M. M. House mental classification revisited: Intersection of particular patient types and particular dentist's needs

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Fifty-three years ago, M. M. House devised a classification of patients on the basis of how they behaved in response to the prospect of becoming edentulous and on how they subsequently adapted to wearing complete dentures. Although House's system was an important contribution, it failed to consider the dentist's emotional reaction to a patient's behavior as part of an understanding of how the patient and doctor cope with the dental treatment. This article presents an expansion of the House classification to include the behavior of the dentist as a codeterminer of the patient's behavior. This expanded classification system is based on empiricism and awaits scientific validation or clinical application to determine its ultimate validity, reliability, and effectiveness. (J Prosthet Dent 2003;89:297-302.)

Sixty years ago, the American Association of Dental Schools (now the American Dental Educators Association) first suggested that behavioral aspects of dentistry deserved attention within dental school curricula.[1] Since then, many psychiatrists, psychologists, and psychologically minded dentists have contributed to the body of knowledge about how people react to the experience of being a dental patient.[2-5] Publications have ranged from empirical observations of experienced clinicians, to theoretical musings of psychoanalysts, to formal studies conducted by research psychologists.

In 1950, Dr M. M. House,[6] whose contributions advanced the science and art of prosthodontics, devised a classification system on the basis of patients' psychological responses to becoming edentulous and adapting to dentures. Relying strictly on his clinical impressions, House[6] classified patients into 4 types: philosophical mind, exacting mind, hysterical mind, and indifferent mind.

Philosophical mind

These patients anticipate the need for treatment with complete dentures and are willing to rely on the dentist's advice for diagnosis and treatment. Philosophical patients will follow the dentist's advice when advised to replace their dentures.

Exacting mind

Exacting-mind patients are usually in poor health and need a great deal of treatment, but they are unwilling to accommodate suggestions from the dentist or physician to extract hopeless teeth and become denture wearers. Exacting-mind patients also doubt the dentist's ability to make dentures that would satisfy their esthetic and functional needs. Often, the exacting-mind patient demands extraordinary efforts and guarantees of treatment outcome at no additional cost.

Hysterical mind

These patients are neglectful of their oral health, dentophobic, and unwilling to try to adapt to wearing dentures. Although these patients may try to wear dentures, they often fail to use the prosthesis because they expect it to look and function like natural teeth.

Indifferent mind

Indifferent patients tend not to care about their self image and are not motivated to enjoy eating. They have managed to survive without wearing dentures.

Patients with an exacting mind, hysterical mind, or indifferent mind respond to the prospect of becoming edentulous and the experience of wearing dentures in less than ideal ways. House's[6] classification was designed to help clinicians anticipate a variety of patient responses when faced with specific clinical procedures. The classification system is relatively simple, which is its strength and its weakness.

Following in House's path, O'Shea et al[7] and Winkler[8] described ideal dental patients. O'Shea et al[7] characterized the ideal dental patient as compliant, sophisticated, and responsive. Winkler[8] described 4 traits that characterize the ideal patient's response: (1) realizes the need for the prosthetic treatment, (2) wants the prosthesis, (3) accepts the prosthesis, and (4) attempts to use

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the prosthesis. This patient corresponds to House's philosophical-mind patient.

The literature on the dentist/patient relationship has focused directly on the needs of the patient. Winkler[8] discussed the need to fit oneself to the personality of the patient. Koper[9] characterized and typed patients who have difficulty in adapting to complete dentures as problem patients, difficult denture patients, or difficult denture birds. Jamieson[10] stated that "fitting the personality of the aged patient is often more difficult than fitting the denture to the mouth."

Other authors have also suggested that more than technical competence is needed to forge a patient dentist alliance and that interpersonal aspects of the relationship also require attention. Friedman et al[4] noted the significance of the dentist/patient alliance. He wrote that the clinician has the power to make a significant change in the patient's life. To cross over to adaptability, the patient must have a partnership with the clinician. The feelings that will emerge may be either positive or negative, depending on the clinician's behavior and attitude. The tone of that relationship will become the feelings toward the denture. If the clinician has not forged a trusting relationship with the patient, the denture will be contaminated. However, if a positive relationship develops, the patient accepts both the prosthesis and the clinician.

Krochack,[11] recognizing the critical need to understand the behavior of the dental patient, stated that many patients with favorable anatomy cannot tolerate a well-fabricated denture and yet other patients with unfavorable anatomy willingly endure dentures that may be ill-fitting. He asserted that the inconsistencies of patient adaptation in these situations may be related to the patient's psychological state.

When behavioral scientists began to evaluate dentistry from their perspective, Jackson[1] noted their surprise at the dental profession's inexperience in the area of human behavior. He further stated that the challenge in teaching behavioral science is to significantly impact the clinician to alter his/her interpersonal relationships. Although most dentists agree that communication is important, they tend to believe that it is an innate part of their personality or common sense.

Although dentists may concede the importance of behavioral skills, these skills are rarely placed at the same level of importance as the dentist's technical abilities. However, a study that attempted to determine what patients considered important in a dentist demonstrated that patients place communication (feeling fully informed) and a sense of being understood of equal importance with the technical competency of the dentist.[12]

Kent[13] demonstrated that use of dental services correlated positively to patient satisfaction. The ability of a dentist to determine when a patient has unrealistic expectations and the ability to manage that interaction effectively may avert a conflict.

WHY THE HOUSE CLASSIFICATION REQUIRES REEVALUATION

Among the reasons that the House classification requires reevaluation is that some of the terminology is antiquated, falling out of use, or no longer carries the same meaning within psychiatry. For instance, the word hysterical has come to be regarded as derogatory and judgmental. Although the term has a historical place within psychoanalysis (hysterics served as the original psychoanalytic patients), given House's description of the type today one might speak more of a narcissistic patient.

Another more important reason for reevaluation is that the House classification pertains to the patient in isolation. House provided little attention to how the patient's reactions and behaviors are codetermined by the treatment and behavior of the dentist. As part of a presentation of intersubjectivity theory within the psychoanalytic literature, Stolorow and Atwood[14] critiqued the idea that a patient can be viewed in isolation from the effect of the psychoanalyst. They called this a mistaken notion and an example of "the myth of the isolated mind." Thus the patient's behavior is codetermined by the personality and behavior of the psychoanalyst. The thesis is that it is important to pay close attention to how the observer affects the observed.[15] This interaction is a logical extension of ecological concepts that developed in the late 1960s and 1970s that emphasized mutual interaction of cause and effect. To understand the patient's behavior, therefore, the clinician's personality, subjective responses, and reactions must be considered as contributing factors.

Few articles have been published that focus on the needs of the dentist. Although dentists may believe they are beyond discussing wishes and needs other than those considered purely professional, the dentist may experience wishes to be liked and admired, to be heard and respected as an authority, and to feel in control of the situation. Each of these wishes exists along a continuum. The wish to be liked and admired can become a need to be idealized (placed on a pedestal), the wish to be heard and respected as an authority can become a need to have one's words be taken as gospel, and the wish to feel in control can become a need to dominate.

The purpose of this article is to build on House's contribution to include an understanding that the practitioner's psychology, along with that of the patient, determines how well the dentist adapts to the patient's needs. The proposed new classification includes both the patient and the dentist as codeterminers of treatment outcomes, regardless of whether the patient is edentulous or dentate.

FACTORS AFFECTING THE DENTIST/PATIENT RELATIONSHIP

The authors propose that the relationship between the behavior and reactions of the patient and those of the dentist are determined by the following factors: (1) the patient's ability to adapt to patienthood (the role of the patient), (2) the dentist's response to the patient's adaptation to patienthood, (3) the patient's tendency to unconsciously react to the dentist as if the dentist were someone from the patient's earlier life (transference), (4) the dentist's tendency to unconsciously react to the patient as if the patient were someone from the dentist's earlier life (countertransference), and (5) other nonspecific factors.

Patients vary in their levels of submission to recommendations from the dentist and procedures performed and in their levels of trust for the dentist. This, in turn, may trigger emotional reactions in dentists. It is difficult if not impossible for dentists not to react emotionally to patients who constantly challenge their authority by questioning and doubting whatever recommendations the dentist offers. These reactions may not be apparent to the patient. However, some patients may sense the dentist's frustration, irritation, or impatience, no matter how hard the dentist tries to disguise his/her feelings. Other types of patients who adopt a submissive stance regarding treatment or who seem indifferent toward and unappreciative of the dentist's efforts may likewise create feelings in the dentist. These, in turn, may trigger additional feelings in the dental patient. When the doctor/patient relationship has developed, it may become impossible to say who is reacting to whom, much like a cause-effect cycle in the chicken-and-egg analogy.

Transference is defined as experiencing feelings, drives, attitudes, fantasies, and defenses toward a person in the present that are not entirely appropriate, as they may come to be understood as a repetition of how one had experienced someone from past. The process by which an individual adapts to the role of dental patient can, under certain circumstances, be determined by transference reactions to the authority of the dentist. The similarity of the parent-child role to the dentist/patient role can provoke a patient to regress and to react as if the dentist were that patient's parent. Regardless of whether the patient's parents helped that patient cope with the dependency of childhood can affect all subsequent relationships that individual has with authority figures.

Dentists can play one of several roles in the dentist/patient relationship: (1) a parent who demands unquestioning, even submissive, obedience; (2) a parent who wishes to be pleased, and when pleased will reward the child with praise, approval, and love; (3) a parent who is covertly defied, even frustrated; and (4) a parent with whom one anticipates having a cooperative partnership in which each player satisfies the requirements of their particular role.

Often, the dental patient finds something in the dentist's behavior on which to hang the transference. Accordingly, the transference-based reaction does not seem completely off-base to the patient. The dentist's traits and behaviors can therefore cause emotional reactions in the patient that revive and resemble unresolved relationships from the past. For example, the patient may react to the dentist as an authoritarian who demands unquestioning submission as the patient's parents did.

Additionally, dental patients may react to the needs that the dentist brings to the situation. Just as parents look to their children to satisfy a host of narcissistic (self-centered) needs, dentists look to their patients for the same satisfaction.

Although some people may be inclined to think only in terms of patients' transference reactions to the dentist, dentists react with transference as well. For example, the patient can remind the dentist of someone from the dentist's past toward whom the dentist still has strong feelings, either positive or negative. These feelings may affect the treatment provided by the dentist.

Unconscious transference reactions by the dentist may include an emotional reaction toward another person or previous situation that affects the present relationship with the patient. In many instances, the dentist's emotional reactions to a patient may be repressed. Inevitably, when patients are particularly frustrating or difficult for the dentist, transferential feelings may break through and determine the dentist's behavior toward the patient. In turn, if the patient becomes unconsciously aware that the dentist is overreacting to some aspect of the patient's behavior, the patient may react unconsciously to the dentist's behavior.

Because professionalism dictates that dentists maintain emotional control to avoid negative impact on treatment, dentists may contend that any emotional reaction toward a patient constitutes unprofessional behavior. This attitude is unrealistic because it creates false expectations. Furthermore, it blinds dentists to subtle and perhaps unconscious ways in which they may be reacting to patients.

PROPOSED CLASSIFICATION

Individual adaptation to the role of patient

The proposed classification is based on 2 factors: (1) the level and quality of the engagement or involvement of the patient toward the dentist (including such issues as domination, submission, and idealization and devaluation of the dentist) and (2) the level of willingness to submit (trust) to the dentist. The ideal patient stance, which is most likely to lead to the best treatment outcome, is a reasonable amount (versus an excessive amount) of engagement and willingness to submit

Table I. Behavioral profile of patients

Patient type	Engagement	Willingness to submit (trust)
Ideal	+++: "I see you as a professional who is in a position to help me, and willingly, I accept you in that capacity."	+++: "What you say makes sense, but there are some questions I'd appreciate being answered."
Submitter	++++: "You are the best dentist I've ever had. No, you are the best dentist around. I admire you, idealize you, and think of you in the most glowing terms."	++++: "You know everything and will never make an error. Therefore I will submit to whatever you suggest without question."
Reluctant	++: "Please don't take this personally, but I just don't think you, or any other dentist, is going to be able to help me.	++: "It isn't you I distrust, but my destiny. Nothing ever works out in my life. Therefore I will reluctantly follow your instructions, but I doubt this will work."
Indifferent	+: "I wouldn't even give you a second thought."	+: "You are a dentist like any dentist, what does it matter whom I see. I will listen and follow instructions, I guess, for now.
Resistant	++++: "You authority-types are all the same. You expect us patients to just accept what you say. If you think I'm one of those types of patients, you are sadly mistaken. Prepare to be challenged!"	+: "You've got to be crazy if you think I'm going to do just what you say. I need to grill you to determine that you are not a charlatan!"

(trust). The level of patient engagement with the dentist and treatment process exists along a continuum from completely overinvolved (++++) to disengaged (+). The level of the patient's willingness to submit (trust) also exists along a continuum from willingness to submit to the dentist's recommendations without a second thought (++++) to intense reluctance to do anything the dentist recommends (+).

Behavioral profiles of patients

Table I summarizes 5 patient types: ideal, submitter, reluctant, indifferent, and resistant. Each type is characterized by a rating on engagement and willingness to submit (trust) and by the stance the patient types are likely to take in reaction to being a dental patient.

The ideal patient, which corresponds to House's philosophical mind, is reasonably engaged (+++) and reasonably willing to submit (trust) (+++) to the dentist. This type of patient is not ranked ++++ in either category, because these patients are considered mature with a healthy life balance. They are not vulnerable to regression or excessive dependence on authority figures. Therefore they are not prone to fixate on and be overly absorbed with their particular dental treatment. They have worked through whatever childhood conflicts and animosities they held for authority figures. Furthermore, the ideal patient has a healthy level of distrust. Any reasonable patient should have some skepticism; they should permit themselves to have questions and doubts. Patients deserve explanations for professional dental recommendations to understand the situation and arrive at a final decision regarding treatment. Therefore the ideal patient tends to be neither overly suspicious nor blindly accepting of the dentist's recommendations.

The submitter patient rates ++++ on engagement and ++++ on willingness to submit (trust). Such patients lack discrimination and tend to idealize the dentist, which results in a high degree of engagement and utter surrender. This renders the submitter incapable of providing genuine informed consent because he/she has surrendered the use of critical faculties and therefore cannot be an active partner in the treatment.

The reluctant patient rates ++ on engagement and ++ on willingness to submit (trust). He/she is often leery of the dentist and skeptical of the treatment plan.

The indifferent patient, who corresponds to House's indifferent mind, rates + on engagement and + on willingness to submit (trust). Usually coerced into seeing the dentist by a concerned family member or friend, the indifferent patient is minimally engaged and indifferent to the dentist to the extent that willingness to submit (trust) is not an issue.

Finally, there is the resistant patient. This patient corresponds to House's exacting mind and Boucher's critical patient. Resistant patients are skeptical of the dentist as a person and of being helped by anyone under any circumstance. The resistant patient is, paradoxically, very engaged with the dentist but in an adversarial way. Rather than being dependent, they challenge the dentist. And, like the indifferent patient, there is no trust.

To understand the description of each of the 5 patient types, it is necessary to know the differences among patient types in level of shared responsibility between the patient and the dentist. The best treatment outcome will result with patients who possess House's philosophical mind (ideal patient), who rate +++ on engagement and +++ on willingness to submit (trust). These patients recognize their responsibility, along with the dentist's, as an active partner in the treatment. The ideal patient asks questions, complies without total submission, and challenges the dentist if something does not seem right.

Table II. Intersection of particular patient types and particular dentist's needs

Patient type	Need to be idealized	Need to have the dentist's word taken as gospel	Need to dominate
Ideal	The dentist may be offended by the patient's reasonable attitude that falls short of the dentist's need to be idealized.	The dentist may be offended by the patient's attitude that falls short of the dentist's need for unquestioning acceptance of his/her recommendations.	The dentist may be less than enthused by the patient's wish to be treated as a partner in the process.
Submitter	The dentist may be flattered and potentially seduced into providing treatment aimed at perpetuating the idealization.	The dentist may feel highly respected, but the patient's unquestioning acceptance of the dentist's word means the patient is not exercising his/her responsibility to be a partner in the process.	The dentist may judge these patients as ideal, insofar as they submit to the dentist's domination.
Reluctant	The dentist may either feel offended by the patient's attitude or the dentist may feel challenged by the patient's pessimistic expectations.	The dentist may feel either offended by the patient's attitude or challenged by the patient's pessimistic expectations.	The dentist may win over the patient's confidence or he/she may become frustrated at the patient's continuous failure to comply.
Indifferent	The dentist may feel offended by the patient's disengaged attitude, taking it as a personal failure.	The dentist may feel frustrated when the patient remains disengaged, treating the dentist's recommendations with disregard.	The dentist may feel irritated with an uninvolved patient and may disengage.
Resistant	The dentist may become angry or disappointed with a patient who persistently distrusts. The dentist may compromise the treatment in an effort to please the patient.	The dentist may feel disrespected and may invite the patient to turn elsewhere for help.	The dentist-patient relationship may become irresolvably confrontational as each tries to gain the upper hand.

This sense of shared responsibility does not exist in the other types of patients defined in this article. The submitter, reluctant, and indifferent patients do not get involved as active partners in the treatment. The resistant patient, although actively involved, will neither allow a cooperative relationship or share responsibility with the dentist.

Dentist/patient conjunctions and disjunctions

Table II summarizes the 5 patient types in relation to 3 types of dentist's needs: (1) to be liked and admired, (2) to be heard and respected, and (3) to feel in control. When considering what both dentist and patient bring to the clinical setting, it becomes clear how the interaction affects the ultimate treatment outcome. A conjunction of needs or traits occurs when a dentist's personality and needs are well suited to a given patient's engagement and willingness to submit (trust). If the dentist's personality and needs are poorly suited to a given patient's profile, however, it is referred to as a disjunction. A better understanding of what may occur between the patient and dentist may come from studying conjunctive and disjunctive interactions from a behavioral perspective.

Consider the dominating and controlling dentist an example of a disjunctive interaction. The dominating dentist is an effective match with the submitter patient, who is willing to totally submit and relinquish authority. However, the dominating dentist will get into a control battle with a resistant patient. A resistant patient will also create problems for a dentist who wants approval and acceptance to such an extent that the dentist may compromise the treatment in pursuit of winning the patient's love. A dentist who seeks approval and acceptance can also encounter difficulties with the submitter patient because, sensing that the dentist enjoys being idealized, this type of patient may initially idealize the dentist only to become vastly disappointed and angry should problems develop during the treatment. Such an evolution of feelings can lead the patient to pursue legal action against the dentist.

SUMMARY

This article proposes a new classification system built on House's original mental classification. With contemporary terminology, the new classification system considers the role of the dentist, as well as the role of the patient. The value of this new classification is its effectiveness when applied in a clinical environment. If clinicians find the system instructive and helpful in understanding relationships with patients, then it is worthwhile even if it remains scientifically unproven.

The authors encourage studies to evaluate the validity, reliability, and effectiveness of this classification.

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