Facial Beauty — Establishing a Universal Standard

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Abstract

There is a universal standard for facial beauty regardless of race, age, sex and other variables. Beautiful faces have ideal facial proportion. Ideal proportion is directly related to divine proportion, and that proportion is 1 to 1.618. All living organisms, including humans, are genetically encoded to develop to this proportion because there are extreme esthetic and physiologic benefits. The vast majority of us are not perfectly proportioned because of environmental factors.

Establishment of a universal standard for facial beauty will significantly simplify the diagnosis and treatment of facial disharmonies and abnormalities. More important, treating to this standard will maximize facial esthetics, TMJ health, psychologic and physiologic health, fertility, and quality of life.

Introduction

This is a follow up of my facial beauty article published in 1996. Many concepts presented in this paper may contradict certain mainstream thinking. Some may even be controversial. These concepts are based on the author’s 20 years of clinical observation and experience as well as findings from other researchers and clinicians. Wherever possible, these concepts are supported by references; however, some concepts are so new that there are no studies or references currently available. It is not the intent of the author to create controversy. Hopefully this paper will cause many to seek out the truth, to reassess past concepts, and to critically assess new concepts for the ultimate benefit of our patients. In time, the truth will become self-evident.

The following are concepts establishing the existence of a universal standard for facial beauty based on the divine proportion and its biologic significance:

1. There is a universal standard for facial beauty regardless of race, age, sex and other variables.
2. Universal standard is based on divine proportion, and divine proportion is universal and synonymous with beauty.
3. All living organisms including humans are genetically encoded to develop and conform to the divine proportion.
4. Facial and body disproportions/abnormalities are due to environmental factors and significantly less to genetics.
5. Divinely proportioned faces and bodies are esthetically pleasing, healthy, fertile, and physiologically vigorous.
6. The following biologic equation holds true for all humans regardless of race, age, sex and other variables:

   Divine proportion = facial beauty = TMJ health = psychologic health = physiologic harmony = fertility = total health and wellness = Quality of Life©

Divine Proportion

More and more information is coming to light as to the existence and the significance of the divine proportion. It is all encompassing and it affects living and non-living entities. All living organisms are biologically engineered to conform to this proportion. Man made items and structures appear to be directed to conform to the divine proportion. Even more amazing, non-living, dynamic, entities conform to the divine proportion. Dynamic is defined as moving and is the opposite of static. Ripples of water, ocean waves, and tornadoes are few examples of dynamic, non-living entities. Note that divine proportion, golden proportion and Phi are synonymous terms. The symbol 1 represents Phi, and Phi equals 1.618.

With his permission, Figure 1 shows a few examples from Dr. Eddy Levin’s website, www.goldenmeangauge.co.uk, to show that divine proportion is everywhere. He uses a 3-pronged golden gauge to illustrate divine proportion. The shorter distance of the end prong to the middle prong is 1, and the longer distance of the end prong to the middle prong is 1.618. Divine proportion is seen in art, architecture, fashion, birds, insects, and flowers, just to name a few.

There are possibly billions of examples of divine proportion within the human body. With his permission, Figure 2 shows a few examples from Mr. Gary Meisner’s website, www.goldennumber.net.

In Figure 2, the distance from longest fingertip to the wrist is 1, and the distance from the wrist to the elbow is 1.618. In the bones of the finger, going from left to right, each succeeding finger bone is 1.618, the length of the previous finger bone. In the heartbeat, the EKG shows three peaks. The distance
from the first peak to the second peak is 1; the distance from the second peak to the third peak is 1.618.

Non-living, dynamic, entities conform to the divine proportion like the spiral of a galaxy as seen in Figure 2. The spiral of a galaxy is based on the Fibonacci numerical series $1, 2, 3, 5, 8, 13, 21, \ldots$. Each number is derived by adding the two numbers preceding it. The spiral is constructed by attaching a 1-unit square to another 1-unit square, then attaching a 2-unit square, then a 3-unit square and so on and so forth. See Figure 3. Quarter-circle arcs are drawn starting with the 1-unit square and connecting opposite corners of the squares (using the sides as the radii of the arcs) in such a way that the arcs connect sequentially. What develops is a beautiful spiral known as equiangular spiral or logarithmic spiral and can be found in plants and animals such as seashells.\(^2\)

As shown from the few examples given, divine proportion is everywhere and all encompassing. Even the credit cards conform to this proportion. There are many excellent books on this topic.\(^3\) The intent here is to illustrate its existence and significance. Levin, in his 1978 article,\(^6\) explained its history and mathematics. More important to our profession, he explains how this proportion relates to esthetically pleasing dentition and smile. Mack\(^7\) discusses the importance of treating the...
dentition to the face based on the divine proportion. He warns of potential problems in facial esthetics when only mounted casts are used for diagnosis. He states that the lower 1/3 of the face significantly influences facial appearance. As proof, he sites the public's preoccupation with fullness of the lips and the importance of a pleasing smile.

No major concepts are without contrary opinions. Preston disagreed with the relevance of divine proportion as did Moss et al who found that professional models did not all conform to the divine proportion.

Divine proportion of the human body

There is no greater example of illustrating divine proportion of the human body than Leonardo DaVinci's drawing, Human Figure in a circle, Illustrating Proportions, 1485-90. See Figure 4.
Figure 4 illustrates the human body in perfect proportion. If the distance from the top of the head to the umbilicus is 1, then the distance from the umbilicus to the toe is 1.618. Also, if the distance from the right shoulder to the tip of the left finger is one, then the total height of the human body (head to toe) in an ideally proportioned adult human body is 1.618. These are just a few of possibly billions of examples that could be found in the human body. Divinely proportioned individuals are attractive and tend to be strong, physiologically healthy, and fertile. It would be interesting to study the proportions of Olympic athletes compared to the general population.

More relevant to the dental profession as well as the medical profession (such as plastic surgeons) is the divine proportions of the human face.

The adult human face must also conform to the divine proportion in order for it to be beautiful and biologically efficient. Figure 5 shows some of the vertical relationships of the face. For example, if the distance from LN (lateral side of the nose) to ME (soft tissue menton) is 1, then the distance from LN to TRI (Trichion-beginning of forehead wrinkling when one lifts the eyebrow) is 1.618. Also, if the distance from CH (Cheilion-corner of the mouth) to ME is 1, then the distance from LC (lateral canthus of the eyes) to CH is 1.618.

Figure 5 shows a few transverse relationships of the face that must conform to the divine proportion. For example, if the distance between LN is 1, then the distance between CH is 1.618. The distance between LC is $(1.618)^2$ and the distance between the temporal soft tissues of the level of the eyebrow is $(1.618)^3$ or 4.236.

Figure 5 shows that the external dimension of the adult head must also conform to the divine proportion. Ideally, if the distance from LCHK (lateral border of the cheeks) is 1, then the distance from TH (top of the head) to ME (soft tissue menton) should be 1.618. Figure 6 shows the reality of the theory just proposed. It shows faces of two beautiful women whose external configuration is divinely proportioned.

As seen in Figure 7, if the face from TH to ME is greater than 1.618, the faces will be dolichofacial and have a tendency toward long face syndrome. If the distance from TH to ME is less than 1.618, the faces will be brachyfacial and have a tendency toward a short face syndrome. Both will have esthetic problems as well as greater chance for medical problems. For instance, patients with long face syndrome tend to have a greater incidence of upper airway obstruction and mouth breathing. Patients with short face syndrome tend to have a greater incidence of craniofacial pain and migraine headaches. If TH to ME is equal to 1.618, the faces will be mesofacial and will be ideally proportioned. These faces will be esthetically pleasing and will have significantly less incidence of medical problems. In the frontal view, the universal standard for beauty is the mesofacial face.

There is also a universal standard for facial beauty in the profile view. Figure 8 illustrates 6 different types of profiles A through F. Profile A is a long face with a retrognathic mandible; profile B is a short face with a retrognathic mandible; profile C is a short face with a prognathic mandible; and profile D is a long face with a prognathic mandible. Profile E is a normal vertical with a flat profile, and profile F is fuller profile and is universally accepted as being the most beautiful. The profile most universally accepted as being beautiful is a fuller profile. This was true in 1970 when Peck and Peck did their research. They stat-
...one interesting tendency was apparent from the data. The sample means almost always favored a fuller, more protrusive dento-facial pattern than our cephalometric standards would have liked to present.” This finding was also supported by Auger and Turley in 1999 and Nguyen and Turley in 1998.

It must be emphasized that no one segment of the human population has a monopoly on any of the various profiles shown. The classically beautiful profile F can be found in every sex, age, and race. My clinical observations have shown that there are multitude of medical problems associated with disharmonious profiles A through E, and significantly less medical problems associated with the beautiful profile F. Beautiful profile is determined by divine proportion. See Figure 9.

Often, many orthodontic practitioners feel that facial beauty is racially and culturally influenced. However, many current studies have shown the universality of facial beauty. For instance, there is a high degree of agreement among examiners when assessing facial attractiveness from photographs. A number of recent cross-cultural researchers have shown that the bases for judging facial attractiveness were consistent across cultural lines. They showed that racially and ethnically diverse faces possess similar facial features that were deemed desirable and attractive regardless of the racial and cultural background of the perceiver. This cannot be better illustrated than in Figure 10. At first glance, you will observe four beautiful women of various races with ideal facial proportions. In actuality, all four faces are of the same person (the face on the lower right) with makeup and wig. We must stop looking at superficial differences such as skin color and hair texture, and start looking at similarities that make us one race—the human race.

There is much debate as to the importance of establishing different standards to different races. It is true that each race has certain characteristics. It is also true that different family members of the same race have different characteristics. These differences should be considered “variations.” When considering all of human biology, physiology, and genetics, these differences are so insignificant that they should be considered normal. On the other hand, facial disharmonies such as long face syndrome, short face syndrome, skeletal II’s and III’s, facial asymmetries, and other craniofacial disharmonies have esthetic and physiologic problems; they should be considered abnormal and they all should be diagnosed and treated if necessary.

Relationship between beauty and health

Ricketts discusses in great detail the importance of the divine proportion to beauty and its biologic significance. He states that the appreciation of beauty in humans functions at the limbic level. In other words, individuals of all ages are attracted to beauty; it is a primeval attraction that has its basis in survival. He also states that organisms, including humans that conform to the divine proportion, are not only beautiful, but also biologically healthy. He states, “Biologists and morphologists speak of this in terms of ‘laws.’ There is the first the ‘law’ of conservation of energy—maximum performance with minimum effort. Second, they refer to the ‘law of conservation of tissue’—minimum amount of material to be employed to perform the needed task. A third law...is a combination of the first two. It is an arrangement to provide profound efficiency. Efficiency is required for individual survival.” My own clinical observations have shown that beautiful faces have less medical problems such as craniofacial pain and headaches than faces that are disharmonious and unattractive. As faces deviate further away from the divine proportion, there tends to be greater incidence of medical problems in number and magnitude.

The position of underlying bone has a direct effect on the health of TM joints and physiologic harmony. As stated earlier, patients who are dolichofacial (long face syndrome) tend to have upper airway obstructions. Patients who are brachyfacial (short face syndrome) tend to have myofascial pain and temporomandibular disorder. Both problems are associated with a multitude of other medical problems including irritability, lowering of the immune system, lack
of delta phase sleep, etc. These observations support the various biologic laws discussed earlier, such as conservation of energy and conservation of tissue.

Many researchers including Thornhill and Gangestad and others discuss the importance of bilateral symmetry to physical beauty, health, and sexual attraction in humans and animals. Most interestingly, Rikowski and Grammer found direct correlation to human body odor, symmetry and attractiveness. This study supports the possibility of human pheromones in sexual attraction. In light of this, it must be emphasized that bilateral symmetry is a small part or subset of divine proportion. If an individual is not bilaterally symmetrical, then that individual is not divinely proportioned.

A perfectly symmetrical face does not always correlate to a beautiful face; however, a divinely proportioned face will always be beautiful.

Some practitioners use the term “neuromuscular” position in describing ideal mandibular position. To the vast majority of health practitioners, this term is not well understood. It also places too much emphasis on the nervous and the muscular system. In order to maximize health, every aspect of the human body should be in ideal position. This includes, but is not limited to, nervous, muscular, circulatory, endocrine, respiratory, digestive, immune, reproductive, skeletal, cerebral-spinal, joints, sutures, ligaments, etc. Additionally, all the organs, including the brain, must be positioned and confined to ideal space in order to function maximally and efficiently. In order to accommodate all these biologic and physiologic factors, a more appropriate term is ideal “physiologic” position.

**Impact of environment to facial abnormalities**

There is much debate as to whether facial abnormalities are caused by genetics or environmental factors. Many doctors and researchers believe that abnormalities such as long faces, short faces, skeletal II’s and III’s, small, narrow palates, and others are strictly due to genetics while others believe it is environmental. Perhaps both are right and they may be due to both genetics and environmental factors. However, we as healthcare practitioners must make a firm decision as to which of the two factors predominate.

It is my contention, based on clinical observation as well as other research literatures, that facial “variations” are genetically induced. Facial “abnormalities” are environmentally induced with possibly a small genetic component. Studies by respected researchers bear this out. Linder-Aronson and Woodside studied frontal and lateral head films of 22 out of 120 males who had excessive lower vertical height. They noted that the mean size of the airway through the nose and/or nasopharynx was narrower than the control group. In essence, individuals with long face syndrome had upper airway obstruction and tended to be mouth breathers. They implied that some facial features previously thought to be genetic in origin may also be influenced by environmental factors. Linder-Aronson also noted monozygotic twins in which only the twin with nasal obstruction developed long face syndrome.

Respiratory characteristics can influence facial growth pattern. Studies by Linder-Aronson, Subtelny, Quinn, Principato et al and Cheng et al, and others have implicated nasal airway obstruction and mouth breathing as the likely cause of long face syndrome. Zettergren-Wijk et al studied the effects of surgical removal of swollen tonsils in children, mean age 5.7 years, on dentition and facial morphology. They found normalization of facial disharmony after surgery, but most of the changes occurred in the first year after surgical removal of tonsils and/or adenoids.

Marks blames modern diet for creating much of the allergic problems in humans. He states that cow’s milk in the neonatal period may sensitize the nasal mucous membrane to persistent edema and consequent nasal airway obstruction. Taylor describes this nasal vasomotor reaction in greater detail. Human and animal studies have shown that when forced to breathe orally rather than nasally, vastly different myofunctional habits and jaw position are necessary to accommodate this different method of breathing. It is thought that nasal airway obstruction leads to mouth breathing, lowered tongue posture, decreased swallowing pattern, supereruption of posterior teeth, and open mandibular position. If this abnormal breathing function continues during active growth, then narrowing of the maxillary dental arch may occur as well as increased lower facial height.

Inductive reasoning clearly points to environmental factors as the major cause of facial abnormalities. Why were there almost no dental malocclusion and facial abnormalities in primitive societies and an abundance of these problems in modern society? Price made it his life’s work studying the nutritional problems of modern diet. Around the world, he evaluated local villages that maintained their natural diet with comparable villages that consumed modern food, and the difference in physical development and health were staggering. Those villages that maintained natural diet had broader faces, broader dental arches, with significantly less dental caries and periodontal disease than those that ate modern diet. There were also significant differences in the body types. Those that ate natural diet had stronger, broader bodies than those that ate modern diet.

Practitioners who believe that facial abnormal...
ities are genetic in origin feel that the size of the jaws cannot be changed. They tend to treat crowded dentitions by extracting bicuspids. Those who believe that abnormalities are caused by environmental factors tend to treat crowded dentitions by expanding the dental arches. Many argue that doctors who expand arches are violating the genetic makeup of their patients and that these treatments will relapse. It has been shown by Little et al.\(^63,64\) that first premolar extraction treatments also have a high relapse rate. After 10 years, 70 per cent of premolar extraction cases relapsed; after 20 years, 90 per cent relapsed. Expansion cases also have problems with relapse as shown from studies by Schwarze.\(^65\) This is a dilemma for orthodontic practitioners. However, proper diet and alleviation of upper airway obstruction may be the key to preventing facial abnormalities in young children and providing stability after orthodontic therapy.

**Divine proportion: soft tissue analysis**

Marquardt developed a soft tissue analysis based on the divine proportion.\(^66\) He has a lateral (repose) and a frontal beauty mask based on the divine proportion, more specifically. Fig. 13 (right column) Faces that conform to beauty mask are beautiful regardless of race, age, sex, era, and other variables. There is a male version of beauty mask for males.
cally the golden decagon. Figure 11 only shows the frontal beauty mask. He goes into greater detail on his website: www.beautyanalysis.com.

The mask can be superimposed over properly positioned and properly sized facial photographs to assess esthetic problems. If the face falls in line close to the beauty mask, then the face will be esthetically pleasing. The face will become more and more unattractive as the facial shape and structures move away from the divine proportion. See Figure 12. In this illustration, the beauty mask shows that the face on the top is not too far off from the divine proportion and is average in attractiveness. On the other hand, the beauty mask shows the face on the bottom is significantly off and is very unattractive.

Marquardt believes that facial beauty is universal. If the adult face conforms to the beauty mask, then that face will be beautiful regardless of sex and race. See Figure 13. There are three faces of different races, Caucasian, Asian, and Black. All are beautiful and all conform closely to the divine proportion. Beauty is also timeless as can be seen in the lower right in figure 13. Nefertiti (around 1350 B.C.) was famed throughout the ancient world for her outstanding beauty. She conforms to the divine proportion as shown by the beauty mask. It is interesting to note that Dr. Marquardt, who is on the west coast, has been studying facial beauty for 30 years. This author, who is on the east coast, has been studying the same for 20 years. Both independently came to the same conclusion that there is a universal standard for facial beauty.

**Divine proportion: hard tissue analysis**

An excellent hard tissue analysis for evaluating lateral profiles is the Jefferson Analysis. It was known earlier as Modified Sassouni Analysis or Skeletal Archial Analysis. Previously published articles clearly explain its tracing technique, diagnosis, and skeletal classification system. The Jefferson Analysis treats patients to beautiful faces, healthy TM joints, and physiologic health. It is based on the divine proportion since in almost every instance faces are made more beautiful when treated to this analysis. Credit should be given to Dr. Vikan Sassouni since Jefferson analysis is a modified, simplified, and much abbreviated version of the Sassouni Archial Analysis.

Figure 14 shows a female face with nearly ideal facial proportion and profile. She was 21-year 3-months when this photo was taken and her case was reported in 1993. The cephalometric tracing of this individual uses the Jefferson analysis. This analysis assesses the antero-posterior position of the maxilla and the mandible and assesses lower facial vertical height. The diagnostic interpretation is visual and simple.

In an ideal face in both children and adults, the anterio tip of the maxilla, anterior-nasal spine (ANS), and anterior portion of the mandible, pogonion (P), should be within 2 mm of the anterior arc. Assessment of lower facial vertical height is simple. In an adult face 18 years old and older, menton (M) should be within 2 mm of the age 18 vertical arc. At age 4, menton should be within 2 mm of the age 4 vertical arc. From age 4 to age 18, menton grows downward at a rate of 3/4 mm (0.75 mm) per year. The analysis shows that this individual’s maxilla and mandible
are almost perfectly positioned, both antero-posteriorly and vertically. It is extremely rare to find individuals with such nearly perfect alignment. As expected, she had no symptoms of TMD or craniofacial pain.

Jefferson Skeletal Classification© should be used in conjunction with the Jefferson analysis. The classification system proposed by this author is simple, easy to understand, and practical. See Figure 15.

There are 9 skeletal types: I, IIA, IIB, IIC, IIIA, IIIB, IIIC, BR and BP. Each has an upper and a lower arrow pointing to an arc. The upper arrow represents the maxilla and the lower arrow represents the mandible. The tip of the upper arrow represents ANS; the tip of the lower arrow represents P. The arc in front of the arrows represents anterior arc. Skeletal I shows the tips of both arrows touching the anterior arc. This means that the maxilla and the mandible are both in ideal A-P position. The individual in Figure 14 and her ceph analysis shows her to be Skeletal I.

The rest of the skeletal types represent skeletal problems. For example, Skeletal IIA represents the maxilla being prognathic and the mandible in ideal A-P position. Skeletal IIB represents the maxilla in ideal A-P position and the mandible being retrognathic. Skeletal IIC is combination problem. It represents the maxilla being prognathic and the mandible being retrognathic. Skeletal III’s are just the reverse of Skeletal II’s. BR (bi-skeletal retrognathic) represents both maxilla and mandible being retrognathic. Finally, BP (bi-skeletal prognathic) represents both maxilla and mandible being prognathic. Along with the skeletal classification, the lower facial vertical height (short, normal, or long) must be noted.

The following cases show how the Jefferson analysis and classification are used.

Case 1 in Figure 16 shows a face with facial disharmony. Her ceph analysis shows normal maxillary A-P position; however, her mandible is prognathic. Her lower facial vertical is short by approximately 19mm. Her classification is Skeletal IIIB, short.

Note, this is a pseudo Skeletal III. If her vertical was corrected, her mandible would rotate clockwise and pogo-
nion would rotate back to possibly a more normal A-P position. Prior to treatment, this patient had severe craniofacial pain and other medical problems.

Case 2 in Figure 17 shows a disharmonious face. The cephalometric analysis shows a nearly normal maxillary A-P position; however, the mandible is prognathic. Additionally, the patient is 16y-7m years old and her menton has grown vertically downward past the age 18 vertical arc. Her classification is Skeletal IIIB, long. She had severe upper airway obstruction and severe maxillary and mandibular arch constriction.

Case 3 in Figure 18 shows a disharmonious face. Her cephalometric analysis shows the maxilla as being retrognathic and the mandible as being prognathic. This is a combination problem. Additionally, she is 13y-1m years old, and her menton has not even developed to the age 4 vertical arc. Her classification is IIIC, short. Prior to treatment, she had severe craniofacial pain, headaches, and other medical problems.

Practical application of Jefferson Analysis—case presentation

The following patient in Figures 19, 20 and 21 was treated with the aid of Jefferson analysis to assess her skeletal problems. See Figure 19. As can be seen from the patient’s facial photographs, her lower jaw appears to be somewhat retrognathic. The Jefferson analysis shows that the maxilla is
slightly retrognathic and the mandible is retrognathic. Her lower facial vertical is normal. Her classification is Skeletal BR, normal. Her intraoral photograph shows significant crowding as well as blocked out upper left canine. She had symptoms of TMD and associated physiologic stress.

The patient was treated with an upper Schwarz to expand the upper arch and straight wire fixed appliance. Her post treatment photos and ceph, Figure 20, shows improvements both dentally and facially. Jefferson analysis shows that the maxilla and mandible are now both in ideal A-P position, and her lower facial height is slightly short. Her post treatment classification is Skeletal I, short tendency. By moving the mandible forward, her TMD symptoms were alleviated.
Figure 21 shows the patient’s photographs exactly two years post treatment. There is good evidence that this patient’s self-confidence and feeling of self worth has improved dramatically after the orthodontic and orthopedic treatment. Treating to the divine proportion has improved her facial esthetics, TMJ health, physiologic and psychological health, her total health and wellness, and quality of life.

As previously stated, Mack cautions against just treating the dentition. Esthetics is not just about mounted casts or about perfect alignment of teeth but more importantly about their position in relation to the total face. Frindel studied the importance of a well-positioned smile in a balanced position on the face based on the divine proportion. He correlates this position to a young-looking smile throughout life. A divinely proportioned face is timeless and ageless. Conversely, a face significantly divergent from the divine proportion appears older and will age more quickly over time. Facial disharmony is associated with a multitude of medical problems. This, added to the physiologic stress, can deteriorate the human body and face and accelerate the aging process.

Conclusion

Due to recent advances in science and technology, especially in the area of functional orthopedic therapy, the dental profession is able to treat beyond the confines of the oral cavity. Former Surgeon General, David Satcher, in his report states, “Oral health means much more than healthy teeth. It means being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues, collectively known as the craniofacial complex.” This report also states that “the importance of the face as the bearer of identity, character, intelligence, and beauty is universal.”

In the introduction of this paper, six concepts were presented with references wherever possible. These six concepts form the bases for establishing a universal standard for facial beauty. A single standard for beauty regardless of race, age, sex and other variables will simplify diagnosis and treatment. Implicit in this discussion is the following understanding. It is not enough to just move the soft tissues superficially to make the face appear beautiful. It is tantamount that the facial-skeletal structures be properly aligned and to allow the soft tissues to conform to the hard tissue. In so doing, not only are the faces made more beautiful but the individuals will also be made healthier.

This paper explains how beauty and health are intimately related. Additionally, there are emotional and psychological issues that come with unattractive facial features.

During their formative years, young children suffer the most. Many with unattractive facial features, may also have associated medical problems, and possible learning disabilities. We in the dental profession can harmonize and normalize their face and health. In so doing, we are able to offer these children a life that they may not otherwise achieve: an equal opportunity for health, happiness, and success. We weld tremendous power within our fingertips to intervene professionally and to change the lives of these children in a very positive way. This is a supreme gift bestowed upon us—a gift that we should use wisely and responsibly.

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