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PSYCHOLOGICAL PROBLEMS IN ORTHODONTIC PATIENTS: THE INFLUENCE OF SOME INFANTILE PATTERNS OF BEHAVIOUR ON PROBLEMS WITH ORTHODONTIC PATIENTS*

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Infantile patterns of behaviour persist to some extent throughout life. Children's behavioural patterns are moulded by multiple experiences which impinge upon an hereditary or genetic matrix. Specific styles of response and behavioural pattern can be observed in infants within a few days of birth (Brazelton and Robey 1965). These observations show that there are marked individual differences found in various infants (Korner and Grobstein 1967). Longitudinal studies suggest that some basic components of behaviour are retained throughout childhood and perhaps into adult life (Thomas et al 1963). Infancy, that time in a child's development covering the first fifteen months of life, is increasingly recognised by psychiatrists and other professional workers as a most crucial period in development. Events in this period greatly influence the mental health, future emotional disturbance and personality traits of later childhood and of the adult.

It is possible to define some aspects of infants' psychological development. Other areas are still inadequately understood. This paper briefly discusses some infantile patterns of behaviour, a few psychological problems arising from the retention of infantile patterns of behaviour and a limited view of the relationship between these patterns and problems of the orthodontic patient. It is not in any way intended to discuss possible etiological relationships between psychological disturbance and orthodontic disorders. A brief review of part of the literature available, revealed no significant literature relating to this area of psychiatry or orthodontics.

1. INFANTILE PATTERNS OF BEHAVIOUR.

(a) Mother/Child Relationship.

At this stage of our understanding of child development, there is little specific knowledge concerning the influence of intra-uterine existence on infants' behaviour. However, it is not uncommon to hear mothers describe their unborn child as "a monster" or "a devil." In particular, this appears to refer to children who are hyperactive in utero, the so-called "thumper." At times the mother's perception of her unborn child as a monster may refer to her feeling that her child is unwanted, hated or at times totally rejected. The mother's initial feelings about her pregnancy, along with her ideas and feelings for her unborn child, contribute to her reception of her new born child. This probably plays a major role in her child's behaviour in the earliest stages of infancy. This maternal influence is probably just as significant as inherited and physical factors which can also underly the new-born's behaviour. From conception onwards the inter-relationship between mother and child is of crucial importance to the psychological, as well as to the physical, development of the child.

(b) Mother/Child Inter-Dependence.

Balint writes of "an instinctual interdependence between mother and child." He describes this as "a biological inter-dependence in a dual unit" (Balint 1965). It is clearly observable how dependent the infant is upon the mother's capacity to mother. Less often regard is paid to the mother's need to relate to her child and her dependence on her child's capacity to respond to her. This initial interaction provides the basis for all future relationships. In the first few months of life the infant should acquire what Erikson calls "basic trust" (Erikson 1950). In a mutually rewarding co-existence between mother and child resides the keystone for future healthy development of the child.

(c) "Orality."

One of the early stages of psychological development is named the "oral phase." The mouth has multiple functions in the infant apart from its role in feeding. The mouth is apparently a major perceptual organ (Spitz 1955). Through various oral sensations the infant builds up a partial picture of some aspects of his world. Furthermore, the mouth rapidly becomes a vehicle for the expression of a child's feelings. By sucking and opening and closing his mouth the infant can regulate his need for milk. He can also indicate his feelings by biting, chewing, clenching his jaws as well as by crying, spitting, vomiting and by multiple

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tongue and lip movements. These and other forms of behaviour can be considered to be "oral" activities. With the development of infantile babbling and later through speech a more complex pattern of communication both of feelings and ideas commences. The basic patterns of "oral" behaviour are often continued through verbal communication—for instance through the use of "biting" or "incisive" language.

(d) **Ambivalence.**

An utterly dependent infant is unable to verbalise his demands and needs. The response to pre-verbal cues given by her child is mainly contingent upon the mother's correct perception of these cues. Every mother must at some time and perhaps on many occasions frustrate her child by her inability to respond appropriately to her child's needs. This creates in the child a feeling of angry frustration. At first infants apparently perceive this anger as originating in themselves, as being the result of their own actions. As time passes and the child develops further the mother seems the source of those frustrating and angry feelings. At times she is and at other times it is both mother and child who are angry. However, mother is also felt to be the source of love, food, comfort and defence. This dual role of mothers is part of the origin of the infant's feelings of ambivalence. Out of feelings of ambivalence there arises a further component in the child's early patterns of behaviour.

(e) **Separation Anxiety.**

It is conceptualised that a new born child is unable to differentiate between his own person and that of mother. As the child develops, a distinction of self from non-self grows till eventually the child perceives himself as a separate individual. This stage of individuation is at its height from the age of approximately nine months onwards. It is associated with feelings of ambivalence for the mother and towards himself by the child. To be separate from his loved mother usually invokes feelings of anger in the child. In all children these feelings, along with an actual awareness of separation and the fear of loss of mother's love and support, provoke anxiety,. Separation anxiety is an affect fundamental to most children's experience. They only gradually acquire means of adequately coping with this anxiety.

(f) **Masochism.**

As well as being an uncomfortable or unpleasant feeling, anger in a child can have a more positive role. In the absence of love and complete satisfaction, which is an unavoidable situation at least for minimal periods in the life of all infants, there is a possibility of at least two alternative states of feeling—anger and frustration or nothing. Perhaps the worst feeling an infant can have is of being and having nothing. To be angry and hurt even if this is unpleasant is perhaps better than to feel nothing. Infants appear to utilise this phenomena by building patterns of behaviour that provoke angry responses in their mothers. Some children develop their need to be shown and to feel anger into a major means of making relationships. In part this is the origin of "psychic" masochism—a psychological means of insuring unpleasant pleasure.

Thus, some aspects of infantile patterns of behaviour have been briefly described. A mutually rewarding, trusting relationship between mother and child, mutual dependence, "orality," ambivalence, separation anxiety and psychic masochism are some of the basic components of infantile behaviour.

2. SOME PSYCHOLOGICAL PROBLEMS ARISING FROM THE RETENTION OF INFANTILE PATTERNS OF BEHAVIOUR.

It is not possible in this paper to adequately deal with all the problems that can arise. Furthermore, most of the disordered patterns of behaviour found in children are determined by multiple factors. The following are some problems which may be essentially based in the retention of infantile patterns of behaviour previously described.

(a) **"Hyperactivity."**

When there has been a "breakdown" or lack of development of a mutually rewarding relationship between mother and child, it is likely that the child will show psychological evidence of this. One of the commonest problems seen in a Child Psychiatric Practice is that which arises when the mother has had a depressive illness during her child's infancy. Usually her child becomes aware of the less than adequate relationship that mother can offer. It is impossible for a mother to give sufficient of herself when pre-occupied with her depressive feelings and withdrawn into herself. Frequently the child loses or never acquires the capacity for "basic trust." As the child develops he may show a constant, searching, irritable restlessness. These hyperactive children appear to find it difficult to

relate in other than a superficial manner, appear only minimally and transitorily interested in material objects and seem driven by some "inner force." They seem to retain, in an exaggerated and distorted form, the normal behaviour of early infancy where the child is constantly "searching" his environment for his mother.

(b) **Excessive Dependency.**

A child may be unable to depend on his mother for many different reasons. She could be frequently unavailable to him or when she is with her child so anxious that she cannot meet his demands. Arising out of this, the child may increase his attempts to obtain a nurturing, dependable relationship with mother by remaining excessively dependent. Carried into later phases of childhood this excessive dependency may appear as a child's constant demand that mother feed him, dress him, carry him and protect him. Appropriate in infancy this behaviour denotes in the toddler a lack of development away from infantile patterns.

(c) **Excessive Independence.**

Increasing independence is a normal accompaniment of the toddler phase of development. Excessive independence often commences in infancy when a child, aware of being unable to be sufficiently dependent, protects himself against this hurt by attempting to prove that mother is not really necessary to him. These children show an intense drive towards doing things for themselves. They often walk, talk and feed themselves unusually early in their lives. They may attempt to emulate the activities of their older siblings and parents long before they have the necessary skills. They may shun their mothers and protest if mother attempts to help them with the most complex of tasks.

(d) **Pathological "Orality."**

"Orality" is a general description of the retention of much of those activities found centred around the infant's mouth. Some children with voracious appetites for food, as well as for love and attention, can be said to have retained in an excessive manner this infantile pattern of behaviour. They frequently combine with this appetite a widespread use of other "oral" traits. Thus, they may talk in an infantile manner—with delayed speech development or in a dyslalic manner; they may eat dirt, chew glass or repeatedly ingest poisonous medicines and household cleansing agents; they could continue to suck their thumb and fingers or bite their hands; they may frequently vomit or regurgitate food and so on. As time passes many of these infantile patterns though modified may be retained in part. They may form the basis for an adult's over-eating, gluttony, smoking, incessant talking, drug addiction, etc. All children and adults must retain some of their infantile patterns of "oral" behaviour but if they are present in an excessive manner they betray their pathological nature, as well as a past history of disturbances in the "oral" phase of development.

(e) **Pathological Separation Anxiety.**

A child can only leave behind his infantile patterns of behaviour by becoming a separate, relatively independent individual. If he retains his need to remain close to mother, shows marked anxiety over separation from and a constant fear of losing his mother it is likely that he has not adequately handled the infant's ambivalent bond between himself and his mother. Our society tends in many ways to attempt to sever this bond at an increasingly early age. Advocacy of kindergarten entry at two or three years of age is contrary to the normal need a child has for continuous proximity to mother and over-rates the child's capacity for separation. However, excessive clinging, tantrums if mother is out of sight, and gross difficulties at bed-time in a toddler, can be indications of pathological separation anxiety. Similarly, refusal to stay at kindergarten when aged four to five years, to insist on mother going into the school each day so as to deliver her child to the teacher or the urgent need for mother's clinging attendance on each trip to the dental chair when aged ten years or more may give indication of the retention of excessive separation anxiety. It is, however, not unrealistic in strange and potentially frightening situations for a child of any age to revert momentarily to infantile behaviour and show some anxiety at separation from mother. Difficult situations may arise when there is a combination of an excessive, mutual, ambivalent relationship between mother and child along with mutual separation anxiety. Children with school phobia show an intense dislike of the school situation as a cover for this malignant combination. Some asthmatic children are found to have a similar retention of these patterns of infantile behaviour and relationships.

(f) **Pathological Masochism.**

Perhaps some of the most disordered behaviour found in children is that determined in the main by the retention of a marked need

for masochistic relationships. For children to constantly provoke punishment, to be prone to getting hurt, to repeatedly have accidents, to set up situations where they miss out on food and favours, is contrary to what normal children can be expected to do. Many of these children appear to relish these situations. They also at times dominate their families in a most determined and destructive manner. If a whole family is constantly at the beck and call of a toddler or school-age child, with each family member unable to act without regard to that child's whims, this usually indicates a large measure of masochistic provocation by that child. The parents of these children frequently respond by a form of sadistic retaliation. The greatest problem that arises out of such a situation is the ready manner in which the child carries his masochism into all relationships outside the family and into most areas of behaviour.

These children present as a constant danger to themselves through neglect of their health, refusal to co-operate in medical or dental treatment and a constant denial of the vulnerability of their bodies through reckless, dangerous behaviour. Perhaps more insidiously these children also involve others in their patterns of behaviour, often with a consequent risk to the others' health and, in fact, their lives.

3. THE RELATIONSHIP BETWEEN INFANTILE PATTERNS OF BEHAVIOUR AND PROBLEMS OF THE ORTHODONTIC PATIENT.

An extension of the previously described patterns of disordered behaviour into the orthodontic situation may highlight the relationship. To discuss each problem as a discreet entity may contribute to clearer understanding though in practice no such simple situation is likely to occur.

(a) **"Hyperactivity."**

Firstly the hyperactive child (in this instance excluding hyperactivity for reasons other than those detailed above). The obvious initial problem will be to gain sufficient co-operation from the child. It can hardly be conducive to careful orthodontic practice to have a child constantly leaving his seat, restlessly searching the room and difficult to distract other than momentarily by devices which work for other children. Unfortunately, children who show this form of hyperactivity do not always respond well to tranquiliser drugs and at times are driven to the point of frenzy by their use.

Through frequent short consultations of a patient, consistent and permissive nature, these children may not only eventually accept their orthodontic appliances but their orthodontist as a friend.

(b) **Excessive Dependence.**

Some children may appear to very quickly accept every suggestion made to them, acquiesce to most commands and completely and trustingly allow their orthodontist to do almost anything to them. This, even allowing for the most skilful and sympathetic handling, seems like an abnormal situation. It is often the over-dependent child who will present in this way. Contrary to the hyperactive children, these children are usually easy to manage but there are some difficulties. Just as these children want to be dressed and fed when little so later in childhood they remain dependent on others cleaning their teeth, combing their hair, etc. Where orthodontic treatment is dependent on a child's carrying out repeated tasks the over-dependent child may well be unable to carry these out unaided. This may lead to conflict between the child, his parents and the orthodontist.

(c) **Excessive Independence.**

On the other hand the excessively independent child is less likely to co-operate with all stages of orthodontic treatment. Needing desperately to do things for himself he is constantly interfering with the instructions and activities of others. If such a child perceives his treatment as stemming from his mother's request for it, he may react in his over-independent manner and protest his lack of need for any orthodontic device and thus refuse to co-operate. Even if prepared to accept initial assessment and the early stages of a planned and lengthy process, the overly independent child is often unwilling to continue for long because it robs him of his independence. He may feel tied to his appliance in the same way he would wish to, yet cannot allow himself to, be tied to his mother.

(d) **Pathological "Orality."**

All dental treatment invokes in every child ovent or covert memories of earlier "oral" activities. There may be many forms of "oral" behaviour in response to orthodontic treatment. Two relatively common responses seen in disturbed children are based in the recall of earlier traumatic experiences and a subsequent regression to oral patterns of behaviour. Firstly, children who have had a previous tonsillectomy.

This may have been a more than usually traumatic experience or at a time when the child was at risk for "neurotic" illness. These children not infrequently develop a neurotic disturbance during the time of or following orthodontic (and other dental) treatment. This is characterised by phobias connected with eating, being poisoned, choking, suffocating, etc. The orthodontic emphasis on the oral region recreates a previous period of stress which may have been repressed. With the upsurge of these earlier feelings a neurotic disorder may result. The orthodontic treatment is not the cause, merely the trigger for the development of this illness.

The second response is that associated with an earlier lack of oral satisfaction. Some children who have been relatively deprived of mothering in infancy have retained many oral traits or patterns such as over-eating. Further emphasis on the mouth may precipitate a regresion or reversion to the voracious appetite of the infant. Adolescent girls, who may already be overweight, are perhaps the most prone to develop this type of regressive insatiable appetite. These girls view their orthodontic appliances as unsightly, but often deny that their obesity (and their over-eating) contribute to their unattractive appearance.

(e) **Pathological Ambivalence.**

Children who are incapable of healthy separation from their mothers have been described as commonly having difficulties in handling feelings of ambivalence. These feelings they carry into many areas of their lives. Children will attach their ambivalent feelings to people other than mother and to material objects. Thus, the orthodontist working with such children may unwittingly become the recipient of these feelings. These excessively ambivalent children will often accept their course of treatment as a necessary part of their lives. However, they may show an alternating willingness to co-operate and total lack of interest. Daily procedures may be carried out conscientiously for some time and lead to adequate progress, yet at the time of a subsequent assessment no progress is seen, despite the child's avowal of his sticking to the programme.

There is a frequent association of feelings of guilt with the continuation of an infantile and ambivalent relationship with mother. These children quite readly develop depressive reactions. They may be angry at having to keep to orthodontic schedules, relate this anger to their mothers who arranged their orthodontic treatment and then because of their ambivalence, feel guilty over their unexpressed (or at times overt) anger against mother. In others the loss of their "normal" appearance (particularly in adolescent girls) can precipitate feelings of a depressive nature and at times lead towards depressive illness.

(f) **Pathological Masochism.**

Perhaps the most difficult situation for the orthodontist to handle could come from those masochistic children who appear to delight in harming or damaging themselves. Their lack of concern for pain, their constant, provocative defiance of suggestions for dental care and their apparent lack of interest in the progress of their treatment are some of the features of these children. Masochistic children, despite initial defiance of treatment, may then apparently accept it but they constantly utilise every possible means of ensuring the failure of their orthodontic care. They fail to see that it is themselves they are harming. They need to be in the position where they are criticised and punished. Unfortunately, masochistic children not infrequently do succeed in provoking angry responses from the most controlled and placid of people—to the masochist's intense "unpleasant pleasure."

Fortunately, there are also more positive and healthy attributes arising out of the retention of infantile patterns of behaviour. This paper merely attempts to look at rather superficial aspects of some psychological pathology which may impinge on an orthodontic treatment programme.

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