Self-Concept: perception of self

Psychological Model
- indirect reinforcement of target’s perceptions by beholders’ behavior
e.g. target FEELS ugly from cleft lip or prognathic and reinforced as not normal (ugly) in “beholders” behavior.

Yes, you’re ugly!
I’m ugly!

Sociological Model
- emphasizes the direct impact a perceiver’s behavior can have on a target’s self-concept
e.g. target is called “ugly” by perceiver; perceiver feels ugly due to labeling effects

You’re ugly!
I must be ugly!

"Looking-glass self"
Cooley - "imagination of our appearance to others, the imagination of their judgment of it and this effect on self pride" develops self-concept. (psychological model)

Adams - 4 assumptions of outer appearance effects on inner personal experiences:
1. Different social expectation for attractive vs. nonattractive
2. Attractive persons receive more favorable interactions
3. More frequent favorable social interactions cause attractive people to develop positive social images/behaviors
4. Persons with greater self confidence initiate and maintain satisfying interpersonal relationships

Perception of appearance research
- Attractive persons (physically) have been shown to be more socially successful.
  - more intelligent
  - more socially skilled
  - more friendly, sincere, sensitive
  - more likely to be helped etc.
  i.e. perceived attractiveness is a social asset.

- FACE - usually most important determinant
- MOUTH - one of most important for facial attractiveness vs. unattractiveness

Unattractive persons - more likely to be credited with negative outcome; less likely to be “helped”.
i.e. perceived facial unattractiveness - a social liability; handicap

* Merton - “Person A acts on false (or true) beliefs about a person B that influences and comes to be confirmed/enacted by A”. (sociological model)
* Individuals with impaired appearance also can have problematic social interactions and lower self-esteem similar to the psychological model of self-perception.
Definitions

HANDICAP - difficulty a person has fulfilling family or social roles
DISABILITY - type of limitation imposed by impairment
IMPAIRMENT - any loss or abnormality of structure or function

Unattractiveness as handicap

- Kleck - individuals stigmatized by visible physical impairments view themselves as ineffective in social situations.
- Studies of cleft lip/palate indicate socially reserved; lack social skills; less accepted by parents; more inhibited
- Heller et al. - 33% of Canadian young adults with clefts had inadequate psychosocial adjustment - not related to clinical severity but dissatisfaction with appearance

From cleft + Down’s research is evidence that treatment of craniofacial deformities improves psychosocial well-being.

IS MALOCCLUSION SIMILAR ?!

Shaw - normal occlusion more attractive
Helm - maloccluded child 7 times more prone to teasing (specifically overjet).
Shaw - 4th most common target for teasing (after height, weight, hair)
BUT created more intense unease than other teasing.

Psychosocial Outcomes of TX

- Rutzen - compared patients with malocclusion after 5 yr.: 250 who were treated and 67 patients not tx’d - those treated had significantly more positive assessment of appearance; no self-concept measures.
- Dennington + Korabik - 22 patients - 7 mos. tx - improved self-concept
- Klima et al. 173 kids, 52 moms - no improved self-concept
- Albino + Tedesco - 93 patients; found improved facial appearance before/after conventional OR, but not self-concept (self-esteem, social competence, social goals)

WHEN TO TREAT!!??

No treatment?
- Conventional Ortho?
- Orthognathic Surgery?

Most use occlusal index & standard esthetics measures:
IOTN – Index of Orthodontic Treatment Need (1989)
1. dental health & function measures; 2. esthetic scale
ICON – Index of Complexity, Outcome & Need (2000)
- Newest measure based on expert consensus using IOTN esthetics scale, crossbite, crowding/spacing, antero-posterior, vertical relations.

But, degree of social liability or desire for treatment is not always the same as degree of esthetic or functional impairment! Albino & Tedesco, 1991
The True Clinical Challenge

“The clinician’s challenge is not simply to improve both appearance and function... for a truly successful outcome it must also be the patient’s perception of appearance (and it’s psychosocial meaning) that moves in a significant positive direction... one should never assume this to be congruent with the orthodontist’s evaluation.”

Albino & Tedesco 1991

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Table 1: Critical Factors for Adolescent Cooperation in Orthodontic Treatment (Albino 2004 Saxon-Ortho)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Pre-Treatment</th>
<th>Early in Treatment</th>
<th>Throughout Treatment</th>
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<tbody>
<tr>
<td>Child</td>
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<td></td>
<td></td>
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<tr>
<td>Perceived need for</td>
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<td></td>
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<tr>
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<td>Orthodontic treatment</td>
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<tr>
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<tr>
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<tr>
<td>treatment</td>
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<tr>
<td>Parent’s belief in the</td>
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<td>efficacy of treatment</td>
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<tr>
<td>Perceived impact of</td>
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<td>Support system</td>
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<td>Orthodontist’s role</td>
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<tr>
<td>Team building!!</td>
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The Hedonic Treadmill

“Good and bad events temporarily affect happiness, but people adapt rapidly back to a ‘hedonic neutrality.’

Diener et al. American Psychologist 2006

- an adaptation theory of well-being built on an automatic habituation model where the constant stream of life’s stimuli fade into the background of one’s life and focus. (e.g. sensory stimuli)
Sizing up and managing psychosocial aspects of patients

Kiyak et al. **longitudinal studies!!**

Two 24 mo. studies of psychosocial components of
1. Orthognathic surgery (N=74)
2. Surgery vs. conventional OR vs. non-treated

**Measured:**
- motives for tx
- oral function
- social adjustment before/after tx
- self-esteem, body image
- extraversion
- locus of control
- * satisfaction of outcome
- * patient's expectations before tx
- * social integration
- * neuroticism and depression (MOOD)

**Kiyak's longitudinal study samples**

Study 1 N = 74 (surgery only) → 24 mos
Study 2 N = 188 → 24 mos > 65% female
Surg = 122 → 24 mos
OR = 33
No Tx = 33

**When measured?**

<table>
<thead>
<tr>
<th>Test</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td>6-12 mos.</td>
<td>1st</td>
<td>2nd</td>
<td></td>
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<tr>
<td>before surg.</td>
<td>1 wk.</td>
<td>1 day</td>
<td>6</td>
<td>9 or 6</td>
<td>24 mos.</td>
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**Subjective Expected Utility (SEU)**

(a theory of decision-making)

- Kiyak developed scale to assess patient motives
- 18 motives - scored on 10 pt. scale
- Tx vs. no Tx - 5 items predicted with 80% accuracy
- Surgery vs. no surgery - 6 items predicted with 67% accuracy

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</tr>
<tr>
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<td>34</td>
<td>Friends</td>
<td>59</td>
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<td>Straight teeth</td>
<td>31</td>
<td>Social stability</td>
<td>44</td>
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<td>Gaining insight</td>
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Kiyak & Bell 1991

Table 3.3: Major motives on treatment decisions

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Subjective Expected Utility

- 18 SEU items on 10-pt scale.
- Patients indicate important
nonimportant motives
ie. pro- or antisurgery or
neutral

What is the SEU for this
patient?

Study of SEU expectancies

- reasons to seek surgery were primarily functional
- reasons to reject surgery and do OR were esthetic

Self-perceptions of facial profiles

Groups did not differ significantly on cephalometrics!
- 75% surgical pts. felt they were protrusive
 or prognathic
- 45% non-surgical pts. felt protrusive or prognathic
Surgical patients - exaggerated negative profiles

Gender differences

Introverted men experienced more
post-operative pain.
Neuroticism in women predicted more
post-operative pain in first days after
surgery.

Response to treatment of
malocclusions

after 24 mos.
* 35% TM pre-tx problems -> post-tx 2%
* 16.7% had pre-tx facial pain -> post-tx 2.4%
@ 9 mos. Despite this:
84% rated very high satisfaction
@ 9 mos. 92% would recommend surgery
to others
Cognitive dissonance? - need to justify experiences?
1. neuroticism => 1. complaints (short-term)

Response to treatment of
malocclusions

Overall satisfaction - slight decline @ 9 mos., but
generally improved significantly.
Self-Esteem @ 24 mos. no sign. diff.; slight decline @ 9
mos.
- started with higher levels of self-worth (ceiling);
different from craniofacial patients
Body Image - same after 1 @ 3 wk after
Profile Image - improved over 24 mos. with slight decline
@ 9 mos.
**Postsurgical Orthodontics**

"The 9-month slump"

Ss who were still in orthodontics @ 9 mos. had:
- decreased overall satisfaction + self-esteem
  "lack of closure"?
- Those with OR bands removed had higher satisfaction.

**Comparing Surgery Ss with OR ONLY and No TX**

Body + facial image

Improved most for surgery pts (24 mos.)
No Tx - declined after 24 mos. - indicates decline in self-image, since they said "No thanks." CAUTION must be observed with such patients!

**Pre Tx Needs and Post Tx Outcomes**

No effect of surgery type, specific motives, or problems with oral function on satisfaction, image or esteem post tx.

Satisfaction decreased by difficulties in eating! (@ 24 mos.) esp. when esthetic changes did not live up to expectations
But not with pain or parasthesia. These were more acceptable.

**Mood changes**

- occurred mostly after surgery; decreased after 4-6 wk.
- depression, tension, anger, confusion were correlated with neuroticism at all periods
- co-varied with greater pain or discomfort (e.g. eating)
  OR subjects only experienced emotional shifts that are at least partially relieved by debanding esp. after 6 mos. Or else had a "less than optimal feeling"
Need to warn patients of these signs and that it is reversible.

**THERAPEUTIC CONVERSATION consulting with ortho patients**

"Think of yourself as a drug of positive expectations!"

Try to inspire confidence

"The doctor is the drug"

Use every opportunity to show acceptance and understanding.
Treatment stages

A. Initial assessment
B. Orthodontic consultation
C. Surgical consultation
D. Presurgical treatment assessment
E. Immediate presurgery
F. Immediate postsurgery
G. Postsurgical orthodontics

Steps in psychologic management for each stage follow

A. Initial assessment

Steps in psychologic management:
1. Interview conducted by “warm & friendly” person
2. Explore motives & expectations for tx. Why tx? Why now?
3. Stay realistic – present broad outline, not specific details before a diagnostic workup, including possible surgery

B. Orthodontic consultation

Steps in psychologic management:
1. Spouse / close friend or family should accompany and all problems and solutions be discussed
2. Discuss self-efficacy “Do you feel you can do what is required?”
3. Judge treatment readiness with patient & parents
4. Identify possible barriers to compliance
5. Plan treatment (i.e. decisions) with patient priorities and abilities in mind; discuss possible conflicts

C. Surgical consultation

Steps in psychologic management:
1. Spouse / close friend or family should accompany and all problems and solutions be discussed
2. Discuss functional and esthetic benefits in that order.
3. Provide more info about the surgical experience – broad
4. Provide patient education materials: brochures, DVDs etc.
5. Discuss financial details and offer to help with insurance authorization procedures

D. Presurgical assessment

1. Evaluate patient’s personality characteristics and psychological stability; esp. depression and major life current events that affect planning.
2. Assess coping style - the way a person deals with perceived or real problems
Advanced consultation tips
- evaluating patients for factors other than need or motivation

Coping

Coping Styles and Outcomes

Research shows:
1. “Vigilant Copers” - expected more problems and had them!
   - nervous / low mood = decreased satisfaction
2. “Avoidant Copers” - expected fewer problems and had fewer!

The Hedonic Treadmill

“Good and bad events temporarily affect happiness, but people quickly adapt back to a “hedonic neutrality.”
- an adaptation theory of well-being built on an automatic habituation model where the constant stream of life's stimuli fade into the background of one's life and focus. (e.g. sensory stimuli)

E. Immediate presurgery

1. Review planned surgery in amount of detail that patient personality can handle and that promotes good outcome.
2. Discuss with family members, if necessary, the psychologic and emotional support necessary.
F. Immediate postsurgery
1. Expect some short period of mood swings and negative emotions (esp. for the vigilant coper).
2. A postsurgical telephone call or visit is often a good idea.

G. Postsurgical follow-up
1. Vigilant and older patients usually require more emotional support.
2. Avoidant copers and older patients most often need reminders about oral hygiene or other self-care activities.
3. If healing is going poorly, redouble efforts with questions about motivation and provide relevant information.

Review of tips on therapeutic conversations & consulting with ortho patients
“Think of yourself as a drug of positive expectations!”

Try to inspire confidence:

Use every opportunity to show acceptance and understanding.

Tips for Therapeutic Conversations (review)
(Physically)
1. Eye contact at same level, esp. preTx assessment
2. No physical barriers
3. Consultations away from the clinic

Tips for Therapeutic Conversations (review)
(Psychologically)
1. Have patient describe "the situation"
2. Repeat patient's last words.
3. Don't know what to say? PAUSE!! Let the patient think.
4. How to end pauses: "Any particular thoughts you have?"
more tips....

5. Tend not to answer questions of advice.
   Rather, ask: "What do you think about it?"
6. Activate patient to find answers.
7. Repeat and summarize often

Rounding out & Questions

Extras

**TIPS - improving clinical ethnography**

- Questions are good answers; precision
- Think of yourself as medicine
- Share your own personal experiences
- Give info! Use devices.
- Be an observant patient!

TAK!!