

Chapter 1 : - NLM Catalog Result

Psychosocial Impact of Orofacial Pain. pain as well as an overview of the biobehavioral management of orofacial pain. Psychosocial aspects of pain and pain control are studied because.

Although guidelines have been published by organizations including the American Academy of Orofacial Pain¹ and the American Academy of Oral Medicine, which has published a handbook² for managing various orofacial conditions causing pain, these are not officially recognized as authoritative documents by national associations. The Canadian Dental Association and American Dental Association have not established clinical guidelines for this segment of dental practice. In , the statement was revised in light of continuing research and the strengthened evidence base. The AADR recognizes that temporomandibular disorders TMDs encompass a group of musculoskeletal and neuromuscular conditions that involve the temporomandibular joints TMJs , the masticatory muscles, and all associated tissues. The signs and symptoms associated with these disorders are diverse, and may include difficulties with chewing, speaking, and other orofacial functions. They also are frequently associated with acute or persistent pain, and the patients often suffer from other painful disorders comorbidities. The chronic forms of TMD pain may lead to absence from or impairment of work or social interactions, resulting in an overall reduction in the quality of life. Based on the evidence from clinical trials as well as experimental and epidemiologic studies: The choice of adjunctive diagnostic procedures should be based upon published, peer-reviewed data showing diagnostic efficacy and safety. However, the consensus of recent scientific literature about currently available technological diagnostic devices for TMDs is that, except for various imaging modalities, none of them shows the sensitivity and specificity required to separate normal subjects from TMD patients or to distinguish among TMD subgroups. Currently, standard medical diagnostic or laboratory tests that are used for evaluating similar orthopedic, rheumatological and neurological disorders may also be utilized when indicated with TMD patients. It is strongly recommended that, unless there are specific and justifiable indications to the contrary, treatment of TMD patients initially should be based on the use of conservative, reversible and evidence-based therapeutic modalities. Studies of the natural history of many TMDs suggest that they tend to improve or resolve over time. While no specific therapies have been proven to be uniformly effective, many of the conservative modalities have proven to be at least as effective in providing symptomatic relief as most forms of invasive treatment. Because those modalities do not produce irreversible changes, they present much less risk of producing harm. Professional treatment should be augmented with a home care program, in which patients are taught about their disorder and how to manage their symptoms. See website for supporting references at [www. American Association of Dental Research](http://www.American Association of Dental Research). Policy Statement on Temporomandibular Disorders Revision adopted Although various imaging modalities have been developed and validated for their use in diagnostic assessment of the temporomandibular joint, their value is mainly limited to the discovery of intracapsular pathologic conditions. These beliefs and opinions have resulted in the delivery of extensive and invasive treatment plans to manage TMDs. The current literature has clearly shown that the use of adjunctive diagnostic devices except for various imaging procedures does not contribute to the ability to correctly diagnose orofacial pain problems including TMDs beyond that arising from a thorough history and comprehensive examination. In addition, patients with non-TMD orofacial pain may be wrongly classified as TMD patients, and their real diagnosis may be obscured by subsequent management for TMDs. Management of TMDs by conservative and reversible interventions has been shown to be both appropriate and successful. Furthermore, the importance of biopsychosocial variables, which tend to be minimized when focusing on mechanistic approaches, has been emphasized throughout the medical pain management literature. Because TMDs are similar to other musculoskeletal pain conditions e. This is especially true when pain becomes chronic, because of the increasing recognition of the impact of psychosocial factors on persisting pain, and vice versa. The AADR statement was updated based on the evidence-based scientific findings of the past 14 years, and the revised version includes a number of new

elements. The concept of comorbid pain disorders has been added, reflecting current knowledge about pain susceptibility, neuroplasticity and psychosocial consequences of pain. Recognition of these phenomena has changed the field of pain management in general and has affected our understanding of TMDs. Within the scientific community, the new statement reflects widely accepted concepts and is essentially noncontroversial; however, the practitioner community may have mixed reactions to it. We urge all clinicians to read the statement carefully and look at the supporting references to benefit both patients and professionals in the diagnosis and management of problems causing orofacial pain. Greene is a clinical professor in the department of orthodontics, University of Illinois at Chicago, College of Dentistry, Chicago, Illinois. Klasser is an assistant professor in the department of oral medicine and diagnostic sciences, University of Illinois at Chicago, College of Dentistry, Chicago, Illinois. Epstein is a professor in the department of oral medicine and diagnostic sciences, University of Illinois at Chicago, College of Dentistry, and director of the interdisciplinary program in oral cancer, College of Medicine, Chicago Cancer Center, Chicago, Illinois. The views expressed are those of the authors and do not necessarily reflect the opinions or official policies of the Canadian Dental Association. This article has been peer reviewed. References de Leeuw R, editor. American Academy of Orofacial Pain. Royal College of Dental Surgeons of Ontario. Scientific information statement on temporomandibular disorders. Management of temporomandibular disorders and occlusion. Validity of diagnostic and monitoring tests used for temporomandibular disorders. The clinical usefulness of surface electromyography in the diagnosis and treatment of temporomandibular disorders. Clinical TMJ examination methods. On the management of temporomandibular disorders: Koh H, Robinson PG. Occlusal adjustment for treating and preventing temporomandibular joint disorders. Cochrane Database Syst Rev. Occlusion, orthodontic treatment, and temporomandibular disorders: Are female patients with orofacial pain medically compromised? Genetic architecture of human pain perception. Sensory and motor neurophysiology of the TMJ. Functional and psychosocial impact related to specific temporomandibular disorder diagnoses. Suvinen TI, Kemppainen P. The role of technology in TMD diagnosis. Role of oral medicine in the teaching of temporomandibular disorders and orofacial pain. Temporomandibular disorders and chronic pain: Psychological considerations for chronic orofacial pain. A comparison between masticatory muscle pain patients and intracapsular pain patients on behavioral and psychosocial domains. Dent Clin North Am. Physical self-regulation training for the management of temporomandibular disorders. A randomized clinical trial of a tailored comprehensive care treatment program for temporomandibular disorders. A randomized clinical trial using research diagnostic criteria for temporomandibular disorders-axis II to target clinic cases for a tailored self-care TMD treatment program. Mediators, moderators, and predictors of therapeutic change in cognitive-behavioral therapy for chronic pain.

Chapter 2 : Psychosocial Factors | Pocket Dentistry

The major objectives for the chapter are to provide psychosocial perspectives with regard to current knowledge on clinical presentation, psychological, behavioral and social factors underlying the presentation of dental and orofacial pain as well as an overview of the biobehavioral management of orofacial pain.

Psychosocial Factors Samuel F. Dworkin There is abundant evidence from epidemiologic and clinical research, and more recently from behavioral neuroscience supported by brain imaging studies, that the psychosocial environment contains potent risk factors for pain, especially chronic pain. These factors may be as diverse as the availability of dental treatment and pain medications or the way in which prior experience learning and memory, culture, and society shape how people reveal their pain experience. Most importantly, an understanding of the psychosocial aspects of the pain experience expands possibilities for pain management by creating opportunities for biobehaviorally based treatments that can modify the emotional, cognitive thinking, and behavioral status of a patient to achieve the following objectives: Produce a more compliant and better informed patient 2. Eliminate or minimize negative physiologic and emotional states—especially depression, anxiety, fear, and the anticipation of pain 3. Potentiate the action of sedative, analgesic, and anesthetic pharmacologic agents used to control pain and anxiety 4. Introduce cognitive-behavioral methods to assist the patient in self-management and enhanced self-control for both acute and chronic pain, with and without analgesic or sedative medications This chapter addresses the perceptions, appraisals, and behaviors shown by people reporting dental and orofacial pain. Some biobehaviorally based approaches to the management of acute pain are discussed in chapter 11, while those applicable to persistent or chronic pain are interwoven throughout the chapters in section IV, Management of Orofacial Pain: It is important to remember that the stomatognathic system is responsible for several life-sustaining physiologic processes, including eating, breathing, swallowing, and verbal as well as nonverbal communication. Psychologic factors play an important—some would say a central—role in the perceptions, appraisals, and behaviors of people when pain arises in such a biologically and personally important part of the body as the face and mouth. Acute pain The expectation that the dentist can relieve pain has been strongly positive for dentistry, and dentistry has in fact learned a great deal about pain and pain control, especially when the pain is acute. Alleviation of the pain of dental procedures has been developed to a high degree, and for most people requiring routine dental care, pain associated with treatment is largely preventable. This is true whether the pain is associated with treatments or is postoperative, and whether it accompanies dental, medical, surgical, or invasive diagnostic procedures. The amount and even the location of chronic pain, as well as the behaviors of the patient, are only poorly predicted by physical events. Atypical odontalgia, for example, is usually associated with poorly defined pathologic markers inconsistent with expressed pain perception and behavior. Similarly, myalgia can be a source of minor inconvenience to some patients; for others, it can become a major decades-long disorganizing force associated with significant depression and disruption of everyday activities—yet, there may be no detectable physical change to distinguish the two conditions. So, the impact of persistent pain often cannot be understood in terms of pathology. It is the deleterious and life-changing quality of chronic orofacial pain that makes it such an important area for study and action by researchers and clinicians alike. Thus, mechanistic and strictly biomedical views of pain, while appealing because of their deceptive simplicity, are scientifically unwarranted. The Neurologic and Psychosocial Interface Current neurophysiology and cognitive neuroscience provide a biologic basis for understanding how emotional, cognitive, and behavioral processes can become linked and stored, preserving memories and belief systems that influence the pain experience and guide actions we take to cope with pain. There is increased acceptance among patients and clinicians alike that the complex, hard-to-understand pain-related behaviors are real bodily processes that result from complex central processing of pain information. Biopsychosocial Model of Pain Figure presents a schematic for integration of physiologic or pathophysiologic activity with associated psychologic states and socially and

**DOWNLOAD PDF PSYCHOSOCIAL IMPACT OF OROFACIAL PAIN
DWORKIN, S.F.**

culturally determined behavior. The model, known as the biopsychosocial model, is currently accepted as the basis for understanding complex physiologic and psychosocial interactions evident in all disease and illness. The model has been applied to the understanding of chronic pain and has served as the basis for extensive research into chronic orofacial pain. [Log In](#) or [Register](#) to continue [Share this](#):