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The power of interpersonal relationships in dentistry and patient's pain

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Dental pain is a signal which can shape the individual psychological reaction on the one hand (Barber, & Adrian, 1982) and the interpersonal relation between the doctor and patient on the other hand, holding both organized and psychogenic components, with mixed origins (Feldman, 2004).

The psychological participation in the pain process, includes sensory modality reaction experienced by the patient (Tenenbaum, Mock, Gordon, Goklberg, Grossi, Locker, & Davis, 2001), peripheral components of pain - including reactions specific to the patients personality (Frischenschlager, & Pucher, 2002); preexistent emotional disorders which cause the pain to be more frequent and intense in correlation with the stress that appeared (Chapman, & Gavrin, 1999) and not lastly the problem of psychosocial "learning" of painful manifestations (Melamed, & Mealiea 1981; Littlewood, & Mitchell, 1998).

In dentistry there are present a high number of stress factors, capable of causing a psychogenic pain: anxiety, depression, even the patient's relation with the dentist and the general health status of the patient. All of these factors can influence the quantity and quality of pain (Asmussen, Peutzfeldt, & Sahafi, 2005).

Patients with pain will express in psychological language, even if this is an organ involved. For this reason in this case pain is hard to be taken as an indicator of organic structure (Hendricson, & Cohen, 2001; Klingberg, & Broberg, 2007).

For patients with a long medical history, many times dentistry therapy could have a lower efficiency. Dentist's experiences with this type of patients are often difficult (Abrahamsson, Berggren, Hallberg, & Carlsson, 2002). The dentistry issue is situated in a framework that includes past experiences of patients in terms of response to stress, anxiety, and the manner in which they evolved other bodily disorders (Klasser & Greene, 2009). Another important issue is the personality structure of every patient.

The dentist also faces in his area of expertise with the psychiatric state of his patients, which is a important factor in the perception of pain (Fenton, Hood, Holder, May, & Mouradian,

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2003). It seems that patients with emotional disorders are more sensitive than the other individuals (Locker, 2003).

Most tolerant to dental pain are known to be sociopathic personalities, presenting a low level of emotional response (Blair, 2001) while schizophrenics have a high level of tolerance towards pain, being capable of self inflicted dental mutilations (Bochner, 1988).

The issue of learned behaviors represents another category encountered in the dentistry domain. The explanation is based on the fact that if physical suffering in childhood were treated with kindness, then the child will learn that pain can be communicated to the dentist and will not be accompanied by a high level of anxiety remains viable (Smith, & Freeman, 2010).

The answer to pain is an individual variable but experimental data have clarified the psychological aspects of pain, finding that an individual modifies his subjective assessment of pain intensity when the experimenter manipulates the factors concerning the origin or the importance of pain. The cognitive model the patient develops during his encounter with pain will influence pain coping strategies (Crisson & Keefe1988).

Anxiety and fear are the most common emotional answers that accompany painful behavior (Asmundson & Katz, 2009). If anxiety rises before or after beginning the treatment, the pain threshold will decrease and will influence the sensitivity of the patient. Also in the case of chronic anxiety the sensitivity of pain increases (Asmundson & Taylor, 1996). Most of the pain perception by the patient is actually under the control of the dentist (Baron, Logan, & Hoppe, 1993).

The knowledge level of therapeutic maneuvers will dispel the uncertainty of what will happen, which is the reason why the dentist must provide patients a true "map" of the situations treatment, focusing on the following aspects: what steps and what intensity, the approximate duration of labor, a clear description of the main periods of labor and what the patient will feel during the treatment.

The information and explanations reduce ambiguity and uncertainty (Ng, SChau, & Leung, 2004).

In dentistry, after sedation many patients are for example: anxious, suffer from extra systoles, chest pain, in which case a simple explanation could solve these phenomena (Girdler, Hill, & Wilson, 2009). Also anxiety and pain level are much lower if the patient has the opportunity during therapeutic maneuvers to attain some control. All of these strategies are relatively ease for the dentist.

Over time the experiences of dental office visits imprint the subject with a negative image pattern which is based on the anxiety felt. When asked what they remember about the visits to the dentist for the purpose of treatment, most subjects related mostly felt anxiety (Earl, 1994). Similarly, anxious patients reported the period of pain of up to three consecutive months from last

receiving dental treatment at the dentist, despite immediate reports that did not record painful phenomena (Stouthard & Hoogstraten, 1987; Freeman, 1991).

Dentist-patient relationship demonstrates the power of interpersonal relationships particularly important in dentistry. The dentist should be seen by the patient as an empathetic personality, reliable, supportive, patient oriented. In addition to chemotherapy pain can be controlled trough non-pharmacological methods like hypnosis (Roberts, 2006; Glazer, 2002).

The relation between dentist - patient has major significance in this cycle which can redirect and reduce organic and psychological stress, pain and anxiety by establishing appropriate therapeutic alliances adequately fitted in a positive plan, alliances translate in treatment application (from the dentists perspective) and raising the confidence from the subject.

References

Abrahamsson, K. H., Berggren, U., Hallberg, L., & Carlsson, S. G. (2002). Dental phobic patients' view of dental anxiety and experiences in dental care: a qualitative study. *Scandinavian journal of caring sciences, 16*(2), 188-196.

Asmussen, E., Peutzfeldt, A., & Sahafi, A. (2005). Finite element analysis of stresses in endodontically treated, dowel-restored teeth. *The Journal of prosthetic dentistry, 94*(4), 321-329.

Asmundson, G. J., & Katz, J. (2009). Understanding the co-occurrence of anxiety disorders and chronic pain: state-of-the-art. *Depression and anxiety, 26*(10), 888-901.

Asmundson, G. J., & Taylor, S. (1996). Role of anxiety sensitivity in pain-related fear and avoidance. *Journal of behavioral medicine, 19*(6), 577-586.

Barber, J., & Adrian, C. (Eds.). (1982). *Psychological approaches to the management of pain*. Psychology Press.

Baron, R. S., Logan, H., & Hoppe, S. (1993). Emotional and sensory focus as mediators of dental pain among patients differing in desired and felt dental control. *Health Psychology, 12*(5), 381.

Bochner, S. (1988). *The psychology of the dentist-patient relationship*. Springer Science & Business Media.

Blair, R. J. R. (2001). Neurocognitive models of aggression, the antisocial personality disorders, and psychopathy. *Journal of Neurology, Neurosurgery & Psychiatry, 71*(6), 727-731.

Chapman, C. R., & Gavrin, J. (1999). Suffering: the contributions of persistent pain. *The Lancet, 353*(9171), 2233-2237.

Crisson, J. E., & Keefe, F. J. (1988). The relationship of locus of control to pain coping strategies and psychological distress in chronic pain patients. *Pain, 35*(2), 147-154.

Earl, P. (1994). Patients' anxieties with third molar surgery. *British Journal of Oral and Maxillofacial Surgery, 32*(5), 293-297.

Feldman, J. B. (2004). The neurobiology of pain, affect and hypnosis. *American Journal of Clinical Hypnosis, 46*(3), 187-200.

Fenton, S. J., Hood, H., Holder, M., May, P. B., & Mouradian, W. E. (2003). The American Academy of Developmental Medicine and Dentistry: eliminating health disparities for individuals with mental retardation and other developmental disabilities. *Journal of Dental Education, 67*(12), 1337-1344.

Freeman, R. (1991). The role of memory on the dentally anxious patient's response to dental treatment. *Irish Journal of Psychological Medicine, 8*(02), 110-115.

Frischenschlager, O., & Pucher, I. (2002). Psychological management of pain. *Disability & Rehabilitation, 24*(8), 416-422.

Girdler, N. M., Hill, C. M., & Wilson, K. (2009). *Clinical sedation in dentistry*. John Wiley & Sons.

Glazer, D. (2002). Hypnosis in Dentistry. *International Handbook of Clinical Hypnosis*, 285-298.

Hendricson, W. D., & Cohen, P. A. (2001). Oral health care in the 21st century: implications for dental and medical education. *Academic Medicine, 76*(12), 1181-1206.

Klasser, G. D., & Greene, C. S. (2009). The changing field of temporomandibular disorders: what dentists need to know. *J Can Dent Assoc, 75*(1), 49-53.

Klingberg, G., & Broberg, A. G. (2007). Dental fear/anxiety and dental behaviour management problems in children and adolescents: a review of prevalence and concomitant psychological factors. *International Journal of Paediatric Dentistry, 17*(6), 391-406.

Littlewood, S. J., & Mitchell, L. (1998). The dental problems and management of a patient suffering from congenital insensitivity to pain. *Int J Paediatr Dent, 8*(1), 47-50.

Locker, D. (2003). Psychosocial consequences of dental fear and anxiety. *Community Dentistry and Oral Epidemiology, 31*(2), 144-151.

Melamed, B. G., & Mealiea Jr, W. L. (1981). Behavioral intervention in pain related problems in dentistry. In *The comprehensive handbook of behavioral medicine* (pp. 241-259). Springer Netherlands.

Ng, S. K., Chau, A. W., & Leung, W. K. (2004). The effect of pre-operative information in relieving anxiety in oral surgery patients. *Community dentistry and oral epidemiology, 32*(3), 227-235.

Roberts, K. (2006). Hypnosis in dentistry. *Dental update, 33*(5), 312-314.

Smith, P. A., & Freeman, R. (2010). Remembering and repeating childhood dental treatment experiences: parents, their children, and barriers to dental care. *International Journal of Paediatric Dentistry, 20*(1), 50-58.

Stouthard, M. E. A., & Hoogstraten, J. (1987). Ratings of fears associated with twelve dental situations. *Journal of dental research, 66*(6), 1175-1178.

Tenenbaum, H. C., Mock, D., Gordon, A. S., Goklberg, M. B., Grossi, M. L., Locker, D., & Davis, K. D. (2001). Sensory and affective components of orofacial pain: is it all in your brain?. *Critical Reviews in Oral Biology & Medicine, 12*(6), 455-468.