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Original Research Article

Patient Satisfaction and Perceived Outcomes After Orthodontic Treatment: A Cross-Sectional Study

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ABSTRACT

Background: Orthodontics has gone beyond the correction of malocclusion and the goals of treatment include improvement of oral function, facial esthetics, psychological health, and quality of life. Assessing patient-reported outcomes is therefore vital to gain insight into the overall effect of treatment, not just the clinical data. The objective of this study was to evaluate patient satisfaction and perceived aesthetic, functional, and psychosocial outcomes after fixed orthodontic treatment.

Methods: This cross-sectional descriptive study used questionnaires to collect data from 120 patients (aged 14 years or older) who had fixed orthodontic treatment 6 to 12 months prior. A structured and validated questionnaire was used to gather data on treatment motivation, perceived changes in dental appearance, functional outcomes, psychological well-being, and overall satisfaction, all of which were sent via Google Forms.

Results: Most participants (90.8%) reported a perceived improvement in tooth alignment, which was the most frequently reported positive outcome. 88% reported increased confidence in smiling, and 85% reported a perceived improvement in oral hygiene.

Conclusion: Most participants reported high satisfaction and favorable perceived aesthetic, functional, and psychosocial outcomes after fixed orthodontic treatment.

Keywords: Orthodontics, Patient satisfaction, Fixed orthodontic treatment, Psychosocial well-being.

BACKGROUND

The aim of orthodontic treatment has come a long way from just focusing on malocclusion and occlusal harmony to a more holistic approach to patient needs, including those pertaining to psychosocial and quality-of-life factors [1]. Depending on the extent the occlusion may be malformed, it may hinder the ability to chew and to speak properly. It is reported that there is a strong association between dental appearance and oral health-related quality of life (OHRQoL) [2]. Researchers have shown that malocclusion causes a significant psychological

discomfort and social withdrawal and that many patients seek orthodontic treatment not necessarily for functional correction, but rather for better self-image and social confidence [3]. Patient-reported outcome measures (PROMs) have been introduced into orthodontic research, giving a more holistic picture of the success of treatment [4]. These findings have since been confirmed by subsequent systematic reviews which have documented measurable improvements in OHRQoL as a result of orthodontics by adolescents who have undergone treatment before 18 years of age and improvements in emotional and social dimensions of OHRQoL across all measures after treatment [5].

Qualitative research also suggests that appearance and social acceptance are important factors influencing both adolescents' choices of undergoing fixed-appliance treatment and the process of making that decision [6]. Patient-centered motivators emphasize the importance of addressing the perspectives of patients and delivering customized, compassionate treatment from an orthodontist. A prospective study showed that orthodontic treatment had a significant impact on the psychosocial and functional life of adolescents [7]. Patients' self-image, as well as their interpersonal relationships and communication skills were improved. While there have been some studies showing that ortho treatment has beneficial effects on psychological outcomes, self-confidence, and social function, there are limited data available for rural populations, though there is great literature from academic and urban populations [8].

Hence the present study was conducted to evaluate the satisfaction and quality of life of the fixed orthodontic treatment patients in North Karnataka region.

MATERIALS AND METHODS

Study design and setting

This cross-sectional, questionnaire-based study included 120 patients who had completed fixed orthodontic treatment within the previous 6 to 12 months. Participants were recruited from the Department of Orthodontics and Dentofacial Orthopedics across dental institutions in North Karnataka. The study was conducted and reported in accordance with the STROBE guidelines for observational studies.

Ethical considerations

The study protocol was reviewed and approved by the Institutional Ethics Committee (IEC), Al-Badar Rural Dental College & Hospital, Karnataka (Approval No.: ARDH/2024-2025/EC/1-13). The procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation and with the Declaration of Helsinki. Written informed consent was obtained from all participants prior to enrollment (assent, together with guardian consent, was obtained for participants below the age of majority), and the confidentiality of participant data was maintained throughout.

Selection and description of participants

Inclusion criteria: patients aged 14 years and above; completion of fixed orthodontic treatment; and a post-treatment period of 6 to 12 months.

Exclusion criteria: craniofacial anomalies or syndromes; incomplete orthodontic treatment; and psychological or cognitive impairments affecting questionnaire responses.

Data collection instrument

Data were collected using a structured questionnaire developed for the study and administered through Google Forms. The questionnaire recorded information on treatment motivation, treatment duration, functional outcomes, psychosocial changes, and overall satisfaction, and comprised the following ten items:

1. What was the primary reason for seeking orthodontic treatment?
2. What was the total treatment duration?
3. Did you notice a change in tooth alignment?
4. Did you experience pain or discomfort during treatment?
5. Did you feel more confident in smiling post-treatment?
6. Did you observe an improvement in oral hygiene?
7. Did you experience difficulty in chewing post-treatment?
8. Did you experience difficulty in speech or talking post-treatment?
9. Did you feel an improvement in mental well-being?
10. Rate your overall satisfaction with the orthodontic treatment.

Statistical analysis

Responses were compiled and analyzed using descriptive statistics. Categorical variables were expressed as frequencies and percentages, and the continuous variable (age) as mean ± standard deviation. Data were analyzed using IBM SPSS Statistics version 24.

RESULTS

All 120 participants had completed fixed orthodontic treatment 6–12 months before questionnaire

administration. The results are listed below by the 10 themes covering the treatment motivation, the duration of treatment, the perceived clinical changes, discomfort experienced during the treatment and a variety of aesthetic, functional, and psychosocial outcomes. A frequency table (Tables 1–10) are provided for each theme. Percentages are based on the total sample and due to rounding may not add to 100%.

Presented in Table 1 is the chief complaint for the patients seeking orthodontic treatment. The most common reason, reported by 54 respondents (45%), was malaligned teeth followed by enhancing the smile in 38 respondents (32%). Combined these two aesthetic and functional issues made up just over three-fourths of the sample (92 out of 120; 77%). For another 18 patients (15%) peer or family pressure was their biggest motivation, and difficulty chewing was the smallest, with only 10 patients (8%). The distribution suggests that the choice to treat was mostly based on appearance rather than on a clear functional impairment, as more than 60% of participants had chosen to take treatment because they perceived it was needed.

Table 1: Primary reason for seeking treatment

Reason	Frequency	Percentage
Malaligned teeth	54	45%
Smile enhancement	38	32%
Chewing difficulty	10	8%
Peer / family pressure	18	15%

N = 120.

The average duration of active treatment is shown in Table 2. Most respondents (53, 44%) reported a treatment length of 12-18 months, with 36 (30%) reporting 18-24 months of treatment. Twenty-two patients (18%) reported a shorter course of 8–12 months and prolonged treatment (more than 24 months) was rare, with only 9 patients (8%) reporting this. There were extended treatment times, although nearly three-quarters of the patients (75 of 120; 62.5%) completed treatment within 18 months, and the vast majority (111 of 120; 92%) finished treatment within 24 months.

Table 2: Treatment duration

Duration	Frequency	Percentage
8–12 months	22	18%
12–18 months	53	44%
18–24 months	36	30%
More than 24 months	9	8%

N = 120.

Patients' perceptions of changes in tooth alignment are presented in Table 3. Most participants (109; 90.8%) reported an improvement in tooth alignment after treatment, while 6 (5.0%) reported no improvement and 5 (4.2%) were unsure.

Table 3: Perceived change in tooth alignment

Response	Frequency	Percentage
Yes	109	90.8%
No	6	5%
Maybe	5	4.2 %

N = 120.

Table 4 provide details of the intensity of pain/discomfort experienced during treatment. The vast majority of the patients experienced some level of pain; just 17 (14%) patients reported having no pain at all. The most common experiences were mild discomfort (43 patients, 36%), followed by moderate discomfort (36 patients, 30%). 20% (24) reported severe pain. Overall, 79 participants (65.8%) reported mild or moderate discomfort during treatment, while 24 (20.0%) reported severe pain.

Table 4: Pain or discomfort during treatment

Level	Frequency	Percentage
No pain	17	14%
Mild	43	36%
Moderate	36	30%
Severe	24	20%

N = 120.

Table 5 show the level of patient confidence to smile following treatment. The majority were confident, 106 (88%) answered "Yes." 7 respondents (6%) reported that the situation did not improve and 7 (6%) were not sure (equal small proportions). This marked increase in confidence with regard to a smile is reflected in the high level of improvement in tooth alignment reported in Table 3, this finding indicates a favorable perceived aesthetic and psychosocial outcome.

Table 5: Improved confidence in smiling

Response	Frequency	Percentage
Yes	106	88%
No	7	6%
Maybe	7	6%

N = 120.

Table 6 show the patients' perceptions of improvement in oral health after treatment. Most participants (102; 85%) reported a perceived improvement in oral hygiene after treatment, whereas 12 (10%) reported no improvement and 6 (5%) were unsure.

Table 6: Improvement in oral hygiene

Response	Frequency	Percentage
Yes	102	85%
No	12	10%
Maybe	6	5%

N = 120.

The chewing difficulties that remained after treatment are summarized in Table 7. Most participants (90; 75%) reported no difficulty chewing after treatment, while 18 (15%) reported difficulty and 12 (10%) were unsure.

Table 7: Chewing difficulty post-treatment

Response	Frequency	Percentage
Yes	18	15%
No	90	75%
Maybe	12	10%

N = 120.

Table 8 present post treatment speech difficulty. Most participants (94; 78%) reported no speech difficulty after treatment, while 14 (12%) reported speech difficulty and 12 (10%) were unsure.

Table 8: Speech difficulty post-treatment

Response	Frequency	Percentage
Yes	14	12%
No	94	78%
Maybe	12	10%

N = 120.

Table 9 show the effect of treatment on mental wellbeing. Most participants (98; 82%) reported an improvement in mental well-being, while 12 (10%) reported no improvement and 10 (8%) were unsure.

Table 9: Improvement in mental well-being

Response	Frequency	Percentage
Yes	98	82%
No	12	10%
Maybe	10	8%

N = 120.

Overall satisfaction with orthodontic treatment

The overall satisfaction (1-5 Very poor to Excellent) is reported in Table 10. They were very satisfied; 46 respondents (38%) gave the rating of good (4) and 55 (46%) rated excellent (5). Overall, 101 participants (84.2%) rated their satisfaction as good or excellent, whereas 19 (15.8%) rated their satisfaction as moderate, poor, or very poor.. The high score at the positive end of the scale in table 10 reflects the high level of satisfaction with orthodontic treatment as reported in all other tables (Tables 1-9) and highlights the high level of satisfaction of the large majority of patients with their orthodontic treatment.

Table 10: Overall satisfaction with orthodontic treatment

Rating	Frequency	Percentage
1 (Very poor)	2	2%
2 (Poor)	5	4%
3 (Moderate)	12	10%
4 (Good)	46	38%
5 (Excellent)	55	46%

N = 120.

The primary reasons for seeking treatment were malaligned teeth and smile enhancement (Table 1). Most participants reported treatment durations of 18 months or less (Table 2). A perceived improvement in tooth alignment was reported by 109 participants (90.8%), while 6 (5.0%) reported no improvement and 5 (4.2%) were unsure (Table 3). Mild or moderate discomfort was reported by 79 participants (65.8%) (Table 4). Favorable perceived aesthetic and psychosocial outcomes were reported, with 106 participants (88%) reporting increased confidence in smiling and 98 (82%) reporting improved mental well-being (Tables 5 and 9). In addition, 102 participants (85%) reported a perceived improvement in oral hygiene (Table 6). Most participants reported no difficulty with chewing (75%) or speech (78%) after treatment (Tables 7 and 8). Overall, 101 participants (84.2%) rated their satisfaction as good or excellent (Table 10).

DISCUSSION

Predominance of esthetic motivation in the current study agrees with the study carried out by Felemban OM et al. [9] which revealed that patients' motivations for orthodontic treatment were largely esthetic, with functional motivations ranking second. The importance of appearance can be explained in a wider psychosocial framework of the modern society and the role of facial and dental attractiveness in the perception of the self and communication with the others. Having a well-aligned dentition is often correlated with attractiveness, health, confidence and social competence. This means that a person could choose to get orthodontic treatment even if malocclusion is not causing significant function or an impairment. The findings of this study also showed that the association between the esthetic motivation and the previous studies were similar, which means that esthetic motivation is not limited to a very urbanized or high

economic status population. Although socioeconomic status, access to dental care and health literacy were different, the motivations exhibited by rural patients in this study were similar to those found in urban populations. It could be because people have more information about orthodontic treatment via social media, digital media, and greater awareness of oral care.

Longitudinal evidence also showed that satisfaction with dental appearance is related to occlusal outcomes and that it is usually enhanced after orthodontic therapy, which further highlights the role of dental appearance [10]. Given that the enhancement in the appearance may be one of the key mechanisms that leads to the overall psychosocial benefits of orthodontic treatment, it is important to understand its implications. Correction of malalignment may also lead to increased confidence for patients who were not satisfied with their smile to begin with. This enhancement can then impact communication, smiling behavior, social interaction, and emotional health. Therefore, psychological aspects of orthodontic treatment and the psychological effects of orthodontic treatment may be closely related; esthetic dissatisfaction may be the initiating factor and a good-looking smile may be the psychological reward after orthodontic treatment.

As for the duration of treatment, most of the respondents in the present study were treated between 12-18 months (44%), and 30% were treated for 18-24 months. The treatment times are similar to the reported time for comprehensive orthodontics treatment. Many factors affect the time spent in treating malocclusion, such as the degree and nature of the malocclusion, the surgical requirements, growth status of the patient, appliance system, patient co-operation, biological response to orthodontic forces, and the treatment objectives set by the orthodontist. The present study did not specifically analyze the association between treatment duration and overall satisfaction. In the present findings, although there were indications that the more treatment length is extended, the more patients will be burdened and uncomfortable, and the higher the treatment costs. Unlike Reichert A et al. [11] who found that those who were treated for shorter durations were more satisfied. This difference could be due to patient expectations, treatment complexity, the type of appliance employed, differences in demographic characteristics, and relative importance placed on the treatment outcomes. When patients believe the treatment is progressing and ultimately will give them esthetic and functional results they are looking for, they may be willing to endure a longer treatment time. So, it is important to remember that treatment time may not be enough to determine patient satisfaction.

Another important finding of the present study was the high proportion of participants who perceived their orthodontic treatment as effective. About 91% of the patients indicated that they saw the alignment of their teeth improving after undergoing orthodontic treatment. A high proportion suggests that most patients felt the therapy had made a real difference to them and they felt better at the end of the treatment compared with the main reason they had sought therapy. Notably, the high proportions of participants reporting improved tooth alignment and improved mental well-being indicate favorable perceived aesthetic and psychosocial outcomes. This discovery calls attention to the need to not assess only by clinical factors, such as overjet, overbite, alignment and occlusal association, when determining the success of orthodontic treatment. Patient-reported outcomes are additional measures of the impact of treatment on the patient's life and satisfaction. Systematic reviews have also found that the use of fixed labial orthodontic appliances normally results in high satisfaction rates from the patients and increased self-confidence in their oral health [12]. Since these results are similar, the achievement of orthodontic correction may have objective and subjective effects on health and appearance.

In the present study, pain and discomfort were seen as significant issues when considering treatment. About 36% of them said they had mild pain while 30% had moderate discomfort while undergoing orthodontic treatment. Orthodontic pain has been well documented and believed to be due to compression of the periodontal ligament, inflammatory reactions, and remodeling of the adjacent alveolar bone after application of orthodontic forces. This discomfort is usually short-lived but may make it difficult to eat, chew, sleep, brush teeth and maintain a healthy lifestyle. The findings are similar to those of Chen M et al. [13] who noted that the quality of oral health was adversely impacted during the initial stages of orthodontic care. The treatment period, therefore, can be a very delicate period of time for the patient and the discomfort could outweigh the benefits of treatment initially. The use of clear communication about what to expect in terms of pain and duration of treatment, and practical advice for managing pain, could enhance treatment acceptance and adherence.

The current results showed significant functional improvements after orthodontic treatment as well. 85% of the participants reported that their oral hygiene improved; 75% reported no difficulty with chewing after

treatment. In addition, 78% indicated that they had no speech impairments after treatment. The results of this research indicate that orthodontic treatment can not only esthetically correct the dentition, but can also help improve oral function. A proper alignment can make it easier to access surfaces of the teeth when brushing and cleaning between teeth, which can make plaque control easier. As for malocclusion correction, their masticatory efficiency and intercuspation may be improved, which will lead to better chewing comfort and functional efficiency. The results are in line with the results obtained by Alzoubi et al., [14] who found that people with fixed and functional orthodontic appliances showed improvements in their functional and oral hygiene conditions. Patients who are able to keep their teeth more clean after treatment might also be impacted by the treatment's long-term effects, as better oral hygiene can lead to less plaque buildup and better periodontal health.

Another aspect relevant to the orthodontic treatment is the speech related outcome as tooth position and appliance placement can temporarily affect articulation. Results of this study indicate that speech impairment was not a significant long-term problem in the current sample, as 78% of respondents reported no speech problems. Some appliances may cause tongue discomfort or changes in articulation in the beginning, but with time, adaptation usually takes place. The patient-counselling implications of this finding are relevant to the patient because speech-related concerns could also be of significant importance to the decision of whether to accept treatment, especially in patients with jobs or daily routines that require extensive speaking. It is important that the clinician inform the patient that there will be some changes in speech that are transient and temporary with some orthodontic appliances, but do not necessarily mean permanent.

One of the most significant study results was the improvement in psychological outcomes with 82% of the participants stating that their mental health status improved after orthodontic treatment. This finding reminds us of the wider psychosocial implications of correcting malocclusion. An unattractive or socially undesirable appearance of the teeth can negatively affect self-esteem, body image, social confidence and emotional health, especially in people who feel they have poor looking teeth or undesirable teeth. After treatment, smile esthetics offer improvements which can lead to less embarrassment and self-consciousness, and increase confidence in social interactions. The results of these studies support those of Feu et al. [15] that there was an improvement in psychological discomfort and disability after orthodontic treatment. There may be a psychosocial burden associated with dental appearance, which orthodontic correction may help to minimize and thus help stabilize and integrate the emotional aspects of dentistry.

Patient-reported oral health-related quality-of-life measures can also be used for the psychological benefits identified in the present study. The psychosocial impact of dental aesthetics is evaluated using instruments such as Psychosocial Impact of Dental Aesthetics Questionnaire, which focuses on the social and psychological impact of dental appearance [16]. These measures acknowledge that clinical indices alone do not completely describe the effects of malocclusion. A patient's perception of how they look and their social and previous experiences, as well as their own expectations, can cause vastly different psychological reactions in two patients with the same degree of malalignment. Thus, using patient-reported outcomes in orthodontic care gives a more holistic picture of the outcome of orthodontic care.

LIMITATIONS

The results are encouraging, but there are some limitations to consider. The cross-sectional design will provide only one-time 'snapshot' of outcomes, and will not be able to document dynamic changes over the course of treatment. Longitudinal studies would be more appropriate to monitor changes in quality of life, especially the initial deterioration and subsequent improvement in quality of life previously reported. There is no control group to make comparisons with untreated people, so it is difficult to say that everything is due to orthodontic treatment. Thirdly, generalizability is restricted because it was obtained from institutions in a single region where there are unique sociocultural features.

Longitudinal and multicenter designs should be used in future research to reflect cultural variations and dynamic changes of quality of life. Incorporating psychosocial aspects into clinical practice will contribute to the future advancement of orthodontics as a discipline that takes care of the functional and emotional requirements of the patient, achieving the best health outcomes as a result. The study also relied on self-reported responses, which may be subject to recall and social desirability bias. Objective clinical measures of orthodontic outcomes, oral hygiene, and functional performance were not included.

CONCLUSION

In this cross-sectional study, most participants reported high satisfaction and favorable perceived aesthetic, functional, and psychosocial outcomes 6–12 months after fixed orthodontic treatment. Longitudinal studies using validated patient-reported outcome measures are needed to evaluate changes in patient satisfaction and quality of life over time.

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Ethical Approval: The study protocol was reviewed and approved by the Institutional Ethics Committee (IEC), Al-Badar Rural Dental College & Hospital, Karnataka (Approval No.: ARDH/2024-2025/EC/1-13).

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AUTHOR CONTRIBUTIONS

Prasad Konda: Conceptualization, study design, data collection, clinical investigation, manuscript drafting, and final approval of the manuscript.

Md. Arshad Hussai: Methodology, data collection, questionnaire administration, literature review, manuscript drafting, and final approval of the manuscript.

Dawood Bangalorewale: Conceptualization, study supervision, methodology, data analysis, interpretation of results, critical revision of the manuscript, correspondence, and final approval of the manuscript.

Uroosa Aymen: Data collection, literature review, interpretation of findings, manuscript drafting, and final approval of the manuscript.

Sayeeda Laeque Bangi: Data collection, literature review, manuscript review, critical revision, and final approval of the manuscript.

Snehalatha C Mukhtedar: Study supervision, interpretation of results, critical revision of the manuscript, and final approval of the manuscript.

All authors have read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

ABBREVIATIONS USED IN THE STUDY

a) OHRQoL: Oral Health-Related Quality of Life
b) PROMs: Patient-Reported Outcome Measures
c) STROBE: Strengthening the Reporting of Observational Studies in Epidemiology

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