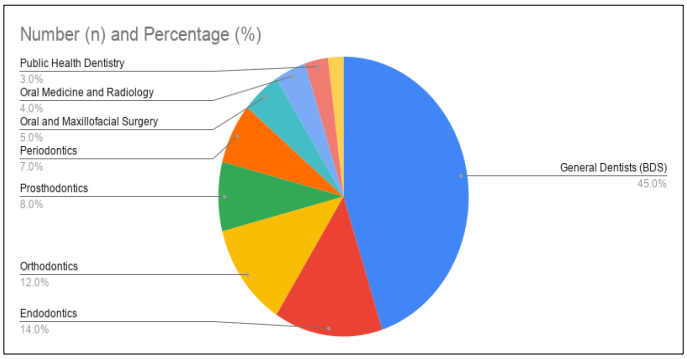

Figure 1:

A major finding of the study was the difference in formal training. Nearly two-thirds of pedodontists (64.0%) reported having received formal training in child-abuse recognition or reporting, whereas only 28.0% of other dental practitioners reported such training. The corresponding lack of training among other practitioners (72.0%) is striking and likely underlies the group differences seen in the other outcome domains. (Fig 2)

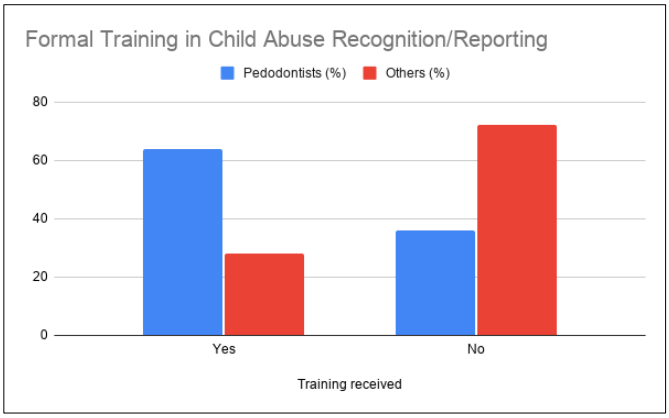

Figure 2:

Prior studies have shown that training improves recognition of suspicious signs, familiarity with reporting procedures, and willingness to intervene [5,9,12]. The training gap observed here suggests that child protection content may be more strongly emphasized in pediatric dentistry than in general dentistry or other specialties.

Knowledge-based responses also showed a clear advantage for pedodontists. (Fig 3)

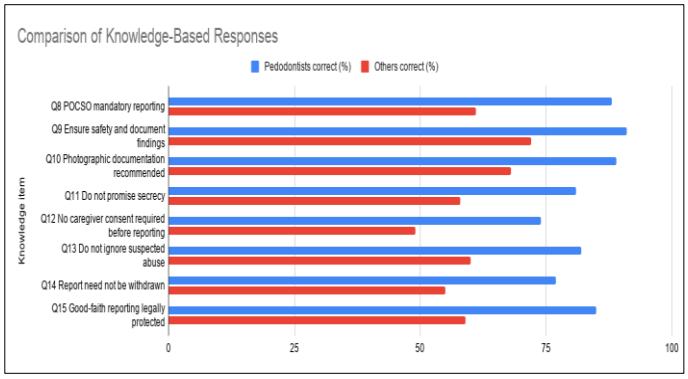

Figure 3:

Correct knowledge among pedodontists ranged from 74.0% to 91.0%, compared with 49.0% to 72.0% among other dental practitioners ($p < 0.05$). The highest correct response among pedodontists was for the statement that the first step in suspected ongoing abuse is to ensure the child's safety and document findings (91.0%). High correct response rates were also observed for photographic documentation being recommended (89.0%) and awareness that dentists are mandatory reporters of suspected child sexual abuse under POCSO (88.0%). Among other practitioners, the highest score was again for ensuring safety and documenting findings (72.0%), but important legal and procedural items were much lower, including the needlessness of caregiver consent before reporting (49.0%), the principle that a report need not be withdrawn (55.0%), and not promising secrecy (58.0%).

These findings have practical significance. Deficits in legal and procedural knowledge may prevent appropriate reporting even when clinicians suspect abuse. A practitioner who incorrectly believes that caregiver consent is required, or that legal threats necessitate withdrawal of a report, may fail to act. This interpretation is consistent with prior literature identifying uncertainty about legal obligations as a major contributor to

underreporting [6-8,13]. The fact that both groups performed relatively better on immediate clinical responsibilities such as safety and documentation than on legal nuances suggests that dentists may be more comfortable with general clinical duties than with reporting law and procedure.

A similar trend was evident in the clinical judgment scenarios. (Fig 4)

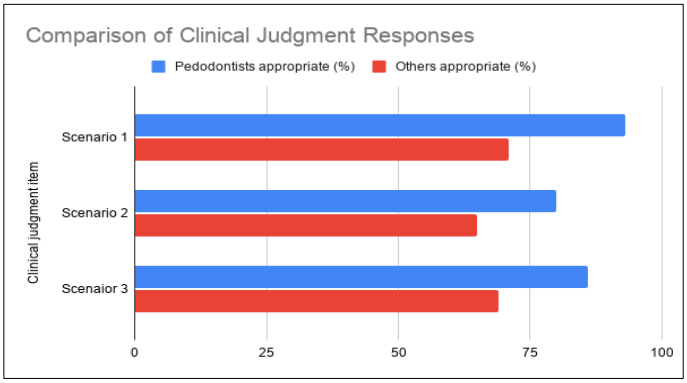

Figure 4:

Scenarios

Scernario 1- A 6-year-old returns for the third time in six months with the same abscessed molar. Parent ignores extraction advice and requests antibiotics again. Would you report this case?

In the present study, the clinical scenario involving repeated dental infections was used to assess the ability of practitioners to recognize dental neglect. Persistent untreated caries despite prior advice reflects a failure to seek necessary care and is widely considered indicative of neglect.

Scenario 2

A single father brings his 7-year-old after a year's gap explaining job loss prevented visits. Child is well cared for. Would you report this case?*

In contrast, the scenario involving financial or temporary hardship does not necessarily constitute neglect. In these cases, the caregiver demonstrates awareness of the child's condition and expresses willingness to seek treatment but is limited by external constraints. The presence of intent to provide care, even if delayed, differentiates these situations from true neglect. Proper clinical judgment requires consideration of socioeconomic context to avoid misclassification.

Scenario 3

A mother refuses fluoride varnish but agrees to fillings and diet advice. Would you report this case?

Similarly, the scenario involving parental refusal of the ideal treatment in favour of an alternative approach is not considered neglect when the chosen option remains clinically acceptable. Caregivers have the right to make informed decisions regarding treatment, and deviation from the optimal plan does not equate to neglect unless it results in harm or denial of essential care. Respecting parental autonomy while ensuring the child's well-being is a critical aspect of ethical practice.

Appropriate responses were higher among pedodontists for all three scenarios: 93.0% versus 71.0% in Scenario 1, 80.0% versus 65.0% in Scenario 2, and 86.0% versus 69.0% in Scenario 3 ($p < 0.05$). These findings suggest that pedodontists were better able to apply safeguarding principles to practical situations rather than simply recalling factual information. This may reflect their greater exposure to pediatric case management, repeated interactions with caregivers, and training in interpreting child behaviour and patterns of care. Previous research has similarly emphasized that recognition of child maltreatment requires both knowledge and sound contextual judgment [4,10,11].

Perceived barriers were common in both groups but were markedly more frequent among other dental practitioners. (Fig 5)

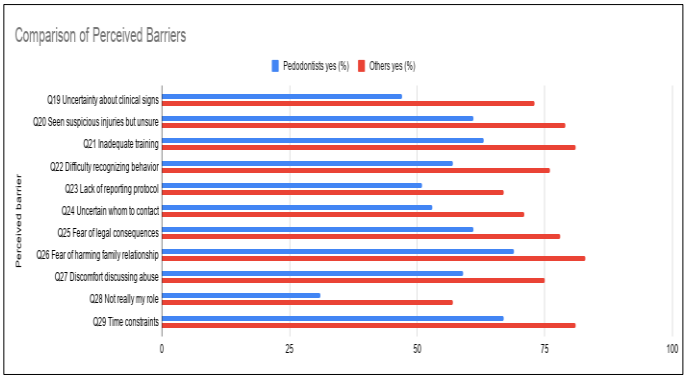

Figure 5:

Uncertainty about clinical signs was reported by 47.0% of pedodontists compared with 73.0% of others. Likewise, 61.0% of pedodontists and 79.0% of others reported having encountered suspicious oral or facial injuries but being unsure whether they were accidental or intentional. Inadequate training was endorsed by 63.0% of pedodontists and 81.0% of others, while difficulty recognizing behavioural or emotional cues was reported by 57.0% and 76.0%, respectively. These findings indicate that uncertainty in recognition remains a central barrier, particularly outside pediatric dentistry.

System-level barriers were also prominent. Lack of a clear reporting protocol was reported by 51.0% of pedodontists and 67.0% of others, and uncertainty about whom to contact was reported by 53.0% and 71.0%, respectively. ($p < 0.05$) This suggests that reporting may be hindered not only by lack of knowledge but also by inadequate institutional support. Similar patterns have been described in prior healthcare studies, where unclear procedures and lack of designated reporting pathways reduced clinicians' willingness to intervene [9,13].

Fear-related barriers were among the most common in both groups. Fear of legal consequences was reported by 61.0% of pedodontists and 78.0% of other practitioners. Concern that reporting might harm the relationship with the child's family was reported by 69.0% and 83.0%, respectively. Discomfort initiating sensitive discussions about abuse was also common, affecting 59.0% of pedodontists and 75.0% of others. These findings are highly consistent with earlier reports that dentists often hesitate to report because of fear of blame, confrontation, or medicolegal repercussions [5-8]. The persistence of these concerns even among pedodontists indicates that specialty training improves preparedness but does not eliminate the emotional and professional difficulty of reporting suspected abuse.

The perception that abuse reporting was "not really my role" was also substantially more common among other dental practitioners (57.0%) than among pedodontists (31.0%). This difference may reflect the stronger professional identification of pedodontists with child advocacy and comprehensive pediatric care. In contrast, some general dentists and non-pedodontic specialists may still view child protection as mainly the responsibility of physicians, social workers, or law enforcement. This role-perception gap is important because failure to see safeguarding as part of dental responsibility may prevent action at the earliest stage.

Time constraints were another notable barrier, reported by 67.0% of pedodontists and 81.0% of others. This suggests that even when practitioners recognize concern, busy clinical practice may prevent further exploration, documentation, and reporting. Therefore, educational interventions alone may not be sufficient. Clear reporting protocols, accessible referral contacts, and efficient documentation systems may help reduce the practical burden of acting on suspected abuse.

Taken together, the findings indicate a coherent relationship between training, knowledge, clinical judgment, and perceived barriers. Pedodontists had higher rates of formal training, better knowledge, stronger clinical judgment, and lower barrier endorsement than other dental practitioners. This pattern

is consistent with the broader dental literature, which shows that pediatric-oriented training and child protection education improve professional readiness to identify and respond to maltreatment [5,9,10,14].

At the same time, the study also shows that pedodontists were not free of barriers. More than half still reported inadequate training, uncertainty about referral pathways, discomfort discussing abuse, and time constraints. This suggests that current training may improve awareness without fully preparing dentists for the operational and emotional complexities of reporting. Accordingly, dental curricula and continuing education should include not only recognition of signs but also legal responsibilities, communication skills, documentation standards, and locally relevant reporting pathways.

Conclusion

Pedodontists demonstrated better knowledge and more appropriate clinical judgment regarding child abuse and neglect reporting than other dental practitioners. They were also more likely to have received formal training, whereas other dental practitioners reported substantially greater uncertainty, fear-related barriers, and system-related obstacles.

These findings underscore the need for strengthened child protection teaching across undergraduate, postgraduate, and continuing dental education, particularly for general dentists and non-pedodontic specialists. Institutional reporting protocols and clearer referral pathways are also needed to translate knowledge into action.

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