

Social impact of cleft lip repair on married adults: an uncommon finding from a semi-urban African settlement

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Abstract

An orofacial cleft may have an appreciable psychosocial impact on patients that could affect their social lives, including the choice of who they marry. We retrospectively reviewed the impact of repair of cleft lip on marriage in adult patients in our institution by questioning a group of patients treated from July 2009–June 2017. There were 120 adult patients who had cleft lips repaired, of whom 17 (14%) patients changed their marital status. The mean (SD) ages of the 17 were 32 (1), range 20–41, years. Five of the 17 were men, and 12 women, with a male:female ratio of 0.4: 1. All 17 patients confirmed that the unrepaired cleft affected the choice of who they initially married. After repair, the five male patients married additional wives (one wife each (n=4), and two wives (n=1)). Of the 12 female patients all divorced their spouses, but only nine had remarried at the time of the study. We conclude that unrepaired cleft lip in an adult in our environment may affect the choice of partner. This choice may be altered if facial aesthetics improve after repair of the cleft.

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Introduction

An orofacial cleft is one of the most common congenital abnormalities, and it has considerable psychosocial impact on patients, parents, and relatives. This has led to developments in counselling techniques that are used during management. It has also led to encouragement of early forms of repair, including the possibility of an intrauterine repair.¹ Many non-governmental agencies such as the 700 Club and Smile Train have developed facilities, particularly in developing countries, and have accounted for a large number of repairs yearly.

There are still occasions where these patients are not treated until adulthood, and unrepaired clefts of the lip have been associated with many challenges for those affected. The psychosocial impacts can be varied and far-reaching,² and reported problems can be related to appearance,³ anxiety, and depression.^{2–6} The associated social anxieties may stem from being stared at,⁷ teased, and bullied.⁸ Making friends and establishing relationships can prove challenging in adolescence, as these people are always teased about their defects.⁸

It has been suggested that adults living with repaired clefts are less likely to marry than the normal population, or tend to do so later in life.^{2,4} The choice of who to marry tends to be out of their control as it is largely dependent on who accepts them the way that they are. Anecdotal findings show

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that they are often accepted only by people with some form of physical challenge.

It has also been reported that having a cleft results in the increased chance of having a child with a cleft, and this has been known to affect the decision to have a child.² The repair of these clefts in adulthood is thought to give an exaggerated improvement in the facial value and self-worth of such patients. This sudden perceived increase in quality of life tends to give rise to psychological, behavioural, and social changes that affect important decisions, including the need to marry more wives or even divorce some existing ones.

In this study we have reviewed married adult patients with repaired clefts of the upper lip in a semi-urban African setting to see how the repair has affected their marriages.

Patients and methods

We retrospectively reviewed patients who had repairs of cleft lip in adulthood at the Maxillofacial Surgery Department of the Federal Medical Center Nguru, Yobe State, North East Nigeria by inviting and questioning a group of patients who had cleft lips repaired during the period July 2009–June 2017. The participants of interest were those who were married before they had a cleft lip repaired. Data were abstracted by an interviewer, who recorded information on their sociodemographic characteristics, whether the unrepaired cleft affected the choice of a previous marriage, the marital status of the patient before and after repair, the presence or absence of physical impairment of the spouse, and the time of repair of the cleft in relation to the divorce. The clinic nurse recorded the perceptions of all the subjects interviewed.

Inclusion criteria were all patients aged 13 years and over who had had a cleft lip or cleft lip and palate repaired. Patients who had an isolated cleft palate or patients who declined to participate were excluded from the study.

Statistical analysis

The data were analysed using SPSS for Windows (version 15.0, SPSS Inc). Absolute numbers were used to describe categorical variables. Quantitative variables were described using mean or median together with the indication of scatter as appropriate.

Results

A total of 131 adults had operations for cleft lip and palate during the period of the study and were invited to take part, but only 124 of them responded of whom four were excluded. Those excluded were three who had an isolated cleft palate and one who refused to participate. A total of 120 adult patients who had cleft lips repaired therefore took part in the study. There were 44 men (37%) and 76 women (63%)

Table 1
Personal details of the patients.

Variable	No.
Age (years):	
10–20	3
21–30	5
31–40	8
41–50	1
51+	0
Sex:	
Male	5
Female	12
Education:	
Uneducated	0
Koranic	4
Primary	9
Secondary	4
Tertiary	0
Tribe:	
Hausa	3
Kanuri	14
Others	0

Table 2
Time of divorce from the time of cleft repair.

Age (years)	No.	<6 months	6 months–1 year	1–5 years
10–20	3	1	2	–
21–30	5	2	3	–
31–40	8	4	3	1
41–50	1	–	1	–
Total	17	7	9	1

with a male:female ratio of 0.6:1. Their mean (SD) age at the time of repair was 29 (2) years, range 13–52.

Of the 120 who had repair of cleft lip, 17 (14%) had a change in marital status and affirmed that the unrepaired cleft affected the choice of who they initially married. Their sex and ages are shown in Table 1. Most (13/17) were at their peak reproductive age (21–40 years) and primary school certificate was their highest educational qualification. Five of the respondents had spouses with at least one form of physical impairment, including one who was deaf and dumb, and one case each of monocular visual impairment, blindness, amputation of a right upper limb, and asymmetrical lower limbs.

After repair of the cleft lip, all the patients were satisfied with the operation, and five of the men married additional wives (one wife each in four cases, and two in one case) between the time of the operation and the study. Of the 12 female patients, all had divorced their husbands. However, only nine had remarried at the time of the study. Most of the changes in marital status (16/17) occurred within the first year after operation (Table 2). The complications recorded included palatal fistula (n = 2), keloid/hypertrophic scar (n = 1), and notch of the lip (n = 2).

Discussion

Cleft lip and palate are among the most common craniofacial anomalies and human congenital birth deformities. The prevalence of cleft lip and palate is increasing, varying both racially and geographically.⁹ It is said to occur in 1/500 to 2500 births,⁹ and recent studies have suggested that cleft lip and palate is one of the most prevalent birth defects in the USA, with more than 6500 documented cases in 2001.^{9,10} This report varies slightly from reports within African populations, which range from as low as 0.3/1000 live births in Nigeria^{11,12} to 1.65/1000 live births in Kenya.¹³

Studies of people with craniofacial abnormalities (including cleft lip) have shown that they develop in a normal manner and do not experience psychological problems, but an appreciable number have been documented to be at risk of impaired psychological adjustment, diminished social skills, and poor parental acceptance.^{14,15} A review of relevant publications has shown that existing studies were made mainly among white patients and those living in urban areas. Most of these studies also looked at the social lives of adults who had orofacial cleft repair at varying times during their childhood, compared with the present study in which the clefts were repaired in adulthood among semiurban dwellers.^{3–5}

With the introduction of free surgical repair of cleft lip and palate in our centre by the charity Smile Train in 2009, about 131 adults have had surgical repairs. Cleft lip in particular imposes a large burden on the health, quality of life, and socio-economic wellbeing of affected patients and their families. It becomes worse when the child with a cleft becomes an adolescent and grows into adulthood without surgical intervention.¹⁶

The age and sex distribution of patients in the present study are similar to those previously documented for orofacial clefts.¹⁷ We aimed to gain insight into older peoples' experience of cleft lip and palate, particularly as it affects their marriage and social lives, which is an aspect that has to our knowledge rarely been discussed.

A large number of sociocultural myths are related to the aetiology of orofacial clefts, one of which is that the cleft serves as a punishment for parental sins.¹⁸ These myths are more likely to be accepted amongst rural dwellers, particularly where there is poor educational attainment (as among patients in the present study). Acceptance of these perceptions may affect how other members of the community interact with those with orofacial clefts. The finding of a serious effect on the marriage and social lives of the people we studied is at variance with the findings of Hamlet and Harcourt,¹⁹ who noted that the romantic relationships of their participants were not adversely affected by their clefts or the outcome of the repairs. They reported that it was rather the patients' low self-esteem from the cleft that limited their interaction with the opposite sex rather than discrimination by others. They cautioned, however, that their study was conducted at a time when pressure to marry and have children was probably more that it is today.

Patel and Ross¹⁸ also studied 20 subjects of whom 13 were single, 3 were married, and 4 were in relationships. However, they also reported that the deformity had no effect on their partners. The finding of the present study is in agreement with the qualitative studies by Macgregor,²⁰ Berk et al,²¹ and Marcusson et al,³ who recorded a considerable effect on the social lives as well as the relationships. Maslow²² described human needs as being hierarchical with the need to satisfy the next strata increasing as soon as the one before it had been satisfied. Most of these subjects in the study group were happy with their spouses, or at least managed the relationships before their cleft repair, but seemed to show considerable dissatisfaction once their cleft was repaired and their options for a potential life partner widened.

The observations made in the present study may have been possible as most of the patients got married at a relatively early age and were still of reproductive age, even after several years of marriage. It may also be related to the fact that divorce is culturally accepted in certain African traditional settings as a means of dissolving an unacceptable union. In addition the Islamic religion is predominant in the area studied, and it allows a man to marry up to four wives. Divorce by these subjects after cleft lip repair may have resulted from a feeling of mismatch between their status before and after the repair. The treatment was thought to have conferred an improvement in their quality of life.

Our finding that some women are divorced but yet to be married is in keeping with African cultural practice, by which a woman needs only to declare her status as being single after divorce, and plays only a minimal role in attracting a suitor. Hamid and Sanusi²³ pointed out that some of the reasons for delayed remarriage among divorced women include the suspicion of prospective suitors that these women may have been divorced from a previous marriage as a result of impatience. Sometimes this fear and suspicion is mutual, as the divorced women also bring the experiences in their previous marriage into perspective in taking the decision to consent to a new marriage.

Anxiety and depression have been reported to be twice as high in adults with cleft lip and or palate as in controls.⁴ Dissatisfaction with facial appearance as often seen in these patients has also been found to be a predictor of depression in adult patients with cleft lip and or palate when compared with controls.³ This level of anxiety, depression, and dissatisfaction with facial appearance could have been the reason for their divorces. Other factors that are beyond the scope of the present study could have contributed to divorces. Glick²⁴ and Goode²⁵ have argued that the rate of divorce is often increased in areas with large numbers of adolescent and teenage marriages, as in the present study.

Although the study of controls was not part of our investigation, a study of divorce from Northern Nigeria showed an increasing trend in recent times.²³ Reasons for this include early marriage, poverty, women's disrespect of marital norms, disagreements with mothers-in-law, and lack of sincerity among couples.²³

To our knowledge the present study is the largest single report of the impact of repair of clefts on marriages among an adult population. However, it may be limited by the absence of a control group as well as by the acceptance of the assertion by the participants that the repaired cleft was solely responsible for their change of marital status. Knowledge of increased chances of divorce and remarriage after repair in these subjects is important for marriage counselling to reduce its impact on the divorced spouse, as it could have been anticipated even before the marriage was contracted.

Conclusion

Unrepaired cleft lip in an adult in our environment may affect the choice of marriage partner. This choice may be altered by improved facial aesthetics after repair of a cleft lip, leading to adverse consequences on the family and community. This underscores the need for awareness of this possibility by both marriage counsellors and intending couples.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Ethics statement not required. All patients gave informed consent.

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References

- Devarakonda V, Kumar S, Daneshwari V. Intrauterine cleft repair: step towards perfection. *J Int Oral Health* 2012;**4**:12–6.
- Roberts RM, Mathias JL. Psychosocial functioning in adults with congenital craniofacial conditions. *Cleft Palate Craniofac J* 2012;**49**:276–85.
- Marcusson A, Paulin G, Ostrup L. Facial appearance in adults who had cleft lip and palate treated in childhood. *Scand J Plast Reconstr Surg Hand Surg* 2002;**36**:16–23.
- Ramstad T, Ottem E, Shaw WC. Psychosocial adjustment in Norwegian adults who had undergone standardised treatment of complete cleft lip and palate: Education, employment and marriage. *Scand J Plast Reconstr Surg Hand Surg* 1995;**29**:251–7.
- Mani M, Carlsson M, Marcusson A. Quality of life varies with gender and age among adults treated for unilateral cleft lip and palate. *Cleft Palate Craniofac J* 2010;**47**:491–8.
- Foo P, Sampson W, Roberts R, et al. General health related quality of life and oral health impact among Australians with cleft compared with population norms: age and gender differences. *Cleft Palate Craniofac J* 2011;**49**:406–13.
- Rumsey N, Harcourt D. *The psychology of appearance*. Maidenhead, UK: Open University Press; 2005.
- Hunt O, Burden D, Hepper P, et al. Self-reports of psychosocial functioning among children and young adults with cleft lip and palate. *Cleft palate Craniofac J* 2006;**43**:598–605.
- Ellis III, et al. Management of patients with orofacial clefts. In: Peterson LJ, Ellis III E, Hupp JR, editors. *Contemporary oral and maxillofacial surgery*. 4th ed. St. Louis: Mosby; 2003. p. 623–45.
- Tolarova MM, Cervenka J. Classification and birth prevalence of orofacial clefts. *Am J Med Genet* 1998;**75**:126–37.
- Iregbulem LM. The incidence of cleft lip and cleft palate in Nigeria. *Cleft Palate J* 1982;**19**:201–5.
- Gupta B. Incidence of congenital malformations in Nigerian children. *W Afr Med J Niger Pract* 1969;**2**:22–7.
- Khan AA. Congenital malformation in African neonates in Nairobi. *J Trop Med Hyg* 1965;**68**:272–4.
- Broder H, Richman L. An examination of the mental health services offered by cleft craniofacial team. *Cleft Palate J* 1987;**24**:158–62.
- Endriga MC, Kapp-Simon KA. Psychological issues in cranio facial care: state of the art cleft palate. *Cleft Palate Craniofac J* 1999;**36**:3–11.
- Topolski TD, Edwards TC, Patrick DL. Quality of life: how do adolescents with facial differences compare with other adolescents? *Cleft Palate Craniofac J* 2005;**42**:25–32.
- Adesina OA, Efunkoya AA, Omeje KU, et al. A prospective study of cleft lip and palate amongst children and adults in North-Eastern Nigeria. *Pak Oral Dent J* 2016;**36**:359–63.
- Patel Z, Ross E. Reflections on the cleft experience by South African adults: use of qualitative methodology. *Cleft Palate Craniofac J* 2003;**40**:471–80.
- Hamlet C, Harcourt D. Older adults' experiences of living with cleft lip and palate: a qualitative study exploring aging and appearance. *Cleft Palate Craniofac J* 2015;**52**:e32–40.
- Macgregor FC. Facial disfigurement: problems and management of social interaction and implications for mental health. *Aesthetic Plast Surg* 1990;**14**:249–57.
- Berk NW, Cooper ME, Liu YE, et al. Social anxiety in Chinese adults with oral-facial clefts. *Cleft Palate Craniofac J* 2001;**38**:126–33.
- Maslow AH. A theory of human motivation. *Psycholo Rev* 1943;**50**:370–96.
- Hamid RA, Sanusi IA. Challenges and negative effects of divorce among Muslim women in Northern Nigeria. *J Arts Humanit* 2016;**5**:13–25.
- Glick PC. *American families*. New York: John Wiley; 1957. p. 103–63.
- Goode WJ. *After divorce*. Glencoe, IL: Free Press; 1956.