and communication skills seem to play the major role in behaviour guiding children but who should be reframed first, child or dentist?

We have attempted to explain reframing using Eric Berne's transactional analysis.[2] Personalities are made up of three parts or ego states: the Parent, the Adult and the Child. The child ego state is of two types: the 'free child' and the 'adapted child'. The former can be playful, authentic, expressive, and emotional; the latter is the part of the personality that has learned to comply with the parental messages received while growing up.[2-4] Communication between two people involves six ego states (three for each person) and is called a transaction which is said to be complementary or reciprocal when the ego state addressed is the same as the ego state that responds. In general or in a dental setting, we tone down our voice and try to talk to the child using euphemisms or second language. Baby talk is used to communicate with infants and toddlers. To treat a five-year-old we need to sound like a five-year-old. This helps the child to socialise and identify with us like an equal and not a stranger. It is important for all dentists treating children to realise the child ego state in them. Bringing out the 'free' child in us helps in complementary transaction and better communication with the child. It is the dentist's mind that needs to be reframed first, for s/he needs to learn to own the problem and show a positive attitude in treating children rather than complaining that children are difficult to manage.

S. Asokan, Tiruchengode
S. Nuvvula, Nellore

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STANDARDISED ORTHODONTICS

Sir, adult patients that could possibly benefit from orthodontics commonly present to us with degenerating dentitions, missing teeth, poor aesthetics and compromised periodontal health. This makes it difficult if not impossible to achieve Andrew's six keys of ideal occlusion.[1]

Therefore, all adult orthodontic treatments require an inter-disciplinary approach to facilitate optimal aesthetics, stability and function. Graber[2] recommends the following treatment objectives which can be offered after a thorough assessment:

1. Parallelism of abutment teeth
2. Most favourable distribution of teeth
3. Redistribution of occlusal and incisal forces
4. Adequate embrasure space and proper tooth position
5. Acceptable occlusal plane and potential for incisal guidance at satisfactory vertical dimension
6. Adequate occlusal landmark relationships
7. Better lip competency and support
8. Improved crown to root ratio
9. Improvement of self-correction of mucogingival and osseous defects
10. Improved self-maintenance of periodontal health
11. Aesthetic and functional improvement.

Comprehensive orthodontics will always attempt to fulfil all treatment objectives that are set out above. Short-term orthodontics may fulfil some of the above treatment objectives in the form of a compromised treatment or as an adjunctive treatment.

A standardised approach for record taking, diagnostic procedures and assessment is required for both comprehensive and short term orthodontics. Only then can patients be well informed of possible treatment objectives and the advantages and disadvantages of alternative treatment plans.

The quicker the dental profession work towards a standardised approach, the better it will be for the future of adult orthodontics.

R. Aulakh
By email

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