The torture victim and the dentist: The social and material dynamics of trauma re-experiencing triggered by dental visits

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Abstract

Introduction: A significant proportion of refugees have been subjected to torture involving their mouth or teeth. Still the importance of oral health challenges is often overlooked. We present an exploration of the process through which trauma-related reactions are produced in torture victims in the course of undergoing dental treatment.

Methods: Ten resettled refugees from Africa and the Middle East who experienced torture were recruited among patients affiliated with specialized clinics for oral health rehabilitation in Norway. Data were collected through semi-structured exploratory interviews, and analysed using a qualitative content analysis approach.

Results and discussion: Our data suggest that dental treatment often involves an experience of being suspended, albeit temporarily, in an objectified position, acted on by subjects capable of producing deeply undesirable mental, emotional, or bodily states. Going to the dentist entails choosing or accepting to be in a passive position, acted upon by elements in the clinical situation. These elements, we propose, may usefully be considered as subjects, i.e. agents. Three main categories emerged as the most prominent factors with such an agentic capacity: 1) pain, 2) traumatic memories and 3) the dentist. Submitting to dental treatment hence requires the patient's willingness to give in to the actions of these factors, and avoiding treatment may therefore, in this situation, represent a means of retaining control.

Keywords: oral health, dental treatment, torture survivors, posttraumatic stress, rehabilitation

Introduction

The flow of refugees towards Europe during the last decade has placed increased demands on the health care services. Torture prevalence in refugees varies across studies, but is considered to be substantial (Sigvardsdotter et al., 2016; Steel et al., 2009), and survivors of torture often suffer from oral health problems with potentially grave and debilitating physical and psychological implications (Høyvik et al., 2019). Yet, challenges related to oral health and dental treatment are often overlooked in the overall rehabilitation of torture victims. In a recent survey of newly arrived

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refugees in Norway, 47% reported torture experiences, and 35% reported having been subjected to torture involving their mouth or teeth (Høyvik et al., 2019).

Torture entails depriving the victim of control, which is a significant factor in the development of trauma disorders (Başoğlu, 2009), and systematic reviews have estimated the prevalence of post-traumatic stress disorder (PTSD) in torture survivors to be at least 31% (Abu Suhaiban et al., 2019; Steel et al., 2009). Additionally, a comorbidity above 65% is found between PTSD, depression, and anxiety disorders (Close et al., 2016).

Studies have shown that oral treatment-needs, and oral impacts on quality of life in refugee populations are generally high (Abu-Awwad et al., 2020; Bhusari et al., 2020; Keboa et al., 2016). Moreover, research populations with impaired mental health show a higher burden of oral health problems than comparable healthy populations. The accumulation of oral disease is explained by an array of factors, including reduced ability to maintain oral hygiene, irregular eating habits, tooth grinding, medication, and reduced utilization of dental health services due to both psychological and financial factors (Kisely, 2016). Certain types of mental disorder are highly associated with dental anxiety and Lenk et al. (2013) found the highest relative risk in patients with PTSD.

High dental anxiety, with avoidance of oral health services and deterioration of oral health, is a public health problem that affects about 5% of the adult population (Svensson et al., 2016). The relationship between torture, PTSD symptoms and dental anxiety was supported by a recent survey (Høyvik et al., 2019) in which the odds of high dental anxiety were 6.1 times higher in torture victims compared to other refugees, and 9.3 times higher in torture victims with PTSD symptoms. Cognitive theories have proposed that individuals with PTSD hold maladaptive beliefs that contribute to maintaining the disorder (Ehlers & Clark, 2000), and such beliefs of uncontrollability, unpredictability and dangerousness have been linked to fear of going to the dentist (Armfield et al., 2008).

The nature of torture and the characteristics of oral health and dental treatment infuse dental care with specific challenges and dangers for survivors of torture. Not only is the oral cavity generally perceived as a private and sensitive area, which makes it an attractive target for the inflictors of torture, a lot of what goes on in the dental office may also evoke the torture situation itself. The patients find themselves in an objectified position – deprived of control, positioned passively underneath a dentist who administers sharp instruments, bright light and water, and records medical history in a way that may evoke interrogation. Thus, as theorised by Singh et al. (2008), undergoing dental treatment may re-activate psychological trauma in torture survivors.

Despite these assumptions, little research is found on the specific nature and consequences of oral health challenges faced by torture victims, and a deeper understanding may be an essential contribution to the development of targeted dental treatment programs. Some parallels might, however, be drawn to studies on victims of sexual abuse. Fredriksen et al. (2020) propose that the experiences of dental anxiety are triggered not only by sensory stimuli associated with the dental procedures, but to a large extent by sensory stimuli bearing comparison with previous traumatic experiences. To our knowledge, however, the nature of such triggering events has hitherto received scant attention in research. Hence it is our purpose in what follows to contribute to such an examination. Based on the accounts and reflections of refugee dental patients with experience of torture, we aim to explore the pos-

sible dynamics of social and material factors working together to set off and sustain distressing reactions.

Material and method

The study followed a qualitative design, with semi-structured exploratory interviews. Informants were recruited by professionals affiliated with specialised clinics for oral health rehabilitation of traumatized patients (TADA-service, Norwegian Directorate of Health). The names and contact information of consenting candidates were forwarded to the research group, who invited the informants to take part in the study by telephone. Those who agreed to participate signed a written informed consent form. Inclusion criteria were 1) age > 18 years; 2) experience of torture; 3) post-torture dental treatment experience in Norway.

The research group acknowledged beforehand the relatively small population from which our study aimed to recruit, and also anticipated a low consent rate given the study topic. On this basis, and aiming to maximize variation in a limited sample, a desired minimum sample size was set at 10–15 informants, comprising different ages, genders, countries of origin, types of torture experienced and dental treatment experienced. The interview study explored the informants' reactions and reflections, looking to identify patterns and understand the dynamics involved in their experiences of dental care following past torture experiences.

The interviews took place between April 2019 and January 2020, and were all conducted by the first author in mutually agreed, non-clinical environments. All interviews were audiotaped with the consent of the informants. To minimise language and cultural barriers, professional interpreters were available to all informants, and five informants chose to use one. Three interviews were conducted in Norwegian and two in English.

To explore torture survivors' challenges related to oral health and dental treatment, an interview guide was prepared based on literature review and the professional experiences of the multidisciplinary research group. The interview guide identified six thematic areas for semi-structured exploration in the research interviews: 1) Expectations – reflections regarding treatment needs an how they might be met by the dental personnel, 2) Confidence – issues involving trust and understanding, 3) Security – discussing what affects the feeling of security in the dental treatment situation, 4) Dental anxiety – feeling of fear and anxiety before, during, and after dental treatment, 5) Satisfaction – exploring factors contributing to satisfaction with treatment and caregivers, and 6) Interplay – interaction and distribution of tasks and responsibility between dentist and patient. Interviews were conducted seeking to cultivate an atmosphere conducive to the pursuit of emergent themes while maintaining a sensitivity to the informants' reflective process. Thus, the interview guide was not followed point by point, but rather applied as a checklist.

The audio files were transcribed verbatim by the first author, omitting directly and indirectly identifiable personal data, to protect the informants' anonymity. In the presentation of data, all names are fictitious.

Description of informants

Two women and eight men aged from 28 to 65 were interviewed. They were all survivors of torture and originated from five different countries: Iran (3), Eritrea (3), Syria (2), Somalia (1) and Iraq (1). Years of residence in Norway varied from 4 to 30, and there was a great variety with respect to fluency in Norwegian, level of education, work experience and participation in society. Dental treatment

experiences from their home countries varied from zero to yearly prophylactic dental examinations, but they had all received dental treatment in Norway. None of the informants had any recollection of dental anxiety before their torture experiences. All of them presently experienced some difficulties in the dental treatment situation, whereas half of them reported a high degree of dental anxiety.

The informants were not asked to disclose details of their torture experiences, but the majority were quite eager to share. Informants' experiences of torture and imprisonment comprised: tooth extractions to inflict pain; lack of necessary dental treatment; blows and kicks against all parts of the body including the mouth; lack of opportunity to maintain personal hygiene, including tooth cleaning; denial of food; isolation; prolonged darkness; extreme light or noise; attack from behind; intimidation and unpredictability; the use of electrical currents; witnessing, or being forced to participate in killing or torturing others; hanging, suspension, choking, often involving water, and having nails pulled out. Some of the informants had experience with all of the above, and two informants claimed to have seen people die because of oral infections.

Analysis

The data were analysed using a qualitative content analysis approach aiming to classify the research material into identified categories representing explicit or inferred communication (Schreier, 2012). An inductive process was pursued in dialogue with the pre-defined topics reflected in the interview guide, as the objective was to extract new theory on a topic where prior knowledge is limited.

The transcriptions were thoroughly assessed and recurring topics were identified and formulated into preliminary codes by the first author. Next, the material was revised by all co-authors, and salient themes were developed through coding, re-coding and grouping of themes. Due to the small size of the study material, the authors developed a closeness to the transcribed interviews and found no additional gain in computer-based coding.

Ethical considerations

Torture victims may be vulnerable in the sense that merely reflecting on their past experiences may set off unpleasant reactions. To minimise the risk for re-traumatization, the interviewer was careful to not in any way put pressure on the informants and to avoid active probing into their torture experiences.

There was still a risk that some might feel discomfort during the interview. The interviewer was experienced in working with torture victims and in dealing with anxiety reactions in the dental setting and was thus prepared to handle psychological reactions that might occur. Moreover, the researchers cooperated closely with the recruiting clinics, and psychologists were available if needed. Informants were told that the interviewer would be available for telephone consultations after the interview, offering assistance or guidance with regards to possible reactions should they occur. Finally, all informants had access to specialised clinics where they could receive facilitated dental treatment should such needs be disclosed.

The informants were informed of their right to withdraw from the study at any time, and without any consequences for themselves, but none chose to do so. The Norwegian Ethics Committee approved the project (2015/2154/REK South-East C).

Results

All informants expressed a strong desire and need to have their oral problems treated. Nev-

ertheless, they also described obstacles they found hard to overcome. They all talked about difficulties with seeking and undergoing dental treatment, and half of them described severe dental anxiety. System challenges faced by refugees in general, such as access, monetary issues and language barriers, were also brought up by several informants, but such barriers are not explored further here. Instead, our focus is on the challenges that are particular to survivors of torture. These may usefully be introduced by the account of Gebre, a man in his thirties from The Horn of Africa, who summarizes the experience of the dental patient with experience of torture like this:

> *You never know if a person is traumatized! You never know what terror it could add to a person's experience if… if maybe you are not prepared for this type of treatment… all the machines that will come… You will see… and you will be below the dentist, and then… It's like you are powerless, you know! So… it could end up being a very bad experience, and then you don't want to go back to the dentist again!*

Gebre's only experience with dental treatment prior to his resettlement seven years ago was an emergency extraction. He found his first dental appointments in Norway frightening, but stated that he eventually managed to build trust in his dentist. He has since trained as a health professional himself and now finds it easy to adequately describe his past experiences. Still, his notion of feeling powerless came up in many situations across several of the interviews.

One dimension of this powerlessness relates to experience under treatment of being unaware of, and defenseless against, what happens next. Most informants emphasize the problems they experience with finding themselves in a situation where they are unable to foresee the pain or discomfort that might occur at any moment. Some draw explicit parallels to their torturers' use of surprise to scare them and leave them constantly on guard. Hamid (47 yrs), a Syrian man who had no dental treatment experience before he was subjected to torture involving his teeth, said:

> *When I sit there in the dental chair, I get really anxious, and I think a lot about what will happen. Especially when they turn on those lights… the white ones… then I feel like I'm being interrogated by someone.*

In most informants' reflections, the emphasis on the element of surprise is accompanied by stark descriptions of the effects to which that experience gave rise. Farouk, a 55-year-old man who grew up in a wealthy family in Iraq, was used to annual dental checkups and treatment. He has nevertheless had to force himself to visit a Norwegian dentist on a regular basis, and he describes his dentist as a busy man who rushes back and forth and works, 'fast, fast, fast', without informing Farouk about what he is about to do to him. Farouk describes what this unpredictability does to him:

> *I get very scared! Then some water comes here (point to his pants)… For almost half an hour, or 45 minutes it is very dangerous! So much pain in my stomach… and then in my throat… then the legs… and the back… yes… And then I am… just like in prison!*

Explicitly, or by implication, all informants express a strong need to retain a sense of control in most situations to avoid torture-related reactions. Both Hamid and Farouk describe how, when going to the dentist, they

have to more or less give in to being acted upon by different agents in the clinical room. While there, they are temporarily deprived of the ability to actively (re-)act on and manage what is happening to them. As a consequence they are pacified in a second sense, i.e., they become objects being acted upon by the automatic reactions that arise as everyday treatment events unfold, causing them severe discomfort. Informants describe how, for example, the sight of the equipment, the anticipation of pain, or the dentist's behavior may set off bodily reactions they cannot control, such as coughing, shivering, or stomachache, or psychological reactions such as a mental disconnection from thoughts and surroundings (dissociation) and the involuntary appearance of memories of past traumatic events (flashbacks).

An image emerges then, in which the informants, as dental patients, experience themselves as objects subjected to elements that includes ones that we do not usually think of as subjects, that is, as actors with agency. In what follows we present three main categories into which these agents may, we suggest, usefully be categorized: 1) the pain, 2) the traumatic memories, and 3) the dentist. We explore the interplay between these elements positioned as subjects, i.e., as agents by virtue of their capacity to effect reactions in the patient, and the patient as the object in and upon whom reactions occur and are brought to bear. Yet the process thus described is located in the interplay of social and material elements inherent in the treatment situation, rather than in the patient as such. Material elements pertains to objects, organs, and organisms, whereas social elements encompass relations between actors. Notably, actors here include also the patient's bodily expressions, distressing thoughts and images, since the appearance of these elements in the clinical setting assumes an autonomous agency (with whom the patient is confronted and has to interact) that can be usefully compared to an interactional "Other". Hence, rather than simply asserting the presence of a triggering process, we proceeded to explore specific qualities of that process or, more specifically, what we describe as the 'social and material dynamics' of the triggering event.

Pain

All informants talk about oral pain as a main driver for wanting or needing dental treatment. They describe how they have experienced beatings against their mouth or face, teeth being pulled out in prison and the lack of possibility to maintain personal hygiene, which among other things have resulted in severe dental decay. Reza, an Iranian man in his late fifties, gives an illustration of life in prison:

> *When you are isolated in prison there is no window. You have no circulation of air. It affects the entire body, including the teeth, because there is only CO_2 inside the room. There is no oxygen… And they hit a lot… with their fists. The jaws are fractured, and also the teeth get broken. And for months you can't brush your teeth… can't use toothpaste, nothing. And then it gets night… you can't sleep at night because of the anxiety and stress you are in. The teeth starts grinding into each other, and you can't control your legs…*

Reza has a university degree, but suffers from PTSD. After ten years in Norway he cannot hold a job and does not speak the language. His jaw was broken by his torturers and, although he was used to regular dental checkups during his upbringing, he developed a destructive dental and medical anxiety that has prevented him from seeking treatment that could reduce his pain.

Despite their impaired oral health, many informants express a will to endure a lot of pain before seeking dental treatment. The reasons they suggest are complex but, apart from challenges associated with the resettlement process, they express exhaustion and anxiety after imprisonment and trauma. The fear that a dental visit would bring on more pain, physical or mental, is apparent, although none of the respondents have any recollection of dental anxiety prior to the torture exposure.

All informants describe negative experiences from dental treatment, and for about half of them it is something they dread long before the appointment. They describe it as something dangerous that they cannot control. The pain may appear at any time, and at uncontrollable strength. Amir (60), another Iranian man, had several teeth fractured from beatings and kicks during imprisonment, and the only treatments offered were un-anesthetized tooth extractions, which he remembers as being extremely painful. The fear of re-living the experience made him avoid dental treatment for several years after resettlement. About going to the dentist he says:

> *After the prison it became very difficult. The worst is… it is very painful. A picture of torture appears… It hurts! … Sometimes I cough, and I get shaky… And another thing… when it has been a long time since the last time, a picture comes, and I shiver! When I go into the office… at the dentist's… and look at this and that machine… then it happens automatic!*

Pain sets in motion uncontrollable shaking and shivering in his body, and if the time between dental appointments is too long, his body forgets any positive experiences and he may experience flashbacks in which he sees images of previous traumatic episodes. Sometimes merely the anticipation of pain may bring about the reactions, long before any actual pain has occurred. He describes how his body and mind reacts automatically, and sometimes makes him lose track of time and place. With words like *"I'm gone", "I'm not here", "I see things", "I'm lost"* and *"I skip time"* he describes the psychological reactions of flashbacks and dissociation, and he points out the importance of going to a dentist who knows how to bring him back.

It is consistent throughout the interviews, even among informants who do not describe themselves as dentally anxious, that sudden and intense pain from clinical procedures harms the patient's sense of control. The pain becomes the active party, acting upon the patient who is put temporarily in a non-agentic position in which she/he can exert little control. This objectification may be partial, as when the patient shivers or becomes nauseous but still has some consciousness of what is going on, or total, as when the patient dissociates.

Anesthetics may provide pain relief, but may also entail having to choose between two evils. For some informants, the thought of needles or the feeling of numbness may accentuate the sense of losing control more than they represent relief from pain. Somalian Aaden describes how the sensation of not being able to feel his face, brought about by anesthesia, gives rise to dread at the involuntary thoughts of being permanently paralyzed. Two of the informants had been offered dental treatment under general anesthesia. Although the sedation made the actual treatment easier, post-operative pain, changes in the mouth, and the taste of blood left them with the sense that something had been 'done to' them after waking up.

Traumatic memory

In addition to pain inflicted by dental procedures, most of the informants convey how

particular things or situations that remind them of previous traumatic experiences can set off involuntary, unpleasant bodily or mental reactions. As Amir describes, the reactions *"happen automatic"*, especially in situations that involve an element of surprise. He describes how he is taken back to unforeseen episodes of violence in prison if an unannounced person, e.g., the dental secretary, suddenly appears behind him.

Aaden's heart starts pounding and his body freezes at the sight or taste of blood. If the dental personnel are inattentive, he may disconnect mentally from his surroundings and experience flashbacks. Vibration and sound have the same effects. He says:

> *The pain, it's… the pain I can take! Yeah! I have experienced so much pain. It is this one: 'Woooo… vibration and drilling and… sound… That sound - like bullets! It's taking me back all the time… times of bad things!*

His PTSD-symptoms are not only present during the treatment session. He explains that sometimes it gets worse when he gets home. Farouk, who in his own words, has 'been through all methods of torture', tells a similar story. He is exhausted for 2–3 days after dental treatment. His stomach and legs hurt, he cries and is tired but unable to sleep.

Reza states that since his imprisonment it has become very difficult for him to trust other people. He feels unsafe and alert in most situations, but when it comes to dental treatment he is extremely anxious. He knows that the dentist is not intending to harm him. Still it is difficult for him to control his body and his thoughts when he gets in a prone position. He says:

> *When I come near the dental equipment and look at it… all those episodes are experienced all over again. Because of, in prison… it is like this: maybe it is a doctor, maybe it is a dentist… maybe it is a treatment… But they also work with the government, and they misuse their profession!*

His anxiety clearly and directly relates to his past trauma. More specifically, he speaks of how experiences in the present can cause memories of experiences in the past to pay hurtful visits to him, and he has no capacity to do anything to prevent this. Instead, he has to suffer these visits, passively awaiting their fading away, for now.

Zahra is a busy, hard-working and reflective Iranian woman in her sixties. She eloquently puts the experience of agentic thoughts into words when she states that, to her, one of the most difficult challenges related to dental treatment is "*the pain in my thoughts"*. She explains:

> *It is just thoughts… I close my eyes and wait… or I sit there in the dental chair, and so… the thoughts come back…*

What she is talking about are vivid thoughts of torture. For example, the dentist's use of water can activate her memories of almost being drowned. She explains how these trauma-related thoughts are brought to mind more often in situations where she experiences loss of control.

Some of the informants express that they know and understand, cognitively, that the dental treatment is safe, but still find it almost impossible to fight their reactions. Reza explains that his cognitions and his emotions get mixed up, and although his head tells him that he is safe, his body will not always listen. Amir describes how some days are worse than others. Some days he is not ready for someone to work in his mouth:

Maybe… it may be that I had a bad day the day before. It may be, for example, that the night before was very hectic, and that I am tired and exhausted in a way…

Zahra gives an example of how the mental processes may be disrupted altogether:

One day I went to a dentist… I felt the panic coming… but luckily it came afterwards! I endured quite a lot, sitting there getting finished. But afterwards I went to a café, and I sat there for three hours without knowing… Then, after three hours, I suddenly realized: Why am I sitting here? I looked at my watch and three hours had passed…

During the dental appointment, she managed to maintain a sense of control, but afterwards the invasion of traumatic memories took over completely and left her with no agency at all. This is an example of the total objectification that occurs during dissociation – when the mind takes a break from handling information.

To sum up, the informants describe how agentic elements in the dental treatment situation contribute to positioning them as a passive intermediary object between these agents and the invasion of the traumatic memory. In this sense, the traumatic memory also acquires an agentic capacity, a capacity to propose itself to the patient in ways that appear impossible for them to prevent, and which in turn give rise to unpleasant bodily, as well as mental and emotional, effects.

The Dentist

Although most of the informants rationally believe that the dentist wants to help them, half of them say they are 'afraid of dentists'. Some describe the dental practitioner as the one who inflicts pain and hence is apiece with what reminds the patient of his traumatic experiences. Some informants describe memories of dentists, or someone impersonating a dentist, acting as torturers. Zahra gives an example:

I saw them be taken to the 'dentist'… or to the room where they would be tortured. And when they came back they had no teeth! And they got no anesthesia. They got nothing. They just pulled them out to inflict pain on them!

As dental patients, most of the informants link the problems that arise from being unable to anticipate when pain will occur to the fact that they cannot see what is happening in their mouth, the site of treatment being blocked from view. It is apparent, too, that the dentists' behavior is crucial to whether or not adverse reactions are activated, by virtue of the patients' descriptions of being unable to survey and recognize activities in the clinical space around them. Farouk, who has never found the right time to inform his dentist about his torture experiences, says:

Sometimes he does… he wants to take x-rays and such… he puts something inside here… then he goes there… and then comes quickly… and then a picture there… Everything becomes chaos! Then the secretary comes, and they both talk over my head: Get this, get that… and maybe do like this, and back… like that! And that I have to lie 'like that', and then… they just… Afterwards a lot of pain is coming here… Immediately – pain in my stomach! That way it mixes in my stomach!

It makes Farouk insecure when they are rushing back and forth, working and talking above his head. His emphasis on speed is echoed by many of the other informants, who

express that they get scared or uneasy if the dentist is working too fast.

Hamid, who had no dental treatment experience pre-resettlement, shares his opinion of the first dentist he met:

> *He behaved like… like he was a civilian police officer, as if he worked for the national security services or something!*

He says that this dentist made him feel as if he was under interrogation. He never smiled and was hard-handed and inaccurate in his work. Hamid got the impression that he did not like his job; he was just eager to finish and get on with the next patient. All informants underline the importance of communication and being treated with respect. Farouk relates this to his prison experiences and explains how his guards never talked to him when they came to torture him. Some informants also mentioned how a lack of interpreters accentuates their notion of not knowing what is about to happen, and thus increases their fear and insecurity.

Our interpretations of informants' reflections indicate that the dentist's capacity to bring about trauma-related reactions in the patient increases, or even is created, by the fact that it is inflicted on a patient who is unaware of what is going on. Thereby, the patient's experience of being a passive object is accentuated – a phenomenon which is particularly problematic to torture victims. Among the three categories of agents discussed in our analysis, the dental practitioner's position as subject is more powerful than the others, given her/his potential to set in motion both the pain and the traumatic memories. However, as the dental practitioner does not control the agentic capacity of the pain and the traumatic memories, it is reasonable to consider all three of them subjects with individual agency.

Discussion

This study explores oral health challenges in refugees with experience of torture, and proposes an analysis of what we have called a social and material anatomy of the process, through which trauma-related reactions are produced in such patients in the course of undergoing dental treatment. Although some previous studies have provided examples of such challenges (Keller et al., 2014; Singh et al., 2008), this is to our knowledge the first in-depth exploration of how they come about. The analysis shows how going to the dentist entails actively choosing or accepting to be in an objectified position, having to lie down in the dental chair and prepare to be in a passive position, acted upon by the elements of the clinical situation which we, therefore, propose are usefully considered as agents.

The present study indicates that the predominant dental treatment challenge for torture victims is the triggering of trauma-related reactions. Hence it supports previous research that has shown a strong relation between PTSD symptoms and dental anxiety (Høyvik et al., 2019; de Jongh et al., 2006). It is clear that although several of the informants understand the connection, and reflect on the unwanted, automatic reactions while they occur, they often lack the agency to break the process once it is set in motion.

Despite the great desire of many torture survivors to have their teeth restored, the fear of uncontrollable pain during dental treatment may prevail. When such pain is accompanied by adverse bodily reactions, or visions of horror, dental treatment is easily postponed or avoided, as explained by several of the informants. The propensity to avoid dental appointments was also found in victims of sexual violence (Larijani & Guggisberg, 2015).

When facing the need for dental treatment, the traumatized patients are left with

two options: 1) to consciously let go of their agency and surrender to the dental treatment, with the risk of psychological consequences, or 2) to hold on to their agency and avoid the treatment, with further deterioration of oral health as a probable outcome. From the torture victims' perspective, to refrain from placing themselves in the dental treatment position is one of very few available alternatives to mitigate psychological damage.

If the dental treatment is not avoided it is often endured under great strain, as described by several of the informants, and pain sensations during treatment hold the capacity to trigger traumatic reactions. This supports previous research that has indicated a complex relationship between torture, pain and intrusive memories, pointing to the importance of attempting an integrated treatment of pain and traumatic symptoms for survivors of torture (Taylor et al., 2013). The ability of PTSD symptoms to enhance the experience of pain, and vice versa, applies also to orofacial pain (Burris et al., 2009), which emphasizes the importance of oral rehabilitation despite the possible traumatic reactions related to the treatment.

In the same manner as patients become objects acted upon by pain, we have described how memories may acquire an agentic capacity to act on the patient in ways they consider impossible to prevent. Similar findings were reported by Taylor et al. (2013), who described how uncontrollable bodily and mental reactions in torture victims were often activated by trauma memories. Likewise, a study of sexual-abuse survivors described how anxiety reactions in the dental setting were frequently triggered by stimuli that bore similarity to previous traumatic experiences (Fredriksen et al., 2020).

There is historical evidence of dentists participating in torture, either directly or by treating injuries only to make the victims ready for new maltreatment (Speers et al., 2008). Moreover, there is an inherent power dynamic between care providers and patients, which to a survivor of torture may trigger recollections of the power dynamic that occurs between the perpetrator of torture and the victim. Some informants describe how a person who reminds them of someone from their past, or who behaves in a certain manner, can bring about memories of traumatic experiences. Thereby, the dentist in person becomes the triggering agent even by virtue of the representation of 'dentist' she/he unwittingly evokes.

The feeling of powerlessness is pervasive in the interviews. Svenaeus (2015) argues that for torture victims, pain inflicted on them as objects is often interpreted more as power than as pain. As the agent whose actions cause the experience of pain, the dentist is the party to hold power in the clinical encounter. In our analysis, the agency of the dentist extends also to the power to activate the other subjects: the pain and the traumatic memories. However, whereas the dentist is usually perceived as a trigger only when she/he is present, the pain and the traumatic memories bear the capacity to act as triggers far beyond the actual treatment situation, as explained by several informants. Physical and mental exhaustion in the aftermath of dental treatment is also described by Fredriksen et al. (2020) in their study of sexual-abuse survivors.

Being subjected to torture entails a loss of trust in humanity through the violation of bodily autonomy and feelings of self-worth (Bernstein, 2015). Most informants point out that it takes time to build trust in new people. Any unforeseen gesture is alarming, which enhances the probability that the dentist may trigger trauma-reactions. However, informants in this study also describe how reactions recede once trust is achieved. For this

reason, once they have found a dental professional they feel understands, they attach great importance to the ability to retain that relationship of trust.

Limitations

Statistical generalizability was not an aim in this qualitative study. All informants were patients referred on grounds of oral health challenges. The severity of PTSD symptoms may have precluded the most mentally impaired torture victims from participating. However, the final sample of 10 informants represented a satisfactory range with regard to ages, genders, countries of origin, types of torture and dental treatment experienced, and was comparable to other qualitative studies involving torture victims (Isakson & Jurkovic, 2013; Taylor et al., 2013). Diversity was also present in the informants' differing capacity to reflect on their experiences and the modes in which such reflection was articulated.

Restricting to fluent Norwegian- or English speakers was not feasible, given the limited population from which the informants were recruited. The disadvantages from interpretation was mitigated by using professional, experienced interpreters, and an interviewer who was experienced in communicating through interpreters. Nevertheless, the use of non-native languages in research interviews may impede the expression and interpretation of nuances of meaning. On the other hand, this circumstance also prompts deliberate probing and discussion of concepts and terms, thus potentially strengthening exploratory capacity.

To implement the study, it was an advantage that the interviewer, being a dentist, had prior knowledge of the subject and the circumstances. However, this entails a risk of subjective bias or interpretations errors. Professional assumptions and possible blind spots that might results from the first author being a dentist, was counterbalanced by all authors taking an active part in the planning of the study and the analysis of the material to ensure multiple perspectives.

Moreover, there was only one interview with each informant, on a theme that included also previously unarticulated reflections on personal experiences. Hence, participants may have had new reflections subsequent to the interview, and talking to them again might have shed further light on the topic. However, due to the psychological strain it was to some of the informants to go through with the interview, a follow-up would not be ethically justifiable.

Conclusions and implications

The present study provides new knowledge about the process that complicates torture victims' ability to engage in and tolerate dental procedures, and points to the activation or aggravation of trauma-related reactions as a major challenge. To surrender to dental treatment means to give in to being suspended albeit temporarily in an objectified position, acted upon by subjects capable of producing deeply undesirable mental, emotional and bodily states. We have pointed to pain, traumatic memories and the dentist as the most prominent factors with such an agentic capacity.

All professionals who work with torture victims should be aware that these individuals often suffer from comprehensive oral health problems that affect their quality of life on many levels. Although dental care may be desperately needed, the perceived parallels between the dental treatment and the patients' previous torture experiences, may activate severe physical and psychological reactions. Thus, dental visits are either avoided or suffered through, with the risk of immediate or lasting consequences.

The clinical implications for dental health personnel that may be drawn from the present study are important and worthy of further exploration. However, some preliminary recommendations may be outlined: First, the dentist should have the understanding of who may be a potential torture victim, and have knowledge about common challenges faced. Enough time must be reserved to ensure a thorough report, however without the dentist prying into the details of the torture experiences. Trauma reactions are set off by different stimuli depending on personal experiences, hence triggers need to be explored individually. Furthermore, always giving a heads up about everything that will happen is important to ensure predictability and increase the patient's sense of control and agency. Finally, all dentists working with traumatized individuals have to know how to handle psychological reactions – to know how to bring the patient back to 'here and now'.

Professionals such as social workers, psychologists, physicians and physical therapists, should be encouraged to ask their clients about oral health, and offer to help with further referral. At the same time they should keep in mind that, although dental treatment is clinically necessary, it may represent a major challenge if the patient is not met with the necessary psychological insight. Thus, the referral should include parts of the patient's trauma history relevant for dental care, and the designated dentist should be familiar with the principles of trauma-informed care. Collaboration between professional groups is important in the rehabilitation of torture victims, and is best achieved when all providers understand the patients' needs.

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