



## Developing Knowledge among Dentists about Somatic Symptom Disorder in Dental Patients-A Mini Review

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### Abstract

Dentists are not trained in dental school to identify and recognize patients with Somatic Symptom Disorder (SSD) before initiating dental treatment. Lack of such recognition could result in misdiagnosis, inefficient management of treatment time, and dental treatment failure. The aim of this mini review is to develop awareness and provide basic knowledge about SSD among dentists. Several recommendations are made to assist dental students and dentists in attaining basic knowledge and training related to this psychiatric disorder.

**Keywords:** Dentist, Student, Somatic symptom disorder, Medically unexplained oral symptoms, Awareness, Knowledge, Psychiatric, Consultation liaison.

### Introduction

Dentists are trained in dental schools to provide treatment for patients with straightforward health problems that respond to routine dental therapy. Reviewing the current dental literature reveals that psychology and psychiatry are not included as subjects in the dental curricula of undergraduate or postgraduate education.

It is not uncommon that persons might have SSD without being aware of it, simply because they have never visited a psychiatrist. Many general dental practitioners might have encountered such persons in dental practice without recognizing the clinical presentation. Lack of recognition of SSD in dental patients could result in misdiagnosis, inefficient management of treatment time, and dental treatment failure [1].

The dental literature lacks in-depth information regarding how to identify persons with SSD before initiating dental treatment. The aim of this mini-review is to develop awareness and provide basic knowledge about SSD among dentists. This would assist them in recognizing SSD in undiagnosed persons who seek dental treatment and prevent dentists from initiating extensive treatment before managing this disorder. For a more systematic understanding of SSD, its definition and causes, epidemiology, diagnostic procedures, and treatment methods are to be described below.

SSD is a quite common psychiatric condition characterized by preoccupation with physical symptoms that are attributed to a psychologic disorder rather than organic disease. The exact cause of SSD is not clear. However, it seems to be associated with any of the following traits, or a combination of them: (1) genetic traits, e.g. pain sensitivity, (2) a personality trait that involves negative emotions and poor self-image, (3) difficulty dealing with stress (4),

decreased emotional awareness, which can make patients focus more on physical issues than emotional ones (5), learned behaviors, e.g. getting attention from having an illness or increasing immobility from pain behaviors [2].

SSD usually starts before the age of 25 or 30, although it can begin in adolescence, and can last for many years. This disorder appears to be more common in women than men, with a lifetime prevalence of 0.2 to 2 percent in women compared with less than 0.2 percent in men. This disorder ranges from mild to severe and from general to very specific [3].

Persons with SSD complain of persistent or recurrent vague physical symptoms accompanied by dysfunctional cognitive, affective, or behavioral reactions. Diagnosis of SSD relies on three main criteria which include somatic symptoms, excessive thoughts, feelings, and behaviors, as well as chronicity. The first criterion of 'somatic symptoms' denotes one or more symptoms that result in disruption of daily life. While, the second criterion of 'excessive thoughts, feelings and behaviors' entails the presence of somatic symptoms or associated health concerns. To meet this criterion, at least two of the following are needed: high level of health-related anxiety, disproportionate and persistent concerns about the medical seriousness of symptoms, and excessive time and energy devoted to these symptoms or health concerns. Whereas the third criterion of 'chronicity' refers to a duration of typically greater than 6 months [4,5].

The distinctive sign to recognize SSD is that symptoms cause a severe impact on daily activities with inability to frequently school or work and inability to pursue hobbies or sport activities. Patients usually spend much time at home and have limited relationship with peers. So, the effects of symptoms on thoughts and behaviors are more important than the symptom itself. The disproportion between reported symptoms



and the severe limitations in daily activities should be used as a diagnostic clue [6].

Management of mental disorders including SSD is provided by mental health professionals. It focuses on helping the person with SSD to live as much of a normal life as possible. The two modalities used for managing SSD are Cognitive Behavior Therapy (CBT) and Mindfulness-Based Therapy (MBT). CBT is the most consistently supported treatment for SSD. It helps patients find ways to reframe and gain control of their situation, and break what can become a self-fulfilling cycle of pain and despair. CBT uses specific techniques which include relaxation training, problem-solving, visualization, biofeedback, exercise, and breathing techniques. MBT; the second management modality, helps patients increase their awareness of what they are sensing and feeling in the moment, without interpretation or judgment. The practices used involve various breathing techniques and guided imagery to relax the body and mind and help reduce stress [7].

In the dental office, patients with SSD typically present complaining of certain physical symptoms without identifiable causes. Such symptoms are known as Medically Unexplained Oral Symptoms (MUOS) [8,9]. MUOS may be the first or only manifestation of a mental health problem including chronic orofacial pain, occlusal discomfort, burning mouth syndrome, salivary gland complaints, atypical odontalgia, phantom bite syndrome, oral cenesthopathy (Oral Dysesthesia) and halitophobia and preoccupation with dentures [10-17]. Temporomandibular Disorder (TMD) is another example of psychiatric-related complaints in the dental office [18]. The TMD has symptoms like those of SSD which are sometimes difficult to be differentiated.

Lack of detection and identification of SSD by dental practitioners can result in inappropriate dental treatment, e.g. dental surgeons might provide TMD patients with unnecessary and irreversible surgical treatment although their physical symptoms could be due to mental disorders. After completion of dental treatment, patients frequently report back to dental office with persistent symptoms and require dentists to re-evaluate their dental work. Re-examining of these patients still do not detect any organic pathology related to such symptoms [4,5]. In an attempt to address the patients' suffering, dentists may feel pressure to intervene with further treatments such as replacement of fillings, providing endodontic treatment, or even extracting the tooth. However, these dental re-treatments result in no improvement of persistent symptoms and cause additional distress and impairment [7].

In medicine, it is a common practice that surgeons tend to rely on a psychiatric evaluation prior to initiating invasive and permanent procedures, e.g. cosmetic plastic surgery. This evaluation is done to either exclude inappropriate candidates or develop a plan for management [19]. As for the dental practice, a number of primary care activities can be conducted in the office such as screening of diabetics and managing hypertension [20]. Additionally, dental patients are never referred to a psychiatrist nor screened in dental office for psychiatric illnesses prior to initiating extensive dental procedures, e.g. placing dental implants especially in maxillary anterior region of the mouth. Failure to screen for psychiatric illnesses leaves the dentist and the patient susceptible to extreme likelihood of time consuming and costly dental problems.

Efforts are warranted to provide practicing dentists with basic knowledge about SSD in the form of seminars, courses, and/or workshops, along with short training courses on screening dental patients for SSD. It is further recommended that basic psychiatric assessment training programs be incorporated in dental curricula at undergraduate or postgraduate levels. Upon detection of a patient with SSD, it is advised that dentist/dental student makes a consultation with the patient's family doctor and other health providers involved prior to initiating any dental treatment. This is done to either exclude

inappropriate candidates or develop a plan for management. Additional efforts should be made towards establishing a psychiatric consultation liaison service in dental centers to assist dental practitioners in diagnosing and managing patients with SSD prior to initiating any invasive dental treatment.

## Conclusion

Somatic Symptom Disorder should be strengthened in dental education, and screening of dental patients for SSD should be paid attention to in dental practice. Dental students and dentists should be trained to recognize patients attending the dental office with SSD. Failure of such recognition leaves the dentist and the patient susceptible to extreme likelihood of additional distress, time consuming and costly dental problems.

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