Orthopsychiatry in orthodontia

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INTRODUCTION

You, as orthodontists, occupy a position of importance and prestige in our society. You are respected for your status as professional people, admired for your achievement, deferred to as experts in your field and valued for your technical skills. What you do shows. You are doers in an age of technology when tangible, visible results are prized. You are looked upon with esteem as substantial, financially successful upper middle class members of our society. This is predominantly the setting in which you are cast by your patients, adults and children. From this idealized conception grow certain defined expectations about your responsibility and behavior.

Angle, in his classic work, writes that "the study of Orthodontia is indissolubly connected with that of *art* as related to the human face." I submit that it is also related as intimately to the *art* of *interpersonal relations*. Your work involves, therefore, not only professional knowledge, disciplined judgment, competence and skill, but also understanding of people, particularly children, a capacity for interpersonal relationships with them, and the use of this relationship to further your treatment objective. You carry responsibility for inspiring confidence in the patient, for engaging the patient's active cooperation in long, continuing work with you. In these areas, orthodontia embraces some of the principles of orthopsychiatry.

As I understand it, you study the presenting deformity not only in terms of the teeth but of the surrounding tissues and the jaws as well. You obtain a history of the development of the malocclusion and the familial history. You formulate a diagnosis. You consider treatment in terms of the stage of development and appropriateness of timing. You weigh carefully methods and choice of treatment. When you apply pressure, you do it gently, commensurate with the tolerance of the surrounding tissues to withstand it. You enable teeth to move but you do not forcefully push them. You respect the rhythm of growth in the dental apparatus and the uniqueness of each case. When you achieve the desired result you continue to lend support for a period (by retainers, I think you call them) until the new position is firmly established. I want to point out that for the maximum success of your work it is essential you show the same respect for, and understanding of, the *whole* child as you show for the dental apparatus. Conversely, if you are considerate and thoughtful of the patient, you will tend to be more gentle and respectful of the mouth and dental tissues, and their response will be more positive to you. And you will find ways and means of easing the child's discomfort if you care for the whole child.

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Just as knowledge of the stages of development is important for your understanding of dentition, so knowledge of the chronology of emotional development is basic to an understanding of the child. Therefore, we'll consider personality development in chronological sequence, very briefly, of necessity, with an awareness that there are individual variations in emotional development as well as in physical growth.

Interest in children, intuitive understanding and good intentions are basic for work with children, but they alone are not enough.

Personality development, like tooth development, is a life long continuous process passing through successive stages. At each stage the child is confronted by characteristic problems which he must learn to solve. So all of life is learning toward the goal of emotional maturity.

Emotional Maturity

Emotional maturity is a relative concept. It represents an ideal which few attain completely. The emotionally mature person has certain characteristics. He can see a situation realistically, as it is—not as he wishes it to be. He can handle the situation rather than escape it. He can enjoy prosperity but also accept adversity and frustration without uncontrolled rage. He can take responsibility for his behavior without blaming others. He is independent and can stand on his own feet but he can also share with others, consider their needs and interests as well as his own. He is secure in his sexual role. He can love and be loved. In other word, he has capacity for interdependence. He can enjoy the present but he can postpone immediate pleasures in the interests of planning for the future. He enjoys a sense of adequacy and competence and is relatively free from inferiority. He is cooperative rather than destructively competitive. He lives in harmony with his conscience. His concern is for himself, his family, his community—this includes your patients—and for the world in which he lives.

First Year

Think of the child at birth, born with a given constitution into a given family. He is completely dependent, physically and emotionally, on his environment. He needs to be cared for and loved if he is to survive and develop. His first discomfort is hunger, which gradually he learns is relieved by food. This is associated with the person who feeds him and gives care—mother. Thus, his first social experience is around eating and his first interpersonal relationship is with mother. From the repeated experience of feeling hungry, being fed, feeling satisfied, the baby develops a sense of security. If the relationship between mother and infant is mutually satisfying, if the baby is fed according to his need, if mother's handling is consistent and predictable, the baby develops a sense of confidence and trust out of his experience that his needs *have* been met. This is an important pattern for his future relationships to people, and lays the foundation for such qualities as friendliness, generosity and optimism in the adult personality.

The crucial importance of a mother or "mother person" and maternal care for the child's development in the first year of life is illustrated by Dr. Rene Spitz in a study published in Volume I, "Psychoanalytic Study of the Child." He contrasts children whom he observed living in two different institutions. In one institution each child was cared for by its own mother or a full-time substitute. In the other, a nurse had the responsibility for eight infants Though she liked the children, she had minimal contact with them. The find-

ings are startling. Those children who were deprived of maternal care, stimulation, love in the first year of life showed severe developmental retardation, (irreparable after the first six months) susceptibility to physical illness and a higher death rate. So you see, the pediatric prescription—Vitamin T.L.C. (tender loving care)—three times a day is scientifically valid—just as valid as Vitamin D for prevention of rickets and Vitamin C for prevention of scurvy.

For the first year of life the mouth is the receptive organ through which the child takes in the whole world—breast, bottle, thumb, toys—and this is associated with mother and comfort and security and pleasure. The importance of the mouth is reinforced by the advent of teeth. Teeth are a source of pride to the child and the parent. You all recall, I am sure, asking Johnny to show your best friend his teeth, and he was proud at being told: "What beautiful teeth you have!" With his teeth the child bites, originally to relieve tension in the mouth, but he learns quickly from the parent that biting is bad, hurtful and destructive; so his teeth are not only an object of pride but a means of hurting others. You don't, of course, treat children in the first year of life but it is important for you to know that the mouth and teeth retain psychological significance throughout life, that many problems in children, fears you later encounter in them, and disturbances in their relationship to others and to you, had their roots in this period.

The question of the relation of thumb sucking to malocclusion is often raised. Sucking is a basic need in the first year of life but children vary in their need for this activity. Often the child sucks out of his need for more sucking pleasure than he gets in his feeding; sometimes to compensate for too early or too abrupt weaning. Normally it diminishes gradually. Often between three and five years the child may resume sucking when life is too hard for him; when other pleasures are not permitted; when he feels displaced by a younger baby; or if he is being pushed beyond his capacity. He sucks to comfort himself. I am told that there is no evidence that thumb sucking for short periods in infancy or early childhood produces malocclusion. However, continued and persistent thumb sucking when permanent teeth have erupted *may* cause malocclusion. The answer to such problems is complex. The malocclusion may need to be corrected; however, awareness on your part that it is a symptom of psychological conflict would help him in dealing with the child. In the six, seven, and eight year old vigorous and persistent thumb sucking is an indication that emotional development is being blocked. Punitive measures, shaming or ridiculing the child, have no therapeutic value and may create further problems. The child may conceal his activity and thumb sucking may then be replaced with other habits. The child's esteem may be injured and his capacity to handle other tasks appropriate to his level of development impaired. Your warmth, interest, and attention, on the other hand, may provide him with the gratification he is lacking and thus enable him to need less sucking. If thumb sucking persists, you would need to appraise the desirability of treatment, as well as the permanence of orthodontic improvement, in the presence of continued unsolved emotional conflicts. You may in such a case serve the child most constructively by suggesting psychiatric evaluation.

Second Year

In the second year, the child begins to walk, talk, to do things for himself.

He gets pleasure from trying out his growing physical equipment. His world is enlarged, his horizons are broadened. He gets gratification from mastery, from being more independent. Normally he shows some negativism, some defiance of restrictions. He is learning that he is a person in his own right. As he begins to be concerned about his body and his functions, he develops fears of being hurt. These fears in some form persist thruout life. Until now, mother was the protector who met the child's needs. Now she begins to require him to conform to adult standards, especially in terms of toilet training. This is an important step in his socialization. Here, too, he shows his assertiveness. Toilet functions are regarded by the child as private, personal, pleasurable activity. If mother can handle toilet training with kindliness, patience, relaxation, with regard for the child's physical maturation and his emotional readiness, she can enlist the child's interest and cooperation. Gradually the child will learn. He will progress and retreat for we know learning is not accomplished in consistent progression! As he learns he develops a sense of achievement in performance. He gains independence as he masters this new experience. He accepts more responsibility for his own behavior; learns self control. After a time, he takes pleasure in being clean. Initially he conforms out of a wish to retain mother's love. Slowly he begins to conform out of the wish to be the kind of person that is lovable. He begins to incorporate the social values of his parents. The child learns best out of his wish to be loved. Equally important, he develops a healthy attitude to authority; he may learn faster out of fear of physical punishment or threats or fears of mother's withdrawal of love, but such learning makes for hostile submission, not for autonomy or self-control. Respect for the child's assertion lays the basis for qualities of initiative, sharing, giving, cleanliness, respect for authority in the adult personality. During this period, because of parental demands for conformity, the child often feels anger at his parents and is often attacking and destructive. It is important that the parent not retaliate with hostility or threats. An adult does not bite back the child because he has bitten. This does not mean that we allow the child to destroy or hurt others. But we can understand his wish to do so, and with kindness, firmness, and restraint if necessary, help him learn what is acceptable behavior. The child needs to have limitations but these must be reasonable and consistent. This feeling of ambivalence—love and hate—developed in this period, you often encounter in your older children's relationship to you and to their treatment. Hopefully, as we achieve maturity, love will predominate in our relationships.

Three to Six Years

Between three and six years, the child becomes increasingly aware of, and curious about, himself and about differences between boys and girls. He asks questions, investigates, finds pleasure in exploration of his own body. It may be disturbing to parents, but it is a normal developmental interest. He is curious about where babies come from, and where he came from. He should have answers that are not evasive. His sexual curiosity should neither be stimulated nor inhibited, nor condemned as bad.

His relationship to his parents changes. While the child loves both parents, at this age he develops a strong emotional attachment to the parent of the opposite sex, the boy to the mother and the girl to her father. It is not uncommon to have a three-year-old announce that she is going to marry her father. This romantic attitude is not uncommon in the orthodontic office.

I know a two and one-half year old who came for orthodontic treatment. She was pretty but was motivated by a wish to be prettier. She came willingly because she was identified with her mother who also wore braces. She continued to come happily out of love for her orthodontist. Visits were a social occasion. She dressed with care (similar to that of the adolescent girl on her first dates) in yellow dress, socks, and ribbon, because this color, he, the doctor, liked and because this dress he admired. This was a wonderful romance! And her teeth were straightened.

A boy of the same age might have reacted differently, to you as a man. His competition with father would be in the ascendency in this period. His wish to replace him, to have mother's exclusive interest might make him feel guilty and arouse fears of retaliation. So your relationship with such a boy would need to take into account the fact that you symbolize the father. Therefore, he has respect and affection for you, but also fears you. You would need through your friendliness to reassure him that your intention is to help him.

Normally, by the time the child is five or six he solves the problem of his rivalry, jealousy, and resentment by identifying with, and becoming like, the parent of the same sex. With this he has developed a conscience, the internal, still small voice of the parents that tells what is right and wrong. This conscience can be quite strict. Take the five year old boy who after a difference with his father decided to pack his pajamas, and naturally his tooth brush, and leave home. A policeman saw him make several trips around the same block and asked him what he was doing. The boy's reply was "I am running away from home, but I am not allowed to cross the street."

By six years of age the child's intensive involvement with parents is over temporarily. His energy is directed to people and interests outside the family. His curiosity about himself shifts to learning in general. He is ready for school.

Six to Ten Years

The period of six to ten is characterized by industriousness, learning and achievement. The child's ego is strengthened by what he learns and his social experiences at school. In the first few years he still looks for security to the teacher as a parental figure, but his major source of security is his participation in his peer group. He wants to be part of the group; to be liked and accepted. Games afford him an opportunity to develop skills, to have social relationships, to learn to share, to take turns, and to work out his competitive feelings. It is important that the teacher and the parents help him feel competent. His conscience made up of parental standards, values and prohibitions, is modified by what he learns, by what example the teacher sets, by the values, attitudes and standards of his peer group. He needs freedom to learn, to experiment, to develop at his own pace. He needs also help in learning what is acceptable behavior and limitations. This period is one of relative calm and conformance if the child has satisfactorily solved his earlier problems. A child of these years, needing orthodontic treatment, can be approached through his intellectual interest in learning.

Ten to Twelve Years

The period of ten to twelve, preadolescence, presents quite a contrast and marks the beginning of sexual stirrings and great physical changes which bring emotional upheaval. The child feels insecure. His behavior

changes from the earlier conformance to renewed defiance of parents and adult authority. He tends to throw over parental values, becomes untidy, irresponsible, disrespectful, often too fat. There is some interest in the opposite sex but this is expressed in an aggressive manner. The child tends to form groups of the same sex which carry over into early adolescence. He must dress and be exactly like the others. This sameness gives him some support. His defiance of adult standards is a gesture toward leaving his parents. The problem is to permit him some defiance to foster his growing sense of power and identity and yet help him develop the proper values. This is a period in which cooperation may be difficult to win in treatment. For example, the child who temporarily protests parental standards, by resisting cleanliness, may also resist the instruction and admonition of the orthodontist to brush his teeth. Two years later, the same patient, conscious of girls, will be scrubbing hard not only to please the orthodontist!

Adolescence

Adolescence is a period of storm and stress, of great insecurity and uncertainty to both parents and children, even when earlier parent-child relationships have been predominantly positive. It is a time when earlier conflicts are reactivated. The child is torn between his need for dependency and his drive toward independence. In his struggle for emancipation, he must rebel against the parents. His self assertion is great because his turmoil is great. He is unable to tolerate criticism or advice. He struggles to be a man, to establish his relationship to the other sex. He has conflict between his strong impulses and what is permitted by society.

His equilibrium totters because his sexual impulses are strong; because his ego is bombarded by both inner demands and outer pressures. Parents and society require that the adolescent grow up, be a man, be independent, but at the same time he is a dependent college boy. His conscience is weakened because the old values are being doubted or defied, and the new ones, those of his age-mates, are in a state of flux and are not yet integrated.

Anna Freud describes adolescents as excessively egoistic. They regard themselves as the center of the universe, yet at no time in later life are they capable of so much self sacrifice and devotion. On the one hand, they throw themselves into the life of the community—on the other, they long for solitude. They oscillate between blind submission to some self chosen leader and defiant rebellion against any and every authority. They are selfish and material minded, yet at the same time full of lofty idealism. They worship heroes—this is the time when *you* can recruit the orthodontists of the next generation!

Summary and Conclusions

Your patients are children, boys and girls, probably more girls, referred for correction of malocclusion, sometimes for improved function, more often for enhanced personal attractiveness. They vary in age. I am told the largest group are pre-adolescents and early adolescents.

What are the implications of this understanding for your handling of children?

(1) It is important that you have awareness that the child is a different person at different developmental stages and has different needs and problems.

(2) Your own feelings about a child are an important factor in your treatment. Concern and sympathy with the child, respect for him as a person in

his own right, form the most effective basis for a helping relationship.

(3) The child, as well as the parent, needs a frank and forthright explanation, before treatment begins, of what is involved in treatment, what *you* will need to do, what you will expect of *him*. Such an explanation to the child shows your respect for him. It engages his participation. It lessens his anxiety and makes him feel he has some control over what is to be done. If you do not make him the focus of concern, and invite his active participation, you may play into his feelings of helplessness and his fears. Explanation to the child should be geared to the child's age and understanding, but should be made no matter how young he is. It is important to indicate what treatment can accomplish, but equally important to say what it cannot do. This helps modify the child's unrealistic expectations and fantasies that the actual correction of the malocclusion cannot possibly satisfy. It is important to talk through with the child the matter of appointments, his acceptance of treatment recommendations, duration of treatment, to the extent that this is possible even if it is only an estimate. I know you have this kind of discussion as well as discussion of fees with parents. It is important also that the child patient be helped to anticipate some discomfort, some pain, perhaps impatience over protracted treatment, and unsightliness of apparatus. Such preliminary discussion with the child lays the foundation for a good relationship with you. It helps you to evaluate the child's attitude towards treatment, the strength of his motivations and his readiness to work with you.

(4) The child's positive feeling to you is his strongest motivation in conforming and cooperation with you. Because you are mature, because you are the authority, you carry the major responsibility for fostering good relations. It is true that children will relate to you in terms of their own needs, partially in terms of the patterns they have developed to their parents and subsequent figures of authority. If the relationship with the parent is favorable, the child will get on with you, but even if the relationship with the parent is not good, the child can have positive feelings for you if you can inspire confidence, show him acceptance and use your authority benignly. You can thus provide the child with an experience with a different kind of adult from his parents.

(5) And finally, all of us, adults and children, have in fantasy an image of what we would like to be. You can be an example of an emotionally mature, socially productive professional person and become for the child an ego ideal whom he wants to emulate. In the last analysis "Character is caught, not taught." Thus you have the opportunity and the challenge not only to help guide the alveolar processes for greater harmony of teeth, jaws and face, but also to participate in the molding of a healthy personality. I feel a deep conviction that to the extent that you succeed in this, you, yourself, will grow and be enriched.

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