CPD: ONE HOUR

# Trauma-informed, *sensitive practice*

**Linda M. Douglas**[1] explains how to provide 'The Umbrella of Safety' for patients with dental phobia.

I was inspired to write this article after hearing comments from exasperated colleagues about our more challenging patients. For example: angry, or seemingly apathetic individuals; those who refuse to be reclined in the chair when there is no obvious physical impediment; irregular attenders; and those with poor self-care. These behaviours might be a result of mental health issues, like dental phobia. Since reading *The handbook on sensitive practice for healthcare practitioners: Lessons from adult survivors of sexual abuse*,[1] and literature on trauma-informed practice,[2] I gained some insight into what might be happening with these individuals, and now feel more empathy.

Dental phobia is classified as a specific phobia within the *Diagnostic and statistical manual of mental disorders*.[3] Dental phobias might be a consequence of negative experiences with childhood dental care: for example, some individuals might have suffered from childhood neglect, resulting in frequent dental pain. In the past, many indigenous children in Canadian residential or Indian day schools endured non-consensual dental treatment, and extractions without local anaesthesia.[4]

Others with dental phobia might have a history of being childhood victims of violence, or sexual abuse. Survivors of abuse have experienced violation of their personal boundaries. They have been traumatised, betrayed, and are often stigmatised, and made to feel powerless. Childhood sexual

**CPD questions**

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[1] *Linda Douglas, RDH, BSc, is a British dental hygienist based in Ontario, Canada. Linda has previously written for* BDJ Team *on caring for dental patients with eating disorders (http://go.nature.com/2fKzNaF) and making oral cancer screening a routine part of your patient care (http://go.nature.com/2xvO8e0 and (http://go.nature.com/2xuCrJk).*

abuse, particularly of young children may also be oral in nature, causing many survivors to experience difficulties tolerating various aspects of oral healthcare.

## Factors causing irregular attendance

A history of trauma or abuse could lead to depression or low self-esteem, and feeling unworthy of proper health care. Patients might also have an aversion to being touched, and having their personal space invaded. Certain aspects of a dental visit might trigger flashbacks, making such patients feel abused all over again. This can manifest as distrust, anxiety, hypersensitivity, irritability and a tendency to startle easily; some individuals also display anger, or aggression. Triggers vary considerably: from sights, sounds and smells, to something about a clinician's appearance which reminds a survivor of their abuser. For example, the view of the ceiling while lying in the dental chair could be a trigger, which reminds the survivor of the position they were forced into while being abused.

Some victims of abuse cope with the violation of their body or personal space by entering a dissociative state, in order to detach themselves from the abuse they are powerless to fight off. In this state, they experience altered perception, sensation and sense of time. These individuals have also learned to ignore or dissociate from pain, which could lead survivors to ignore symptoms of disease and delay seeking help, thus delaying an accurate diagnosis.

*'A HISTORY OF TRAUMA OR ABUSE COULD LEAD TO DEPRESSION OR LOW SELF-ESTEEM, AND FEELING UNWORTHY OF PROPER HEALTH CARE. PATIENTS MIGHT ALSO HAVE AN AVERSION TO BEING TOUCHED, AND HAVING THEIR PERSONAL SPACE INVADED.'*

## Prevalence of childhood abuse

The incidence of child abuse, especially sexual abuse, is under-reported because the victims are usually coerced into secrecy with threats of harm; many survivors maintain this secrecy into adulthood, partly out of shame. A 2003 study found that 32.3% of women and 14. 2% of men reported sexual abuse in childhood, and 21% of adults who reported histories of childhood sexual abuse also experienced other physical maltreatment.[5] Research has shown that child abuse occurs in all countries studied,[6] and is not limited by ethnicity or socio-economic status. Children with disabilities are more likely to be abused than children without disabilities.[7] Studies suggest that sexual abuse of male children by adult females occurs more frequently than was previously thought. Sadly, this is often taken lightly, as an experience any boy should be glad to have, when they experience as much violation and trauma as female survivors.

## Factors which compromise self-care

Survivors of sexual abuse are often stigmatised, feeling hate, shame and guilt about their bodies that can lead to a distorted sense of self, and low self-esteem. This could contribute to a failure to care for oneself: manifesting as risky behaviours, self-harm, poor health practices, and poor hygiene.

Survivors who became dissociative during episodes of abuse might continue to dissociate whenever they are under stress. If they are stressed during their visits for dental care, they might appear to be apathetic.

## How can we help?

Understanding how these factors affect our patients is termed trauma-informed practice.

These nine Principles of Sensitive Practice form the framework of The Umbrella of Safety, and facilitate feelings of safety for our patients:

1. **Respect:** this means acknowledging the inherent value of each individual, and suspending critical judgement. Respect means a great deal to survivors of abuse; we can show respect by listening to the patient, and heeding their concerns. This helps to foster trust.
2. **Taking time:** making the patient feel genuinely heard and not rushed.
3. **Rapport:** display caring, concern and empathy; use active listening techniques.
4. **Sharing information:** being transparent, by informing patients of their choices so they can give us their informed consent. They also need to know what to expect during their treatment, and the rationale and length of time needed for each procedure. Follow up verbal oral health counselling with written materials.

5. **Sharing control:** Helping the patient to feel a sense of control during treatment by working *with*, not just *on* the patient addresses abuse-related fears and facilitates compliance. We should ask them what they can tolerate. In addition to obtaining informed consent before a procedure, we should reaffirm consent at different stages of the appointment. The patient should be assured that they can stop for a break at any time, and that they can indicate if they are not comfortable by communicating with previously agreed hand signals.
6. **Respecting boundaries:** the total disregard of personal boundaries during abuse teaches victims that their wants and needs are of no consequence. We should ask for consent before entering the patient's personal space, as well as before beginning a procedure.
7. **Fostering mutual learning**: survivors of trauma have often learned not to question professionals, and may need encouragement to assert their autonomy and participate fully in their own health care. We clinicians can also learn from our patients how best to manage their care.
8. **Understanding non-linear healing:** the ability of the patient to tolerate examination and treatment might vary from one visit to the next, as they experience good days, and bad days.
9. **Demonstrating awareness and knowledge of interpersonal violence:** we can do this by having educational brochures on this topic in the dental practice; this also shows survivors they are not alone, and helps them to feel more comfortable about disclosing their history to us.
10. If a patient chooses to disclose their history to us, we must ensure that he or she is comfortable with how we record their history in our notes, and whether they want other healthcare providers to be informed also.

## Oral health counselling for survivors

We mean well, but tend to couch our health education in negative terms, by warning patients of the dire consequences of not following our advice, rather than focusing on the positive results they can achieve by improving their self-care. Knowledge alone is usually not sufficient to motivate change within a patient; empathy, open-ended questions, and active listening on our part are necessary to facilitate change. Motivational interviewing[8] integrates well with the principles of sensitive practice, because it is a collaborative, non-judgmental, and non-confrontational technique that fosters patient autonomy; we are in partnership with our patient.

***'HELPING THE PATIENT TO FEEL A SENSE OF CONTROL DURING TREATMENT BY WORKING WITH, NOT JUST ON THE PATIENT ADDRESSES ABUSE-RELATED FEARS AND FACILITATES COMPLIANCE.'***

Active listening techniques include open-ended questions, to encourage patients to do most of the talking, affirmations to validate their feelings, reflective listening and summarising to show that we respect what the patient has to say, and show that we have been listening carefully. The desire for improved health, and the motivation to change comes from the patient, and is therefore more lasting and effective.

## Conclusion

Child abuse, especially sexual abuse is under-reported; less than half of survivors disclose their experiences to anyone; therefore dental health professionals cannot always be aware of which patients are survivors of abuse. For this reason, implementation of the principles of sensitive practice, and trauma-informed practice should be the standard of care for all of our patients.


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