

'We are not just a body to fix': dental care experiences of survivors of modern slavery and human trafficking

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Abstract

Aims

This study reports on a focus group with survivors of modern slavery and human trafficking to understand experiences of dental care to inform trauma-informed teaching, training, and recommendations for improvement of services.

Methods

A multidisciplinary team of a psychologist, dentist, public health professional, actors and community organisation specialising in supporting survivors of modern slavery and human trafficking developed a qualitative study to better understand the dental health experiences of survivors of modern slavery and human trafficking. Five adults with lived experience of modern slavery or human trafficking were recruited via the community organisation to a focus group held at a Dental School. The discussion was audio-recorded, transcribed, and analysed using reflexive thematic analysis from a contextualist epistemological perspective on NVivo.

Results

Four themes were developed: precarious pathways to dental care; trust travels across health services; the dental encounter as an embodied loss of control; and agency must be enabled, not presumed. Dehumanisation and recognition formed an overarching analytic frame.

Conclusions

Survivors encountered systemic and interpersonal barriers to dental care. Listening, explanation, continuity and meaningful choice may support more humanising, trauma-informed dental encounters without requiring disclosure of trauma.

Key Points

- Dental experiences of survivors of modern slavery and human trafficking remain under-researched, despite the potential for dental procedures and service barriers to reproduce experiences of powerlessness and loss of control.
- Dehumanisation and recognition shaped participants' accounts across access, previous healthcare encounters, embodied dental treatment and opportunities to exercise agency.
- Universal adaptations to trauma-informed dental care should routinely provide explanation, choice and procedural control, without requiring patients to disclose trauma to receive responsive care.

Introduction

Modern slavery describes slavery, servitude, forced or compulsory labour and human trafficking. Human trafficking refers more specifically to the recruitment or movement of a person for exploitation and may occur internationally or within one country. Those caught in these processes may experience insecure immigration status which may itself be used as a means of control, restricting a person's ability to leave or seek assistance.¹ Research documents substantial physical and mental-health consequences for trauma survivors,^{2,3} as well as poorer oral health outcomes^{4,5} linked to neglect, malnutrition, and physical abuse, alongside a range of extrinsic and intrinsic factors. Exploitation may be associated with injuries to the head and neck including bruising, fractured or luxated teeth.⁶

For many survivors, the dental environment can inadvertently mirror experiences of exploitation or torture.⁷ Lying passively in a dental chair can trigger feelings of powerlessness, and common circumstances such as a dentist's fingers or tools in the mouth can risk activating trauma for patients.^{7,8} Survivors also face a range of barriers to accessing care including discrimination and lack of knowledge of systems.⁹

Existing dental literature has largely considered professionals' role in recognising victims of trafficking for safeguarding,¹⁰ rather than survivors' oral-health needs or experiences of accessing and receiving dental care. Health professionals are often in a unique position to identify survivors,¹¹ and deliver trauma-informed care that create a safer and more inclusive experience for patients. This paper responds to Smith et al's¹² call to better understand patient perspectives to deliver trauma-informed care.

The study brought together a multidisciplinary team with the aim to explore and understand dental care experiences of survivors of modern slavery and human trafficking and to inform the development of simulated actor teaching and trauma-informed care training to improve services. This paper will report on the focus group outcomes only.

Methods

The research was funded by Brigstow Institute and ethical approval (ID:30681) was obtained from the University of Bristol Workstream 1 Research Ethics Committee.

Five participants, three women and two men, with lived experience were recruited via a local charity specialising in supporting people who had experienced modern slavery and/or human trafficking. All had experience of dental treatment in the UK. All spoke English as an additional language and were experienced Lived Experience Consultants (LECs) used to advocacy.

The focus group was held in July 2026 and lasted for 150 minutes, with the recorded element lasting 105 minutes. Before the recording, introductions were made, refreshments shared and the study discussed, information sheet reviewed, and signed consent taken for recording and use of quotes (with clear option to withdraw consent for personal contribution within two weeks).

The group was facilitated by the PI (NA) and cofacilitated by the Dental Public Health professional (AM) using a semi-structured topic guide developed from review of relevant literature, exploring access to dental services, experiences of treatment, and recommendations for trauma-informed care. We did not ask about personal histories of trauma. Also present were a charity staff member known to the LECs, and two actors to develop simulated actor scenarios for undergraduate teaching (to be addressed in a separate paper). During the planning process, the LECs were aware of everyone who would attend; this included actors whose presence and role were reiterated at the beginning of the session.

Payment was made to the charity to compensate for their administrative time and support with recruitment, and the charity paid the participants for their time directly from this fee.

The discussion was audio recorded on an online platform which generated a transcript which the PI reviewed for accuracy. The transcript was shared with the partner organisation and participants to review, correct, clarify or redact information and choose how they wanted to be identified, and ensure there were no details that could compromise safety.

Typically, in qualitative research pseudonyms are generated for outputs. Allowing participants to choose their own pseudonym has been discussed in terms of psychological importance¹³ and epistemic justice.¹⁴ Recognising this population is often rendered invisible in healthcare services, a pseudonym may feel like further erasure, so we invited choice of name, initials, or pseudonym for research outputs. Two selected their first names and three selected their initials. This recognised participants' interests in both protection from unwanted identification and acknowledgement as knowledge contributors. All potentially identifying locations were removed. The transcript was then sent to the rest of the research team and uploaded onto NVivo for analysis.

Analysis

The transcript was analysed using Braun and Clarke's reflexive thematic analysis¹⁵ with an experiential orientation focusing on how participants understood and made sense of their healthcare experiences. A contextualist epistemological position was adopted recognising accounts were shaped by social structures, institutional contexts and the focus-group interaction.¹⁶

The PI undertook familiarisation, coding, and iterative theme development. Developing interpretations and themes were discussed with the multidisciplinary team as a form of reflexive dialogue rather than to establish coding reliability or consensus. The analysis is framed within the PI's discipline of psychology which informed the coding process.

Results

Participants described feeling reduced to an administrative problem, assumed social category or body requiring treatment. Care was experienced as more humane when professionals listened, explained

procedures, demonstrated concern and enabled choice. Four themes captured how this pattern operated across access, previous healthcare encounters, embodied treatment, and agency.

Theme 1: Precarious pathways to dental care

Participants described access to dental care as uncertain, fragmented, and dependent on circumstances beyond their control. Difficulties included prolonged wait times, inability to register with a local dentist, uncertainty about costs, and disrupted continuity. Voluntary-sector dental visits and wellbeing events provided valued access to advice, but these offered intermittent substitutes rather than stable pathways or continuing care.

Waiting was experienced not as a neutral delay but as prolonged exposure to untreated pain. Clarice, who had been in pain since 2025 said,

'I'm on the waiting list, and my appointment is on March 2027... It means that if before 2027 the pain kill me, or I'll just wait till 2027.' - Clarice

Geographic movement also disrupted continuity; OF remained dependent on a dentist outside the area after being unable to register locally,

'I've never found a dentist [locally], so I still rely on my dentist [elsewhere] ... I haven't had a chance to go back to my dentist.' - OF

SA was advised she would need specialist treatment but not informed whether the costs would be covered,

'They say I have to get to the specialist and I have to pay for it. That's £1,000, and I don't have that one, and I don't know, is that my NHS also cover it or not? So they don't have this communication.' – SA

Theme 2: Trust travels across services

Participants did not view dental services independently of their wider healthcare encounters. Experiences of GPs, hospitals, interpreters, receptionists and mental-health services shaped whether they expected dental professionals to listen and provide safe care. Being rushed, ignored, disbelieved or categorised before being heard shaped expectations of dental care.

'Before we survivor even come to you, we carry so much already inside us. We are not just [a] body to fix. We are people who have been mistreated, who have been ignored, who have been treated like we did not matter. That is what stop us sometimes long before we even sit in the chair.' - Clarice

She described being vigilant in appointments to determine whether she would be safe,

'We are on alert. We are auto-vigilance. We watch ... if I enter somewhere, I watch the way they look at me. Just the way you treat me would determine if I will come back next time.' - Clarice

Sharing a positive experience, Clarice singled out being listened to,

'The way they listen to me, they take time to listen ... When you enter into other doctor room, it is like you have to do fast and rush ... but they [mental health team] take time for you.' - Clarice

Where trust was built, it created a sense of safety and support. SA had recently moved to a new dental provider; she described feeling unwell at her appointment, and how she felt safe and seen when the dental practice called to check in on her.

Immigration-related categorisation could also undermine trust. SA felt she was treated differently due to her sense the receptionist assumed she was an asylum seeker,

'She thinks I'm an asylum seeker, and she treats me like this. It's not even that I'm an asylum seeker. So I just feel bad.' – SA

Theme 3: The dental encounter as an embodied loss of control

Participants described being touched, positioned, and treated while unable to speak. In these accounts, the sense of loss of control was accompanied by a feeling their fear was secondary or even irrelevant to treatment delivery. For some participants, this triggered panic and hypervigilance and sometimes led to missed appointments.

Clarice said,

'Especially dentists, because dentist is touching. Before I sit in the chair, that you put something in my mouth, you have to know that I can have panic attack. I can react ... if you didn't say to me, announce that you do this or this.' - Clarice

She described how experiences of oppression could remain psychologically present during treatment even when undisclosed,

'You cannot even open your mouth. Maybe you are facing torture; you are facing oppression...We live it in those rooms with them.' - Clarice

Highlighting the importance of explanation SA discussed missing appointments due to fear resulting from insufficient information,

'Before giving us the option, [they need] to say what the procedure is ... Three times I miss, I miss because I was afraid, because I didn't know what was happening.' - SA

This fear resulted in an inability to communicate or process information and seeking an escape,

'The first three or four appointments I couldn't even speak ... because of how they treat me and how the conversation, how the communication was ... the person will be inside fearful and can't talk. Just [thinking] 'When is the treatment finishing? I want to go.' - SA

Theme 4: Agency must be enabled, not presumed

Participants indicated that humanising dental care required more than professional kindness. It involved recognising patients as knowledgeable agents and offering choice over trauma disclosure and treatment.

There were contrasting views over disclosing a history of trauma, and whether responsive care could be obtained just by confident presentation,

'I think people will treat you based on how you present yourself. So, if you go confidently and say, "This is what I want," then they will actually listen to you ... personally, I have, and I felt like I was listened to.' - OF

However, for Clarice her confidence had not resulted in positive treatment:

'I've been confident enough, and they treat me less than human ... I'm somebody very confident. But they broke it.' - Clarice

Patients also differed on disclosing trauma,

'Before I sit in the chair ... you have to know that I can have panic attack ... You have to know a bit, to summarise this for me.' - Clarice

SA similarly explained,

'I'll say [yes], because that's something they will know, like I have trauma, so they can shape it [the appointment] differently.' - SA

In contrast, OF said,

'I like to just keep my privacy to myself ... Just offer me that service, just as it should be ... If I was given a box to tick, I would not.' - OF

Participants therefore differed over whether disclosure would facilitate safer care or compromise privacy.

Being able to take someone in to the appointment offered a bridge between disclosure of trauma and additional support,

'If you have somebody you trust, and they know your trauma experience, then [you] might feel more confident to go with them ... if you're going to break down ... they can comfort you and then help you speak.'
- OF

Discussion

This paper explored experiences of dental care among survivors of modern slavery and human trafficking. Dehumanisation and recognition formed an overarching pattern across participants' accounts. Fragmented access, previous experiences of not being heard, loss of control, and limited opportunities to exercise agency reinforced a sense of being treated as an administrative problem or simply a body requiring treatment. In contrast, being listened to, clear explanations, follow-up, and meaningful choice communicated participants' knowledge, preferences, and emotional experiences mattered. Thus trauma-informed dental care involves not only reducing distress in the chair but creating relational and organisational conditions for agency. Whilst access challenges and feeling rushed during appointments are not unique to this patient group, in the context of histories of coercion, disbelief, and limited agency these processes acquire a particular resonance.

The findings are consistent with evidence that dental treatment can evoke vulnerability and loss of control among people with histories of trauma. Research with torture survivors has identified positioning, restricted communication, touch, and dental instruments as potential triggers for trauma reactivation,^{7,17} while research with survivors of sexual abuse has emphasised the importance of predictability, communication, and control during treatment.⁸ The present study extends this literature by demonstrating distress was not confined to procedures in the dental chair. Participants' expectations of dental care were shaped by experiences across health services, with uncertain entitlement, cost, and geographical movement impacting continuing care. This complements evidence concerning barriers to healthcare among trafficked populations,⁹ but adds survivor accounts specifically concerning oral healthcare - an area where literature has largely focused on professionals' identification and safeguarding responsibilities.^{10,11}

Across the four themes, participants' accounts can also be interpreted through the lens of mechanistic dehumanisation in healthcare. Haslam describes mechanistic dehumanisation as the denial or lack of recognition of personal factors including emotional responsiveness, individuality, and agency¹⁸. Participants' descriptions of being treated as a body to be fixed, categorised, or unable to influence treatment resemble this form of dehumanisation. Haque and Waytz identify de-individuation and diminished patient agency as processes through which healthcare can become unintentionally dehumanising.¹⁹ Interpersonal warmth was valuable but insufficient where patients lacked information, procedural control, or were not treated as credible. Recognition was communicated materially through time, listening, explanation, and choice. In this sense, agency was relational rather than simply an individual capacity. Confidence and agency could be enabled through supportive encounters or eroded when a patient's testimony and preferences were disregarded.²⁰

Participants' differing views about disclosing trauma have important implications for trauma-informed practice. Some considered disclosure helpful to enable professionals to anticipate or adapt; others regarded trauma as private and did not want care to depend on disclosure. This divergence cautions against treating disclosure as a route to offering or receiving trauma-informed care. Requests for

disclosure may expose patients to stigma, unwanted identification, or pressure to narrate experiences that are clinically unnecessary. They can also result in dental professionals receiving information they are untrained to support or unable to signpost.²¹ The findings instead support a universal trauma-informed approach in which predictability, explanation, consent, and opportunities for control are routinely available; while patients retain the option to disclose needs or experiences. Disclosure may thus support individual adaptations but should not be a prerequisite for compassionate and responsive care.

The findings identify several practicable ways of supporting safety and agency in dental settings, presented in Fig. 1. Before the appointment, patients could be informed they may bring a trusted companion, and interpreter requirements discussed. A possible open question of “Is there anything we can do to help you feel safer or more in control during dental treatment?” can be asked to all patients but may be more significant in building safety for patients with a history of trauma. Before treatment begins, professionals can explain what will happen, check understanding, and agree on pause/stop signals. During treatment, dental professionals can announce touch and procedural transitions, attend to non-verbal signs of distress, confirm continuing consent rather than assuming it from silence, and not interpret missed attendance as non-compliance. Choice regarding practitioner gender and appointment length may not always be feasible, but preferences can be invited and accommodated where possible. Follow-up after a distressing encounter may also communicate continuing concern. Training co-developed with survivors and trauma-informed-care specialists could help dental teams understand how routine clinical and administrative practices may be experienced, provided lived-experience involvement is voluntary, appropriately supported, and remunerated.

Strengths and limitations

This study offers survivor accounts of an under-researched aspect of healthcare. A strength of the study was its process-based approach to representation, through which participants exercised control over transcript content, quotation and identification. Nevertheless, the findings should be interpreted as contextually situated rather than representative of all survivors of modern slavery and human trafficking. The study involved five participants recruited through one support organisation, all of whom had experience as lived-experience consultants and sufficient English to participate. Their familiarity with consultation and advocacy settings may have enabled open sharing. The focus-group format enabled participants to compare and challenge perspectives but may also have constrained discussion of sensitive or divergent experiences. This paper includes quotes from only three of the participants. Whilst the other two participants made valuable contributions and interactions, generally agreeing with statements made, we have chosen quotes that are more illustrative of points. Analysis was led by one researcher and necessarily shaped by their disciplinary and reflexive positioning, although developing interpretations were discussed reflexively with the multidisciplinary team.

Conclusion

This study identified barriers to dental care extending beyond service access to experiences of not being heard, being categorised and losing control during treatment. Universal adaptations to trauma-informed dentistry in general practice should routinely promote dignity, predictability, communication and meaningful control, and need not depend on knowing a patient's trauma history. Listening to survivors' recommendations can help dental services recognise patients as knowledgeable agents rather than bodies requiring treatment.

Declarations

Ethics Declaration

The authors have no competing interests to declare.

Consent to Publish

Informed consent was obtained from all individual participants included in the study.

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Data Availability Statement

The data supporting this study's findings are available from the corresponding author upon reasonable request, subject to privacy and ethical restrictions.

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Figures

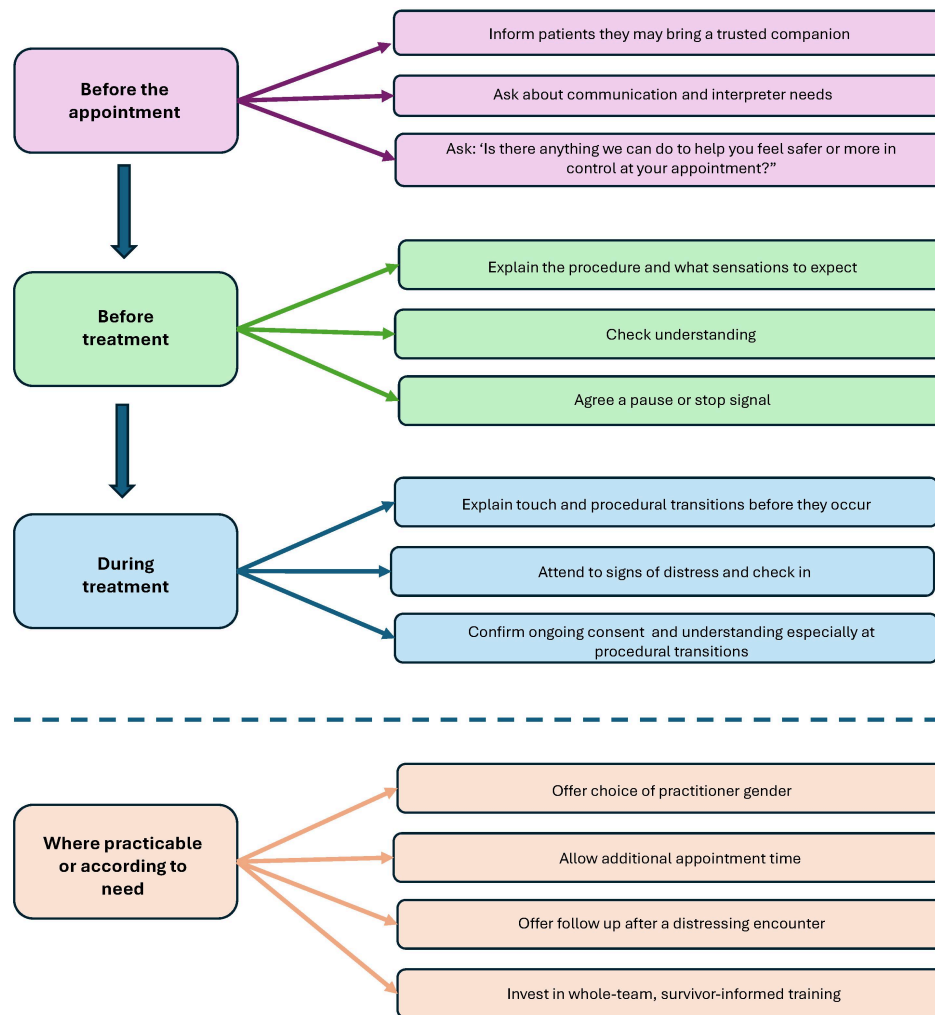


Figure 1. Practical steps for universal trauma-informed dental care without the requirement of trauma disclosure

Figure 1

A model for universal trauma-informed dental care