Psychologic Management of the Young Orthodontic Patient

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Introduction

The child orthodontic patient represents a unique management problem in the dental office.[1,2] Most orthodontic treatment is initiated during the prepubertal or early pubertal developmental period of the child. This is the time when children become body conscious and vain.[3,4,5] The orthodontist is able to bring about an esthetic as well as functional improvement for his patients. Usually the "price" is a temporary upset in esthetics and occlusal comfort just when the blossoming teenager wants to be "normal" and have an identity with his peers.[6,7,8,9] This phenomenon is the basis for many management problems in an orthodontic practice.

Patient Source

The patient who seeks orthodontic care usually has had his difficulty for a number of years. During these years he has had time to adjust or maladjust to his malocclusion. The influence of the dental problem on adjustment depends on both the severity of the deformity and the particular personality being influenced. A dental-facial deformity cannot be an altogether indifferent event on personality development. Often the individual's conscious feelings are only a small part of the total impact that the abnormality has made on him. The shy, introverted, inhibited adolescent with a severe malocclusion may dislike the way he looks, yet, he may not be aware that he is ashamed of his looks and rarely smiles. His lack of smiling is a way of defending against further shame. This is an example of the use of defense mechanisms as a way of not experiencing anguish. These mechanisms produce a homeostatic equilibrium in our inner and outer personality environment. Parents of children with disease experience pain of their own and, therefore, develop their own defense mechanisms against the anguish. Because people are unconscious of their defenses, they are only partially aware of why they are seeking help.

Since the problem has existed for a number of years, one must speculate as to why the patient and family come for treatment now. The question of "why now" is a favorite of psychiatrists, but it is an essential one. In many instances there has been some disequilibrium in the patient or the family and reestablishment of equilibrium is sought by coming for orthodontic help. For example, parents are disturbed by their thirteen year-old son's becoming moody and withdrawn. The boy's malocclusion becomes the focus for the family and they seek help for this problem. Their concern is appropriate, but a change in personality of an adolescent may have a number of explanations. Another family with a similar problem, including the dental difficulty, might be "blind" to malocclusion and be concerned with religious feeling and turn towards pastoral counseling as a solution.

What in fact are the reasons for seeking orthodontic treatment? The overt reasons are readily obtainable from what the patients and their parents say.

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Common reasons given are: to prolong the longevity of the teeth; improve physical appearance, prevent teasing, and concern with body image prior to dating.

In every case there are covert reasons why parents want orthodontic help for their children. They may feel guilty at having created an inherited malocclusion in their child. They may feel inadequate as parents for not stopping the child's thumb-sucking habit earlier. Sometimes the reasons for obtaining help have less to do with the child than from the narcissistic needs of the parents. For example, they may desire to have the child treated orthodontically as a sign of the father's socioeconomic success. A mother may want to improve her daughter's facial appearance in order that the mother might vicariously live through her own fantasies of becoming an actress.

Difficulty arises if the reason the parents desire therapy is in conflict with the needs of the child. The mother may want her son to have a career as a handsome film actor. The aspirations of the son may be more realistic. Although he prefers not to be called "Bucky," he is not about to relinquish his own sense of career independence and have orthodontic treatment only to satisfy his mother. Uncovering the covert reasons is important for the successful management of the patient. The lack of recognition of these reasons may later sabotage therapy. For example, a mother with a severe untreated malocclusion may seek treatment for her child who has a similar malocclusion. She has genuine concern about the appearance of her fourteen year-old daughter. However, she is not conscious of competitive jealous feelings and, as the girl's appearance improves, these negative feelings increase. The girl, because of adolescent rebelliousness, does not keep her appointments, and her mother "forgets" to remind her. In order not to appear as an inadequate mother, she defensively rationalizes, "Well, the trouble with her teeth wasn't serious anyway." An orthodontist, sympathetic to the *mother's needs,* might have made sure to compliment her appearance appropriately, and avoided letting the mother know how pleased he was about how well her daughter was progressing.

Obviously, there are many reasons why a family may seek orthodontic help for their child and there is nothing wrong with a reason simply because it is covert. It is not implied that because a referral stems from the family emotional pathology rather than "altruism" the patient should not be treated. The point is that orthodontists attuned to the emotional conflicts from the outset will more likely achieve management success with their patients.

General Management of the Patient

The concept of Erik Erikson,[10] who views childhood as a series of stages, is generally accepted in the field of child development. According to his theory, there are certain age specific tasks within each stage of childhood. Upon the successful mastery of a particular task, the child gains greater psychological strength and independence. There is a price paid for this development, the loss of a prior pleasure. The negativistic toddler is an example both of the concept of task mastery and pleasure loss. The task to be mastered, in this age group, is increased independence from mother. Through his negativism he is independent. One has only to try to feed a fifteen month-old who demands to feed himself to realize the force that mastering independence takes. The child will deny himself food and provoke both mother's anger and denials of pleasure, rather than give in and be fed.

Each stage of life has its own task and each prepares the individual for

the next one. Adolescence is a preparation for adulthood. The tasks of adolescence are: complete independence from parents in order to become self-sustaining; the mastery of heterosexuality in order to mate and become a parent oneself; and the finding of identity in order to become a productive member of society. These years are also a time of great internal and external body change. The adolescent has intense concern with his body, independence, not only from parents but from all authority figures, and with the opposite sex. The importance and intensity of these concerns cannot be overemphasized.

In applying the concept of the tasks of adolescence to orthodontic treatment, it is easy to see how the adolescent might well have ambivalent feelings toward therapy. Orthodontics is intimately connected with adolescent concerns. His facial appearance is being altered. He may feel very positive about a dental deformity of long duration being corrected. He may eagerly look forward to being more attractive to girls in the future, but what about the repulsive appliance of the present? The dentist can be viewed either as an older man who is interested in his growth and with whom he can identify, or as another authority figure to rebel against.

Psychological problems can easily arise. Whether they do or not depends on two issues. The first is the patient's individual response to his dental deformity. He may have private fantasies as to what caused his malocclusion. If the problem has caused him a great deal of difficulty socially and he believes that diet or thumbsucking is the etiology, he may experience great personal guilt. If he believes it is hereditary, he may be very angry at his parents. The deformity is part of his body image. He has very personal fantasies about what he looks like during treatment and what he will look like upon completion. It is paramount that these fantasies are not exaggerated by an orthodontist "overselling" his professional talent.

The second issue depends on which battlefield the child chooses to play out his adolescent problems, in or out of the office. For example, the rebellious child at home may not need to rebel against the dentist. On the other hand the "angel" at home may displace all rebelliousness onto the dentist and have parents who cannot understand why their child is having a problem in following instructions.

Any patient placed in a dental treatment situation will undergo a certain degree of anxiety.[11] These are usually directly related to stress found from previous dental or oral experiences.[12,13,14] Also, a number of well-controlled dental therapeutic studies indicate that patient personality factors appear to play an important role in the management of dental patients.[15,16,17,18] Therefore, in addition to recording the usual dental and medical histories, the orthodontist should set aside some time for patient observation and diagnostic thinking concerning the personality of the patient. This simply means that one must develop a little of the talent of the psychiatrist; that is, be a good listener and allow the patient full freedom of response to his feelings of anxiety.[19] The emotions expressed are often surprising and are "appropriate to a state of conflict in the unconscious" found in the patient.[20] The usual "covert" and "overt" reasons for anxiety may become mixed up. For example, one would expect that if extractions were mentioned, the patient would express a fear for the related pain. The threat for many patients, however, is to their natural oral eroticism and/or oral aggression,[21] the mouth being intimately related to sexual stimulation and basic animal protection. Instead, the adolescent shows concern about the postoperative swelling and facial appearance, or his ability to eat a dinner that evening.

The concerns expressed will vary widely taking the form of somatic symptoms related to the cultural and social background of the patient.[22] Therefore, the careful observation of what the patient says and does during the initial phases of his contact with the orthodontist will give many clues about his future interpersonal relationships.

The development of a working doctor-patient relationship is the next step in dealing with the child although it often begins long before the dentist physically sees the patient.[23,24,25,26,27] It starts with the attitude of your receptionist, the smile of your assistant, the decor of your waiting room, and the general atmosphere of your practice. We are concerned with specifics here, so an example of doctor-patient routine is in order.

After the initial examination and the consultation appointment is made, both the parents and the child should be present for the detailed explanation of your diagnosis, treatment plan, and financial arrangements. It is best to direct the conversation toward the child.[28] The child will appreciate this and feel that your treatment is tailored for him.[29] Also, this approach precludes talking over the head of parents, since you must express your diagnosis and treatment plan on simple terms for the child at a level which is easily comprehended by the parents. If a parent does not fully understand what you have said, he may not wish to appear ignorant in front of the child or spouse and may refrain from asking an important question. To direct the session toward the child, be careful to mention the child's name frequently by the name the child wishes to be called. Nothing can ruin a doctor-patient relationship faster than calling a child by a disliked name.

If your treatment plan involves the extraction of teeth, a wide variety of psychological problems may ensue. Baldwin[30] has studied this problem in depth and is the best source of information about the pre-and postextraction fantasies of children. There are a few important principles to keep in mind when explaining to a patient that extractions will be necessary to correct a malocclusion. It is important to present the possibility of extractions to the patient as early as possible during the initial examination or early treatment planning. This gives the child an opportunity to work through the idea of extractions in his own mind. Baldwin[30] found that the time helps decrease anxiety. It is also necessary to explain that there will be enough teeth for dental function after oral surgery. The primary concern of most children is whether they will be able to eat after teeth are removed. Of almost equal concern is the cosmetic appearance after surgery. A patient needs reassurance that although there will be spaces where teeth were extracted, it will not be unsightly or a source of embarrassment to the patient. Many patients tend to regard dental extractions as a sort of condemnation. Obviously, reassurance is paramount. Extractions are a means to the end of therapy rather than a threat. Finally, if the case is to be a serial extraction, it may be necessary to remove twelve teeth over the course of treatment. The thought of removing twelve teeth is overwhelming to anyone. Care must be taken to point out that *one* "baby tooth" in the upper and lower jaw will be removed on each side. This gives the illusion of a smaller number and few patients will bother to add the total number of teeth which will be extracted.

Psychological Management of the Patient by Specific Age Groups

Young child from six to nine

This age group is perhaps the easiest with which to work. The approach can be the same when dealing with boys or girls. In their early school years natural

curiosity makes their attention readily available. The best method for obtaining cooperation is to actively *teach* the child the purpose of your treatment. The technique consists of careful explanations about what you intend to do and a brief why, using language that the child can understand. This may be supplemented with charts, simple stories which the child can read himself or short single concept films. Children of this age are natural imitators. They tend to do almost anything they are told to do, particularly if it is with precise directions. This is why most children of this age respond well to toothbrushing charts and tables which allow them to see how well they are progressing. This, in effect, is a simplified teaching machine. They generally respond well to mastered tasks. Praise should be given freely as a means of encouragement and re-enforcement. The bribe of a toy or trinket for good behavior is a reward from the dentist for subjugating their desire to know what is happening to them. Bribery should therefore not be used. A last word of clinical precaution. It is difficult to use removable appliances in children from six to nine. First, these children are in the early mixed dentition when undercut areas for appliance retention are hard to find. Secondly, the appliances are constantly flopping around precisely when they are learning to articulate adult speech patterns. Thirdly, they are attempting to break their infantile habits of digital sucking and tongue thrusting. These appliances are complicating an already complex task. For these reasons intraoral appliances should be fixed to bands in these children.

Early adolescent (ten-thirteen years)

Females mature more rapidly than males during this age. Generally, sexual differences become important to the girl child. Since boys retain many of the emotions of the early period, it is best to discuss management of the males first and the females later.

The boy retains his curiosity about the "why" of treatment during this period, but the "how" begins to capture his imagination. This is the age of experimentation with clocks, model airplanes, chemistry and electrical sets, and sophisticated tools. He is fascinated by scientific instruments and mechanical gadgets. He is also looking for a hero to emulate. It is not unusual for a personable dentist to fill this hero's role for the child. A boy will look for male identification earlier if he has difficulty identifying with his father. During this time a boy usually develops a keen interest in competitive sports. He becomes dedicated toward building his coordination, his body and his general knowledge of sports. Boys of this age become progressively dirtier both generally and more specifically, oral-hygiene-wise. Everything that he touches bears his mark, and his mouth harbors traces of the variety in his monumental appetite.

To gain cooperation from a boy of this age group, one must show interest in his interests. One must again be careful to explain each procedure to the child and why. He may have outgrown his interest in programmed material, but "show and tell" explanations will lead him to ask "how do you do that, or how does this machine work?" It is important to take the time to answer his questions. Let him observe operative procedures through a hand mirror. Allow him to hold some materials such as periphery wax, alginate or blunt hand instruments. If he seemed quite excited by this, the reward of a trip to the laboratory will turn the young patient into a fast friend. This, of course, may encourage the creation of the second father image. To lessen the intensity, it is easy to divert this fantasy by referring to how much John Jones, his friend, enjoyed seeing this

same apparatus. One could also ask if the boys know of any other children his age who would be as interested in learning about dentistry. Thus your attention to the boy becomes a recruiting effort for your profession. Attention is given without it being personalized. Conversation may include inquiries about the boy's athletic interest, his team, or the local favorite team. It is wise to have your assistant keep an eye out for any reports of all your young patients' adventures in the local paper and clip them to their charts. If you show you care for the young patient, he will care for you by being cooperative.

Combating the hygiene problem is discouraging. Appeal to his maturity and point out the proper home care methods to the boy and encourage them without resorting to scare tactics or nagging. The child will eventually discover girls and soap at about the same time and your efforts will be rewarded.

The female of ten to thirteen years is quite different from the boy but an equal challenge. She is giggly, silly, extremely vain, and passionately interested in her developing body. Any dental procedure that might affect her looks is either accepted with exuberance or dread. She is very susceptible to flattery which is good, but this can lead to the "crush syndrome" which can be a management problem. Finally she is very gossipy and often newsy. Efforts to establish rapport through conversation can end up as a talked-away morning.

Although girls of this age group are fun to work with, it is wise to handle this developing young lady with care in any dental practice. Friendliness may be demonstrated by a smile and a compliment on behavior or an achievement. References to her body, however, may invite problems. If you say she has gotten quite tall, which is usually true in this age group, she may become self-conscious and uncomfortable. Even innocent references to an attractive sweater may create a body image and be upsetting to her. To summarize, conversation should be brief, pleasant, impersonal and thoughtful. Dental procedures that will alter her looks must be explained in detail, especially for the thirteen-year-old. For this reason it is best to break down the stages of treatment into weeks and months which are more tolerable to the child.

The "crush syndrome" is one of the most difficult management problems in any practice. A bit of flattery, coupled with the image of an intelligent male healer, can turn the preteen into a secret paramour. She may appear at your office, call you on the telephone, send love notes or present you with gifts. Obviously, the behavior must be discouraged, but bluntness will hurt the child psychologically. This is an early love fantasy and very important to her. The best method for dealing with this situation is to substitute reality for the fantasy. It is best to remain cordial and friendly but talk about the real world such as your wife and your family. Comment that your wife and you think her little gift is thoughtful for such a sweet eleven-year-old. At the same time, focus the reality building by discussing males her own age. You thus will retain this normal drive which got misplaced and will covertly encourage her activity with males. She has only misdirected her expression of "growing up." Each case is individual and must be treated with the patient in mind.

The teenager (fourteen to eighteen years)

The male and female once again are different in their behavior patterns and sense of propriety. First we shall examine the male. He usually presents himself as the great stoic, caring little for anything or anyone except his peers. Actually, this is a compensation for an anxiety. He is trying to express the

adult image which is overtly uncomfortable for him. He wishes to be treated as an adult but often expresses himself as an irrational child in his rebelliousness.[31] Examples of this behavior are well illustrated in Ginott's *Of Parent and Teenager*.[5] His interests have now narrowed to normal development of his body, acceptance by his peers, and sex. He spends hours primping himself in the mirror, fighting acne and engaging in body-building exercises. He is desperately fighting anything that makes him look different from the group with whom he identifies. If long hair is "in," he conforms inch for inch. Being different can be grounds for exclusion. Nobody is more dependent, during his search for independence, than the teenage male.

Management of the teenage male is a matter of sympathy and understanding. One must be direct and forthright. Being devious or overly complex will lead to suspicion. A question should only be answered when you are sure. Trust is the most valuable asset to be sought from this age group and, correspondingly, it is the most easily lost. It is imperative that treatment plans be discussed with the same logic, references to responsibility and firmness, as with an adult patient. This allows the boy to assume the adult role which will soon be reality. Finally, if discipline becomes a problem the dentist has an advantage. He is an authority figure outside the family. The chances are good that a boy will readily discuss why he is not following your instructions. Telling him to obey will usually get you nowhere. Frank discussions about the root of the problem and its alternative solutions will usually work wonders.

The teenage female has some of the same psychic developmental problems as the male but expresses them differently. She is body, peer, and sex conscious also. She wants to be as well-developed as her peers but not to excess or less proportionally. Orthodontic appliances offer a threat to her immediate body image or, if she has an unesthetic malocclusion, they offer a promise. Complicating the picture, appliances are also a status or separatist symbol from neighborhood to neighborhood. This is why any given teenage girl may approach the orthodontist with a whole spectrum of emotions completely unrelated to the practitioner or her malocclusion.

Obviously, the thrust in management must be toward the cosmetic and status value. The teenage girl is easier to communicate with than the boy. Once trust is established, she will usually be cooperative. This is probably due to her earlier maturity. Discipline should again be handled by discussing the root of the problem and its various solutions rather than making "parent like" demands for cooperation.

Latent crush syndromes at times occur in this age group, particularly in the rejected girl with the unesthetic malocclusion. The orthodontist is freeing her of her problem. He takes on the proportions of a hero who might accept unspent affection. The method of dealing with this "crush" was outlined before. This type of problem, however, can be more difficult to solve since you now have a young woman to remove from fantasy who may look more attractive to you and the world.

One final point should be made about the teenage patient. They are trying to assume the role of an adult and they do not believe their parents have an understanding of any of their problems. Therefore, detailed consultations and progress reports should be given to the parent and child, but separately. The patient will take comfort in knowing that his parents are concerned about his treatment, but the patient will take offense if he feels they are directing it. The primary relationship is with the child and not with the parents.

SUMMARY

Patient management in an orthodontic practice is a challenge which requires a knowledge of patient anxiety, motivation, and self-image. A general approach to the problem was given by applying basic child psychology to age and sex groups as commonly seen in a dental practice.

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