Being considerate every step of the way: a qualitative study analysing trauma-sensitive dental treatment for childhood sexual abuse survivors


This qualitative study aimed to obtain a deeper understanding of what makes adult dentistry possible for child sexual abuse survivors. Sixteen adult informants were recruited from four Centres against Sexual Abuse and interviewed. Qualitative analysis of the transcribed interviews was conducted consecutively until thematic saturation was reached at 16 informants. A conceptual framework was generated, and informants’ experiences of what makes dental treatment achievable were summed as the dentist working in a trauma-sensitive way, captured by the core category: Being considerate every step of the way. The underlying categories are: (i) offering a good start; (ii) being competent; (iii) being aware of the influence of staff behaviour; (iv) building a safe relationship; (v) arranging a secure treatment situation; and (vi) exploring individual triggers. The findings revealed that dental staff should have adequate competence to build secure relationships and explore individual triggers in dental treatment situations when treating child sexual abuse survivors. Dentists should have a trauma-sensitive approach to all patients. When treating child sexual abuse survivors, dentists should demonstrate utmost consideration every step of the way, building long-term solid relationships, and discussing and testing coping strategies individually adapted to the specific needs of the child sexual abuse survivors, in a safe environment.

People suffering from traumatic life events, including childhood sexual abuse (CSA), often experience difficulties with receiving dental treatment. In 1996, Walker et al. (1) found that a history of childhood trauma, such as sexual abuse, was significantly associated with elevated dental anxiety. This has been supported in an epidemiological study (2). De Jongh et al. (3) found that having been a victim of a violent crime as well as having bad dental treatment experiences was predictive for dental phobia and a post-traumatic stress disorder (PTSD) diagnosis.

In a study, published in 2001, of 99 women with CSA experience, Willumsen (4) found that the mean score on dental anxiety assessments was significantly higher than for Norwegian women in general. Among women with sexual abuse experiences involving oral penetration, 85% reported very high dental anxiety. Dental anxiety is also associated with experiences of pain and distress from the anticipation of painful dental procedures (5, 6). However, among the same sample of CSA survivors, it was found that interpersonal factors concerning communication, trust, fear of negative information, and lack of control, were rated as much more fear-evoking for CSA survivors than for women who had dental anxiety but no CSA experience (7). In a study from 2007, 111 women with CSA were found to exhibit higher psychological strain during dental treatment, and CSA survivors often preferred a female dentist, and reported reminiscing about the original abuse situation to be a considerable problem (8). In addition, women exposed to CSA seemed to have a high level of avoidance behaviours, demonstrating a large number of irregular recall examinations.

Considering the obvious challenges faced by sexual abuse survivors in coping with dental treatment situations, there are surprisingly few scientific reports addressing relevant coping strategies.

In a theoretical paper, Raj et al. (9) describe a framework demonstrating how dentists can use a trauma-informed care pyramid to help interact with traumatized patients and to help patients cope with dental treatment situations. Dougall & Fiske (10) also...
describe how the consequences of prior sexual abuse may affect the dental treatment situation, and they give advice similar to those of RAJA et al. on how dentists can best help their patients through establishing a positive rapport, sharing control, treating the client as a partner, recognizing difficulties, and showing flexibility in problem solving.

To increase our understanding of this complex topic, qualitative research methods have high value. Despite their relevance, very few qualitative studies have been carried out, and only one such study [STALKER et al. (11)] could be found in a systematic library search. In this Canadian study, the researchers interviewed 58 men and 19 women with self-reported histories of CSA (11). They suggested how dentists could make dental treatment tolerable for patients with a history of CSA, how dentists might respond sensitively to patients’ needs, and highlighted the patients’ need to feel in control through, for example, control of body position or use of a hand mirror.

The aim of the present qualitative study was to obtain a deeper understanding of what makes dental treatment possible for CSA survivors by exploring how they experience dental treatment and the behaviour of the dental staff, as well as describing their coping strategies associated with dental treatment. With expanded knowledge in this area, dentists may be able to adapt the dental care situation more effectively to the traumatized patients’ needs.

**Material and methods**

A grounded theory (GT) approach following the principles set out by CHARMAZ (12), which includes guides on reading, re-reading, and coding the interviews, was chosen as the research method. Memo writing was used to aid data collection. This variant of GT is useful in research fields where theory surrounding the phenomenon has not been fully developed. Patterns and synthesized themes were constructed from the informants’ experiences and perspectives.

**Enrolment procedures**

Employees from four Centres against Sexual Abuse (SMSO), selected among the 22 such centres in Norway, were invited to recruit informants. The SMSOs provide a low-threshold service that is free of charge, and clients can remain anonymous. The informants were informed verbally and in writing about the study, and gave their written consent. The inclusion criterion was CSA experiences. Exclusion criteria were symptoms of psychosis, ongoing drug addiction, cognitive disabilities, and difficulties expressing oneself in Norwegian.

**Description of informants**

Twelve women and four men were interviewed. All reported multiple sexual abuse incidents. The number of abuse incidents varied from three different rape situations to daily sexual abuse over several years. The abusers were reported to be father (n = 4), mother (n = 1), stepfather (n = 2), uncle (n = 4), brother (n = 2), friend of family (n = 4), social service worker (n = 1), cousin (n = 1), boyfriend (n = 1), friend/neighbour (n = 5), and grandfather (n = 2). One reported gang rape. Four informants reported one abuser, the others reported two or three different abusers. Thirteen informed of a male abuser, and three reported both female and male abusers. Ten informants reported that abuse started before the age of 6, five before age 12, and one at age 15 yr. All except one reported both sexual contact and penetration. Six informants reported regular dental treatments and 10 reported irregular dental treatments. Self-reported oral health was good in nine informants and poor in seven.

**Data generation**

As a foundation for the research the authors discussed relevant issues of dental treatment in CSA survivors using their clinical experience. From these discussions, the key concept for this study was decided to be recommendations for dental practice based upon CSA survivors’ experiences.

The interview guide was constructed by a multidisciplinary research team consisting of two dentists, a psychologist, and a social worker, based on a review of the literature as well as on clinical practice of the researchers. The two major open-ended questions regarding experiences of dental treatment were: ‘Tell me what you remember from your experiences of dental treatment as a child (up to 18 yr of age)’ and ‘Tell me about your experiences of dental treatment as an adult’. Six informants were interviewed by the first author (a dentist), four by the social worker, and six by the psychologist, all for approximately 1h 30 min to 2 h. The interviews were audiotaped, and verbatim transcripts were compiled. After the first few interviews, the interviewers were calibrated by listening to each other’s tapes. The interview guide was rechecked, discussed, and revised to ensure minimal deviation in interview focus and style. The data collection continued until the point of thematic saturation, where new interviews failed to provide any new or thematically different information (13). NVIVO 11 PRO Software (QSR International, Daresbury, UK) was used for the analyses.

**Analysis**

All transcripts were analysed by the authors, as suggested by CHARMAZ (12). Analyses were performed consecutively and were continued until saturation was reached after having analysed 16 transcripts. First, all authors read and then discussed the interviews. The focus was an open-minded awareness in the search for a holistic view and an overall first impression of each interview (14). Second, the initial coding, separation, sorting, and synthesis of the data were undertaken by the first author. Preliminary categories were developed by the first author based on the experiences described
by informants. These preliminary categories were discussed in the research team. The third stage of the analysis included comparisons of the tentative categories in all interviews according to the constant comparative method, first by the first author, then discussed in the research team. The analytic process comprising re-reading of data, arranging and re-arranging tentative categories, then led to the construction of six main categories. The categories were considered as saturated when the data material no longer yielded new theoretical insight or revealed new properties within the category. All authors were active in all stages to ensure multiple perspectives and to reduce subjective bias (15, 16). Lastly, the core concept of ‘being considerate every step of the way’ was constructed, capturing the six main categories with properties that gave an overall analytic impression of a trauma-sensitive dental treatment for CSA survivors (see Table 1).

The Regional Committee for Medical and Health Research Ethics, South East Norway, approved the study.

Results

The informants had a considerable amount of experience with dental treatment, both positive and negative. The findings of this study highlighted that issues had arisen before, in all stages of treatment as well as after the consultation. Many informants had experiences where dentists had shown consideration during part of the treatment but not throughout the entire course, as preferred. Thus, the core category developed was entitled Being considerate every step of the way, based on the following six main categories with their characteristic properties (see Table 1).

Offering a good start

Adjusting appointment procedures to individual needs
Offering frequent appointments
Providing a welcoming reception
Proposing a non-treatment pre-visit

Offering frequent appointments was of vital importance according to the informants. Some informants wanted to make the next appointment before leaving the office to prepare themselves in advance and in order to feel in control. Others preferred to be called at short notice.

I received the appointment in the post and immediately began to panic. I was probably totally exhausted long before I showed up at the dentist. To me, it would be preferable if I received a message like: ‘Tomorrow you have an appointment at the dentist’s.’ (ID3)

Offering a long-term patient–dentist relationship

Yes, what is really important to me, is to come for a check regularly, more often than needed, because my anxiety reaches a peak again if the next treatment is too far ahead in time. The more often I go, the lower the anxiety. (ID1)

Arranging a secure treatment situation

Providing a welcoming reception
Providing quality dental treatment
Having a general knowledge of sexual abuse
Knowing about the patient being a CSA survivor

Offering a welcoming reception was highlighted as a factor that contributed to informants feeling welcome upon entering the clinic. A befitting, friendly, helpful dental assistant who smiled when following the patient
into the treatment room was desirable for most informants.

It’s okay if it is in a welcoming way, not dangerous, in a way, and colours contribute as well as music playing and nice people. (ID7)

Proposing a non-treatment pre-visit without any dental treatment being carried out was perceived as very helpful.

They would not have to do much treatment, but having the opportunity to use a visit or two on getting to know each other! Because I think that is very important, being familiar with the persons (dental personnel). (ID6)

Being competent

Different aspects of competence were highlighted as important for trusting the dentist and feeling safe.

Providing quality dental treatment by having good knowledge of their profession and superior skills in dentistry was important for many informants.

He was very competent too. When I sat in the chair, the phone rang and I overheard how a dentist asked him for advice, so I became aware of his competence. In addition, he had a calming effect on me. (ID1)

Having a general knowledge of sexual abuse was considered to be helpful.

And to know that the dentist is familiar with the reasons for... removes many of the difficulties and emotional obstacles, and things like that. (ID9)

Knowing about the patient being a CSA survivor was a desire by most informants, but some would not or could not tell about this. Some expressed a desire for the dentist to understand, without them having to disclose their trauma history.

It would have meant a lot to me if I was asked early in the process, so I could... I think it would be easier to connect my dental anxiety to the experiences of abuse. It would have given me a feeling of being seen, and of having a dentist who cared for how I am... and, knowing one is being taken care of. (ID16)

Understanding the importance of gender can be decisive for managing dental treatment as CSA survivors often do not wish to be treated by dentists of the same gender as the sexual abuser.

I prefer a female dentist. That feels safer because I hate male professionals, I don’t trust men. (ID7)

A few expressed that gender was irrelevant. The gender of the dentist was reported to be less important when the informant was accompanied by a supporting friend or family member.

Comprehending the importance of mood was important as many had experiences of being reprimanded by the dentist during treatment, and felt the dental staff to be harsh, authoritarian, and have an unfriendly tone.

It was so overwhelming, very authoritarian, and very... military, in a way. Yes, when they are leaning over you and are giving you a powerful speech, yes, with angry power, in a way... (ID15)

Dentists and dental assistants who laughed and made some jokes during treatment were considered calming by some; others felt overlooked and not taken seriously if the staff talked too much among themselves or used much humour.

Obtaining awareness on the influence of bodily characteristics was reported as crucial because certain hallmarks of the dentist reminded many informants of the abuser.

Likewise, when a person is breathing close to you, the sound of heavy breathing from people working, it is awful to me. Heavy breathing, I can sit in the dental chair and remember what happened... I can be brought back in a way that makes me feel it is happening all over again. (ID3)

Some informants expressed that the odour of a male dentist would evoke memories of a male abuser. One male informant preferred to be treated by a large male dentist to prevent himself from punching the dentist when memories were triggered during treatment.

Building a safe relationship

The informants reported that establishing a good relationship with the dentist, based around a sense of safety, security, and open communication, was challenging.

Being a fellow human was considered a decisive factor, meaning that dentists saw the person for who they are, without making them feel objectified as ‘a mouth’ or ‘teeth’.

Yes, she is not really a dentist; she is a more of a fellow human. ‘I will take care of you, even though I’m doing this.’ (ID6)

Paying attention to non-verbal signals was important because the majority of informants reported having problems with expressing themselves verbally during treatment.
I know I just have to look at her, and she will understand that I need a break. It’s not easy for me to say ‘May I have five minutes break?’. I can’t manage to do that. (ID3)

Exchanging mutual information was considered to improve treatment.

We are communicating about what is going on. ‘Now I’ll do this and that, I know you will react in this or that way, and I will take this into consideration.’ (ID12)

Respecting individual needs of CSA survivors was reported as very important and the informants’ needs were very individual.

It’s not obvious that the things that are helpful to me will be helpful to others who were sexually abused. It might be advantageous for someone to be distracted, to watch a TV-screen, or to use sedatives or other things that are not good for me. This is individual. (ID1)

Another example was that some informants felt more secure when there were two dental staff in the treatment room, while others wanted just one. A third example was that some informants wanted a closed door to the treatment room while others preferred an open door to avoid feeling locked inside the room.

Offering a long-term patient–dentist relationship was highlighted. A specific dentist, with whom the informant had the right chemistry, was preferable. Informants felt sceptical and sensitive concerning a change of dentist.

What I think would have been helpful is to go on a regular basis, to develop trust in the dentist, and so on. Yes, to be followed up. It has to be on a long-term basis, not ending the relationship after just one treatment. It is also about the follow-up on the teeth, because the problems do not suddenly disappear when you have new teeth. I don’t believe so. (ID15)

Arranging a secure treatment situation

Making dental treatment a good experience for the informants presupposed that they perceived it as safe and foreseeable and that dentists were being considerate.

Entering agreements, such as deciding on a stop signal, were reported by the informants to increase a feeling of control. But this was based on the assumption that the dentist kept their promise, and several informants did not feel worthy of attention, which made it difficult to raise their voice in treatment situations.

‘I’ll only count to three’, and you are lying in the chair, terrified, stiff with horror, ‘One, two… and threeeee!’ Number three was delayed in a way that made me push her away from me, because she never stopped, and it was so painful. Yes, she was not to be trusted at all. (ID7)

Offering time was emphasized as significant.

They have to be calm and signalize that they have a lot of time. ‘We will do this in your tempo.’ Giving me a feeling that what will be going on is up to me (laughing). (ID3)

Striving for patient control and use of coping strategies was important for receiving treatment in a good manner. Coping strategies include thinking of pleasant things, holding hands tightly, use of breathing and relaxation techniques, closing the eyes, concentrating on the dentist talking, or listening to music. A radio or headphones with music could be of help. One informant said she focussed internally on a line of words that made her feel good. However, negative coping techniques, which were difficult for dentists to detect, were also frequently reported.

I’m not present at all. When they come close to my mouth or when I’m told to open my mouth, it is like my body is swelling, I can hardly breathe and it is like I’m disappearing, in a way. (ID6)

Giving the opportunity to bring a support person made the informant feel more in control and protected. This could be auxiliary personnel or a friend who can help to explain the patient’s needs and interrupt the dentist when necessary.

When I was going to dental treatment, I brought a trusted person (from the SMSO), and then I felt safe. (ID8)

Focussing on pain relief with different perspectives was highlighted. Some informants tolerated considerable pain because they recognized agony too well and were used to handling it, while others wanted to avoid pain. Yet others struggled with having injections and a feeling of numbness.

I prefer to feel nothing, so that means I got to have a local anaesthesia… I really hate local anaesthesia. Well, number one is, it is painful, and I don’t like the feeling of… you can feel the poison being pushed into… Suddenly you can’t feel your face. Oh, I can’t stand it! (ID7)

Exploring individual triggers

‘Trigger’ is a term used to describe sensations, images, or experiences that provoke a traumatic memory. Avoiding or minimizing these reminders of trauma that might arise during dental treatment was reported to be very important to informants.

Investigating the dental chair position was important as several informants felt vulnerable and exposed when being pulled back in the dental chair and lying in a horizontal position. The feeling of being under the command of somebody was reported as being less oppressive when sitting in a more upright position.

To be pulled back (in the dental chair). Imagine the feeling. You have no control. They have the control over me. I can’t handle that situation. (ID14)
Reducing possible perceptions of being trapped was emphasized. Most informants had previously been held down physically or experienced the feeling of being restrained in the dental chair. The dental staff, parents and equipment had all contributed to this feeling. One informant sensed that the whole treatment room was closing in on him.

You are really exposed in the dental chair, with the tray right over your stomach, and things like that. The possibilities to escape are minimal, with armrests on both sides too. (ID8)

Explaining the smell of dental equipment and materials can counteract negative sensations of the distinct dentistry smell.

Everybody knows the dental odour. And I associate dentists with something frightening – a frightening odour is taking me back to the abuse. Thus, it is just another warning sign starting to flash. (ID3)

Finding solutions to mouth-related obstacles can help in overcoming problems with opening the mouth and having fingers or dental equipment put inside it.

Putting things in the mouth. My mouth is the problem, sort of, yes, it was there everything was going on; it was in the mouth he (the abuser) was active. (ID14)

Retching, vomiting, and panic attacks were all described as reactions experienced to things being inside or near the mouth. One informant described rubber gloves as being particularly problematic because they reminded him of condoms that were used during his sexual abuse. On the other hand, though, another informant had differing experiences with rubber, believing that the rubber dam had positive connotations, because of the sensation that the dentist was working ‘outside’ the mouth. Efficient removal of fluids by an attentive dental assistant and allowing pauses in treatment for spitting and calming down were reported as being advantageous.

Discussion

The data analysis generated a conceptual framework capturing how dental treatment is made achievable for CSA survivors through showing consideration every step of the way in the treatment. This implies dental staff who pay detailed attention to every part of the dental consultation, adjusting routines and behaviour to meet the individual needs of the CSA survivors from the first contact.

All informants in this study were open to themselves and the interviewers about their history of CSA. However, within standard dental practice it is almost certain that many CSA survivors will feel unable to share any CSA history with their dentist. Therefore, dental personnel should bear this in mind during consultations with all patients.

The six categories (offering a good start, being competent, being aware of the influence of staff behaviour, building a safe relationship, arranging a secure treatment situation, and exploring individual triggers) all support the use of trauma-sensitive approaches in dental care.

Howard Bath (17, 18) has described a model known as ‘the three pillars of trauma-informed care’, and the results of the present study support the concept of these three pillars. The first pillar is safety. Our informants expressed a need to feel secure in the dental treatment situation (arranging a secure treatment situation), and to establish this they needed to feel that they were in control. They expressed a need to be included in decision making regarding treatment choice and the execution of the treatment. Several reported a safe environment to involve avoidance of feeling of being trapped by staff and equipment, and to be heard regarding their needs; for example, being allowed to bring a support person. Safety itself depends on the development of a solid relationship between the CSA survivor and the dentist.

The second pillar is a healing relationship (building a safe relationship). The informants reported needs related to being treated as humans, and the need to feel that all dental staff were interested in them from their very first contact with the clinic (offering a good start). To achieve this, informants highlighted the need for dental staff to be mindful of how they may affect interpersonal trust and respect, through their communication, gender of dentist, and other attributes (being aware of the influence of staff behaviour). The majority reported that a stressed-out dentist exerted a particularly negative influence. These observations are supported by the findings of Berenson et al. (19), who found that a respectful, empathetic interaction with staff is a precondition for patients with dental anxiety daring to undergo treatment. They also found humour to be a positive factor during treatment. In our study, a light atmosphere was reported as being useful by some informants, but others reported that humour should be used with caution as it was felt that their issues were heeded less if humour was prominent.

The third pillar described by Bath (20) is affect regulation, referring to the skills needed to handle trauma reactions that arise during dental treatment. Informants in this study reported that a warm, calm attitude from the dentist had a soothing effect when they felt negative triggers, and that this assisted them in calming down. Bringing along a support person may also help to reassure informants when feelings of disappearing (hypoactivation) occur. The informants also underline the importance of being allowed by the dentist to use their own personally preferred coping techniques (e.g., listening to music on headphones and counting to three before opening the mouth).

Acknowledging individual patient needs during treatment was reported to be very important. The dentist and the CSA survivor must always discuss individual triggers (exploring individual triggers) and agree upon how treatment procedures can be best carried out. The results also supported that dental anxiety is a common problem for CSA survivors (2, 4, 21). Thus, treatment of dental anxiety needs to be addressed in CSA
survivors, with this study showing that while frameworks for anxiety management (22) and standard treatments for dental anxiety (23, 24) and sedation may be used, even this anxiety treatment ought to be based on individual needs.

Furthermore, several experts (25, 26) have emphasized the need for education of dentists on the topic of sexual abuse (being competent). This is supported by the informants in the present study. Most informants expressed that they would like the dentist to have a general understanding of sexual abuse. Some reported it as unimportant that the dentist knew about them personally being a CSA survivor as long as the dentist revealed competence on handling reactions and situations that could arise during treatment. However, as highlighted by some informants, a dentist’s knowledge of sexual abuse was of little benefit to them if they did not experience a relationship of trust and good connection with the dentist.

A strength of this study is that three of the research members undertook all interviews and transcribed the material themselves. This contributed to additional familiarity and intimate knowledge of the data. A multidisciplinary research team ensures different perspectives and identifies nuances in informants’ stories, thereby detecting matters that might otherwise be missed (15, 16). One possible limitation may be that informants recruited from the SMSO population differ considerably from CSA survivors who do not use such a Centre because they experience long-term consequences of abuse to a lesser degree. Another limitation may be that the informants did not have an opportunity to comment on the codes or results. The key clinical aim of this study should be to highlight the importance of dentists having a general knowledge of CSA and implementing trauma-sensitive approaches. The dentists need to know how to assess CSA survivors and openly ask about difficulties with managing dental care. They also need sufficient time to put this into practice. Based on current knowledge of CSA survivors and dental treatment, not taking enough time to build a trusting relationship and failure to perform dental treatment based on an individual’s needs should be regarded as malpractice, equivalent to failing to take the necessary time to perform root canal treatment in all canals of an infected tooth.

It seems that the CSA survivors, from their extreme experiences, can make very valuable points that are useful for most dentists and other dental anxious patients. Thus, the three pillars of trauma-informed care may constitute general principles that should be born in mind during all dental treatment situations. According to the Missouri Model (27), a ‘trauma-informed approach’ is not simply a framework that can be implemented and deemed successful based on adherence to set guidelines. Rather, it is a profound paradigm shift in knowledge, perspective, attitudes and skills among clinicians and staff that continues to deepen and unfold over time. Leaders in the field talk about a ‘continuum’ of implementation where organizations move through stages; these stages start by becoming trauma-aware, before moving to trauma-sensitive, to responsive, and finally to being fully trauma-informed.

All dental patients must feel safe enough, they must have relationships with the clinicians that are solid enough, and their affect regulation must be adequate enough to be able to cope with the situation.

Dentists should have a trauma-sensitive approach to all patients, and when treating CSA survivors, dentists should demonstrate utmost consideration every step of the way. Dentists need to build long-term solid relationships with CSA survivors, discuss and test coping strategies that are adapted to their specific needs, and perform treatment in a safe environment.

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