

## ORIGINAL ARTICLE

# Dental care of patients exposed to sexual abuse: Need for alliance between staff and patients

Eva Wolf<sup>1</sup>  | David Grinneby<sup>1</sup>  | Petra Nilsson<sup>1</sup>  | Gisela Priebe<sup>2</sup> 

<sup>1</sup>Department of Endodontics, Faculty of Odontology, Malmö University, Malmö, Sweden

<sup>2</sup>Department of Psychology, Lund University, Lund, Sweden

## Correspondence

Eva Wolf, Department of Endodontics, Faculty of Odontology, Malmö University, SE-205 06 Malmö, Sweden.  
Email: eva.wolf@mau.se

## Funding information

TePe, Malmö, Sweden; Faculty of Odontology and Centre for sexology and sexuality studies, Malmö University

## Abstract

The aim was to explore the experiences of sexually abused individuals as dental patients. Purposively selected were 13 informants (11 women) aged 19–56. All had experienced sexual abuse as children or adults and memories of this abuse had been triggered and expressed during a dental appointment. They were encouraged to relate in their own words their experiences of the dental appointment. The interviews were recorded digitally, transcribed *verbatim*, and analysed according to Qualitative Content Analysis. The overall theme illustrating the latent content was *The dental appointment – a volatile base requiring predictability and a secure working alliance*. The first category covering the manifest content was *The dental care provider* “assumes responsibility,” with two subcategories: (i) *contradictory disclosure*, and (ii) *alliance formation – a levelling of power*. The second category was *The patient is* “in focus,” with two subcategories: (i) *alertness to signs of discomfort*, and (ii) *attention to obvious but subtle expressions of needs*. On an understanding that the patient has been sexually abused, an individually tailored, patient-centered approach to treatment is suggested. Dental care providers may also need to be aware of and reflect on their position of power, in relation to the patient and its possible chairside implications.

## KEYWORDS

dental fear, dissociation, patient-centered, power, sexual abuse disclosure

## INTRODUCTION

Sexual abuse is frequent in the general population, both nationally and on a global level [1,2]. The negative consequences for both psychic and somatic wellbeing are well-documented [3–6]. With reference to dental care, Akinkugbe et al. [7] reported that a history of childhood sexual abuse was associated with postponement of appointments, extraction of ≥6 teeth, and a reported time lapse of at least two years since the last dental visit. Moreover, extreme dental fear is reported

to be more common among survivors of sexual abuse than in non-abused individuals [8,9].

Routines have been developed for providing care for patients with dental fear [10,11]. These routines are in accordance with what is prescribed by Swedish legislation [12]. According to the Dental Care Act, dental care in Sweden must meet the patient's need for security in care and treatment and be based on respect for the patient's integrity and autonomy. To the extent possible, care and treatment should be planned in consultation with the patient [12]. The intentions

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

© 2021 The Authors. *European Journal of Oral Sciences* published by John Wiley & Sons Ltd on behalf of Scandinavian Division of the International Association for Dental Research.

are, thus, good but the dental profession clearly fails to fulfil these ambitions. One of the consequences of extreme dental fear is poorer oral health [13]. This is partly due to avoidance of dental care [14–17]. A recent publication also revealed that a visit to the dentist can be perceived as an echo of the sexual abuse and reawaken devastating physical reactions and negative emotions (such as feelings of shame, guilt, lack of control, and powerlessness) similar to those experienced during the episodes of abuse [18]. These responses contribute to avoidance of dental care.

Prolonged postponement of dental treatment, even when in pain, might lead to serious dental problems. When the patient eventually seeks care, complicated and lengthy treatment will be required. In this context, everyone loses: the patient, the dental care provider (i.e., dentists and dental hygienists), and the community, because of the ultimately greater cost. This raises some health economic issues. To the best of our knowledge, there are no published studies on this topic; health economics, in general, strives to maximize the health benefits that can be achieved on a given budget [19]. Thus, although the initial costs may be lower when patients fail to seek regular treatment, this must be considered a negative trend because of the greater long-term overall costs. There is, therefore, a public health benefit in developing strategies that enable the delivery of effective dental treatment to sexual abuse survivors with grave dental fear.

An insider perspective (i.e., qualitative data collected from interviews of individuals who have experienced sexual abuse), with the aim of understanding and exploring, rather than explaining and predicting, has the potential to provide an in-depth view and explore feelings, perceptions, meanings, expectations, motives, and attitudes [20]. It is important to understand how delivery of dental care is perceived by people who have been subjected to sexual abuse, to be able to provide adequate care on the patient's terms and with oral health as a result.

The aim of the present study was to explore the experiences of sexually abused individuals as dental patients.

## MATERIAL AND METHODS

The study was carried out by a research team including EW, who is an endodontist with previous experience of conducting in-depth interviews, resulting in several scientific publications. She is involved in undergraduate and postgraduate education on the topics of men's violence against women and violence in close relationships, with associated external engagements. GP is a psychologist with extensive research experience in child sexual abuse and some experience in research based on qualitative data. DG and PN are both Doctors of Dental Surgery, with previously limited research experience.

A total of 18 potential informants were contacted in different ways and invited to participate in the study. Three people (asked by their therapist) declined to participate, and two people (asked by a contact at a trauma treatment center) did not respond to the request. Finally, 13 Swedish informants were enrolled in the study. Eight of the informants contacted the project leader after receiving information through a podcast on the webpage of a privately practicing psychologist specialized in sexual trauma. Contact with a midwife yielded another four people who were willing to participate. The final informant volunteered after being made aware of the project at a sexual abuse conference.

The informants were strategically selected. Absolute inclusion criteria were that the informants had been subjected to sexual abuse as children and/or as adults. Memories of the abuse episodes would also have been triggered by dental and/or dental hygienist appointments. Informants would have worked through their trauma with a therapist, be able to express themselves in Swedish, and be at least 18 years of age.

Eleven women and two men aged between 19 and 56 years old participated in the study. Their socio-economic status varied from being a student or working to being in early retirement; some were single, while others lived in a partnership or were married; some had a child/children while others did not. The abuse experience also varied from sexualizing looks and caresses to repeated abuse over many years. Eleven of the informants had been abused during childhood, eight of them both as children and as adults. The perpetrators were both men and women, and most often acquainted with the victim, though not in all cases. All informants self-reported some degree of dental fear.

The interviews were conducted face-to-face in a non-clinical location chosen in agreement with the informant. The three main areas covered during the interviews (one with each informant) undertaken in Swedish by EW were:

- (i) Please describe, in as much detail as possible, one or more dental appointments at which you were reminded of the sexual abuse you have experienced.
- (ii) How do you perceive the effect of sexual abuse on your oral health?
- (iii) How do you perceive the effect of sexual abuse on your general health and quality of life?

The first interview area mentioned above led to narratives about mental and bodily expressions during dental encounters [18] but it also led to tangible comprehensive narratives about receiving dental care. The meaning units addressing this topic were selected for further analysis in this paper.

Based on the different answers by the informants, follow-up questions were asked that were intended to invite further reflection and development, in order to obtain a more detailed overall picture. The interviews took place between

April 2017 and May 2018, lasted between 41 and 93 min, and were recorded digitally and transcribed *verbatim* by a secretary, under a confidentiality agreement. The transcripts were not returned to the informants for comments or correction. Names and places that could be linked to the informant were anonymized and the text was then translated into English under a confidentiality agreement, by a likewise authorized translator, and checked for authenticity by EW.

Qualitative content analysis was conducted according to Graneheim and Lundman [21]. The interviews were read in their entirety several times to gain an overall understanding of the content. The interviews were then separated into meaning units, i.e., a space was made in the text when there was a change in the content of what was said. The meaning unit was then condensed into more readily manageable material: redundant words were removed in order to shorten the text while retaining the basic content. The condensed meaning units were then coded to summarize the meaning of each unit (Table 1). The different codes were compared for similarities and differences and then stratified into subcategories and categories that describe the manifest content (clearly visible level). The underlying, latent content (the interpretative level) was formulated into an overall theme. One author (EW) conducted the interviews in Swedish and also sorted the texts into meaning units.

The work continued by assessing each meaning unit in relation to the purpose of the study: initially, those considered relevant were selected independently by EW, PN, and DG,

and then discussed for definite determination. For the meaning unit condensation and coding, the interviews were shared by EW, PN, and DG and then reviewed together and revised in case of disagreement. There were minor differences in vocabulary but not in essence. To illustrate the identified pattern, the codes were grouped by all authors into subcategories and categories, followed by a theme formulation, as described above. The informants did not provide feedback on the findings.

## Ethical considerations

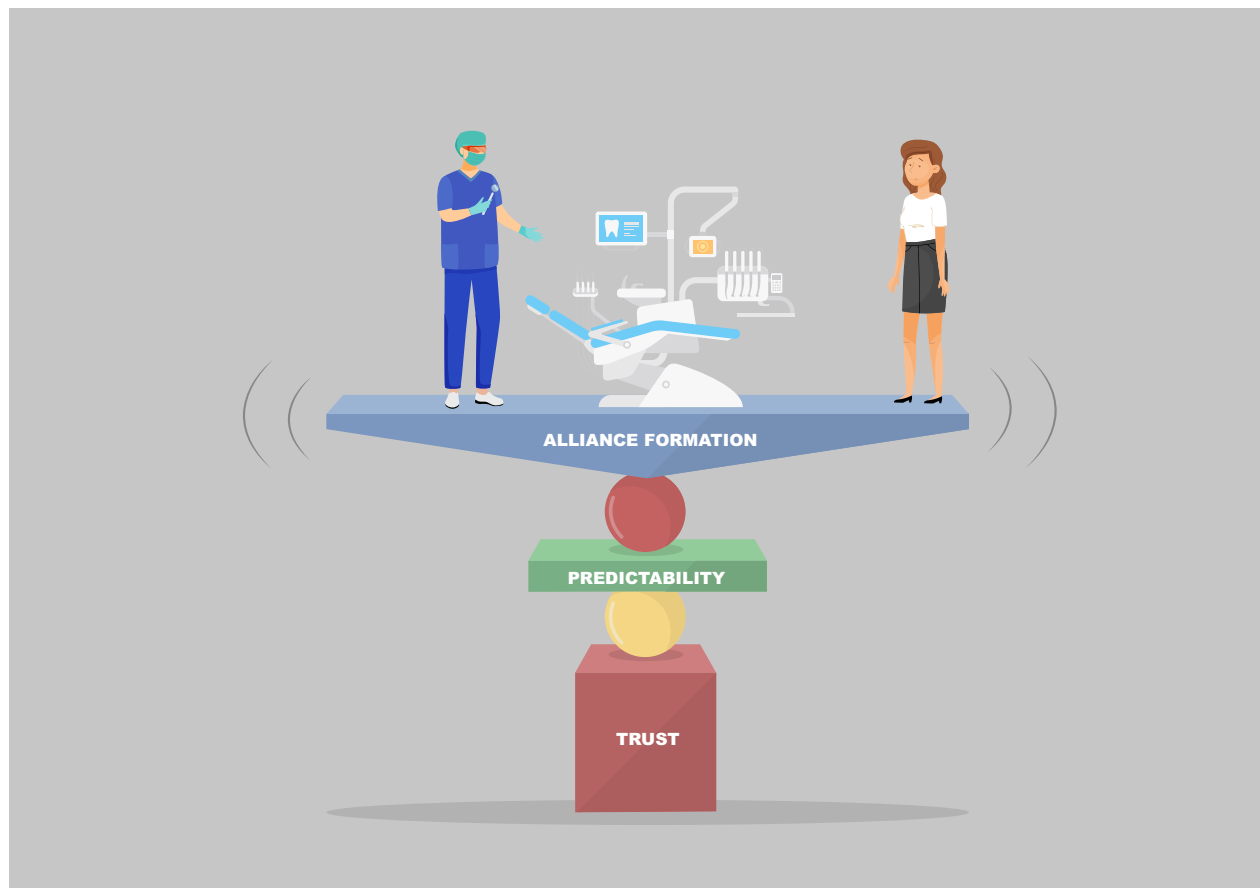
The study was conducted in accordance with the 1964 Declaration of Helsinki II (version 2002 revision, [www.wma.net](http://www.wma.net)). Written informed consent was obtained from each participant. The authorized secretary and the translator signed confidentiality agreements. The Regional Ethical Review Board, Lund University, Lund, Sweden, approved the study (Dnr 2014/780).

There is a risk that interviews about experiences of sexual abuse can induce discomfort and raise the need to talk further about feelings and thoughts evoked by the interview. Therefore, after initial contact, the interviewer met the informants for a single, preliminary meeting (two meetings were carried out on Skype) to inform them about the project orally and in writing, and to give the informant an opportunity to ask questions about the study. The informants provided their

**TABLE 1** Qualitative content analysis process used to analyse interviews and extract results

Theme	The dental appointment—a volatile base requiring predictability and a secure working alliance		
Category	Subcategory	Code	Condensed meaning unit
The dental care provider “assumes responsibility”	Contradictory disclosure	Hesitant disclosure	I can talk about my experience in detail without making it confronting for others. When I am so frightened then say those words: “I have been the victim of abuse.” Then my protective system collapses. If one is asked the question, one can say yes or no.
	Alliance formation- a levelling of power	Participation	She could have eased by saying: “Now I’m going to take the mirror. I’ll just check how it looks.” Then I would have been included. It would have been better with more communication. She sometimes asked: “Will it be ok if we put a cotton roll?”. I was able to give it a try and said: “No, that’s not going to work” so they took it out.
The patient is “in focus”	Signs of discomfort	Self medication	It was a return visit because I had bitten off the tooth. To get there I need to take tablets, tranquilizers. And so I get there and I am rather out of it, because I take a big dose.
	Obvious but subtle expressions of needs	Sensitivity to atmosphere	One is aware of the security in the room. And if they are relaxed and pleasant to each other, it is nicer for me myself.

*Note:* The identified pattern described in the theme covering the latent content, and categories, subcategories, covering the manifest content, as well as examples of codes and condensed meaning units.



**FIGURE 1** The dental appointment—a volatile base requiring predictability and a safe working alliance

therapist's contact information. In cases where there was currently no therapist, this was arranged and the interviewer contacted the therapist before an interview was undertaken. The informants were entitled to two therapy sessions financed by the research grant. This was utilized by four informants and another six had therapy sessions scheduled with their therapist at the expense of the social welfare authority.

## RESULTS

### The dental appointment—a volatile base requiring predictability and a safe working alliance

The overall theme illustrating the latent content was *The dental appointment—a volatile base requiring predictability and a safe working alliance* (Figure 1). There is no inherent trust in the dental care provider, but rather a great concern that the visit will prove just as terrible as anticipated. The pattern identified illustrates the need for the dental care provider to accept responsibility for taking care of the patient and also to focus on the patient.

Just that they are standing *over* one . . . , or are sitting *over* one – like this therefore – just *that* is a big thing, very big. Because it puts them in a position of power. [...] And then it gets that way that one goes through it (the abuse) again...Ehh . . . . and one feels the powerlessness: “Yes, but it's probably ok. They can probably do this.... Everyone else has in fact done it”.

(Informant 7)

The first main category covering the manifest content was *The dental care provider* “assumes responsibility,” with two subcategories: (i) *contradictory disclosure*, and (ii) *alliance formation—a levelling of power*. The second category was *The patient* is “in focus,” with two subcategories: (i) *alertness to signs of discomfort*, and (ii) *attention to obvious but subtle expressions of needs*. The use of quotation marks [“..”] illustrated that the dental care providers did not always assume responsibility for providing patient-centred care, nor were the patients always in focus and their needs observed and acknowledged.

## The dental care provider “assumes responsibility”

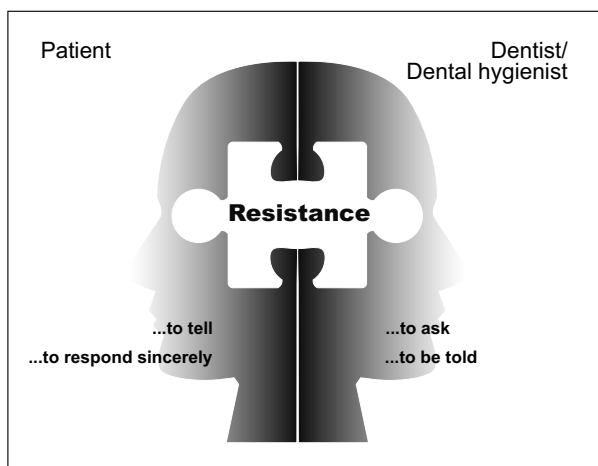
The category *The dental care provider* “assumes responsibility” covered the requirement that the dental care provider, being in a superordinate position by virtue of professional knowledge, should be the one ensuring that the dental appointment is successful for all parties. The dental care provider can take the initiative to address the issue of violence and sexual abuse, or share power with the patient, but does not always do so.

*Contradictory disclosure*, the first subcategory, illustrated the difficulty involved in bringing the abuse experience to light (Figure 2). Few informants had told the dental care provider about their experiences of sexual abuse, and if so, only after a long time. Although these particular informants had no problem in talking about the experience of abuse in general, there could still be strong resistance to discussion during a dental appointment.

Now I have come quite a long way, so that I can in fact... I have in fact given lectures about this. [...] I can in fact talk about my experience of abuse in quite a lot of detail, without it...., making it .... too confronting for others. Ehm.... But when I *am* in ...., in a situation where I *am* so frightened, .... then to say those words: “I have been the victim of abuse”, would in fact... Because then..., then my protective system collapses. Then..., then I would never get to the stage of being able even to get myself into the dental chair.

(Informant 11)

They know that I am frightened, but not really why. Eh.. Because it is very difficult. So



**FIGURE 2** The contradictory disclosure—a fourfold resistance to bringing the sexual abuse experience to light

they often ask me “Do you know why you are afraid?” when I am already lying down. And it ... Yes, but then I am already very vulnerable. Eeh..., because then ... then I can't in fact ... It isn't easy to flee then. And then it isn't all that simple to say: “Oh well, I was raped all throughout my childhood.”

(Informant 11)

Although the great resistance to disclosure was apparent and expressed as a tendency to deny or to react with anger when asked, the informants still expressed a wish to be asked about the abuse experience.

EW: Yes, if someone had asked you when you were twelve?

..... I would have appreciated it. Because somewhere I was in fact searching ... for someone I could tell about it, who was willing to listen, who was willing to.... to be able to actually stand there... and be able to take it in. .... So that I would have been able to have .... to have got hold of it myself in some way. Because now I continued to just flee... from ... it in some way.

(Informant 13)

If one is asked the question. One can say yes or no.

(Informant 11)

If the question was asked, there might be denial a couple of times, but the informant him/herself could then decide whether or not to tell the dental care provider about their experience and, sooner or later, there would be disclosure.

Of certain significance was one occasion when a dental appointment was scheduled and the dentist knew about the history of sexual abuse, but the informant experienced the response of the dental care provider as incomprehensible.

In fact I explained why. And I said that I had been the victim of sexual abuse. “This is .... special.. [...] In fact she could have like *met* me there and say: “Yes, I heard that it's tough and...., it's ok. We don't have to do anything today”. *Nothing*. In fact it was like totally ... cold, in fact.

(Informant 7)

The informants expressed a desire that health care providers should generally improve their skills in asking



uncomfortable questions and not be surprised if the truth came to light, and also to be able to respond to the information with respect.

*Alliance formation—a levelling of power*, the second subcategory, comprises the negative consequences of the power exercised by the dental care provider, as well as the possible positive outcomes of levelling this power. Feelings of powerlessness were difficult to handle, caused insecurity, and were sometimes impossible to tolerate, resulting in the patient never returning for further treatment. Although a built-up capital of trust was sometimes reported to be robust enough to withstand mistakes, situations where mutual agreements were broken were particularly negative. One single (unconscious) mistake from the dental care provider could have major consequences and mean that the patient does not return.

Because there I felt tramped over. Because it was like: “But has she forgotten?” [...] We had an agreement. And then it just felt as if she had *forgotten* about it. That's how it seemed to me. And then it got... As soon as they continued it felt almost like a new episode of abuse. It was like: “Yes, but I am in charge. I decide here, like. Be quiet”.

(Informant 7)

The insensitive exercise of power by a dental care provider was considered to be devastating.

I hardly had time to sit myself down in that dental chair. There was sort of no talk of showing me a needle or .... It was just sort of ... straight into it.. [...] It was like: “Sit down and now we're going to do this.” [...] And it just didn't work.

(Informant 1)

Take out a tooth, that isn't much fun. [...] And that's very violent and it ..., especially with those roots. And ... Eh ..., so it became a really difficult thing. And then..., then when I *didn't* want them to take the tooth out, then.... So that also became one more..., one more incident that was difficult, that the dentists are the culprits like.

(Informant 2)

The main problem associated with a dental appointment was not pain: the most devastating aspect was the perceived powerlessness. The informants felt that loss of control would make them feel like a victim and the dental care provider would instead have all the power.

The informants described several ways in which the dental care provider could achieve a safe working alliance with the patient. An agreement and an ‘approval’ from the dental care provider, in addition to waiting until the patient was ready to proceed with the next treatment step, could reduce the feeling that power lay with the dental care provider. Informants stated that this had facilitated treatment; procedures then felt less like abuse.

If they say like: “But it's ok.” Because then it feels a little as if one has got an ok from ...the ones who decide, in some way. Eeh.. Because in there it is still you (the dental care provider) who decide. \*Laugh\* If you say so. Yes in one way then. And if one gets an ok there, then ..., then it will feel a little more as if it is in fact we are deciding together in some way. Then there is no power ... ranking, so.

(Informant 6)

Exercise of power on the part of the dental care provider sometimes meant that the patient reacted correspondingly. This was expressed as the possibility of saying “no” (i.e., to avoid a situation like the abuse situation). Active resistance to undergoing treatment under sedation with tranquilizers or nitrous oxide gas and preferring general anesthesia could also bring about feelings of triumph and being in control, as opposed to the abuse situation.

Then when I was there, the most recent visit, when I had general anaesthetic, I really felt that ..... \*little laugh\* .... Yes, they really tried right to the end. It was almost as if it like.... Giving someone general anaesthetic, that's a big problem, in fact. Mm ... .. But that they gave up... .. I think that was neat..., that it was..., then I didn't need to like make a fuss any more. They gave up.

(Informant 12)

## The patient is “in focus”

The category *The patient is “in focus”* comprises what might be considered the essence of being the subject of individualized dental care (i.e., signs expressed by the informants to be observed by dental care providers in relation to or during the dental appointment and also what needs must be met for the treatment to be characterized as patient-centered).

*Alertness to signs of discomfort*, the first subcategory, comprises, as the informants in this study reveal, mostly different expressions of their dental fear. A fear they think the dental care provider should be able to detect.

Perhaps in any case they should observe that another person ..., that everything may not perhaps be quite as it should be. I thought in fact, to be honest, that I was showing it quite clearly just the same.

(Informant 12)

The informants express bodily reactions, like remaining upright when the chair is reclined close to a horizontal position, and being stiff or shaking when brought in from the waiting room and/or during treatment.

When you have to get into the dental chair the..., my whole body in fact starts to shake. And ... yes ... because in fact they are nice but it feels as if I am on the way to my execution. [...] I lie there shaking like mad during the whole .... and almost get cramps.

(Informant 11)

Perspiration, a flow of tears, a frequent wish to spit, excessive salivation, and nausea when instruments and other equipment were inserted into the mouth were signs mentioned by the informants. Being touched was sometimes difficult to tolerate, although the informant was aware of the necessity in the dental setting.

As long as it (the touching) isn't my head and face and such, then it works. [...] One shields oneself or one shuts down.

(Informant 13)

To shield or switch off, together with freezing and stopping breathing, is also associated with the psychological reaction called dissociation: this occurs when someone perceives themselves to be locked into an unbearable situation. This was frequently mentioned by the informants. Aggressive behavior triggered by a similarity with the episodes of abuse was also expressed.

When he did this (the dentist pulled the cheek), that was when I became angry. I thought: "No, I'm not going to sit still and let this happen again", and that was when I hit him. Pure reflex. I didn't do that to my assailant, but then I knew.. I was so little then, so I ... .. and I made a promise to myself, without telling..., that I would never allow anyone to do something like that to me again, you see. ...So that ... the dentist copped what I couldn't do to my assailant when I was too little.

(Informant 9)

The informants also described self-medication with tranquilizers. Communication then became somewhat difficult, or the patient fell asleep during treatment.

Sometimes.... Sometimes I took pain..., I took painkillers, as self-medication.... And it could happen that I actually fell asleep, because I was affected.

(Informant 2)

Other indications, which were somewhat more difficult to discern and act upon, were reluctance to make an appointment despite an obvious objective need, repeatedly late cancellations, and unexplained broken appointments, as well as coming as far as the waiting room but leaving before being admitted to the surgery for treatment. Further signs were an explicitly expressed wish for sedation or general anesthesia as the only solution, and a preference for the dental clinic to assume responsibility for scheduling annual examinations.

*Attention to the obvious but subtle expressions of needs*, the second subcategory, comprises an explicit need to be in focus during the dental appointment, appreciation when this need was met, but also a clear awareness by the patient of being marginalized.

The informants wanted the dental care providers to avoid making them feel guilty about neglecting their oral health, even when the patient's oral status might be questionable or the patient had not sought dental care for a long time. The informants also expressed the need for dental care providers to be attentive to different reactions and emotional states.

I have lost it a few times, so I have fainted. And I have cried at the dentist's. And to think that no-one has asked me then or understood that: "Yes, but you have...yes you have dental fear haven't you?" "Yes." And then nothing further like. [...] That they have..., just not furth..., asked why."How can we make it easier for you?" But no, nothing like that.

(Informant 6)

The informants appreciated a positive working relationship between the dentist and the dental nurse and also expressed the view that the dental care provider should be able to involve the patient in the treatment and facilitate communication.

Because it..., it is something I often experience that ... when I have been to the dentist, that..., that there is no-one who addresses *me*. Instead they talk like over my head..... Ehh, and ..., and they don't like..... yes addresses me in

that way.....because one can.... Even if I dis-sociate, even if I am in ..., in an abuse situation – although I am at the dentist's – so .... I can be recalled to the here and now. [...]... so to speak, tries to contact me too.

(Informant 11)

A strong wish was that the dental care providers were responsive to and interpreted implicit expressions: to be able to see beyond mixed messages. This is illustrated in the following quote, whereby the informant agrees to continue the treatment but has other implicitly expressed hopes.

Because one ..., one asks only once. So: "But is it ok?" "Absolutely!" Instead of looking at me: Do I really mean this? "Are you sure? Do you mean it or should we ...?"[...] Fit the puzzle pieces together like. "Are you sure?" like.

(Informant 6)

The informants also commented on the importance of active involvement of the dental nurse in the treatment session. Some informants explicitly stated that the nurse was more understanding and helpful than the dentist; the nurse was occasionally described as a symbol of security.

If you have someone who gives you confidence .... with their hand and checking like: "Does it feel alright? Ehh..... don't forget to breathe." In fact, she (the dental nurse) keeps an eye on everything.... Therefore one felt safe *there*, because she was keeping an eye on things. Because I was fully occupied with keeping control of myself, not to give *in* to my feelings that this is an .... assault, but that I am at the dentist's.

(Informant 7)

The informants requested individualized treatment and care, characterized by concern and respect. This could contain an explicit question from the dental care provider as to whether all steps during treatment should be explained in advance, keeping syringes out of sight, telling the dental nurse to be attentive to the patient, observing that the patient was tense or had stopped breathing and suggesting measures of relief. The care provider could just adopt a relaxed reassuring approach, without knowing why this was important.

My impression is in fact that: Yes. Well I dared to open my mouth and I dared to let her like take the next step. [...]... And she was prepared to take me as she found me, even though she didn't know why (I was frightened) or anything. But she took it on just the same ....

Just taking things very quietly and respecting my fear.

(Informant 13)

The sex of the dental care provider was also discussed. For some of the informants, the sex was of minor importance but, occasionally, a female dental care provider was preferred.

Then I have mostly had female dentists and I think I prefer that too. Because of what I have been through. Once as an emergency patient, then I in fact had a male. And he was in fact nice and so on, but the good dentists I have had who are women, they are often.... In fact they are gentler and have more empathy.

(Informant 10)

## DISCUSSION

The sexually abused individuals' experience of dental treatment was based on a volatile foundation. For a successful outcome to be possible, predictability and formation of alliance (power levelling) between the parties were important. There was no obvious inherent trust of the dental care provider, but great concern that the visit would prove just as terrible as anticipated. There was an identified need for the dental care provider to assume responsibility for addressing the patient's need to be in control of the situation and also to ensure that treatment was delivered in an individualized, patient-centered approach. However, these needs were not always acknowledged or catered for.

There was a risk of bias when collecting and analysing data, as two of the authors were generally familiar with the research field and had a preunderstanding of possible overall difficulties an experience of sexual abuse might imply. However, there was awareness of the importance of bracketing the preconceived understanding during the interviews and the analysis, which is facilitated by the interview technique where the interviewer does not lead, but rather follows the informant.

An interview conducted with open-ended questions creates a unique opportunity for elucidation of what the *individual* regards as important and not necessarily what the *researcher* initially considered important. This became obvious during the interviews: initially, there had been no intention of asking explicitly about the provision of dental treatment, but the topic was frequently mentioned by the informants and, therefore, became the basis for the analysis in the present study. Saturation can be estimated only once all material has been collected and analyzed [21] and the pattern emerges. Some uncertainty about saturation, however, does not necessarily invalidate the findings: it might indicate



that the area of interest has not yet been thoroughly explored [22]. The results would have probably been even more detailed if dental treatment had also been an explicit area of investigation.

The method and analysis illuminate the complexity of the participants' experiences in its own context [23]. The results are probably transferable to other sexual abuse survivors who suffer from dental fear, but may be less relevant in cases where dental appointments are not associated with great discomfort. Although dental fear is reported to be over-represented among sexual abuse survivors [8,9,24], the fear may in fact be multifactorial. Moreover, in this study, dental fear is self-reported by the informants and not measured on a validated scale.

The informants' narratives were colored by subsequent life experiences and their psychological treatment. This could not, however, be avoided in such a study, where ethical considerations are of utmost importance. Only informants who were aware of their abuse experience and who had (at least partly) been able to work through their trauma with a therapist were deemed eligible for inclusion. To our knowledge, whether psychological trauma treatment is particularly relevant to the dental care context has not been determined (i.e., concomitant with psychological recovery, a patient also experiences a decrease in or disappearance of dental fear, if the topic has not been covered specifically during the therapy).

The present study focuses on the dental care provider's responsibility for ensuring that the dental care encounter is safe and endurable for the patient. The subcategory 'contradictory disclosure' supported the observation that sexually abused patients are often reluctant to talk about their experiences [1,25,26]. They do not object to being asked about violence [27], but are, for significant reasons, not always prepared to answer sincerely, as expressed in the present study. Patients are also reported to prefer less specific questions, for example, the care provider asking if something can be done to make the patient feel more comfortable [28].

Disclosure is reported to also be difficult for the care provider [24,29], as indicated in the present study. The reported reluctance of care providers to ask questions about violence [24,29] is debated [30,31] but it is certainly in conflict with the requirement of the Swedish National Board of Health and Welfare [32].

The caregiver should decide when and how dental personnel [...] must ask questions about violence in order to identify victims of violence and children who have witnessed violence and are in need of care.

Even more serious than the dental care provider avoiding asking the patient about any experience of violence is the response described by the informants: when the patient explicitly

disclosed experience of abuse and the dental care provider did not respond with empathy. Altogether, this indicates a four-fold resistance comprising the patient's reluctance both to tell and to answer sincerely about a violence experience, as well as the dental care provider's reluctance to ask and to respond adequately to a disclosure of violence (Figure 2). Previous studies show improved collaboration between the dentist and the patient in cases where the dentist took the information seriously and did not underestimate the magnitude of the problem [8,28].

It is also important, in a general context, to encourage disclosure of abuse experience, because this is the key to recovery [33] and, thus, an opportunity to avoid or relieve serious health consequences [1,3–5,33–35]. Routine screening for experience of violence in order to facilitate disclosure has been suggested in the literature [36,37] and has resulted in increased disclosure [38]. When a dental care provider is informed of abuse (ongoing, past experience, children involved, etc.) the dental care provider has a duty to act, not only with respect to provision of dental care, but also in accordance with the national legislation; in certain cases, legislation encourages contacting the police or reporting to social services.

The suggested need for alliance between the parties at the dental encounter can be discussed in regard of the concept of power. The dental care providers might be unaware of the consequences of their position of power as an expert, or the consequences of certain actions of their own (or lack of action) while providing treatment. An *expert* in dental encounters can have the upper hand but can also invite the subordinate patient to equality [39] and to form an alliance between the two parties, thus, levelling the power. This is expressed not only by the informants in the present study but also in previous studies: a trauma-sensitive approach [40] by the dental care provider is required as a countermeasure for patients who feel invaded during the physically subordinate position in the dental chair, causing devastating anxiety [41].

There is a reported lack of knowledge among dental care providers about the experience of sexual abuse and its consequences [42,43]. Morriss [44] distinguishes between what one has an "opportunity" to do (ableness) and what one "manages" to do (ability). Here, the relationship between power and responsibility is important [45]. Most of our actions have a number of unintended consequences. It is important to claim that those in power have the responsibility [46] and, in the case of dental care providers, also an obligation to promote the interests of others, but they may fail to do so intentionally or out of ignorance. By using the inherent power position in a constructive way in the dental care setting, treatment of a patient suffering from dental fear can be carried out successfully.

The present study highlights the importance of putting the patient in focus (i.e., adopting an individually tailored treatment approach), and, as reported earlier, making an effort to empower the patient to cope with undergoing dental

treatment [47]. Thereby, the dental care provider is alert to signs of discomfort and implicitly or explicitly expressed patient needs, in order to achieve a successful treatment outcome from both dental care provider and patient perspectives. This has been reported previously, not only in patients with experience of sexual abuse [28] but also in patients with dental fear [11] unrelated to sexual abuse. The informants expressed the need to be taken seriously by the dental care provider and also commented on the important role of the dental nurse in being attentive to individual expressions. Certain ways of securing patients' consent could be discussed and be of interest when studying what makes people compliant. With respect to dental encounters with patients who have experienced sexual abuse, this must be seen in relation to dissociative reactions [48], as reported here. During a dissociative reaction, the patient feels or acts as if the traumatic event is recurring. To unaware dental personnel, the patient appears to be calm and confident and treatment proceeds without the patient's conscious permission, invading the patient's personal boundaries and, in turn, increasing the risk of inducing further trauma. The possible consequences of this are unknown.

The concept of trauma-informed care [36] is also relevant with respect to alertness to patient discomfort and expressions of need. Under trauma-informed care, health care providers should understand how their patients' history of trauma may affect current symptoms and reactions and, regardless of their primary mission, provide services that meet the special needs of trauma survivors and make this service available to all [36]. Trauma-informed care includes making services as sensitive as possible and encouraging patients to participate in treatment decisions [40]. The literature on trauma-informed physical health care is still limited [37], especially with respect to dental care. The present study contributes to knowledge of this field.

The importance of knowledge development concerning the experiences of sexually abused individuals as dental patients is relevant in a Swedish context since a new mandatory examination objective *Show knowledge of men's violence against women and violence in close relationships* was recently (2018, 2019) introduced as a unit in eight educational courses at universities, including undergraduate dental and dental hygienist courses [49]. As the prevalence of child or adult sexual abuse is high [1,6,50,51,52,53], most dental care providers are treating patients with these traumatic experiences, although they are not always aware of the circumstances. The Swedish government has, therefore, assigned to the National Board of Health and Welfare the task of disseminating knowledge of violence to health care educators and providers, including dental care providers, by organizing courses, seminars, and work-shops, many of which are free of charge. Greater awareness of possible reaction patterns among these patients might contribute to bridging the lack

of knowledge and experience that exists in dealing with an affirmative answer to questions of violence, as well as the dental treatment of sexual abuse victims [18,54,55]. On an understanding that the patient has been sexually abused, an individually tailored, patient-centered, and trauma-informed approach to treatment is suggested. Dental care providers may also need to be aware of and reflect on their position of power and its possible chairside implications.

## ACKNOWLEDGEMENTS

All the participating informants are gratefully acknowledged for their valuable contributions. The study was supported by grants from the following organizations: Faculty of Odontology and Centre for sexology and sexuality studies, Malmö University (Malmö, Sweden), and TePe (Malmö, Sweden).

## CONFLICT OF INTERESTS

The authors state no conflicts of interest.

## AUTHOR CONTRIBUTIONS

All authors gave their final approval and have agreed to be accountable for all aspects of the work. EW conceived, planned and collected the material for the project. EW, DG, PN conducted the analysis too which GP also contributed. EW, DG, PN, GP wrote the manuscript draft. Final manuscript editing was performed by EW and GP.

## ORCID

Eva Wolf  <https://orcid.org/0000-0001-7425-1038>

David Grinneby  <https://orcid.org/0000-0002-7253-7793>

Petra Nilsson  <https://orcid.org/0000-0002-4063-0803>

Gisela Priebe  <https://orcid.org/0000-0001-8386-8881>

## REFERENCES

1. World Health Organization. World report on violence and health. Geneva: World Health Organization; 2002.
2. Uppsala Universitet. Våld och hälsa: en befolkningsundersökning om kvinnors och mäns våld utsatthet samt kopplingen till hälsa. NCK-rapport 2014:1. Nationellt centrum för kvinnofrid (NCK); 2014.
3. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *Am J Prev Med*. 1998;14:245–58.
4. Kirkengen AL. *Inscribed Bodies: Health Impact of Childhood Sexual Abuse*. Dordrecht, the Netherlands: Kluwer Academic; 2001.
5. Dube SR, Felitti VJ, Dong M, Giles WH, Anda RF. The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Prev Med*. 2003;37:268–77.
6. Karayianni E, Fanti KA, Diakidoy IA, Hadjicharalambous MZ, Katsimicha E. Prevalence, contexts, and correlates of child sexual abuse in Cyprus. *Child Abuse Negl*. 2017;66:41–52.

7. Akinkugbe AA, Hood KB, Brickhouse TH. Exposure to adverse childhood experiences and oral health measures in adulthood: findings from the 2010 Behavioral Risk Factor Surveillance System. *JDR Clin Trans Res*. 2019;4:116–25.
8. Willumsen T. Dental fear in sexually abused women. *Eur J Oral Sci*. 2001;109:291–6.
9. Willumsen T. The impact of childhood sexual abuse on dental fear. *Community Dent Oral Epidemiol*. 2004;32:73–9.
10. Armfield JM, Heaton LJ. Management of fear and anxiety in the dental clinic: a review. *Aust Dent J*. 2013;58:390–407.
11. Brahm C. The fearful patient in routine dental care [dissertation]. Gothenburg: Department of Behavioural and Community Dentistry. Institute of Odontology, Sahlgrenska Academy, University of Gothenburg; 2018.
12. SFS1985:125. [Internet]. Tandvårdslagen, 1985 [cited 2020 Sep 10]. Available from: <http://rkrattsbaser.gov.se/sfst?bet=1985:125>
13. Kundu H, Singla A, Kote S, Singh S, Jain S, Singh K, et al. Domestic violence and its effect on oral health behaviour and oral health status. *J Clin Diagn Res*. 2014;8:ZC09–12.
14. Schuller AA, Willumsen T, Holst D. Are there differences in oral health and oral health behavior between individuals with high and low dental fear? *Community Dent Oral Epidemiol*. 2003;31:116–21.
15. Armfield JM, Spencer AJ, Stewart JF. Dental fear in Australia: who's afraid of the dentist? *Aust Dent J*. 2006;51:78–85.
16. Pohjola V, Lahti S, Vehkalahti MM, Tolvanen M, Hausen H. Association between dental fear and dental attendance among adults in Finland. *Acta Odontol Scand*. 2007;65:224–30.
17. Armfield JM. The avoidance and delaying of dental visits in Australia. *Aust Dent J*. 2012;57:1–5.
18. Wolf E, McCarthy E, Priebe G. Dental care – an emotional and physical challenge for the sexually abused. *Eur J Oral Sci*. 2020;128:317–24.
19. Hodgson TA, Meiners MR. Cost-of illness methodology: a guide to current practices and procedures. *Milbank Mem Fund Q Health Soc*. 1982;60:429–62.
20. Pope C. Qualitative methods in health research. In: Pope C, Mays N, editors. *Qualitative Methods in Health Care*, 2nd edn. London, UK: BMJ Publishing Group; 2000.
21. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24:105–12.
22. Morse JM, Field P. *Qualitative Research Methods for Health Professionals*, 2nd ed. Thousand Oaks, CA: Sage Publications; 1995.
23. Bower E, Scambler S. The contributions of qualitative research towards dental public health practice. *Community Dent Oral Epidemiol*. 2007;35:161–9.
24. Leeners B, Stiller R, Block E, Görres G, Imthurn B, Rath W. Consequences of childhood sexual abuse experiences on dental care. *J Psychosom Res*. 2007;62:581–8.
25. Samelius L, Wijma B, Wingren G, Wijma K. Somatization in abused women. *J Womens Health*. 2007;16:909–18.
26. Priebe G, Svedin CG. Child sexual abuse is largely hidden from the adult society. an epidemiological study of adolescents' disclosures. *Child Abuse Negl*. 2008;32:1095–108.
27. Nelms AP, Gutmann E, Solomon ES, Dewald JP, Campbell PR. What victims of domestic violence need from the dental profession. *J Dental Educ*. 2009;73:490–8.
28. Kranstad V, Søftestad S, Fredriksen TV, Willumsen T. Being considerate every step of the way: a qualitative study analysing trauma-sensitive dental treatment for childhood sexual abuse survivors. *Eur J Oral Sci*. 2019;127:539–46.
29. Love C, Gerbert B, Caspers N, Bronstone A, Perry D, Bird W. Dentists' attitudes and behaviours regarding domestic violence – the need for an effective response. *JADA*. 2001;132:85–93.
30. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. *Br Med J*. 2002;325:314–8.
31. Coulthard P, Warburton AL. The role of the dental team in responding to domestic violence. *Br Dent J*. 2007;203:645–8.
32. SOSFS. [Internet]. Socialstyrelsens föreskrifter och allmänna råd om våld i nära relation. 2014;4; 2017:8 [Cited 2020 Sept 8]. Available from: <https://www.socialstyrelsen.se/regler-och-riktlinjer/foreskrifter-och-allmanna-rad/konsoliderade-foreskrifter/20144-om-vald-i-nara-relationer/>
33. Jeong S, Cha C. Healing from childhood sexual abuse: a meta-synthesis of qualitative studies. *J Child Sex Abus*. 2019;28:383–99.
34. Samelius L, Wijma B, Wingren G, Wijma K. Lifetime history of abuse, suffering and psychological health. *Nord J Psychiatry*. 2010;64:227–32.
35. Caravaca Sánchez F, Ignatyev Y, Mundt AP. Associations between childhood abuse, mental health problems, and suicide risk among male prison populations in Spain. *Crim Behav Ment Health*. 2019;29:18–30.
36. Harris M, Fallot RD. Envisioning a trauma-informed service system: a vital paradigm shift. *New Dir Ment Health Serv*. 2001;89:3–22.
37. Reeves E. A synthesis of the literature on trauma-informed care. *Issues Ment Health Nurs*. 2015;36:698–709.
38. Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev*. 2013;4:CD007007.
39. Giddens A. *The Constitution of Society: Outline of the Theory of Structuration*. Cambridge, UK: Polity Press; 1984.
40. Raja S, Rajagopalan CF, Kruthoff M, Kuperschmidt A, Chang P, Hoersch M. Teaching dental students to interact with survivors of traumatic events: Development of a two-day module. *J Dent Educ*. 2015;79:47–55.
41. Fredriksen TV, Søftestad S, Kranstad V, Willumsen T. Preparing for attack and recovering from battle. Understanding child sexual abuse survivors' experiences of dental treatment. *Community Dent Oral Epidemiol*. 2020;48:317–27.
42. Skelton J, Herren C, Cunningham LL Jr, West KP. Knowledge, attitudes, practices, and training needs of Kentucky dentists regarding violence against women. *Gen Dent*. 2007;55:581–8.
43. Drigeard C, Nicolas E, Hansjacob A, Roger-Leroi V. Educational needs in the field of detection of domestic violence and neglect: the opinion of a population of French dentists. *Euro J Dent Educ*. 2012;16:156–65.
44. Morris P. *Power: A Philosophical Analysis*, 2nd edn. Manchester, UK: Manchester University Press; 2002.
45. Connolly WE. *The Terms of Political Discourse*, 2nd edn. Oxford, UK: Robertson; 1983.
46. Lukes S. *Power: A Radical View*, 2nd ed. Basingstoke, UK: Palgrave Macmillan; 2005. expanded edn.
47. Søftestad S, Kranstad V, Fredriksen TV, Willumsen T. Invading deeply into self and everyday life: how oral health-related problems

- affect the lives of child sexual abuse survivors. *J Child Sex Abus.* 2020;29:62–78.
48. American Psychiatric Association. DSM-5 Task Force. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
  49. Svensk Författningssamling. [Internet]. Förordning om ändring i högskoleförordningen; 1993:100 [Cited 2020 Sept 8] 2017:857. Available from: [https://www.lagboken.se/Lagboken/start/sfs/sfs/2017/800-899/d\\_3045625-sfs-2017\\_857-forordning-om-andring-i-hogskoleforordningen-1993\\_100](https://www.lagboken.se/Lagboken/start/sfs/sfs/2017/800-899/d_3045625-sfs-2017_857-forordning-om-andring-i-hogskoleforordningen-1993_100)
  50. Barth J, Bermetz L, Heim E, Trelle S, Tonia T. The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. *Int J Public Health.* 2013;58:469–83.
  51. Conley AH, Overstreet CM, Hawn SE, Kendler KS, Dick DM, Amstadter AB. Prevalence and predictors of sexual assault among a college sample. *J Am Coll Health.* 2017;65:41–9.
  52. López S, Faro C, Lopetegui L, Pujol-Ribera E, Monteagudo M, Avecilla-Palau À, et al. Child and adolescent sexual abuse in women seeking help for sexual and reproductive mental health problems: prevalence, characteristics, and disclosure. *J Child Sex Abus.* 2017;26:246–69.
  53. Azzopardi C, Eirich R, Rash CL, Macdonald S, Madigan S. A meta-analysis of the prevalence of child sexual abuse disclosure in forensic settings. *Child Abuse Negl.* 2019;93:291–304.
  54. Harmer-Beem M. The perceived likelihood of dental hygienists to report abuse before and after a training program. *J Dent Hyg.* 2005;79:1–12.
  55. Aved BM, Meyers L, Burmas EL. Challenging dentistry to recognize and respond to family violence. *CDA J.* 2007;35:555–63.

**How to cite this article:** Wolf E, Grinneby D, Nilsson P, Priebe G. Dental care of patients exposed to sexual abuse: Need for alliance between staff and patients. *Eur J Oral Sci.* 2021;129:e12782. <https://doi.org/10.1111/eos.12782>