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THE EDITOR'S CORNER

The Most Difficult Cases

The "typical" orthodontic patient used to be easy to describe: a 12-year-old boy or girl from a middle- to upper-class home, in good overall health and physical condition, normal to high in intelligence, and—other than perhaps being the victim of teasing due to a less-than-ideal smile—relatively well adjusted socially and psychologically. Thirty to 40 years ago, when many of us started practice, there were enough of these "typical" patients available to keep every orthodontic specialty practice humming along at a brisk and profitable clip.

Since then, however, we have seen a significant shift in the demographics of our patient population. The percentage of children entering our practices from minority and multicultural families is rising substantially. We're treating more and more adult patients, some of whom are seeking retreatment years after their initial courses of orthodontics in junior high or early high school; in fact, many practices now see more adults than adolescents. And pediatric and general dentists currently provide a sizable proportion of the orthodontic care for patients who would once have been considered "typical". Under these demanding circumstances, there is actually more need than ever for true orthodontic specialists. Not only are orthodontists educated and certified as possessors of the highest level of skills in the field, but the general public *expects* us to have such skills. In other words, we are the ones who are called upon to handle the most difficult cases.

When asked to define "the most difficult cases", most of us would think of problems such as high-angle, growing Class III patients with anterior open bites or skeletal Class IIs with deep Brodie crossbites. Our immediate inclination is to consider the anatomical and technical issues that are most difficult to overcome. In reality, though, we are all well enough trained and experienced to handle the most challenging malocclusions, especially in collaboration with our surgeon colleagues. The most difficult cases are actually the ones that are atypical from a behavioral or psychological point of view.

Training in the management of craniofacial anomalies, such as the malocclusions associated with cleft palate and hemifacial microsomia, is an integral part of every orthodontic specialty program, usually occupying a significant amount of curricular time. Much less time is devoted to the management of emotional and behavioral anomalies—known in the educational psychology vernacular as emotional and behavioral disorders (EBDs). This is unfortunate, since EBDs are much more prevalent than craniofacial anomalies and, therefore, much more likely to be seen in an orthodontic office. In today's practice environment, where pediatric and general dentists are treating "the easy cases" and referring the "more difficult cases" (by their definition) to us, you can safely assume that these "more difficult cases" will include EBD patients.

EBD is a broad category that comprises problems ranging from fears and phobias (including dental phobia) to anxiety and depression to attention deficit hyperactivity disorder, conduct disorder, panic disorder, obsessive-compulsive disorder, and autism spectrum disorders. "Externalizing behaviors" manifest in blatant outward conduct; "internalizing behaviors", being inwardly directed, are more difficult to detect. Although many of my colleagues report an increasing frequency of EBD among the patients they examine, I don't remember ever discussing such emotional and behavioral issues during my own orthodontic training, nor did I see them included in the curricula of any graduate programs I examined over my many years as a site visitor for the ADA Commission on Dental Accreditation. This curricular deficiency needs to be recognized and addressed.

In the current issue of JCO, we take a first step toward closing that educational gap. A multidisciplinary team from several prestigious institutions—headed by an orthodontist, Dr. Robert H. Schindel—presents a fascinating article entitled "Behavior Modification of Children with Autism Spectrum Disorder in an Orthodontic Setting". I expect to implement their system of Applied Behavioral Analysis in my own practice, and I certainly hope to see more submissions of articles addressing the orthodontic management of patients with EBDs.

RGK