Barriers and facilitators survivors of sexual abuse experience in oral healthcare and dental professionals' perspectives.

I. Montaque

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University of Essex

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Research Summary

Aims: The aim of the current research is to explore the barriers and facilitators to oral healthcare as experienced by survivors of sexual abuse. An additional aim of the research is to explore dental professionals' views on these barriers and facilitators and explore potential implications for professionals' practice**.**

Background: Current research concludes that physical healthcare is fraught with difficulties for survivors of sexual abuse accessing care and treatment. This is relevant in oral healthcare, where current research has highlighted broad psychological and social difficulties for survivors seeking care related to their oral health. At present, there is little research exploring dental professionals' views of survivors' experiences in the context of their clinical practice.

Methodology: A Participatory Action Research approach was used throughout the research to involve survivors as co-researchers in designing the research and analysing the results. A critical realism approach was used to qualitatively explore the barriers and facilitators to oral healthcare from the perspective of survivors of sexual abuse. Purposive and snowball sampling recruited 8 survivors who participated in semi-structured interviews. Two focus groups with a total of 8 dental professionals was utilised as a methodology to explore their views of survivors' experiences, which were presented for discussion in the focus groups.

Results: Reflexive Thematic Analysis was used to interpret six themes from interviews with survivors: Dissociation from my Mouth, Commands to be Vulnerable, Avoidance of Routine Examinations and Unexpected Procedures, "Just Make it a Bit More Human" Relational Practice, Psychological Grounding and Stabilisation, A Sense of Community. The same approach was used to interpret three themes from focus groups with dental professionals: Competing Demands, Red Tape and Restrictions, "I'm Not Sure How That Would Work" Navigating Sexual Abuse is Difficult in Practice.

Conclusion: Survivors indicated a multitude of factors related to systemic barriers, psychological safety and holistic care that supported or hindered their engagement in oral healthcare. The findings from dental professionals provides insight into the constraints on the profession and wider discourses that influence survivor’s experiences in oral healthcare. The themes suggest that the transformation of oral healthcare requires systemic progression to meet the needs of survivors. Trauma-informed care could offer a foundation to develop oral health services with the addition of nuanced recommendations to meet survivors’ needs and ensure dental professionals and services feel confident and supported in adopting these changes.

CHAPTER ONE: INTRODUCTION

Chapter Overview

This chapter outlines the background to the present study based on relevant literature and theory. Firstly, the broad definition of psychological trauma is outlined with discussion around the manifestation and impact of these experiences for individuals. Following this, the focus will narrow to explore the experience of sexual abuse as a sub-type of traumatic experiences with a discussion around the theories and impact associated with this type of trauma. The chapter will subsequently outline the healthcare provisions and needs for survivors of sexual abuse including a discussion around trauma-informed care. Following this, the experiences of survivors engaging in oral healthcare services will be discussed. The chapter concludes with presentation of a metasynthesis of the existing literature related to experiences of physical healthcare for survivors of sexual abuse. A rationale for the present research will be presented in accordance with the findings from the review and the background literature.

What is Psychological Trauma?

The definition of psychological trauma is broad and has undergone several updates over the years to encompass new understandings, along with an expansion of its meaning in common vernacular (Sweeney & Taggart, 2018). The most recent versions of psychiatric classification manuals, *The International Statistical Classification of Diseases and Related Health Problems* (11th ed.; ICD-11; World Health Organization, 2019) and The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2022), define a traumatic event as “the exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence”. This definition reflects the pathologised concept of psychological trauma under the diagnosis of Post-Traumatic Stress Disorder (PTSD). From a psychiatric perspective, these medical manuals outline that individuals who have experienced traumatic events may exhibit a range of symptoms, including intrusive distressing thoughts, avoidance of stimuli that reminds them of the trauma, and alterations in arousal and reactivity. Survivors of prolonged and repeated trauma may meet the diagnostic criteria for complex-PTSD (C-PTSD; Herman, 1992) which is made when the criteria for PTSD is met in addition to three further symptoms related to disturbances in self-organisation. Survivors may have difficulties with emotion regulation, a negative self-concept and experience interpersonal difficulties (World Health Organization, 2019).

There is broad consensus on the features that define psychologically traumatic experiences (Weathers & Keane, 2007); event(s) that present as threatening, uncontrollable or overwhelming could potentially be "traumatic". However, diagnostic manuals omit an individual's subjective perception about distressing events which is argued to be important, as the meaning imposed on events can impact the type and severity of symptoms (Weinberg & Gil, 2016). The subjective basis of traumatic events offers explanation for the individual differences of trauma presentations and the interaction with personal factors such as a perceived sense of disempowerment and disconnection (Herman, 1998). This is an important consideration as outcomes from traumatic events are not consistent; the same event may have a profound impact for one, and little to no impact for another (Bowman, 1999).

The occurrence of traumatic events are reported to be more frequent within marginalised communities, including those from low socioeconomic backgrounds, racialised communities and younger people (Hatch & Dohrenwend, 2007). As such, it is imperative to encompass sociocultural influences when conceptualising trauma. The multitude of wider factors that can influence the aetiology and expression of trauma may suggest that the psychiatric model is too reductionist and dismisses the personal interpretation of traumatic experiences (Van der Kolk et al., 1996). Despite the debates surrounding the conceptualisation of trauma, there is a clear need to support individuals and communities who have been exposed to traumatic events. In the United Kingdom alone, it is estimated that 4 in 100 people are diagnosed with PTSD each week (Mind, 2020) and the prevalence of undiagnosed PTSD and experience of traumatic events is thought to be much greater (Benjet et al., 2016; Kessler et al., 2017).

The dominance of the medical model and diagnostic conceptualisation of psychological trauma is apparent throughout mental illness policy, practice, and research (Lebowitz & Appelbaum, 2019). A focus on diagnoses, symptoms and medicalisation implies categorising humans and their experiences in an attempt to oversimplify and quantify objective truths about them (Lilienfeld & Treadway, 2016). Despite these critiques, the medical model has become the culturally accepted lens to view mental illness in Western society but is subject to sustained and ongoing challenge (Beresford & Russo, 2021). Overreliance on these models can appear reductionist in the complexity of discussions surrounding the definition, experience and impact of psychological trauma. Therefore, throughout this research a broader view has been taken to acknowledge the biopsychosocial (Engel, 1977) and cultural contributors to the concept of psychological trauma. Where reference is made to psychological trauma this is meant in a holistic sense; no singular definition has been imposed upon experiences, and the subjective nature of these events has been upheld. Phrases such as “difficulties”, “impairment” and “struggle" have been used to reflect the often pathologised view of trauma which is used in empirical research. It is recognised that this way of communicating concepts and experiences can be stigmatising and problematic without context (Wakefield, 1992). These terms have not been used with the intention of reducing experiences or suggesting human deficit, instead, this research emphasises the individual interpretation of traumatic experiences and the resulting impact on identity and sense of self, which may not be captured through a single, medicalised lens.

The Manifestation of Psychological Trauma

The prognosis following trauma is not consistent, with outcomes ranging from subtle to destructive (Galatzer-Levy et al., 2018). Medical manuals conceptualise the manifestation of trauma as “symptoms”, characterised by re-experiencing the traumatic event(s), avoidance of associated memories or activities, and hypervigilance (American Psychiatric Association, 2022; World Health Organization, 2019). Many reactions following traumatic experiences may not be reflected in diagnostic manuals but are equally relevant to understand the complex effects on individuals (Center for Substance Abuse Treatment, 2014). In addition, trauma symptoms are not exclusive to a diagnosis of PTSD or solely precipitated by traumatic events, as stressful events can lead to a similar profile of symptoms (Robinson & Larson, 2010).

Historically, research and clinical practice acknowledged the acute implications for individuals who experienced traumatic events but limited consideration was given to the longitudinal impact (Van der Kolk, 2003). Months, and often years, after trauma there can be psychological, social and physical impairment. As such, there has been a shift to better understand the chronic implications that can arise from traumatic experiences (Jones & Wessely, 2006). These new understandings seek to look beyond an individual’s “symptoms” to consider the impact of trauma in a social and cultural context across time (Magruder et al., 2017). The impact of trauma is vital to have insight into the ways that trauma alters lives and, therefore, support individuals who have experienced such events and potentially identify ways to intervene through preventative strategies (Magruder et al., 2016). To understand these outcomes, several theories have been outlined to conceptualise the processes and impact of trauma from different but connected perspectives.

Psychological Theories of Trauma

An individual's psychology offers some contribution to understanding the experiences that occur following trauma (Brewin & Holmes, 2003). Psychological theory underlying cognitive and behavioural factors propose processes that may be implicated in the manifestation of trauma.

Cognitive and Neurobiological Processes

Traumatic experiences can significantly alter the way an individual views the world or appraises information. From a neurobiological and cognitive perspective, there is evidence to suggest that traumatic events are represented in a unique way, in that they are stored and recalled differently to other memories (Van Der Kolk, 1998). Studies exploring the role of memory processes following trauma have suggested that these events appear to be imprinted differently into the wider memory system, meaning they are recalled in high detail (Harvey & Bryant, 1999). As such, trauma memories are experienced as salient and prone to being reactivated when triggers occur in the present day (Bower & Sivers, 1998; Zoellner & Bittenger, 2004). These memory processes may influence the experience of flashbacks and triggers, which are features of a PTSD/C-PTSD presentation (Giourou et al., 2018).

Flashbacks and Triggers

In accordance with the medical definition of PTSD, symptoms such as high-frequency distressing and intrusive memories are cognitive characteristics of the disorder (American Psychiatric Association, 2022). Research suggests that memory function plays an important role in some symptoms of PTSD, as individuals often have a recall bias for traumatic memories and over-retrieval of information that relates to traumatic events (Buckley et al., 2000). This may contribute to individuals "re-living" their experiences in flashbacks (Brewin

& Holmes, 2003) that feature intense sensory detail and can seem as if the historical trauma is occurring in the present moment (Brewin, 2001b). It is posited that these flashbacks do not occur at random but are triggered by reminders connected to the historical event which are then galvanised through other memory systems to elicit biological, emotional and cognitive recall of the event (Van der Kolk, 1998). Triggers can be in the conscious awareness of the individual or may go unnoticed and operate on a sub-conscious level, causing the recall to feel spontaneous (Brewin, 2001). Despite anecdotal accounts of flashbacks described by survivors of traumatic experiences and reference to these experiences in the literature, there is little research to support the pathway of reactivation on a biological and psychological level (Brewin & Holmes, 2003).

Experiencing a flashback can lead to a dissociative response, which is argued to be an insufficiently recognised but major psycho-biological reaction in C-PTSD (Van der Hart et al., 2005). Psychological theories underlying dissociation can offer some insight into how this connects to the profile of a trauma presentation.

Dissociation

Individuals with a diagnosis of PTSD have been shown to have higher interrelation with dissociation (Van der Kolk et al., 1996). Dissociation is described as a mental process where there is a disconnection between a person’s consciously available thoughts, memories, feelings and actions (American Psychiatric Association, 2022). As such, an individual may experience a distortion of time, space or their personal identity (Van der Hart et al., 2004). Dissociative symptoms may be akin to a “freeze” response (Nijenhuis et al., 1998) and offer a protective function in situations where perceived danger is present or a trigger has occurred (Panzer & Viljoen, 2004). Dissociation can provide a defensive distance between the experience and the individual, however, a long-term consequence is an inability to connect with emotional responses and a lack of integration between psycho-biological systems (Van der Hart, 2004). This can be detrimental to a person’s sense of identity and functioning (Sinason, 2002). Dissociative symptoms as an outcome of experiencing trauma is not linear, but is influenced by complex pathways and individual differences such as family pathology and other mental health experiences (Mulder et al., 1998; Nash et al., 1993). This indicates that a causal link between trauma and dissociative symptoms may not be established and there are other non-psychological contributors (Merckelbach & Muris, 2001).

These psychological theories can provide information about the role of memory, recall, triggers and dissociation that form experiences after trauma. An individual’s traumatic past invading into their present day experience is a central feature of PTSD/C-PTSD (Herman, 1998) and this is captured through psychological explanations of the impact of trauma. As part of a holistic biopsychosocial model, physiological theories also offer some conceptual understanding about changes that can occur at a biological level.

Physiological Theories of Trauma

Research has outlined that exposure to traumatic events leads to several biological changes caused by activation of the stress response which operates from a psychological and physiological base, comprising many processes and pathways (Bremner & Vermetten, 2001). When exposed to extreme stress, like a traumatic event, the hypothalamic-pituitary-adrenal (HPA) axis is activated which leads to the release of “stress hormones” including cortisol, epinephrine and norepinephrine (Basu et al., 2013; Solomon & Heide, 2005; Van der Kolk, 1994) to prepare the body to respond to danger. This leads to an increase in sympathetic response, essentially the biological basis of the fight-or-flight response.

Over-activation of the HPA axis and a persistent stress response can have a detrimental cascading effect to the rest of the body (Bremner, 2005). McEwen’s (1998) model of allostasis, which refers to the body’s attempt to maintain stability through stress, was used by Wilson et al. (2004) to conceptualise the compounding physical impact in PTSD. Allostatic load occurs when the body is overwhelmed by stressors which can compromise physical health if enduring. In the occurrence of traumatic events, allostatic load increases which Wilson et al. (2004) uses to explain an individual's experience of physical health difficulties because of psychological trauma. The body's immune response is also part of the body's stress system; the release of pro-inflammatory cytokines by the immune system hinders the body's ability to heal and increases inflammation (Padgett & Glaser, 2003). These are released when psychological stress occurs (Robles et al., 2005), which consequentially causes physical complaints and changes that arise from psychologically traumatic experiences (Kendall-Tackett, 2009). It may be difficult for individuals who have experienced trauma to make the connection between their physical and psychological wellbeing as it becomes part of their everyday embodied experience that operates outside their immediate awareness (Leuzinger-Bohleber, 2018).

Psychological trauma disrupts the brain and body's homeostasis which can have both acute and chronic effects (Solomon & Heide, 2005). An example of the chronic physiological effects of psychological trauma comes from the notion of Adverse Childhood Experiences (ACE). A high prevalence pattern of Childhood Sexual Abuse (CSA) was observed among patients receiving treatment for obesity (Felitti et al., 1998) and it was proposed that ACEs may be a risk factor for physical health difficulties later in life. Research supports this claim, with childhood trauma accounting for an increased risk of adult health problems, such as heart disease, obesity, cancer, depression and addiction (Felitti et al., 1998). Further to this, "The body keeps the score" is a popular notion in trauma research, coined by psychiatrist Van der Kolk, (1994) based on concepts by earlier scholars such as Herman (1992). It conceptualises trauma on a physiological level and summarises that traumatic memories are incorporated into the declarative memory store in a different manner to non-traumatised memory, and may lead to trauma being organised on a somatosensory level (Van der Kolk, 1994). As such, the physical symptoms that occur in the manifestation of PTSD are proposed to be the body "storing" trauma memories. Based on this notion, the multi-faceted experience of PTSD validates the interdependence of physical and psychological reactions that an individual may experience (Van der Kolk, 2003).

Rather than compartmentalising these theories in understanding trauma, a holistic approach embedding all approaches can have utility for practice and research. The interplay between psychological, biological and social conceptualisations of trauma is supported by literature and often described by individuals who have experienced trauma symptoms, which provides empirical and anecdotal support for a holistic approach (Christopher, 2004).

Although outcomes from different traumatic experiences, such as war, domestic violence and natural disasters may hold symptomatic similarities, there may be specific triggers and contributors to the manifestation of trauma reactions following sexual abuse (Shakespeare-Finch & Armstrong, 2010). This research will focus on the experience of trauma from sexual abuse, the spectrum of its impact, and how these overt challenges pose a difficulty for survivors.

What is Sexual Abuse?

Sexual abuse or assault refers to non-consensual sexual contact obtained by force, threat of harm or in a situation where an individual cannot, or does not give, consent (Koss et al. 1994). The prevalence of sexual abuse occurs across all nations, cultures and communities and poses a significant public health issue globally (Barth et al., 2013); in the UK it is estimated that 20% of women and 4% of men will have experienced sexual abuse at some point in their life (Criminal Injuries, 2023). There are variances in the way that sexual abuse is defined across health and social care settings, including criminal justice, policy, health and psychology (Mathews & Collin-Vézina, 2019). These definitions also vary within the literature, with some studies broadly defining sexual abuse as “unwanted sexual experiences, with or without contact” and other definitions specifying actions (Haugaard, 2000). Although a robust definition may not be required when supporting individuals who have experienced sexual abuse, it is noted that intrusive and severe forms of sexual abuse involving penetration is correlated with more adverse outcomes (Briere, 1992). Despite the absence of a shared, theoretically informed definition, there are agreed commonalities about the detrimental health and wellbeing impact for survivors of sexual abuse. In the UK, a broad definition is upheld – any act involving force or enticement to engage in, or take part in, sexual activity either by contact or non-contact constitutes sexual abuse (Independent Inquiry into Child Sexual Abuse, 2022)

Within this research, sexual abuse has not been operationally defined, instead it has been led by the participants in the study to self-define as survivors of sexual abuse. It was felt that restrictive and imposed definitions of sexual abuse could remove the abusive aspect of unwanted sexual experiences which are not often captured in academic work (Moreira et al., 2024). As the focus of this research was not on survivors’ experience of sexual abuse, there was no further enquiry around their history and participants were invited to participate if they felt the concept of being a survivor applied to them. Although the “survivor” movement has been accepted across many domains to move away from “victim” status and offer a more empowering stance following trauma (Naples, 2003), it is recognised that the term “survivor” is not assimilated by many who have experienced sexual abuse. However, the term “survivor” has been used within this research to refer to individuals who have experienced sexual abuse and utilise a more strength-based term.

The Impact of Sexual Abuse

The sequelae of sexual abuse can result in chronic psychological, social and physical difficulties (Trickett et al., 2011). Research has outlined that there are some patterns in outcomes for various groups or identities which can aid understanding of the factors that influence outcomes (Jina & Thomas, 2013). For example, the age at which sexual abuse occurred is felt to be relevant in the development of difficulties, due to the interaction with psychological and physiological chronological development (Trickett & McBride-Chang, 1995). In addition, a meta-analysis concluded that females experience more difficult outcomes following sexual abuse (Rind & Tromovitch, 1997) and racially marginalised groups and communities may see more negative outcomes following sexual abuse (Gangoli & Hester, 2023). These findings suggest that sexual trauma does not affect groups equally and the severity of outcomes vary when contextual factors are considered; an intersectional approach brings out the complexity of multiple forms of marginalisation (Forde et al., 2019) and the potential cumulative effect of trauma (Khan, 1963). There are several different perspectives outlining the impact of sexual abuse which provides insight into why these adversities can be substantial for survivors.

Psychological Impact of Sexual Abuse

Psychologically, an individual can experience unhelpful emotions, negative schemas about the self and others, and feelings of guilt and shame as a result of trauma (Lisak, 1994). A meta-analysis found that those who have experienced Childhood Sexual Abuse (CSA) are more likely to develop mental health difficulties, such as depression, anxiety and C-PTSD (Hailes et al., 2019; Hillberg et al., 2011). In instances of CSA, young people can exhibit a pattern of behavioural problems and poorer psychological functioning (Papalia et al., 2017). Increased rates of self-injurious behaviour occurs amongst survivors which may be due to emotional regulation difficulties and reduced self-esteem (Lilly et al., 2014; Maniglio, 2011). In addition, research has indicated that when sexual abuse is perpetrated by people who are positioned in helping and authority roles outcomes can be particularly severe (Trickett et al., 2001). It is proposed that this is due to a sense of betrayal and often silencing around disclosing experiences (Wohab & Akhter, 2010) which can create isolation and helplessness. These findings indicate that a full spectrum of psychological, interpersonal and behavioural difficulties follow the experience of sexual abuse, some of which may not be captured within medicalised symptoms.

There is some variability in findings related to the outcomes of CSA, therefore, it has been argued that there is not a causal link between CSA and adverse outcomes (Kilpatrick, et al., 1981). However, evidence often concludes there is a strong associative link between the experience of sexual abuse and personal psychological distress and interpersonal functioning (Kendall-Tackett et al., 1993; Reeves & Humphreys, 2018; Tsur et al., 2023). Situating the psychological impact and factors in the social and cultural context is important to determine how other types of abuse, deprivation, marginalisation and protective factors can influence outcomes (Hulme, 2004). As such, survivors are not a homogenous group – it is expected that there will be variability in the outcomes with mediating factors and risk factors having an impact on presentation (Gesink & Nattel, 2015; Romans et al., 1995; Wolfe & Birt, 1995).

Social Impact of Sexual Abuse

Social functioning can be affected as a result of sexual abuse which can alter how an individual constructs their identity in accordance with their social world (Davis & Petretic-Jackson, 2000). Survivors are often harmed by societal messages and stereotypes surrounding sexual assault, which can also exacerbate symptoms and restrict access to care (Arnold & Jeglic, 2024). These stereotypes are used more frequently and harshly in their application to marginalised groups (Abbey et al., 2010; George & Martínez, 2002) indicating further need to uphold an intersectional lens when conceptualising the impact of sexual abuse. A detrimental social impact following sexual assault can pose further vulnerability for survivors by compounding other health areas and reducing access to protective mechanisms in the form of health and social care support (Testa et al., 1992). This is important, as the long-term impact of sexual assault can be dependent on many factors including the amount of formal and informal support received and the balance with other protective life factors (Campbell et al., 2009). The ability to access care is dependent on social functioning, as such, consideration of the social impact holds relevance for treatment and intervention as the continuation of social difficulties may widen the health inequalities within this population and further marginalise survivors.

Research by Clarke et al. (2023) explored social outcomes for adolescent survivors and found that there was a consistent and persistent absence from school when experiencing sexual abuse. This disengagement from developmentally appropriate occupation is deemed a psychosocial risk factor and their findings suggest that vulnerability of social exclusion could perpetuate further disruption following sexual abuse. Other psychosocial risk factors are more common in CSA survivors compared to non-abused individuals, including substance use, smoking, risky sex behaviours, and lack of regular exercise (Chartier et al., 2009; Springs & Friedrich, 1992; Walker et al., 1999). In a longitudinal study, survivors of CSA were found to have fewer friends and increased social adjustment problems (Abdulrehman & De Luca, 2001) furthering isolation from the wider community.

Physical Health Impact of Sexual Abuse

It is well documented that a history of sexual assault is linked to poor physical health outcomes (World Health Organization, 2013). When compared to individuals who have not experienced sexual assault, survivors have poorer physical health markers (Kendall-Tackett, 2009). Child sexual abuse is a predictor of self-reported and objective measures of poorer health in adulthood, indicating the long term physiological impact of trauma (Downing et al., 2021). Adverse health outcomes are seen across a variety of physical health areas for individuals with a history of CSA (Irish et al., 2010). Specifically, gynaecological problems, chronic pain, gastrointestinal difficulties and chronic fatigue are reported more in the survivor population in comparison to non-abused individuals (Drossman, et al., 1995; Heim et al., 2009; Lampe et al., 2000; Springs & Friedrich, 1992; Ulirsch et al., 2014). Sickel et al. (2002) longitudinal study over eight years found that female survivors of CSA scored higher on healthcare utilisation and had increased gastrointestinal and gynaecological difficulties in comparison to females without a history of CSA. These outcomes increased with the intensity of CSA experienced.

As a potential mechanism to explain this, the stress-illness theory suggests that there is an interaction between pre-existing health symptoms and emotional responses arising from traumatic experiences (Koss et al., 1991). This increases stress which then suppresses the immune system, resulting in higher risk of physical health difficulties. The hypothalamic-pituitary-adrenal (HPA) axis also plays a role in the body's response to stress (De Bellis & Zisk, 2014). Excessive or prolonged activation of the HPA axis when under chronic stress can compromise immune and inflammatory response which can manifest as pain related health problems, disruption to metabolic processes, and illness and infections (Campbell et al., 2008). These processes suggest a mind-body connection when an individual has experienced trauma. This has implications for medical professionals practice across multiple disciplines with survivors as patients, as they may require support for simultaneous and interacting physical and psychological health presentations (Kendall-Tackett, 2009).

Neurobiological theories do have their limitations; an explicit focus on physiological changes in explaining adult health problems is potentially narrow and reductionist in the complexity of the issue (Hulme, 2004). The variability in research findings exploring the association between sexual abuse and physical health outcomes demonstrates that a singular lens is not sufficient as an explanation. A cross-sectional study concluded that sexual assault is a predictor for increased risk of some physical health conditions, such as arthritis and breast cancer (Stein & Barrett-Connor, 2000), but a causal link was not established and some specific diseases had less significant outcomes. A meta-analysis summarised that a small-moderate association exists between CSA and a variety of health outcomes (Irish et al., 2010). Despite the variability in findings and the methodological limitations around inferring causality, it is generally concluded that sexual abuse is associated with an increased risk of physical health difficulties and some research has supported causality as a conclusion (Golding, 1999).

In summary, survivors may face a variety of physical, psychological and social difficulties following sexual abuse. The physiological impact appears to directly and indirectly affect bodily processes and mechanisms, resulting in poorer health outcomes (Hulme, 2004). As such, survivors may require holistic support from healthcare professionals or services to support them with arising difficulties, more so than the general population. It is pertinent that physical health services are set up to support survivors who may have additional psychological needs in these contexts based on the longitudinal impact of trauma. The exploration of healthcare provisions available for survivors and their experiences in healthcare has utility for ascertaining the factors that promote appropriate care and identify potential system short-falls.

Healthcare Provisions for Survivors of Sexual Abuse

Survivors of sexual abuse, like all individuals, need to access healthcare but it is reported that the need is greater amongst this community. For example, adults who experienced sexual abuse reportedly use healthcare services more frequently than those who have not experienced abuse (Elhai et al., 2005). A subjective need to utilise health services is also reported amongst survivors, with Newman et al. (2000) study of six hundred and eight women showing that survivors had significantly more self-reported health symptoms and doctors' visits in comparison to those without a history of CSA. Actual attendance at the doctor was also higher for the survivor group. Despite the subjective perception of increased need for health services and higher rates of physical health difficulties, a review found that survivors accessing healthcare services are frequently underserved (Bach et al., 2021). The findings of this review indicate that there are several overlapping factors that are a barrier to survivors accessing care, including a lack of appropriate services for intersectional identities and communities. This is also supported by Sweeney et al. (2016) who conclude that poor access to services, delayed access to appropriate service, and a lack of suitable provisions compounds the difficulties around physical healthcare contact for survivors.

Studies have identified that survivors report specific difficulties in healthcare settings that are linked to their past experiences of abuse (Havig, 2008). For example, healthcare contact is often perceived as intrusive or triggering, and survivors describe a mistrust of professionals working in these settings (Monahan & Forgash, 2000). Procedure related aspects of healthcare (Havig, 2008) and interactions with healthcare providers (Montgomery et al., 2015) can replicate a lack of control and are therefore reminiscent of past experiences of abuse. These triggers can make survivors feel psychologically unsafe in these settings (Coles & Jones, 2009) meaning many survivors avoid healthcare altogether (Cadman et al., 2012). Inability to access the care that is needed can exacerbate the physical health related difficulties (Rajan et al., 2021). These well researched findings locate the barriers within the healthcare system rather than within survivors (Reeves, 2015), which supports the movement for trauma-informed health care.

Trauma-Informed Care

Providing healthcare that is sensitive to the needs of people who have experienced trauma is a central feature of Trauma-Informed Care (TIC) (Reeves, 2015). TIC is a guide which outlines that the impact of violence and victimisation needs to be understood by systems and healthcare providers in order to uphold principles which facilitate survivor's engagement in healthcare (Butler et al., 2011). Survivors may be reluctant to disclose their history for a variety of reasons (McGregor et al., 2010; Teram et al., 2006) and unpredictable, trauma-based symptoms may show up in healthcare contexts where the connection to past experiences is unclear (Harris & Fallot, 2001). Therefore, many healthcare providers may be unaware of their patients' history and how this could affect them in an appointment (Harris & Fallot, 2001b). As a significant portion of the population is affected by psychological trauma, contact between healthcare services and survivors will be a frequent occurrence (Rosenberg, 2011). TIC proposes that services should be structured with this in mind rather than only providing adaptations when a survivor offers information about their history (Bargeman et al., 2021). As such, the notion of TIC aims to standardise the principles of safety, collaboration and empowerment for *everyone* entering health services, to ensure that a disclosure is not needed to access suitable care.

TIC is a systemic approach to healthcare transformation which encourages the operation of services in alignment with theories about the impact of trauma (Sweeney & Taggart, 2018). As such, psychological theories of trauma have informed the principles of TIC to highlight that trauma memories can be triggered during interactions in physical healthcare settings to leave survivors feeling unsafe and uncontained (van Loon et al., 2004). Therefore, increasing the patient's autonomy, working in a transparent manner and embedding cultural and psychological safety considerations in these settings will alleviate distress and avoid re-traumatising patients who are accessing care (Lewis et al., 2019; Reeves, 2015). Trauma-informed care also has advantages for staff working in services, capturing the multifaceted support to benefit the wider healthcare system (Sweeney et al., 2016).

It is unclear if the principles of trauma-informed care are actually implemented in clinical practice, and, if so, how effective they are for survivors of traumatic experiences (Berliner & Kolko, 2016). Operationalising the concepts related to TIC is challenging due to the lack of shared definition and variability in application of these concepts across settings (Donisch et al., 2016). It is argued that TIC simply reflects good, ethical practice and is not specific or nuanced sufficiently to meet the needs of survivors (Berliner & Kolko, 2016). Outcomes measuring the usefulness of TIC have concluded this approach is too broad for implementing across a variety of health and social care settings and further refinement is needed (Hanson & Lang, 2016). These conceptual and practice issues may offer insight into the difficulties executing TIC at a macro-level. As an alternative, the term "psychological safety" relates to some of the principles that underpin TIC and may offer more clarity on operationalising, measuring and evaluating this in services (Newman et al., 2017).

In the UK, trauma-informed care has been variably assimilated into statutory care. Some trusts within the NHS have embedded TIC into their system and there has been more uptake in mental health care settings (Muskett, 2014). Anecdotally, TIC is regarded as a useful approach for people entering services, but larger, national adherence is undeveloped (Emsley et al., 2022). A possible reason for this is the lack of evidence base; a review of trauma-informed care in mental healthcare settings identified that there is little evidence to support its effectiveness in the UK (Dawson et al., 2021). Government backing and financial support would facilitate effective implementation throughout wider systems, however, this is yet to be seen in the NHS (Sweeney et al., 2018).

The broad ranging difficulties survivors face in physical healthcare settings and the fragmented uptake of trauma-informed care in the NHS implies that survivors may be denied the opportunity to engage in care that is fit for their needs. An area of practice where this may be relevant is oral healthcare. The next section will outline the definition of oral health and its connection to overall psychological wellbeing. This will include a discussion around the current literature which has explored survivor's experiences in oral healthcare settings.

Defining Oral Health

Oral health is an important aspect of overall health status, and should be viewed as a component of holistic wellbeing (Gift & Atchison, 1995). The definition of oral health spans biological, psychological and social elements, highlighting a multifaceted and complex area of health (Brondani & MacEntee, 2014). There are many functions associated with oral health, including the ability to speak, chew, taste and convey a range of emotions (Glick et al., 2016). Recent updates to the definition of oral health emphasise the positive aspects and moderating factors that lead to good health, rather than a focus on the absence of disease (Hescot, 2017). The broad definition demonstrates that oral health has relevance for disciplines outside of dentistry and is a fundamental component of general health (Alpert, 2017). As such, health-related quality of life encompasses oral health (Glick et al., 2016).

In line with the definition of oral health, this area of health reflects biopsychosocial components in addition to an individual's perception, attitudes and values of their oral health status (Brondani & MacEntee, 2014). The importance of good oral health in contributing to overall wellbeing is supported by research findings. A systematic review found that poor oral health status was linked with other physical and psychological health impairments, such as dissatisfaction with the teeth and mouth and lower ratings on health-related quality of life measures (Naito et al., 2006). When viewing oral health from a holistic perspective, it becomes apparent that accessing dental care contributes to an individual overall sense of wellbeing, including their mental health (Kisely, 2016).

Oral Healthcare for Survivors of Sexual Abuse

Dentistry in the UK is structured to offer both NHS and private options. This structure can lead to practical, logistical and financial barriers for many, but these can be amplified for survivors of sexual abuse. Vulnerable and underserved communities experience enduring and systemic barriers related to oral healthcare (National Research Council. 2012). Survivors of sexual abuse are a marginalised community whom often report difficulties with access to care or returning for dental treatment (Alyce et al., 2022). Recent evidence suggests that a history of trauma is a predictor of poor oral health (Bright et al., 2015; Ford et al., 2020) suggesting an association between these experiences and an increased need to access oral healthcare. This community often report an increased need for dental care compared to the general population, due to higher rates of missing teeth, dental caries and gum disease (Kundu, et al., 2014; Leeners, et al., 2007). However, dental care is not easy for survivors of sexual abuse. The next section will explore some of the difficulties survivors face in these settings with consideration around the current research perspective which captures survivor's general experiences in oral healthcare.

Why is Oral Healthcare a Difficulty for Survivors?

Individuals who have been subjected to sexual abuse may find various aspects of dental care difficult. Existing research in this area has provided some general insight into the experiences of oral healthcare for survivors of sexual abuse. A systematic review (Larijani & Guggisberg, 2015) presents a synthesis of literature exploring the association between a history of sexual abuse and dental fear and summarised that varying degrees of association exist between these two factors. Stalker et al. (2005) findings from 58 male and 19 female participants who had experienced CSA reported that the position in the chair, perceived criticism from the dentist and being asked about their history of abuse was particularly difficult. These findings were supported by Fredriksen et al. (2020) whose interviews with survivors found that specific dental procedures are triggering due to the direct similarities to abusive experiences, such as having implements in the mouth. Other similarities include being left alone with a person in authority (Wolf et al., 2021b) and having to lay on the back (Leeners et al., 2007). Research by Wolf et al., (2020) and Alyce et al. (2022) indicated that survivors found dental appointments triggered a bodily recall of historical abuse, causing them to re-live the trauma of sexual abuse. Overall, attending the dentist as a survivor appears to have echoes of past abuse within the procedural aspects of dental care and the psychological and physical reactions that are triggered during the dental encounter. For survivors, this culminates in anxiety during the procedure, reliving past trauma and enduring intense emotions after attending appointments (Dougall & Fiske, 2009; Fredriksen et al., 2020; Softestad et al., 2020).

Survivors' appear to value their oral health but difficult experiences can prevent them getting the care they deserve (Wolf et al., 2021). However, perspectives from the literature have indicated that not all experiences at the dentist are harmful for survivors (Alyce et al., 2022). Dentist's being considerate of survivors needs throughout the entire appointment (Kranstad et al., 2019) facilitates psychological safety and offers autonomy (Alyce et al., 2022) which is in line with trauma-informed care. Research has emphasised that collaboration between the dentist and survivor-patient is required to overcome the difficulties, and that dentists can embody this by representing predictability and trust (Dougall & Fiske, (2009); Wolf et al., 2021b). Trauma-informed care in a dentistry setting has been viewed as helpful throughout the entire appointment to make attendance at the dentist possible (Kranstad, et al., 2019) and reduce feelings of mistrust and danger (Wolf et al., 2021b). Raja et al. (2014) taught dental students about how survivors may present in a dentistry setting and used trauma-informed care to teach them behavioural techniques to aid survivor engagement in treatment. Their findings indicated that this three hour lecture format can be helpful for dental student’s knowledge and practice, however, it has not been explored how this can be consistently applied in the dentistry setting, and if it these “adaptations” are possible for dental professionals in their everyday practice.

It is important to gauge the personal perceptions of survivors accessing physical healthcare to ascertain their experiences as patients. The next section presents a meta-synthesis summarising the qualitative experiences of survivors in physical healthcare settings to offer understanding of how survivors encounter physical healthcare across a multitude of settings.

SYSTEMATIC REVIEW

Overview

In this section, a metasynthesis of recent research exploring physical healthcare experiences for adult survivors of sexual abuse is presented. The aim of this review is to provide an insight into the recent literature perspective of how survivors describe their contact with physical healthcare services with a view of collating themes within the literature and highlighting gaps in understanding.

Design

Metasynthesis is as an approach to synthesise and integrate findings across qualitative studies, and is recognised as a method of reviewing data in a systematic manner (Barnett & Thomas, 2009). This approach was deemed appropriate for the research question over other methods of reviewing literature, to examine the meanings and perspective across a broad range of qualitative studies (Barnett & Thomas, 2009). Other types of qualitative synthesis focus exclusively on the results of included articles, a meta-study includes a critical appraisal of each article’s underpinning research processes (Paterson et al., 2001). The metasynthesis process involved several steps; a research question was defined, studies were selected in accordance with the inclusion criteria, the quality of the studies was assessed as part of analysing the data using Thematic Analysis, and the synthesised themes were presented.

Inclusion and Exclusion Criteria

To define the inclusion criteria, the Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER; Cooke et al., 2012) tool was used. In accordance with the research question and the SPIDER tool, all articles using qualitative research methods (defined as interviews, focus groups or open questions) to explore survivors experiences in any physical healthcare setting were included within the review. Any study that involved participants who identified as a survivor of sexual abuse (which was defined as self-reported experience of sexual abuse at any age) was included within the review. Literature that involved participants who were over the age of 18 and their experiences related to accessing healthcare as an adult were included for review. Literature was excluded if participants contact with health services was directly related to their post-assault care or involved contact with mental health services. Where research included additional interviews with healthcare professionals, data from a control group, or data from participants who had experienced other forms of trauma, the synthesis focussed solely on data from participants who met the inclusion criteria.

Search Strategy

An electronic search was conducted in October 2023 using the search terms shown in Table 1. The search terms were inputted into databases APA PsycInfo; CINAHL Ultimate;

Dentistry & Oral Sciences Source; MEDLINE Ultimate and OpenDissertations, which resulted in 354 articles. In addition to these methods, a review of reference lists and a hand-search resulted in 6 articles. The PRISMA flowchart in Appendix A shows the search strategy and how the search arrived at the included papers. The search was screened to include only those in English and published between 2013 and 2023. This cut-off date was selected to ensure that literature was recent and allow an update to a previous review exploring healthcare experiences of survivors and sensitive practice which was published in 2008 (Havig, 2008). A summary of the included articles is shown in Appendix B with a total of 385 participants included across the selected literature.

Table 1.

Table of search terms used in the metasynthesis

Category	**Information**
Search terms	healthcare experience OR health care experience OR hospital experience OR health service experience OR health facilities experience AND sexual abuse OR survivors of sexual abuse OR sexual victimization OR sexual violence
Databases	APA PsycInfo; CINAHL Ultimate; Dentistry & Oral Sciences Source; MEDLINE Ultimate; OpenDissertations
Other Search Strategies	Reference lists, Hand-search and Cited articles.

Quality Appraisal

After the screening and selection process, assessment of quality was undertaken by using The Critical Appraisal Skills Programme qualitative tool (CASP; Critical Appraisal Skills Programme, 2018). Ten indicators form the qualitative CASP tool which are used to assess the methodological quality of the studies and guide the critique of the literature. A table showing the CASP checklist is shown in Appendix C.

A summary of the included literature is shown in Table 2 with asterisk to identify which themes appeared in each paper.

Table 2.

Summary of literature included in the metasynthesis with identification of which themes are included in each article.

Authors **Themes**	**Alyce et al. (2022)**	**Crockett (2017)**	**Gesink & Nattel (2015)**	**Jonsdottir et al. (2022)**	**LoGiudice (2022)**	**Meier et al. (2021)**	**Reeves & Humphreys (2018)**	**Ross et al. (2023)**	**Schnur et al. (2018)**	**Tsur et al. (2023)**
'Re-experiencing trauma within healthcare settings'	*	*	*	*	*	*	*		*	*
They call us crazy – Medical Gaslighting in Healthcare Settings	*	*	*	*	*		*	*		*
Navigating a dual identity: Challenges around disclosure	*	*	*		*	*	*	*		*
Providing what we never had - holistic care	*	*	*	*	*	*	*	*		

The synthesis generated four themes across the literature findings, which are discussed in the next section.

Synthesis

Thematic analysis was used to analyse findings across the studies and systematically identify patterns, which then became the themes of the synthesis (Thomas & Harden, 2008).

Theme One: 'Re-experiencing Trauma within Healthcare Settings'

Results from the synthesised studies demonstrated a link between participant's trauma history and physical healthcare contact. The findings indicate that triggers, reminders and memories of sexual abuse appeared to be present when accessing and engaging in healthcare services. Trauma responses that were triggered were conceptualised by the authors as survivors past traumatic experiences being enacted in the healthcare space, rather than a fear of healthcare alone (Alyce et al., 2022; Gesink & Nattel, 2015; Reeves & Humphreys, 2018; Schnur et al., 2018; Tsur et al., 2023). Several aspects of physical healthcare procedures had direct links to abusive situations, resulting in participants re-living and re-experiencing certain aspects of their past whilst undergoing treatment (Alyce et al., 2022; Gesink & Nattel, 2015; Jonsdottir et al., 2022; LoGiudice, 2022; Schnur et al., 2018; Tsur et al., 2023). For example, the physical nature of procedures were analysed as "intrusive" (Alyce et al., 2022; Gesink & Nattel 2015; Reeves & Humphreys, 2018; Tsur et al., 2023), which holds links with invasion of the body when experiencing sexual abuse. Treatment procedures in "sensitive areas" was noticed by participants as a pathway to trauma-responses emerging in healthcare settings (Alyce et al., 2022; Jonsdottir et al., 2022; Reeves & Humphreys, 2018; Schnur et al., 2018). Painful procedures recalled "painful memories" for participants (Reeves & Humphreys, 2018) and the summarised findings indicated that treatment in areas where the body has "held" trauma is particularly difficult and results in simultaneous recall of traumatic experiences and physical pain. Many participants encountered actual harm at the hands of healthcare professionals and other service users (Crockett, 2017); these experiences were a direct route to re-traumatisation and added to a “cumulative trauma” experience (Tsur et al., 2023).

A myriad of responses showed up in healthcare settings following a trigger, but results across the studies appeared to indicate a feeling that past “abuse was happening in the present moment” which explains a fight/flight/freeze response (Alyce et al., 2022). Many studies reported that survivors experience dissociation, which authors conceptualised as a protective mechanism from the danger perceived in healthcare settings (Alyce et al., 2022; Gesink & Nattel, 2015; Jonsdottir et al., 2022; Tsur et al., 2023). The author’s conclusions around the frequent reaction of dissociation may indicate that survivors need to detach from the process of healthcare because of the pain it recalls. Providers who did not consider their body language, even when participants deemed these interactions as “benign”, often led to automatic responses as participants felt endangered (Reeves & Humphreys, 2018). Language used by the provider was also reminiscent of sexual abuse (Jonsdottir et al., 2022; LoGiudice, 2022; Tsur et al., 2023), with phrases such as “Be still,” “Calm down,” and “Don’t move,” causing a physiological and psychological reaction for participants. The “destabilisation” that occurs due to re-traumatisation led the researcher to conclude that the emotions elicited by healthcare experiences are “complex”, indicating they may be intertwined with past trauma.

Other triggers leading to a recall of experiences are more subtle. Multiple professionals in appointments led to a sense of “embarrassment”, which was a triggering emotion for many participants (LoGiudice, 2022). A power imbalance was also noted as an antecedent to feeling destabilised in care settings (Gesink & Nattel, 2015; Reeves & Humphreys, 2018) as this may replicate the dynamic in abusive experiences, which caused participants to feel vulnerable throughout the healthcare space (Jonsdottir et al., 2022). Findings indicated that participants seeking care whilst feeling vulnerable required them to put trust in providers, however, they are viewed as “strangers” to participants leading to reservation and hypervigilance (Tsur et al., 2023). The clinical environment was also felt to be an “unpredictable” trigger for many participants and caused a desire to avoid (Gesink & Nattel, 2015).

Theme Two: They Call Us Crazy – Medical Gaslighting in Healthcare Settings

Across the findings, it was suggested that survivors believed the healthcare professionals they interacted with lacked knowledge about the impact of psychological trauma. Professionals appeared to “dismiss the impact” of participants trauma responses or did not consider how this would be transferred into the clinical space (Jonsdottir et al., 2022; Reeves & Humphreys, 2018; Ross et al., 2023; Tsur et al., 2023). The findings reported a contrast in knowledge about psychological trauma between survivors and physical healthcare providers; participants were aware of the links between their physical condition and psychological contributors but this was felt to be outside of the professional’s knowledge or awareness (Jonsdottir et al., 2022; Ross et al., 2023). Participants lived experience aided theoretical knowledge around the impact of trauma, but robust theoretical knowledge appeared to be absent for healthcare professionals (Jonsdottir et al., 2022). Professionals failing to integrate recent understandings about trauma-informed care and broader systemic shortfalls (Alyce et al., 2022) made the gap in knowledge more obvious to participants.

Across various healthcare settings, insufficient support (Jonsdottir et al., 2022; Ross et al., 2023) and perceived ignorance from healthcare professionals (Alyce et al., 2022) signalled the lack of knowledge about trauma and added to the challenges participants faced when accessing care. Healthcare providers breaking boundaries and invading personal space throughout procedures was interpreted by participants as a deficit in understanding about how they may react to this invasion (Alyce et al., 2022; Crockett, 2017; Gesink & Nattel, 2015; Reeves & Humphreys, 2018). Some studies mentioned that disclosures were offered in an attempt to obtain more sensitive care, but this was not always the outcome from healthcare providers (LoGiudance, 2022). As a result, survivors were reliant on healthcare providers using their intuition to support them in a psychologically safe way, rather than knowing they were prepared with training and knowledge about trauma-informed care (Tsur et al., 2023).

As well as dismissing psychological needs, findings suggested that healthcare professionals over-exaggerated psychological contributors in a way that “gaslit” the reality of participant’s physical health difficulties (Alyce et al., 2022; Reeves & Humphreys, 2018; Ross et al., 2023). Healthcare professionals often failed to provide support for ailments they deemed “in their head” or “fabricated” (Ross et al., 2023), indicating “mistrust” of survivors accounts (Reeves & Humphreys, 2018; Tsur et al., 2023). Findings suggest that “reframing” participant’s physical health difficulties was a common occurrence (Reeves & Humphreys, 2018; Ross et al., 2023; Tsur et al., 2023). In a possible compensatory mechanism for the lack of knowledge, findings suggested that participant’s mental health experiences were emphasised to overshadow the experiences of trauma, which minimised their healthcare needs and overlooked the survivor identity (Reeves & Humphreys, 2018). This resulted in “misdiagnoses” and prolonged survivor’s physical and psychological pain (Ross et al., 2023). Across findings, participants reported “inappropriate treatment pathways” and “missed referrals” to appropriate services (Ross et al., 2023; Tsur et al., 2023), as such, survivors in physical healthcare settings appear to feel let down and betrayed.

This theme also captured how a lack of knowledge leads to the use of unhelpful stereotypes by physical healthcare professionals when interacting with patients with a trauma history (Alyce et al., 2022; Jonsdottir et al., 2022; Reeves & Humphreys, 2018; Ross et al., 2023). Providers label survivors “crazy” or “complex” which gives insight into the medical gaslighting that occurs in physical healthcare settings for participants (Reeves & Humphreys, 2018; Ross et al., 2023; Tsur et al., 2023). Being viewed in this way leaves participants feeling stigmatised and shamed in their interactions with staff who used unhelpful “assumptions” to conceptualise their health status (Gesink & Nattel, 2015). Deeming participants “crazy” had significant consequences for survivor’s healthcare experiences, as they are then queried about the ability to make “informed decisions” about their own care (Reeves & Humphreys, 2018). These findings suggest a lack of knowledge leads to further marginalisation, potentially oppressive practices and prejudice within the survivor community.

Theme Three: Navigating a Dual Identity: Challenges around Disclosure

A further theme that captured a poignant aspect of survivor’s experiences was their dilemmas around disclosing their experiences of sexual trauma with healthcare providers. The findings reported that many participants were aware that they held historical experiences of sexual abuse and a physical health need, but fear, shame and stigma influenced their decision to keep the former private (Alyce et al., 2022; Crockett, 2017; Gesink & Nattel, 2015; Meier et al., 2021; Reeves & Humphreys, 2018). The “battle” of “making the invisible, visible” provides insight into how sharing this is not a straightforward or simple decision for survivors (Meier et al., 2021). Many studies reported that participants did not want to disclose both aspects of their identity to their healthcare provider (Alyce et al., 2022; Meier et al., 2021; Reeves & Humphreys, 2018) instead opting to convey emotions such as "anxiety" or "panic" which were easier to share (Alyce et al., 2022).

There were multiple reasons cited for not sharing a disclosure in healthcare settings. Some findings indicated that intersectionality (Crenshaw, 1989) and sharing multiple marginalised identities (such as gender identity) felt "complex" in healthcare settings (Crockett, 2017). Others reported that healthcare providers were in a "task-focused" role and a disclosure was not felt to be compatible with the professional's agenda (Alyce et al., 2022) or they believed that providers would use a disclosure to minimise their physical health difficulties (Reeves & Humphreys, 2018). Participants also had concerns that they wouldn't be believed about sexual abuse experiences (Reeves & Humphreys, 2018), the impact of the abuse would be misunderstood (Crockett, 2017) or they would be "judged" for their experiences (Reeves & Humphreys, 2018). Unfortunately, their predictions often came true during the occasions where participants felt that providers dismissed of the impact of sexual abuse and treated them poorly (Crockett, 2017; Reeves & Humphreys, 2018).

The findings discussed that a disclosure was sometimes believed to hinder participant's healthcare, rather than facilitate it (Alyce et al., 2022; LoGiudice, 2022; Tsur et al., 2023). On a broader level, participants were deterred from sharing their history because they feared harmful judgement that society, and therefore their healthcare provider, would hold about survivors (Meier et al., 2021; Reeves & Humphreys, 2018). In addition, participants also felt silenced by the need to "please" or "comply" with a provider who they perceived to be in a position of power, which may be similar to past abuse experiences (Meier et al., 2021). The findings across studies indicated parallels with past abusive experiences, where participants perceived they have to offer vulnerability (through disclosure) to a more powerful person (the healthcare provider).

Many participants were not asked about their experience of trauma or sexual abuse, meaning it was their responsibility to determine the usefulness of a disclosure in this setting (Alyce et al., 2022; Gesink & Nattel, 2015). When the enquiry around past experiences of abuse was led by the practitioner or service, the findings concluded that participants expressed concerns around "tokenism" (Gesink & Nattel; 2015). The findings reported that the use of pre-appointment screening information to collect information about trauma caused distress for some participants (Ross et al., 2023) despite this being a suggested solution that participants offered as a means of discussing their history (Alyce et al., 2022). The authors reported that survivors desire open, genuine conversations about their experiences to offset the intrusive nature of these questions (Alyce, 2022; Gesink & Nattel, 2015; Ross et al., 2023). Paradoxically, several participants' believed that a disclosure should not be necessary if services and providers aligned their practice in a trauma-informed way (Gesink & Nattel, 2015).

Some of the challenges participants face related to a desire to disclose information about their history (LoGiudice, 2022) but there are conditions around this, including time, trust and opportunity to build a good rapport with their provider (Alyce et al., 2022; Gesink & Nattel, 2015; Reeves & Humphreys, 2018). Findings reported that there was often relief that followed sharing a disclosure (Reeves & Humphreys, 2018) which appeared to unburden them from withholding information. There were occasions when disclosures were met with empathy and compassion following "iterative" conversation which supported a more positive experience for participants (Alyce et al., 2022).

Theme Four: Providing What We Never Had – Holistic Care

The final theme captured several positive physical healthcare experiences outlined in findings which researchers reported were linked to demonstration of considering survivors holistic needs. Results across the studies indicated that when interactions considered participants psychological and emotional wellbeing this set a foundation of trust and assurance, leading to better engagement in the service (Alyce et al., 2022). This also increased the likelihood that participants would return for treatment or engage in factors that facilitated better health outside of appointments (Jonsdottir et al., 2022). The reports indicated that holistic care viewed survivors as collaborators in their care, rather than passive recipients (Meier et al., 2021). Choice and control was an imperative part of holistic care (Alyce et al., 2022; Reeves & Humphreys, 2018) and autonomy communicated that participant's voices had been heard. Providers explaining procedures allowed complex medical procedures to be "demystify" (Gesink & Nattel, 2015) and facilitated transparency throughout care. Control was also afforded by extra time within appointments (Reeves & Humphreys, 2018) to offset overwhelming feelings and allow survivors to engage at a more comfortable pace. These factors mediate against the requirement of enduring procedures that are psychologically triggering (LoGiudance, 2022) and the anxiety felt during appointments (Gesink & Nattel, 2015; LoGiudance, 2022).

Adaptations in line with participant's needs (Alyce et al., 2022; Gesink & Nattel, 2015) demonstrated that despite a power-imbalance, survivors were in control of their own bodies (Jonsdottir et al., 2022). A consistent and available practitioner was linked to holistically considered care (Alyce et al., 2022; Jonsdottir et al., 2022; LoGiudance, 2022) as well as the offer of a gender-considered chaperone throughout treatment (Reeves & Humphreys, 2018). This appeared to demonstrate to participants that the provider and service recognised the need to build trust and rapport with an ally. The findings across studies emphasised the importance of provider’s willingness to adapt (Reeves & Humphreys, 2018) where a desire to make adjustments for the benefit of participants showed investment in their care. Offering participants a psychologically safe means of pausing or stopping the procedure if they became emotionally overwhelmed was valued and enabled safer treatment on both sides of the collaboration (Alyce et al., 2022; LoGiudance, 2022). Personal factors from the practitioner, such as empathy and compassion, was facilitative in helping participants adjust to both the physical pain and the emotional turmoil (Ross et al., 2023; Jonsdottir et al., 2022). It may be concluded that these qualities offer survivors positive experiences that they were not afforded during situations of abuse and allow a re-modelling of situations where they are hypervigilant and feel unsafe.

Outside of the one-to-one interactions, findings across studies indicated that communicating survivor’s psychological needs in documentation, consultations and care plans showed trauma-informed care within the system (Ross et al., 2023; Meier et al., 2021). In addition, participants being asked about their abuse history through screening processes (LoGiudance, 2022) was a tangible demonstration that services cared about factors that might affect their care. Holistic support also comes in the form of liaison with other organisations to create a team approach (Jonsdottir et al., 2022). Practitioners who adopted a multi-disciplinary approach were interpreted as survivors “main supporters” (Jonsdottir et al., 2022), which indicates that participants required someone who embodied this role whilst they are involved in healthcare. Findings across studies implied that the clinical environment was often a reflection that the system had considered the comfort of participants as survivor-patients and their psychological and physical safety had been taken into consideration (Ross et al., 2023). Some participants described that they often wanted to be seen as “victims” in physical healthcare settings and they felt this would lead to more compassionate and sensitive care (Crockett, 2017). The semantics around this indicate that being seen as a victim of abuse rather than a “survivor” would communicate the sense of vulnerability participants carry with the aim of signalling they need more sensitive care.

Discussion

This meta-synthesis aimed to review the physical healthcare experiences from the perspective of adult survivors of sexual abuse. Four themes were revealed, which reflect a myriad of experiences across different physical healthcare settings from a diverse, international sample of participants. The review offers some insight into the factors that signify participants experience in healthcare. Firstly, a theme related to historical sexual abuse experiences showing up in healthcare settings demonstrated that overt and covert trauma triggers were common and survivors experienced re-traumatisation (Crockett, 2017). There was a theme related to unhelpful, derogatory and negative stereotypes being applied to survivors in healthcare setting by both providers and the system in a way that was gaslighting of their physical health difficulties (Reeves & Humphreys 2018; Ross et al., 2023; Tsur et al., 2023*)*. As such, the care they received was dependent on healthcare providers accepting, or rejecting, the legitimacy of their physical health complaints when they had factored in their mental health history. A further theme related to dilemmas around disclosure were shared throughout findings as participants found it difficult to know when, how and if they should share part of their identity (Alyce et al., 2022). Finally, a theme captured the multiple positive experiences that were connected through the global consideration of survivors needs and may related to providing what they never had during abusive situations (Jonsdottir et al., 2022; Ross et al., 2023).

In combination the themes appear to capture that the healthcare setting and interactions recreates the abusive architecture through various means, such as language, physical environment and interpersonal dynamics. Underpinning all of this is a (mis)use of power. The findings imply that survivors may routinely struggle with several aspects of healthcare due to the hypervigilance, stress and anxiety as a result of trauma histories which come to the forefront during appointment and detracts from the focus of getting support as a physical healthcare patient. As such, healthcare represents another opportunity for survivors to be marginalised or re-traumatised, which is pertinent in light of potential intersectionality. This structure has the potential to be empowering (holistic healthcare needs, recognition of survivor status) or disempowering (re-traumatisation, use of unhelpful stereotypes, gaslighting and minimising concerns). An empowering structure enables rewriting the trauma script through providing the trust, care, support and guidance that they never had in other situations where they were betrayed and abused by a person in a more powerful position. Within this architecture, it appears that the providers may inadvertently come to represent the abuser in these settings, indicating the importance of provider relationships, the removal of medical gaslighting and overuse of personal biases being applied to survivor groups. The themes indicate that within healthcare development, providers and systems holding knowledge around the impact of trauma is a foundation to appropriate care for survivors, but more nuanced developments are required. However, the positive experiences captured as a theme identifies that holistic care is possible in these settings to allow survivors the opportunity to engage in care that meets all their needs.

Strengths and Limitations

The metasynthesis provides some understanding of how survivors experience physical healthcare services but identifies that further understanding is required about the nuanced factors that may facilitator or hinder these experiences .The findings provide an update on a previous review (Havig, 2008) to outline a summary of results across relevant healthcare literature.

Although generalisability is not the aim of qualitative research, there are limitations in the applicability of the findings from this review for the experiences of survivors as a community. The breadth of diversity in participants is positive, but shows that intersectionality is required when considering the findings across the sample. Several of the studies have drawn data from a broader study where the focus was not necessarily on healthcare experiences, which may have implications for the validity of the findings in relation to the question. Recruitment methods varied, with snowball sampling, clinician recruitment and advertisement used; these methods may bias the sample. The breadth of healthcare settings included in the review strengthens the findings, however, this may limit the applicability of findings for specific settings. Participants across the samples also reported the experience of multiple traumas in addition to sexual abuse, which may mean the findings do not specifically relate to sexual abuse experiences alone.

Rationale for the Present Study

Research to date has highlighted the difficulties survivors face accessing oral healthcare and problems when in dental appointments and the metasynthesis provides some understanding of the themes that relate to survivors experiences in physical healthcare settings. The current qualitative research in the field offers insight into the broad experiences of survivors in a dentistry setting, however, it is unclear what the specific factors within survivors experiences are and how these help or hinder access to oral healthcare. The only study which has conducted research in this area in the UK is Alyce et al. (2022), which drew data from a broader study. The UK has a distinctive healthcare set-up in regards to oral healthcare, with NHS, community dentistry and private dentistry available (Lynch & Calnan, 2003) and exploration across all these settings will allow for understanding of the factors in statutory and privatised contexts. Research thus far has suggested reasons why survivors might find dentistry triggering and suggested providers adapt their care in line with TIC, although it is unclear if these are possible in practice and what dental professional's attitudes and perceptions are (Alyce et al., 2022; Dougall & Fiske, (2009); Larijani & Guggisberg, 2015; Raja et al., 2014). There is utility in exploring dental professionals perceptions are on survivor's experiences, and if they feel they can take the appropriate steps to support survivor-patients in the dental chair.

Aims and Objectives

The current research aims are to explore the barriers and facilitators to oral health care for survivors, as well as dental professionals' views on the barriers and facilitators survivor needs. Exploring both of these both perspectives simultaneously together can provide a sense of what hinders and enables oral healthcare for survivors, and how dental professionals view these factors in the context of their practice. Insight into these experiences from both stakeholders could lead to transformative, appropriate, healthcare which meets the needs of survivors and is possible in practice. Therefore, this research will aim to answer the following questions:

- What are the barriers and facilitators of oral healthcare for survivors of sexual abuse?
- How do dental professionals perceive these barriers and facilitators, and what implications do these have for their practice?

This research aims to uphold community psychology principles throughout the process by collaborating with survivors using a Participatory Action Research (PAR) approach (Baum et al., 2006). This will form a fundamental part of the research and will be done with the intention of involving and including survivors’ voice and expertise in the design, methodology, analysis and dissemination of the project. Upholding a participatory approach throughout the research process integrates survivors into the research process as collaborators, rather than solely as participants.

It is proposed that understanding of both research aims are vital for enhanced insight into the factors that help and hinder dental care and if dentistry practice can be developed with consideration of these factors. A co-production approach has not been seen in published literature within the United Kingdom, therefore, this research approach represents a novel consideration in the field.

CHAPTER TWO: METHODS

Chapter Overview

This chapter will present an outline of the methodological process conducted as part of this research, along with justification for the qualitative paradigm and participatory action research approach used. Firstly, the philosophical paradigm will be discussed, providing support for the critical realist position. A positionality statement is included within this chapter and reflected on further in the discussion section. The procedure for recruiting participants and conducting the interviews and focus groups will be outlined. Data collection occurred between March 2023 and February 2024. To conclude the chapter, ethical issues will be presented.

Philosophical Paradigm

As part of the research methodology, it is important to outline the philosophical foundation on which the project is rooted. The philosophical research paradigm is comprised of the belief system and theoretical framework which sets the way of understanding reality and the methods of studying it. Identifying the ontological and epistemological positions is an essential step for ensuring the research methods are consistent with the philosophical underpinnings (Howell, 2013) and situating the researcher as an active component within this process (Coolican, 2018). The different positions under the branches of philosophy serve to offer a perspective on how the standpoint affects the entire research process (Moon & Blackman, 2014). Acknowledging the positionality and the foundations upon which the research is set can facilitate transparency, therefore, strengthening the rigour of the research (Jacobson & Mustafa, 2019; Willig, 2013). As such, the following sections will provide details of the ontological, epistemological and methodological frameworks that have been adopted in this research.

Ontology

Ontology questions: how do we know something exists? It relates to what exists in the world that people can acquire knowledge about. There are several ontologies that exist on a continuum with relativism at one end, which posits that multiple realists exist and interpretation is required in order for it to be real, and realism at the other, which outlines that there is an objective reality that can be understood by using appropriate methods to study it (Braun & Clarke, 2013). Researchers who adopt a position of relativism assign to the philosophy that multiple truths exist and these are all valid for understanding a phenomena (Coolican, 2018). They may use contextual information to analyse and conceptualise their understanding of the world and experiences (Denzin & Lincoln, 2017). A realism position assumes that there is a single objective truth and this truth exists outside of the human experience (Coolican, 2018). As such, objective measurement would be used to discover the true, single reality (Denzin & Lincoln, 2017). In the middle of the continuum is the critical realist position. If this positon is adopted by the researcher, then the stance is assumed that knowledge of the world varies by the individual, but the complete reality of this cannot be understood (Bhaskar, 2016; Pilgrim, 2019; Stutchbury, 2021).

Epistemology

Epistemology is concerned with the ways of knowing and learning about reality. In combination with the ontological positon, epistemology aids understanding around acquiring and conceptualising knowledge in a manner that is consistent with the stance on what reality is (Grix, 2019; Scott & Usher, 2010). Similar to ontology, there are several epistemologies which can be understood on a continuum. Positivism describes that meaning exists within the object and this reality is objective and discoverable through the research process (Braun & Clarke, 2013). Conversely, constructivism outlines that the meaning exists within the subject and the subject imposes this meaning onto the object, therefore, the research process creates the reality (Braun & Clarke, 2013). Epistemology also encompasses how the researcher understands their own thinking, how their knowledge is made and to what extent this should be impartial in the research process.

Research Paradigm

The philosophical orientation of the researcher is important to consider as part of this project, as this guides and impacts on the action, process and steps taken as part of the research. This can be outlined in the research paradigm, which combines the position on the ontology and epistemology with the researcher’s beliefs and values (Braun & Clarke, 2013). A critical realist position has been adopted by the researcher for this project, which theorises that social context is required to understand the reality (Bhaskar, 1979). This approach assumes that the data does not capture a direct reflection of occurrences in the world, but it can tell us what is going on and can be interpreted to gain further understanding (Willig, 2013).

Critical realism is not associated with a particular methodology, but can be used as a broad framework on which the research is set (Fletcher, 2017). In relation to the current research, a critical realist approach links to the phenomena in question and acknowledges how survivors' experiences will be subjective and set within the social context and their background. It also aligns with the research question exploring dental professionals' views on the barriers and facilitators, by drawing parallels through a focus on understanding what meaning they draw from survivors' experiences of oral healthcare. As such, a critical realist approach will facilitate understanding the underlying mechanism and reasons behind survivors and dental professional's experiences and perspectives.

Qualitative versus Quantitative Methodology

Research paradigms can be understood as qualitative, quantitative and mixed methods (Kuckartz, 2014). It is not only the methodological approaches and techniques that contribute to the differences in qualitative and quantitative methods, but they also differ in philosophy and epistemology (Yanchar & Westerman, 2006). Quantitative methodologies adopt positivist philosophies and assume that knowledge is learned and acquired through experimental methods. These methodologies often aim to test out hypotheses and establish causality through controlled experiments and statistical reporting (Harper & Thompson, 2012; Neuman, 2014; Robson, 2002). In comparison, qualitative methodologies are concerned with the interpretation of personal, subjective experiences (Carter & Little, 2007), consistent with interpretivist philosophy. These methodologies argue that multiple realities can exist and are socially constructed (Hudson & Ozanne, 1988; Robson, 2002) and utilises qualitative methods to acquire this knowledge (Deetz, 1996; Reeves & Hedberg, 2003).

Rationale for Qualitative Design

Prior research in this area highlights that oral health is an important and relevant topic for survivors, dentistry and clinical psychology (Fredriksen et al., 2020; Willumsen, 2004;

Wolf et al., 2021). However, there is a dearth of literature which explores the barriers and facilitators survivors face regarding oral healthcare in the context of the UK. In addition, there is little research exploring the views dental professionals hold about survivors' experiences of oral healthcare. One aim of the research is to develop an understanding of the accounts from survivors, therefore, a qualitative methodology is viewed as an appropriate approach to offer a systematic method of gaining insight into these experiences. Adopting this methodology assumes that the experiences of those accessing dental care after lived experience of sexual abuse cannot be accurately captured by quantitative methods. Qualitative methods allow for a depth of exploration into the experiences as they are told (Banister et al., 2011) and the research aims to analyse the meanings and interpretations of these experiences to add to the depth of understanding (Willig, 2012). With the semi-structured nature of some qualitative approaches, a flexible and adaptive approach can be employed to capture the data which adjusts to the nuances in the participants' responses. This has benefits for a newly researched area and topic.

Similar justification applies to the second stage of the research topic. At the time of undertaking this research, there is no published literature exploring the views of dental professionals in conjunction with survivors' experiences of barriers and facilitators. Quantitative research in the area has offered understanding of professionals' knowledge and attitudes related to sexual abuse (John et al., 1999) and qualitative studies have highlighted the need for alliance between survivor-patients and dentists (Wolf et al., 2021b), but there is a lack of research about the views and perceptions of professionals in these settings related to the experiences survivors have.

Based on this, qualitative methods were utilised to gather data related to the perceptions, views and experiences of survivors and dental professionals. Different qualitative approaches have been adopted for the various stages of the project: semi-structured interviews have been used for data collection with survivors, and focus groups were used with dental professionals. Semi-structured interviews offer a method of exploring a topic of interest and allows the researcher to elicit information from the participant based around a prepared guide or schedule (Galletta, 2013). Alternatively, focus groups allow the generation of qualitative data in relation to the topic of focus through discussions between participants linked by a common experience, identity or demographic (Kitzinger, 1995). The benefits of these approaches are discussed further in this section.

Community Psychology Paradigms in Research

This research project has community psychology principles at the core of its approach and this forms a fundamental aspect of the project methodology. Community psychology, in simple terms, is concerned with the relationship between social systems and individual wellbeing in the context of the communities they live and operate in (Levine et al., 2005). Community psychology seeks social justice through social change to support individual and community wellbeing (Levine et al., 2005; Nelson & Prilleltensky, 2005). A commitment to "structural-level" change is upheld to facilitate this. As well as considering the application of these principles to improve people's health and the effectiveness of systems, this approach also offers an analytical perspective which can be utilised in research (Nelson & Prilleltensky, 2005).

This project has adopted these principles to include the values of social change and collaboration in the design, methodology and analysis. Participatory Action Research (PAR) is a dynamic approach that moves between action and reflection (Smith et al., 1997) and approaches enquiry in cohesion with the communities related to the research question (Baum et al., 2006). This type of inquiry aims to produce "knowledge and action directly useful to a community" and empower communities to be involved in this process (Reason, 1994). PAR is not an approach, per se, but can be thought of as creating a context in which knowledge may develop and change might occur (McIntyre, 2007). PAR falls most closely within the critical theory paradigm (Ponterotto, 2005). As such, adopting a critical realism approach is consistent with PAR and vice versa. Consistencies in these approaches can aid researchers to explain social phenomena and suggest practical or policy recommendations to address societal issues (Fletcher, 2017).

The project works at the intersection of psycho-social issues and it could be argued that these cannot be thought about in isolation. The breadth of the topic spans many macro-level structures and disciplines that can be encompassed using a community psychology praxis. As such, community psychology principles upheld throughout this project recognises the way of seeing people's behaviour and well-being in the context of their community and social systems (Levine et al., 2005) and taking a community, participatory approach to the research process encompasses the community as collaborators.

Participatory Action Research Approach

Throughout the project, consultation and collaboration has been done with a local service, Healthwatch Essex. Healthwatch Essex is an independent charity which undertakes research related to the experiences of using health and social care services and advocates for local communities holistic health needs. As an organisation, Healthwatch Essex collects data about the lived experience of health and social care for members of the public in the Essex region. This information is then used to inform the way local services are designed and delivered, with transformative action at the core of their approach. They are an established and community focused service known in the region by the public and professionals. The organisation has an established survivor support group, The Trauma Ambassador Group (TAG), whom meet monthly to discuss issues that affect people who are survivors of traumatic experiences. The TAG and it's members form a vital part of this research through co-production, consultation and co-analysis with the group at stages throughout the research process. By working alongside an organisation with social change at the core of its values, this project recognises the importance of these approaches in facilitating macro-level change.

Researcher Positionality

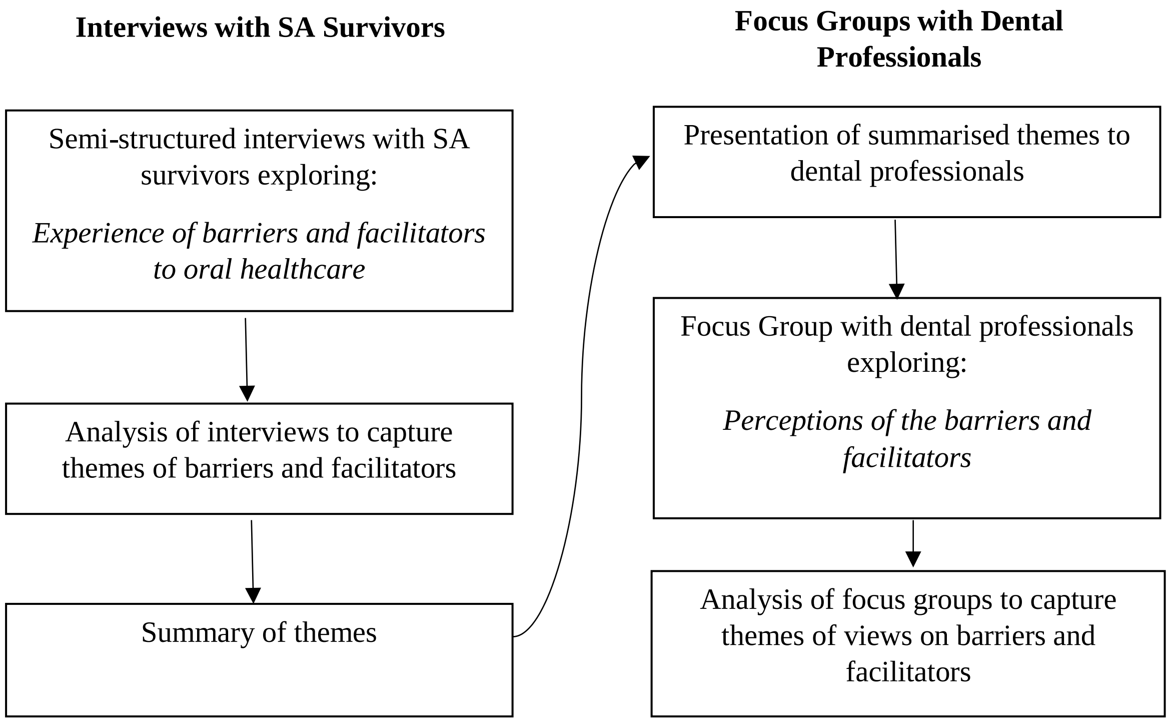
Recognising and using the researcher as an active agent in the research process can strengthen the rigor and trustworthiness of the research (Braun & Clarke, 2013; Leibing & McLean, 2007). This allows the reader to set the findings within the social, cultural and political context of the researcher's identity (Finlay, 2002). In line with this, it is important to outline my positionality which forms part of the context for this research. At the time of submitting this research, I identify as a 31 year old Black British female of mixed heritage. Other prominent features of my identity are important to acknowledge within the context of this research, such as my low-income background and being a survivor of experiences that are traumatic. The multiple, intersecting aspects of my identity has enriched my understanding of this project from a personal perspective and has been implicated in being immersed in this project. I have reflected on this further in chapter four.

Research Design

Ethical approval for the project has been approved by the University of Essex. The research design was co-produced with the TAG at Healthwatch Essex. The specific process of co-production throughout this project meant that several steps were engaged in to collaborate with the survivor population on elements of the project. The researcher engaged in TAG meetings to discuss survivor's experiences of oral health and accessing the dentist. These discussions were used to structure the research design in collaboration with survivors, which was then formalised by the researcher to produce a preliminary design. An iterative process of designing and discussion with members of the TAG was conducted to ascertain their views and feedback on the design. The final design was confirmed with the TAG members who were in support of each stage in the research design and the research questions in focus; this is shown in Figure 1.

Figure 1.

Research design process shown in two stages, starting with interviews with survivors. After analysis of themes, these will be used in stage two, where themes are presented to dental professionals for discussion in focus groups.



An additional co-production approach involved co-analysis of the results with participants who took part in the study. Professional consultation in the field of dentistry was conducted in addition to co-production with the TAG members. A local community dentist and a Professor in the school of Health and Social Care at the University of Essex, whom also practices as a dentist in private practice, offered consultation on the final research design. Both experts were satisfied with the questions, design and process. Stage one involves interviews with survivors of sexual abuse, exploring their experiences of the barrier and facilitators to oral healthcare and stage two involves focus groups with dental professionals, exploring their perceptions of the barriers and facilitators experienced by survivors.

Data Collection Methods

It is important that the data collection methods align with the philosophical and theoretical frameworks, and also function to answer the research question (Coolican, 2018). Various qualitative methods were considered in relation to the research question and a multi-method approach was adopted to suit the various stages of the project.

Semi-structured Interviews

Interviews are a common and direct method of collecting qualitative data that offer a methodology of exploring lived experiences or perspectives. Semi-structured interviews are used to elicit depth of information about a topic or experience using pre-determined questions with a degree of flexibility in the line of questioning based on participants' responses (Schmidt, 2004). This responsive approach means the researcher can interact with the nuances in perspective that the participants share to allow depth of insight into the experiences. Salient points in the participants' answers can be explored to allow the researcher to capture new understanding or perspectives that may not have been anticipated when designing the semi-structured interview guide (Charmaz, 2002). The flexibility of this approach makes it a popular method in qualitative research (Kallio et al., 2016) and is one of the reasons why this was chosen as an approach for stage one in the project. The critical realist paradigm of the research aligns with semi-structured interviews (McEvoy & Richards, 2006) as an approach that will offer important insight into the multiple experiences of oral healthcare for survivors. In addition, this is an under-researched area, therefore, semi-structured interviews were selected for stage one data collection methods to uncover original understanding about the topic.

Focus Groups

Focus groups encourage free-flowing conversations and are valuable for providing a community understanding on a topic or question (Kieffer et al., 2005). Group processes have been posited to aid exploration of members' views and allow clarity of these views through discussions between members (Kitzinger, 1995). The discussions within focus groups may also elicit group cultures and norms, which could be particularly insightful when discussing topics amongst colleagues as a group, rather than as individuals (Kitzinger, 1995). This part of the research aims to explore dental professionals' views on the barriers and facilitators experienced by survivors. The group interaction aspect of focus groups is deemed useful for exploring this aim as the exchange of multiple perspectives could be advantageous to understanding views within and between dental professionals. (Kitzinger, 1995). Workplace culture is also an important factor for the topic and this may be elicited and examined more easily through focus groups. This method was considered beneficial for acquiring an inter-disciplinary perspective on the barriers and facilitators survivors' experience and allow discussion of the multiple approaches to clinical practice. A dynamic group process may support further insight into this topic from the perspective of "naturally occurring" groups by the definition of professionals who work in the same industry. The set-up of a focus group may aid eliciting inter-professional views and contribute to initial understanding of the topic (Vaughn et al., 1996).

A semi-structured interview format will be used as a guide for the focus groups where questions will be informed by the themes that survivors share. In addition, literature and professional expertise was consulted to inform the nature of questions and the interview schedule. The researcher will act as a group facilitator and use this interview format to offer prompts in response to participant's discussions (Kitzinger, 1995).

Research Materials

Invitation to Research (Appendix D). A document was produced for distribution to potential participants inviting them to participate in the research. This document was sent alongside the Participant Information Sheet, to provide information about the purpose of the study and its requirements. The Invitation to Research email and poster for dental professionals was co-produced with TAG members.

Participant Information Sheet (Appendix E). To give participants sufficient time to read and consider the information related to the project, Participant Information Sheets were distributed to all potential participants prior to them agreeing to take part. There was no time limit imposed on participants reading the information sheet. Two versions of these were made: one for participants with lived experience of sexual abuse and one for dental professionals. Contact details of the researcher was included on the Information Sheets and all potential participants were encouraged to make contact if they had questions related to the study.

Demographic Information Sheet (Appendix F). To collect information about the participant's demographics, a Demographic Information Sheet was distributed prior to the interviews and focus groups. Several demographics were requested from participants, including gender, age and ethnicity. Participants in the focus group were also asked for their current job role and participants in the interviews were asked when they most recently attended the dentist.

C**onsent Form (Appendix G).** Informed consent was a fundamental aspect of the project. Written consent was obtained from all participants in the interviews and focus groups. Consent forms were provided to all participants and a signature was required on the Consent Form before commencement of the interview or focus groups.

Interview Topic Guide (Appendix H). When utilising semi-structured interviews, a guide can provide some structure and consistency in the questions asked. Having pre-determined questions is the difference between unstructured and semi-structured interviews and gives consideration to the areas of interest in line with the project (Gill et al., 2008). A guide for the focus group was also created to facilitate discussions in accordance with the themes from survivor's experiences. The semi-structured interview guide was developed in collaboration with the project supervisor and after consultation with literature.

Stage One: Semi-structured Interviews with Survivors

Participants

Inclusion & Exclusion Criteria. Participants were eligible to participate in the study if they met pre-determined inclusion criteria. Adult participants (aged eighteen or older) with lived experience of sexual abuse could participate in the study. A definition of sexual abuse was not provided to participants, instead, their own definition was deemed sufficient and was not required to be discussed with the researcher unless this was the participants' preference. Those involved in the study were also required to live in the local region, as an important aspect of the research was that experiences were contextualised in the local area. Participants were excluded from the study if they did not meet these three inclusion criteria.

Procedure

Recruitment. The focus of recruitment was concentrated in organisations and services that support survivors in the local area. The networks associated with Healthwatch Essex was the primary pathway to support recruitment of participants. Due to the nature of the research question, a purposive sampling method and subsequent snowball method was employed to recruit survivor participants to the study. The Invitation to Research email (Appendix D) was distributed via Healthwatch Essex mailing lists to inform potential participants of the project. Other participants were recruited through previously recruited participants networks and connection.

Once participants had responded to the study recruitment email, they were sent correspondence thanking them for their interest and asking them for a preferred method of communication. The Participant Information sheet (Appendix E) was attached to this email, which participants were asked to read through before arranging an interview. Once an interview was arranged, a screening process was conducted to ensure participants were eligible to take part in the study. This involved checking that participants met the inclusion criteria; they were asked for their age and if they lived in the East Anglia region. A Demographic Information sheet (Appendix F) was also sent to participants to capture this information as part of the study. A voucher in the amount of £20 was provided to participants who were involved in the project. Participants who supported the data analysis process were provided with an additional voucher at a rate of £15 per hour.

Data Collection. Eight semi-structured interviews were conducted. A Consent Form (Appendix G) was sent to all participants and was required to be signed prior to commencement of the interviews. All interviews took place at the participants preferred time and date and they were presented with a choice of the format for their interview; all participants opted for remote interviews. Interviews were held over Zoom and in addition to Dictaphone recording Zoom’s built-in software was used to record. All interviews were manually transcribed. Prior to the interviews starting, participants were asked to confirm that they had read and understood the Participant Information sheet. Participants were reminded of their right to withdraw from the study at any point and there was an opportunity for participants to ask any questions they had prior to the interview starting. A semi-structured interview topic guide provided a set of open questions related to the topic of focus (Appendix

H). The length of interviews ranged from 35 minutes to 1 hour and 5 minutes. At the end of the interview, there was another opportunity for participants to ask questions or discuss support services if required. Each participant was reminded of support services they could access based on the interview topic. Members of Healthwatch Essex TAG were signposted into support under Healthwatch Essex and participants not linked to Healthwatch Essex were signposted to their GP.

Stage Two: Focus Groups with Dental Professionals

Participants

Inclusion & Exclusion Criteria. Dental professionals, by definition, includes all registered and training staff working in the dental profession, including dental nurses, dental hygienists and dentists (Trathen & Gallagher, 2009). This definition formed part of the inclusion criteria for participation in the focus groups. Both training and qualified staff were able to participate in the focus groups as this was considered vital to gain different perspectives on the topic and allow a breadth of experience and length of time working in services. Private practices registered in the East Anglia region were part of the inclusion criteria for recruitment and professionals working across the NHS and private practice were not excluded from the study. Participants were allowed to participate in the study if they met this predetermined inclusion criteria.

Procedure

Recruitment Participants in the focus groups are made up of practitioners working or training in the dental profession. A level of familiarity and practice culture was also deemed important as part of the project, which would be achieved through collecting data from focus groups comprised of colleagues or students from similar institutions. To recruit dental professionals as participants in the focus group, the Invitation to Research email and poster

(Appendix I and Appendix J) was sent out to 107 private dental practices in the East Anglia region. Due to a lack of response from this method, participants were also approached via the University of Essex teaching staff and students on the Oral Health Sciences course. Emails were sent to qualified professionals who also held academic roles at the university and an email was sent to students training to be Dental Hygienists registered on the Oral Health Sciences programme. For reasons related to availability in the teaching schedule, the staff and student focus groups were separated. Students were compensated £20 for participating in the project. All participants involved in the research were recruited via responses to emails distributed through University of Essex.

All potential participants were sent an email containing the Participant Information sheet (Appendix K) and Demographic Information sheet (Appendix L). These were completed prior to the commencement of the focus group.

Data Collection. Two focus groups made up of various dental professionals and students were conducted as part of this project. Eight focus groups were arranged, however, six of these groups did not have sufficient numbers of participants to qualify for a focus group. Consent Forms (Appendix D) were sent to all participants which were required to be signed prior to commencement of the focus groups. One focus group was made up of five participants whom were qualified dental professionals and also held academic roles at the University of Essex, whereas the second focus group was made up of three participants who were in training. The qualified dental practitioners worked across both NHS and private practice. In line with the co-production approach of the project, the aim was to have a survivor-participant present in each of the focus groups to contribute to discussions, however, practical barriers and time constraints prevented this. All focus groups took place at an agreed time and date. Interviews were conducted over Zoom, which was also used to record using the built-in software on the platform, as well as an encrypted Dictaphone. All focus groups were manually transcribed. Prior to the focus groups starting, all participants in the focus groups were asked to confirm that they had read and understood the information provided on the Participant Information Sheet. Participants were reminded of their right to withdraw from the study at any point. There was also an opportunity for participants to ask any questions they had prior to the focus group starting. Participants were presented with questions (Appendix M) using the themes generated from data with survivors and were asked to discuss with each other what these themes meant for them personally and professionally. The length of focus groups averaged 1 hour and 21 minutes.

Ethical Considerations

Participant Information Sheet. The participant information sheet was developed to provide information about the project and allow the reader access to sufficient information about the research. The TAG members were consulted on the development of the information sheet for dental professionals.

Consent Forms. Informed consent is a central, fundamental aspect of conducting research. Consent was obtained in written format and information was provided to participants about how their data would be handled, used and disposed of. The process of anonymity was included on the consent form to ensure that participants were aware that they could not be identified based on their responses. Participants were also made aware of their right to withdraw from the study at any time and withdraw their consent. At the end of the consent form for survivors there was an optional section to indicate if participants would like to be involved with the data analysis process.

Confidentiality and Anonymity. The sensitive nature of this topic in the local context meant that the process of maintaining the confidentiality and anonymity of participants was of utmost importance. The grouping of demographic information (such as age brackets) supported this procedure as well as applying pseudonyms to the data. All other identifiable information across the interviews and focus groups were anonymised to protect the participants further. The interview data was downloaded and stored securely before being transcribed by the researcher. All transcripts were given a unique code to ensure that only the researcher is aware of which participant corresponds to which transcript. Careful consideration was given to the possibility that participants involved in the process of analysis may be able to recognise others from their anonymised quotes because of the familiarity in TAG activities. It was decided that the balance between protecting the participants confidentiality and including TAG members as part of the analysis process had been achieved through the process of anonymising transcripts and informing participants prior to taking part in the project that there was an invitation to be involved in the analysis process.

Data Management. Throughout the procedure of the project, all personal information that was collected was handled correctly and in line with University procedure. Anonymising the data was a central part of the data management and data that contained identifiable information (consent forms and demographic information sheets) were held only by the researcher and were stored securely and separately from interview and focus group data. Encrypted devices were used to hold data and were only accessed by the researcher and the academic supervisor if requested as part of the validity process. The Participant Information Sheet provided all participants with details of how their information would be used and stored, including the potential use of their responses in the project write up and dissemination process.

Risk

Protection from Harm. The research recognises the vulnerability of the participants involved and the sensitivity of the topic. Participants were not required to discuss their experiences of sexual abuse, however, indirect or direct links may be made within the interview discussions. To mitigate the risk to participants and ensure safety throughout and beyond the process of the project, all participants were given unlimited time to read through the information sheet, verbal and written consent was obtained and a discussion around support services was held at the end of interviews. As part of the ethics process, a risk assessment was completed.

Designing the Semi-structured Interview

To begin the process of designing the interview topic guide, existing literature in the area of oral health for those with experience of trauma was reviewed. As there is limited previous research in the area, related areas of research were also consulted to ascertain insight into possible interview schedules. Consultation was sought with professionals in the field of Dentistry. The main consults were the TAG group who offered advice on general topic areas for the interviews with survivor participants, and were involved in the process of constructing the guide for focus groups with dental professionals.

Data Analysis Methods.

The process of data analysis began with transcribing the interviews and focus groups verbatim. The data was transcribed manually and was then organised to enable the codes and themes that were generated as part of analysis stage. Interpretative analysis approaches have been used to produce ideas about the experiences participants have shared and the possible ideas about how and why they have been described in this way (Braun & Clarke 2013). Two participants from stage one of the project were involved in a workshop to co-analyse the interview data. Selecting an analysis method that is in line with the philosophical stance and the research questions is important; for the purpose of this research, Reflexive Thematic

Analysis has been identified as the most appropriate method. The justification for selecting this approach is discussed in this section.

Reflexive Thematic Analysis (RTA). Reflexive Thematic Analysis is a flexible approach to identifying patterns and reporting on the themes from a qualitative data set (Braun & Clarke, 2006). Within the approaches flexibility, there is a systematic approach to generate themes. The process of thematic analysis allows the researcher to describe the data produced and interpret aspects of the wider topic based on the accounts and experiences of participants (Boyatzis, 1998). The systematic approach to analysing data using Reflexive Thematic Analysis allows the researcher to comment on and engage in the process to discuss how they went about analysing the data. This lends to evaluating both the data and the researcher’s positionality that is brought to the research process. The process of themes emerging is not a passive process, but contributed to by the process of the researcher’s engagement in the analytical process (Braun & Clarke, 2013). The more contemporary approach of Reflexive Thematic Analysis (RTA) has been used in this project (Braun & Clarke, 2019). This approach acknowledges the lack of neutrality from the researcher, and welcomes this subjectivity in the research process. The critical realist approach of the research topic is in line with the analytical approach of RTA because of the approaches share a constructivist element and both approaches accept that the understanding of reality requires researchers to be reflexive and interpretative in their analysis. This approach also complements the inclusions of a co-analysis team and recognises the strengths that come with additional reflexivity and interpretation.

The six stages of RTA were followed as part of this project. Two members of the TAG were involved in the data analysis process through contribution of analysing interview data, analysing for codes and checking the produced themes for validity. An online, half a day workshop was held over Zoom and information was given about RTA before each transcript was presented to participants for joint coding. The discussions in the workshops and the co-analysis process allowed the themes to be generated. When completed, the co-analysis team agreed on the validity of the final themes. The two participants involved in this process were provided with a voucher in the amount of £15 per hour.

SECTION THREE: RESULTS

Chapter Overview

This chapter presents the results from the present research. The results from interviews will be presented first, followed by the results from focus groups. First, the demographic information of the involved participants will be displayed. Secondly, the themes that emerged from the data will be presented using verbatim extracts from the interview and focus group transcripts. The themes from interviews were co-analysed with two participants who were involved in the research. To protect the participant’s anonymity, all identifiable information has been redacted and pseudonyms have been used.

Stage One: Interviews

Interviews were conducted with 8 participants who met the inclusion criteria and identified that they were survivors of sexual abuse. The interviews ranged from 35 minutes to 1 hour and 5 minutes.

A summary of the participants who took part in the interviews is shown in Table 3. All participants were female and indicated their ethnicity as White British or White Other. The length of time since the last dental appointment ranged from 2 months to 1 year and 2 months. All age categories were represented in the sample, with the most participants in the 55-64 category.

Table 3.

Demographics of the participants included in stage one of the study

Participant	**Age**	**Ethnicity**	**Sex**	**Length of time since most recent dental appointment**
Megan	55-64	White, Other	Female	1 year, 1 month
Cora	18-25	White, British	Female	1 year, 2 months
Sally	45-54	White, British	Female	2 years
Lynda	55-64	White, British	Female	7 months
Audrey	65+	White, British	Female	2 months
Kim	45-54	White, British	Female	2 months
Evie	55-64	White, British	Female	7 months
Britt	26-34	White, British	Female	1 year 1 month

From the interviews that were conducted, six themes were identified which are presented in Table 4.

Table 4.

Summary of themes from interviews

Themes
Dissociation from my Mouth
Commands to be Vulnerable
Avoidance of Routine Examinations and Unexpected Procedures
“Just Make it a Bit More Human” Relational Practice
Psychological Grounding and Stabilisation
A Sense of Community

Theme One: Dissociation from My Mouth. The first theme summarises an overarching feeling that participants had dissociated from their mouth which hindered access to oral healthcare. Throughout the discussions there was an implicit and explicit sense that many participants had relinquished psychological ownership over their teeth and mouth, which was identified through description of a dislike, and often hatred, for their own mouth:

“Yeah, my teeth is the one, number one thing, that and my self-harm scars, are the things that I don't like about myself.” (Britt)

It appeared that a disconnection and detachment from the mouth links to participant’s trauma memories associated with the area. Kim identified a direct link between sexual abuse and dissociating from her mouth because of what it represented:

> “The reason that I’ve been, like, had this fear of looking at them, is because whenever I like catch a glimpse I would see my abusers, so my Dad’s face er he, his mouth, and it took me a lot of years to come to the conclusion that I’ve dissociated from my mouth.” (Kim)

As Kim’s mouth holds representation to an abusive figure, she appears to relinquish ownership of her mouth and therefore any association with her abuser. Evie described disconnecting from her mouth because of the trauma memories it holds:

> “He [perpetrator of abuse] would actually like, say, put things in my mouth to stop me, I guess, screaming, crying out, whatever I don't know and it would be, not being crude, it'd be disgusting things like a hanky or a sock or even my knickers you know so it wasn’t, it was quite traumatising.” (Evie)

The traumatic memories associated with the mouth initially severs participants connection with their mouth but there appears to be attempts to assimilate it back into the identity, however, difficulties interacting with or looking at their own teeth remain, as described by Kim:

“I spent most of my mouth most of my life with my mouth shut erm but I’m on my own journey, although I’ve managed to actually like, I still can’t look at my teeth” (Kim)

This dissociation appears to underlie some of the participant’s difficulties around oral self-care. Cora described not being able to attend to her own teeth because this was not viewed as part of her, which resulted in dental caries:

> “I'm going to have tooth loss and tooth decay erm so that's the biggest one is the impact that it actually has on the gums and the wellbeing erm but I think lack of self-care like it's such a huge one” (Cora)

A lack of ownership and a dislike for the mouth fuels a belief that participants are not deserving of oral healthcare. This results in shame, which prevents participants seeking care; Britt described this when comparing her own teeth, which she believed were in a poor state, to the “really nice” teeth of her dentist:

> “I just don't like it. I think I they're gonna judge me, are they gonna think I'm like a crack head or something, cause of the way I look…I don't think it's necessarily understood the the various reasons why, cause they [dentists] have, they have really nice teeth” (Britt)

The condition of the mouth appears to be an outward display of the internal neglect and dissociation felt by participants. Feeling shamed and stigmatised by this outward appearance has direct implications for accessing care when problems arise, as it prolongs and perpetuates difficulties. Participants described accessing dental care only when absolutely necessary and this was often precipitated by a *feeling* that something wasn’t right, rather than explicitly noticing that there was pain, discomfort or observation of something untoward. Having to use intuition indicates the level of dissociation from the mouth:

> “When there was something that didn't feel quite right I was like, oh my God I really need to think about going [to the dentist] like I can't put it off you know I was worried about losing my teeth and you know all these things that kind of go in your head (laughs) erm so it's like I kind of forced myself to go really” (Sally)

Cora described a cyclical process where dissociation leads to not attending to her teeth, which makes her feel undeserving of care and then feeling unclean because she cannot access care:

> “Deep feelings of not deserving to be looked after or clean and then it kind of puts a little bit of a gap or something to try and stop that, then leading into erm- feeling, you know, gross or feeling dirty or feeling unclean then that leading back into oh I don't deserve it because I'm dirty and unclean all because I let them deteriorate.” (Cora)

The impact of not assimilating the teeth and mouth into identity also impedes social functioning, which is imperative for attending the dentist. Cora shared how the dislike for her teeth prevents her from living the life that she wants to:

> “I never want to smile because I'm embarrassed about the look of my teeth I don’t want to talk to people cos it’s embarrassing in case my breath smells and that is like constant and it's, although it's like such a basic thing people probably go “What?” like, “That's not a big deal”, it is because that is like vital isn't it to communicate and socialise in order to actually have any life at all.” (Cora)

Dissociation from the oral cavity appears to be one factor that gate-keeps a fulfilled and valued life and becomes another contributing factor to marginalisation following sexual abuse. Participants described harnessing dissociative responses to manage dental care. This passivity can be viewed as a barrier, as it prevents involvement in the procedure which is needed to cognitively and emotionally evaluate the process:

> “When I get in the chair I just have to disassociate …. I mean, I know you can't talk to them anyway but I just have to, like, say just disassociate to get through it and I run out of that room as fast as I possibly can after and don’t go back” (Evie)

Paradoxically, participants report hatred for their teeth but also a strong desire to care for this area. This contradiction may reflect a desire to nurture the area that holds so many traumatic memories and experiences, but a strong aspect of self-blame and dissociation prevents this:

> “I definitely keep trying to like, sort my health out and my like, you know, my mouth my gums or even, you know, even physical health and stuff but I just seem to let myself down at the last hurdle” (Cora)

Theme Two: Commands to be Vulnerable. Throughout the interviews, participants indicated an expectation to be vulnerable during procedures. Several aspects of the interaction were implied to require vulnerability which was almost expected in exchange for treatment. Feeling unsafe upon entering the practice was palpable and additional layers of perceived danger were added when dentists directed participants to be further vulnerable in their communication style. Megan described that her dentist gave commands before the procedure started which sets an assertive, authoritarian tone:

“Immediately he said “Come in” and said “Sit down” which isn’t unusual…I think a sense of they don’t just ask “Is it okay?” they just give instructions.” (Megan)

The choice of language implies urgency and is directive rather than conversational, which suppresses participants’ voice and autonomy in the interaction. Several participants indicated that a male, authoritative dental professional was particularly triggering as this links to past abusive situations and evoked a need to comply*:*

"My dentist is male and and I think it's one- that that kind of stresses me and they're also in that authority, they feel like authorities, so they're kind of, a bit intimidating and it's a bit invasive" (Cora)

Megan appeared to experience somatic level re-traumatisation which was exacerbated by interpreting the actions of her dental practitioner as dangerous:

> "I could feel my heart rate increase I felt quite sweaty which must have been noticeable for him erm because he said "Oh are you a bit anxious?" and of course I wasn't going to explain why I felt anxious … and when I sat in the chair he patted my shoulder which to me felt as though, as if he was pushing me" (Megan)

Megan's described a power-imbalance contributed to her feeling vulnerable:

> "It was, a fe- a disproportionate feeling of power imbalance that I was about to sit down that… and I would feel vulnerable you know I was sitting lower and he was standing erm he'd shut the door, I was very much aware there wasn't anyone else in the building." (Megan)

The dental practitioner positioned physically and metaphorically above participants is perceived as further command to be submissive and, therefore, vulnerable. For Sally, the close proximity appears to evoke feelings of suffocation and restriction, which ultimately hindered her going to the dentist:

> "Close proximity with somebody else, you know, it feels quite even now as well, you know, quite invasive erm you know, having some some person that you don't really

> know- in your mouth (laughs) you know you've got a shield all over your face and all of that sort of stuff and and obviously you can't speak." (Sally)

Many participants shared that physical touch in the mouth area is directly linked to past abusive experiences, as Britt described how this directly triggers traumatic memories:

"For me it's like it's the oral rape and things like that, and having things in your mouth, and you don't really want it there and stuff, is that, it's that like triggering sort of thing" (Britt)

Overall, the underlying vulnerability increases endangerment with hyper-arousal and flashbacks, making the oral healthcare interaction reminiscent of historical sexual abuse. For several participants, they implied dental professionals believe they are entitled to touch without seeking permission, which feels they are being forced upon. To endure the vulnerability, invasiveness and powerlessness, Evie uses avoidance and dissociative techniques to comply with these demands:

> "I just have to put my head somewhere else and think like countdown like you know, I'll start from 100, or, by the time, you know I get to this number it should be over, and that sort of thing just anything to try and just, deflect or disassociate anything." (Evie)

Other techniques to manage vulnerability come in the form of a shared communication to stop or pause procedures. However, participants reported occasions when dental professionals do not adhere to this, which enhances mistrust in the interaction and makes participants feel unsafe:

> "There was just all this stuff in my mouth and I was really just like traumatised but I was like working through it you know I was working with it and she said "Give me a minute, give me a second" I was like don't tell me to fucking put my hand up if you're not going to stop." (Kim)

There is a sense that participants would accept vulnerability through complying and suppression of their voice and needs. Participants conceptualised they were over-reacting if they felt vulnerable, which emphasises the self-blame in these interactions. Sally mentions that she feels her reality is different to that of the practitioner and appears to gaslight herself into believing that she is overreacting:

> “You feel like everything's your fault and you're, you're blowing out proportion and you know who would believe you? Why would, you know, why would you feel like that? You know like they're doing nothing wrong and you're the one that's being completely hysterical.” (Sally)

The dental interaction mirrors past abuse, where following direction and remaining obedient is a theme of the experiences. Participant’s apprehension about not being believed about their interpretation of events may also link to past experiences of abuse. To manage, participants occupy a passive position:

“I think you know when you've been abused in some sort of way you’re very passive about everything and you know and you just kind of do what you're told.” (Sally)

Several participants highlighted a dilemma around disclosing their trauma history because this potentially opens them up to danger, especially if a dissociative response is triggered:

> “If you’re in a room with a male on your own, the last thing you’d want to say to them is I’m I- shut down you know you’re not- I’m gunna be non-responsive erm because that makes you feel even more vulnerable” (Megan)

Participants have to trust that knowledge about their background will be used to enhance care, rather than be misused inappropriately. Therefore, participants disclosing their past trauma and communicating their needs is not a viable solution to overcome vulnerability.

Evie reflects on vulnerability at the dentist when childhood sexual abuse was occurring. The felt danger is powerful, resulting in an involuntary reaction to prevent treatment and ultimately leads to dental avoidance for years following:

> “The dentist was a man and obviously I was still- I was being abused at that time- and obviously my perp was a man of the same sort of age frame and all I can remember is him coming towards me with like the injection because they were going to obviously numb it … apparently I grabbed hold of his arm and threw him, where I got the strength from, because I was 5 or 6 I don't know erm so in the end I had to go in and be completely put out at a later date- so after that I didn't go to the dentist for years.” (Evie)

Evie’s account indicates that co-occurring dental trauma and childhood sexual abuse leads to a negative association in adulthood. This is somewhat different from the descriptions of a trauma response in adulthood, and represents another oral healthcare barrier. This also indicates a risk of real-time associations between sexual abuse and oral healthcare in childhood, meaning ordinary and routine experiences for a dental professionals will be experienced as highly dangerous and untoward for a survivor. The vulnerability needed for the procedure feels inescapable, which means participants are forced to face re-traumatisation if they endure dental care. Often, dental pain is determined to be more bearable than the psychological pain of re-traumatisation resulting in participants avoiding dental care.

Theme Three: Avoidance of Routine Examinations and Unexpected Procedures. A further barrier is the unexpected nature of check-up or routine examination appointments. The majority of participant’s most recent contact with the dentist was for necessary or emergency care, and regular attendance, as recommended, was reduced or avoided. Britt described that routine examinations are so unbearable that she replaces this with oral self-care:

> “I don't make check-ups, I don't do that. I just brush and floss, and look after my teeth the best I can, and if I get too like pain in any way, I'll I'll try ring up the dentist and deal with it.” (Britt)

Participants described that the structure of routine examinations was anxiety provoking and uncertain. Sally felt that these appointments invited procedures and interventions that she was unprepared for, which required more courage than she had available:

> “The fear and and the unknown you know, you don't quite know what's going to happen and you know you might have an x-ray or something and they find something there and and it's the whole process of then thinking oh my god, like okay, I’m here today but now I've got to come back again, you know, it’s taken me all my courage today to attend this appointment” (Sally)

Many participants could not tolerate these types of appointments for long and would feel panicked, anxious and uncomfortable throughout:

“I was there [check-up appointment] fifteen minutes that was as long as I was going to stay and the whole time I felt as though my heart was beating out of my chest.” (Megan)

Megan described fleeing from an appointment despite the severity of her difficulties:

“I had the check-up done and I’d actually cracked a tooth and I made an excuse that it needed to be re-booked erm and that I would come back and I didn’t, I didn’t go back.” (Megan)

Sometimes the avoidance is subconscious, as Cora conceptualises forgetting the date of a routine examination as a method of avoiding.

> “The next one wasn't for quite a few months anyway, again- um, and by that point I had forgot again and not gone um but I think if I could, I think there's the memory thing and then there's a level of avoidance” (Cora)

Participants outlined that these appointments cause physical pain that was not present upon entering the interaction, which is then associated with harm rather than care:

“I've gone to dentists before when I was absolutely fine, for a check-up, and then they've ended up causing me pain I've walked away in pain and then been in pain for days.” (Britt)

As such, participant’s accounts appear to be different from dental phobia or anxiety, in that they over-estimate threat but this fear is supported when they are in appointments. Further to this, Britt described how the pain caused by her dentist elicited a sense of betrayal as she had been informed the procedure would be painless:

“This is the only check-up I've had, and they decided to clean my gums and they said it wouldn't be painful well, it was a lie, it was extremely painful, and it was horrendous…I bled and it felt torturous.” (Britt)

Likening the procedure to “torture” indicates the overwhelming physical and psychological pain participants endure through routine examinations. There may be a baseline of dental anxiety and distress for participants, but this appears to interact with trauma through the amplification of adversity. The sense of betrayal felt when appointments cause pain, infections or the practitioner disregards the survivor perspective may link to past experiences of being abused by someone in authority. This compounds the perceived unease in appointments.

After a negative experience at a check-up appointment, Sally attempts to “rationalise” the emotions that have occurred and convince herself that her experiences were not entirely negative to combat her instinct to avoid these appointments:

> "I might say to myself well actually it wasn't that bad like what am I worried about? But the trauma coming out in my body will tell me otherwise and I'm more likely to go with my body than I am with my head." (Sally)

In a context where care requirements are not transparent, unexpected treatment that is not communicated effectively is particularly traumatic for participants. The reaction in these instances can be linked to a trauma response, indicated by Kim who has an understandably intense response to an unforeseen and uncommunicated procedure that her dentist felt was necessary:

> "He actually took my crown off without telling me I was going ballistic, 'scuse my French, I said "You don't fucking do that, what have you done, you don't fucking do that to people without asking them" he said "Well I had to take it out to clean it and put I back in". (Kim)

In this interaction the dentist may have minimised the significance of his approach for Kim, indicating an incongruence between the healthcare provider and participants agendas in routine examinations. Several participants reported that they were "forced" to attend a routine examination because physical pain had signalled a need for treatment. Using bodily cues offers a sense of predictability for participants as they can then expect that an intervention will be required:

> "I wouldn't go down there if I'm not in pain I wouldn't just be oh, let's go and have a little check-up, cause I made that mistake before, when I left in pain, like I said so I wouldn't, I don't do that no more." (Britt)

Theme Four: "Just Make it a Bit More Human" Relational Practice. All participants outlined that elements of relational practice in their contact with oral healthcare aided their experience at the dentist. Broadly speaking, this was framed in the personal qualities that dental professionals held, related to warmth, empathy and openness. Evie links the personable qualities of her dentist to breaking down barriers to care:

“She's so lovely and gradually I have sort of been managed to tell her why I'm so fearful of the dentist and I think now that barrier's gone.”(Evie)

Compassion is demonstrated through the perceived effort that dental practitioners offer within the appointment. For Britt, this is embodied by the procedure being explained with reassurance, indicating that she is seen as a human who has thoughts, feelings and needs, rather than just a patient.

“They were like really warm and they were like “Don't worry”, and then she went through the effort of like going through every step with me of the whole treatment and the whole process” (Britt)

Core clinical skills are alluded to through simple and light touch interactions that are beneficial for treatment; Cora stated that her dentist introducing themselves by name builds a trusting rapport:

> “For the dentist to say a bit, not obviously anything majorly personal, but just very very basic information so, you know, their name they actually say each time they meet you oh “Hi my name is” so you know the name of the person that you're actually talking to.” (Cora)

This suggests that the dental professional also presenting as human is powerful for participants to overcome the perceived unsafe, clinical environment of a dental practice. Cora reflected on how a slower, more interactive procedure is more relational:

> “When it was bit slower and not so rushed erm and if maybe he was a bit more clear on what he was going to do like oh and it more verbal so he says “Oh I'm gonna erm use the blah blah now” and “I'm going to go in this area” you know rather than just suddenly you're getting poked and jabbed around in different areas of your mouth” (Cora)

Sally outlined that she does not hold unrealistic expectations for her dental professionals to get everything in the appointment correct but the soft, sensitive skills can create connection which significantly increases her comfort:

> “I think we appreciate is the fact that someone's taken the time out to actually listen to us and try and do the right thing you know we don't expect miracles and them to be one hundred percent know what to do but just that empathy even and the compassion and around it actually makes the huge amount of difference.” (Sally)

Participants appear to value their dentists being receptive which allowed openness about broader matters. For Audrey, a curious stance facilitated a disclosure about her past experiences of abuse that was affecting her oral health:

> “He gave me permission to speak out [about historical sexual abuse] because he made a comment “What's going on in your life?”, erm and that and because he was a very communal man as such or a communal erm person as a dentist erm I felt comfortable to tell him.” (Audrey)

Giving permission to narrate her story allows space for exploring the connections between oral health difficulties and past abuse, thus, enhancing dental care. This use of an open question that is perhaps not perceived as directly relevant to dental care conveys care and investment in participants as people.

Britt mentioned that advice given from a non-judgemental stance is a mediator against shame:

“Just not being judgmental in any way… you can give out advice, or, you know just things like, oh, maybe you could need to brush more, or whatever advice it is, but just not in a judgmental way” (Britt)

Cora recognised that the power imbalance can be broken down through informal conversations and sets a foundation to gather relevant information to the procedure and inform adaptations to care:

> “I suppose a lot of us has been let down so many times erm that you’re going to sit with someone who is supposedly like knows, everything, and everything about the subject and they're going to tell you what you need to do and um- probably just like having a chat with them really just literally having a chat and then getting to know you as well” (Cora)

This indicates participants have awareness that a knowledge and expertise imbalance exists in the interaction which they rely on to receive specialist care but this creates a dynamic that can be far removed from relational practice. Cora linking this to being “let down” implies that power has previously been misused by those in perceived authority, therefore, a dental practitioner using this power to be gentle and supportive rewrites a trauma script and sets a positive relational dynamic.

Several participants recognise that because they have avoided or prolonged dental appointments it is possible that they will enter the interaction in pain. This might contribute to them being hypervigilant, therefore, meeting a practitioner who sees them as a human, and also presents as a human, puts them at ease:

> "The majority of survivors only go if they're in absolute pain sometimes that have had- erm- oral sexual violence that can be really triggering for people erm so any sort of oral pressure that they're not in control of can feel sort of panic stricken…so we need warmth." (Megan)

On a political level, Cora reflects on how private dental services often feels like an exchange of services akin to a customer-provider interaction, which isn't always conducive with a relational style of healthcare practice:

> "Basically humanising the service so it's about, erm it's about care it's not about, yeah, okay everything is based on slightly American free market style and I don't know what market we work in the UK but it's everything is kind of capitalist so yeah, like there has to be some sort of gain for the person like running the dentist or something like that, I get that, but care shouldn't be lost in the crossfire" (Cora)

This suggests that participants may feel dental professionals see relational aspects as additional, unnecessary "extras" to offer in appointments, as the professionals may perceive there is is no gain for them and it requires more work. However, participants desire the human element to be at the forefront of care.

Theme Five: Psychological Grounding and Stabilisation. Participants outline that dental professional's offering psychological stabilisation and grounding techniques allowed them to regain control during appointments. The implementation of these techniques mediated the often inevitable hyper-arousal, panic and dissociation during appointments:

> "Even when you, you feel you've kind of got there and you're feeling so much better … it can be something really little that will just set off some sort of memory or a trigger

> somewhere in your body you know that takes you back certain times of your life." (Sally)

Evie implies that she cannot overcome emotional dysregulation alone and her dental team supporting her to reduce unhelpful reactions before the appointment prevents them escalating further in the interaction:

> "Our dentist is in like a square so we will walk right round a couple of times, we don't go straight to the desk so you know, it's just that oh, I can just get get back into myself and just give myself a bit of breathing space." (Evie)

A consistent dental practitioner is grounding for Britt, as this provides predictability and avoids repetition of her history and needs at every contact:

"If you go in to, the to the dentist and see a different dentist every time, because you don't see the same dentist, it's not helpful to have to go in there and say the same thing" (Britt)

Dental assistants play a vital role in stabilisation, as Evie implies that a different persona takes over during dental appointments and the assistants support her to regain her sense of self:

> "Get me back into their other head sort of thing and I think that's what the [dental] assistant does with me and I think that's quite an integral, and don't dismiss that, that's a big part of making me feel comfortable." (Evie)

Informality and humour helps Kim cope with emotional dysregulation at the start of an appointment:

> "He helped me cope because he used sense of humour and I knew him from dancing… he was absolutely crazy and he'd tell funny stories, you know, first time I went in there

> in front of the reception he said “Come on let’s have a dance” so we had a full song and dance” (Kim)

Kim seeing her dentist in non-clinical settings allows her to associate her practitioner with familiarity and therefore safety. Dental care involves overwhelming sensory experiences for participants; intense lights, the sensation of latex gloves, lying down and procedural noises can all trigger reactions. The importance of grounding and stabilisation becomes clear for direct triggers, however, many participants stated that triggers are often unknown and only realised after the interaction. In these instances, practical grounding techniques and an attentive practitioner share the responsibility for identifying and managing seemingly spontaneous triggers:

> “Taking note of our body languages as well, you know erm cos like you say we don't always verbalise how we feel, but just to be aware of ways that maybe survivors would sort of show you, you know, other than just sort of speaking about it.” (Sally)

These practices unburden participants from needing to know their triggers, control them, and soothe the responses, which facilitates collaborative care. When trauma symptoms do arise, Evie indicated that she moves into an emotional part of her brain and her dentist grounds her back in the “logical” part of her brain so that she can engage in treatment:

> “She brings me back to the front part of my brain I think, you know, she might talk about like erm my grandkids or how did your son’s wedding go, you know blah blah blah, you know and it's like it's like what we do in therapy.” (Evie)

These skills appear to be second nature to the practitioner, indicating that generic patient engagement skills can be sufficient for soothing trauma responses. Audrey described “alarmed aloneness” to capture the hypervigilance and isolation she feels during appointments which can be alleviated through the dentist being psychologically-minded, rather than procedurally focused.

> “If there's a person that's erm- er receptive to you er you feel comfortable, it's when there's a a lot of tick box exercises and … it feels distant erm that you start to feel probably the anxiety because you're put back in a place of the alarmed aloneness” (Audrey)

Verbal reassurance throughout the appointment was beneficial for the majority of participants. This practice may be viewed as patronising, but for Britt a nurturing dynamic allowed her occupy a role of being looked after and therefore allow treatment:

> “She was like, well “Now I'm going to do this”, “Now I'm going to do that”, and “Don't panic”, and “It's fine”, “Do you want a minute to breathe?” and all of that and yeah, all right, I I kind of feel like, I'm a little child again because I need that reassurance I guess, but it helps” (Britt)

The tone of communication is important to stabilise Kim; “mumsy” indicates a nurturing tone that is akin to being soothed by someone caring:

“It was just her voice, she’s like “You okay you’re doing really well” she’s got a really mumsy voice and she is quite mumsy” (Kim)

Physical contact during difficult procedures was a display of empathy and connection. A female dental practitioner holding Britt’s hand represented safety and containment:

> “I'd get into a state in the dentist chair, so I'd have to have like be calmed down, and I'd have someone hold my hands like I was a kid…there was a female nurse in there and she held my hand, she was really nice.” (Britt)

A nurturing tone and physical reassurance may link to past abusive experiences, where conveying gentleness and care was required but the opposite was enacted. A trauma screening tool was suggested by several participants to encourage their attendance at the dentist. Lynda described that this opt-in approach would provide greater understanding of her needs, including stabilisation techniques:

> “If there was a question regarding erm any sort of abuse physical, mental anything which you don't have to answer if you don't want to, you know, that thing erm because then maybe it would give the dentist erm a greater understanding of the patient” (Lynda)

The practice environment can also aid a sense of safety and stabilisation as Megan recognised that auditory input through the use of a radio leads to realxation:

> “Having the radio on helps, some dentists have the radio on now. But if their perpetrator used the radio to mask the sounds that can be really triggering, some clients like to be in complete silence…one size fits all will never work.” (Megan)

Megan recognises that individualised approaches to stabilisation are required to ensure techniques account for individual survivors needs. Other practice considerations including bathroom facilities, visual distraction, and a light space demonstrate a psychologically-informed environment. At the end of the appointment, participants are often left with the aftermath of trauma symptoms and their impact. As such, stabilisation is valued when leaving the practice, as re-traumatisation can continue outside the dental practice:

> “It's that same feeling that you had back then [during sexual abuse] even though it's not the same situation- you know that logically in your mind … and then it's like a cascading effect for like for the rest of the day that I think, well, why can't I be normal?” (Evie)

Stabilisation throughout the dental interaction can prevent potential negative associations (such as feeling “abnormal”) when leaving the appointment, which could hinder returning for care.

Theme Six: A Sense of Community. A theme of community appeared pertinent to participant’s engagement in oral healthcare. There was reference to the wider system and dental practice that helped them feel welcome, safe and included, essentially, collective principles throughout the practice was an external display of community values. Megan described being treated like a friend which goes deeper than a patient receiving care, instead, her description implies that she is part of something familial:

“I was never treated like a patient I was always treated like a friend it’s like “Oh come in have a coffee come and sit in the staff room” you know it was kinda that experience” (Megan)

Inclusion facilitated a culture that welcomed participants as associates in the service. Lynda describes feeling “lucky to be part” of her practice, which shows she feels like an intrinsic part of the system.

“It's really such a good dentist, so you know we are lucky, I'm very lucky to be part of that practice.” (Lynda)

The regularity and familiarity of dental professionals facilitated an ongoing relationship, as individual professionals represented a link to the wider community. Evie eventually built up enough trust with her regular dentist to disclose why dental care was a difficulty:

“Over the years because I've built up such a good relationship with her and I have managed to tell her why [dental care is difficult].” (Evie)

A community-focused approach to dentistry allows an exchange of knowledge as participants have a voice. Participants who feel comfortable enough to share their story into the community contribute to dental care being trauma-informed when this information is received well and leads to adaptations:

> "I think being open and honest and telling her gradually you know erm and I think we've both sort of learnt from each other, so it's a two way street" (Evie)

Several participants alluded to a small, familiar dental team being more personal and allowed them to be visible as both a survivor and a patient:

"I'm thinking of years ago it was sort of quite terrifying going to the dentist, whereas now I think because of this team it's a small it's a small practice. I feel safe there, I feel it's fine." (Lynda)

A multi-practitioner approach made the appointment feel safe, as Sally described "safety in numbers" to prevent isolation and provide protection. She directly links this to her survivor identity, indicating a protective community minimises trauma repeating:

> "There's normally a nurse in there as well so you're not, it's not just you and that one person, … which I think is good for a sexual abuse survivor because obviously it's you know safety in there, …if they step out of line and that other person is going to see as well so- there's a bit of just safety in numbers" (Sally)

Evie indicated that before she gets into the dental chair, the community pulls together to support her in accordance with her needs:

"I know which room I'm going in I know it's two females in there, like the dentist and her assistant and because they both know how I am [worried about the dentist]" (Evie)

Interestingly, Audrey reminisced about dentistry being synonymous with community values in her former years but she felt there has been a shift away from this. When aspects of these values, such as trust, connection and dependency were present in her current dental practice, Audrey felt this aided treatment:

“Back in my day dentists were really erm- a part of the community erm and I think my dentist’s children went to school with my children…there’s a bit of that [community] feel now which helps me” (Audrey)

From the first point of contact at reception, there is opportunity for participants to feel welcomed and included in the community. This demonstrates that a whole-systems approach to care is required, not just during the encounter focused on procedures:

“I would say erm having receptionists as well that are, even on the phone are trained to go slower, if people need things explain to them slowly.” (Cora)

Participants felt their dental community should possess values such as informality and dependableness which Audrey believed is easy for dentists to achieve and would counterbalance the clinical space:

> “That's not a difficult thing to do and and and be be like a community as such. Not not not so not such a clinical erm thing, I mean, it doesn't hurt anybody to to say “How are you doing?” or something like that It's just being personable.” (Audrey)

Participants proposed that improving dental practice for survivors includes requires a community that has knowledge and understanding of trauma. Sally described how she would welcome a trauma-specific service to create a more specific community:

“Maybe we could have like a trauma clinic or something, where people can go in where people have been trained to specifically for that” (Sally)

In addition, Megan considered the idea of a single-sex practice. Connection through a shared demographic that conveyed safety was a factor she actively sought when registering with a dental practice:

> "I don't think we'll ever have a stage where we have all female practice you know that ideally that would probably encourage some women to go and I'm aware that it's not just female survivors but erm I think that that would encourage people." (Megan)

Stage Two: Focus Groups with Dental Professionals

Two focus groups were conduct with qualified dental professionals and dental professionals in training. Participants who were in training were regularly treating patients under supervision in clinical practice across the East Anglia region. The qualified dental professionals worked across private and NHS practice and also held academic roles at the University of Essex. Participants were presented with the themes from interviews with survivors and were asked to discuss them; specifically what their views, opinions and practice considerations were.

The first focus group lasted 1 hour and 5 minutes and the second focus group lasted 1 hour and 37 minutes. The first focus group had five participants and the second focus group had three participants. One of the participants in focus group two had to leave before the end of the focus group. The demographic information for the participants is shown in Table 5.

Table 5.

Demographic information of participants involved in the focus groups

Participant	**Gender**	**Age**	**Ethnicity**	**Role**
Alana	Female	45 – 54	White Other	Dental Hygienist and Therapist
Hannah	Female	26 – 34	White British	Dental Therapist
Khloe	Female	26-34	Other Mixed Background	Dental Therapist

Amara	Female	45 – 54	Indian	Dentist
Lola	Female	26 – 34	White British	Dental Therapist
Tessa	Female	18-25	White British	Oral Health Science Y2
Amber	Female	26-34	White British	Oral Health Science Y2
Aimee	Female	26-34	White British	Oral Health Science Y2

The analysis generated three themes related to dental professionals' views of the barriers and facilitators generated from survivor-participants, these are presented in Table 6.

Table 6.

Themes from focus groups

Themes
Competing Demands
Red Tape and Restrictions
"I'm not sure how that would work" Navigating sexual abuse is difficult in practice

Theme One: Competing demands. The existence of competing demands between survivor's needs and dental practice was outlined as a theme, and participant's accounts indicated these conflicting agendas required balancing. There was recognition of the challenges that dental treatment poses for patients and that specific aspects may be unmanageable for survivors. Participants outlined that they may disregard this in day-to-day practice and overlook survivor's struggles with invasive and painful procedures:

"Dental professionals maybe don't kind of bear in mind how it can be quite like an invasive erm kind of area to kind of, to treat and also lose sight maybe of that" (Khloe)

Participants shared that steps in some procedures become "automatic" and may occur without communication to the patient:

> "When the patients come into the dental chair, we automatically going to put the chair down because that is the only position that we are able to work with, because otherwise it will be absolutely be more difficult in a way, difficult to treat patients" (Alana)

Alana's account suggests that dental professionals act in accordance with their care agenda meaning communication with the function of offering transparency and preparedness may be omitted, despite the conflict with survivors' needs for this. There was some disagreement amongst participants regarding how they communicate procedures, which may form competing demands *between* dental professionals. Amara implied that as a dentist she has more demands on her which means she could seek permission but this will take away from her away from her wanting to practice how she desires:

"If you're talking about the adaptations like Alana said, that we do all, we could always ask our patients like, "Is it alright if we put the chair down?", or "Is it alright if we start the procedure?" (Amara)

Alana shared that adaptations would be afforded to other vulnerable groups, such as pregnant people and children, but if a survivor's status was "hidden" these adaptations may not be offered because from her perspective the challenges posed by the procedure are unclear:

"I think with more focus on pregnant women and early people, but in young people automatically I will put a chair down because we don't think that probab- that is a problem" (Alana)

There was some variability in perspectives, as participants who had experience in specialist sectors working with vulnerable patients appeared willing to make adaptations standard practice:

"Adaptations can be made for pretty much everything by making adaptation does mean, you know, it might mean that perhaps some areas of treatment may be compromised." (Khloe)

However, even with enthusiasm to make adjustments, adaptations were felt to compromise care and put a strain on the practitioner. As such, for Amara, alterations to standard treatment would be an exception rather than the rule:

> "We can obviously, or ask him … can I- would you like me to stand, I mean, and work on you, or it's okay to put the chair back, you know, that one kind of adaptation we can do but for that we already need to know [that they're a survivor], because standing dentistry is not actually very comfortable for the dentist, but for one off cases who we know that has had that kind of experience, we can probably make that adaptation." (Amara)

Participants appear to evaluate the level of importance between survivor needs versus clinical care and most indicated that as an outcome professional's needs are prioritised. Khloe's account indicates that survivor's would have to choose between enduring a trigger or receive compromised care:

"We can treat you sitting up, we just need to let you know that access around this area might be a bit more challenging are you happy if we can do what the best that we can" (Khloe)

Alana mentioned that forewarning survivors to expect pain could mediate the competing demands, as this was an unavoidable aspect of oral healthcare:

> "Perhaps we might need to be more emphasis emphasizing to everyone "Is that okay? If I put the chair down", I am I, perhaps, during the consent, perhaps asking them during the procedure with "I'm going to give you a little bit of pain"" (Alana)

Presenting survivors with choice was felt to be a reasonable adaptation to remove uncertainty and provide some control. Khloe outlined that this is hypothetically possible, indicating that this is not routinely done in practice:

> "You could say, "Okay, we've got two equipments we can use to help with kind of removing water from the mouth, it can be this hoover, or like this suction", which is this one, show it, and then show the other ones like, "Do you have a like preferred choice?"" (Khloe)

Amara implied that dental professionals are already working at maximum capacity and adaptations were viewed as "additional" work, which implied that nothing more could be done from the professional side of the collaboration:

"I really don't know if there can be anything more that a dental professional can really fit in to what he or she is already doing" (Amara)

The perceived need to uphold a professional, clinical image was discussed as potentially incompatible with factors that aided survivors accessing care. Stereotypical professionalism amongst dentistry was discussed, and participants outlined that they hold themselves and the profession to certain standards which reduces opportunity for relational interaction with survivors:

> "I feel like there is a stigma behind it. I feel like when you come to the dentist you should be obviously you do have to carry yourself very professionally… and people that are very high earners may find it harder to build that relationship" (Amber)

Amara does not view this as detrimental, as she believes survivors may wish to be treated by someone who presents as more clinical:

"There are certain patients who would feel more comfortable when the dentist is professional, you know, so it works, it like sometimes for the dental professional it can become a double edge sword" (Amara)

This appears to be in direct contradiction to the attributes survivors identify as facilitative who indicate that professionalism and relational practice are not mutually exclusive.

Despite the highlighted difficulties with implementing adaptations, participants felt that practicing in this manner would have a positive influence on the survivor community accessing oral healthcare. Even if dental treatment was not possible, the opportunity to build trust and rapport were felt to be satisfactory outcomes for the majority of participants:

> "I think sometimes doing them adaptations which might mean, yeah, your treatment might not at that day be the best that you want it to be, but if it's going to make the patient feel more comfortable on in the long term trust you more, then you can then achieve that in future." (Khloe)

The discussions indicate a sense of compromised care that is required to meet the needs of survivors. Dental professionals appeared to recognise the compromise from standard care but this was all they could offer based on the requirements survivors might need. However, the compromised care offers a foundation for a positive experience and opportunity to build a rapport, which professionals highlight as important benefits.

Theme Two: Red Tape and Restrictions. Throughout discussions, restrictions on practice were mentioned when contextualising the barriers and facilitators survivors experienced in oral healthcare. These spanned the dental system at an individual, institutional and societal level. Participants described that the confines of their role hindered the ability to work in a way that was informed by trauma experiences. At a practice level, internal pressures and key performance indicators negatively influenced implementing better care for survivors:

> "The pressure of having to see, maybe a certain number of patients, in a certain amount of time, financial pressures which might be being like, be pushed from either the practice, or could be being pushed…from the kind of the NHS banding system" (Khloe)

Meeting with a different practitioner on each visit was reported as standard practice, and wider restrictions prevented this from being altered, which creates a detached service for survivors:

"They don't want to see a different person who'll be dealing with them with their teeth, or the even the support staff, if it changes the so that's a barrier" (Amara)

Khloe alluded to the hierarchical NHS banding system and power dynamics perpetuating the unhelpful aspects of the medical model being enacted in dental appointments, leading to survivors feeling stigmatised:

"It's more about the engagement and breaking down the hierarchy, which sometimes can and is very common within not just dentistry, but with any kind of medical in like medical profession and having that like, said that non-judgmental element" (Khloe)

The differences between NHS and private practice was discussed, with the former viewed as more restrictive around practicing in line with survivors needs. Alana noted red tape concerning information sharing procedures could re-traumatise survivors who have to repeat their history:

"Work in a private practice or any other NHS practice outside hospitals er we don't have that much information about history medical history but in a hospital setting" (Alana)

Limited NHS funding was a confusing problem to solve when these wider systemic factors were heavily influential for service improvement:

“I don't know how you would try and improve that with the way the NHS is, it's so tight with budgets and things like that” (Amber)

Amara’s reports hidden pressures in the NHS that are felt internally have a direct impact on the time and resources available for survivors needs:

“The dental professionals are also working under a lot of time constraints they have their own pressures, too, because every patient is different” (Amara)

Amber indicated that larger, corporate practices would have increased opportunity to collaborate alongside survivors and would find it easier to make adaptations. Her discussion implies that survivors could, or should, go to these practices as NHS restrictions mean that service flexibility is limited:

> “Smaller run practices it's [adaptions] gonna impact them more so so if you've got like a big corporate company like Mydentist, or you know, Rygate smiles that has like 5 or 6 different other practices it'd be, it's better for them to kind of be able to work together [with survivors]” (Amber)

This contradicts survivor’s desire for smaller, more community focused practices. Amber’s account may reflect the current landscape of the profession, with reduced availability of services, high staff turnover, increased patients, and a move to more corporate model, all hinder the alignment of services with survivors needs. The majority of participants agreed the dental system has less community values, and Lola noticed the image this must portray to survivors looking for safety within their care:

> “This is something that maybe is becoming less achievable in our current than like NHS dentistry, we're moving a lot more away from the privately individualised owned dental practices, more to some more corporately owned ones where you have a higher you have a higher turnover and actually, we're currently obviously experiencing a problem with retention, with dentists” (Lola)

Khloe’s account implies that a more corporate, privatised dentistry structure may not be conducive with healthcare and, therefore, may not be invested in trauma-informed care as this is not an economical way of working:

“Have we become a materialistic market now that, you know, there aren't like, that people might not see, as you know for health as such any more, and for other purposes?” (Khloe)

There was discussion around different job roles and their restrictions; Tessa mentioned that hygienists and nurses may have more time to interact with patients compared to dentists and implantologists due to the red tape in their practice:

> “Hygienists might have more of an opportunity because of the the appointment, the structure of the appointment. There's more opportunity to sit and talk for longer periods of time, I feel like, compared to implants where things have to be done in a certain time frame otherwise treatment might be unsuccessful” (Tessa)

A multidisciplinary approach was discussed as useful for care, but a possible hindrance when creating connections that would be beneficial for vulnerable groups. Amber shared that making referrals for survivors contributed to a fragmented service, but these restrictions appear to be the status quo:

“You're never always going to be treated by one person, even in a small practice like you said, you'll always be treated by the hygienists and then dentists, or vice versa.” (Amber)

The wider social view of dental professionals was mentioned, with some participants recognising how common dental phobia is within the general population sets a tone of fear:

“And I know we’re not the most liked profession in the world!” (Khloe)

Systemic dismantling of the profession was suggested as a way of changing the image of the profession on a societal level to overcome some of these restrictions, as it was felt that all practitioners have the opportunity to do more:

> “It's more about how we are being perceived as a profession, and that the human, the humanistic kind of element of it, is more about, you know, you're not going there to be told off, this is how you should do this, this is how you should do that. It's more about the engagement and breaking down the hierarchy.” (Khloe)

Despite the difficulties and challenges, it was felt that all professionals have the opportunity to include survivors in their dental care. The breadth of red tape and restrictions within dentistry is felt to limit the practical elements of care that survivors feel is helpful, however, there is a sense that dentists have relinquished professional responsibility for the existence of factors that prevent care aligning with survivors needs. Although they are not explicitly blaming the system, there is a sense of being complicit with a system which continues re-traumatisation of survivors when it is indicated that simple changes would be effective.

Theme Three: “I’m Not Sure How That Would Work” Navigating Sexual Abuse is Difficult in Practice. Participant’s highlighted beliefs that navigating sexual abuse within dental care is challenging. The topic of sexual abuse and supporting survivor-patients was felt to be outside of their knowledge and competency. Participants reported that sexual abuse was common in society, but rare in their practice, as such this topic is overwhelming:

“It's a very difficult, a very, very complex, subject as such sexual violence” (Alana)

Tessa described that working with survivors of sexual abuse is a “grey area”. This phrase may reflect the black and white, scientific, clinical way of working in dentistry, which is not compatible with sexual abuse and survivors needs:

“I don't know a bit of a grey area that, I'm not sure how how that would work.” (Tessa)

As such, this area is confusing for participants. In practice, Alana’s example from working with a survivor of sexual abuse gives insight into the helplessness she experienced:

> “This 15 years old child who was sexual abuse already constant by their step father that really was a clear indication that she dissociated from her oral cavity because she did refuse, point blank at the beginning, we didn't understand why she did refuse to to brush her teeth because the things that perhaps will we look at this as a simplicity to brush the teeth… so for us how to overcome the situation to be honest I find as a professional extremely hard… To be honest, I am I am helpless.” (Alana)

This shows that participants struggle to conceptualise the psychological barriers that hinder oral healthcare for survivors. This implies a gap in training and knowledge around trauma-informed care and importantly a lack of confidence navigating survivor’s needs in dental care. Several participants indicated that they received safeguarding training on sexual abuse, but working with survivors as patients is a missing element:

“We are really educated to do, to study and updated on safe safeguarding issues and things like that but actually, we don't touch anything about sexual sexual abuse” (Alana)

There was some disagreement amongst participants about how relevant they felt this topic would be in their day-to-day practice. At one end of the spectrum, Tessa felt this topic was a gap in her skillset because she believed working with survivors would be commonplace but others held the opposing view:

> “There's not much training on this with patients, and I think it should be a lot more and prominent in the industry, because it is more likely to happen that you come across these situations.” (Tessa)

Khloe acknowledged that her experience with vulnerable groups was accompanied by further training about dental phobia and anxious patients. She recognised that clinical experience is needed alongside increased knowledge to create the confidence needed to collaborate with vulnerable groups:

“We have a bit more, maybe experience and training in that and understanding of that feeling of the vulnerability that people would feel where perhaps erm in other, maybe other services, they might not have that exposure as much” (Khloe)

Alana highlighted that she feels the topic is difficult because of societal stigma and shame that exists around sexual abuse. This stigma is projected onto all survivors as Alana states a firm belief that survivors would be secretive about their history and how this could influence a dental appointment:

“People are not open to it, they wouldn't come to to you, when, if you've completed the medical history, they will not tell you I've been sexually abused because of the stigma that is behind that” (Alana)

This account indicates that sexual abuse isn’t something that has been deconstructed through normalisation. As such, participants discussed that enquiring about sexual abuse within their roles would require tentative exploration and was felt to be out of their remit. Amara shared that up until a disclosure is offered, she would treat the person as a “normal” patient:

“We would not be treating him or her any different from what we would be treating a a normal person who hasn't been sexually abused” (Amara)

Participants queried how to introduce a conversation around sexual abuse and implied that a direct approach was not something they felt comfortable doing and it appeared that anxiety deterred them from taking the responsibility for initiating this during appointments:

“How we're going to ask this type of question to a patient? Have you been sexually abused?” (Alana)

Screening tools and questionnaires are suggested as helpful ways to introduce the topic and make this standard procedure for all. Lola offers a suggestion of facilitating a conversation through a tool, as she recognises the burden that a disclosure places on survivors:

> “People probably wanna like try and get on as much as they possibly can, and almost suffer in silence…which wouldn't be nice. It'd be nice to maybe make some sort of pathway that you could communicate your needs without having to actually physically speak to somebody about it” (Lola)

Participants appeared apprehensive around offending patients when talking about sexual abuse or sexual activity in general, indicating a general lack of confidence around this type of enquiry. Tessa discusses sexual activity when relevant in her practice, but felt this may be a trigger for survivors:

“There is a grey area with giving a patient advice on sexual activity when they have maybe been a survivor of sexual abuse” (Tessa)

Lola added to this by indicating that the process of disclosure could be re-traumatising and other participants agreed that a non-verbal method of communication could facilitate an open conversation:

> “Maybe there could be some sort of like form that you could fill in beforehand before you turned up to practice that you could be emailed over to the practice before you

> went in with, like your worries and concerns and stuff like that, so that when the you come into the surgery you don't have to, maybe formally like, identify yourself as a survivor and go through that the traumatic experience" (Lola)

Some participants felt survivors would not be recognised as survivors because they would go undetected in the encounter; Amara shared a belief that survivors would not exhibit symptoms of trauma and anxiety in the dentistry setting:

"We wouldn't really have a clue, because if somebody who's been sexually abused would generally come across as the, as just any other person it's, it would not be shown in any expressions" (Amara)

There were conflicting views around this, as some participants mentioned that survivors would exhibit outward signs and symptoms to show they were uncomfortable but participants were unsure how to respond if this occurred:

"You normally will see somebody [survivor] really struggle within that setting generally, I don't think that within our training it's it's specific for helping" (Lola)

Interestingly, Tessa mentioned signs of difficulty may be outside of the awareness of the professionals, which may explain why some would not pick up on signals:

"Body language might not say exactly what you're feeling, and sometimes body language isn't even picked up by a clinician sometimes" (Tessa)

The difference between an anxiety response and a trauma response was potentially confusing for participants. Amber outlines a need for education around the differences to enable survivors to be supported in appointments:

> "Sometimes hard for a clinician to to tell whether it's normal anxiety or whether it's actually being triggered like a a PTSD trigger almost, for example, because of abuse.

> So it's hard to define the two different things….that's probably a a barrier there for me to know which way to go with handling the patient” (Amber)

These accounts indicate a lack of integration between dental practice and survivors needs; a gap in knowledge, experience and skillset may be contributing to the dynamic being out of sync. However, dental professionals are not completely removed from the topic as they discuss sexual activity with patients and are required to know about sexual abuse from a safeguarding perspective. Several participants’ showed relevant knowledge about re-traumatisation, external expressions of trauma and overlaps with an anxiety presentation, suggesting knowledge isn’t as lacking as portrayed and perhaps the key element is confidence.

SECTION FOUR: DISCUSSION

Chapter Overview

The final chapter will review the findings across the interviews and focus groups which explored the barriers and facilitators to oral healthcare as experienced by survivors and the perspectives of oral healthcare professionals. To begin this chapter, a summary of the findings will be presented. The findings will then be contextualised in accordance with current literature and theory, with discussion of conceptual contributions and psychological theory. Following this, recommendations will be outlined based on the findings in their application to relevant clinical practice areas. To finish this section, a reflexive account will be outlined to detail the researcher’s positionality to give further context to the project.

Main Findings

Statement of Findings

The aim of the present research was to explore the barriers and facilitators to oral healthcare for survivors of sexual abuse and dental professionals' perspectives on survivors' experiences. This is believed to be the first study in the UK to focus explicitly on the barriers and facilitators survivors face together with dental professionals' perspectives. Eight survivors participated in semi-structured interviews which were analysed using Reflexive Thematic Analysis to reveal six themes. In addition, two focus groups were conducted with qualified and student dental professionals; five professionals formed one focus group and three students formed another. Three themes were generated from focus group data using Reflexive Thematic Analysis.

Participants described psychological, social and interpersonal barriers and facilitators related to oral healthcare. The psychological sense of participants dissociating from their oral cavity was captured as a significant barrier. Their accounts implied that the impact of historical sexual abuse leads to detachment from their mouth as a protective factor, but this hindered attending to their oral health and accessing dental treatment. Interactions at the dentist were perceived to require vulnerability from participants because they had to endure painful procedures in a setting where there was reduced autonomy and control. Dental practitioner's verbal communication and body language also influenced the perception of a power imbalance, which held parallels with previous traumatic sexual abuse and often resulted in re-traumatisation. Participants shared that the unexpected nature of routine examinations were particularly challenging, as they posed uncertainty and, consequentially, prediction of danger. It is proposed that these appointments were particularly intolerable because of the betrayal that is felt when the uncertainty leads to pain and discomfort enacted by a healthcare professional. This results in avoidance of these types of appointments because participants cannot trust the person in the position of power, which holds similarities to abusive experiences. Underpinning the barriers appears to be the links, or triggers, to historical abusive experiences which are then recalled through re-traumatisation into the present healthcare interaction. This mechanism offers explanation for the distress and discomfort felt throughout appointments that may be specific to survivors of sexual abuse.

Dental professionals working alongside survivors in a relational manner was facilitative for oral healthcare. Sensitive care that considered participants psychological and interpersonal needs encouraged future and routine attendance. Unfortunately for several participants, being triggered felt inevitable when engaging in dental care but a compassionate provider who supported them to stabilise following emotional dysregulation was valued. Specifically, psychological grounding and stabilisation techniques in the appointments were a mediator against unhelpful trauma responses. These techniques were factors that dental professionals could implement, but were also seen within the practice environment. The practice upholding values of connection and inclusion communicated that all aspects of survivor’s identity was welcome within the space. When a sense of community was felt participants offered their narratives into this system, thus contributing to the profession being more trauma-informed when these trauma narratives were responded and adapted to.

Dental professionals and students were presented with the themes that were generated from survivor’s experiences and were asked to discuss their views with each other. These discussions highlighted a perception of competing demands where participants felt survivor’s needs would be incompatible with “standard” dental treatment. There appeared to be enthusiasm around enhanced collaboration with survivors but, ultimately, adaptations were felt to compromise certain aspects of routine care and dental professionals preferred methods of practice. Participants described that the facilitators in survivor’s accounts were hindered by restrictions throughout the wider profession and system. Limits on time and resources generated internal and external pressures which prevented practice in line with survivors needs for holistic consideration. A theme around a perceived difficulty of exploring sexual abuse in dental care was outlined and participants stated that their core training did not prepare them for navigating this in their practice. Their views around sexual abuse and the survivor population appeared to be influenced by societal stereotypes, however, there was some indication that participants held some knowledge around the impact of trauma and how this could present in dental appointments. As such, the lack of confidence related to skills and knowledge captured in this theme holds importance to the way that participants conceptualise survivor's experiences.

Relevance to Theory and Practice

The findings from the present research support previous research conclusions as well as offering novel insight into the barriers and facilitators as told by survivors. In addition, new information about how survivors' experiences are viewed by professionals treating them in dentistry settings and the possible implications in oral healthcare is outlined. Multiple domains (biopsychosocial) are reflected in the definition of oral health (Brondani & MacEntee, 2014) and these are echoed in the breadth of findings, therefore, providing support for the relevance of this topic for clinical psychology. Participants accounts indicated that healthcare treatment is triggering, which supports previous research findings which outline that survivors accessing physical healthcare is fraught with difficulties partly because of the responses induced (Coles & Jones, 2009; Monahan & Forgash, 2000). Specifically, the results support findings that dental care poses a threat of re-traumatisation (Larijani, & Guggisberg, 2015; Stalker et al., 2005; Wolf et al., 2020) because there are explicit and implicit links to previous abusive experiences (Dougall & Fiske, 2009; Wolf et al., 2021). The procedure related aspects of oral healthcare replicating the historical abusive experiences supports findings from healthcare settings outside of dentistry where survivor-patients draw similarities between the two experiences (Montgomery et al., 2015).

The findings from this research offers nuanced understanding about the barriers for survivors which offers some explanation around *why* dental care is difficult for this particular community. The findings add to the themes identified in the metasynthesis, which highlighted the implications of power, intersectionality and misaligned practices across the physical healthcare setting. The theme of dissociation from the mouth adds to current understanding around the individual barriers that survivors might face and provides support for dissociation as avoidance, but also a protective mechanism (Van der Kolk et al., 1996). The findings by Alyce et al. (2022) and Wolf et al. (2020) indicate a somatic level recall for survivors engaging in dental care and present research findings support this through indication that there are internal and external reactions to re-traumatisation in dentistry. The findings related to somatic recall of sexual abuse experiences in oral healthcare support research conclusions which allude to trauma memories being stored on a somatic level (Van der Kolk, 2003). In addition, the perceived commands to be vulnerable within the dental chair and the betrayal felt during unexpected procedures offers specific reasons for the intolerance, and resulting avoidance, of dental appointments. Discussions from dental professionals outlined a sense of anxiety and apprehension, which is also felt by survivors entering the interaction. Combining these findings may indicate that contagion of anxiety and threat occurs between survivor-patients and dental professionals in the dental chair. This offers understanding into the relational psychological processes that may be operating during appointments and how anxiety and threat perpetuates in the dynamic.

Previous research shows that some survivors have positive experiences of dental care (Alyce et al., 2022) and upholding trauma-informed care allows survivor’s to engage in treatment (Raja et al., 2014). Positive aspects were captured within the discussion of facilitators and all participants within the present research had accessed the dentist in the past two years, indicating that total avoidance was not part of their experiences. This is encouraging in light of the research question, as it suggests that the existence of barriers are not a complete deterrent despite the perceived threat it poses. Alyce et al. (2022) suggest that mitigating factors such as choice and control can offset the barriers and negative experiences survivors face, which is supported within the present research findings. Dentists using psychological grounding techniques, whether intentional or not, provides useful understanding about how practical strategies can be used to support the psychological needs of survivors who experience triggers in oral healthcare settings. These are not explicitly referred to in previous literature, but can add to some of the practical guidance that is already mentioned in the work by Larijani and Guggisberg (2015) and Stalker et al. (2005). The findings offer of some theoretical understanding about the macro-level, community aspects that facilitate engagement in dental care. Dental practices upholding community values throughout the system appears to be in survivor's best interest and is consistent with the General Dental Council (2023) principles related to ethical standards for a safe dental team.

The findings offer understanding of the challenges surrounding trauma-informed care as highlighted in previous research (Sweeney et al., 2018). The themes indicated by dental professionals support findings which suggest further refinement is needed to TIC (Hanson & Lang, 2016) to make service-specific recommendations. A conclusion from the findings is that national adherence to TIC and its principles may not be prevalent in dentistry practice or teaching as identified by previous research (Emsley et al., 2022). This also provides explanation for the lack of confidence around working with survivors as also outlined in previous research (Raja et al., 2015). As such, the results show that TIC in dentistry is still an emerging approach which has not been assimilated into standard practice. The GDC (2023) guidelines for safe practice have recognised the need for dental practitioners to identify signs of “emotional abuse” but the behaviours and practices that accompany this recognition may need to be developed in practice. Further in this section some suggestions are provided for developing and maintaining TIC and its principles in oral healthcare settings.

The results from survivors propose additional understanding about the spectrum of triggers and presentations experienced in a dentistry setting. Dissociation from the oral cavity, aggression and violence in the face of perceived threat, and passivity may reflect the fight/flight/freeze response influenced by the stress response (Basu et al., 2013; Solomon & Heide, 2005; Van der Kolk, 1994) but these nuances in a healthcare setting are not reflected within the medical model conceptualisation of trauma symptoms. Therefore, these displays suggest trauma responses that are not pathologised, but still hold relevance to the difficulties that survivors face in healthcare settings. It could be inferred that these “sub-clinical” concerns are more individually focused and simply reflect counter narratives to the medical model (Kiyimba et al., 2022) however, these are in the experience of participants in the study thus hold relevance to the topic. The findings also support the emotional dysregulation, problems in interpersonal relationships and negative self-concept presentation seen in C-PTSD (Herman, 1998) which appear to play out in healthcare settings under the threat of re-traumatisation

Dental phobia and anxiety is commonplace (Oosterink et al., 2009). The results and experiences as reported by survivors overlap with a presentation of anxiety or dental phobia. The findings, however, allow differentiation between these two presentations. The proposed mechanism through which oral healthcare leads to re-traumatising for survivors and the specific triggers and connections to previous abusive experiences show how the foundation of responses lay in past experiences. The factors that are facilitative for survivors demonstrate that oral healthcare can be achievable for survivors through welcoming the survivor identity, soothing the associated trauma responses, and macro-level consideration, which may not be seen in an anxiety presentation. However, discussions within focus groups identified that professionals may find it challenging to make the distinction between a trauma presentation and an anxiety presentation indicating that more explicit distinction is required for oral healthcare professionals.

Conceptual Contributions

The findings offer novel conceptual understanding about the experience of oral healthcare for survivors and the perspectives of dental professionals. New or updated theoretical standpoints as an outcome of this research can aid understanding and practice.

The themes from survivor's accounts around dissociating from their mouth is conceptually relevant for understanding survivor's responses following traumatic experiences and the barriers to oral healthcare treatment. This theme suggests that survivors have consciously and subconsciously psychologically detached from this area of their anatomy because of the memories and trauma it holds. This concept offers understanding around how survivors may view their teeth and mouth and the potential impact for their care. Dissociation from the oral cavity may lead to difficulties accurately describing symptoms and it may become harder for survivors to notice if there are changes or difficulties. This response can also impede treatment effectiveness, as a connection with the anatomical area is required for complete engagement in treatment and self-care (Larijani & Guggisberg, 2015). This has implications for treatment, as it means that survivors may engage in less self-care and professional care because of the relinquished ownership. The separation of the mouth from their physical and psychological identity offers insight into how a multi-disciplinary approach will be required to support survivors engaging in oral healthcare. Medical and biologically informed treatment approaches alone could be ineffective to overcome this psychological barrier, as connection with the mouth is required for survivors to notice, attend and care for their teeth and mouth. Body-oriented therapy or sensory motor therapy could offer a relevant approach for formulation and re-integration with the oral cavity following sexual abuse, which could be led by a clinical psychologist (Price, 2005; Scaer, 2014)

As an outcome of this research, further conceptual understanding around the distinction between anxiety and trauma is provided. Anxiety and trauma responses can present as overlapping when there is perceived threat (McMillan & Asmundson, 2016) and previous research in the area of sexual abuse and dentistry has highlighted the significance of anxiety for survivors throughout the entire interaction (Fredriksen et al., 2020; Søftestad, et al., 2020). This anxiety is challenging for survivors, however, the present findings offer support of a connection between historical trauma and the presentation that occurs during dental care. Hypervigilance, mistrust, the need for control and autonomy, over-estimating threat, dissociation and a desire for community appears to have origins in the past experience of sexual abuse, therefore, the findings support research which implies that these internal and external experiences are trauma driven (Søftestad et al., 2020).

Previous unpublished research has explored dentists' self-reported practice approach when working with trauma symptoms (Gray, 2020) but this is believed to be the first research of its kind to elicit dental professionals' perspectives in direct relation to survivors' experiences. Research has highlighted that dental practitioners should have competency working with survivors of traumatic experiences (Raja et al., 2014), and the current research maps out the spectrum of knowledge and expertise that is required when working with survivors. Firstly, general knowledge around sexual abuse and the experience of subjective and objective symptoms appears to be a deficit in dental professionals training to outline the challenges, difficulties and strengths of survivors and what this means for their engagement in oral health care. In addition, focus group results imply that building confidence around working with survivor groups is needed. Further to this, systems support is imperative to enable implementation of the individual level education and training. The results from focus groups offer conceptual understanding of the structural-level development required to support survivors in oral healthcare settings and ensure practitioners are supported to work in more trauma-informed ways. When there is a deficit in knowledge, training and education is often the proposed solution to the problem, however, the researcher argues that this alone may be reductionist as a solution to the complexity of the problem (Jarvis-Selinger et al., 2012). In line with community psychology principles, the findings suggest that community, connection and advocacy are also important in serving the needs of marginalised communities and adjusting dental professionals' knowledge and attitudes in providing care (Holtzman & Seirawan, 2009).

Integrated findings across interviews and focus groups offer several contributions around the concept of barriers and facilitators for survivors. Survivor's accounts indicate that there are psychological, interpersonal and practical barriers that prevent them engaging in oral healthcare and the focus group data provides some understanding about their existence in the dentistry setting. For example, the notion of competing demands is highlighted as a possible explanation for why dental professionals are not able to flexibly make adaptations for survivors. In addition, the restraints on dental professionals practice on a broader level combined with a lack of understanding about sexual abuse gives insight into why survivors feel there are commands to be vulnerable. However, the facilitators discussed throughout interviews is demonstrative of the potential to work in accordance with survivors needs and there is learning to be drawn from professionals and practices that currently provide this.

Clinical and Practice Implications

The clinical implications as an outcome of this research are far reaching and apply outside the dentistry profession. Clinical psychology and mental health services can advocate for clients who have experienced trauma when accessing physical healthcare services to uphold a holistic approach. Knowledge around trauma theories and how trauma may show up in dentistry settings could be disseminated by psychologists. Clinical psychologists are well positioned to support survivors with the elements that span psycho-social difficulties, for example, survivors dissociating from their oral cavity would require a multi-disciplinary approach to cover therapeutic, medical and occupational therapy considerations. Psychology disciplines could engage survivors in therapeutic support to reclaim ownership over their teeth and mouth, which can be done in accordance with dental professionals to ensure the recommendations and skills can be applied in the dentistry setting and during oral self-care. At present, clinical psychology has some involvement in oral health services. A few dental psychology service operate in London which supports oral health patients who may have psychology needs. These services are psychology-led and could offer a useful basis for the development of a multi-disciplinary, trauma-informed service that could be developed in other parts of the country.

Dental professionals are patient-facing, therefore, there are opportunities for them to offer education, advice and empowerment about the potential dissociation survivors may experience and the effects it can have on oral health (Raja et al., 2014). This will in turn support survivor's participation in the treatment and attending to their oral healthcare in between appointments. Public health information will have limited effectiveness if survivors do not feel a connection to their teeth and mouth, therefore, clinical considerations about public health messages aimed at survivors will require integration with psychological determinants and contributors to oral health (Daly et al., 2013).

The unexpected nature of routine examinations contributed to the mechanism of re-traumatisation for some participants. This demonstrates that survivors may need to have information prior to appointments explaining the care they will receive and have opportunity to ask any questions. Practical considerations, such as extra time in appointments could ease the pressure from both sides of the collaboration. It was suggested from the findings that the sense of betrayal is instrumental in the difficulties surrounding these appointments. Community facing workshops or outreach work by dental practices could support overcoming this and allow survivors to connect with individual dental professionals and the wider practice. Survivor-participants alluded to specialist “trauma-clinics” being developed to help them accessing oral healthcare. It is hoped that as part of the action-research element of this project, a pilot study implementing and evaluating a local, trauma-informed dental clinic could be an outcome. This could be developed collaboratively with survivors at a local level informed by the findings from the research so survivors can access TIC oral healthcare.

Within the UK, the vast majority of statutory healthcare is free at the point of access. In dentistry, sections of privatised healthcare services exist with the option of NHS funded places and treatment available. Implementing proposed changes for service development in line with survivors needs across both of these systems may pose a challenge in terms of the policy and practice differences. The discussion of resourcing issues within focus groups and interviews is a major barrier to change. The multiple competing pressures are acknowledged in light of these issues, which requires a multi-targeted approach. Both private and statutory services were referred to in participant’s experiences, therefore, both sectors should be included if these findings are used to progress and transform services. Participants in the focus groups outlined that dismantling the hierarchy within dental care could contribute to better treatment and outcomes for survivors. This broader level factor gives insight into how the structure of healthcare may contribute to, or perpetuate, the difficulties survivors face. Staff at all levels within the system will be required to adopted trauma-informed care for the approach to be effective, therefore, addressing power imbalances within the system may be required to ensure this does not interrupt TIC.

Across interviews and focus groups, sharing information about survivor’s history was routinely mentioned. Some survivor-participants mentioned that offering a disclosure sometimes made dental appointments more suitable for them and dental practitioners felt that a disclosure would be beneficial for their practice. There appears to be a need to offer this information in a sensitive way that benefits both sides of the collaboration, which is highlighted in previous research (Alyce et al., 2022). A screening process may be a useful tool for structuring this information gathering enquiry and making this standard for all who enter the dental practice. This process is not simple or easy and is influenced by several contextual and personal factors; healthcare services screening for trauma does not come from a neutral perspective (Berliner & Kolko, 2016). Gathering this information should be conducted with a purpose and function in mind and adequate training should be provided. The use of a trauma card which identifies the holder as a survivor of sexual abuse was referred to during interviews and this has been helpful in services. This has been a local provision led by Healthwatch Essex and developed, used and evaluated by trauma survivors in the Trauma Ambassador Group (Montaque, Taggart, Westfield-De Cortez, in press). The card has enabled trauma survivors to non-verbally communicate a disclosure and share that they may find the interaction challenging. The results from the pilot project use of this card showed promising findings about the utility and effectiveness of this card across multiple health and social care settings. When receiving this information, practitioners must be confident and competent in responding to a disclosure. Further developments on the trauma card project will support practices and practitioners to respond to a disclosure in a trauma-informed way and align their practice in accordance with GDC “safe practitioner” principles.

Focus group data indicated that dental professionals need support with distinguishing between an anxiety presentation and trauma presentation and understanding the triggers and “symptoms” that may be noticeable when survivors are in the dental chair. This is a valid consideration given the high prevalence of dental phobia and trauma survivors. It was indicated that dental professionals already receive training on supporting patients with dental phobia. Although the practice foundations may be similar when working with both of these groups, knowledge of the nuances are required to support trauma survivor’s specific needs. This is something that could be embedded into future training.

Trauma-informed Oral Healthcare

Trauma-informed care is posited to offer survivors a safe and sensitive means of engaging in healthcare (Reeves, 2015). Although there is limited empirical support around the effectiveness of trauma-informed approaches within wider healthcare (Berliner & Kolko, 2016), there is some support for these practices having value within a dentistry setting (Raja et al., 2014) and scope for this to be used as a framework to facilitate the reform of systems. Research findings which propose that dental professionals working with survivors of sexual abuse should adopt trauma-informed care (Dougall & Fiske, 2009; Larijani & Guggisberg, 2015; Raja et al., 2014; Stalker et al., 2005) are supported by the findings of the present research, as these principles are linked to the factors that are facilitative for survivors (Kranstad et al., 2019). Psychological safety, collaboration and empowerment should be upheld by creating an environment that is led by a trauma-informed leader who is committed to measuring the impact of practice. The Roots Framework (Thirkle et al., 2022) could be used to measure current levels of trauma-informed practice and develop an action plan for improvement which can then be evaluated. Using this tool will enable the definition of trauma-informed oral health to be clear within services and will also allow continuous accountability around the development of services in line with TIC and GDC guidelines. The use of such tools can also support a review of current practice from a practical and logistical perspective, which is important in light of dental professionals indicating a lack of time and resources hinders TIC.

Interestingly, there is limited TIC guidance for physical health settings (Menschner & Maul, 2016). The development of a trauma-informed oral healthcare service has scope to lead the design and evaluation of this approach using the findings from this study, which can then be used as a blueprint for other services. Features of a TIC oral health service should be aligned with welcoming the survivor's whole identity through the integration of physical and mental health needs, striving for an approach that humanises all needs, and challenging the discourse of trauma-informed approaches being about "broken" minds not bodies (Berliner & Kolko, 2016). This could be achieved through the offer of psychological interventions alongside oral healthcare treatment, using graded-exposure principles in a relational way to support survivors to access treatment. Investment up-stream is required for this which will have economic and health benefits in the long run as survivors will not prolong oral health difficulties through avoidance.

The researcher argues that the findings of the present research imply that broad TIC alone may be insufficient to meet the needs of survivors as dental patients. Some of the themes captured offer more specific detail about the factors that are facilitative for survivors. For example, the theme around the utility of dental professionals having psychological grounding skills could be integrated into professional development training in accordance with general knowledge around psychological trauma. This would practically support survivors who experience re-traumatisation during appointments and offer dental professionals a skills-based approach. There are wider systemic issues, such as competing demands and restrictions which influence practitioner's ability to implement adaptations. Adequate training and dissemination of knowledge without system reform maintains restrictions for survivors and may continue the struggles that practitioners have around their ability to flexibly accommodate their practice. It is imperative that restrictions are not used as a scapegoat for providing a good quality, trauma-informed service as participant's accounts imply that despite the deficit in training and knowledge across the profession, some services are providing oral healthcare in a safe, empowering and collaborative manner. Bringing together the dental community could have power in overcoming the restrictions on practice and ensure that systems scrutinise policies, procedures and practices to make service improvements for survivors, even before they get into the dental chair.

A deficit in knowledge and confidence in working with survivors was found within the results of this research. Therefore, clinical experience to build confidence working with this population should form part of rolling out trauma-informed care in services, through workshops, reflective practice and clinical scenarios. Previous research has indicate that this should be done over a period of years (Ivanoff & Hottel, 2013), which could be applied in a higher education setting. However, the findings from this research outline that perceived confidence working with survivors does not accurately predict knowledge in the area which is also noted by Raja et al. (2015). In the present research, some dental professionals shared knowledge about the challenges survivors may face in dental appointments but a distinct theme around the confusion, complexity and difficulty navigating this in practice was identified. For knowledge and guidance to be effective from the bottom-up, the results from the present study suggest that a review of oral health course curriculum in higher education could allow training and teaching on working with survivors of sexual abuse to aid competency and confidence in practice. A participatory approach to developing and disseminating this training will ensure that the survivor voice is at the forefront of education. Research has assessed the effectiveness of a trauma-informed workshop for dental students focused on interactions with patients who have experienced traumatic life events and found that confidence and competency increased in this population (Raja et al., 2015). This could be developed further using the findings from this research.

The variability of professionals and their different training may have implications for the application of findings from the present research. As shared by participants within the focus groups, the various disciplines within dentistry operate and practice differently. The lack of consistency across the professionals may be a barrier when attempting to standardise practice, as particular disciplines such as dental hygienists and dental nurses reportedly have more time and contact with patients. There is a risk that these professions will be targeted to carry the trauma-informed work because of the increased opportunity for them to work in this way, but it is imperative that the work is a shared endeavour to ensure everyone who has the potential of connecting with a survivor upholds TIC. Survivors also indicate that a whole team approach is a valued aspect of their oral health care.

Reflexivity

Reflexivity is an important aspect of research methodology, which can enhance the rigour of the research through the process of identifying how the researcher’s interests and positionality influences the qualitative research process (Darawsheh, 2014). This is considered an iterative process, where the research is shaped by the researcher and the researcher is shaped by the research (Palaganas et al., 2017). Therefore, reflexivity is a significant part of the research process and findings.

The process of this research project was heavily influenced by areas of interest; community psychology, health psychology and working with survivors of sexual abuse. I was keen to combine a variety of interests throughout this project to understand more about these areas from a research perspective. The topic aligned with the values and principles of community psychology, in that social justice is relevant to public health issues and the importance of available healthcare for all (Powers & Faden, 2006). The idea for the project developed from informal discussions and anecdotal accounts of oral healthcare being a difficulty for survivors. As this emerged from the "community" it felt pertinent to develop this idea into a research project that held value for survivors and could bring about change. It was important for me to incorporate a participatory approach and empower survivors to be involved in the process of research (Reason, 1994).

In the initial stages of the process, I made notes about the design and development stage. I felt that this should be a shared endeavour, despite the project being part of a course requirement that would enable me to qualify as a clinical psychologist. I was aware of the power that comes with being positioned as a researcher and the lack of altruism that comes with this, which was in conflict with what I was trying to uphold. I grappled with this at times throughout the project, and wanted to create a sense that the project belonged to the community and my role was to guide the process. However, I quickly realised that I do not occupy a "neutral" guiding stance and my positionality has influence and power. As such, I began to let go of the idea of ownership of the project, and focused on the need to create a context around the project that would facilitate knowledge development and support change to occur (McIntyre, 2007).

Background reading in preparation for the project made prominent the dearth of literature in the area which was surprising given the broad definition of oral health and its connection to psychological and social areas and its relevance to clinical psychology research and practice. I reflected on the possible contributors for this and if the structure of privatised dental care in the UK had contributed to services having ulterior motives not related to health. I wondered about how this would fit with the blame and shame people may feel for their oral health and the stereotypes that exist around poor oral health. As some participants mentioned, the financial burden of accessing this type of care brought to light the economical perspectives related to this topic and the pressure put on survivors to pay for healthcare services they find re-traumatising.

Several participants throughout the interviews voiced their reactions whilst discussing the topic, with tension, sweating and anxiety reported throughout. Some participants apologised for over speaking in response to my questions and others were initially short and precise in their answers. Others offered positive experiences as an instant reaction in response to the initial question, and only revealed their true experiences later in the interview. I attributed this spectrum of responses to anxiety around potential re-traumatisation when re-visiting a difficult topic. This made me reflect on the idea of psychological safety in the realm of research. This is a theme which is captured throughout the project, but I wondered if a space of psychological safety was conducive with eliciting the type of responses that would be useful for the depth of data needed for analysis. I was curious if the process of engaging in this type of research would be re-traumatising for survivors but was reassured by the ethical considerations and close working with Healthwatch Essex.

I was aware of my different emotions when conducting interviews with survivors and after some interviews I logged in my journal about a desire to align with survivors stories and accept these as truths. This was in comparison to the focus groups with dental professionals. During the difficulties with recruitment, I reflected on potential projections related to a sense of blame. I felt that I must have done something wrong to mean that the recruitment difficulties were hindering the progress of the project, but this manifested as shifting the blame onto the dental professionals. I logged in my journal, *"Why don't they care?"*; conflating active participation with dental professionals being invested about enhancing their care for survivors. I was aware of these feelings ahead of the first focus group and had to ensure I did not let this influence the data collection and interpretation. I perceived some defensiveness from dental professionals when discussing some of the themes generated from survivors experiences. I found this caused a feeling of defensiveness in me and I aligned even further with survivor's stories and felt a sense of wanting to advocate for them. I was unsure of how this would influence the data and if the themes would be influenced based on this. A narrative around “victim and villains” emerged from my reflections and I was mindful of not imposing either of these narratives onto the research process or findings. Over the course of the project and after deeper reflection, these perspectives softened. I was able to see that the oral health profession is structured in a manner that perhaps does not allow for consistent display of the facilitators that survivors shared, which makes the barriers somewhat inevitable. Participants made reference to not knowing what more they could do within their capacity which I began to interpret differently. I saw these views as less defensive, and more desperate to do more in an already stretched and demanding role.

Process of Data Analysis

Thematic analysis was used in a reflexive way throughout this research. When coding the data, I found that several codes overlapped across themes, which was helpful for understanding the complexity and links between participant’s experiences but difficult for capturing accurate themes. Involving participants within the analytical process was a supportive process to ensure the validity of themes. Once completed, I found this approach to be a cornerstone of the project which allowed participants to shape the results and check the validity of the findings in representing their experiences. The process was enjoyable and I found that the reflections and themes elicited through discussion were much richer than doing this alone. Although the original plan was for survivors to be present in the focus groups, this did not occur due to time constraints. I wanted to ensure that survivor’s voice and experience was not overcomplicated by applying a scientific or rigid process, however, I believed that the empowerment throughout the use of this process would offset the academic approach that was required for the project.

Research Context

This research occurred at a time when the dental care industry in the UK was under ever-growing pressure, with a shortage of spaces for NHS patients in dental practices and a shortage of dental professionals in statutory care. News headlines reporting on this issue was frequent at the time of the research. Acknowledgement of the pressures within the industry are important for this research, as improving care for survivors may be deprioritised when the sector is under external and internal scrutiny. My experiences on clinical placement where there are similar issues related to pressures, strain and lack of funding made me consider how dental professionals may be focused on these wider issues rather than specific issues as outlined in this research. However, it is felt that times of pressure can present as opportunities for reform where implementing better care for survivors and alterations to policy and legislation could be progressive. Holding this in mind was beneficial for recommendations that emerge from the research, to ensure that examples of positive practice are highlighted in recommendations.

Positionality throughout Participatory Action Research

This process has allowed me to deeply and meaningfully reflect on my position as a researcher. As a researcher who has lived through traumatic experiences I became aware of how visible and invisible this label was to participants across the study and how this influenced the research process. I felt this was much more noticeable when working in line with PAR principles. I found that I related to some of the quotes from survivors, particularly around the description of somatic complaints, a mistrust of those in positions of power and authority and the plethora of difficulties that can arise from being triggered. I became more aware of my own experiences related to the physical manifestation of psychological difficulties, and recalled the times my own difficulties had been misunderstood or misheard. I found myself drawn to these elements that were shared throughout interviews because of the visceral reaction they evoked and was mindful of not using this as a benchmark to analyse experiences. I did not explicitly reveal my survivor status to research participants but through informal discussions outside of the research process I was aware that my lived experience was more noticeable than I intended.

In the first year of the research, I became aware that I had not been to the dentist in over seven years. This was not something I had thought about explicitly before starting this project but I am more aware of the value I place on oral self-care. I subsequently paid privately to access the dentist, believing that this would be an opportunity to gain first-hand insight into the process and emerge myself better in the research process, however, I did not foresee the privilege and moral injury that came with being able to afford, access and engage in oral healthcare. I became concerned that accessing oral healthcare during the research process as a survivor of traumatic experiences may bias my findings, but I concluded that I was better able to understand the research question by going through this process and utilised peer supervision spaces to reflect on this.

Using Reflexive Thematic Analysis, I was able to consider the biases and assumptions I held whilst working on the research and analysing the data. As a black female researcher, I was acutely aware of issues related to intersectionality. All participants in the study were female, and gender was a key feature of the survivor’s stories. I wondered about the feminist lens that was used to capture and analyse the data and how I often associated this with positivity but how male survivors may have been marginalised through the process of this project. I was aware that the recruitment methods would favour those from certain groups and marginalise voices that would be important for broadening perspectives. I believe it is important that these stories are told within the research and was somewhat disappointed that I had not managed to achieve a diverse sample that represented the populations in need of oral healthcare. I thought about the communities in which people similar to me would operate and the potential of outreach work to encompass these demographics into the research. I endeavour to build on this when disseminating the findings and engaging in the action-research element of the project in the near future.

Strengths and Limitations

Data and Participants

Data were generated from a total of 16 participants across the interviews and focus groups. The participants who engaged in interviews were from a diverse age range, however, the ethnicity and gender of participants was homogenous. As seen in the literature, an intersectional approach is vital to understand the interacting and complex nature of multiple layers of trauma and marginalisation (Forde et al., 2019; Gangoli & Hester, 2023; Hatch, & Dohrenwend, 2007; Hulme, 2004). The results may have differed for participants from racially marginalised backgrounds given the intersection with greater adversity and disadvantage (Gangoli & Hester, 2023), which may mean their engagement with dental care is also different. It may have been useful to capture data from male identifying survivor participants, as some of the themes (psychological grounding and stabilisation) may have been experienced differently, or not at all, for male survivors. A diverse range of participant demographics was represented within the focus groups, however, only female identifying participants were involved. As outlined within interviews, male dental practitioners were particularly triggering for several participants, therefore, there is utility in capturing the perspectives from other gender identities. Discussions in the focus groups indicated that different specialities and disciplines within dental professionals may have more time and resources to practice in a trauma-informed manner. For future exploration of this topic, a more diverse sample in terms job role and oral healthcare sector would have been useful.

The interviews ranged from 35 minutes to 1 hour and 5 minutes and the focus groups length ranged from 1 hour and 5 minutes to 1 hour and 37 minutes. An increase in interview and focus group length would have resulted in more data and, in turn, deeper understanding about the topic in focus. As two focus groups were conducted, additional focus groups would have supported the findings relating to dental professionals views of the barriers and facilitator survivors experience in oral health care.

All survivor-participants included in the study had accessed the dentist within the last two years which shows that complete avoidance of this area of healthcare was not applicable to their situation. This is positive, but there will be several survivors for whom attending the dentist is not a possibility at all. Further research could explore experiences from participants who have not attended the dentist for a prolonged period of time.

Recruitment

The study sample adopted snowball methodology to recruit survivors whom were willing to share their experiences of oral healthcare and the barriers and facilitators they face. Snowball sampling is useful for reaching and advertising to participants who are connected by other participants. A different method of recruitment may have resulted in more varied participants in terms of background, especially those from marginalised groups. A total of four participants reached out to be involved in the project, but did not respond when arranging a date for an interview. Further exploration for the reasons behind this would have been useful for understanding the barriers associated with participating in the research.

There were difficulties with recruitment across interviews and focus groups. A total of 107 emails were sent out to local dental practices inviting them to be involved in the project, however, there were no responses to any of these emails. There were significant difficulties arranging focus groups with dental professionals and students; eight focus groups were arranged and only two went ahead due to difficulties recruiting sufficient participants to make a group. Informal conversations with dental professionals about the project indicated enthusiasm and a need to contribute to research in the area, however, this did not translate to action or successful recruitment. This provides interesting insight into how the topic and research may be viewed by dental professionals.

All dental professional participants were recruited via a higher education institution by advertising the study to academic professionals and students on an Oral Health Sciences course. The professionals also held clinical roles, but their position in education may have influenced their perspectives on the topic. Future research could implement other recruitment methods to reach professionals across a variety of dentistry settings and reduce bias in the sample.

Community Psychology Paradigm

A strength of the research was the use of a participatory approach. Survivors were involved in all stages of the research from design through to analysis. This allowed the survivor community to shape the direction of the research and be involved in the process of contributing to research in the field. The cultural perspectives and experiences survivors offer in contributing to new knowledge was a premise for opting for this approach which enhanced several aspects of the project and ensure the research stayed within the survivor and local community. The involvement of survivors in the process of analysis ensured the generated themes were an accurate reflection of their experiences. Enhanced survivor involvement was desired through other elements of the project, for example, the aim was to have survivor presence within the focus groups but this was not possible to arrange within the timeframe. Future developments in this area could ensure a participatory approach throughout and advocating for survivors taking the lead on elements of the research.

The psychological needs of individual are closely connected to the wider political and social landscape. Adopting a community psychology approach in this project allowed these macro-level influences to be encompassed and viewed oral healthcare as a broader public health issue. The wider implications are aligned in relation to survivors individual needs within the dental chair, but also a sense of community and connection around their involvement in their oral healthcare. As such, the wider context of dental appointments cannot be understated in this research area. Healthcare access is a basic human right and a core right of citizenship; marginalised groups such as survivors may experience erosion of these rights. As such, it is important that the principles of social justice are central to these issues to ensure that marginalised communities do not move further away from basic needs.

Research Methods

Qualitative methodology was adopted to provide valuable insight into the barriers and facilitators of survivors and the perspectives of dental professionals. Adopting a quantitative methodology for the research question did not feel appropriate based on the lack of focus on measuring or quantifying survivor's experiences. As this is a novel research area, it felt significant to capture the experiences as told by survivors as well as how dental professionals perceive survivors experiences which could be achieved through qualitative methodology. One-to-one interviews were used as a method for exploring barriers and facilitators with survivors rather than focus groups to ensure individual perspectives were heard. Interestingly, several participants responded to the first question in the interview ("Please share your experiences of dental care or attempting to access dental care") by stating that they had positive experiences of dental care and it was only after further probing and follow up questions that true perspectives were uncovered and barriers were discussed. This possibly gives insight into personal and societal barriers, such as stigma, shame and avoidance when discussing experiences related to healthcare access as a survivor of sexual abuse.

Further Research

Future research could explore the differences between private and NHS experiences for survivors. There is a need to conduct further research with a diverse sample of participants, including those from marginalised groups to ensure an intersectional lens throughout the analysis. This could add further understanding to the factors that facilitate and hinder care across these different settings. The differences in policies and practices that affect survivors could be explored further from the perspective of dental professionals who work across both sectors. As discussed above, a pilot project related to trialling a trauma-informed dentistry curriculum and service could be launched to develop the action-research element of the project and develop and evaluate application of the findings in the region.

The research is located in wider public health and further review of the policies and practices of dental care professionals could benefit top-down reform. Clinical psychology is well positioned to explore policy level issues that influence the care of survivors in these settings.

Conclusion

In conclusion, the present findings offer insight into the barrier and facilitators to oral healthcare from the perspectives of survivors of sexual abuse and the views that dental professionals hold in accordance with survivor's experiences. Collectively, the results provide some understanding about the existence of barriers and how dental professionals and dental practices may inadvertently contribute and maintain these for survivors. The facilitative factors in participant's accounts and the enthusiasm shared by participants in the focus groups gives some optimism for progressing oral healthcare for survivors of sexual abuse. There are several improvements suggested to better oral healthcare practice for survivors, and trauma-informed care can be used as a foundation. The participatory approach within this research gives strength and empowerment to the survivor voice, which is a cornerstone of this project.

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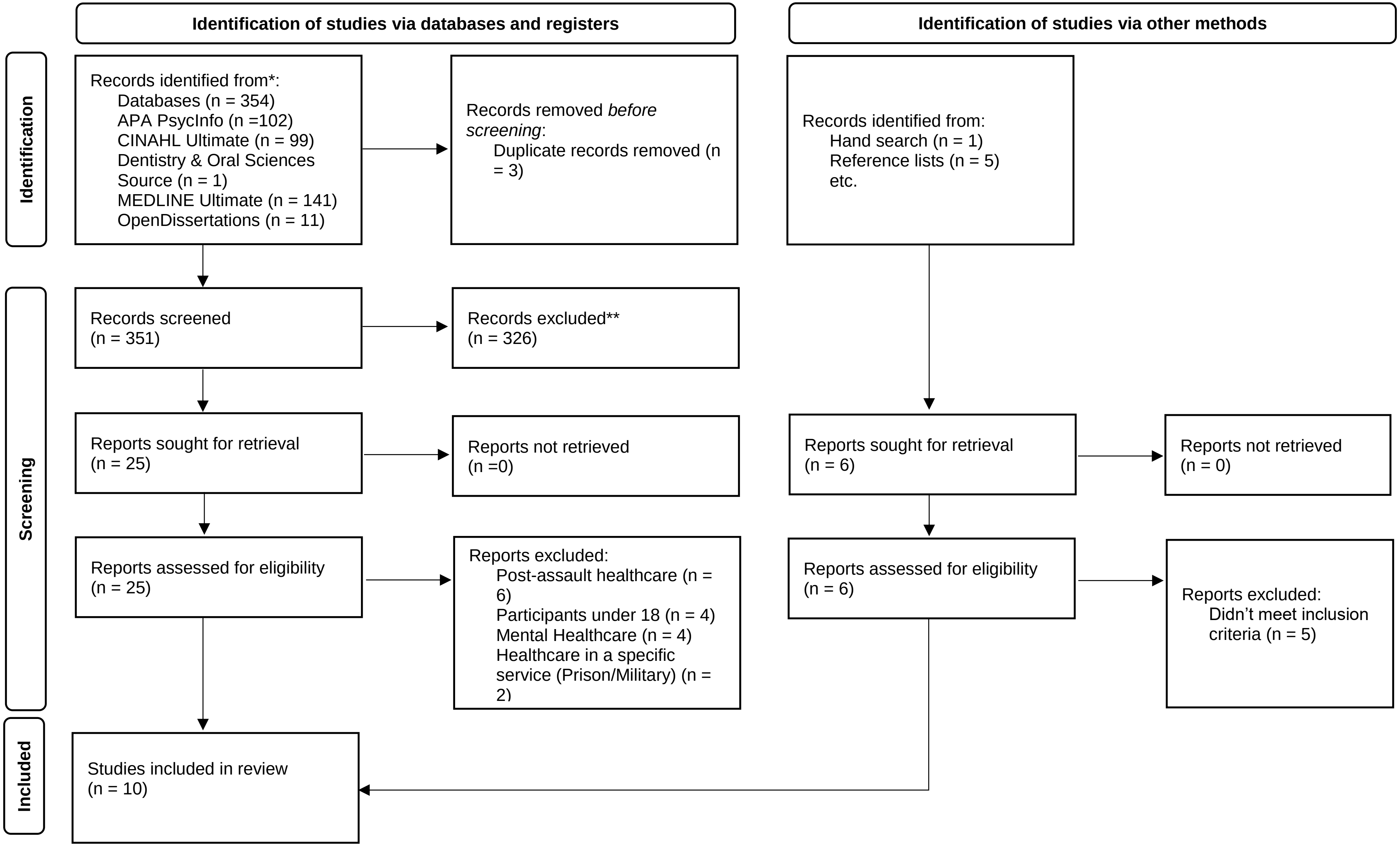
APPENDICIES

Appendix A: PRISMA Flowchart



Appendix B: Summary characteristics of articles included in the meta-synthesis

Author/Title/Location	**Aim**	**Healthcare setting**	**Sample size**	**Methodology/Method**	**Inclusion Criteria**
Alyce et al. (2022) Avoiding psychological (re) traumatisation in dentistry when working with patients who are adult survivors of child sex abuse. United Kingdom	To analyse and report CSA survivor perspectives of dental care and offer suggestions for practice.	Oral health care	17	Secondary data analysis Semi-structured interviews Thematic Analysis	Adult participants CSA survivors Experience in healthcare setting
Crockett (2017) Trans Masculine Healthcare: Utilization After Sexual Violence. United States of America	Exploring trans masculine folks experiences with healthcare utilisation	Any physical healthcare setting	8	Semi-structured interviews Interpretative Phenomenological Analysis	Adult participants Survivor of sexual abuse Experience in healthcare setting
Gesink & Nattel (2015) A qualitative cancer screening study with childhood sexual abuse survivors: experiences, perspectives and compassionate care. Canada	Our objective was to learn CSA survivor perspectives on, and experiences with, breast, cervical and colon cancer screening with the intention of generating recommendations to help healthcare providers improve cancer screening participation	Breast, cervical and colon cancer screening	12	Semi-structured interviews Thematic Analysis	Adult participants CSA survivors Experience in healthcare setting
Jonsdottir et al. (2022)	Increased knowledge and deeper understanding	Healthcare during childbearing	9	Semi-structured interviews Thematic Analysis	Adult participants

'We experienced lack of understanding in the healthcare system'. Experiences of childhood sexual abuse survivors of the childbearing process, health and motherhood. Iceland	are needed of survivors' experiences of the childbearing process, health and motherhood.				CSA survivors Experience in healthcare setting
LoGiudice (2022) A narrative analysis of the in vitro fertilization experiences of survivors of sexual abuse. United States of America	To explore the lived experience of in vitro fertilization (IVF) from the perspective of survivors of sexual abuse	In Vitro Fertilization (IVF)	3	Participants wrote a narrative text Narrative Analysis	Adult participants Survivor of sexual abuse Experience in healthcare setting
Meier et al. (2021) "I'm More Open to Talking About It": Women's Experiences With Sexual Abuse and Reproductive Health. United States of America	The purposes of this article were to understand how women perceived their sexual abuse experiences and how these experiences integrated into their overall reproductive health, reproductive planning, and health care access.	Reproductive Healthcare Services	16	Secondary Data Analysis Grounded Theory	Adult participants Survivor of sexual abuse Experience in healthcare setting
Reeves & Humphreys (2018) Describing the healthcare experiences and strategies of women survivors of violence. United States of America	The purpose of this study was to develop knowledge on women survivors' healthcare experiences and strategies	Any healthcare setting	14	Semi-structured interviews Thematic Analysis	Adult participants Survivors of traumatic experiences including sexual abuse

					Experience in healthcare setting
Ross et al. (2023) Gynaecological care of women with chronic pelvic pain: Patient perspectives and care preferences. United States of America	To explore the experiences and care preferences of women with chronic pelvic pain, with or without a history of sexual trauma, seeking gynaecological care	Gynaecological Care	13	Focus groups	Adult participants Survivors of sexual abuse Experience in healthcare setting
Schnur et al. (2018) Cancer treatment experiences among survivors of childhood sexual abuse: A qualitative investigation of triggers and reactions to cumulative trauma. United States of America	Study's objective was to identify key themes pertaining to CSA survivors' cancer treatment experiences.	Cancer care	159	Secondary data analysis Online survey responding to open ended questions Thematic Analysis	Adult participants CSA survivors Experience in healthcare setting
Tsur et al. (2023) "When I was a child, the doctor advised me to have sex more gently": The perceptions and experiences with the healthcare system as conveyed by adult survivors of child sexual abuse. Israel	Specifically, this study aims to uncover the perceptions and experiences of female survivors of CSA concerning their encounters with the healthcare system.	Any healthcare setting	53	Secondary data analysis Written narratives from open ended questions Thematic analysis	Adult participants CSA survivors Experience in healthcare setting

Appendix C: CASP Qualitative research checklist of articles included in the meta-synthesis

Paper	Aim	Methods	Design	Recruitment	Researcher/ Partnership considered	Ethics	Analysis	Findings	Value	Outcome
Alyce et al. (2022)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Crockett (2017)	✓	✓	✓	✓	X	✓	✓	✓	✓	Included
Gesink & Nattel (2015)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Jonsdottir et al. (2022)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
LoGiudice (2022)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Meier et al. (2021)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Reeves & Humphreys (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Ross et al. (2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Schnur et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Tsur et al. (2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included

Appendix D: Invitation to research for survivors

Invitation to Research Study

Recruitment of participants to: Barriers and Facilitators to Dental Care: The Experiences from Survivors of Sexual Abuse and the Perspectives of Dental Professionals.

Have you avoided, accessed, or attempted to access, the dentist? If so, we need you!

As part of a research project into experiences of dental care for survivors of sexual abuse, we are looking for people interested in taking part in a research interview where you will discuss your experiences of dental care.

Further research is needed into the experiences of survivors of sexual abuse accessing, or attempting to access, dental care in the East Anglia region. There is also little research which offers understanding of dental professionals' views of survivors' experiences. This research hopes to provide greater understanding about the experiences of survivors and the perceptions dental professionals hold about these experiences in the context of their work.

It is hoped that this research will be used to highlight areas of good practice, inform better practice and improve the experiences of survivors attempting to access dental care

What is involved?

You will be involved in a one-to-one interview, which will be recorded. You will be asked to discuss your experiences related to dental care. The discussions will last around 60 minutes and will take place via Zoom or face-to-face. You will be sent a £20 voucher as a thank you for participating.

Am I eligible to take part?

If you are over 18 and live in the East Anglia region you are eligible to take part in this research. Your participation is entirely voluntary and you are under no obligation to take part.

How do I get in touch?

If you meet the above criteria and you are interested in taking part, please send an email to the Principal Researcher, Indiana Montaque on im21078@essex.ac.uk you will be sent a full information sheet and consent forms before participating in the research.

Appendix E: Participant Information Sheet for stage one of the research

Participant Information Sheet – Phase One

Participant Information Sheet for**: Barriers and Facilitators to Dental Care: The Experiences of Survivors of Sexual Abuse and the Perspectives of Dental Professionals.**

Thank you for your interest in this research project which is being carried out in line with the requirements of the Doctorate in Clinical Psychology programme at the University of Essex. To support your decision to take part in the study, this information sheet will outline the purpose of the research and what is involved in taking part. Please take the time to read the information in full. You are encouraged and welcome to contact the research team with any questions or concerns; contact information is provided at the bottom of the information sheet.

What is the project about?

This research project is interested in exploring the experiences of dental care for survivors of sexual abuse. Existing research highlights that there is a need to understand further about how survivors experience attending the dentist. In addition, little is known about dentists view on survivors' experiences of the dentist, therefore, it is hoped that this research will address this gap in the research.

Am I eligible to take part?

If you have experienced sexual abuse at any age, are aged 18 or over and you live in the East Anglia region you are eligible to take part in this research. You are not required to have accessed the dentist to take part in this study.

Do I have to take part?

No. Participation in this research project is entirely voluntary.

Can I withdraw from the study if I change my mind?

Yes. You can withdraw from the study at any time, and you do not need to give a reason. If you choose to withdraw from the study, any identifiable information will be removed from the study. Data which is not identifiable will still be retained as part of the study.

What is required of me if I decide to take part?

If you decide to take part please contact the Principal Researcher, Indiana Montaque, using the email address at the bottom of this sheet. This will initiate the process of organising an interview as part of the research. Before the interview, you will be sent a consent form which you will be required to sign before starting the research. You will also be sent a demographic information sheet to complete. Following this, the Principal Researcher will then be in contact to arrange a suitable date and time to conduct the interview. The interview may take place via an online platform, such as Zoom, or face-to-face. If using Zoom, you will be sent an invitation for the date and time of the interview. The Zoom invite will also include a password which will be required to enter the Zoom link. If your interview is face-to-face, a location that is secure will be used, such as a room at Health Watch Essex.

The interview will last approximately 45-60 minutes and will involve questions about your experiences of dental care. The aim of these questions is to gather some understanding of experiences for survivors. There are no right or wrong answers to these questions; the researchers are interested in your experiences as told by you.

The interview will be audio recorded using the recording function in Zoom and a Dictaphone as back up or a Dictaphone only if your interview is in person. Your interview will be transcribed by the Principal Researcher, who will anonymise any identifiable information using pseudonyms. If you choose to be contacted at a later date during the analysis stage to check themes for accuracy, you will be contacted by phone or email. Direct anonymised quotes from the research may be used in the final write up and in future publications of the research.

This research is taking a participatory approach to the research, meaning participants will be offered the opportunity to be involved in the data analysis process. This will involve a half day group workshop (approximately four hours) with the researcher and other participants to generate themes from the anonymised interview transcripts. This stage is optional – if you decide to participate in the analysis of the results, you will be contacted by the researcher to organise a time to meet for this process.

What are the possible disadvantages of taking part?

Experiences of dental care might not always be positive, which may mean that this topic becomes emotionally difficult to discuss. If there becomes a point in the interview where you cannot continue with the questions, need a break, or would like to withdraw from the study, you will be supported to do what you need. A full debrief will be provided after the interview and you will be invited to share your reflections about taking part should you wish to do so.

During the debrief process you will be signposted to relevant support services should you experience distress as a result of taking part in this interview. This will include directing you to your GP or wellbeing support at Healthwatch Essex.

What are the possible benefits of taking part?

This research aims to provide deeper understanding about the experiences of dental care for survivors and dental professionals views on these experiences. The outcomes of this study hope to inform service developments across several settings, including clinical psychology, dentistry and dental professions and survivor networks. It is hoped that this research will be used to inform training and practice.

As a way of expressing gratitude for participating in the study, you will be sent a £20 voucher. If you decide to be involved in the analysis process, you will be provided further vouchers in the amount of £15 per hour that you are involved in the process. You will still be provided with this, even if you withdraw from the study.

What will happen to the results of the research?

This project is being carried out as a thesis project, in line with the requirements of the Doctorate in Clinical Psychology at the University of Essex. The final project will be submitted to the University as part of this process. The findings will be disseminated to services involved in the project via oral presentation, posters and written reports. It is hoped that the research will be submitted to a peer-reviewed scientific journal to contribute to the literature on this topic. In addition, a copy of the final report will be sent to you.

Is my information confidential?

The information that you provide as part of this study will be kept confidential unless there appears to be a risk of harm to yourself or to others. If you share something and it is felt that there is a risk of harm to yourself or to others, the information will be shared with the appropriate services and organisations to keep you and others safe. If this happens, the researcher will inform you of their concerns before sharing the information. Overall, all the information that you provide for this study will be securely stored, and all identifiable information will be removed or altered. All information will be anonymised using a pseudonym so that your interview is not identifiable in any way. This includes names, healthcare services, locations and other organisations that might be shared within the interview.

The interviews will be audio recorded using a Dictaphone which if for the sole and explicit purpose of aiding the transcribing of the interview. Once the interview has been recorded, it will be stored within a password-protected secure drive at the University of Essex, before being transcribed. Only the researcher will have access to the recorded data. The researcher will delete the original file from the Dictaphone once the transcribing process has been completed. Your data will be stored in line with the Data Protection Act (2018) and University of Essex data protection policies. All your data will be held on password protected devices. Only Indiana Montaque will have access to the confidential information and only the research team will have access to the anonymised data. The anonymised version of your transcript will be used by the group of researchers and co-researchers (other participants) when analysing for themes.

How will my information be used?

The University of Essex is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and we will act as the data controller for this study. Therefore, we are responsible for looking after your information and using it in a responsible, appropriate manner. The University will keep the data obtained in the study for five years after the study has finished. Your right to access, change or move your information are limited, as we will need to manage you information in a specific way in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. You can find out more about how we use your information by contacting the Information Assurance Manager on 01206 874853.

Indiana Montaque (Principal Researcher) will keep your name and contact details confidential, and this will not be shared with the University. This information will only be used when needed, for the purposes of contacting you as part of the study or to oversee the quality of the study. Certain individuals for the University of Essex and external regulatory organisations may look at your record to check the accuracy of the research study. When submitting this research to The University of Essex, the information will be sent without any identifying information. The people who analyse the information will not be able to identify you due to the process of anonymising your transcript. Indiana Montaque will keep your identifiable information from this study for five years after the study has finished.

Who has approved this project?

The following will be included once ethical approval has been confirmed: This project has received appropriate ethical approval from the University of Essex. What do I do if I have a complaint? If you wish to raise any concerns or have a complaint about this project, please contact the Principal Researcher: Indiana Montaque im21078@essex.ac.uk If you would like to speak to someone other than the Principal Research, please contact Dr Danny Taggart, Clinical Psychologist and Research Supervisor – dtaggart@essex.ac.uk

If you are unsatisfied with the responses from the research team, or you feel that you cannot approach the principal researcher, please contact the Departmental Director of Research in the School of Health and Social Care, Professor Camille Cronin (Camille.cronin@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (sarahm@essex.ac.uk) . If you have any questions or would like to discuss anything further before deciding whether to take part, please contact the research team using the following contact details:

Principal Researcher Indiana Montaque im21078@essex.ac.uk

Academic Supervisor Dr Danny Taggart dtaggart@essex.ac.uk

Appendix F: Participant Demographic Sheet for Stage One of the research.

Participant Demographic Sheet – Phase One

Participant Demographics Sheet for: **Barriers and Facilitators to Dental Care: The Experiences from Survivors of Sexual Abuse and the Perspectives of Dental Professionals.**

Participant ID Number:

Please do not write your name on this form. In order to keep the data anonymous, it will be stored separately from any other information that you provide during the study (e.g. the consent form and audio recording) and will not be linked with your responses.

For the following items, please tick the most appropriate box/ write your response on the line provided.

How would you currently describe your gender identity?:

Please specify: ....

Prefer not to answer

Age: 18-25 26-34 35-44 45-54 55-64 65+

Ethnicity:

White

British/ English/ Welsh/ Scottish/ Northern Irish

Irish

Gypsy/ Irish Traveller

Other

Black/ Black British

African

Caribbean

Any Other Black/ African/ Caribbean background

Asian/ Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

Mixed/ Multiple ethnic groups

White and Black African

White and Black Caribbean

White and Asian

Any other Mixed/Multiple ethnic background

Other ethnic group

Arab

Any other ethnic group

…………………………………………………

The most recent time you went to/attempted to access the dentist

…………………………………………………………………

Appendix G: Participant Consent Form

Participant Consent Form

Consent form for project: **Barriers and Facilitators to Dental Care: The Experiences from Survivors of Sexual Abuse and the Perspectives of Dental Professionals.**

Participant ID Number:

Please initial each box. There are seven mandatory items and two optional items.

1. I confirm that I have received a copy of and read the information sheet for the above study ☐
2. I have been given the opportunity to ask questions and the researcher has answered them appropriately ☐
3. I understand that participation in this study is voluntary. I understand I am free to withdraw from the study at any time, without providing any reason for my withdrawal. If I choose to withdraw from the study, all identifiable data collected will be removed from the study. Any data that is not identifiable will be anonymised and retained ☐
4. I agree for my participation to be audio recorded for the purposes of the study only ☐
5. I understand that my data will be stored securely, in line with the Data Protection Act (2018) ☐
6. I understand that direct quotes from the interview will be included in the final write up of the study. I understand that these quotes and my information will be anonymised and I will not be identifable from this ☐
7. I agree to be contacted at a later date to be involved in the process of data analysis. This will include checking themes that have been identified by the researcher for their accuracy (this is optional) ☐
8. I would like to be sent a copy of the final written report (this is optional) ☐
9. I agree to take part in the above study ☐

Name of Participant ……………………………………………………………………….

Signature …………………………………………………………………………………….

Date …………………………………………………………………………………………

Name of Researcher ……………………………………………………………………….

Signature ……………………………………………………………………………………..

Date ……………………………………………………………………………………

Appendix H: Interview topic guide

Topic Guide for stage one – interviews with survivors

1. Please share your experiences of dental care or attempting to access dental care
2. How would you describe your most recent attendance at the dentist?
3. What would make attending the dentist easier?
4. What makes attending the dentist harder?
5. What is the impact of all this?
6. What do you think is needed to improve dental services for survivors of sexual abuse?
7. What do you think should stay the same to ensure survivors of sexual abuse can access the dentist?

Appendix I: Invitation to Research Email for stage two of the research, distributed to dental professionals.

Invitation to Research Study

Recruitment of participants to: **Barriers and Facilitators to Dental Care: The Experiences from Survivors of Sexual Abuse and the Perspectives of Dental Professionals.**

Are you a dental professional working or studying in East Anglia? If so, we need you!

Written in collaboration with the Trauma Ambassador Group at Health Watch Essex

We are a group of survivors and researchers, seeking dental practices interested in being involved in research exploring experiences of dental care for survivors of sexual abuse.

Why are we doing this research?

Further research is needed into the experiences of dental care for survivors of sexual abuse. There is a gap in the research understanding dental professionals' views of survivors' experiences. This research hopes to address this gap and provide greater understanding about the perceptions dental professionals hold about survivors' experiences.

It is hoped that this research will be used to highlight areas of good practice, inform ways to improve care and benefit the experiences of survivors attempting to access dental care.

What is involved?

You will be involved in a focus group with various dental professional colleagues or students where you will be asked to discuss factors related to survivors' experiences of dental care. The discussions will last around 60 minutes and will take place via Zoom or face-to-face.

If you are a student, you will be provided with a £20 for your participation.

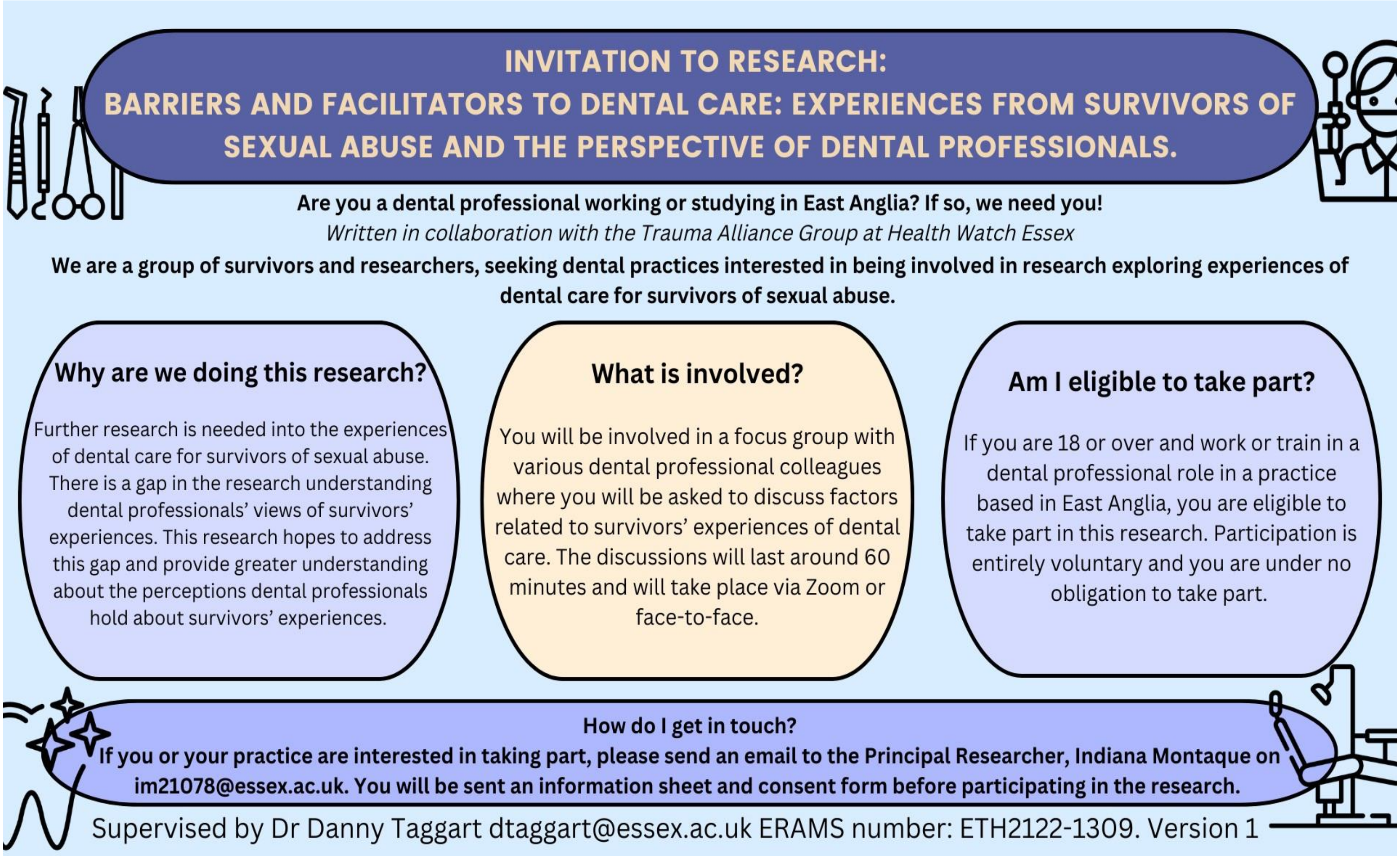
Am I eligible to take part?

If you 18 or over and work or train in a dental professional role in a practice based in East Anglia, you are eligible to take part in this research. Participation is entirely voluntary and you are under no obligation to take part.

How do I get in touch?

If you or your practice are interested in taking part, please send an email to the Principal Researcher, Indiana Montaque on im21078@essex.ac.uk. You will be sent a full information sheet and consent forms before participating in the research.

Appendix J: Invitation to research poster for stage two of the project



INVITATION TO RESEARCH:
BARRIERS AND FACILITATORS TO DENTAL CARE: EXPERIENCES FROM SURVIVORS OF SEXUAL ABUSE AND THE PERSPECTIVE OF DENTAL PROFESSIONALS.

Are you a dental professional working or studying in East Anglia? If so, we need you!

Written in collaboration with the Trauma Alliance Group at Health Watch Essex

We are a group of survivors and researchers, seeking dental practices interested in being involved in research exploring experiences of dental care for survivors of sexual abuse.

Why are we doing this research?

Further research is needed into the experiences of dental care for survivors of sexual abuse. There is a gap in the research understanding dental professionals' views of survivors' experiences. This research hopes to address this gap and provide greater understanding about the perceptions dental professionals hold about survivors' experiences.

What is involved?

You will be involved in a focus group with various dental professional colleagues where you will be asked to discuss factors related to survivors' experiences of dental care. The discussions will last around 60 minutes and will take place via Zoom or face-to-face.

Am I eligible to take part?

If you are 18 or over and work or train in a dental professional role in a practice based in East Anglia, you are eligible to take part in this research. Participation is entirely voluntary and you are under no obligation to take part.

How do I get in touch?

If you or your practice are interested in taking part, please send an email to the Principal Researcher, Indiana Montaque on im21078@essex.ac.uk. You will be sent an information sheet and consent form before participating in the research.

Supervised by Dr Danny Taggart dtaggart@essex.ac.uk ERAMS number: ETH2122-1309. Version 1

Appendix K: Participant Information Sheet for Stage Two of the research

Participant Information Sheet – Phase Two

Participant Information Sheet for: **Barriers and Facilitators to Dental Care: The Experiences of Survivors of Sexual Abuse and the Perspectives of Dental Professionals.**

Thank you for your interest in this research project which is being carried out in line with the requirements of the Doctorate in Clinical Psychology programme at the University of Essex. To support your decision to take part in the study, this information sheet will outline the purpose of the research and what is involved in taking part. Please take the time to read the information in full. You are encouraged and welcome to contact the research team with any questions or concerns; contact information is provided at the bottom of the information sheet.

What is the project about?

This research project is interested in exploring the experiences of dental care for survivors of sexual abuse. Existing research highlights that there is a need to understand further about how survivors experience attending the dentist. In addition, little is known about dentists view on survivors' experiences of the dentist, therefore, it is hoped that this research will address this gap in the research.

Am I eligible to take part?

If you are aged 18 or over, a dental professional in work or training and you live in the East Anglia region you are eligible to take part in this research.

Do I have to take part?

No. Participation in this research project is entirely voluntary.

Can I withdraw from the study if I change my mind?

Yes. You can withdraw from the study at any time and you do not need to give a reason. If you choose to withdraw from the study, any identifiable information will be removed from the study. Data which is not identifiable will be still be retained as part of the study.

What is required of me if I decide to take part?

If you decide to take part please contact the Principal Researcher, Indiana Montaque, using the email address at the bottom of this sheet. This will initiate the process of organising a focus group as part of the research. Before the focus group, you will be sent a consent form which you will be required to sign before starting the research. You will also be sent a demographic information sheet to complete. Following this, the Principal Researcher will then be in contact to arrange a suitable date and time to conduct the interview. The focus group may take place via an online platform, such as Zoom, or face-to-face. If using Zoom, you will be sent an invitation for the date and time of the interview. The Zoom invite will also include a password which will be required to enter the Zoom link. If your focus group is face-to-face, you will be notified of the location. If you are a student, you will provided with a £20 for your participation.

The focus group will last approximately 60 minutes and will involve questions related to survivors of sexual abuse experiences of dental care. The aim of these questions are to gather some understanding of dental professionals perceptions of these factors. There are no right or wrong answers to these questions; the researchers are interested in your views and discussions of the factors with your colleagues.

The interview will be audio recorded using the recording function in Zoom and a Dictaphone as back up or a Dictaphone only if your focus group is in person. Your focus group will be transcribed by the Principal Researcher, who will anonymise any identifiable information using pseudonyms. If you choose to be contacted at a later date during the analysis stage to check themes for accuracy, you will be contacted by phone or email. Direct anonymised quotes from the research may be used in the final write up and in future publications of the research.

What are the possible disadvantages of taking part?

The focus of discussions may be emotionally difficult as they relate to survivors' experiences of dental care. If there becomes a point in the focus group where you cannot continue with the questions, need a break, or would like to withdraw from the study, you will be supported to do what you need. A full debrief will be provided after the interview and you will be invited to share your reflections about taking part should you wish to do so.

What are the possible benefits of taking part?

This research aims to provide deeper understanding about the experiences of dental care for survivors and dental professionals views on these experiences. The outcomes of this study hope to inform service developments across several settings, including clinical psychology, dentistry and dental professions and survivor networks. It is hoped that this research will be used to inform training and practice.

If you are a student, you will provided with a £20 for your participation.

What will happen to the results of the research?

This project is being carried out as a thesis project, in line with the requirements of the Doctorate in Clinical Psychology at the University of Essex. The final project will be submitted to the University as part of this process. The findings will be disseminated to services involved in the project via oral presentation, posters and written reports. It is hoped that the research will be submitted to a peer-reviewed scientific journal to contribute to the literature on this topic. In addition, a copy of the final report will be sent to you.

Is my information confidential?

The information that you provide as part of this study will be kept confidential unless there appears to be a risk of harm to yourself or to others. If you share something and it is felt that there is a risk of harm to yourself or to others, the information will be shared with the appropriate services and organisations to keep you and others safe. If this happens, the researcher will inform you of their concerns before sharing the information. Overall, all the information that you provide for this study will be securely stored, and all identifiable information will be removed or altered. All information will be anonymised using a pseudonym so that your interview is not identifiable in any way. This includes names, healthcare services, locations and other organisations that might be shared within the interview.

The interviews will be audio recorded using a Dictaphone which if for the sole and explicit purpose of aiding the transcribing of the interview. Once the interview has been recorded, it will be stored within a password-protected secure drive at the University of Essex, before being transcribed. Only the researcher will have access to the recorded data. The researcher will delete the original file from the Dictaphone once the transcribing process has been completed. Your data will be stored in line with the Data Protection Act (2018) and University of Essex data protection policies. All your data will be held on password protected devices. Only Indiana Montaque will have access to the confidential information and only the research team will have access to the anonymised data.

How will my information be used?

The University of Essex is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and we will act as the data controller for this study. Therefore, we are responsible for looking after your information and using it in a responsible, appropriate manner. The University will keep the data obtained in the study for five years after the study has finished. Your right to access, change or move your information are limited, as we will need to manage you information in a specific way in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. You can find out more about how we use your information by contacting the Information Assurance Manager on 01206 874853.

Indiana Montaque (Principal Researcher) will keep your name and contact details confidential and this will not be shared with the University. This information will only be used when needed, for the purposes of contacting you as part of the study or to oversee the quality of the study. Certain individuals for the University of Essex and external regulatory organisations may look at your record to check the accuracy of the research study. When submitting this research to The University of Essex, the information will be sent without any identifying information. The people who analyse the information will not be able to identify you due to the process of anonymising your transcript. Indiana Montaque will keep your identifiable information from this study for five years after the study has finished.

Who has approved this project?

The following will be included once ethical approval has been confirmed:

This project has received appropriate ethical approval from the University of Essex.

What do I do if I have a complaint?

If you wish to raise any concerns or have a complaint about this project, please contact the Principal Researcher: Indiana Montaque im21078@essex.ac.uk If you would like to speak to someone other than the Principal Research, please contact Dr Danny Taggart, Clinical Psychologist and Research Supervisor – dtaggart@essex.ac.uk

If you are unsatisfied with the responses from the research team, or you feel that you cannot approach the principal researcher, please contact the Departmental Director of Research in the School of Health and Social Care, Professor Camille Cronin (Camille.cronin@essex.ac.uk). If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (e-mail sarahm@essex.ac.uk).

If you have any questions or would like to discuss anything further before deciding whether to take part, please contact the research team using the following contact details:

Principal Researcher Indiana Montaque im21078@essex.ac.uk

Academic Supervisor Dr Danny Taggart dtaggart@essex.ac.uk

Appendix L: Demographic Information Form for Stage Two of the Research

Participant Demographic Sheet – Phase Two

Participant Demographics Sheet for: **Barriers and Facilitators to Dental Care: The Experiences from Survivors of Sexual Abuse and the Perspectives of Dental Professionals.**

Participant ID Number:

Please do not write your name on this form. In order to keep the data anonymous, it will be stored separately from any other information that you provide during the study (e.g. the consent form and audio recording) and will not be linked with your responses.

For the following items, please tick the most appropriate box/ write your response on the line provided.

How would you currently describe your gender identity?:

Please specify: ....

Prefer not to answer

Age: 18-25 26-34 35-44 45-54 55-64 65+

Ethnicity:

White

British/ English/ Welsh/ Scottish/ Northern Irish

Irish

Gypsy/ Irish Traveller

Other

Black/ Black British

African

Caribbean

Any Other Black/ African/ Caribbean background

Asian/ Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

Mixed/ Multiple ethnic groups

White and Black African

White and Black Caribbean

White and Asian

Any other Mixed/Multiple ethnic background

Other ethnic group

Arab

Any other ethnic group

…………………………………………………

Occupation: …………………………………………………….…………………….

Current Job Role: ………………………...…………………………………………

Length of time qualified: ……………………………………..……….............

Current service: ………………………………………………….………….........

Service Location: ....

Length of time working in current service: ……………………………….............

Appendix M: Focus group interview guide for stage two

Thank you for attending this focus group. The research is exploring survivors of sexual abuse experiences of oral health care. When I use the term “survivor” I am referring to anyone identifying as being a survivor of sexual abuse

Survivors were asked about the barriers and facilitators to oral healthcare. There are three barriers and three facilitators. I will go through each of them and I would like you to discuss between you your views, opinions and anything else that comes up in relation to the factors that survivors say helps or hinders their oral healthcare experiences. I will offer some further information about what survivors have said if needed, but please discuss anything that comes to mind first. If you need further clarification, I can offer further information

Barriers:

For the barriers, there were three main themes that came up

Survivors mentioned that they felt oral health care professionals demanded vulnerability from them in the way that the procedure is set up, in the way that dentists communicate with them, and the amount of interaction in the procedure. What does this mean to you?

Survivors mentioned that there is an uncertainty that comes with routine examination, which they experienced as a barrier to care. There are elements of these appointments that they find unclear, and unknown, which means they avoid them. What does this mean to you?

Survivors mentioned that they have psychologically dissociated from their mouth, in the sense that they don’t feel they have ownership over their mouth anymore due to the trauma they have endured and that this is a barrier to dental care. What does this mean to you?

Facilitators:

For the facilitators there were three main themes

Survivors mentioned that they felt that when their dental professional works with them in a relational way, this is something that helps them engage in oral health care. The dental professional taking their time to introduce themselves, building a rapport and being warm aids the interaction. What does this mean to you?

Survivor mentioned that they felt a sense of dental community aided their attendance at the dentist. Factors such as a small practice, having a regular professional who helps them feel safe aided them attending the dentist. What does this mean to you?

Survivors mentioned that dentists helping them with techniques to help manage trauma responses or fear aided the interaction. This could be things like the dentist giving them permission to speak out or helping them with techniques to feel calmer. What does this mean to you?