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REVIEW ARTICLE

"MANAGEMENT OF PSYCHOSOMATIC ORAL DISEASES AND NEUROTIC ORAL SYMPTOMS" – A REVIEW

Xavier Pradeep D'mello A*[1]., Ramya V[2]., Frankantony P Britto[3] Sudeep D'mello A[4] and Shravya M[5]

Department of Oral and Maxillofacial Pathology, AJ Institute of Dental Sciences, Mangalore, Karnataka, India. PIN– 575004

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ABSTRACT

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Psychosocial factors are recognized as an essential for health and as influential in disease. A psychosomatic disorder involves both body and mind. The mouth represents an organ of the expression of certain instinct ional cravings and is charged with a high psychologic potential. These diseases have physical symptoms originating from mental or emotional causes. Most common ones are stress, anxiety and depression. A wide spectrum of psychiatric disorders affects oral and para oral structures which have a definite psychosomatic cause, but unfortunately they remain unrecognized because of the common and limited nature of their presenting features. Emotional or psychological factors have been emphasized as potential influences with respect to a person's health, resulting in an increased popularity of holistic medicine. Several studies relying on self-reported patient information between psychological state and incidence or progression of disease have been done and results have been interesting. With the above background this article attempts to review the current available literature on management of psychosomatic oral disease and neurotic oral symptoms.

INTRODUCTION

The term psychosomatic is derived from the Greek word 'psyche' and 'soma'. Psyche in ancient times meant soul or mind and recently it has become to mean behavior. Soma refers to physical organism the body. Term 'psychosomatic' refers to influence of psychological processes on the biological processes. Term 'psychosomatic' is used to refer to a variety of concepts from diseases to bio-psychological research to consultation liaison work. The word 'psychosomatic' is frequently used to depict illnesses in a pejorative way. Psychosomatic diseases are bodily (somatic) disorders, thought to be initiated or aggravated by physiological disorders that persist for over 2 years. The basic concept in psychosomatic medicine was first introduced clearly by Freud, who used the term "conversion hysteria" in describing the reaction in which emotional conflicts are converted into bodily or somatic symptoms[1].

Psychogenic disorders may also be responsible for the oral complaints such as atypical facial pain and burning mouth syndrome, dry mouth or factitious injuries. The symptoms cause enough real sufferings to patient. Symptoms are usually not provoked by recognizable stimuli such as hot or cold foods or mastication. The oral mucosa is highly reactive to psychological influences. In some areas oral disease may be direct expression of emotions or conflict, while in other instances lesions of the mouth may indirect result of emotional problem. Oral health is an integral to general health and also a critical component of general health. Psychosocial factors are recognized as an essential for health and as influential in disease[2]. The mouth represents an organ of the expression of certain instinct ional cravings and is charged with a high psychologic potential. Changes in the psychological functioning in patients may be related to manifestation of pain in some patients with atypical odontalgia, temporomandibular disorders, chronic orofacial pain, burning mouth syndrome, aphthous stomatitis etc[3, 4].

Psychiatric And Pain Rating Scales[5]

The principal difficulty and criticism in making a diagnosis of a psychogenic disturbance either for individuals or groups is measurement. In the absence of any neurotransmitter assay the

*✉ *Corresponding author:* **Xavier Pradeep D'mello A**
Department of Oral and Maxillofacial Pathology, AJ Institute of Dental Sciences, Mangalore, Karnataka, India. PIN– 575004

clinician has to resort to rating scale questionnaires measuring behavior and symptoms in order to support his clinical diagnosis.

Psychiatric rating scales are completed either by the patient (Self-rating) or the clinician (observer rating). The most common forms are

1) 'Case finding' instruments.
2) Mood check list.
3) Personality scales.
4) Life event scales.
5) Illness behavior.
6) Pain.

Management

Pharmacotherapy many different psychiatric conditions are worsened by stressors. When major psychiatric conditions like depressions or psychosis are present, the most appropriate medications for those Axis I diagnosis. However, more typically the picture is one of anxiety disorder, but still very distressing to the patient. In such settings referral to psychiatrist and pharmacological therapy and with anxiolytics or short term hypnotic agents can be extremely helpful[6].

In psychosomatic oral diseases, placebo effects of systemic medicaments or locally applied ointments cannot be discontinued; in many instances it appears to be responsible for successful therapy .whatever medicament is used, it should be given to the patient with a positive approach. Corticosteroid creams or ointments are helpful in oral ulcerative disease because they are anti inflammatory and relieve some of pain sensations, so that the patient should be told that this agent doesn't work in all cases and that other agents may be successful in his particular case. If there is no response to any agents used and the patient's complaints are severe, the anxiety factor can be discussed with patient and anti anxiety drugs prescribed or psychiatric consultation suggested[7].

When we believe that a significant emotional factor is etiology of a disease, we present this concept to patient. In most such cases patients are relieved to know that they are affected by "disease of civilization" rather than an infection or neoplasm. We point out of patient that "neurotic is normal" that we are all neurotic to a varying degrees, but each patient's subconscious respond to emotional stress in different ways. This patient's subconscious has selected the mouth as target area for resolution of stress. The patient is told that his condition is one that he will have to learn to live with for a prolonged period of time, that treatment may help alleviate the stress of lesion and the painful symptoms but may not completely cure the disease or prevent its recurrence. this approach is particularly applicable to oral lichen planus of bullous or erosive type[8].

Recurrent herpes labialis can be often prevented if the patient is told to rub some corticosteroid ointment such as Terra-Cortril, into labial mucosa about 24 hours before the lesion erupt. Most patients are aware of probable onset of disease by a tingling sensation that a prodromal manifestation of herpes labialis. Once the lesion have developed the ointment may help reduce the discomfort, but it will not significantly alter the course of disease[9].

Psychosomatic oral diseases do not appear to be helped by tranquilising or anti-anxiety drugs. Neurotic symptoms on the other hand, may be alleviated by the anti anxiety drugs as described in table 1.

Table 1 Anti anxiety drugs for treating Neurotic symptoms[10].

DRUG	mg	DOSAGE
Meprobromate (Miltown, Equanil)	200 – 400	tid or qid.
Diazepam (Valium)	2 - 5	tid or qid.
Chlordiazepoxide (Librium)	5 - 10	qid.
Oxazepam (Serax)	10 - 15	qid.
Hydroxyzine (Atarax, Vistaril)	25 - 50	qid.

These drugs seldom have serious side effects are relatively safe. All of these drugs can produce drowsiness and patients be warned of this, particularly if they drive cars or are employed in occupations requiring alertness. These drugs should not be prescribed for pregnant woman owing to possible teratogenic effects and that they should not be prescribe if patient is also taking CNS depressant or alcoholic.

If the patient suffers from insomnia and inflicts the oral trauma during these hours of half sleep, various sleeping preparations can be prescribed to be taken before retiring for the night.

For muscle pains or spasms caused by clenching or grinding of the teeth, methocarbamol (Robaxin) 750 mg qid is often helpful. Diazepam (valium) 2to 5 mg qid may also be used for its muscle relaxant effect as well as for its tranquilizing action. Single tablet of diazepam 5mg or flurazepam 30 mg can be helpful if taken before bed time[11].

If the patient with neurotic or oral symptoms appears to be suffering from depression or other mental disorders, seek the psychiatric consultation. Do not undertake anti depressant drug therapy this requires psychiatric evaluation and psychiatric management. Appropriate psychotherapy may not be always easily available however and the depressed patient may have to be managed by a general practice physician. This is particularly true for the unhappy elderly patient who feels deserted by his family and by society in general.

Cognitive Behavioral Therapy

Cognitive behavioral therapies are increasingly used to help individuals better manage their responses to stressful life events. These treatment methods are based on the notion that cognitive appraisals of stressful events and coping efforts related to these appraisals play a major role in determining the response to stress[12].

A model of stress and coping has been enveloped that serves as the conceptual foundation for most cognitive behavioral stress management protocols this model maintains that there are two types of cognitive appraisal that are especially important in mediating retains to stress. The first, primary appraisal refers to the way in which an individual evaluates the significance or meaning of a given event. When event (being diagnosed with a chronic illness such as rheumatoid arthritis) are appraised as harmful ad threatening (e.g. "because of my rheumatoid

arthritis, I will never be able to do anything really care about"), the individual is more likely to become anxious, depressed, and withdrawn. However, if the same event is viewed as challenging (although my arthritis prevents me from doing some physically demanding activities, there are many other important and meaningful activities that I can do and enjoy). Then more positive outcomes are more likely to occur. Secondary appraisal refers to the process of evaluating what can be done about the stressful event. Several factors can influence such secondary appraisals including the breadth of individual's repertoire of coping skills, their mastery of specific coping skills and their expectation that their skill will be effective.

Cognitive behavior therapy approaches to stress management have 2 major aims. The first aim is to help individuals become more aware of their own cognitive appraisals of stressful events. The second aim is to each individual how to develop and maintain the use of a variety of effective cognitive and behavioral stress management skills.

Self-Observation

One of the most effective ways of helping individuals become more aware of how they respond to problem situations is to have them keep a daily record of their behavior. A daily dairy formatis often used with patients being asked to keep a record of how they responded to challenging or stressful events that occurred each day. Entries are made in three columns: antecedents, behaviors, and consequences. In the "antecedents" co-patients record a specific environmental. The event might be an interpersonal stressor such as having an argument with a spouse or a confrontation with a coworker, or an intrapersonal stressor such as a flare in pain symptoms, or a major natural disaster.

To asses appraisals of the stressor, patients are asked to rate how stressful they found this event on a 0 to 100 scale (eg, 0 = not at all stressful; 100 = the most stressful event I have ever experienced). In the column marked behaviour, patients are instructed to record their cognitive and behavioral reactions to the stressful event. The term "Behaviour" is broadly defined so that it not only encompasses overt behavioral responses but also more covert cognitive affective and physiological responses. Thus, in the behavioral response column individuals might indicate specific coping behaviors they engaged in.

Self-observation is effective for several reasons. First, it makes individuals aware of behaviors that they usually fail to notice. An individual whose style of dealing with social anxiety is to use avoidance, for example, may avoid potentially stressful situations in a more or less fashion (eg, routinely refuse invitations), use very subtle forms of avoidance (eg, arriving late or leaving a party early), or arrange their lifestyle (eg, work alone) so that they have very few chances to confront their fears.

Participants who keep daily diaries are often struck by the variations in their own reactions across different events. For example, while they may cope effectively with one stressful event (eg, meeting an important work deadline), they find themselves unable to deal with another stressful event (eg, an argument with their teenage son or daughter).

Self observation highlights the role that coping efforts, cognitive appraisals and physiological responses play in explaining these very different responses to stressful situations. Interestingly, individuals who keep daily dairy records of stress-related behaviors often make changes in their own behaviour, even before other stress management methods are introduced.[9, 13].

Cognitive restructuring

A hallmark of cognitive behavioral therapy is its insistence that cognition plays a central role in the stress and coping process. In cognitive behavioral therapy cognitive appraisals about stressful events are considered to be the key factor in determining stress related responding. Given this emphasis on cognition, it is not surprising that a major thrust of cognitive behavioral therapy approaches to stress management is on helping participants to become aware of and to change their maladaptive thoughts, beliefs and expectations.

Cognitive therapist have developed protocols for helping distressed individual restructure dysfunctional, emotional reactions that are excessive or prolonged are often the result of cognitions that are distorted or dysfunctional.

The second step in cognitive restructuring is monitoring and analyzing dysfunctional thoughts. As can be seen each of these thoughts can be linked to a negative emotion. A careful analysis of each though also reveals an inherent error in logic. Certain types of errors or cognitive distortions occur quite frequently and individuals can thus be taught to recognize them[14].

The third step in cognitive restructuring is to challenge and challenge cognitive distortions. They are asked to select one or two questions that are useful in identifying the underlying logical problems in their thinking. Finally, participants develop a rational response that represents a more accurate and helpful cognitive response to the situation.

Relaxation Training

Relaxation skills can be very helpful in managing stress. When individuals learn to relax, their overall muscle tension is reduced, as is their overall level of autonomic arousal. Individuals who are able to relax are also more likely to be able to think more rationally and to be able to restructure negative cognitions when faced with stress.

In the 1920s Edmund Jacobson developed progressive relaxation training as a way to help individuals to control excessive muscle tension. Jacobson approached relaxation as a motor skill and emphasized that, like any skill, repeated practice was necessary for skill mastery. In traditional Jacobsonian relaxation training the goal is to heighten an individual's awareness of very low levels of muscular tension. The patent is instructed to focus on sensations that occur when tensing a single large muscle group (eg, the forearm flexors-tensed by bending the left hand back at the wrist. The individual is then instructed to release the tension in that muscle group and study the resulting physical sensations. Wit repeated practice.

Trainees often become quite adapt at recognizing control signals indicative of tension and letting the tension go traditional Jacobson relaxation training is effective: however, it does require a substantial time commitment on the part of the participant[12].

In the 1950s Jacobsonian relaxation training was modified by behavior therapist so that it could be more easily incorporated into treatment programs. The modified training program was similar to Jacobson's n emphasizing that relaxation could be achieved by using a series of exercises involving tensing and relaxing muscle groups, but differed in that it was much briefer. Numerous modified versions of Jacobson's original method have been developed and refined over the years.

One of the most important tasks in relaxation training is helping patients learn how to generalize their skills in relaxation form home practice sessions to stressful and demanding daily life events. Several techniques are used to enhance generalization. The first is a method developed by Jacobson called differential relaxation.

In differential relaxation, the trainee is instructed to engage in a daily take and only use the muscles that ate necessary for carrying out the task. For example, while writing ones name needs to be activity in muscles of the hands and arms but the muscles in the face, lower trunk, legs and feet can be deeply relaxed[12].

CONCLUSION

Mouth is mirror of the body says Williams Osler, as mouth reflects many systemic diseases. The different oral manifestations are like spontaneous gingival bleeding in hypertension and in blood dyscrasias like Leukemia, Thrombocytopenic purpura etc., dry mouth in diabetes, enamel hypoplasia in Rickets etc., stress also induces oral lesions, but stress may not be the cause in many of the lesions in some subjects. Proper history and essential investigations will ensure correct diagnosis of the etiological factor and thus results in successful treatment plan. Clinical subject's free form stress must be properly differentiated as other causes like immunological, hormonal and metabolic disturbances may be the etiological factor in these subjects. Oral lesions not related to stress, if subjected to antipsychotic measures, it might lead to further complications.

Assessment of psychosocial factors and psychosomatic treatment that follow the various Guidelines for the Diagnosis and Treatment of Psychosomatic Diseases can be an effective treatment modality with a better prognosis of the individuals.

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