Access to dental care for victims of domestic violence

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ACCESS TO DENTAL CARE FOR VICTIMS
OF DOMESTIC VIOLENCE

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ABSTRACT

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This thesis presents an ethnographic description of women living in Safe Nest, a shelter for victims of domestic violence in Las Vegas, Nevada. The purpose of this research is to investigate why dental care is rarely utilized by women residing in the Las Vegas shelters, even when dental conditions may be impeding an individual's level of self-confidence and opportunities for employment. This study presents evidence that access to dental care is hindered by social and economic factors and a lack of communication between residents in the shelter and the service providers in the community.

Since utilization of health care services is dependent on cultural and contextual factors, this study provides insight into the victims' knowledge and need of dental care. The goal of this research is to increase information of available resources and expand perspectives about the complex issues surrounding the acquisition of dental care by victims of domestic violence.
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Carolynn Taylor
CHAPTER 1

INTRODUCTION

This thesis presents an ethnographic study of the social and economic factors which inhibit access to high quality dental care by the residents of a shelter for victims of domestic violence in Las Vegas. The purpose of this research is to investigate why dental treatment is rarely utilized by women residing in the Safe Nest Shelter, even when dental conditions may be impeding an individual’s level of self-confidence and opportunities for employment. This thesis argues this lack of treatment is not due to lack of need, but rather to an inability to pay for dental care services and to communicate those dental needs to the professional community.

Domestic violence involves people of all backgrounds and socio-economic levels; with estimates of prevalence as high as three to four million American women each year (NCIPC 2006). In Nevada, twenty-four hour surveys on domestic violence estimate that as many as 166 victims per day receive housing assistance in either emergency shelters or transitional facilities (NNEDV 2006). Many domestic violence victims must flee their homes with only a few personal items and little or no money (Hatton 2001; Ganley 1998). As a result, community outreach is crucial to the recovery of these victims (Campbell and Soeken 1999; Williams 1998).
Although some assistance exists for domestic violence victims (such as food stamps, advocacy, counseling, and temporary shelter), there appear to be few resources for dental care. Since utilization of health care services is dependent on cultural and contextual factors, this study seeks to provide useful insights into the victims' beliefs about dental care; to increase information on the availability of dental care resources; and to expand perspectives on issues of dental care acquisition for the Las Vegas community.

Importance of Good Oral Health

Good oral health contributes to quality of life by enhancing appearance, confidence, speech, as well as the ability to eat, enjoyment of food, and longevity of life. During the past fifty years, the meaning of oral health has evolved from a narrow focus on teeth to the recognition that the mouth can function as a "sentinel or early warning system" for the health of the rest of the body (Oral Health in America 2000:13). A growing body of research now suggests that chronic oral infections may be associated with increased risk of heart disease; low birth weights and premature deliveries; and complications in the control of blood sugar in diabetics (Timothe et al. 2005; Mathews 2002; Roberts et al. 2002; Oliver et al. 1998). Dental pain can also interfere with daily activities.

In addition to these physical manifestations, poor oral health can strike at our very identity and diminish how we see ourselves and how others see us. The field of dentistry currently lists the essential functions of the teeth as mastication, speech, and aesthetics, acknowledging that aesthetics can have a considerable
influence on how we view ourselves and how we function in society. Since appearance can be crucial to obtaining employment, oral health is an important part of the overall challenge of attaining independence and autonomy.

In his report, *Oral Health in America 2000*, David Satcher describes profound oral health disparities affecting the poor and racial/ethnic minority populations. This report is the first of its kind, exposing the link between oral health and other medical conditions and describing the state of oral health for millions of Americans as a "silent epidemic" (*Oral Health in America 2000:1*). This report further states that the infrastructure for oral health care is insufficient to address the needs of many disadvantaged groups, with homeless families experiencing even more problems accessing health care than other segments of the poor (Stevens 1992).

Since social and economic factors play roles in determining when and how people access dental care, access to dental care is a complex issue. Cultural beliefs, language skills, and multigenerational poverty present additional barriers to care. In order to overcome these barriers, current trends in research suggest that more information is needed on homeless, state and local, minorities, and diverse segments of the population. (*Oral Health in America 2000; Gift et al. 1992; Hatton et al. 2001; Hatton 1997*).

Presently, there is a paucity of research on these vulnerable and marginal segments of society. This study seeks to examine access to dental care as it pertains to one such vulnerable group, women residing at Safe Nest, a shelter for domestic violence (DV) victims located in Las Vegas, Nevada. It is based on
interviews, examination of records, and participant observation in the shelter setting. The women in this study share a common task, seeking to rebuild lives after abuse. This study highlights the value of oral health in this process of access to care and the impact this has on self image.

Perceptions of Need

The inspiration for this study came from a meeting at the Center for Urban Partnerships that was being held on the University of Nevada Las Vegas (UNLV) campus. This meeting was intended to help students design proposals for a community project competition and I had no intention of participating in the competition. I was attending on behalf of people who could not afford dental insurance and I wanted to know what people without money could do about dental care.

Each student was invited to stand up and explain why he or she was there. After a short time, I realized that most of the attendees were social work students and I was impressed with the different suggestions for community projects. Most suggestions concerned the homeless, such as feeding the homeless or rescuing homeless teenagers from the streets.

The more I listened, the more insecure I felt about what I was planning to do. At last my turn came and I stood up and asked if anyone knew where people without employment and insurance could get dental care. I explained that I had spent several months trying to find affordable dental care and that I had been unsuccessful. To my amazement, I received little support from the audience. I was told that the Dental School at the University of Nevada, Las Vegas (UNLV)
offered services for low income people. I then asked if any other resources were available and no one knew of any. The general attitude was that dental care was a problem already solved. I said that many people did not know about the UNLV Dental School.

Each person who had voiced an idea was invited to take a separate table to discuss their ideas further. People began to gather at the tables with the topics that were of interest to them. Only one person came to my table, a social work student named Kristina Ricker who was working in the Safe Nest Shelter for Victims of Domestic Violence. Kristina said that residents in the shelter also had trouble locating dental services, especially if their needs were not treatable in an emergency room. For example, one woman had an abscessed tooth and the emergency room could only treat for the infection. The tooth would then need to be filled or pulled, procedures that are not available in emergency rooms. Consequently, she and I decided to search for available resources.

After three months of exhaustive investigation revealed no new resources for treatment, we received an invitation to join the Community Coalition for Oral Health (CCOH) and we were told that this organization would assist us. In August 2004, I attended my first meeting of the CCOH as the advocate for Safe Nest. A small group of eight dental professionals were in attendance, most of whom were dental hygienists. They wanted specific information about the residents at Safe Nest. They wanted to know how many women needed dental help, what kind of treatment was needed, how often dental needs arose, and what did the women do about dental care now? I quickly realized that serving as
an advocate was going to be a learning experience. I also knew that it would be impossible to get serious consideration for a cause I knew so little about. Clearly more information was needed!

Domestic Violence and Access to Dental Care

Domestic violence is rarely an isolated or individual event (Ganley 1998). Abusive behaviors can be physical, sexual, psychological, and economic in nature, occurring primarily in intimate relationships (Straus and Gelles 1990). Domestic violence can take place in any type of intimate relationship; however, the majority of reported cases list the perpetrators as men with victims as women (Douglas 1991; BJS 2004). Estimates currently suggest between two and three million of such male initiated assaults occur to women in the United States each year (BJS 2004).

Effects of Victimization and Survival Strategies

Perpetrators of domestic violence use whatever means necessary to intimidate their victims into surrendering control (Ganley 1998). Tactics such as isolation and misinformation are used to achieve the ultimate goal of having control over the victim by severing the victim from all social/support networks (Ganley 1998; Campbell 1992; NWHIC 2007). According to Anne Ganley, domestic violence is

Purposeful and instrumental behavior. The abuse is directed at achieving compliance from or control over the victim. ...Domestic violence involves a pattern of behavior and certain tactics require a great deal of planning to execute... Domestic violence is repeated because it works and thus the pattern of behavior is reinforced.
The use of the abusive conduct allows the perpetrator to gain control of the victim through fear and violence. [Ganley 1998:24]

Victims use different strategies to cope with and minimize the abuse. “These strategies may appear to be ... passiveness or submission on the part of the victim, when in reality she has learned that these [behaviors] are sometimes successful approaches for temporarily avoiding or stopping the violence” (Ganley 1998:34). Jean Baker Miller (1986) elaborates that since such subordinate type characteristics are particularly pleasing to the dominating person; these behaviors become well developed over time. Another consequence of extended periods of domination was noted by Conception and Ebbeck who found that abused women could experience “a total loss of self” resulting in their inability to care about anything (2005:203). Eventually, this kind of domination may lead to loses in memory, a lack of perception, and a sense of helplessness which further inhibit the victim’s ability for effective problem solving (Vitanza et al. 1995).

Unlike victims of violence perpetrated by strangers, victims of domestic violence must overcome social and economic barriers in order to free themselves from their abusers (Hart 1993; Gordon 1996). A woman leaving her abuser may suddenly find herself with no place to live, little or no money, and no idea what to do next. Accordingly, she may have difficulty dealing with the stigma associated with her new role of being divorced, unemployed, or needing public assistance (Dutton 1992; Hatton 2001). Women experiencing such abrupt changes often need assistance in seeing their options realistically and in making decisions for themselves (Cascardi and O’Leary 1992; Hirschmann 1996). Therefore, it is
understandable that victims who have lived in a domestic violence situation for
an extended period of time may have complex psychological, economic, social,
and physical issues to overcome.

Posttraumatic Stress Syndrome (PTSD)

Posttraumatic stress syndrome (PTSD) names the type of symptoms many
victims of domestic violence experience. According to the Diagnostic and
Statistical Manual of Mental Disorders (DSM-IV 1994), PTSD is defined by two
criteria: exposure to a traumatic event and symptoms that occur following that
event. These symptoms include re-experiencing the event in nightmares,
flashbacks or thoughts, trouble falling asleep or staying awake, difficulty
concentrating, avoidance or withdrawal behaviors, and feelings of detachment or
emotional numbing (Hughes and Loring 1999; Breslau 2004; American
Psychiatric Association 1994). Because PTSD so accurately describes the
experiences and symptoms of battered women, mental health professionals
recommend that PTSD therapy be incorporated into programs for DV intervention
(Jones et al. 2001; Kubany et al. 2004; Johnson and Zlotnick 2006).

Note to Care Providers

It is important for health care providers to be aware that victims who seem
reluctant to carry out the recommendations for care may in reality be unable to
do so. These women may lack the assertive skills necessary to seek out and
obtain the care they need (Hatton 2001; Foa et al. 2000; Johnson and Zlotnick
2006). An understanding of the victim's passive or inappropriate behaviors as
"survival strategies" is essential to the successful implementation of programs on
health intervention (Ganley 1998). Studies have found that interventions to address PTSD issues are most effective if they are initiated while the women are in the process of leaving their abusers, seeking services, and first entering the shelter environment (McWhirter 2006; Johnson and Zlotnick 2006). In Judith Gordon's (1996) analysis of community services, she found that it was the assistance in obtaining services that participants rated as most valuable. Recognizing and understanding the unique needs and circumstances of DV victims can improve access to quality and comprehensive dental care.

Social and Economic Factors in Access to Care

Access to care involves more than the provision of services; it requires that provider and patient make contact, interact over a period of time, and communicate. Communication between health care provider and patient is essential in determining the best care for the patient. It is the patient’s participation in the health care process that is so important to her. Therefore, the patient’s perception of satisfactory access to dental care can only be achieved if the patient is confident that she made the best choice in her treatment.

Penchansky and Thomas (1981) define access to health care as the "fit" between characteristics of the health care providers and the expectations of the patients. They state that each of five characteristics must be in place before satisfactory access can be achieved: (1) Affordability- providers' charges and clients ability to pay; (2) Availability- extent the provider resources/technology can meet the clients needs; (3) Accessibility- geographic location; (4)
Accommodation- provider ability to meet preferences/constraints of client; and (5) Acceptability- extent that client is comfortable with provider (Penchansky and Thomas 1981).

A similar definition by Gulzar offers further support for the need of patient satisfaction in access to health care. Gulzar defines access as the “fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services” (1999:17). This study draws from these concepts in its analysis of access to dental care for the residents at Safe Nest.

Study Aims and Research Questions

This study explores why residents residing in Safe Nest Shelter for Victims of Domestic Violence rarely utilize dental care resources. The purpose of this research is to gain a better understanding of the residents’ knowledge and perceptions about dental care resources and to convey those insights to the dental care providers in the Las Vegas area. Additionally, this research will explore the archived records of residents at Safe Nest for the past year to determine how previous dental care needs have been documented and if patterns of need are present.

This information will increase the understanding of the professional dental care providers about this population and thereby lead to improved communication between the residents and dental care providers, improved
access to dental care, and increased utilization of dental care resources. This information could also assist the CCOH to implement strategic programs toward accomplishing their goals – to optimize the health of Nevadans through a focus on oral health and to achieve optimal oral health for Nevadans by advocating for increased prevention, access, and awareness (CCOH 2003).

This study was guided by the following research questions:

- What are the perceptions of the residents at Safe Nest about dental care?
- What is their knowledge of dental care resources in the Las Vegas area?
- What are the dental needs of the residents at Safe Nest shelter?
- Do the residents’ dental care and hygiene practices as children contribute to their present dental issues?
- What are the reasons that residents do not seek dental care when it is available?
- Is there is a stigma associated with having dental problems?
- What documentation of dental need can be produced that will be recognized by the professional community and used in advocacy for residents at Safe Nest?

This study will address the preceding research questions within the following format. The Literature Review, Chapter Two, will include a background on anthropological approaches in health care research and relevance of health care
in domestic violence shelters. The Methodology, Chapter Three, will discuss ethnographic approaches and criteria for data collection and analysis. The Qualitative Research Results, Chapter Four, will contain analysis of interviews with shelter residents. The Quantitative Research Results, Chapter Five, will contain analysis of the data collected from the shelter case files of 2006. Finally, the Discussion and Conclusion and Recommendations, Chapters Six and Seven, will cover the research findings, comprehensive analysis, and recommendations to the professional community.
CHAPTER 2

LITERATURE REVIEW

Anthropology in Action

Applied anthropology has long been recognized for its commitment to people who have limited access to social, economic, and political resources. The anthropologist's desire to view life from other peoples' perspectives and help improve their quality of life "is one of the most significant elements in the anthropological tradition" (Schensul 1987:211). Applied anthropology may best be understood as the application of anthropological research to the solution of human problems (Schensul and Schensul 1978). However, anthropologists do not always agree on the best way to identify social problems or the most effective way to help others understand those who are struggling at the margins of our society.

It is the method of the anthropological research and the use of that research that draws so much criticism from their academic contemporaries. Because objectives of applied research steer toward social change, these methods are frequently criticized for losing objectivity. But as the complexity of today's social environment becomes increasingly apparent, it is just as obvious that no single discipline or theoretical approach will be able to effectively solve the serious
social issues of modern society (Schensul et al. 2000). Applied anthropologists argue that the need for interdisciplinary and collaborative research is particularly suitable for creating a dialogue between community and national agencies that could lead to a better understanding of social problems and a greater insight into possible solutions (Schensul and Stull 1987). Despite such noble efforts, some anthropologists continue to question if they are doing enough.

The notion of action anthropology was first conceived in 1948 during an anthropological field-training program in Iowa that would eventually become known as the Fox Project. The Fox Project was under the direction of Sol Tax, a professor from the University of Chicago. Planned as an ethnographic study, the project was designed to give six graduate students the opportunity to conduct interviews, attend ceremonies, and observe the Meskwaki, a tribe of Native Americans historically noted for their resistance to change (Tax 1958).

The Meskwaki had survived an onslaught by the French during the eighteenth century, endured government relocation from Iowa to Kansas in the 1840s, and resisted conversion by generations of Christian missionaries (University of Chicago Magazine April 2004). In 1948 few of the Meskwaki had indoor plumbing, homes with electricity, cars, telephones, or an education beyond high school (Mertens 2004). As the plight of the Meskwaki people became more evident to the graduate students, they began to challenge their traditional anthropological research approaches. Conventionally, anthropologists believed that collecting information on cultures was valuable in and of itself and that "pure"
scientific research did not interfere in the lives of the people being studied (Mertens 2004).

The students found it increasingly difficult to answer the Meskwaki’s questions about what benefit the research would hold for the tribe. Ultimately, despite criticism from the academic community, the students became involved in various social programs such as a craft industry featuring designs of a Native American artist and a program intended to help the Meskwaki attend college (Peattie 1960; Gearing 1960). This new model of anthropological involvement was named action anthropology, a concept that would challenge traditional approaches and confront the reasons for anthropological research.

Although applied anthropology was not a new concept, the Fox Project was the first time that anthropologists intentionally proposed to work with the people in their study and to assist their research subjects in bringing about social change (Gearing, Netting and Peattie 1960). A few years later, with the surge of community organizations during the 1960s, many American anthropologists began moving from traditional applied research toward action style approaches, an approach to be known as collaborative research (Schensul 1978). This method of research generated closer relationships between the anthropologists and community representatives by requiring that the anthropologist work with the research community to identify problems, generate research questions, design methodologies, and utilize data to advocate for social change (Schensul 1987; Ervin 2005).
Today this practical approach to problem solving is recognized as naturalistic research (Kiefer 2007). Naturalistic research begins “not with a theory or a model, but with a problem – a situation that must be understood in order to reach a specific goal” (Kiefer 2007:40). Kiefer proposes that naturalistic research is particularly useful in the study of health sciences by offering an advantage not found in positivist approaches when dealing with issues of meaning and pattern coherence. Because human behavior is guided by the meanings people attach to events, the process of attaching meanings does not follow a predictable cause-and-effect pattern:

Rather: (a) it is experience based, which means it varies from person to person, group to group, and day to day; (b) it is contextual, that is, the meaning one attaches to any thing or event is highly dependent on the whole configuration of things, events and the meanings that surround it; and worst of all, (c) meaning formation is creative, in the sense that people can and do make up new meanings for things as they go along—meanings that have never been attached to those things before. [Kiefer 2007:41]

While traditional anthropology helps the anthropologist to understand why people live as they do, action anthropology allows the anthropologist to work closely with a community in order to better understand the issues that confront it, devise solutions to problems, and assist the people in implementing change. Within such a setting, the action anthropologist is able to study individual people as social actors and better identify the complex processes at various social levels (Hannerz 1992; Obrist et al. 2003). As a participant observer, the anthropologist can detect patterns of behavior, observe interrelationships between people, and determine who wields power (Kiefer 2007). Consequently, priorities for research
are driven by questions of how people interact, interpret, and respond to the conditions in which they actually live.

This type of naturalistic research is important in gaining an understanding of an individual's perspective of health and illness and in determining how and when an individual will seek health care. It is particularly important when the social process is under constant redefinition by the actors and when rapidly changing urban settings and structural conditions force people to find their own ways of sustaining and restoring health (Freidenberg 1988; Obrist 2003).

Women residing in domestic violence shelters are often forced to leave the abusive environment with little more than the clothes on their backs. Such rapid transition from one setting to another can create situations where women must quickly learn to adapt to new circumstances. In such situations, the role of the action anthropologist thus blends with that of social scientist and advocate by defining the topic of study by its usefulness with the aim to understand social change and to transform a situation or maybe to solve problems. Hence, anthropological research can provide valuable insight for evaluating and implementing programs of health intervention in the shelter setting.

Shelters and Health Seeking Behaviors

Domestic violence shelters offer protection, counseling, and social support for women in crisis. Because the foremost concern of shelters is in separating the victim from the assailant and providing safe room and board, most of the shelter staff is typically trained in social work and crisis intervention. Moreover, health conditions are usually self-reported by the victims. Consequently, shelter staff
may not be qualified to conduct thorough health screenings and many health conditions may remain unreported (Hollenkamp and Attala 1986).

Due to the fact that domestic violence shelters must remain secret, their very nature impedes opportunities for research. A major obstacle to working in a domestic violence shelter is getting permission. Before a person can enter the Safe Nest shelter as a volunteer, she must submit to a background check and go through thirty hours of training. Training sessions are conducted twice a year in fall and spring. These classes fill up fast, so a person must register early. As a result, it was a year before I completed my training and received permission to enter the shelter.

Although over 700 shelters now operate in the United States, little research has been conducted on the interaction between shelter services and the needs of shelter residents. Despite the lack of literature, current research suggests that there is a growing need in the study of domestic violence issues for research that allows individual voices to be heard (Bhuyan and Senturia 2005; Krishnan et al. 1997; Gordon 1996; U.S. Public Health Service 2000). Phyllis Baker's (1997) research on why battered women make choices relevant to their needs recommends that further ethnographic discovery is needed to analyze the battered woman's understanding of their own experiences.

Previous research on poor and marginalized populations indicates that dental care may pose important health issues for shelter residents. A study of adults in a Central Harlem community cited poor oral health as the number one health complaint in the 1992-1994 population based survey (Zabos et al. 2002). Mary
Ellen Gauthier's (1998) research on the health care needs of sheltered homeless women in Las Vegas found dental problems to be the most common complaint with sixty-four percent of the women in her study voicing complaints about dental problems. Gauthier further cautions that a limitation may exist on previous studies concerning the health of sheltered women because most of the data was collected from shelter staff directors and staff with the review of policies as the priority. A lack of data is also addressed by Gift et al. (1992:1667) who suggests that "lower socioeconomic individuals often use home remedies and self-care to avoid professional care, while upper socioeconomic individuals engage in self-care to complement professional care."

In spite of the resource availability, utilization of health care by abused women depends on many complex issues. One study of abused women indicates that even when social supports are available, battered women tend to be depressed and have difficulty expressing their needs and seeking health care (Constantino et al. 2000). McFarlane et al. (1992) found that battered pregnant women are less likely to obtain pre-natal care or begin pre-natal care later than non-battered women and may have increased use of cigarettes, alcohol, and drugs; behaviors that increase risks to both dental and overall health.

A study by Obrist, Tanner, and Harpham (2003) argues that economic and social constraints may take priority over a woman's basic health concerns leaving them overlooked as they struggle to meet their needs for survival. Additionally, research on homeless women shows that even when arrangements are made, they often miss appointments and fail to follow-up (Hatton 2001). In two other
studies of domestic violence (DV) shelters, evidence suggests that a woman's perception of the availability of social support can improve health and interpersonal relationships with others or the lack of resources can inhibit women from experiencing as much agency as is needed for change (Campbell and Soeken 1999; Williams 1998).

Since research indicates that injuries to the head and neck are commonly found in cases of domestic violence, this study expects to find evidence of dental trauma (Peujrye-Hissong, Davis, and Weinberg 1983). In addition to trauma, research further shows that domestic violence victims often suffer from long periods of economic and social isolation, thus suggesting pre-existing dental conditions may also be evident.

Shame and Health Seeking Behaviors

As people become socially and economically marginalized, they may be even more susceptible to the pressures of society. Thomas Scheff (1994) examines the connection between shame and social conformity. Scheff presents evidence that shame could be a primary social emotion, generating a constant monitoring of the self in relation to others. As a result, a person could not only be in a continual state of self assessment; a person could also be at continual risk of a negative evaluation by others. This ongoing process of self evaluation is the reason why a growing number of sociologists now believe that shame is one of the most powerful influences on social behavior. Goffman (1963) posits that there are great rewards in being seen as normal, and that unthinking routines for
normals, become management problems for the discredited in our society. One method of managing shame may be avoidance.

It is the high visibility of teeth that make them such convenient objects for social assessment, and as modern advertisements draw public attention to particular features such as teeth; these features become even more visible (Shilling 1993; Giddens 1991). Consequently, the stigma of inferior dentition could be hindering employment opportunities, social interactions, and self-confidence for battered women.
CHAPTER 3

METHODOLOGY

Working with Safe Nest

My affiliation with Safe Nest began over two years ago when I agreed to serve on the Community Coalition for Oral Health (CCOH) on their behalf. Soon after I became involved with CCOH, I realized that I needed to become more familiar with the shelter, a process that turned out to be far more difficult than I expected. Although I had been associated with Safe Nest for almost a year; I was still required to go through the standard clearance and complete the mandatory preparation program before I was allowed to enter the shelter. As previously stated, a year passed before I was placed on the volunteer's schedule and assigned a regular four-hour weekly time slot.

My first duties as a volunteer included answering the phones, driving the women to pottery classes, and verifying the residents' daily chores. Although I was now working at the shelter, it took several more months before I earned the trust of the staff and residents. Eventually, I gained the confidence of the shelter staff and obtained permission to conduct my thesis research at the shelter. I would like to take this opportunity to extend my gratitude to the Safe Nest staff and especially to Kathleen Brooks, Associate Director of Safe Nest, for her assistance and endorsement of this research.
Study Approval

Approval for this study, Protocol # 0612-2186, was granted by the Institutional Review Board at the University of Nevada, Las Vegas on February 21, 2007.

Qualitative and Quantitative Methods

The goal of this research is to investigate why dental care is so little utilized by women residing in the Safe Nest shelter, even when dental conditions may be impeding their self confidence and ability to secure employment. Qualitative methods consisting of in-depth ethnographic interviews and participant observation were used to assess the resident’s knowledge and perceptions about access to dental care resources. Quantitative methods consisted of a survey of the archived records for 2006. The survey was exploratory in nature with the intent to determine frequencies of dental needs and treatments and examine how dental needs and treatments are documented in resident files.

Ethnographic Methods

Ethnography allows us to view the world through the eyes of others. It "offers us the chance to step outside our narrow cultural backgrounds ... and to apprehend the world from the viewpoint of other human beings who live by... meanings systems" that are very different from our own (Spradley 1979:v). Therefore, ethnography is ideally suited for use in the evaluation and development of intervention programs because it allows us to "capture the views of program participants about their experience of the program, the program's
acceptability, and whether or not the program had an influence on their thinking or behavior" (Schensul et al. 2000:45). Ethnographic interviews can reveal "key cultural constructs as defined by members of the target population" (Schensul et al. 2000:17). These constructs may then be used to develop culture-specific interventions that will increase the likelihood of acceptance and utilization by the program recipients (Schensul et al. 2000:17).

Participant observation can be used in the shelter setting to detect themes and inconsistencies in social interactions between shelter staff and residents (Spradley 1980). The observer may choose to become an active participant in the community of study with the intent to win acceptance of the research subjects and gain a better understanding of the "cultural rules of behavior" (Spradley 1980:60). Consequently, the research for this study was based on ethnographic interviews, examination of archived records, and participant observation.

Interviews

This study included in-depth, semi-structured interviews consisting of questions that were open-ended with the intent to encourage the women to formulate their own narratives as much as possible. Questions for the interviews were formulated to address the information needed by the CCOH in recognizing needs for dental care, to assess the resident's knowledge of dental resources, and to determine the resident's ability to use available resources for care (Appendix D).

The order of the interview was designed to ask questions covering recent and general events first. The first question asked how long it had been since the
resident's last visit to the dentist. Questions involving more complex answers were asked later in the interview, giving the interviewee time to become more relaxed with the process and better able to remember important information and details.

In order to preserve the anonymity and safeguard the dignity of the residents participating in this research, fictitious names were given to each interviewee. Interviews were conducted in a private room at the Safe Nest shelter. No shelter staff members were present during the interview process. Participants were told about the project and allowed time to ask questions. Participants were then given the informed consent forms and again reminded that their participation was entirely voluntary and that they could refuse to answer any questions and decide to withdraw from the interview at any time.

Participants

Participants in this study were drawn from women residing in Safe Nest, a shelter for victims of domestic violence, located in Las Vegas, Nevada. Participants were recruited through announcements made during weekly meetings and referrals from shelter staff. Selection of project participants included four criteria:

1. Female;
2. Resident of Safe Nest shelter;
3. Age 18 or older; and
4. Had not seen a dentist within the past 12 months.
Data Gathering

Archived Records

Documentation is critical to the process of advocacy. The most credible way to establish a pattern of need to professional care providers is through record documentation. Therefore, it is important that intervention programs are keeping data in a way that will be recognized by those who can provide resources for care.

In addition to interviews, this study includes a survey of the entire archived case files for 2006 in an attempt to retrieve any information that may pertain to dental issues. This review covered two hundred and ninety-five records revealing data in the following categories:

- Length of stay in the shelter
- Number of years since last dental visit
- Dental problems at the time of intake
- Dental referrals and treatment
- Recent or current dental problems (Yes or No)
- General health conditions (if noted)
- General health conditions (Heart Disease, Diabetes, Pregnancy, High Blood Pressure)

Analysis

The Penchansky and Thomas model for defining access to health care was used in developing the criteria for health care access evaluation. Benchmarks for access were set according to the participant’s perception of the dental care
provider's affordability, availability, accessibility, accommodation, and
acceptability. Open-ended questions were designed to elicit the participant's
knowledge and perceptions about the process of obtaining dental care. Interview
transcripts were coded and placed in locked storage on the UNLV campus.

The goal of retrieving data from the archived case files for 2006 was
exploratory in nature. The archived files represented all women entering the
shelter from January 1, 2006 to December 31, 2006, with the exception of
fourteen files representing women who were still actively in residence at the time
of this survey. A systematic examination of the case files was performed to
search for information pertaining to types and frequencies of dental needs, dental
treatments, and procedures of documentation. The following procedure was
used in the review of the records.

1. Review of Emergency Medical Care permission Form (Appendix G)
2. Review of Adult Medical History Form (Appendix G)
3. Review of Bodily Injury Form (Appendix G)
4. Review of Referral Form (Appendix G)
5. Review of Agency Use Form (Appendix G)
6. Review of Resident Log (Appendix G)
CHAPTER 4

QUALITATIVE RESEARCH RESULTS - INTERVIEWS

The Women Speak for Themselves

Five residents of the shelter participated in interviews for this study. For the purpose of anonymity, fictitious names were used. All participants were female, three were African American and two were Caucasian. Three of the women were mothers with dependent children. Four of the women were unemployed at the time of the interviews. The ages of participants ranged between thirty and thirty-seven years, with the exception of one woman who was fifty-nine years old.

The interviews took place at the Safe Nest shelter in a private room. The resident and I usually sat at a table across from each other. I explained that I did not work for the shelter and that I was just a volunteer. Although the women were very willing to volunteer for this study, all appeared to be nervous. I told them that while I could not offer them anything in return for doing the interview and that I could not get them dental care, I did appreciate their help with the study.

After a misunderstanding that occurred after the first interview, I decided to begin each subsequent interview by emphasizing that I could not help the residents find dental treatment. When I completed the first interview with Jada, she said that she knew another woman in the shelter who needed dental care badly and she would go ask her if she wanted to do an interview. Soon after...
speaking with Jada, this resident came into the room and told me that she heard I could help her get dental care. I explained that I could not get dental care for anyone; I was just trying to find out if the women knew how to get dental care and if they needed care. She said that she wasn’t doing an interview unless I could promise to get her care and she left.

I also told the interviewees that nothing they said would be released without their permission and that none of the shelter staff would be present during their interviews. I asked if I could do anything to make them feel more comfortable in speaking to me. I explained that I would not be tape recording anything so no one could identify their voices and that I would try and write down as much as I could. Each of the women was relieved that I would not be taping. I then asked if I could get a few direct quotes, if that was all right.

The interviews took place between March 17 and May 1, 2007. The data shows that the residents’ infrequent utilization of dental care is not a matter of desire or ignorance or fear, but it is a matter of social and economic factors. Review of the interview transcripts revealed trends in the following categories: economic factors, social factors, physical factors, dental phobias, dental values, knowledge of dental resources, and dental needs.

All five interviewees gave the lack of funds as the main reason for not getting dental care. Three of the five women described dealing with the stigma of bad teeth and were distressed about the appearance of their teeth. All five interviewees mentioned pain as their primary reason for seeking care now and each of the women said that dental health was important to them. All five
residents expressed a desire to get dental care if they knew how and each of the
five showed concerns about their dental health and the impact it could be having
on their general health.

Economic Factors

A central theme concerning the women's access to dental care was the lack
of money. Each woman mentioned that the lack of funds presented a significant
obstacle to getting the type of dental treatment they desired. In my first interview,
Jada said, “I only go when I’m in pain.” She described how she first takes Motrin
and then goes to the dentist after a week or so if it doesn’t work. She explained
that she doesn’t go to the dentist because she doesn’t have money, so she only
has one option. To Jada, “Most places only want to pull your teeth.” She said
the dentist told her that she needed dentures because that was the cheapest
thing she could do. However, she couldn’t afford to get dentures so in a
somewhat emotional manner Jada said, “I can’t live with it. No teeth. I’d rather
live with the pain and look half way decent.”

Barbara’s story was very similar. Barbara described having just enough
money to pay for a dental exam at the local dental school. “You had to pay as
you go and I had to pay about $90.00 for the first visit.” When the dentist told her
that her teeth would cost $20,000.00 to fix, she said, “I just didn’t have the
money.” And, “I thought it was a good price though, because it would cost almost
twice that much if I went to a private dentist, but I never got any treatment.”
Although Barbara had gum disease and what she viewed as a life threatening
condition, she was still unable to pay for any type of dental treatment.

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Marie explained that the lack of money had also prevented her from getting treatment when she needed it. She said, "Just to walk in is $75.00." And, "Even with insurance it was like a $500.00 deductible and that is really hard when you are a single parent." Although she had dental insurance, the deductible of $500.00 made her treatment out of reach.

Finally, Lisa and Dee told how they were able to go to the dentist when they had dental insurance and had not been to see a dentist since. For Lisa, her last visit to the dentist was "Four years ago, the last time I had insurance." Although Lisa's dental needs did not seem to be visibly apparent, she was in considerable discomfort and I had to cut the interview short.

In Dee's case, it had been over a year since her last dental visit. Dee explained that she stopped going to the dentist because "My husband wouldn't keep me on his insurance when we started having problems because he didn't want to pay for a lot of dental work and then have me leave."

All the women talked about how expensive dental care had become. Four of the five women believed that to have a tooth pulled was the only option for treatment. Each of the women attributed this lack of choice to their inability to pay for other options.

Physical Factors

Another prevalent theme was the issue of pain. Each of the women was in pain at the time of the interview and all stated that pain was the main reason for seeking dental care at that time. Jada and Lisa confessed to taking more than the recommended dosage of over-the-counter pain medications to deal with their
discomfort. Jada said, "Sometimes I take four Motrin at a time, sometimes 16 to 20 in a day to kill the pain." Then she reflected for a minute and said, "I will probably have to let the tooth be pulled because I know that it isn't good on your stomach to take so many Motrin." I asked if she would talk about the pain. She said, "Oh my God you can't sleep; you know you pull your hair while you're walking." Lisa said that she takes Advil for her dental pain. Then she added, "Sometimes, I have taken six at a time."

Three of the women described how pain kept them from eating certain foods and drinking cold liquids. Jada said that she couldn't eat anything sticky or gummy, "So I refuse food and say I'm just trying to lose weight."

In addition to the physical pain, Barbara talked about living with the fear that her gum disease was posing a potential threat to her life. "My gums bleed every night and you wake up with blood on your pillow." Barbara talked about watching CNN and learning that bacteria from dental decay and gum disease were causing heart attacks in women. Barbara further described how the gum disease had caused her teeth to become loose. "My front tooth is loose so I can't bite sandwiches; I have to cut them into little pieces like you would for a child." Then Barbara said, "I never thought about biting sandwiches with your front teeth until my tooth got loose." I would also like to note that Barbara had to get up out of bed to do the interview, her pain was so severe.

Marie explained that her teeth were so sensitive that she could only chew on one side. She said, "In fact, I have a toothache right now." She described how she lives with recurring pain. "I just close my eyes and wait for it to go away;
sometimes it takes three to five minutes.” Marie said that she takes Tylenol but that doesn’t really help. She said, “I’d rather have a baby than a toothache because it even messes with your vision.”

Each of the women said that pain was the main reason for agreeing to take part in the interview. Each woman described how the pain was interfering in how and what they could eat, if they could sleep, and what they felt like doing during the day. Each one hoped that the information might lead to better resources of treatment in the future.

Social Factors

Three of the women were very aware of a stigma for having bad teeth. Jada explained, “I am self-conscious about it and so I avoid talking to people.” And, “I never look at them in their face, I usually talk with my head to the side or down so people can’t look directly at my mouth.” She told me that she wanted to look presentable so her kids wouldn’t be ashamed of her. She said it would be nice if people understood how someone like her feels about having her teeth just pulled and not fixed. Jada talked about being frustrated that Nevada did not have a program to help adults with dental problems. She said, “Don’t they realize that adults need good teeth also, they have to support the children.”

Barbara said, “I went back [to the dentist] in 1999 because my mouth tasted foul and that was when they first detected the gum disease.” As a result, her gums bleed on a daily basis. I noticed that throughout the interview Barbara was always holding her hand in front of her mouth when she talked. So I asked if she
was self conscious about her teeth. She said, "Yes, I am always thinking about the appearance and the smell."

Dee discussed making her own false tooth out of paper and super glue because she just couldn't stand living with a gap in the front of her mouth. Dee said, "I like to smile but I don't smile around guys when I meet them because I think they treat me badly because of my teeth." She said, "I really lack self esteem because of my teeth and I think guys can tell that."

All of the women described how instances concerning dental pain or dental appearance impacted their daily routines and their ability to interact with people. I cannot help but speculate how a job interview would go if such distress was present in a person and evident to the interviewer.

Dental Phobia

When I asked the women if they ever had a bad experience with the dentist, only Lisa talked about a fear of going to the dentist. She described dental visits as being "scary, I don't like the sounds, smells, or the drill and I don't like needles either."

Although Jada said that she never had a bad experience with a dentist, she did offer the following description of a dental visit. "One time the dentist had to call for his assistant and it took them three hours to pull it. The tooth broke and it had to be cut out and stitched."

Barbara and Marie also said that they never had any bad experiences with a dentist, but they both remembered experiencing unsettling visits to the dentist as children. Each went because of a toothache and ended up getting teeth pulled.
Barbara said that she often wonders if two teeth should have been pulled. Marie said she had four teeth pulled, "But I didn't feel like he needed to pull those teeth." Lisa's interview was not completed due to her pain and I wasn't able to ask her this question.

Dental Values as a Child – Education and Practices

All of the women could describe some experience with dental visits as children. All of the women said they brushed their teeth regularly as children. All of the women conveyed the knowledge that dental care was important to them as a child. Three of the women saw the dentist on a regular basis, at least once a year during early childhood, and one woman began regular visits in her teens. Jada and Marie talked about how their parents encouraged their childhood dental care habits.

Jada said, "My parents were all over me about my teeth." And, "My parents made me brush daily and wouldn't let me have any candy or juice." She remembers going to the dentist every six months. She said she had to have a lot of work done as a child. Jada explained, "One time I was getting like four root canals and had to take gas during the treatment." And "That is probably why my parents were so strict, but I just had bad teeth. That is why I do that with my kids, too."

Barbara said that her grandmother took her to the dentist once a year as a child. She said she needed braces when she was 9 or 10 years old but they couldn't afford to get them. However, she has always brushed regularly.
Marie also remembers going to the dentist every six months as a child and brushing twice a day. Although Lisa didn’t go to the dentist regularly until she was in her teens, she then went about once a year. Only Dee described her childhood experience in terms of not being able to get dental care when she needed it.

Dental Values as an Adult – Awareness of Need

All of the women described the practice of daily dental hygiene as an adult. All professed to brushing at least once a day, with the exception of Lisa who said she has always brushed twice a day. All of the women had noteworthy dental needs at the time of the interviews and all described how dental decay or possible dental infections were causing considerable pain.

Marie and Lisa had possible abscesses and were attempting to get dental appointments as soon as possible. Marie’s tooth had become infected about six months earlier and she was given antibiotics for the infection. However, because of a lack of money, she was not able to see the oral surgeon for treatment and the tooth was causing pain again. Lisa believed that she had an abscess and was intending to talk to her advocate soon.

Jada, Barbara, and Dee had a significant number of teeth missing and this was impairing their ability to chew food. Each of these women struggled with the idea of eventually losing more teeth. Jada stated, “Most places only want to pull your teeth.” She wished she could get them fixed or replaced, not just pulled. Barbara said, “I have only one molar left to chew on and it is loose.” And, “I don’t
know what I am going to do when that one goes." Dee was hoping that she could afford a new type bridge instead of settling for dentures.

Although Marie had arranged a dental appointment she told me, "I have an appointment now to see the dentist, but this doctor only pulls teeth." She knew she would not be able to get the tooth replaced but her immediate concern was just to get out of pain.

Three of the women described their dental health as poor and knew they needed more treatment, but were dealing with their needs one day at a time and as emergencies arose. Each of the women believed there was little hope of getting the type of treatment they really needed and were reluctant to discuss their future projections.

Dental Problems – Types and Frequencies

I was not surprised to find dental issues beyond trauma or injuries that could have taken place at the time of an assault. Domestic violence is very much about control (Ganley 1998; Campbell 1992). Since control can be exerted over finances and social interactions, I expected to find dental conditions that had been occurring over long periods of time (Hart 1993; Gordon 1996). Dental conditions such as gum disease, abscesses, missing teeth, loose teeth, and sensitive teeth were presented.

Each of the women in the interviews described a history of dental problems. Jada was the only interviewee who talked about dental injuries from her abuser. She said her abuser hit her in the mouth and knocked out one of her front teeth and twisted another around. Jada had other teeth that were broken and loose.
and needed to be replaced. She, too, described years of needing dental treatment.

Barbara suffered with loose teeth and painful gums, a condition resulting from years of ongoing gum disease. Barbara said, “I have to gargle with peroxide and brush with baking soda and salt.” Barbara’s gum disease was not only painful but posing a potential threat to her overall health. She knew that dental disease is serious and told me, “It is scary, when I think about it, because I have been living with this stuff [gum disease] for eight years.”

For each of the women dental pain was interfering with their ability to eat and routine daily functions.

Resident’s Knowledge of Dental Resources

Four of the women had a limited knowledge of dental resources. Jada had the most to say about how to get dental care. When I asked Jada if she knew how to get dental care while she is in the shelter, she said, “NO! Or I would be at a dentist right now.” Jada described enrolling in Medicaid on a trial basis to see if she could get dental treatment that way. She expressed knowledge of how the Medicaid system worked in California and was shocked that adults did not have options for dental care in Nevada.

Barbara’s explanation of how to get dental services in the shelter was, “Yes, you go to your advocate and you go to UMC in an emergency.” Marie had already talked with her advocate and arranged for a dental appointment. Dee said, “I just mentioned it on my paperwork and nothing was said about it.”
Lisa was very new to the shelter and was intending to talk to her advocate about getting an appointment. She didn’t know what kind of treatment was available. She said, “They [shelter workers] were willing to take me to University Medical Center (UMC) emergency room last night so that I could get something for the pain, but I didn’t want to be dropped off there late at night, have to wait eight hours, and then have to ride the bus back.” She said, “It just wasn’t worth it.” Instead, she decided to take Tylenol PM and go to bed. As our conversation ended, Lisa who was visibly still in pain asked, “Could you get me to see a dentist any faster?”

Jada, Barbara and Marie told me that the only option for dental care in the shelter was to get a tooth pulled. Each described being told that the shelter has a dentist who would pull a tooth. Marie said she was all right with having her tooth pulled because she just wanted to be out of pain. Jada said that even though she was in pain, if pulling teeth was the only option, it was really no option. She just couldn’t live with losing any more teeth and not having them replaced. Although Barbara was in pain and knew about the option to get your tooth pulled, she was not willing to go to the shelter’s dentist either.

After the interviews concluded, Jada and Lisa asked if I could talk to their advocates about their need for dental care. Dee asked me how to contact UNLV Dental School so she could get an appointment.

Findings

The interview process was difficult at times. I missed out on two interviews because the residents were not available at the same time I was. One resident
declined an interview when she learned she would not get dental care. Another opportunity for an interview was lost because the resident left the shelter before our appointment could take place. Schedules change unexpectedly for shelter residents. Sudden opportunities for employment, training, or visits with their families were usually given priority. Residents could also be dealing with physical or mental trauma, and episodes of depression or anxiety would flare up without warning. Because of this nature of the shelter environment, I also learned to take advantage of any opportunity as it came up. Unfortunately, I was not able to do as many interviews as I planned and a few of the interviews were not as complete as I would have desired.

My difficulty in arranging interviews led to further insights concerning the women's inability to secure dental care. Even when interviews were in the shelter and scheduled at their convenience, residents still had to be tracked down and reminded of their appointments. If keeping the appointment for my interviews was this difficult, how difficult would it be for the women to go to a different and unfamiliar location, with little expectation of treatment, and no real incentive for following through to the appointment?

Observing the Women in Context

For the past year, my interactions with the staff and residents in the shelter have given me an understanding of the process by which information is transmitted and received between staff and resident. This direct observation of residents' behavior helped to uncover some of the meanings residents hold
about dental health and the obstacles they have in obtaining access to dental care. Analysis of these observations led to the following insights.

The Intake Process

When a woman first arrives at the shelter she is often experiencing emotional or physical trauma. She could have children with her who are also upset and difficult to manage. Shelter staff usually asks the woman if she would like to complete intake documentation at the time, but this is seldom possible. On many occasions the staff is only able to welcome the woman and escort her to a room where she can settle in and adjust. New residents are given a few days to report back to the office and complete the necessary paperwork. Even then, only the most urgent needs might be addressed and documented.

I have witnessed several women as they completed their intake process and all of them were in a hurry to finish and brushed past questions when they could. On two occasions, the woman’s children were playing in the office and causing a significant distraction for both the resident and the staff.

Effects of Victimization and Survival Strategies

As a volunteer at the shelter, my duties often involved asking the residents to attend pottery classes, report to the office, or follow through with their appointments for GED pre-testing. I began to notice that the residents struggled with telling me “no” if they didn’t want to do something. Residents would often agree to attend meetings and activities when asked and then forget about them or make excuses for not keeping their appointments. Since compliance can be a strategy for survival, I began to think that some of the residents were agreeing
with requests before actually thinking them through. I observed that the women were sometimes not comfortable saying that they do not want to do something.

**Priorities in the Shelter Environment**

On several occasions the staff would discuss their frustration about appointments not kept by residents in the shelter. It seemed that immediate concerns or opportunities would take priority. Residents often lived more in the moment, taking advantage of opportunities that were available in the now.

I first began to notice this behavior when I started transporting the residents to pottery classes. After each class the residents would agree to go again the next week. Although we always left at the same time each week, I would usually have to walk around the shelter and remind the residents that I was leaving again just before we left. This routine took place over and over, even if the resident had been attending classes for weeks. This observation led me to believe that some of the residents may lack life skills needed to determine priorities and the self-discipline to follow through when it is important to do so.

In much the same way, I wondered if dental pain may be a concern of the moment. If the resident was in pain, then it would get her immediate attention. As the pain subsides, other concerns would take center stage. This behavior could also be symptomatic of living under tactics of domination where the future is always uncertain.

**The Support System**

Domestic violence shelters are designed to provide immediate and temporary safety for victims. Safe Nest provides crisis counseling for women and children,
programs for children, occupational counseling, food, and shelter. In addition to these services, the staff also assists with the acquisition of food stamps, Medicaid, legal counsel, clothing for employment, bus passes, and public housing. I cannot imagine where these women would be without such a refuge.

Residents within the shelter also give a sense of security to each other. I have witnessed camaraderie between residents that is supportive and comforting. Residents often provide childcare for each other. However, despite these interventions, support beyond the shelter is still needed to ensure the resident’s transition to independence.

Many of the women lack support from family. On three occasions, residents told me about the alienation from their families. Sometimes the family would refuse to interact with the victim because she stayed with her abuser or because the family feared that the abuser would cause trouble for them also.

Another issue is relocation. It was not unusual for victims to be relocated to a different town for reasons of safety. As a result, the women would not know anyone in the new place. These women may also lack knowledge of the bus routes and schedules. Sometimes women who have been isolated for extended periods of time also lack social skills or exhibit anxiety when attempting to interact with others. On several occasions, I saw women and children disrupting the shelter routine with outbursts and anxious behaviors. Although these issues were effectively dealt with in the shelter, they presented barriers to connecting to other types of support systems.
Gender Issues

It is understandable that mothers may have some fear about leaving their children with other people or prospective strangers. Although the women in the shelter were willing to watch one another's children, trusting others was still a major issue to these women and these concerns were voiced to me by the residents.

Another concern that women shared with me was their fear to do things alone or to be out late at night. If the women were from Las Vegas, they were often afraid of running into their abusers and if the women were not from Las Vegas, they were afraid of being somewhere they do not know.

Residents' Knowledge of Dental Resources

As previously discussed, residents had knowledge of only a few resources for dental care. Unless they were new to the shelter, most of the women who had completed their intake process knew that the shelter could refer them to get a tooth pulled if they needed to.

Dental Needs in the Shelter

It was difficult to estimate how many women in the shelter had dental problems. During the year that I worked in the shelter, everyone I spoke to about dental problems could think of at least one woman in the shelter who was dealing with dental pain at the time of our conversation. When I was recruiting for participants of this project I personally spoke to ten women about their dental conditions and all admitted to being in pain and needing extensive dental
treatment. Unfortunately, only five of these women were willing to participate in this study.

Findings

The main objective of the Safe Nest shelter is the safety of the women, and the primary concern of the women who enter the shelter is security. New residents often had fears about going outside the shelter and did not want to risk alienating the shelter staff. Due to these concerns, they were sometimes hesitant to interact with the staff and other residents. This type of guarded behavior was not surprising in view of the traumatic situations from which most of these women fled. An effect of living in this type of trauma for an extended period of time was the inability of the victim to develop life skills. Hence, many women entering the shelter did not have the skills necessary to seek out and obtain dental care.

However, with so many major life changes taking place, dental care was not their primary concern. Instead, survival was their main challenge and they managed the best way they could by handling their needs as they were presented.

Additionally, it took time to overcome issues and gain the trust needed for open communication, and as one might expect, this study finds that it was not uncommon for women to use various forms of coping or survival behaviors in dealing with their situations at the shelter. Such behaviors also presented barriers to making a successful connection between the resident and the dental care provider.
Conclusions

Analysis of the qualitative research provided evidence of the following themes: dental needs, knowledge of treatment options, financial limitations, knowledge about dental care as a child, and lack of skills for seeking dental care.

Dental needs were evident throughout the interviews and observations. These women had substantial needs for dental care, they were aware of their needs, and they were aware of the serious nature of their dental conditions. Each woman was in pain during the interview. Barbara knew that her gum disease could be affecting her general health, as well as posing a potential threat to her heart.

Knowledge of treatment options was evident. During the interviews, each woman described the type of treatment she would prefer but stated that only one option, tooth extraction, appeared to be available to them.

Financial limitations presented a central theme and the main reason that women could not get the kind of treatment they desired. Each woman stated that the lack of money prevented them from going to the dentist on a regular basis or when they needed to.

Knowledge about dental care as a child was also common among the interviews. It was evident that all of the women went to the dentist as children and were knowledgeable about proper brushing and the importance of regular dental exams during their childhood.
Lack of skills to obtain dental care presented additional barriers for these women. It was evident that each woman accepted the limited information about dental resources. Only Jada tried to find additional resources for dental treatment through Medicaid. For these women, the importance of security and daily survival usurped all other needs in the shelter. Since residence at the shelter was on temporary basis, the struggle to obtain employment and find permanent housing was paramount.
CHAPTER 5

QUANTITATIVE RESEARCH RESULTS

Looking at the Files

Examination of the closed case files [dating from January 1, 2006 to December 31, 2006] was conducted between February 24, 2007 and March 10, 2007. Two hundred and ninety-five closed case files were surveyed, representing the women admitted to the Safe Nest shelter during 2006. Files representing thirteen women who were still in residence at the time of this research were not examined. The intent of this search was to retrieve information about dental needs, referrals for treatment, and the types of treatment residents received while in the shelter. Data was analyzed for frequencies, revealing the following patterns.

Years Since Last Visit to the Dentist

The results of the review, shown in Figure 1, indicate ninety-five women (32%) reported that they had seen a dentist within the last year. Seventy-eight women (26%) saw a dentist within the last two to five years. For twenty-six women, it had been over five years. Fifty-four of the records left the answer blank and in thirty-one of the records; a question mark (?) was written in response to this question. The remaining records noted the following answers: (1) child, meaning that they haven't seen a dentist since they were a child, (2)
long, suggesting that it had been a long time, (1) many, suggesting more than two years, (1) N/A, (4) none, (1) unsure, and (1) years, meaning more than one year. Figure 1 shows each category and the frequencies for each type of answer.

![Years Since Last Dental Visit](https://via.placeholder.com/150)

**Figure 1 Years Since Last Dental Visit**

The quantitative data demonstrate that the need for dental care is acute. According to the numbers representing the women for whom we have data, at least one hundred and nine women (37%) have not seen a dentist in over a year. If you add the thirty-one women who didn’t know how long it had been since their
last dental visit, then the data suggests that an estimated forty-seven percent of this population is not receiving the acceptable standard of dental care.

When compared with the national figures, the findings are alarming. The Behavioral Risk Factor Surveillance Survey (BRFSS) 2004 reported that 64% of adults (19-59 years of age) had seen a dentist in the past year. According to the Health, United States, 2006 survey, 67.4% of adult females (18-64 years of age) had seen a dentist in the past year. In comparison, this study shows that only 32% of the women at Safe Nest saw a dentist in the past year, representing a trend that is half that of the national average.

Responses to Dental Need

As shown in Figure 2, in response to the question asking if the resident currently has or recently had a problem with her teeth, sixty-nine women (23%) checked yes. Thirteen women indicated they had immediate needs. As we learned from the interviews, the definition of need to the women in the shelter is not the medical definition of need but a crisis definition.

To women in the shelter the definition of need is an acute need or the state of being in pain. The residents' definition of urgent need means a critical need usually referring to the inability to stand the pain any longer or the existence of conditions such as an abscess or broken tooth. The records indicate that out of these sixty-nine women with acute conditions, nine women received referrals for dental care and three received treatment. It is noteworthy to point out that all three treatments were for tooth extractions.
These numbers also represent part of a more general pattern at the shelter, the tendency for the women to be out of touch with health issues. As noted in Figure 3, one hundred and fifty-three women did not answer the questions about their general health. As we discovered in the interviews, these women are overwhelmed with so many issues of crisis that they are not in touch with issues about their health and are less in touch with issues concerning their teeth. As a result, it is a safe assumption that these numbers are understated and underreported.

General Health

This study found that one hundred and fifty-three women (52%) (see Figure 3) did not answer the question regarding their overall health. As stated previously, the lack of response to this question exemplifies the women’s inability to answer questions about their health and consequently the data on health
issues is largely underreported. Of those that did answer this question, seventy-three women reported that their health was "good", sixty indicated "fair", and nine said "poor".

Other general health conditions (see Figure 4) noted in the files were as follows: head or neck injuries (58), pregnancy (27), diabetes (17), heart disease (10), and high blood pressure (29). These numbers represent those women in the population who are at higher risk of health complications. For example, out of the twenty-seven known pregnancies in the shelter, seventeen had not seen a dentist within the previous year. According to recent research, poor oral health can now be linked to adverse outcomes in pregnancy. Therefore, it is recommended that pregnant women see their dentists at least once a year and preferably twice (Boggess and Edelstein 2006).

In addition, similar studies on periodontal disease are linking gum disease to complications in diabetes and heart disease (Matthews and Perio 2002; Matthews et al. 2002). These studies also recommend that people with these conditions see their dentist at least once a year to prevent complications. These findings suggest that the thirteen women with diabetes and the six women with heart disease who have not seen a dentist within the last year are at higher risk of serious complications from their diseases. Analysis of the data shows that according to a conservative estimate, thirty women or at least ten percent of the women in the shelter during 2006, are at greater risk of serious complications in their health due to oral health issues.
Length of Stay in the Shelter

Another significant finding in the data was the length of stay. Safe Nest shelter provides temporary assistance for domestic crises. The program is not intended for long term stay; therefore, it is important that health care providers be
aware of the short length of time that women stay in the shelter. As shown in Figure 5, one hundred and eighty-nine of the women (64%) stayed in the shelter thirty days or less. To bring further clarity to the graph in Figure 5, it should be noted that one hundred of the one hundred eighty-nine listed in the “1 to 30” day column stayed in the shelter for only seven days or less. This means that health intervention programs need to address health needs quickly and soon after the women first enter the shelter.

![Length of Stay in Shelter](image)

Figure 5 Length of Stay in Shelter

Conclusion

The data in this study are representative of a much larger portion of the women as a whole. Analysis of the data provides strong evidence that dental needs are present at the shelter and that more options for dental treatment are needed. These options should include preventative care for women at higher
risk of health complications and timely care for women with emergency dental
issues. In addition to these types of need, as we learned from the interviews,
restorative dental treatment is also not only needed but vital to the process of
rebuilding self esteem. The quantitative data supports the findings in the
interviews that a significant number of the women in the shelter are not just in
need of dental care, but they are living with debilitating dental conditions resulting
in chronic pain and greatly inhibiting their ability to perform even daily tasks.
CHAPTER 6

DISCUSSION

This study is exploratory in nature. It seeks to examine why dental care is rarely utilized by the women residing in Safe Nest shelter for victims of domestic violence even when dental needs appear to be impeding their opportunities for employment and their levels of self esteem. This study hypothesizes that social and economic factors present the primary barriers in the women's ability to access quality dental care. Additionally, evidence of difficulty in communicating the dental needs of the residents to the professional community was presented.

Value of Using a Combination of Research Approaches

Qualitative Methods

As qualitative methods, interviews and participant observation gave insight into the residents' perceptions that could not have otherwise been obtained. The women's behavior during the interview process substantiated their struggle to deal with their dental problems. I witnessed behaviors such as their inability to remain still for extended periods of time; holding hands over their mouths when talking; avoiding looking straight at me; frowning and grimacing; and moments of emotional display such as raising voice inflections and lowering their eyes when talking about difficult topics, obvious signs of their physical and psychological
discomfort and evidence of their struggle with low self esteem and shame (Goffman 1963; Gidden 1991; Shilling 1993; Scheff 1994).

Ethnographic methods also allowed observations of residents' behaviors that were symptomatic of PTSD. As discussed in Chapter Four, it was not uncommon for the women to forget about appointments, withdraw to their rooms, and avoid social interactions with both the staff and other residents. The interviews lend support to these observations by revealing further evidence of the women's difficulty in asserting themselves, their lack of follow through, and their emotional detachment from apparent serious health conditions. Observations in the shelter provide evidence that these women are primarily concerned with survival, they take life one day at a time, and they are doing their best to meet each challenge as it appears. This research illuminates the women's inability to effectively communicate their dental needs to those who could provide services to them.

In spite of their difficulty with the interviews, the women's participation in the research process was empowering (Kiefer 2007; Fraser 2004; Obrist et al. 2003). After the interviews, four of the women expressed that their participation in the study had a positive effect on them because they were able to share their opinions and become part of the solution. By positioning themselves “as consumers of services,” the women gained an understanding about the obstacles that were hindering their access to health care (Gordon 1996:325). As unintentional as it was, the interviews had validated their plight and self worth (Hamilton and Coates 1993).
Quantitative Results

Analysis of the data provides additional evidence of dental need with sixty-nine women indicating a need for dental care. The files show that only nine of these women were referred for dental care and only three of those received treatment. As seen in the interviews, the data also supported the women’s perceptions that they have only one option of treatment, tooth extractions.

A surprising discovery in the records was the absence of dental trauma. Although previous research indicates that injuries to the head and neck are commonly found in cases of domestic violence, this study found only one instance of dental injury in fifty-eight accounts of head or neck injuries recorded in 2006 (Peujrye-Hissong, Davis, and Weinberg 1983).

Another interesting result of the quantitative research was that roughly one third of the women entering Safe Nest during 2006 stayed for only one week or less. This means that completion of many of the intake records may not have been possible due to the brief length of time the women were in the shelter. It also means that health needs must be addressed as soon as possible.

Dental Needs

Addressing dental needs should begin with identifying those who are in greatest need and at highest risk. This means that women in pain and with life threatening dental disease should receive immediate treatment. This list would include the women with other health conditions such as pregnancy, heart disease, diabetes, and high blood pressure. As stated in Chapter 5, almost ten
percent of the women in this study fell into this category. The American Dental Association (2004) recommends that people with chronic health conditions should see their dentist twice a year for exams and cleaning. These preventative measures are usually less expensive and should be easier to obtain.

Dental treatment should also include restorative treatment. Restorative dental care is beyond emergency measures, it is treatment with the intent to make one whole and restore ones function in society. As stated in the National and State Objectives on Oral Health, the goals of the Call to Action are to (1) promote oral health, (2) improve quality of life, and (3) eliminate oral health disparities (USDHHS 2003). According to The Burden of Oral Disease in Nevada, “Oral-facial pain, as a symptom of untreated dental and oral problems and as a condition in and of itself, is a major source of diminished quality of life...It is associated with sleep deprivation, depression, and multiple adverse psychosocial outcomes” (pp17). Women living in chronic dental pain do not have quality of life. Therefore, adequate access to dental care is essential to their process of recovery.

Access to Dental Care

This study finds that access to dental care for the residents at Safe Nest shelter is not satisfactory. For the purpose of this study, access to dental care was evaluated using the criteria defined by Penchansky and Thomas (1981) for assessing access to health care. According to Penchansky and Thomas (1981), each of five criteria for access must be met in order for satisfactory access to be achieved. Results of this study indicate that residents could not afford to pay for
dental care and therefore their ability to access care did not satisfy the criteria of affordability. In addition, as stated by the residents, the only accommodation being made was for free dental care that was only available at the UMC emergency room and one local dentist. Services from both providers were limited to treating infection at UMC and tooth extractions at a local dental office. Since these services pertained to emergencies only, they were not considered as options of treatment by the residents. Therefore, three more of the criteria, acceptability, availability, and accommodation, were also not satisfied.

Accessibility which pertains to geographic location was the only criteria that could have been satisfied. As a result, this study finds that the women at Safe Nest were not satisfied with their choices of treatment; treatment was not available when they needed it; and no accommodations were being made to address their particular circumstances.

Social and Economic Factors

As previously stated in Chapters Two and Four, research shows that domestic violence victims often suffer from long periods of economic and social isolation, thus suggesting pre-existing dental conditions would be evident. This study finds substantial evidence of long term and pre-existing dental problems. Dental conditions such as tooth abscesses and gum disease are problems that take time to develop and can be particularly dangerous if left untreated. This research offers proof that those dental conditions were present in the shelter and that they were having a considerable impact on the women's daily functions.
Evidence from this study provides further insight into the complex economic situations of the women in the shelter. Lack of money was the primary reason stated by the interviewees as a barrier to accessing dental care. In turn, their dental pain and dental issues presented a barrier to the women's ability to obtain and keep employment. When employment was secured, demands like permanent housing, transportation, and support for children left little possibility of affording dental care. Therefore, it is apparent that financial accommodations must be made before these women can access dental care.

As one might expect, social ramifications of DV victimization were prevalent. Life in the shelter presents issues of stigmatization associated with being homeless, unemployed, and needing public assistance (Hatton 2001). In addition to these concerns, this study finds that four of the five interviewees were struggling with poor self image and the stigma of having bad teeth.

**Final Remarks**

In conclusion, this research offers support for Obrist, Tanner, and Harpham's (2003) hypothesis that survival needs limit resident response in such programs. This study finds that the women residing in the shelter were facing complex psychological, economic, and social concerns in their struggle to survive. It further finds that these issues present social and economic barriers in their ability to access quality dental care. If this thesis accomplishes its goal, it will serve to facilitate the access of these abused women to the care they desperately need.
CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

A Long Way to Go

This study was a learning process for me. Like the women in this study, I did not know what to expect when I first walked through the doors of the shelter. Although I have read much of the literature on domestic violence, it did not prepare me for the situations I was about to see. The interviews with the women at Safe Nest were unsettling to say the least. As illustrated in the interviews, these women have serious dental needs that require extensive dental treatment. It is difficult to maintain emotional distance about so much suffering, but in order to document and demonstrate their needs, some degree of objectivity is essential.

Access to dental care for the women residing in Safe Nest shelter is not adequate. As stated earlier, according to the residents, there are only two options for treatment: the UMC emergency room for tooth infections and a local dentist for tooth extractions. This study provides evidence that the lack of access is not a matter of education, but a matter of economic resources. Therefore, due to the fact that the residents do not have the financial resources to pay for the treatment they need, it is imperative that community resources are located and persuaded to accommodate the special circumstances of these women.
Recommendations to Safe Nest

The review of the case files revealed important information about the documentation process and the need to capture data that will enhance the prospects for advocacy and increase the professional community’s awareness of dental needs at the shelter. Consistent record keeping that targets the type of information most recognized by health care professionals is critical in the development of advocacy. With this in mind, I would like to make the following recommendations.

1. A good start would be to take specific information about the needs at Safe Nest to the community for assistance. Contacts can begin with the CCOH. Next, actively solicit dental care professionals from the community. The dental programs at University of Nevada Las Vegas (UNLV) School of Dental Medicine and Community College of Southern Nevada School of Dental Hygiene would make good candidates for recruitment.

2. Once resources have been established, create a referral sheet with all available resources listed, describing the services, cost, location, and contact information of each. This form can be signed by the resident at the time of referral thus noting the resident’s acknowledgement of receiving the referral and their understanding of the information it contains.

3. The shelter staff can begin identifying those women with the greatest needs or health risks for referrals.
4. Establishing programs for regular dental screenings and exams would build awareness of the needs and provide credible documentation for the professional providers. This type of documentation could then be used to open other doors for treatment.

5. If possible, providing transportation to and from dental appointments would increase the likelihood that residents would keep appointments.

6. Document all dental needs and services. Even if actual names of residents can not be used, this information is crucial.

Further Research

It would be advantageous to study other outreach programs that have been successful in helping victims of domestic violence. One such program is the Cass Dental Clinic for the Homeless in Phoenix, Arizona. This program offers comprehensive dental care by utilizing students from several dental schools in the area and is now one of the largest volunteer clinics in the country. Another inspiring example is the Tuft's Dental Outreach to Survivors (DOTS) program in Boston, Massachusetts. Tuft's program offers free dental care to survivors of domestic violence who have already left or started the process of leaving their abusers (Mitchell 2007).

During the course of this study, it was discovered that a significant number of women in the shelter were missing teeth. Unfortunately, time and circumstances did not permit further investigation, however, a study should be conducted on the prevalence of this condition and the possible impact it has on securing employment.
Another interesting result of this study that warrants further research is the lack of evidence of dental trauma. This could be due to underreporting of this information by victims.

Going Back to CCOH

I have been privileged to work with the staff at Safe Nest during this past year. I am impressed with the dedication and passion they have for these women who are in need of shelter and protection. I did not set out just to do a study. It has always been my intention to take this information back to the community and complete the task I began as the advocate for Safe Nest. The advantage of doing action anthropology is that it holds the possibility of bringing about change (Kiefer 2007). Consequently, the findings of this research will be taken back to the CCOH and to Safe Nest where I am now ready to discuss how many women are in need of dental care, what kind of care they need, and what they are doing for care now.
Jada

Jada, a thirty-seven year old African American woman, was an unemployed single parent with four children. Although Jada was very willing to volunteer, she appeared to be nervous. We sat at a large table across from each other. I explained to her that I did not work for the shelter, I was just a volunteer. She was impressed that I would donate my time. I told her that nothing she said would be released without her permission and that none of the shelter staff would be present during her interview. I asked if I could do anything to make her feel more comfortable in speaking to me. I explained that I would not be tape recording anything so no one could identify her voice and that I would try and write down as much as I could. I then said that I would like to get a few direct quotes if that was all right.

I began the interview by asking Jada how long it had been since her last dental visit. She said it had been about four years. She explained that she went because she was in a lot of pain from a broken tooth. The tooth was located in the back and side of her mouth. She said the dentist had to pull the tooth. Jada said that she was supposed to return later to have more teeth pulled and get dentures, but she just couldn’t bring herself to get all of her teeth pulled at that time.

She told me that earlier in her life she had been in a car accident and the steering wheel of the car hit her in the mouth, cracking many of her teeth. She
had to wear wires that were kind of like braces for a year and a half. When that
didn’t work, the dentist said that she needed dentures because that was the
cheapest thing she could do. She could have also had implants, but that was too
expensive. Jada said, “I felt like I was too young to have all my teeth pulled, so I
didn’t go back.” She continued, “I was figuring that in time I could come up with
a plan to do something else besides the dentures, but with kids and stuff that
didn’t happen.”

I then asked Jada how often she goes to the dentist and for what reasons.
Jada said, “I only go when I’m in pain.” She described how she first takes Motrin
and after a week or so if that doesn’t work, then she goes.

I asked Jada if she missed appointments. She said yes, if she was not in
pain she would not keep the appointment because “they only want to pull teeth.”

Next we discussed what her dental care was like as a child. Jada said, “My
parents were all over me about my teeth.” She had regular dental visits, about
every six months. “My parents made me brush daily and wouldn’t let me have
any candy or juice.” She said she had to have a lot of work done as a child.
“One time I was getting like four root canals and had to take gas during the
treatment.” “That is probably why my parents were so strict, but I just had bad
teeth.” “That is why I do that with my kids, too.”

I asked how she felt about going to the dentist. She said that the dentists had
always been really nice to her and it would be no problem if she could just get the
treatment she needed. Jada said, “Most places only want to pull your teeth.” She
wished she could get her teeth fixed or replaced, not just pull them and leave
them missing. She said that she has never had a bad experience, but she does get nervous and think about the pain. "Every time I go they say I have long roots." "One time the dentist had to call for his assistant and it took them three hours to pull it. The tooth broke and it had to be cut out and stitched."

I then asked if Jada had any dental needs now. She said, "Yes, the works." Then she continued, "I was thinking about the Total Makeover show." I could tell this made her a little uncomfortable and she began to move about in her chair. At this point I decided to tell Jada that I had been a trained dental assistant and that I was familiar with teeth and had seen many different types of dental problems. This seemed to make her more comfortable with me.

She said that she just wants to look presentable, so her kids won't be ashamed of her. She wants to work in public service and have a nice smile. She then said, "Well, I guess I have a nice smile but I have bad teeth." And, "I am self-conscious about it and so I avoid talking to people." "I never look at them in their face, I usually talk with my head to the side or down so people can't look directly at my mouth."

I asked if she was in any pain. Jada said, "Sometimes I take four Motrin at a time, sometimes 16 to 20 in a day to kill the pain." Then she reflected for a minute and said, "I will probably have to let the tooth be pulled because I know that it isn't good on your stomach to take so many Motrin." I asked if she would talk about the pain. She said, "Oh my God you can't sleep, you know you pull your hair while you're walking."
Before she came into the shelter, her abuser knocked out a tooth and twisted another one around. Now about every two to three weeks it flares up and her gums hurt all the time. Jada then added, “And cold bothers me, I can’t drink anything cold.” She said, “I can’t eat sweets, nothing gummy, and nothing that will stick to my teeth.” If she does, she has to brush them right away. “So I refuse food and say I’m just trying to lose weight.”

The staff [Safe Nest] said they could make an appointment for her to have it pulled, but wherever they could send her would only pull it. Then she said not to tell them [Safe Nest staff] but that’s why she didn’t go. She said, “I can’t live with it. No teeth. I’d rather live with the pain and look half way decent.” She then said that she thinks it would be nice if people understood how someone like her feels about having her teeth just pulled and not fixed.

Then I asked if she knew how to find dental care while she is in the shelter. Jada said, “NO! Or I would be at a dentist right now.” She then said that she said “no,” because she doesn’t have money so she will only have one option. “But if I know they would help me, I would be on time.” She then explained that she was put on Medicaid for a three month trial period and tried to call around to get dental care. She specifically wanted to know about dentists because in California the state will pay for adults and children. She said that Nevada doesn’t have a dental program, only a couple of places to pull your teeth. She said, “Nevada doesn’t take care of adults, only children.” They will pay for the children. “Don’t they realize that adults need good teeth also, they have to
support the children?" My interview ended with Jada telling me that she prays to God that her children would have nice teeth.
Barbara

Barbara, a fifty-nine year old African American woman, was an unemployed divorcee with three grown children. I began the interview by asking Barbara how long it had been since her last visit to the dentist. She said, “It was in July of 2004.” I asked the reason for the visit. Barbara said, “I went because of pain in my gums and my teeth were loose.” She explained that the dentist said she had gum disease and that she probably had some nerve damage.

I then asked if she received any treatment. She said that she had gone to the Loma Linda Dental School in California and she was only able to get the evaluation. “You had to pay as you go and I had to pay about ninety dollars for the first visit.” The dentist said that he could do all the work but she needed about $20,000.00. He told her that price would include three implants. She said, “I just didn’t have the money.” “I thought it was a good price though, because it would cost almost twice that much if I went to a private dentist, but I never got any treatment.”

She went on to talk about how expensive dental treatment was. She told me about a friend of hers that paid $50,000.00 to get all of his dental work done. She said that his teeth looked real nice now, but he had to pay cash in order to get them fixed for that amount. She said that she couldn’t imagine paying that much money for anything.
I asked her to tell me about the last time she went to a dentist and received any treatment. She said it was in 1998 to get two teeth pulled. She said, "I went back in 1999 because my mouth tasted foul and that was when they first detected the gum disease." The dentist said it would take three treatments and her dental insurance deductible of $100.00 would have to be paid in advance, before she could get treatment. "Right after that, I lost my job and wasn't able to pay for the treatment." She then told me about her grandmother who died from an abscessed tooth in 1939. She said that she takes dental problems very seriously. She said that she heard on CNN about how the same bacteria in tooth decay and gum diseases is causing women to have heart attacks and that she was afraid. She said, "It is scary, when I think about it, because I have been living with this stuff for eight years."

I asked if she has had any bad experiences at the dentist. She said it wasn't a bad experience, but when she was young her grandmother took her to the dentist because one tooth was hurting and the dentist ended up pulling two teeth. The dentist said that he thought she would eventually be having trouble with the other tooth, so he pulled it too. She said that she often wonders if he should have pulled that other tooth. Then she remembered that one time when she had a tooth pulled, the dentist said her roots were unusual, having three roots, and that it made them hard to come out. The dentist really had to work at getting the tooth out and she could feel it when it was pulled. Barbara then said, "The only real dental work I have ever had was a crown on my front tooth."
I then asked her to describe her dental care as a child. Barbara said that her grandmother took her to the dentist at least once a year. She said she needed braces when she was 9 or 10 years old and the dentist said that was why her teeth were shorter than they should be. However, she has always brushed regularly.

I asked if she would be willing to talk about her dental health now. She said that her dental health now was poor. "My gums bleed every night and you wake up with blood on your pillow." I asked what she is doing for her dental needs now. She said, "I have to gargle with peroxide and brush with baking soda and salt." I then asked if she takes anything for the pain. She said that she isn't taking anything. Barbara then said, "I have only one molar left to chew on and it is loose." "I don't know what I am going to do when that one goes." Her teeth were very sensitive so she doesn't drink coffee or anything cold.

Barbara then showed me the gap between her front teeth and said that it wasn't always there. Her teeth are loose and shifting. She moved one of her front teeth with her finger. She then added, "My front tooth is so loose that I can't even bite sandwiches, I have to cut them into little pieces like you would for a child." Then she said, "I never thought about biting sandwiches with your front teeth until my tooth got loose."

I asked if she knew how to get dental care while she is in the shelter. Barbara said, "Yes, you go to your advocate and you go to UMC in an emergency." She said that her advocate told her that the shelter has a dentist who will pull a tooth.
I noticed that Barbara talked with her hand over her mouth throughout most of the interview, so I asked if she was self conscious about her teeth. She said, "Yes, I am always thinking about the appearance and the smell." It should be noted that Barbara had to get out of bed to do the interview. She had been lying down because of a toothache.
Marie

Marie, a thirty-seven year old African American woman, was a single parent with one child. The first thing I noticed was that Marie seemed hesitant about the interview. I asked if she still wanted to do the interview. She asked me how long it would take. I said that I could probably get the information within twenty minutes if that was all right. She said that was good because she didn't feel good. She had a toothache and she needed to see a dentist, that's why she decided to participate in this study.

I began the interview by asking if she knew how to get dental care while she is in the shelter. She said, “Yes, you talk to your advocate and they will get you an appointment.” She told me, “I have an appointment now to see the dentist, but this doctor only pulls teeth.” I asked if she was OK with that. She said she would rather get it pulled than have a root canal. She told me, “I have heard a lot about root canals, and I don’t want one, so I would rather have it pulled and be out of pain.” I asked if she knew what was wrong with the tooth. She said, “Not really, the tooth is chipped and the filling fell out.” She then said that she had just been to a dentist in October of last year because the tooth was infected. The dentist gave her some antibiotics and referred her to an oral surgeon but she couldn’t go. She explained that the deductible for her insurance was $500.00 and she didn’t have the money.
I asked if she usually followed through with her dental appointments when she makes them. She said, "Yes, absolutely." She told me that she always follows through, especially when she had insurance because with insurance, if you don't show up they still charge you. She then described how it used to be very hard to get dental insurance and how expensive dental offices in Las Vegas used to be. She thinks they are less expensive now because there are more dentists and more of them take Medicaid.

I asked when she had last seen a dentist before her appointment last October. She said, "Ten years." I asked why she went ten years ago. She said to have her wisdom teeth removed. I asked why it had been so long. She said, "Just to walk in is $75.00. Even with insurance it was like a $500.00 deductible and that is really hard when you are a single parent." I asked if she had any bad experiences with a dentist. She said she didn't think so.

Next, we talked about her dental care as a child. Marie said, "When I was nine years old I had four teeth pulled." Then she added, "But I didn't feel like he needed to pull those teeth." I asked if she knew why those teeth were pulled. She said, "No." I asked how often she went to the dentist as a child and how often she brushed her teeth. She said, "My parents took me to see the dentist regularly, about every six months, and I had to brush twice a day."

I asked Marie how often she goes for dental care now. She said that she only goes in emergencies. She then said, "If I had dental insurance, I would go once a year for cleanings."
When I asked how she would describe her dental health now. She said, "Poor. In fact, I have a toothache right now." She described how she sometimes can't sleep and she can't eat anything cold. She said that her teeth are still sensitive and that she can't chew, at least on one side. I asked what she does for the pain. She said she takes Tylenol but that doesn't really help. Then she said, "I'd rather have a baby than a toothache because it even messes with your vision." And, "I just close my eyes and wait for it to go away, sometimes it takes three to five minutes."

I asked if I could follow up and see how she was doing after her dental appointment. Marie said yes. I thanked her for helping me with the interview.
Lisa

Lisa was a single thirty-three year old Caucasian woman without any children. I began the interview by asking how long it had been since she last visited a dentist. She said, "Four years ago, the last time I had insurance." Then I asked the reason for the visit. She said that she went to get a check up and cleaning. She told me that when she had dental insurance, she would go about every six months for regular cleanings and check ups.

I noticed that Lisa seemed uncomfortable, so I asked if she still wanted to do the interview. She said, "Yes, but I am just in pain." I asked if she would describe her dental health now. She said, "Not too good because I am in pain right now." I asked what the problem was. She said that she thought she had an abscess. I asked if she knew how to get dental care while she is in the shelter. She said that she believes she should talk to her advocate. She then explained, "They [that the shelter workers] were willing to take me to University Medical Center (UMC) emergency room last night so that I could get something for the pain, but I didn't want to be dropped off there late at night, have to wait eight hours, and then have to ride the bus back." She said, "It just wasn't worth it." Instead, she decided to take Tylenol PM and go to bed.

I asked if that was how she usually handled her dental pain and she said yes, or that she sometimes takes Advil. I then asked how much Advil. She replied, "Sometimes, I have taken six at a time." Since Lisa was visibly not feeling well, I
decided to thank her for doing the interview and I asked if she had any questions for me. She said, "Yes, could you get me to a dentist any faster?" I told her that I would leave a message for her advocate.

Next, I asked Lisa to describe her dental care as a child. She told me that she never went to the dentist as a young child because they lived in a rural community. But when she became a teenager, her family moved closer to a town and she began to go to the dentist once a year. I asked how often she brushed her teeth, and she said that she has always brushed her teeth twice a day, even as a child.

I then asked Lisa how she felt about going to the dentist now. She said, "It's scary, I don't like the sounds, smells, or the drill and I don't like needles either." I asked if she had ever had a bad experience with a dentist. She told me that she has never had a bad experience, but she just doesn't like to go. I then asked if she usually kept dental appointments when she had them. She said, 'Yes, always." I asked for the main reason of not going to the dentist. She replied, "Money."

Lisa was frowning and showing signs of discomfort, so I thanked her and ended the interview. Aside from her physical discomfort, Lisa appeared to be very comfortable with the interview. She did not display any behavior indicative of being self-conscious about her appearance.
Dee

Dee, a thirty year old Caucasian woman, was a divorcee with one child. She began her interview by explaining that it had been well over a year since she had seen a dentist. I asked if she could explain why she went and she told me it was to get her partial plate fixed or replaced. Dee had a partial plate that held a left front tooth and a premolar. She said that many years ago she had been in a car wreck that broke her front tooth and knocked out her premolar. The front tooth eventually died and she trimmed it down with fingernail clippers. She explained that it didn’t hurt to do that because it was dead. She said, “I made another tooth out of paper and used super glue to hold it in place.” Eventually her husband got insurance through his job, so she was able to go to the dentist. The dentist made her a partial plate to replace the teeth which worked all right until the front tooth broke. Consequently, over a year ago, she went to get the partial fixed.

She said she was still not happy with how the new tooth looked. She said anyone could tell that it was false and it did not match the other front tooth very well. She was very self conscious about the looks of her front teeth. Dee said, “I like to smile but I don’t smile around guys when I meet them because I think they treat me badly because of my teeth.” She said, “I really lack self esteem because of my teeth and I think guys can tell that.”

Dee then said that she really needed dentures, because she was missing so many teeth. She took out her partial and showed me how many teeth she was
actually missing. It looked like she was missing about six or seven teeth and I could tell that she had quite a lot of dental work done in the past. Dee asked what I thought about the appearance of her front teeth. I told her that I really couldn't tell that one of them was false. We then discussed the possibility of getting a bridge that would remain fixed in place. She said she heard about a new type of bridge made of "molten lava" that was much better than the old types and may cost less.

Next, we discussed her dental care as an adult. She said she went regularly to the dentist until three years ago when she was divorced. She was married for ten years and went to the dentist regularly during most of that time. However, she explained, that she had to stop going because, "My husband wouldn't keep me on his insurance when we started having problems because he didn't want to pay for a lot of dental work and then have me leave." That didn't seem to upset her because she said she was trying to leave. She said she has always brushed her teeth everyday.

I asked about her dental care as a child. Dee said she had braces when she was young and lived with her grandmother. Then her mother came and took her away from her grandmother and she was not allowed to go to the dentist again. Dee said she had bad teeth and needed to go back to the dentist but her mother was not a good mother and didn't care about her teeth. Although she brushed her teeth daily, she still lost two of her permanent molars at an early age. She told me that she blames her mother for that.
I asked how she felt about going to the dentist and if she ever had a bad experience. Dee said she has always liked to go to the dentist. She said she always keeps her appointments when she has them and she thinks her dental care is very important. That’s why she wanted to do the interview; she was hoping that I knew how she could see a dentist. I told her that I really didn’t have a connection with any dentist.

I asked if she knew how to get dental care while she is in the shelter. She said that she told her advocate that she needs to see a dentist, but nothing was said. I asked if she asked directly. She said, “No, I just mentioned it on my paperwork and nothing was said about it.”

I asked if she was in pain. Dee said, “Yes.” I asked what she was doing for the pain. She told me she takes aspirin. I asked her to describe her dental health now. Dee said it was not good. She has “huge” cavities in several teeth and needs root canals and crowns. She is missing two molars and is afraid she will be losing another. She then asked if I knew how to get an appointment at the UNLV Dental School. I said I could get her the information.

Dee told me that she just got a job and was going to try to save up money so that she could begin getting her teeth fixed. She said that she knew it would take time to get an appointment at the dental clinic so she would start saving money now. I thanked Dee for helping me with the interview and left information about the UNLV Dental School clinic in her case file.
APPENDIX B

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APPENDIX C

RESEARCH PROTOCOL PROPOSAL FORM
Office for the Protection of Research Subjects

Research Protocol Proposal Form
for Research Involving Human Subjects

Evidence of CITI certification (www.citiprogram.org) must be submitted with this protocol proposal form.

Instructions:
1. Complete all sections of this form. Do not reference other sections as a response (i.e. "see section..." or "see attached...")
2. Obtain all necessary signatures.
3. Submit one complete protocol package with all enclosures. You will be notified if additional copies are necessary.
4. Projects with funding/proposed funding must include copy of the application or proposal.

Note:
1. Handwritten forms will not be accepted.
2. INCOMPLETE FORMS WILL BE RETURNED.
3. For your records, it is important that you keep a copy of this completed form.

1. Submission Date: 12/05/2006

2. Duration of Study
   - Anticipated Start Date: 2/20/2007
   - Anticipated Termination Date: 6/01/2007

NOTE: Research Studies may not begin until you have received notification of IRB approval. All research proposals are approved for a maximum of 1 year and can be re-reviewed at any time within that year at the discretion of the IRB.

3. Research Protocol Title (Research Protocol Title must match the funding/proposed funding application or proposal):
   Access to Dental Care for Victims of Domestic Violence

4. Investigator(s) Contact Information
   (One person must be designated as the PI. The PI must be a UNLV faculty or professional staff member in all cases involving studies carried out by students or fellows.)

   A. Principal Investigator (Name and Credentials): John Sweatnam, PhD
      - Faculty: ☑
      - Faculty Advisor: ☐
      - Professional Staff: ☐
      - School/College/Center: Liberal Arts
      - Department: Anthropology and Ethnic Studies
      - Mailing Address: University of Nevada, Las Vegas, Las Vegas, NV 89154
      - Phone Number: 702-895-3831
      - Fax Number: 702-
      - E-Mail Address: sweatnam@unlv.edu

   B. Student/Fellow Investigator (Name and Credentials): Carolyn J. Taylor
      - Undergraduate: ☐
      - Master: ☑
      - Doctorate: ☐
      - Fellow: ☐
      - School/College/Center: Liberal Arts
      - Department: Anthropology and Ethnic Studies
      - Mail Stop: 5003

Protocol Proposal Form - Ver. 2 - 6/2005

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5. Research Team Members: List all research team members who will be involved in this research project. Research team members are persons who have direct contact with subjects, contribute to the research in a substantive way, have contact with subjects' identifiable data or biological samples, or use subjects' personal information. (For additional guidance, refer to the sample form on the OPRS website.)

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<th>ROLE IN CONSENT PROCESS</th>
<th>SPECIFIC EXPERIENCE WITH ROLE IN PROTOCOL</th>
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<td>Carolyn Taylor</td>
<td>Interviewing consenting subjects, collecting and compiling data, analyzing data</td>
<td>Disseminate and collect consent forms</td>
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6. Project Site(s) (Check all boxes indicating where the study is conducted.)

- University of Nevada, Las Vegas (UNLV)
- Maryland Campus (main)
- Paradise Campus
- Shadow Lane Campus
- UNLV leased property. Explain:
- Other: (Specify and Explain): Safe Nest Shelter for Victims of Domestic Violence
NOTE: If the project site is other than UNLV, Facility Authorization Letter must be submitted.

7. Research Terms
Provide up to three terms, keywords, or short phrases that describes the research to be performed using the guidelines below:

1. Research area (biomedical, social behavioral): Social Behavioral
2. Study topic area (e.g., physical therapy, psychology): Applied Anthropology
3. Subject class (e.g., healthy adults, prisoners): Adult Women Residing in Shelter

8. Proposal Summary
Summarize the proposed research project. The summary should be written in non-technical language that can be understood by non-scientific individuals. The summary must not exceed 200 words.

8.1 A brief statement of the research question (hypothesis) and related theory supporting the reason for the study.

Although women at the Safe Nest Shelter express a need for dental care, health care providers report little response to existing programs offering services free of charge. This study will provide in depth information concerning the knowledge residents have of available services, the presence of competing demands on their time, the difficulty of accessibility to sites in which services are rendered, and the uncertainty residents encounter as to their treatment by service providers. The study will test Obrist, Tanner, and Hareham’s (2003) hypothesis that survival needs limit resident response in such programs.

8.2 A brief description of the procedure(s) involving human subjects.

Three to six residents and two to five staff will be interviewed using open ended ethnographic techniques to reconstruct the individual’s perceptions of their individual need for dental care, their knowledge of the availability of services, their understanding of the process by which access is obtained, and their emotional response to occupying the role of being cared for by individuals with whom they have no prior existence. By examining health seeking behaviors in the shelter context, the study will provide insights into the dilemmas faced by abused women in improving their appearance, dental health, and opportunities for employment in fields in which appearance is crucial.

PLEASE NOTE: Complete description of the study procedure(s) must be specified in Section 26.

9. Number of Research Subjects
Total number of subjects: 3 - 6

10. Research Subject Classification
10.1 Check all applicable boxes

- □ UNLV Students (general student body)
- □ Student Subject Pool (Dept.):
- □ Healthy Adults - Age range: ______
- □ Minors (under age 18) - Age range: ______
- □ Clark County School District Students
- □ Cognitively or Psychologically Impaired (See consent form guidelines)
- □ Non-English Speaking (Include consents in the appropriate language)
- □ Elderly Subjects
- □ Prisoners or Parolees
- □ Healthy Control Group
- □ Pregnant Women
- □ UNLV Employees
- □ Institutionalized Residents
- □ Other - Describe: Adult Females - Victims of DV

10.2 Summarize the inclusion and exclusion criteria that must be met in order for a person to participate in the study.

Inclusion: Women residing in shelter over 18 years of age AND SHELTER STAFF

Exclusion: Individuals not residing in shelter and under 18 years of age
10.3 What is the gender of subjects?  
- [ ] Male  
- [ ] Female  
- [ ] Both

10.4 Are there any enrollment restrictions based on gender, pregnancy or childbearing potential?  
- [ ] Yes  
- [ ] No

If yes, please explain the nature of the restriction(s) and provide justification.

Safe Nest only allows women and children to reside in shelter. RESTRICTIONS FOR INCLUSION IN THIS STUDY WILL BE THAT THE PARTICIPANT IS AN ADULT (18 YEARS OF AGE OR OLDER) RESIDENT OF THE SAFE NEST SHELTER AND HAS NOT SEEN A DOCTOR WITHIN THE PAST 12 MONTHS.

10.5 Are there any enrollment restrictions based on race or ethnic origin?  
- [ ] Yes  
- [ ] No

If yes, please explain the nature of the restriction(s) and provide justification.

11. Purpose of Study

Results of study can be applied to public health issues and improve access to dental care for women in shelters.

12. Privacy and Confidentiality

Privacy refers to a person's desire to control the access of others to themselves. Privacy concerns people. Confidentiality refers to the researcher's agreement with the subject about how the subject's identifiable private information will be handled, managed, and disseminated. Confidentiality concerns data.

12.1 What are the methods used to ensure confidentiality of participation and data obtained?  
Names and other personal identification will not be collected on materials other than consent forms. Interviews will be conducted in the shelter and in privacy.

12.2 What safeguards are used to protect against identifying, directly or indirectly, the subject involved in the study?  
No identifiers will be used. Personal identification will be coded and names will not be available to anyone except the investigators.

12.3 What safeguards are used to protect the information from disclosure?  
Informed consent forms and all notes will be locked in Anthropology office safe on UNLV campus. No Names or identification will be on interview notes.

12.4 What provisions exist for controls over access to data?  
Access will be limited to John Swelnam, PhD and Carolyn Taylor.

12.5 Are subjects asked to fill out any materials that are shared with other groups (e.g. voluntary health organizations, advocacy groups) that provide identifiers?  
- [ ] Yes  
- [ ] No

If yes, describe: ________

12.6 Will the subjects' data be coded?  
- [ ] Yes  
- [ ] No

If yes, how? SUBJECTS WILL BE ASSIGNED RANDOM NUMBERS BETWEEN 1 AND 12 AND RECORDS OF THE ENCODING WILL BE KEPT AT THE ANTHROPOLOGY OFFICE IN A LOCKED STORAGE.

12.7 Will data generated be used for purposes other than this research project?  
- [ ] Yes  
- [ ] No

If yes, how? ________

12.8 Where will the data be stored? (For review/audit purposes, records must be stored on UNLV property.) Anthropology office on UNLV campus.

12.9 How long will the data be stored? 45CFR46.115(b)-Records relating to research which is conducted shall be retained for at least 3 years after completion of the research. Three Years.

12.10 What are the plans for the final disposition or destruction of the data? Shredded after three years.
### 13. Recruitment Procedures

**13.1** Describe below the processes used for selecting subjects and the methods of recruitment, including use of letters and/or advertising. Include, when, how and by whom the subjects will be recruited. Do not include inclusion and exclusion criteria which were already listed in Section 10.2.

Subjects will be recruited from residents of the Safe Nest Shelter in Las Vegas, Nevada. Project will be announced and described by Carolyn Taylor at weekly meeting for residents and any volunteers will be invited for interviews. Carolyn Taylor will inform volunteers of their rights to withdraw from the study at any time and volunteers will be reassured that complete confidentiality will be preserved. If residents agree to participate in the study, they will be given information of who to contact if they have any questions and an informed consent form.

**13.2** Will subjects be recruited from one or more schools, community centers, organizations, trade groups etc.?  
- [ ] Yes  
- [X] No

If yes, please specify the source(s): __________

NOTE: Provide a Facility Authorization Letter from the performance site facility giving the PI permission to perform the study at that site.

**13.3** Indicate the types of recruitment materials to be used below (check all that apply). Attach copies of all recruitment materials to this application.

- [ ] Advertisements
- [ ] Newsletters
- [ ] Internet
- [ ] Brochures
- [x] Radio
- [ ] Contact letters (Physician Letters, Teacher Letters)
- [ ] Flyers/Posters
- [ ] Television
- [ ] Other (Describe) ________

This research study will not be using any of the above information.

**13.4** Will subjects be recruited from a non-public registry?  
- [ ] Yes  
- [X] No

If yes, specify the source: __________

NOTE: Provide a letter from the director of the registry authorizing your access to the identifiable data for the purpose of this study. The letter needs to clearly describe how access to the identifiable information is ethically possible, (i.e. it confirms that subjects have given permission for contact and authorized the distribution of their names and address).

**13.5** Are you studying pre-existing data? (e.g. academic records, medical records or specimens)  
- [X] Yes  
- [ ] No

If yes, specify the source: RESIDENT INTAKE FORMS DATING FROM 1-1-06 TO 12-31-06 WILL BE EXAMINED. SIGNED RELEASE FORMS WILL NOT BE NEEDED BECAUSE NO INDIVIDUAL INFORMATION WILL BE TAKEN. THIS STUDY WILL ONLY BE IDENTIFYING FREQUENCIES REGARDING LENGTH OF TIME SINCE LAST DENTAL VISIT, LENGTH OF STAY IN SHELTER, AND NUMBER OF REFERRALS TO DENTAL PROFESSIONALS FOR TREATMENT.

**13.6** Do you or any member of the research team have an authoritative role (i.e. Instructor, Counselor, etc.) over the research subjects?  
- [ ] Yes  
- [X] No

If yes, please explain: __________

### 14. Research Activities (Part A)

Please check any/all that apply to the proposed research study.

- [ ] Collection of data is through non-invasive procedures routinely employed in clinical settings, excluding x-rays or 

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microwaves (e.g., physical sensors that do not shock or invade the subject's privacy, weighing or testing sensory acuity, magnetic resonance imaging, EEG, EKG, moderate exercise or strength testing with healthy non-pregnant subjects).

☐ Collection of data involves review of data, documents, records or specimens that were originally collected for non-research purposes (e.g., medical records).

☐ Existing human biological specimens will be used.*

☐ Prospectively collected human biological specimens will be used. **

Indicate source and dates when the data were collected: _____

* Specimens must be "on the shelf" at the time of the submission of the application.

** Specimens will be collected after the study has started.

☐ Collection of data is from audio or visual recordings.

☒ Research activities involve observing individual or group characteristics when considering the subject's own behavior (including perception, cognition, motivation, identity, language, communication, socio-cultural beliefs, practices or behavior).

☒ Research employing survey, interview, oral history, focus group or program evaluation measures for purposes of research.

☐ Research activities involve medical devices that have been approved for marketing and are used as prescribed.

Identify device(s): _____

☐ Blood samples are collected by finger stick or venipuncture only from non-pregnant healthy adults in amounts less than 550 ml in an eight-week period and no more than twice per week.

Provide a brief description of blood collection methods: _____

☐ Prospective collection of biological specimens by non-invasive means (e.g., hair and nail clippings, extracted teeth, excreta and external secretions, unanesthetized saliva, placenta removed at delivery, amniotic fluid obtained at rupture of membrane prior to or during delivery, dental plaque and calculus, mucosal and skin cells collected by swab and sputum collected after saline mist nebulization).

☐ None of the above categories apply to the proposed research study.

---

15. Research Activities (Part B)

15.1 Please check any/all that apply to the proposed research study

☐ False or misleading information to subjects (deceptive studies)

☒ Procedures for debriefing subjects: Results of study will be given to Safe Nest.

☐ Invasive biomedical procedures

Explain procedure: _____

Are provisions for medical care necessary?

☐ Yes, please explain: _____

☐ No, please explain: _____

Has a qualified UNLV Faculty Member participated in planning the study?

☐ Yes, please identify by name and qualifying credential: _____

☐ No

Will the study involve drugs, radiation, lasers, high-intensity sound, etc.? 

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16. Medical Devices

16.1 Are you using a medical device?  □ Yes  ☒ No
   If no, then continue to section 17. If yes, please complete the answers below.

16.2 Is this a SIGNIFICANT RISK (SR) or NON-SIGNIFICANT RISK (NSR) device?  
   □ SR  □ NSR

16.3 Is this an INVESTIGATIONAL MEDICAL DEVICE  
   □ Yes  □ No
   APPROVED MEDICAL DEVICE FOR AN UNAPPROVED USE.  □ Yes  □ No
   If yes, indicate DEVICE name:
   IDE number:  
   Sponsor/Manufacturer:  
   NOTE: Please provide the investigator's brochure when using an investigational device.

FDA APPROVED MEDICAL DEVICE FOR AN APPROVED USE:  □ Yes  □ No
   If yes, indicate DEVICE name:
   Sponsor/Manufacturer:  
   NOTE: Please provide the package insert when using an approved device.

16.4 Is the IDE (Investigational Device Exemption) held by the sponsor or by the investigator?  
   □ Sponsor  (Please forward copies of the annual report from the sponsor to the IRB.)
   □ Investigator (Please provide a copy of the original IDE application and copies of the annual reports at the time of periodic review)
17. Risks

17.1 Summarize the nature and amount of risk (including side effects) or substantial stress or discomfort involved. There will be no risk of physical harm. Minimal risk will be transitory and well guarded against. Emotional discomfort or stress may be possible as participants remember events that led up to dental trauma.

17.2 What are the potential risks/discomforts associated with each intervention or research procedure? Participants may feel shame or embarrassment about dental health issues.

17.3 Estimate the probability (i.e. not likely, likely, highly likely, etc.) that a given harm will occur, its severity, and its potential reversibility. Not Likely

17.4 What procedure(s) will be utilized to prevent/minimize any potential risks or discomfort? Examples of risk include physical risks, psychological risks (such as substantial stress, discomfort, or invasion of privacy) and social risks (such as jeopardy to insurability or employability). Participants will be regularly reminded that they need not answer all questions and that they can withdraw from the study at any time without prejudice to status in shelter, interviews will be conducted at the shelter and in privacy.

17.5 What is the overall risk classification of the research?

☐ Minimal  ☐ Greater than minimal  ☐ Significant

☐ If unknown, please explain:

18. Benefits

18.1 Describe the probable benefits of the research for the individual subject(s).

Results of the study could increase individual’s understanding of how to access dental care and may expand availability of dental care to residents. Shelter staff will be better informed and able to assist individuals in need of dental care.

18.2 Describe the probable benefits of the knowledge gained for society. Societal benefits generally refer to the advancement of scientific knowledge and/or possible benefit to future subjects.

Dental care providers will have a better understanding of barriers to dental care for women in shelters. Results may also be used to increase information about dental needs, improve accessibility dental care and provide better information to be used for advocacy.

19. Risk-Benefit Ratio (Explain how the potential benefits of the research outweigh the potential risks and how these risks are justified.)

This study will have minimum risks to subjects, in that the subjects may feel uncomfortable discussing their experiences with dental care. Information from this study could have a significant positive impact on the availability of access to dental care for victims of domestic violence. Results from this study could improve the individuals’ understanding about access to dental care and increase awareness of the need for dental care from the dental care providers in the Las Vegas area.

20. Cost to Subjects (Do not include financial costs in this section. See Section 22.)

20.1 Briefly describe the activity (i.e. laboratory testing, survey completion, travel time) that involves participation time: personal interview

20.2 Amount of participation time: 120 minutes per day for 1 day(s)

20.3 Describe any additional costs: 0
21. **Project Funding**

21.1 Funding Status:  □ Funded  □ Pending  □ None (go to section 22)

Note: If funded/pending funding, please submit a copy of the application or proposal.

21.2 Funding Source:

- □ Federal/State
- □ NIH  □ NSF  □ NASA  □ BRIN  □ DOE  □ Other: [____]
- □ UNLV Internal Grants
  - □ SITE  □ NIA  □ URA  □ ARI  □ Other: [____]
- □ Other: [____]
- □ Self-funded

21.3 Are there any other contributions or support (e.g., devices, drugs, etc.) provided by a company/sponsor/granting agency?

- □ Yes  □ No  If yes, explain: [____]

21.4 Is there any type of contribution (aside from devices or monetary funds) being made by a company/sponsor/granting agency?

- □ Yes  □ No  If yes, explain: [____]

21.5 Has this project been submitted to the Office of Sponsored Projects (OSP)?

- □ Yes  □ No  Submission date: [____]
  If no, explain: [____]

21.6 Sponsor: [____]  Contract or Grant Number: [____]

22. **Financial Information** (For additional guidance, refer to the sample form on the OPRS website)

22.1 What are the financial costs involved as a result of participation in the research study?

- □ Yes  □ No

If yes, please describe: [____]

22.2 Are there additional expenses for the subject related to this protocol?

- □ Yes  □ No

If yes, please describe: [____]

22.3 Will subjects be paid or otherwise compensated for research participation?

- □ Yes  □ No

If yes, please respond to the following questions:

a) Describe the nature of any compensation to subjects. Include cash, gifts, travel reimbursements, etc. [____]

b) Provide a dollar amount, if applicable, and indicate method of payment. [____]

   - □ Cash  □ Check  □ Other: [____]

c) When and how is the compensation provided to the subject? [____]

d) Schedule of payments: [____]

23. **Consent**

Refer to the UNLV Informed Consent Template to ensure that your submission follows the current standard consent format.

Attach a copy of all consent form(s) and/or informational letter(s) used to describe the research study to potential subjects.

Note: Consent must be obtained from subjects prior to enrollment/participating in the research study.

23.1 Describe the consent process for enrolling subjects into this study. Subjects will be invited to participate in the study during a residents meeting at the shelter. Subjects will receive an oral explanation of the research project and information on whom to contact with questions. Subjects will be reminded that participation is voluntary and the...
subjects may withdraw from the study at any time without censure from Safe Nest or UNLV. If the subject wants to participate, a written consent form will be given to the subject for their signature.

23.2 Where will the consenting process take place? Safe Nest Shelter

23.3 Will there be an opportunity for the subject to take the consent form home to discuss their participation? ☒ Yes ☐ No If no, explain why. 

23.4 What method(s) will be used to educate and increase the potential research subjects' knowledge of the research project and their rights as a subject? Oral description of project and answer any questions.

23.5 What method(s) will be used to evaluate the understanding of the potential research subject's comprehension about the research project and their rights as a subject? (Check all that apply)

☐ Verbal feedback of information
☐ Pre and Post-test
☐ Other (describe): 

23.6 Please list all Consent Forms (Please compose all consent forms in a language appropriate to the study population.)

Title of Consent Form Purpose
1. Informed Consent Form The subject understands the purpose of the project and agrees to participate, acknowledging their rights and the limits of UNLV liability.

2. 
3. 
4. 

23.7 Debriefing: If the study includes a debriefing script or information given to subjects, please attach with the submission.

Is a debriefing script necessary? ☐ Yes ☒ No

24. Conflict of Interest (Conflict of interest refers to any situation in which financial, professional, or personal obligations may compromise or present the appearance of compromising an individual's professional judgment in designing, conducting, analyzing, or reporting research.)

Does a conflict of interest exist with this study? ☐ No ☒ Yes. explain: 

25. Project Enclosures (Check all appropriate boxes and include the items with the Proposal Form)

☒ Informed Consent Form(s) ☐ Grant/Contract Application/Proposal
☐ Child/Youth Assent Form ☒ Facility Authorization Letter
☐ Debriefing Script ☐ Research Instruments (Surveys, Questionnaires, etc.)
☐ Waiver of Documentation of Consent ☐ Recruitment Information (Ads, Web postings, letters, etc.)
☐ Other items: 

26. Complete Description of the Study Procedures

3 to 5 residents of Safe Nest will be interviewed (face to face) in a private room at the Safe Nest Shelter. In addition, 3 to 5 Safe Nest staff at the shelter will also be interviewed (face to face) in a private room at the Safe Nest Shelter. The interviews will seek to elicit residents and staff ideologies and knowledge of dental care. Additional information pertaining to length of time since last dental visit and dental conditions at the time of intake to the shelter will be retrieved from archived and current files. All personal information will be coded.

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LIST OF RESEARCH QUESTIONS

Protocol #0612-2186: Access to Dental Care for Victims of Domestic Violence

QUESTIONS TO INITIATE THE INTERVIEW:

General reminder will be given before interview.

I would like to thank you for volunteering to participate in this study. Since participation is voluntary, you may refuse to participate at any time during the interview. Please take as much time as you need to answer.

Interview Questions are as follows:

- When was your last dental visit?
- What was the reason for the visit?
- What were the results?
- Would you be willing to talk about your experience?
- How often do you go to the dentist? What is the reason for most appointments? (Emergency, Cleaning, Exams)
- Could you describe your dental care as a child?
- Has it changed as an adult? If yes, how has it changed?
- How do you feel about going to dentists?
- How would you describe your dental health now?
- Do you have any dental needs now? Could you describe the need?
- What are you doing about the needs now? What do you do in an emergency?
- Do you know how to find dental care now (While you are in the shelter)? Please describe.
- When you make an appointment do you follow through? If not, why?
APPENDIX E

SOCIAL/BEHAVIORAL IRB - APPROVAL NOTICE
Social/Behavioral IRB – Expedited Review Approval Notice

NOTICE TO ALL RESEARCHERS:

Please be aware that a protocol violation (e.g., failure to submit a modification for any change) of an IRB approved protocol may result in mandatory remedial education, additional audits, re-consenting subjects, researcher probation suspension of any research protocol at issue, suspension of additional existing research protocols, invalidation of all research conducted under the research protocol at issue, and further appropriate consequences as determined by the IRB and the Institutional Officer.

DATE: February 21, 2007
TO: Dr. John Swetsnam, Anthropology
FROM: Office for the Protection of Research Subjects
RE: Notification of IRB Action by Dr. J. Michael Stitt, Chair
Protocol Title: Access to Dental Care for Victims of Domestic Violence
Protocol #: 0612-2186

This memorandum is notification that the project referenced above has been reviewed by the UNLV Social/Behavioral Institutional Review Board (IRB) as indicated in Federal regulatory statutes 45 CFR 46. The protocol has been reviewed and approved.

The protocol is approved for a period of one year from the date of IRB approval. The expiration date of this protocol is February 20, 2008. Work on the project may begin as soon as you receive written notification from the Office for the Protection of Research Subjects (OPRS).

PLEASE NOTE:
Attached to this approval notice is the official Informed Consent/Assent (IC/IA) Form for this study. The IC/IA contains an official approval stamp. Only copies of this official IC/IA form may be used when obtaining consent. Please keep the original for your records.

Should there be any change to the protocol, it will be necessary to submit a Modification Form through OPRS. No changes may be made to the existing protocol until modifications have been approved by the IRB.

Should the use of human subjects described in this protocol continue beyond February 20, 2008, it would be necessary to submit a Continuing Review Request Form 60 days before the expiration date.

If you have questions or require any assistance, please contact the Office for the Protection of Research Subjects at OPRSHumanSubjects@unlv.edu or call 895-2794.
APPENDIX F

INFORMED CONSENT FORM
TITLE OF STUDY:
ACCESS TO DENTAL CARE FOR VICTIMS OF DOMESTIC VIOLENCE

INVESTIGATOR(S): JOHN SWETNAM, PHD
CAROLYNN TAYLOR

CONTACT PHONE NUMBER: (702) 895-3831

Purpose of the Study
You are invited to participate in a research study. The purpose of this study is to determine if women living in the Safe Nest Shelter for victims of domestic violence need dental care and if they will use the resources that are available.

Participants
You are being asked to participate in the study because you currently reside at Safe Nest (ARE A FEMALE 18 YEARS OF AGE OR OLDER) AND HAVE NOT SEEN A DENTIST WITHIN THE PAST 12 MONTHS or are a staff member at Safe Nest. Even when the need for dental care is indicated by residents and shelter staff, dental care is rarely utilized by female residents of Safe Nest. This study will investigate if dental needs are present and if the needs are being addressed.

Procedures
If you volunteer to participate in this study, you will be asked to do the following:

a. Participate in an individual face-to-face interview of 60 to 120 minutes conducted by Carolynn Taylor from the University of Nevada, Las Vegas.

b. The interview will be conducted at a time that is convenient for you, in a private room at the Safe Nest Shelter.

Benefits of Participation
There MAY be direct benefits to you as a participant in this study.

• Results of the study could increase your understanding of how to access dental care.
• Shelter staff may be able to assist individuals in need of dental care by being better informed.
• Results of this study could improve information about the dental care needs of women residing in shelters.
TITLE OF STUDY: ACCESS TO DENTAL CARE FOR VICTIMS OF DOMESTIC VIOLENCE

INVESTIGATOR(S): JOHN SWETNAM, PHD
CAROLYNN TAYLOR

CONTACT PHONE NUMBER: (702) 895-3831

• Data from this study could also provide better information to advocates for victims of domestic violence and to open resources for dental care that are not currently available.

Risks of Participation
There are risks involved in all research studies. This study may include only minimal risks. You may feel uncomfortable when answering some questions.

Cost /Compensation
There will not be financial cost to you to participate in this study. The study will take approximately two hours of your time. You will not be compensated for your time. The University of Nevada, Las Vegas may not provide compensation or free medical care for an unanticipated injury sustained as a result of participating in this research study.

Contact Information
If you are willing to participate in this study and are available between February 20, 2007 and May 1, 2007, please contact Carolynn Taylor at (702) 303-7931. If you have any questions or concerns about the study, you may contact John Swetnam at (702) 895-3831. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact the UNLV Office for the Protection of Research Subjects at 702-895-2794.

Voluntary Participation
Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with Safe Nest or the University of Nevada, Las Vegas. You are encouraged to ask questions about this study at the beginning or any time during the research study.
INFORMED CONSENT
Department of Anthropology

TITLE OF STUDY:
ACCESS TO DENTAL CARE FOR VICTIMS OF DOMESTIC VIOLENCE

INVESTIGATOR(S): JOHN SWETNAM, PHD
CAROLYNN TAYLOR

CONTACT PHONE NUMBER: (702) 895-3831

Confidentiality
All information gathered in this study will be kept completely confidential. No reference will be made
in written or oral materials that could link you to this study. To preserve confidentiality, codes and age
categories will be used in place of names and specific information. All records will be stored in a
locked facility at UNLV for at least 3 years after completion of the study. After three years, all the
information gathered will be shredded.

Participant Consent:
I have read the above information and agree to participate in this study. I have been able to ask
questions about the research study. I am at least 18 years of age. A copy of this form has been given
to me.

Signature of Participant ___________________________ Date ____________

Participant Name (Please Print) ___________________________

Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.
Safe Nest-T.A.D.C.
EMERGENCY MEDICAL CARE PERMISSION FORM

I agree to let Safe Nest-T.A.D.C. staff/volunteer member transport me and/or my dependents to the nearest medical facility in an emergency in which I am incapacitated or unavailable to accompany my dependents. I agree to let a physician treat me (if I am incapacitated) or my dependents (if I am unavailable) for emergency situations.

CLIENT GENERAL INFO – ALL NAMES IN FULL (please only fill out info for children residing in shelter):
Client’s Name: ____________________________
Child #1 Name: ____________________________
Child #2 Name: ____________________________
Child #3 Name: ____________________________
Child #4 Name: ____________________________

Do you have health insurance for (circle one): Yourself only Children only You & children
Company: ____________________________
Under what name is policy? ____________________________

Copy of insurance card attached to this form on ____________________________ by ____________________________ (staff)

Emergency Contact: ____________________________ Phone: ( )

Doctor (Medical) ____________________________ Where? ____________________________ Phone ____________________________
Doctor (OB/GYN) ____________________________ Where? ____________________________ Phone ____________________________
Doctor (Mental) ____________________________ Where? ____________________________ Phone ____________________________
Doctor (Peds) ____________________________ Where? ____________________________ Phone ____________________________
Doctor (other) ____________________________ Where? ____________________________ Phone ____________________________

ALERT INFORMATION (current or recent conditions for adult & children in shelter):

ADULT
CHILD
□ □ None
□ □ Allergies, medication
□ □ AIDS
□ □ Asthma
□ □ Blood Pressure, high
□ □ Cancer
□ □ Diabetes type Meds? Y N
□ □ Disability, Developmental
□ □ Disability, Physical
□ □ Hearing disorder
□ □ Hepatitis type Meds? Y N
□ □ Head Lice
□ □ Heart disease
□ □ HIV Positive
□ □ Kidney Disease
□ □ Mental Health Disorder
□ □ Pregnancy Month
□ □ Respiratory Disorder
□ □ Scabies
□ □ Stroke
□ □ Suicidal/Self Abuse
□ □ Thyroid Disease
□ □ Tuberculosis
□ □ Other

□ □ Allergies, foods
□ □ AIDS
□ □ Asthma
□ □ Blood Pressure, high
□ □ Cancer
□ □ Diabetes type Meds? Y N
□ □ Disability, Developmental
□ □ Disability, Physical
□ □ Hearing disorder
□ □ Hepatitis type Meds? Y N
□ □ Head Lice
□ □ Heart disease
□ □ HIV Positive
□ □ Kidney Disease
□ □ Mental Health Disorder
□ □ Pregnancy Month
□ □ Respiratory Disorder
□ □ Scabies
□ □ Stroke
□ □ Suicidal/Self Abuse
□ □ Thyroid Disease
□ □ Tuberculosis
□ □ Other

LIST ALL MEDICATIONS (INCLUDE VITAMINS, OVER-THE-COUNTER & PRESCRIPTIONS):

ADULT

CHILD

When was your last: Chest X-ray ____________ Dental Exam ____________ TB Skin Test ____________
Pap Smear ____________

Please read and initial:
The information provided on this form is true and correct to the best of my knowledge
I understand the information on this form will be kept in confidence by all staff ____________

Client’s Signature or Name of Minor Parent/Guardian Signature

Staff Signature Date

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# ADULT MEDICAL HISTORY

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<th>Do you currently have, or recently had a problem with:</th>
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**Have you ever had:**
- Yes
- No
- Unsure

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<th>Condition</th>
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<td>Other:</td>
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**Have you been vaccinated for:**
- Yes
- No
- Unsure

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**Have you ever been hospitalized?**
- Yes
- No

**Have you ever had surgery?**
- Yes
- No
- If yes, explain:

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**When was your last:**
- Chest X-Ray
- Dental Exam
- TB Skin Test
- Pap Smear

**Are you currently taking any medications?**
- Yes
- No

**How would you rate your present health status?**
- Good
- Fair
- Poor

**Do you have any of these communicable diseases?**
- Tuberculosis
- Hepatitis
- Venereal Disease
- Other:

**Have you had any of the following in the last 3 months?**
- Painful periods?
- Weak or sick periods?
- Had to rest with periods?
- Tense or jumpy periods?
- Hot flashes or sweats?
- Trouble with vaginal discharge?

**Do you feel you have any problems needing immediate attention?**
- Yes
- No

**Do you have health insurance?**
- Yes
- No

**With whom?**

---

MedicalHistoryAdult

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BODILY INJURIES

☐ NO BODILY INJURIES REPORTED  ☐ INJURIES REPORTED AS BELOW

Description of injuries (include abrasions, bruises, cuts, bites, burns, fractures, etc. Describe size & appearance of injuries. Note swelling & tenderness)

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

☐ PHOTOS OF INJURIES TAKEN ON

☐ PHOTOS PLACED IN ENVELOPE BY

Resident Signature  Date  Parent/Guardian Signature  Date

Staff Signature  Date

BODILY INJURIES
AGENCY USE FORM

CLIENT #

1. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

2. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

3. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

4. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

5. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

6. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

7. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

8. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
   COMMENTS

9. DATE OF VISIT AGENCY
   ADVOCATE TRANSPORTED: YES NO
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Giddens, A.  

Gift, Helen C., with Susan T. Reisine, and Dina C. Larach  

Goffman, E.  

Gordon, Judith S.  

Gregg, H.G., with R.P. Duncan, and B.J. Shelton  

Gulzar, Lalla  

Hamilton, B., and J. Coates  

Hannerz, U.  

Hart, B.  

122
Hatton, Diane C., with Dorothy Kleffel, Susan Bennett, and Elizabeth A. Gaffrey  
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Kiefer, Christie W.  

Kimball, S.  

Krishnan, S.P., with J.C. Hilbert, D. VanLeeuwen, and R. Kolia  

Kubany, Edward, with Julie Owens, Mari McCaig, Elizabeth Hill, Cindy Iannce-Spencer, and Ken Tremayne

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Matthews, D.C.

McFarlane, J., with B. Parker, K. Soeken, and L. Bullock

McWhirter, P.T.

Mertens, Richard

Miller, Jean Baker

Mitchell, Jacqueline


Naylor, L.L.

Oliver, R.C., with L.J. Brown, and Loe Harald


Obrist, B., P., with Van Eeuwijk, and M. Weiss

Obrist, Brigit, with Marcel Tanner, and Trudy Harpham

Obrist, Brigit

Partridge, W.L., and E.M. Eddy

Peattie, Lisa R.

Peujrye-Hissong, C., with C. Davis, and H. Weinberg

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Straus, M.A., and R.J. Gelles

Tax, Sol

Timothe, Peggy, with Paul Eke, Scott Presson, and Delores Malvitz

Timothe, Peggy, with Paul Eke, Scott Presson, and Delores Malvitz


Vitanza, S., with L.C. Vogel, and L.L. Marshall

Williams, Jean C.

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