Psychological Considerations in Maxillofacial Prosthesis – A Review

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ABSTRACT

BACKGROUND

The theoretical and analytical work of these authors help identify the variables that the dentist must consider. There is, however, no comprehensive structure that would bring together the various aspects of psychological awareness that are most relevant to patients undergoing maxillofacial prosthetics.

Important psychological factors are involved when disease, injury, or treatment causes significant maxillofacial changes. The assessment of the patient’s behavior is important for the success of the treatment. It helps in understanding whether the said treatment can be carried out effectively or understood and appreciated by the patient once it is completed. [1] The result for a successful treatment outcome depends upon the prosthodontist making a correct diagnosis and looking out for problems beyond the field of dentistry alone. This is even more important while dealing with patients having orofacial defects as the maxillofacial region is of utmost importance during one’s early development. The oral cavity of the infants is one of the most prominent regions due to most of the developmental changes that occur in early life because of which Freud and other scientists named the first year of life as the “oral stage”. [2]

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DOI: 10.14260/jemds/2022/117

How to Cite This Article:
DOI: 10.14260/jemds/2022/117

Submission 20-04-2020,
Peer Review 11-03-2022,
Acceptance 17-03-2022,
Published 26-04-2022.

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Commonly used classification to classify the mental status of patients is not of much relevance to those patients with debilitating diseases or those who have come out of traumatic events. Also, those patients whose faces are different and/or those who have lost crucial functions of life such as speech or swallowing may be faced with difficulty in social acceptance, which affects their mental psyche. This further brings down their morale and zest for life pulling away from normalcy.

Under such circumstances, the patient might keep unachievable expectations from the prosthodontist which further affects his performance. In such cases, the prosthodontist must decide whether the treatment is to be continued at that point in time or delayed. Also whether the treatment can be carried out with help of professionals from other fields like social workers and psychologists.

The goal of a prosthodontist is a fruitful treatment result, at the same time keeping in mind the emotional and mental well being of the patient as well as of the staff. There must be a decisive devoir to the treatment goals by both doctor and the patient. Therefore, it is of preeminent importance that the prosthodontist understands the different psychological diagnoses, for the success of the treatment.

Disturbances in a person's thoughts, feelings, or actions are described as psychological differences. These differences can range from minor irritation to severe impairment in a person's ability to work as an individual, in a family, or a group.

30 to 40% of people in a given population usually face some sort of a mental illness during their lives as cited in several international surveys. They also show that anxiety disorders are more prevalent than depression. In children and the elderly, the estimate and type of mental illness alter with age and gender. Depression and anxiety occur almost in equal prevalence among girls and boys until mid-adolescence, which is later on led by girls. Among prosthodontic patients, children come mostly with congenital defects or variance in growth and development whereas adolescents and young adults often present with developmental defects or trauma.

Mental illness has gone up in the elderly as the larger proportion of the population surpasses beyond the age of 65. Dementia, accompanied by impaired intellectual functioning and memory loss, occurs mostly among the elderly.

Lower socioeconomic classes have more people affected with mental illness which sharply declines with better education and income. Hence it is of utmost importance that these maxillofacial patients be dealt with proper care and understanding to fit back into society.

Men and women have an almost equal prevalence of mental illness except that men have more antisocial personalities and substance abuse though depression, as well as anxiety disorders, are seen more in women.[1-2]

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**Anxiety Disorders**

These include exorbitant apprehension, worry and fear. The disorders included in this group are obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and generalized anxiety disorder in which people live in constant anxiety about routine circumstances in their lives.

Panic disorder is an anxiety disorder characterised by extreme, exaggerated fear as well as physical symptoms such as tachycardia and dyspnoea.

Panic disorder is usually seen in young adulthood. The risk of women having it is doubled and also seen in those individuals with substance abuse.

Obsessive-Compulsive Disorder (OCD) is a mental health problem in which people have recurring thoughts or images (obsessions) or feel forced to practise those activities (compulsions).

Patients with post-traumatic stress disorder (PTSD) relive traumatic events from their history and experience high levels of anxiety and pain as a result. PTSD does not have any specific predilection for age but women are more prone to get affected by it. This occurs commonly in people who have been to war zones, have faced some kind of violence, accidents, rapes etc. PTSD is usually seen in people with substance abuse and depression.

Women get more affected by social phobia which starts usually at a very young age and can later lead to depression and substance abuse.

**Mood Disorders: Depression and Mania**

These are also called affective disorders, as they disrupt a person's emotional life. Depression is a prominent condition quite often seen after a heart attack, stroke, diabetes and cancer but is treatable, this further worsens the situation of the people by affecting their social skills, sleeping patterns, appetite etc.

Mania, on the other hand, is characterised by an abnormally elevated mood, which is often accompanied by excessive pretension, irritability, agitation, and a disrupted or reduced sleeping pattern.

Bipolar disorder, also known as a manic-depressive syndrome, is characterised by mood swings between mania and depression.

**Schizophrenia and other Psychotic Disorders**

Losing touch with reality is the defining feature of this with both women and men equally affected. Delusions and hallucinations, disorganised thought and expression, bizarre behaviour, a reduced range of emotional responsiveness, and social isolation are all signs of this condition.

**Personality Disorders**

Their perceptions of themselves or others are usually downgraded. They can also exhibit low self-esteem or excessive narcissism, as well as weak impulse control, social difficulties, and inappropriate emotional responses.

**Cognitive and Dissociative Disorders**

Dementia and delirium are cognitive conditions that cause a significant loss of mental control. Memory loss, difficulty listening, abstract thinking, and the ability to recognise objects are all symptoms of dementia.
Such disorders may be caused by a variety of factors, including medical conditions, alcohol misuse, and adverse drug or poisonous substance reactions.

Changes in a person’s consciousness, memories, identity, and perception of the world are all symptoms of dissociative disorders.

Amnesia, dissociative identity disorder, depersonalization disorder, which is characterised by a constant sensation of being disconnected from one’s body or mental functioning, and dissociative exhaustion, which is characterised by a sudden removal from home or work with accompanying memory loss, are among them.

**Somatoform and Fictitious Disorders**
These are usually associated with certain physical symptoms which per se cannot be explained by a medical condition.

It can be accompanied by conversion disorder where the patient sometimes experiences deafness or being dumb which cannot be traced back to any medical condition. When a patient lives in constant fear of contracting some sort of serious illness or misinterprets any symptoms as some major disease is known as Hypochondriasis.

People with factitious disorders make up fake symptoms to gain medical attention.

**Substance-Related Disorders**
These sort of behavioural or addictive disorders are usually due to exposure to toxic substances, drug abuse or side effects of medications.

**Eating Disorders**
These are alterations in eating behaviour most commonly seen in young women. Anorexia nervosa and Bulimia nervosa are two disorders in which individuals are afraid of gaining weight and either may not eat enough or indulge in periods of binge eating accompanied by self-induced vomiting or the use of laxatives, diuretics, or other drugs to avoid weight gain.

**Impulse Control Disorders**
These individuals are unable to control their urges to participate in risky behaviours such as exploding rage, stealing (kleptomania), and so on.

**After this Review of the Common Psychological Impairments, the Psychological Changes in the Maxillofacial Patient are as Follows**
Maxillofacial patients are divided according to the cause of their diagnosis i.e. acquired, congenital and developmental defects.

Ablative cancer surgery or trauma has been performed on patients with acquired maxillofacial defects. Losing normal anatomy or function with a blink of the eye makes both of these groups similar to each other. ‘Why me?’ is a common question asked by cancer survivors due to the trauma they have had to go through as well as the possibility of them going through all this turmoil again.

Patients with larger defects are less demanding compared to patients with smaller defects. The trauma patient is usually younger than the cancer patient, especially when the trauma is self-inflicted. In such cases, their demeanour is relatively upbeat and has a ‘la belle indifference’ demeanour when confronted with the upward struggle of multiple, difficult procedures to restore the patient’s face.

Congenital defect patients understand that they are different from the normal and may believe that they are subpar compared to their circle of interaction. They also understand their chances of passing on their defects to future generations. In such households, there are high chances the parents might blame the children for it and thus lose familial harmony. Such patients may have to undergo several sequential surgeries for near to full recovery.

Anomalies in growth and development may not be visible at first in a developmental defect patient, but they may become noticeable over time. The emotional reactions of developmental defect patients may be similar to those of congenital defect patients, but as the defect becomes evident over time, the patient may or may not learn to cope with the changing situation.

**Loss and Grief in Maxillofacial Defects**
Once patients realize that they have cancer or have experienced any other debilitating crisis creating a loss, they look at it as both a present as well as future loss. This can come out in the form of anxiety, depression or posttraumatic stress disorder. In any event, there is a cycle of loss, grief and reintegration which must be completed by the patient and also understood by the prosthodontist.

Loss is described as a “state of deprivation or being without anything one has and valued” (Peretz 1970). Cancer can cause the loss of a facial feature or any other body part, which can be one of life’s most traumatic experiences. This is difficult because they lose what once held a lot of memories and may even lead to decreased social acceptance including rejection by their respective partners.
The situation may be further aggravated if they fail to bring back the same social interaction they had before.

Loss of a significant person, loss of a part of the self, loss of material objects and developmental loss are the four categories put up by Peretz. Loss can be only be defined by the person who feels the effect. Loss can cause a decrease in one’s self-esteem and even the thought of it is quite depressing.

Grief

**Stages of the Grief Process Include**

Shock and denial: there will be changes in sleep patterns and eating, which are usually symptoms of depression with a higher risk of suicide. They consider their past as an ideal environment.

Guilt, anger, and a search to find ways to discharge emotional pain: there is fear of this new phase that is not familiar which can translate into anger. This may lead to substance abuse to cope with the feeling.

Adjustment, acceptance and growth: This is the ideal stage for the prosthesis to be given as the patient realizes that even the past had its faults and the future may not be as bleak as once visualized and is ready to move forward in life.\(^3\)

A Prosthodontist needs to Empathize with the Patient

Since a prosthodontist would never have gone through the same life-altering grief’s it’s very important to understand how the loss of a loved one or any other major changes might affect oneself which makes it easy to understand the patient as well referral to a psychotherapist. At the same time should also anticipate some kind of response triggered from the patient’s grief.

Grieving is not something that can be rushed, it has to be given an ample amount of time. If the stages are not properly recognized by the prosthodontist, it may lead to further confusion and suffering to the patient.

Grief can cause physical illness, poor judgement, weakened inhibition, clouded intellect, and blurred perception. Patients who experience traumatic losses will always be torn between what is ideal and what they want leading to helplessness.

Grief is so powerful that overcoming it fully is always viewed as distant. Partially recovered grief can also be manifested again with the slightest triggers. Therapy for children in such cases is strongly indicated. Children often grieve openly and can blame themselves for the losses which can follow them into adulthood leading to mental disabilities.

The maxillofacial patient’s standard of life is impacted which exposes him or her to a variety of psychological impairments. Measuring the differences occurring due to the disease process in patients affected by various diseases can be measured by Quality of Life (QOL) surveys.

There are different ways to evaluate the psychological impairment status by psychometric testing like Personality Inventory, Cornell Medical Index, Minnesota Multiphasic, Eysenck Personality Inventory and the Social Adjustment rating scale but the prosthodontist should evaluate by sensing the patient’s vibe – attitude, demeanour, appearance, emotional state, mood, manner of speech, cognitive processes and then make the correct referral.

The disorders told about before can affect the patient to various extents, so it’s very important to understand what stage they are in the process of overcoming the trauma before their referral with the social worker. Listening to their worries and listening to what they haven’t said contribute towards the success of the treatment.

It’s very important to involve the patient’s family and close friends in the treatment as they help the patient in coping with trauma and helping the treatment to become a success.

The treatment should always be centred on and catered to each patient taking into consideration their ethnic background and taking their ideas about the treatment into consideration.

Referral to Mental Health Services

Before referring, the prosthodontist should know whether the patients are ready to accept their deficiencies with their maxillofacial prosthesis and go ahead with referrals. Referrals can be made to the following professionals: social workers who bring together the family as well as the environment of the patient, psychologists who are focused on the individual and psychiatrists who are specialized physicians who can prescribe medication.

Suggestions for the Prosthodontist for Dealing with Patients with Maxillofacial Defects

1. Always look into the emotional part of both the patient and the healthcare worker. The patient’s unwillingness to follow the treatment plan may be caused due to psychological barriers.
2. Be a good listener and listen to both what the patient says and does not say. There can be difficulties that need not be directly put forth by the patients.
3. Always send the patient first to a social worker to evaluate the mental and psychological well being of the patient and always make the referral with direct contact with the social worker.

A traumatic incident can help in improving the patient’s attitude towards life. Loss can help in forming the core of a character. Benefits of adversity to trauma patients include altered life priorities, increased sense of self-efficacy, enhanced sensitivity towards others, improved personal relationships and increased spirituality.

However, maxillofacial patients will find it difficult to see this until they can conjoin a meaning to the adversity. There is a technique of psychotherapy called “Reframing”, where an event is renamed as a positive aspect in accordance with the patient’s ability to face serious issues. Once this is done, the patient can be suggested to think about ways that they have gained from the experience, making the traumatic event they faced seem more understandable and easier to think about. Positive outcomes for maxillofacial treatment can be anticipated at this point because patients have started to see themselves as capable human beings and no more as victims.\(^4\) If the patient is positive towards the treatment and willing to adapt to the demands of the prosthesis with
complete cooperation, the quality of life of patients can be improved.[5-6]

**CONCLUSIONS**

Therefore, if the goal of the health care professionals is to increase the efficiency of function, then following bio-behavioural interdependence is of utmost importance. Identifying this relationship helps in making complete dental health care a reality rather than a hypothetical idea.

**REFERENCES**


