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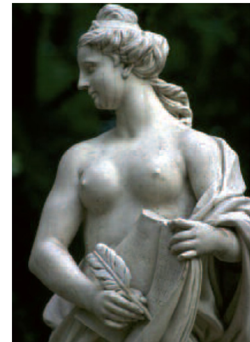
Requests for so-called esthetic treatment from the three orthodontic age groups: psychological perspectives and consequences for managing the care of these patients



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ABSTRACT

Requests for orthodontic treatment have changed over the last few years due to the influence of social discourse and the promotion of the ideal of a forever young and ''perfect'' body.

The esthetic nature of these requests, even if they have always been implied in any orthodontic consultation, has changed and recently esthetics has been increasingly emphasized by prospective patients.

One consequence of these urgent requests is that orthodontists are on a slippery slope to becoming service providers and they therefore run the risk of no longer being recognized as Health Professionals.

Another consequence is that we now have patients with a very different ''profile'' which we will attempt to define in this article.

We will discuss esthetic treatment requests and the respective problems for each of three orthodontic age groups (children, adolescents and adults). We will illustrate these problems with three specific clinical cases. And since we are not trained to either identify or successfully manage the problems associated with this type of request, each of us has had to come up with our own clinical response. However, once we are certain or even suspect that we are dealing with a patient at risk (we will define this later) for whom an orthodontic solution is not appropriate, we then have to overcome our own reservations and refer the patient to a mental health professional whose specialized care will make it possible for the patient to become clearer about esthetic requests.

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In most cases after everything is resolved, we can then professionally and respectfully take on the management of the patient. By taking these precautions, we will conduct ourselves as Health Professionals who seriously assess both the somatic and psychological dimensions of our patients' requests.

KEY WORDS

Esthetic treatment requests,

Psychological risk,

Psychotherapeutic management,

Orthodontic treatment.

For some years now, we have witnessed a change in requests for orthodontic treatment. Although esthetic enhancement has always been considered an integral part of and the real motive behind any consultation, in present day society and culture the primary focus is on the body.

Without too much exaggeration, we can speak of a quest for an eternally young body or a defect-free body. We have ''front row balcony seats'' and if we just listen attentively, we can be among the first to see for ourselves the effects of social discourse or ''social pressure'' on the requests of certain patients, which they disguise as a request for orthodontic treatment: a so-called esthetic request.

The aim here is to identify the main line of thinking that will help us manage these so-called esthetic requests in the context of orthodontic care requests.

We will see the different elements based on an approach organized around the age of the patient, divided into three categories: children, adolescents and adults.

These three categories correspond to the different psychological aspects that will be the object of this article. In fact, we cannot approach young children accompanied by their parents (children are rarely the source of the request) in the same way as adolescents, whose body is undergoing the transformations of puberty, a phenomenon exacerbated sometimes by a confrontational relationship at home. Adults are dealing with ever increasing pressure on them and are also dealing with an ageing body. The impact of ageing on the teeth brings them in for consultation.

1 – BODY IMAGE – MIRROR IMAGE – ANATOMICAL BODY

First of all, we are going to establish some fundamentals relating to body image, the image in the mirror (mirror image) and the anatomical body.

We intervene in the oral and maxillo-facial realm in/on the body of a patient. The mouth is at the intersection of the interior and exterior of the body. The representation that the patient has of this body is the consequence of a structural phase in the development of the child called the Mirror Stage. This phase of development was first described by Jacques Lacan in 1936. For the sake of clarity, we are going to give the broad and simplified lines of this process in the formation of the *Ego*. The child will see itself in the mirror before realizing itself as a separate unified being.

This phase takes place somewhere between 9 and 18 months and includes the following stages. To begin with, the visual perception that the child has of his body is fragmented, namely, he only sees parts of it - the extremities, quite far from an anatomically unified being. He is going to be confronted by an image in the mirror.

This image is initially taken for another child (a play mate for example) and is not recognized as an image, a mirror image, much less his own image. Later, this image will not be recognized as his own because the child is generally carried by the mother who calls him by name, he will be able to ''validate'' his image as his own through this ''back and forth'' movement in front of the mirror. All these representations of the body are also acquired through nursery rhymes that often name each part of the body.

Therefore, we see that if the child fails to acquire a body image at this stage, problems with recognition of his mirror image will persist for him through adolescence and for the adult that he will become, and in extreme cases, he will still have a fragmented image of his own body. Some of these patients come to consult us regarding a so-called esthetic request and we have to be especially watchful in order to ''recognize'' them because the answer to give them will not be orthodontic treatment in the majority of cases.

Other patients will name the facial traits of their image in a mirror which indicates that what's ''visible'' is not evident to everyone. This is why it is important to make our patients talk – children and their parents, adolescents and adults so that we can have access to the representations that they have of their dental alignment and we should do this from the outset in the context of the consultation.

2 – THE CHILD PATIENT

Young patients come in for consultation accompanied by their parent(s) and are often just entering the mixed dentition stage where they are

confronted with the replacement of the upper and lower incisors which can bring with it a variety of smiles combining ''*holes*'' ''*excavator teeth*'' ''*rabbit teeth*'' ''*her teeth were so white and cute before*'' ''*Doctor is it normal for the edges of the teeth to look like lace?*'' in other words, an infinite variety of names for this anomaly. Children hear all these somewhat graphic qualifiers used to describe their smile. Some children find it funny, others less so. We have to help them.

Let's take two clinical examples in order to clarify the specificities of esthetic requests as they apply to these patients.

When a child comes in and asks for some enhancement, it is often in the aftermath of having been made fun of by his classmates and we have to listen very attentively because otherwise there is a risk that he will become withdrawn. But how can we be there for them when words are not enough?

It frequently happens that we are sought out by children and their parents who ask us to help them. In the office, we are dealing with an urgent request to orthodontically correct a problem, that is sometimes not well articulated (*i.e.* they have hardly discussed the particulars among themselves). It is a real call for help, because the patient can no long tolerate the frequently mean mockery of his classmates and the parents cannot find the right words to calm down their child. We absolutely must take this very seriously by explaining to the young patient and his parents that later, it will not be difficult to correct this ''defect'' if it continues because otherwise misunderstandings about treatment solutions can add to the worry and uneasiness of the situation. Then, ask the child to express and describe what he is feeling. If all our attempts to communicate fail in the office and they persist with their request, we can of course perform some early treatment so that the child feels less vulnerable to the taunts of his classmates but at the same time we must warn him that they might now make fun of his appliance or maybe his clothes.

Similarly, it sometimes happens that a child comes in for consultation because the parents want to correct a ''defect'' the moment it appears. How can we be an advocate for communication and for listening to the child's side of the story?

We are dealing with children who are not the ones asking for treatment but they wind up in our office chair because of the anxiety of the parents. The parents talk a lot during these consultations and sometimes we can learn why it is so difficult for these parents to tolerate a physical ''defect'' carried by their child. Either the parents do not want ''him to blame me later for not doing anything'' with no request from the child, but we are seeing less and less of this. Or the parents feel bad for the child because of this defect whereas the children themselves are not complaining about it. The child should not be transformed into an object for care and we should advocate for open communication and for the parents to listen to the child's perspective on this issue. We cannot allow the parents to become the ones who ''prescribe treatment''.

3 – THE ADOLESCENT PATIENT

Adolescence brings with it changes associated with puberty and the appearance of secondary sex characteristics that entail a clear sexual differentiation of the body where the boy – girl differences are physically more marked even if they have been there since birth.

There is a meeting with the opposite sex, a change in their feelings about their bodies and the emergence of adolescent sexuality during which they are very aware of how the other sex views them.

For the majority of us whose patients are mostly adolescents, we have to deal with a request for treatment that may be sought in order to please the other (other sex) and at the same time take into consideration how conspicuous the device is which also attracts the attention of the other sex, and consequently for some patients it becomes impossible to be around others with a device that is to top it off visible. Each male and female patient will have to deal with these two issues (even if the lingual technique is being used more and more with adolescent patients, it still remains marginal with regard to the total number of adolescents with braces).

How do we manage a body image that is changing and a body that is changing?

The consequences for esthetic requests and for esthetic ''demands'' from adolescents are of course variable. Some will press ahead with esthetic enhancement and deal with the inconveniences, others cannot get beyond the restrictions imposed by treatment. In certain cases, they have a totally indifferent attitude towards esthetic problems. When we ask them ''*What do you think of your teeth?* '' the answer is ''*They're fine*'' or ''*I like them*''. If we press them and ask ''*If we exclude any possibility of orthodontic treatment, what do you think of your teeth?*'' then they open up and provide a variety of details about the alignment, the position of the teeth and the jaws.

Social pressure from their peer group, the wish to be part of the group is very strong for both adolescents and children. Every day, we all hear parents say to us: ''*In my day, if someone had braces, everyone noticed. Now, they all have them!*'' Sometimes parents think that this will be the decisive argument and then find themselves contradicted by their child who doesn't want treatment. Our role is to help the adolescent make their own decision.

In addition, we also see patients who, once we have done an assessment and made a diagnosis, it turns out that they are adolescents whose discrepancy is beyond orthodontic treatment alone and will require a surgical correction. However, it is not possible to operate because they are too young. As we will see later with adults, the therapeutic decision to withhold treatment often surprises the patient and the family and they rarely agree immediately. It is up to us to use this waiting time until the end of the growth period to make a decision that will involve esthetics

but beyond that the integration of a new image of their face.

Three clinical examples of patients at risk

To start with, we should first clearly understand what we mean by the term ''patients at risk''. Of course, we are talking about psychological risk, *i.e.* risk that consists of creating an insurmountable problem for the patient by initiating and establishing the process of orthodontic treatment. In general, these are patients whose personalities and psychological problems are not, at this time, compatible with the rigors of orthodontic treatment. Because of these risk factors, orthodontists should deny their request for treatment even if these patients show all the visible signs of orthodontic problems and we should also withhold treatment if we suspect that the inconveniences associated with orthodontic treatment are the ''secret motive'' behind their request for care.

- **Anorexia and barriers in the oral region**

By barrier, we mean the devices used for orthodontics because when they are in place, dental movement is no longer free and is constrained by orthodontic mechanics with all its consequences: discomfort caused by the brackets, pain associated with activation, dietary restrictions... Out of respect for the patient, how can we not grant this request?

– **Manon X, 11 year old girl,** for whom I began the correction of a severe maxillary overbite. Manon was shy, not very talkative but she had ''agreed with no hesitation'' to treatment and so, the procedures were performed in the presence of her mother. ''Brilliant student, model patient''. One day, at the time of her appointment, I received a phone call from Mrs. X who told me that her daughter was hospitalized and ''*had a problem with anorexia*''. The mother told me that she was ''*very upset because of this*'' and that her relationship with her daughter was ''*difficult and confrontational*''. Manon came alone to the next appointment (three months later), undoubtedly because of the recommendations of the team in charge of managing her anorexia. I spoke with her and asked if she had returned to school. She told me that everything was going well with her and that her mother was the only one worried and, to my surprise and amazement, that the pain caused by the activation of her appliances made it possible for her not to eat.

I then realized why this young patient so eagerly pursued these barriers in the oral sphere by using orthodontic treatment as a gateway, why she unhesitating agreed to treatment and then she used and subverted her braces because of her issues with food and her mother. Therefore, I decided to stop treatment and quickly removed the brackets as I explained to her that I could not be part of her problem, that she had more important challenges than straightening her teeth right now. I let her mother know without going into the details.

- **Piercing and removing brackets. The cases of 2 patients. Non-stop hindrance and stimulation of the oral sphere.**

- **Clémence 16 years old,** comes in for consultation because she ''*thinks the teeth right here* (upper lateral incisors) *aren't pretty and wants an invisible treatment*''.

I had treated her older brother using the facial technique and treatment had gone well without any particular hitches.

Clémence was so nauseous when I was taking impressions that I had to prescribe anti-nausea medication in order to finish making the impressions. Next, and it happened during every office visit, anytime I touched anything other than her teeth, it would invariably set off nauseous reflexes that made treatment difficult and sometimes impossible, because it was accompanied by unexpected lurching and put her into an utter state of panic and anxiety that she had great difficulty controlling. I was concerned and asked Clémence if these fits of nausea had ever occurred before and she told me that she ''*was always like that* ''. Treatment was moving along ''at cruising speed'' at the end of several appointments for activation in spite of her frequent episodes of brackets popping off and the delays associated with de-bonded brackets. After 8 months of treatment, I am really stunned when one day I see that she has a tongue piercing! I then realize that she can tolerate the constant pressure on her tongue that before would automatically trigger nausea and even that this is what she wants. I discuss this with her and explain that constantly having lingual movements could have negative consequences for treatment. Finally, once I noticed that the lingual brackets had been subverted from the original therapeutic purpose so as to allow her to exert permanent pressure on the tongue, thus combining pain and pleasure. After trying several times to straighten matters out with Clémence and her parents which had no effect on how often her brackets popped off, her lateness or her missing appointments, I decided to discontinue treatment. First of all in order not to harm my patient and also because obviously because the circumstances weren't right for obtaining serious therapeutic objectives.

During my telephone conversations with the parents, I learned that Clémence, who was frequently absent from school, ''*was difficult to manage/control*''. Obviously, her first priority was not straightening her teeth and the conditions arranged initially concerning invisibility as well as the nausea should have set off an alarm. In any case, she was in too much difficulty to articulate anything about her anxieties and escaped by magnifying this uncontrollable problem that as far as we're concerned, has to do with pressure in the oral environment. Her investment in orality came in many specific forms: nausea, the orthodontic device and the discomfort that it entails, the pain from the piercing when it was fitted and she sought the permanent lingual pressure that comes with it.

- **Charlotte T. 16 years old,** who was referred by her dentist, comes in for a second opinion. Charlotte wants to improve her dental alignment. The mother-daughter conflict is immediately apparent, from the very beginning of the consultation, even before addressing the

''question of orthodontics'' they are interrupting one another, the mother is acting more like a girlfriend than her mother (meaning she is talking to her on the same level). Right away, the mother is trying to influence me to take her side with lots of little winks behind her daughter's back, to cajole me into asking her daughter to remove the lip and tongue rings she recently got since her efforts had been fruitless. Their little number was shop worn and was playing out in front of me, the new audience they both wanted. This was indefensible behavior. For the following reasons, they should have both been listening in a respectful manner to what I, the one responsible for care, had to say. On one hand, I was neither an accomplice nor in connivance with the mother ''behind the back of my patient'' and, on the other hand, if Charlotte wanted treatment, so be it, but then she had to take off the rings. I convinced her by showing her all the periodontal damage caused by the piercings on the lips and spoke to her about the previous example and how it negatively affected the lingual function.

Presently, she has facial brackets, the treatment is going well and she comes alone for her appointments.

We can see from these three paradigmatic examples that we have to be attentive and watchful at the very beginning of our first consultation in order to establish a good therapeutic relationship with our patients while maintaining a certain distance, in other words without becoming their accomplices but accepting the value of what these young people have to say given all the consequences that can result from it. In fact, the orthodontist must acknowledge and respect what they say. Their words become a promise and they in turn must be respectful of the advice and directives that we give them. Orthodontic care must not be caught up in a parent-adolescent conflict. We also must know how to stop orthodontic treatment when we discover that the treatment is being ''used to manipulate'', even if it is done unconsciously by the patient because this is when our treatment objectives should be discontinued.

4 – THE ADULT PATIENT

Everyday we receive requests for treatment from adults. We should open our office to them. Of course, the frequency varies depending on the choice of the orthodontist whether to treat adults or not. The development of so-called ''invisible'' techniques has considerably increased the number of requests because previously the conspicuousness of the brackets deterred certain patients from opting for treatment. Moreover, the reliability of some lingual techniques has considerably boosted patient confidence and given us therapeutic choice that we did not have until now.

However, some adults get swallowed up in this invisibility and come in for consultation due to societal pressure that constantly promotes

the image of a young body in good health. For example, a recent advertisement for clinical training read ''*Make the use of hyaluronic acid a part of esthetic treatment for the smile*''. We are being urged to perform ''procedures'' in the perioral or extraoral regions solely for esthetic purposes that have no impact on the masticatory function or dental alignment. Procedures that used to be performed by dermatologists or plastic surgeons, can now be part of dental treatment and we are going to see patients who come only with this request. We are being asked to perform unusual treatment and we were not trained to deal with this request or with its psychological ramifications. Practitioners have to set their own limits and scope of treatment in respect to the patient, because we now have legal jurisdiction to practice an increasingly larger number of procedures. It is unfortunate that the emphasis has been placed on the technical skills rather than on the psychological consequences of this ''expansion'' of our legal rights.

It is up to us to receive and then analyze this request and not let ourselves become engulfed in a treatment that, in some cases, will be a failure as far as the patient is concerned even if ''it is undeniably a technical success''. Certainly, every request for esthetic enhancement is not an indication that the patient is at risk or has a personality ''problem''. Orthodontists have to form their own opinions for each patient and the ***triad patient-practitioner-therapeutic relationship*** must be redefined for each situation.

Above all, we should allow time for the patient to formulate his request and not immediately presuppose that what we see as the obvious problem is the reason the patient is consulting us. In the realm of esthetics, the Look is essential regardless of how the patient looks to him or herself or whether it is the look of the other (the orthodontist, a work colleague, a spouse. . .).

In this exchange, we should be wary if the stated problem creates in the patient a focal point around which a whole series of complaints revolve bringing with it in extreme cases a total social paralysis. These patients stop working, there is a complete halt organized around this defect (in extreme cases some patients no longer have the capacity for work and they have great difficulty interacting with others.

We should invite patients to tell us what they expect from orthodontic treatment and then we will be able to distinguish a realistic expectation (*improved* alignment or smile for example) and an expected change in his life. In the same way, the idea of beauty (*''they aren't beautiful'' ''I want it to be beautiful!'')* is too vague a description and if the patient cannot narrow it down and be more exact it is a sign of unreasonable expectations and/or a fragile personality. Our first response to requests like these should not be orthodontic treatment initially but instead to refer patients to their doctor or a mental

health professional (psychologist or a similar psychotherapist).

Special cases

- **Body dysmorphia disorder**

This is an obsession with some physical defect that the patient designates as the cause of his problem and it will only be solved when it is removed. As we saw earlier, if we really want to sidestep the Look in the first place, the horror that the patient's self-image produces for him can be understood by the words used in trying to tell us the reason for the consultation. Withholding treatment must be the rule here if we are not yet prepared to refer the patient for psychiatric counseling.

- **Some psychological disorders**

They are more difficult to assess but we should focus our attention on the number of procedures or surgeries on the body or corporeal envelope, the number of previous orthodontic treatments and whether the patient has taken any psychotropic drugs. In cases where the orthodontist has lingering doubts, it is best to wait it out and take the advice of the patient's general practitioner who will refer the patient to a specialist or a psychotherapist if necessary. Any intervention on our part by some concrete procedure on the patient's body could incur the risk of creating an insurmountable crisis for our patient.

- **Lingual orthodontics**

Some patients come in for consultation for lingual treatment because for them the preliminary requirement for any treatment is already fulfilled: the invisibility of the device. What has made patients reticent up to now was: *''braces, even if they're invisible, you can see them!''* Since visibility is no longer a problem, these patients now come in for consultation with a specific request that is almost always for esthetic enhancement. By undergoing an orthodontic evaluation, they can assess the therapeutic treatment possibilities and make their decision.

- **Although they are still not a majority of orthodontic patients, adults do not come in to ask a professional for an opinion but rather to ask a technician to perform some specific procedure that they have already decided on beforehand, just as patients do for plastic surgery**

The diagnosis and treatment plan is not the patient's responsibility. Besides the frequent dissatisfaction of these patients with the results, they think of us as nothing more than service providers. We also are sometimes faced with parents of adolescent patients who come to ask us for some specific procedure for their child but not for our professional opinion. Orthodontists have to assert themselves when faced with a request like this.

- **Surgical patients**

We are going to give an example that illustrates the difficult case of a patient request and how treatment and its consistent application during every session made it possible to successfully manage patient treatment.

Mrs. H, is 48 years old when she comes in for her first appointment. When I ask her why she is coming in for consultation, she answers *''I'm here because I can't see my teeth when I smile, I would like to understand why. Why can't I see all my*

teeth? It's my body, I want some answers''. Her very first consultation with an orthodontist took place more than 20 years ago. ''*I haven't smiled for over 20 years now!'' ''They didn't tell me that it was going to be this way and that they couldn't correct anything.''*

This patient is very reserved but has a job as a sales manager for a communications company and her first exchanges with the secretarial staff are barely cordial, probably indicative of some malaise. Subsequently, her interactions with the staff became warm and friendly.

At the very end of the first appointment, I explain the various treatments and mention that maxilo-facial surgery could be the therapeutic option after we have consulted with the surgeon if the intended result is the answer to the request that she has expressed: ''*put some teeth in my smile''.* In any case, she left smiling at the end of the first appointment, with the perspective of a completely new treatment for her.

She presents a serious phonation problem with nasal leakage for which she had a procedure on the velum of the palate that ultimately hadn't fixed the problem. She will have several sessions of speech therapy during treatment and after surgery, with a very clear message from maxilo-facial surgeon that ''no improvement of the leakage can be expected from the surgery but a primary veloplasty will be attempted at the same time''.

At every appointment, she would ask me to explain the surgery and I could feel some apprehension and even anguish at the idea of being operated on. I always told her that she didn't have to have an operation and I supported her at every appointment.

She benefitted from a pre-surgical preparation using the lingual technique and from Lefort I surgery with a 7 mm lowering of the maxilla.

The esthetic and functional results were very good, especially for the patient who was thrilled with the outcome. She now felt more confident about herself. I also noticed that the way she held her head was different - her head was more upright.

– **Discussion:** the way the initial request came across as a demand gave me some reservations as to the pertinence of treatment, especially any orthodontic surgery protocol. When a patient begins talking in the following manner ''I have a right to...'' or ''I have the right to...'' we have to pay close attention because, in some cases, this is the sign of a rather paranoid personality. We're putting the patient at risk because what the patient is saying has nothing to do with orthodontic treatment, and similarly we're taking a liability risk in case the patient is dissatisfied. Equally, if prior to treatment, a patient takes on a very demanding tone implying and for some it is a strong conviction, that they have been wronged because their appearance doesn't suit them then the result will not suit them either. But during all the initial appointments and afterwards during treatment, Mrs. H was able to adjust her expectations and very quickly dropped her demanding attitude that she displayed before beginning treatment. The quality of the surgery is one of the keys to achieving a successful end result.

5 – HOW TO HANDLE PATIENT PROBLEMS OF A PSYCHOLOGICAL NATURE THAT ARE DIRECTLY LINKED TO ORTHODONTIC TREATMENT

It sometime happens, despite all the precautions taken before undertaking treatment to refer at risk patients, some start treatment and then become destabilized. This is either because the pain and the constraints of the appliance become unbearable for them or because the result is viewed by the patient as a complete failure even though the results obtained are technically sound.

In certain rare cases, the surgical results can disturb the patient to such an extent that they no longer recognize themselves in the mirror and become totally destabilized. We have to be very attentive to the psychological pain of these patients. In cases like this, we should have contingency plans and refer the patient for psychotherapy treatment with a specialist so that they can talk about the pain and fear they experienced when confronted by an unrecognizable image of themselves. The psychic pain is often accompanied by postoperative pain syndrome. In certain rare cases, intense pain begins shortly after leaving the hospital. When this happens, we should refer the patient to a mental health professional (psychoanalyst, psychologist, psychotherapist…). The orthodontist must overcome any reticence to do so, because trying to put in words the psychic pain one is experiencing is not a crazy notion, and at any rate, there is nothing bad about it.

When our patient is in a state of distress, time will not heal it and it is professionally debatable to allow our patient to remain in that state if some therapeutic measure other than further orthodontic treatment or medication is called for. It is preferable that orthodontists overcome their reservations and hesitation before being confronted by a patient in distress. Therefore, when the case warrants it, if we have a ''psychiatric'' contact that we know and trust, we can confidently refer our patients at the appropriate time.

6 – CONCLUSION

For some years now we have been asked to treat patients who place a high priority on the esthetics undoubtedly because of social discourse and the accompanying array of images that promote an eternally young body… or at least one that appears young.

Moreover, orthodontics is caught up in a changing society that is more and more often labeled a *service sector society.* If we are not careful and not solidly grounded in the ethics of health professionals, the esthetic dimension of requests will consequently put us on and already sometimes has put us on the slippery slope towards becoming service providers… (witness the rise of *Smile Salons*: the Health Bar and

Whitening Counter for the benefit of the patients in the office...). Then we are denied our place as health professionals.

Not every esthetic request is high risk. We can answer most in the affirmative but not without some preliminary exchange and discussion in order to assess any psychological risk. We should not be in a rush to perform corrective treatment for a designated defect because this headlong rush can have disastrous consequences for a patient who has not been evaluated for psychological risk factors.

The possibility of saying no, out of respect for the patient and the dental code of conduct, and therefore refusing orthodontic treatment for some requests should not be excluded. We owe it to our patients to support them and to refer them to a specialist's care and by doing this, it just might be possible to give well thought-out treatment in most of those cases.

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