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Short Communication

Childhood Bullying and One Way to Keep your Kids Out of the Statistics: Non-Surgical Interventions for Congenital Ear Deformities

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Introduction

Bullying is quickly emerging as one of the most crucial issues in our school systems, affecting nearly one out of every three children. Many victims [1] of childhood bullying suffer from depression, persistently low self esteem and subordination to others [2]. Bullying can fracture children's home life as well; documented discrepancies exist between depressed and non-depressed children's perceptions of their family. Depressed children tend to perceive their mothers as providing less care [3], precluding healthy mother child bonding. It is therefore critical that bullying be addressed early within the family structure to mitigate its adverse effects on familial bonding.

While there are various forms of bullying, this paper focuses on childhood appearance-based bullying. Children with ear deformities are placed at high risk of bullying later in life due to their anatomical abnormalities and associated physical appearance; defects such as prominent ears provoke embarrassment, ridicule, and ultimately emotional stress [4]. Bullying, which the National School and Safety Center considers to be the most enduring and underrated problem in the United States, has specifically been associated with cosmetic ear deformities such as prominent, cup, and Stahl's ears [1]. When Cooper-Hobson et al surveyed all children from the ages of 5-16 undergoing otoplasty from 1999-2003, 41% of them reported bullying as their primary surgical motivation [4]. A landmark 1992 article similarly found high rates of ridicule among children with cosmetic ear defects. 88% of children reported teasing, with 55% reporting concurrent depression and 52% of the entire sample reporting increased anxiety due to the ear deformity. In order to increase children's social integration expecting parents [5] must be aware of the effective cosmetic interventions available. Existing non-surgical auricular repair techniques are currently underutilized due to lack of knowledge regarding available options amongst parents and doctors.

Otoplasty effectively corrects cosmetic ear deformities and along with that, reduces bullying and decreases emotional and social isolation among affected children. Cooper-Hobson et al.'s post-operative questionnaire found an increase in children's happiness of 97%, and a 92% boost in self-confidence after cosmetic ear surgery. Otoplasty further reduced the rates of bullying, often erasing it altogether - of those who reported being bullied prior to surgical intervention, 100% experienced a reduction in bullying, and 59% reported complete cessation [4]. The 1992 Bradbury study found similarly significant reductions, with 83% of children reporting less teasing and hurtful comments. The Bradbury study also demonstrated improvements in post-surgical self-image, with 91% of children reporting decreased self-consciousness after otoplasty [5].

While it is difficult to accurately report post-operative otoplasty complications given the variety of techniques, otoplasty has both short- and long- term sequelae. Calder and Naasan's 1994 study reviewed 562 consecutive otoplasty cases and found 16.6% of patients undergoing otoplasty to have at least one complication, including residual deformity, infection, hematoma, or anterior skin necrosis [6]. Limandjaja et al.'s 2009 review found that short-term otoplasty complications including hematomas, infection and skin necrosis ranged from 0%-8.4%, while long-term complications such as scarring, asymmetry and hypersensitivity, ranged from 0%-47.3%. Common complaints among children following otoplasty include post-op pain and hypersensitivity, which can be as high as 34% and 27%, respectively.

Non-surgical interventions such as ear splinting for cosmetic ear deformities have the potential to improve hundreds of people's lives with simple, effective, and essentially risk-free methods. Splinting typically uses tape to place semi-rigid material and mold children's ears into a more normal shape. While duration of treatment varies, effects can be seen in as early as two weeks after placement. Yet meta-analyses have demonstrated that the splinting technique remains relatively unknown and therefore below its maximal efficacy. Van Wijk et al.'s 2009 literature analysis of splinting techniques noted the current variety of opinions regarding the length and inclusion criteria for successful splinting. Their review also noted the increased success of early splinting in infants younger than 6 weeks.

Two-hundred and nine ears in 132 infants were treated, with 81 patients completing the study. Of those who completed the study, the authors found good (anatomically normal ear) results in 28%, fair (some improvement, but persistent deformation) in 36% and poor (deformation maintained) in 36%. The authors noted that children splinted before 6 weeks of age had 66.67% rates of improvement or complete resolution, whereas splinting of older infants produced poor results [7]. They observed, based on the literature, that 6 months of age appears to be the latest possible point for non-surgical intervention, though significantly better results are seen the earlier splinting is done. The review also found that earlier interventions require shorter lengths of splinting for successful results: 2 weeks of splinting are often enough for newborns, whereas older children require up to 6 months of splinting with ultimately poorer outcomes.

However, the authors also concluded that persistently low rates of otolaryngology referrals for babies with ear deformities severely limit the ability to intervene in a timely fashion [7].

Van Wijk et al.'s review did not include newborns less than 3 days of age, which the authors hypothesized decreased splinting success. The authors insinuate that earlier splinting referrals would improve

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the rates of cosmetic ear deformity resolutions, and recommend increased collaboration with midwifes, obstetricians, and pediatricians to achieve that goal. A 2012 pilot study by Peterson et al. demonstrates the importance of early splinting intervention for success. The study enrolled 10 infants under 3 days of age with 19 abnormal ears for ear splinting. Initial splint length varied from 4 days to 4 weeks, with follow up at 1 week, 2 weeks, 3 weeks, 4 weeks, 3 months, 6 months, and 12 months. All 10 infants demonstrated substantial improvement after splinting. 8 out of the 19 ears were classified as 'normal' ears after intervention and 11 classified as markedly improved [8].

It is significant that the 2012 pilot study relied on referral from audiologists, who could identify congenital ear deformities before 3 days of age. The early referral proved instrumental to guaranteeing splinting success, in contrast to the markedly lower success rates observed by van Wijk et al. with later splinting.

It is essential that families and medical staff be alerted about the importance of early referral for cosmetic ear deformities. If these non-surgical interventions gain popularity, physicians may begin offering them as economical, effective treatments to their infant populations. Increasing awareness about minimally invasive options could lead to non-surgical cosmetic interventions becoming a routine offering during pediatricians' post-natal examinations.

Many expecting mothers are not aware of the harmful, lasting effects that a benign abnormality may have on their child. This is due in part to the fact that there is currently no medical, public health, or media campaign whose goal is to spread awareness about the prevalence of and simple solution to this problem. Our aim is to create greater awareness about congenital ear deformities so that we may ultimately spare affected children from the difficulties of future bullying or surgery by introducing non-invasive ear splinting that can confer more normal ear anatomy and external appearance.

Any ability we have to minimize children's exposure to bullying increases their chances of living happy, healthy lives. Unfortunately, most bullying remains out of our control. Yet ear deformities can be easily repaired, quickly and cheaply, and may potentially improve these children's lives. As a parent, it is crucial to actively intervene in infants' lives and make a significant positive impact whenever possible.

Expecting parents have the opportunity to intervene on their newborn infant's behalf simply by knowing to look for the problem. If parents suspect the problem is present, they should seek non-surgical repair of the infant's ears, which may help reduce childhood bullying and increase their child's happiness, resilience, and drive.

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