

# The self-perceived impact of sexual abuse on daily life and general health - an issue to consider in dental care

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## Abstract

**Background/Aim:** To analyse, from the perspective of adults with a history of sexual abuse, the impact of the experience on their general health and well-being.

**Material and Methods:** The participants comprised 12 strategically selected informants (10 women), aged 19–56; all sexually abused during child- and/or adulthood. They were interviewed in-depth and encouraged to describe the impact of the sexual abuse on their daily lives. The consequences of sexual abuse on oral health have previously been reported. The interviews were recorded digitally, transcribed *verbatim* and analysed according to qualitative content analysis with an inductive approach.

**Results:** The overall theme illustrating the latent content was *Sexual abuse experience—limiting long-term consequences, always present in body and mind*. The first category covering the manifest content was 'A lost foothold', with two subcategories: (i) *emotional repercussions* and (ii) *physical health repercussions*. The second category was 'The significance of distance to trauma', with two subcategories (i) *keeping a distance and tending to escape* and (ii) *processing the trauma experience—a struggle towards balance*.

**Conclusions:** A history of sexual abuse cannot be understood in isolation: the long-term repercussions pervade daily life. However, after disclosure of the abuse and processing the trauma, it is possible to ameliorate some of the negative effects. In this context, the dental setting emerges as a potentially important venue for disclosure as almost every person, sooner or later, visits the dentist.

## KEYWORDS

dentistry, health consequences, qualitative

## 1 | INTRODUCTION

Violence, including sexual abuse, is a common global phenomenon<sup>1–3</sup> and has been declared by the World Health Organization (WHO)<sup>4</sup> to be a threat to public health, because of the wide ramifications, with societal as well as individual, sociological,<sup>5</sup> physical,<sup>6</sup> psychological<sup>7</sup> and behavioural sequelae.<sup>8</sup>

In a systematic review and meta-analysis, the prevalence rates of sexual abuse among men and women were reported to be 8% and 18%, respectively.<sup>9</sup> A Swedish population-based study reported that 11% of men and 27% of women had been exposed to sexual abuse while under 18 years of age and 6% of men and 28% of women reported experiencing sexual abuse after the age of 18 years.<sup>10</sup>

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Although experience of sexual abuse is not necessarily the direct cause of serious short- and long-term personal consequences for general and oral, physical and mental health, it is reported to have an impact, regardless of whether or not a memory persists.<sup>11-17</sup> This link between the experience of abuse and deterioration in health is reported to be related to a disturbance in the body's management of stress hormones, leading to dysfunction of the systems which regulate immune and inflammatory responses.<sup>18,19</sup> This relationship is not only strong, but also gradually incremental, that is, repeated molestation is associated with further health impairment.<sup>11,13,15,20</sup> WHO has therefore declared that sexual abuse warrants priority in-depth investigation.<sup>4,12</sup> The Agenda for Sustainable Development 2030 also includes several goals intended to eliminate sexual violence.<sup>21</sup>

Physical injuries detected after sexual violence are reported to range from 59% to 80%: thus, in 20%–41% of cases, no visible signs of injuries are recorded.<sup>22,23</sup> Of particular relevance for dental personnel is physical injury related to oral abuse. Studies by Riggs et al.,<sup>22</sup> Sugar et al.<sup>23</sup> and Karanfil et al.<sup>24</sup> did not report any oral injuries at all. On the other hand, Brew-Graves & Morgan<sup>25</sup> reported few oral injuries (19%), presenting as abrasion, bruising and petechiae: these were classified as 'minor and did not require treatment'. The authors observed that little specific attention was paid to the mouth area.<sup>25</sup>

Gender-based violence, in particular men's violence towards women, has a huge financial cost. The European Institute for Gender Equality estimated the annual cost of violence in close relationships and gender-related violence in Europe, Australia, Canada and United States. Based on extrapolation of population size and on the 2012 cost level,<sup>26</sup> the estimated costs in Sweden were ~45.5 billion Swedish crowns (SEK) (€ 1 = 11.88 SEK, \$ 1 = 10.93 SEK, Aug 2023) per year. Most of the cost (59%) was related to an estimated loss of quality of life.<sup>26</sup> Thus, as well as physical injuries, it is important to consider other, more insidious aspects of the effects of violence such as personal suffering, fear, pain, premature death, deterioration in quality of life, loss of trust, insecurity and poor interpersonal relationships. These indirect effects are often excluded from calculations.<sup>27</sup>

Many studies of the correlation between sexual abuse and health are based on analysis of quantitative data. These data lack to some extent the context of the experience. Studies based on qualitative data are suited to analyses of, for example, perceptions, preferences, attitudes and experiences, which can contribute to a more extended knowledge<sup>28</sup> and are appropriate for exploring a particular phenomenon in context.<sup>29,30</sup>

This interview study is based on interviews with adult survivors of sexual abuse. All had experienced how undergoing dental treatment triggered reminders of sexual abuse,<sup>31</sup> that the dental appointment was a volatile base requiring predictability and a levelling of power to be acceptable to attend<sup>32</sup> and that the sexual abuse experience had negative consequences on oral health.<sup>17</sup> The aim of this study was to analyse, from the perspective of adults with a history of sexual abuse, the impact of the experience on their general health and well-being.

## 2 | MATERIALS AND METHODS

The research team included EW, an endodontist, and author of several previous scientific publications with a qualitative approach. She is involved in undergraduate and postgraduate education on the topics of men's violence against women and violence in close relationships, with associated external engagements. GP is a psychologist with extensive research experience in child sexual abuse and experience in research based on qualitative data.

The following absolute inclusion criteria were applied for strategic selection of informants:

- A Has experienced sexual abuse as a child or adult
- B Is or has been receiving psychological treatment for the sexual abuse experience
- C >18 years.

Eight informants contacted the first author (EW) after listening to a podcast (comprising a conversation between the dentist (interviewer to be) and a psychologist in private practice as to how or if an experience of sexual abuse might have an impact, not only on dental attendance but also on oral and general health). Alternatively, informants, after reading written information, contacted the psychologist's website. Four informants were recruited through contact with a retired midwife who had specialized in treating drug-addicted, sexually abused women. One informant contacted EW at an official event. Another 5 potential informants were contacted via their therapist or via a contact centre for the sexually abused. Three declined to participate and two did not respond, leaving 13 informants in all.

An initial individual meeting was scheduled (two on Skype), at which each of the 13 informants was provided with verbal and written information. On this occasion the informant was encouraged to ask any question about the study and the interviewer was given the opportunity to confirm that the inclusion criteria were fulfilled, and that sufficient depth could be achieved during the interview. The contact details of each informant's therapist were noted. If the informant did not currently have a therapist, measures were taken to arrange this ahead of the scheduled interview. EW also contacted the therapist in advance of the interview. The offer of two therapy sessions, to be financed by the research grant, was accepted by 4 informants. Another 6 informants scheduled a session with their current therapist, but without burdening the research grant.

EW conducted all the audio-taped interviews in a non-clinical environment, either at the Faculty of Odontology, if convenient for both parties, or at a location chosen by the informant. All informants signed an informed consent form. The interviews were conducted between April 2017 and May 2018. The duration varied from 41 to 93 minutes. The interview topics were:

- Please describe, in as much detail as possible, one or more dental appointments at which you were reminded of sexual abuse you have experienced

- How do you perceive the effect of sexual abuse on your oral health?
- How do you perceive the effect of sexual abuse on your general health and quality of life?

The interview technique encourages informants to present their specific stories and experiences in their own words and from their own perspectives. Follow-up questions were asked in order to enhance reflection and development.

Qualitative content analysis with an inductive approach was based on principles formulated by Graneheim & Lundman.<sup>33</sup> The interviews were transcribed verbatim by an authorized medical secretary. The transcripts were scrutinized and supplemented by EW.

- The transcripts were read through several times to get a sense of the whole
- The text was cut at the point at which a change in meaning occurred: *meaning units* were identified
- The meaning units were condensed into succinct formulations by excluding unnecessary words: *condensed meaning units* were achieved.

The informants' experience of how the dental setting triggered reminders of episodes of sexual abuse has been reported previously. It was concluded that dental appointments could cause a psychologically stressful reaction, a trauma-related reminder of the abuse. Some of the reactions are easily recognizable for dental staff, suggest that the dental setting be a suitable venue for disclosure of abuse, if questions were to be asked about experience of violence.<sup>31</sup> Also reported previously were the informants' perceptions of the attitudes of dental clinic staff and how they were received in the dental setting.<sup>32</sup> With reference to the informants' perceptions of the impact of the sexual abuse experience on their oral health, this also has been reported previously. It was concluded that maintaining oral health was challenging, not only emotionally but also because of barriers to daily self-care and regular dental attendance which the informants found difficult to surmount.<sup>17</sup>

The unit of analysis for this study was the perception of the impact of sexual abuse on general health and well-being. The meaning units covering this topic were identified and selected for analysis by EW. In one of the interviews (no. 4) the topic of this study was not addressed, an error on the part of the interviewer. The analysis is therefore based on 12 interviews (Figure 1). Each selected condensed meaning unit was analysed, focusing emotions and meanings with links to expressions in the narrative. A code was assigned, reflecting the central meaning of the unit (Table 1). When clustering the codes (EW and GP), varying patterns of the informants' experiences emerged. The interviews were re-read to enable a re-contextualization of the identified patterns. This emergent pattern, including variations, was classified into categories and subcategories (EW and GP) to communicate the descriptive (manifest) level of the

content. A theme covering the interpretative (latent) level of the content was also identified. The authors reached consensus about the identified pattern via questions, comparisons, and discussion. Quotations from the interviews, which were used as illustrations, were translated into English. The informants were not invited to comment on the transcriptions or provide feedback on the findings. One informant requested a copy of the transcript of her interview, which was sent to her. She did not, however, request any alteration to the text. The Standard for Reporting Qualitative Research (SRQR) checklist was completed.

The study was conducted in accordance with the 1964 Declaration of Helsinki II (version 2002 revision, [www.wma.net](http://www.wma.net)). The authorized secretary, who transcribed the interviews, signed a confidentiality form. A requirement from the ethical review board was that all participating informants should have, or be offered, contact with a psychologist or corresponding therapist. This was arranged and the Regional Ethical Review Board, City University, City, Country approved the study, Dnr 2014/780.

### 3 | RESULTS

Ten of the informants were women and two were men. They were aged between 19 and 56 and were single, married or cohabiting, with or without children. They were employees or working in private enterprise, students or early retirees. All informants had to some extent processed the sexual abuse they had been experienced. Some, but not all, described mental health problems such as anorexia, bulimia, self-injury or other challenging issues such as drug abuse, prostitution and imprisonment. All reported dental fear, most often severe.

The informants' experiences of sexual abuse ranged from sexual harassment, single episodes of abuse, or repeated abuse over several years, with or without penetration, to several months of captivity, being subjected to rape and sold for sexual services. Ten informants had been exposed to childhood sexual abuse, two only as adults and eight as both children and adults. The informants reported abuse by one or more perpetrators. Most of the perpetrators were acquainted with the victims. There were female as well as male perpetrators.

The analysis identified an overall theme covering the latent content, labelling the impact of sexual abuse on general health and well-being to be *Sexual abuse experience—limiting long-term consequences, always present in body and mind* (Table 2). Sexual abuse, in the form of isolated or repeated episodes, is perceived, explicitly or implicitly, as having a lifelong limiting impact on life and health, both mental and physical. Thus, both life conditions and health can be regarded as being filtered through the abuse experience.

*It's there within me, even though it is in fact ..... Yes, it is in fact 45 years since I was subjected to it. [...] It is not the sort of life you would wish on anyone else.*

(Interview 9)

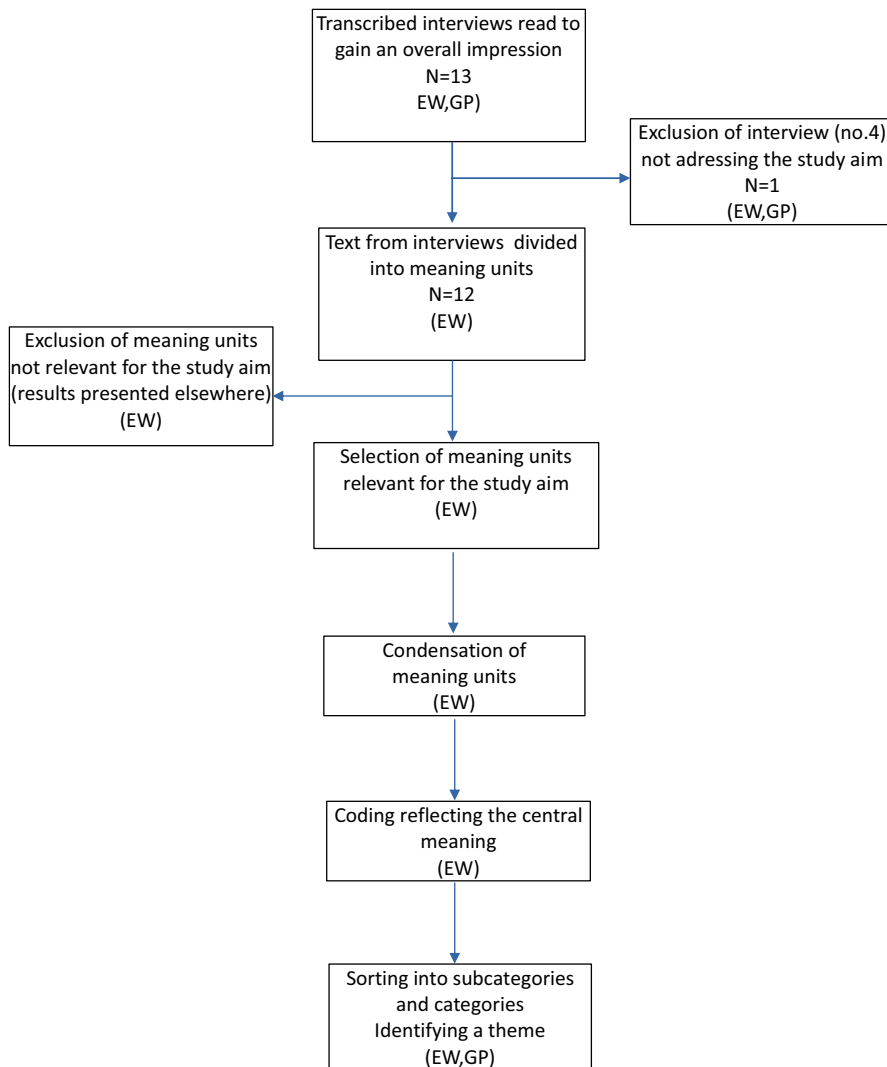


FIGURE 1 Flow chart of informant recruitment process.

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

Meaning unit	Condensed meaning unit	Code	Subcategory	Category
<i>I was in fact nothing. I was just a wet patch on the floor .... I had no ... self worth.... I didn't love myself and I didn't enjoy life and I just wanted to die ..... Eh... .. I spent a lot of time in therapy and was given different pills ... for depression and God knows what else. And nothing worked</i>	I was nothing, had no self worth I didn't love myself, didn't enjoy life, wanted to die. I spent time in therapy, was given pills, nothing worked	Self-devaluation	Emotional repercussions	A lost foothold

Note: One meaning unit condensed into more succinct formulation, that is, a condensed meaning unit is visualized with the corresponding code, subcategory and category.

Sexual abuse experience—limiting long-term consequences, always present in body and mind	
The lost foothold	The significance of distance to trauma
Emotional repercussions	Keeping of distance and tending to escape
Physical health repercussions	Processing the trauma experience—a struggle towards balance

TABLE 2 The identified pattern described in a theme, covering the latent content and categories, subcategories, covering the manifest content.

## 4 | A LOST FOOTHOLD

The first category covering the manifest content was: 'A lost foothold', which could be described as related to different negative consequences for health: emotional (first subcategory) and physical (second subcategory), all of which permeate daily life long after the abuse has stopped.

### 4.1 | Emotional repercussions

This subcategory contains exclusively negative emotions, notably a lack of security and an apparent lack of self-esteem.

*I was in fact nothing. I was just a wet patch on the floor. ... I had no ... self- worth... I didn't love myself and I didn't enjoy life and I just wanted to die. Ehh ..... I spent a lot of time in therapy and was given different pills ... for depression and God knows what else. And nothing worked.*

(Interview 7)

The low self-esteem resulted in a general lack of trust, making it impossible to trust other people. It also had the effect of diminishing one's own sense of worth in different situations.

*I can in fact see it, how ... how stagnated and how small I have made myself through all these years.*

(Interview 13)

The abuse experience has led to mistrust, especially towards men, due to the harassment in a relationship. The informants described how as adults they lacked enough energy to build a relationship or make a conscious choice to live alone.

*Yes ..... In fact, that is what one ... in fact one has felt that one hasn't been able to trust them. And just the fact that there has been maltreatment in these relationships.....*

(Interview 3)

The informants also had obvious difficulties in determining their own limits, of accepting that good things can happen or, on the other hand, of feeling that they had no boundaries, and were not able to protect themselves.

*It has affected all my life..... Partly this feeling of being so totally alienated. So I have really tried to belong all the time, and this has also meant that I have like renounced myself. Yes, I have opened my boundaries completely. Anything just to belong.*

(Interview 13)

This subcategory also includes feelings of shame and guilt about being abused, as well as such insecurity that they felt unable to disclose the abuse experience during consultation with a therapist.

### 4.2 | Physical health repercussions

The explicit expression of the abuse experience emerged as neglect of self-care and an unhealthy lifestyle with a negative impact, not only on health, but also with a huge impact on the whole of life.

Informants also described how a sexually suggestive look and comments from the perpetrator about their body were perceived as threats and caused a physical response.

*Just the threat of him being able to do something to you. So the only thing he did was that he in fact sexualised me throughout the whole of my growing up. Looked at me in a sickening way, sent like signals... Ehh ... could also put it into words when I was a little older. And commented on my body and things like that. Ehh .....So then I started to conceal my body.*

(Interview 10)

The physical consequences were described as an enduring suppression of the informant's own physical needs. This could also manifest itself as making things worse for oneself, exposure to danger on repeated occasions or even not allowing oneself to rest.

*So that both the fact that I associate the bed with the abuse, but also that in a bed you rest and relax and recover. I haven't been able to allow myself to do that either.*

(Interview 11)

Muscle tension in different parts of the body was described as a consequence of protracted duration of the abuse.

*It is probably more this pain, things like that, I believe. That the tension in my body and... (...) Especially for the tension like .... it is in fact.... Yes, shoulders, and to .... and then, my head is in fact absolutely tensed up. You get like tension headache and.... And if you don't breathe properly that can also give you a headache. Ehh ..., so much of this has led to one not feeling well ... in your body.*

(Interview 6)

Apart from the emotional and physical sequelae of sexual abuse, financial stress was also a common reason for not seeking dental care and thus a barrier to maintaining or attaining oral health. Some informants stated that their oral health had also been directly affected

by the abuse experience: they had great difficulty in keeping dental appointments or maintaining good oral hygiene and this has led to poor oral health and difficulty eating.

*I avoid going to these health checks ... I mean these recall notifications that one gets. Yes, from health ..., dent ... dental health. Yes, eh ... because I become ... I become physically ill ... and I can't bring myself to get on my way. And that also means that ... a little hole can in fact be big the next time. And it ... it influences both my wallet and ... and like yes, my oral health then. Ehh ... So that it ... yes ... if it hadn't been for the abuse then I might have had good oral health, but in fact I haven't.*

(Interview 11)

The feeling of being trapped which the informants experienced in the dental chair meant that they ignored recall notices for dental check ups, thus their oral health deteriorated further.

## 5 | THE SIGNIFICANCE OF DISTANCE TO TRAUMA

The second category covering the manifest content was 'The significance of distance to trauma'. The category covers behavioural consequences (first subcategory) with shielding from the traumatic experience and memories, but also to other human beings, physical and emotional in different ways. The category also covers the results of processing the trauma (second subcategory), that is, a better balance and quality of life, facing the consequences and improving well-being.

### 5.1 | Keeping a distance and tending to escape

In order to maintain emotional distance from the trauma, the informants described adopting what might be labelled extreme behaviour. This could mean unhealthy food, intense focus on herbal remedies and health food products or an eating disorder, in order to achieve the desired result: relieving anxiety.

Drug-induced escape was mentioned in the context of others' inability to confront and 'see' the informant and also their own wish to neglect their well-being.

*I was so afraid that it (the abuse experience) was going to come out. And the heroin had in fact helped a great deal with ... That it is in fact the way it is. [...] The anxiety disappears; your emotions become blunted in that way.*

(Interview 2)

The informants described an early start to addiction during childhood, in parallel with the early sexual assaults and even multiple use of different strategies to numb their discomfort.

*I have used food, I have used sex, I have used shopping, I have used... In fact I'm addicted to bloody everything. To deaden, to deaden, have a little ..., a little.... Perhaps a little moment of happiness.*

(Interview 5)

Self-harm of different kinds was described, like not caring at all that something bad might happen or deliberate exposure to danger. More direct self-harm behaviour was also mentioned, with respect to having sex, cutting oneself and attempts to commit suicide.

The sexual abuse experience was also described as having caused repeated destructive behaviour, repeated relationships with abusive men and also a tendency for the next generation to copy the behaviour. Another way in which the tendency to escape manifested itself was through dissociation, including in everyday life as well as during dental appointments.

In everyday situations, the informants described having a persistent urge to sit close to an exit or to look for escape routes. They also avoided undergoing dental treatment for fear being reminded of the extreme vulnerability that the abuse had entailed. In the dental setting, this could trigger an aggressive outburst, as had happened before. With reference to the dental setting and the urge to escape, the informants stated that during the abuse, they wanted to run away, but were unable to do so. However, with a dental appointment there were some options; you could avoid making an appointment, you could repeatedly leave late cancellations or fail to keep a scheduled appointment, or even leave during treatment when traumatic memories were triggered.

The difficulties associated with close relationships and bodily contact could be addressed by training with a physiotherapist. There were also barriers to having sexual relations with a partner and repeated (surprising and even more unsuccessful) attempts to reject a partner who against all odds was staying.

Informants expressed great sadness at a decision made on the bases of an incorrect initial assumption, taking the initiative to leave one's children in the care of other people.

*But just the fact of making a decision from ..., from the wrong perspective has probably been that ..., the greatest grief and the biggest part... of it. [...] ... and I felt that when I couldn't look after myself, then I couldn't care for them either. So it was .....out of love.*

(Interview 13)

The informants also described many difficulties in daily life, implying that the subject avoided dealing with processing the trauma. The strong need to have control and to search for a balance in life could manifest itself as compulsive behaviour.

## 5.2 | Processing the trauma experience – a struggle towards balance

This subcategory revealed the positive effect achievable by disclosure of the sexual abuse and processing the traumatic experience. The informants described experiencing relief from physical ailments, such as muscle tension and pain.

*I have in fact had that (jaw pain) such a lot. Ehh..... And it...., it is also in fact...., one doesn't understand that before you experience how it feels otherwise, or you find out that it shouldn't be like that. .... So when it started to ease, I just said "Oh, is this how your jaws are meant to feel?" Yes ..... And I am more aware today when I start to feel that I am perhaps not expressing my real truth or don't set boundaries ....., and then I tense up immediately.*

(Interview 13)

The informants also reported that following disclosure and processing of the abuse experience, other conditions such as obesity and diabetes had subsided or abated.

*I feel happy .... \*laughs\* ... that I have made this journey ....., and I have lost 75 kg in weight. I have taken the weight of the whole of me off my shoulders. And I'm free of diabetes.*

(Interview 1)

With reference to maintaining sexual health, making an appointment with a gynaecologist could be a tremendous challenge, but could also be overcome after psychotherapy. However, with respect to dental appointments, barriers persisted.

*It has taken a long time ..... to come as far as I have. And it ....., it has needed many hours of therapy. Ehh... I have in fact had to have ..... therapy in order even to be able to get into the chair for gynaecological examination. [...] Now it works ....., much better than going to the dentist.*

(Interview 11)

Before the traumatic abuse experience had been processed, difficulties also arose with respect to close bodily contact. After several appointments with a physiotherapist, the informant was able to endure bodily contact without discomfort and able to breathe comfortably. Although having anyone touch their head and face was still repulsive, they reported some progress.

*Earlier I would hardly allow anyone even to touch me. I mean, without making a big scene. So that it ... yes .....*

*It isn't really like that now. No....., now I can manage to hug at least.*

(Interview 12)

There was grief over previously lost friendships but also reassurance that change is possible.

*Have sort of lost all my mates and ..... Ehh ..., it is only now that I am starting to rebuild my life.*

(Interview 8)

Also clear was a belated realization that, at least in parts of the world, there is some good, after all.

The informants longed for the positive effect of processing past devastating experiences, but there was also awareness of the bodily memories to be dealt with and that the process takes time.

*I want it to go more quickly. Ehh ..... But my body decides for itself in fact.*

(Interview 10)

Thus, the informants acknowledged that progress could not be hurried, but they perceived the potential to (re)gain a better quality of life following therapy or processing the trauma experience in other ways.

## 6 | DISCUSSION

The informants' own perspectives disclosed experiences affecting the individual in different ways but also the individual's relationship to the social environment. It was clear that experience of sexual abuse was perceived to have insidious long-term effects and an all-embracing impact on emotional and physical health, private life and social activities. Thus, the legacy of sexual abuse pervades all aspects of the survivors' everyday life. However, the interviews also revealed that processing the trauma offered a pathway to eventual relief. This reinforces the opportunity of dental professionals to contribute to facilitating disclosure and to offer trauma-informed care that facilitates for sexually abused persons to receive dental care.<sup>32</sup>

Health and social consequences of the abuse experience were reported and can be discussed from the perspective that sexual violence is one of the deepest violations of an individual's human rights,<sup>34</sup> partly attributable to a putative difference between bodily and sexual integrity, where the latter is considered to be the most intimate.<sup>35</sup> Rape in particular, is therefore often perceived as more humiliating than other forms of physical violence. This might also, in part, explain why an allostatic overload,<sup>36</sup> caused by toxic stress, induced by sexual abuse, is reported to be one mechanism underlying negative health effects, as several body systems such as immune

response and hormonal activity are affected.<sup>18,19</sup> Toxic stress thus has a detrimental effect on multiple brain structures and functions, resulting in impaired health and well-being, especially if the trauma was experienced during childhood.<sup>37</sup>

The strategy of keeping ones distance as an escape behaviour can be addressed from different perspectives. Daily living events, usually considered quite normal, were avoided and perceived as somewhat threatening, as previously reported.<sup>38</sup> The informants in this study also described emotional escape and attempts to relieve anxiety by using, for instance, drugs and unhealthy food. This is in accordance with previous reports.<sup>11</sup> Such behaviour could be interpreted in terms of the concept 'protecting armor in daily life', developed by Torp Stensvehagen et al.<sup>38</sup> referring to the strategy of shutting out stressful thoughts and locking in stressful memories and emotions.<sup>38</sup>

The concept of escape is also relevant to the dental perspective and is reflected in the reported tendency to avoid dental appointments<sup>32</sup> followed by difficulty in maintaining good oral hygiene. The sequelae are poor oral health and difficulty in eating.<sup>17</sup> Poor oral health is reported to have a negative impact on quality of life and thus on well-being.<sup>39</sup> As mentioned above, both eating disorders and drug abuse are reported to be correlated with poor oral health<sup>40,41</sup> and thus, well-being. These conditions should be considered in relation to dental treatment planning. Failure to take a thorough dental history and not seeking to support sexually abused individuals with dental fear and poor oral health, might also be regarded as a breach of the requirements of The Swedish Dental Care Act.<sup>42</sup> This law stipulates that the goal of dental care is to ensure good dental health and dental care, on equal terms, for the entire population. Dental care must also satisfy the patient's need for security when undergoing care and treatment.<sup>42</sup> For adults with a history of sexual abuse, this requirement is not being met.

Dental fear<sup>43-45</sup> and poor oral health<sup>46</sup> are well documented in people with a history of sexual abuse<sup>46</sup> hence their dental treatment can be not only more complex but also more time-consuming. This raises the issue of health economics with regards to this patient group. Fees for dental treatment are charged for items of service rather than for interpersonal consultations between patient and dentist.<sup>47</sup> For patients with dental fear and a history of sexual abuse, this approach to delivery of dental care is highly questionable. In order to provide a dental experience which is acceptable to the patient, it is essential that the dentist should address the person presenting with the disease and not focus solely on the diseased body part (oral cavity).<sup>32,48,49</sup>

Maintaining distance is also considered relevant in daily life after processing the trauma, in an effort to leave difficulties behind, at least partly. This is in accordance with previous research<sup>38</sup> which among women noted three stages of development after an experience of sexual abuse: (1) avoiding and escaping—coping, (2) accepting and disclosing—starting a process of recovery, (3) reconciling and repossessing—living with the experience. The key factor facilitating progress from Step 1 to Step 2 and subsequently to Step 3, was disclosure of the sexual abuse experience.<sup>38</sup> In accordance

with previous reports,<sup>34,50</sup> this further reinforces the need for disclosure in order to minimize negative consequences and to support recovery. Thus, not only general health professionals but also dental professionals should question patients about exposure to violence. This provides an opportunity for appropriate referral for trauma processing. It is reported that neither patients seeking medical<sup>51</sup> nor dental care<sup>52</sup> generally object to questions about exposure to violence. Health care providers are also reported to be more prone to ask questions about an experience of violence if they have received education on the subject.<sup>49</sup> The WHO recommends that such education should include basic knowledge of the impact of an experience of violence and also how and when to ask questions.<sup>50</sup> It is important to note that it is not enough to ask the patient about experience of violence, a good outcome also requires a clear strategy for following up and referring the victim of violence for adequate support and treatment.<sup>53</sup>

To access the informants' subjective perspective of the phenomenon being investigated in a systematic way, qualitative content analysis<sup>33</sup> with an inductive approach was chosen. This approach to analysing qualitative data is reported to provide valuable insights into an individual's experiences.<sup>54</sup> The informants' varied experiences of sexual abuse and molestation, social background and life experience favoured broad access to information. Although the number of informants (12) might be considered limited, this does not necessarily invalidate the findings.<sup>55</sup> Nor does the size of the selection group determine the transferability of the results: it is, however, essential that the informants have experienced the phenomenon being investigated and can give detailed descriptions.<sup>56</sup> Such was the case in the present study: it was considered that and saturation was achieved. Indisputably, the informants' narratives were filtered through experiential lenses developed over time, and as a consequence of such interventions as psychological and sometimes other therapy. However, rather than presenting definitive answers, the results further support earlier research, that experience of sexual abuse should not be considered as an isolated event: it permeates the survivors' entire existence.<sup>6,57</sup>

Sexual abuse cannot be understood in isolation, but as a traumatic experience with pervasive, insidious long-term implications for the daily life of the people exposed. In this context the dental team has a potentially important role in facilitating disclosure of abuse, because sooner or later, almost every person visits the dentist. After disclosure and processing of the trauma, the negative effects can be alleviated.

## AUTHOR CONTRIBUTIONS

EW conceived the study and design, collected the material, contributed to analysis, writing, editing, and critical review; GP contributed to analysis, writing, editing and critical review.

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sexology and sexuality studies, Malmö University, Malmö, Sweden. TePe Ltd., Malmö, Sweden.

### CONFLICT OF INTEREST STATEMENT

Both authors gave their final approval and agree to be accountable for all aspects of the work. There were no conflicts of interest.

### DATA AVAILABILITY STATEMENT

Data availability we cannot provide. At our application for ethical approval it was a definite demand that only the researchers have access to the digitally sound recordings and verbatim transcriptions of the interviews. This in order to secure the informants' anonymity.

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