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“One step at a time”: Analysing Young Patients’ Video Diaries in an Ethnographic Tracing of Fixed Appliances

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Abstract

The present article examines children’s and young people’s experiences of receiving state-financed orthodontic treatment. Using video diaries and follow-up interviews, the aim is to explore how fixed appliances act on patients’ bodies and social life. The combination of methods reveals complex experiences. The main narrative, primarily found in the interviews, presents a vision of an improved bite that patients and orthodontists share. In the video diaries, a parallel narrative of extended bodily hardship is revealed. Owing to the step-by-step process where appliances are gradually tightened, the young patients manage to bear the treatment. However, they cannot foresee its extension.

Introduction

Mathilda and I were sitting on a sofa in a resting place at the orthodontic clinic. Mathilda, who was 15, had kept a video diary over her first weeks with fixed appliances and just arrived for an interview. While she was searching her bag for the camera, I asked how the days had been: “Totally problem-free actually,” she answered happily. While interviewing Mathilda and watching her video diary, however, I found that her statements included somewhat contradictory aspects of having braces. Mathilda, like most of the other young patients I interviewed, was satisfied and happy to start the treatment. They wanted to “fix” their teeth, get rid of problems they had with their bite, or just get a nicer smile. Mathilda’s direct answer was a presentation of her feelings “here and now,” when the worst days of treatment were over. When we looked through her video films, I found out about the many hardships the fixed appliances prescribed to her – a period that few would call problem-free. The video films the young patients’ produced, together with the stories they told during the interviews, revealed their contrasting and complex experiences of the long-term treatment, which was delegated to the appliances at their home.

Children’s and young people’s experiences of receiving medical treatment and managing illness conditions have been of interest to medical anthropologists and medical sociologists since the 1960s (e.g., Mattingly, 2010). Orthodontics differs from the studied practices, in that

it does not concern chronic diseases or acute processes and thus it is not strictly necessary. The most common reasons for orthodontic treatment concern dentists', parents' or children's dissatisfaction with the esthetics of the bite (SBU, 2005). Consequently, the legal and ethical aspects of orthodontics are similar to some of the aspects associated with the medico-legal complications of treating children, but also to some of the risks associated with elective cosmetic procedures carried out on adults (Lewis, 2011; p. 139). Clinicians' responsibility is far-reaching and includes addressing the child's concerns, providing the child with sufficient information, ensuring that the child understands the information and is able to make his/her own decision, and finally, using the alternative the child has chosen in the definitive treatment plan (Gill and Naini, 2011). Given these specific conditions, research on children's responses to treatment is of great importance. Previous research has dealt with the physical, social and psychological effects of orthodontic treatment, and how pain and discomfort affect these aspects (e.g., Jawad, 2011). Little attention, however, has been paid to how children and young people carry the treatment through and how they find meaning in their work on their bodies.

Against this background, the larger project on which the present article is based involves participant observations and video observations at two orthodontic clinics (approved by the Regional Ethical Review Board, Reg. No. 2013/317-31). The observations focus on the multistage process preceding possible treatment and patients' video diaries on the first year of treatment with fixed appliances. Concentrating on the interaction between orthodontists and the patients, the project aims to study how norms concerning the bite and the teeth are "done" in practice (Wickström, 2016). The specific aim of the present article is to explore how young people experience orthodontic treatment in the long run. What do the fixed appliances prescribe to the patients' bodies and social life? How do the patients manage the treatment? The analysis presented below is based on young patients' video diaries and the follow-up interviews at the clinic. The vision of an improved bite, which the patients and the orthodontists share, constitutes the ground for the narrative of the treatment that the young patients wish to convey and hold on to. However, in the video diaries, a parallel message of bodily hardship is expressed and a more complex understanding of the treatment is made possible.

State-financed orthodontics in Sweden

Dental service is financed by the Swedish state for children and young people up to 20 years of age, the aim being to create equal conditions for children and young people to have good

occlusal development. Orthodontics emphasizes function as well as appearances, but in today's orthodontics esthetic arguments have come to dominate both supply and demand (Exley, 2009). Among Swedish adolescents, more than one in four undergo state-financed orthodontic treatment. Having one's teeth "fixed" means improving the bite, but it is also an indication of one's health identity and that one is taking care of oneself.

Fixed appliances are used to move the teeth to better positions. The appliances work more on bones than on teeth; the bony tissue is moved (SBU, 2005). The pressure applied by the appliances leads to regression of the surrounding bony tissue on the side of the pressure. At the same time, new bone is formed on the side to which the teeth are being pulled. Removal of teeth causes inflammation in the tissues surrounding the teeth, which may cause pain and soreness during different phases of the treatment. The pain starts four hours after the fixed appliances have been put in place. It increases for up to 24 hours and then decreases successively up to the seventh day (SBU, 2005). The inflammation provides good conditions for moving the teeth and should not be treated with anti-inflammatory medication. Instead patients can take paracetamol.

Almost all treated individuals show an inflammatory root resorption owing to teeth movement (Darendeliler and Cheng 2011; p. 117). Even if a reparative process commences when the force is reduced, approximately 20 percent of patients show decomposition of the roots of the teeth. But the most common problem is that patients' teeth may relapse after completion of treatment. It is recommended that patients use retainers after the active treatment period. Scientific research is insufficient concerning the long-term consequences of the complications, as well as concerning long-term satisfaction and durability (SBU, 2005).

A sociocultural approach to the study of children in medicine

The research field of particular relevance to the present article is the sociocultural study of the human body, the approach suggested by Chris Shilling (2003). The relationship between the body and society is conceptualized as reciprocal and symbiotic. Concerning studies of childhood and children's bodies, sociocultural studies of the body enable observation of the materiality, practices and social processes involved in producing bodies (Prout, 2005).

Offers of medical treatment present children and young people with an official discourse of health, which includes social norms for what it means to take care of one's body. Regular controls of the body and the institutions children are referred to impact on how they

understand the capacities, appearances and meanings associated with their bodies (Shilling, 2008).

In an ethnographic study of dentistry, Sarah Nettleton (1992) draws on Foucault's notion of power, called a "strategic relation," which is exercised "at the level of the technologies or practices of social institutions" (p. 114). It is not a question of discipline exercised by dentists individually or as a group, but concerns activities and routines at the clinic and in daily life, such as eating, washing and sleeping (Foucault, 1979). In his last book, Foucault (1986) describes discipline as the way in which people learn to care for the self; they should be self-aware, self-reflective and enjoy cultivating the self (p. 68). In orthodontics, social norms in combination with the clinical processes of visualizing divergences and improvements of the bite constitute an incentive to desire a better and nicer bite (Wickström, 2016). The material representations of the bite function as the cognitive infrastructure for the orthodontic work, coordinate action and trigger a desire for an ideal bite: the exceptional normal.

Alan Prout (2005) argues for a balanced representation of children's possibility to act. Children are limited by the circumstances under which they live, but they also manage, negotiate and extend their possibilities. They have to come to terms with the institutional contexts in which their bodies are weighed, measured and given meaning. Through their creativity, children can use their participation in societal institutions as resources for work on their identity. In order to study children's creativity, sociocultural researchers must observe what children do. Examining the work done on children's bodies must also include material organization (Prout, 1996). The task for researchers of children and childhood in relation to medicine is to trace the materials, practices and social processes implicated in the production of bodies.

Tracing orthodontic technology and children's experiences

Moving out from the local sites, traditionally in focus for ethnography, makes it possible to examine circulation of cultural meaning, objects, and identities in time-space (Marcus 1995; p. 96). Marcus use the concept of Strategically Situated Ethnography and argue that everyday actions within a single site constitute a sensed awareness of other specific sites and agents to which subjects have relationships. Young patients' experiences are related to clinical practice and materiality, but also to families and peers. Inspired by Marcus, I made a research design in which I could examine the subjects as well as broader aspects of their treatment. I followed the patients at the clinic while they traced the treatment process for me at their homes by

producing video diaries, thus expanding the ethnographic field. After the examination and planning of treatment, the fixed appliance was put in place in the patient's mouth. From that point on, the orthodontic work was to some extent delegated to the appliances. The patient's daily life had to be arranged for handling the appliance and its side effects, and the parents were sometimes involved in supporting their child.

In 2014, two orthodontists assisted me in recruiting young patients to keep video diaries for three periods during the course of a year (1-2 weeks each time), starting on the very day they got their braces. Five girls and one boy from 13 to 17 years old agreed to join the study, by their parents' consent. They delivered a total of 59 films after the first period. After half a year, keeping video diaries was met with some resistance, and even more resistance after a year. During the second period, four of the six patients delivered 10 films. During the last period, three patients delivered 9 films. The result confirms the difficulties involved in using video diaries in research with young patients (cf. Yates, 2010). However, the participants (all but one) wanted to be interviewed instead. Moreover, their disinclination caused me to develop the method.

Some of the participants not only shared their private "diary notes", but also gave me admittance to a brother or a sister, to school and discussions with friends – a kind of fieldwork I could not have managed myself. 14-year-old Hanna delivered films in which she talked into the camera, but also in which she was interviewed by her sister or discussed the treatment with a school friend going through the same process. Encouraged by Hanna, I gave all of the participants suggestions about different ways of keeping video diaries.

After each of the three video diary periods I conducted individual follow-up interviews. I had a set of questions in mind but the films and what the participants had been through were the main focus for the interviews. An interview lasted approximately half an hour and I did 19 in total. In the interviews, the participants gave another version of the films – as they looked back on what had happened. The combination of methods helped in tracing the network of orthodontics.

The video diaries and the follow-up interviews presumed specific ethical considerations. Because the research concerned sensitive personal issues, I considered ethics to be part of the entire research process (cf. Quennerstedt and others, 2014). I constantly observed the participants' reactions and the interviews turned out to alternately involve looking at all the diary notes, only at the beginning of every film, or not looking at all. Observing the reactions

and asking the participants now and then about their attitudes toward what we were doing was indispensable. Tracing the treatment with fixed appliances revealed three themes representing how the patients found their way through the treatment and negotiated the challenges and hardships they faced: “understanding the extent of treatment over time,” “self-governing” and “prescriptions extended in time and space.”

Understanding the extent of treatment over time

To create an improved bite, the orthodontic clinic acts on children’s bodies using the appliances. Much effort is needed on the part of the orthodontists and assistants to carry out this work. The child and to some extent the parents have to be allies, and the three-stage process at the clinic is intended to motivate them. At the last stage, the information session, the orthodontist describes the treatment plans in detail and emphasizes how the patient, and sometimes the parents, must work at home. However, being given information does not guarantee that the patient understands what is going to happen. Maria, who is 17 years old, finds it difficult to know what is going to happen. “I didn’t really know what they were going to do. They take it like one step at a time.” The following account from the field is an example of the difficulties patients have in grasping the consequences of treatment, despite all the information.

Ellen is 10 years old and considered to be in very great need of treatment, due to her underbite. She is supposed to have braces for most of her youth. In the following, the orthodontist, Ellen and her mother are sitting in front of the computer discussing the treatment and how to use a removable appliance at home. The conversation reveals that, even now at the last stage, the mother realizes more about the work involved.

Orthodontist: I would like to make an appliance that looks like this (she holds a so-called petite masque, see illustration Figure 1). Then you get like a pull forward of all the upper jaw. You use it in the afternoons at home and definitely every night. What you get then is that you grow (shows with her hands forward) and you grow in breadth. Because Mom and Dad will help you to screw on this appliance so that you stimulate the growth, so that you set it bigger and bigger and bigger every day.

Ellen: Is it difficult to breathe when you have it?

Orthodontist: No it's not, it is a bit difficult to know where to put your tongue [...] so in the beginning it will make you a bit angry.

Orthodontist: (turns to the mother) But you have to be prepared to do a lot of pepping during the first week.

Mother: Mm [...]

Orthodontist: As a parent you almost always think 'My god will this work, will she manage to sleep with this.' And actually it works much, much better than you might think.

Gradually Ellen's mother gets a picture of the extended treatment and the work involved. Listening to the orthodontist, she seems to question the whole idea of treatment.

Illustration. Petite masque. © Billy Sand.

Ellen is supposed to put on the petite masque as soon as she comes home from school and to wear it in the afternoons and at night. Orthodontic specialists report: "If a removable appliance is worn less than 4 to 6 hours per day, it will produce no orthodontic effects" (Proffit and others, 2013; p. 283). The appliance does the work, but at the same time it prescribes work for Ellen and her parents. It makes play difficult. The upgrading of the petite masque may cause pain. The appliance will do the work only if Ellen takes it on and if the

parents screw on the appliances as they are told. Another phase in delegating the work to the appliances is for the orthodontists to motivate the children and young people to control and govern themselves.

Self-governing

An important step in information provision at the clinic is to sign a treatment agreement where the patient and the parent accept the conditions: the timetable, the risks and instructions for taking care of the devices. The responsibility is handed over to the patient and the parents. The routine of informing about the treatment and the strategic relation entailed in signing the agreement suggest discipline in the Foucauldian sense (1986). The expectations placed on the young patients and their expectations of themselves are to “care for the self” and assume responsibility for the treatment.

The most important aspect of “assuming responsibility” is to avoid the risk of possible treatment side effects: caries and tooth loss. The orthodontists and assistants inculcate the need to avoid sweets and soft drinks, as well as to carefully brush and clean the teeth in specific ways. They train the patients and distribute special toothbrushes for the purpose. In the following, John, 17, is asked to change his habits so that the treatment can be successful:

Orthodontist: Absolutely the biggest risk with fixed appliances is that you don't get it totally clean, but also that you eat too much sugar and such things, which will lead to leaching. The teeth become discolored, you get caries, such things. You have to stop that. This is the only demand.

John: Can't I have soft drinks at all?

Orthodontist: I think that we should say no to soft drinks with sugar, everything with sugar so to speak. You can allow yourself to have it on specific occasions but not during the week. [...] You really want this to be functionally good and esthetically nice for you, and then it's wrong to drink lots of sugar.

John worries most of all about having to change his eating and drinking habits. After a while, however, some of the patients told me that they found the dietary warnings exaggerated and started behaving almost like they had before with regard to eating. For example, Mathilda says: “It sounds like a tough job - I do not follow the rules exactly.” Julia, 13, eats what she wants and it works, she says. The orthodontists and assistants know that the patients modify the rules or get tired of treatment. To help the patients to endure, the orthodontists and

assistants encourage them to return to the clinic within a short time if the appliances need maintenance work. Victor, a 14-year-old boy, says that he was allowed to come within two or three hours when he phoned. But Maria complained about getting access or getting an appointment very early in the morning.

The patients are also encouraged to work hard with the process of moving the teeth. When John and his mother came to receive information from the orthodontist, John explained that he wanted to be done with the appliances before completing his high school certificate examination. The orthodontist explained how John could contribute:

Orthodontist: You have to work with the elastics day and night, perhaps for nine months. If you can make it work, then perhaps you needn't have these bigger hinges. You may perhaps get it straight quite quickly. One and a half years if you make this work optimally. You can influence some aspects of this yourself, so it works as smoothly as possible.

To some extent, the patients *may* work varyingly hard. This involves, e.g., putting on new elastics after each and every meal or snack, as John is asked to do, or using removable appliances on a regular basis, as was the case with Ellen. With regard to other aspects, however, working hard may not help. The propensity of boney tissue to change in the preferred direction depends on individual conditions. The patients cannot do much more than *hope* to avoid complications and that the teeth will move as planned and according to the time schedule. In the last interview I had with Victor, who had delivered many video films and talked positively about having braces, he related a story of disappointment. What he had thought was the last semester with fixed appliances had been prolonged by one year:

Victor: It's pretty hard really. I'd rather take it out now. It would have been nice to get it out. I have had it one year now. But now this is how it is and you can't back out.

Victor had been warned by the orthodontist that the treatment might be prolonged, but still the news made him disappointed and tired. However, he saw no way out, except to take the next step, but stated that he did not regret starting the treatment. Victor's feeling of no return is interesting here, as are Ellen's mother's hesitations. The multistage process at the clinic includes considerable time for information, and the orthodontists work to understand patients' priorities and to build trust with the patient and the parents (cf. Proffit and others, 2013; p. 150). However, there are non-articulated and non-foreseeable aspects involved, and the

process works to make the patients accept the plans or to carry on with what has already started. Despite all the efforts made to involve the patient and the parents in the decisions, they reach new points at which they realize there is no going back. The step-by-step process makes the treatment possible.

Prescriptions extended in time and space

During the interviews, I asked how the last week had been. I often got answers like Mathilda's, referred to in the introduction: "totally problem-free actually". Listening to the video diary and discussing it with the patients provided a more complex picture.

Technological devices affect the users' bodies and create certain behaviors (Fox, 2012; p. 190). The video diaries demonstrate the effects on the patients' bodies and the patients' strategies for dealing with them. Some of the side effects were non-cyclic, extending over the entire treatment period, while a cyclic process started every time the appliance was upgraded.

The non-cyclic prescriptions affected the patients' bodies to various degrees. For some, the bonded brackets and the arch wires created oral ulceration. One experience they all shared was that food got stuck in the appliances. Some of the patients involved friends in checking their braces for food scraps after every meal or snack. Julia said it was difficult to know where to put the removable elastics when eating lunch at school, and Victor found the appliances a hindrance during sports activities. The appliances also prescribed regulation of eating and cleaning habits. To protect the wires from strain and the teeth from caries, the patients had to avoid some of their favorite food and drinks. Julia complained about having difficulties speaking and feeling stiffness in her jaws. Finally, the patients worried about their appearance. "I look like I have a pile of scrap metal in my mouth," said Hanna.

On day six, Mathilda talked into the camera about pain: "The wire was too long. There was quite a big sore on the inside of my cheek, but I took a pair of tweezers and adjusted the wire." She managed the braces herself and did not have to visit the clinic. Still, the problem tormented her at night. She complained about not being able to lie on her side because then the braces pressed against the sores. After one month, Mathilda produced her last film, where she pointed out another avoidable prescription, that of having to carefully clean one's teeth and take care of the appliances. Mathilda told about the work she had to do in the evening: "I'd rather sleep. But then it can be a tough job to have to brush your teeth carefully and with two different toothbrushes." She complains, but her next comment shows that she is committed to continue: "Actually, I think I will buy a third toothbrush, a very small one this

weekend so I can brush between my teeth.” Mathilda is dedicated to taking care of her teeth during treatment.

The data reveals how the effects of the treatment stretch out in time, over days and years, as well as in space, at home and school. Sensations, changing appearances, and sometimes an unpleasant odor occupy space and time. Not surprisingly, the mouth comes to the forefront and other parts of the body recede into the background. The phenomenological concepts *disappearance* and *dys-appearance* are useful here (Leder, 1990). Ordinary functioning means that the body disappears from one’s attention. When one is in pain, on the other hand, a specific body part or the whole body dys-appears. The body becomes an obstacle to continuing with one’s usual routines and projects. The affected person is pulled back to the here and now, and the spatial as well as temporal sphere is constricted (Leder, 1990). The young patients reported spending a great deal of time and energy on handling the prescriptions and the side effects. Their bodies responded, indicating that progress was being made. When it was “going well” they felt pain. Like feeling stiff after exercising. When there was no pain, they were relieved, but they also wondered if anything was happening, if any work was being done. The patients also reported that the appliances made them eat better food and take better care of their teeth than they had before. Above all, the patients were willing to invest in an improved bite and nicer smile.

After the first week of pain, sores and speaking difficulties, the mouth and the appliances felt rather normal to the patients. Increasingly, the focus on the mouth disappeared. However, the fixed appliances soon had to be upgraded to move the bones and consequently the teeth further. The recurrent upgrading created a cyclic process of pain and difficulties for the patients. The assistant or the orthodontist did the upgrading at the clinic by attaching a thicker wire or shortening the existing wire. At home, Ellen’s parents did the work and gave the petite masque another screw. When the appliances were upgraded, the teeth and the jaws dys-appeared for the patient again. The inflamed tissues around the teeth, a precondition for moving teeth, caused pain and soreness and made it difficult to chew. Some patients reported not having been able to eat for days or even weeks and that they had been hungry and tired. On day eight, however, Mathilda registered in her video diary that “today has been a good braces-day”. This is in line with orthodontic theory, according to which inflammation and pain decrease after the first week (SBU, 2005).

In the end, however, the range of the treatment is again enlarged. In orthodontics a number of factors can lead to relapse (Littlewood, 2011; p. 348). To counteract these tendencies,

retainers are needed after the active treatment period. According to Littlewood (2011; p. 350), patients who do not wish to risk any relapse are “advised to continue wearing retainers for as long as they wish to maintain straight teeth”. Some of the young patients in the study were advised to use retainers for the rest of their life to minimize chances of relapse. But even if the retainer made the mouth dys-appear somewhat again, treatment in the non-active phase disappeared for others, because retainers are hidden, which the patients experienced as a relief.

The overall aim of orthodontic treatment is to spare children and young people from problems with the bite or the teeth and from feelings of shame. When Ellen first came to the orthodontic clinic, she was ashamed of her underbite. The medical examination transformed the appearances of her bite into divergences in need of long-term treatment (Wickström, 2016). The treatment aimed at making her proud of her bite and satisfied with herself. Interesting here is that, for some of the patients, the feeling of relief started long before the teeth were moved, actually on the very day they got braces. Friends encouraged them by saying that the braces looked good on them. Anna, 17, told me that she could finally smile on her school picture because she now looked nice in her braces. The braces acted as accessories and became part of the young patients’ health identity. At the clinic, they were offered a choice of colored rubber bands for the brackets, with a maximum of three colors at a time. They chose their favorite color or the colors of their football team, turning the fixed appliances into an attribute of their interests. John, on the contrary, wished to hide the appliances as much as possible and argued with his mother about paying more for transparent and invisible ceramic brackets. Caring for one’s outward appearance by concealing or turning the fixed appliances into a piece of art can be seen as the young patients’ strategies for avoiding the side effects and focusing on their identity.

Discussion

Children and young people who are offered state-financed orthodontic treatment are privileged. Resources are invested in their bite and teeth, and they are given the opportunity, at an early age, to solve functional problems or make their smile nicer. The specific legal and ethical responsibilities placed on orthodontists result in activities that involve the patient and the parents in the decisions. Nevertheless, the patients are part of social processes in an institution that impacts their understandings of oral health and the meaning of the appearance of their teeth (Wickström, 2016). Moreover, their ability to understand the extent of the treatment they have agreed to is limited.

According to Fox (2012), all medical technology works on the body and establishes a health identity in the patient. Body technologies spare bodies from their physical limitations, or in the case of orthodontics, from identified “divergences” from a specified norm. But technologies also put new limits on the body (Fox, 2012). The video diaries show how the delegation of treatment to the appliances at home requires time, space and work. The orthodontists try to motivate the patients to assume responsibility and work hard. The appliance as a device cannot itself determine when it is time to be tightened. Thus, the treatment includes regular upgrading by the orthodontists. The patients are guided and accompanied one step at a time.

Extending the treatment over time is a precondition for the technology. The ability of the teeth to move and then remain in their new positions requires a slow process. The step-by-step process allows patients to endure the treatment and have breaks. Progressing gradually also enables patients to go on with their ordinary life without too much difficulty. On the other hand, the extension of the treatment and the drawn-out management make it impossible for patients, and to some extent for orthodontists, to know the whole picture from the beginning. The young patients cannot understand the consequences of the extended work or the extent of the maintenance work. Still the treatment requires long-term commitment. The treatment is not phased out quickly and terminating it in advance is difficult.

The strength of the present study is its combination of methods, which has made it possible to show the complexity of treating children and young people. The analysis shows that the patients and orthodontists share a vision of the meaning of an improved bite and smile, a vision they are eager to convey. During treatment, the young patients need to maintain that vision. However, in the video diaries a parallel picture is conveyed. Thus, two narratives are present in the young people’s stories: a narrative of ‘much longed-for and successful change’ and one of ‘enduring incalculable side effects and tightening of treatment.’ It is not the case that one narrative is truer than the other. Rather, the two narratives show the complex experiences of being targeted by, and of participating in, activities and routines in institutions that are working to improve children’s and young people’s health. The longing for change is related to social norms and to the activities in the clinic, where orthodontic norms in relation to the mouth are enacted. Both kinds of norms are related to beauty ideals (Wickström, 2016). The narrative of enduring refers to how the patients come to understand, a little at a time, the side effects of the treatment, and are guided step-by-step into the next phase. When the worst week has passed, the narrative can shift. Children and young people are willing to work hard

and temporarily submit to extended bodily hardships to invest in their bodies, hopefully find strength in a better-looking bite and create better opportunities for themselves.

The young patients also give the braces new meanings. They negotiate the restrictions and try to act like normal, or even enjoy the situation. Some “brighten up” the braces or turn them into accessories, which makes them feel more secure and less ashamed when they smile. In the long run, the patients’ attitudes toward the braces help to make the braces more acceptable in society which is a relief to the patients. At the same time, the changed attitudes together with the improved technical knowledge change the norms for the teeth and increase the request for orthodontic treatment from parents and young people (Wickström, 2016). Thus, the present project does not only contribute to a better understanding of the relief as well as the burdens that orthodontic treatment means to the young patients. It may also spur discussions about how dentistry should deal with increased demands from patients and parents, as well as acknowledge and handle dentistry’s own roll in that increase.

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