Problem patients with stomatognathic fixed psychogenic disorder

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This paper describes common features and characteristics of patients with a specific manifest psychogenic or psychosomatic disorder. The intention as a dental author without special psychological or psychiatric training is a rather descriptive presentation of abnormalities of these patients, from which possibly colleagues can drawn their own conclusions for better handling of these patients in practice or indications with the aim of better detection and negative selection. The facts and considerations presented are based on my own personal experience as a rather exposed specialist for function and esthetics of the DGÄZ. It is possible that the frequency of such problem patients is lower in a general dental practice, but it can be assumed that every dentist regularly has to deal with patients in whom a current mental disorder is present or becomes apparent in the course of extensive treatment, since one third of the population exhibit one or more clinically significant mental disorders in the course of 12 months. Anxiety disorders are the most common of these, at 16.2%. Somatoform disorders are represented by 3.3% [1].
Some of the frequently encountered abnormalities of such patients are listed and explained here. It is not possible to answer the exact underlying causes, but the overall picture gives an impression of regularly recurring phenotypes.

Peculiarities of the masticatory system and teeth

Our stomatognathic system has a special status among the parts of the body and is apparently particularly suitable as a starting or reference object of a “idée fixe”. In addition to all the known properties and functions of the teeth what makes them extraordinary is the fact that they are the only visible parts of the body that are made of solid substance and can be permanently restored or changed by human hands. Unlike hair or fingernails, which are only cosmetically altered and subject to constant growth and regeneration, the intended goal of restorative dental treatments is usually final.
At the same time, however, everyone is aware that one's own natural teeth, as unique and extremely resilient living organs, are very valuable and a loss of substance of enamel, dentin, pulp is basically irretrievable and these should be kept healthy for life if possible. In addition,

the natural replacement of teeth is associated with high financial costs. Thus, one is aware of both the high value of one's own teeth and the theoretical possibility of restoring or even improving them. Promises made by us dentists support the impression that it must be possible to completely remedy every dental problem in the sense of a "restitutio ad integrum". The fact that this cannot be the case per se for any type of prosthesis should be constantly recalled by both laymen and specialists. This contradiction creates a dichotomy, which obviously under certain conditions, e.g. a psychological predisposition, a mental trauma or a negative dental history, etc., can lead to the development of a psychosis fixated on the condition of the teeth and the masticatory organ.

Schizophrenic tendencies

In various aspects, these patients behave in a contradictory way, without being aware of it or being dissuaded from it. These patients often try to get the dentist or the practice team to act according to their own ideas by whining, begging or ingratiating themselves, but then also suddenly by threatening and exerting pressure. Patients are obviously not aware of the fact that begging a third party appeals to their humanity, while threats create aversion and that this is contradictory and not effective. As a dentist, one should be careful when a patient extends invitations in private or brings gifts right at the beginning. In most cases, these patients behave themselves during the initial consultation and try to convey a particularly conciliatory impression. Since they usually have a long history of unsuccessful treatments and conflicts with other dentists, these patients have the right intuition that they must not scare off the next dentist right at the beginning. This is also part of this split mentality: all the other dentists are supposedly all bad and the newly found dentist is the only one who can and should now bring salvation. Very high expectations are placed in the new practitioner and cautious or relativizing statements are brushed aside. The insight that the majority of all dentists can normally provide reasonable care for almost all patients would lead directly to the insight that the problem lies not with the dental profession but with oneself. However, the denied possibility of thinking oneself disturbed, or being thought crazy, is what cannot and must not be.

Another frequent aspect of the split is the conviction that one's own case is actually quite easy to treat, coupled with the assumption that one knows exactly what to do and, in contrast, the obvious fact that all previous treatments have failed. Not infrequently, these

patients acquire extensive detailed knowledge on the Internet, especially about materials. If patients' usual and proven therapy suggestions do not match their preconceived ideas about the "right" treatment or material, then the utmost caution is required not to be influenced as a dentist or dental technician. This also applies to the timing. Furthermore, it is also inconclusive that the "final" and "correct" restoration of teeth is perceived as very urgent and crucial, but at the same time most of these patients often cope for years with extensive or inadequate temporary restorations, missing teeth and insufficient bite conditions (because, after all, people can objectively survive without teeth). Finally, the two faces of the patients become apparent at the latest when the initial exaggerated expectations have turned into bitter disappointment. Then such patients often become vile and put their energy into harming the dentist as much as possible, be it through refusal to pay, burdensome correspondence, the involvement of dental chambers, insurance companies and courts, negative reviews on the Internet or (as experienced by themselves) even stalking.

Loss of confidence - phobia

As already mentioned, the basic trust in the dentists' abilities and intentions, which is necessary for any treatment, has been lost in such patients. This often leads to the desire for remote control of the dentist, dental technician and practice team. The trauma of failed dental treatment or irretrievable loss of tooth substance, teeth or hard/soft tissue may lead to such a loss of confidence. As a result, every statement made by the doctor is initially received very critically and accepted only if it agrees with the patient's own preconceived ideas. If it does not match, then the patient inwardly distances himself from the dentist again, which is usually clearly expressed by body language and facial expressions. Observe your patients especially carefully in the moments when you speak uncomfortable truths. One patient, whom I looked at and said on the top of her head that I realize that what I said about her situation was not what she wanted to hear, actually said it and said that what I said was 50% of what she wanted to hear. Any further conversation or even treatment was unnecessary at this point. I could only give her the "advice" to better look for a colleague who says 100% of what she wants to hear.

It is not uncommon for traits of phobias to come to light. And not so much in terms of a "fear of the dentist" but rather in relation to materials, poisoning or botched work in the

mouth. Various anxiety disorders are also relatively common among mental disorders in general, so that a general tendency to exaggerated fears may play a role here.

Centering the problem

As a further characteristic, the dental problem moves massively into the center of one's own attention, thinking and acting. An unimaginable amount of time, energy and money is spent on the dental issue and the associated sideshows.

While normal patients are not continuously concerned with the condition in his mouth, these patients deal up to several times a day with their teeth.

The dental problems are often also perceived as the cause of or in connection with other complaints or discomforts. Other possible causes are ignored. A thorough anamnesis often reveals a myriad of other ailments that obscure or complicate the basic problem and an accurate diagnosis. If, as is often the case, these subjective ailments are also based on psychogenic causes or components, the elimination or even improvement of this multifaceted pattern of complaints by the dentist, as expected by the patient, becomes impossible.

A clear indication of a psychogenic cause is when, according to the patient, there has been a short-term improvement after a certain treatment measure, but then it has not completely disappeared or, even more clearly, a different or new problem has now come forward. "Yes, but" is what you will hear most often then, and you can promise the patient that no matter what you do as a dentist, a new problem will always come up.

Attention Deficit

This is related to another common characteristic, which is that for quite a few of these patients, the continuous treatment itself is a means of maintaining undivided attention for extended periods of time on a regular basis. Unconsciously, the treatment is never meant to be completely over. Here it is exploited that a doctor should always believe a patient's statements first of all. Especially in the case of teeth, a patient should not leave the office with disturbing contacts, pain or an uneasy feeling. Since the patients themselves are not aware that they are not expected to track down the last imperfection or discomfort, but to eventually adapt the new condition, the patient's statements also appear authentic, so that it is often difficult to refuse further corrective measures.

The indication of discomfort is also the most effective means of the patient to build up psychological pressure, because a doctor does not refuse a painful case and makes earlier appointments for it. In one example experienced, a patient forced the reworking of long term provisional by stating that the margins were leaking and that this was causing extreme pain. While the temporaries were then reattached after the margins had been relined, the non-anesthetized teeth were completely insensitive when dried with the airblast. So it is quite possible to be lied to by patients willingly or unwillingly.

The reasons for withholding, concealing or distorting important information can be many and varied. Often the patients are not aware or do not admit that basically a completely different desire is driving them, such as dissatisfaction with their appearance, fear of aging or death or psychological suffering of various kinds.

If, however, the dentist believes that the problems can be solved with dental means, competence and special care, it is strongly recommended to make a separate fee agreement with such patients, calculated on the basis of the time spent. This is because this type of care and treatment, which also involves an extreme amount of communication, is in no way covered by the (German) codes of renumeration. In addition, prepayments should be requested in 100% of the estimated amount, since these patients are usually subject to the erroneous assumption that the fee is only due after the subjective well-being and all supposed problems have been resolved. In such cases, payment of the invoice is regularly refused and legal disputes arise, sometimes with several dentists in succession.

Previous treatments

The continuous change of dentist over many years is one of the clearest indications of the presence of a psychological cause. As soon as a patient states that an ongoing treatment was interrupted in the provisional phase or that a denture fitted not long ago was defective, the list of previous dentists should be queried specifically and completely. In general, many patients are reluctant to name a previous dentist with whom they were not satisfied. If there is a suspicion of a psychological component, it is advisable to refuse treatment unless the entire history is disclosed. In one of my cases, it turned out after the fact that 24 colleagues, some of whom were known to be highly competent, had already been at work without success. It is also important to know which treatments had been discontinued by the dentist or the patient and for what reasons.

Function and esthetics - Obsessive-compulsive disorder

The conditions perceived by patients as intolerable are largely in the areas of function and/or esthetics. Function in the broadest sense here includes not only occlusion and masticatory function, but also phonetics, lip, tongue, and mouth feel, and anything else indicated by the patient as bothersome and unpleasant. One of my patients was fixated on the fact that the airflow palatal to an upper anterior tooth had to have a certain resistance because that was crucial for the singing hobby, which is obvious nonsense.

It can happen that a restoration or even just a small area in the mouth manifests itself as so disturbing for the tongue that it makes patients think of nothing else. The formation of such problems shows very great similarity with other obsessive-compulsive disorders, which are among the most common mental disorders of all. A negative spiral develops, in which the filter thresholds are lowered by the compulsive frequent mental preoccupation or the constant palpation of the disturbance site (with lip or tongue) and the insensitivity is intensified or neuronally programmed. Similar to the way the auditory system filters out a lot of noise and background noise to avoid stimulus overload, most sensations in the mouth are normally filtered out. The stomatognathic system is an extremely finely calibrated nerve-controlled cybernetic system with highly sensitive sensors, but it does not normally respond to every stimulus. For example, it does not perceive whether one cheek pocket is larger than the other. However, these are exactly the typical indications of patients with the described disorder.

In the field of aesthetics the same process takes place. Attention is fixed on otherwise irrelevant details, a fixed obsession is established, satisfaction is never achieved. This can manifest itself, for example, in an excessive need for perfection and symmetry (although no natural face or mouth or dentition is ever perfectly symmetrical) , or in the desire that a restoration should not differ at all from the natural model.

General mental disorders and stresses

Statistics show that mental disorders are relatively common. On the other hand, this area is strongly stigmatized and tabooed in our (German) society. The frequency with which mental disorders are reported on dental anamnesis forms is not in proportion to their actual

occurrence. Especially obsessive-compulsive disorders or even bulimia, which is relevant for dentistry, are intentionally or unintentionally suppressed by patients. Few things seem as shameful to people today as being considered psychologically abnormal. Strong repression mechanisms are at work here.

In addition, the mental health status is usually dealt with on anamnesis forms in the dental practice with only one question among many others. Therefore, it seems reasonable to take an additional comprehensive medical history in this direction if a mental disorder is suspected. Independent of diseases of the psyche, people in today's society are exposed to a variety of psychological stresses. Their nature can be health-related, private, family-related, occupational, financial, social and many more. kind. Stress, in particular, represents a significant stress factor. These stresses, too, are not usually readily entrusted by patients to a dentist who, in addition to his role as a doctor, is also perceived as a craftsman, at least not at the outset and without inquiry.

The much safer assumption for any dentist, unfortunately, is that the unknown normal-appearing patient may bring with him a psychological burden or problem, rather than that he will certainly be normal. To keep this in mind and not lose sight of it, it is a good idea to go through the list of questions in the appendix as an internal checklist when patients are acting abnormally. This is not a medical history sheet that could be presented to a patient without very likely losing him or her afterwards. However, some of the questions can be used for a special history if the patient wants treatment and is aware of the psychological component. It is certainly also useful to have a psychologist, psychotherapist or similar specialist available in one's network to be able to recommend professional help to patients if necessary.

The first prerequisite for the possibility of therapy or change of condition is the patient's own insight that something is wrong. If this is not the case in a likely or obviously disturbed patient, extensive prosthodontic dental procedures should be discouraged.

The aim of this article is to raise awareness of the risks that are solely due to the patient's psychological setup and have nothing to do with the patient's own dental competence. After all, once such a failure has occurred, doubts always remain as to whether it could have been done better, and it is usually associated with massive anger, frustration and personal

dissatisfaction. It is therefore better to identify such problem patients at the outset and to refrain from treatment.

Literature

1. Jachertz, N: Mental illnesses, high incidence, low treatment rate, Deutsches Ärzteblatt treatment rate, Deutsches Ärzteblatt PP Heft 2, February 2013, pp. 61-62. http://www.aerzteblatt.de/archiv/134430

Appendix:

Questionnaire on psychological and psychosomatic problems with dentures

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This questionnaire is an important tool to provide you with the best possible treatment. Your answers may help your doctor to better understand your complaints. Please answer each question as best you can. Please do not skip questions unless prompted.

Please mark with a cross or enter a number

1. how serious do you consider your dental problem(s) to be
   - not serious
   - severe
   - very serious

2. does your dental problem(s) affect your performance?
   - no
   - yes

3. do you feel that your dental problem(s) are the cause of other physical complaints or discomforts
   - no
   - yes If yes, which ones?

4. Do you suffer from a single problem with your teeth or oral cavity, or from several problems?
   - one
   - several Please name the problem or list the problems in bullet form:

5. how long has the problem(s) existed for

approx. days
Since approx. weeks
Since approx. months
Since approx. years

6. how many dentists have treated the problem so far?

Number:
Which dentists were they?

7. were certain colleagues/treatments successful?

no
yes If yes, which ones?

8. were previous treatments discontinued by the treating dentist?

no
yes. If yes, when and by whom?

9. were previous treatments discontinued by you?

no
yes If yes, when and by whom?

10. how often do you mentally deal with your teeth?

Several times a day
Approx. once a day
Approx. every 2nd day
Approx. once a week
Approx. once or twice a month
Less often

11. how many minutes a day are your teeth in contact (upper jaw to lower jaw)

Approx. minutes

12. how difficult do you consider your problem(s) to be to solve

easily? Why?
moderately difficult
difficult
very difficult
hopeless

13. how much hope do you have that a new treatment will sufficiently relieve will sufficiently alleviate or eliminate the symptoms or problem? or eliminated?

very low Why?
low
medium
large
very large

14: How mentally balanced are you in everyday life?

very balanced
balanced
moderately balanced
not balanced

15. how much stress do you have to cope with in everyday life?

extremely much stress
a lot of stress
normal stress
little stress
no stress at all

16. do your dental problem(s) affect you psychologically?

no
yes, If yes, how?

17. do you have to cope with other special psychological stresses (not caused by the teeth)?

no
yes What is currently stressing you the most in your life?

18. do you have your own ideas about how the dentist should properly treat your problem(s)?

no
yes, If yes, how?

19. are you worried about your health?

no
yes If yes, which ones?

20. how urgently should treatment be started?

immediately
soon
not urgently

21. how important is it to you that the appearance of dentures corresponds exactly to your own ideas?

very important
important
medium
not very important
not important at all

22. do you suffer from discomfort of the tongue, cheeks, lips with your teeth or dentures?

no
Yes, If yes, which?

23. do you suffer from problems of pronunciation, airflow or mouthfeel or similar with your teeth or dentures?

no
yes, If yes, which ones?

24. do you suffer from changes in taste, burning mouth or other problems in the oral cavity?

no
Yes, If yes, which ones?

25. how critical are you of the statements made by dentists in general?

not critical at all
a little critical
medium
critical
very critical

26. how important is it to you that the statements made by dentists correspond to what you would like to hear or know yourself?

not at all important
little important
medium
important
very important

27. how extensively have you informed yourself about your problems, e.g. on the Internet or in professional articles?

not at all
a little
medium
in detail
very detailed

28. are you a dental fear patient (in)

no
yes

29. do you suffer from general fears (e.g. fear of flying, claustrophobia, anxiety or similar)

no
yes, If yes, which ones?

30. in the last 4 weeks, have you had an anxiety attack
(sudden feeling of fear or panic)?

no
yes, If yes, has this happened before?

31. in the past 4 weeks, how often did you feel affected by the following complaints:

Not at all worrying On single days On more than half of the days

- nervousness
- Anxiousness
- Tension

32. in the last 4 weeks, how often did you feel affected by the following complaints:

- Not at all On single days On more than half of the days

- slight fatigue
- Feeling restless, making it difficult to sit still
- Difficulty falling asleep or staying asleep

33. in the last 4 weeks, how often did you feel affected by the following complaints:

- Not at all On single days On more than half of the days

- Difficulty concentrating on something
(e.g., when reading or watching television)
- irritability, hypersensitivity On single days

34 Do you have an eating disorder?

No

yes If yes, in what form?

35. do you have an alcohol problem?

No

yes

36. do you suffer from depression

no

yes

37. do you take medication for anxiety, depression or stress?

No

yes If yes, which ones?

38. do you have or have you had an obsessive-compulsive disorder?

no

yes If yes, which?

39. have you ever been diagnosed with a mental illness?

no

yes If yes, which one?

40. do you suffer from loneliness?

no

yes

41. do you suffer from financial worries?

no

yes

42. are you satisfied with your general appearance/body?

no

yes

43. have you undergone cosmetic surgery?

no

yes, If yes, which ones?

44. to question 43: if yes, are you satisfied with the result(s)?

no
yes

45. how important is the appearance of your teeth to you

Not important
little important
medium important
very important

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