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ALÉM DAS LESÕES FACIAIS: CONSEQUÊNCIAS DA VIOLÊNCIA DOMÉSTICA CONTRA AS MULHERES PARA A SAÚDE BUCAL E O PAPEL AMPLIADO DOS PROFISSIONAIS DE ODONTOLOGIA

BEYOND FACIAL INJURIES: ORAL HEALTH CONSEQUENCES OF DOMESTIC VIOLENCE AGAINST WOMEN AND THE EXPANDING ROLE OF DENTAL PROFESSIONALS

MÁS ALLÁ DE LAS LESIONES FACIALES: CONSECUENCIAS DE LA VIOLENCIA DOMÉSTICA CONTRA LAS MUJERES PARA LA SALUD BUCAL Y EL PAPEL AMPLIADO DE LOS PROFESIONALES DE LA ODONTOLOGÍA

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Resumo

Introdução: A violência doméstica contra as mulheres permanece como um dos mais disseminados desafios globais de saúde pública e direitos humanos. Como a cabeça, a face e o pescoço são frequentemente alvos durante episódios de violência interpessoal, as lesões orais e maxilofaciais estão entre as consequências físicas mais comuns vivenciadas pelas vítimas. Apesar dessa estreita relação, a carga de agravos à saúde bucal associada à violência doméstica e a contribuição dos profissionais de Odontologia para seu reconhecimento e manejo permanecem insuficientemente exploradas na literatura odontológica. **Objetivo:** Esta revisão narrativa examina criticamente as consequências da violência doméstica contra as mulheres para a saúde bucal, com ênfase nos padrões de trauma dentofacial, nas necessidades de reabilitação em curto e longo prazo, nas barreiras ao atendimento odontológico e no papel ampliado dos profissionais de Odontologia na identificação, documentação e abordagem multidisciplinar das vítimas. **Métodos:** Foi realizada uma revisão narrativa estruturada por meio de buscas eletrônicas nas bases PubMed, Scopus e Web of

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Science. Foram considerados estudos publicados em inglês que abordassem violência doméstica, violência por parceiro íntimo, saúde bucal, trauma dentário, lesões faciais, reabilitação odontológica, Odontologia Legal e atendimento odontológico informado pelo trauma. As publicações relevantes foram selecionadas por meio de avaliação qualitativa, visando fornecer uma visão abrangente das evidências atuais. **Resultados:** A literatura demonstra consistentemente que a violência doméstica frequentemente resulta em lesões que afetam o complexo craniofacial, incluindo fraturas dentárias, avulsão, luxação, perda dentária, lesões de tecidos moles, fraturas mandibulares e disfunções temporomandibulares. Além do trauma imediato, as vítimas frequentemente apresentam dor crônica, comprometimento da mastigação e da fala, prejuízo estético, sofrimento psicológico e redução da qualidade de vida relacionada à saúde bucal. O acesso à reabilitação odontológica é frequentemente retardado pela vulnerabilidade socioeconômica, pelo medo de retaliações, pelo trauma emocional e pela disponibilidade limitada de serviços especializados. Evidências recentes também destacam a posição estratégica dos profissionais de Odontologia no reconhecimento de padrões de violência, na documentação de lesões, na prestação de cuidados informados pelo trauma e no encaminhamento para redes multidisciplinares de apoio. **Conclusões:** A violência doméstica deve ser reconhecida não apenas como causa de trauma dentofacial, mas também como importante determinante das iniquidades em saúde bucal. Os profissionais de Odontologia ocupam uma posição singular nos sistemas de saúde para identificar vítimas, oferecer reabilitação integral e contribuir para a intervenção e proteção precoces. O fortalecimento da formação profissional, das habilidades de documentação forense, da colaboração interdisciplinar e da prática clínica informada pelo trauma pode melhorar substancialmente a qualidade do cuidado oferecido às mulheres afetadas pela violência.

Palavras-chave: Violência doméstica; Violência por parceiro íntimo; Mulheres; Saúde bucal; Trauma dentário; Reabilitação odontológica; Odontologia Legal; Cuidado informado pelo trauma.

Abstract

Background: Domestic violence against women remains one of the most pervasive global public health and human rights challenges. Because the head, face, and neck are frequent targets during episodes of interpersonal violence, oral and maxillofacial injuries are among the most common physical consequences experienced by victims. Despite this close relationship, the oral health burden associated with domestic violence and the contribution of dental professionals to its recognition and management remain insufficiently explored within dental literature. **Objective:** This narrative review critically examines the oral health consequences of domestic violence against women, emphasizing patterns of dentofacial trauma, short- and long-term rehabilitation needs, barriers to dental care, and

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the expanding role of dental professionals in the identification, documentation, and multidisciplinary management of victims. **Methods:** A structured narrative review was conducted through electronic searches of PubMed, Scopus, and Web of Science. Studies published in English addressing domestic violence, intimate partner violence, oral health, dental trauma, facial injuries, dental rehabilitation, forensic dentistry, and trauma-informed dental care were considered. Relevant publications were selected through qualitative appraisal to provide a comprehensive overview of current evidence. **Results:** The literature consistently demonstrates that domestic violence frequently results in injuries affecting the craniofacial complex, including dental fractures, avulsion, luxation, tooth loss, soft tissue injuries, mandibular fractures, and temporomandibular disorders. Beyond immediate trauma, victims often experience chronic pain, impaired mastication and speech, aesthetic compromise, psychological distress, and reduced oral health-related quality of life. Access to dental rehabilitation is frequently delayed by socioeconomic vulnerability, fear of retaliation, emotional trauma, and limited availability of specialized services. Recent evidence also highlights the strategic position of dental professionals in recognizing patterns of abuse, documenting injuries, providing trauma-informed care, and facilitating referral to multidisciplinary support networks. **Conclusions:** Domestic violence should be recognized not only as a cause of dentofacial trauma but also as a significant determinant of oral health inequities. Dental professionals occupy a unique position within healthcare systems to identify victims, deliver comprehensive rehabilitation, and contribute to early intervention and protection. Strengthening education, forensic documentation skills, interdisciplinary collaboration, and trauma-informed clinical practice may substantially improve the quality of care provided to women affected by violence.

Keywords: Domestic violence; Intimate partner violence; Women; Oral health; Dental trauma; Dental rehabilitation; Forensic dentistry; Trauma-informed care.

Resumen

Introducción: La violencia doméstica contra las mujeres continúa siendo uno de los desafíos globales más extendidos en materia de salud pública y derechos humanos. Debido a que la cabeza, la cara y el cuello son objetivos frecuentes durante episodios de violencia interpersonal, las lesiones orales y maxilofaciales se encuentran entre las consecuencias físicas más comunes experimentadas por las víctimas. A pesar de esta estrecha relación, la carga de alteraciones en la salud bucal asociada con la violencia doméstica y la contribución de los profesionales de la Odontología a su reconocimiento y manejo siguen siendo insuficientemente exploradas en la literatura odontológica.

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Objetivo: Esta revisión narrativa examina críticamente las consecuencias de la violencia doméstica contra las mujeres para la salud bucal, haciendo hincapié en los patrones de trauma dentofacial, las necesidades de rehabilitación a corto y largo plazo, las barreras para la atención odontológica y el papel ampliado de los profesionales de la Odontología en la identificación, documentación y manejo multidisciplinario de las víctimas. **Métodos:** Se realizó una revisión narrativa estructurada mediante búsquedas electrónicas en PubMed, Scopus y Web of Science. Se consideraron estudios publicados en inglés que abordaran violencia doméstica, violencia de pareja íntima, salud bucal, trauma dental, lesiones faciales, rehabilitación odontológica, Odontología Forense y atención odontológica informada por el trauma. Las publicaciones relevantes fueron seleccionadas mediante una evaluación cualitativa con el fin de proporcionar una visión integral de la evidencia actual. **Resultados:** La literatura demuestra de manera consistente que la violencia doméstica frecuentemente provoca lesiones que afectan al complejo craneofacial, incluidas fracturas dentales, avulsión, luxación, pérdida dental, lesiones de tejidos blandos, fracturas mandibulares y trastornos temporomandibulares. Más allá del trauma inmediato, las víctimas suelen experimentar dolor crónico, deterioro de la masticación y del habla, compromiso estético, malestar psicológico y una reducción de la calidad de vida relacionada con la salud bucal. El acceso a la rehabilitación odontológica se retrasa con frecuencia debido a la vulnerabilidad socioeconómica, el miedo a represalias, el trauma emocional y la disponibilidad limitada de servicios especializados. Evidencias recientes también destacan la posición estratégica de los profesionales de la Odontología para reconocer patrones de violencia, documentar lesiones, proporcionar atención informada por el trauma y facilitar la derivación a redes multidisciplinarias de apoyo. **Conclusiones:** La violencia doméstica debe reconocerse no solo como una causa de trauma dentofacial, sino también como un importante determinante de las inequidades en salud bucal. Los profesionales de la Odontología ocupan una posición única dentro de los sistemas de salud para identificar a las víctimas, proporcionar rehabilitación integral y contribuir a la intervención y protección tempranas. El fortalecimiento de la formación profesional, de las habilidades de documentación forense, de la colaboración interdisciplinaria y de la práctica clínica informada por el trauma puede mejorar sustancialmente la calidad de la atención brindada a las mujeres afectadas por la violencia.

Palabras clave: Violencia doméstica; Violencia de pareja íntima; Mujeres; Salud bucal; Trauma dental; Rehabilitación odontológica; Odontología Forense; Atención informada por el trauma.

1. Introdução

Violence against women represents one of the most persistent violations of

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human rights worldwide and continues to impose a substantial burden on public health systems. According to global estimates from the World Health Organization, approximately one in three women experiences physical and/or sexual violence during her lifetime, with intimate partner violence representing a major component of this burden (WORLD HEALTH ORGANIZATION, 2021). Beyond its immediate physical consequences, violence against women contributes to long-term psychological morbidity, social exclusion, economic vulnerability, and persistent health inequalities (CAMPBELL, 2002; GARCIA-MORENO et al., 2006).

Among the physical manifestations of interpersonal violence, injuries involving the head, face, and neck are particularly relevant to dental practice. The face may be intentionally targeted during assaults, and the oral and maxillofacial region is therefore frequently exposed to traumatic injury (OCHS; NEUENSCHWANDER; DODSON, 1996). A recent systematic review and meta-analysis involving victims of domestic violence reported a substantial burden of oral, dental, and maxillofacial injuries, reinforcing the relevance of violence-related trauma to dental practice (SOUZA CANTÃO et al., 2024). These findings highlight the importance of the oral and maxillofacial region as an area routinely examined by dental professionals and potentially affected by interpersonal violence.

Dental and maxillofacial consequences of violence may include dental fractures, luxation, avulsion, tooth loss, soft-tissue injuries, maxillofacial fractures, and temporomandibular dysfunction (ANDREASEN; ANDREASEN; ANDERSSON, 2018; ANDREASEN, 2018). However, the clinical impact of domestic violence on oral health extends beyond the initial traumatic event. Untreated injuries may progress to chronic pain, pulpal necrosis, periapical disease, tooth loss, occlusal dysfunction, and complex restorative and rehabilitative needs. These sequelae may compromise mastication, speech, facial appearance, and oral health-related quality of life

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(LOCKER, 1988; WORLD HEALTH ORGANIZATION, 2022).

The consequences of violence may also be amplified by psychological and social factors. Anxiety, depression, shame, fear, and coercive control can interfere with treatment-seeking behavior and continuity of care (CAMPBELL, 2002). Women exposed to abuse may encounter financial dependence, restricted autonomy, social stigma, fear of retaliation, and difficulties accessing specialized healthcare services. These barriers may delay the diagnosis and treatment of oral conditions, allowing potentially manageable injuries to evolve into complex rehabilitative challenges.

Domestic violence should therefore be considered an important social determinant of oral health. Its effects extend beyond the occurrence of individual injuries and may influence access to care, treatment adherence, oral health outcomes, and long-term rehabilitation needs (WORLD HEALTH ORGANIZATION, 2022). Understanding this broader relationship is essential for moving beyond a purely trauma-centered approach toward a more comprehensive model of oral healthcare for women affected by violence.

Within this context, dental professionals occupy a uniquely strategic position. Routine dental care frequently involves examination of the head, neck, face, and oral cavity, creating opportunities to recognize injuries and other findings potentially associated with interpersonal violence. Recurrent trauma, injuries inconsistent with the reported history, lesions at different stages of healing, and behavioral indicators may raise concern and warrant sensitive clinical assessment (OCHS; NEUENSCHWANDER; DODSON, 1996). Recent literature has reinforced the potential role of dental professionals in identifying signs of domestic violence, documenting injuries appropriately, fulfilling relevant reporting responsibilities, and supporting referral to appropriate services (LEVIN; BHATTI, 2024; TOCCALINO et

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al., 2025).

Nevertheless, recognizing possible signs of violence does not necessarily translate into effective clinical action. Evidence continues to indicate important gaps in the preparedness of dental professionals and dental students to respond to patients affected by intimate partner violence and abuse. Reported barriers include uncertainty regarding professional responsibilities, fear of causing harm or offending patients, limited training, lack of institutional protocols, and uncertainty about available referral pathways (LOVE et al., 2001; WARMILING et al., 2018; FARMER; ELLIS; ALDERSON, 2024). These limitations may contribute to missed opportunities for identification, support, and appropriate multidisciplinary care.

Growing attention has therefore been directed toward trauma-informed healthcare, which emphasizes patient-centered communication, emotional and physical safety, trust, collaboration, and respect for patient autonomy (RAJA et al., 2015). These principles have particular relevance for dental practice, where anxiety, fear, and previous traumatic experiences may substantially influence clinical interactions and treatment adherence. Trauma-informed oral healthcare may help professionals provide care in a manner that minimizes retraumatization while facilitating safe communication and access to appropriate support (MAHOOD et al., 2024).

At the same time, advances in forensic dentistry have reinforced the importance of accurate and objective injury documentation in cases involving violence against women. Recent evidence highlights persistent challenges related to inadequate professional training, limited knowledge of behavioral indicators, fear of intervention, absence of specific protocols, and difficulties associated with the presence of the aggressor during healthcare encounters (DROUILLARD; GARCÍA

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NAVARRO, 2026). Strengthening forensic awareness and documentation practices may therefore contribute not only to the clinical management of injuries but also to medico-legal processes and broader multidisciplinary responses to violence.

Rather than viewing oral injuries solely as isolated consequences of physical aggression, dentistry should recognize clinical encounters as potential opportunities for identification, safe communication, documentation, treatment, rehabilitation, and referral (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025). This perspective positions oral healthcare professionals not only as providers of restorative treatment but also as potential participants in integrated and violence-responsive healthcare networks.

Therefore, this structured narrative review aims to critically examine the oral health consequences of domestic violence against women, with particular emphasis on patterns of dentofacial trauma, rehabilitation needs, barriers to accessing dental care, trauma-informed clinical management, forensic documentation, and the expanding role of dental professionals in identifying and supporting women affected by violence.

Although these terms may overlap, they are not interchangeable. Domestic violence refers broadly to violence occurring within a domestic or family context, whereas intimate partner violence refers specifically to violence perpetrated by a current or former intimate partner. Gender-based violence encompasses violence directed against individuals because of gender and may include, but is not limited to, violence occurring within domestic or intimate relationships. In this review, these

concepts are considered in relation to violence against women and their potential oral and maxillofacial consequences.

This review also introduces the Dental Window of Opportunity, a conceptual

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framework intended to organize the potential points at which dental professionals may contribute to the recognition of violence-related oral and maxillofacial consequences and facilitate access to appropriate healthcare, protection, and support services. The framework is proposed as a conceptual model derived from the thematic integration of the literature and should not be interpreted as a validated screening instrument or standardized intervention protocol.

2. Methods

2.1 Study Design

This study was conducted as a structured narrative review aimed at providing a comprehensive and critical synthesis of the scientific literature concerning the relationship between domestic violence against women and oral health. The review was designed to integrate evidence from different study designs and disciplinary perspectives relevant to dentistry, oral health, craniofacial trauma, forensic practice, and multidisciplinary care.

Although narrative in nature, a structured literature search and study selection process was adopted to improve the transparency and reproducibility of evidence identification. This review was not designed as a systematic review or meta-analysis and did not aim to provide a quantitative synthesis of the available evidence.

2.2 Information Sources and Search Strategy

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The literature search was updated on September 1, 2026, before revision and resubmission of the manuscript. Electronic searches were conducted in the PubMed and Scopus databases.

The search strategy combined terms related to domestic and intimate partner violence with terms related to oral health, dentistry, dental trauma, oral injuries, facial injuries, maxillofacial injuries, and forensic dentistry.

Searches were performed in the Title/Abstract fields in PubMed and in the

Article Title, Abstract, and Keywords fields in Scopus. No restrictions regarding publication date, document type, or language were applied.

The complete electronic search strategies for both databases are provided in Supplementary Table S1.

2.3 Eligibility Criteria

Publications were considered eligible when they addressed the relationship between domestic violence, intimate partner violence, or violence against women and at least one domain relevant to oral health or dental practice.

Eligible evidence sources included original research studies, observational investigations, systematic reviews, narrative reviews, clinical guidelines, consensus statements, and other relevant scientific publications addressing oral manifestations and consequences of violence, craniofacial and maxillofacial injuries, dental trauma,

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oral health consequences, dental rehabilitation, forensic documentation, barriers to oral healthcare, or the role of dental professionals in the identification and management of women exposed to violence.

Publications focusing exclusively on accidental trauma, sports injuries, military trauma, or violence unrelated to interpersonal or domestic contexts were excluded. Studies that did not provide information relevant to oral health, dentofacial consequences, or dental practice were also excluded.

2.4 Study Selection

Study selection was conducted by two reviewers. Titles and abstracts were screened for relevance to the predefined thematic scope and eligibility criteria. Publications considered potentially relevant were subsequently assessed in full text. Any discrepancies regarding eligibility were discussed and resolved by consensus.

The electronic searches identified 667 records, including 241 records in PubMed and 426 records in Scopus.

After removal of 202 duplicate records, 465 unique records remained for title and abstract screening. During this stage, 443 records were excluded because they

did not meet the thematic scope or eligibility criteria of the review.

Twenty-two publications were selected for full-text assessment and informed the core thematic synthesis. Additional authoritative reports and foundational

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references were used, when necessary, to provide epidemiological, conceptual, and clinical context.

The study identification and selection process is presented in Figure 1.

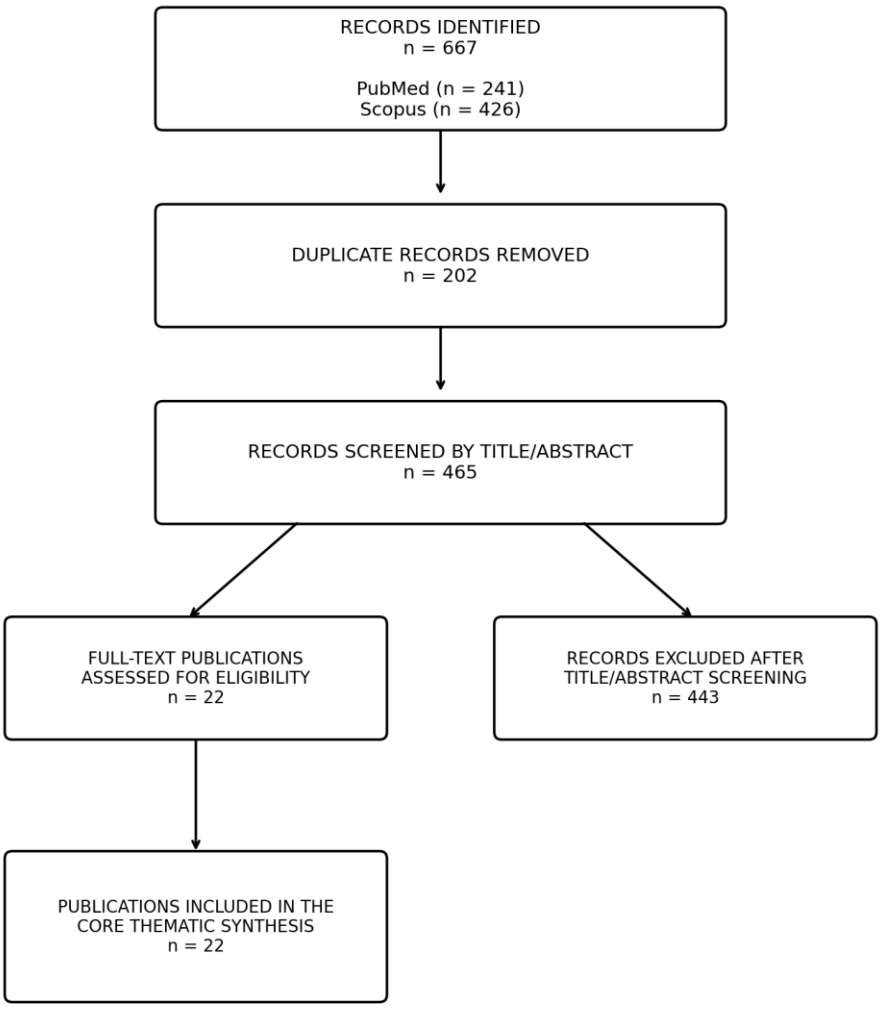

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Figure 1. Flow diagram of the identification, duplicate removal, screening, full-text assessment, and selection of publications informing the core thematic synthesis.

2.5 Evidence Appraisal and Data Synthesis

Because this study was designed as a structured narrative review rather than a systematic review, no single formal risk-of-bias assessment tool was applied uniformly across all included evidence sources. The qualitative appraisal considered the relevance of each publication to the objectives of the review, the appropriateness of the study design for the topic addressed, the clarity of the reported findings, and the contribution of the publication to the thematic domains examined.

Priority was given, whenever applicable, to systematic reviews, scoping reviews, large observational studies, clinical guidelines, consensus statements, and recent evidence addressing specific clinical, epidemiological, or professional questions.

The publications included in the core thematic synthesis were analyzed qualitatively and organized into thematic domains comprising: epidemiology and magnitude of violence against women; patterns of craniofacial, maxillofacial, and oral injuries; oral health consequences and functional repercussions; dental treatment and rehabilitation needs; barriers to accessing oral healthcare; trauma-informed and patient-centered dental care; forensic and clinical documentation; and professional responsibilities and multidisciplinary referral.

The synthesis was narrative and thematic. Evidence directly obtained from studies involving women exposed to domestic or intimate partner violence was

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distinguished, whenever possible, from evidence derived from the broader literature on traumatic dental and maxillofacial injuries.

Additional authoritative reports and foundational references were used to contextualize epidemiological estimates, oral health concepts, and clinical aspects of traumatic injuries when these topics were not sufficiently addressed by the publications included in the core thematic synthesis.

Areas characterized by limited direct evidence were identified as knowledge gaps and were not interpreted as established conclusions.

2.6 Conceptual Framework Development

Following the thematic synthesis, recurrent domains relevant to the role of

dental professionals in the continuum of care were identified. These domains included recognition of possible violence-related injuries, safe communication, objective clinical documentation, dental treatment and rehabilitation, multidisciplinary referral, and follow-up.

These domains were integrated into the **Dental Window of Opportunity**, a conceptual framework proposed by the authors to organize the potential points at which dental professionals may contribute to the recognition of violence-related oral and maxillofacial consequences and facilitate access to appropriate healthcare and support services.

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The framework was developed through the thematic integration of the evidence identified in the core narrative synthesis, together with relevant contextual and conceptual literature. It should therefore be interpreted as a conceptual and hypothesis-generating model rather than a validated clinical screening instrument or standardized intervention protocol.

2.7 Presentation of Selected Evidence

The 22 publications selected for full-text assessment informed the core thematic synthesis. Their characteristics and contributions to the main thematic domains are summarized in Supplementary Table S2.

The relationship between the thematic domains and the supporting references is presented in Supplementary Table S3.

Table 1 summarizes the principal evidence and key contributions relevant to the central themes of this review. A comparison between existing approaches relevant to violence-responsive and trauma-informed dental care and the proposed Dental Window of Opportunity is provided in Supplementary Table S4.

Table 1. Characteristics of key studies included in the review

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Author (Year)	Country	Study Design	Population/Source	Main Findings	Relevance to the Review
Love et al. (2001)	USA	Survey study	Dentists	Many dentists reported limited preparation to identify and manage domestic violence cases.	Professional preparedness and education
Gerbert et al. (2000)	USA	Survey study	Dentists	Identified barriers to recognizing and addressing domestic violence in dental practice.	Role of dentists in detection and referral

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Ochs et al. (1996)	USA	Observational study	Patients with facial injuries	Head, neck, and facial injuries may represent indicators of domestic violence.	Recognition of injury patterns
Hsieh et al. (2006)	USA	Educational intervention study	Dentists	Training improved knowledge and confidence regarding domestic violence management.	Dental education and professional training
Garbin et al. (2015)	Brazil	Observational study	Dental professionals	Reporting of domestic violence remains limited despite professional responsibility.	Forensic documentation and reporting

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Warmling et al. (2018)	Brazil	Cross-sectional study	Dentists	Knowledge gaps persist regarding identification and management of violence against women.	Professional preparedness
Levin & Bhatti (2024)	International	Narrative review	Dental literature	Reinforces the strategic role of dentists in identifying, reporting, and supporting victims of violence.	Expanding role of dental professionals
Mahood et al. (2024)	International	Scoping review	Trauma-informed oral healthcare literature	Identified frameworks and recommendations for	Trauma-informed care

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				trauma-informed dental care.	
Femi-Ajao et al. (2023)	United Kingdom	Qualitative study	Dental professionals	Explored experiences implementing domestic violence response pathways in dental settings.	Clinical implementation and referral systems
Toccalino et al. (2025)	International	Scoping review	Gender-based violence and dentistry literature	Demonstrated the growing role of dentistry within multidisciplinary responses to gender-based violence.	Contemporary evidence base

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Drouillard & García Navarro (2026)	International	Systematic review	Forensic dentistry literature	Highlighted the importance of forensic dentistry in identifying and documenting violence against women.	Forensic dentistry and documentation
WHO (2025)	Global	Global prevalence estimates report	Population-based data	Approximately one in three women worldwide (31.6%; approximately 840 million women and girls) have experienced physical and/or sexual intimate partner	Epidemiological foundation highlighting the global magnitude of violence against women.

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violence or non-partner sexual violence during their lifetime.

3. Oral Health Consequences of Domestic Violence Against Women: Current Evidence and Clinical Perspectives

3.1 Domestic violence and patterns of dentofacial trauma

Domestic violence is characterized by repeated episodes of physical, psychological, sexual, and economic abuse that may escalate over time. Among women exposed to physical aggression, injuries involving the head, face, and neck are particularly relevant to dental practice, making the craniofacial complex an important anatomical region for the recognition of possible violence-related trauma. However, the frequency and distribution of specific injuries vary substantially

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according to the population studied, definitions of violence and injury, clinical setting, and methods used for injury assessment (WORLD HEALTH ORGANIZATION, 2021; OCHS; NEUENSCHWANDER; DODSON, 1996; SOUZA CANTÃO et al., 2024).

A recent systematic review and meta-analysis by Souza Cantão et al. (2024) synthesized the available evidence regarding oral, dental, and maxillofacial injuries

among victims of domestic violence. The review demonstrated a substantial burden of injuries affecting the oral and maxillofacial region, while traumatic dental injuries represented a distinct outcome within the available evidence. Importantly, the included studies showed considerable heterogeneity, reflecting differences in study populations, injury definitions, assessment methods, and clinical contexts. Therefore, prevalence estimates should be interpreted cautiously and should not be generalized uniformly across all populations exposed to domestic violence (SOUZA CANTÃO et al., 2024).

The face is closely associated with personal identity, communication, emotional expression, and social interaction and may be affected during episodes of physical aggression. Consequently, injuries involving the oral and maxillofacial region may represent clinically relevant findings in women exposed to interpersonal violence. However, no individual injury pattern should be interpreted as diagnostic of domestic violence, and clinical findings must always be assessed within the broader context of the patient's history, safety, and circumstances (OCHS; NEUENSCHWANDER; DODSON, 1996; LEVIN; BHATTI, 2024; TOCCALINO et al., 2025).

Clinical manifestations may vary according to the intensity, frequency, and

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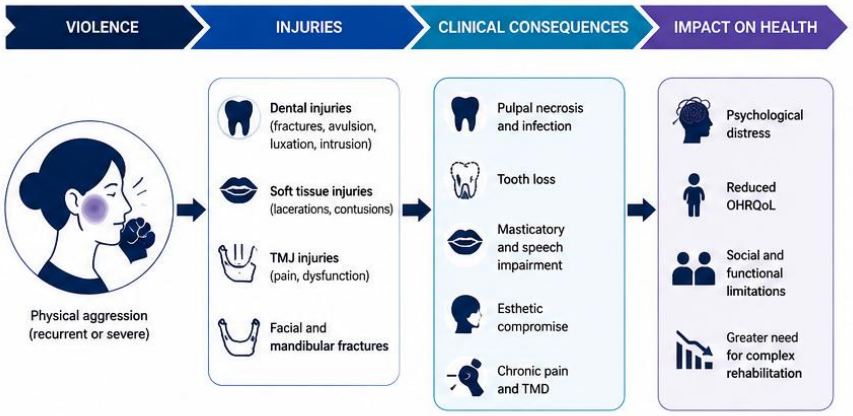
mechanism of aggression. Depending on the traumatic mechanism, injuries involving both hard and soft tissues may occur. Reported manifestations include dental fractures, luxation injuries, avulsion, tooth displacement, alveolar and mandibular fractures, lip and gingival lacerations, tongue trauma, and temporomandibular disorders (OCHS; NEUENSCHWANDER; DODSON, 1996; ANDREASEN; ANDREASEN; ANDERSSON, 2018; SOUZA CANTÃO et al., 2024).

The biological progression from domestic violence to oral health impairment is illustrated in Figure 2



Clinical manifestations vary according to the intensity, frequency, and mechanism of aggression. Direct punches, kicks, blunt objects, falls secondary to assault, and strangulation attempts may produce injuries involving both hard and soft tissues. The most frequently reported findings include uncomplicated and complicated crown fractures, root fractures, luxation injuries, avulsion, tooth displacement, alveolar fractures, mandibular fractures, lip lacerations, gingival injuries, tongue trauma, and temporomandibular joint disorders. The biological progression from domestic violence to oral health impairment is illustrated in Figure 2.

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Figure 2. Biological and clinical consequences of domestic violence affecting the oral and maxillofacial region.

The principal patterns of dentofacial injuries reported in the literature and their potential long-term consequences are summarized in Table 2.

Table 2. Patterns of dentofacial injuries associated with domestic violence against women

Injury Type	**Clinical Presentation**	**Potential Long-Term Consequences**
Crown fracture	Enamel and dentin fracture with or without pulp exposure	Pulp necrosis, endodontic treatment, tooth loss
Root fracture	Fracture involving cementum, dentin, and pulp	Tooth mobility, root resorption, extraction

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Luxation injuries	Tooth displacement without complete avulsion	Pulp necrosis, ankylosis, periodontal damage
Tooth avulsion	Complete displacement from the socket	Permanent tooth loss, need for prosthetic rehabilitation
Alveolar fracture	Fracture involving supporting bone structures	Occlusal instability, surgical intervention
Soft tissue injuries	Lacerations, abrasions, hematomas, ecchymosis	Scarring, functional impairment
Mandibular fractures	Fractures affecting mandibular structures	Malocclusion, chronic pain, surgery

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Temporomandibular injuries	Joint and muscular trauma	Chronic temporomandibular disorders, restricted function

Note: The injuries listed are reported in the literature on domestic violence and interpersonal violence. The potential long-term consequences are based primarily on the broader literature on traumatic dental and maxillofacial injuries and should not necessarily be interpreted as outcomes directly measured in women affected by domestic violence.

Importantly, the coexistence of injuries at different stages of healing should alert clinicians to the possibility of recurrent abuse. Likewise, repeated fractures affecting anterior teeth, unexplained tooth loss, chronic facial pain, and inconsistent explanations regarding trauma mechanisms should prompt careful clinical assessment within a safe and confidential environment.

Although dentofacial injuries are widely recognized consequences of domestic violence, they remain substantially underreported in dental settings. Fear of retaliation, emotional dependence, financial vulnerability, and concerns regarding disclosure frequently prevent women from revealing the true circumstances of their injuries. Consequently, oral manifestations of violence are often managed solely as isolated traumatic events, while the underlying cause remains unidentified.

These observations reinforce the need for dentists to move beyond a purely restorative perspective and recognize dentofacial trauma as a potential clinical marker of interpersonal violence.

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3.2 Immediate oral consequences of domestic violence

The immediate oral consequences associated with domestic violence may extend beyond visible dental fractures. Depending on the mechanism and severity of

the aggression, women may present with injuries involving dental and periodontal tissues, oral soft tissues, maxillofacial structures, and the temporomandibular region. However, the specific frequency and distribution of these manifestations vary across studies and clinical settings, and evidence derived specifically from victims of domestic violence should be distinguished from the broader literature on traumatic dental and maxillofacial injuries (SOUZA CANTÃO et al., 2024).

Dental trauma may include fractures affecting enamel, dentin, cementum, and pulp tissues, as well as crown-root fractures, luxation injuries, tooth displacement, and avulsion. These injuries may require immediate clinical assessment to preserve dental structures, manage pain, and optimize the long-term prognosis. Luxation injuries, including concussion, subluxation, extrusion, intrusion, and lateral displacement, may compromise pulp vitality and periodontal healing (ANDREASEN; ANDREASEN; ANDERSSON, 2018; ANDREASEN, 2018).

Soft-tissue injuries involving the lips, buccal mucosa, tongue, gingiva, and other perioral structures may also occur following direct trauma to the face. Hematomas, ecchymosis, abrasions, and lacerations may have clinical and potential forensic relevance and should be objectively documented when identified during dental examination. Nevertheless, no isolated soft-tissue injury should be considered specific or diagnostic of domestic violence (OCHS; NEUENSCHWANDER; DODSON, 1996; DROUILLARD; GARCÍA NAVARRO, 2026).

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Trauma affecting the temporomandibular region may also result in pain, muscular dysfunction, restricted mandibular movement, and other functional complaints. Depending on the mechanism and intensity of trauma, temporomandibular structures may be affected directly or indirectly. These manifestations require appropriate clinical assessment, particularly when functional limitations persist following facial trauma (ANDREASEN; ANDREASEN; ANDERSSON, 2018).

Beyond structural damage, acute oral and maxillofacial trauma may impair essential functions such as mastication, speech, swallowing, and mandibular movement. Pain and functional limitations may consequently affect nutrition, communication, and daily activities during the recovery period. The extent of these consequences depends on the nature and severity of the injuries and on the timeliness of access to appropriate dental and multidisciplinary care (ANDREASEN; ANDREASEN; ANDERSSON, 2018; WORLD HEALTH ORGANIZATION, 2022).

Collectively, the available evidence indicates that oral and maxillofacial consequences associated with domestic violence may be clinically complex and should not be approached solely as isolated emergency injuries. Dental professionals should consider both the immediate management of traumatic conditions and the broader clinical context in which injuries occur, including the need for careful documentation, patient-centered communication, and, when appropriate and safe, referral to multidisciplinary support services (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

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3.3 Long-term oral health consequences

The long-term oral health consequences associated with domestic violence may extend beyond the immediate traumatic episode. Although some injuries receive emergency treatment, biological, functional, aesthetic, and psychosocial repercussions may persist when trauma is untreated, inadequately managed, or followed by barriers to continued healthcare (SOUZA CANTÃO et al., 2024; WORLD HEALTH ORGANIZATION, 2022).

Untreated or inadequately managed traumatic dental injuries may result in complications such as pulp necrosis, inflammatory root resorption, periapical pathology, tooth discoloration, chronic infection, and eventual tooth loss. Missing teeth may subsequently contribute to functional and occlusal alterations, migration of adjacent teeth, supraeruption of antagonists, alveolar bone resorption, and reduced masticatory efficiency. These biological consequences are well documented in the broader literature on traumatic dental injuries and may become particularly relevant when women exposed to violence experience delays or interruptions in accessing appropriate dental care (ANDREASEN; ANDREASEN; ANDERSSON, 2018; ANDREASEN, 2018).

Repeated or severe trauma involving the facial and temporomandibular region may also be associated with persistent pain, muscular dysfunction, restricted mandibular movement, and other temporomandibular complaints. However, the relationship between domestic violence and chronic temporomandibular disorders is complex and may also be influenced by psychological distress and other biopsychosocial factors. These manifestations should therefore not be attributed exclusively to physical trauma without appropriate clinical assessment.

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The consequences of oral injuries may also extend to appearance, oral function, and psychosocial well-being. Visible dental defects, fractured anterior teeth, and tooth loss can negatively affect self-perception, communication, and social participation. Oral conditions and their functional or aesthetic consequences may contribute to reduced oral health-related quality of life, particularly when access to restorative and rehabilitative care is limited (LOCKER, 1988; WORLD HEALTH ORGANIZATION, 2022).

Trauma-related experiences may additionally influence interactions with healthcare services. Trauma-informed care literature recognizes that previous experiences of violence can affect perceptions of safety, trust, physical proximity, and clinical procedures. Consequently, some patients may experience heightened anxiety or discomfort during dental care, potentially affecting communication, treatment acceptance, and continuity of care. These responses should not be presumed in every woman exposed to violence but should be considered within a patient-centered and trauma-informed approach (RAJA et al., 2015; MAHOOD et al., 2024).

From a public health perspective, domestic violence may contribute to cumulative oral health inequities through the interaction between physical trauma, psychological and social consequences, socioeconomic vulnerability, and barriers to accessing healthcare. Under these circumstances, injuries that might otherwise receive timely treatment may progress to more complex restorative and rehabilitative needs(WORLD HEALTH ORGANIZATION, 2021; WORLD HEALTH ORGANIZATION, 2022; TOCCALINO et al., 2025). The interrelationship between oral health consequences, psychosocial impacts, and barriers to accessing dental care is illustrated in Figure 2.

Figure 2. Interrelationship between potential oral health consequences,

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psychosocial impacts, and barriers to accessing dental care among women affected by domestic violence.

Recognizing these potential long-term consequences is important for planning individualized care that addresses both oral rehabilitation needs and the broader circumstances that may affect treatment access, safety, communication, and continuity of care.

3.4 Oral health-related quality of life

The consequences associated with domestic violence may extend beyond clinical indicators traditionally used to assess oral health. Functional recovery alone may not fully restore well-being when patients continue to experience psychological distress, altered self-image, social difficulties, or other consequences associated with previous traumatic experiences.

Studies evaluating oral health-related quality of life have consistently demonstrated that tooth loss, chronic pain, impaired mastication, speech limitations, and compromised dental aesthetics may negatively affect physical, emotional, and social well-being. Although evidence specifically examining oral health-related quality of life among women affected by domestic violence remains limited, these consequences may be particularly relevant in individuals experiencing the combined

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effects of traumatic injuries, psychological distress, and barriers to accessing continued healthcare (LOCKER, 1988; WORLD HEALTH ORGANIZATION, 2022).

The deterioration of oral health may also affect communication, self-perception, interpersonal relationships, and social participation. Visible dental or facial consequences of trauma may contribute to reduced self-confidence and psychosocial distress. Therefore, successful dental rehabilitation should not be understood solely in terms of restoring oral structures and function but should also consider outcomes that are meaningful to the patient, including comfort, appearance,

communication, and participation in daily life (WORLD HEALTH ORGANIZATION, 2022; MAHOOD et al., 2024).

Patient-reported outcome measures, including oral health-related quality of life questionnaires, may represent useful complementary tools for evaluating treatment outcomes beyond conventional clinical parameters. Their use in clinical research involving women affected by violence may contribute to a more comprehensive understanding of rehabilitation outcomes and to the identification of domains that are not fully captured by clinical examination alone.

Taken together, the available evidence supports the importance of patient-centered approaches that integrate oral rehabilitation with attention to psychological, social, and contextual factors that may influence recovery. However, further research is needed to specifically investigate long-term oral health-related quality of life and rehabilitation outcomes among women affected by domestic violence (MAHOOD et al., 2024; TOCCALINO et al., 2025).

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4. The Expanding Role of Dentistry in the Care of Women Affected by Domestic Violence

4.1 Trauma-informed dental rehabilitation

Dental rehabilitation for women affected by domestic violence may extend beyond the replacement of missing teeth or restoration of damaged oral structures. Previous experiences of violence and trauma can influence how some patients perceive healthcare environments, communicate with professionals, and respond to clinical procedures. Therefore, when relevant to the patient's circumstances and preferences, dental rehabilitation should incorporate patient-centered and trauma-informed principles alongside appropriate technical care (RAJA et al., 2015; MAHOOD et al., 2024).

Trauma-informed care is based on recognizing that previous traumatic experiences may influence perceptions of safety, trust, control, and physical proximity during healthcare encounters. In dental practice, these factors may affect communication, treatment acceptance, and continuity of care. Importantly, trauma-related responses vary substantially between individuals and should not be

presumed solely on the basis of a history of violence (RAJA et al., 2015; MAHOOD et al., 2024).

Within dental practice, trauma-informed care may involve creating an environment in which patients feel respected, listened to, and able to participate in decisions concerning their care. Practical approaches may include explaining procedures before initiation, seeking consent throughout treatment when appropriate,

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respecting the patient's pace and preferences, protecting privacy, and using nonjudgmental communication. These strategies are intended to promote emotional safety, trust, and patient autonomy within the clinical encounter (MAHOOD et al., 2024).

Rehabilitation strategies should be individualized according to the nature and extent of oral injuries, functional needs, patient preferences, and access to continued care. Depending on the clinical presentation, treatment may involve restorative procedures, endodontic therapy, periodontal treatment, removable or fixed prostheses, implant-supported rehabilitation, management of temporomandibular conditions, and oral surgery. In complex cases, multidisciplinary collaboration may be required to address both oral health needs and broader psychological or social circumstances (WORLD HEALTH ORGANIZATION, 2022; TOCCALINO et al., 2025).

Importantly, rehabilitation outcomes should not be evaluated solely according to conventional clinical indicators. Pain reduction, recovery of oral function, comfort, appearance, oral health-related quality of life, and outcomes considered meaningful by the patient may also contribute to evaluating the broader impact of rehabilitation (LOCKER, 1988; WORLD HEALTH ORGANIZATION, 2022).

4.2 Forensic dentistry and documentation of injuries

Forensic dentistry may play an important role in the multidisciplinary response to violence against women. Because dental professionals routinely examine the head, neck, face, and oral cavity, they may be in a position to recognize and

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objectively document injuries that could be relevant to subsequent clinical, protective, or legal processes (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

Accurate clinical documentation represents one of the most important contributions that dental professionals can make when injuries are identified.

Records should describe relevant clinical findings objectively, including the anatomical location, dimensions, appearance, and characteristics of lesions, as well as the patient's statements when voluntarily provided. When clinically indicated and legally and ethically appropriate, photographs and radiographic examinations may complement written records (DROUILLARD; GARCÍA NAVARRO, 2026).

Objective and contemporaneous dental records may become relevant in subsequent clinical or legal assessments. However, dentists should avoid making unsupported conclusions regarding the cause or perpetrator of injuries. Documentation should distinguish clearly between objective clinical observations and information reported by the patient, preserving accuracy and professional neutrality (DROUILLARD; GARCÍA NAVARRO, 2026).

Beyond injury documentation, dental professionals should be familiar with principles related to confidentiality, informed consent, applicable reporting obligations, and referral pathways within their local jurisdiction. egal requirements concerning notification, mandatory reporting, and the filing of police complaints vary substantially between countries and regions. These processes are not necessarily equivalent and may involve different legal duties and procedures; therefore, professionals should follow applicable legislation and institutional protocols rather

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than relying on generalized recommendations (TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

The available literature highlights the need for greater professional education regarding the recognition and documentation of violence-related injuries and the ethical and legal responsibilities associated with suspected abuse. Undergraduate and continuing education may therefore contribute to improving professional preparedness and confidence, particularly when training is combined with clear institutional pathways for documentation, referral, and multidisciplinary collaboration (LOVE et al., 2001; HSIEH et al., 2006; WARMLING et al., 2018; DROUILLARD; GARCÍA NAVARRO, 2026).

4.3 The expanding role of dental professionals

Traditionally, dental professionals have been primarily associated with the prevention, diagnosis, and treatment of oral diseases and injuries. However,

increasing recognition of the potential relationship between interpersonal violence and injuries affecting the head, face, and oral cavity has expanded discussions regarding the role of dentistry in identifying, responding to, and supporting individuals affected by violence (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025).

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Routine dental examinations may provide opportunities to observe clinical findings or circumstances that warrant sensitive attention. These may include recurrent or unexplained injuries affecting the craniofacial region, inconsistencies between the reported history and clinical findings, injuries presenting at different stages of healing, or behavioral and contextual indicators suggesting that the patient may not feel safe or able to communicate freely. However, no individual clinical finding or behavioral characteristic should be interpreted as diagnostic of domestic violence. When concerns arise, professionals should prioritize patient safety, privacy, respectful communication, and appropriate clinical documentation rather than attempting to independently investigate or confirm abuse (OCHS; NEUENSCHWANDER; DODSON, 1996; LEVIN; BHATTI, 2024; TOCCALINO et al., 2025).

Several clinical and contextual findings may raise concern and justify a more sensitive and patient-centered approach during dental appointments. These findings should be interpreted cautiously and within the broader clinical and social context of each patient. Key examples and potential professional responses are presented in Table 3.

Table 3. Examples of clinical and contextual findings that may warrant sensitive attention in dental practice

Finding or circumstance	**Potential relevance**	**Possible professional response**

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Recurrent traumatic injuries affecting the oral or facial region	May warrant consideration of repeated trauma	Conduct an appropriate clinical assessment and, when safe, provide an opportunity for private conversation
Multiple injuries with different apparent stages of healing	May suggest injuries occurring at different times	Document objective findings carefully and avoid unsupported conclusions
Delay in seeking treatment for significant injuries	May reflect multiple barriers to accessing healthcare	Explore barriers to care using nonjudgmental communication
Reported history inconsistent with clinical findings	May warrant further clarification	Record statements and clinical findings objectively

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Repeated missed appointments or interrupted treatment	May be associated with social or practical barriers	Maintain supportive communication and facilitate continuity of care when possible
Visible anxiety or discomfort during examination	May reflect a range of previous experiences	Apply patient-centered and trauma-informed principles
An accompanying person who persistently prevents private communication	May limit the patient's ability to communicate freely	Seek an appropriate and safe opportunity to speak with the patient privately
Repeated soft-tissue or facial injuries	May warrant careful clinical assessment and documentation	Consider appropriate referral pathways when concerns arise

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The role of dental professionals may therefore extend beyond the immediate treatment of oral conditions. When appropriate, dental care may include recognizing potential indicators of violence, creating conditions for safe communication, documenting objective findings, managing oral injuries and their consequences, and facilitating access to appropriate multidisciplinary support services. The extent of this involvement will depend on the professional's training, the clinical context, local

referral pathways, and applicable ethical and legal requirements.

The continuum of potential contributions by dental professionals is illustrated in Figure 3.

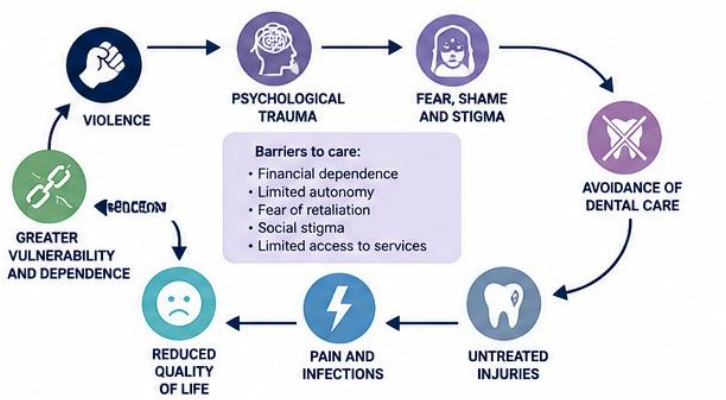

Figure 3. Conceptual clinical pathway illustrating potential contributions of dental professionals to the recognition, documentation, clinical management,

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rehabilitation, and referral of women affected by domestic violence.

The potential role of dental professionals across the continuum of care is summarized in Table 4.

Table 4. Potential contributions of dental professionals across the continuum of care for women affected by domestic violence

Stage of care	**Potential contribution of the dental professional**
Recognition	Recognize clinical or contextual findings that may warrant sensitive attention
Safe communication	Provide an appropriate environment for respectful and patient-centered communication

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Documentation	Record objective clinical findings using appropriate notes, photographs, or imaging when indicated
Acute management	Provide appropriate care for oral and maxillofacial injuries
Rehabilitation	Address functional and restorative needs according to clinical and patient-centered priorities
Trauma-informed care	Promote safety, trust, autonomy, and patient participation during care
Referral	Facilitate access to appropriate healthcare, social, protection, or specialist services when relevant
Follow-up	Monitor oral health and rehabilitation needs while respecting patient circumstances and preferences

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Professional preparedness	Maintain appropriate education and awareness regarding violence-related health issues

Importantly, dental professionals should avoid assuming investigative, forensic, or law-enforcement functions beyond their professional competence and legal responsibilities. Their primary role is to provide appropriate oral healthcare, recognize findings that may warrant concern, document clinical observations objectively, and facilitate access to qualified services when appropriate (DROUILLARD; GARCÍA NAVARRO, 2026; TOCCALINO et al., 2025).

By recognizing domestic violence as a healthcare and social issue with potential oral and maxillofacial consequences, dental professionals may contribute to broader multidisciplinary efforts aimed at reducing barriers to care and supporting individuals affected by violence. Nevertheless, dentistry should be understood as one component of a broader network of healthcare, social, legal, and protection services rather than as an isolated solution to domestic violence (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025).

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4.4 Ethical and legal responsibilities

Managing situations in which domestic violence is suspected requires careful consideration of ethical principles, patient safety, professional responsibilities, and applicable legal requirements. Dental professionals may experience uncertainty regarding the appropriate course of action, particularly because legislation, mandatory reporting requirements, and available protection services vary substantially across jurisdictions (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

Regardless of local legal frameworks, patient-centered care should prioritize safety, dignity, respectful communication, and avoidance of unnecessary retraumatization. Confidentiality and patient autonomy should be respected within the limits established by applicable law and professional ethical obligations. When concerns regarding possible violence arise, conversations should be conducted privately whenever feasible and safe, particularly when an accompanying individual may limit the patient's ability to communicate freely (MAHOOD et al., 2024; TOCCALINO et al., 2025).

Dental professionals should avoid coercive questioning or pressuring patients to disclose experiences of violence. Instead, a supportive and nonjudgmental approach may help create conditions in which patients can communicate concerns voluntarily. Professionals should also be prepared to respond appropriately when a disclosure occurs, including providing relevant information, addressing immediate oral healthcare needs, and facilitating access to appropriate services when requested or clinically necessary (LEVIN; BHATTI, 2024; MAHOOD et al., 2024).

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Knowledge of local referral pathways and institutional procedures is essential. Collaboration with physicians, psychologists, social workers, forensic specialists, and specialized protection services may facilitate comprehensive care while reducing the risk of fragmented management or secondary victimization. When reporting is legally required, clinical documentation should remain objective, accurate, and consistent with applicable ethical and professional standards (TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

Ultimately, ethical dental practice in this context extends beyond technical

competence. It includes awareness of the potential health consequences of violence, recognition of professional limits, respect for patient autonomy and dignity, and appropriate participation within multidisciplinary networks capable of addressing oral healthcare needs alongside broader health and social concerns.

4.5 Future perspectives

Growing recognition of domestic violence as a relevant determinant of health with potential oral and maxillofacial consequences highlights several priorities for future research and professional development. Additional epidemiological studies are needed to better characterize the frequency, distribution, and clinical patterns of oral, dental, and maxillofacial injuries associated with different forms of interpersonal violence. Future studies should also distinguish more clearly between injuries directly documented among women exposed to violence and evidence extrapolated from the broader literature on traumatic dental and maxillofacial injuries (SOUZA CANTÃO et

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al., 2024).

Further research is needed to investigate the long-term consequences of violence-related oral injuries, including rehabilitation outcomes, oral health-related quality of life, functional recovery, and barriers to accessing continued dental care. Longitudinal and mixed-methods studies may be particularly valuable for understanding how clinical, psychological, social, and structural factors interact throughout the recovery process.

Future investigations should also evaluate the effectiveness and implementation of educational interventions aimed at improving dental professionals' ability to recognize potential indicators of violence, communicate safely and respectfully with patients, document clinical findings objectively, and collaborate within multidisciplinary healthcare and support networks (HSIEH et al., 2006; WARMLING et al., 2018; FEMI-AJAO et al., 2023).

The incorporation of trauma-informed principles into undergraduate and continuing dental education represents another important direction. Future research should evaluate the feasibility, acceptability, and effectiveness of training programs and institutional pathways designed to support trauma-informed communication, clinical documentation, referral, and continuity of care within different healthcare and sociocultural contexts (MAHOOD et al., 2024; TOCCALINO et al., 2025).

The development and evaluation of structured clinical pathways may also help reduce professional uncertainty. However, such approaches should be adapted to local legal frameworks, available referral networks, and institutional resources rather than applied as universally standardized protocols.

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Finally, digital health technologies, electronic health records, teledentistry, and other emerging tools may create opportunities to improve continuity of care, documentation, and communication between healthcare services. Their potential contribution to the management of violence-related health concerns requires careful evaluation, particularly regarding confidentiality, data security, patient safety, and the possibility of unintended harms. Technology should therefore complement, rather than replace, ethical, patient-centered, and trauma-informed professional care.

The Dental Window of Opportunity proposed in this review should also be considered a starting point for future research. Its conceptual structure requires empirical evaluation to determine its feasibility, acceptability, clinical usefulness, and potential applicability across different dental and healthcare settings.

5. Discussion

Recent systematic and scoping reviews have strengthened the recognition of dentistry as a relevant component of multidisciplinary responses to domestic and gender-based violence. Building upon this evolving body of evidence, the present critical narrative review moves beyond the description of dentofacial injuries by integrating oral rehabilitation, trauma-informed care, forensic dentistry, and the potential contribution of dental professionals throughout the continuum of care (LEVIN; BHATTI, 2024; TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

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The findings of this review indicate that the relationship between domestic violence against women and oral health extends beyond the immediate occurrence of visible injuries. However, an important distinction must be maintained between evidence directly derived from women exposed to domestic or intimate partner violence and knowledge obtained from the broader literature on traumatic dental and

maxillofacial injuries. The available evidence supports the relevance of craniofacial and oral injuries within the context of interpersonal violence, but substantial heterogeneity exists regarding study populations, definitions of violence, clinical settings, and the outcomes evaluated (SOUZA CANTÃO et al., 2024).

Historically, research in this field has focused predominantly on the identification and description of craniofacial trauma associated with interpersonal violence. Although this body of research has contributed substantially to the recognition of potential injury patterns, important gaps remain regarding the subsequent clinical trajectory of affected women. In particular, relatively limited evidence directly addresses long-term dental rehabilitation outcomes, oral health-related quality of life, functional recovery, and continuity of care among women exposed to domestic violence.

The present synthesis therefore suggests that the clinical relevance of domestic violence should not be restricted to the immediate traumatic event. Delayed treatment, restricted access to healthcare, psychological distress, socioeconomic vulnerability, and other social circumstances may influence the progression and management of oral conditions. Nevertheless, the specific contribution of each of these factors to long-term oral health outcomes among women affected by violence requires further investigation.

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This broader perspective supports consideration of domestic violence as an important social and structural factor that may influence oral health and access to dental care. Exposure to violence may coexist with financial dependence, restricted autonomy, social isolation, fear, and other barriers that affect the ability to seek and continue treatment. Consequently, oral rehabilitation should not be understood solely as the technical restoration of damaged structures but as one component of a broader process aimed at restoring oral function and addressing patient-centered needs.

One of the principal themes emerging from the literature is the expanding potential role of dental professionals within multidisciplinary responses to violence. Dental appointments may provide opportunities to observe injuries or clinical circumstances that warrant sensitive attention, particularly because routine examinations involve the head, neck, face, and oral cavity. However, no isolated injury pattern, behavioral characteristic, or clinical finding should be interpreted as diagnostic of domestic violence (OCHS; NEUENSCHWANDER; DODSON, 1996; LEVIN; BHATTI, 2024).

When concerns arise, the role of the dental professional is not to independently investigate or confirm abuse. Rather, appropriate contributions may include providing necessary clinical care, creating conditions for respectful and safe communication, documenting objective findings, and facilitating access to appropriate services when relevant and consistent with patient safety and local requirements. This distinction is essential to avoid placing unrealistic investigative responsibilities on dental professionals while recognizing their potential contribution within broader healthcare and protection networks (TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

The incorporation of trauma-informed principles represents another important

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development in contemporary oral healthcare. Previous experiences of violence and other forms of trauma may influence how some patients perceive safety, trust, control, physical proximity, and clinical procedures. These responses vary substantially between individuals and should not be presumed solely on the basis of a history of violence. Nevertheless, trauma-informed care provides principles that may help dental professionals promote respectful communication, patient autonomy, emotional safety, and participation in clinical decision-making (RAJA et al., 2015; MAHOOD et al., 2024).

Within dental practice, trauma-informed care does not necessarily require the creation of an entirely separate clinical service. Its principles may be incorporated into routine care through clear explanations, respect for patient preferences and pace, appropriate consent, privacy, nonjudgmental communication, and attention to circumstances that may affect a patient's sense of safety. However, the evidence base supporting the implementation and effectiveness of trauma-informed oral healthcare remains limited, reinforcing the need for further empirical evaluation (MAHOOD et al., 2024).

Forensic dentistry also represents an important component of the professional response to suspected violence. Accurate and objective clinical records may be relevant to subsequent clinical, protective, or legal processes. Detailed descriptions of injuries, appropriate photographic documentation, and complementary examinations, when clinically indicated and ethically and legally appropriate, may strengthen the quality and usefulness of dental records (DROUILLARD; GARCÍA NAVARRO, 2026).

At the same time, dental professionals should distinguish clearly between objective clinical observations and conclusions regarding the cause or perpetrator of

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an injury. Records should accurately document clinical findings and, when voluntarily provided, relevant patient statements, without unsupported interpretation. Legal obligations, reporting requirements, confidentiality rules, and evidence-handling procedures vary substantially across jurisdictions and should therefore be guided by applicable legislation and institutional protocols rather than universal assumptions (TOCCALINO et al., 2025; DROUILLARD; GARCÍA NAVARRO, 2026).

The literature also highlights persistent limitations in professional preparedness. Earlier and more recent studies have identified uncertainty among dental professionals regarding the recognition of possible violence-related injuries, communication with affected patients, documentation, reporting responsibilities, and referral procedures (LOVE et al., 2001; HSIEH et al., 2006; WARMLING et al., 2018). Educational interventions may improve knowledge and confidence, but sustainable improvements in clinical practice are likely to depend not only on individual training but also on the availability of institutional protocols, referral pathways, and multidisciplinary support networks (FEMI-AJAO et al., 2023).

An additional challenge concerns the limited availability of evidence specifically addressing long-term rehabilitation and patient-centered outcomes among women affected by domestic violence. Much of the detailed knowledge regarding pulp complications, tooth loss, occlusal alterations, and other consequences of traumatic dental injuries originates from the broader traumatology literature. These mechanisms are clinically relevant when trauma occurs in the context of violence, but they should not automatically be interpreted as outcomes whose frequency or distribution has been specifically established among women exposed to domestic violence.

Similarly, the available literature provides a strong conceptual basis for

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considering the psychosocial consequences of oral injuries, including their potential effects on appearance, function, self-perception, and social participation. However, dedicated studies evaluating oral health-related quality of life specifically among women affected by domestic violence remain limited. This gap represents an important direction for future research.

These limitations do not diminish the relevance of oral healthcare in this context. Instead, they highlight the need for greater methodological precision when interpreting the current evidence. Future investigations should distinguish between direct evidence obtained from populations exposed to violence and evidence extrapolated from broader dental trauma or rehabilitation research. Such distinction

may help prevent overgeneralization while identifying clinically plausible areas that require direct investigation.

Collectively, the available evidence supports a conceptual shift in dentistry. Oral and maxillofacial injuries should not be considered exclusively as isolated biological consequences requiring technical treatment. In an appropriate clinical context, they may coexist with broader health and social circumstances that warrant sensitive attention. This perspective reinforces the importance of integrating clinical competence with ethical practice, trauma-informed principles, multidisciplinary collaboration, and patient-centered care.

The Dental Window of Opportunity

Building upon the thematic synthesis and existing literature addressing trauma-informed oral healthcare, gender-based violence, and forensic dental practice, we propose the *Dental Window of Opportunity* as a conceptual framework

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for organizing the potential contribution of dental professionals within the continuum of care for women affected by domestic violence.

The framework does not constitute a validated screening instrument, clinical protocol, diagnostic tool, or standardized intervention. Rather, it integrates complementary domains that have frequently been discussed separately in the existing literature, including the recognition of possible violence-related injuries, trauma-informed communication, objective clinical and forensic documentation, dental treatment and rehabilitation, multidisciplinary referral, and follow-up.

Existing initiatives have already contributed important perspectives to the development of violence-responsive dental care. The DRiDVA initiative, for example, focuses on implementing pathways for identifying and responding to domestic violence and abuse within dental settings and has generated important evidence regarding the practical challenges of implementation (FEMI-AJAO et al., 2023). In parallel, the literature on trauma-informed oral healthcare emphasizes principles such as safety, trust, patient autonomy, collaboration, and the prevention of retraumatization (MAHOOD et al., 2024).

Broader evidence syntheses have also described the expanding role of dentistry in identifying and supporting individuals affected by gender-based violence (TOCCALINO et al., 2025), while recent forensic literature has emphasized

professional education, injury recognition, objective documentation, and medico-legal responsibilities (DROUILLARD; GARCÍA NAVARRO, 2026).

The proposed contribution of the Dental Window of Opportunity is therefore

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not the creation of an entirely new set of professional responsibilities. Its incremental contribution lies in bringing these complementary domains together through a conceptual pathway centered on the dental clinical encounter. The framework emphasizes how a single encounter may, when appropriate and consistent with patient safety, involve more than the treatment of an isolated oral injury.

Routine dental examinations involve direct assessment of the head, neck, face, and oral cavity and may therefore provide opportunities to recognize injuries or other findings that warrant sensitive attention. Depending on the clinical context and the patient's circumstances, the encounter may also provide opportunities for respectful communication, objective documentation, treatment of oral consequences, rehabilitation, referral to appropriate services, and continuity of care.

Rather than presenting dental professionals as solely responsible for identifying or managing domestic violence, the framework emphasizes their potential role as participants within broader healthcare, social, and protection networks. The proposed model therefore connects clinical care, trauma-informed practice, forensic awareness, rehabilitation, and referral within a single conceptual continuum.

The Dental Window of Opportunity should consequently be interpreted as a hypothesis-generating and organizational model derived from the thematic integration of the literature. Its practical applicability, feasibility, acceptability, clinical usefulness, and effectiveness require empirical evaluation across different dental, healthcare, legal, and sociocultural settings.

The proposed Dental Window of Opportunity framework is illustrated in Figure 4.

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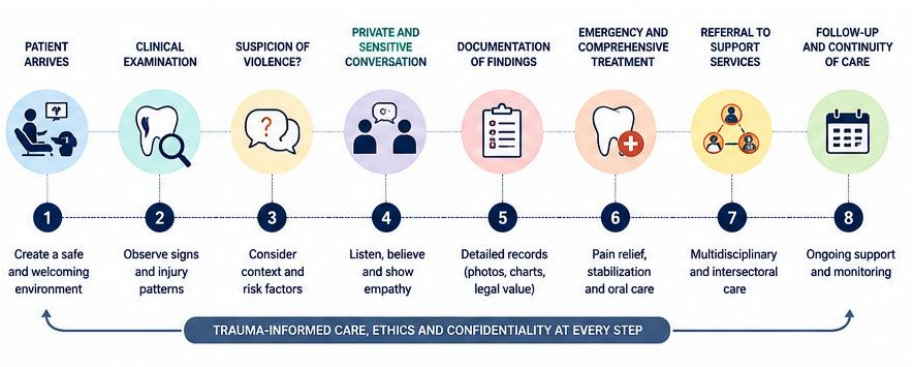

Figure 4. The Dental Window of Opportunity: conceptual framework illustrating potential points at which dental professionals may contribute to the recognition of violence-related oral and maxillofacial consequences, trauma-informed communication, clinical and forensic documentation, dental treatment and rehabilitation, multidisciplinary referral, and follow-up.

In this context, the Dental Window of Opportunity provides an organizational framework for considering how recognition, communication, documentation, treatment, rehabilitation, and referral may intersect within dental care. Its principal value lies in encouraging a broader and integrated understanding of the potential contribution of dentistry while preserving professional limits and the central role of multidisciplinary care.

Clinical implications for dental professionals

The evidence synthesized in this review has several implications for daily dental practice. Dental professionals may benefit from greater awareness of the potential oral and maxillofacial consequences of interpersonal violence and from

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training that supports respectful and appropriate responses when concerns arise.

Potential priorities include:

- recognizing clinical or contextual findings that may warrant sensitive attention without treating any isolated sign as diagnostic of violence;
- providing an appropriate environment for respectful, private, and patient-
- centered communication whenever feasible and safe;
- documenting objective clinical findings accurately, using detailed notes, photographs, and complementary examinations when clinically indicated and legally and ethically appropriate;
- understanding local institutional procedures, applicable legal requirements, and available referral pathways;
- incorporating trauma-informed principles that promote patient autonomy, emotional safety, trust, and participation in decisions concerning care;
- addressing acute treatment and long-term rehabilitation needs according to clinical priorities and patient preferences; and
- collaborating, when appropriate, with multidisciplinary healthcare, social, forensic, and protection services.

Importantly, dental professionals should avoid assuming investigative or law-enforcement functions beyond their competence and legal responsibilities. Their primary contribution remains the provision of appropriate oral healthcare, the objective documentation of clinical findings, respectful communication, and participation in referral pathways when appropriate.

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Research gaps and future priorities

Despite growing recognition of the relationship between domestic violence and oral health, important gaps remain in the available evidence.

Future investigations should prioritize:

- well-designed epidemiological studies characterizing oral, dental, and maxillofacial injuries among women exposed to different forms of interpersonal violence;
- prospective and longitudinal studies evaluating long-term oral rehabilitation outcomes;
- studies specifically examining oral health-related quality of life and other patient-reported outcomes among women affected by domestic violence;
- evaluation of trauma-informed and violence-responsive models of dental care;
- assessment of educational interventions aimed at improving professional preparedness, communication, documentation, and referral;
- development and evaluation of clinical pathways adapted to local legal frameworks and healthcare systems;
- investigation of barriers to accessing emergency treatment, rehabilitation, and continued oral healthcare; and
- empirical evaluation of the feasibility, acceptability, and clinical usefulness of the Dental Window of Opportunity framework.

Future research should also explicitly distinguish between evidence directly

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obtained from women exposed to domestic violence and evidence extrapolated from the broader literature on dental trauma and oral rehabilitation. This distinction is essential for strengthening the evidence base and preventing clinically plausible assumptions from being interpreted as established population-specific findings.

6. Conclusion

Domestic violence against women represents a major public health and human rights challenge whose consequences may extend well beyond visible physical injuries. Because the head, face, and oral cavity may be affected during episodes of interpersonal violence, dental professionals may occupy an important position within broader healthcare responses by recognizing clinical findings that warrant sensitive attention, documenting objective injuries, providing oral treatment and rehabilitation, and facilitating access to appropriate multidisciplinary services.

The available evidence indicates that the oral and maxillofacial consequences associated with domestic violence may extend beyond immediate trauma and include functional impairment, pain, aesthetic concerns, psychosocial repercussions, and complex rehabilitation needs. However, important gaps remain regarding the long-term oral health outcomes and oral health-related quality of life of women affected by

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domestic violence, highlighting the need for further population-specific research.

Contemporary dental care should therefore consider the potential relevance of trauma-informed and patient-centered principles when caring for individuals affected by violence. Clinical competence may be complemented by respectful communication, attention to patient safety and autonomy, accurate clinical documentation, awareness of applicable ethical and legal responsibilities, and collaboration with appropriate healthcare, social, and protection networks.

Rather than viewing oral injuries solely as isolated consequences requiring technical treatment, dental encounters may represent valuable opportunities to

address broader clinical and patient-centered needs. The Dental Window of Opportunity, proposed in this review, provides a conceptual framework for integrating recognition, trauma-informed communication, objective documentation, treatment, rehabilitation, referral, and follow-up within the continuum of dental care.

The proposed framework should not be interpreted as a validated screening instrument or standardized clinical protocol. Its feasibility, acceptability, and clinical usefulness require empirical evaluation across different dental and healthcare settings. Nevertheless, it may provide a useful conceptual basis for future research and for strengthening the integration of dentistry within multidisciplinary responses to violence against women.

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