Psychosomatics in Patient Management

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Orthodontics will solve the problem of patient management only when it reaches that stage of its development wherein psychology is employed on an equal basis with biology and mechanics.

Peculiarly, the growth and development of the orthodontic profession may be said to parallel that of the patients it serves.

The infant learns the mechanics of his muscles and how to coordinate them in walking, talking, etc., and becomes aware that he is a separate being from all other human beings.

Orthodontics was mechanical in its infancy. It was engrossed with appliances and gadgets and systems and techniques, and treatment was carried on empirically by the trial and error method. When Doctor Angle introduced his classification system and refined mechanics, the profession learned to coordinate its forces and suddenly became aware that it was a separate entity, a specialty of dental science.

With advent of puberty the child's sex glands undergo rapid growth and attain adult function, and he enters the critical seven year teen-age adolescent period, acutely aware of the biological forces working within himself.

Our profession entered the biological phase of its development some fifteen years ago when research workers began to make known their findings. From the accumulated mass of data we have become aware of the nature of the growth and development and relationship of facial and jaw parts and have acquired a sense of approaching maturity as a profession.

The outstanding fact about the adolescent, however, is that while he is no longer a child, neither is he an adult. True, in his late adolescence he has reached physical maturity, but mentally and emotionally he is not yet adult due to the time lag. That will come later when he has absorbed more of the psychological background of experience.

Similarly, the orthdontist is acutely aware of the biological forces working within the human face and jaws and he realizes that these basic forces are the framework upon which his mechanics must be built. But this is not enough. Our profession will not reach maturity until it has entered the third phase of its development, the adult psychological phase shall we say, in which orthodontists will learn the basic psychological drives which motivate human behavior.

We need more psychological "know-how" in understanding and getting along with the patient, and, in our opinion, this training should be given the orthodontist by experts at the university level. Along with mechanical and biological principles he should be taught the psychological principles of human motivation and behavior control.

I know of no such course of instruction. Nor is the subject given any more than scant attention in dental literature. Never is it discussed at meetings. It seems to be considered a problem to be solved by the individual orthodontist. This paper is an illustration of how one individual is attempting to solve that problem. It is humbly offered for what it is worth.

Orthodontists are supreme optimists. We spend precious time studying and

[1] Read before the Charles H. Tweed Foundation for Orthodontic Research, Tucson, Arizona, April 4, 1951.

analyzing a case, plan the intricate treatment procedure, hook up the appliance, set powerful forces to work, and then hope for the best.

Unbelievably, we have no positive control over the elastic forces we unleash upon the teeth. We are entirely at the whim and mercy of the patient as to the outcome of those forces.

I'm sure every orthodontist appreciates the essential importance of gaining and maintaining the patient's cooperation over an extended period of time. It is vital. Once gained it means success. Once lost, it becomes the weakest link in orthodontic treatment, and spells half-success or failure.

Specifically: whenever tip-back bends are placed in the archwire they must immediately be augmented by intermaxilliary and/or headgear elastic force. If these elastic forces are not applied by the patient we cannot even set up adequate anchorage, let alone move the teeth properly.

Then too, lack of patient cooperation means prolonging the treatment time because of broken appointments, broken or loose bands, broken or lost bite plates or retainers.

Moreover, lack of attention to mouth hygiene can mean a hazardous exposure to caries or periodontal disturbances.

And finally, consider the wear and tear on the orthodontist himself, due to lackadaisical behavior on the part of the patient. The orthodontist delivers highly skilled technology on a pressing time basis. It demands his concentration of thought and effort. Let the irritations and annoyances of unnecessary loose or broken bands or archwires interfere with his smoothly aligned schedule, let the emotional pressure build up as the waiting room fills up with emergency treatments, and you have the potential basis for a shortened and harassed professional life.

Indeed, the problem of handling the patient is equally as important as any other phase of orthodontic treatment. And it must be solved if we are to maintain our integrity and attain full maturity as a profession.

In our effort to solve this very human problem let us not be too hasty in pointing the accusing finger at the patient. Since Webster defines the word cooperation as "collective action for mutual benefit" it obviously follows that the *orthodontist* and the *parents,* as well as the *patient,* are actors in this drama. Let us first, then, examine the attitude of the orthodontist, the way he thinks about the people around him.

All great leaders are known to have the natural talent to get along with and to inspire people to do things. People with these native personality traits were first called Extroverts by Dr. Carl Jung.

The Extrovert's thoughts are directed outward from himself; he is not self-centered. He doesn't worry too much, laughs easily, and makes friends readily. He is careful not to hurt the feelings of others. He is the salesman type. In short, because he likes and is genuinely interested in people he gets along well with them and knows how to handle them. He inspires a mutual feeling of friendship and confidence.

The orthodontist who is an Extrovert is the one who gets the greatest amount of cooperation from his patient.

On the other hand, Dr. Jung labeled opposite personality traits as introvertive. The Introvert is self-centered; his thoughts are directed within himself. He is shy and makes friends slowly. His feelings are more easily hurt. He is not a good public speaker; he is embarrassed before crowds. He would rather be alone with a book, or just alone. He likes fine, delicate work and pays attention to details. He is inclined

to be argumentative. Examples of Introverts are engineers, accountants, architects, yes, and dentists.

Now of course, Introverts and Extroverts exhibit the extremes of personality traits. About a third of the population fall within the Ambivert classification, somewhere in the middle.

All the training received in dental college, however, tends to make one introvertive. The dental student deals with inanimate objects and dead tissues, things which are not human and alive and cannot talk back. Consequently, he has little experience in getting along with people. Even the patients he works on in the school clinic for a year or two he treats impersonally. They are usually considered merely as cases which provide necessary units for graduation.

As a result, when the dental or orthodontic student graduates, unless he is naturally an Extrovert he is decidedly at a disadvantage in understanding and handling patients. Being self-centered and shy and all bottled up within himself, his thoughts do not go out spontaneously to the patient. He does not inspire friendship and cooperation because he has no common ground upon which to make an approach.

Now, this is unfortunate because we must realize that we live in a world of people. And these people come into our offices every day as patients. We must make up our minds *to like them.* We must show them that we like them and are interested in them as individuals. Only in this way can we gain their cooperation in the important work we are trying to do for them. One of Dostoevski's characters said that to love people you may have to hold your nose and shut your eyes, but love them you must!

Happily, we can train ourselves to become Extroverts. It is not too difficult if one is persistent. It is a matter of establishing a habit pattern of thinking and then acting it out. Every orthodontist owes it to himself and to his patients to become more extrovertive. It will mean a happier relationship for both. And a more successfully treated case.

One of the most helpful things I found for getting me out of my shell and into a closer association with my patients was Dr. George Crane's compliment idea. This is an effective device for extroverting oneself right in the office. It consists of searching out some worthwhile thing about each patient and then paying an honest compliment.

It might be a colorful shirt a boy is wearing or his prowess on the athletic field, praise for the hobby he is interested in, or just light kidding about the 'flat-top, 'butch' or the wave he so painstakingly puts in his hair. It might be a new dress or the color of a girl's hair, or the meticulous care she gives her mouth, or some particular achievement in school.

Seek out something about the patient, or anything he does or any group he is associated with or has a high regard for, such as Scouts, YMCA, YWCA, the school football team, etc., which deserves an honest compliment. There is a difference between that and cheap flattery, which any child will recognize as insincere. A compliment recognizes the importance of the one complimented and gives him deserved credit for his achievement.

Try this plan for thirty days. Make it a point to vary it, but pay each patient one honest compliment each time he comes into the office. You will be delighted at the change in you yourself and at the new interest with which you will regard your patients. Furthermore, you will be amazed at the patient's response, at his changed attitude toward you. This is a two-way extrovertive magic. You will sense the melting away of a barrier of restraint

between you and the patient, followed by a genuine glow of friendliness and respect as he plys you with his confidences. Then it is that your cooperation problem will diminish. And all because you have shown a friendly interest in a human being who appreciates being considered as an individual and who wants to be noticed and loved. Adolescents, like adults, are hungry for recognition.

What I have said about the orthodontist extroverting himself applies equally as well to his assistant. She too, must do the same. And if she will diligently apply the compliment idea the whole atmosphere of the office will change.

Let us now see the part the Parents play in this four-way cooperative plan. Usually it is the Mother who brings the child to our office for examination the first time. In our opinion this is not enough .We think it is very important that both parents and child together meet with us so that we can explain the problem and how we propose to solve it. We always insist on having the Father present whenever possible.

With study models and Xrays, together with 'before and after' plaster models of similar cases, we all sit around the desk. We analyze and explain the case to them. We show how teeth should mesh — using lay terms for their easier understanding — then we compare the meshed case with the patient's study models.

We explain the significance of a closed bite, how when corrected it lengthens the lower third of the face, seeming to build a chin. If the case is a "D-P", we explain why teeth should be embedded in sound bone upright over the dental arch for stability, for health and longevity, and for appearance. We even have them feel the lower anteriors of a 'before and after' D-P case and through their tactile sense they understand and exclaim at the upright angulation of the teeth and retraction of the tooth and bony bulge which distorts the lips and proflie. It is surprising how interested people are in the human body, especially if it is their child's or their own.

Then we make the statement that "the mouth is the psychologic key to happiness". Using photographs we show how the relaxing and smoothing out of strained distorted muscles improves the appearance. What this means in the way of preventing or overcoming an inferiority complex! How one's confidence in oneself is restored! What self-confidence and poise and an attractive smile mean in business success, yes, and in matrimonial chances!

Why spend all this time, you may wonder? Well, there are several reasons. First: we never begrudge the time spent in telling the story of orthodontics. Second: we want the parents and the patient to understand and appreciate the great need for the work to be done, and to have such a strong desire for it that they will leave nothing undone in the way of cooperation to attain it. Third: we want the Father to know that no matter what cash value he may give to us it can never match the use value that we will give to his child in return. Being practical and wanting his child to have the best in health and happiness, and at the same time seeking to protect his investment, he is not likely to tolerate any lack of cooperation on the part of the child which will jeopardize these two things. He will be our ace in the hole should we get into difficulty with the patient. A letter stating the terms agreed upon, briefly recounting the nature of the work to be done, and stressing the value of cooperation, is sent to him as a future reminder of the things discussed.

And finally, we want to see the family group together not only to study

their facial patterns but to appraise them psychologically, their attitudes and behavior toward the problem and toward each other. Are the parents stable and emotionally mature? Is the Father the meek or bully type, does he brow-beat the family, is the Mother a nagger, is the patient an only child, is he spoiled? Remember that a child is the product of his heredity and his family environment. A great deal can be learned from the family picture which will be of immense value to us, for sometimes, in order to handle the child it is necessary to handle the parents.

And now we come to the fourth member of this cooperation problem, the patient himself.

Here we are with the family group gathered around the desk. We have just finished explaining the case to them when abruptly we turn to the prospective patient and ask him a direct question: "How do you feel about this, Jim? Do *You* want your teeth straightened?" Usually, a startled look comes over his face; apparently his feelings in the matter have never been sought before. He stammers an affirmative. We talk directly to him now, asking his opinion. We have placed him on the adult level and suddenly he feels his importance. We explain that through no fault of his or anyone else, his jaws just haven't grown enough to house all his teeth, so that he is faced with the handicap of going through life with crooked teeth.

That it is his problem, but Mother and Dad love him enough that they are willing to give up things in order to pay me to straighten his teeth so that he will have a chance for health and happiness. Now it is entirely up to him; he is told that he has come to me for help, that I will gladly work hard, use my skill and judgment and experience to help him, but that I can't do a thing for him unless he is willing to help himself. I must first know how badly he wants them straightened. Would he rather have nice even teeth like this, or like this? (showing 'before and after' models). If he indicates he'd rather look like the treated model I say: "That's fine, Jim. That's all I wanted to know. That makes us pardners, for with your help I know I can treat your teeth and make them look nice like this boys looks," (indicating treated model.)

"You see, Jim, sometimes Mothers and Fathers practically drag their boys or girls into my office and tell me to straighten their teeth, when they don't want it done. That makes a policeman out of me and I'm *NOT* a policeman. I'm an orthodontist. If they don't want this work done badly enough to work just as hard as I do, then I don't want them as patients. I have too many other boys and girls who do want it done and are willing to work with me."

Usually, right here the Mother will rush to the rescue and ask: "What do you mean, what does he have to do?" This gives me a chance to explain, to lay down the rules, so to speak. First: we must have full cooperation! Broken appointments slow progress, prolong the treatment, and waste my time. Second: patient must restrict his diet; we tell about the two-way test for all foods: one — is it sticky?; two — is it hard? We give examples. Third: he must brush his teeth properly and keep his mouth clean to ward off decay. And finally, he must wear his bite plate, headgear and elastics. We explain the meaning of wearing elastics, how they are a definite force to put pressure on teeth to move them. If no elastics are worn by the patient there will be no tooth movement. We illustrate how elastics supply force by stretching one and placing it from the distal of a lower model to the anterior of an up-

per, explaining how teeth move.

Now, psychologists claim the big problem with handicapped people is to get them to acknowledge their problem as their own, and to accept it without bitterness. Once that is done the mind clears and becomes serene and they work wholeheartedly for rehabilitation to correct or alleviate their condition.

It is the same with a malocclusion patient. He suffers from a psychological complex brought on by the unmerciful stings of thoughtless playmates, which causes a maladjustment. Once he accepts it as his problem, and is encouraged by our promise that it can be corrected provided he work with us, he is eager to commence treatment. He will promise to cooperate in every way. We have him now in the position of coming to us and asking for help. And he is willing to carry his share of the load.

Another thing: we have treated him as we would another adult. All his life he has been patronized as a child; always under parental wraps, perhaps with the old attitude that a "child should be seen but not heard". Or more confusing still, he is often placed in a queer position by the inconsistent attitude of the parents. Father might say one time: "Jim, you are a man now; you shouldn't do things like that any more" and then a half hour later, forgetting the power of suggestive psychology, he carelessly treats Jim as a child. This bewilders Jim; he is humiliated and embarrassed and resentful. Always remember this one rule: *NEVER* treat an adolescent like a child; always treat him like an *ADULT!*

As we go along with the treatment we never make any demands, never argue. That breeds resentment. When we want something done we use an expectant matter-of-fact manner and a positive tone to suggest what we want done. If you are on friendly terms with the patient and he likes you and you like him, don't underestimate the power of suggestion. He'll go along with you under those conditions.

If the patient fails to cooperate and we need to jack him up — and be sure to do it the first time he slips — we use the sandwich method of criticism. That is: put the criticism in between two compliments, and end it with a positive suggestion for the action you want. For instance: if he misses an appointment, first praise him for his fine attendance record or cooperation so far, then point out that he was absent, how that slowed the work and perhaps jeopardized the result, not to speak of the loss of time to you. Then add that you know there must have been some reason for it, and you know that he won't let it happen again. This method takes out the sting and prevents resentment, and he, appreciative that you have not nagged or argued but have talked to him man to man like an adult, will admit his wrong and promise to do better in the future. Dismiss the matter from your mind then; never hold a grudge. When you do, the patient senses it and will be forced to build up a counter-offense. Thus resentment comes into the picture and out goes cooperation.

Incidentally, we try to have the patient regard us as his friend. To that end we make as many friendly contacts with him as possible. Every patient receives a Christmas and a birthday card, and yes, even a valentine in February, which seemed to create quite a stir. Also we send either a card or write a short sympathy note should there be illness or death in the family.

On my desk is a large leather bound scrap book in which every patient is invited to write. It contains limericks, snap shots, drawings, autographs and whatnot. The patients like to pore over the book noting what others have written. And mothers find it an amusing human document.

Then too, as a matter of course, we

have a stack of high and junior high school annuals for years back. In short, we try to furnish a friendly atmosphere and show a kindly human interest in our patients and their problems to the end that they will consider us not only as their orthodontist but as an understanding friend as well, one whom they like to be around.

A knowledge of the psychology of adolescence is requisite to solving the problem of patient management. Orthodontists are dental specialists in human growth and development, but they must learn to understand it from a psychological standpoint as well. They must realize that the patients they treat are undergoing the critically sensitive seven year teen-age adolescent period, the transition stage between childhood and adult age. This calls for an attitude of understanding, sympathy and patience towards the patient.

They must appreciate that the internal developments which take place during this period produce profound alterations anatomically, physiologically, emotionally, intellectually, and morally.

The girl matures a year or two ahead of the boy. At puberty, she becomes spindly legged, her breasts fill out, her shoulders seem to narrow as her hips broaden, and the pelvic curvature becomes more exaggerated. She commences her menstrual periods, which may or may not produce physical or psychological reactions affecting her personality. She is extremely sensitive to the rapid physical changes in her body, and becomes acutely aware of the opposite sex.

The boy rapidly gains in height, his shoulders broaden, his chest thickens and his abdomen flattens as his waist and hips narrow down. His voice runs the gamut of the vocal scale much like that of a mocking bird in the dead of night. He takes a greater interest in his appearance, combs his hair, shines his shoes, and finds time for a curiously deepened interest in the opposite sex.

The adolescent has his own peculiar problems. If he seems trying to you at times remember that he is confused in his efforts to adjust himself to his new body, to the new outside world around him, and to the gigantic sex force which stalks constantly the inner recesses of his consciousness. He is no longer a child, neither is he an adult except in sexual maturity. Mentally and emotionally, he is immature because he has no life experience as yet. He has no pcychological background, nothing to base his judgments upon.

He is confused, sensitive, groping; he escapes to day-dreaming when the going gets too rough. All in the world he wants is to have some adult to whom he can go and confide and tell his problems and receive counsel.

I will not go into the subject of adolescence deeply for I am not a pschiatrist. All I want is for you to try to get the viewpoint of the adolescent. Don't criticize the present generation. Let's be frank and honest about our own adolescence. We had our faults and frailties. Let's rather cultivate a frankness and sympathy and an understanding comradeship with the youth of today.

Go to your library and look in the file under the word Adolescence. You will find upwards of a hundred books by experts in that field. Delve into the subject. You will find it fascinating and revealing and by gaining a better understanding of youth, the real medium with whom you work, you will find your patient cooperation problem much easier to solve. Indeed, it will practically disappear.

Summary

1. Patient management problem will be solved when the orthodontist understands and employs the psychological

principles of human motivation and control.

2. The orthodontist must extrovert himself is he would get along well with the patient.

3. Seek out one worthwhile thing about the patient at each visit and pay him a compliment.

4. Always treat the patient as an individual and as an adult.

5. Try to make the patient feel you are his friend as well as his orthodontist.

6. Remember that all adolescents (adults too) feel the need for

a — Affection. — We need to know we are wanted, that we are loved.

b — Adequacy. — To feel that we can achieve, accomplish things.

c — Recognition. — We want people to recognize our achievements. We want to be well thought of; we want others to see worthwhileness of our endeavors, to recognize us for things we do.

7. Finally, always remember that all human beings, young as well as old, are controlled by their hearts and not by their heads. Emotion and not educated reason or calm judgment, rules us in most of life's situations. In short, be a human being in your relationship with your patients and you will not have to worry about patient cooperation.

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