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BULLYING AND MALOCCLUSION: FOOD FOR THOUGHT

Orthodontology

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ABSTRACT

Bullying is a pandemic. Being bullied is still often wrongly considered as a 'normal rite of passage'. As Orthodontists, we come across several adolescent patients who are being bullied on a day to day basis. Malaligned teeth are a big reason for children being bullied. This review summarizes the long term effects of bullying associated with malocclusion and the need for orthodontic treatment felt by the bullied youngsters.

KEYWORDS

INTRODUCTION:

Contemporary orthodontics has increased its spectrum of age in adults but adolescents will consistently establish a significant part of our patients. All things considered, orthodontic treatment can give dramatic dentofacial changes during pubertal growth spurt, which may benefit the orthodontic patients both in esthetics and function ultimately providing psychosocial benefit.

Every orthodontist at some point of time in life confronts a "goofy youngster", who is being tormented at school or society. The guardians who are very eager for orthodontic treatment to be done as an issue of earnestness as they feel this will be the answer to all their kid's issues, however, is this the situation? Is tormenting or bullying straightforwardly related to malocclusion? Assuming this is the case, will rectification of tooth malposition bring about the discontinuance of the tormenting and an improvement in the kid's confidence?

Bullying also known as peer victimization can be defined as "a specific form of aggression with an imbalance of power, whereby a more powerful individual repeatedly and intentionally causes harm to a weaker individual".[1] Peer victimization in youngsters is a pandemic. Tormenting can be done in various ways i.e. direct bullying and indirect bullying. Direct bullying encompasses physical violence and verbal demonstrations of animosity whereas indirect bullying comprises gossip spreading and social rejection. Harassment and exploitation may prompt feelings of loneliness, dejection, and low self-esteem, especially in adolescents. It has been reported that up to 21% of children get bullied.[2] Both girls and boys get bullied. Boys tend to be more presented to direct physical attacks more than girls. The amount of physical bullying decreases with age but social rejection stays inside the child.

A persistently bullied child presents with specific physical and psychological characteristics. Victims tend to stay victims for a long time even if the situation changes. This review summarizes the long term effects of bullying associated with malocclusion and the need for orthodontic treatment felt by the bullied youngsters.

PREVALENCE OF BULLYING:

According to a study done in the UK, 10% of children of age group 8-9 years are harassed multiple times a week whereas 26% of children are harassed sometimes. Within 11–12-year-olds, 15% are bullied 'sometimes or more often' and 2% 'several times a week'.[3] According to Whitney and Smith,[4] 27% of 8-11 year old is 'harassed sometimes' and 10% are harassed once a week. Within 11-16-year-olds, 10% are 'harassed sometimes' and 4% 'harassed at least once a week'. Analitis et al. (2009)[5] investigated the prevalence of bullying among 8-18-year-old students in 11 European countries and reported that 20.6% of the entire sample was being bullied. The UK was found to have the highest prevalence at 29.5%, although in Ireland, an earlier nationwide survey of 8249 students reported the prevalence of bullying as 49.8%. prevalence of bullying can range from 10-60% which means 100 to 600 million youngsters are involved in bullying each year.[6]

IDENTIFYING A BULLIED ADOLESCENT:

As far as physical appearance is concerned bullied youngsters have been reported less attractive than those who are not exposed to tormenting. These adolescents are underconfident and show odd mannerisms.[7] These kids are very anxious all the time and unreliable with low self-esteem.[8] They likewise have depressive inclinations that may endure in adulthood. This may prompt underachievement at studies, the disguise of conduct, and psychosomatic abnormalities.[9] Harassed youngsters start embracing a non-decisive role in social communication. They tend to low less social interaction and show little enthusiasm for the prosperity of others. They usually have no friends and isolate themselves. These characteristics are also influenced by social foundation and parenting.

BULLYING AND DENTOFACIAL CHARACTERISTICS:

Facial and dental appearance has a significant effect on an individual's perception, social class, fame despite the fact this is not well defined in real life. The significance of dental appearance to an individual doesn't appear to be affected by social foundation or training, even though the acknowledgment of dental treatment of "crooked teeth". A significant association has been found between an individual's physical appearance and self-esteem. Dental appearance is on a high priority list for both males and females. Malocclusion endures past youth into adulthood. A milder deviation in facial features may induce teasing which is harmful to the mental health of an individual. As in any social conversation eyes connect with the face it is difficult to always camouflage it.

Dental features are a common target for peer victimization. The more the dental deviation more is the victimization. Ironically, patients undergoing orthodontic treatment have also been bullied. Fixed appliances were found to attract more names and teasing than removable appliances.[10] In a study done by Iyad K-AL Omari et al,[11] a noteworthy connection can be seen between bullying on account of dentofacial features and negative consequences on the quality of life. Their results feature the significance of bullying and give significant information to the society (including the orthodontist and school) to provide an anti-bullying atmosphere to adolescents.

BULLYING AND NEED OF ORTHODONTIC TREATMENT:

Is tormenting or podding in this manner a significant intention in looking for orthodontic treatment? Baldwin DC et al[12] reported that amongst the individuals looking for orthodontic treatment, 15% faced bullying routinely. The primary propelling factor for treatment gives off an impression of being the guardians (and most particularly the mothers) yet the qualities of the kid and his/her relationship with the guardians seem to decide how he/she responds in the treatment setting. The advantages of orthodontics for an improvement in self-perception have been recorded for the adult population. however, in kids, although there is normally an improvement in self-evaluation of dental-facial appeal with orthodontic treatment, it doesn't appear to improve in general self-perception, self-concept, or confidence. Disappointment and victimization were reported more in individuals with outrageous overjets, extraordinary deep bites, and space anomalies, which are simpler to treat in growing children. It has also been reported that children who get orthodontic treatment have higher accomplishment aspirations than those who do not get the treatment.[13] This indicates that status-seeking is a motivation for orthodontic treatment, which is

somehow influenced by financial factors.[14,15,] A youngster's mental profile impacts the treatment demands, as those with high confidence are the first to show up for treatment.[16]

DISCUSSION:

Malocclusion has a role in the child being tormented at school, tenaciously harassed youngster speaks to specific psychological types. Physical appearance plays a role in the formation of the victimized youngsters and this would appear to incorporate facial and dental highlights. Advantages of orthodontic treatment in youngsters are hard to evaluate in psychological terms, however, these advantages become obvious in adulthood, as familiarity of malocclusion increases with age. It is hence plausible that by treating 'goofy' children, we are helping to create psychologically healthier adults.

According to the British Psychological Society in dentistry, 10% of children would have a significant anxiety disorder or behavioral problems.[17] Further work should be done in this territory, however, it is significant that each case is dealt with separately and on its benefits as the mental effect of harassing, whatever the reason, can be destroying for a kid and have enduring impacts.

As orthodontists, we may be the first ones to identify a child being bullied. We should sharpen our knowledge about the problem so that we can help youngsters overcome this. Adequate methodologies ought to be made to address this issue in our first discussion with the guardians and then the kid. If bullying is accounted for, psychological help ought to allude. All things considered, our span as orthodontists in this issue appears to require outrageous duty. We might be the principal medical services experts to approach tormenting reports since it is so personally connected with our strength.

CONCLUSION:

Bullying is a worldwide problem that has been there in society since always. Dentofacial abnormalities have been a major cause of tormenting. These kids need help for overall growth which can improve their quality of life. As health care professionals we must take a step forward and come together to help these youngsters.

REFERENCES

1. Volk AA, Camilleri JA, Dane AV, Marini ZA. Is adolescent bullying an evolutionary adaptation? Aggr Behav. 2012;38:222-38.
2. Boulton MJ, Underwood K. Bully/victim problems among middle school children. Br J Educ Psychol 1992; 62: 73–87.
3. Boulton MJ, Underwood K. Bully/victim problems among middle school children. Br J Educ Psychol 1992; 62: 73–87
4. Whitney I, Smith PK. A survey of the nature and extent of bullying in junior/middle and secondary schools. Educ Res 1993; 35: 3–25
5. ANALITIS, F., VELDERMAN, M. K., RAVENS-SIEBERER, U., DETMAR, S., ERHART, M., HERDMAN, M., BERRA, S., ALONSO, J. & RAJMIL, L. 2009. Being bullied: associated factors in children and adolescents 8 to 18 years old in 11 European countries. Pediatrics, 123, 569-577
6. Volk AA, Camilleri JA, Dane AV, Marini ZA. Is adolescent bullying an evolutionary adaptation? Aggr Behav. 2012;38:222-38.
7. Lowenstein LF. The bullied and non-bullied child. Bull Br Psychol Soc 1978; 31: 316–318
8. Olweus D. Victimisation by peers: antecedents and long-term outcomes. In: Rubin KH, Asendorpf JB eds. Social Withdrawal, Inhibition and Shyness in Childhood. Hillsdale, NJ: Lawrence Erlbaum Associates, 1993; pp.315–341.
9. Schwartz D, Dodge KA, Coie JD. The emergence of chronic peer victimization in boys' play groups. Child Dev 1993; 64: 1755–1772
10. Prove SA, Freer TJ, Taverne AA. Perceptions of orthodontic appliances among grade seven students and their parents. Aust Orthod J 1997; 15: 30–37
11. Al-Omari IK, Al-Bitar ZB, Sonbol HN, Al-Ahmad HT, Cunningham SJ, Al-Omiri M. Impact of bullying due to dentofacial features on oral health-related quality of life. Am J Orthod Dentofacial Orthop. 2014;146(6):734-739. doi:10.1016/j.ajodo.2014.08.011
12. Baldwin DC, Barnes ML. Psychosocial factors motivating orthodontic treatment. IADR 1965; 44: Abstract 461.
13. Hilzenrath SS, Baldwin DC. Achievement motivation – a factor in seeking orthodontic treatment. IADR 1970; 49: Abstract 433.
14. Linn EL. Social meanings of dental appearance. J Health Hum Behav 1966; 7: 289–295.
15. Stricker G. Psychological issues pertaining to malocclusion. Am J Orthod 1970; 58: 276–283
16. Birkeland K, Boe OE, Wisth PJ. Relationship between occlusion and satisfaction with dental appearance in orthodontically treated and untreated groups. A longitudinal study. Eur J Orthod 2000; 22: 509–518
17. Lindsay S. A guide to purchasers of clinical psychology services. Briefing paper no.11: Clinical Psychology in Dentistry. Leicester: Division of Clinical Psychology, The British Psychological Society, 1996; p.4.