

---

# RELIGION, SUBJECTIVITY AND ORAL HEALTH ETHICAL DILEMMAS IN PEDIATRIC DENTISTRY

**Adriana Bălan<sup>1</sup>, Gheorghe Bălan<sup>2\*</sup> and Vasilica Toma<sup>1</sup>**

<sup>1</sup>*Gr. T. Popa' University of Medicine and Pharmacy, Faculty of Dental Medicine,  
Str. Universitatii, Iasi, Romania*

<sup>2</sup>*Gr. T. Popa' University of Medicine and Pharmacy, Str. Universitatii, Iasi, Romania*

(Received 11 October 2013, revised 27 October 2013)

---

## **Abstract**

The spiritual development of the child must occupy a main place among the interests of the practicing dentist, the physiological premonitions related to the child oral health being often connected in this age period with spirituality and faith. In this way, the child patients are continuously facing a straight association between their own growth and development, doctor and spirituality. This article aims to study the relationship between subjectivism, spirituality or religion and paediatric oral health, thus delimitating the possible ethical dilemmas which the paediatric dentist would encounter in his practice, together with his deontologically required constant concerning about the spiritual values of the patient and his family. Despite the fact that the therapeutic option or following a certain treatment are subordinated to the autonomy of the patient or his legal representatives, in many cases this autonomy can be affected by variable degrees of religious devotion, an aspect hard to quantify in scientific studies. Various aspects like the substances used in the dental practice, the recommended dietetic hygienic-alimentary regime, establishing the visit to the dentist or its duration can be therefore decisively influenced by patient religion and culture. The paediatric dentist must be always ready to meet subjective customs, practices, beliefs or superstitions and to consider them seriously as an integrant part of his professional relation. Through the multitude of the existing professional relationships, their frequency and the special quality of the involved parts, the doctor-patient relationship in the dental area, mostly in the paediatric field should be of more concern for the bioethical research community.

*Keywords:* medicine, dental care, children, spirituality, bioethics

---

## **1. Introduction**

The childhood period extends for a generous temporary area, from birth to late teenage. From the legal point of view, a child means any under age person (less than 18 years). During this entire period, the dentistry represents one of the fields of medical care that maybe gets mostly in contact with the child, as it is well known that a considerable percentage of all the dentist's patients are represented by the children. The paediatric dentist constantly comes to meet the

---

\*Corresponding author, e-mail: balan.gheo@yahoo.com, tel.: +40745255247

diagnosis, therapeutic and prevention necessities of a category of patients in continuous physical, intellectual, emotional and not in the end, spiritual development. Even if it is often placed on a second place by the specialized literature, the spiritual development of the child patient must occupy a main place among the interests of the practicing dentist, because the physiological premonitions related to the child oral health are often connected in this age period with spirituality and faith. In this way, the child patients are continuously facing a straight association between their own growth and development, doctor and spirituality. The dental care is really contributing to the child psycho-emotional development, the relationship with the dentist helping the infant to develop quite early the capacity to take his own decision [1]. Moreover, the childhood represents an optimum time interval to get familiar with some long term habits and skills with respect to the protection of his oral health; the absence or the low quality of these prophylactic methods result in chronic malfunctions and disabilities, with an important echo on his general health even at adult age. The caries, periodontal affections, the abuse and also the need of orthodontic care are the main causes of a defective oral health, with a negative impact on both, the child somatic development (generating chronic pain and malnutrition), and his psycho-social development (contributing to the alteration of his self respect and image, to post-abuse physical traumas, etc). Therefore, the dentist would occupy an important place among the main actors in the process of child education, and, as we have seen, in the psycho-social, emotional and spiritual development.

The hereby presented work proposes the approach of the relationship between subjectivism, spirituality or religion and the child's oral health, thus delimitating the possible ethical dilemmas with which the paediatric dentist could confront in his practice, together with his moral duty to constantly concern about the spiritual values of the patient and his family. Conceptually, the identification of ethical dilemmas must start from the recognition of the value of certain cultural and moral traditions, as the moral and therefore the ethics can not exist outside the tradition common for a given group [2]. Therefore we can define the ethical dilemmas as those situations which in a specific system of values claim the application of particular rules and principles that can not be mechanically generalized and applied. From a historic-teleological point of view, this concept was introduced just like one of Christian inspiration, based on the necessity of an *ethics of situations*, applicable in a different way to each individual [3]. Our study starts exactly from the premise that in a multi-cultural society it is mandatory to make room for each individual tradition, the Christian tradition in itself pleading for non-alienation and individual intrusion in society [4]. In this connection, the child dentist comes to meet the medical needs of a population with a variable degree of vulnerability, as we have seen, thus joining a basic system of ethical professional values. Yet, meeting with the child-patient at the key moments for his social integration, for building his own image, and also for his spiritual becoming, needs a continuous particular ethical approach by the practitioner in order to build a solid doctor-patient relationship. Moreover,

the child dentist must superpose the developing individual values of the minor over a system of more or less usual heterogeneous values of the family or his legal representatives, outside which the professional relation can often operate.

We can therefore notice that the pedodontal medical practice, even if subjected to the modern tendency of ethical secularization, can not elude individual cultural and spiritual values, which often demand unusual acts of medical conduct. In the next sections we shall make reference to these and to the relation between religion, subjectivity and dental medical practice, with a view to finally establish possible principial solutions to the identified ethical dilemmas.

## **2. Religion, cultural identity and Medical science**

Numerous specialized studies recognize the more pregnant and visible role of religion and faith in the medical practice [5]. The medical scientific literature reports statistic data according to which, as a whole, more than half of medics believe that God or another super-natural power intercedes in the preservation of patient health condition [6]. Accordingly, part of them consider that the relationship between Medicine and religion is so important, that the failure in bringing the religious rituals into the medical praxis might be considered as a form of medical malpractice [7]. More and more often, proposals of the medical world concern aspects such as taking up spiritual anamneses, spiritual evaluation of patients, creation of categories of diagnoses like spiritual trauma or justification of therapeutic abandon for spiritual reasons [5, 6].

We are crossing a period when the impact of religion and spirituality in general reaches maximum quota in the medical world. Secular hypostases and practices specific to the classical medic-patient relationship can no longer prevail today, confronted with the subjective religious and cultural needs of the patients and their family. Yet, we can state without many restraints that the paediatric dentistry was in time naturally related with the spirituality, due to the necessity to explain some physiological phenomena, sometimes vulnerable if not even traumatizing, to a category of patients less receptive to abstract scientific truths. For instance, the toothache, eruption, teeth exfoliation, as well as the necessity to visit the dentist, or the extraction procedures, even in the case of heterogeneous cultures, were accounted for by spiritual, divine phenomena, due to supernatural forces, thus making easier for the child to understand and receive some phenomena, otherwise with scientific value [8]. Therefore the doctor needs to react professionally as if God (or other divinity of supernatural power) would exist, setting this spiritual dimension above his own person [9]. This causal chain raises various bioethical problems concerning the primacy of spirituality over the basic science. If in the near past the bioethics has suffered a visible secularization process [4, 10], perhaps nowadays the Medical science needs to get to a consensus with the religion or the spiritual dimension of the existence in a wide sense, within the concept of modern soul medicine.

Numerous landmarks from the specialized literature [11-13] underline the necessity of an adapted dialogue between the Medical science and religion within the context of interdependence between the physic diseases and soul diseases. The relationship with the Creator is considered to improve the quality of the patient life, this concept being received as a Christian one, as it proposes a holistic vision of man, in the creationism spirit [11]. That is why the patient should be guided to pay attention to the spirit of closeness between faith and Science and to learn the dialogue with the divinity on the basis of its autonomy [12]; and when the Medical science ceases to offer plausible and valid proofs, the improvable can be seen exactly as a prove of the spiritual mystery of the life [13]. What concerns the area of the paediatric dentistry, providing the oral health among paediatric population is considered to have a major contribution to the ulterior quality of the patient health, his self-confidence and development of child own image [14], a psycho-evolutional context improved by lending him a fitted spiritual education.

Therefore, from a bioethical point of view, when we speak about Christianity or other spiritual orientations one must recognize, at least the influence of emerging religion in the patients' life and in their relations with the doctors. By virtue of respecting the patient autonomy, the bioethics and medical deontology will get confronted more and more with the necessity of reconsidering their relationship with the spirituality. The child patient depends on the autonomy of his legal representatives, being signally subjected to external familiar religious practices, these being able even to represent a strong orientation factor in the selection of curing dentist [15]. The pedodontal practitioner will always be confronted with his professional obligations to provide an optimum status of the oral health of his patient, yet continuously complying with parental autonomy, even when we speak about religious options and beliefs.

### **3. Religion and culture-related ethical dilemmas in paediatric dentistry**

Respecting the patient cultural and religious identity must be one of the main aspects of deontological interest for the practitioner dentist. The child patient and his family and close relations often follow certain rituals, customs or traditions specific for their religion or spiritual orientations. These practices have a different impact, on the one side on his oral health, and on the other side on his relationship with the dentist. Within this section of our work, we mean to present some situations generating ethical dilemmas for the child dentist; whether we speak about the ergonomic or 'rheological' adaptation of the doctor-patient relationship, or about the individualization of the therapeutic conducts, the paediatric dentist will have to face the intrusion of the spiritual factor in his current activity.

Despite the fact that the therapeutic option or following a certain treatment are subordinated to the autonomy of patient or his legal representatives, in many cases this autonomy can be affected by variable degrees

of religious devotion, an aspect hard to quantify in scientific studies. Factors like the substances used in the dentist practice, the recommended dietetic hygienic-alimentary regime, establishing the visit to the dentist or its duration can be decisively influenced by patient religion and culture [16].

Not in the least, the conduct of the patient or his family concerning the eruption or loosing the childhood teeth can considerably vary from one cultural area to another. Even the attitude to the dentist in itself is more or less influenced by religion, race or culture.

### ***3.1. Diet and ingredients in dental products***

Various diet-related factors can be conditioned by norms and rules which concern the patient spiritual life. From the number of meals a day, the conduct concerning the animal or vegetal food, to the attitude to the consumption of alcohol or derived products, we can identify numerous situations in which the child oral health can be affected.

In what the Christian patients are concerned, there might be persons who refuse to consume animal products, because these are obtained by exerting cruel acts on animals. At the same time, there might be patients who do not agree with dietetic or pharmaceutical products obtained through genetic derivation or whose production is based on genetic experiments on human products [16]. The Christian fast of Wednesday and Friday or that from fast calendar periods is characterized by a regime consistently richer in carbohydrates. Depending on the glycaemic composition of each utilized aliment, it is possible that during certain periods the pH of the patient mouth diminishes considerably, which predisposes to the installation of dental caries, mainly with children.

In exchange, when we speak about the Muslim patients, the religious restrictions imposed to aliments are much more exhaustive. They are forbidden not only to consume mutton or pork, but also the industrial derivatives of these products. The same prohibitive attitude operates regarding chemical derivatives such as the 'E-s' (food additives). That is why the dentist is recommended to be very careful with the chemical composition of the utilized dental products and the usual products recommended for mouth hygiene. The Islamic fast occurs during the Ramadan days, when the Muslims abstain from the consumption of food and even water all day long. The lack of food and liquid contribution can result in irritability and adrenergic syndrome, in the accentuation of hydro-electrolytic and acido-basic unbalances or to hypoglycaemia. All these must be taken into account with respect to the patient dental management. Moreover, sulphuric products can accumulate during the day in the oral cavity, which can cause a halena that is prone to the differential diagnosis, with deficiency of oral hygiene or with other associated oral-digestive pathology [16, 17]. A special attention must be paid to the treatments and medications prescribed during the Ramadan days, since many of the Muslim patients will refrain from ingesting any amount of liquids, which can disturb the medicament therapy per bone, as well as the utilization of various substances during the dental care, possibly

assimilated with aliments. In all the cases, it is indicated that, when prescribing a hygienic-dietetic or pharmacologic regime, the dentist opts as far as possible, for products certified according to the Islamic Halal rules [16].

It is possible that the patients of Judaic religion refuse, in a variable proportion, the alcohol or derived products and the pork, mainly if these are not Kosher certified. During the fast periods, mainly on Yom Kipur and Av, the patients use to deny the consumption of any aliment or water, such that the dental therapy, the pharmacologic treatment or the oral hygiene can be disturbed. In the case of these populations of patients, it is even more important that the dentist performs a precise anamnesis concerning the quantity of sweets ingested by the children, because the sweets, as integrant part of several religious and popular rites, get to be used as the main stimulant and reward for children, being yet a risk factor for the oral pathology [15, 16].

The Hindu patients obey a strict vegetarian regime of spiritual origin, avoiding even the root crops consumption. They refrain from the consumption of meet, dairy or other animal derivates, as well as of alcohol. In the case of these patients, the oral treatment and hygiene can be seriously affected, since many of the materials used in the dentist practice are manufactured based on animal protein derivatives (gelatine, glycerine). A special attention must also be paid to the materials that contain carotene, or to mouthwash and to alcohol-based disinfecting solutions [16].

Therefore there is a multitude of situations in which the practitioner dentist can get confronted with religiously conditioned inter-ethnic or inter-cultural barriers which could considerably affect the quality of the medical act and the doctor-patient relationship. As we have seen, the dentist must know in details the chemical composition of the materials used in his practice, as well as of the products specific to oral hygiene; there might be difficulties in the case of tooth paste, mouthwash, resins, powders, binders or disinfecting solutions which include glycerine or gelatine in their composition, the E-dyeing or aromatizing stuffs or alcohol - very important being in this case the accurate product tagging and certification according to the religious traditions such as Kosher or Halal. In all these cases, any medical option must be taken only by respecting the autonomy of the patient and/or his legal representatives, this being based on the informed consent, from which the religiously and spiritually conditioned details can not be missing.

### **3.2. *Timing of appointments***

Programming and duration of the dentist visits can interfere with certain religious practices or rites, very important for many devoted families. Some of these rites might affect to a very small extent the visits at the dentist's practice, as they occur beyond the usual dentist's working program, for instance the Sunday Christian Mass. Yet other religious habits, given their daily character or their duration are to be considered at the moment of establishing the follow-up appointments at the dentist's practice [18] or in the case of complex treatments

that needs more sessions. For instance, in the Muslims case, you should know that many of them allocate certain hours daily to prayers, the most important and respected by many of them being those of Friday afternoon. It is therefore recommended to avoid the programming in the second half of the day or during the Ramadan days, in this last case for dietetic reasons (*vide supra*). The Jewish patients respect in an astonishing proportion the Sabbath which, according to the tradition, starts Friday at sunset and ends Sunday at sunrise. During this period, the devoted Jews will avoid any professional activity, physical work, travels, etc., such that they will not be able to participate in the dentist's sessions. Under these circumstances, the programming for Friday must be avoided, as many families are preparing for Sabbath [15]. The same is true for the days of festival, such as Gedaliah, Yom Kipur, Teves, Easter, Tammy or Av [16].

### **3.3. Eruption and loss of teeth**

The eruption and exfoliation of the temporary teeth are important events in the child's life, expected and pursued with interest by most of the parents, with strong psychological consequences. These events, physiological in fact, have also a very big cultural importance. This can be translated into a multitude of practices, rites, symbols and superstitions connected with the significance of these moments. Despite the fact that these conducts can be considered as specific to certain religions, being, no doubt, dominated by the presence of some religious symbols, the study of the specialized literature places them preponderantly within the sphere of ethnic, racial, geo-regional culture. Even so, we can detect certain superstitions with universal, global character, taken over from one population to another and differently adapted.

We can mention among these [19]: utilization of coral as mystic material, a protector of the children at the moment of eruption, often worn as a collar around the neck, looking in the mirror, considered as bringing good luck, health, and beauty to the new teeth; worn in various collars (of flowers, with gems, etc) to bring the child positive energies, a practice with a strong Christian base being that of the collar made of hair taken from the donkey back- element considered as blessed by Jesus Christ at His Advent to Jerusalem, which should protect the child against pain: burning or throwing the exfoliated teeth, to be taken by various divine or spiritual forces for the good health and beauty of the new teeth. All these are practices and superstitions encountered with various populations of the world. Nevertheless, there are certain practices that can damage the oral and general health of the child, such as [20]: the technique of gingival incisions, invented by the surgeon Ambroise Paré, in order to facilitate the eruption; utilization of the mercury salts, of opium derivates or of some nauseating substances in order to kill the pains and to speed up the teeth eruption and exfoliation; gum injuring through massage or by chewing abrasive materials; consumption of various potions made of ashes obtained from teeth burning, wine and honey. Irrespective of these so-called rituals, the dentist must be aware of their existence and of the possibility that they are used by the family; this,

mainly because it is well-known that the practitioner can often give up when confronted with family superstitions, contrary to his professional belief, from reasons pertaining to cultural differences, non-discrimination, miscommunication, or by the compromise made to allow him to continue a long lasting professional relationship [19].

One should not disregard the psychological implications of eruption and loss of teeth. Either we refer to the context of the genesis of dental neurosis or to the symbolic value of the tooth in the psychological plane, the specialized literature has a rich history in interpreting the implications of these physiological events in the human psychic, the first scientific researches dating back after the World War II: the study of Coriat in 1946 - Dental Anxiety: 'Fear of Going to the Dentist' [21], and the communications of Sandor Lorand and Sandor Feldman, 1955, in front of the New York Psychoanalytic Society [22].

From a psychoanalytical point of view, the tooth is offered a strong symbolic value, straightly connected with various physical or psychical traumas, and materialized in what we call a certain psychological and psychopathologic context, namely dental neurosis. During the psychotherapy sessions for this type of neurotic anxiety, an important role is given to the symbolic teeth value. According to the model of regressive symbolistics, many of the dental neurosis under-layers dates back in patient childhood and teen age, for various moments of somatic, emotional, sexual or social reasons, when he was confronted with psychical traumas latter on symbolized through the tooth semantic field - from connotation of sexual nature (sexual organ, mother matrix, the beginning of the sexual life) to the religious symbolistics (returning to the Eden past, persistence of sin, unlike the passing character of the tooth), the teeth eruption and loss offer a vast ground of psychoanalytical interest [23]. Whence the importance of implementing during the paediatric dental treatment various behavioural therapy techniques too.

Continuously related to the culture of the patient and his family, to their religious and spiritual orientations, the dentist should overcome the anatomo-physio-pathologic limits of the case, pursuing the child-patient protection against the inherent psychological traumas in the context of childhood vulnerability and popular culture, often negative in relation with the dental therapy.

### **3.4. General culture related aspects**

When we speak about the culture, we mean a series of social patterns, actions or beliefs specific to a certain group of population to whom guiding principles of social cohabitation within socially valuable norms, customs, and traditions are offered [8]. For instance, besides the rites and practices of traditional religious nature, the religion can also offer certain written or unwritten norms, acting on the collective moral, and becoming common elements of folklore within certain groups. These norms can influence to a variable extent the patient health condition, influencing the relationship between the member of the corresponding group and the doctor, but also their attitude

toward medical care. In whatever concerns the child oral health, the specialized literature quotes, for instance, the existence of a relationship between the Judaism and the devoted sanogeneous status, which is quite hard to be scientifically argued [15].

Nevertheless, one of the objectives that the dentist must take into account is that, in order to reach an optimum status of communication with certain patient category, it is necessary to understand their culture. Being characterized by a variable degree of secularization and open to laicism, certain groups of patients will have the tendency to establish social and professional connections exclusively within the religious community by means of the Church media, such that the doctor must be prepared to be present, if necessary, in the patient area of interest. At the same time, some patients might prefer a doctor of a certain sex [15] or might reject the possibility to reuse certain materials within the dentist practice [16]. The dentist must be open minded to these fears or principles, mainly when, after previous information, the patients and their families are not willing to give up these beliefs. Not all religions plead for individual free will, and in the same time there are many groups of patients who, even if devoted, accept modifications of certain rites or precepts in case of illness.

An unusual case for child dentistry, yet with an obvious cultural and religious connotation, is that of a little girl who, presumably due to her anxiety and discomode determined by the visits to the dentist, mutilated through relatively complex (using blood and hen feather) one of the dolls of the playing space from the dentist practice, according to the Voodoo practices; these rites with religious connotations, having Christian, Islamic and Yoruba African elements, specific to Caribbean islands, through which a person uses a totemic symbol (animals, statuettes, puppets, moulds, etc) against which he metaphysically, repeatedly lays curses, such that these pursue that person at a physical level [24]. Even if these practices are an exception in the current medical activity, they are still a manner through which the patients religious culture can seriously impede their relations with the dentist, revealing strong conflicts and psychological traumas, dental neurosis in particular, that could not be detected other wise, especially in the case of children.

#### **4. Conclusions**

The child patient is in himself a vulnerable patient, given his various degree of developing discernment, his susceptibility to trauma and abuse, as well as his continuous dependence on the adult help. The various degrees of vulnerability accentuate the opening to disparity in lending dental medical care and can also represent a predisposing factor for psychical traumas associated with the visits to dentist practice. These can result in the development of a dental neurosis syndrome. By superposing to this context the cultural, spiritual, religious and subjective peculiarities specific in fact to each patient and his family, numerous ethical dilemmas arise, with various degrees of versatility, that can affect the child access to dental medical care generally, and the doctor-

patient relationship in particular. In this connection, the paediatric dentist must be always ready to meet subjective customs, practices, beliefs or superstitions and to consider them seriously as an integrant part of his professional relation. As already presented, the autonomy of the patient and of his legal representatives, their informed consent, even the therapeutic conduct, are being influenced and need to be adjusted according to the patient spiritual life.

Our study pursued not an exhaustive presentation of all the particular situations that might constitute an ethical professional dilemma, but laying down certain coordinates that bind together the dental medical activity with religion and subjectivity. Based on a complex referencing from bioethical, theological and dentistry areas, we proceeded to the systematic presentation of certain sensitive conjuncture points, with the view to make the practitioners aware of the importance of taking them into account. The present work comes into prominence through the scrupulosity of references analysis and the multitude of scientific and spiritual facets dynamically surprised and exposed.

At the same time, the study remains open to new research directions in a border-line scientific area, or rather of multidisciplinary nature, the ratio between religion and Theology, on the one side, and dentistry bioethics on the other side, leaves room for potential ample studies, at this moment only existing a cumulus of hypotheses and theoretical premises.

Through the multitude of the existing professional relationships, their frequency and the special quality of the involved parts, the doctor-patient relationship in the dental area, mostly in the paediatric field should be of more concern for the bioethical research community. At a moment when there is much talk about the spirituality in medicine, the medicine of the soul or of the spirit, the moment when more and more professionals rally to faith in spirituality above science, ethical dilemmas such as those we exposed above will be more and more frequent and incisive.

## References

- [1] J. King, *Dental Care for Children*, in *Dental Law and Ethics*, P. Lambden (ed.), Radcliffe Medical Press, Oxon, 2007, 99-107.
- [2] L.S. Cahill, *Can Theology Have a Role in >>Public<< Bioethical Discourse?*, in *From Christ to the World: Introductory Readings in Christian Ethics*, W.G. Boulton, T.D. Kennedy & A. Verhey (eds.), William B. Eerdmans, Grand Rapids, 1994, 371-375.
- [3] J.F. Fletcher, *Morals and Medicine*, Princeton University Press, Princeton, 1954.
- [4] L. Balogh, *Journal for the Study of Religions and Ideologies*, **8(23)** (2009) 3-12.
- [5] R.P. Sloan, *European Journal of Integrative Medicine*, **1** (2009) 3-7.
- [6] F.A. Curlin, S.A. Sellergren, J.D. Lantos and M.H. Chin, *Arch. Intern. Med.*, **167** (2007) 649-654.
- [7] W.L. Larimore, *Am. Fam. Physician*, **63** (2001) 8-40.
- [8] Y. Butani, J.A. Weintraub and J.C. Barker, *BMC Oral Health*, **8** (2008) 26.
- [9] R.J. Neuhaus, *First Things*, **177** (2007) 26.

- [10] D. Callahan, *Religion and the Secularization of Bioethics*, in *From Christ to the World: Introductory Readings in Christian Ethics*, W.G. Boulton, T.D. Kennedy & A. Verhey (eds.), William B. Eerdmans, Grand Rapids, 1994, 367-370.
- [11] N. Goldura, *Eur. J. Sci. Theol.*, **6(2)** (2010) 9-12.
- [12] M. Stavinschi, *Eur. J. Sci. Theol.*, **1(3)** (2005) 27-33.
- [13] O. Iftime, *Eur. J. Sci. Theol.*, **2(1)** (2006) 21-46.
- [14] M. Cernușcă-Mitariu, L. Ștef, F.A. Pavel and S. Morar, *Eur. J. Sci. Theol.*, **9(2)** (2013) 65-70.
- [15] S. Scambler, C. Kass, D. Wright and J.E. Gallagher, *BMC Oral Health*, **10** (2010) 14.
- [16] C.R. Mattick, *J. Orthod.*, **30(1)** (2003) 88-92.
- [17] S. Darwish, *Br. Dent. J.*, **199(8)** (2005) 503-504.
- [18] B. Breistein and D.J. Burden, *Am. J. Orthod. Dentofac. Orthoped.*, **113** (1998) 408-413.
- [19] P. Kapoor, H. Singh and D. Kapoor, *Indian Journal of Dentistry*, **2(3)** (2011) 88-90.
- [20] M.P. Ashley, *Br. Dent. J.*, **191** (2001) 4-8.
- [21] I.H. Coritac, *The Psychoanalytic Review*, **33** (1946) 365-367.
- [22] S. Lorand and S. Feldman, *The International Journal of Psychoanalysis*, **36** (1955) 145-161.
- [23] D. Capps and N. Carlin, *Pastoral Psychol.*, **60** (2011) 773-789.
- [24] E.J. Neiburger, *New York State Dental Journal*, **67(6)** (2001) 26-27.