

Providing dental care to survivors of childhood sexual abuse

Treatment considerations for the practitioner

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“Yeah, [going to the dentist is] a little difficult for me, because of what had happened to me in the past. I just get that feeling ... when you have no control because you’re in the chair, your mouth is frozen, and you’re pretty much at the mercy of that person.”

—A male survivor of child sexual abuse

Many adults do not anticipate a visit to the dentist joyfully. However, some people experience dental care as a frightening ordeal to be avoided if at all possible and endured only when necessary. This article reports the findings of a

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research study that investigated how some adults with self-reported histories of childhood sexual abuse experience dental treatment. On the basis of this study, we present some ideas that dentists might wish to consider as they reflect on their interactions with patients.

In view of the prevalence of a history of childhood sexual abuse in the general population, dentists probably see patients with such histories several times a week. While prevalence rates vary among studies, reliable evidence indicates that up to 13 percent of females and between 5 and 10 percent of males have been exposed during child-

Background. Adults who experienced childhood sexual abuse frequently find dental treatment difficult to tolerate. Increased understanding of common long-term effects of this trauma may help dental professionals to respond more sensitively to patients who have experienced it.

Methods. The authors recruited 58 men and 19 women with self-reported histories of childhood sexual abuse from social agencies serving this population and interviewed the participants about their experiences with health care professionals, including dentists. The authors analyzed interview transcripts using the constant comparative method to identify main themes and patterns.

Results. Participants reported aspects of dental treatment that can be particularly difficult for them and offered ideas about how dental health professionals could make the experience more tolerable for them. The data analysis produced suggestions about how dentists might respond sensitively to patients who frequently cancel appointments, are distressed by certain body positions, need a sense of control and fear judgment. The authors also report participants’ thoughts about questions from dental practitioners regarding a history of childhood sexual abuse.

Conclusions. Adults who report a history of childhood sexual abuse are more likely to experience dental treatment more positively when dental professionals have some understanding of the long-term effects of such abuse, including how it can affect dental treatment interactions. Such knowledge enables dental professionals to respond to their needs in a sensitive manner.

Key Words. Sexual child abuse; long-term survivors; client-centered practice.

hood to acts of sexual abuse that involved penetration.¹ When studies include less intrusive forms of sexual abuse, the proportion increases to between 15 and 30 percent of females and between 3 and 15 percent of males.¹

The term “child sexual abuse” is used to describe a wide range of acts, but

legal and research definitions require two criteria:

- the act, involving a child, is intended for sexual stimulation;
- “an “abusive condition” such as coercion or a large age gap between the participants indicating lack of consensuality.”^{2(p32)}

Children who are sexually abused often are physically or emotionally abused as well.¹

To consider the clinical implications for the dentist working with formerly abused adults, it is important to first reflect on the dynamics and sequelae of sexual abuse. The sexual abuse of a child usually occurs in a situation in which the child is alone with an older person; this person is seen by the child as having more knowledge, experience and authority than the child, and the child frequently feels confused, helpless or frightened by the older person’s behavior. Abusers often “groom” their victims, beginning with activities that seem harmless, such as giving a back massage, and they frequently attribute positive motives to their sexual behavior, suggesting that it represents love or necessary education.³ It is only later that the child realizes that he or she was manipulated into cooperating, and that his or her needs and interests were not the concern of the offender. Frequently, the sexual activity involves the child’s mouth, genitals or both.

It is not difficult to see the parallels between some aspects of the abuse experience and elements of dental care. Patients are expected to trust the professional to do what is best for them. The professional often assures them, much as their abusers did, that while the experience may be painful or unpleasant, in the end it will be good for them. The treatment requires that a part of the body be touched or intruded on. The patient is expected to lie passively in a chair with the clinician working above him or her. Often, the patient is alone in the room with the dental professional.

Some of the psychological effects of childhood sexual abuse can interfere with a person’s ability to benefit from dental care. Partly because when, as children, they tried to tell someone about the abuse, they either were not believed or were blamed for the inappropriate sexual behavior, many adult survivors feel guilt and expect that others will judge them negatively. This can lead to increased sensitivity to perceived criticism and difficulty in asserting themselves.⁴ Understandably, reluctance to trust others and attempts to

control a situation when feeling vulnerable are not uncommon behaviors in adults who were abused as children.⁵ Sexual abuse in childhood now is recognized as frequently leading to post-traumatic stress reactions involving changes in neuroanatomy.⁶ People who have experienced traumatic events often dissociate as a way of coping with overwhelming stimuli.⁴ (Dissociation is defined as “a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.”^{7(p477)}) The tendency to use dissociation to avoid anxiety-provoking stimuli can be transferred to situations that simply remind the person of the traumatic event.

Given the long-term impacts of childhood sexual abuse and the fact that dentists are likely to treat—knowingly or unknowingly—patients who have such a history, it is important for the dental team to gain some insights about how they can work with these patients more effectively. We have found no previous research investigating how adults with childhood sexual abuse histories experience dental treatment. Our study did not focus exclusively on participants’ experiences with dental care, but in the course of talking about their experiences with a range of health care professionals, the participants talked about their experiences when seeking dental treatment.

METHODS AND SUBJECTS

We conducted individual interviews with 49 men and 19 women, and we talked with nine additional men in a group setting; all identified themselves as having experienced childhood sexual abuse.² (We also interviewed 27 women sexually abused as children for a previous study focusing on experiences with physical therapists.⁸) We recruited participants through agencies, and by contacting people who provide counseling and support for survivors of childhood sexual abuse. (Mental health professionals commonly use the term “survivor” to refer to people who report childhood sexual abuse because it emphasizes the strength of these people’s coping strategies rather than their victimization.) We sent a written description of the study and posters to the service providers. People interested in participating in the study were invited to contact the researchers. Our ethics review boards required that we ask potential participants if they had a therapist or other support person with whom they could talk afterward if the interview was upsetting to them.

The interviews were conducted primarily in agency settings located in Ontario, Saskatchewan, Manitoba and British Columbia, Canada. A small number of interviews were conducted in the researchers' offices or other facilities, and one interview was conducted by phone. Each of the subjects was offered an honorarium to cover expenses and express appreciation for his or her participation.

Three of the authors (C.L.S., C.A.S. and E.T.) conducted the interviews, which were audiotaped and transcribed. The interviewer explained to the participant that the researchers were interested in knowing about the participant's experiences with health care professionals such as physicians, dentists, nurses and physical therapists. The interviewer asked the participant to talk about his or her experiences (both more and less positive) and about practices that he or she thought would be sensitive to survivors' needs. No attempt was made by the interviewer to predefine relevant data or to use predetermined questions. The interviews focused on the experiences that the participant identified. Using the constant comparative method,⁷ we coded the interviews using NVivo version 2.0161 software (QSR International, Melbourne, Australia).⁸

RESULTS

Subject demographics. The mean age of the participants was 44.7 years (range, 24-62 years). Thirty-two (41.6 percent) were single, 33 (42.9 percent) were married or in common-law relationships, and 11 (14.3 percent) were separated or divorced; marital status information was missing for one participant. Three (3.9 percent) had attended or completed primary school, 24 (31.2 percent) had attended or completed secondary school, 19 (24.7 percent) had attended or completed post secondary programs other than university programs, and 31 (40.3 percent) had attended or completed university programs. Sixty-eight participants (88.3 percent) were white, and nine (11.7 percent) were Aboriginal.

Strategies for treating survivors. Survivors of childhood sexual abuse may present a challenge to dental practitioners, in terms of both

appointment scheduling and actual treatment. However, there are strategies that can be used to assist a reluctant, apprehensive patient in tolerating the procedure without prompting him or her to resort to behaviors that negatively affect his or her dental health or evoke frustration on the part of the dentist.

The participants made some suggestions about how dentists can make the dental environment and the procedures themselves more comfortable. We have added others that are based on the participants' comments. It is important to note that these are suggestions for consideration rather than prescribed guidelines. We also want to emphasize that survivors are not a homogeneous

group, and our study may not have captured the full range of responses that survivors may experience. Furthermore, "sensitive" dental treatment of survivors may not be a viable option for every practitioner; in many cases it will consume more time, which may be difficult in a tightly scheduled practice. It also requires a certain level of understanding and compassion that not every dentist may be willing or able to provide. If a practitioner feels uncomfortable or unable to offer

the support that an abuse survivor requires, he or she probably ought to consider referring the patient to another office that might be better suited to the patient's immediate needs. If such a referral is explained as being in the patient's best interest, it is less likely to be perceived as abandonment or rejection. That said, here are some concerns shared by the survivors, and some suggestions for addressing their needs.

Being asked about a history of abuse.

Child sexual abuse is more prevalent in our communities than many of us would like to believe; it occurs in all socioeconomic groups. Therefore, many dental patients will be abuse survivors. But should they share this with a dentist? And should dentists ask? While participants frequently connected their difficulties with dentists to their abuse experiences, many felt it would be inappropriate for a dentist to ask a direct question about abuse, and some said they would not answer such a question honestly. Other participants, however, felt disclosure to their dentist would set the stage

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for a more positive working relationship. In light of this, less specific questions might be helpful—for example, “Are there any parts of dental treatment that are particularly difficult for you? Is there anything we can do to help you feel more comfortable?” One survivor said, “Just ask that question, ‘Are you comfortable? Is there anything you need?’” This kind of task-focused question allows the survivor to respond in a manner appropriate to his or her comfort level.

Tendency to cancel appointments. Survivors’ heightened sensitivity to dental procedures is paralleled by their increased tendency to cancel appointments as a means of avoidance. One man said he often cancels dental appointments: “I put it off for about five or six times ... my wife has been bugging me for a while now: ‘The dentist has been calling you, you’ve got to go now.’ [I say] ‘OK, I’ll call her back’ and I don’t call her back.”

A strategy to avoid the inconvenience and financial implications of repeated rescheduling might be to offer a “same-day” appointment. If the patient feels “ready” on a particular day, he or she may call the office seeking to take a slot left open by a short-notice cancellation, if one is available, for that same day.

Discomfort with body positioning. Reclining in a dental chair can feel threatening to the survivor. As one man describes the experience: “You are ... supine ... with your head lowered ... so you are really vulnerable physically, and many of us have been violated orally ...”

Another describes the experience as a heightened “power imbalance.” While supine positioning cannot be avoided, it will be accepted more readily if the explanation is given that it affords better visibility and therefore renders higher-quality treatment. Offering the patient the opportunity to “watch” part of the treatment via a mirror may provide him or her with an additional feeling of security.

Sense of loss of control. The practitioner who can help the survivor feel some sense of control during treatment will be addressing the patient’s abuse-related fears and laying the groundwork for greater compliance. Actions as simple as asking permission to perform a procedure can reduce the patient’s feeling of anxiety and powerlessness. Survivors also appreciate the concept of “inform before you perform,” as described in these statements:

■ “I find her good because she does explain

everything that she is going to do and why she’s doing it at the time and sort of checks, ‘Is that O.K.?’”

■ “He tells me what he’s going to do next. So, long before I can anticipate, he’s already told me ...”

Although the practitioner may perceive these explanations as repetitious, they are valuable to the apprehensive patient. Allowing “breaks” during treatment, addressing the patient’s comfort by checking in with him or her frequently and following up on negative body language are helpful to all patients, but especially so to survivors of childhood sexual abuse. In many offices, patients know that raising a hand during treatment is the commonly used signal for “stop,” and they know their request will be respected. Several of the participants confirmed that their experience of this practice was helpful. “If I [put] my hands across like this, or I was blinking continually that was, ‘stop,’ you know, and I was in control,” said one participant. “Most of the time [with this dentist] it’s like, ‘You know the signals, right?’ And I go ‘yeah.’ And he’d always review the signals ... ‘This is what you can do for yes, this is no, this is stop.’”

Fear of judgment and sensitivity to perceived criticism. One man talked about how he avoided going to the dentist because he was ashamed of his fear of dental treatment. He also expected to be reprimanded for neglecting his teeth: “When they do my teeth, they are going to say, ‘Oh, you haven’t been taking care of them, you should have come in before.’”

While patients deserve and expect a realistic evaluation of their dental health, they may become upset on hearing a poor prognosis for a condition that would have been preventable if treated in a timely fashion. We are not recommending that dentists deliver a “sugar-coated” message. However, given that many clients arrive at dentists’ offices with the belief, rooted in childhood, that they are “bad” or “undeserving” and may expect to be judged harshly, it is important that dentists phrase their message carefully so as not to appear to be scolding or condescending. Often, a simple change of vocal tone can accomplish this.

Neglect of dental health may be an indicator that the patient does not consistently value his or her body or self. Rather than reprimand such a patient, consider asking how you can help the patient take better care of his or her teeth.

Latex gloves and condoms. More than one survivor talked about how, for them, the smell of latex gloves is associated with sexual abuse. “[Visiting] dentists, for me is, even on a good day, a total, absolute nightmare,” said one participant. “I’ll tell you why: number one, the gloves smell like condoms.”

Especially in today’s climate, gloves are essential. However, if your patient seems particularly anxious about the use of latex, you could consider using vinyl as an alternative. As with all of the other suggestions, consider your own comfort level. A positive experience for the patient almost always is associated with a positive experience for the dentist.

CONCLUSION

The survivors we interviewed were aware that dentists are not expected to have expertise in treating the effects of childhood sexual abuse. However, they indicated that dentists who have some understanding of the traumatic effects of childhood sexual abuse and who respond sensitively to signs of discomfort are much appreciated. Dentists who are willing to work with their patients to make dental treatment less problem-

atic for them also contribute to an experience of mastery for the survivor that can have far-reaching positive effects. ■

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