A report on the development of a dental service for adult survivors of childhood sexual abuse

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Literature review

It is difficult to say exactly how many children are sexually abused, due to under reporting, and to the different research methods used when collecting data. Finkelhor (1994) reports that one in five girls and one in ten boys may be sexually abused in childhood. His earlier work in 1990 (Finkelhor et al., 1990) estimates from one quarter to one third of females before the age of 18 had been sexually abused. An extensive study of child sexual abuse in 1983 reported that among adult Canadians, 53% of women and 31% of men were sexually abused when they were children (Bagley, 1998), although these high prevalence rates have not been replicated in other studies. In 1999, the United States Department of Health and Human Services survey of recent epidemiological studies, found that 15–33% of females and 13–16% of males were sexually abused in childhood. Clearly, these figures vary greatly.

Children who have disabilities are especially vulnerable to sexual abuse (Sobsey and Varnhagen, 1991; Graham, 1993). A 1993 report by the United States National Center on Child Abuse and Neglect goes on to state that the rate of sexual abuse of children with a disability is higher than the rate of children with no disability.

The long-term effects of child sexual abuse persist into adulthood. It is a significant factor in adult mental health (Goodman et al., 1997; Harman, 1992) with higher levels of mental health symptoms in survivors (Banyard et al., 2001; Moeller and Bachmann, 1993). In particular, depression, anxiety, self-harm, suicidal thoughts and acts, earlier onset of bipolar illness, increased alcohol and drug abuse and low self esteem (Beitchman et al., 1992; Bagley et al., 1994; Boudewyn and Liem, 1995; Hays and Stanley, 1996; Wennmger and Heiman, 1998; Leverich et al., 2002). The duration, severity and frequency of abuse are directly related to a greater impact in adult life (Boudewyn and Liem, 1995; Callahan et al., 2003).

Survivors are more likely to develop an eating disorder such as bulimia or anorexia; one study claimed 61% of girls with eating disorders had reported sexual abuse (Miller, 1996; The Royal College of Psychiatrists, 1999). Survivors may also suffer from a complex post-traumatic stress disorder with extreme anxiety, dissociation, or flashback (Hays and Stanley, 1996; Willumsen, 2001).

A Medline search using the keywords “sexual abuse and dentistry” listed 32 articles. Most articles primarily covered the use of bitemarks in rape cases and oral signs and symptoms of abuse. In the lone European article that specifically covered dental fear and sexual abuse (Willumsen, 2001), the author noted that knowledge of the consequences of sexual abuse on dental anxiety is limited. This Scandinavian study looked at the anxiety levels towards dentistry experienced by 99 women who had undergone sexual abuse. All the women had higher scores on the dental fear scale used than the female Norwegian population; interestingly, approximately half had not previously linked the dental phobia with their abuse. Several individuals had reported that successful treatment helped them regain feelings of control over their mouth and helped their psychological health.

Abuse-related crises in adult life could be triggered by dental treatment (Hays and Stanley, 1996; Willumsen, 2001). Triggers can be the physical contact or more specific similarities, for example silver instruments and a knife being held at someone's throat. Symptoms of the complex post-traumatic stress disorder mentioned earlier can occur.

Two further articles on sexual abuse and dental fear (Hays and Stanley, 1996; Walker et al., 1996) expand on the difficulties experienced by these patients. Such patients have fears of being trapped in the dental chair, being in a horizontal position, feeling claustrophobic, being alone with someone more powerful, loss of control, having objects placed in their mouth, being unable to breathe or experiencing choking or severe gagging that interferes with treatment. Essentially, the impact of childhood sexual abuse can cause difficulty later with oral health care due to a symbolic re-creation of the experience.

An American study (Riley et al., 1998) found that female patients who had a history of sexual abuse had a tendency to amplify and over-interpret somatic symptoms when they
attended a facial pain clinic. It was also noted in the studies mentioned previously (Hays and Stanley, 1996; Willumsen, 2001) that sexually abused persons might exhibit unusual pain reactions. Survivors may also have problems associated with TMJ and bruxism, which is known to be stress related (Hays and Stanley, 1996).

Project rationale, background and significance

Safeline (Surviving Abuse with Friendship and Education) is a voluntary association established in the early 1990s, mainly by survivors of childhood sexual abuse. Their services include individual counselling, support groups, confidential telephone help lines and newsletters. Although the clients are predominantly female, since the website (www.safelinewarwick.co.uk) was established, Safeline report contact with an increasing number of male survivors and those with sensory impairments as well as other disabilities such as agoraphobia and mobility problems.

In 2001/2002 Safeline conducted a research project for the Trust centred on a questionnaire completed by 41 clients and semi-structured interviews with 15 of the clients (Shoreman, 2002). The study reported that impacts of abuse on interviewees’ lives were often extensive and varied. They included effects on their social networks, capacity to work, use of services, public transport and any service provided by men. When asked about barriers to services, dentistry was noted as a particular problem. The expected barriers of fear, perceived cost, transport issues and time lost from work were mentioned. Specifically to this group, over a quarter of the respondents cited childcare problems as they found it very difficult to trust anyone else to look after their children. Seven per cent of the respondents had agoraphobia and/or literacy problems. Survivors felt they would be a nuisance to service providers and take up services needed more by others. Individuals described the way in which their lives were re-arranged so that women provided all regular services. Others who had been fed tranquilisers by abusive parents were for example unable to face recommended operations or medical interventions involving sedation or anaesthetics.

In addition, the Safeline website had received several comments which highlighted shared experience of profound anxiety about dentistry. Many survivors had seemingly never made contact with dental services.

The aim of the project was to co-work with Safeline to set up a service designed to overcome the barriers experienced by survivors of childhood sexual abuse and encourage engagement of the service by the target population.

Study

The first objective was to train the dental team to increase knowledge and understanding of the impacts of sexual abuse on adult survivors.

Safeline organised a study day in the format of an inter-active workshop entitled ‘Working with Adult Survivors of Childhood Sexual Abuse’, attendance was optional. The aim of the day was to improve practitioners’ skills and confidence in working with people who have been sexually abused. Topics covered included the statistics on sexual abuse, why children don’t tell and silent ways of telling, who can be an abuser, the cycle of abuse, effects in adult life, particularly triggers and flashbacks, responding to survivors, treating people and looking after yourself. A survivor was also present to give a verbal account of her experiences and answer questions.

Fourteen out of 19 staff attended, all participants completed anonymous evaluation sheets. When asked about the workshop as a whole, on a scale of 1 to 5 with 1 being very useful and 5 being not useful, 6 people scored 1, 6 people scored 2 and 2 persons scored 3.

The second objective was the planning and implementing of a dental service to increase access for anxious patients with a history of sexual abuse.

The service proposals and referral forms were drafted utilising the information from the literature review and advice from the Project Manager at Safeline. Referral forms (available from the author) enquired about previous dental experiences and particular difficulties or worries patients had, such as choking or losing control. If completing the referral form brought back distressing thoughts or feelings, the counsellor worked through these issues before submitting the referral. The dentist was therefore made aware of any issues without having to explore these areas in detail with the patient, which was felt to be inappropriate.

A copy of an NHS fees guide was sent to help with overcoming perceived cost as being a barrier to care (Shoreman, 2002). Only single courses of treatment were offered as it was hoped the patient could work through the trigger with Safeline counsellors and then be able to access general dental services. Safeline increased awareness of the service via their helplines, newsletters, group meetings and counselling sessions.

New patients were telephoned initially, if requested, before attending the clinic for assessment, often with a Safeline ‘buddy’ – a survivor, or a non-survivor who understands the issues, and can help prevent crises by being available when other people are not (Shoreman, 2002). Neutral ground or introductory home visits for initial assessments were available, if required. The dental service provided the study day, time, clinics, staff and extra services (sedation, general anaesthesia etc) out of the dental budget and Safeline funded the ‘buddying’ system and counselling.

In the period from April 2004 to May 2005 seven patients were referred. Four attended their initial appointments, had an oral examination on that day and completed courses of treatment. Three failed to attend. All had been initially contacted by telephone and talked through any concerns with the dentist.
Discussion

The study day generated a lot of interest from our staff; some had treated known survivors in the past and were keen to learn more. Many were concerned that the day would be harrowing or upsetting. The workshop run by Safeline on a difficult subject was obviously informative and thought provoking, but also enjoyable and received many positive comments from staff.

The most important general aspects of service provision for survivors are confidentiality, privacy, continuity, quick response, accessibility and flexibility. Talking to a survivor at the workshop revealed she and many others were paranoid, defensive and trusted no one. Verification of police checks may be requested. Survivors are often over-protective of their children and cannot leave them with others. Tremendous anger can be provoked in a survivor; for example, she had hit a dentist once when she panicked. They also have good and bad days and would cancel an appointment at short notice if they couldn’t stand anything in their mouth that day.

Conclusions

For dental visits, survivors cite the following strategies as helpful:

- To increase the patient’s sense of control and safety, arrange pre-appointment telephone calls, always have a dental nurse present and leave the door open
- Long introductory appointments are helpful to gain trust, as is bringing along a third party
- An agreed sign to stop (commonly raising a hand) is helpful
- To prevent flashbacks avoid physical contact, however well meaning, as far as possible and have the dental chair upright (Hays and Stanley, 1996)
- Survivors are taught to focus on something to stay grounded and avoid flashbacks; a picture of a tropical island on the surgery ceiling above the dental chair was recommended
- If a flashback occurs in the dental chair this can resemble a trance like state, and the patient may speak in a child-like voice. A simple technique, which can be used by dentists, is that you stop, say clearly to the patient that they are at the dentist and that they are safe. If a Safeline ‘buddy’ is present, the dentist would defer to them. They have used a child’s tooth fairy book to help ground and refocus a patient who was having a flashback, as the patient dissociated into a child like state and could relate to this.
- The fact the referral has come from Safeline. The patients know you understand their history and why they are dental phobic without having to discuss the abuse directly. They also take great comfort from knowing Safeline have validated and trained the dental team.

Safeline continue to inform clients about the dental service, many are very interested but remain too frightened to attend a dentist. Clients need more time and when appropriate, counsellors will support patients in coming forward. This explains the initial low number of referrals.

Finally, the training offered was most useful for other dental phobics not from Safeline who do not necessarily reveal sexual abuse in their history, including patients with mental health problems, self-harm or eating disorders. The likelihood that they may have been abused is borne in mind and greatly helps patient management, but is not discussed.

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References


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