ADA CE Program ARTICLE 1

COVER STORY

Treating patients with traumatic life experiences

Providing trauma-informed care

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ABSTRACT

Background and Overview. Dentists frequently treat patients who have a history of traumatic events. These traumatic events (including childhood sexual abuse, domestic violence, elder abuse and combat history) may influence how patients experience oral health care and may interfere with patients' engagement in preventive care. The purpose of this article is to provide a framework for how dentists can interact sensitively with patients who have survived traumatic events.

Conclusions. The authors propose the trauma-informed care pyramid to help engage traumatized patients in oral health care. Evidence indicates that all of the following play an important role in treating traumatized patients: demonstrating strong behavioral and communication skills, understanding the health effects of trauma, engaging in interprofessional collaboration, understanding the provider's own trauma-related experiences and understanding when trauma screening should be used in oral health practice.

Practical Implications. Dental patients with a history of traumatic experiences are more likely to engage in negative health habits and to display fear of routine dental care. Although not all patients disclose a trauma history to their dentists, some patients might. The trauma-informed care pyramid provides a framework to guide dental care providers in interactions with many types of traumatized patients, including those who choose not to disclose their trauma history in the context of oral health care.

Key Words. Trauma-informed care; mandated reporting; patient-dentist interaction; posttraumatic stress disorder; communication skills; behavioral science.

JADA 2014;145(3):238-245.

doi:10.14219/jada.2013.30

Health care delivery in the United States has changed dramatically during the past few decades; simultaneously, the role of dentists has evolved as well. A landmark report by the Institute of Medicine suggests that dental practitioners work closely with other health professionals—particularly when patients have complex health conditions—and that this trend will continue in the future. The report also recommended the provision of holistic patient care and modeling of excellent clinical and communication skills as a teaching tool for dental students.[1] The importance of interprofessional and patient collaboration is emphasized by the American Dental Association in its strategic plan, which includes a goal to "improve public health outcomes through a strong collaborative profession, and through effective collaboration across the spectrum of our external stakeholders."[2] On average, dentists see their patients more frequently than do physicians, and dentists often see patients over their entire life span. Therefore, dentists are in a unique position to develop a close rapport with patients and to refer patients to other services and care providers in the medical system.[3]

Similar to other health care professionals, dentists are likely to treat patients who have experienced a wide

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range of traumatic life events. Examples of traumatic events may include child abuse or neglect, domestic violence, sexual assault, elder abuse and exposure to combat. From a psychological perspective, trauma happens when a person experiences, witnesses or is confronted with death (or threatened death), serious injury or a threat to physical integrity.[4] In the immediate aftermath, adult victims of traumatic events may respond with fear, anxiety, helplessness or horror and children may respond with feelings of disorganization or agitation. Trauma overwhelms a person's short-term ability to cope. Trauma also can disrupt longer-term functioning and influence use of health care, including oral health care. Therefore, it is important for dentists to be aware of the basic approaches to providing trauma-informed care (TIC), which we will outline in this article. We will propose the TIC pyramid, which is rooted in a review of the literature and clinical data and offers a way for oral health professionals to conceptualize how to apply TIC principles in practice.

According to results from large-scale studies that are representative of the U.S. population, traumatic events (such as child abuse or neglect, domestic violence, sexual assault, elder abuse and exposure to combat) all are highly prevalent among U.S. citizens.[5] In a large epidemiologic survey, 22 percent of women and 4 percent of men reported having been sexually assaulted as an adult.[6] Seventeen percent of women and 8 percent of men reported that they experienced sexual abuse as children.[7] One of every five U.S. women and one of 14 U.S. men reported being physically assaulted by an intimate partner in their lifetime.[8] In a 2008 study, approximately 6 percent of older people reported experiencing significant abuse in the preceding month and 25 percent reported experiencing significant psychological abuse, which includes issues such as financial control and medical neglect by caregivers.[9] Finally, 10 to 20 percent of men and 2 to 10 percent of women in the United States reported combat exposure, either as soldiers or as civilians who immigrated to the United States from war-torn countries.[5]

All of these traumatic events involve violation of a person's bodily integrity and may influence his or her attitudes toward medical and dental care. The high prevalence of traumatic events suggests that dentists are likely to encounter survivors of violence and other traumatic events in their practices. For example, victims of domestic violence may be likely to seek emergency dental care because orofacial injuries are a common result of battering. In addition, head and neck injuries occur in more than one-half of child abuse cases, and the oral cavity is a frequent site of sexual abuse in children.[10]

THE LINK BETWEEN TRAUMATIC EVENTS AND HEALTH CARE

Traumatic events often have emotional consequences in the short term, such as anxiety, social isolation and difficulty trusting others.[11] Sleep disturbance also is common in the immediate aftermath of a traumatic event.[12,13] In the long term, survivors may engage in behaviors that help them cope with traumatic memories but that have negative health consequences.[13] For example, trauma survivors may smoke cigarettes, drink alcohol or overeat to manage their emotional distress. Although these behaviors may provide short-term improvements in mood, they have long-term negative consequences for health,[14-16] including oral health.[17]

Although these types of negative coping methods (such as smoking, alcohol use and overeating) contribute to higher levels of health problems and high levels of overall health care use for illness,[18] trauma survivors may avoid seeking preventive medical and dental care.[19-22] Trauma survivors may underuse preventive care for psychological reasons. Psychological factors such as anxiety and depression contribute to rescheduled, missed or canceled appointments.[22] In addition to emotional distress, patients often experience physiological reactions when trauma memories are retriggered.[13] Many health care visits involve the provider's needing to touch the patient's body and be in close proximity to the patient. For some traumatized patients, this may be prone to retriggering memories of trauma, depending on the nature of the trauma.

The care provider's behavior also may be a key factor in engaging patients in preventive care. When providers are empathic and sensitive, survivors of sexual violence report that they are more likely to follow up on medical appointments and engage in preventive care.[23] However, when survivors are treated negatively or insensitively by the medical system, they may feel revictimized, leaving them less likely to seek help from the health care system in the future. These negative experiences have been termed "secondary victimization."[24-26] In the medical system, this may occur when providers refuse to recognize an experience as criminal victimization, when they engage in intrusive or inappropriate conduct, when they focus exclusively on biomedical concerns without demonstrating appropriate empathy for the patient and when they display victim-blaming attitudes (for instance, beliefs that trauma is not serious, victims should have protected themselves better and so forth). Victims who report secondary victimization also may experience more psychological and physical health symptoms (such as depression, pain and gastrointestinal issues) than do victims who have positive contacts with health care professionals.[27]

DENTISTRY AND SURVIVORS OF TRAUMA

Little research is available about how dentists interact with survivors of traumatic events. We examined literature published from 1990 to the present by using

ABBREVIATION KEY. **TIC:** Trauma-informed care.

the Google Scholar, PubMed, Science Direct and PsychINFO databases. Key words included "trauma informed care" as well as combinations of the phrases "dentistry and traumatic events," "dentistry and domestic violence" and "dentistry and sexual abuse" and "trauma informed care in medicine," "trauma informed care and medical students" and "trauma informed care and dental students." Most of the literature in dentistry has focused on various types of traumatic events individually (for instance, child abuse and domestic violence) rather than on trauma survivors as a whole. In practice, dentists may assess the etiology, physical signs and symptoms of a traumatic event, but they may be hesitant or reluctant to consider domestic violence or sexual abuse, even when there is immediate physical evidence that suggests a pattern of battering or invasion. In a survey of women in domestic violence shelters, more than one-half of the participants had seen a dentist when signs of abuse were present, yet 88 percent reported that they were not asked about the source of their injuries. Sixty-nine percent felt they would have liked the dentist to ask about their injuries.[28]

Consistent with this finding, in a survey of practicing dentists, 87 percent reported that they never screened for domestic violence and 18 percent never screened even when patients had visible signs of trauma on their heads or necks.[29] Dentists in this study cited several barriers to screening, including the presence of the patient's partner or children in the waiting room (77 percent), lack of education (68 percent), concern about offending patients (66 percent) and their own embarrassment about bringing up the topic (51 percent). Dental students who underwent a brief educational session regarding interpersonal violence afterward showed an improved understanding of the health-related aspects of violence.[30] It is encouraging that education appears to break down some of these barriers.

Although to our knowledge there have been no formal surveys of dentists' attitudes about working with survivors of adult and childhood sexual assault, articles have been written from the perspective of victims seeking dental care. Common fears reported by victims are having to lie down for treatment, having objects put into their mouths, the dentist's hand over the mouth or nose, not being able to breathe or swallow and worry that the dentist may get angry.[31] Thus, dental care–related phobia cannot be seen simply as fear of pain and needles.[32] Dental care–related anxiety experienced by survivors of traumatic events may be much more complex and affect a broader range of fears that influence dental treatment. For example, it is reasonable to think that being in a supine position, being unable to talk and fearing being touched may greatly affect some combat veterans, patients with a history of domestic violence and patients who have experienced elder abuse.

Several aspects of dental appointments may be particularly stressful for trauma survivors. Mouth props are commonly used in dentistry. They typically are harmless and are convenient for the dentist. However, trauma survivors may feel anxious and powerless because they cannot close their mouths. Similarly, when dentists make alginate impressions for diagnostic casts, patients may feel they cannot breathe or may experience a severe gag reflex. The saliva ejector may make patients feel out of breath and can trigger feelings of panic in patients who already are anxious about dental care. Some dentists engage in oral cancer screenings that require touching the patient's tongue, floor of the mouth or oropharynx. Patients may experience this as forceful and invasive. Much more research is needed to understand how dentists can work effectively with survivors of traumatic events across a variety of trauma types and age groups.

In recent years, there has been an increasing awareness of the importance of TIC in better serving patients who have lived through highly stressful life events. The basic definition of TIC is care in which every part of service is "assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services."[33] TIC has been explored in relation to social service agencies for more than a decade.[34] This approach emphasizes the importance of screening patients for a history of trauma, educating staff members about the effects of trauma, making services as sensitive as possible and encouraging clients to be involved in treatment decisions. TIC principles in human service organizations include recognizing the effect of violence and trauma on individuals and communities, prioritizing recovery from trauma, encouraging client-provider collaboration, focusing on clients' strengths, allowing clients to decide how and when they discuss a trauma history, and using clients' feedback to evaluate and tailor future services.[35]

Services need not be trauma-specific to be trauma informed. Trauma-specific services are geared directly to the needs of trauma survivors; TIC services can be put in place on an organizational level to make trauma survivors more comfortable, but they do not require a person to disclose or discuss his or her particular trauma history.[35] In addition to health care, recent efforts have focused on applying trauma-informed principles to many systems, including child welfare, education and juvenile justice.[36,37] Given recent efforts to educate dentists regarding behavioral aspects of care, the current time is fitting for dentists to be educated about and to gain understanding of the basic principles of TIC and how they can be applied to everyday practice.

THE TRAUMA-INFORMED CARE PYRAMID FOR DENTAL PRACTICE

The definition of TIC is broad and inclusive, but from the standpoint of oral health care providers, it can be difficult to understand how the general principles of TIC

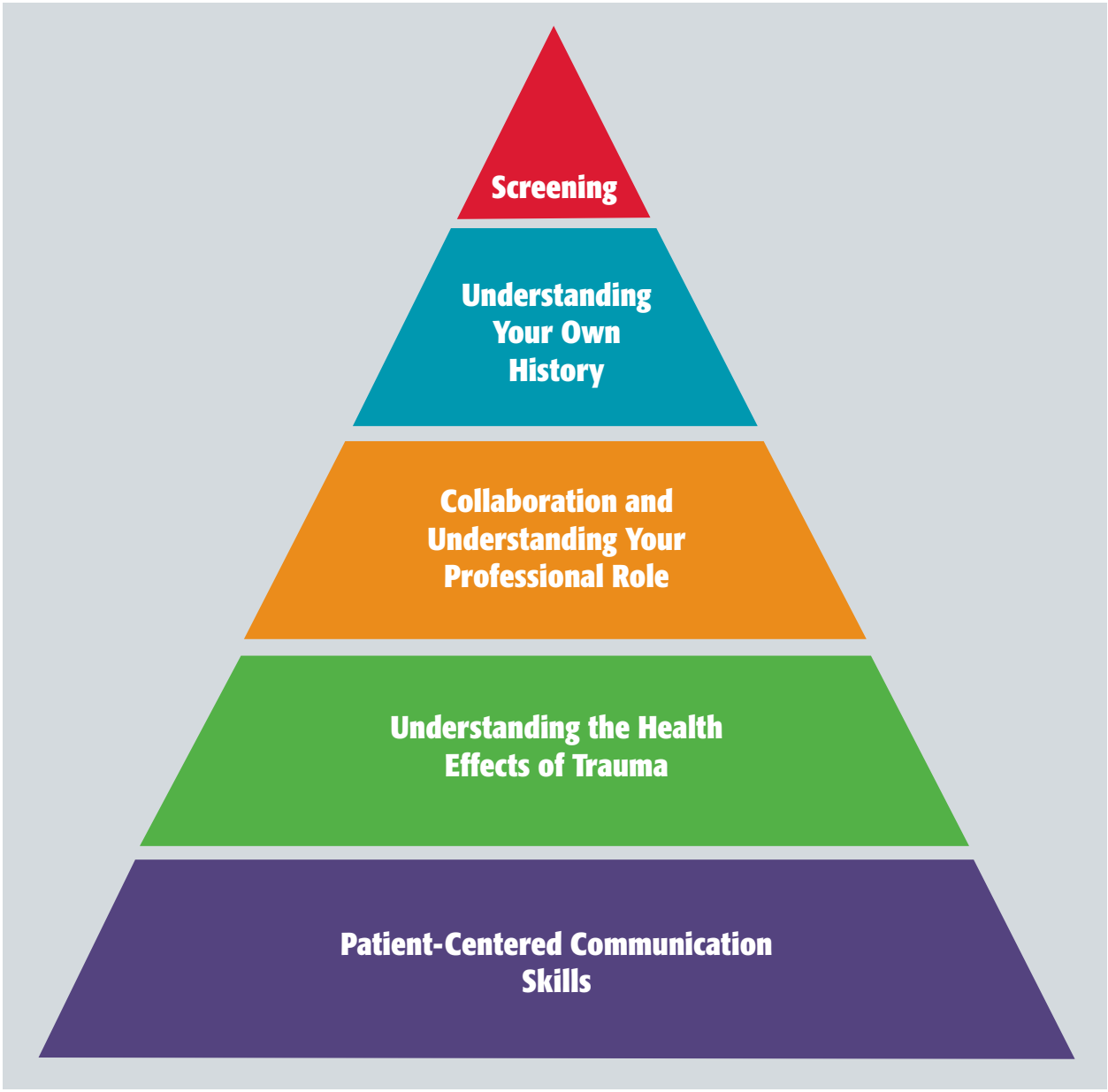

Figure. The trauma-informed care pyramid.

can be integrated into daily practice. We propose the TIC pyramid as an attempt to provide specific guidance for dentists according to setting, specialty and individual patient needs. Each level of the proposed TIC pyramid is informed by research findings and clinical data. The pyramid also is based on our experiences in educating dental students regarding issues related to health care communication, mandatory reporting and working with highly anxious patients. These suggestions encompass appointment-level behaviors and specific provider-level behaviors, as well as practice-level changes.

Level 1: patient-centered communication skills. At the base of the TIC pyramid (Figure) are patient-centered communication skills. Specific communication and behavioral techniques can help manage patients' anxiety and increase the provider's rapport with trauma survivors. Many of these behaviors fall under the guise of universal trauma precautions, which do not require screening of patients or knowledge of a patient's trauma history (or lack of it) (Box 1). Instead, they involve small changes to practice that can be used with all patients, and these changes may be particularly beneficial for establishing trust with traumatized people. For example, trauma survivors often report that a lack of control in

BOX 1

Universal trauma precautions.

BEHAVIORAL STRATEGIES
Ask your patient whether there is anything you can do to make him or her more comfortable.
If the patient seems worried or anxious about a specific procedure, ask him or her to think about what has helped with a stressful situation in the past.
Use tell-show-do desensitization to let the patient know what you are going to do in advance—give him or her an overview of the entire appointment. Use the tell-show-do technique during the appointment as needed.
Let the patient know that he or she can raise a hand (or use another signal) and you will stop the procedure, if it is medically safe to do so.
SAMPLE COMMUNICATION STRATEGIES
"What can I do to make you more comfortable during the procedure or examination today?"
"Before we proceed, is there anything else you think I should know?"
"Just to let you know, this is generally how this type of appointment runs. First, I will get a history, then we will take a look in your mouth, and then we will take x-rays. I'll come back to talk and answer questions."
"So you know what to expect, what we would normally do for this type of appointment is first discuss your history. Next, I will look in your mouth and, if necessary, we'll take x-rays. Please feel free to ask me any questions along the way, or get my attention by raising your hand if you need a break."
"I am going to do a percussion test on your tooth. To do this, I will gently tap your teeth. Let me show you on my hand, or we can use yours. It will feel like this [tap on hand]. Let's try it on your tooth."

medical settings increases their anxiety.[38] Obviously, it is not possible for dentists to let patients control the entire appointment, but they can offer patients an overview of the dental procedures involved in the appointment to help decrease their anxiety and increase their comfort level. For example, before using the saliva ejector, the dentist can inform the patient that he or she may experience a momentary sensation of feeling out of breath.

A frequently used intervention is the "tell-show-do" technique, which can help patients feel more in control.[39] When performing an examination, the dentist can tell the patient that his or her teeth will be dried with air, blow air on the patient's hand or arm to demonstrate how it feels, and then do the air-drying on the patient's teeth. This intervention decreases the patient's anxiety about the unknown and the feeling of surprise when cold air hits his or her teeth.

A simple but often overlooked way to mitigate anxiety is to ask every patient what can be done to make him or her more comfortable during the appointment. A patient anxious about the supine position may feel more comfortable, warm and welcomed after being offered a blanket or low pillow for his or her back. Dentists also can ask patients if there are specific things that worry them about the dental appointment (such as lying back, being unable to talk, fear of gagging, possibility of pain) and whether they would like to signal to indicate that they are in distress.[40] For example, if a patient is worried about the use of a mouth prop, the dentist can explain to the patient that he or she will need to keep the mouth open for a long period, give the patient an opportunity to see and feel the prop before its use and encourage the patient to raise his or her hand if he or she needs the prop removed.

Providers should assess every patient for possible dental care–related fears, not just patients who may have a history of traumatic events. If a patient reports fear, the provider can build up the treatment plan slowly and base it on the principles of systematic desensitization.[41] Although many dentists use systematic desensitization to help with specific dental care phobias, these same principles have been used successfully in helping patients cope with anxiety related to traumatic events.[42] Systematic desensitization pairs relaxation with facing feared situations in a slow and graded manner. When helping patients who are anxious, it is important to ask patients themselves what has helped them cope during past appointments. For example, if a patient is fearful of a routine cleaning, a provider can ask, "Has listening to music during a procedure helped you get through this type of procedure before?" or "Is there anything you can visualize to help you relax?"

Providers also should remember that reassurance is not the same as assessment of anxiety; telling patients they have nothing to worry about may not help patients feel more in control, particularly those who have a history of trauma. Although working with patients who have dental care–related anxiety can be frustrating for providers, it is important to remember that stressful life experiences may be driving some of this anxiety. A thorough explanation of the appointment, use of tell-show-do procedures, use of start-stop signals, assessment of anxiety, and use of systematic desensitization constitute the "patient-centered communication" base of the TIC pyramid (Figure) and can be used with all patients, not just those who are survivors of trauma.

Level 2: understanding the health effects of trauma. The next level of the pyramid (Figure) consists of being aware of and understanding the effects of trauma. This does not require the dentist to delve into the trauma history; it simply means the dentist is educated about the health-related effects of traumatic events. For example, when dentists discuss negative coping behaviors with patients (such as smoking, drinking, high intake of sugary food and drink), they should be aware that these behaviors may be related to stressful life experiences. This does not mean that every patient who engages in these behaviors has been traumatized. Approaching patients in a collaborative, nonblaming manner increases the likelihood that the patient will discuss behavior change and continue to engage in treat-

ment. This approach, consistent with patient-centered communication skills and the principles of motivational interviewing, can be used with every patient, not only traumatized patients.[43]

Level 3: collaboration and understanding the professional's role. The third level of the pyramid (Figure) involves collaboration with other professionals and a thorough understanding of the dentist's professional role. Providers should maintain a list of referral sources for patients, including local referral sources specifically for those who do disclose a trauma history (such as area therapists or hotline information). The National Center for Trauma-Informed Care[44] website maintains an updated list of referral and support services that can be useful for survivors. Ideally, this type of information could be made readily available to all patients (such as by placing it in the waiting room). Providers also should strive to build up a list of local referral sources (such as physicians and oral surgeons) who have the excellent communication, behavioral and professional skills needed to care for traumatized patients. Even a basic awareness of these resources can be helpful in building a long-term relationship with traumatized patients and engaging them in care.

The issue of confidentiality is key when treating survivors of trauma. Dentists should have a thorough understanding of the mandated reporting requirements in their states and should inform patients when confidentiality needs to be breached (in most states, in the case of child and elder abuse). To be trauma informed, it is important for providers to be aware of their legal obligations; however, many dentists report confusion about and discomfort with mandated reporting laws.[45] Equally importantly, dentists should respect the wishes of survivors to report (or not report) abuse when mandated reporting is not required (for example, many states do not require domestic violence to be reported).

Level 4: understanding one's own history of trauma. Another key aspect of TIC (Figure) is for providers to understand their own trauma histories. Some medical and dental care providers may have their own history of childhood or adult abuse. When providers are themselves survivors of traumatic events, they may feel uncomfortable talking about these issues for fear of retriggering their own feelings.[46] It is important for providers to learn empathic communication skills, one reason being that using such skills can help them avoid retriggering their own memories of trauma. However, it is not appropriate for dental care providers to delve into patients' psychological histories, and most would feel uncomfortable doing so. Providers can be respectful while also keeping focus on the present appointment. For example, if a dental patient reports a history of oral sexual abuse that causes her anxiety at dental visits, a provider can thank her for disclosing the information and ask how to make her more comfortable during the appointment. In this way, providers acknowledge the patient's history without crossing the boundaries of their professional competence.

BOX 2

Screening dental patients for history of traumatic events.

DO YOU THINK THE PATIENT IS IN IMMEDIATE DANGER, ARE YOU A MANDATED REPORTER IN THIS SITUATION OR BOTH? POSSIBLE QUESTIONS, IF YES
"Do you feel safe at home?"
"Is anyone making you feel unsafe right now?"
"Do you have a safe place to go when you leave this appointment?"
"Is anyone hurting you?"
IF THIS IS A NONEMERGENCY SITUATION, ARE YOU WORKING WITH A HIGH-RISK POPULATION? IF YES
Do you have the time and staff available to review the results?
Do you have time to review the results with the patient?
Do you have the ability to provide patients with the appropriate referrals to community-level services?
THINGS TO SAY IF THE PATIENT REPORTS A HISTORY OF TRAUMATIC EVENTS
"I am sorry that happened to you. How are you doing now?"
"Thank you for telling me. Is there anything I can do as your dentist to make you feel more comfortable?"
"I appreciate your telling me that. No one deserves that to happen to them."
"Do you think any of these experiences affect you today? If so, would you like a referral to talk more about some of these issues?"

Level 5: screening. The final level of the pyramid (Figure) involves screening for traumatic events. Although practitioners in many primary care settings have begun to screen for trauma, we do not recommend that all dental care providers routinely do so. Most dental care settings do not offer providers the time and resources to conduct or discuss the results of screening. Patients also may find that this type of questioning is intrusive when coming from their dental care provider.[31] However, there are exceptions to this guideline. First, providers who work with high-risk populations may decide to screen routinely for a history of trauma. Child abuse happens in every community and demographic group; however, research findings suggest that children with special needs (such as developmental or cognitive impairments) may be at elevated risk of experiencing abuse, and parental stressors such as extreme financial hardship and depression also may increase the risk of child abuse.[47] The Adverse Childhood Experiences checklist[16] is one measure that can be used in practice.

Second, dentists must screen for abuse when pediatric or adult patients have acute orofacial injuries (or other visible bruising, broken bones or lacerations that suggest abuse). Questions can range from indirect (for instance, "Do you feel safe at home?") to more direct

(for instance, "Sometimes when I see injuries like this, they are the result of someone's hurting someone else. Can you tell me if that applies here?"). Dentists can use the approach of asking, validating the patient's perspective, documenting relevant information and providing referrals.[48] If screening is used in a clinic or hospital setting, staff members must be able to provide up-to-date referral sources and have enough time to discuss the results with patients. We highly recommend that staff members practice these sensitive conversations by using role play to develop a greater level of confidence and comfort in these interactions. Box 2 provides a summary of guidelines for screening dental patients for a history of traumatic events.

FUTURE DIRECTIONS

The levels of the TIC pyramid are based on our current understanding of the literature and our clinical knowledge of best practices with traumatized patients. However, investigators in future studies should focus on ways to examine each of these levels critically, as we attempt to implement TIC on a larger scale in oral health care. For example, the importance of interprofessional collaboration is well documented.[49] It will be important for future work to focus on whether trauma survivors place a high level of subjective value on these referrals and whether they follow up on them. We also need to develop a better understanding of the barriers to and facilitators of collaboration. For example, it is possible that dentists would like to develop a strong referral network but lack adequate time or appropriate resources to do so.

An issue addressed in the TIC pyramid is the importance of providers' recognizing their own trauma histories. Little is known about how many oral health care providers have their own trauma histories. TIC initiatives will be strengthened by understanding the prevalence of trauma history among dentists, as well as by understanding how providers with trauma histories can manage their personal stressors in the work environment.

Routine screening for violence has been used in many health care settings.[50,51] However, not all settings may be appropriate for screening. It is important to conduct studies of dental patients about their screening preferences. Patients should guide decisions about what settings (such as hospitals versus outpatient clinics) and what type of assessment (online, written, interview) most likely will elicit honest disclosure and open discussion.

Finally, all of the TIC practices can be examined by educating a large number of oral health care providers in the TIC pyramid model and comparing their behavior with that of providers who have not been so educated. The ultimate goal of TIC is to increase patient engagement and to reduce disease burden. If providers who are educated in TIC can effect these types of outcomes, it will make a strong case for the importance of these principles. Clearly, there is much work to be done as we move the science and practice of TIC forward.

CONCLUSIONS

Traumatic events are highly prevalent in our culture, and they have negative physical and emotional health consequences. It is important for dentists to understand the extent of trauma and how it may influence patients' experiences in seeking oral health care. Strong behavioral and communication skills form the basis of TIC. Universal trauma precautions such as start-stop signals and anxiety assessments can be used with all dental patients.[52] However, trauma survivors may require more than these basic skills. Trauma-informed practice requires maintaining referral sources, having a thorough understanding of mandated reporting requirements and allowing the patient to decide whether abuse will be reported (in cases in which the dentist is not legally required to do so).[35] TIC also involves providers' being aware of their own history and how it may influence patient-dentist communication. Finally, TIC requires dentists to be aware of situations in which screening may be useful, warranted or required and to be sensitive in their approach to screening.

Dental care providers have a unique niche within the health professions. Ideally, patients develop a sense of trust and rapport with their dentists over a lifetime. Given the high prevalence of trauma in our society, learning to better engage trauma survivors in dental care may improve patients' lives and could affect oral health on a national level. ■

Disclosure. None of the authors reported any disclosures.

1. Field MJ, Jeffcoat MK. Dental education at the crossroads: a report by the Institute of Medicine. JADA 1995;126(2):191-195.
2. Jakush J. Board adopts 2011-2014 ADA Strategic Plan. www.ada.org/news/4301.aspx. Accessed Dec. 27, 2013.
3. Dworkin SF. The dentist as biobehavioral clinician. J Dent Educ 2001;65(12):1417-1429.
4. American Psychiatric Association. DSM. www.psychiatry.org/practice/dsm. Accessed Dec. 27, 2013.
5. Wilson JP, Keane TM, eds. Assessing Psychological Trauma and PTSD. 2nd ed. New York City: Guilford Press; 2004.
6. Elliott DM, Mok DS, Briere J. Adult sexual assault: prevalence, symptomatology, and sex differences in the general population. J Trauma Stress 2004;17(3):203-211.
7. Putnam FW. Ten-year research update review: child sexual abuse. J Am Acad Child Adolesc Psychiatry 2003;42(3):269-278.
8. Tjaden P, Thoennes N. The role of stalking in domestic violence crime reports generated by the Colorado Springs Police Department. Violence Vict 2000;15(4):427-441.
9. Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. Age Ageing 2008;37(2):151-160.
10. Kellogg N; American Academy of Pediatrics Committee on Child Abuse and Neglect. Oral and dental aspects of child abuse and neglect. Pediatrics 2005;116(6):1565-1568.
11. Brewin CR. Cognitive and emotional reactions to traumatic events: implications for short-term intervention. Adv Mind Body Med 2001;17(3):163-168.
12. Kimerling R, Ouimette PC, Wolfe J, eds. Gender and PTSD. New York City: Guilford Press; 2002:117-149.
13. Raja S, Orsillo SM. Overcoming Trauma and PTSD: A Workbook

Integrating Skills From ACT, DBT, and CBT. Oakland, Calif.: New Harbinger Publications; 2012.
14. Banyard VL, Edwards VJ, Kendall-Tackett KA. Trauma and Physical Health: Understanding the Effects of Extreme Stress and Psychological Harm. Abingdon, Oxfordshire, England: Routledge; 2009.
15. Breiding MJ, Black MC, Ryan GW. Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005. Am J Prev Med 2008;34(2):112-118.
16. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. Am J Prev Med 1998;14(4):245-258.
17. Hollister MC, Anema MG. Health behavior models and oral health: a review. J Dent Hyg 2004;78(3):6.
18. Hager AD, Runtz MG. Physical and psychological maltreatment in childhood and later health problems in women: an exploratory investigation of the roles of perceived stress and coping strategies. Child Abuse Negl 2012;36(5):393-403.
19. Farley M, Patsalides BM. Physical symptoms, posttraumatic stress disorder, and healthcare utilization of women with and without childhood physical and sexual abuse. Psychol Rep 2001;89(3):595-606.
20. Farley M, Golding JM, Minkoff JR. Is a history of trauma associated with a reduced likelihood of cervical cancer screening? J Fam Pract 2002;51(10):827-831.
21. Leeners B, Stiller R, Block E, Görres G, Imthurn B, Rath W. Consequences of childhood sexual abuse experiences on dental care. J Psychosom Res 2007;62(5):581-588.
22. Ford JD, Trestman RL, Tennen H, Allen S. Relationship of anxiety, depression and alcohol use disorders to persistent high utilization and potentially problematic under-utilization of primary medical care. Soc Sci Med 2005;61(7):1618-1625.
23. Campbell R. The community response to rape: victims' experiences with the legal, medical, and mental health systems. Am J Community Psychol 1998;26(3):355-379.
24. Campbell R, Raja S. Secondary victimization of rape victims: insights from mental health professionals who treat survivors of violence. Violence Vict 1999;14(3):261-275.
25. Madigan L, Gamble NC. The Second Rape: Society's Continued Betrayal of the Victim. New York City: Macmillan; 1991.
26. Williams LS. The classic rape: when do victims report? Soc Probl 1984;31(4):459-467.
27. Campbell R, Raja S. The sexual assault and secondary victimization of female veterans: help-seeking experiences with military and civilian social systems. Psychol Women Q 2005;29(1):97-106.
28. Nelms AP, Gutmann ME, Solomon ES, Dewald JP, Campbell PR. What victims of domestic violence need from the dental profession. J Dent Educ 2009;73(4):490-498.
29. Love C, Gerbert B, Caspers N, Bronstone A, Perry D, Bird W. Dentists' attitudes and behaviors regarding domestic violence: the need for an effective response. JADA 2001;132(1):85-93.
30. Everett RJ, Kingsley K, Demopoulos CA, et al. Awareness and beliefs regarding intimate partner violence among first-year dental students. J Dent Educ 2013;77(3):316-322.
31. Stalker CA, Russell BD, Teram E, Schachter CL. Providing dental care to survivors of childhood sexual abuse: treatment considerations for the practitioner. JADA 2005;136(9):1277-1281.
32. Oosterink FM, de Jongh A, Aartman IH. What are people afraid of during dental treatment? Anxiety-provoking capacity of 67 stimuli characteristic of the dental setting. Eur J Oral Sci 2008;116(1):44-51.
33. Substance Abuse and Mental Health Services Administration. Trauma-informed care and trauma services. www.samhsa.gov/nctic/trauma.asp. Accessed Dec. 27, 2013.
34. Harris M, Fallot RD. Envisioning a trauma-informed service system: a vital paradigm shift. New Dir Ment Health Serv 2001 Spring;(89):3-22.
35. Elliott DE, Bjelajac P, Fallot RD, Markoff LS, Reed BG. Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. J Community Psychol 2005;33(4):461-477.
36. Ursano RJ, Benedek DM, Engel CC. Trauma-informed care for primary care: the lessons of war. Ann Intern Med 2012;157(12):905-906.
37. Ko SJ, Ford JD, Kassam-Adams N, et al. Creating trauma-informed systems: child welfare, education, first responders, health care, juvenile justice. Prof Psychol Res Pr 2008;39(4):396-404.
38. Katon W, Sullivan M, Walker E. Medical symptoms without identified pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. Ann Intern Med 2001;134(9, pt 2):917-925.
39. Ost LG, Skaret E. Cognitive behavioral therapy for dental phobia and anxiety. Oxford, England: Wiley-Blackwell; 2013.
40. Humphris GM, Clarke HM, Freeman R. Does completing a dental anxiety questionnaire increase anxiety? A randomised controlled trial with adults in general dental practice. Br Dent J 2006;201(1):33-35.
41. Longman LP, Ireland RS. Management of dental anxiety. In: Ireland R, ed. Advanced Dental Nursing. 2nd ed. Oxford, England: Wiley-Blackwell; 2010:160-168.
42. Roberts NP, Kitchiner NJ, Kenardy J, Bisson J. Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. Cochrane Database Syst Rev 2009;(3):CD006869.
43. Miller WR, Rollnick S. Motivational Interviewing: Preparing People for Change. 2nd rev. ed. New York City: Guilford Press; 2002.
44. Substance Abuse and Mental Health Services Administration. Welcome to the National Center for Trauma-Informed Care. www.samhsa.gov/nctic. Accessed Dec. 27, 2013.
45. Yellen CN. Abuse mandated reporting for dental professionals. RDH Magazine 2009;29:72-79.
46. Lipsky LV, Burk C. Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others. San Francisco: Berrett-Koehler Publishers; 2009.
47. Centers for Disease Control and Prevention. Child maltreatment: risk and protective factors. www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html. Accessed Dec. 27, 2013.
48. Hsieh NK, Herzig K, Gansky SA, Danley D, Gerbert B. Changing dentists' knowledge, attitudes and behavior regarding domestic violence through an interactive multimedia tutorial. JADA 2006;137(5):596-603.
49. Rafter ME, Pesun IJ, Herren M, et al. A preliminary survey of interprofessional education. J Dent Educ 2006;70(4):417-427.
50. MacMillan HL, Wathen CN, Jamieson E, et al; McMaster Violence Against Women Research Group. Screening for intimate partner violence in health care settings: a randomized trial. JAMA 2009;302(5):493-501.
51. Prins A, Ouimette P, Kimerling R, et al. The primary care PTSD screen (PC-PTSD): development and operating characteristics. Prim Care Psychiatr 2003;9(1):9-14.
52. De Jongh A, Adair P, Meijerink-Anderson M. Clinical management of dental anxiety: what works for whom? Int Dent J 2005;55(2):73-80.