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ORIGINAL ARTICLE

Torture victims' perspective on dental treatment: "Every sign you make, every move you take" – A qualitative study

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Abstract

Torture victims struggling with post-traumatic stress often experience elements in the dental treatment situation that may trigger trauma-related reactions. The aim of the study was to explore intervention strategies that will enable dental health workers to adapt dental treatment to the needs of torture survivors. Exploratory interviews were conducted with 10 torture-exposed resettled refugees with dental treatment experience in Norway. The data was analyzed using qualitative content analysis, which suggested that to minimize trauma-reactions, dental personnel should focus on creating a safe therapeutic space and strengthening the patient's sense of control. Four main categories of clinical advice were proposed: (i) Acquire knowledge about psychology, consequences of torture, cultural differences, trauma-informed care, and the patients' individual needs; (ii) Recognize the trigger-potential of busyness or delays; (iii) Avoid surprises, such as sudden moves or actions and explore triggers individually, but make sure not to evoke images of interrogation, and; (iv) Provide overview both with respect to visibility in the clinical room, and to predictability regarding the dental treatment. Although undergoing dental treatment may be challenging for torture-exposed individuals, it is possible to reduce the predicaments considerably by making feasible adaptions to the treatment and adopting a trauma-informed approach.

KEYWORDS

abuse, dental anxiety, dental fear, oral health, post-traumatic stress disorder

INTRODUCTION

Considering the flow of refugees to Europe over the past decade, all clinical dental health personnel are likely to encounter torture victims in their operatory from time to time. Torture prevalence varies between groups of forced migrants, but is significant, and with considerable impact on mental health [1]. Individuals suffering from traumatic life events, such as sexual abuse, violent crimes, or torture are more prone to dental anxiety and symptoms of post-traumatic stress disorder (PTSD) [2–5].

Torture, as defined by the United Nations Convention against Torture, comprises severe physical or mental pain or suffering that is intentionally and purposefully inflicted by a person acting in an official capacity [6]. Torture victims who struggle with dental anxiety and re-activation of trauma symptoms in the dental setting require a facilitated approach to dental treatment [7–9]. Trauma-informed care (TIC) [10],

which acknowledges the role trauma may play in the treatment process, is often recommended [11, 12]. However, most of the literature on TIC in dentistry has focused on survivors of child sexual abuse (CSA). In contrast to CSA-survivors, most torture victims have suffered their trauma in adulthood and are therefore more likely to be familiar with dental treatment before being subjected to torture. Hence, they are more likely to be able to reflect on the differences between their torture experiences and the dental treatment. Moreover, many torture victims have grown up experiencing a normal attachment development, and thus do not suffer from the developmental disturbances often observed in CSA-survivors [13].

The nature of dentistry entails temporarily placing the patients in a passive position where they may experience loss of control and feel helpless, in order to facilitate the dentist´s working conditions. Thus, the person undergoing treatment is temporarily rendered an object (patient) of the subject (dentist) performing treatment. These particular characteristics of dental treatment are not addressed in guidelines on general care for torture victims [14]. On the other hand, these general guidelines should be of important concern to the TIC-approach to provide dental care to torture survivors, such as avoiding situations reminding of interrogations, considering use of interpreters, and being aware of cultural differences in the understanding of mental health [14].

Dental anxiety in torture victims has been shown to correlate strongly with PTSD-symptoms [5], but to our knowledge, research on treating dental anxiety in patients with PTSD-symptoms have focused on individuals with PTSD-symptoms related to traumatic dental treatment experiences. Thus, the results cannot be readily generalized to trauma due to torture or sexual abuse [15–16]. Moreover, previous research and advice on providing dental treatment to torture survivors has largely been based on the experiences of the caregivers. Consequently, there is not enough empirical evidence to specify clinical recommendations or to develop guidelines for dental treatment of PTSD-patients [17].

Dental treatment will most likely consistently be associated with difficulty for torture survivors. It is however presumptively possible to reduce these challenges considerably by identifying individual triggers and making relatively minor adjustments to the way treatment and clinical communication is performed in the operatory. Thus, the aim of this study was to explore feasible intervention strategies for adapting dental treatment to the needs of torture victims.

MATERIAL AND METHODS

Ethical considerations

The study did not involve any clinical interventions. Nevertheless, for traumatized individuals, being reminded of their horrible experiences, and being asked to reflect on them, may bring about unwanted reactions. The study was conducted in close collaboration with the recruiting clinics, where assistance from psychologists was available if needed, and where the research participants already had, or would receive, adapted and free dental treatment. Moreover, the interviewer was experienced in working with torture survivors and with treating dental anxiety, and she was focused upon being attentive to early signs of traumatic reactions, and to be prepared to handle such reactions should they occur. She was careful not to put any pressure on the informants and to avoid active probing into their trauma experiences. Informants were moreover informed of their right to withdraw from the study at any time without detriment to them and without stating a cause and were invited to contact the interviewer should they have questions or need guidance after participation in the interview. The project was approved by the Norwegian Ethics Committee (2015/2154/REK South-East C).

Study design and participants

A qualitative study design was employed using semi-structured, exploratory interviews with refugees resettled in Norway, in the period between April 2019 and January 2020. All the research participants had experiences of dental treatment after resettlement, some at specialized dental clinics for individuals exposed to torture, abuse or who have dental anxiety (TADA) [18], and some in general practice. All the latter were on the TADA waiting-list, and all informants were recruited by professionals affiliated with TADA clinics. All included informants were of legal age (≥ 18 years), had been subjected to torture, and had experience with dental treatment subsequent to their torture experiences.

Due to the relatively high degree of traumatization in the research population, a low consent rate was expected. The aim was to recruit 10–15 informants, aiming to maximize variation within the limited sample with respect to origin, age, gender, torture experiences and dental treatment experiences.

In total, 10 informants, 8 men and 2 women, agreed to participate and signed informed consent forms. Age ranged from 28 to 65 years, and residency in Norway from 4 to 30 years. Four informants who originated from Iran or Iraq had all had yearly dental check-ups and treatment in their home countries, and two Eritrean informants had one encounter each with emergency dental treatment prior to their torture. None of these six participants had memories of anxiety reactions associated with these dental visits. The remaining four informants, who originated from Syria (2), Somalia, and Eritrea, had no experience of dental treatment, or memories of having dental anxiety previous to their torture experiences. Following their torture experiences, all informants reported some difficulties with dental treatment,

and half of them disclosed reactions reflecting high dental anxiety.

A wide range of known torture methods were represented among the research participants including infliction of physical pain (e.g., by strokes, kicks, suspension, electrical currents, and tooth extractions), deprivation (e.g., of sleep, light, food, personal hygiene), surprise attacks and interrogations, water torture, choking, and having to watch others being killed or tortured.

All interviews were conducted by the first author in non-clinical settings chosen in agreement with the informants. Three interviews were conducted in Norwegian, two in English, and five in the informants' native language assisted by professional interpreters. The decision to conduct the research interview in a second language or with the assistance of an interpreter was made based on thorough, individual assessment, and in accordance with the preferences of the informants. The interviews were audiotaped with consent.

The interviews aimed to explore how torture survivors prefer, or need, to be met in the dental setting. An interview guide was developed based on prior knowledge and experiences in pursuit of that aim, comprising of six thematic areas: Expectations of what would happen, confidence and trust issues, security in the dental setting, dental anxiety, satisfaction with treatment and caregivers, and the distribution of tasks and responsibility between the dentist and the patient. The guide was applied as a checklist, not as a fixed structure for the interviews, which aimed to elicit and pursue the informants' reflections [19].

Qualitative data analysis

Analysis of data was performed using a qualitative content analysis approach which entails classifying the data into categories aiming to represent what is communicated by the informants, explicitly or implicitly [20]. Some of the informants' statements point to more themes than those extracted and are presented to illustrate each case in the text, as is practically always the case in analysis of qualitative data. The audiotaped interviews were transcribed verbatim in the language in which the interviews were conducted, and anonymized by the first author, hence all names in the result section are fictive. Next, the first author reviewed the transcriptions thoroughly, some in English and some in Norwegian, and suggested preliminary codes, all in English, corresponding to recurring topics. Thenceforth, the material was assessed by all co-authors, resulting in the development of themes through coding, re-coding, and grouping of themes, combining bottom-up coding frameworks with themes corresponding to the thematic areas of the interview guide. The authors found no gain in computer-based coding as they developed a closeness to the relatively small amount of material.

RESULTS

All informants talked about oral health problems directly or indirectly stemming from their torture experiences, and for half of them these consequences had impacted their quality of life substantially. They described how dental pain may be excruciating and unbearable, and affect their ability to eat, to relax and sleep, to clean their teeth, and even to concentrate on everyday activities. Some also described how lacking teeth in visible areas, or bad breath from oral infections had made them restrain from socializing with other people, and one had trouble speaking clearly due to malfunctioning dentures.

All informants described perceived barriers to seeking and receiving dental treatment, and half reported to be highly dentally anxious. Through their narratives it became apparent that to submit to dental treatment, and the temporary objectification it entails, may be highly problematic, involving debilitating sensations of uncontrollability, unpredictability, and powerlessness.

Farouk (55) disclosed that he was subjected to "*all available torture methods they had in Iraq.*" The following passage from his interview may represent and exemplify the adverse effects of loss of control, and the perceived parallels between the dental consultation and previous torture experiences that were implied by several of the informants:

> Farouk: "You sit there… and suddenly he does like this with your head!"
>
> Interviewer: "Oh, yes… he touches your forehead and bends your head backwards?"
>
> Farouk: "Yes! And then he starts approaching… Very dangerous when he is sitting behind me… and such… Like he is going to hit me! Or when some employees are coming… talking to the doctor… talking behind my head… And then it all gets mixed, and I get scared… My body starts doing 'this'…"
>
> Interviewer: "You start shivering?"
>
> Farouk: "Yes, right away… and then he fetches the thing they are hanging here."
>
> Interviewer: "Yes, the bib around your neck?"
>
> Farouk: "The bib, yes… You know, when I was convicted I had to watch them hang people…

and help them throw them in the car… to let them die…" (He starts crying)

Interviewer: "Ohh… I'm sorry… You don't have to tell me in detail…"

Farouk: "…and suddenly he… here… and then he directs that light from underneath, and…"

Interviewer: "The dentist?"

Farouk: "Yes, and then he is rough with the mouth, and then… with the machine: Brrr, brrr, brrooooo… up and down… He must tell me that he is going to do it!"

He illustrated how being surprised, startled, or rushed by the dentist's actions, or feeling insecure of what is going to happen next, could set in motion unwelcome physical and/or mental reactions. His neck started burning, and his stomach ached. He described how he experienced flashbacks of previous hurtful experiences, and how he believed his dental treatment was significantly complicated by his dentist being unaware of his torture history.

The informants in this study all gave voice to the experience of being particularly sensitive to loss of control, and its capacity to undermine perceived safety and trust in others. Gebre, an Eritrean man in his thirties put it into words:

"A person needs this… this level where this person is mentally ready and feeling comfortable. So… every sign you make, every move you take – it affects the way the person gets comfortable!"

Their experiences differed, however, as did their abilities and ways of coping, which highlights need for flexibility in the treatment of these patients.

Reflecting the content of the interviews, the adverse phenomena experienced by patients undergoing treatment is presented under four subthemes, exploring how clinical practice may be adapted by dental personnel working with torture survivors in order to mitigate the impact respectively: (1) Fear that the dental practitioner does not know and understand; (2) Distressful experience of time and tempo; (3) The anxiety of surprise, and; (4) The horror of losing overview.

Fear that the dental practitioner does not know and understand

Particular aspects of the interplay between dental practitioners and patients seemed to have the potential to activate traumatic reactions. Aaden, a Somalian man in his forties, who had no dental treatment experience prior to his torture experiences, said:

"He thinks you are just normal, and he doesn't think you have any problems or anything, because he doesn't know you. Then… and you can't tell him your background and your problem. Soo… you just try… (the dental treatment), then it's… the worst nightmare!"

His first dental appointment in Norway 17 years ago was his very first experience with dental treatment. He had to have two teeth extracted, and the taste of blood triggered a flashback of his previous torture experiences. He felt that the dentist did not understand what was happening – that he saw him just as every other patient. He believed it was not in the dentist's thoughts that his patient might be a torture survivor, and thus he lacked insight in how to help him. This episode made Aaden fear and avoid dental appointments for years to come. Eventually he had received more appropriate help. He explained how his current dentist was able to help him based both on his specific knowledge of Aaden's personal experiences, as well as his insight in the general needs of dental patients who are torture survivors:

"When I 'skip' sometimes, when I sit there, when I'm lost, he reminds me where I am, and which year I'm in, and… Yeah! And he tells me: 'Now you are not in that time – you are in THIS time! Norway – this year!' He makes it better: 'Yes, you are here! Now, now, now, now!' Then I don't skip too much. Louder he's saying: 'Now it's fine! Listen!' (Clapping his hands four times)."

The significance of the dentist's knowledge and awareness was also emphasized by Zahra, a busy, hard-working Iranian woman in her sixties, who reflected:

"I would look for a dentist who… has understanding. That is important! And who is familiar with… different situations. When you, for example, have been through torture… have been through prison, through war, through… Then we are not really regular people in the eyes of others – or in the eyes of ourselves, you know!"

She said that as long as the dental workers kept in mind that what she had gone through *"might suddenly come back,"* the treatment was manageable.

Reza, a highly educated man who had not been able to resume work after his torture experiences, talked about

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how his ability to trust in others had been broken down in prison. He emphasized the need to establish rapport before commencing on the treatment:

> "You must find a solution to make me trust you. You must be kind to me… normal behavior! Don't see me as a customer! You must make me trust that you will help me! It's not a relation between money and people – it's a relation to someone who gets help from you. What works very well for me… yes, before you start treating me, it's better that we talk with each other."

Through the interviews, it came forth that to earn the trust of torture exposed patients, the dental workers need to have knowledge about the individual patient, and just as important, they should have knowledge about the needs of torture victims in general. All the informants agreed that it is important that the dentist knows that they have a history of torture. However, how this information should be acquired was not straightforward. Many found it difficult to tell, as uttered by Iranian Amir (60):

> "It is difficult to tell… everything like it… to the dentist. Sometimes it comes – sometimes not… don't dare say anything… not one word!"

He was a victim of dental torture who expressed that *"to know the patient—know the story"* is a prerequisite for dentists working with patients "like him." Because his dentist knows what he has been through, and what may trigger reactions in him, he said, she is attentive to him and notices, for example, when he starts to shiver. He said that his dentist calms him down by putting her hand on his.

Farouk, who found it difficult to talk about his experiences, and cried a lot during the interview, expressed that the dentist ought to understand intuitively that a refugee patient may possibly be a torture victim. He said:

> "Those who come from countries at war… they have almost always experienced that… Prison! Torture!"

Still, he said he was quite certain that his dentist had not reflected on this. Zahra revealed that she felt that some dentists only saw the mouth and the needed dental work – that they didn't see her as a human being. To her, it was crucial to find a dentist willing to listen to her story, although she acknowledged that this might be a psychological strain for the dentist. She said that her dentist needed to be a person who was *"willing to endure some pain."*

Several of the informants acknowledged that the dentist may be hesitating to ask directly about torture experiences, for fear of triggering trauma-related reactions. Zahra suggested a more indirect approach:

> Zahra: "They can ask the patient: 'Is there more you would like to tell me? Are you willing to… if I ask you some questions?' And then, some say yes, and others say no."
>
> Interviewer: "But how will I dare… how should I ask, to retrieve these experiences?"
>
> Zahra: "For example, if I come to you, we say hello, and then we talk for a while. Then you could ask: 'Have you been through things that is a strain on you? Is it ok if I ask a bit more about that? Are you with me?"

If the patient was not ready to reveal their experiences, and information was not available from other sources, Farouk said the dentist might simply ask:

> "Are there any images that you don't like? Some things you don't like in my office?"

Some informants underlined the importance of interdisciplinary collaboration and would prefer a system where the dentist was informed beforehand, whether it be by social workers, physicians, or psychologists. Iranian Reza (57), for example, found it extremely stressful *"to explain over and over again."*

From the interpretation of the interviews, an approach may be proposed where the dentist shows understanding, and treats the patient accordingly, without necessarily talking explicitly about the traumatic experiences. This was exemplified by Aaden:

> "They must ask what he thinks, and about what he thinks about sitting in the chair, and what he thinks about treatment. And they must ask him what he thinks – and understand him. That's the most important!"

Distressful experiences of time and tempo

Both high treatment speed and long waiting time between appointments, or in the waiting room, came up as problematic to the informants. Farouk grew up in a wealthy family where he was encouraged to visit the dentist for routine check-ups. He had continued this habit after his resettlement, despite the reactions the treatment inflicted on

him. He had sought out a random dentist, and said about him:

> "He just works, works, works… so fast, fast, fast… It gets very dangerous!"

Throughout the conversation he repeated similar statements several times; *"Fast, fast, hurry, hurry, work, work, brrr, brrr (sound of drilling)."* What Farouk talked about represents two different difficulties with speed. Firstly, with the dentist's high work-speed, Farouk could not *follow*, only allow the treatment to *happen to him*. The speed accentuated his passive status as object, with little or no anticipation let alone control of the actions to which he was subjected. If he should have needed a break, the high pace even reduced his ability to communicate this to the dentist. Secondly, the dentist appeared busy and inattentive and, in Farouk's experience, focused mainly on finishing the dental work. To Farouk, this signaled that he did not want to be disturbed. In a further example from Farouk, the following quote refers to an appointment where he had a dental bridge prepared without being offered anesthesia:

> "Yes, sometimes it's painful. He does it fast! When he does it fast, sometimes I'm in a lot of pain. He must work more slowly! But I don't know why he… Every time I go there and sit… he shows up late… And then, in 15 minutes he is done!"

Farouk's traumatic reactions, which he referred to by saying *"it gets dangerous,"* were described in a previous section. The associated physical and mental manifestations of distress not only affected him during the treatment session, he explained, but could last for 2–3 days beyond every appointment.

Yet another recurring theme related to the experience of inconsiderate treatment was the importance of keeping time. Zahra said:

> "I've been there twice when the dentist was delayed. The first time I got very, very angry, and… shivering and such…"

Several informants expressed that observing other patients in the waiting room was distressing, and that delays signaled that they were not seen as important patients by the dentist. Farah (55), who used to be a businesswoman in Syria, was also frustrated by the duration of the treatment process:

> "There is one thing that is very tiresome… that they need so much time to finish the job. And the time between each appointment is very, very long. You don't need to go to the dentist for two or three years – it is better to do it as soon as possible! But they can't do anything… But it may be because I get free treatment, that this is the reason… But I'm not sure."

Aaden put forward that one dentist he saw previously, used to clap his hands when he was finished, and say: *"Your time is up—time to go!"* He had reached the conclusion that he needed to go to a dentist who was *"patient and understands the patient!"* Farouk related his dentist's hurry to the fact that he did not know his story. He thought that if he knew, he might work and act a bit slower. But he found it difficult to tell him, since it appeared to him that the dentist didn't have the time to listen. He exemplified:

> "He doesn't have the time… he… quick, quick, quick, is fixing… He just… works with the machine: trsssssss… just washing, like that – and cleaning." "You know, when people don't know you – and he doesn't know me… so he just wants to finish… 15–20 minutes!"

To conclude from the informants' narratives, they expressed that it is important that the dentist is aware of the power inherent in controlling other people's time. Dental professionals might take into account that spending some extra minutes in the beginning to build trust and establish rapport, may save both the patient and the dentist a lot of time and agony later in the process. Similarly, having to wait too long for treatment may be perceived as not being worthy of prioritization.

The anxiety of surprise

The unforeseen nature of stressors that occur in treatment settings may cause anxiety. Reza said that his consistent feeling of being unsafe is particularly aggravated by this unanticipated aspect of his dental treatment experiences:

> "Always, always, I feel unsafe! But when it comes to treatment – then I'm very afraid! I have anxiety, still. Because, when they come and put on that cloth (the bib)… or if it's a tight sweater… or a tie… I can't have it! Because I'm very afraid, I get anxious, and the flashbacks come back!"

He said that unprepared sight of certain dental equipment may trigger flashbacks – mental re-experiencing of torture episodes, and revealed how his prison guards used forceps to remove nails from his hands and feet. Several informants talked about mental reactions to sudden sounds or actions behind them, and Zahra said:

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> "After being in prison, I had such a fear of water! Because they tried to choke my head in water… and such things…"

The informants' examples of what could destroy safety and trust and set in motion trauma reactions in the dental setting were pervasively related to situations where things happened that they could not foresee or control, situations where many signs were present that pointed to danger, pain, and the memories of danger and pain. Potential reminders of previous traumatic experiences that came up repeatedly during the interviews were sudden or unexpected pain or procedures, unforeseen movements or positioning, dental equipment and machines, water, blood, light or darkness, anesthetics, or insensitive, inattentive, or hastening dental personnel.

The importance of knowing that the patient is a torture survivor, which was highlighted in a previous section, is closely related to the need for exploration of individual triggers to avoid negative surprises and further psychological traumatization. The objective is not to pry into the details of the torture experiences, but rather to explore which aspects of the treatment situation are particularly distressing to the patient in question.

The taste of blood brought about reactions in Aaden. He said it brought him back *"to times of bad things."* However, his current dentist was aware and understanding, and helped him avoid being surprised by his worst trigger:

> "This guy, he takes care of the blood – I don't taste it. He puts something on both sides and tries to control that the blood doesn't come in my mouth."

All informants stressed the importance of being informed about what will happen before it did. Knowing offered them a chance to prepare their body and mind, as exemplified by Amir and Farouk:

> "I would like… everybody does, that they tell me what they are going to do. I must prepare myself if there's going to be anesthetics! It's natural for me to get anxious when I… syringe… anesthetics!" (Amir)

> "I must give the message to my head. Then my body, my head, will not hurt. But he just ts-ts – he says nothing, then finished… fast-fast-fast… So, I get very tired (meaning mentally exhausted)!" (Farouk)

Hence, they did not want to avoid the procedures, rather to not be surprised by them – to know of them in advance. Moreover, knowing also entailed the possibility to stop if they did not agree with what was going on. Zahra said:

> "I need to know the details… to know it: I have the power! Like… that they don't suddenly pull out the tooth, or does damage to… That it is what is supposed to be done, you know!"

Aaden also underlined that it had taken a lot of time and effort for him to build trust in his dentist, and for them to work together to explore his triggers. As a result, what happened during his dental appointments was predictable to him, as long as he was seeing the dentist he knew, and who knew him. He said that having to see a new dentist would be challenging to him, a view that was supported by several other informants.

Most informants disclosed that they had difficulties with trusting other people. Thus, abrupt behavior could surprise the patient and be misinterpreted as anger or aggression. Syrian Hamid had his very first dental treatment experience in Norway and compared the dentist's behavior with that of a police officer. He emphasized that dental professionals *"must never get angry or sulky in front of patients"* and that what was important to him was:

> "That he behaves well towards the patients… not stressed or nervous… takes one step at a time, for example. He must give me all the details before he starts!"

To sum up, the informants were consistent in highlighting the importance that the dentist and patient together have knowledge and ability to identify and minimize exposure to triggers, since the early warning signs that a traumatic reaction is imminent differs from patient to patient. The dentist may further avoid negative surprises and earn the patients' trust and confidence by informing about what will happen during every step of the consultation.

The horror of losing overview

Although most informants generally wished to avoid looking at the dental equipment, they all expressed the need for everything in the dental setting to be predictable, including, if possible, the predictability that could be derived from having a visual overview of the setting. Farouk's narrative exemplified how undesirable reactions were set off by people talking and acting from a position behind him in the room, as this recalled how, when in prison, the guards often snuck up from behind to torture him. He said that this happened in different settings, not only during dental appointments, and that to him, the remedy was to maintain visibility.

Hence, one dimension of having overview was about physical positioning in the clinical room and being able to see what is going on. Aaden, for example, said that he needed to keep his eyes open "*cause if I close them, I'm more 'going'!,*" meaning that he more easily disconnected from his thoughts and surroundings if he closed his eyes. Hamid was offered to wear sunglasses during dental treatment to avoid the strong light. He said:

> "When you are imprisoned, you get this… (demonstrates blindfolding) in front of your eyes. So, it's worse for me… Yes – those glasses remind me of… of the prison. They make it go dark!"

Another dimension of overview entailed how visibility promotes predictability. Seeing what *was* going on facilitated knowing what was *about to* happen. Gebre, who had recently studied to become a health professional, explained:

> "If maybe you are not prepared for this type of treatment… All the machines that will come, and… you will see… and you will be below the dentist, and then… It's like you are powerless, you know!"

He said that as long as the dentist talked him through the treatment step by step, he felt safe. However, if overview was lacking, the risk for being taken by surprise increased, and consequently the risk for traumatic reactions.

Suggestions on how the dental personnel could safeguard the patients and provide oversight were put in words by several informants. Farouk started with the physical positioning of the dentist:

> "Don't go behind him – go with him! Or a little in front – not behind!"

Then he underlined that everything the dentist did must be visible:

> "He must show me what he is doing. Very, very important! Also, when we… when he tells me 'sit here', and that he tells me 'I will pull the chair down – or up.' He has to tell me… 'Be aware of the light – can you close your eyes? The light will come, so don't open.' Then it gets better – not so much pain in my stomach."

The informants seemed to highlight the importance of securing oversight, which involved the physical positioning in the clinical room, as well as the predictability of knowing what would happen before, during, and after the consultation.

DISCUSSION

This study explored dental treatment challenges in refugees subjected to torture, and how they prefer to be met by oral health professionals. It was salient that helping torture survivors undergo dental treatment entails increasing their control and agency in a situation where they, as all patients of dental treatment, must by necessity tolerate temporary suspension in a passive position as the objects of treatment. A lot of what the informants talked about concerned a need to counter the consequences of this objectification, that is, the need for carving out a measure of agency for the torture-exposed patient in the treatment situation.

As illustrated in Table 1, four themes stood out as especially important to achieve the integral sense of agency: (i) It is crucial that dental professionals are aware that the patient is a trauma-survivor, and that they have knowledge about TIC [10]; (ii) The potential negative impact of hurry or delays should be acknowledged; (iii) Surprises should be avoided, necessitating that triggers must be explored individually, and; (iv) The patient should always be given full overview regarding both visibility and predictability.

It was understood that the findings from this qualitative study were not generalizable. Instead, the intention was to seek out informants among torture victims who struggled with oral health challenges. Severe PTSD-symptoms may have refrained some torture survivors from participating. However, diversity was satisfactory with respect to gender, age, native country, type and duration of torture experiences, and experience with dental treatment.

To obtain an adequate sample, it was necessary to include informants who did not share a common language with the interviewer. Thus, half of the interviews had to be conducted with an interpreter present. Communicating through interpreters, as well as communicating in non-native languages, may entail some disadvantages, which may become even more relevant in conversations using many words – such as these in-depth interviews. If the interpreter is not well familiar with the topic under discussion, misunderstandings may occur, and due to linguistic nuances, it may sometimes be difficult to convey every detail. Moreover, some immigrant groups in Norway are small, and thus there is a risk that informants are reluctant to speak freely, fearing that their story will be revealed to their community.

Mitigation of these limitations was attempted with the use of professional interpreters experienced in interpreting health-care consultations. Additionally, the interviewer was previously experienced in working with interpreters. A possible positive consequence of the language challenges might have been the constant need for probing and discussion of terms and concepts, thus potentially strengthening the interviews' exploratory capacity.

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TABLE 1 Clinical advice to dental personnel on how to enhance torture victims' sense of control and safety in dental consultations.

Themes	Categories
Emphasize knowledge and trauma-awareness	Basic psychology Patient history Consequences of torture Trauma informed care (TIC) Cultural understanding
Acknowledge the impact of hurry or delays	Fast work pace may accentuate the feeling of objectification Hurry may give an impression of insensitivity Delays that are not explained may signal that the patient is unimportant
Avoid surprises	Explore triggers thorough and individually Adapt the treatment to each patient's needs Avoid people suddenly appearing from behind Make sure the consultation does not resemble an interrogation: - Ask questions politely and respectfully - Avoid having too many people in the room
Provide overview	Strive to stay in the patient's field of vision Avoid sudden noises or talking behind the patient Ensure predictability by informing the patient about: - Every step of the consultation - All procedures as detailed as preferred by the patient - Treatment-alternatives and treatment-plan - What to expect subsequent to the treatment

Four themes were identified regarding torture victims' perspectives on dental treatment. Theme 1 implies that it is crucial that dental professionals are aware that the patient is a trauma survivor, and that they have knowledge of psychology and TIC. All informants emphasized the importance of dental workers having knowledge about how traumatic experiences may affect individuals. Crosby [21] pointed out some challenges with obtaining a full medical history in refugees, including lack of trust, language barriers and cultural differences. Often there is a perceived power differential, where the refugee is not comfortable initiating conversation topics. Torture exposure may destroy the victims' trust in other people, and rebuilding of trust has been identified as one of the first steps towards seeking and receiving help from others. This demands more effort than with the average dental patient, and building a trusting relationship with traumatized refugee patients requires meticulous focus on respect, empathy and attentive listening [21]. The dental professional needs to believe in their stories and allow them to share at their own pace [22].

Although knowledge of the patients' torture experiences is important, having to tell their stories over and over again may also be re-traumatizing. However, a recent study from Norway points to a lack of uniform systems, which makes torture rehabilitation fragmented and random [23]. Several informants expressed that dentists need to understand that a large proportion of refugee patients have suffered trauma and need to be familiar with the needs of trauma victims in general. This is in contrast to the need of knowing the patients' trauma-history in detail and corresponds well with the principles of trauma informed care [10].

Theme 2: The potential negative impact of hurry or delays should be acknowledged. From the narratives, two distressful aspects of time and tempo emerged. First, if the torture-exposed patient gets the impression that the dentist is in a hurry to finish the dental work, this may increase the patient's feeling of being defenseless. As a passive object, the patient's sense of control and agency is diminished, and this may, for example, reduce the patient's ability to utilize a stop-signal, but also set in motion distressful reactions in its own right. While uncontrollability has been significantly associated with dental fear in general [24], van Rosmalen-Nooijens et al. [25] highlighted control as the most important need, deeply interconnected with safety and trust, in a study of health care provision to young adults exposed to family violence.

The second time-related aspect, having to wait too long, either in the waiting-room or between appointments, may be perceived in a similar way. The notion that other people were in control of their time reflected what they had experienced in prison. Jerlang [26] underlined that dental professionals should never let a torture victim wait for treatment without proper explanation. It has been reported that for many torture victims, the waiting time between episodes of torture-exposure may be just as traumatic as being in the torture situation, in that the time is spent imagining what may happen the next time [27]. Parallels from this may be drawn to dental care, when waiting for the next dental appointment may be just as difficult as actually coming in for treatment.

Theme 3: Surprises should be avoided, imposing that triggers must be explored individually. I In accordance with the informants' stories, dental professionals treating torture victims should aim to eliminate all elements of surprise in the

consultations. Anything that is unforeseen and uncontrollable, such as sudden smells, sounds, movements, sensations, or sights, holds the capacity to trigger trauma-related reactions. The informants describe reactions that may be both physical and psychological, which in some cases last for days beyond the treatment. They manifest as for example, bodily pain, anxiety reactions, exhaustion, vivid re-experiencing of the trauma (flashbacks), or mental disconnection from time and place (dissociation), which are all common symptoms of post-traumatic stress [28].

Being startled by surprises seems to be closely related to perceived loss of control, the importance of which has been discussed in a previous section. As torture experiences, and thereby what triggers reactions, vary between patients, it may be inferred that dentists working with torture survivors should explore and identify triggers individually to minimize the risk for setting off distressful reactions. A similar approach was suggested in a recent study of sexual abuse-survivors [29]. Additionally, the risk for negative surprises may be further reduced by providing information about what will happen during every step of the consultation.

Theme 4: The patient should be given full overview regarding both visibility and predictability. Step by step information minimizes the risk of negative surprises, but additionally it contributes to providing overview. Sense of control is closely related to predictability [24], and the dentist should be attentive to what kind, and to what degree of oversight the patient needs. Moreover, when working with torture survivors, the dentist should avoid moving, working, and talking behind the patient's back, and be considerate as to what the patient would benefit from not having to see.

Arriving at the individual adjustments that make dental treatment achievable, may be a time consuming and demanding process. Thus, some informants expressed that for them to switch to a new dentist means to start all over again. When a safe relationship is built, they prefer to continue seeing the same dentist. Similar findings in persons traumatized by sexual abuse were reported by Kranstad et al. [12].

In general treatment of dental anxiety, cognitive behavioral therapy (CBT) is widely used [30, 31]. However, CBT involves exposure to triggers and the use of stop-signals. The interviews revealed that several informants experienced a lack of agency during dental treatment that made it difficult for them to communicate their needs to the dental professional. Torture victims who experience a situation where the dentist expects them to give a stop-signal when they are not capable, may easily be triggered in a way that increases their anxiety.

To be able to effectively treat dental anxiety with exposure therapy, the patient must be mentally and emotionally present. Thus, post-traumatic symptoms involving dissociation may be a challenge. Exposure therapy requires a safe and stable life-situation and has been argued to be contraindicated to patients lacking emotional stability and ability to regulate affects [32, 33]. Van der Kolk [33] stated that exposure therapy without the right psychological preconditions, may result in re-traumatization rather than habituation, as the traumatic reactions hinder the patient from taking control or processing what is going on. Instead, to implement the dental treatment, triggers should be presented in very small doses. A gradual, facilitated approach should be applied, where, as emerging from the present study, a strong therapeutic relationship ensures that signs of trauma-reactions are discovered when the patient is safe within the window of tolerance [34].

The results add to the knowledge needed to create guidelines for dental care to torture survivors with complex trauma and may provide a foundation for future quantitative studies. Caring for torture survivors should be part of the curriculum in all programs for dental education, as well as other institutions educating professionals who will meet refugees through their work. Receiving proper treatment is highly important for the patients concerned, and often possible to achieve using only small adjustments.

AUTHOR CONTRIBUTIONS

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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