



Do We Need House in the House?

Prosthodontics has evolved from complete denture fabrication to a fascinating mix of extensive, eclectic, expensive, and invasive evidence-based interventions. Yet, it appears that in certain teaching and practice jurisdictions, Koper's Birds and the House Classification are regarded as essential guides for patient evaluation.

Koper's lecture on "denturus calamitous americanus" provided a witty overview of problem denture patients,¹ while House's unpublished classification was first described in Payne's chapter in Sharry's text, and referenced as "unpublished notes of study club no. 1."² Regrettably, neither effort has been validated by substantive clinical trials and both are exclusively denture-wearing related. Classification systems should be reliable and valid so that they offer the same result each time, as well as relevance to the clinical environment.

Denture-wearing patients have been simplistically, indeed almost dismissively, classified as typical, difficult, and maladaptive, without any scientific regard to their correct psychologic status. This approach has now led to so-called "typical" patients becoming "difficult" ones given the context of a decrease in complete denture curriculum time in predoctoral dental education. On the other hand, difficult and truly maladaptive patients (those who simply cannot tolerate wearing a denture) are now candidates for implant therapy with excellent prognoses. Psychologically impaired patients (whose emotional problems transcend dental management) are now requesting implant therapy and risk creating the same adverse doctor-patient problems often described in the complete denture literature.

Ideally, we would like to be able to evaluate our new patients to determine if they are treatable in our environment and, if possible, to prognosticate their psychologic response to long-term prosthodontic therapy.

There are currently three major classification systems in use by psychiatrists and psychologists:

1. The Diagnostic and Statistical Manual of Mental Disorders, ed 4 (DSM-IV), which has five axes resulting in 13 major disorder categories with 157 disorder names with codes
2. The International Statistical Classification of Diseases and Related Health Problems (ICD), which has 304 disorder codes
3. The Neuroticism-Extroversion-Openness (NEO) Personality Inventory, which is a measure of five major domains of personality that may be overlapping

The revised DSM-V has created extensive controversy well before its publication (due in spring 2013).^{3,4}

Still, with all of the possible diagnostic codes available, Personality Disorder—Not Otherwise Specified, which is a blanket label for "this patient has problems," is currently the most common diagnosis in the personality category.³

While the NEO Personality Inventory, currently in vogue with psychologists, appears the most user friendly, it is not possible given the time available in a typical advanced education program in prosthodontics to attempt to duplicate a PhD psychology program, where candidates are taught not only how to diagnose but also how to treat the psychologic illness. Also, will a defined mental disorder alter the clinician's treatment plan or only the interaction with the patient and/or the enactment of the plan? And, what about any potential legal ramifications? We are advised in risk management courses in New York State not to put a psychologic diagnosis in our charts since we are not licensed to make one.

The relationship between a mental health therapist and a patient is termed "the working alliance," and there is evidence that a strong alliance—when a patient feels comfortable and has a sense of common goals or purpose with the therapist and a sense of safety and trust in the process—predicts better outcomes in therapy. Intuitively, we know this also exists in dentistry, since it has been shown that a patient's evaluation of a clinician was a factor influencing pretreatment expectations and posttreatment satisfaction.⁵

While prosthodontic education provides the intellectual foundation to determine the most efficacious treatment choices and the clinical abilities to provide those treatments, the necessary skills to manage the broad spectrum of personality types encountered in private practice are lacking. It therefore becomes

difficult to determine which patients may not be treatable because of either the patient's or prosthodontist's psychologic issues.

While it is important to have students observe a faculty member in the dental school environment, where the dynamic is a triad of patient-student-faculty rather than the less than ideal private practice dyad of patient-clinician, dental schools remain sheltered environments where the "ugliness" of the dysfunctional patient-student relationship is resolved by faculty, clinic managers, etc, along with frequent institutional culling of such patients. There is also less concern for economic impact, colleague or patient referral implications, and/or adverse internet postings.

The so-called expert opinion of faculty is also problematic. Senior faculty, most of whom have little or no formal training in the psychologic management of patients, have learned how to deal with patients via the trial and error technique. In addition, patients self-select their practitioners, a referral filter bias, and end up in an environment where they have an acceptable comfort zone. So the techniques of Dr G may work well in that environment while the techniques of Dr Y may work well in another. However, it remains doubtful whether Dr G's techniques will necessarily work well on Dr Y's patients or vice versa.

Management of patients needing extensive prosthodontic care is predicated on a close, trusting doctor-patient relationship. The more successful the relationship, the more successful is the treatment outcome. While this is common knowledge, we still do have not have the proper tools to guide us in evaluating the psychologic status of each patient and are best served by using a strategy of universal precaution: treating patients with empathy and concern as if they were an emerging psychologic problem and trying to avoid any interpersonal animosity. While we health professionals know this, part of continuing personal growth is to explore why, despite this knowledge, we

often break these rules. Understanding ourselves and what our trigger points are is integral to the creation of a working alliance with our patients.

We should be teaching critical thinking not dogma. Unfortunately, we have little science to support what we do when pairing psychology and prosthodontics. Medicine has recognized that patient management is adversely affected by communication problems between doctor and patient and that the clinical interpersonal skills necessary to minimize these problems can and should be taught.⁶ What is needed is substantive dental research that will guide us in developing courses to train faculty to teach students how to identify the problem and domains along with the methods to diagnose and deal with them, how their own personalities impact their reactions, and strategies to minimize and/or resolve the risk of escalation in potentially adverse doctor-patient interactions.

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