Psychiatric Disorders in Dental Practice

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Foreword

The origins of Dentistry have ensured that it has a firm base in tangible physical conditions and in technically precise means of treating them. It is only quite recently that Behavioural Science has been included in the undergraduate curriculum with the intention of producing dentists who are better prepared to look at their patients as whole human beings. Dentists have needed to be encouraged to recognize that the occurence of dental caries and periodontal disease is influenced by psychological and social factors as well as the physical conditions in the patient's mouth. Similarly facial pain and temporomandibular joint dysfunction were for many years regarded as purely mechanical problems. Treatment frequently involved extensive surgery or restorative dental care but the lack of awareness of the psychological/ psychiatric components of the problem led to very variable results being achieved.

A number of texts have been published in the last ten years dealing with the relationships of Psychology and Sociology to Dentistry but there have not been comparable texts associating Psychiatry and Dentistry. the authors have attempted to fill this niche with the current volume. They are to be congratulated on addressing the difficult task of concisely outlining the range of psychiatric conditions from which individuals may suffer and clearly demonstrating how some of these can present as orofacially related conditions.

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In memory of Joyce

Preface

We are aware of the need for dental students and practising dentists to know the significance of psychological disturbances and disorders in dental practice. This book services such a need.

In Section A of the book the scene is set. An outline of psychiatric disorders is given and the resources available to treat the variety of disorders is described.

Section B describes the psychiatric syndromes. It provides an up-to-date, detailed yet condensed description in a form which is not readily available for dentists in other texts. Section B is of great importance in giving a clear description of the psychiatric illnesses that the dentist will inevitably see in his patients in clinical practice. It must be emphasized that in gaining insight it will make management easier and more effective and also help to inform the dentist when to refer to a clinical psychologist or psychiatrist; to refer early is to avoid unnecessary suffering for both patient and clinician.

In Section C, the psychiatric conditions particularly relevant to the dentist are discussed in detail. Dental phobias, facial pain and facial deformity are considered in separate chapters because of their importance to dentists. The reader may well turn to Section C before Section B to get an idea of the nature of these conditions and will gain a great deal of understanding merely by reading these chapters. For greater depth of understanding, however, it is necessary to refer to Section B. Sections B and C are very much complementary to one another.

The final section of the book describes treatment methods and looks forward to the future, hoping that there will be increased understanding of the nature of psychiatric disorders by dentists and better liaison, when necessary, between dentists and psychiatrists and clinical psychologists.

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Chapter 1

Psychiatry in dental practice

Preclinical and clinical dental students have long been taught medicine and surgery. However psychological illnesses have usually been given scant attention. The recent mandatory introduction of the behavioural sciences into the dental curriculum has remedied this and caused us to address some important problems long ignored.

The aim of this book is to give an outline of the major psychiatric disorders and diseases while highlighting those conditions of particular importance to the practising dentist. Oral disorders that are usually associated with psychiatric disorders and disturbances, or which have a significant psychological component, are also described.

Most dentists appear to have little understanding of the nature or scope of psychiatric disorders and disturbances. As a result they may feel ill at ease at having to understand and manage disturbed behaviour in patients and find it difficult to recognize the presence of psychopathology or assess its significance. Although dentists might have the view that some patients' problems are 'all in the mind', they are poorly equipped to communicate the nature of the problem with medical practitioners or psychiatrists. The psychiatrists remain distant to the dentist and the nature of their work is poorly understood. They are sometimes perceived as having more serious problems to deal with than those relatively mild problems of some dental patients with psychiatric disorders; there is in some instances justification for this view. Apart from a few notable exceptions, liaison between dentists and psychiatrists is poor.

There are several other important reasons why dentists should be aware of the nature of psychological medicine:

1 Psychological disorders are very common and do not just affect an odd few people. In fact, vast numbers are affected in the UK in the course of a year. According to the Mental Health Foundation (1990):
   - Around six million people suffer from mental illness

- One in 12 of the population receives psychiatric treatment of some kind
- One in 22 of the population suffers from depressive illness
- One in 100 of the population suffers from schizophrenia during his/her lifetime
- Around one million people are alcoholics
- No-one is immune from mental illness and no family is exempt.

Therefore it is inevitable that many patients attending for routine dental treatment will be suffering from and presenting with signs and symptoms of a psychological illness.

2 Psychological disorders may produce many problems relating to dental treatment. Poor motivation may lead to lack of compliance or unreliable attendance. Phobic patients, for example, are notoriously bad at keeping dental appointments and may often cancel at the last minute. Such behaviour is a source of frustration and sometimes bewilderment, resentment and hostility to clinicians, apart from being a waste of time and a strain on limited NHS resources.

3 Many psychiatric disorders which commonly occur, such as anxiety and depression, are often accompanied by oral symptoms such as facial pain or preoccupation with dentures. Unusually, oral symptoms are the only manifestation of the psychiatric disorder. These problems are discussed in detail in Section C.

4 Many drugs used in the treatment of psychological disease have important side-effects which cause symptoms related to the mouth.

The information in this book should lead to improved early recognition of psychological illness by the dental surgeon. Such recognition leads to accurate assessment and diagnosis which is the first step to correct management and treatment. Knowledge of behaviour problems associated with psychological illnesses enables the dentist to prepare treatment plans with realistic goals and to tailor the treatment plan to the patients' needs. Recognition of physical symptoms associated with psychological illnesses helps to avoid inappropriate investigations and unnecessary treatments that are a waste of time and a source of frustration and resentment for clinicians.

Clearly, not all patients identified or suspected by the dentist as having a psychiatric disturbance or disorder will need to be

referred. For the majority of dentists working in dental practice the psychological component seen in their patients will be associated with underlying personality disorders or neuroses. The supportive psychotherapy or counselling this requires can in large part be provided by the dentist himself, especially with the additional knowledge which such a book as this supplies. The reader is particularly encouraged to take note of the description of supportive psychotherapy in Section D. This treatment is a form of counselling and is certainly practised knowingly or unknowingly by most dentists when dealing with anxious or 'difficult' patients. If the dentist establishes a working relationship with professional detachment, yet with an understanding warmth, patients will respond by being more relaxed and open to management and treatment, whatever their initial problems or fears. Some patients, for example those with severe dental phobias, may require additional treatment that may also be provided by the dental surgeon, such as relaxation therapy, hypnosis, antianxiety drugs or relative analgesia.

There is, however, a boundary beyond which referral becomes essential because the dentist does not have the necessary expertise to treat the patient; the dentist must be able to recognize the patients who require such referral to a psychiatrist or clinical psychologist. The information in this book will aid recognition of those disorders and enable the dentist to communicate more effectively with colleagues. If, as is usual, the patient remains under the care of the dentist for dental treatment, supportive psychotherapy by the dentist remains an important component of the overall dental management.

A few dental centres in the UK have established liaison psychiatry within their clinical practice. This implies close contact of dentist with psychiatrist and is regarded as being superior to mere referral, which entails loss of contact. An increased awareness of the massive psychopathology within dental practice and dental hospitals should encourage an increase in liaison psychiatry.

In summary, it is hoped that this book will:

1 Aid the dentist to recognize psychological factors and psychological illness in his patients
2 Enable the dentist to prepare dental treatment plans with more realistic goals for affected patients
3 Provide a wider understanding of orofacial manifestation of psychiatric disorders

4 Emphasize that the majority of patients with psychological illness may be treated successfully within general dental practice with the appropriate knowledge and insight while there are also patients who require referral for specialist help from psychiatrist and clinical psychologist
5 Illustrate the advantages of liaison psychiatry in relation to dentistry
6 Indicate the urgent need for further research into the nature of orofacial manifestations of psychiatric disease
7 Prove the need for a team approach to the management of dental patients, of which the preparation of this book is a practical example.

Reference

Mental Health Foundation (1990) *Mental Illness: Fundamental Facts*, Mental Health Foundation, London.

Chapter 2

Outline of psychiatry

Definition of mental illness or disorders

To produce a clear definition of mental illness is surprisingly difficult, as with other commonly used terms such as health, normality and disease. In everyday speech the word 'illness' is loosely used and in psychiatric practice the terms 'mental illness' and 'mental disorders' are also used with little precision. Not even the Mental Health Act of 1983, the most important legislation dealing with the mentally ill, defines mental illness.

An obvious way of tackling the subject would be to examine the concept in general medicine and to look for any worthwhile analogies with mental illness. In the former an important distinction is made between disease and illness; disease referring to objective physical pathology and illness to subjective awareness of distress or limitation of function. A person can have a disease without being ill, as with a benign tumour, or one can be ill without having a disease, as with the loss of a limb by trauma. However, this distinction bears little relevance to psychiatric disorders since the vast majority have no demonstrable physical pathology. Thus, most psychiatric disorders are best regarded as illnesses.

Continuing the analogy with general medicine, mental illness may be regarded as having three ingredients: absence of health, presence of suffering and pathological process (physical and/or psychological). The difficulty of this definition is that, as already stated, health is even more difficult to define. Some patients may not experience suffering; for example those suffering from mania have no demonstrable physical pathology or gross structural pathology, whereas there are genetic and biochemical grounds for supposing that schizophrenia and depressive disorders may have a physical basis.

The psychiatrist more crucially has to make sense of the wide-ranging phenomena related to disturbed or distorted thinking, feeling and behaviour encountered, so that he/she can manage to treat them rationally and improve the outcome. To this end the psychiatrist has realized that the best way of doing so is to

commence with presenting basic data, that is the symptoms and signs, and to group them into syndromes, that is a constellation of symptoms occurring frequently together and having implications for treatment and prognosis.

Classification of psychological disorders

Mental handicaps (now known as learning difficulties) are usually separated from mental illness and will not be dealt with in this book. Mental illness can be divided into the following groups:

1 Neuroses
2 Personality disorders
3 Psychoses
4 Others (deviant behaviours).

Neuroses are regarded as 'breakdowns', the milder form of mental and emotional disorders, although the symptoms can be quite disabling to a patient's life. Neurotics have insight and are in touch with reality. For example, phobic states are a neurotic illness where a person will have a fear of a specific object but will know that it is nonsensical.

Personality disorders are those conditions in which various traits which may be present in normal persons come to dominate and colour the whole personality. For example, in obsessional personality disorder the obsessional part dominates the conditions. Personality disorders resemble neuroses in that the persons have insight and are in touch with reality. On the other hand, psychopathic personalities, the most extreme of the personality disorders, are aggressive, impulsive, show no guilt and fail to learn from their past mistakes.

Psychoses, on the other hand, are what the layman terms insanity or madness in which the patients suffer from severe symptoms such as delusions or hallucinations. Such patients lack insight and are divorced from reality. Personality and behaviour are more severely damaged than in the neuroses. The main differences between neuroses and psychoses are detailed in Table 2.1.

Other disorders are largely deviant behaviours and include alcoholism and addiction, which are increasingly seen in clinical practice and are described in Chapter 4.

Table 2.1 Characteristics of neurosis and psychosis

Neurosis	Psychosis
'Breakdowns'	Madness, insanities
Has insight	Partial or no insight
In touch with reality	Divorced from reality
Little deviation from normal personality	Radical change of personality
Thinking usually coherent	Thinking disordered (though it can be in a limited sphere)
	Behaviour grossly deviant
	Feelings persistently severely disturbed

Subclassifications of the neuroses, psychoses and personality disorders are described in detail in Chapter 3. It is particularly important for the dentist to be aware of the existence and nature of the neuroses and personality disorders because they are conditions which commonly occur and, inevitably, dentists will meet them in patients. In being aware of their presence the dentist will be in a better position to decide on appropriate treatment plans. Though the dentist will have far less contact with psychotics, knowledge of the types of psychoses will, again, be of assistance in dealing with them more effectively, if necessary.

In discussing the classification of psychiatric disorders, mention must be made of two major international classifications, namely *The Diagnostic and Statistical Manual of Mental Disorders*, 3rd Revision, DSM-III-R of the American Psychiatric Association (1987) and the very recently updated *International Classification of Diseases ICD10* (World Health Organization, 1993). A simplified classification of mental disorders based on these classifications, which illustrates the diversity of mental illness, is given in Appendix 1.

Demography (Mental Health Foundation, 1990)

Contrary to public conception, psychological medicine does not embrace merely small, homogeneous groups of people. In fact, psychological illness constitutes a vast problem. In the UK, about six million people suffer from mental illness during the course of a year; this represents one in ten of the population. Even this figure is an underestimate of the true prevalence, for it is based on the number of people identified by general medical practitioners as suffering from mental illness according to the official *International Classification of Diseases* mentioned above.

Mental illness is to be found largely in the adult population. More women (55%) than men are victims. Of those affected the great majority (4·5 million people) are in the 50–64 age range within the working population. A further 1·2 million are over the age of 65. In addition, 300 000 children under the age of 15 suffer from mental illness.

Mental illness ranks alongside heart and circulatory disease as one of the nation's biggest health problems: before 1989 it was estimated that there were more than six million sufferers of each of these diseases. By comparison, cancer affects two million, mental handicap one million and AIDS can be counted in thousands, although this number is increasing.

Mental illness is not regarded as a killer in the same way as heart disease and cancer. Yet, in addition to the massive extent of suffering caused by mental illness, it does result in the death of substantial numbers of people. It is estimated that some 20 000 people die each year as a result of mental illness, including 4500 suicides, 1800 as a result of alcohol and drug misuse and 13 500 from causes attributable to chronic mental disorders of the elderly. Thus, mental illness annually kills four times as many people as die in road accidents (5300).

It was estimated that of all mentally ill patients visiting their general medical practitioners in 1989, 3·6 million (60%) suffered from neurotic conditions – mainly depression and anxiety states. A further 1·9 million (33%) had behavioural or acute stress disorders and 410 000 (7%) were suffering from psychotic illness. Whilst severe mental illness is difficult to estimate it can be seen that in 1989 4% of the population, that is 2·3 million people, suffered from *major* depressive illness. At least 410 000 suffered from a psychotic illness and a million more individuals were severely affected by acute anxiety, stress disorders and addictive disorders such as alcohol and drug misuse. Therefore, severe major mental illness may well affect a minimum of four million people every year. These statistics and the vast numbers involved in the general population makes it inevitable that a dentist will treat a significant number of patients with psychological illness.

Psychiatric resources

Psychiatric resources to deal with the vast and various problems of the mentally ill comprise personnel and material.

Personnel

Personnel include psychiatrists, psychiatric nurses, psychiatric social workers and clinical psychologists; these act more effectively as a team. The patient has direct access to each individual member of the team, and especially to the psychiatrist, who specifically in the case of a compulsorily detained patient under the Mental Health Act (1983) becomes the responsible medical officer with special duties and responsibilities towards the patient. The psychiatrist is usually the leader of the team. It is therefore essential that any patient referred to the psychiatrist knows that he of she is being referred to a physician.

A psychiatrist is a qualified medical doctor who undertakes further training in the speciality of psychological medicine (psychiatry). After basic training in psychiatry usually he/she sits an examination for membership of the Royal College of Psychiatrists and after further supervised work at a higher level applies for the post of consultant psychiatrist. Again, it must be stressed that the psychiatrist is first and foremost a medical doctor – a physician with a basic medical qualification and a further higher qualification in psychological medicine.

Psychiatric nurses are those men and women who have trained and gained appropriate qualification as nurses in this field of managing and caring for men and women suffering from psychiatric disorders. Some have also qualified as general nurses in the medical/surgical field and they are said to be 'doubly' qualified. Increasing numbers of these nurses now work exclusively or for a greater part of their time in the community and are known as community psychiatric nurses. They usually undertake additional training in community psychiatric nursing and an additional qualification after about a year's training. They work closely with patients and their families in their homes or in institutions within the community.

Psychiatric social workers also play a considerable role in psychiatry. To be able to fulfil all their duties in the field, including statutory duties, they must become 'approved' social workers. This means that they must have additional expert training and experience in the field of psychological medicine. In addition to having expert knowledge about welfare rights, practical aids and community facilities, they have practical powers and duties under the Mental Health Act (1983) and other legislation. Though the vast majority of psychiatric social workers are employed by and are the responsibility of the Director of Social Services of that area or district, they may be

based in local authority offices as well as in psychiatric units or hospital.

Clinical psychologists have a degree in psychology, following which they undergo a further 2 or 3 years of clinical psychology training. Some also do some research and gain a higher qualification such as a PhD and then are able to use the prefix 'doctor' as a title. This, together with the emphasis on *clinical* psychology, can be confusing to patients who may wrongly believe that clinical psychologists are medical doctors. Initially, clinical psychologists assessed mental states (especially intelligence) and devised personality and IQ tests for patients. Recently, they have become involved more in management and treatment, especially of certain kinds of conditions such as neuroses, using specific treatments such as behaviour therapy. They are restricted to the use of psychological methods of management treatment and may not prescribe drugs or other physical treatments such as electroconvulsive therapy or any medical procedures. Dentists should be aware of this important distinction, and if any medical treatment needs to be given or continued it is essential that patients are referred to the psychiatrist. However, if measures such as relaxation therapy or hypnosis are needed the patients could be appropriately referred to the clinical psychologist.

Discussion of the team would not be complete without the mention of occupational therapists who play a very important part in the management of many of these patients, especially long-standing patients who need a great deal of rehabilitation. Occupational therapists have developed expert techniques in assessing the chances of rehabilitation, and apply them in the occupational and industrial spheres, helping people to return to full employment.

It is important that dentists know of the existence of the local mental illness team, the point of contact and who to refer patients to for various kinds of illnesses or disorders. It is useful to create a working relationship with specific personnel so that quick, clear advice can be given when necessary. Sometimes, the need for such advice is urgent whilst at other times the need is for a more long-term commitment of support, especially to such patients as chronic schizophrenics and the mentally handicapped.

Material, sites and settings

The main inpatient facility for the mentally ill is still the unit within the district general hospital, although many of the large mental institutions still exist, albeit in a reduced state. The

inpatient facility is required from time to time for all kinds of the mentally ill. It is certainly needed in the case of acute psychotic episodes and sometimes for disturbed neurotics, as well as personality disorders. Sometimes, the patient may be referred to day hospitals or units for assessment and then for daily attendance at these units.

Outpatient facilities involve regular outpatients and both new and long-stay patients. There are usually general adult outpatient clinics as well as special clinics held, for example, for addicts and those with psychosexual problems. The emergence of community psychiatric nurses, facilities in the community, outpatient and day hospitals and day centres reflects the change in emphasis that has occurred in the last thirty years in the UK where community psychiatry has played an increasingly important part.

In addition to the facilities mentioned, there is increasing liaison between psychiatrists and general medical practitioners. The general practitioners will have their own psychiatric staff and psychiatrists may visit health centres or surgeries regularly to see patients or to discuss cases with the general practitioners. Dentists may refer patients for psychiatric advice and assessment direct to psychiatrists or to certain other members of the psychiatric team when appropriate, or they may refer them via their general practitioners. Again, if an acute problem arises in a patient who is being treated for some time then it is possible to call for assistance from a community psychiatric nurse or psychiatric social worker.

One of the dangers of the new emphasis on community care is that there are groups of people within the community who are not in touch with any of the Mental Health or Social Services. These people will fall through the net of community care with resulting deterioration in physical and mental state.

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Chapter 3

Psychiatric disorders

A classification of psychiatric disorders is given in Chapter 2. Three important categories of psychiatric syndrome are recognized, namely neuroses, personality disorders and psychoses. These disorders are discussed in detail in this chapter.

It is important to distinguish neuroses and personality disorders from the other major category of mental disorders, the psychoses. These latter conditions are those recognized by the layman as insanity or madness. In contradistinction to the neuroses and personality disorders, persons with psychoses lack insight and are divorced from reality. They hold false beliefs impervious to reason which are termed delusions. They may also have other severe symptoms such as hallucinations where they will hear 'voices' which do not exist or see 'visions' which have no basis in reality.

NEUROSES

Neuroses or psychoneuroses are minor mental disorders in which the patients suffer or complain of unpleasant symptoms, during the course of which they retain contact with reality and have insight. For example, they may say they have a fear that prevents them leaving the house, yet they know it is absurd. The neuroses, as shown earlier, occur commonly and a great number of people suffer from various neuroses to a varying degree. Though they are regarded as minor mental disorders, often labelled 'breakdowns' or 'nervous illnesses' they are, nevertheless, in their most severe state very crippling and the cause of a great deal of suffering. Because those who suffer from neuroses appear and look quite normal it is difficult for people to understand how much they do suffer. To tell them to 'pull themselves together' is most inappropriate.

Morbid anxiety

Anxiety is a universal emotion. It is an unpleasant feeling or affect, an experience of unease, or of fearful anticipation. There is

Table 3.1 Types of anxiety

Normal	
Morbid	
Generalized (anxiety neurosis)	
Intensive/episodic (panic attacks)	
Focal anxiety (phobic states)	
Obsessional neurosis	Morbid anxiety 'transferred'
Hysterical neurosis	
Neurotic depression neurosis	
Mixed neurosis	
Minor stress disorders	
Post-traumatic stress disorders	

acknowledged normal anxiety which can be used for good effect. For example, a mother's anxiety regarding a child's safety will cause her to warn the child that a fire can burn and harm. However, if this so-called normal anxiety becomes excessive it can have a negative or ill effect on a person and his or her behaviour. Such an anxiety is termed morbid anxiety; this morbid anxiety underlies neurotic states. There are several types of morbid anxiety neurosis (Table 3.1).

Morbid anxiety is a predominant feature of the anxiety neuroses. The anxiety is excessive and experienced as a free-floating, undirected emotional state, (the cause of which the victim is unable to explain) in an otherwise mentally normal individual. Intense episodic anxiety is known as panic attacks. During these, actual physical symptoms predominate, accompanied by fear of a serious consequence such as a heart attack. Where the intense anxiety is focused on a specific item, e.g. an object such as spiders, or situations such as open spaces, it is termed phobic anxiety disorder. Thus, phobic anxiety disorders have the same core symptoms as generalized anxiety disorders, but these symptoms only occur under particular circumstances.

Morbid anxiety also underlines other neurotic states such as obsessional neurosis, hysterical neurosis and depressive neurosis, but the morbid anxiety is 'transferred' into characteristic symptoms which give these neuroses their names.

Anxiety neurosis

In generalized anxiety neurosis there is an undirected or misdirected free-floating anxiety which is inappropriate or out of proportion in intensity and severity or duration to the stimulus.

When this results from some specific identifiable danger it is called fear rather than anxiety. Significantly, anxiety and depression can be differentiated but there is much overlap of the two emotions. This is seen most clearly in a mixed anxiety–depressive state and often in neurotic depression, where a large element of anxiety is often present. Again, anxiety and irritability can be differentiated though they too often coexist.

Anxiety neurosis comprises both physical and psychological symptomology. These can be mixed though one can predominate in a specific patient. The psychological symptoms consist of a core generalized free-floating anxiety, a feeling of unease, undirected with no known cause or accompanied by restless concern and anticipatory fear. Associated with this central anxiety are other psychological symptoms such as inability to concentrate, sensitivity to noise and general restlessness. As these symptoms persist, lack of concentration worsens and the patients feel that they are losing their memory. As a result of this the patients will begin to believe and perhaps say that they are going out of their minds and often add that no-one understands how they feel.

Physical symptoms and signs of anxiety neuroses are in the main the result of an arousal of the autonomic nervous system. As a result of such arousal patients complain of palpitation, dry mouths, panting, shortness of breath, pallor, cold extremities, gastric and intestinal discomfort, churning, choking, tightness in the throat and trembling.

Often, patients worry excessively about their physical state, believing that they have some severe physical condition; hence the need for a medical opinion in order to be able to effectively reassure them. Often sleep is disturbed. They suffer from initial insomnia and find it difficult to go off to sleep. Appetite is poor and there is often accompanying weight loss. Sometimes the psychological and physical symptoms occur together, but not necessarily so. Sometimes the general anxiety is prominent with little somatic manifestation.

Behaviour can be affected to a significant degree. The patients may not be able to perform at work, college or school to their usual standards so their work suffers, adding further fuel to the fire and making them more anxious. Some young people, at this point, tend to 'run away' from the situation and stay away from school or college.

Anxiety states can also be assessed according to the time factor. Acute anxiety states come on quickly, are quite severe and of short duration, while chronic anxiety states are persistent and long standing. Sometimes an acute on chronic state may occur