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Editorial

Strategy of Psychosomatic Therapy. Considerations for Dentists

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Although dentistry is a profession dedicated to treat somatic disorders of the oral- and orofacial region primarily, there are certain oral/orofacial psychosomatic manifestations dentists should also deal with. This is because majority of psychosomatic dental patients refuse to accept psychological background of their symptoms, and instead of psychiatrists or psychotherapists, first they visit dentist and insist on the somatic origin of their symptoms. Therefore, a simple referral to psychiatrist and/or psychotherapist would not solve the problem in most cases, majority of patient would continue doing "dentist shopping" (i.e. frequent and useless change of dentist) with futile attempts at somatic therapies and/or surgical interventions. Consequently, an initial psychosomatic intervention is needed prior to definitive therapy, which is a scope of dental profession's duty. The most important goals of this initial psychosomatic intervention are avoidance of further useless invasive dental treatment and motivation of patients to participate in a definitive psychosomatic therapy, which is the highest-level care of psychosomatic dental patients.

In contrast to the initial dental intervention the definitive psychosomatic therapy is clearly not a scope of every dentist's duties. The definitive psychosomatic therapy should be carried out by specialized dental professionals as members of a specialized psychosomatic team including experienced dentists and other medical and psychological/psychotherapeutical professionals. This is because in most cases close collaboration with medical professionals (especially with psychiatrists and neurologists) and with psychologists/psychotherapists is clearly needed.

Gradual escalation of the psychosomatic treatment modalities and avoidance of irreversible forms of somatic treatment are "cornerstones" of both the initial psychosomatic intervention and the definitive psychosomatic therapy. Besides proper communication with the patient, several placebo and/or palliative methods (i.e. physiotherapies, medication, medicinal herb therapy, diet therapy, complementary/alternative medicine etc.) are frequently used for both the initial psychosomatic intervention and the definitive psychosomatic therapy. Use of certain psychotherapeutic approaches and administration of various mind-body therapies (i.e. relaxation, hypnosis, self-hypnosis, meditation, photo-acoustic stimulation, biofeedback etc.) are also frequently used especially for the definitive psychosomatic therapy.

The most frequent oral/orofacial psychosomatic symptoms are atypical facial pain, burning mouth syndrome, myofascial pain, temporomandibular dysfunction, bruxism and other parafunctions, gagging, psychogenic denture intolerance, psychogenic taste disorders, certain recurrent oral ulcerations or inflammations, some oral allergic reactions, psychogenic occlusal problems, tic, psychogenic salivation problems, and oral discomfort, but any other symptoms mimicking somatic symptoms of jaws, mouth and teeth may appear. The symptoms may appear singly or in combination. Since the appearing psychogenic symptoms may mimic a great variety of (most of) somatic symptoms of jaws, mouth and teeth, a clear-cut diagnosis and proper differential diagnosis could be rather difficult; even if a history of symptoms that are inconsistent with the physical findings and a history of a precipitating life event after which the symptom first appeared are hallmarks of such psychosomatic manifestations.

In early recognized cases the most important goal is the avoidance of further useless invasive dental treatment, especially because aggravation or spread of symptoms following invasive dental interventions may occur frequently. The prevention of symptom chronification is also crucial, because chronification (especially with prolonged unsuccessful somatic/operative dental therapy in the history) frequently render pain and other symptoms intractable. Prevention of symptom chronification can be carried out efficiently with the simple avoidance of repeating unsuccessful dental treatments in many cases, in other cases symptom-centered palliative methods, certain psychotherapeutic approaches and mind-body therapies should also be used.

In lately recognized cases the prognosis is rather poor primarily because of chronification processes leading to a relatively large amount of patients without any success or with suffering from several residual symptoms. Therefore, these patients should be made aware that it may not be possible to provide a permanent cure for their problem, but that they can learn to manage in a satisfactory manner. Home practice of most mind-body therapies, diet- and medicinal herb therapy as well as complementary and alternative medicine therapies regularly supervised by the specialized dentist (and/or other professionals) are good tools to manage such residual symptoms as well as to maintain clinical results and to prevent relapse (and/or exacerbation of symptoms).

The oral/orofacial psychosomatic manifestations are caused by either acute psychological stress conditions (i.e. existential trauma, workplace problems, relationship problems with the sexual partner etc.) or by chronic conditions like depression, neuroses, chronic anxiety, death anxiety, schizophrenic or paranoid reactions (etc.). The patients usually display a lower level of psychopathology comparing to psychiatric patients; but in some cases, severe psychopathologies including psychoses may also appear as a background of these manifestations. In such cases referral to psychiatrist and definitive psychiatric therapy (instead of psychosomatic therapy) is crucial; although a supportive type psychosomatic dental care may also be needed for stabilizing oral functions and oral health.

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