 DOI: 10.2478/aoj-1990-0015

Troubled orthodontic patients: the role of the social worker

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ABSTRACT: Cooperation and social problems of orthodontic patients are discussed using four case histories, and the significant role of the social worker in managing such patients is explained.

Reference: Aust.Orthod.J.11(4):232-235

MeSH words: compliance; counselling; family therapy; orthodontics; social problems; social workers
Key words: cooperation, disadvantaged patients

INTRODUCTION

Many articles have been written on the necessity for patient cooperation to ensure the successful outcome of dental or medical treatment (Calnan 1983, Jenkins et al. 1984, Cockburn et al. 1988, Folger 1988, Ley 1988, Egolf et al. 1990).

Patients who attend The Royal Dental Hospital of Melbourne are means tested to determine eligibility of treatment. Eligible patients must have either a full pension and a health benefit card or a health care card which is provided for people with a limited income. The Department of Social Security both assesses eligibility (according to income and assets) and provides cards and patients are, therefore, likely to be disadvantaged members of the community with social difficulties.

The orthodontist because of his long term association with each patient frequently becomes aware of some of the social problems experienced by the patient. The unique availability of a social worker in a dental setting allows a multidisciplinary approach to the management of these patients and in this article four case histories of patients who were referred by the orthodontist to the social worker, because of obvious social problems, are described.

CASE REPORTS

Patient No 1.

A 16 year old female of Italian descent.

Orthodontist's observations

The diagnosis was a Class II division I malocclusion with a 10mm overjet, and crossbite of the right buccal segments. Bands and archwires were cemented and cross elastics placed on 15, 16, 45, 46. Ten weeks later the crossbite had not improved, and so the strength of the elastics was increased and Class II elastics prescribed. At the next monthly visit the patient admitted that she did not wear her elastics regularly, because it was difficult to eat with them in place. Having removed the elastics, she usually forgot to replace them. Three months later the buccal segment relationship was correct but 13, 23 had not moved.

A further seven months of treatment did not produce any improvement in the relationship of the canines and during this time the patient said she was preoccupied with her Higher School Certificate (H.S.C.) examinations, not of elastics, that her parents were conservative and that she had trouble with her brother. These factors and comments resulted in the patient being referred to the social worker. An immediate improvement in cooperation was noticed and subsequently even a reverse overjet was produced, because she wore her elastics so conscientiously.

The patient's behaviour and comments were such that the orthodontist realised she had problems which were outside his field of expertise. The initial visit to the social worker was sufficient to produce a significant change in attitude and cooperation. Following referral she has been happy and smiling at each appointment.

Social worker's observations

At the time of referral by the orthodontist this patient was 17 years old. She was undertaking H.S.C. studies and was the oldest of three children, having a sister aged 15 years and a brother aged 11 years. There were many conflicts at home regarding independence, choice of career etc. She also had conflicts with her brother and difficulties with her studies. Her self image was extremely poor and she was depressed. She expressed a desire to continue with orthodontic treatment but admitted to not complying with treatment.

Social work management included individual counselling and psychotherapy, aimed at ego building, and helping the patient cope with her home problems. The patient needed considerable support and encouragement. Treatment also included family therapy and both the patient's mother and father were interviewed. The patient was seen at monthly intervals and considerable improvement was noticeable after the first individual counselling session. It was not found necessary to refer the patient for management of her depression, as she made such rapid progress in response to a personal interest taken in her and an improvement in her self image.

Despite the fact that this patient failed her H.S.C. her progress was maintained and she found clerical

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work with a municipal council. She has maintained this position over the past three years and continues to live at home and has a fairly good relationship with her family. She is happy with her appearance and life generally.

Patient No 2
An eight year old male of Anglo-Saxon descent.
Orthodontist's observations
The diagnosis was of a Class I malocclusion with Class III tendencies, and a repaired cleft lip.

The patient was initially treated with a removable appliance to procline three maxillary incisors. Definitive treatment was postponed until eruption of the full permanent dentition had taken place.

At a review appointment, five and a half years later, the patient's mother exhibited signs of exasperation with her son. Tensions between mother and son were apparent at each following visit. The mother said she was experiencing many problems with her son and she agreed to a suggestion to consult the social worker. Subsequently, the patient's mother asked that he attend by himself. He broke the next appointment but following this, fixed appliance treatment proceeded smoothly.

The patient was sufficiently motivated to overcome personal and family problems which did not have any harmful effects on his orthodontic treatment.

Social worker's observations
At the time of referral by the orthodontist the patient was 15 years old and had a younger brother of 14 years. He was living with his mother, his parents having separated many years previously. His father provided some financial support but otherwise was not involved in care of the family and reportedly had a drug related problem. The patient saw his father as a provider of extra money when he needed it.

The patient was initially seen in The Royal Dental Hospital's inpatient ward where he had been admitted for management of an impacted 23. His mother had requested the interview, following referral by the orthodontist, after the patient had run away from home.

The patient's mother was concerned that her son would again abscond and was particularly concerned that he had been found with a known paedophile before being taken to a remand centre for adolescents. On interview it was felt that her fears were well justified.

Social work management with this patient included individual counselling and also family therapy with the patient's mother and younger brother. The patient made a contract to stay at home during which time there was concentration on issues such as time limits, chores at home and mutual respect. Whilst orthodontic treatment has proceeded other issues such as truancy, drinking and graffiti painting on trains have been dealt with also.

Although this family has many ongoing problems and the patient's brother is now undergoing social work management also, many problems have been overcome and the patient has matured considerably. He is now in regular employment in a local hardware store and only paints grafitti on commission. Social work management for this patient has provided some stability.

Patient No 3.
A 14 year old male of Australian parents.
Orthodontist's observations
The diagnosis was a Class I malocclusion with missing 12, 47 and peg 22.

At the initial examination the patient's mother was told it was slightly too early to commence treatment. The mother was eager to start and seemed anxious. Over the next few visits the patient's mother exhibited a need to talk. The availability of the social worker was pointed out and subsequently a request was received for a referral.

Orthodontic treatment was uneventful although the orthodontist did not feel that he had become as well acquainted with the patient as with others.

Social worker's observations
Social work management of this patient included individual counselling with the patient and family therapy. The patient was 14 years old at the time of referral. He lived with his mother and had a 31 year old schizophrenic brother who was very demanding of the mother and was disruptive to family life. The patient's mother had been married twice, had two sisters and had been thrown out of the family home at age 14 years. She was attractive and well dressed and appeared highly anxious and agitated. She felt she could not cope with the behaviour of her 14 year old son.

Further investigation revealed that the mother was a manic depressive and had a previous psychiatric history. She described love affairs with previous male therapists and was reluctant to obtain further psychiatric referral.

Counselling sessions with the mother dealt with rationalising ways of coping with the behaviour of her schizophrenic son and of the patient. Counselling sessions with the patient encouraged him to be more mature and not to be as antagonistic towards his mother. Some degree of harmony was maintained and progress was discussed in joint interviews in which new goals were set. Because the patient was also experiencing problems at school, the social worker also liaised with the school which took an active interest in the patient and provided encouragement and support. A review after debanding found the patient was happy at home and had an improved relationship with his mother. He had changed schools and now attended a Technical School and planned to complete year 12 the following year.

Patient No 4.
A 16 year old female of Greek background.
Orthodontist's observations
The diagnosis was a Class I malocclusion, 13, 14 and 23, 24 transposed, 36 extracted, mandibular centre-line three mm to the left.

During the appointment at which the maxillary fixed appliance was fitted the patient would not speak. The patient was still unhappy at the next two visits which were followed by two cancelled and two broken appointments. When the patient did return some four months later she was fifteen minutes late and the archwire had been out for several weeks. The patient said that she did not want to have fixed appliances.

When the orthodontist stated that at the first visit he always made a special point of asking the patient, not the parent, if the patient was prepared to wear fixed appliances she replied that her mother wanted her to wear them. When asked whether she could not stand up to her mother the rejoinder was that the orthodontist did not know what Greek mothers were like.

At the next visit she was thirty minutes late, and the following one was broken. Subsequently she agreed to meet the social worker but broke the appointment. The orthodontist sent a letter to the father requesting his attendance but no parent came. Eventually both patient and mother attended and once again the patient agreed to see the social worker. The orthodontist suggested that the mother bring the patient to ensure punctuality but allowed the patient to decide whether her mother would speak to the social worker.

Three months later the patient wanted a fixed appliance placed on the mandibular arch!

This patient had seen a social worker previously and her mother doubted that further visits would help to resolve the patient's problems. The patient had not worked

since she left school two years ago and she obviously had long-standing social problems which the orthodontist was not trained to resolve.

The orthodontist devoted a considerable amount of time and energy to this case and his hopes lay as much in producing a well-adjusted useful member of society as in creating a well-aligned dentition.

Social worker's observations

This 17 year old patient was living at home with her parents and two sisters. She had left school two years previously but had not worked. At the initial interview she appeared sulky and sullen and chewed gum. She had little to say and was uncooperative. A further appointment was made at which the patient seemed to be a little more relaxed than before and willing to discuss her problems. She expressed terrible conflict with her mother and said that her mother was 'mad'. Her mother had threatened to kill her boyfriend who was of a different ethnic background. A restraining order had been taken out by her boyfriend's family against her mother. The patient had little interest in life, was not working and was not receiving Unemployment Benefits. She was allowed very little freedom. Because of her financial situation and the restrictions of her cultural background she would find it very difficult to leave home. Counselling was, therefore, aimed at helping the patient to cope better at home and also to find employment which would make her financially independent and enable her to spend less time in the house. The patient's mother was also seen with the permission of the patient and advised at this stage.

Further counselling sessions were spent improving the patient's presentation when applying for a job and as a result her self-esteem and feeling of self worth seemed to improve considerably. As a result she did obtain employment as a check-out girl at K-Mart but, unfortunately, remained in this position for three months only as she did not like it. She was hopeful of finding further employment and was keen to complete orthodontic treatment. It is felt, however, there will still be some problems regarding compliance in further management of this patient. One of the most perturbing aspects of this patient's presentation was her lack of any close feelings for any members of her family, even her four year old sister. Social work management hopefully will continue.

DISCUSSION

The objectives of the social work department are to provide a social work service to patients, their families and significant others within a broader arena of the welfare system that provides service in the fields of health, child and family welfare, nursing, education, civil and political rights and income maintenance. Opportunities also exist for the social worker to be involved in education and research.

A thorough assessment of each patient's social situation is made and a realistic treatment program formulated. Treatment is carried out by individual counselling and psychotherapy, family therapy and home visiting. Practical help such as financial assistance is provided where necessary and much use is made of community resources. An information and referral service is offered where required.

Patients are referred from Hospital and University Departments, community agencies and individuals. In addition, many employees of both the Hospital and University are seen. A great emphasis is placed on confidentiality and a person's right to self-determination.

The four patients described in this article illustrate the difficult family circumstances of some orthodontic patients and the necessity to assess and treat the psychosocial factors, with appropriate intervention, as a necessary part of comprehensive management.

The social worker applied certain principles of therapeutic approaches to all four patients (Caplan and Lebovici 1969, Laycock 1970, Carkhuff 1973, Dragastin and Elderg 1975, Okun 1976, Whiteley and Flowers 1978, Reade et al. 1985).

1. Development of a rapport with the patient and skilful questioning were necessary to elicit a thorough history.
2. An attempt was made to establish a relationship of empathy with a positive regard for all patients.
3. Other family members were seen whenever possible. This enabled assessment and management of the social situation of the patient.
4. Individual counselling, psychotherapy, behaviour therapy and family therapy were provided where necessary.

Because orthodontists usually see their patients with fixed appliances, once per month for two years and then less frequently for several more years, the opportunity exists to have a close professional relationship with them. Thus orthodontists may become aware of a family's social problems but the resolution of these problems may not be easy. Orthodontists are not trained, nor do they have the time, to correct these situations and the social worker is a suitably qualified professional to consult.

No patient or parent is forced by the orthodontist to make an appointment with a medical or paramedical practitioner such as the social worker. The opportunity is offered to the patient or parent and a reply is requested at the next appointment. Every attempt is made not to force the patient into an action against his/her will.

CONCLUSION

Some patients will cooperate even under the most difficult personal circumstances while others need a multidisciplinary approach, including counselling, if their orthodontic treatment is to be completed satisfactorily.

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